International Journal of Humanities & Social Science Studies (IJHSSS)
A Peer-Reviewed Bi-monthly Bi-lingual Research Journal
ISSN: 2349-6959 (Online), ISSN: 2349-6711 (Print)
Impact Factor: 6.8
Volume-XI, Issue-VI, November 2025, Page No. 62-68
Published by Scholar Publications, Sribhumi, Assam, India, 788711
Website: http://www.ijhsss.com
DOI: 10.29032/ijhsss.vol.11.issue.06W.157

From India to Westminster: The British Encounter with Cannabis in India and the Making of Imperial Drug Policy (1800–1930)

Smt. Saptaparna Maitra
Assistant Professor, Dinabandhu Mahavidyalaya, Bongaon, Kolkata, West Bengal, India

Received: 08.10.2025; Accepted: 07.11.2025; Available online: 30.11.2025
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Abstract

This article examines the complex British encounter with cannabis in India from the early nineteenth to the early twentieth century, tracing how colonial governance, metropolitan science, parliamentary debate, and medical practice shaped its global fate. Although cannabis—known locally as bhang, ganja, and charas—had deep cultural and medicinal roots in South Asia, British officials framed it as a "discovery" and reinterpreted its uses through imperial scientific and administrative lenses. The article begins with William Brooke O'Shaughnessy's influential Bengal experiments, which introduced "Indian hemp" into Western therapeutics. It then explores the colonial state's excise regimes, the anxieties over "hemp insanity," and the fiscal-moral dilemmas that culminated in the Indian Hemp Drugs Commission (1893–94). The Commission's vast inquiry emphasized regulation over prohibition, balancing indigenous practices with imperial control. Meanwhile, scientific circles in London, particularly through the Royal Society's networks, debated cannabis's therapeutic potential even as its clinical reliability waned. Parliamentary debates reflected missionary and temperance critiques, but ultimately relied on the Commission's moderate conclusions until the international narcotics regime of the 1920s shifted policy toward prohibition. The article also considers parallel developments in Egypt, South Africa, and the Caribbean, where racialized labor politics shaped harsher restrictions. By situating cannabis at the intersection of medicine, empire, and global control, the article demonstrates how pragmatic regulation in India gave way to twentieth-century prohibition, highlighting the contingent nature of drug policy within imperial frameworks.

Keywords: Cannabis Regulation in Colonial India, Indian Hemp Drugs Commission (1893–94), Imperial Medicine and Narcotics Policy, British Colonial Governance and Cannabis, Global Prohibition and Empire

Introduction:

The British encounter with cannabis in South Asia produced a dense tangle of medical enthusiasm, administrative caution, scientific curiosity, and moral anxiety. Nineteenth-century officials, physicians, and metropolitan commentators often wrote as if they had 'discovered' a strange narcotic in India—bhang, ganja, and charas—whose social embeddedness and therapeutic promise sat uneasily alongside fears about insanity, idleness, and imperial order. The colonial state oscillated between fiscal pragmatism and moral scrutiny; learned societies and scientific circles in London absorbed and recirculated tropical knowledge; Parliament intermittently interrogated the substance's effects; and medical practitioners within and beyond India experimented with preparations,

documented case histories, and argued over etiology. This article synthesizes these strands to reconstruct how the 'British discovery' of cannabis in India unfolded and how diverse imperial actors— colonial governments, the Royal Society–centred scientific world, the House of Commons and Lords, and medical practitioners— debated and dealt with cannabis in India and other colonies. While the substance had millennia of cultural life in South Asia, the British recontextualized it through the apparatuses of empire: dispensaries, excise departments, asylum statistics, blue books, and metropolitan debates (Mills, 2003; Booth, 2003; Abel, 1980).

Two features define this history. First, cannabis knowledge travelled along imperial circuits. The Calcutta Medical College, the Bengal dispensary tradition, and Presidency surgeons mediated reports to metropolitan audiences; these circulated through journals, lectures, and society meetings before informing parliamentary queries and administrative reforms (Mills, 2003). Second, responses to cannabis were never unitary. Provincial governments crafted revenue regimes and licensing systems; scientists debated pharmacology; MPs staged intermittent moral inquiries; and doctors produced contradictory findings, especially around "hemp insanity." The Indian Hemp Drugs Commission (1893–94) became the hinge: it assembled an unprecedented ethnographic, medical, and administrative archive and recommended regulation rather than prohibition— an outcome that would shape policies across the empire well into the twentieth century (Government of India, 1894/2010; Mills, 2003).

Framing a "Discovery": Knowledge, Translation, and O'Shaughnessy:

To speak of British 'discovery' is to highlight an imperial gaze that reframed established South Asian practices as new to the West. Cannabis preparations—bhang (leaf beverage), ganja (flowering tops), and charas (resin)—were woven into ritual calendars, leisure, and indigenous pharmacopeias across India (Clarke & Merlin, 2013; Warf, 2014). What changed under British rule was the translation of this knowledge into the idiom of metropolitan science and the colonial clinic. The emblematic figure was William Brooke O'Shaughnessy, an Irish physician in Bengal whose experiments in the late 1830s and early 1840s introduced "Indian hemp" to anglophone therapeutics. O'Shaughnessy's *The Bengal Dispensatory* catalogued the plant's preparations and reported dramatic successes in analgesia, spasm control, and infantile convulsions—case narratives that would echo through Victorian medicine (O'Shaughnessy, 1842).

O'Shaughnessy's interventions mattered for three reasons. First, they stabilized 'Indian hemp' as an object of pharmacological inquiry by specifying preparations and doses— tinctures, extracts, and resins—rather than relying on anecdotal travel writing. Second, they mobilized the colonial laboratory and hospital as sites of credible evidence, aligning tropical materia medica with metropolitan scientific standards. Third, they linked therapeutic promise to administrative caution: even as doctors praised sedative and antispasmodic effects, administrators asked whether intoxicant markets should be taxed, licensed, or curtailed (Mills, 2003; Abel, 1980).

The Colonial State: Revenue, Regulation, and "Hemp Insanity":

From the 1830s through the 1890s, Indian provincial governments confronted cannabis primarily as an excisable commodity. The excise departments' regimes—licensing cultivation areas, auctioning retail shops, and taxing production—mirrored those for opium and alcohol but retained distinctive features tied to agronomy and regional custom (Mills,

2003). Ganja cultivation concentrated in districts such as Rajshahi; charas entered from Himalayan zones or across frontiers; bhang use was diffuse and culturally embedded. Administrators produced copious data: shop numbers, seizures, consumption estimates, and asylum admissions. Such numeracy both justified control and generated anxiety when correlations—especially between "hemp use" and insanity—seemed suggestive.

'Hemp insanity' became the most charged claim in official correspondence. Asylum superintendents occasionally listed cannabis among precipitating factors for admissions, and spectacular cases—delirium, violence, psychosis—attracted administrative attention. Yet statistical attribution was unstable: diagnostic categories varied, self-reports were unreliable, and comorbidities (alcohol, poverty, infectious disease) complicated causal narratives (Mills, 2003). Administrators faced an awkward calculus: cannabis revenues were significant, particularly for provincial coffers, but moral pressure—from missionaries, temperance advocates, and some medical men—pushed toward stronger control. The compromise was incremental: tighter licensing, restrictions on adulteration, surveillance of 'drugs shops,' and periodic local prohibitions where "public opinion" demanded (Government of India, 1894/2010).

The Indian Hemp Drugs Commission (1893–94): Empire's Grand Inquest:

Parliamentary questions in London and pressure from temperance and missionary groups culminated in the appointment of the Indian Hemp Drugs Commission, an eight-member body that took testimony across the subcontinent, consulted medical experts, collected asylum and excise data, and produced a seven-volume report. Few colonial inquiries rival its scope. The Commission's core findings punctured two common claims: that moderate hemp use was a major cause of insanity and that prohibition would be administratively or socially desirable. Its conclusions emphasized a gradient: occasional and moderate consumption produced limited harm; excessive use carried risks (mental disturbance, dyspepsia, social neglect); and policy should target abuses while respecting entrenched custom (Government of India, 1894/2010).

The Commission's method and rhetoric were revealing. It integrated indigenous knowledge—hakims, vaidyas, cultivators—into a bureaucratic archive, performing the cosmopolitanism of late-Victorian social inquiry while subordinating vernacular expertise to imperial reason. It also framed policy in fiscal-administrative terms: licensing and taxation would better contain abuse than blunt prohibition, which would stimulate illicit markets and alienate populations (Mills, 2003). The report's afterlife was long. Its moderation furnished a touchstone for defenders of regulation in India and offered precedents for other colonies whose administrations faced rising moral politics around intoxicants (Booth, 2003; Mills, 2003).

London's Scientific World: The Royal Society and the Circuits of Credibility:

While the Royal Society itself did not legislate drug policy, it formed part of a metropolitan knowledge ecosystem that authenticated colonial science. Tropical materia medica flowed from India to London via officers of the Indian Medical Service, botanical collectors, and correspondents who deposited specimens, papers, and claims into networks that included the Royal Society, the Royal College of Physicians, the Pharmaceutical Society, and allied learned bodies. The imprimatur of these institutions—through notices, lectures, and transactions—conferred legitimacy on colonial observations and catalyzed further experimentation (Abel, 1980; Mills, 2003).

In this circulatory system, cannabis occupied an ambiguous status. On one hand, O'Shaughnessy's Bengal work and its metropolitan uptake produced an early therapeutic vogue: tinctures and extracts appeared in dispensatories; pharmacists stocked preparations; and clinicians reported successes in pain and spasm management (O'Shaughnessy, 1842; Abel, 1980). On the other hand, the unpredictable pharmacokinetics of nineteenth-century preparations—variable resin content, inconsistent dosing—yielded uneven clinical results. As the century wore on, newer alkaloidal drugs with more stable profiles (e.g., morphine, chloral hydrate) overshadowed cannabis in British practice. Scientific societies thus hosted debate more than consensus: was cannabis a promising sedative or an unreliable intoxicant? The answer depended on preparation, dose, and clinical aim, and many practitioners hedged (Abel, 1980; Booth, 2003).

Parliamentary Scrutiny: Moral Politics, Empire, and the Question of Harm:

Parliament engaged cannabis episodically, often as part of larger conversations about imperial intoxicants. In the 1890s, missionary petitions and temperance agitation helped prompt inquiries into Indian hemp, crystallizing in the Commission. MPs navigated competing values: respect for indigenous custom; concern about public order and 'native welfare'; faith in fiscal prudence; and an emerging humanitarian critique of intoxicants. The Commission's conclusions gave Parliament a technocratic refuge: moderate, culturally sensitive regulation could align imperial responsibility with administrative efficiency (Government of India, 1894/2010; Mills, 2003).

After World War I, international drug control regimes reframed the landscape. The Geneva Opium Conferences (1920s) and subsequent conventions extended surveillance from opiates and cocaine to cannabis. Metropolitan policy hardened: by 1928, Britain added Indian hemp to domestic dangerous drugs controls, though medicinal exceptions and scientific attention persisted. Parliamentary debates increasingly nested cannabis within a moralized global narcotics narrative, less tied to Indian social life than to international treaty obligations and domestic policing (Booth, 2003; Mills, 2003). Thus, the imperial arc ran from Indian regulation premised on custom to metropolitan prohibition premised on treaty discipline—a shift that strained the earlier Commission's ethos.

Medical Practitioners: Clinical Enthusiasm, Asylum Statistics, and Therapeutic Drift:

Across the nineteenth century, physicians in India and other colonies explored cannabis's therapeutic and toxicological profile. Clinical enthusiasm was especially pronounced in the 1840s–1860s: case reports recounted relief of tetanus spasms, neuralgia, and dysmenorrhea; pediatric indications (convulsions) gained notoriety from O'Shaughnessy's striking narratives (O'Shaughnessy, 1842; Abel, 1980). Yet the variability of galenical preparations blunted reproducibility. Without standardized extracts, dose-finding was erratic, and idiosyncratic reactions—euphoria, dysphoria, delirium—frightened physicians. By late century, when alkaloid chemistry and synthetic sedatives promised precision, cannabis slipped toward therapeutic margins in British practice, even as Indian practitioners continued to incorporate it within local pharmacopeias (Mills, 2003; Clarke & Merlin, 2013). Asylum doctors were pivotal in shaping perceptions of harm. Their annual reports catalogued 'causes' of insanity, often listing hemp alongside alcohol. But, as the Commission showed, attribution relied on contested self-report and moral inference. A patient who used hemp might be labelled 'hemp-mad,' but whether the drug was causal or incidental was

uncertain. The Commission's cross-examination of superintendents and statistical critique were influential: it refused to equate correlation with causation and urged administrative modesty (Government of India, 1894/2010). The episode exemplified a broader feature of imperial medicine: the production of numerical knowledge that stabilized administrative action while masking epistemic fragility (Mills, 2003).

Beyond India: Cannabis in Other Colonies:

Egypt and the Eastern Mediterranean

In Egypt—under Ottoman administration, then British occupation from 1882—hashish had a long cultural life and an uneven regulatory history. British administrators inherited prohibitions and customs controls that aimed to suppress imports while taxing what slipped through. Medical commentators recycled Indian debates: was hashish a cause of insanity and crime, or a manageable intoxicant? The Indian Commission's moderation did not translate directly to Egypt, where prohibitionist currents ran stronger and where urban policing made hashish a convenient target (Booth, 2003; Warf, 2014).

Southern Africa

In the Cape and later Union of South Africa, dagga (cannabis) figured in labor and racialized social control. Administrators linked dagga to African and indentured labor communities and debated whether prohibition would stabilize work discipline. Regulatory approaches oscillated—regional bans, fines, and later narcotics controls—foreshadowing twentieth-century criminalization. Here, unlike India, fiscal reliance was weaker, and moral-labor politics more overt (Booth, 2003).

The Caribbean

In Jamaica, Trinidad, and British Guiana, cannabis—often associated with Indian indentured communities—entered colonial attention in the late nineteenth and early twentieth centuries. Officials borrowed frames from India: excise and licensing at first, then rising anxieties about crime and morality as global narcotics discourse hardened. Missionary critiques and elite fears of working-class leisure shaped prohibitive turns in the 1910s–1920s, culminating in local bans aligned with British metropolitan policy after 1928 (Booth, 2003; Warf, 2014).

Across these geographies, a pattern emerges: where cannabis was culturally embedded and fiscally useful (India), regulation dominated; where officials linked it to "undesirable" populations or labor disorder (South Africa, Caribbean), prohibitionist moves appeared earlier; and after the 1920s, international treaties drew colonies toward a shared prohibitive template (Mills, 2003; Booth, 2003).

Race, Class, and the Politics of Intoxication

British responses to cannabis were never purely pharmacological. They were saturated with assumptions about race, class, and civilization. In India, officials could respect bhang as a 'harmless' festival drink for respectable Hindus while denouncing ganja or charas as the resort of mendicants and the 'idle poor.' In South Africa and the Caribbean, cannabis was marked as the intoxicant of racialized laborers, reinforcing paternalist and coercive governance. Such hierarchies informed excise zoning, policing priorities, and the rhetorical escalation from 'drug' to 'danger' (Mills, 2003; Booth, 2003). The IHDC's insistence on a harm gradient was a partial check against moral absolutism, but its methodology also

domesticated difference: by assimilating Indian practice to bureaucratic categories, it legitimated control even as it rejected prohibition.

Science, Standardization, and the Fate of Cannabis in British Medicine

Why did cannabis, so promising in the 1840s, recede in British therapeutics by the fin de siècle? Three structural shifts mattered. First, chemistry and industrial pharmacy privileged alkaloids and later synthetics whose dose-effect curves could be standardized—morphine, codeine, chloral, barbiturates—while resinous cannabis resisted uniform extraction and quality control with nineteenth-century techniques (Abel, 1980). Second, professional authority reorganized around clinical trials, hospital statistics, and laboratory physiology; case-based enthusiasms lost prestige. Third, international narcotics control reframed cannabis as a problem rather than a resource, discouraging pharmaceutical investment and narrowing legitimate indications (Booth, 2003; Mills, 2003). The result was a paradox: colonial India continued to normalize moderate cultural use under licensing, while metropolitan Britain drifted toward prohibitive law and therapeutic neglect.

Parliament, Treaties, and the Turn to Prohibition

Between the IHDC and the interwar period stood the rise of international drug control. Britain, a chief architect of the League of Nations' narcotics regime, gradually expanded its domestic dangerous drugs lists to include cannabis. By 1928, British law criminalized non-medical dealings while tolerating strictly circumscribed pharmaceutical uses. Parliamentary debates referenced foreign pressures and domestic duty rather than Indian custom; the idiom shifted from imperial governance to national and international public health. This legal turn influenced colonies: administrators introduced prohibitions or tightened regimes to align with metropolitan policy and treaty obligations (Booth, 2003; Mills, 2003). In doing so, they eclipsed the IHDC's nuanced balance with a one-size prohibitionism that would dominate the twentieth century.

Conclusion:

The British 'discovery' of cannabis in India was less a singular event than a layered process: the translation of indigenous practices into colonial pharmacology; the inscription of intoxicant markets into fiscal-administrative regimes; the staging of scientific credibility across Calcutta and London; the politicization of harm in Parliamentary debate; and the diffusion of policy across an empire marked by racial and labor hierarchies. The Indian Hemp Drugs Commission stands as the emblem of late-Victorian technocracy: comprehensive, empiricist, skeptical of moral panic, and oriented toward regulation. Yet its legacy was overtaken by twentieth-century prohibition shaped by international treaty politics and the ascendancy of standardized pharmaceuticals. That arc—from discovery to doubt, regulation to prohibition—demonstrates how imperial knowledge-making and governance co-produced the modern meanings of cannabis. It also suggests a counterfactual: had the IHDC's calibrated model, grounded in cultural pragmatism and graded harm, remained authoritative, the global history of cannabis regulation might have unfolded differently.

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