Drug Legalization, Democracy and Public Health: Canadian Stakeholders' Opinions and Values with Respect to the Legalization of Cannabis

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The legalization of cannabis in Canada instantiates principles of harm-reduction and safe supply. However, in-depth understanding of values at stake and attitudes toward legalization were not part of extensive democratic deliberation. Through a qualitative exploratory study, we undertook 48 semi-structured interviews with three Canadian stakeholder groups to explore opinions and values with respect to the legalization of cannabis: (1) members of the general public, (2) people with lived experience of addiction and (3) clinicians with experience treating patients with addiction. Across all groups, participants tended to be in favor of legalization, but particular opinions rested on their viewpoint as stakeholders. Clinicians considered the way legalization would affect an individual's health and its potential for increasing rates of addiction on a larger scale. People with lived experience of addiction cited personal autonomy more than other groups and stressed the need to have access to quality information to make truly informed decisions. Alternatively, members of the public considered legalization positive or negative in light of whether one's addiction affected others. We elaborate on and discuss how scientific evidence about drug use impact values relates and how can different arguments play in democratic debates about legalization.

Introduction

Almost a century after the criminalization of cannabis in Canada, the federal criminal law surrounding possession and use of cannabis was amended on 17 October 2018 (Tattrie, 2016). The set of new regulations (the Cannabis Act) provides a legal framework for the possession and use of cannabis (Government of Canada, 2018). The Canadian federal government enacted this legislation to outcompete organized crime in the cannabis industry and to adapt to the growing social acceptability of cannabis use in Canada. In preparation for this legislative change, Health Canada engaged in regulatory consultations in various formats (i.e. online submissions, written submissions, roundtables and web-based discussions) to solicit the perspectives of diverse Canadian stakeholders on pre-identified elements of discussion centered on the proposed governmental system of licenses, permits, authorizations and related rules and requirements for the different kinds of authorized activities (e.g. cannabis tracking systems, licenses, product labeling; Health Canada, 2018). This activity amounted to several hundred responses and submissions of individuals, community groups, industry representatives, provincial and territorial representatives, and Indigenous governments and representative organizations (for further details, please see: Health Canada, 2018). Public health experts were also consulted, among other groups involved in the policy amendments (e.g. industry, municipalities, provincial governments, patients, law enforcement) while academics also debated the issue (Fischer *et al.*, 2016; Kalant, 2016). Yet, 5 years after its enactment, objective evaluations of the successes and shortcomings of the Cannabis Act are few and complex. While the Canadian government has been commended for favoring a harm-reduction approach with the policy change (Cox, 2018), it has also been criticized for prioritizing the cannabis industry's interests over those of public health (DeVillaer, 2019; Koutouki and Lofts, 2019). Much of the policy's implementation has been left to the provincial and territorial governments, including age restrictions and retail structures, which has led to national inequities in prioritization and regulation. In parallel, much of the public's response, albeit mostly welcoming, has been detached from (public) health matters. For example, Canadian print media engaged significantly with the economic aspects of legalization (Sorensen *et al.*, 2022) and social media users acclaimed cannabis use as a lifestyle choice (van Draanen *et al.*, 2020).

Drug legalization and drug policy generally have tended to be deeply rooted in traditional morality as well as racism and xenophobia (Earp *et al.*, 2021). Considering these more traditional and dogmatic policies are being questioned—especially in light of their impact on people's well-being and autonomy (Rochette *et al.*, 2021), the process of opening debates about the impact of drug policies comes as a sign of democratic and scientific progress. Pragmatic ethics provides a particularly helpful lens in analyzing the democratic aspects of promoting personal empowerment and social change through public health policies such as decriminalizing illicit substances. Pragmatic ethics is perhaps best described not as a distinctive normative ethics theory competing with theories such as virtue ethics or principlism, but as 'a method for understanding better – or reconstructing – already existing theories, and more generally, a method that enables greater awareness of our actual moral life' (Serra, 2010). It invites a return to experience such that, for example, a topic like drug legalization is viewed not only in terms of traditional moral principles[1] but most importantly in light of actual real-world experiences, behaviors and aspirations. Also, it calls upon developing ethical approaches which are flexible and adaptive to the evolution of social practices and scientific knowledge by favoring democratic and open-ended methods (Pappas, 2008). In other words, pragmatic ethics proposes to put morality to the test of inquiry (Martela, 2015, 2017).

This orientation is particularly relevant in conducting research in an area like drug legalization policies because it supports the shift from historical dogmatic and moralizing positions (Courtwright, 2001) to democratic and scientific ones for which others advocated (Blachman *et al.*, 1989). Accordingly, a change in policy such as the Canadian legalization of cannabis is a pertinent historical event for investigating how it impacts people with different backgrounds and lived realities. Understanding the potential differences of opinions and values between various individuals and groups toward the legalization of cannabis is important within a democratic public health ethics model (Jennings, 1990; Massé, 2003) notably in light of a pragmatic ethics orientation (Pappas, 2008). Not only can such an investigation shed light on the many angles with which stakeholders and other individuals approach the topic, so too are their opinions constitutive of what renders this policy change ethical or not in light of their experiences and aspirations. To make headway in this direction we undertook a qualitative, interview-based study with (1) people with lived experience of addiction,[2] (2) clinicians with experience treating patients with addiction and (3) members of the general public. Although this sampling is limited for practical reasons, it offers the potential to broaden the understanding of views and values toward the legalization of cannabis in Canada. In doing so, we join prior efforts to use qualitative methods to understand various aspects of cannabis use, including uptake of substance use-related services (Turuba *et al.*, 2022), attitudes of clinicians toward the broadening of access to medical use of cannabis to youth (Gunning *et al.*, 2022) and patterns of purchase of cannabis products (Donnan *et al.*, 2022). The recent literature has focused on the qualitative investigation of the impact of cannabis on mental health (e.g. Ghelani, 2021) as well as emerging questions related to the use of cannabis medically (e.g. Bottorff *et al.*, 2013; Elliott, 2020; Gibbard *et al.*, 2021; Gunning and Illes, 2021; McTaggart-Cowan *et al.*, 2021; Ng *et al.*, 2021; Gunning *et al.*, 2022). There has been less attention granted to legalization beyond the medical context in qualitative research which supports our effort to investigate this topic from different perspectives on cannabis use outside of that context.

Aim

This study aims to explore the opinions and values of three stakeholder groups regarding the legalization of cannabis in Canada. These groups are: (1) people with lived experience of addiction, (2) clinicians with experience treating patients with addiction and (3) members of the general public.

Method

Study Design

This qualitative study utilized semi-structured in-depth interviews (Poupart, 1997). During the months of February–August 2019, 48 interviews were conducted among three stakeholder groups to explore opinions and values toward the legalization of cannabis in Canada. Participants were recruited as part of a larger study on voluntary decision-making within the context of drug addiction. The results reported in this paper rely exclusively on the analysis of participant's responses to the following open-ended interview question (as part of a longer interview): *What are your thoughts on the recent legalization of cannabis in Canada?* Probing questions that delved into the possible advantages or disadvantages of cannabis legalization, and the amount and quality of educational information made available to the public were also asked. In general, the pragmatic orientation of the study led us to develop an open discussion to hear relevant values and real-world experiences toward cannabis and drug legalization.

Participants

People with lived experience of addiction

Sixteen persons with lived experience of addiction were interviewed for this study. To be eligible, participants had to have experienced a (self-reported) addiction, whether prior to or during the study. Participants were recruited via online advertisements posted on a social media platform (Facebook) and a Canadian-based classified ad website (Kijiji). These posts selectively targeted three major Canadian cities affected by drug use and frequently investigated in public health studies (Toronto, Montreal and Vancouver) (Werschler and Brennan, 2019). Interested participants responded to these ads by contacting the third author (CB) directly. After initial screening for eligibility, participants were scheduled for an interview. This group comprised of nine men and seven women, with those stating their ages ranging between 22 and 55 years of age (n = 15; mean = 36.53; SD = 10.34). Participants self-identified as having developed an addiction, for some point in time, to at least one of the following drugs: alcohol, cannabis, prescription drugs, cocaine, crack cocaine, nicotine, hallucinogens, cough syrup, ketamine and amphetamine (*speed*). Many participants reported addictions to multiple substances.

Clinicians

Sixteen addiction clinicians were interviewed for this study.[3] To be eligible to participate in the study, members of the clinicians' group had to have experience in addiction treatment. Participants were recruited by purposeful sampling and through professional networks. The group comprised of eight men and eight women. A wide variety of specializations were noted: addiction counseling, family medicine, addiction medicine, addiction psychiatry, clinical psychology, nursing and infectious diseases. These participants also worked in diverse clinical contexts: addiction care centers, hospitals, medical clinics, clinical research centers and ambulatory services. The clinicians who stated their years of practice had anywhere from 8 to 44 years of practice in addiction (n = 14; mean = 19.07; SD = 10.64).

Members of the public

Sixteen members of the public were interviewed for this study. To be eligible, participants had to have never experienced drug addiction prior to and during the study.[4] Participants in this group were recruited via the same strategies as people with lived experience of addiction. The group was comprised of seven men and nine women, between the ages of 23 and 70 years old (n = 16; mean = 40.25; SD = 16.15).

Procedure

After receiving ethics approval for the larger study by the Institut de recherches cliniques de Montréal's research ethics board, tailored recruitment for each specific group was carried out as described above. All participants were mailed a \$50 CAD check as compensation for their participation. The majority of interviews were conducted in English by CB (n = 43). Some participants (n = 4) expressed a desire to participate in French; these interviews were conducted by MR and MV. Participants' identifying information was kept securely by CB. All material was anonymized before being made available to the rest of the research team.

Transcription, Coding and Data Analysis

Most audio recordings were sent to an independent professional transcriptionist via an encrypted file transfer system (n = 45) or transcribed by a member of the research team (n = 3). The French interviews were first transcribed in their original language and subsequently translated into English by MR or MV.

Before coding, participant group information and group number were anonymized and hidden, to avoid any potential biases. The coding process was carried out using MaxQDA software 2022 (VERBI Software, 2021, version 12.3.9) and followed the six steps for thematic analysis described in (Braun and Clarke, 2006): (1) data familiarization; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; (5) defining and naming themes; and (6) producing the final report (Braun and Clarke, 2006). Two coders familiarized themselves with the data. The initial coding was led by MR, then discussed with other team members for verification (MV and ER). MV searched for themes, and began the process of defining and naming subthemes, with MR reviewing about 10 per cent of the material to ensure consistency and accuracy, and with punctual revision and input by the research supervisor (ER) for quality assurance. The final definitions were proposed by MV, then submitted to both the first author (MR) and research supervisor for revision and feedback. A coding framework was then generated and applied by MV to generate the final definitions and themes. Last, the report was exported by MR from MaxQDA to map out and interpret any interesting patterns.

In addition to taking a thematic approach, MV undertook an interpretive analysis through which participants' perspectives were classified according to their stance in relation to the factors identified in the thematic analysis. Their stances could be classified as 'positive', 'neutral', 'negative' or 'mixed'. In addition, to convey the nuances in the stances of the participants, the data were further analyzed to establish a distinction between a view expressed irrespective of other specific aspects of legalization (true positive/true negative), and a view explicitly attached to more than one aspects of legalization (relative positive/relative negative). This analysis was also subjected to the process of revisions by MR and ER. In this study, pragmatic ethics influenced our approach to data analysis in the sense that it guided which data should be considered relevant in trying to learn about real-world experiences and values and why these matter at a policy level in a democracy. This pragmatic orientation to data analysis had implications such that high importance was granted to the arguments and points of view shared by the stakeholders. Specifically, the thematic analysis allowed us to identify the topics important to them, and the interpretive analysis allowed us to identify explicitly their personal stances and feelings about these topics, such that our reporting of the stakeholders' real-world experiences was greatly enriched.

In the Results section, when referring to specific participants, we use an anonymous designation made up of an abbreviation based on the participant's group (LE for Lived Experience, P for Public and C for Clinicians) and the participant's interview number. Quantifiers are used sparingly and mostly qualitatively (e.g. a few, some, several, many) consistent with recommendations made in qualitative research on addiction (Neale *et al.*, 2014). Quantification is used in the tables to identify trends which are then explored qualitatively in the text.

Results

The results are organized according to three sections: (1) views on legalization, (2) views on cannabis and cannabis use, and (3) correspondence between themes (1) and (2).

Views on Legalization

In this section, we present the general views of participants on the legalization of cannabis in Canada, then introduce the major themes that emerged as salient for participants when describing or explaining their views.

General view on legalization

We gathered general opinions on legalization of cannabis for 44 out of 48 participants. The extracts in Table 1 are representative illustrations of some of the opinions shared by participants in all groups.

At least half of the participants in each respective group felt positively about the legalization of cannabis. Several reported only enthusiastic feelings (i.e. 'true positive' stances), where some identified it merely as a step in the right direction or as having more advantages than disadvantages (i.e. 'relative positive' stances). Participants expressing a positive attitude, and especially members of the people with lived experience of addiction group, tended to allude to autonomy or choice to found their opinions, often stating that legalization permits people to make more informed decisions about cannabis use, or in the case of relative positive statements, that they considered cannabis a less threatening substance than other legal ones. For example, one participant clinician stated: 'So, if we've legalized alcohol, it seems to me to be something that's rather appropriate for cannabis because on most levels, it poses less risk to public health and security than alcohol does. So, just logically, if we've legalized alcohol, I don't see any reason why we shouldn't have legalized cannabis' (C14, example of a relative positive stance). Another participant with lived experience communicated that: 'I'm absolutely for it […] I think that legalizing it was a very good idea' (LE5, example of a true positive stance).

Many participants held a 'neutral or mixed' stance toward legalization, either because they felt unbothered by its actual and potential implications or because they had both positive and negative feelings about it. For

Table 1. Views on the legalization of cannabis by group

Views on legalization	P	LE	C	Example citation
True positive	3	5	3	'So, I'm very happy with the legalization. I think it's making life better'. (LE8)
Relative positive	7	2	4	'It seems to me to be something that's rather appropriate because on most levels, it poses less risk to public health and security than alcohol does'. (C14)
Neutral or mixed	5	6	5	'I'm fence-sitting on it because I realize there's lots of people who do need to use, [but] there's nothing wrong with responsible recreational use'. (LE13)
Relative negative	1	1	1	'I don't like that one […]. Now kids can bring cannabis as a candy in school'. (P7)
True negative	0	0	1	'It's an absolute bust! It's a flop, it's a joke!' (C10)

example, a participant with lived experience explained: 'I think it doesn't make a difference to anyone who's already smoking it' (LE4, example of mixed or neutral stance). Similarly, a clinician stated: 'I don't see it changing much. It doesn't change our experience with helping addiction, addicts at all. It's the same as before' (C8, example of a mixed or neutral stance).

A few participants saw mostly disadvantages to legalization (i.e. 'relative negative' stances). They invoked reasons such as: legalization makes cannabis too readily available, or the government did not adequately prepare for the process of legalization. When participants were asked about disadvantages of legalization, they tended to name concerns for cannabis consumption among youth, and some expressed dissatisfaction with the fact that the policy change was not accompanied by retroactive measures. For example, a participant from the clinician group stated: 'I'm really tormented on that one. Some people will be harmed by it. Did we have to legalize it before we…? Like, could we have learned a little bit about it before legalizing it perhaps? Not convinced. Not convinced it needed to go that far that quickly' (C5, example of a relative negative stance). Only one participant had exclusively negative feelings about legalization (i.e. 'true negative' stance), and her feelings mainly concerned the government's process and decisions.

Crime, incarceration and policing

Participants who discussed the effectiveness and implications of incarcerating and policing individuals for using or possessing illicit substances generally supported the legalization of cannabis. Clinicians tended not to address issues with drug crimes, except two who stated that they did not believe the legal system was an adequate tool for addressing addiction. Members of the public expressed significant concern about the criminal records of those arrested prior to legalization and the weight of knowing they were criminalized for non-violent offenses. One member of the public who, along with her entire family, had been supporting her brother's struggle with addiction for 20 years, shared the following:

> I think the part that sort of upsets me about it is that there are people that are incarcerated for offenses prior to legalization… that would have… yeah. So, that's the part that grinds my gears. […] And their families' lives have been ruined by them being incarcerated. Or, you know, maybe they're not even still incarcerated, but they have these things on their record, and so they have issues with obtaining gainful employment. (P8, 41 years old)

Similarly, for people with lived experience of addiction, the consequences of heavy policing and politicization of addiction were a concern. For some, this meant 'the cops laying off of [them]' (LE14, 22 years old), while others thought about the benefits of removing charges for small possession, and of freeing up time to focus on policing more dangerous offenses, like impaired driving.

Market, sales and economy

Participants who referred to the positive economic effects of legalizing cannabis mostly referenced the legalization's ability to generate profit and restrict black market activity. Despite this, some participants in the lived experience and clinician groups had negative feelings about this. For example, a 29-year-old male living with a ketamine addiction expressed feeling bothered by the idea of the government 'making money off of [the same people they were putting in jail]' (LE4).

Some clinicians acknowledged the government's goal of reducing illegal sales while denying that the goal had been accomplished through legalization. People with lived experience of addiction saw the economic repercussions of legalization as an opportunity to change the healthcare system around drugs and addiction, providing ideas on how to invest the profits from cannabis sales. For example, one participant, a woman who sought help for alcohol use disorder by following the 12-step treatment program, referred to the possibility of building 'a whole health services around it, from the funds that you get' (LE12, 36 years old).

Information, research and education

Although participants that discussed matters related to information, research and education were mostly happy with the legalization of cannabis, the general sentiment expressed was a need for more information to the public, more thoughtful education efforts and more research on the effects of cannabis. Specifically, there was a very strong feeling, especially among members of the public, that not enough information around safe use was available. Many criticized the government's educational efforts as being 'ridiculous' (LE9, 33 years old) and 'kind of terrible' (LE16, 35 years old), although members of the public tended to see them as helpful more often than other groups.

Whereas participants with lived experience of addiction in general wished for legalization to generate a wider distribution of information on the medicinal and beneficial properties of cannabis, clinicians tended to wish for more widespread communication on the potential for addiction and risky behaviors linked to substance misuse. One member of the public directly attributed their positive view of legalization to the opportunity for more information, noting that legalization is 'great because it means now there are grants that are going into it, and there will be research' (P16, 30 years old). One participant with lived experience of cannabis addiction, however, believed that no amount of information would enlighten the population's decisions, and that only experience with the substance could serve this function (LE8, 35 years old).

Consequences of legalization

Participants who felt positively about legalization mostly thought that either it did not have noticeable consequences or, when prompted about the specific outcomes of legalization, shared the sentiment that it was too early to tell. Some possible consequences were divisive, the most common being the normalization of the cannabis use with, on one side, participants seeing normalization as opening the door to more easily acknowledging substance use problems and seeking help. On the other, normalization was seen as complicating the clinician's role, given that it makes them 'work against the current when [they] are trying to warn [patients] on unwanted consequences' (C2, addiction psychiatry, 15 years of practice) of cannabis use. Some participants reflected on the implications for other drugs. A nurse clinician with over 18 years of experience in the addiction treatment sector said:

> We need to see how that translates societally and see what will happen in the future. But can we do that with cocaine, can we do that with heroin? […] For sure it remains to be evaluated. In an ideal world it would be great if it could be done, but how? (C12)

Accessibility, regulation and production

Participants in all groups expressed the hope that cannabis legalization would bring users the possibility of accessing a safer product, which 'might decrease the harm' (LE11, 52 years old) compared to using products from the illegal market. Many estimated that, prior to legalization, the safe supply of cannabis was lacking, mitigating its potential benefits to users. Since cannabis was considered by participants as being widely available on the black market, they recognized that if the government could not produce the volume necessary to supply its citizens, people would continue to rely on the black market for access. Many expressed, however, that legalization could ensue in at least reduced contact with dealers. This was seen in a good light, both because the quality and purity of products on the illegal market are questionable, and because dealers can sell consumers other stronger, more dangerous drugs. The idea that contacting a dealer is in itself a deterrent to using cannabis was also shared by one participant from the public, who reported growing up in Switzerland where cannabis use was considered normal. This participant said:

> If you had to get it from a dealer, that might prevent some people from trying to access this. Whereas, if you can go to a shop and buy it, and you can send your friend, and it's legal, I think it might be more accessible for the average citizen. (P14, 25 years old)

One clinician with 40 years of experience as a clinical psychologist expressed not understanding why this substance was deemed 'worthy of being legalized and readily accessible and others not' (C14). Last, multiple participants across all groups mentioned notions of control, controlling who buys the product, what form it takes (e.g. edibles were still illegal at the time of interviews), ingredients and who distributes it. This was mostly a welcomed form of control, except for one participant with lived experience of addiction to alcohol, cannabis and prescription drugs, who did not endorse 'institutionalizing and regulating' (LE2, 27 years old) cannabis yet had a neutral stance on the legalization of cannabis as a whole.

Process and execution of legalization

There was a commonly shared understanding, among a subset of participants in all groups, that the legalization of cannabis was expedited too quickly and that it lacked adequate preparation, although only one person directly attributed their negative view of legalization to this. Participants made statements like: 'I don't feel like we were ready for that' (LE13, 43 years old), 'What was the emergency about this?' (P6, 70 years old), 'It's absolutely ridiculous, I find, the way that it's been done. There's been a total loss of control' (C10, family medicine, 15 years of practice), etc. Among other concerns, lack of planning and regulations around impaired driving and edibles were prevalent in discussions on how legalization unfolded in Canada. Interestingly, an addiction psychiatrist expressed that 'How we've done it is probably a careful way to put in place cannabis legalization' (C7, 10 years of practice), but believed there were still important aspects to consider in avoiding potential carelessness with substance regulation.

Minimum age and youth

One theme most associated with a negative view toward legalization concerns how it affects youth and children, and whether the minimum legal age for consumption is adequate. It also emerged as a major concern among participants with neutral/mixed or positive views of legalization. An important subset of these concerns revolved around the thought that setting a minimum age, regardless of the age set, might not work in discouraging cannabis consumption among youth. This view was most common in the public group. Only one participant felt that legalization would have an effect in reducing consumption in youth. This participant, a 22-year-old male who self-identifies as having had addictions to prescription drugs, cannabis and cigarettes, noted:

> I know a lot of people, you know, they didn't drink alcohol till they was like 17, 18 years old because that's the right age, right? But then, when it came to weed, it was like, it was just illegal no matter the age you were, so some people were 14, they were smoking weed, you know? Now I think kids are just going to wait until they're 17 or 18 and then start smoking because they can get it legally. (LE14)

One participant in each group expressed the wish that the minimum age would increase from 18 to 21 or to 25. These participants all referred to research on the effects of drugs on the developing brain to support their opinion.

Views on Cannabis and Cannabis Use

More than half of the respondents ($n = 25$; 10 clinicians, 9 members of the public and 6 people with lived experience) specifically disclosed opinions on cannabis and cannabis use when situating their views on the legalization of cannabis.

General opinion on cannabis and cannabis use

Some trends appeared in the way our stakeholder groups attributed value to cannabis use (refer to Table 2). Specifically, most clinicians viewed it as negative, often stating side effects of long-term drug use and the potential to develop conditions like addiction, lung cancer, etc. That said, there were several clinicians with neutral or mixed views on cannabis and cannabis use, with only one having a positive view. Members of the public showed no particular trend in their views on cannabis, while people with lived experience mostly viewed cannabis positively, with one participant holding mixed views, and one negative. See Table 2 for representative statements explicating the participants' views.

Perceptions toward cannabis consumption

For the social acceptability of cannabis, participants speculated that it was 'a very normalized drug' (LE2, 27 years old), irrespective of its change in legal status. For example, they said: 'I don't think there was ever that much of a stigma' (LE1, 35 years old), and 'People were already smoking all over' (P5, 40 years old). One participant, a member of the lived experience group with a prior addiction to cocaine, acknowledged this normalization while considering it dangerous and comparing it to the acceptability of alcohol. He shared that the people with an addiction to alcohol were 'slowly dying because it's socially acceptable' (LE9, 33 years old), and that it could eventually be the same thing with cannabis.

Table 2. View on cannabis and cannabis use by group

Views on cannabis	P	LE	C	Example citation
True positive	0	2	0	'I think marijuana is a drug that we should be able to have a choice […]; if you want to consume it, you can choose to consume it in a way that feels right to you'. (LE5)
Relative positive	4	2	1	'I think there's a lot of benefits to marijuana use when it comes to like, just medical reasons, you know'. (P3)
Neutral or mixed	2	1	3	'So, you've got a huge spectrum, right? So, on the one hand, very positive and beneficial, when used in certain settings and in certain ways, to very detrimental'. (C16)
Relative negative	1	0	2	'I've heard for young people […], especially for adolescents, there is more risk in the consumption of affecting the developing brain'. (P14)
True negative	2	1	4	'I've seen tremendous damage by marijuana, and I am concerned for young people'. (C13)

Table 3. Intersection of views on legalization and views on cannabis and cannabis use

		Views on legalization		
		Negative	Neutral or mixed	Positive
Views on cannabis and cannabis use	Positive	0	2	6
	Neutral or mixed	0	3	3
	Negative	3	2	5

Effects, dosage and potency

Participants considered both the short-term and long-term effects of cannabis use. Many raised points about the unknown, specifically that we do not yet know how long smoking cannabis 'clouds and impairs decisions' (P12, 65 years old). There was also a concern that we do not know if cannabis causes any permanent effects. One participant with lived experience recounted that in the period when they smoked cannabis habitually, it affected their life in a substantial way: 'it changes your mindset, it changes your attitude, it changes the way you look at life' (LE9, 33 years old). Some participants in all groups also stressed that the standard dose, or what could be considered safe use of cannabis, was largely unknown. They supported this argument by invoking multiple factors that could make this hard to define, such as the weight of the person using it, their tolerance to cannabis and the potency of the product.

Medical use

Although this study did not tackle cannabis for its medical use *per se*, any participants praised or alluded to the medicinal benefits that cannabis could provide for a variety of diseases; many said it could help with anxiety, cramps, chronic pain or symptoms of mental illness. One participant with a past addiction to alcohol and prescription drugs and who now works in the addiction healthcare field reflected on the misuse of prescribed cannabis: 'I just wonder how many people are injured, need rescued, and the long-term impact on their life, because they're using [medical cannabis] recreationally and not smart' (LE13, 43 years old).

Addiction and harm potential

Different viewpoints were expressed concerning the addictive potential of cannabis. Participants expressed that cannabis 'itself has nothing that makes it addictive, chemically' (P1, 32 years old). Some clinicians countered these points with statements like 'I don't think there is enough acknowledgment that there can be a substance use disorder with cannabis' (C6, family medicine, 13 years of practice). A few clinicians also brought up comparisons with the harms of other drugs such as alcohol and tobacco, saying that although probably less harmful than alcohol, drug-related or drug-induced diseases 'incur great social and healthcare costs' (C14, clinical psychology, 40 years of practice), whereas some members of the public considered the most evident harm to be on others, via dangerous behaviors such as driving under the influence or more specific instances like 'working at a construction place [and] smoking dope and laughing [around] big machinery' (P11, 63 years old).

Convergence between Views on Legalization and Views on Cannabis and Cannabis Use

We compared the views each participant had about legalization and about cannabis. One participant expressed a view on cannabis but none on legalization, leaving us with 24 participants (9 clinicians, 9 members of the public and 6 people with lived experience) for whom we could proceed with the analysis (see Table 3). All participants with a negative perception of legalization also had a negative perception of cannabis and cannabis use. The reverse was not true as, for all participants with a negative perception of cannabis and cannabis use in general, it was more common for them to be in favor of legalization (a positive perception of legalization was most common; see General view on legalization section).

Many participants addressed both Views on Legalization and Views on Cannabis and Cannabis Use, with statements such as: 'I don't see it as a legal issue. I see it as a medical issue. I think by making drugs illegal, you're actually making the [medical] problem worse' (C5, addiction medicine), or 'There are long-term effects, probably, to consume pot, but it's not a reason not to legalize it' (P6, 70 years old). No clinician had an overall positive view of cannabis and cannabis use. In fact, most of them had a negative view of the substance, although they were equally susceptible to feeling positively, negatively or to be neutral/ambivalent toward legalization. Participants whose opinions fell at the intersection of negative/negative were more likely to be clinicians, whereas those who fell at the intersection of positive/positive were more likely to be people with lived experience of addiction with addictions to multiple substances. Finally, there was no notable pattern in the correspondence of opinions toward legalization and toward cannabis and cannabis use for the members of the public.

Discussion

Our study aimed to explore stakeholders' opinions, experiences and values on the legalization of cannabis in Canada. This is one of few studies explicitly targeting values and engaging stakeholders in open discussion on their views on cannabis and cannabis policy since much of the literature has focused on attitudes of acceptance more narrowly (Kvillemo *et al.*, 2022). Opening up research to values and moral reasoning is important to understand relationship between drug policy, public health and democracy in keeping with the view that democracy is an experience and a way of life (Pappas, 2008; Dewey, 2012). For example, our results showed that in all groups (lived experience of addiction, public and clinicians), participants tended to be in favor of legalization, but a great diversity of arguments stood out among them. Specifically, clinicians considered the way legalization would affect an individual's health and its potential for increasing rates of addiction on a larger scale. People with lived experience of addiction cited personal autonomy more than other groups and stressed the need to have access to quality information to make truly informed decisions. Alternatively, members of the public considered legalization positive or negative in light of whether one's addiction affected others. The diversity of values and interests at hand lead us to discuss two questions related to our findings: (1) how does scientific evidence about drug use impact values related to drug use and (2) how and what role can different arguments play in democratic debates about legalization.

Drug Use-Related Values, Scientific Evidence and Public Debate

Our findings on differences of opinion and values between stakeholder groups illustrate the challenge of fostering informed and rational public discussion on drug use, a highly stigmatized subject and behavior. This is important, since stakeholder groups, and what they consider to be the shortcomings and benefits of legalization, can have lasting effects on policy development and revision (Haines-Saah and Fischer, 2021). There is considerable complexity in fostering constructive and inclusive public dialogue around drug legalization policy. One of the main issues is the use and interpretation of scientific evidence around drug use and its connection to values and moral standpoints. Often, different stakeholders in drug policy debates tend to see their own view as evidence-based (i.e. morally neutral) and others' as morally driven, artificially separating scientific evidence from morality, beliefs and political goals (Zampini, 2018). For example, in our study, drug use normalization was often seen in a good light by people with lived experience of addiction, who welcomed an increased social tolerance toward drug use and imagined it as alleviating tension for people who use drugs, given that it allows them to be more open about their addiction and more easily seek help if need be. Opposingly, clinicians were more resistant to normalization and stated that it complicated their role of protecting patients' health. Unlike the findings of an Australian study with people who use drugs (Greer and Ritter, 2020), participants with lived experience of addiction in our study rarely expressed skepticism over the government ensuring the control and regulation of drugs. However, one participant questioned the role of the government in providing appropriate and balanced health information related to drug use to the population, and another, the double role of selling one substance to people who use drugs and incriminating them for using other substances. These observations suggest that supporting public debates on drug legalization involves complex and situated issues in the use of scientific evidence, whose interpretation can be subject to significant biases and conflicts of interests based on one's experiential and occupational standings (Brown and Goodin, 2021). Again, the issue is less about claiming evidence than recognizing that there is no pure scientific evidence devoid of interpretation, a process where values are crucial in understanding the social problems that need addressing and the relevant and appropriate policy solutions.

Another important limitation in supporting public debate on drug legalization is that morality is often attributed to substances and to substance users with limited understanding of the social and political history shaping those opinions and values. Generally, drug use in countries like Canada has been extensively stigmatized as shown in public media coverage of fetal alcohol spectrum disorders (FASD) (Bell *et al.*, 2016; Sattler *et al.*, 2017). Importantly, views on drugs and toward specific drugs are shaped by socially constructed understandings such that common attitude toward drugs may be discrepant with the actual risks they pose (Nutt *et al.*, 2007). In Canada, the prohibitive laws surrounding cannabis (and other drugs) – originate in specific moral beliefs steeped with racism (Wohlbold and Moore, 2019; Owusu-Bempah and Luscombe, 2021) and colonial ideologies (Courtwright, 2001). Furthermore, an ambiguous moral identity is often attributed to psychoactive substances, that is, they are praised when they have potential medical benefit and vilified when they are subject to misuse (Buchman *et al.*, 2017) or are heavily used by particular communities (e.g. the racist social reactions to and criminalization of Black mothers who used crack cocaine during the 1980 crack epidemic in the USA; Besharov, 1989; Metzl and Roberts, 2014). Although we cannot delve into this extensively discussed latter example, it serves as a caution of more contemporary intersections of drug policy discussions and racism and supports the need for 'spaces for critical perspectives and interpretations' (Kiepek *et al.*, 2019).

Despite the apparent openness of Canadian cannabis policy to provide greater freedom and welcoming different values and opinions, which we acknowledge as a welcomed progress, there is still room for further questioning to reveal how attitudes toward drugs are socially shaped. For example, new evidence points to the possibility of cannabis decriminalization reducing racial disparity in the cannabis possession arrests rates in the USA (Gunadi and Shi, 2022), although other factors of racial disparity remain largely unaddressed, even within progressive drug policy movements like the harm-reduction movement (Godkhindi *et al.*, 2022). Participants in our study did not directly speak about these issues, which could be as a result of broader limitations regarding recruitment/who we spoke to and/or broader hesitation to comment on the topic. However, the silence in this area speaks volumes. The latter could be partly explained by the larger social context of Canadian policing and governing authorities that consistently fail to acknowledge past and ongoing racial injustices stemming from drug prohibition and regulation (Khenti, 2014; Owusu-Bempah and Luscombe, 2021). Still, the ongoing lack of attention to the disproportionate amount of Black and Indigenous folks who are still serving sentences for use or possession of cannabis as well as the structural obstacles faced when trying to access safe and equitable healthcare is another area where current values supporting policies needs to be challenged. Opening drug policies to revision and questioning is a first step that could make headway in this direction. One of the main issues here is to recognize that values and knowledge are interwoven such that was discussed and what is not discussed reflects the position of individuals, the values associated with specific substances and the stigma associated with specific groups of people.

The Diversity of Expertise in a Democratic Public Health

We discussed how current values and attitudes toward cannabis are partly informed by scientific evidence, and that sorting what evidence is and which evidence counts are questions that directly concern the democratic nature of debates about drug policies. Our findings highlighted that clinicians envisioned a strong role of health authorities in evidencing and policing drug use. In a democratic public health system, the vitality of the political system depends on its engagement with its citizenry (Massé, 2003), but healthcare professionals, especially the medical body, have great influence on public policy (Foucault, 1994).

Interestingly, clinicians in our study generally supported legalization, but those who spoke about the characteristics of cannabis as a psychoactive substance expressed greater concern than other groups over the consequences of cannabis on the health of individuals. They also claimed prevention efforts would be complicated by the fact that it is impossible to foresee who will be most impacted by the policy change and who will be most susceptible to developing substance use disorders. Their views and concerns were aligned with the role that the influential Canadian Medical Association (CMA) played in the deliberations conducted by the Canadian government's Task Force on Cannabis Legalization and Regulation. Although the CMA supported the legalization of cannabis in Canada, it also advised the government to prioritize a public health approach and a 'comprehensive national strategy to address the harms associated with psychoactive drugs' (Canadian Medical Association, 2018). Incidentally, clinicians in our study expressed worries that the public was excited by the benefits of cannabis while neglecting to acknowledge its potential dangers. This resonates with findings in the literature showing that clinicians are cautious about supporting both the legalization of recreational (Brooks *et al.*, 2017; Wolf *et al.*, 2020) or medical cannabis (Jones, 2008). In other studies, providers have admitted to a knowledge deficit regarding the benefits and risks of cannabis (Brooks et al., 2017; Ng *et al.*, 2021). This was not the case for the clinicians in our study, suggesting that the voice and the potential democratic roles of clinicians specializing in addiction might be distinct from those of other healthcare providers. Similarly, the Canadian Centre on Substance Abuse (now called Canadian Centre on Substance use and Addiction), mandated by the Canadian Government to provide national leadership on drug policy, identified the goals for healthcare workers in the substance use fields as to 'delay, reduce or eliminate drug use', to 'de-normalize substance use' and to 'reduce stigma and discrimination against people who use' (Canadian Centre on Substance Abuse, 2014).

The compatibility of this harm-reduction public health framework and the de-normalization of drug use, coupled with the aim of reducing stigma against people who use drugs, is questionable and raises question about the role of scientific and clinical expertise in a democracy. Can clinicians simultaneously promote cannabis use de-normalization while not also engaging in the use of stigma as a public health tool (Bayer and Stuber, 2006; Fong *et al.*, 2009; Bell *et al.*, 2010), as was the case on the path of de-normalizing (decreasing social tolerance toward) cigarette use in Canada? It is unclear how a drug use de-normalization goal could be achieved without negatively affecting people who use drugs, especially when it comes to reducing stigma and encouraging trust in healthcare providers. This tension between anti-stigmatization and de-normalization has also been shown to have serious social and health implications in the context of FASD and schizophrenia. In the first context, the stigmatization of mothers who drink alcohol during pregnancy or give birth to children with FASD in Canada (Aspler *et al.*, 2018) causes fear which makes it harder for them to access health services (e.g. appropriate pre- and postnatal care, mental health; Eggerston, 2013). In the latter, cannabis use among people living with schizophrenia or at risk of developing it is the target of numerous public health prevention efforts, yet when the patients themselves are asked, they report therapeutic benefits of cannabis use that help them cope with their symptoms and help them find a sense of normalcy with their condition (Costain, 2008).

Such differences of opinion and values between clinicians and other stakeholder groups call into question clinicians' role in democratic discourse. What role should medical experts play in fostering public debate about drug policy? Is this matter only for medical experts to delve into? Should lay citizens have a say in shaping policies that impact them? Importantly, because of the stigma associated with drug use, the stigmatized identities of people who use drugs can act as an obstacle not only to proactively manage their own health, but also to their opportunities for civic participation in public health democracy. The diverse viewpoints shared by people with lived experience in our study point toward more liberal ideologies around drug use and the need to let people make their own decisions, discover experiences for themselves and see whether drug use is right for them. This stands in tension with clinicians' harm-reduction orientation calling for more drug use prevention and less drug use normalization. Opening up public health debates to participants typically considered non-experts (e.g. lived experience and expertise), such as what we did at a small and experimental scale, could be valuable in the future given that legalization, within a pragmatic public health approach, must consider those most intimately affected, and the potential for everyone alike to lead healthy lives and thrive in society. Doing so could help supplement traditional expertise (e.g. content expertise) with other forms of knowledge (e.g. experiential expertise). Further, understanding the subtlety of the variations in the opinions of participants alongside the breadth of factors directly and indirectly associated with legalization is important for science communicators and policy makers in preparing eventual public debates on and messaging around drug policy changes (Lancaster *et al.*, 2013; Vann, 2022). Assuming single arguments or single narratives regarding drug policies—and assuming the existence of a single public with monolithic interest—may lead those who disagree to feel alienated from public debate and public policy, especially since voices in the medical field tend to be heard strongly, potentially to the detriment of the diversity of opinions and experiences in marginalized communities.

Limitations

We acknowledge that voluntary convenience sampling and snowballing recruitment methods created sample biases. The scale of our sample ($n = 48$) and the geographic extent of our data help mitigate this risk although imperfectly. Our data analysis implicated multiple coders and rounds of revision, which strengthened the observations made. That said, it is worth noting that in the time since the data were collected, edibles and other forms of cannabis products have been legalized in parts of Canada (although still subject to provincial and territorial regulations or prohibitions), something which our study did not account for. Likewise, given that the data for our study were collected in 2019, it is impossible for us to speak to whether the opinions of these stakeholder groups shifted between data collection and time of publication. No matter, our results hold relevance as they shed light on the state of stakeholders' views as they were shortly after the drug policy change, a time from which there is much to learn in projecting potential avenues toward the decriminalization or legalization of other psychoactive substances in Canada and elsewhere.

Conclusions

This study explored stakeholders' views on the legalization of cannabis. It sheds light on the relationship between the perceptions of cannabis as harmful for individual health, its risk to public safety and reasons for supporting the legalization of cannabis. Our study showed a great diversity of potentially conflicting reasons for supporting the legalization of cannabis. While clinicians held rather well to a harm-reduction framework, this was not the case for those with lived experience of addiction and members of the general public. The former often stated personal autonomy and informed choice as strong rationales for the policy, while members of the public cited public interest and safety. In a democracy, complete public agreement cannot be expected on such complex matters but processes where the experiences of various stakeholders are heard can be implemented. Broadening the understanding of the democratic public sphere to be inclusive of various experiences would be a welcomed step for further policy discussions. Likewise, although opening drug policy to rational discussion is an important milestone, there is still much to be done to bring greater rationality to the understanding of drug risks. Within such efforts, clinicians, researchers and biomedical scientists have an important role to play but they also bring their own value frameworks (e.g. harm-reduction and de-normalization) which are not always entirely compatible with democratic ideals since de-normalization can fuel stigmatization processes.

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Conflict of Interest

The authors declare no conflict of interests.

Notes

1 Although often undistinguished and etymologically synonymous terms derived from Latin and Greek, respectively, we use the term moral and morality to designate the more implicit habits which structure and guide our lives while we reserve the term of ethics to designate the structured and explicit reflection on moral habits and moral life. Hence, ethics takes moral life as its object of inquiry and is thus a science of this domain of human life. For explanations, see clarifications published in Racine *et al.* (2017) and Hartman *et al.* (2020).

2 We are sensitive to ongoing discussions about the appropriateness of terminology in the field of addiction/substance use disorders. At the time of our interviews, our recruitment publicities and interview questions used the word 'addiction'. In writing this paper, we chose to keep the word 'addiction' when discussing our own study and findings for transparency—especially since the 'people with lived experience of addiction' in our study have not all received a medical diagnosis of substance use disorder. When reviewing and discussing literature, we used the expression 'people who use drugs', which encompasses people with histories of using and misusing drugs as well as people with a medical diagnosis of substance use disorder.

3 Only one participant in this group was uncomfortable sharing opinions on the legalization of cannabis in Canada.

4 One participant identified as having a gambling addiction without having had a present or prior drug addiction and therefore met eligibility criteria as a member of the public.

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