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The Routledge Handbook of Post-Prohibition Cannabis Research

The place of cannabis in global drug prohibition is in crisis, opening up new directions for socially engaged cannabis research. *The Routledge Handbook of Post-Prohibition Cannabis Research* invites readers to explore new landscapes of cannabis research under conditions of *legalization with, not after, prohibition*: "post-prohibition." The chapters are organized into five multidisciplinary sections: Governance, Public Health, Markets and Society, Ecology and the Environment, and Culture and Social Change. Case studies from the United States, Uruguay, Morocco, and the United Kingdom show readers alternative ways of thinking about human–cannabis relationships that move beyond questions of legality and illegality. Representing a cross-section of cannabis scholarship, the contributors provide readers with critical perspectives on legalization that are not based upon orthodoxies of prohibition. While legalization signals a global shift in the legitimacy of cannabis research, this collection identifies openings for academics, policy makers, and the public interested in ending the drug war, as well as a way to address broader social problems evident in the age of neoliberal governance within which prohibition has been entangled.

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Deep Respect After Profound Neglect

Spiritual Health and Safety for Use of Cannabis and Other Entheogens in an Integrative Public Health System

Sunil Kumar Aggarwal

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Cannabis, Entheogens, and Spirituality in Public Health

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Cannabis is a botanical revered in numerous religious traditions as an entheogen, or substance that can induce awe or inspiration. It is lauded for its ability to promote inner peace, heighten the experience of the present moment, and aid in meditation to attune a partaker to a Higher Self consciousness. A critical point is that even those who may not be utilizing cannabis as part of any kind of recognized religion may still be using it in a manner consistent with spiritual intents or as an expression of the spiritually related concept of freely exercising sovereignty over one's consciousness. Cannabis use referred to as 'recreational'—literally, to 're-create' or 'renew'—may be better understood under the wider category of spiritual well-being related use, given that the pursuit of pleasure, happiness, and connection are all aspects of the fulfillment of human spirituality. Similarly, medical use of cannabis for health, well-being, and fulfillment of hope in the face of existential threats to survival and life quality that disease and disability present integrally involves a spiritual health dimension, in addition to physical and mental ones.

In 1983, the World Health Organization (WHO) first recognized the implicit spiritual dimension in health, and in 1998, the WHO executive board added "spiritual" to the definition of health itself, resolving, "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity" (Chirico 2016, 13). Spiritual health or spiritual well-being, a corollary concept, has been defined as "a state of being where an individual is able to deal with day-to-day life in a manner which leads to the realization of one's full potential; meaning and purpose of life; and happiness from within" (Dhar et al. 2011). Spiritual health is increasingly being addressed in palliative care for patients with serious and life-threatening illness, and there is an ongoing need for this across the full spectrum of health services. To help guide clinicians,

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in 2009 the US National Consensus Project developed this definition of spirituality which goes beyond religious concerns to include philosophical and existential ones:

> Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.
>
> *(Puchalski et al. 2009, 887)*

In the US public health sector, spiritual issues have mostly focused on respecting select groups' religious practices with regards to participation in state health programs (Brougher 2012). Examples include allowance for conscientious objector exemptions for members of qualified religious groups from mandatory enrollment in health coverage programs (e.g., the Amish and Medicare), presumed consent to emergency medical therapy (e.g., Jehovah's Witnesses and blood transfusions), and required licensure and underage restriction when serving sacramental psychoactive substances (e.g., Christians and ceremonial alcohol use).

Increasingly, exemptions to federal drug abuse prevention and control public health laws are being made for religious "entheogen" use practices. "Entheogen" is defined in the *Oxford English Dictionary* as "a chemical substance, typically of plant origin, that is ingested to produce a nonordinary state of consciousness for religious or spiritual purposes." It is a more neutral and nuanced alternative to the terms 'psychedelic' (mind-manifesting), 'hallucinogen' (hallucination-inducing), and 'psychotomimetic' (psychosis-mimicking), referring to drugs—psychoactive chemicals, plants, fungi, or animal secretions—"which provoke ecstasy and have traditionally been used as shamanic or religious inebriants, as well as their active principles and artificial congeners" (Ruck et al. 1979, 145). Prohibitions on drug preparation, use, and exchange under the half-century-old Comprehensive Drug Abuse Prevention and Control Act have been lifted for members of select religious groups whose use of select entheogens is now protected under enacted legislation or federal court rulings. This includes lawful recognition of the cultivation, preparation, and use of the entheogen peyote, a mescaline-containing cactus, by the Native American Church since 1993 and the entheogen ayahuasca by the Brazilian Unio de Vegetal and Santo Daime Churches since 2006. Despite recognized traditions in other countries (e.g., South Africa, Jamaica, and India), cannabis' entheogenic use has not been recognized under US law.

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Aside from these exceptions, the US public health system has generally neglected the field of study concerned with the human relationship with entheogens, ignoring the possibility of healing in spaces with cannabis or other entheogens and assuming danger and high abuse potential instead. Yet, strict public health drug policies are allowing for select groups' religious practices. This begs the question: Why make exemptions only for select groups and entheogens? Spirituality is a universal, core dimension of health, irrespective of membership in any particular religious sect (Puchalski et al. 2009). Why can't respect for spiritual health and safety be universalized for all persons and all entheogen practices?

In this chapter I attempt to bridge this breach in the public health system with regard to cannabis primarily and other entheogens. In the first section, using the method of radical empiricism, I share my experience of the value of cannabis-occasioned consciousness states to help describe the space. In the second section, I explore the public health system's approach to cannabis and other entheogens from the perspective of licensed health professionals who negotiate a critical distance in engagement with the state. In the third and final section, I propose further research directions into the spiritual health value of

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cannabis and other entheogens in the context of an emerging fifth wave in public health focused on well-being in the face of global existential threats.

Hearing and Validating the Call

I heard the call to help develop public health safe use protections to integrate healing with cannabis and other entheogens through my own profound healing experiences with these substances. Due to the prohibitionist drug education programming of my youth, I had long dutifully avoided marijuana self-experimentation until undergoing a romantic relationship breakup as a pre-med student brought me to question this. Self-experimentation revealed an entirely undiscovered geography of therapeutic potency and potentiality. Here was a mild euphoriant that occasioned a state of mind wholly different from that produced by legally available inebriants such as alcohol, coffee, cigarettes, and energy drinks. When taken in more protected contexts, THC-rich cannabis helped me achieve flow state: a feeling of being completely absorbed in an activity—be it technical, creative, convivial, playful, or peaceful, while simultaneously performing at an optimal level (Csikszentmihalyi 1991). For someone like me who had been plagued by anxious unrest and a vocal inner critic, this simultaneously alert and relaxed flow state was integrating and liberating. Over time, I came to appreciate cannabis as a 40 million-year-old natural entheogen (Aggarwal 2018). With the smoking of virtually unprocessed, dried, resinous cannabis flowers, I experienced intentional connection with a socially foraged semi-domesticated herb that healed by helping me forget and remember. I forgot worries and negative thoughts and emotions that detracted from being fully present in the moment. I *re-membered*—or, put back together again more robustly—parts of my body, mind, and spirit, in a way they are rarely perceived. Normally, separative pathways dominate, such as when I have persisting pain in a limb or feel like my emotions are distanced. Cannabis-occasioned consciousness integration, freely chosen, helps me see things in a "cleansed" manner—I gnostically, or in a spiritually knowing way, remember that I am a human being with a finite lifespan with beautiful abilities, senses, and capacity to act for a greater purpose. Rather than the default mode, beset in possible anxiety and worry, which might tend towards social withdrawal, this mode is pro-social, engaged, and flowing. With a sensation of time slowing, there is an expansion of spatial awareness and environmental receptivity, deepening the therapeutic value of local land and seascapes. Overall this fosters an abiding sense of inner balance and inner and communal unity, and it provides relief from separation, disintegration, and emotional withdrawnness.

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I similarly came to appreciate firsthand the potencies of other entheogens such as psilocybin-containing mushrooms, LSD, MDMA, DMT, *Salvia divinorum*, coca leaves, opium congeners, ayahuasca, ketamine, and powdered tobacco herbal mixtures. While I do not have space to elaborate, I experienced with several of these most profoundly ego dissolution, with all the attendant pain and challenge of sorting through long-held attachments. These occasioned a powerful healing unitive or nondualistic consciousness and a deeply felt sense of awe and reverence for life and the universe, which I returned with as my ego re-formed anew.

Like others, the insights I gained in my twenties into other-than-default modes of consciousness while exploring with cannabis and other entheogens changed my orientation towards science and medicine (Tart 1990). I find compelling the conjecture that the

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discovery and use of entheogens may have been the fountainhead for the development of human religion and catalyzed evolutionary developments in human consciousness (Hoffman 2006). The therapeutic relief from mental distress, promotion of well-being, and occasioning of deep insights into life and the nature of reality provided are worth understanding and sharing with others, as feasible. Given the stigma associated with cannabis and other entheogens and the limited awareness of spiritual health in medicine, I sought out validation in scientific work on other health dimensions. Learning from experts and conducting field research, I came to appreciate the state of science regarding cannabis' applications in medicine and preventative health, beyond the clinically evident medical applications for pain, nausea, and muscle spasms (Pacher and Kunos 2013). Cannabinergy, mediated by the endocannabinoid system (ECS), a homeostatic cell signaling system found throughout the body and many other organisms, validates many claims of cannabis's salutary effects. Lead scientists at the National Institutes of Health opine,

> modulating ECS activity may have therapeutic potential in almost all diseases affecting humans, including obesity/metabolic syndrome, diabetes and diabetic complications, neurodegenerative, inflammatory, cardiovascular, liver, gastrointestinal, skin diseases, pain, psychiatric disorders, cachexia, cancer, chemotherapy-induced nausea and vomiting, among many others.
>
> *(Pacher and Kunos 2013, 1918–19)*

Moreover, a recent analysis of high-quality studies of THC-rich cannabis' impact on physical health has shown periodic use correlates with measurable population-level reductions in rates of obesity, diabetes mellitus, cancers, mortality from traumatic brain injury, use of alcohol and prescription drugs, driving fatalities, and opioid overdose deaths https://www.ebook-converter.com (Clark 2017). A reduction of 989–2,511 premature deaths for each 1% of the population using Google Books Download Demo Version cannabis was measured, and prevention of 23,500–47,500 deaths annually was projected were cannabis accessible nationwide (Clark 2017). Another recent analysis of National Vital Statistics showed a 10.8% reduction in adult male suicide rates after states liberalized their cannabis laws between 1990 and 2007 to allow medical use (Anderson, Rees, and Sabia 2014). Clearly, physical and mental public health benefits with cannabis use are scientifically valid, yet it seems ignorance and fear of its potential spiritual health benefits create a systemic breach that stymies full avail.

The Healer's Social Responsibility to Acknowledge the Breach

Licensed health professionals as public health agents have a responsibility to advocate for safe environments for all health-related behaviors. The state expects licensees to practice safely within their professional scope and creates licensing schemes to protect the public from unscrupulous individuals who may use the cover of a healing art to practice malfeasance (see Sexton Chapter 29, this volume). Licensees in turn become part of an ancient guild of healers who serve under oath with conscience and commitment, held to standards of self-regulation provided by health professional guild organizations.

Respect, protection, and value optimization for health-related behaviors with cannabis and entheogens is an important public health goal. Each licensee should articulate an educated assessment of public health policy in this area. Here is mine, having held state licenses to practice medicine and prescribe federally controlled substances for over a decade. My study of history has shown me that the drug-war status quo is a byproduct of a

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system of domination tied to racism and colonialism in which traditional entheogen use behaviors are disrespected and outlawed. The cannabis plant, semi-domesticated in South-Central Asia around 18,000 years ago (Duvall 2015), has been a focus of administrative bureaucracies for over a century and appears to have been brought to the attention of public health regulators by politicians and members of law enforcement.

Cannabis formally became an object of international public health concern under a UN-negotiated treaty in the 1950s, the Single Convention on Narcotic Drugs, heavily pushed by US delegates and adopted in 1961. The US enjoyed hegemonic supremacy in the wake of the Second World War, which it employed to develop and pass the treaty and two others over a 20-year period. Its inclusion (along with coca leaves and opium poppy) was pushed by Harry J. Anslinger, a former alcohol prohibition enforcer and the first director of the Federal Bureau of Narcotics. He had led a media-aided lurid and sensationalistic crusade against marijuana 25 years earlier, connecting its use to homicidal mania and racial integration fears, which culminated in the passage of the 1937 Marihuana Tax Act signed into law by President Roosevelt. This law was struck down by the Supreme Court in 1969. Despite protests from federal health scientists threatened with blacklisting, President Nixon's administration then implemented the modern prohibition framework around marijuana and other entheogens, in line with the UN treaties. They used the scheme as a tool to suppress political dissent and funded a public health science bureaucracy that *prima facie* viewed all illegal drug use as pathological (Aggarwal 2015).

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In institutional public health, fear and ignorance of cannabis' entheogenic qualities has significantly restricted its application as a preventative and ameliorative therapeutic agent in physical and mental health. These qualities are stigmatized and misconstrued as either trivial or inherently pathological by the public health establishment and the reason for its alleged danger and severely restricted accessibility. This provides cover to statutory federal law which maintains a sweeping prohibition of cannabis under the public health banner of drug abuse prevention and control. Even in locales which have state-legal access to cannabis for personal use, whether under medical authorization or not, vestiges of prohibition persist, justified as necessary to protect public health and safety. These include "carve-outs" in areas such as employment, housing, family law, road safety, the tax code, healthcare, and education, in which cannabis' legality and acceptability are ruptured or absent, imperiling one's ability to socially function and control one's health and body. These carve-outs are a manifestation of the entheogen breach in the public health system, which is likely contributing to eroding public trust in medical institutions. Gallup found in 2018 that public trust in the medical system is at 36%, unchanged for 30 years and less than half of what it was in 1974 (Keckley 2018).

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Repairing the Breach: Health as Integrative

In early 2019, an influential WHO expert committee completed a critical review that called for relaxation of cannabis's prohibitive international scheduling, the first official rupture in the international treaty system regarding cannabis in over 50 years (Ghebreyesus 2019), ultimately leading to the UN's decision to remove cannabis from the most restrictive schedule in international law reserved for substances intended for complete eradication. After over 80 years of prohibition enforcement, accompanied by state-funded mass education campaigns highlighting the danger and deviancy of marijuana use, this scheme

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has become unpopular. Mass movements have arisen in the last several decades that have reformed local and state laws and in turn fueled shifts in public attitudes. Being 'high on marijuana' is slowly being destigmatized. A supermajority now feel that marijuana prohibition is unwarranted and medically necessary use is a fundamental right (Marijuana Majority 2019).

The shift in the present landscape allows for re-evaluation of public health understanding of the necessity and purpose of the pursuit of non-ordinary states of consciousness and enhanced sensation in general (Weil 1975). With new laws and evolving social mores, there is increased acceptance that there is something fundamental, natural, or unstoppable about the human pursuit of psychoactivation via cannabis that warrants tolerance and even curiosity or wonder. Institutional public health, through incorporating an integrative scientific understanding of health and well-being that includes mind, body, spirit, community, and environmental relationship dimensions, can broaden its prior unidimensional paradigm. An integrative public health science approach to cannabis and other entheogen use will require an openness and attunement to subjective experience and non-ordinary states of consciousness as valid sources of knowledge about health, as the privileging of ordinary state consciousness and harm-focused-only objective assessment has significantly limited scientific exploration of spiritual health.

How did institutional public health become wedded to what educator and psychologist Thomas Roberts (2019, 25) has called the "single-state fallacy" in human and natural sciences? Philosopher Arthur Buehler (2015, 325–26) has called this "cognocentrism," which posits that only the ordinary state, default "armchair" mode of consciousness, is knowledge-rich. Historically, the development of scientific inquiry in the Western tradition required a negotiation with Catholic Church authorities regarding which domains were deemed as acceptable fodder for inquiry. Known as the Cartesian split, after 16th-century French monk and philosopher Rene Descartes, the striking of this bargain by protean scientists allowed for the development of empiricism and structured inquiry into the material nature of reality. However, inquiry into the nature of soul—or spirit or consciousness—was off-limits for scientific study per the negotiated agreement with the Church, as "Care of the Soul" was reserved for the Holy Catholic Church alone. Transgression was a capital offense punishable by torture and death—the fate of many so-called heretics such as Giordano Bruno. This bounded enterprise of inquiry was still sufficiently suitable to probe the mechanics of motion, the nature of chemical reactions, the inheritance of traits in life, and other phenomena. Ultimately, after further clashes with the Church, including the trial of Galileo Galilei, and with the help of the telescope and further development of its prestige, scientific inquiry was able to interrogate geocentrism and explore freely the movement patterns of outer space celestial objects. A similar revolution with aid of entheogens has yet to occur for 'inner space' exploration.

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During the Renaissance, healing arts developed and practiced by traditional healers in Europe, such as herbalism and shamanism, along with indigenous peoples' healing practices encountered by European explorers in the 'Age of Discovery,' were regularly criminalized, oppressed, or simply ignored. The demonic concept of the witch and witchcraft developed by Church authorities was the frame under which such suppression occurred. European alchemists, interested in the nature of consciousness, resisted the Cartesian split and took their work underground. In this vacuum, the birth of 'modern scientific medicine,' chronicled by Michel Foucault (2010) in *The Birth of the Clinic: An Archaeology of Medical*

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Perception, occurred over a period of time in France when Cartesian-split scientific inquiry was applied to the study of human disease through correlation of post-mortem pathological studies with pre-mortem observations. This was the birth of the 'clinical gaze,' in which medicine became connected with objective reduction of symptom clusters and illness presentations to tissue pathology (Sullivan 2003). In this type of medical science, there was and is no regard for subjectivity of the patient—only the gaze of the medical practitioner is seen as a warranted position from which to ascertain fact.

Out of this Cartesian-split medical science, the discipline and practice of public health was born, as a way to move clinical concerns 'upstream' in the population to prevent disease and promote health. Historians have described four waves in the development of public health, corresponding to specific concerns in given periods (Hemingway 2011). The first wave (1830–1900) had to do with civil engineering and 'the great public works period.' This arose in response to the Industrial Revolution in Northern Europe and North America, which led to conditions of overcrowding and lack of sanitation and clean water, leading to the transmission of infectious diseases. The second wave (1890–1950) was grounded in "the germ theory of disease and refinement of the scientific approach in hospitals" (Hemingway 2011, para. 1). This era corresponded with the rise of scientific rationalism in medicine, engineering, and municipalism and the development of hospitals and further specialization in medicine, in which the body was increasingly viewed as a machine divisible into discrete parts or organ systems. The third wave (1940–1980) was the "restructuring of institutions, welfare reforms, new housing, social security and the development of 'health services.'" This wave was influenced by the "materialist philosophies of Marx and Engels" that viewed health as "the compound result of the conditions of everyday life" (Hemingway 2011, para.
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1–4). The fourth wave (1960–2000) had as its "dominant focus of activity the 'risk' theory of disease causation, and lifestyle issues, smoking, diet, and physical activity" as well as nascent concerns with social inequalities in health. This behaviorist focus emerged as "chronic diseases caused the majority of death and disability in the western world" (Hemingway 2011, para. 1–5).

Given the complexity of current health threats such as rising obesity, pandemics, war, violence, anxiety and depression, global climate change, environmental and ecological degradation, worsening inequality, and cycles of trauma, scholars are recognizing a fifth wave in public health cresting: an emphatic focus on well-being that centers on "a new image of what it means to be human" (Hanlon et al. 2011, 34). In this wave, there is an emphasis on the development of an integrative public health paradigm that draws from the work of philosopher Ken Wilber. In a pair of widely cited articles, University of Glasgow Public Health Professor Phil Hanlon and colleagues described the rise of this new wave aimed at achieving the goal of enhancing well-being in the 21st century, in the face of radical and unprecedented challenges and strife (Hanlon et al. 2010, 2011). This paradigm calls for a healing of the Cartesian split that became embedded early on in public health and a return into the wheelhouse of health science and healthcare concerns related to the experience of the inner self, interiority, subjecthood, and the way that groups and collectives are experienced inter-subjectively.

In this fifth wave public health, we reintegrate the spiritually neutered foundations of science. The integrative turn in science is focused on recognition that the reductionistic Western model of scientific inquiry, especially when it comes to engagement with the biosphere, cosmos, and what it means to be human, is only one way to know and

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understand the world. In order to have richer inquiry, it is necessary to understand and integrate other ways of knowing, such as indigenous science (Bartlett, Marshall, and Marshall 2012). Canadian biologist Cheryl Bartlett describes integrative science emerging in the mid-1990s as a radical innovation in post-secondary science education. Her work is about fostering a new consciousness in which we "realize that we have options and alternatives as to our ways of knowing about and participating in the web of life, while realizing that science is and must always be a practical engagement with the real world" ("About the Institute" 2019). Her team champions a science inclusive of multiple perspectives, respectfully and meaningfully engaged with communities. Bartlett quotes Elder Albert Marshall of Eskasoni First Nation in Nova Scotia, who describes integrative science as a "two-eyed seeing," or

> learning to see from our one eye with the strengths of Indigenous knowledges and ways of knowing, and from our other eye with the strengths of Western (Eurocentric or mainstream) knowledges and ways of knowing … and learning to use both these eyes together, for the benefit of all.
>
> *("Joining Two Worlds" 2008)*

Let us now apply this integrative public health perspective towards achieving universal respect for spiritual health and well-being practices, specifically what has been dismissively called 'recreational use' of cannabis and other entheogens. At a macro level, the practice of public health through local, state, regional, national, and international health departments and agencies has yet to recognize that the two gravest threats to the long-term survival and well-being of the human species include human-activity-driven global climate system breakdown due to fossil fuel extraction and burning industries and the continued omnicidal threat of full-scale nuclear war. These threaten the survival of whole populations in staggering dimensions. What happens to the practice of public health by institutions, academicians, policy makers, and others when prevention of these grave threats becomes a central agenda item?

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Such global existential issues are also present in every individual. From the time that human beings develop an awareness of our mortality, we develop existential concerns that can vary in intensity from mild to severe, depending on a variety of factors and triggers such as actual or threatened death, injury, illness, deprivation, and other trauma. In the field of hospice and palliative medicine, medical professionals are trained to diagnose and treat clinically significant existential distress associated with life-threatening or life-limiting illness. But it is fair to say, as observed by Scottish psychiatrist R. D. Laing, "life, you see, is a sexually transmitted disease and there's a 100 per cent mortality rate" (Hilmore 1985). This underscores the universality of the condition of existential stress and why spiritual health and well-being is an essential core dimension of health. Given the critical nature of socialization in mammalian neuropsychological development, existential concerns also arise in relation to crises and disturbances in social acceptance, such as ostracization, betrayal, oppression, or related pressures, traumas, or catastrophic illnesses that act as 'social death threats.' There is likely an evolutionary aspect to this as humans for millennia lived in hunter-gatherer clans, dependent on the group for basic shelter, protection, and survival. Any form of outcasting from that social protection would likely translate into death, thus triggering existential concerns. Social psychologist Ernest Becker (2007) posited that much of the social fabric of contemporary civilization is held together by collective "denial of

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death." In other words, individual existential concerns are mollified by being in social connection.

Given these individual and global social existential conditions, it is necessary for optimal spiritual health and well-being—a core dimension of health—that individuals be able to search for meaning and purpose. Individuals must have ongoing opportunities for *mental or spiritual consolation* and to *create again* and *renew* their spirit as they face ongoing and increasing existential concerns. All the italicized foregoing words are the definitions of the words in late Middle English and Latin from which our contemporary word "recreation" comes from. Safe recreational use of cannabis and other entheogens cannot be seen as psychopathological when the essential role recreation plays in the universal human pursuit of meaning, purpose, and renewal in the face of existential realities is understood.

Such use, which has long-standing traditional and indigenous antecedents, must be respected and protected as a matter of public health as potentially vital integrative health behaviors, even if this greater framing is not apprehended by individuals or social institutions at present. Arising from the Cartesian split, the single-state fallacy and cognocentric bias which undergird cannabis and entheogen prohibition laws and the orientation of contemporary US public health institutions are based on the flawed yet pervasive idea that all noteworthy understanding in the world is only gleaned from the ordinary rational-discursive state of mind, seen as the preferred default healthy way to be. This devalues and neglects the validity, healing potential, and tradition of entheogen-aided multistate consciousness living and places spiritual health and well-being in a blindspot. It discounts, per Buehler, the "almost limitless possibilities in the rainbow of human-consciousness" (2015, 326). An increasingly large body of literature in the last 30–40 years has substantiated the normalcy of this view of consciousness in areas such as the study of altered states, transpersonal psychology, mind-body medicine and psychiatry, the anthropology of consciousness, and the philosophy of consciousness. Like the telescope opened new vistas of understanding in astronomy and cosmology in the 17th century, a look through "the telescope of altered states" may allow public health researchers "to experience a vast inner universe" that may have profound impacts on developments in science, health, and social relations (Buehler 2015, 325–26). A great deal of further research and inquiry is needed in this area.

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Conclusion

The prohibition of cannabis and other entheogens via the Controlled Substances Act in the US and similar laws globally, though adopted under the banner of public health promotion, does not further public health but rather amounts to a prohibition on societal ability to freely pursue science and discovery, promote individual and community efficacy and well-being, and fully practice the healing arts. Through adopting this spiritual health-inclusive integrative view towards individual and public health as part of the fifth wave, and by expanding the public health and spirituality nexus in the US beyond select religious groups to include all, the breach in the public health system that neglects the value and power of cannabis and entheogens can begin to be repaired by creating and protecting safe use spaces. For example, we have started to create a safe use space in a clinic in Seattle, the Advanced Integrative Medical Science Institute, that Dr. Leanna Standish and I co-founded in October 2018, which offers patients cannabis- and ketamine-assisted psychotherapy and a

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future home for approved MDMA, psilocybin, and ayahuasca-assisted therapy.

With a larger project of research and development, inclusive of engagement with indigenous communities and other communities, as well as institutional engagement, cannabis and other entheogen use practices can be depathologized at their core, and recreational-medical-spiritual use can be seen in unity. Their safe and maximally beneficial use can be cultivated by the public health system. They can be accepted widely for the therapeutic and well-being promoting potential they possess for all, regardless of spiritual or religious affiliation or health status.

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