Submission No 64

INQUIRY INTO ROAD TRANSPORT AMENDMENT (MEDICINAL CANNABIS-EXEMPTIONS FROM OFFENCES) BILL 2021

Organisation: Australian Medicinal Cannabis Association

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Submission to Inquiry into the Road Transport Amendment (*Medicinal Cannabis - Exemptions from Offences*) Bill 2021 by the AUSTRALIAN MEDICINAL CANNABIS ASSOCIATION

Introductory comments

The Australian Medicinal Cannabis Association (AMCA) is an ASIC and ACNC registered association representing more than 150 stakeholders from the breadth of the medicinal cannabis sector including cultivators, manufacturers, importers, distributors, researchers, medical practitioners, nurses, pharmacists, patients and their carers, consumers, and broader advocacy groups.

AMCA welcomes the opportunity to make a submission to the inquiry into the Road Transport Amendment (*Medicinal Cannabis - Exemptions from Offences*) Bill 2021

We are aware that the *Road Transport Act* 2013 (NSW) sub-section 111 (1) makes it an offence for a person to drive a motor vehicle in the presence of a "prescribed illicit drug" in the person's oral fluid, blood or urine. Under the current legislation, a "prescribed illicit drug" is defined to include delta-9-tetrahydrocannabinol (also known as THC), methylamphetamine (also known as speed), 3,4-methylenedioxymethylamphetamine (also known as ecstasy) and cocaine. The legislation currently prescribes that if a person undergoes a random, roadside drug test and any prescribed illicit drug, including THC, is detected in their saliva (oral fluid), blood or urine, even if it was prescribed by a medical practitioner, the person faces considerable penalties and / or fines, possible court proceedings and / or potential loss of their driving licence for six months (section 205 of the Act).

AMCA believes that:

- since medicinal cannabis (including THC) was legalised in 2016, it should no longer be categorised as a prescribed illicit drug. In contrast, methylamphetamine, 3,4-methylenedioxymethylamphetamine and cocaine all remain illicit drugs (and, notably, are prohibited drugs in all states and territories) and are deemed to have no therapeutic value;
- patients who are legally prescribed medicinal cannabis in Australia should not be subject to prosecution simply for driving with THC in their system, unless they otherwise commit a road traffic offence that is punishable under the law.
- medical practitioners are already entrusted to advise patients taking many medications that can cause impairment, such as opioids and benzodiazepines, and it is unfair and discriminatory for legally prescribed medicinal cannabis (including THC) to be treated any differently.

AMCA strongly supports the Bill, introduced by Ms Cate Faehrmann MLC in the Legislative Council on 17th November 2021, which will address unjust and out-of-date drug driving legislation which unfairly discriminates against patients who have been legally prescribed medicinal cannabis.

However, we believe that the proposed amendments do not sufficiently address the changes needed. Specifically, we strongly believe that, rather than sub-section 111(1A) being inserted after sub-section 111(1) of the Act, THC should no longer be categorised as a prescribed illicit drug and should not be subject to the offence provisions under the Act at all.

Instead, patients driving on THC obtained and administered in accordance with the law and administered by a medical practitioner should be cautioned on potential impairment and permitted to drive as advised by their medical practitioner. This is in line with similar drugs such as opiates and benzodiazepines.

Terms of Reference

(a) the Road Transport Amendment (*Medicinal Cannabis-Exemptions from Offences*) Bill 2021 be referred to the Standing Committee on Law and Justice for inquiry and report

(b) the committee report by 23 June 2022.

Context

AMCA has taken the approach that it is relevant and appropriate for our submission to provide context around:

1. the medicinal benefits of cannabis as, unlike illicit drugs, it offers scientifically proven therapeutic value for patients
2. the strict regulations that already provide a high level of control over the production, quality and accessibility of healthcare practitioners and patients to medicinal cannabis including:
    a) the relationship between cannabis and the law, both internationally and within Australia;
    b) the scheduling under which medicinal cannabis is controlled; and
    c) the highly regulated routes through which patients and their clinicians must already navigate to access legally prescribed medicinal cannabis.
    d) strict controls governing clinical trials
3. the increasing use of medicinal cannabis as a therapeutic treatment for various indications

AMCA trusts that providing this context will demonstrate that before a patient on legally prescribed medicinal cannabis ever steps into their vehicle, strict production, quality and access protocols will have been followed, including regulations requiring patients to have tried all other approved drugs for their condition before medicinal cannabis can be prescribed.

In our view, any discussion of medicinal cannabis should also be underpinned by the *International Convention on Economic, Social and Cultural Rights* (**ICESCR**), which states that **everyone has the right to the highest attainable standard of physical and mental health**,[1] and to the *Australian Charter of Healthcare Rights,* which provides that **all Australian patients have the right to receive safe and high-quality care in an effective continuum**.[2]

As medicinal cannabis is for most patients, a last line of therapy, we consider it unfair and discriminatory for these patients to be prevented from driving, when similar or stronger narcotics are not subject to the same extensive restrictions.

[1] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3(entered into force 3 January 1976)
[2] ACSQH, *Australian Charter of Healthcare Rights* (2008) Australian Commission on Safety and Quality in Health Care < https://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Charter-PDf.pdf>; The University of Sydney Community Placement Program in Partnership and MGC Pharmaceuticals, *Medicinal Cannabis in Australia: Science, Regulation & Industry*, White Paper (2016).

1. Medicinal benefits of cannabis

Cannabis, derived from the plant *Cannabis sativa*, contains approximately 140 chemical constituents called 'cannabinoids'. The most well-known cannabinoids are cannabidiol (**CBD**) and *delta*-9-tetrahydrocannabinol (**THC**). THC was the first cannabinoid to be isolated for scientific research in 1964 and it is the key psychoactive constituent.[3]

Research in the 20th century revealed the intricate endocannabinoid system which comprises several biochemical receptors throughout the human brain and body upon which cannabinoids were observed to act and produce a variety of therapeutic and psychoactive effects.[4]

There is clinical evidence to demonstrate the therapeutic value of THC and CBD in the treatment of a range of medical conditions, including AIDS/HIV,[5] Alzheimer's disease,[6] chemotherapy-induced nausea and vomiting,[7] cancer,[8] diabetic peripheral neuropathy,[9] epilepsy,[10] multiple sclerosis,[11] anxiety and depression.[12] There is also some evidence that THC and CBD may assist in the symptomatic relief of chronic pain,[13] glaucoma,[14] Tourette syndrome[15] and sleep disorders.[16]

Strict legal and regulatory controls over the production, quality and accessibility

2 (a) Cannabis and the Law

International obligations

Australia is a party to three significant international agreements which concern the supply and use of narcotic drugs (including cannabis).

i. Primarily, the Single Convention on Narcotic Drugs 1961[17] (Single Convention) requires signatories to prevent abuse and diversion of narcotic substances by limiting cultivation, production, manufacturing and other activities (including use and possession), but permits the provision of narcotic substances for medical and scientific purposes, subject to adequate controls, and specifically carves out of its scope of operation cannabis for industrial or horticultural purposes.[18] The Single Convention is implemented into Australian law by a number of instruments at the Commonwealth and state/territory level, primarily, at the former, by the Act.

[3] E Russo, 'Taming THC: potential cannabis synergy and phytocannabinoid-terpenoid entourage effects' (2011) *British Journal of Pharmacology* 1344.
[4] D Piomelle and E Russo, 'The cannabis sativa versus cannabis indica debate: an interview with Ethan Russo, MD' (2016) 1(1) *Cannabis and Cannabinoid Research* 44, 45.
[5] Victorian Law Reform Commission, *Medicinal Cannabis: Report*, Report No 32 (August 2015), 39 and 64.
[6] L Eubanks et al., 'A molecular link between the active component of marijuana and alzheimer's disease pathology' (2006) 3(6) *Molecular Pharmaceutics* 773, 775.
[7] Lynch and Ware, above n 7, 295 and 299.
[8] Whiting et al, above n 6, 2460.
[9] J Croxford and T Yamamura, 'Cannabinoids and the immune system: Potential for the treatment of inflammatory diseases?' (2005) 166(1) *Journal of Neuroimmunology* 3, 12.
[10] M Tzadok et al., 'CBD-enriched medical cannabis for intractable paediatric epilepsy: The current Israeli experience' (2016) 35 *Seizure* 41, 43.
[11] Croxford and Yamamura, above n 14; Whiting et al., above n 6, 2461 and 2465.
[12] Whiting et al., above n 6, 2463.
[13] Lynch and Ware, above n 7, 293-299.
[14] T Jarvinen, D Pate and K Laine, 'Cannabinoids in the treatment of glaucoma' (2002) 95 *Pharmacology & Therapeutics* 203, 215.
[15] Whiting et al., above n 6, 2464.
[16] Ibid.
[17] *Single Convention on Narcotic Drugs 1961*, opened for signature 30 March 1961, 520 UNTS 204 (entered into force 13 December 1964), as amended by the *1972 Protocol amending the Single Convention on Narcotic Drugs 1961*.
[18] Ibid, Art 2; and Art 28 for cannabis cultivation specifically.

ii. Australia is a party to the *Convention on Psychotropic Substances 1971*[19] which describes the obligations of parties to facilitate the use of psychotropic substances for medical and scientific purposes (and to limit their availability for other use(s)), and the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*,[20] which aims to promote cooperation between parties to address the illicit trafficking of narcotic drugs and psychotropic substances.

iii. The Commonwealth Government is ultimately accountable for ensuring that any national, state or territory scheme for the cultivation, production, manufacture or supply of cannabis and products derived from cannabis is consistent with Australia's international obligations, including where responsibility for regulating aspects of the regime is devolved to the states and territories (as it is in relation to industrial cannabis). As a signatory to the Single Convention, Australia is obliged to regularly provide information to the International Narcotics Control Board (**INCB**), such as annual estimates of harvest areas and yields, amount of raw material and refined products in stock, amounts required for importation and relevant trends in use for medicinal purposes.[21] Failure to meet such international obligations poses certain diplomatic and economic risks, including potential damage to Australia's international reputation (in particular, for its progressive, balanced and comprehensive approach to dealing with the problems posed by the use and misuse of drugs in the community).[22]

iv. Critically, the legal and policy issues that arise in relation to medicinal cannabis can be readily differentiated from those applying to the regulation of cannabis for non-medical purposes. The priorities, considerations and challenges which affect decisions in relation to medicinal cannabis differ significantly from those for non-industrial, recreational or other use.[23]

Regulation of Cannabis by the Commonwealth and States/Territories

Medicinal cannabis and cannabis-related activities are tightly controlled in Australia. The cultivation, production, manufacture, import, export, distribution, trade, possession, use and supply of cannabis and cannabis-derived products are regulated by several Commonwealth and state/territory laws:[24]

i. The *Criminal Code 1995* (Cth) and separate state and territory criminale, drug misuse and/or drug/poison control legislation generally make it illegal to traffic, import, export, manufacture, cultivate or possess cannabis or cannabis products.[25]

ii. The *Narcotic Drugs Act 1967* (**ND Act**) permits the cultivation and production of cannabis[26] and the manufacture of medicines comprising or derived from cannabis or its constituent parts.[27] However, the ND Act narrowly and inflexibly observes Australia's obligations under the Single Convention with tight controls that are, in some respects, unnecessary.

[19] *Convention on Psychotropic Substances 1971*, opened for signature 21 February 1971, 1019 UNTS 175 (entered into force 16 August 1976).
[20] *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*, opened for signature 20 December 1988, 2138 UNTS 214 (entered into force 11 November 1990).
[21] Ibid Arts 18-20; Explanatory Memorandum, Narcotic Drugs Amendment Bill 2016 (Cth), 7.
[22] Explanatory Memorandum, Narcotic Drugs Amendment Bill 2016 (Cth), 6.
[23] For example, see, R Pacula et al., 'Developing public health regulations for marijuana: Lessons from alcohol and tobacco' (2014) 104(6) *American Journal of Public Health* 1021.
[24] Ibid, 6.
[25] See, for example, *Drugs, Poisons and Controlled Substances Act 1981* (Vic) and *Therapeutic Goods Act 2010* (Vic); *Controlled Substances Act 1984* (SA); *Drugs of Dependence Act 1989* (ACT) and *Criminal Code Regulation 2005* (ACT); Misuse of Drugs Act 2001 (TAS) and *Poisons Act 1971* (TAS); *Cannabis Law Reform Act 2010* (WA) and *Misuse of Drugs Act 1981* (WA); *Drug Misuse and Trafficking Act 1985* (NSW); *Drugs Misuse Act* (QLD) and *Police Powers and Responsibility Act 2000* (QLD); and *Misuse of Drugs Act* (NT).
[26] *Narcotic Drugs Act 1967* (Cth), Ch 2 Pt 2 Div 1-2.
[27] Ibid, Ch 3 Pt 2 Div 1-3.

iii. The *Customs Act 1901* (Cth) addresses the import[28] and export[29] of narcotic substances generally, and the *Customs (Prohibited Imports) Regulations 1956* (Cth) and *Customs (Prohibited Exports) Regulations 1958* (Cth) provide a mechanism for the importation and exportation, respectively, of cannabis for medical and scientific purposes, subject to the appropriate licence and permit(s).[30]

iv. The *Therapeutic Goods Act 1989* (Cth) (**TG Act**), *Therapeutic Goods Regulations 1990* (Cth (**TG Regulations**) and other subordinate legislation and guidelines, and complementary state and territory legislation, regulate the availability of medicines and other therapeutic goods in Australia.[31]

v. The states and territories, through drug misuse, poison/drug control and/or hemp-specific legislation, license and control the cultivation, production and manufacture of cannabis, including industrial hemp and its derivative products.[32]

2 (b) Scheduling of Cannabis Products

Scheduling is a national classification system (*Standard for the Uniform Scheduling of Medicines and Poisons -The Poison Standard*) that controls how medicines and poisons are made available to the public. Medicines and poisons are classified into Schedules according to the level of regulatory control over the availability of the medicine or poison required to protect public health and safety. (https://www.tga.gov.au/scheduling-basics)

The Schedules are:

Schedule 1	Not currently in use
Schedule 2	Pharmacy Medicine
Schedule 3	Pharmacist Only Medicine
Schedule 4	Prescription Only Medicine OR Prescription Animal Remedy
Schedule 5	Caution
Schedule 6	Poison
Schedule 7	Dangerous Poison
Schedule 8	Controlled Drug
Schedule 9	Prohibited Substance
Schedule 10	Substances of such danger to health as to warrant prohibition of sale, supply and use

[28] Ibid, s 49.
[29] Ibid, s 112.
[30] *Customs (Prohibited Imports) Regulations 1956*, r 5.
[31] *Therapeutic Goods Act 1989* (Cth), Pts 3-1 and 3-2.
[32] See, for example, the *Hemp Industry Act 2008* (NSW).

Scheduling of cannabinoid products for pharmaceutical use

Cannabinoid preparations for pharmaceutical use are subject to very strict criteria. They must comprise at least 98 per cent of CBD and no more than 1 per cent of THC.

All medicinal cannabis products are Schedule 8 medicines, apart from products containing CBD in at least 98% purity (which are Schedule 4 medicines), or products containing CBD that are registered in the ARTG in doses not exceeding 150 mg/day (which are Schedule 3 medicines). Even non-narcotic forms of medicinal cannabis which have no psychotropic effects whatsoever are categorised as Schedule 8 medicines, even though many of these would more appropriately be dealt with as lower risk medicines.

These extreme restrictions on the legitimate pharmaceutical use of cannabinoid products have a number of significant consequences:

i. The predominant inclusion of medicinal cannabis products in Schedule 8 categorises them as high-risk medicines that must be strictly controlled, even though many medicinal cannabis products which fall into Schedule 8 do not have the safety concerns that would justify their inclusion in Schedule 8.

ii. Sponsors are deterred from applying for registration of their products on the ARTG, as a Schedule 8 classification would severely restrict the ability to market and sell their products.

iii. Many doctors are simply too uncomfortable to prescribe medicinal cannabis products to their patients. We believe that this is simply a symptom of the stigma that still attaches to medicinal cannabis, and those doctors not having received adequate education and training on this topic.

iv. Concerns about the liability risk that the use of an "unapproved" product presents, which has not been helped by the positioning of the majority of medicinal cannabis products as Schedule 8 medicines (which are regarded as high-risk medicines) which should only be used as last-line therapy.

v. Finally, patients are deprived of the opportunity to access the forms of medicinal cannabis that could provide significant benefits for serious conditions that are not adequately controlled by existing medications.

N. B. Cannabinoid products that contain only CBD at dosages less than 150 mg/day and are registered in the ARTG are classified as Schedule 3 (over-the-counter) medicines. However, these formulations are of limited benefit in the treatment of serious or chronic conditions.

2 (c) Australian prescribing regulations for Medicinal Cannabis

Pharmaceutical preparations of cannabis contain specific, known quantities of synthetic or naturally-derived cannabinoids and have been developed by various medicinal cannabis companies, both in Australia and Overseas, for restricted supply under the medicinal cannabis regulatory framework which commenced in 2016.

There are two routes for medicinal cannabis to be made legally available to patients in Australia:

Registration in the ARTG

Only therapeutic goods which are entered in the ARTG are lawfully able to be commercially supplied in Australia. However, due to years of prohibition, which included access to cannabis for clinical trials, there are currently only two medicinal cannabis products registered on the ARTG - Sativex (nabiximol) and Epidyolex (cannabidiol).

Despite the legalisation of cannabis in Australia in 2016, the pathway to ARTG registration is an onerous and very costly one, requiring the submission of a complex dossier of chemical (e.g. pharmacokinetic data), safety, tolerability, preclinical and clinical and manufacturing data to the TGA. The costs of producing such data is prohibitive, running into tens of millions of dollars, and the process is not commercially viable when weighed against the inability to obtain IP protection and the unlikelihood of obtaining Pharmaceutical Benefits Scheme (PBS) listing.

For example, after Sativex was registered in the ARTG, the sponsor applied for its listing on the PBS but the proposed price for Sativex, which was "cost minimised" against baclofen, was not commercially viable for the sponsor. In the absence of PBS listing, the only means by which patients are able to access medicines is through a private prescription, at a cost that is usually several orders of magnitude higher than the cost would be under a subsidised prescription.

Access Schemes

Due to the limited access to medicinal cannabis for patients provided by registration pathways, the primary means of accessing medicinal cannabis are two "Access Schemes" (SAS and APS). Although both schemes are unduly burdensome for the prescriber, they are the primary route through which patients may be legally prescribed medicinal cannabis in Australia.

(a) Special Access Scheme (SAS)

The SAS was introduced to provide a mechanism for patients to access therapeutic goods that are not entered in the ARTG. It is intended to facilitate the supply of a therapeutic good to a single patient on a case-by-case basis.

The expectation is that a health practitioner seeking access to a medicine for their patient under the SAS will have considered all appropriate treatments that are entered in the ARTG and available in Australia <u>before</u> submitting an application for access under the SAS.

In its administration of the SAS as it concerns medicinal cannabis, the TGA has made it clear that it has a responsibility to encourage the use of medicines that are included in the ARTG, as these products have been evaluated to ensure they meet strict standards of safety, quality and effectiveness.

For this reason, it is expected that medical practitioners (prescribers) will have considered <u>all clinically appropriate treatment options that are included in the ARTG before applying to access an unapproved medicinal cannabis product under the SAS</u>.

What this means in reality is that as far as the TGA is concerned, medicinal cannabis products should not be accessed by medical practitioners for their patients as first-line therapy, even though medicinal cannabis has quite clearly been shown to have benefit as an alternative treatment option that is not last line, or as adjunctive therapy.

(b) Authorised Prescriber Scheme (APS)

Authorised Prescribers (APs) are medical practitioners who are authorised to prescribe unapproved therapeutic goods for a particular condition or class of patients in their immediate care.

To become an AP, a medical practitioner must:

i. have the training and expertise appropriate for the condition being treated and the proposed use of the product; and

ii. be able to best determine the needs of the patient; and

iii. be able to monitor the outcome of therapy; and

iv. obtain approval from a Human Research Ethics Committee (**HREC**) or seek endorsement from a specialist college.

However, an APS authorisation is granted only to specified patients under the AP's immediate care (and not, for example, to other practitioners to prescribe/administer the product). This use in specified patients is also limited to the particular condition and/or class of patients specified in the authorisation, meaning that if the AP wants to administer the product to a patient for another condition or to a different class of patients, then another APS application is required.

2 (d) Clinical Trials

Generally, clinical trials are intended to investigate the safety, tolerability and efficacy of a treatment for a particular indication, in a particular cohort of patients. There are two schemes under which clinical trials involving therapeutic goods may be conducted:

i. the Clinical Trial Approval (**CTA**) scheme; and

ii. the Clinical Trial Notification (**CTN**) scheme.

Clinical trials for medicinal cannabis, as for pharmaceutical drugs, requires a clinical trial protocol, investigator's brochure, patient information sheet and informed consent form, indemnity form and other documentation to be submitted to the HREC or specialist college for assessment and approval. Once a clinical trial is approved, if there are any deviations required from the clinical trial protocol, a separate approval to vary the protocol must be obtained from the HREC.

3. Increasing use of medicinal cannabis as a therapeutic treatment in Australia

As Ms Faehrmann noted in her second reading speech:

"…the number of Australians accessing medicinal cannabis has exploded. Up to 12 October [2021], the TGA had approved over 180,000 applications for medicinal cannabis products. FreshLeaf Analytics, the leading supplier of data on the medicinal cannabis industry in Australia, has reported that the number of active medical patients has grown from 30,000 at the end of 2020 to 70,000 in September. That number is predicted to reach 75,000 by the year's end, with the exponential growth of the industry expected to continue into 2022 and beyond."

Summary

The Senate Inquiry "*Current barriers to patient access to medicinal cannabis in Australia*" (2020) noted current driving laws as one of the major barriers being experienced by patients across Australia.

With regard to the Terms of Reference to this inquiry, the position of AMCA is that the current driving laws are unfair to the increasing number of patients who depend on their legally prescribed medicinal cannabis to prevent their seizures, relieve their pain, control their chemotherapy-induced nausea, etc. and to provide efficacy where other pharmaceutical or surgical treatments have failed them.

Many of the current drug driving laws in Australia focus only on the presence of <u>any</u> level of delta-9-tetrahydrocannabinol (THC) rather than impairment. In most states, a randomised drug test detecting <u>any</u> THC in the saliva, blood or urine will result in an automatic loss of licence and possibly criminal charges, whether the driver is impaired or not and even if they can present evidence of an authentic prescription. This is despite treatment with medicinal cannabis arguably resulting in safer drivers, especially those who are prescribed the medicine for indications causing pain, tremor or spasms.

This will usually have a profoundly negative effect on the patient who may lose their job, their ability to manage their personal or family affairs, or to even to attend their regular medical or clinical trial appointments. The current laws can therefore have social, economic and psychological implications for patients (and their family or carers) who have to decide between continuing the treatment they need or losing their right to drive. The effects on peoples' lives is especially profound in rural and regional communities where it is not as simple as travelling by bus, taxi or train.

What is most disturbing is that the current laws are not based on scientific evidence. In fact, the evidence is to the contrary – in 2021, a Report by the Lambert Initiative based at Sydney University demonstrated that: [33]

- THC concentrations in blood and saliva are poor indicators of cannabis-induced impairment; and
- THC can be detected in the body weeks after cannabis consumption while it is clear that impairment lasts for a much shorter period of time

Professor Iain McGregor, who led the study said "*Our legal frameworks probably need to catch up with that and, as with alcohol, focus on the interval when users are more of a risk to themselves and others. Prosecution solely on the basis of the presence of THC in blood or saliva is manifestly unjust.*

"*Laws should be about safety on the roads, not arbitrary punishment. Given that cannabis is legal in an increasing number of jurisdictions, we need an evidence-based approach to drug-driving laws*".

The current driving laws for THC are not only unfair, they are inequitable as they do not apply to other legally prescribed narcotics such as opioids (e.g. oxycodone) and benzodiazepines that can cause significant impairment for drivers, but that are not tested in current drug driving tests. Instead, patients prescribed those medicines are advised by their medical practitioner not to drive if impaired. AMCA believes this would also be appropriate for medicinal cannabis prescribing, including products containing THC.

AMCA welcomes and strongly supports this proposed amendment, respectfully requesting note of our recommended changes, and hopes it will be a step in applying the same standard to medicinal cannabis as for other similar prescription medicines. We trust that scientific evidence, not stigma, will continue to guide policy in the future.

We would welcome the opportunity to appear before the Committee to provide further information and legal insight. If you have any questions or require further information, please do not hesitate to contact Gail Wiseman

Gail Wiseman
General Manager, on behalf of the Board and members of AMCA
30th April 2022

AMCA
Australian
Medicinal Cannabis Association

[33] McCartney, Danielle et al. "Determining the magnitude and duration of acute Δ^9-tetrahydrocannabinol (Δ^9-THC)-induced driving and cognitive impairment: A systematic and meta-analytic review." *Neuroscience and biobehavioral reviews* vol. 126 (2021): 175-193.