Submission No 65

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

Organisation: Society of Cannabis Clinicians Australian Chapter

Date Received: 1 May 2022

SOCIETY OF CANNABIS CLINICIANS AUSTRALIAN CHAPTER

SOCIETY OF CANNABIS CLINICIANS AUSTRALIAN CHAPTER

Submission to Inquiry into the Road Transport Amendment (*Medicinal Cannabis - Exemptions from Offences*) Bill 2021

Introduction

The Society of Cannabis Clinicians Australian Chapter (SCCAC) was formed on 4th November 2020 as the Australian Chapter of the renowned and respected international Society of Cannabis Clinicians. It is an educational and scientific society of qualified physicians and other professionals dedicated to the promotion, protection and support of cannabis for medical use.

SCCAC welcomes the opportunity to make a submission to this inquiry into the Road Transport Amendment (*Medicinal Cannabis - Exemptions from Offences*) Bill 2021 introduced by Ms Cate Faehrmann MLC in November 2021.

The introduction of this Bill provides the long overdue opportunity to address out-of-date drug driving legislation. For too long, the *Road Transport Act 2013* (NSW) sub-section 111 (1), as it currently stands, has unfairly discriminated against patients legally prescribed medicinal cannabis. Patients on other potentially impairing prescription medicines such as benzodiazepines and opioids are not subject to presence-based roadside drug testing, and there is little evidence to justify the differential treatment of medicinal cannabis patients.[1] This is unfair to the increasing number of patients who depend on their legally prescribed medicinal cannabis to relieve a number of symptoms and/or clinical indications and to provide efficacy where other surgical or pharmaceutical 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. A randomised drug test detecting <u>any</u> THC in the saliva, blood or urine may result in an automatic loss of licence and possible 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.

Current driving laws are not based on scientific evidence. A 2021 report published by the University of Sydney's Lambert Initiative for Cannabinoid Therapeutics (Report) considered 80 publications which reviewed 1534 outcomes to characterise the acute effects of a single dose of THC on driving performance and driving-related cognitive skills.[2] The Report indicated that:

- 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.

The authors concluded that the effects of THC were less pronounced in regular users compared to occasional cannabis users, most likely due to the development of tolerance. The Report cited two Canadian guidelines (Mothers Against Drunk Driving and Health Canada) advising that an individual should wait from 4-6 hours after using medicinal cannabis (THC) before driving.

*N.B. THC is stored in body fat

[1] Perkins ibid

[2] 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.

However, the authors of the aforementioned Report suggested from their analyses that most driving-related cognitive skills recover within 3-5 hours of inhaling 10 and 20 mg of THC, respectively, with most individuals recovering within 5-7 hours, respectively.

Prof. Iain McGregor, who led the research has 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 drug 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.

We believe this would also be appropriate for the prescribing of medicinal cannabis including products containing THC.

As such, we feel it is pertinent to highlight the many legal, regulatory and prescribing steps already in place before a patient in Australia can be legally prescribed medicinal cannabis in Australia.

Terms of Reference

The NSW Legislative Council's Standing Committee on Law and Justice is inquiring into the potential to amend the current legislation which applies to THC and driving offences in New South Wales. As the Terms of Reference for the Inquiry are not specific, our considerations are general.

Context

1. International laws

a) *The Single Convention on Narcotic Drugs 1961*[3] (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.[4] The Single Convention is primarily implemented into Australian law by the Act.

b) *The Convention on Psychotropic Substances 1971*[5] 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))

c) *The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988*,[6] aims to promote cooperation between parties to address the illicit trafficking of narcotic drugs and psychotropic substances.

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

[3] *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*.
[4] Ibid, Art 2; and Art 28 for cannabis cultivation specifically.
[5] *Convention on Psychotropic Substances 1971*, opened for signature 21 February 1971, 1019 UNTS 175 (entered into force 16 August 1976).
[6] *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).

derived from cannabis is consistent with Australia's international obligations. This includes 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.[7]

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).[8]

2. Regulations of 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:[9]

a) The *Criminal Code 1995* (Cth) and separate state and territory criminal, drug misuse and/or drug/poison control legislation generally make it illegal to traffic, import, export, manufacture, cultivate or possess cannabis or cannabis products.[10]

b) The *Narcotic Drugs Act 1967* (**ND Act**) permits the cultivation and production of cannabis[11] and the manufacture of medicines comprising or derived from cannabis or its constituent parts.[12]

   The ND Act narrowly and inflexibly observes Australia's obligations under the Single Convention with controls that are, in some respects, unnecessarily tight.

c) The *Customs Act 1901* (Cth) addresses the import[13] and export[14] 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).[15]

d) The *Therapeutic Goods Act 1989* (Cth), *Therapeutic Goods Regulations 1990* (Cth) and other subordinate legislation, guidelines, and complementary state and territory legislation regulate the availability of medicines and other therapeutic goods in Australia.[16]

Especially relevant for healthcare practitioners is the requirement that medical practitioners are to ensure that their patients have tried all other approved drugs for their condition before medicinal cannabis can be prescribed.

---

[7] Ibid Arts 18-20; Explanatory Memorandum, Narcotic Drugs Amendment Bill 2016 (Cth), 7.
[8] Explanatory Memorandum, Narcotic Drugs Amendment Bill 2016 (Cth), 6.
[9] Ibid, 6.
[10] 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).
[11] *Narcotic Drugs Act 1967* (Cth), Ch 2 Pt 2 Div 1-2.
[12] Ibid, Ch 3 Pt 2 Div 1-3.
[13] Ibid, s 49.
[14] Ibid, s 112.
[15] *Customs (Prohibited Imports) Regulations 1956*, r 5.
[16] *Therapeutic Goods Act 1989* (Cth), Pts 3-1 and 3-2.

3. Scheduling of Cannabis Products

The 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 classifies medicines and poisons 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 noted below:

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

Scheduling of cannabinoid products for pharmaceutical use

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).

The scheduling of legitimate pharmaceutical cannabinoid products categorises them as high-risk medicines that must be strictly controlled, despite many medicinal cannabis products, including non-narcotic forms of medicinal cannabis, having no psychotropic effects or safety concerns that would justify their inclusion in Schedule 8.

This has the following unfortunate effects on prescribers and products and, ultimately, patients:

(a) Many clinicians are uncomfortable to prescribe medicinal cannabis products to their patients due to the stigma still attached to medicinal cannabis, including its scheduling, which has been exacerbated by the lack of sufficient education and training on this topic.

(b) Many medical practitioners have concerns regarding liability risk associated with the use of an "unapproved" product. This is 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.

(c) Many products will never be listed on the ARTG, as a Schedule 8 classification would severely restrict the ability to market and sell sponsors' products. Many patients are therefore deprived

of the opportunity to access alternative forms of medicinal cannabis that could have potentially provided significant benefits for serious conditions not adequately controlled by existing medications.

N. B. Although cannabinoid products containing CBD at dosages <150 mg/day and registered in the ARTG are classified as Schedule 3 (over-the-counter) medicines, they are of limited benefit in the treatment of serious or chronic conditions.

4. Australian prescribing regulations for Medicinal Cannabis

The legalisation of medicinal cannabis in 2016 led to two routes being made legally available for supply to patients in Australia:

Registration in the ARTG

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

Although medicinal cannabis has been legal in Australia since 2016, securing ARTG registration is challenging and expensive. Chemical (e.g., pharmacokinetic data), safety, tolerability, preclinical, clinical and manufacturing data must be supplied to the TGA for product review. Such efforts and costs have to be weighed against the lack of intellectual property (IP) protection and the very low probability of ever securing Pharmaceutical Benefits Scheme (PBS) listing.

TGA Access Schemes

Due to the limited access to medicinal cannabis for patients provided by registration pathways for the reasons just mentioned, two "Access Schemes" (SAS and APS) have become 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.

Healthcare practitioners seeking access to a medicine for their patient under the SAS should have considered all clinically appropriate ARTG treatment options that are included in the ARTG before applying to access an unapproved medicinal cannabis product under the SAS. The reason ARTG listed products are preferred by the TGA is that they have been evaluated to satisfy strict standards of safety, quality and effectiveness.

Although medicinal cannabis has quite clearly been shown to have benefit as an alternative treatment option that is not last line, or as adjunctive therapy, the above guidance essentially relegates medicinal cannabis products to last-line therapy.

(b) Authorised Prescriber Scheme (APS)

Authorised Prescribers (APs) are medical practitioners who are approved 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.

APS authorisation is granted only to specified patients under the AP's immediate care. The use in specified patients is also limited to the particular condition and/or class of patients specified in the authorisation. If an AP needs to administer the product to a patient for another condition or to a different class of patients, another APS application is required.

Since its legalisation in 2016, the number of applications through these access schemes has risen exponentially as more and more patients have requested medicinal cannabis as a treatment option, and a growing number of healthcare practitioners have become more familiar with medicinal cannabis and the schemes associated with its prescription.

180,000 applications were approved by the TGA up to 12th October 2021 and the number of active patients in Australia rose from 30,000 at end 2020 to 70,000 by September 2021 (These statistics were noted by Ms Faehrmann in her second reading speech).

5. Clinical Trials

Medical practitioners play an important role in recommending patients to be considered for enrolment in clinical trials.

The purpose of most clinical trials is to investigate the safety , tolerability and efficacy of a treatment for a particular indication in a particular cohort of patients.

The two schemes under which clinical trials involving therapeutic goods may be conducted are:

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

ii. the Clinical Trial Notification (CTN) scheme.

As for pharmaceutical drugs, clinical trials for medicinal cannabis require documentation including a clinical trial protocol, investigator's brochure, patient information sheet, informed consent and indemnity forms to be submitted to the Human Research Ethics Committee or specialist college for assessment and approval. Once approved, a separate approval to make any required changes to the protocol must be obtained from the HREC.

Key Concerns

The Act currently 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. Thus, if a person undergoes a random, roadside drug test and <u>any</u> prescribed illicit drug is detected in their saliva (oral fluid), blood or urine, <u>even if it was prescribed by a medical practitioner</u>, the person faces considerable penalties, fines and potential court proceedings and/or loss of their driving licence. This latter point can significantly impact the lives of Australians living in rural and remote communities.

Under the Act, "prescribed illicit drugs" include delta-9-tetrahydrocannabinol (THC), methylamphetamine ("speed"), 3,4-methylenedioxymethylamphetamine ("ecstasy") and cocaine.

Yet medicinal cannabis (including THC) has been legal since 2016. Thus, the drug-driving laws are not only out of date but unreasonable for the tens of thousands of Australians now using legal, prescribed medical cannabis.[17]

[17] McCartney, ibid

In contrast to THC, 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. The therapeutic value of THC and CBD has been demonstrated in the treatment of a range of medical conditions, including AIDS/HIV,[18] Alzheimer's disease,[19] chemotherapy-induced nausea and vomiting,[20] cancer,[21] diabetic peripheral neuropathy,[22] epilepsy,[23] multiple sclerosis,[24] anxiety and depression.[25] There is also some evidence that THC and CBD may assist in the symptomatic relief of chronic pain,[26] glaucoma,[27] Tourette syndrome[28] and sleep disorders.[29]

Many of the Australians who could benefit from the use of legally prescribed medicinal cannabis are anxious about the possibility of facing prosecution, fines and/or loss of licence. Others leave their prescriptions unfilled, deterred by the risk of prosecution. The possibility of losing their licence is especially concerning for patients in rural and remote locations for whom there is less availability of public transport and more reliance on cars.[30] Additionally, researchers have highlighted that such laws have impacted recruitment of participants into clinical trials due to not being able to drive whilst using investigational products in the active phase.

Patients for whom medicinal cannabis could provide a means of coming off high doses of opioids and benzodiazepines are also disadvantaged by the risk of prosecution[31] despite a recent clinical study finding that road safety risks with THC were similar or lower than many other prescription medications that can cause impairment, including opioids, benzodiazepines and antidepressants.[32] Yet such prescription medications are not subject to presence-based testing, which further highlights the unfairness for medicinal cannabis patients.[33]

As medical practitioners are already entrusted to advise patients to be cautious with driving when prescribing any medication that might cause impairment (including opioids and benzodiazepines), it seems highly discriminatory for legally prescribed medicinal cannabis (including THC) to be treated any differently.

SCCAC Recommendations

SCCAC is concerned that the proposed amendments, as they stand, do not sufficiently address the changes needed. Although an exception to the current legislation has been created through the proposed insertion of sub-section 111(1A) after sub-section 111(1) of the Act, this exception will not address the fact that, as a legal drug, THC should not be categorised as a prescribed illicit drug and should not be subject to the offence provisions under the Act at all.

---

[18] Victorian Law Reform Commission, *Medicinal Cannabis: Report*, Report No 32 (August 2015), 39 and 64.
[19] 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.
[20] Lynch and Ware, above n 7, 295 and 299.
[21] Whiting et al, above n 6, 2460.
[22] 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.
[23] M Tzadok et al., 'CBD-enriched medical cannabis for intractable paediatric epilepsy: The current Israeli experience' (2016) 35 *Seizure* 41, 43.
[24] Croxford and Yamamura, above n 14; Whiting et al., above n 6, 2461 and 2465.
[25] Whiting et al., above n 6, 2463.
[26] Lynch and Ware, above n 7, 293-299.
[27] T Jarvinen, D Pate and K Laine, 'Cannabinoids in the treatment of glaucoma' (2002) 95 *Pharmacology & Therapeutics* 203, 215.
[28] Whiting et al., above n 6, 2464.
[29] Ibid.
[30] Senate Report op.cit.
[31] Perkins op. cit.
[32] Booker, C (June 11, 2021) 'It's discriminating': Study finds no justification for medicinal cannabis driving ban https://www.theage.com.au/national/victoria/it-s-discriminating-study-finds-no-justification-for-medicinal-cannabis-driving-ban-20210610-p57zsc.html
[33] Perkins ibid

SCCAC believes that patients who are legally prescribed medicinal cannabis products in Australia should not be subject to prosecution simply for driving with any level of THC in their system, unless they otherwise commit a road traffic offence that is punishable under the law. As medicinal cannabis is for most patients, a last line of therapy, we consider it unfair and discriminatory for patients that are legally prescribed medicinal cannabis to be prevented from driving, when similar or stronger narcotics are not subject to the same extensive restrictions.

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 (because it is stored in fat). However, impairment lasts for a much shorter period of time, especially in patients taking medicinal cannabis who develop a tolerance to it with longer term use.

SCCAC believes the focus of driving laws with regard to medicinal cannabis should be on impairment. 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.

We propose that patients driving on THC-based medicinal cannabis products that have been legally obtained and administered by a medical practitioner should be able to be cautioned by their medical practitioner on potential impairment in line with similar drugs such as opiates and benzodiazepines, and permitted to drive as advised by their medical practitioner. This would entrust and authorise trained and authorised medical practitioners to advise patients on their suitability to drive and address the current inequity.

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 to access for patients.

SCCAC believes that any discussion of medicinal cannabis should be underpinned by the:

1. *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**[34]; and
2. *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**.[35]

SCCAC is concerned that driving laws in Australia have continued to discriminate against the increasing number of patients who depend on their legally prescribed medicinal cannabis for a variety of indications for which alternative treatments have failed.

We believe that the barriers to patients being able to access medicinal cannabis resulting from out of date driving laws negatively impact medicinal cannabis patients' physical and mental healthcare rights.

The detrimental effects on the patient (and carer or family members) who may be unable to manage their job, personal or family affairs, or attend medical or clinical trial appointments is considerable. This may have social, economic and psychological implications for patients who have to make the choice between continuing the treatment they need or losing their right to drive.

[34] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3(entered into force 3 January 1976)
[35] 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).

We are, therefore, encouraged that long-needed changes to the *Road Transport Act* 2013 (NSW) may arise from the Road Transport Amendment (*Medicinal Cannabis exemptions from Offences*) Bill 2021.

While supporting the Bill, SCCAC requests that our proposed recommendations are also considered, being:

- that medicinal cannabis should no longer be categorised as a prescribed illicit drug, nor included under the Act with speed, ecstasy and cocaine.
- that medicinal cannabis (THC) be brought into line with other legally prescribed narcotics such as opioids and benzodiazepines that are prescribed on the understanding that medical practitioners will counsel patients that they should not drive if impaired.

SCCAC welcomes and strongly supports this Bill, while hoping that the Inquiry will accept our recommended amendments, and trusts that this will result in applying the same standard to medicinal cannabis as for other similar prescription medicines.

We would welcome the opportunity to appear before the Committee to provide further information and medical insight.

If you have any questions or require further information, please do not hesitate to contact the undersigned

Gail Wiseman

General Manager

Society of Cannabis Clinicians Australian Chapter (SCCAC)

30th April 2022

SOCIETY OF CANNABIS CLINICIANS® AUSTRALIAN CHAPTER