Spécificité de la situation périnatale dans deux régions Australiennes : la fondation du Consortium International

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The international consortium for pregnancy and addictions is a collection of clinicians and researchers involved in the treatment of drug use in pregnancy. It was formed after a meeting of Assoc Prof Alison Ritter, of the National Drug and Alcohol Research Centre, Australia, Prof Gabrielle Fischer, of the University Hospital, Vienna, Austria and Dr Judy Myles, from the University of London in 2003. The initial interest occurred regarding after a number of papers had been published regarding the use of buprenorphine in pregnancy.

Sponsorship for a meeting of interested researchers and clinicians was obtained from Reckitt Benckiser. A list of clinicians and researchers was generated after reviewing relevant publications and discussions with key experts in the field. This included clinicians and researchers from Austria, Australia, Belgium, Canada, Denmark, France, Germany, Norway, Sweden, the UK and USA. The first meeting of this group was held at the 67th Annual Meeting of the College of Problems of Drug Dependence in San Juan, Puerto Rico, in June 2004, as a satellite meeting. This group as continued to meet at subsequent CPDD annual meetings in 2005, 2006 and 2007. This allows discussions of key issues in substance abuse research in pregnancy and facilitates discussion between key players in the field as well as an opportunity for greater understanding of the differences in substance abuse treatment in pregnancy across countries and reflection on important issues.

In Australia, treatment for opiate dependence, using methadone commenced in the 1970s. Buprenorphine was introduced in 2001. Currently opiate substitution treatment occurs for approximately 39,000 people, and occurs in specialist treatment centres (30%) and general practitioners and community pharmacies (70%). When buprenorphine was introduced in 2001, pregnancy and breastfeeding were listed as contra-indications to using the medication. However, after considering international research and experience in the use of the medication, Australian National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn have supported the use of buprenorphine in pregnancy and breastfeeding since 2006, in situations where buprenorphine maintenance is appropriate. Methadone remains the first line treatment of opiate dependence in pregnancy.

Significant recent work in Australia includes the work of Lucinda Burns from the National Drug and Alcohol Research Centre. She has used data linkage methods to link

patient records in assessing associations between substance exposure and perinatal outcomes. This work has confirmed in Australian populations associations between late stabilisation on methadone and patients being younger, more likely to smoke tobacco, more likely to be Indigenous Australians, presenting late in pregnancy and more likely to have premature deliveries.

A recent report by the Health Ombudsman in the state of New South Wales has investigated a number of cases of infant death related to methadone exposure. These cases involved children being given 'take-away' or non-supervised doses of methadone. The cases highlight an urgent need for improved communication between drug treatment services and child welfare services to prevent further child deaths and provide earlier alerts for children at risk.

These deaths also provide an opportunity for reflection of the reduced overdose risks associated with buprenorphine maintenance. While there may be many cases of accidental child exposure to buprenorphine, to date there does not appear to have been any child deaths related to buprenorphine. This may relate not only to the pharmacological properties of buprenorphine being a partial opiate agonist, but also to the optimal mode of absorption being a sublingual route. These factors may combine to make buprenorphine exposure less dangerous if involved in accidental child poisoning. Whether this means that buprenorphine may have an advantage in the treatment of opiate dependent patients who have children at risk of harm requires more debate and research.

A final interesting example of how popular politics may affect national drug policy is the Australian Government Committee on Family & Human Services report from 2007. This report recommended a number of extremely regressive plans for drug treatment in Australia including: adoption for children whose parents use *any* illicit drugs (while alcohol was not considered in the report); the quarantining of welfare payments for people who used illicit substances; a change in the objective of opiate substitution treatment in Australia to obtain a 'drug-free' state; and a policy of only funding treatment agencies whose goal is abstinence. The report also recommended the use of naltrexone implants for patients, despite the fact that the safety, efficacy and effectiveness of this treatment has not been demonstrated, in fact the medication is not licensed in this form in Australia!

This federal Australian government has since changed, making any implementation of such a policy very unlikely. However, even in a country that has maintained an international reputation of reasonably progressive drug policy, this report highlights how easily drug users, particularly pregnant drug users or drug users with children, can become the focus of sensationalistic partisan political approaches.

In conclusion, this series of examples have been used to demonstrate the importance of continuing to develop a robust evidence base for substance abuse treatment in pregnancy, and the value international associations and collaborations can have. This can become particularly important during periods of development, for example the implementation of new medications, and during periods of partisan political arguments against evidence

based treatment. Inspired by the sensible arguments of Associate Professor Hendree Jones, the author would like to recommend the ongoing development of the international consortium, and suggest a need for an international consensus statement regarding the standard of treatment that should exist for pregnant women who use substances, for their benefit, for the benefit of their children and for the broader society.