centre in East Africa and one of only two in the whole Sub Saharan Africa', and a challenge to say the least.

'Some things are exactly the same; many, many things are just another world. It is very interesting to work where there are no services or free health care. Some estimates say that half of the injecting drug users out there are HIV positive,' Telfer explains.

The project aims to empower local people to help themselves: 'We have given them the skills we have learnt from here… the big struggle is to get everything structured enough.'

'I know that the work we have done has really made a difference,' she adds. 'We have counselling as a basic intervention but the culture there is that you don't talk about problems, so introducing counselling there has really helped.' There is so much more to be done, Telfer acknowledges: 'needle exchanges are desperately needed'.

Back home it has just been announced that Bristol is to be getting an extra £1.3 million of funding for drug treatment services. But despite celebration in some quarters, Telfer thinks more still needs to come. The 37 per cent increase leaves Bristol as 145th in the funding league table of 149 drug action teams.

'The national average is twice what Bristol gets [so] it is great news. But it needs to be the first step of many to close that gap, she says. 'This is postcode lottery at its worst.'

In real terms, this means a rise of £200 per head to £1,000 – where some others are getting as much as £4,000 per head, she explains.

As part of the funding boost, BDP have just been given support to mentor the children of drug using parents, an extension of the service's work with parents and their maternity drugs service. 'Previously, users would avoid antenatal care as they felt they were being incredibly judged,' Telfer points out.

Supporting inclusion of drug users has been important to the service's ethos over the past 21 years. 'One of the most important things we have done, along with others, is to set up the shared care service, so people can get their scripts from GPs and not mental health services and it is very normal for users,' says Telfer. 'GPs should be able to cope, but if not they can refer people on.'

'This partnership model shows that if you make treatment very accessible then people will come and use it,' she adds.

Bristol now has over 70 per cent of GPs that will prescribe, which means services like BDP don't get completely overloaded like many other areas of the country.

There have been other, community-based successes for the project. Launching a drug and alcohol-free social event, based on the Community Reinforcement Approach, helped service users avoid relapse by filling leisure time.

With the therapeutic value of gardening now acknowledged, BDP has also taken inspiration from Monty Don's TV programme, 'Growing out of trouble', by providing a free allotment and a memorial garden for their clients.

Telfer anticipates some of the challenges on the horizon: 'Cocaine use is huge now and we haven't seen the impact from that yet, but it is inevitable that it will with the level of use we are seeing.

'Methamphetamine is a huge problem in other parts of the world and the only logical answer as to why it isn't here is that it is being kept out by the gangs that control the drug trade. But it can only be a matter of time.'

Looking ahead to 2008, BDP are planning a conference reflecting on what has changed for drugs and drug treatment over the last 21 years. For the immediate future though, there is the birthday event to organise with Baroness Doreen Massey, Chair of National Treatment Agency coming to open the partly refurbished drop-in centre on 9 March.

Marc Leverton is a journalist based in Bristol.

Post-its from Practice

Good drug, bad drug?

Benzodiazepines are not always the bad guys, says Dr Chris Ford

One of my partners at the surgery came to ask me to see a patient he was concerned about. Imran was a 34-year-old Asian man, who had been housed temporarily around the corner from the practice, in bed and breakfast. He suffered from depression and was receiving methadone from one of the local specialist drug services. His behaviour at the surgery was also causing problems. He was attending erratically, seeing a variety of doctors and demanding benzodiazepines. On some occasions he received them and then over-used them, on other occasions he didn't and then verbally complained.

I said I was happy to see him and assess the situation. When Imran attended he seemed frightened. He talked rapidly and appeared distressed. On discussion he told me he had had a benzodiazepine problem for nearly 20 years. He was receiving 80mg of methadone from the drug service and using no opioids on top. They had assessed that he did have a benzodiazepine problem but their policy, like many other drug services, was only to prescribe for a short-term detoxification. Admittedly this is also the advice given in the last clinical guidelines, but I feel it doesn't deal with the reality of this problem[1].

He explained that Valium had been his first addiction after a traumatic childhood and that he had used it for over 20 years consistently. It had even been prescribed during his two short periods in prison, although his methadone wasn't! He also explained that his alcohol intake dramatically increased when he couldn't get them. As he is hepatitis C positive this is important. His whole story was confirmed on talking to the drug service, even including that they were increasingly concerned about his alcohol intake and that all urines taken had been positive for benzodiazepines!

Imran said he was taking on average 30mg a day of diazepam but found them hard to manage when he bought or got them from the surgery. We consequently agreed as he was picking up his methadone daily that we would prescribe him 30mg of diazepam on a daily pickup also. He was very relieved and grateful as he left the surgery with his instalment prescription for diazepam and the benefits of this decision have since become very apparent.

Illicit benzodiazepine use, particularly by opioid users, is prevalent and a major problem for users in and out of drug treatment. Up to 90 per cent of people attending drug treatment centres reported benzodiazepine use in a one-year period and there is a high prevalence of benzodiazepine use in methadone maintenance patients. Some GPs are still more comfortable with prescribing benzodiazepines than methadone to problem drug users, whereas the reverse should be true[2]. There is still no 'gold standard' treatment for benzodiazepine dependency and little evidence for the value of substitute prescribing of benzodiazepines, which I feel allows most of us to resort to opinion-based medicine. But does the lack of evidence mean it is bad?

Clinically, I find maintenance benzodiazepine prescribing very useful in certain selected patients and feel that a policy of never prescribing them creates enormous difficulties for some, for whom they are a serious problem.

Imran, I feel, is one of those. He now attends the surgery regularly, usually early for his appointment with the counsellor or myself. He never over-uses, his mood has improved and he has stopped drinking altogether! He is very grateful and his view is that he has been given back his life.

Benzodiazepine addiction is a serious problem and I am not underplaying it, but they are also incredibly useful drugs so let's not throw the baby out with the bath water.

Dr Chris Ford is a GP at Lonsdale Medical Centre and Clinical Lead for SMMGP

1. *DOH (Department of Health) (1999). Drug Misuse and Dependence – Guidelines on Clinical Management. London: The Stationery Office.*
2. *Ford, C., Roberts, K. and Barjolin JC. (2005) Guidance on Prescribing Benzodiazepines to Drug Users in Primary Care. Substance Misuse Management in General Practice. Available online from www.smmgp.org.uk/download/guidance/guidance006.pdf*