**Benzodiazepines + MATOD - Client Agreement**

The use of benzodiazepines such as diazepam, oxazepam and alprazolam, and related drugs such as zolpidem and zopiclone raises a number of issues. This class of drug can be dangerous, causing **sedation**, falls, **dependency/addiction, withdrawal symptoms** and even **overdose.** Longer term they may be linked to poorer brain function. These drugs also have negative effects on pregnancy outcomes.

Combining benzodiazepines with opioids (including prescribed methadone and buprenorphine) significantly increases the risk of **sedation**, **overdose** and **death**.

Benzodiazepines and related drugs make it far more likely to have a **motor vehicle accident**, especially when combined with alcohol, opioids, cannabis or any other illicit drugs. Even if only taken before bed at night time, long-acting benzodiazepines can **impair daytime driving.**

Benzodiazepines **do not work long-term** for sleep problems or anxiety disorders. When anxiety or sleep disturbance re-emerges in people who cease their benzodiazepines, it is usually a sign of withdrawal.

You have been taking the following benzodiazepines and other sedative drugs: …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

It is important you reduce and stop your regular benzodiazepine use. Generally this is best managed by a slow reduction in the benzodiazepine dose over a period of weeks or months. This helps avoid withdrawal symptoms, or a rebound of your anxieties or sleep disturbance.

The following withdrawal schedule is to help you safely and comfortably reduce your use:

|  |  |
| --- | --- |
| Reason for prescribing |  |
| Current drug and dose |  |
| Reduction rate |  |
| Next review of plan (date) |  |
| Other health providers involved in plan |  |

I, [name and DOB]……………………………………………………,

understand the risks of continuing benzodiazepines and the benefits associated with gradual discontinuation.

* understand the possible adverse effects these medications have on driving.
* am aware that if I have not followed this agreement, my doctor(s) may not continue to prescribe certain medications. I am also aware that it may include reducing my methadone/ buprenorphine dose, and/or restricting any unsupervised dosing.
* understand that DASSA may (with my consent) seek information about prescriptions I receive from other doctors through the PBS.

After I have been informed about the proposed withdrawal treatment plan and had the opportunity to ask my questions, I consent to undertake this treatment plan.

Signature (client)………………………………………………… Date………………………

Signature (DASSA clinician)…………………………………… Date ………………….......

**Follow-up plan revisions**

|  |  |
| --- | --- |
| Date |  |
| Current drug and dose |  |
| Reduction rate |  |
| Next review of plan  (date) |  |
| Other health providers involved in plan |  |
| DASSA clinician involved in revision |  |

|  |  |
| --- | --- |
| Date |  |
| Current drug and dose |  |
| Reduction rate |  |
| Next review of plan  (date) |  |
| Other health providers involved in plan |  |
| DASSA clinician involved in revision |  |

|  |  |
| --- | --- |
| Date |  |
| Current drug and dose |  |
| Reduction rate |  |
| Next review of plan  (date) |  |
| Other health providers involved in plan |  |
| DASSA clinician involved in revision |  |

|  |  |
| --- | --- |
| Date |  |
| Current drug and dose |  |
| Reduction rate |  |
| Next review of plan  (date) |  |
| Other health providers involved in plan |  |
| DASSA clinician involved in revision |  |