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Policy Statement
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The Policy of Blind Dosing and Patient Dignity

Methadone maintenance treatment has been the most effective treatment for addiction to heroin resulting the cessation of her oin use and criminal behavior. Prior to the development of methadone maintenance treatment over 28 years ago narcotic addiction w as considered incurable and a behavioral disorder under the control of law enforcement. Drs. Dole and Nyswander brought the treat ment of heroin use back into the doctor's office treating the addict as any other patient with a chronic disease. However, the original methods employed by Dole and Nyswander have sometimes been misunderstood often impacting negatively on a treatment that is vi rtually life saving for the addict.

Blind dosing has become a policy that some programs located outside of the New York City area employ for various reasons. Several basic characteristics can be found within programs with blind dosing policies: 1) an adequate dose is not prescribed, 2) dosa ge has become a problem and 3) the program does not believe in the disease concept of addiction, 4) the program views methadone as a substitute drug, 5) the program does not understand the physiological differences found in addicts, 6) the program does not follo w a medical model, 7) the program does not appreciate or understand the biological determinants of drug craving, and 8) the progra m is basically administered by behaviorists who treat heroin addiction as a character disorder.

Many programs believe that blind dosing is a therapeutic strategy to remove the issue of depending on a chemical substance f or support, to make them feel normal and to get them through the day, so the addict can begin to look to oneself instead. Unfortunat ely, it has the opposite effect of being destructive to the therapeutic relationship between the patient and counselor and the patient an d program. The trust that is necessary for quality methadone treatment is never developed because the patient feels betrayed and mal igned by the one thing that is suppose to understand them. And patients who are truly a very small minority and may have problems such as competition with other patients for the highest dose never have this problem dealt with in a therapeutic manner. Blind dosin g is the program's way of avoiding the problems that these patients may have. A cop out!

For programs that blind dose, successful patients are rare because only the motivated patient who is determined is able to cha nge their life may be able to. This is not to say that blind dosing is inconsequential to these patients, rather they are better equipped f or rehabilitation and able to overcome their feelings of anger toward the clinic. For the unmotivated and ambivalent methadone patie nt with low self esteem blind dosing can be disastrous for their response to treatment. These patients come into treatment with feelin gs of low self esteem and hopelessness and need to develop a trusting relationship with their counselor and the program, which is th wartedThe majority of these patients could be successful too, but without their development of trust in the program they can never b egin to acquire the necessary attributes such as responsibility and independence to change their lives.

The treatment style of these clinics have been defined as reformist. According to Rosenbaum (1985) while the reformist treat ment style may work for a short period of time, but eventually the patient will become angry and feel left out of treatment decisions. The reformist philosophy is too damaging to one's self worth for any extended period of time resulting in a low retention rate for th ese programs. Those in need of help may accept degrading definitions of themselves temporarily, however the human psyche will at tempt to maintain one's integrity and dignity, and will not tolerate long-term degradation, at least not happily. Thus patients become embittered and resentful toward the clinic eventually realizing that the program is wrong about many things, including their treatme nt. The patient no longer takes their treatment seriously and becomes frustrated and ambivalent. They can no longer be engaged in p articipating in their treatment or it's process.

Research has found that patients report that receiving methadone was both, the best liked and most useful aspect of treatment (Stark & Campbell, 1991). Studies indicate that patient's awareness and influence in dosing decisions are important treatment practi

ces and related to retention in treatment (D'Annuno and Vaughn, 1992; Watters, 1986). D'Annuno and Vaughn (1992) studied 172 methadone programs and found that many have policies that are not effective, including blind dosing and the patient's noninvolvement regarding dosing decisions were noted. For over a decade HIV has been spreading through the injecting drug user community thus emphasizing the importance of retaining patients in treatment. Methadone when given in a adequate dose will block the craving for heroin resulting in the cessation of heroin use and criminal activity (GAO, 1990). Therefore, if for no other reason retention in methadone treatment should be a priority for programs (Schuster, 1989). From the patient's point of view they have a right to know that they are receiving an adequate dose.

However, their are other aspects of this that many programs may never think of, perhaps because they know very little about methadone themselves and which places them in jeopardy. If a patient is blind dosed and not receiving a blockade dose of methadone and then overdoses they, or their family should they die could sue the program. There would be little for the program to protect itself with in such a legal matter, since the National Institute on Drug Abuse, the Center for Substance Abuse Treatment and the American Methadone Treatment Association all have policy statements which say that blind dosing in ineffective and wrong. A second problem is the diversion of methadone by staff which is very tempting in such a situation. If patients do not know their dose it would be very easy for program staff to take a few milligrams from every dose. At the end of the day these few milligrams per patient would become a nice perk for the employee, especially considering the cost of illicit methadone in some locals. For the safety of the program it is common sense that patients should know their dose.

Blind dosing is contrary to the modality developed by Dole and Nyswander that has been so successful in treating heroin addiction. Dr. Nyswander believed and taught other professionals to "...first listen to your patient and you will never make a mistake" (Dole, 1992). She treated her patients with dignity and respect, as worthy individuals deserving of medical care and treatment and as valuable as any other individual receiving treatment for a chronic condition. And that was why the Dole - Nyswander program was so successful. Now I ask you, if you went to a physician who prescribed a medication that is described as a "powerful narcotic" but would not tell you the dose, how would you feel? Would any responsible adult in their right mind take it? Would you go back to the physician?

Methadone patients like any other health consumer want to know, and have the right to know their dose. Program staff that believe in these antiquated policies need to look within and ask themselves how they would feel if they were the patient. They need to realize the destructive effects of blind dosing on the treatment process and have the courage to reverse the policy. In doing so programs will give the patient's the dignity that they deserve thus allowing patients to go on with the difficult task of changing their lives instead of being concerned with "What dose am I on?"

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