S2S 2053 Recovery Oriented Methadone Maintenance
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Module 3 Post Test

1. The authors concluded in the first two articles of the publication that it was time that the professional field stopped debating the _____of MM and focus energies on elevating the quality of the MM treatment.
a. morality
b. efficacy
c. appropriateness
d. all of the above

2. TIP 43, as referenced by the authors, set forth a clear vision for the future of MM by saying that providers will be under greater pressure to offer a richer mix of _____.
a. dosing variability
b. comprehensive services
c. medication options
d. culture and gender specific options

3. Opioid addiction has been defined as a chronic, progressive illness for more than a century, but the treatment of this disorder has been conducted primarily within a/an _____ model of service delivery.
a. acute care
b. residential care
c. long term care
d. extended care

4. One of the assumptions of recovery management (RM) is that _____.
a. addiction is a brain disease with neurological defects that can be corrected through acute detoxification
b. principles and practices that characterize effective management of other chronic illnesses cannot be adapted to addiction treatment
c. high rates of drug seeking following cessation of treatment is a manifestation of the neurobiological defects
d. acute episodes of detoxification and biopsychosocial stabilization constitute sustainable recovery

5. _____ arenas of service practice distinguish recovery management from acute care models of addiction treatment.
a. five
b. six
c. eight
d. ten

6. There are few studies available that illuminate the potential differences between public and private MM programs, in spite of growing privatization of MM in the United States over the past 2 decades.
T F

7. Street myths about methadone are particularly magnified within _____ communities.
a. minority
b. rural
c. urban
d. therapeutic

8. The average duration of heroin use prior to first admission to treatment ranges from 6-10 years to _____ years.
a. 14.5 years
b. 16.5 years
c. 18 years
d. 19.5 years

9. Between _____ of persons on waiting lists fail to enter addiction treatment.
a. 10-15%
b. 20-30%
c. 25-50%
d. 30-60%

10. MM treatment access can be limited by _____.
a. lack of geographical proximity
b. restrictive admission criteria
c. demand for daily attendance
d. all of the above

12. Program related factors that relate to early dropout include _____.
a. conflict with one's counselor
b. dissatisfaction with methadone
c. life events/logistics
d. incarceration due to past behavior

13. _____ is identified as a promising practice related to early engagement and retention.
a. expanded clinic hours
b. same day dosing
c. no dose floors or ceilings
d. all of the above

14. To improve recovery orientation of programs, the authors state that it is important to make the transition from_____.
a. stigmatizing language to recovery terminology
b. professionally directed treatment plans to patient directed recovery plans
c. diagnostic focus to addressing individual behaviors
d. all of the above

15. Nursing time in OTPs is consumed primarily with _____.
a. dispensing medication
b. assisting with physicals and medical procedures
c. drug testing
d. all of the above

16. The percentage of addiction counselors with a history of personal recovery decreased from more than 70% in the late 1960's to _____ in 2009.
a. 50%
b. 45%
c. 30%
d. 25%

17. Only _____ of all MM staff in the United States self identified as being in recovery.
a. 5%
b. 10%
c. 15%
d. 20%

18. Service relationships in MM treatment have been inordinately shaped by the _____.
a. regulatory environment
b. business orientation of OTPs
c. reliance on the disease concept
d. both a and b

19. As noted by the authors, concerns about the quality of MM treatment includes _____ issues.
a. 3
b. 4
c. 5
d. 6

20. Once optimal dose stabilization is achieved, the patient is not in _____.
a. opioid impairment
b. opioid withdrawal
c. opioid tolerance
d. a and b only

21. The authors report that recovery outcomes vary significantly across OTPs and a portion of that variability is attributable to _____ factors.
a. dosing
b. programmatic
c. counselor
d. regulatory

22. MM patients often have not been afforded the intensity of education and counseling to address issues of global health and functioning that are present in other treatment modalities in part because of _____.
a. high ratios of patients to counselors
b. lack of counselors active in recovery
c. lack of professional development
d. all of the above

23. A higher percentage of MM patients received ancillary services when these services were provided _____.
a. on site at the clinic
b. at community based organizations
c. through the insurance company
d. free of charge

24. Through several studies, MM is defined as _____ treatment.
a. curative
b. corrective
c. coercive
d. both a and c

25. The best single predictors of post MM abstinence from heroin are longer periods of time in treatment, discharge status of treatment completion as planned and _____.
a. status of the patient's significant other and families
b. employment during and after MM treatment
c. medical follow up after MM treatment
d. cultural identification and support

26. When patients leave treatment during a period of recovery stability, they often _____.
a. resume opioid use and clinically deteriorate
b. re enter treatment in crisis
c. re enter treatment with less severity than earlier admissions
d. all of the above

27. In general, a key predictor of the degree of effectiveness of MM is _____.
a. a well trained, professional staff
b. regulatory compliance
c. duration of active participation in treatment
d. stable dosing

28. In some OTP studies, the rate of involuntary/administrative discharge exceeds _____ of all discharges.
a. 40%
b. 50%
c. 60%
d. 65%

29. The management of chronic illness, including opioid addiction, focuses on nesting a recovery management process within _____.
a. each patient's natural environment
b. a safe and welcoming non medical environment
c. the community at large
d. all of the above

30. Until the founding of _____ in 1991, there was a lack of recovery mutual aid society explicitly for people in medication assisted recovery.
a. Medication Anonymous
b. Opioids Anonymous
c. IV User Anonymous
d. Methadone Anonymous

31. The _____ is defined as the duration of current sobriety that predicts lifetime sobriety-the point at which the risk of future lifetime relapse drops below 15%.
a. recovery safety zone
b. recovery status quo
c. recovery stability zone
d. recovery stability point

32. Studies show that self efficacy, social support and participation in pro-social activities are identified as major _____ for sustaining recovery.
a. risk factors
b. protective factors
c. strength factors
d. recovery factors

33. MM has historically been evaluated using 2 broad benchmarks: _____ and the percentage of clients who maintain abstinence or no longer meet diagnostic criteria for opioid dependence following treatment.
a. changes in behaviors that generate cost and harm to society
b. urinalysis screening results
c. program participants' average daily dose
d. dropout rates after 90 days

34. The authors note that it is important to acknowledge that every MM program sees patients that are not represented and reflected in the _____ that the field relies on to support evidence based practices.
a. professional journal submissions
b. anecdotal field research
c. randomized clinical trials
d. all of the above

35. To elicit changes in practice, the authors summarize the need to re-align the philosophy of MM toward a greater focus on long term individual and family recovery, as opposed to a narrower focus on _____.
a. reduction of social harm
b. general rates of abstinence
c. drug screening results
d. MM dropout rates

36. Questions regarding the future direction of ROMM treatment are present, according to the authors, and need to be addressed, in part, by the _____.
a. policy makers
b. scientists
c. treatment professionals
d. patient advocacy movement