Methadone and the Anti-Medication Bias in Addiction Treatment
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<u>Post-Test</u>

1. In the United States between 1919 and 1924, White recounts that 44 communities operated _____ maintenance clinics.
a. methadone
b. morphine
c. buprenorphine
d. dilaudid

2. Attempts at morphine and heroin maintenance were plagued by the pharmacological properties of the drugs-patients cycled between acute _____ and acute withdrawal.
a. intoxication
b. nausea
c. fever
d. pain

3. Methadone is a long acting _____ narcotic used in the treatment of heroin addiction.
a. natural
b. sympathetic
c. synthetic
d. illegal

4. Blockade dosages of methadone are defined by White and Coon as _____ mg per day.
a. 50-75
b. 75-100
c. 80-120
d. 100-150

5. Blockade dosages of methadone last _____ hours.
a. 10-15
b. 12-20
c. 15-25
d. 24-36

6. White reports that Dr. Dole, a methadone pioneer, found the "_____ normality" of patients to be the most striking characteristic of the medication.
a. physiological
b. psychological
c. emotional
d. social

7. At the time of writing, White estimates that approximately _____ of the 900,000 opiate addicts in the United States were enrolled in methadone maintenance treatment.
a. 153,000
b. 165,000
c. 179,000
d. 184,000

8. Reviews by nearly every major health policy body conclude that orally administered methadone can be provided for a prolonged period at stable dosages with a high degree of long term safety and without significant effects on _____ functioning.
a. psychomotor
b. cognitive
c. emotional
d. both a and b

9. MMT delivered at optimal doses decreased the death rate of opiate dependent individuals by as much as _____ %.
a. 25
b. 35
c. 50
d. 75

10. MMT reduces or eliminates illicit drug use by _____.
a. minimizing narcotic craving
b. creating immediate withdrawal if other opiates are introduced
c. blocking euphoric effects of other narcotics
d. a and c only

11. Dr. Avram Goldstein (2001) compared the role of methadone in the treatment of opiate dependent individuals with the role of _____.
a. insulin in the treatment of diabetes
b. anticonvulsants in the treatment of seizure disorders
c. ventolin in the treatment of chronic asthma
d. all of the above

12. White and Coon compare the lack of access to MMT for hundreds of thousands who need it (long wait lists) parallels the period in which _____ patients died needlessly from lack of access to pharmacotherapies with proven efficacy.
a. oncology
b. tuberculosis
c. heart disease
d. asthma

13. Which is NOT identified by White and Coon as a problem found in some MMT clinics:
a. exorbitant fees
b. methadone dosages used to reward or punish client behaviors
c. ill trained staff lacking in cultural competence
d. lack of insurance coverage for MMT

14. White and Coon identify _____ as their greatest concern with MMT.
a. utility of long term opiate maintenance
b. federal, state and municipal regulation
c. lack of a vibrant culture of recovery around methadone
d. community and treater biases

15. The authors define poor _____ as the failure to imbed methadone within a comprehensive menu of habilitation and recovery support services.
a. clinical technology
b. MMT clinic administration
c. recovery community "buy in" to MMT
d. all of the above

16. Most negative symptoms attributed to the use of methadone are related to _____, not the methadone itself.
a. initial under- or over-dosing
b. untreated medical conditions masked by heroin use
c. interactions between methadone and other drugs
d. all of the above

17. The authors cite an example of rejection by mainstream recovery culture for MMT patients as _____.
a. not being welcome to attend NA meetings
b. not being welcome to speak at NA meetings
c. not being eligible for 30 day coins, etc at meetings until they are medication free
d. all of the above

18. Among those in the recovery community, MMT patients are often _____.
a. viewed as not being abstinent
b. denied the status of being in recovery by their peers
c. denied the legitimacy of being a person in recovery
d. all of the above

19. Within the larger world of addiction treatment and mutual aid societies, recovery for the person in MMT is often viewed as beginning when the individual _____.
a. enters treatment
b. starts attending 12 step meetings
c. stops taking methadone
d. they are never viewed as being in recovery

20. The American Association for the Treatment of Opioid Dependence (AATOD) is identified as a _____ group.
a. consumer advocacy group
b. professional advocacy group
c. mutual aid society
d. medical research group

21. Many methadone patients view their lack of craving as a sign of _____.
a. the beginning of the recovery process
b. treatment effectiveness
c. no longer needing treatment
d. all of the above

22. At the time of writing, White and Coon identify over 600 chapters of _____, a mutual aid society.
a. Medication Assisted Recovery Anonymous
b. Methadone Anonymous
c. Heroin Anonymous
d. Opiate Anonymous

23. Although there are positive signs regarding the future of methadone maintenance, there are two troubling conditions identified by the authors: 1) great misconceptions that continue to surround MMT and 2) _____.
a. increased regulatory control
b. increasing cost factors
c. lack of access to or substandard care
d. negative long term effects of methadone

24. As treatment continues to evolve, addiction professionals will encounter _____ that challenge bigotries and biases that have masqueraded as professional wisdom.
a. advocacy groups
b. outspoken stable MMT patient
c. medical profession trade groups
d. scientific findings