S2S 2053 Recovery Oriented Methadone Maintenance
White and Mojer-Torres
Northeast ATTC/Great Lakes ATTC/DBHMRS, 2009

Module 1 Post Test

1. _____ are networks of formal and informal services developed and mobilized to sustain long term recovery for individuals and families impacted by severe substance use disorders.
a. Recovery Maintenance
b. Recovery Support
c. Recovery Management
d. Recovery Oriented Systems of Care

2. The "system" identified in ROSC is not a local, state or federal treatment agency but a macro level organization of a community, state or a nation.
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3. ROMM provides an alternative to acute care (heroin detoxification) and _____ care (long term medication as a form of social pacification)
a. preventative
b. post acute
c. palliative
d. none of the above

4. White and Mojer-Torres identify the ultimate aim of ROMM as an enhanced quality of life for each MM patient and his or her family, with larger _____ benefit viewed as flowing from this primary achievement.
a. social
b. financial
c. spiritual
d. all of the above

5. The publication defines the term _____ as " a permanent altering of the root cause of" a disorder.
a. healing
b. cure
c. treatment
d. management

6. Recurrence of symptoms can occur even with medication adherence, most often when larger aspects of the patient's _____ health are disrupted.
a. biological/psychological
b. social
c. spiritual
d. all of the above

7. In the history of substance use treatment in the United States, morphine addiction was often treated with _____, and alcohol dependence was often treated with opium, morphine, cocaine, amphetamines, sedatives and tranquilizers.
a. opium
b. amphetamines
c. cocaine
d. sedatives

8. Early medical treatments for opioid addicted individuals focused on the best procedures for _____ of withdrawal and strengthening the patient's physical, emotional and moral constitution, and was almost always followed by relapse.
a. pacing
b. eliminating
c. avoiding
d. expediting

9. Intractable (hard to treat) addicts, most with _____, were maintained on morphine or opium by their physicians, or, more commonly were subjected to ineffective and potentially lethal withdrawal schemes.
a. psychiatric disorders
b. chronic medical problems
c. criminal histories
d. all of the above

10. In the mid 1930's, with jails inundated with addicts who had violated the Harrison Act, Congress passed legislation allowing construction of 2 federal "narcotics hospitals" in Lexington, KY and _____.
a. New York, NY
b. Chicago, IL
c. Philadelphia, PA
d. Fort Worth, TX

11. _____ nearly died as an organization in 1959 and did not generate a viable service structure or sizeable membership until after methadone maintenance was pioneered.
a. Alcoholics Anonymous
b. Narcotics Anonymous
c. Al-Anon
d. Addicts Anonymous

12. In 1964, Dr. Vincent Dole, Dr. Mary Jeanne Kreek and _____ led a research project at Rockefeller Institute to develop a medical treatment for heroin addiction.
a. Dr. Marie Nyswander
b. Dr. Ian Cameron
c. Dr. Richard Goldberg
d. Dr. Theodore Krinsky

13. By 1984, the total number of drug treatment program in the United States had grown to more than _____.
a. 2500
b. 3000
c. 4500
d. 5000

14. The original MM treatment protocol was a three phase process: _____, counseling and rehabilitation, and maintenance.
a. detoxification
b. acute withdrawal
c. induction
d. stabilization

15. The involvement of the other staff in the MM pilot project shifted the goal of MM from palliation to an active and highly individualized process of _____.
a. harm reduction
b. recovery management
c. dosing and administration
d. socialization and community reintegration

16. MM pioneers operated on the premise that heroin addiction is a genetically influenced, chronic brain disease.
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17. Addiction recovery, in the pilot programs, was defined in terms of overall _____ and not viewed as contingent upon cessation of MM.
a. health and functionality
b. treatment compliance
c. daily dosing
d. length of treatment

18. According to the authors, recovery orientation in the evolution of MM was limited by two aspects: MM treatment was aimed specifically at remission/reduction/ cessation of heroin use without a focus on a larger construct of _____ ,and that primary emphasis was placed upon the importance of pharmacological stabilization.
a. recovery from addiction
b. 12 step supports
c. wraparound services
d. community integration

19. White and Mojer-Torres state that often the counseling bar has been set low in MM, dominated by mechanics of medication management and _____ that would be unthinkable in other modalities.
a. dose adjustment
b. regulatory compliance
c. lifestyle reconstruction
d. assertive recovery management

20. In 1967, there was a _____ waiting list for admission into New York MM clinics.
a. 6 month
b. one year
c. 18 month
d. two year

21. According to the authors, sustainable recovery was viewed as requiring _____ of most patients over a number of years.
a. abstinence
b. continued or intermittent treatment
c. negative drug screens
d. treatment compliance

22. _____, a recovery focused element, was weak or even missing from early MM treatment models.
a. family education
b. assertive follow up after disengagement
c. linkage to local recovery mutual aid groups
d. all of the above

23. In 1971, two members of Congress returned from a visit to Vietnam and reported that "_____ of GIs were addicted to heroin."
a. 5-10%
b. 10-15%
c. 15-20%
d. 20-25%

24. In 1976, there were approximately _____ patients receiving MM services as compared to only 22 in 1965.
a. 50,000
b. 75,000
c. 80,000
d. 100,000

25. Regulatory guidelines restricted who could provide MM to approved clinics and _____.
a. hospital pharmacies
b. private physicians
c. Board Certified Addiction Medicine Specialists
d. none of the above

26. In 1988, the White House Conference for a Drug Free America called for _____.
a. abolishment of MM
b. investigation of NIDA
c. mandatory sentencing for methadone diversion
d. a and b only

27. The most significant factor that brought MM back into favor in national policy was _____.
a. ever increasing drug related crime rates
b. MM's documented reduction of HIV transmission rates
c. new leadership in the "drug czar's" office
d. none of the above

28. MM pioneer Dr. Vincent Dole stated that " _____ is an improvement in the sterile policy of blaming the addict for having a chronic, relapsing disease….but is not the methadone maintenance treatment described in the early literature"
a. recovery orientation
b. the medical model
c. disease concept
d. harm reduction

29. MM programs during the 70's and 80's were increasingly characterized by inadequate staffing levels, hiring staff philosophically opposed to maintenance and relegating physicians to conducting physicals and writing prescriptions rather than providing _____.
a. administrative leadership
b. clinical leadership
c. primary care services
d. all of the above

30. In 1988, _____ of MM patients received suboptimal doses (less than 60 mg) daily.
a. 62%
b. 74%
c. 88%
d. 91%

31. In a quote by Zweben and Payte (1990), MM clinics in the 70's and 80's "quickly learned that survival depended upon the condition of the _____ and not the patient.
a. physical plant
b. records
c. staffing
d. budget

32. Media reports following the initial announcement of MM's development characterized methadone as a _____.
a. dangerous drug
b. "simple switch in addictive substances"
c. panacea
d. social problem

33. Early critics felt that addicts maintained on methadone suffer from _____ impairment: that MM is a "crutch."
a. cognitive
b. emotional
c. behavioral
d. all of the above

34.The Office of National Drug Control Policy ("the Drug Czar") reaffirmed the effectiveness of MM in the 1990's.
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35. A 2009 analysis of MM programs in the U.S. found that _____ of all patients pay out of pocket for their own treatment, at an average cost of $4176 per year.
a. 20%
b. 25%
c. 50%
d. 66%

36. In 2005, national standards were created for addiction treatment that called for treating persons with severe substance use disorders via a _____ care model.
a. acute
b. chronic
c. medical
d. palliative