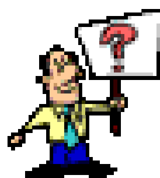
# The Methadone Awareness Test*

## How Much Do You Really Know About Methadone?

## Take the Methadone Awareness Test and Find Out

**The test includes ten questions that professionals and patients should be able to answer with ease. The test covers a broad spectrum of issues. Some of the questions are based on myths and misunderstandings. Can you tell which ones are? How much do you really know or is your knowledge based on myth and rumor. Take the test and find out.**

*The Methadone Awareness Test has been updated from the website.



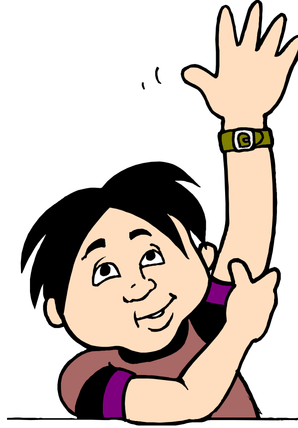
# Who is the Methadone Awareness For?

**Both professionals and patients can take the test. Either way the test can tell a program some significant information about both.**

**When staff do not do well on the test usually the patients will not either. Patients look to staff for information and it is imperative that staff know simple basic information about methadone.**

**When staff score well but the patients do not then the program should begin to think about how they are educating patients. Another significant influence could be the stigma and prejudice outside the program setting. It is so great that programs need to constantly repeat the correct information to patients. It is easy for outside influences to corrupt the good work that the program was doing. Why are patients not getting the message? It is the way the program does methadone education or are outside influences interfering with it or is it a combination of both.**

**It is unusual to see patients scoring well and the staff not doing well. Where are patients getting their information that staff can not seem to access? This would most certainly place staff at a disadvantage and promote feelings of incompetence and stagnation within the clinic. Staff should be given methadone education to make them competent.**



# Taking the Test

## Three Ways to Take the Test

**You can give the test like a usual test situation: timed and no access to answers or you can use the test questions to generate discussions. This is one of the reasons that references to the answers were provided. Or you can take the test by yourself to get an idea of your knowledge about methadone.**

## Timing the Test

**You may time people taking the test. It should take no more than 15 minutes to complete it.**

## Get Ready

**If this is a test situation hand out the introduction and the test (pages 1-4).**

## Taking the Test to Evaluate Your Knowledge

**If you are taking this for your own information you can time yourself. The questions are on the next page and you should not look at the answers until you finish.**

**Check the Time. Turn the page to take the test.**

# Methadone Awareness Test

**Answer True or False for each question.**

| | | **Answer** |
|---|---|---|
| 1 | Is methadone maintenance trading one addiction for another? True or false. | |
| 2 | Pregnant women should withdraw or at least lower their dose of methadone so that the baby is not born dependent. True or false. | |
| 3 | Methadone gets into the bone marrow, rots the teeth, and "depletes calcium"? True or False. | |
| 4 | Methadone suppresses the immune system so that HIV+ methadone patients should be encouraged to withdraw. True or false? | |
| 5 | If it is necessary for a methadone patient to take pain medication they do not need strong narcotics because the methadone will block the pain. True or false? | |
| 6 | Methadone causes patients to become alcoholics and/or cocaine abusers. True or false? | |
| 7 | Methadone is more addicting than heroin. True or false? | |
| 8 | Methadone patients should not be allowed to operate heavy machinery or to drive a car. True or false? | |
| 9 | Methadone was named for Adolph Hitler. True or false? | |
| 10 | When they do autopsies on methadone patients, the patients' internal organs are dyed bright orange. True or false? | |

**Finished: Add Up Your Score**

Then turn the page for the answers.

**SCORING: Give yourself 10 points for each question you answered right.**

**SCORE: _______ %**

# Answers

## QUESTION 1

FALSE. The MMT patient is DEPENDENT on their medication. Not addicted!

The correct definition of addiction refers to the loss of control over drug use or other behaviors such as eating or gambling. By these criteria as laid out in the Diagnostic and Statistical Manual of Mental Disorders IV, the methadone patient is not addicted to his/her medication and methadone does not fit the criteria as an addictive drug (Methadone Treatment Works, 1994). In fact, the experts in the field compare an individual on methadone chemotherapy therapy to a diabetic who is dependent on their daily dose of insulin. Both are medical conditions for which medication can control, but not cure. When a patient does not take their medication they get sick. This is true of many chronic medical conditions, but we would never think of calling a diabetic an insulin addict!

Confusing dependence and addiction diminishes the meaning of it  It is because opiate addiction is the traditional example given to describe addiction because both dependence and addiction are involved. However dependence is not necessary for addiction to occur, as in gambling or sex. And dependence does not always and in fact rarely leads to addictive behaviors, as in pain patients. Advances in neuroscience have demonstrated that opiate addiction is a brain disorder and that for most long term addicts the damage is permanent.  It is unfortunate that opiate addicts are consistently blamed for causing their condition when the same is also true for most other chronic medical conditions (i.e. the diabetic that does not follow their diet or exercise, skin cancer patient that sat out in the sun.)

References

1. METHADONE TREATMENT WORKS: A Compendium For Methadone Maintenance Treatment, Monograph Series Number 2. Chemical Dependency Research Working Group: December 1994. Available from NYS Office of Alcoholism and Substance Abuse Services.
2. Himmelsbach C. Clinical studies of morphine addictions. Proceedings of the 49th Annual Scientific Meeting of the Committee on Problems of Drug Dependence, No 81. NIDA, 1968.
3. Martin, Wilker, Eades et al. Tolerance and physical dependence on morphine in rats. Psychopharmacology 1963 4: 247-260.
4. Kreek MJ. Semin Neuroscience 1997 9: 140-157.

## QUESTION 2

FALSE. Withdrawing the mother results in increase risk of drug use and infant mortality.

Current research shows that doses below 60 mg day are not effective and hence not appropriate and that low dose policies for pregnant and non-pregnant patients are associated with increased drug use as well as reduced program retention. Medical withdrawal of opiate dependent women

is not recommended in pregnancy because of increased risk to the fetus of intrauterine death even under optimal circumstances.

In fact, increased or split doses of methadone may be needed in the later stages of pregnancy since greater plasma volume and renal blood flow can contribute to a reduced level of methadone in the blood. Studies show that there is no relationship between a mother's dose and the likelihood of the baby being born opioid dependent. Studies do show however, that there is a direct correlation between increased dose and increased birth weight, the most reliable indication of neonatal health. Since methadone does not cross the placenta well only about 50% of neonates have any symptoms of abstinence and they are usually mild. The Neonatal Abstinence Syndrome is easily treated and does not have long term effects on the infant. Thousands of children have been born to methadone mothers, many of which are now adults living normal lives indistinguishable from their peers.

References

1. Mitchell J. (Chair) Treatment improvement protocol on pregnancy and substance abusing women. CSAT TIP, 1994.
2. Kaltenbach K, Finnegan LG. Methadone maintenance during pregnancy: Implications for perinatal and developmental outcome. In: T. Sonderegger (ed), Perinatal Substance Abuse: Research findings and clinical indications, 1992.

## QUESTION 3

FALSE. These are some of the many myths of methadone.

Few drugs have been studied as extensively in humans as methadone. Hundreds of thousands of people have been maintained on methadone, many since the treatment was developed over thirty years ago. Methadone and methadone therapy are so tremendously misunderstood (for many reasons) that any study indicating such serious side effects would have been massively publicized and almost certainly resulted in ending the program. The only side effects of methadone in stabilized patients however, are increased sweating and constipation, neither of which affect the majority of methadone patients and can usually be handled with a dose adjustment. As used in maintenance treatment, methadone is one of the safest medications known, even safer than aspirin.

References

1. Kreek, M.J. Medical safety and side effects of methadone tolerant individuals. Journal of the American Medical Association; 1973 (Feb 5) 223(6): 665-668.
2. Kreek, M.J, Dodes, L., Kane, S.; Knobler, L. & Martin, R. Long-term methadone maintenance therapy: Effects on liver function. Annals of Internal Medicine, 1972 (Oct) 77(4): 598-602.

## QUESTION 4

FALSE. Methadone normalizes endocrine and immune functions deranged by injection of impure street narcotics.

Recent studies have demonstrated that methadone normalizes immune and endocrine function and may even enhance it in some instances (Dole 1988, Kreek 1973). Other opioids inhibit and suppress immune function; an undesirable side effect when someone is ill. Methadone is the only opioid that does not inhibit and there is evidence that it may enhance immune function.

References

1. Kreek MJ. Medical safety and side effects of methadone in tolerant individuals. JAMA 1973 223(6): 665-668.
2. Dole VP. Implications of methadone maintenance for the theories of narcotic addiction. JAMA 1988 260(20): 3025-3029.

## QUESTION 5

FALSE. Methadone patients feel the normal range of pain.

When methadone is administered to treat addiction the tolerance to the analgesic effects develop quickly and methadone patients feel the pain within the normal range (Dole, Nyswander, Kreek, 1966, Gordon, 1994). Due to cross tolerance and the blockade effect methadone patients will usually need significantly higher doses of narcotic analgesics administered and more frequently (Payte, Khuri, Joseph, Woods, 1994).

Not understood by many physicians is the blockade effect of methadone that protects methadone patients from respiratory depression. Thus clinicians need not be concerned about administering too much.

References

1. Dole VP, Nyswander ME, Kreek MJ. Narcotic blockade. Archives of Internal Medicine, 1966(October) 118: 304-309.
2. Gordon NB. The Functional Potential of the Methadone Maintained Person. METHADONE TREATMENT WORKS: A Compendium For Methadone Maintenance Treatment, CDRWG 1994.
3. Payte JT, Khuri E, Joseph H, Woods J. The Methadone Maintained Patient and Pain Medication. METHADONE TREATMENT WORKS: A Compendium For Methadone Maintenance Treatment, CDRWG 1994.

## QUESTION 6

FALSE. Secondary drug use is related more to the patients drug use prior to entering methadone treatment.

Methadone maintenance is not a treatment for non-opioid drug use. While a significant minority of methadone patients become alcoholic, of these over 98% were heavy or problem drinkers prior to their introduction to heroin . The statistics for cocaine abusers are similar. The patient who responds best to methadone maintenance treatment is one who has a long history of opioid dependence, has repeatedly attempted to cease such dependence without success, and one for whom opioids are the primary substance of abuse (Dole, Joseph, 1978). This is not to infer that patients with secondary drug use problems should not be admitted to methadone treatment. When methadone treatment was in the research phase at Rockefeller University subjects with alcohol or other drug problems were not omitted from the study. Or rather Drs. Dole and Nyswander thought so only to discover years later that many of the early patients had secondary drug problems and these patients also benefited from methadone treatment.

References

1. Dole VP, Joseph H.Long term outcome of patients treated with methadone maintenance. Annals of the New York Academy of Sciences 1978 311: 181-189.
2. Joseph H, Appel P. Alcoholism and methadone treatment: Consequences for the patient and the program. Am Jour Drug Alcohol Issues; 1985, II(1,2): 37-53.

## QUESTION 7

FALSE. In question one the differences between addiction and dependence were discussed.

In terms of physical dependence, double blind studies done at Lexington have demonstrated that when comparing the withdrawal symptoms of patients maintained on equivalent doses of methadone and short acting opioids like heroin, those of the former group were less severe than those of the latter group (Himmelsbach, 1968; Martin, Wilker, Eades et al. 1963). Withdrawal from methadone does last significantly longer than that from short acting opioids, however, and this clearly contributes to the patients perception that methadone is more difficult.

References

1. Himmelsbach C. Clinical studies of morphine addictions. Proceedings of the 49th Annual Scientific Meeting of the Committee on Problems of Drug Dependence, No 81. NIDA, 1968.
2. Martin WR, Wilker A, Eades GC et al. Tolerance and physical dependence on morphine in rats. Psychopharmacology 1963 4: 247-260.

## QUESTION 8

FALSE. Stable MMT patients can not be distinguished from control groups by way of anything short of a toxicological screening.

Extensive research has demonstrated that stabilized methadone patients are indistinguishable from control groups in cognitive functioning and motor skills. And in fact for some tests methadone patients were the superior group (i.e. reaction time, IQ, driving) (Gordon 1994, Gordon 1973, Gordon, Warner, Henderson 1972).

References

1. Gordon NB. The Functional Potential of the Methadone Maintained Person. METHADONE TREATMENT WORKS: A Compendium For Methadone Maintenance Treatment. CDRWG 1994.
2. Gordon NB. The functional status of the methadone maintained person. In Simmons LRS, Gold MB (eds), Discrimination and the Addict, pp. 101-121; Sage Publications, 1973.
3. Gordon NB, Warner A, Henderson A. Psychomotor and intellectual performance under methadone tolerance. In Proceedings of the 4th National Conference on Methadone Treatment, New York; National Association for the Prevention of Addiction to Narcotics, 1972.

## QUESTION 9

FALSE. Dolophine is a trade name and was given to methadone the United States.

Methadone is the generic name and was also given to methadone the United States. This is a very commonly believed myth. While it is true that methadone was first synthesized by German pharmacologists before WWII began. They called methadone Hoechst 10820 or polamidon. While their were a few studies in Germany its properties as a useful medication to withdraw addicts was not discovered until after the war at the Public Health Service Hospital in Lexington.

Dolophine the original trade name for methadone hydrochloride, was not derived from the name “Adolph” but from the Latin “dolor” (pain) and “phine” from Morpheus the Greek god of dreams that morphine is named after (Woods 2001).

References

1. Woods J. The Psychopharmacology of Opioids: How Methadone Works. Education Series 5.2, 2001.

## QUESTION 10

FALSE. This may not be as common as the other myths in this test, but it comes from the same kind of thinking or rather, lack of thinking.... We asked the person who first told us this myth

why they thought this was true. The answer was the same thing we always hear “because everyone knows that’s true!”

So here is the challenge for you test-takers, when you hear myths about methadone talk to the person. Ask them where they heard it and if they have any scientific evidence to back it up. The point is that patients are the ones that can stop myths because they comes from us. Myths help patients fill the void when program do not provide adequate information (Velten 1992, Woods 2001).

References

1. Velten E. Myths About Methadone. Education Series 3, 2001.
2. Woods J. The Psychopharmacology of Opioids: How Methadone Works. Education Series 5 (1-3), 2001.

## SCORING

100 Excellent (Get a job teaching about methadone)

80-90 Good (Which ones did you miss?)

60-70 So So (Mediocre! Better get reading.)

0-50 Bad (You need a lot of work?)