Medication Assisted Treatment Specialist (MATS):

EXAMINATION STUDY GUIDE

ICAADA
The Association for Behavioral Health Professionals

ACNOWLEDGEMENTS

The *Medication Assisted Treatment Specialists (MATS): Examination Study Guide* is a resource sponsored by ICAADA, a subsidiary of Mental Health America Indiana (MHAI). This guide is to serve as a study aid to assist individuals seeking the MATS credential to prepare for and pass the ICAADA MATS Certification Exam. This guide was developed by ICAADA and is considered the intellectual property of this organization.

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INTRODUCTION AND PURPOSE

Introduction:

A Medication Assisted Treatment Specialist (MATS) is a behavioral health professional who has received additional training in the role certain medications can play in recovery from substance use disorders. MATS professionals understand that recovery is a unique experience for every individual and that many may choose medication assisted treatment as a pathway to their recovery goals. MATS professionals deliver evidence-based support in a wide range of settings, including federally qualified Opioid Treatment Programs (OTPs), inpatient and outpatient substance use disorder treatment programs, and physician practices.

ICAADA is committed to building and strengthening the addiction treatment workforce in Indiana through the provision of quality training and professional development opportunities, as well as facilitating the certification for both beginning and experienced treatment professionals. Toward that end, ICAADA commissioned the development of a robust credential for individuals seeking to work with individuals using MAT as a recovery support. Candidates must complete 35-hours of distance learning, a three-day live training, and passing the Medication Assisted Treatment Specialist Examination offered by ICAADA to receive this credential.

Purpose of this Guide:

This guide was designed as a study aid to help MATS professionals prepare for and pass the ICAADA Medication Assisted Treatment Specialist examination. The content of this guide is based on the knowledge, skills, and job tasks derived from the 2020 MATS Focus Group at the request of The Indiana Department of Mental Health and Addiction (DMHA) and ICAADA. The goal of this focus group was to draw from the wisdom of subject matter experts in the field of medication assisted treatment in Indiana to update and improve the existing MATS Examination and training materials from The Connecticut Certification Board.

This Guide was developed by ICAADA, in consultation with subject matter experts, with input from MATS candidates who have taken or are preparing to take the certification exam.

Overview of this Guide:

The first portion of this Study Guide summarizes key concepts from the Connecticut Certification Board's distance learning modules, assigned readings, and three-day MATS training, so that users can review content in the four domains of MAT practice:

- Pharmacotherapy
- Recovery supports
- Education
- Professional Responsibility

The remainder of this Study Guide is comprised of tools to help you approach the exam with confidence. This includes a discussion of the structure of the examination, sample questions similar in format and level of difficulty to those on the examination, along with an answer key and explanations of the correct responses, and an extensive glossary to consult for more in-depth review of important topics.

Please note: This study guide is not designed to replace the distance learning, the three-day training, and/or the materials associated with the training. This guide merely highlights key topics for review and helps to familiarize test-takers with the structure and format of the exam.

PHARMACOTHERAPY

This portion of the examination is designed to test your understanding of medications used in the treatment of substance use disorders (SUDs), as well as the ability to identify locations and modalities of MAT. This makes up the largest portion of the test questions. For a more thorough understanding of the use of pharmacotherapy for the treatment of SUD, please refer to *SAMHSA's Treatment Improvement Protocol 63: Medications for Opioid Use Disorder* (*TIP 63)*.

Areas for Review:

- Diagnostic Criteria associated with substance use disorders
- Comfortability with the signs and symptoms of both intoxication and withdrawal for the substances commonly associated with MAT (i.e. alcohol and opioids).
- Have a thorough understanding of the medications commonly used in MAT, their associated diagnoses, and the role they play in improving outcomes for individuals with substance use disorders.
- Be able to identify and apply the ASAM Dimensions of Substance Use Disorders and their associated levels of care in a clinical scenario.
- Review the phases of MAT (Induction, Stabilization, Maintenance, and Tapering)

Methadone

For Use with Opioid Use Disorder

Candidates	**•Currently "opioid-addicted" or OUD moderate or severe** **•Having a history of at least 1 year of opioid addiction before admission. May be waived for:** **○ Pregnant women** **○ Former clients [up to 2 years after discharge]** **○ Clients within 6 months of release from incarceration** **•Able to provide voluntary, written informed consent** **•Admission criteria for clients younger than 18 include:** **○ Two documented, unsuccessful, medically supervised withdrawals OR** **○ Treatment without OUD medication in a 12-month period.** **○ Parent or legal guardian must provide written informed consent**
Contraindications	**•Allergy to methadone** **•Acute asthma** **•Clients with abnormally high carbon dioxide blood levels (from pulmonary disease or sleep apnea)** **•Paralytic ileus (paralysis of the intestine)**
Settings	**•Federally certified, accredited Opioid Treatment Centers (OTPs)** **•Acute inpatient hospital settings for OUD treatment**
How It Works	**• Full Opioid Agonist** **• Administered orally** **•Alleviates withdrawal symptoms and cravings for illicit opioids.** **•Once a stabilized does is reached, it provides a blockade effect for self-administered opioids.**
Side Effects	**Constipation** **Nausea** **Sweating** **Sexual dysfunction or decreased libido** **Drowsiness** **Amenorrhea** **Weight gain** **Edema** **Trouble breathing (if dose is too high)** **Blood pressure dropping**

Buprenorphine

For Use with Opioid Use Disorder

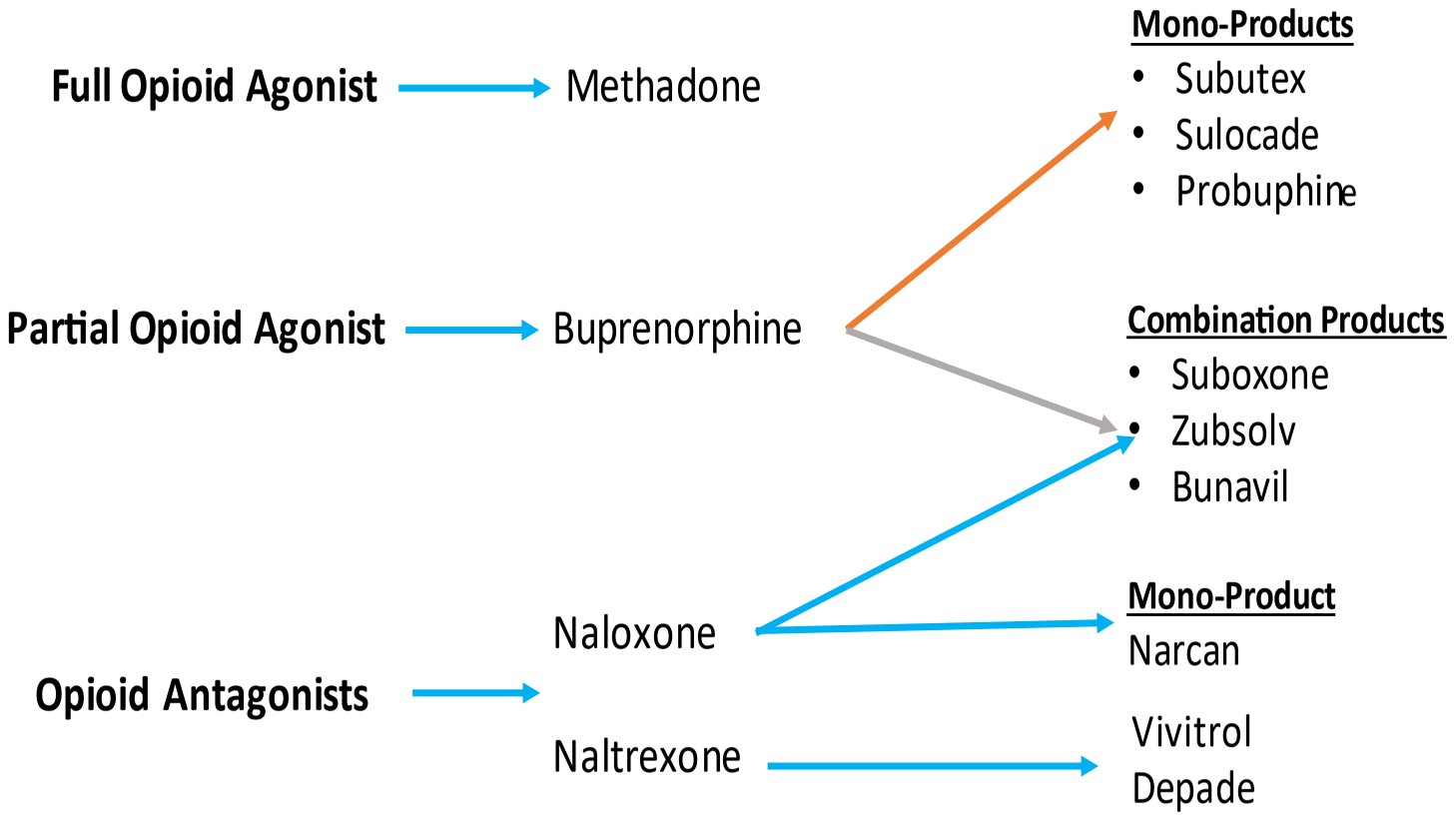
Candidates	**•No evidence clearly predicts which clients are best treated with buprenorphine.** **•Clients who have responded well in the past should be considered.** **•Prior illicit use of diverted buprenorphine does not rule OUD treatment with buprenorphine** **•Unsuccessful treatment experiences with buprenorphine in the past do not necessarily indicate that buprenorphine will be effective again.** **•Stable clients are the best candidates for buprenorphine implants.** **•Must be able to provide informed, written consent.**
Contraindications	**•Allergy to buprenorphine** **•Seizures** **•Hepatitis/Impaired Liver Function** **•Pregnancy (with combination products)**
Settings	**•Data 2000 Waivered Providers (Physicians, Physician's Assistants, Nurse Practitioners)** **•OTPs**
How It Works	**•Partial Opioid Agonist** **•Frequently combined with Opioid Antagonist (Naloxone)** **•Partially blocks the Mu Opioid receptor sites, providing relief from withdrawal symptoms and cravings, and blockade against self-administered opioids.** **•Partial blockade creates a "ceiling effect" with a much lower potential for abuse and overdose.**
Formulations	**•Mono-product (Buprenorphine only)** **○ Subutex** **○ Sublocade (Monthly injectable)** **○ Probuphine (Implant)** **•Combination Products (Buprenorphine + Naloxone)** **○ Suboxone** **○ Zubsolv** **○ Bunavil**
Side Effects	**•Respiratory Problems** **•Sleepiness, dizziness, and problems with coordination** **•Allergic reaction** **•Oral hypoesthesia (oral numbness)** **•Constipation** **•Glossondynia (tongue pain)** **•Oral mucosal erythema (lesions in the mouth or on the tongue)** **•Vomiting** **•Intoxication** **•Disturbance in attention** **•Palpitations** **•Insomnia** **•Opioid withdrawal syndrome** **•Excessive sweating** **•Blurred vision** **•Back pain**

Naltrexone(Vivitrol, Depade)

Used for both Alcohol and Opioid Use Disorders

Candidates	**•Individuals that have been abstinent from opioids for 7+ days.** **•Individuals willing to be monitored**
Contraindications	**•Naltrexone allergy** **•Recent use of Opioids** **•Need for opioid management of pain** **Acute Hepatitis or liver failure**
Settings	**•Does not require a DATA 2000 waiver and can be provided by any prescriber.**
How It Works	**•Binds to the mu-opioid receptor sites and blocks further activation.** **•If an individual uses naltrexone after recently using opioids, they will go into precipitated opioid withdrawal.** **•Individuals do not receive the dopamine production (euphoric effects) associated with alcohol use or self-administered opioids.**
Formulations	**•Oral naltrexone (Depade, ReVia) is available, but has much poorer results that the intramuscular injection (Naltrexone XR-NTX)**
Side Effects	**•Insomnia** **•Injection site pain** **oIntense pain** **oThe area feels hard** **oLarge area of swelling** **oLumps** **oBlisters** **oOpen wound** **oDark scab** **•Hepatic enzyme abnormalities** **•Nasopharyngitis (swelling of the nasal passages, similar to a common cold)** **•Risk of opioid overdose, particularly as the shot wears off** **•Liver damage** **•Severe allergic pneumonia** **•Serious allergic reactions**

Formulations of Commonly Used Opioid Medication Assisted Treatment



Disulfiram (Antabuse)

For Use with Alcohol Use Disorder

Candidates	**•Can achieve initial abstinence for at least 12 hours** **•Are committed to maintaining abstinence** **•Agree to take the medication** **•Do not have contraindications to disulfiram**
Contraindications	**•Known hypersensitivity to disulfiram or derivatives such as those** **used in pesticides, rubber vulcanization** **• Sulfur or Nickel allergies** **• Severe myocardial disease or coronary occlusion** **• Pregnant or nursing women** **• History of cardiac disease, diabetes, hypothyroidism, epilepsy,** **cerebral damage, chronic or acute nephritis, hepatic cirrhosis, or hepatic insufficiency** **• Hepatitis C** **• Children and adolescents** **• Clients receiving "alcohol-containing preparations" or that will be exposed to ethylene dibromide or its vapors** **• Clients 61 years or older**
Settings	**Frequently prescribed by addiction specialists and primary care settings**
How It Works	**• Aversive treatment, disrupts the metabolism of alcohol, causing a severe reaction when clients mix it with alcohol.** **• The reaction may be moderate or severe depending on the individual.**
Formulations	**Tablet taken orally once a day.**
Side Effects	**Skin/ Acne Eruptions** **Headache** **Allergic dermatitis** **Impotence** **Fatigue** **Metallic or garlic-like aftertaste** **Swollen or sore tongue**

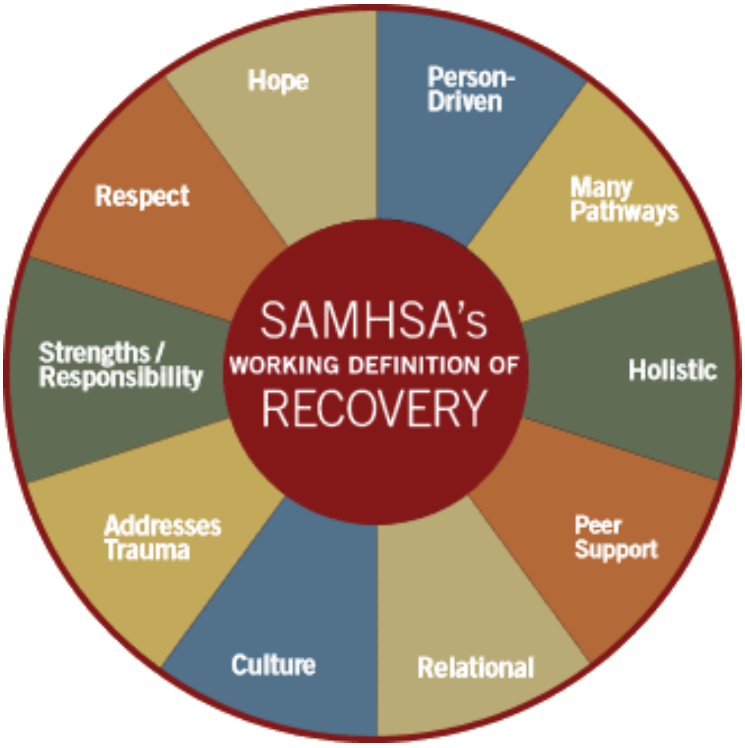
Acamprosate (Campral) For Use with Alcohol Use Disorder	
Candidates	**Individuals that are interested in abstinence from alcohol, rather than those looking to reduce alcohol use.**
Contraindications	**Previous hypersensitivity to acamprosate** **Severe renal impairment**
Settings	**Primary care settings**
How It Works	**• "It is not clear"** **•May normalize glutamate production and absorption** **•Has been shown to increase the continuous abstinence rate and double continuous abstinence duration**
Formulations	**Two tablets taken three times per day**
Benefits	**By regulating brain functioning, clients report fewer symptoms of what is referred to as Post-Acute Withdrawal.**
Side Effects	**Diarrhea (most common)** **Suicidal ideation** **Intestinal cramps** **Headache** **Flatulence** **Change in libido** **Insomnia** **Anxiety** **Muscle weakness** **Nausea** **Itchiness** **Dizziness**

RECOVERY SUPPORTS

This portion of the exam tests your understanding of recovery and your ability to apply the concepts of recovery to real world clients. This is also the domain that tends to trip up test-takers. This section is not about memorizing information, so much as being able to show that you can integrate what you know to help individuals in the real world. Quite simply: this is where the rubber meets the road.

What are "Recovery Supports"?

Recovery Supports are any person, place, or thing that provides support to an individual's unique recovery journey. As a MATS Professional, you must be comfortable with assisting individuals in a variety of ways that supports them on their pathway. This is consistent with SAMHSA's 10 Guiding Principles of Recovery.



Recovery supports include, but are not limited to:

- Medications
- Family Support
- Peer Support Groups
- Structured Treatment
- Trauma-Informed Care
- Culturally-Competent Care
- Churches
- Medical Professionals
- Housing
- Vocational Resources
- Child Care

How to Study Recovery Supports:

Professionals granted the MATS credential must be comfortable promoting the individual's needs and preferences rather than seeing themselves as "an expert" on medication assisted treatment. It is very hard to point to a text or to provide a set of bullet points on Recovery Supports, because it is much more about a "stance" towards recovery than about data.

Success in your role as a MATS Professional will depend on your ability to see your clients as "whole people", not as diagnoses or doses of medication. Can you build rapport? Can you meet the client where they are and make their priorities your priorities? As a MATS Professional, *you* are a recovery support.

Therefore, to study for this portion of the exam, be sure to look at the case examples you are provided in the MATS training materials. What types of support would make those client's recovery journey's easier and more stable?

Pro Tip:

The individual is ALWAYS the expert in the Client/MATS Professional Dynamic.

If an answer makes it seem like the professional is the expert, it's probably NOT the right one.

A Case Study:

You are a MATS Counselor working in an OTP. John is a 24-year-old Caucasian male, and he has been on your case load for 6 months. He has not had any illicit drug screens for the last 4 months, but today reports to you that he used methamphetamines with his roommate. John reports he could "probably" move back in with his brother, who does not use substances. John states that he does not know if he can keep coming to the clinic due to being financially strapped after recently losing his job. He expresses a significant amount of concern about not being able to stay on his medication, because it's "the only thing keeping me clean".

List 5 different threats to John's stability:

_____

_____

List 5 different recovery supports that you could help to link John with:

_____

_____

List 5 different strengths that John already has that you can work with:

_____

_____

Areas for Review:

- Mental health diagnoses, medications, and their impact on MAT for Substance Use Disorders
- Motivational Interviewing and the Transtheoretical Model of Change
- Principles associated with Trauma-Informed Care and Cultural Competency
- The relationship between MAT and 12 Step Recovery Groups, such as Narcotics Anonymous
- The difference between treatment and recovery

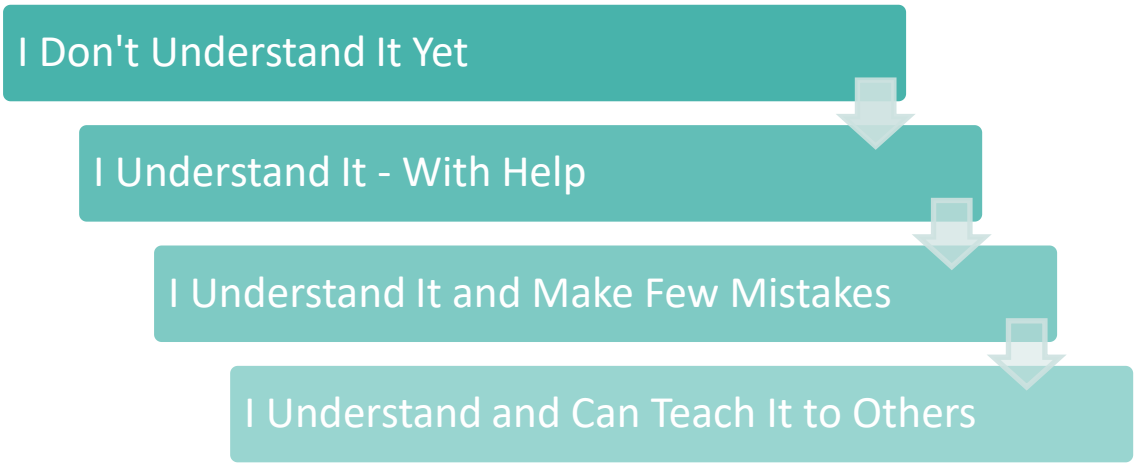
Commonly Psychiatric Medications and MAT

DIAGNOSIS	TYPE OF MEDICATION	COMMON MEDICATIONS	ISSUES WITH MAT
Psychotic Disorders	**Typical *or* First Generation Neuroleptics (aka Antipsychotics)**	***Thorazine*(chlorpromazine)** ***Clozaril* (clozapine)** ***Haldol* (haloperidol)**	**Individuals on antipsychotics may require a lower dose of methadone to prevent sedation.**
	Atypicals *or* Second Generation Neuroleptics (aka Antipsychotics)	***Risperdal* (rispiridone)** ***Zyprexa* (olanzapine)** ***Seroquel* (quetiapine)** ***Clozaril* (clozapine)** ***Latuda* (lurasidone)** ***Geodon* (ziprasidone)** ***Abilify* (aripiprazole)** ***Invega* (paliperidone)** ***Invega Sustenna* (paliperdidone injection)** ***Saphris* (asenapine)**	**Individuals on antipsychotics may require a lower dose of methadone to prevent sedation.**
Bipolar I/II	**Mood Stabilizers**	***Lithium* (LiCO3)** ***Depakote* (valproic acid)** ***Lamictal* (lamotrigine)** ***Tegretol* (carbamazepine)** ***Trileptal* (oxcarbamazepine)**	**Tegretol (carbamazepine) may cause severe opioid withdrawal; may reduce both methadone and buprenorphine serum levels.**
Major Depressive Disorder	**Selective Serotonin Reuptake Inhibitors (SSRIs)**	***Prozac* (fluoxetine)** ***Paxil* (paroxetine)** ***Zoloft* (sertraline)** ***Lexapro* (escitalopram)**	**SSRIs may increase methadone and buprenorphine serum levels.**
	Serotonin-Norepinephrine Reuptake Inhibitor (SNRIs)	***Cymbalta* (duloxetine)** ***Effexor XR* (venlafaxine)** ***Pristiq* (desvenlafaxine)**	**SNRIs may increase methadone and buprenorphine serum levels.**
	Non-SSRI/SNRIs	***Remeron* (mirtazapine)** ***Wellbutrin* (bupropion)**	**N/A**
Anxiety Disorders	**Selective Serotonin Reuptake Inhibitors (SSRIs)**	***Prozac* (fluoxetine)** ***Paxil* (paroxetine)** ***Zoloft* (sertraline)** ***Lexapro* (escitalopram)**	**SSRIs may increase methadone and buprenorphine serum levels.**
	Benzodiazepines	***Ativan* (lorazepam)** ***Valium* (diazepam)** ***Klonopin* (clonazepam)** ***Xanax* (alprazolam)**	**Benzodiazepines increase the risk of respiratory arrest when combined with an opioid agonist or partial agonist**
	Beta-blockers	***Inderal* (propranolol)**	**N/A**
	Other	***BuSpar* (buspirone)**	**N/A**
ADHD	**Stimulants**	***Ritalin, Metadate, Concerta, Daytrana* (Methylphenidate)** ***Adderall* (Amphetamine)** ***Dexedrine, Dextrostat* (Dextroamphetamine)** ***Vyvanse* (Lisdexamfetamine Dimesylate)**	**Stimulant medications require monitoring due to abuse potential.**
	Non-stimulants	***Strattera* (Atomoxetine)**	**N/A**

EDUCATION

This portion of the exam was created to test your ability to educate clients, family members and community members on the basic principles of MAT. Less specific than many of the Pharmacotherapy questions, these are the concepts that you will most frequently share with clients and other stakeholders. As a MATS Professional, you may be called upon to be a well-informed, enthusiastic ambassador for Medication Assisted Treatment. Being able to share the fundamentals of this intervention, readily and easily, helps your clients retain access to life-saving medications.

Evolution of Understanding:

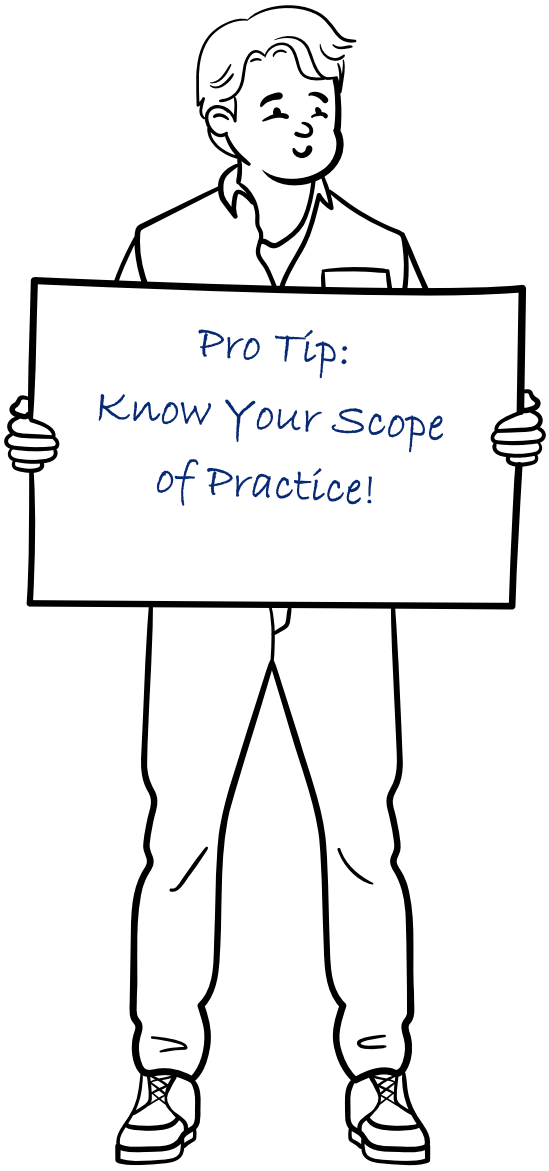


Areas for Review:

- The process of MAT – Screening through Tapering
- Pros and Cons associated with each medication used in MAT
- Understanding the Brain Disorder Model of Addiction

PROFESSIONAL RESPONSIBILITY

While this portion of the exam may have the fewest questions, it is the most bedrock to our profession. To grant a MATS credential, ICAADA must ensure that the recipients are able to practice ethically and responsibly. This is for the safety of the clients, the community, the employers, and YOU! Once you have done the distance learning, sat through the training, and passed the exam, you don't want to lose your credential by behaving unethically.



Areas for Review:

- Scope of Practice for MATS Professionals
- Privacy laws governing SUD treatment
- Ethical principles of MAT
- How to resolve ethical dilemmas
- When to seek supervision
- Principles associates with good clinical documentation

MATS Code of Ethics:

I. Ethical Principle 1: Non-Malfeasance: As a MATS professional, I am committed to "First, do no harm." I am committed to ensuring that the services that I provide do not increase the hardship and suffering of those I am charged with helping.

A. Conflicts of Interest and Dual Relationships

1. I will not engage in professional relationships or commitments that conflict with family members, friends, close associates, or others whose welfare might be jeopardized by such a conflict of interest.
2. I will not engage in a "dual relationship" with any client, meaning a relationship between myself and my client in which multiple roles are inhabited in addition to the therapeutic alliance (i.e. salesperson/customer, sponsor/sponsee).
2. Because a relationship begins with a power differential, I shall not exploit relationships with current or former clients for personal gain, including social or business relationships.
3. I will not, under any circumstances, ever engage in sexual behavior with current or former clients and not accept as a client anyone with whom I have ever engaged in sexual behavior.
4. I will not accept substantial gifts from clients, other treatment organizations, or the providers of materials or services used in my practice.
5. I will seek supervision when unsure of any current, previous, or perceived conflict of interest to the services provided.

B. Nondiscrimination

1. I will ensure the services I provide are not discriminatory against any populations, or persons served, based upon ethnicity, race, color, religious or spiritual belief, gender identity, sexual orientation, mental or physical ability, criminal justice background, or any other category that may separate them from my personal beliefs

C. Initiation and Discharge

1. I will work to ensure than all clients are only initiated on medication assisted treatment when they can provide informed consent,

understanding the risks as well as the benefits of their chose course of intervention.

2. I will work to ensure that discharge from treatment is conducted in accordance with sound, medically acceptable practice. The patient will be assured of due process if the discharge is administrative in nature.

II. Ethical Principle 2: Beneficence: As a MATS professional, I am committed to providing services that provide a benefit to the presenting problem for which the client is in my care.

A. Professional Conduct

1. I will accurately identify my qualifications, expertise, and certifications to all whom I serve and to any potential employers.

2. I will report any personal, agency, or other professional ethical misconduct in accordance with agency policy and licensing/credentialing body protocol.

3. I will not commit a criminal offense. I understand if I am charged for a criminal offense, the ICAADA Ethics Committee reserves the right, with full ICAADA board approval, to take immediate disciplinary action up to and including suspension of my credential. It is my duty to notify ICAADA immediately if I am charged with a criminal offense.

B. MATS Competencies and Limitations

1. I will ensure all services provided are within my scope of practice, educational qualifications, and competency and are evidence-based, person-centered and outcome driven.

2. I will not provide any recommendations to any client regarding the prescription or administration of medications, such as recommending one medication over another or dosage adjustments, unless my MATS credential is secondary to a state medical license that allows me to make such clinical judgments.

3. I will encourage each client to discuss questions and concerns related to their medication directly with their medical practitioner.

4. I will provide medical practitioners with whom I share clients with important context on individual clients, to assist them in making the safest and most beneficial decisions possible for our clients.

5. I will subscribe to the treatment principles as published in the CSAT TIP 43, Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, which serve as a resource in making therapeutic treatment decisions.

6. I will further my educational knowledge related to the person served and the practices of my profession, particularly when it comes to advancements in the practice of medication assisted treatment for substance use disorders.

C. Trauma-Informed Care

1. I recognize that many clients with substance use disorders will have a significant trauma history that impacts their lives.

2. I will place the safety of the individual as primary in all my interactions with my clients.

3. I will continue to seek out training in trauma-informed care and will be receptive to feedback on the impact of my behavior, interventions, and environment may have on the individual.

D. Cultural Competency

1. I recognize that the cultural context of the individual is a vital piece of their experience and their recovery.

2. I will seek opportunities to develop my cultural competence. I will ask for and be receptive to feedback from my clients and the community at large as to how interventions and practices are viewed through their cultural experience.

E. Clinical Documentation

1. I will maintain required documentation for all consultative sessions, and client records, as required by the agency through which I am employed or the federal requirements making certain that records are documented honestly and stored securely. Agency disposal of records policies shall be adhered to.

F. Supervision

1. I recognize that I will always be refining my professional skills and will require clinical supervision throughout my career.

2. I will seek out supervision within my agency. Ideally, MATS professionals should be supervised by competent senior MATS professionals. When this is not possible, I will seek peer supervision or mentoring from other competent MATS professionals

3. If I am also a person in recovery, I will seek out support and supervision to ensure that I continue to attend to my own recovery.

G. Interdisciplinary Services

1. As a MATS professional, I recognize that I will likely perform my services in the context of an interdisciplinary team. This team may include physicians, nurses, case managers, peer recovery coaches, and therapists.

2. I will stay within my scope of practice, as the insight that I might be able to provide is unique and vital to the clients that I serve.

3. I will honor the scope of practice that my teammates occupy and the expertise each member brings.

III. Ethical Principal 3: Autonomy: As a MATS professional, I am committed to providing services that respect the right of my clients to make their own decisions regarding the care that they require. All services should be rendered such that the individual participates fully in their treatment, except when the present a risk to themselves or to others.

A. Respect for the Individual

1. I recognize that there are many pathways to recovery from substance use disorder. I will respect and honor the journey of the individual by helping each client cultivate a recovery that meets the person where they are.

2. I will work to stay abreast of the recovering community in my area of practice, to be able to provide my clients with a variety of options that may assist them on their unique pathway.

B. Informed Consent

1. I will provide clients with accurate and complete information regarding medication assisted treatment, the nature of available services, and the availability of alternative treatment modalities prior to admission and throughout the treatment process.

2. I will review any treatment agreements and treatment plans with patients on a regular basis to ensure that the client understands their rights, as well as the risks and responsibilities of any given intervention.

3. If a client appears to be unable to provide consent due to intoxication, acute withdrawal, and/or cognitive impairment, I will seek out supervision immediately

C. Confidentiality

1. I will protect the privacy and confidentiality of persons served in adherence with federal confidentiality, HIPAA laws, local jurisdiction and state laws and regulations. This includes electronic privacy standards (social media, texting, video conferencing etc.)

2. I will provide each client with information regarding my role as a mandated reporter and my ethical obligation to prioritize the safety of my clients and my community over confidentiality when an imminent risk presents itself.

D. Mandated Reporting/Duty to Warn

1. I will report all cases of suspected abuse or neglect of minors, and/or neglect, battery, or exportation of an endangered adult to the appropriate authorities.

2. If a client presents an imminent risk to themselves or others, I will take steps to ensure their safety by enlisting the assistance of my supervisor(s) and, if necessary, law enforcement.

3. If a client presents an imminent risk to another individual, I will take steps to warn that individual of the threat, in addition to law enforcement.

IV. Ethical Principle 4: Justice: As a MATS professional, I am committed to providing services that are equitable and fair. Individuals in similar situations should be treated similarly. In addition, I am committed to furthering the reputation and availability of medication assisted recovery in my community.

A. Treatment Environment

1. I will work to provide a safe and clean environment for clients and staff that is conducive to the therapeutic process.

2. I will strive to maintain good relations with the surrounding community and pursue every reasonable action to encourage responsible patient behavior and community safety.

B. Equitable Treatment

1. I will strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people.

2. I will strive to ensure that individuals shall get treated in accordance with their diagnosis, severity of presentation, availability of interventions, and personal preferences.

3. I will do my part to ensure that the fees are fair, reasonable, and commensurate with the services performed. Consideration will be given to clients' ability to pay.

C. Termination of Services

1. I will terminate services to clients and professional relationships with them when such services and relationships are no longer required or no longer serve the clients' needs or interests.

2. I will take reasonable steps to avoid abandoning clients who are still in need of services. I should withdraw services precipitously only under unusual circumstances, considering all factors in the situation, and taking care to minimize possible adverse effects.

3. I will assist in making appropriate arrangements for continuation of services when necessary

C. Promoting Medication Assisted Recovery

1. I will contribute time and professional expertise to activities that promote respect for the value, integrity, and competence of the profession.

2. I will present the benefits and successes of medication assisted recovery and work to reduce stigma associated with addiction and with medication assisted treatment, wherever possible.

PREPARING FOR THE EXAM

Even if you have been working in a MATS position for years, it is important to prepare for this exam. It is crucial to read through each question slowly and attempt to select the correct answer. The questions were created with the three-day training, as well as the distance learning and associated readings, in mind. Below, find details about the exam and test-taking tips.

About the Exam:

The ICAADA MATS Exam is comprised of 50 multiple choice questions. This is a computer-proctored exam. You only need to get 35 answers correct to pass, for a passing score of 70%. There are vignettes (brief, clinical descriptions) with two questions each. The rest of the questions are single questions with a "best answer". You will have an hour to complete the exam.

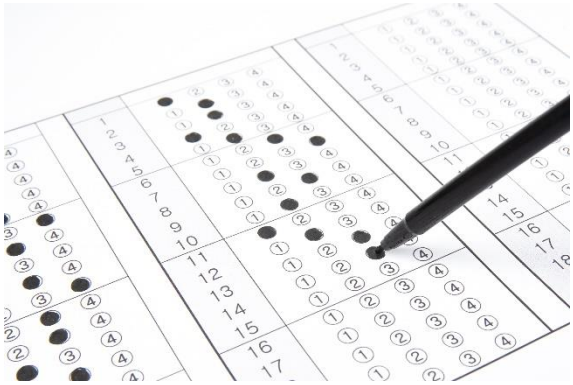
The exam is comprised of the four core areas of focus of the MATS credential: Pharmacotherapy, Recovery Supports, Education, and Professional Responsibility. The number of questions per are of focus is as follows:

MATS Domain	Number of Questions
Pharmacotherapy	20
Recovery Supports	15
Education	10
Professional Responsibility	5
TOTAL	**50**

Test-Taking Tips:

Going into a test with a professional examination can be a stressful and anxiety-inducing prospect. While memorizing the DSM-5 and TIP 63 seems like a good idea, having a good knowledge of basic test-taking techniques will help you to feel confident that your passing score on this exam is reflective of all the hard work you have put into becoming a top-notch addiction professional. Here is a sampling of common test-taking advice:

- **Listen Carefully to Directions**. How much time is available? How will the test be scored?
- **Understand a question before answering it**. Read questions carefully prior to answering. When in doubt, eliminate choices that you know to be wrong, and then choose an answer from the remaining choices. Remember: The correct answer is always listed in multiple-choice exams.
- **Review your work**. The test is not over until the time is up, or every answer has been selected.
- **Answer the ones you are confident about first**. If you have to ponder your answer for a question, skip it and come back. This way, you don't miss "easy" ones due to rushing.



- **Don't submit your test until you confirm you have answered every question**. You automatically miss points for any questions that go unanswered.
- **Stay as calm as you can**. Stay calm and do your best. If you feel like you are getting overwhelmed, look away from the test and take a few breaths.

Pro Tip:

The Exam is not there to trick you. Know the meds. Know your role in the treatment team. Be able to apply the concepts.

You can do this!

SAMPLE EXAM QUESTIONS

The following are 10 sample questions that are similar in structure, difficulty, and tone to the actual MATS Exam. Each of the four domains are represented. Choose the *best* answer, as more than one may seem correct.

1. Which of the following is an example of severe opioid withdrawal?

A. Fatigue
B. Diarrhea
C. Itching
D. Seizures

2. Ensuring that non-English speaking patients of OTPs have access to interpreter services whenever they are on-site is an example of:

A. Cultural Competency
B. Trauma-Informed Care
C. Holistic Services
D. Peer Supported Recovery

3. An OTP allowing a pregnant client to continue to receive medication at a lower cost is an ethical dilemma involving which two MATS ethical principles?

A. Justice and Autonomy
B. Non-Malfeasance and Beneficence
C. Justice and Beneficence
D. Autonomy and Non-Malfeasance

4. If a patient is doing a home induction of buprenorphine, how long should they wait to start taking the medication after their last dose of heroin or short-acting prescription opioid?

A. At least 6 hours after their last dose
B. At least 12 hours after their last dose
C. At least 24 hours after their last dose
D. As soon as possible, so that they do not experience opioid withdrawal

5. According to the White and Coon (2003) article, which of the following is ***not*** one of the confirmed positive effects of methadone maintenance treatment (MMT)?

A. Enhanced compliance with the criminal justice system
B. Decreased death rate of opiate-dependent individuals by as much as 50%
C. Improved global health and social functioning
D. Enhanced productive behavior via employment and academic/vocational functioning

6. If a client discloses to you that they are being followed whenever they are out in public and that they believe that the news channels listening to them, what should you do?

A. Call 911 and initiate an involuntary detention
B. Challenge their thinking directly by telling them that "no one is following them"
C. Tell them that you are there to discuss their addiction only
D. Affirm how difficult that must be for them and attempt to connect them with psychiatric care

7. Dosing of methadone must be individualized because it's bioavailability, clearance, and half-life vary among patients. Which of the following factors may affect serum levels and clinical responses to methadone treatment?

A. Pregnancy
B. History of intravenous heroin use
C. Increased stress
D. None of the above

8. Which of the following is the extended release, injectable formulation of naltrexone?

A. Depade
B. Sublocade
C. Naloxone
D. Vivitrol

Please use the following case example to answer the next 2 questions:

You work as a counselor in the intake department of an OTP and you are assessing Aubrey, a 34-year-old married Caucasian woman presenting with opioid use disorder. Her husband has accompanied her to her assessment. She shares with you that she became addicted to opioids following receiving a prescription for Oxycodone "for years" due to serious back pain. Aubrey has since begun snorting heroin and knows that she is "addicted". She states that her brother is on methadone with another clinic and it has helped him. However, she wants to know what methadone is "going to do for [her] back pain".

9. What is the most appropriate response to Aubrey's question about her pain that you can provide as a MATS Professional working in an OTP?

A. "Many patients experience some pain relief on a therapeutic dose of methadone. I'll tell the doctor that you will need a higher dose to help with this."
B. "You're here because you're an addict, not to treat your pain."
C. "It sounds like pain relief is going to be an important part of your recovery. We have partnerships with recovery-oriented doctors that can do an assessment of your pain and provide you with treatment, as necessary."
D. "If you do about 30 minutes of yoga every day, your back pain will probably get a lot better."

10. Aubrey's husband asks whether she will be "just trading one drug for another" if she starts taking methadone. What is an appropriate response to this question?

A. "Have you looked into a support group like Al-Anon or Nar-Anon for yourself?"
B. "That is a really common concern. It's important to know that having a Substance Use Disorder and being physically dependent on a medication are not the same things."
C. "If you are going to act like this, I'm going to have to ask you to leave."
D. "Aubrey, how long has it been since your last use?"

ANSWER KEY

Below you will find the answers to each of the sample questions, a brief explanation of why the correct answer is correct (and the incorrect answers are incorrect), as well as the domain it represents. In addition, there are references to the distance learning and training materials so that you may be clear on what to review.

1. Which of the following is an example of severe opioid withdrawal?

A. Fatigue
B. Diarrhea
C. Itching
D. Seizures

Answer: B
Rationale: Refer to both the Clinical Opiate Withdrawal Scale (COWS) and page 5-29 in TIP 63. "A. Fatigue" can be a symptom of mild opioid withdrawal but is not considered severe. "B. Diarrhea" is an objective (meaning observable from the outside). "C. Itching" is an example of acute opioid intoxication, not of withdrawal. "D. Seizures" can be an example of severe alcohol withdrawal, not opioid withdrawal.
Domain: Pharmacotherapy

2. Ensuring that OTP non-English speaking patients have access to interpreter services whenever they are on-site is an example of:

A. Cultural Competency
B. Trauma-Informed Care
C. Holistic Services
D. Peer Supported Recovery

Answer: A
Rationale: This is an example of making sure you select the "best" answer, as several may appear correct. Language is an important part of an individual's culture, making interpreter services an example of "A. Cultural Competency." While it may also be "B. Trauma-Informed Care" and "C. Holistic" to have interpreters available, language most directly aligns with culture. Similarly, a person that speaks the same language as your patient is a "peer", this is not an example of "D. Peer Supported Recovery" as interpreters are not required to have lived recovery experience.
Domain: Recovery Support

3. An OTP allowing a pregnant client to continue to receive medication at a lower cost is an ethical dilemma involving which two MATS ethical principles?

A. Justice and Autonomy
B. Non-Malfeasance and Beneficence
C. Justice and Beneficence
D. Autonomy and Non-Malfeasance

Answer: C
Rationale: Refer to the MATS Code of Ethics. Justice requires that providers ensure that clients are treated equitably. Beneficence requires interventions must be beneficial to the client. Thus, it is "beneficial" to pregnant clients that they be given access to stabilizing medication while they and their fetus are at higher risk for poor outcomes, AND it is not equitable that some clients are allowed to pay less for the same service than other patients that would also benefit from the intervention.
Domain: Professional Responsibility

4. If a patient is doing a home induction of buprenorphine, how long should they wait to start taking the medication after their last dose of heroin or short-acting prescription opioid?

A. At least 6 hours after their last dose
B. At least 12 hours after their last dose
C. At least 24 hours after their last dose
D. As soon as possible, so that they do not experience opioid withdrawal

Answer: B
Rationale: This is a memorization question (for details refer to page 3-64 in TIP 63). If you don't know the answer, however, you can still make an educated guess. You can rule out D, because a patient must be exhibiting clear signs of opioid withdrawal prior to buprenorphine induction. If you have ever spoken to a person in acute opioid withdrawal, telling them that they have to wait a whole 24 hours before they can get relief will not go over well. At this point, you can make a guess between A and B.
Domain: Pharmacotherapy

Pro Tip:
Be on the lookout for phrases like
"Which one of the following is NOT…" or "**All of the following EXCEPT…**"
You must understand the question before you can choose the best answer!

5. According to the White and Coon (2003) article, which of the following is ***not*** one of the confirmed positive effects of methadone maintenance treatment (MMT)?

A. Enhanced compliance with the criminal justice system
B. Decreased death rate of opiate-dependent individuals by as much as 50%
C. Improved global health and social functioning
D. Enhanced productive behavior via employment and academic/vocational functioning

Answer: A
Rationale: A is correct because the goal of treatment is to help an individual enter recovery, not for coercion into compliance with the criminal justice system. The answers reflected in B, C, and D, are all listed on Page 3 of the White and Coon (2003) article "Anti-Medication Bias". These answers reflect the overall improved quality of life associated with access to MAT or MMT.
Domain: Education

6. While discussing a patient's significant improvement in their compliance with their MAT medication agreement, a client discloses to you that they are being followed whenever they are out in public and that they believe that the news channels listening to them, what should you do?

A. Call 911 and initiate an involuntary detention
B. Challenge their thinking directly by telling them that "no one is following them"
C. Tell them that you are there to discuss their addiction only
D. Affirm how difficult that must be for them and attempt to connect them with psychiatric Care

Answer: D
Rationale: In this "application" question, there is no specific reading that will be helpful. Instead, focus on having a holistic stance towards this person. A is incorrect because the presence of psychosis (hallucinations and/or delusions) is not enough to warrant an involuntary detention, if the patient is not "gravely disabled" or in any immediate danger. B is incorrect because directly challenging psychosis is not an intervention that a MATS professional has received enough training to provide. C is incorrect because it is dismissive and does not see the "whole person". D is correct because it is a positive and affirming approach to the patient, while also providing overall recovery support by linking the patient with an appropriate intervention.
Domain: Recovery Support

7. Dosing of methadone must be individualized because it's bioavailability, clearance, and half-life vary among patients. Which of the following factors may affect serum levels and clinical responses to methadone treatment?

A. Pregnancy
B. History of intravenous heroin use
C. Increased stress
D. None of the above

Answer: A
Rationale: Refer to TIP 63, page 3-32. The correct answer is "A. Pregnancy". There is no evidence to suggest that the "route of ingestion" of an opioid has an impact on the blood serum level of methadone. While "C. Increased Stress" may be a risk factor for other things that might influence the blood serum level of methadone, such as a change in diet, there is not a clear enough relationship to consider this a correct answer. As there is the presence of a correct answer, the answer cannot be "D. None of the Above".
Domain: Pharmacotherapy

8. Which of the following is the extended release, injectable formulation of naltrexone?

A. Depade
B. Sublocade
C. Naloxone
D. Vivitrol

Answer: D
Rationale: Refer to the medication tip sheets earlier in this Study Guide. "A. Depade" is the oral formulation of naltrexone. "B. Sublocade" is the extended release, injectable formulation of buprenorphine. "C. Naloxone" is a different opioid antagonist altogether. "D. Vivitrol" is the correct answer.
Domain: Pharmacotherapy

9. What is the most appropriate response to Aubrey's question about her pain that you can provide as a MATS Professional working in an OTP?

A. "Many patients experience some pain relief on a therapeutic dose of methadone. I'll tell the doctor that you will need a higher dose to help with this."
B. "You're here because you're an addict, not to treat your pain."
C. "If you do about 30 minutes of yoga every day, your back pain will probably get a lot better."
D. "It sounds like pain relief is going to be an important part of your recovery. We have

partnerships with recovery-oriented doctors that can do an assessment of your pain and provide you with treatment, as necessary."

Answer: D
Rationale: A is incorrect because methadone is not used for pain treatment at OTPs and because you should never give recommendations regarding specific doses of medications. B is incorrect because it is dismissive to the patient's concern for her pain, and it is a belittling response. C is incorrect because you are not a medical professional that is qualified to make specific recommendations for interventions. D is the correct response because it attends to the patient's concern for pain relief while not stepping outside of your scope of practice. See also page 4-36 in TIP 63.
Domain: Recovery Support

10. Aubrey's husband asks whether she will be "just trading one drug for another" if she starts taking methadone. What is an appropriate response to this question?

A. "Have you looked into a support group like Al-Anon or Nar-Anon for yourself?"
B. "That is a really common concern. It's important to know that having a Substance Use Disorder and being physically dependent on a medication are not the same things."
C. "If you are going to act like this, I'm going to have to ask you to leave."
D. "Aubrey, how long has it been since your last use?"

Answer: B
Rationale: Family support can make a huge difference in a patient's recovery and family members frequently need some level of education about MAT to be as supportive as possible. A is incorrect because it is not answering the very real question this family member is asking. B is the correct response because it affirms the concern as being real and provides crucial information to help get Aubrey's husband's "buy in". C is incorrect because it is unnecessarily confrontational. D is incorrect because it ignores the question altogether; yes, you must assess Aubrey, but you have an opportunity to increase family support.
Domain: Education

GLOSSARY

Acamprosate (Campral): a medication used in the treatment of alcohol use disorders. It is thought to increase abstinence through normalizing glutamate in the brain.

Action (Stage of Change): One of the stages of change in the Transtheoretical Model of Change. The stage in which a person is actively making changes to their target behavior.

Alcoholics Anonymous (AA): a mutual support group or fellowship that assists people recover from problematic use of alcohol, through the use of its spiritually inclined Twelve Step program. Provides one option for peer-supported recovery.

Ambivalence: Having to decide between two equally good or equally bad option. Within the context of recovery from substance use, this may mean finding some aspects of substance use destructive, problematic, or painful but other aspects beneficial or pleasant.

ASAM Dimensions: Six areas of assessment for individuals seeking out SUD treatment that evaluates needs, strengths, and risks to determine the most appropriate level of care for an individual. The six dimensions are: acute intoxication/withdrawal potential; Biomedical Conditions and Complications; Emotional, Behavioral or Cognitive Conditions and Complications; Readiness to Change; Relapse, Continued Use or Continued Problem Potential; and Recovery/Living Environment.

ASAM Levels of Care: A continuum of services available to assist individuals develop greater stability in their recovery form SUDs, based on the needs of the individual. These levels of care include Medically Managed Intensive Inpatient Detoxification, Clinically Managed Low-Intensity Residential Services, Intensive Outpatient and Partial Hospitalization, and Outpatient Services.

Buprenorphine: a partial opioid agonist used in the treatment of opioid use disorders.

Burnout: A state of emotional, physical, and mental exhaustion caused by excessive and prolonged stress.

Chantix (varenicline): A smoking cessation medication that inhibits the pleasurable effects of nicotine.

Clinical Institute Withdrawal Assessment – Alcohol Revised (CIWA-AR): An instrument used to assess both subjective (client report) and objective (professionally observed symptoms) to determine the severity of alcohol withdrawal symptoms

Clinical Opiate Withdrawal Scale (COWS): An instrument used to assess both subjective (client report) and objective (professionally observed symptoms) to determine the severity of opioid withdrawal symptoms

Clonodine: An antihypertensive medication that can be used to treat the discomfort associated with opioid withdrawal.

Confidentiality: A legally protected write to privacy between a client and their treatment team.

Contemplation (Stage of Change): One of the stages of change in the Transtheoretical Model of Change. This is the stage in which a person is beginning to consider making a change to the target behavior and is characterized by ambivalence.

Cross-Tolerance: Potential for people tolerant to one opioid (e.g. heroin) to be tolerant to another (e.g., methadone).

Cultural Competence: A range of cognitive, affective, and behavioral skills that lead to effective and appropriate communication with people of other cultures.

Disulfiram (Antabuse): A medication used in the treatment of alcohol use disorders. IT is a medication that causes an individual to become ill if they ingest alcohol while it is

in their system. Symptoms of associated with this reaction include nausea/vomiting, sweating, vertigo, tachycardia, and hyperventilation.

Dual Relationships: Relationships between two individuals in which multiple roles are inhabited. For example, providing counseling services to someone that has provided goods and services to the counselor in the past.

Duty to Warn: The legal and ethical requirement to warn an individual when a client reports violent intentions towards them; one of the exceptions to confidentiality/privacy laws associated with providing counseling services.

Ethical Principles: The four guiding principles of ethical MAT practice: non-malfeasance, beneficence, autonomy, and justice.

Individualized Dosing: A process of ensuring that individual's medication dosing and scheduling is optimal due to metabolism and tolerance of opioid can vary considerably in clients.

Induction Phase: The first phase of medication assisted treatment, with either methadone or suboxone. It is considered the riskiest time in treatment, as the clients may not have discontinued using and may be at risk for overdose.

Intoxication: A state of having mental and/or physical control markedly diminished due to the ingestion of a substance, such as alcohol, cannabis, or opioids.

Chlordiazepoxide (Librium): A benzodiazepine that can be used to manage the risks associated with alcohol withdrawal.

Mandated Reporting: The ethical and legal requirement of counselors to report cases of all cases of suspected abuse or neglect of minors, and/or neglect, battery, or exportation of an endangered adult to the appropriate authorities.

Maintenance Phase: The phase of MAT in which an individual no longer requires routine dosage adjustments, does not experience withdrawal or cravings, and is no longer using illicit opioids.

Maintenance (Stage of Change): The stage of change in which an individual sustains and strengthens changes made to the target behavior and has developed new routines and rituals around their modified behavior.

Methadone: a full opioid agonist used as a maintenance medication for individuals with opioid use disorder. Only dispensed by qualified Opioid Treatment Programs when prescribed for OUD.

Naloxone: An opioid antagonist. It is used as a rescue medication for individuals at risk of an opioid overdose.

Naltrexone: An opioid antagonist used as a maintenance medication for individuals with opioid use disorder and/or alcohol use disorder.

Peak-and-Trough: A series of blood tests that determine an individual's methadone metabolism and the therapeutic dose of methadone.

Precontemplation (Stage of Change): The stage of change in which the individual has not begun to consider making changes to their target behavior.

Preparation (Stage of Change): The stage of change in which an individual is making plans to change their target behavior soon and is considering how they might make this change.

Pharmacotherapy: The usage of pharmaceutical medications in the management of a substance use disorder.

Recovery: A resolution of substance-related problems, improvement in global health and functioning, and citizenship.

Recovery Supports: Anything that supports the individual in their process of making change. This may include medical, psychiatric, vocational, community, or family supports.

Relapse: A return to active symptoms of a disorder that had once been managed.

Remission: A disappearance of the signs and symptoms of a disorder. In the context of an SUD, early remission is more than 30 days but less than a year of no substance use; sustained remission is a year or more of no substance use.

Scope of Practice: The services that a health professional is deemed competent to perform and permitted to undertake.

SOAP Notes: Official documentation of counseling sessions that are organized into the following categories: Subjective Information (client report), Objective Information (observed symptoms); Assessment; and Plan.

Stabilization Phase: The phase of MAT for opioid use disorder in which a client is no longer experiencing sedation, withdrawal, cravings, and the euphoric effects illicit opioids. However, the individual may not have stopped using other non-opioid substances.

Strengths-based Interventions: Collaborative interventions between the client and the counselor that focuses on the client's strengths and assets, rather than problems and deficits.

Supervision: A formal arrangement between two counselors in which the supervisor provides support to the supervisee. This is particularly crucial when navigating ethical dilemmas.

Tapering: The phase of MAT in which some individuals may determine that they would like to discontinue the use of maintenance medications such as buprenorphine or

methadone. Should only be attempted when strongly desired by a stable client who has a record of abstinence from opioids and has adjusted positively in other areas of life while on MAT.

Therapeutic alliance: The cooperative relationship between a counselor and a client that allows the "work" of counseling to be accomplished.

Trauma: Real or imagined threat of loss of life or injury to an individual or someone the individual cares about.

Trauma-Informed Care: An approach to providing services and interventions to individuals that begins with the assumption that most clients have experienced a significant trauma history.

Withdrawal: A group of symptoms that occur upon the abrupt discontinuation or decrease in use of a substance. Specific symptoms vary depending on the substance.