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## Elevating the Quality of Medication-Assisted Treatment of Opioid Addiction: An Interview with Mark Parrino, M.P.A., President, American Association for the Treatment of Opioid Dependence Vice President, World Federation for the Treatment of Opioid Dependence

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### Introduction

The evolution of medication-assisted treatment (MAT) of opioid addiction is one of the most important and controversial chapters within the larger history of addiction treatment in America. At the center of policy debates on MAT in recent decades have been a leading advocacy organization—the American Association for the Treatment of Opioid Dependence (AATOD)—and its leader Mark Parrino. The increased professionalization and enhanced service quality within Opiate Treatment Programs (OTPs) in the United States are direct products of the efforts of AATOD and the leadership of Mark Parrino. I recently (August 2016) had the opportunity to interview Mark Parrino about the work of AATOD and some of the larger issues related to the medication-assisted treatment of opioid addiction. Please join us in this engaging conversation.

### Background and Early Work in the Field

***Bill White*:** What first drew you to the problem of addiction as an area of professional specialization?

***Mark Parrino*:** I was looking for a job as a Drug Treatment Counselor after I graduated from college in 1974. I grew up with heroin addiction in my family since my older brother became addicted to heroin when I was fifteen years old. I had a front line understanding of how heroin addiction affects the individual and the family in addition to affecting the neighborhood.

I was surprised to see how quickly patients responded to methadone maintenance treatment within 1-2 months of being admitted to care. It was remarkable to observe their early success as they left the ravages of heroin addiction and became more stable through a balanced medication

regimen and with the support of compassionate and informed personnel. I also learned that not everyone was compassionate and informed.

My early experiences as a young counselor in a methadone maintenance treatment program also had a profound impact on giving me the understanding that how you treat the patient is more important than the characteristics of the individual as they cross the threshold.

I was also impressed with the fact that most of the patients entered treatment with a sense of desperation. Many of the patients were tired of living such a difficult existence which put them at enormous risk. They were tired of being arrested, spending time in jail and losing the support of their families. It was what many patients perceived as the last stop on the journey before something tragic happened to them like dying.

***Bill White*:** How would you describe the state of the addiction treatment field when you began work as an addictions counselor and clinical supervisor in the mid-1970s?

***Mark Parrino*:** In the 1970s, the treatment system was still developing. There were no clinical guidelines to direct how care should be given to the patient and dosages tended to be sub-therapeutic. In spite of the fact that a therapeutic dose range was established between 80mg-120mg per day, many treatment facilities were uncomfortable in prescribing methadone at such dose levels. This was driven by misunderstanding in how the medication should be used in addition to the absence of any evidence-based guidelines and consistent training.

In my opinion, the treatment environment had a chaotic quality at the time. There were few experienced managers in the early days of treatment, and treatment programs generally were responding to patient's needs without any central organized direction. Sometime, I felt that the atmosphere of the program was similar to the shootout in the OK corral in old westerns. Many of the patients came armed with knives or guns and there was a fair amount of drug dealing in the vicinity of treatment programs. It would take years for this to stabilize.

***Bill White*:** You had a broad range of other roles before becoming President of the American Association for the Treatment of Opioid Dependence (AATOD). Could you describe some of those experiences and how they later informed your work at AATOD?

***Mark Parrino*:** I left my counseling role in an OTP to complete a Graduate degree in Health Policy, Planning and Administration and working for the New York County Health Services Review Organization. I was in the ambulatory department working to develop quality assurance standards for outpatient general medical practices. I became impressed with how medical practices would respond favorably when there were patient outcome measurements in place. This also had a profound effect in changing how I would look at regulatory oversight for opioid addiction treatment and how to balance well-thought-through regulatory oversight with improved patient care. I also became aware of the pitfalls of excessive bureaucratic regulation for the sake of regulation.

**Reflections on the History of MAT and AATOD**

***Bill White*:** Are there definable stages within the modern history of medication-assisted treatment for opioid addiction and within the evolution of AATOD?

***Mark Parrino*:** The development of AATOD has its own story. There were many challenges to OTPs in the late 1970s and early 1980s. A particularly damaging series of articles came out of Broward County in Florida "Methadone: The Deadly Cure." It was a particularly vicious attack on the use of methadone to treat opioid addiction and laid the groundwork for much of the stigma that we still confront at the present time. This series was sent to elected officials throughout the United States and got the

attention of several leading congressman at the time.

I began to work with my colleagues in the nine states of the Northeastern corridor, which had the highest concentration of OTPs at the time. It made good sense to utilize representatives from these nine Northeastern states to develop the Northeast Regional Methadone Treatment Coalition. This became the first vehicle in organizing treatment providers across state lines for a common good. It was understood that no state association or group of providers alone would be able to confront what was becoming a national push to end access to methadone treatment in the United States.

I utilized the framework the New York State Methadone Treatment Conference as a vehicle for the newly formed Northeast Regional Coalition. Our first conference convened in New York in 1984 and these regional conferences drew representatives from many other states outside of the Northeastern corridor. It established an approach of organizing the treatment community at a time when treatment providers favored isolation from one another. The Northeast regional conferences convened in each state of the Northeastern corridor, with the last conference being produced in Newport, Rhode Island during 1989.

The Board of the Regional Coalition agreed to evolve into a national structure and the first American Methadone Treatment Association conference convened in Boston in 1991. This was a major evolutionary step and conference attendants reflected a broader interest in having providers join AMTA from different regions of the country. This organizing initiative continues to the present time with 29 state chapters of AATOD in addition to working with our associates in Mexico and the international community.

***Bill White*:** You played a significant role in the early development of clinical guidelines for methadone maintenance treatment (MMT). How did these guidelines and their integration within the regulation of MMT programs affect the quality of patient care?

***Mark Parrino*:** Once this national association formed, it gave me and the Board of Directors the opportunity of working more closely with federal agencies, which have jurisdiction in this area. I began working with the Office of Treatment Improvement, which was a newly formed entity under the aegis of the Substance Abuse Mental Health Services Administration just after AATOD's inaugural conference convened. I approached SAMHSA/OTI with the concept of clinical guidelines specific to OTPs. I outlined the development of these guidelines selecting chapter topics and authors. I also worked with the leadership of the American Society of Addiction Medicine to have a number of their leading physicians, who had experience in methadone maintenance treatment, to write all the chapters with regard to medical aspects of care while AMTA administrators dealt with all of the other administrative topics. It became SAMHSA's first Treatment Improvement Protocol and its initial draft was released at the AMTA conference of 1992 in Florida. It laid the groundwork for how SAMHSA would inherit the federal oversight from the FDA, drawing upon the clinical guidance of this first Treatment Improvement Protocol to guide therapeutic decisions within the treatment program.

There were two other events that led to the development of these guidelines. The General Accounting Office published a scathing critique of 24 OTPs in 8 states in 1990. The publication "Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed" was the featured report during a major congressional hearing led by Congressman Rangle of New York. It had the impact of getting the FDA to rethink its involvement in overseeing methadone treatment programs, eventually shifting the oversight to SAMHSA in 2001 after years of strategic planning.

There was a second important factor operating at the time, which influenced the development of these guidelines. Dr. John

Ball and his colleagues published a major series of articles after evaluating six OTPs in Baltimore, Philadelphia, and New York. It was a NIDA funded study that lasted for three years. The major part of Dr. Ball's findings was that the major impact on patient outcome was how the OTP staff were organized and trained and how the OTPs were organized. Patient outcome would be related to the stability of program personnel and the therapeutic nature of the treatment environment. What was remarkable about these findings was that patient outcome was not connected to pre-treatment patient characteristics. The GAO report and the John Ball study would have a major impact on my work and the development of SAMHSA's first Treatment Improvement Protocol.

A second major outcome of AMTA and its work with federal agencies would later be seen in the publication of the DEA NTP Best Practice Guidelines. These guidelines were published in 2000 and released at the AMTA conference in 2000 in San Francisco. It represented a significant collaboration between SAMHSA, the DEA, and AMTA in working to resolve policy conflicts and how OTPs could be more compliant with DEA regulations. It went a very long way in stabilizing the system and the DEA is currently updating this document at the present time.

**The Development of AATOD/Increasing Work with the States**

***Bill White*:** There have been many developments since 2000. Could you highlight some of the more important of these developments?

***Mark Parrino*:** The Board of Directors of the American Methadone Treatment Association changed its name to the American Association for the Treatment of Opioid Dependence during its conference in St. Louis in 2001. It was a recognition that other medications were being developed to treat opioid addiction in the United States and that our national organization should not be identified with the use of any one particular medication. It was a landmark moment for our field as treatment programs were beginning to further stabilize following the adoption of new federal oversight through the Center of Substance Abuse Treatment/ SAMHSA in 2001. Federal regulatory oversight of OTPs transitioned from the FDA to SAMHSA during this year.

AATOD also increased its work with state opioid treatment authorities and NASADAD as a better method of balancing the relationship between federal and state oversight standards. This would become an important balancing act to ensure greater stability of the treatment system.

This was a defining period for opioid treatment programs in the United States since they were now accountable to the SAMHSA designated accrediting entities and represented a further stability in quality of care for the patients in treatment. In spite of enormous research in support of the use of medications to treat opioid addiction and the success of treating a large number of patients in a therapeutic environment, there have always been impediments to opening OTPs. The greatest impediment has been a lack of public education about the value of such medications, especially methadone maintenance treatment. There has never been any national educational campaign to explain to the American public what treatment is and is not.

Additionally, and in the earlier days, some of the OTPs did not effectively manage their treatment programs. Community acceptance of the use of methadone would take a dark turn if treatment programs did not effectively manage the patient population and the external environment to the OTPs. In this case, patient loitering was limited to a small but highly visible patient group and that drew the attention of the communities.

Another major impediment is a general misunderstanding of the benefit of using therapeutically developed opioids to treat opioid addictions. For most Americans, this is seen as counter-therapeutic and strange.

## Rationale for MAT and MMT

***Bill White*:** What factors have prevented the broader acceptance of MAT, and MMT in particular, in the United States?

***Mark Parrino*:** The general view is that treating opioid addiction with opioids is substituting one drug for another. This view has also been further supported by other addiction treatment experts and programs, which believe that the only path to treating a patient effectively is in a drug-free or abstinence-oriented environment. In this case, the only path to treating a patient effectively in a recovery-based model is to avoid the use of any medication which has its own habit-forming quality. In this case, two of three federally approved medications to treat opioid addiction do have such dependence creating qualities. These views also impact opening programs in communities, especially when abstinence oriented treatment representatives communicate to legislators and city councils why such medications should not be used in opioid addiction treatment. One state legislator explained he could not support the use of methadone because representatives of a drug treatment community described it as "Satan's drug" or like switching bourbon for scotch.

Other state legislators or policy makers frequently are of the judgment that methadone should be restricted to one or two years of use at most. There is a fundamental misunderstanding of how you treat a chronic relapsing opioid addiction disorder in the United States and abroad. While most individuals will understand that hypertensive or diabetic patients will need to take certain medications for the rest of their lives in order to stabilize, they do not make a similar association with the use of methadone or buprenorphine to be used for a very long period of time or for the rest of the patients' lifetime. In the case of hypertension and diabetes, the medication is seen as therapeutic. In the case of methadone or buprenorphine, it is seen as counter-therapeutic.

Once again, this is driven by misconception and stigma about opioid addiction. It is impossible to argue against someone who suggests that abstinence-oriented treatment represents the best possible outcome for any opioid addicted individual as opposed to using a medication that has dependency-producing properties. The obvious answer is that such outcome represents the best possibility. This has to be measured against how many individuals are able to remain in a "drug-free state" as opposed to someone who is stable on a regimen of therapeutic medications which are offered in conjunction with other support services. Once again, this raises the point of a national public education campaign.

## Expanding Access to OTPs

***Bill White*:** Could you describe trends related to access to medication-assisted treatment of opioid addiction in the United States?

***Mark Parrino*:** There has been an enormous amount of discussion and policy making with regard to expanding access to medication-assisted treatment for opioid addiction. Most of this recent policy discussion is currently focused on increasing access to the use of buprenorphine through DATA 2000 practices. DATA 2000 practices are individual physician practices that treat opioid-addicted individuals with buprenorphine. Some practices are using extended release naltrexone as are OTPs. Extended release naltrexone is the third federally approved medication to treat opioid addiction and it is expected that this medication will be utilized to a much greater degree over the coming years in OTPs and the medical community.

There has been very little policy focus on how to expand access to OTPs. In this regard, it is simpler to approve a doctor's application to treat patients with buprenorphine in a medical practice since that individual will not have to go through community approvals or state regulatory approval as well. For OTPs, there are three

approvals that must be garnered prior to opening. The State Opioid Treatment Authority, in conjunction with state licensing entities, must approve the OTP in addition to the Substance Abuse Mental Health Services Administration and the Drug Enforcement Administration. An OTP cannot open unless it has obtained approvals from all three regulatory entities. The DATA 2000 practice does not have to go through this particular regulatory exercise. Some of the greatest challenges to OTPs are through state legislatures and local zoning boards. Many times, zoning boards will find a way to stall or completely stop the opening of an OTP. In recent years, such zoning board regulations have been struck down in court as OTP operators are more willing and able to challenge these zoning board decisions.

State legislatures will also create impediments through excessive regulation or executing monitoring in opening treatment programs. West Virginia has had a moratorium on opening new programs since 2007. To date, the state agencies involved in this area have not conducted any patient impact analysis. Illustratively, the state of West Virginia has no idea if the existing programs have been able to handle treatment capacity or if West Virginia residents cross the border to access care in adjacent states.

The state of Tennessee has 12 OTPs. While there is no defacto moratorium, no new programs have opened for some time. It is also known that a number of Tennessee residents cross the border to get access to OTPs from the Northern part of Georgia. This patient traffic has recently motivated the Georgia legislature to establish its own moratorium on opening up new Georgia-based OTPs, in order to get a better sense of how the existing OTPs are functioning in Georgia and who they are treating.

The state of Mississippi also presents a good example of the regulatory impediment in opening OTPs. Only one program has opened in Jackson and it has been well documented that more than 1,000 Mississippi residents cross the state borders of Alabama and Louisiana to get access to care. This is limited to the patient who can afford to pay for treatment out of pocket in addition to making the long trip into those states. In Maine, Governor LePage is doing all that he can to close opioid treatment programs which use methadone. He has made a public declaration that he does not think that methadone maintenance treatment is effective.

One might observe that it is fairly remarkable that OTPs exist at all, given such resistance. At present, there are only 1,400 OTPs in the United States treating approximately 350,000 patients on any given day.

There is some favorable news to report at this time. The state of North Dakota is opening up its first OTPs after three years of discussion, regulatory rulemaking, and evaluation. Its state leaders recognized that its refineries also attracted people from throughout the United States who also brought their pain management problems with them. They have taken an enlightened position in contrast to state administrators and political leadership in Maine, Mississippi and West Virginia.

## The Critical Changes Affecting the System

***Bill White*:** What are some of the most important factors now affecting MAT and MMT in the United States?

***Mark Parrino*:** As a greater number of Americans used opioids, prescribed through general medical practice settings for pain management, a greater number of people became dependent and later addicted. Once again, there was little public education for Americans to better understand the signs of danger when they were becoming addicted to their prescription opioids. Illustratively, as a patient starts accelerating the prescribed dosage of a prescription opioid and begins to seek multiple physicians to obtain a greater supply, they begin to get into serious trouble.

If the patient begins to chew the medication or grind it for snorting or injecting, they are on a path of addiction. AATOD has been tracking patient characteristics as they are admitted to OTPs since 2005 through its work with the Denver Health and Hospital Authority through the RADARS® System. We have found that 45% of the patients being newly admitted to treatment are addicted to prescription opioids. Of this group 30% have been injecting such opioids.

The Food and Drug Administration is encouraging pharmaceutical companies to develop abuse deterrent formulations so as to ameliorate this public health exposure. The recent success is provided by Purdue Pharma in reformulating OxyContin. Without any questions, post-marketing surveillance of the newly developed formula demonstrates a remarkable decrease in the abuse and diversion of the medication.

The other major policy changes affecting federal oversight of opioid treatment programs were driven by this pattern of prescription opioid abuse. As SAMHSA learned, approximately 80% of new heroin-addicted individuals report abusing prescription opioids as the gateway drug. Additionally, the patient population, who becomes dependent on these prescription opioids, is primarily white. They are also generally middle class and in the suburbs and rural communities of America. This has altered the political landscape of determining how such patients get access to care, which also explains the support for DATA 2000 practices. Such individuals may prefer to get access to a prescription for buprenorphine, and fill it at the pharmacy as they did with their pain management medications. which were previously prescribed by their doctors in general practice settings. This avoids going to any centralized addiction treatment programs such as an OTP. It is too early to determine how this will affect access to effective opioid addiction treatment in the United States.

## Challenges in Expanding Access to OTPs in the United States

***Bill White*:** What are some of the major challenges now facing those who seek to expand access to OTPs in the U.S.?

***Mark Parrino*:** There have been a number of critical challenges in opening OTPs in the United States, which have already been referenced in the first portion of this interview. There have been challenges from zoning boards, local community groups, and state legislatures in understanding the benefit of treating patients with medication and other services in the OTP settings. To some degree, this is based on how some OTPs have been managed with regard to negative community exposure of patient loitering in the vicinity of the treatment program.

There have also been major financial impediments in how OTPs are reimbursed. Illustratively, CMS Medicare still does not provide any reimbursement for OTP services when treating Medicare beneficiaries. Additionally, at least 16 states do not provide Medicaid reimbursement for OTP services when treating Medicaid beneficiaries. Commercial insurers have been very slow to provide any insurance reimbursement for OTP services and when they do, the conditions are fairly onerous. Accordingly, many patients, who are not covered by Medicaid, Medicare, or commercial insurance are forced to make out of pocket payments. In some cases, even when patients do have commercial insurance, they prefer to make out of pocket payments so that their treatment remains confidential.

AATOD's response to these financial challenges has been to launch a major Medicaid expansion initiative through a series of webinars during 2016. Our colleagues at the Legal Action Center have been critical policy partners in moving this initiative forward. We have also been working with CMS Medicare to develop a reimbursement model for OTPs but this has been unsuccessful to date. We are also working with commercial insurers and will be developing contracting models so that they may use them in working with OTPs.

**Private Equity Investment in OTP Expansion and Acquisition**

***Bill White*:** The privatization of MMT would seem to be one of the most significant recent trends in the operation of OTPs. What factors influenced this trend and how has this affected the accessibility and quality of MMT in the U.S.?

***Mark Parrino*:** There has been increasing media interest in why private equity investment is critical in expanding access to treatment through OTPs. The simple answer is that such investment is filling a void of public funding for OTPs. It is instructive to note that when SAMHSA's first Treatment Improvement Protocol (TIP) was published in 1993, there were 750 OTPs operating in forty states. Approximately 60% of these programs were non-profit. When SAMHSA updated this TIP in 2005, there were approximately 1,100 OTPs operating in 44 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. At the present there are over 1,400 programs operating in 49 states. North Dakota has just opened its first OTP, leaving Wyoming as the only state in the country without any operating OTP.

The reason for this expansion is directly related to private sector investment, which has resulted in expanded access to care. It is equally important to note that all OTPs operate under the regulatory oversight of SAMHSA and the DEA. There is no opt-out provision regardless of ownership status.

A more recent development has been the acquisition of independent OTPs and smaller system OTPs by large system entities. We do not have any meaningful information at the present time about the impact that such acquisition is having on patient care.

**AATOD's Early Response to Policy Challenges**

***Bill White*:** How has AATOD responded to some of these policy challenges?

***Mark Parrino*:** AATOD and its Board of Directors recognized that the treatment community needed to be better organized and guided by balanced regulatory policy. The challenge in 1984 was to organize independent providers into a unified structure. AATOD utilized the progressive content of its conferences to bring providers together under one roof. We worked with federal and state authorities to improve policy integration, which would provide greater guidance to OTPs. AATOD developed the first Treatment Improvement Protocol for SAMHSA in 1993, providing clinical guidance in treating patients effectively. AATOD subsequently worked with the Drug Enforcement Administration and SAMHSA to develop the first DEA NTP Guidelines, which were published in 2000. These guidelines increased OTP compliance with DEA regulations and encouraged a more consistent DEA field oversight for OTPs as well.

AATOD has also worked with the Department of Health and Human Services and its agencies in improving access to treatment and research. AATOD has a history of working with the National Institute of Drug Abuse and many of its funded researchers.

Most recently AATOD developed three comprehensive policy papers for DHHS/SAMHSA during 2016, focusing on service integration through the OTPs as essential hub treatment sites for opioid use disorders. These papers focused on developing better integration between OTPs and DATA 2000 practices, in addition to focusing on OTP-health homes. The papers also presented models of care with correctional facilities, drug courts, and child protective services. The ultimate objective of these papers was to create a long-term strategic policy blueprint for OTPs and policy makers.

**Increasing Recovery-Oriented Patient Care through Medication Assisted Treatment for Opioid Addiction in OTPs**

***Bill White*:** There have been recent calls to increase the recovery orientation of MMT in the U.S. What do you see as the advantages and potential pitfalls in moving towards a more recovery-focused model of MMT?

***Mark Parrino*:** Incorporating recovery-oriented care in OTPs represents an important evolutionary step but one that will require nurturance and training. It is important to keep in mind that when OTPs opened in the late 1960s and 70s, the primary approach was in stabilizing heroin-addicted individuals with a therapeutic dose of medication. As a point of history, the early counselors, especially in New York City, were prior heroin users who were in recovery. A number of such counselors were also methadone-maintained patients.

Counselors would become more credentialed in the 1990s through state credentialing programs. This initiative has intensified over recent years. As an example, one state agency recently closed patient admissions to OTPs until the programs could verify that all counseling staff was certified by the designated credentialing board.

Many treatment programs do not understand how to blend the use of medications to treat substance use disorders with recovery-based initiatives. At times, some recovery-based organizations continue to be of the judgment that the use of medications to treat substance use disorders should be time restricted and should not include methadone. This presents a challenge in how such concepts are blended, given that researchers demonstrated that retaining patients in treatment represents a positive outcome.

Fortunately, our field is the beneficiary of an innovative patient advocacy organization (National Alliance for Medication Assisted Recovery). This patient advocacy organization developed a training course to certify medication-assisted treatment advocates. The course was initially offered during an AATOD conference in Washington, D.C. during 2003, and it continues to be offered through the auspices of NAMA Recovery to the present time. NAMA Recovery also developed the MARS initiative, which was funded by SAMHSA in order to promote peer-to-peer recovery based coaching within the structure of an OTP. Ultimately, there will need to be continued support and funding in utilizing recovery-based coaches through OTPs. This can only be achieved through continued education and cross training.

**The Development of DATA 2000 Practices**

***Bill White*:** The expansion of office-based treatment under DATA 2000 marks a milestone in adding access to medication without the historically required clinical support services. What is your assessment of this use of medication without the integration of these allied services?

***Mark Parrino*:** The Drug Abuse Treatment Act of 2000 accomplished two major objectives. It reversed 80 years of physicians not being able to legally treat opioid addiction as part of their private practice. It also introduced a new federally approved medication (buprenorphine) to treat opioid addiction.

Without question, DATA 2000 created a new option for opioid addicted individuals to access care. Not every patient would choose to be in an OTP and DATA 2000 practices provided another choice. At the present time, there are more patients being treated through DATA 2000 practices than are being treated through OTPs. Given the impediment of opening up new OTPs, as referenced earlier in this interview, it would make sense that this expansion would be more readily accomplished through DATA 2000 practices. The challenge is to better understand what services are offered in such DATA 2000 practices. The recent HHS Final Rule ensures that there would be no substantial regulatory oversight of such practices. Federal officials understood that the OTPs became a highly regulated system at the federal and state level. They wanted to avoid replicating such impediments with regards to DATA 2000. On the other hand,

the federal officials may have swung the pendulum too far to the other side. In this case, there is not any centralized data gathering in understanding what services patients receive through DATA 2000 practices in addition to a prescription for buprenorphine.

## Overcoming Stigma

***Bill White*:** To what do you attribute the professional and social stigma that has long been attached to methadone maintenance treatment?

***Mark Parrino*:** The greatest impediment to the use of any medication to treat opioid addiction is stigma. The stigma is pervasive. It is emotional, not rational. This is why I often reference "heart over mind" in interviews such as this. No matter how you explain the value of using such medications from scientific research or clinical practice, a stigmatized view will prevent any reason from getting through just as water cannot penetrate a rock.

Such stigma can take a generation to clear through and I do not think there is any particular exception in this field. Long-term education and training will help.

## International Work

***Bill White*:** You have had the opportunity to consult internationally on issues related to addiction treatment. Are there lessons we can learn from other countries, from either a policy or clinical perspective, about the management of opioid addiction as a medical problem?

***Mark Parrino*:** AATOD's work with our State Association chapters, treatment providers, patient advocates, and related corporate interests all had an objective of expanding access to quality care in this country, which naturally led to our work with our international partners. We began this international partnership during our last regional conference in Newport, Rhode Island in 1989, featuring the first international panel of experts. This work would later develop into a formal partnership between AATOD and its counterpart in Europe (EUROPAD), eventually leading to the formation of the World Federation for the Treatment of Opioid Dependence in Slovenia during 2007.

This international federation has subsequently worked with major agencies within the United Nations, including the United Nations Office on Drugs and Crime and the World Health Organization. Illustratively, we have worked to expand access to care in other nations, including Ukraine and Vietnam. There are always challenges in treatment expansion no matter what the nation. The partnership with our international colleagues represented another critical factor in AATOD's organizational development. and the World Federation currently has a special consultative status with the U.N.

## Closing Reflections

***Bill White*:** Is there any closing personal or professional guidance you would offer a young administrator, physician, or counselor just beginning work in an OTP?

***Mark Parrino*:** My advice to young clinicians and individuals who seem to be interested in this field is to keep an open mind. This is why AATOD devoted so much of its resources to its conference development in training people who work in our addiction treatment community. It was understood at the very beginning that we have to train our practitioners, who also have to understand what the patient needs. In my judgment, in order for any medication-assisted treatment to be effective, we must focus on better integrated and coordinated care for the patient, including a better method of effectively treating psychiatric co-morbidity. There also needs to be better integrated care through coordinated medical care to treat the patient with any co-morbid disorder. This has already been alluded to in the development of the policy papers for SAMHSA. Treating a patient effectively

means having a far more integrated core of treatment services with different systems of care, including drug courts, correctional facilities and child protective services. We cannot treat this illness effectively if such entities continue to work in isolation. This will take a massive coordination at the federal, state, and local levels.

***Bill White*:** Any closing thoughts on AATOD and its efforts to date?

***Mark Parrino*:** I believe that AATOD has achieved great policy successes since its founding in 1984. The first was in organizing the OTPs. The second was working effectively with federal and state agencies in developing stable policy. The third was working with providers, patient advocates, and a field of interested parties to better integrate how associations work in the common interest of the patient and their families. We have fought many political battles as public officials and elected officials wanted to end access to the use of medication to treat opioid addiction long before buprenorphine and extended release naltrexone was approved. The battles continue and we still are here!

***Bill White*:** Mark, thank you for participating in this interview and for all you have done for the field.

***Mark Parrino*:** Thank you, Bill.

**Resource Note:** Additional information about AATOD and its work gan be obtained at http://www.aatod.org/

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