Opioid Use Disorder and its Treatment

K. Michelle Peavy, PhD
The use of affirming language inspires hope and advances recovery.

LANGUAGE MATTERS.

Words have power.

PEOPLE FIRST.

The ATTC Network uses affirming language to promote the promises of recovery by advancing evidence-based and culturally informed practices.
Why talk about opioids?

• In 2016, approximately 11.8 million people aged 12 or older misused opioids in the past year; 948,000 people aged 12 or older used heroin in the past year (SAMHSA, 2017).

• 2016 saw 63,600 drug poisoning deaths, most of which were opioid related (Hedegaard, 2017).
  • > motor vehicle accident deaths in 2016.
  • > US Soldiers who died during the 20 year span of the Vietnam War.

• Between July 2016-Sep 2017, ED visits for opioid poisoning increased by almost 30% (Vivolo-Kantor, 2018).

• Local data: https://adai.washington.edu/WAdata/King_County.htm
U.S. Drug Poisoning Death Rates
1999-2016

Source: NCHS, National Vital Statistics System, Mortality
Heroin use is part of a larger substance abuse problem.

Nearly all people who used heroin also used at least 1 other drug.

Most used at least 3 other drugs.

Heroin is a highly addictive opioid drug with a high risk of overdose and death for users.

People who are addicted to...

- Alcohol: 2x
- Marijuana: 3x
- Cocaine: 15x
- Rx Opioid Painkillers: 40x

...more likely to be addicted to heroin.

Our experiences with addiction shape how we...

View...  Treat someone struggling with...  Feel about...

Substance Use Disorders
exercise

• What are your **IMAGES AND STEREOTYPES** of individuals with in Medication Treatment for opioid use disorder?
  • What about programs or providers that use medication treatment?

• What **BELIEFS** do you bring to the table when it comes to Medication Treatment for OUD/SUD?

• What **WORRIES OR FEARS** do you have about working with in Medication Treatment for OUD/SUD?
A word about stigma

- [https://www.wnyc.org/story/stigma-addiction-language/](https://www.wnyc.org/story/stigma-addiction-language/)

### Language of Recovery

<table>
<thead>
<tr>
<th>Current Terminology</th>
<th>Alternative Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment is a lifestyle</td>
<td>Treatment is an opportunity for *recovery* (one of the three pathways into recovery)</td>
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<tr>
<td>Substance Abuse</td>
<td>Substance Use Disorder/Substance Abuse</td>
</tr>
<tr>
<td>Drug of Choice/Alcohol</td>
<td>Drug of Use</td>
</tr>
<tr>
<td>Denial</td>
<td>Ambivalence</td>
</tr>
<tr>
<td>Relapse</td>
<td>Recovery Management</td>
</tr>
<tr>
<td>Pathology Based Assessment</td>
<td>Strength/Aetiology Based Assessment</td>
</tr>
<tr>
<td>Focus is on total abstinence from all illicit and non-prescribed substances like CBOCAI identified</td>
<td>Focus on the drug USER feels is causing the problems</td>
</tr>
<tr>
<td>A drug is a drug in a person</td>
<td>Each illicit substance has unique interactions with the brain; medication if available is appropriate.</td>
</tr>
<tr>
<td>Relapse</td>
<td>Recurrence/Return to Use</td>
</tr>
<tr>
<td>Relapse is part of Recovery</td>
<td>Recurrence/Return to Use may occur as part of the disease</td>
</tr>
<tr>
<td>Close/Relate</td>
<td>Drug Free/Free from illicit and non-prescribed medications</td>
</tr>
<tr>
<td>Self Help Group</td>
<td>Mental Health Group</td>
</tr>
</tbody>
</table>
What are opioids?

• Opioids:
  • Mimic endorphin activity. Endorphins = endogenous morphine made by the body.
  • Relieve pain, depress breathing, cause euphoria/”high”, suppress cough and diarrhea.
    • Opioid receptors found primarily in the brain, gut.
  • Examples:
    • Natural - Opium, morphine, codeine
    • Semi-synthetic - Heroin, Dilaudid, Vicodin
    • Synthetics - Darvon, Demerol, Fentanyl, Oxycontin® (oxycodone), methadone
Acute to chronic opioid use

Euphoria

Normal

Withdrawal

Tolerance and Physical Dependence
What Does Addiction Feel Like?

Trigger-induced craving

Preoccupation - with either staying away from the drug or thinking about getting it

Drug use because of failures of executive function, impulse control and judgment and misplaced motivation
Opioid Use Disorder

• What is opioid dependence?
  • Physiological state marked by **tolerance** and **withdrawal**.
  • Happens to anyone who takes opioids for a while. This the normal, typical, expected reaction to ongoing opioid use.
What is “opioid addiction”?

• **Physiological** state marked by **tolerance** and **withdrawal**...  
  
• PLUS  
  • Compulsion & Cravings  
  • Loss of control over use  
  • Continued use despite adverse consequences  
  • Salience

*not counted if prescribed by a physician
Opioid use disorder (OUD)

1 in 4 people who use heroin develop OUD

Disease of the brain’s reward system/relapsing medical disorder

Progressive and Chronic...

Environment
Psychological Factors

Drug Exposure
Voluntary Choice

No OUD

Genetics (34% genetic heritability*)
Trauma

Similar to:
- Hypertension (25-50%*)
- Type 2 Diabetes (25-80%*)

Addiction is
- a chronic, relapsing medical disorder
- A disease of the brain’s reward system

*McLellan et al., 2000
Opioid use disorder (OUD)

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Psychological Factors

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Voluntary Choice

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Addiction is
- a chronic, relapsing medical disorder
- A disease of the brain's reward system

Heroin Use Has INCREASED Among Most Demographic Groups

<table>
<thead>
<tr>
<th>SEX</th>
<th>2002-2004</th>
<th>2011-2013</th>
<th>% CHANGE</th>
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<tr>
<td>Male</td>
<td>2.4</td>
<td>3.6</td>
<td>50%</td>
</tr>
<tr>
<td>Female</td>
<td>0.8</td>
<td>1.6</td>
<td>100%</td>
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<table>
<thead>
<tr>
<th>AGE, YEARS</th>
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</tr>
<tr>
<td>26 or older</td>
<td>1.2</td>
<td>1.9</td>
<td>58%</td>
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<th>RACE/ETHNICITY</th>
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<td>1.4</td>
<td>3</td>
<td>114%</td>
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<tr>
<td>Other</td>
<td>2</td>
<td>1.7</td>
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<table>
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<tr>
<th>ANNUAL HOUSEHOLD INCOME</th>
<th>2002-2004</th>
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<tr>
<td>Less than $20,000</td>
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<td>$20,000-$49,999</td>
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<td>2.3</td>
<td>77%</td>
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<td>$50,000 or more</td>
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<table>
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<td>None</td>
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<td>6.7</td>
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</tr>
<tr>
<td>Medicaid</td>
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<tr>
<td>Private or other</td>
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Heroin Addiction and Overdose Deaths are Climbing

Opioid Epidemic

Changes in prescribing practices for pain (“pain as the 5th vital sign”)  
Development of new pain medications (i.e., OxyContin®)
The amount of opioids prescribed per person was three times higher in 2015 than in 1999.

The amount of opioids prescribed per person varied widely among counties in 2015.
Pills to IV drug use

(Peavy et al., 2012)
Opioid use disorder (OUD)

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Progressive and Chronic...

Similar to:
- Hypertension (25-50%)
- Type 2 Diabetes (25-80%)

Addiction is
- a chronic, relapsing medical disorder
- A disease of the brain’s reward system
Treating OUD like the medical disorder it is

<table>
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<th>SUD Treatment</th>
<th>Medical Treatment</th>
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<td>“Addiction is a disease.”</td>
<td>Views addiction as a “chronic relapsing medical disorder.”</td>
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<td>Treatment begins when patient has already made behavior change or “is ready” make behavior change.</td>
<td>Treatment begins at or before the time when symptoms are interfering with patient health and functioning.</td>
</tr>
<tr>
<td>Views an increase in symptoms as a sign to withhold treatment.</td>
<td>Views an increase in symptoms as a reason to apply more or different treatment.</td>
</tr>
<tr>
<td>Not always 100% effective</td>
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Treatment options - Environment

Despite what we may hear, see and believe...

*most people with substance use disorders do NOT want to be using drugs and alcohol in a harmful way*

- Levels of clinical care
  - Outpatient
  - Intensive outpatient
  - Partial hospitalization
  - Residential
  - Detox
  - Inpatient

- Medication Assisted Treatment (MAT)
  - Opioid Treatment Program (OTP)
  - Office based MAT

- Non-clinical pathways
  - Peer support (e.g., 12-step meetings)
  - Self-help resources
  - Faith-based recovery

- No treatment or recovery services
Setting MAT(ters)

OTP (highly regulated; medication dispensed)
- Methadone
- Buprenorphine

Office based MAT (prescribed; administered)
- Buprenorphine ("OBOT")
- Vivitrol
Medications that target OUD

**Methadone**
- Full agonist

**Buprenorphine** (Suboxone®, Subutex®, Zubsolv®)
- Partial agonist

**Vivitrol** extended release naltrexone
- Antagonist
Naltrexone

- Oral & extended release injectable (Vivitrol).
- Induction:
  - 7-10 days no opioid use – induction burden
  - Precipitated withdrawal
Medication Assisted Treatment with agonists: Why?

• Addiction is a chronic, relapsing medical disorder
• Disease of the brain’s reward system
• Similar to hypertension and diabetes
  • Medication helps stabilize the disorder
Goals of Medication Assisted Treatment (Methadone and bup)

• Stabilize physiology; alleviate intoxication/withdrawal cycle
• Alleviate craving
• Engage the patient in recovery
  • Psychoeducation
  • Enhance motivation - Motivational Interviewing
  • CBT for coping skill development & changing thinking patterns
• Duration of treatment is unknown
Life of an individual with Heroin Addiction

What Does It Feel Like to Be Opioid Dependent?

Diagrammatic summary of functional state of typical "mainline" heroin user. Arrows show the repetitive injection of heroin in uncertain dose, usually 10 to 30 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

From "Narcotic Blockade," by V. P. Dole, M. E. Nyswander, and M. J. Kreek, 1966, Archives of Internal Medicine, 118, p. 305
Methadone: Stabilizing the Patient

What Does It Feel Like to Be on Opioid Replacement Therapy?

Functional state

"High"

"Straight"

"Sick"

AM PM AM PM AM

Days

Stabilization of patient in state of normal function by blockade treatment. A single daily oral dose of methadone prevents him from feeling symptoms of abstinence ("sick") or euphoria ("high"), even if he takes a shot of heroin. Dotted line indicates course if methadone is omitted.

From "Narcotic Blockade," by V. P. Dole, M. E. Nyswander, and M. J. Kreek, 1966, Archives of Internal Medicine, 118, p. 305.
But aren’t they still addicted? The Difference Between “Drug” and “Medication”

**Drug**
- Salience shifts towards the substance of abuse
- Cravings/withdrawal
- Used to enhance or change reality

**Medication**
- ...to a higher quality of life IN RECOVERY.
- Salience shifts....
- Dependence lacks the psychological component of addiction
- Used to participate in reality
Methadone for Opioid Dependence

- Six day per week observed dosing with an RN
- Monthly random, observed UAs
- Mandatory counseling
- Regular Prescription Monitoring Program checks
- Regular medical provider appointments – ARNPs and PA-Cs
- Once stabilized, may start earning take home dose privileges
- Acupuncture
Mountains of evidence supporting methadone for OUD

- Outcomes: Dole & Nyswander, 1965; Mattick, et al., 2009
- ↓HIV/AIDS: Ball et al., 1988; Novick et al., 1990; Gowing et al., 2006
- ↓criminal behavior: Mattick et al., 2009; Nurco et al., 1985
- ↓mortality: Fugelstad et al., 2007; Pierce et al., 2016; Sardot et al., 2017
Finding MAT (Methadone)

- [https://dpt2.samhsa.gov/treatment/directory.aspx](https://dpt2.samhsa.gov/treatment/directory.aspx)
You work in an OTP setting. One of your patients, Isaac, is a 45-year-old Caucasian man. He describes his housing situation as unstable, noting that he “couch surfs” among various sexual partners, all of whom are men. He describes himself as a “reluctant gay man”, noting that his sexual encounters are exclusively with men, but does not engage in meaningful and monogamous relationships with men or women. He reports that he has been estranged from his family since his late teens, when they caught him having sex with another man.

Isaac has a long history of polysubstance use. Since starting treatment at your OTP one year ago, he has significantly reduced his heroin use – from daily use to intermittent use. You review his UA results from the past year, which is consistent with his report about ongoing drug use. He states that he is completely abstinent for a few days at a time, but otherwise engages in drug use with “whatever is there” in the context of being with acquaintances, roommates and to facilitate sexual encounters. In your interactions, Isaac voices ambivalence about his use, and he describes low self-efficacy with regards to change.

<table>
<thead>
<tr>
<th>Month</th>
<th>Heroin</th>
<th>Benzo-diazepine</th>
<th>Meth-amphetamine</th>
<th>Alcohol</th>
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<td>X</td>
<td>X</td>
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<tr>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
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<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Case #1: Isaac

• Questions
  • Describe your conversation with Isaac as you review his UA history.
  • What interventions would you employ with Isaac?
  • Describe the kind of treatment plan you develop with Isaac.
  • What are the factors you consider when developing a treatment plan with Isaac?
Advantages of Buprenorphine

• Can be prescribed by physician
• Long acting (24-36 hours)
• Limited opioid poisoning potential (ceiling effect)
• Minimal subjective effects (e.g., sedation) following a dose
• Lower level of physical dependence
• In combination with naloxone, reduced abuse potential
Finding MAT (Bup)

While patients might be at low risk for opioid poisoning when naltrexone is in their systems, patients are at elevated risk when the medication wears off, in part because tolerance will be low.

<table>
<thead>
<tr>
<th></th>
<th>Naltrexone</th>
<th>Buprenorphine</th>
<th>Methadone</th>
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<tbody>
<tr>
<td>Induction difficulty</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>Medication adherence</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Opioid poisoning risk</td>
<td>Low*</td>
<td>Moderate</td>
<td>High(er)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
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<tr>
<td>Diversion risk</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
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<tr>
<td>Tapering difficulty</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
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<td>Counseling required</td>
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<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stigma</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
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</tbody>
</table>
Which medication is right for me?

- Patient preference
- We cannot yet predict who will do better on which medication
- Successful treatment requires trial and error
- We need a full toolbox of options
  - Treatment availability is an issue
Evidence

Bup vs. Vivitrol

Study indicated withdrawal hurdle to get on to naltrexone (induction), but once people are inducted the outcomes are quite similar.

(Lee et al., 2017)
• Bup less effective than methadone at retaining patients.*
• Of the bup patients who are retained, they had lower rates of illicit opioid consumption, suggesting bup may be most useful in highly motivated patients**

*Mattick et al., 2014
**Hser et al., 2014
Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016

Treatment as prevention for opioid poisoning

• Treatment *is* prevention!
  • Exposure to MAT reduces risk of death individuals with OUD (Gibson et al., 2008; Schwartz et al., 2013).
  • Recent recommendations to combat OD include increasing access to effective treatments: MAT; ED-initiated treatment with buprenorphine/naloxone treatment (Kolodny et al., 2015; Hawk et al., 2015).
• Individuals engaged in treatment are less likely to use drugs → less likely to experience an opioid poisoning.
• Treatment is important, and...
Only survivors can attend treatment.
What is naloxone (Narcan®)?

- Naloxone is...
  - A prescription medicine that reverses an opioid poisoning.
  - Safe and effective; emergency medical professionals have used it for decades.
  - Typically administered into a muscle or intranasally.
  - A substance that takes effect in 2-3 minutes; it lasts 30-90 minutes.

- Naloxone is not...
  - Something that’s used to get high.
  - A medication that affects people who do not use opioids.
Invaluable resource: Stopoverdose.org
Opioid poisoning risks

- Prior opioid poisoning
- Using alone
- Using opioids again after tolerance has dropped
- Mixing opioids with other drugs and alcohol
- Using heroin or pills bought on the street
- Some medical conditions
Minnie

Minnie is a 32-year-old African American woman that you meet at the end of her 4-day hospitalization. She was admitted to the hospital after an opioid poisoning, her third in the past year. Toxicology report indicates fentanyl, heroin, benzodiazepines, and methamphetamine present in her system.

History: Minnie started using alcohol and cannabis around age 15; an older boyfriend introduced her to methamphetamine in her late teens. She had a brief period of abstinence during her only pregnancy at age 19. She was prescribed pharmaceutical opioids following the birth of her son. She found that these medications relieved her feelings of anxiety and allowed her to feel more comfortable, and even energetic. Minnie pursued several prescriptions for opioids in order to maintain a consistent supply. She would sometimes sell her pills in order to buy methamphetamine. Her substance use and associated problems progressed. Minnie regularly engaged in in sex work and other illegal activity to finance her drug use. She reports having a number of “scary” experiences during this time. By age 26, Minnie was regularly using heroin and methamphetamine, she used alcohol and cannabis intermittently. Her late 20s was marked by 3 periods of abstinence, two of which resulted from incarceration for theft and prostitution charges. Her other period of abstinence was prompted by an episode of inpatient treatment after which she attended and benefitted from 12-step meetings. That last period of abstinence ended shortly after Minnie’s 30th birthday. Since then, she has been regularly using methamphetamine and illicit opioids.

You are tasked with developing her discharge plan and making ongoing treatment recommendations. Minnie states that her recent poisoning was quite scary, and she notes she is “done” with using drugs. Minnie states she “wants to be totally clean” and she does not want medications that will “get [her] high.” Although unstably housed at the time of her most recent poisoning, Minnie will be able to live at her mother’s home, where her sister, son, and uncle also live. She states her family is supportive, and they also oppose medications targeting OUD because “methadone makes you fat.”
Minnie (cont.)

• What other questions would you have for Minnie?

• What are Minnie’s strengths?

• What are Minnie’s risks for opioid poisoning?

• Describe your approach when talking to Minnie.

• What information would you provide Minnie?

• What are your recommendations?
Surveys

Please complete the Evaluation Survey online!

Your URL Link Here

Thank you!
Look for our surveys in your inbox!

We’ll send two quick surveys:
one Evaluation now, and
one Follow-Up in a month.

We greatly appreciate your feedback! Every survey we receive helps us to improve and develop our programming.
Visit Us Online!

http://attcnetwork.org/northwest

Upcoming trainings
Resources
Links on key topics
Contact Information

THANK YOU!
References


