

**Learning Together:  
Building Understanding around  
Substance Use**

**FEB. 17TH, 2026**

# AGENDA

- Welcome & Housekeeping
- About Unshame NC
- Webinar Overview
- Speaker Introduction
- Presentation
- Question & Answer
- Closing Remarks

# BEFORE WE GET STARTED

## GROUNDING OURSELVES IN RESPECT

- This session is being recorded and will be made available at [www.unshamenc.org](http://www.unshamenc.org).
- Use the chat for questions and reflections.
- All attendees will be muted.
- To access closed captioning, click More, select language and speech, and choose “Turn on live captions.”
- To adjust your view and see all speakers, click View at the top of your screen and then select Speaker.
- We’ll save time for Q&A at the end.

# WHAT IS UNSHAME NC?

## OVERVIEW

Unshame NC is a statewide campaign led by the North Carolina Department of Health and Human Services, in partnership with Shatterproof, a national nonprofit. Our goal is to remove the stigma around substance use disorder through a community-driven approach focused on awareness, education, and uplifting the voices of lived experience.

## THE CAMPAIGN

The Unshame NC campaign works by partnering with communities across North Carolina to reduce stigma around substance use disorder through education, storytelling, and resource connection. By sharing lived experiences and science-based information, we help build understanding, compassion, and pathways to care so more people feel supported seeking help.

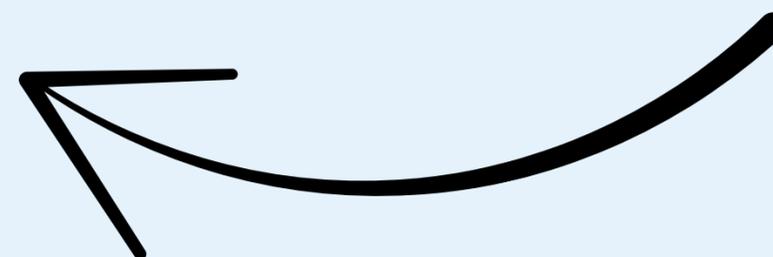
# READY TO GET INVOLVED?

## JOIN OUR CAMPAIGN

Keep up with our campaign and check out our Linktree! **You can follow us on Instagram and Facebook, sign-up for our newsletter, or fill out our interest form to be connected to someone from our team.** For additional questions, please contact us at [unshamenc@shatterproof.org](mailto:unshamenc@shatterproof.org).



SCAN ME



# TODAY'S OBJECTIVES

## THE PURPOSE OF OUR WEBINAR

Today's webinar is the first installment of our Learning Together series, where we'll use a compassionate lens to explore:

- Why people use substances
- The risk factors that can contribute to a progression to a substance use disorder (SUD)
- How substance use affects the brain

Whether you're new to this topic or looking to deepen your understanding, this session is designed for anyone who wants to better understand substance use and the people behind the experiences.

# OUR SPEAKER

## DR. SHUCHIN SHUKLA

Shuchin Shukla, MD, MPH, was born and raised in New Orleans, Louisiana. He completed medical school and public health school at Tulane University and completed a residency at Montefiore Medical Center in the Bronx, New York. He is board certified in family medicine and addiction medicine. He has served in leadership positions related to population-based projects focused on overdose, addiction, HIV, Hepatitis C, and carceral health. He now works as a consultant for the North Carolina Technical Assistance Center, a state funded consortium focused on overdose and addiction among people involved in the criminal legal system. He also serves as Chief Medical Officer for Goldie Health, which provides case management software for post overdose response teams and as medical director at Greenville Comprehensive Treatment Center, an opioid treatment program.



# Learning Together: Building Understanding around Substance Use

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SHUCHIN SHUKLA MD MPH

NORTH CAROLINA TECHNICAL ASSISTANCE CENTER

**Presented By:**  
**Shuchin Shukla**  
**MD MPH**

DISCLOSURE: Chief Medical  
Officer for Goldie Health

- The *North Carolina Technical Assistance Center* is a statewide initiative to provide FREE technical assistance to programs that support individuals at risk of incarceration and overdose.

## AREAS OF EXPERTISE

- Harm reduction
- Reentry from incarceration
- Diversion/Deflection, including Law Enforcement Assisted Diversion (LEAD)
- Jail-based Medication for Opioid Use Disorder (MOUD)
- Naloxone access and distribution
- Program evaluation
- Data management

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# OBJECTIVES

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- 1. Review current overdose trends in North Carolina and why they matter for communities across the state.**
- 2. Examine the reasons people may use substances, how life experiences and risk factors can shape that use, and the progression to a SUD.**
- 3. Learn how SUD affects the brain, including how withdrawal and cravings influence continued substance use.**

# Why are we all here?

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**SHAME** – a painful emotion caused by consciousness of guilt, shortcoming, or impropriety; a condition of humiliating disgrace or disrepute

**UNSHAME** – change the emotion/condition by having compassion

**STIGMA** – a set of negative and unfair beliefs that a society or group of people have about something

**ANTISTIGMA** – reduce misconceptions, change attitudes

How do we get there?

Increase our knowledge and understanding.

Miriam Webster Dictionary 2026

# What is Substance Use?



# What is Substance Use?

Humans have used substances for thousands of years. Even animals use substances.

Why?

For various benefits:

- Feel good
- Fix problems
- Improve health
- Relax
- Have fun
- Connect with others
- Cultural rituals
- Improve performance

ALL substances have risks, including medications and foods.

People use substances because they believe that the benefits outweigh the risks.



# Substance Use Disorder Definition

## Physiologic

- **Tolerance:**
  - (a) a need for markedly increased amounts of substances to achieve intoxication or desired effect, or
  - (b) markedly diminished effect with continued use of the same amount of an substance
- **Withdrawal:**
  - (a) the characteristic substance withdrawal syndrome, or
  - (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms
- *\*tolerance and withdrawal cannot be the only criteria for SUD diagnosis*

## Risk/Harm

- **Recurrent substance use resulting in failure to fulfill major role obligations at work, school or home**
- **Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substances**
- **Important social, occupational or recreational activities are given up or reduced because of substance use**
- **Recurrent substance use in situations in which it is physically hazardous**
- **Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids**

## Lack of Control

- **Substance is often taken in larger amounts or over a longer period than was intended**
- **Persistent desire or unsuccessful efforts to cut down or control use**
- **Great deal of time is spent in activities necessary to obtain substance, use substance, or recover from its effects**
- **Craving, or a strong desire to use substance**

# What is Substance Use Disorder?

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**Chronic, relapsing medical condition. Not a moral failing.**

## **Criteria:**

### **1) Physical Dependence:**

- **Need more of substance to get same effect**
- **Withdrawal symptoms when stop using substance regularly**

### **2) Loss of control**

- **Using more than you want, or for longer time (“taking over your life”)**
- **Wanting to cut back or stop, but can’t**
- **Craving or strong desire to use**

### **3) Continued Use despite risk and harm**

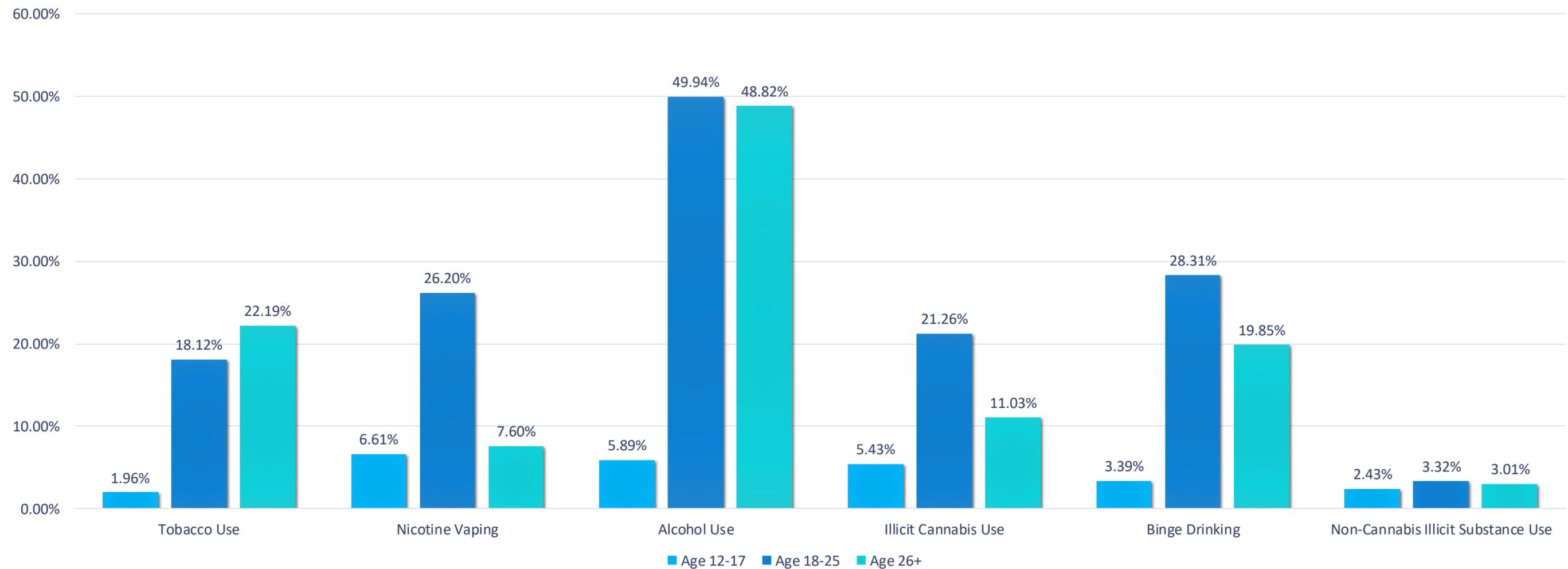
- **Negative effects to career, finances, family life, relationships, physical health, mental health, safety**

# Substance Use in NC

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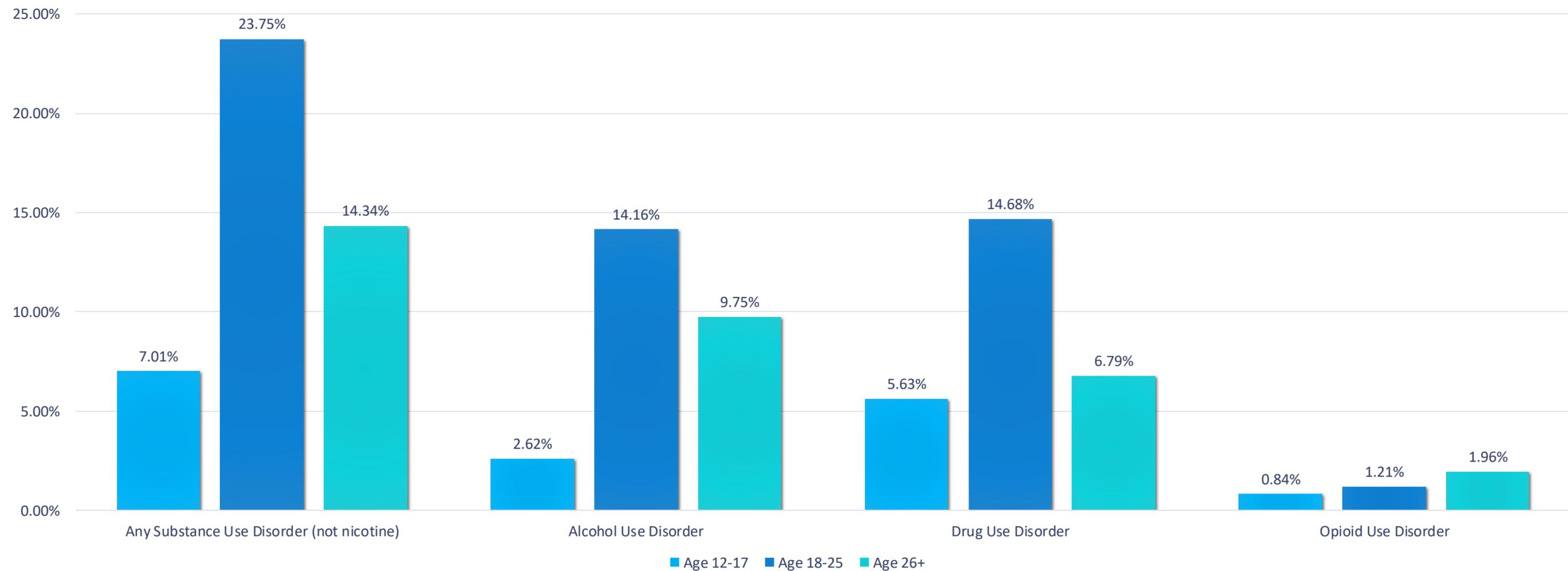
# What people are doing: Substance Use in NC 2023-2024

Percent of Population with Past Month Substance Use



# When it becomes a problem: Substance Use Disorder in NC 2023-2024

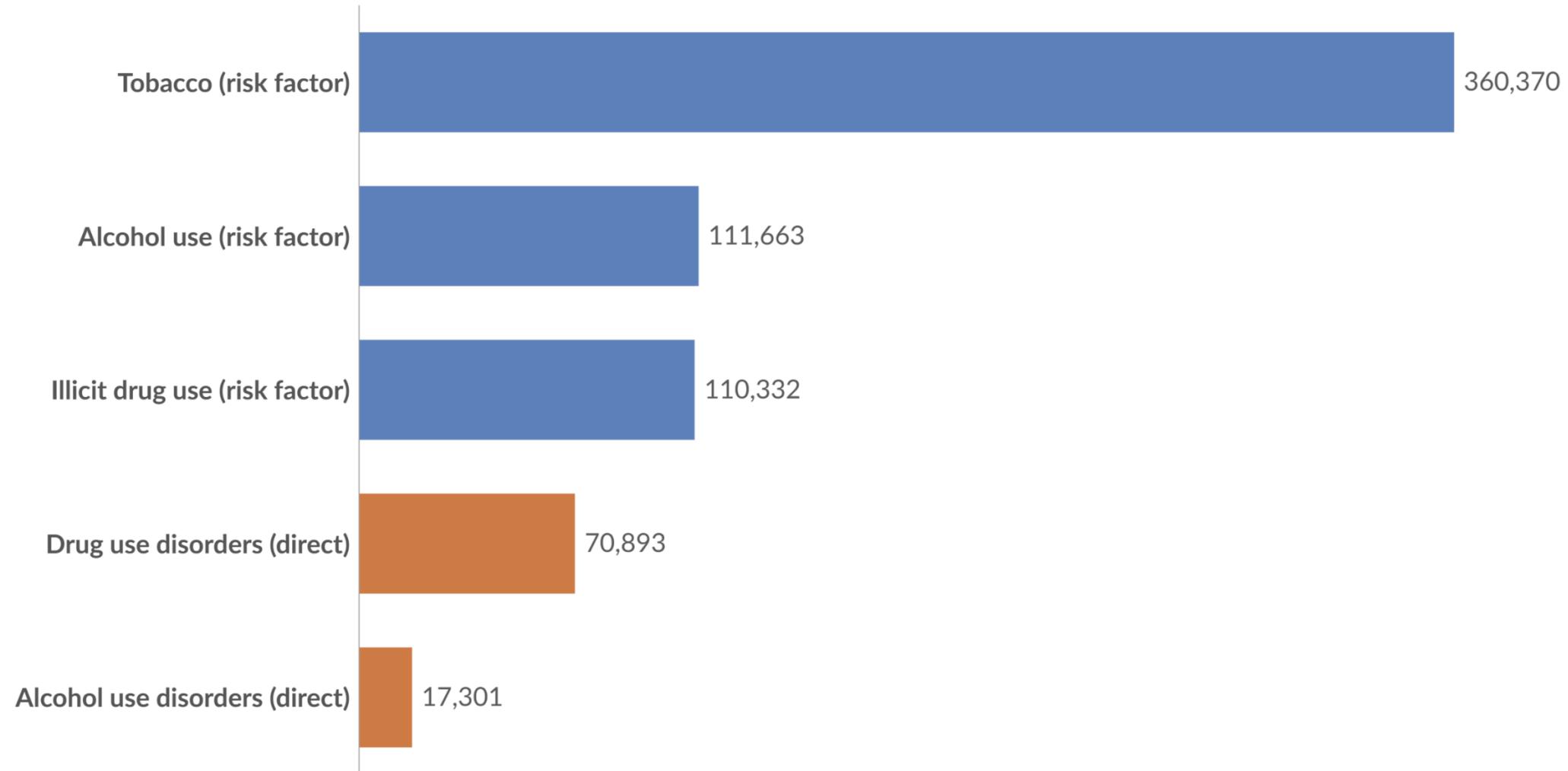
Percent of Population with Past Year SUD



# Deaths attributed to tobacco, alcohol and drugs, United States, 2021



In blue are shown the estimated annual number of deaths attributed to tobacco, alcohol and drugs. In red are shown the estimated annual number of deaths from drugs and alcohol. The difference between both is that they relate to indirect and direct causes of death, respectively.

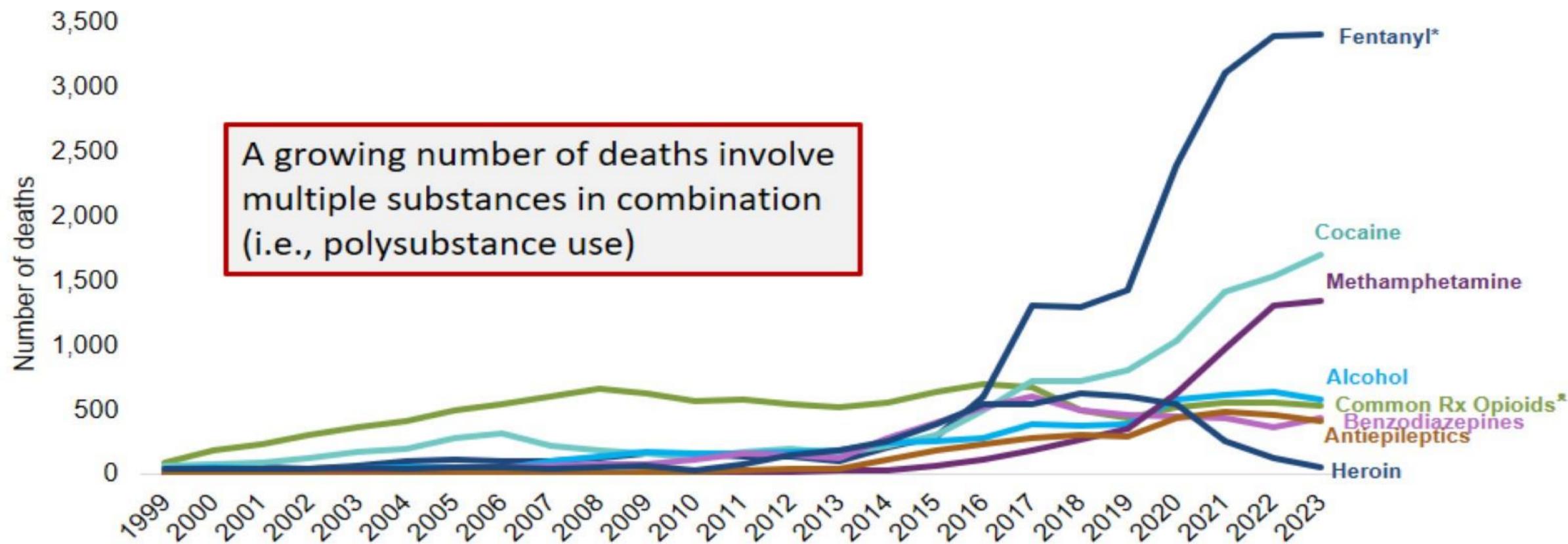


Data source: IHME, Global Burden of Disease (2024)

OurWorldinData.org/illicit-drug-use | CC BY

**Note:** Illicit drugs are drugs that have been prohibited under international drug control treaties. They include opioids, cocaine, amphetamines and cannabis.

## Illicitly manufactured fentanyl\* remains the main contributor to overdose deaths



A growing number of deaths involve multiple substances in combination (i.e., polysubstance use)

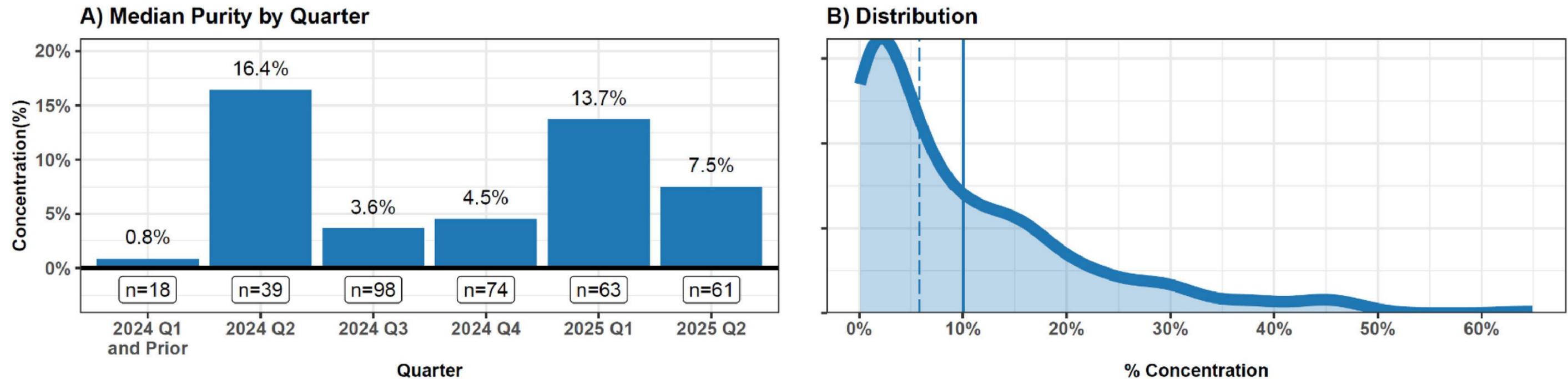
\*Fentanyl surveillance based on Other Synthetic Narcotics (T40.4), which consists of mainly illicitly manufactured fentanyl and fentanyl analogues \*Commonly Prescribed Opioid Medications

**Technical Notes:** These counts are not mutually exclusive; If the death involved multiple substances, it can be counted on multiple lines; Toxicology data is unable to distinguish whether the presence of multiple substances indicate intentional polysubstance use or if one substance was tainted with other drugs (e.g. cocaine laced with fentanyl); All intent medication, drug, alcohol poisoning: X40-X45, X60-64, Y10-Y14, X85 with any mention of specific T-codes by drug type; limited to NC residents

**Source:** Deaths-NC State Center for Health Statistics, Vital Statistics, 1999-2023  
Analysis by Injury Epidemiology and Surveillance Unit

# WHY IS FENTANYL SO DEADLY?

## Variability in Potency



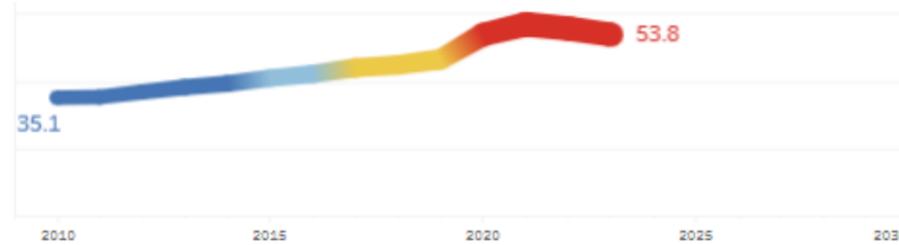
Shover CL, Koncsol AJ, Godvin ME, et al. High variation in purity of consumer-level illicit fentanyl samples in Los Angeles, September 2023-April 2025. *Int J Drug Policy*. Published online August 30, 2025. doi:10.1016/j.drugpo.2025.104977

Every day, North Carolina experiences:

 <p><b>16 deaths due to alcohol use</b> (over 5,800 per year)</p>	 <p><b>180 alcohol-related emergency department visits</b> (over 66,000 per year)</p>	 <p><b>A loss of \$41.2 million due to excessive alcohol use</b> (\$15.0 billion per year)</p>
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Alcohol-Attributable Deaths

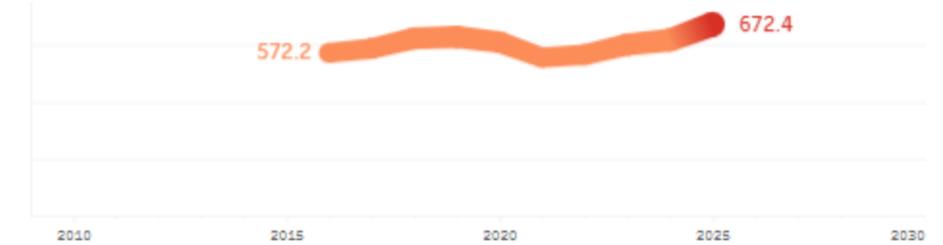
The Total alcohol-attributable death rate in NC was 53.8 out of 100,000 residents in 2023, representing 5,828 people who died from an alcohol-attributable death (i.e, from both acute and chronic causes).



Alcohol-attributable deaths include 58 causes of death due to immediate and long-term alcohol use.

Alcohol-Related ED Visits

The estimated Alcohol-related ED visit rate in NC is 672.4 per 100,000 residents in 2025, representing (projected) 74,272 ED visits involving 100% alcohol-related conditions (e.g., immediate issues, such as alcohol intoxication, as well as long-term conditions, such as liver cirrhosis).  
*Partial year: n=61,893 at 10/12 months*



Alcohol-related ED visits include visits caused by immediate issues, such as alcohol intoxication, as well as long-term conditions, such as liver cirrhosis.

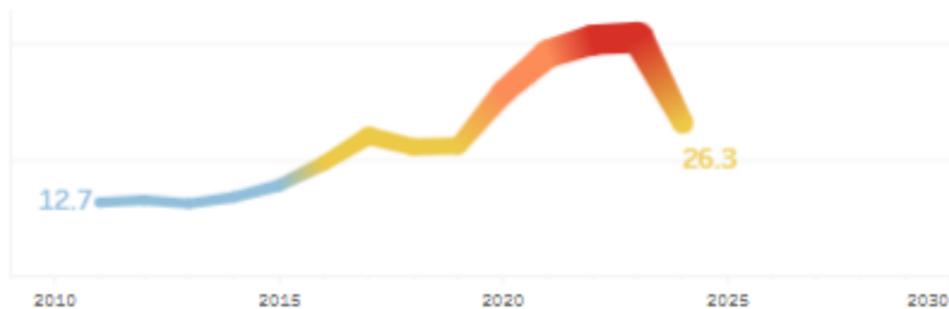
On average, every day in North Carolina, there are...

- 12** Overdose Deaths
- 32** Overdose Hospitalizations
- 47** Overdose Emergency Department (ED) Visits
- 34** Emergency Medical Services (EMS) Encounters for suspected overdose
- 46** Overdose reversals by a community member administering naloxone

**Technical Notes:** Medication and drug overdose: X40-X44, X60-X64, Y10-Y14, X85; Limited to NC residents; ED Visits are based on initial encounter, unintentional and undetermined intent cases, for ICD10CM overdose codes of drugs and medications with dependency potential within T40, T42, T43, T50.7, and T50.9, NC residents, ages 15-65 years. EMS data available for January to May 2023, calculation made by prorating data for one year.  
**Source:** Deaths-NC State Center for Health Statistics, Vital Statistics, 2023; Hospitalizations- North Carolina Healthcare Association, 2023; ED Visits- NC DETECT, 2023; EMS encounters-NC DETECT, Jan-May 2023; Community naloxone reversals-NC Division of Public Health, Safer Syringe Initiative Annual Report, July 2022-June 2023; Analysis by Injury Epidemiology and Surveillance Unit

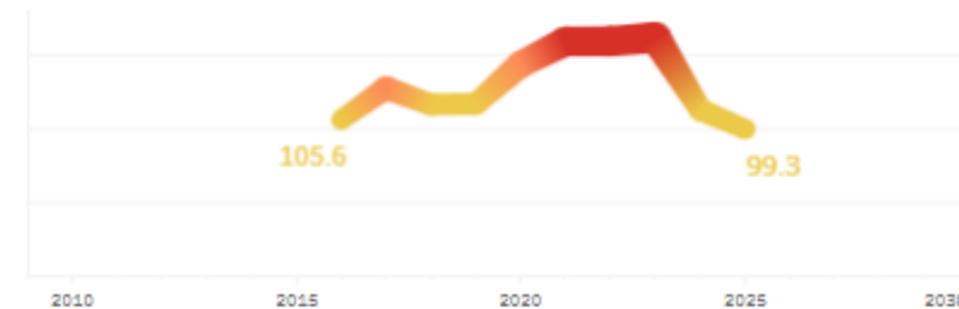
Overdose Deaths

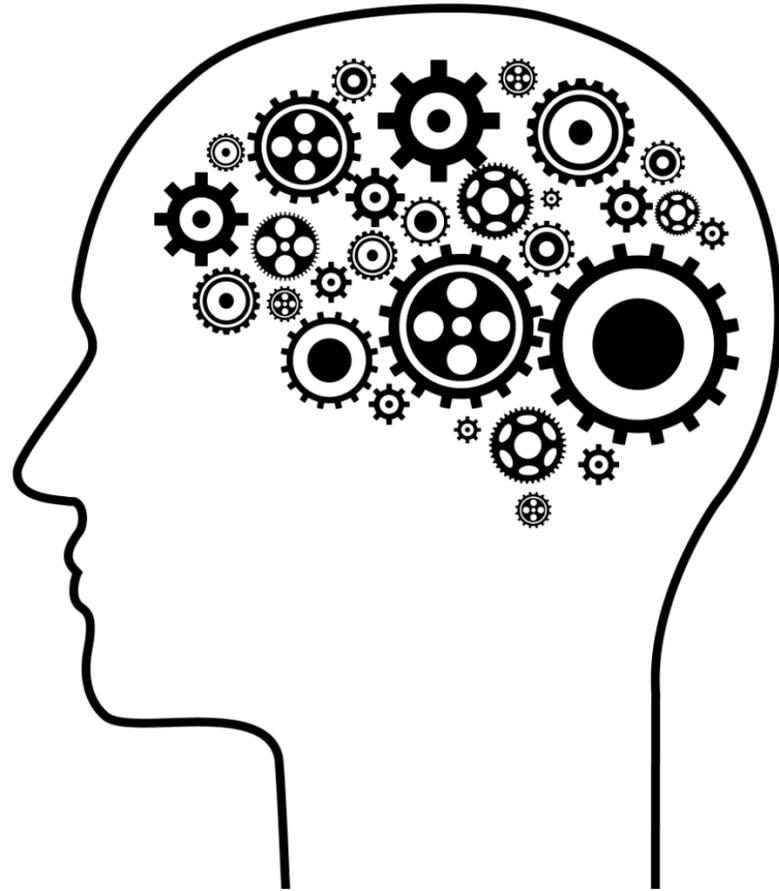
The estimated Overdose Death rate in NC is 26.3 out of 100,000 residents in 2024, representing (projected) 2,908 people who died of an overdose.  
*Partial year: n=2,423 at 10/12 months*



Overdose Emergency Department Visits

The estimated Overdose ED Visit rate in NC is 99.3 per 100,000 residents in 2025, representing (projected) 10,964 ED visits for an overdose.  
*Partial year: n=9,137 at 10/12 months*





**HOW DOES IT  
ALL BEGIN?**

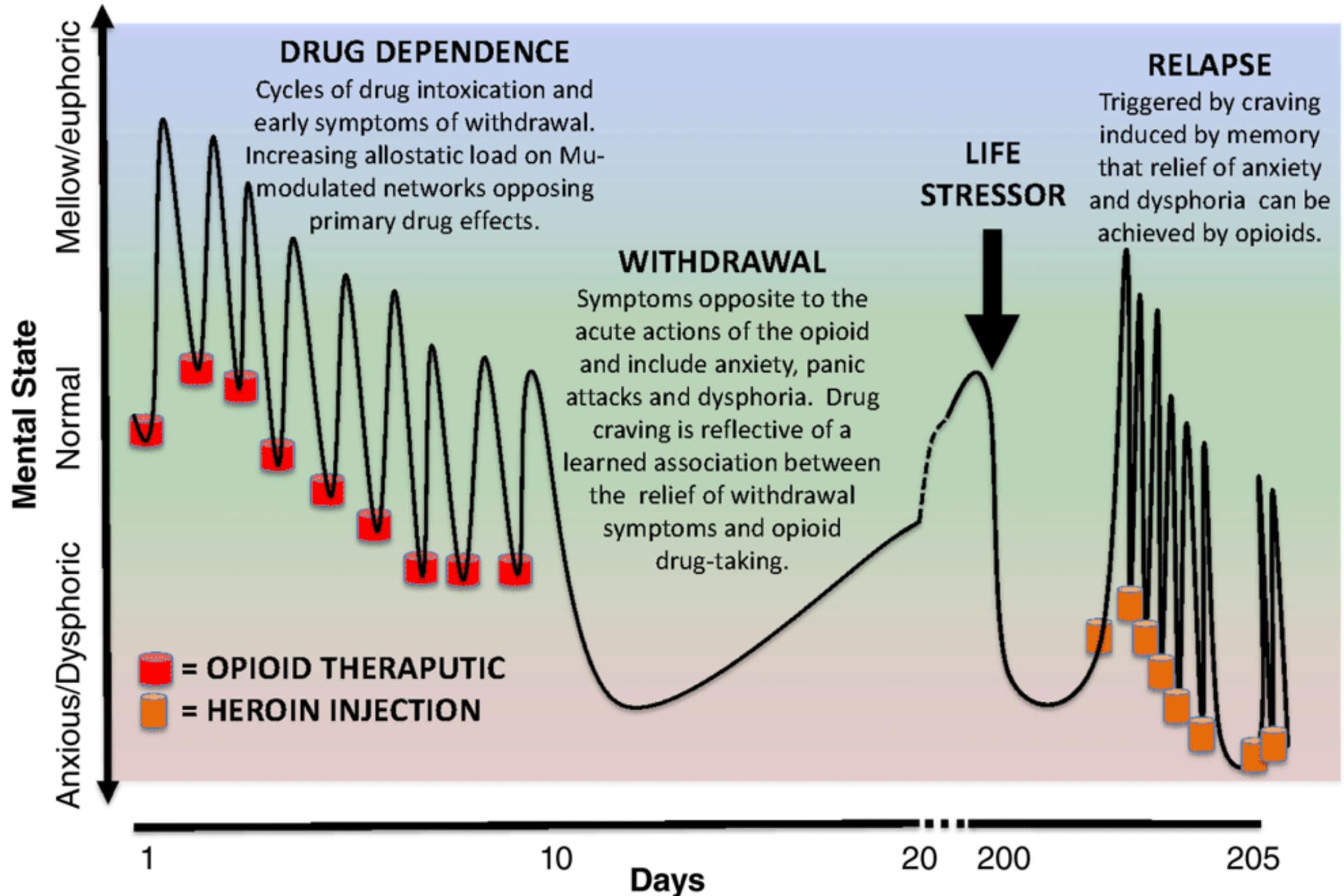
**Substance Use  
and Brain  
Science**

# Why do adolescents start to use substances?

TABLE. Motivations for drug use among persons aged 13–18 years being assessed for substance use disorder treatment who reported use of alcohol, marijuana, or other drugs during the previous 30 days and persons with whom they used substances — National Addictions Vigilance Intervention and Prevention Program Comprehensive Health Assessment for Teens, United States, 2014–2022

	No. (%)
	<b>Overall*</b> 9,543 (100)
<b>Motivation***</b>	
To feel mellow, calm, or relaxed	6,968 (73)
To sleep better or fall asleep	4,216 (44)
To stay awake	1,212 (13)
To feel less shy or more social	2,056 (22)
To stop worrying about a problem or forget bad memories	4,169 (44)
To have fun or experiment	4,771 (50)
To be sexier or make sex more fun	1,033 (11)
To lose weight	400 (4)
To make something less boring	3,893 (41)
To improve or get rid of the effects of other drugs	1,008 (11)
To concentrate better	2,126 (22)
To deal with chronic pain	1,326 (14)
To help with depression or anxiety	3,787 (40)
To fit in	1,144 (12)
Other reason	2,149 (23)

# Why do people keep using substances?



Evans CJ and Cahill CM. Neurobiology of opioid dependence in creating addiction vulnerability [version 1]. F1000Research 2016, 5:1748 (doi: 10.12688/f1000research.8369.1)

# Brain and Substance Exposure

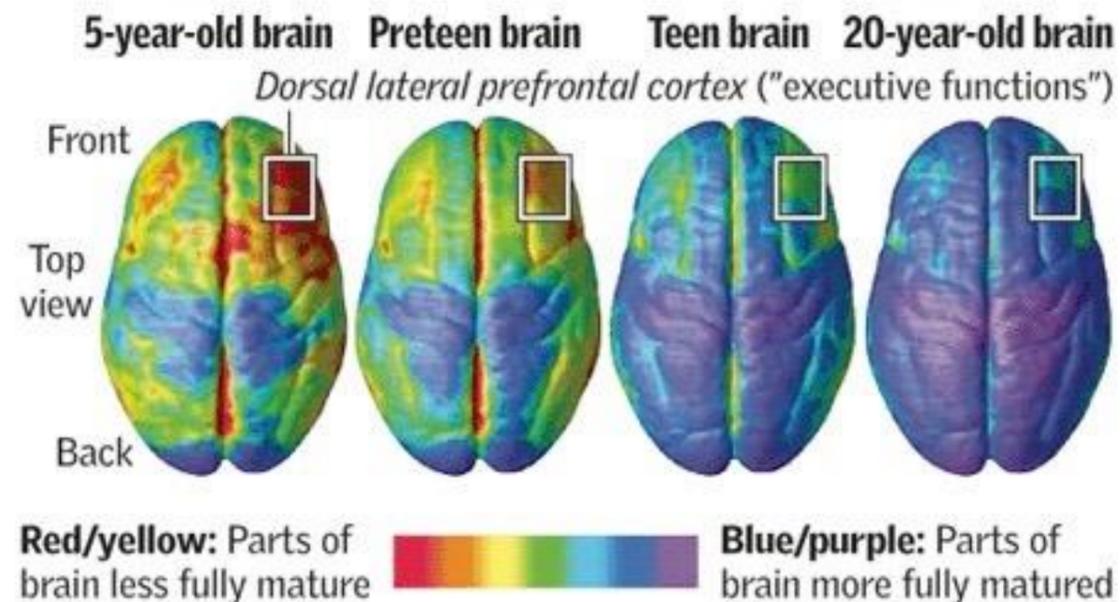
- Most adults with SUD had adolescent substance exposure PLUS trauma exposure...
- But only some people with SU will develop SUD... WHY?

Earlier exposure of all substances is associated with ongoing use and disorder

Gateway drugs include nicotine...

- OUD as the final stage in SUD development?

More *severe* substance use in adolescence predicts future SUD

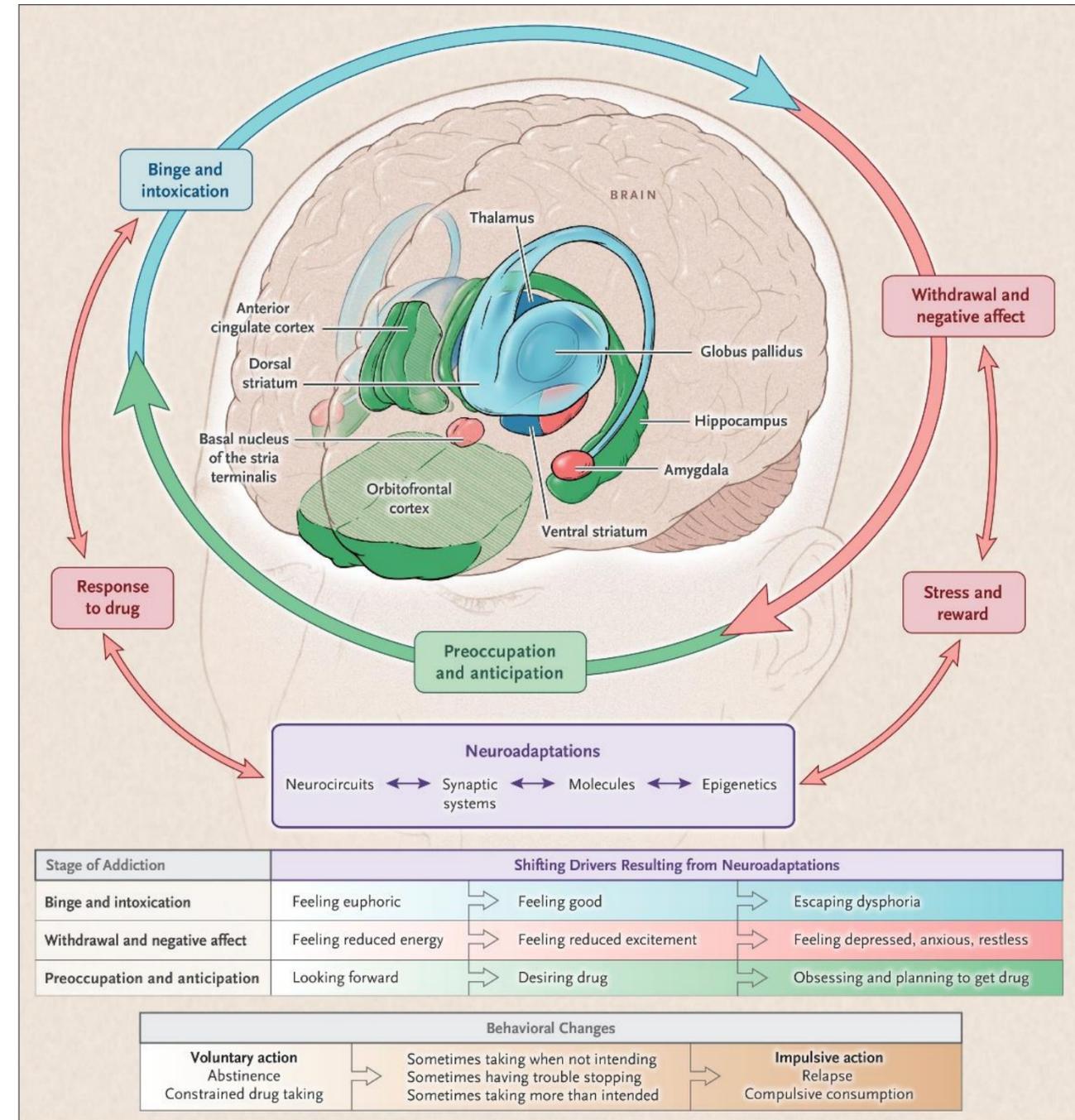
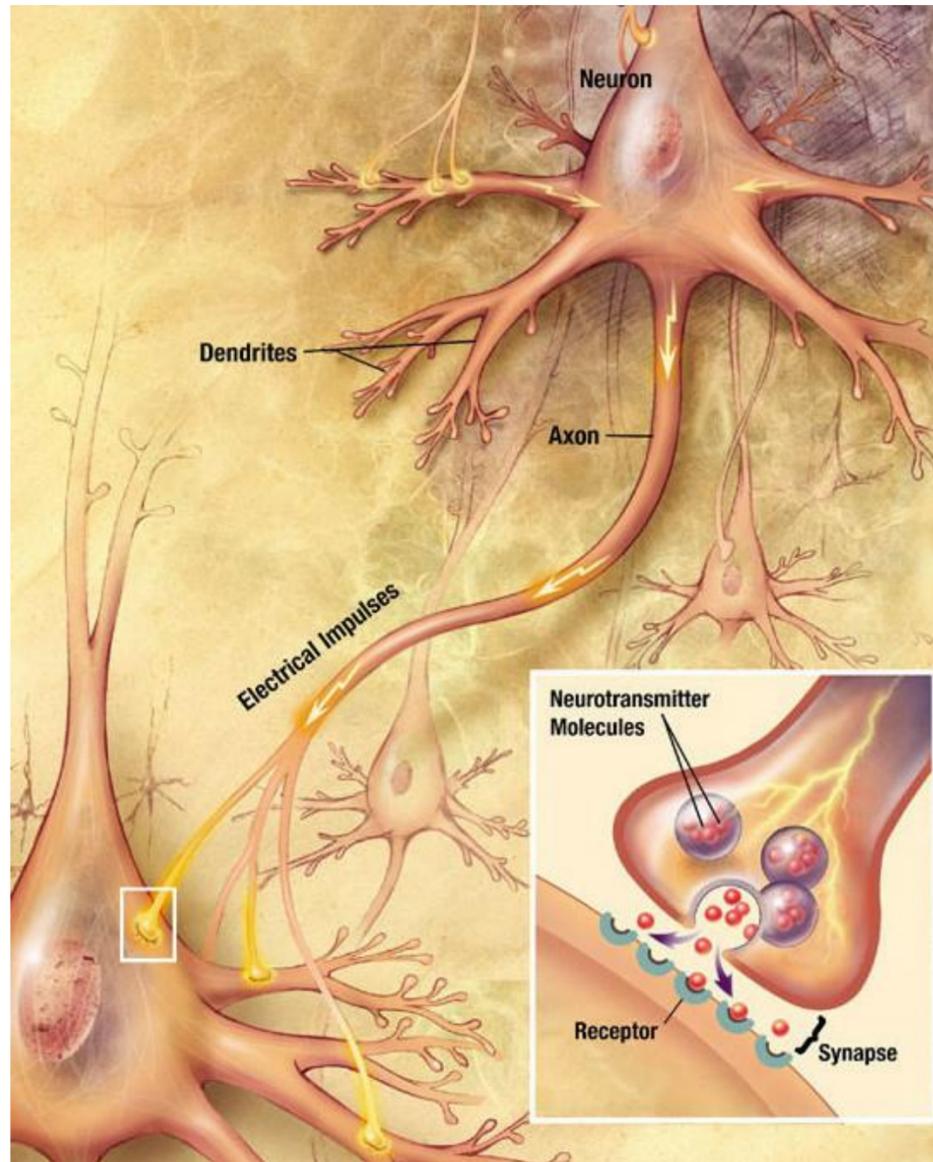


Garofoli M. Adolescent Substance Abuse. *Prim Care*. 2020;47(2):383-394. doi:10.1016/j.pop.2020.02.013

ND Volkow, EM Wargo. [Association of Severity of Adolescent Substance Use Disorders and Long-term Outcomes\(link is external\)](#). *JAMA Network Open*. DOI: 10.1001/jamanetworkopen.2022.5656 (2022)

DAA Baranger, et al. [Association of Mental Health Burden With Prenatal Cannabis Exposure From Childhood to Early Adolescence: Longitudinal Findings From the Adolescent Brain Cognitive Development \(ABCD\) Study](#). *JAMA Pediatrics*. DOI: 10.1001/jamapediatrics.2022.3191

# Neurochemistry and Neuroanatomy



Volkow ND, Koob GF, McLellan AT. Neurobiologic Advances from the Brain Disease Model of Addiction. *N Engl J Med.* 2016;374(4):363-371. doi:10.1056/NEJMra1511480

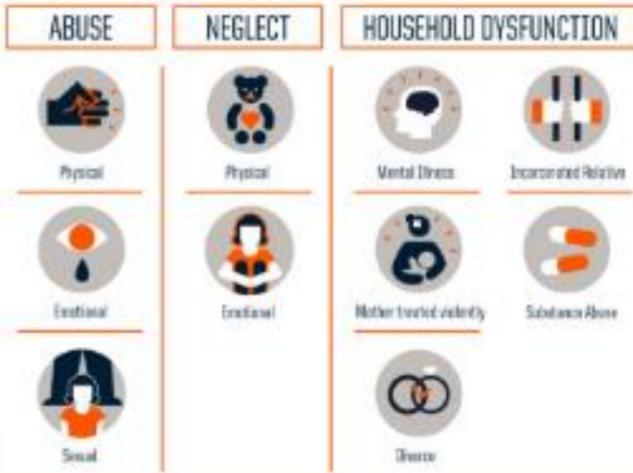
# THE ROLE OF TRAUMA

## THE TRUTH ABOUT ACEs

### WHAT ARE THEY?

ACEs are  
ADVERSE  
CHILDHOOD  
EXPERIENCES

The three types of ACEs include



### HOW PREVALENT ARE ACEs?

The ACE study<sup>™</sup> revealed the following estimates:

#### ABUSE

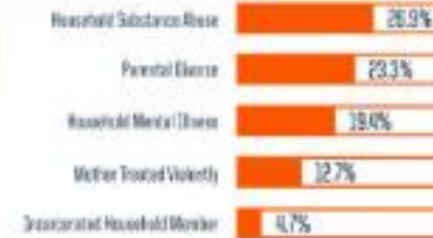


percentage of study participants that experienced a specific ACE

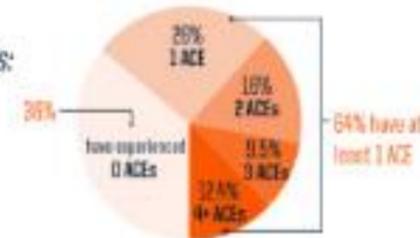
#### NEGLECT



#### HOUSEHOLD DYSFUNCTION

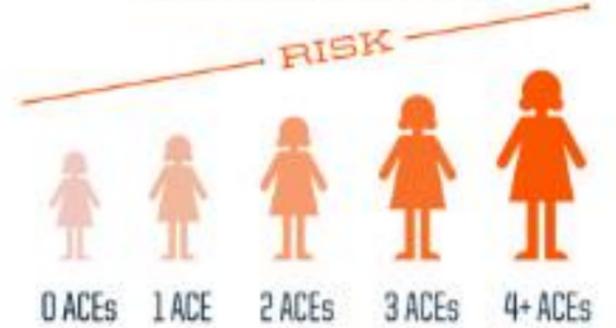


Of 17,000 ACE study participants:



### WHAT IMPACT DO ACEs HAVE?

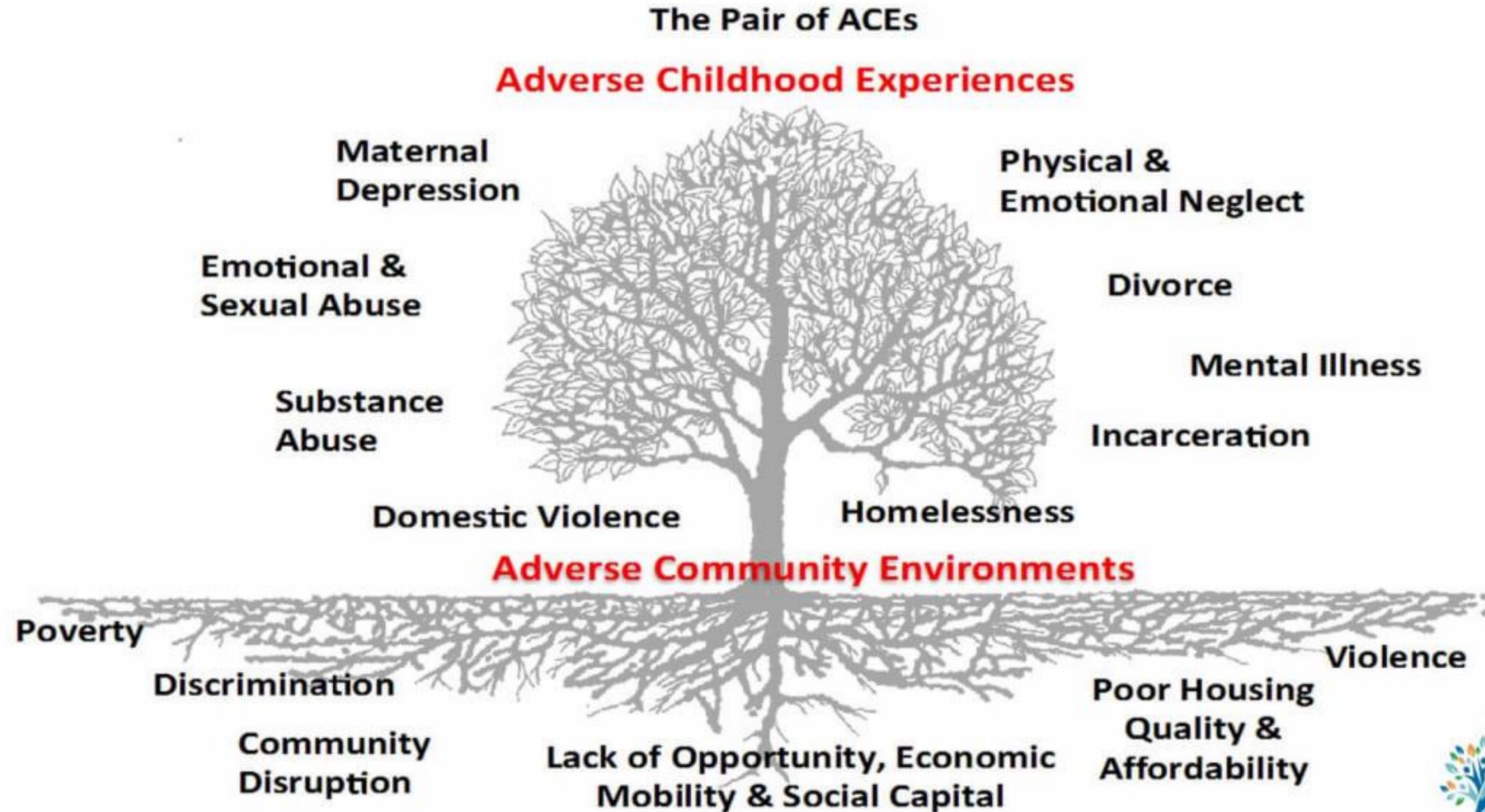
As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:



# The Role of Community and Environment



© Ellis 2020



# Other Contributors, often subacute and undiagnosed

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Lead exposure (prenatal and childhood)

Traumatic brain injury (accidents, sports, explosives, machinery)

Fetal alcohol spectrum disorder

Neurodivergence – ADHD, autism

## Association Between Automotive Assembly Plant Closures and Opioid Overdose Mortality in the United States A Difference-in-Differences Analysis

Atheendar S. Venkataramani, MD, PhD; Elizabeth F. Bair, MS; Rourke L. O'Brien, PhD; Alexander C. Tsai, MD, PhD

**RESULTS** During the study period, 29 manufacturing counties in 10 commuting zones were exposed to an automotive assembly plant closure, while 83 manufacturing counties in 20 commuting zones remained unexposed. Mean (SD) baseline opioid overdose rates per 100 000 were similar in exposed (0.9 [1.4]) and unexposed (1.0 [2.1]) counties. Automotive assembly plant closures were associated with statistically significant increases in opioid overdose mortality. Five years after a plant closure, mortality rates had increased by 8.6 opioid overdose deaths per 100 000 individuals (95% CI, 2.6-14.6;  $P = .006$ ) in exposed counties compared with unexposed counties, an 85% higher increase relative to the mortality rate that would have been expected had exposed counties followed the same outcome trends as unexposed counties. In analyses stratified by age, sex, and race/ethnicity, the largest increases in opioid overdose mortality were observed among non-Hispanic white men aged 18 to 34 years (20.1 deaths per 100 000; 95% CI, 8.8-31.3;  $P = .001$ ) and aged 35 to 65 years (12.8 deaths per 100 000; 95% CI, 5.7-20.0;  $P = .001$ ). We observed similar patterns of prescription vs illicit drug overdose mortality. Estimates for opioid overdose mortality in nonmanufacturing counties were not statistically significant.

FULL TEXT ARTICLE



# Evidence that intergenerational income mobility is the strongest predictor of drug overdose deaths in U. S. Midwest counties

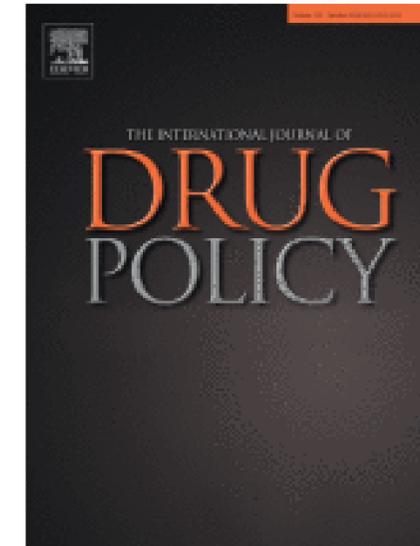


Gene M. Heyman, Ehri Ryu and Hiram Brownell

International Journal of Drug Policy, 2024-10-01, Volume 132, Article 104558, Copyright © 2024 Elsevier B.V.

## Highlights

- Midwest county overdose death rates increased at an exponential rate from 2006 to 2021.
- The increases occurred despite large decreases in access to legal opioids.
- Decreasing intergenerational income mobility was the strongest predictor of overdose rates each year of the study, according to multilevel regression models (county embedded in state).
- Opioid prescription rates were the second strongest predictor from 2006 to 2019, typically registering values that were about one-half to two-thirds smaller than intergenerational income mobility rates.



International Journal  
of Drug Policy

Volume 132

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Risk Factors ->  
Resilience Factors

**FIGURE 2** | Primary Prevention: Examples of Risk and Protective Factors for Those at Risk for Developing Opioid Use Disorder

PRIMARY		 Risks	 Protective factors
<b>INDIVIDUAL</b> 		<ul style="list-style-type: none"> <li>• Adverse childhood experiences</li> <li>• Trauma and stress</li> <li>• Co-occurring psychiatric conditions</li> <li>• Adult unemployment</li> <li>• Abrupt cessation of pain medication and lack of alternatives</li> </ul>	<ul style="list-style-type: none"> <li>• In-school and out-of-school programs that support youth achievement of age-appropriate milestones</li> <li>• Accessible and affordable health care services</li> </ul>
<b>INTERPERSONAL</b> 		<ul style="list-style-type: none"> <li>• Lack of consistent caring adult during childhood</li> <li>• In utero exposure to maternal stress</li> <li>• Racial discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• Stress buffering (e.g., factors that mitigate stress)</li> <li>• Sufficient provider capacity and reimbursement</li> <li>• Social support, connectedness, and opportunity for socialization</li> <li>• Investments in evidence-based prevention (in- and out-of-school time)</li> <li>• Promotion of parental and intergenerational health</li> </ul>
<b>MACRO</b> 		<ul style="list-style-type: none"> <li>• Community disinvestment and poverty</li> <li>• Insufficient insurance coverage for mental health and medical services</li> <li>• Insufficient capacity of pain management and pain management alternatives (and subsequent pursuit of less expensive and more toxic illegal options)</li> <li>• Structural/institutional racism</li> <li>• Punitive drug laws</li> </ul>	<ul style="list-style-type: none"> <li>• Community vitality and economic opportunity</li> <li>• Support for resource-limited families and individuals</li> </ul>

**SOURCE:** Latimore A. D., E. Salisbury-Afshar, N. Duff, E. Freiling, B. Kellett, R. Sullenger, A. Salman, and the Prevention, Treatment, and Recovery Services Working Group of the National Academy of Medicine’s Action Collaborative on Countering the U.S. Opioid Epidemic. 2023. Primary, Secondary, and Tertiary Prevention of Opioid Use Disorder through Socioecological Strategies. *NAM Perspectives*. Discussion Paper, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202309b>.

**NOTE:** Figure created by American Institutes for Research. Copyright 2023. All rights reserved.

## Recovery

# Recovery from a Substance Use Problem

NSDUH asked respondents aged 18 or older whether they thought they ever had a problem with their use of drugs or alcohol. Respondents were then asked whether they thought they had recovered or were in recovery.



## Ever Had a Substance Use Problem

2024

Among the **31.7 million adults** who perceived ever having a substance use problem, **23.5 million adults (74.3%)** considered themselves to have recovered or to be in recovery.

Overall Trend:  
Ever Had a  
Substance Use  
Problem

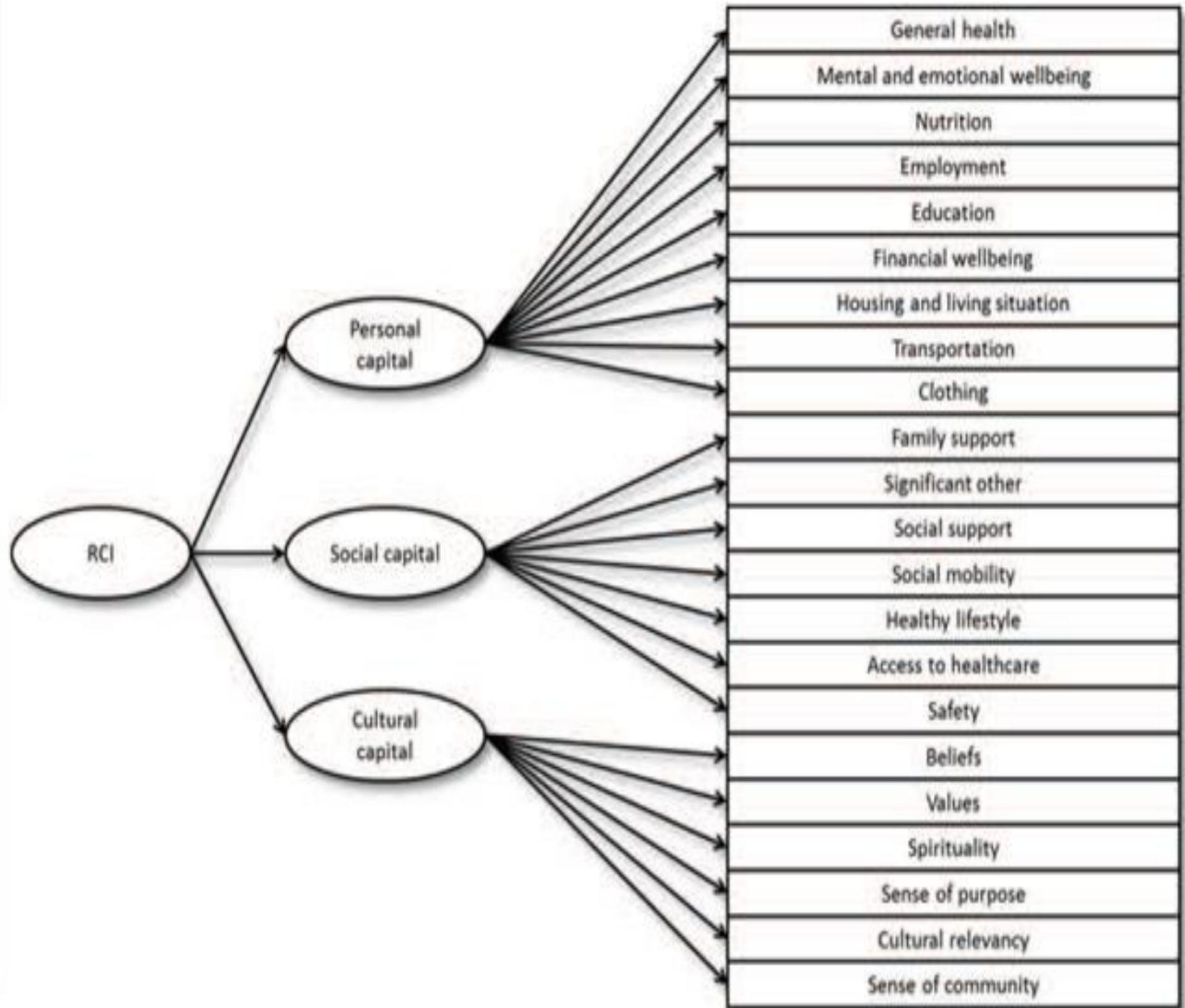
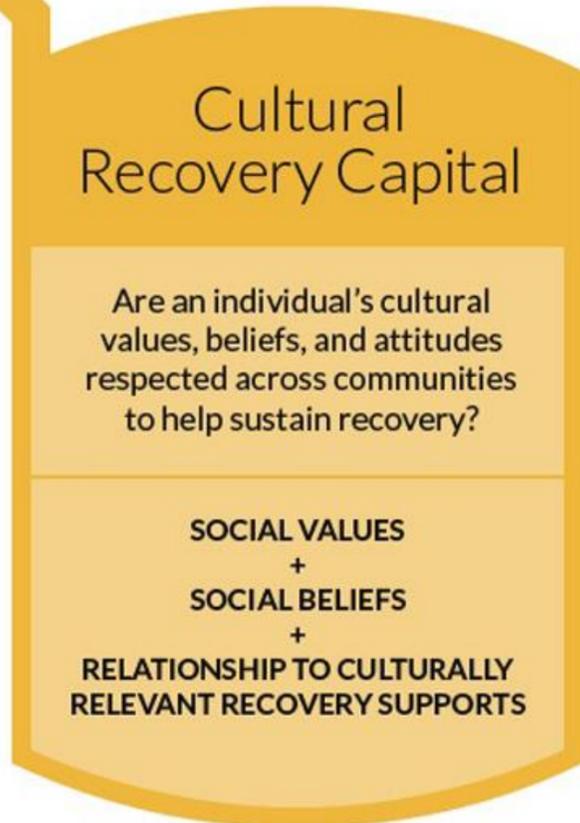
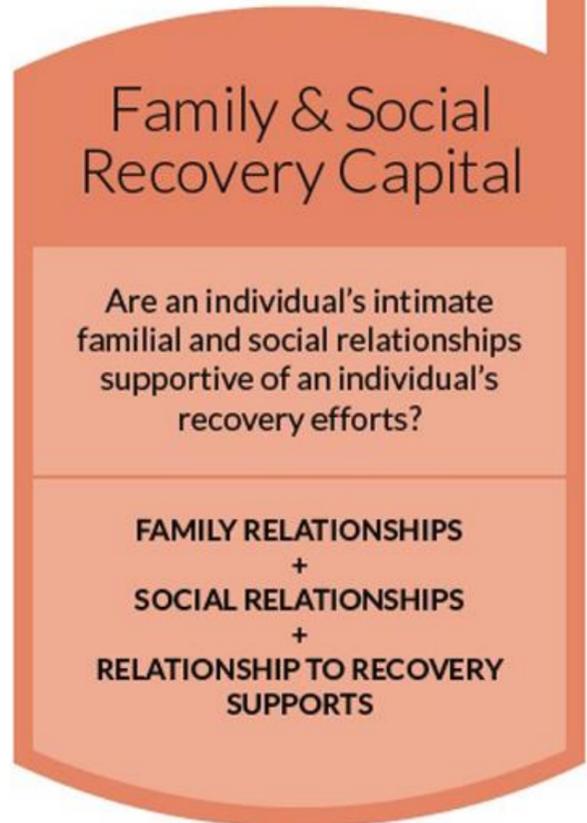
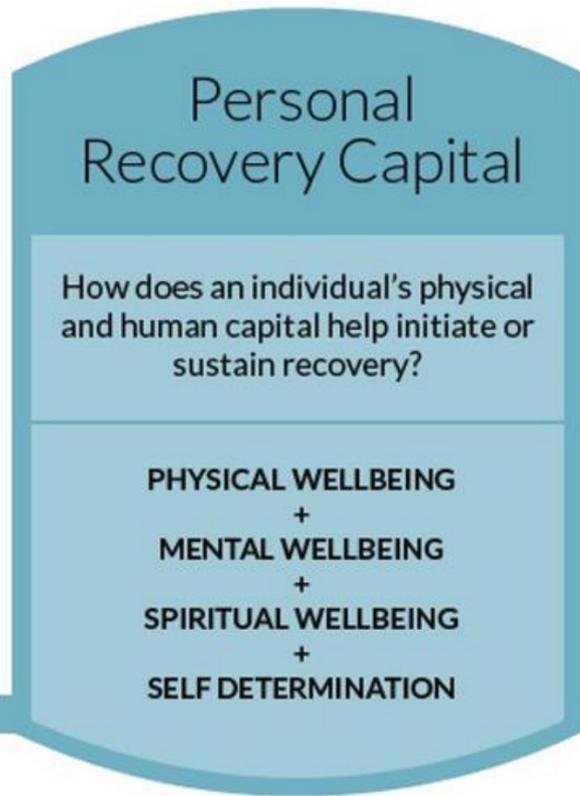


No change

**31.7 million**  
12.2%

**23.5 million**  
74.3%

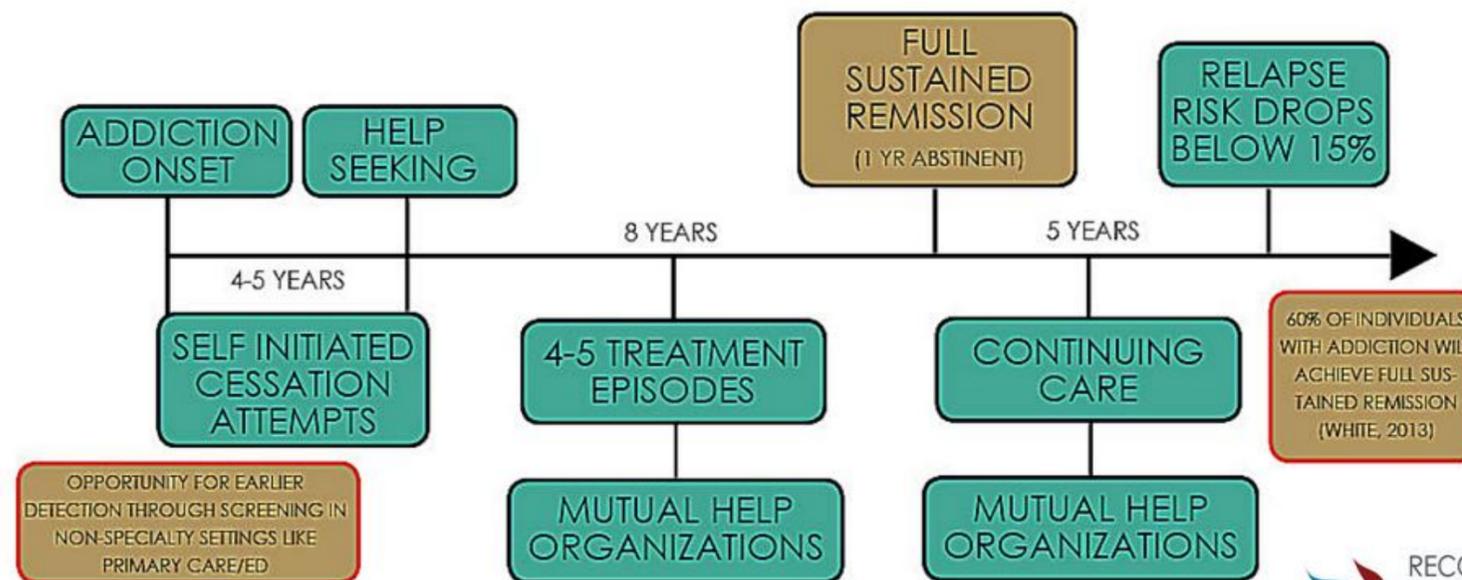
**Recovery**



# Recovery Timeline



## SUBSTANCE USE DISORDER COURSE OF RECOVERY



# What doesn't work?

Original Investigation | Substance Use and Addiction

March 19, 2025

## Law Enforcement Drug Seizures and Opioid-Involved Overdose Mortality

Alex H. Kral, PhD<sup>1</sup>; Jamie L. Humphrey, PhD<sup>1</sup>; Clyde Schwab, BS<sup>1</sup>; [et al](#)

» [Author Affiliations](#) | [Article Information](#)

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### Key Points

**Question** Is there a geospatial association between opioid-involved overdose mortality and law enforcement drug seizures in San Francisco?

**Findings** This cross-sectional study included 2653 drug seizure crime events. Within the surrounding 100, 250, and 500 meters, drug seizures were associated with a statistically significant increase in the relative risk for fatal opioid overdoses 1, 2, 3, and 7 days following law enforcement drug seizure events.

**Meaning** These findings suggest that the enforcement of drug distribution laws to increase public safety for residents in San Francisco may be having an unintended negative consequence of increasing opioid overdose mortality.



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Editors' Choice

## The effectiveness of compulsory drug treatment: A systematic review

[D. Werb<sup>a b</sup>](#) , [A. Kamarulzaman<sup>c</sup>](#), [M.C. Meacham<sup>b</sup>](#), [C. Rafful<sup>b</sup>](#), [B. Fischer<sup>d</sup>](#), [S.A. Strathdee<sup>b</sup>](#), [E. Wood<sup>a b e</sup>](#)

### Conclusion

There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.

# So, then what DOES work?

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Stay tuned for part two of UnShame!

Here's a preview:

Ask your favorite AI platform “is there any medical intervention on earth as effective for improving life expectancy as medication for opioid use disorder?”

# What to do if someone you love has substance use disorder?

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**The opposite of addiction is connection.**

Talk to them, and mostly listen. Show them love and compassion.

Don't judge or shame them. Remember, they are probably dealing with a lot of old trauma and ongoing trauma.

Be a good friend/parent/sibling/cousin/uncle/auntie. Tell them that you care about them, and show them you care about them.

Encourage help but DON'T force them to do something they are not ready to do. Ask them how you can help them. Normalize treatment as healthcare- because that is what it is.

Remember, they may have a complicated relationship with substances: good effects and bad effects. Their motivations may change day to day.

**Treatment works.**

# ANY QUESTIONS?

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**THANKS!**

**Shuchin@email.unc.edu**

- The *North Carolina Technical Assistance Center* is a statewide initiative to provide FREE technical assistance to programs that support individuals at risk of incarceration and overdose.

## AREAS OF EXPERTISE

- Harm reduction
- Reentry from incarceration
- Diversion/Deflection, including Law Enforcement Assisted Diversion (LEAD)
- Jail-based Medication for Opioid Use Disorder (MOUD)
- Naloxone access and distribution
- Program evaluation
- Data management

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The background features a light blue gradient with several overlapping geometric shapes. On the left side, there are two dark blue shapes: a large triangle pointing downwards and a smaller triangle pointing upwards. A prominent yellow parallelogram is positioned vertically, overlapping the dark blue shapes. At the top center, there is a blue trapezoidal shape. The text 'Q&A' is centered in the white space on the right side of the image.

**Q&A**

## Join Us for Part 2 on March, 24th at 12PM

The Basics of the Gold Standard for Treatment



SCAN ME

### Objectives:

- Learn the science behind MOUD, including how they work and why they are safe, effective treatments.
- Understand the different types of MOUD available and the benefits they offer in managing symptoms and improving health and social outcomes.
- Explore the availability of MOUD in North Carolina and the importance of expanding access.

# THANK YOU

We'd also appreciate it if you could take a moment to complete our post-webinar survey—your feedback helps shape future webinar discussions.



SCAN ME

