Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

OPIOID EDUCATION FOUNDATION OF AMERICA

OFFICE OF ALTERNATIVE & COMMUNITY RESPONSES

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New Jersey Coordinator for Addiction Responses and Enforcement Strategies

Treating Trauma to Achieve Recovery

September 11, 2025

Partnership for a Drug-Free New Jersey
In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

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Featured Presenters

Dr. Roxanne Jeffries
DNP, GNP-BC, FNP-BC, PMHNP-BC

Dr. Roxanne Jeffries, DNP, GNP-BC, FNP-BC, PMHNP-BC, is a Board-Certified psychiatric nurse practitioner with more than 20 years of mental health experience. She is the founder of Branch Behavioral Health Services in Pittsburgh and is triple board-certified in gerontology, family practice and psychiatric mental health, earning credentials from the University of Pennsylvania, Drexel University, and Case Western Reserve University. Dr. Jeffries earned her Doctor of Nursing Practice from Case Western Reserve University and is currently pursuing a Ph.D. in Nursing at the same institution. Her research examines the impact of trauma exposure on substance use disorder, opioid use disorder and mental health disorders. She is dedicated to optimizing the health of urban and diverse communities, reducing health disparities, and helping individuals recover from mental health disorders, addiction and trauma. Dr. Jeffries holds unrestricted licenses to practice psychiatry in Delaware, Pennsylvania, New York and Minnesota.

Morgan Thompson
CEO, Prevention Links

Morgan Thompson is a person in long term recovery and the CEO of Prevention Links, a nonprofit focused on preventing the development of substance use disorder and supporting individuals in their recovery journey across the lifespan. In her capacity as CEO of Prevention Links, Ms. Thompson has spearheaded the development and implementation of a number of innovative programs designed to promote health literacy, wellness, and resiliency for individuals impacted by substance use disorder and their families. Ms. Thompson is proud to serve as a member of the New Jersey Opioid Remediation and Recovery Advisory Council, appointed by Governor Murphy.

Dr. Roxanne Jeffries
DNP, GNP-BC, FNP-BC, PMHNP-BC

The Influence of Trauma History on Opiate Use Disorder in an Urban Treatment Facility in Pennsylvania

Presenter: Roxanne Jeffries-Baxter, DNP, PMHNP-BC, FNP-BC, GNP-BC
Study Authors: Roxanne Jeffries-Baxter, DNP, PMHNP-BC, FNP-BC, GNP-BC Christopher J. Burant, PhD
Joachim G. Voss, PhD, RN, ACRN, FAAN

Trauma and OUD: Origin of the Problem

- The problem emerged from clinical observation while working as a Nurse Practitioner in a methadone clinic.
- Patients with OUD consistently presented with higher trauma scores and demonstrated poorer outcomes compared to those with other SUD diagnoses.
- This observation raised critical questions for me about the role of trauma history in shaping OUD treatment outcomes.
- Motivated by this problem, I entered graduate school intending to investigate the influence of trauma on OUD and develop evidence-based, culturally appropriate trauma-informed approaches.

Trauma

Public Health / Overarching Definition (SAMHSA, 2014):

- Trauma can be broadly defined as an experience or event that overwhelms an individual's ability to cope, threatens their sense of safety, and results in lasting adverse effects on physical, emotional, social, or spiritual well-being.
- Trauma may be physical (bodily injury), psychological (emotional harm), or collective (shared by groups/communities), and its impact is shaped by both the event itself and the individual's response.

Clinical / DSM-5 Definition (APA, 2013; APA, 2022):):

- Trauma is defined in the context of PTSD diagnostic criteria as "exposure to actual or threatened death, serious injury, or sexual violence" (APA, 2013, p. 271).
- Exposure can occur by:
  - Directly experiencing the event.
  - Witnessing the event in person.
  - Learning the event occurred to a close family member or friend.
  - Repeated or extreme exposure to details of traumatic events (e.g., first responders).

Trauma

Types of Trauma

- **Adverse Childhood Experiences (ACEs):** Subset of early-life traumatic or stressful events (e.g., abuse, neglect, household dysfunction) that increase vulnerability to PTSD, SUD, and other mental health conditions
  – **Measurement Tool:** *Adverse Childhood Experiences Questionnaire* (Felitti et al., 1998) and adapted ACEs scales
- **Potentially Traumatic Events (PTEs):** Broad exposures that may or may not lead to PTSD (e.g., natural disasters, accidents, combat, interpersonal violence)
  – **Measurement Tool:** *Life Events Checklist for DSM-5 (LEC-5)* (Weathers et al., 2013)
- **PTSD:** A clinical diagnosis requiring DSM-5/DSM-5-TR symptom clusters (intrusion, avoidance, negative mood/cognitions, arousal/reactivity) following trauma exposure
  – **Measurement Tool:** *PTSD Checklist for DSM-5 (PCL-5)* (Weathers, Litz, et al., 2013); gold-standard structured interview = *CAPS-5 (Clinician-Administered PTSD Scale)*

Opiate Use Disorder (OUD)

Definition of Opioid Use Disorder (OUD)

DSM-5 Definition (APA, 2013):

OUD is a **problematic pattern of opioid use** leading to clinically significant impairment or distress, as manifested by at least **2 of 11 criteria** within a 12-month period (e.g., craving, tolerance, withdrawal, unsuccessful efforts to cut down, continued use despite harm). The severity is classified as:

- *Mild*: 2–3 symptoms
- *Moderate*: 4–5 symptoms
- *Severe*: 6 or more symptoms

NIDA / NIH (2023):

OUD is defined as a **chronic, relapsing disorder** characterized by compulsive opioid seeking and use despite harmful consequences, accompanied by long-lasting brain changes.

ASAM (2020):

OUD is a **chronic medical, treatable disease** involving brain circuits, genetics, environment, and life experiences, marked by impaired control, craving, tolerance, and withdrawal.

Why Trauma Increases Risk for OUD

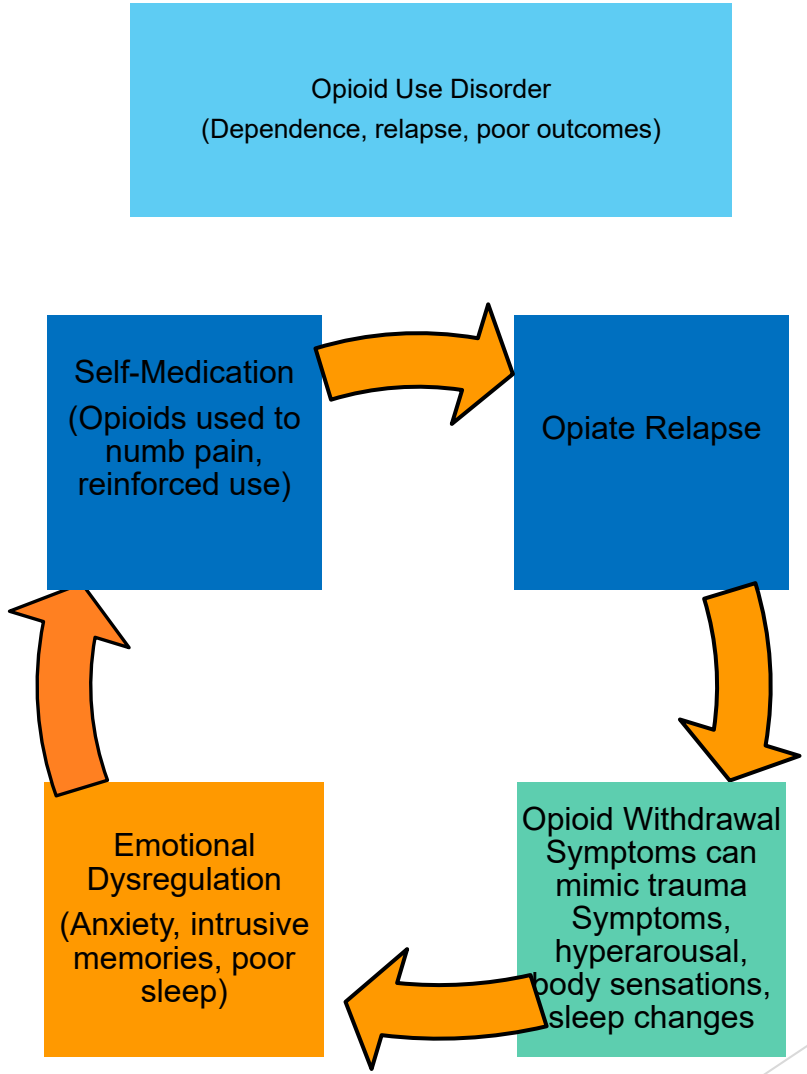
Trauma Exposure[1] (Childhood adversity, PTE, PTSD)

Neurobiological Impact [2] (HPA axis, reward/stress circuitry)

Emotional Dysregulation[3] (Anxiety, intrusive memories, poor sleep)

Self-Medication [4] (Opioids used to numb pain, reinforced use)

Opioid Use Disorder [5] (Dependence, relapse, poor outcomes)



References: [1]Hien et al., 2021; SAMHSA, 2014. [2]Danielli et al., 2022. [3]Van Dam et al., 2012. [4]Khantzian, 1997. [5]Hien et al., 2021.

The Influence of Trauma History on Opiate Use Disorder in an Urban Treatment Facility in Pennsylvania

Study Background

Opioid Overdose Crisis

- **100,000 opioid overdose deaths in the U.S. in 2023 (NIDA, 2023).**

Trauma in the General Population

- **Worldwide: 70% report at least one traumatic event.**
- **30.5% report ≥4 traumatic events (Benjet et al., 2015).**

Trauma and PTSD in SUD Populations

- **Trauma and PTSD are highly prevalent among individuals with SUD.**

Study Background

Trauma and PTSD are highly prevalent among individuals with SUD.

PTSD and SUD frequently co-occur, with studies showing 25–50% of individuals with SUD also meet the criteria for PTSD (Kessler et al., 1995; Mills et al., 2006).

Earlier research: focused mainly on alcohol and stimulants, with limited OUD-specific data (Dahlby & McCabe, 2020).

Recent reviews and U.S. treatment samples report lifetime PTSD prevalence of ~41% and current prevalence of ~33% in OUD, among the highest across substance use categories (Murray-Krezan et al., 2023; Peck et al., 2021).

Gap:

Despite high prevalence estimates, comparative research on trauma severity between OUD and other SUD populations remains limited (López-Castro et al., 2024; Rosic et al., 2021).

Study Purpose

Purpose:
To examine the influence of traumatic events (PTEs) on the development of OUD in an urban treatment facility in Pennsylvania, and to provide foundational work for future interventional studies involving PTEs and OUD.

- **Aim 1:** Describe the demographic characteristics of OUD and SUD participants.
- **Aim 2:** Examine the associations between PTE and PTSD diagnoses of OUD and SUD participants.
- **Aim 3:** Examine the number of PTE occurrences in OUD and SUD participants.

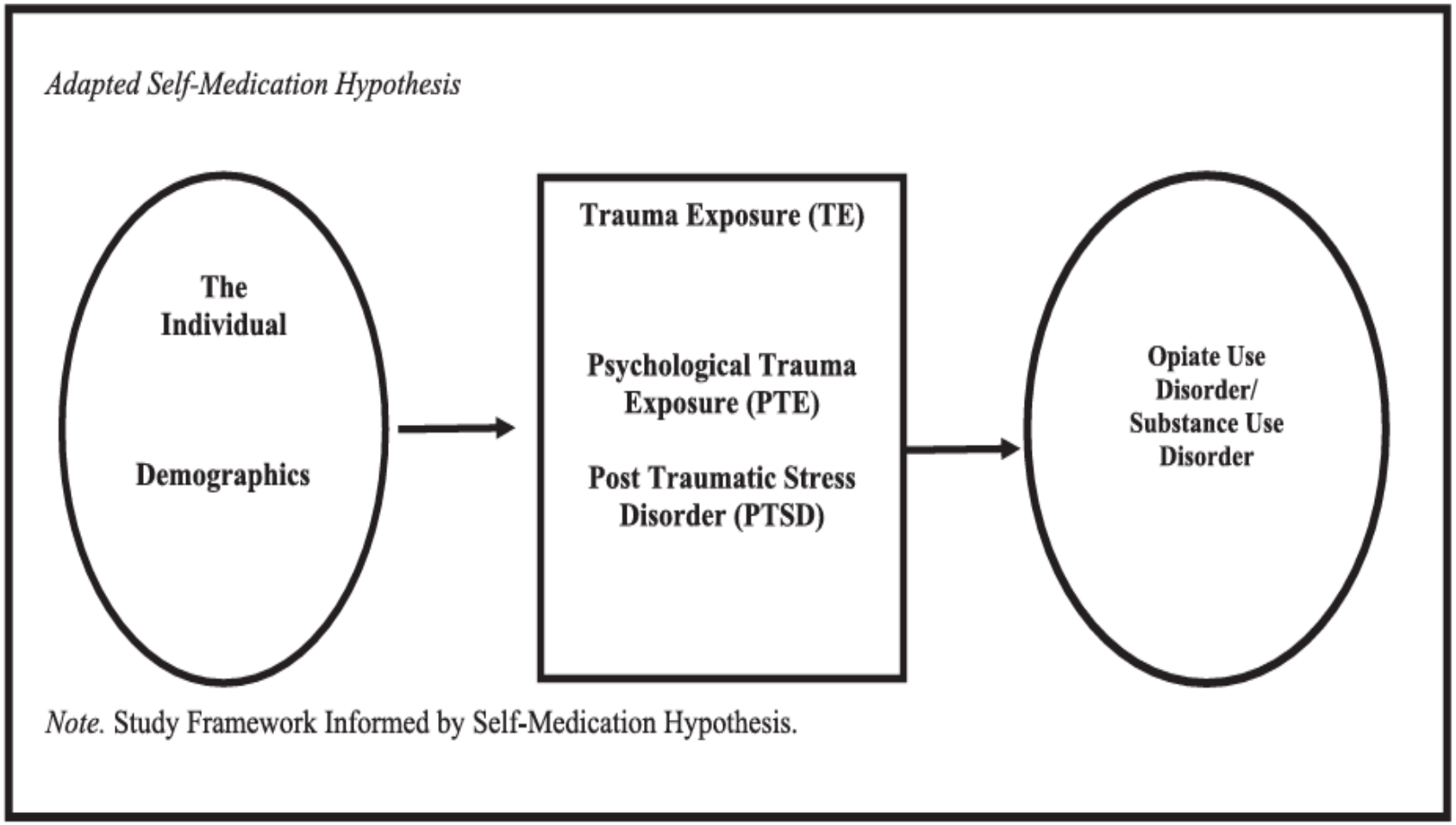
Theoretical Framework

Self-Medication Hypothesis (SMH)

- *"The Self-Medication Hypothesis (Khantzian, 1997) originated as a hypothesis but has since been adapted as a theoretical framework for understanding the link between trauma, emotional distress, and substance use."*
- **Hypothesis:**
  People may use substances to self-medicate to manage **emotional dysregulation** and **distressing symptoms** (Khantzian, 1997).
- **Purpose of SMH:**
  Explains the link between **distressing emotional states** and the **development of SUD**.
- **Theory Structure:**
  - Linear model
  - Consistent with the health model framework
- **Adapted SMH in this Study: Individual → Trauma Exposure → OUD/SUD**

Theoretical Framework

Adapted SMH in this Study: Individual → Trauma Exposure → OUD/SUD



Study Methods

Methods

- **Design:** Retrospective chart review
- **Sample:** *n* = 150 (75 OUD, 75 SUD)
- **Setting:** Urban outpatient substance use facility, Chester, PA
- **Measures:**
  - Demographic survey – assessed gender, age, race, and ethnicity
  - Life Events Checklist (LEC-5) – measured PTE
  - PTSD, OUD, and SUD diagnoses – obtained from medical records

Study Results

- **Demographic**
- **Trauma Exposure (PTE)**
- **PTSD Diagnoses**

Results

Demographics

Characteristics	OUD Group (n=75)	SUD Group (n=75)
Mean Age	37 years	47 years
Female	51%	41%
White	73%	43%
Black	21%	55%

Study Results

Trauma Exposure (Number of PTE)

PTEs Reported	OUD Group n (%)	SUD Group n (%)
0	18 (24.0)	16 (22.4)
1	13 (17.3)	10 (13.2)
2	5 (6.7)	9 (11.8)
3	8 (10.7)	15 (21.1)
4	2 (2.7)	5 (6.6)
5	9 (12.0)	10 (13.2)
6	7 (9.3)	2 (2.6)
7	3 (4.0)	2 (2.6)
8	1 (1.3)	2 (2.6)
9	2 (2.7)	1 (1.3)
10	6 (8.0)	2 (2.6)
12	1 (1.3)	0 (0.0)

Study Results

	PTSD Diagnosis	
Diagnosis	**OUD n (%)**	**SUD n (%)**
Yes	14 (18.7%)	8 (10.5%)
No	61 (81.3%)	67 (89.5%)

Implications

- Key findings
- Limitations
- Future Research

Key Findings

Higher Trauma Burden

- Participants with PTE > 5 were more likely to develop OUD ($\chi^2 = 5.17$, $p = 0.023$).
- Supports the link between trauma burden and OUD risk.

Racial Disparities

- The OUD group was predominantly White, inconsistent with Chester community demographics (69% African American).
- Suggests disparities in referral, treatment access, or justice(Legal) involvement.

Unexpected Findings

- No significant difference in PTSD rates between OUD and SUD groups.
- May reflect underreporting, small sample size, or paper record limitations.

Implications

Study Limitations

- Retrospective design limits causal interpretation.
- Convenience sample from a single treatment site.
- Reliance on paper records may have led to underreporting of data and possible errors.

Implications

Future Research

- **Larger, multi-site studies** to improve generalizability.
- **Racial, ethnic, and sociocultural disparities:**
  - Continue to document and investigate the reasons for potential sources of racial disparity in OUD/SUD treatment
  - Examine the intersection of trauma, race, and social determinants of health in OUD/SUD populations.
- **Intervention studies:** Test whether culturally competent trauma-informed care models improve OUD treatment outcomes among minority populations.

Clinical Practice

Practice Standard

Trauma-Informed vs. Trauma-Based Care

Trauma-Informed Care (TIC) is a system-wide approach that ensures services are delivered in ways that recognize the impact of trauma and prevent re-traumatization for clients.

> It focuses on *how care is delivered*—through safety, trust, collaboration, empowerment, and cultural sensitivity.

In contrast, Trauma-Based Care (TB) refers to targeted clinical interventions—such as Seeking Safety, EMDR, or Prolonged Exposure—designed to directly treat trauma symptoms in individuals with PTSD or trauma-related disorders.

Policy Context

At the **federal level**, SAMHSA sets the standard for TIC and TB through **TIP 57** and the **2023 Practical Guide for Implementing a Trauma-Informed Approach**. These establish national best practices but are not legally mandated.

At the **state level**, **Pennsylvania** encourages and supports TIC and TB in behavioral health and SUD settings through OMHSAS guidance and audit tools, but adoption is **not mandated by law**.

By contrast, **New Jersey** advances TIC through DMHAS and the Office of Resilience, and with **Senate Bill 3297 pending**, the state is moving toward making TIC a **legal requirement** across health and social service systems.

Clinical Practice

SAMHSA's Trauma-Informed Approach (TIC) (Gold Standard in the U.S.)

Six Key Principles:

- Safety
- Trustworthiness & Transparency
- Peer Support
- Collaboration & Mutuality
- Empowerment, Voice, & Choice
- Cultural, Historical, & Gender Issues

Four "R's" of a trauma-informed approach:

- *Realize* the widespread impact of trauma.
- *Recognize* the signs and symptoms.
- *Respond* by integrating knowledge into practice.
- *Resist re-traumatization*.

Clinical Practice

Trauma-Based Care (TBC) in SUD: SAMHSA endorses the use of evidence-based, trauma-specific treatments, but does not designate any one approach as superior.

- **Most consistently cited interventions (with evidence in PTSD+SUD):**
  - **Prolonged Exposure integrated with SUD CBT (COPE/PE**) — exposure-based treatment; U.S. RCTs (e.g., veterans) show PTSD reductions and substance-use benefits when delivered alongside SUD care (Back et al., 2019; see also meta-analytic support in Simpson et al., 2021).
  - **Cognitive Processing Therapy (CPT)** — guideline-endorsed for PTSD, with emerging RCT evidence in SUD/AUD comorbidity (APA, 2017; Simpson et al., 2021).
  - **EMDR** — guideline-endorsed for PTSD; fewer trials in actively using SUD samples than PE/COPE, but growing application in dual-diagnosis care (APA, 2017; Simpson et al., 2021).
  - **Seeking Safety** — widely implemented, present-focused, integrated skills for PTSD+SUD; RCTs and meta-analysis show modest but meaningful effects (Najavits, 2002; Simpson et al., 2021).

Key Findings

Higher Trauma Burden

- Participants with PTE > 5 were more likely to develop OUD ($\chi^2 = 5.17$, $p = 0.023$).
- Supports the link between trauma burden and OUD risk.

Racial Disparities

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Clinical Practice

Based on this study:

OUD clients have higher trauma scores in comparison to SUD clients

We must identify trauma history, document past/current PTSD, ensure accurate diagnosis of new cases, and

Institute culturally tailored trauma-based interventions

Treatment-Level Recommendations

Screening vs. diagnosis (SAMHSA, 2014; 2023)

- Universal trauma screening in all SUD settings — TIC → brief trauma screener for all; ask sensitively; warm handoff if positive.
- Screening ≠ diagnosis — TBC → positive screens receive a same-week diagnostic evaluation by a qualified clinician; use DSM-5 criteria with CAPS-5 (PCL-5 may support but is not diagnostic).

Interdisciplinary roles (APA, 2017; ASAM, 2020)

- PTSD diagnosis by qualified clinicians (e.g., psychiatrist, psychologist, PMHNP, LCSW per state scope).
- Integrate OUD treatment (MOUD) with trauma therapies — TBC within TIC → continue/start MOUD and offer COPE/PE, CBT variants, EMDR, or Seeking Safety.

Integrated care and equity (SAMHSA, 2014; 2023; ASAM, 2020)

- Build referral pathways between addiction providers and trauma specialists — TIC → formalize bidirectional workflows, warm handoffs, and track referral completion/first visit.
- Close equity gaps — TIC + TBC → provide culturally responsive care, partner with community organizations, and track screening/diagnosis/treatment metrics by race/ethnicity.

Clinical Practice

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. American Psychiatric Association. https://www.apa.org/ptsd-guideline

American Psychiatric Association. (2017). *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD)*. American Psychiatric Association Publishing. https://doi.org/10.1176/appi.books.9780890424841

American Society of Addiction Medicine. (2020). The ASAM national practice guideline for the treatment of opioid use disorder: 2020 focused update. *Journal of Addiction Medicine, 14*(2S), 1–91. https://doi.org/10.1097/ADM.0000000000000633

Back, S. E., Killeen, T. K., Badour, C. L., et al. (2019). Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE): A randomized clinical trial in veterans. *Addictive Behaviors, 90*, 369–377. https://doi.org/10.1016/j.addbeh.2018.11.032

Benjet, C., et al. (2015). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine, 46*(2), 327–343. https://doi.org/10.1017/S0033291715001981

Dahlby, M., & McCabe, R. E. (2020). Posttraumatic stress disorder and opioid use disorder: A systematic review. *Substance Abuse Treatment, Prevention, and Policy, 15*(1), 1–12. https://doi.org/10.1186/s13011-020-00264-8

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231–244. https://doi.org/10.3109/10673229709030550

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*(12), 1048–1060. https://doi.org/10.1001/archpsyc.1995.03950240066012

López-Castro, T., Magura, S., & Delucchi, K. L. (2024). Trauma exposure and posttraumatic stress disorder among clients of a syringe services program with opioid use disorder. *Harm Reduction Journal, 21*(1), 19. https://doi.org/10.1186/s12954-024-01019-5

Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry, 163*(4), 652–658. https://doi.org/10.1176/ajp.163.4.652

Murray-Krezan, C., Krystal, J. H., Morgan, P. T., Schottenfeld, R. S., Winhusen, T., & Poling, J. (2023). Prevalence of posttraumatic stress disorder in opioid use disorder: A meta-analysis. *Journal of Substance Abuse Treatment, 149*, 209–219. https://doi.org/10.1016/j.jsat.2023.209219

Najavits, L. M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. Guilford Press.

National Institute on Drug Abuse. (2023). *Opioid use disorder*. National Institutes of Health. https://nida.nih.gov/publications/research-reports/opioids/opioid-use-disorder

National Institute on Drug Abuse. (2023). *Overdose death rates*. National Institutes of Health. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates

Peck, K. R., Khoury, L., Franklin, T., & Brady, K. T. (2021). Trauma exposure, PTSD, and psychiatric comorbidity in opioid use disorder. *Preventive Medicine, 152*, 106589. https://doi.org/10.1016/j.ypmed.2021.106589

Rosic, T., Naji, L., Bawor, M., Dennis, B. B., Plater, C., Marsh, D. C., & Samaan, Z. (2021). The role of trauma in patients receiving methadone maintenance treatment: A systematic review. *Journal of Substance Abuse Treatment, 122*, 108214. https://doi.org/10.1016/j.jsat.2020.10821

Rosic, T., et al. (2021). Traumatic experiences, PTSD, and opioid use disorder: A population-based study. *BJPsych Open, 7*(4), e138. https://doi.org/10.1192/bjo.2021.971

SAMHSA. (2014). *Trauma-informed care in behavioral health services* (Treatment Improvement Protocol [TIP] Series 57; HHS Publication No. SMA 14-4816). Substance Abuse and Mental Health Services Administration. https://library.samhsa.gov/sites/default/files/sma14-4816.pdf

SAMHSA. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

SAMHSA. (2022). *Trauma and violence*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/trauma-violence

SAMHSA. (2024, December 3). *Trauma-informed approaches and programs*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs

Simpson, T. L., Lehavot, K., Petrakis, I. L., & Kaysen, D. (2021). Efficacy and acceptability of interventions for co-occurring PTSD and SUD: A systematic review and meta-analysis. *Journal of Anxiety Disorders, 84*, 102490. https://doi.org/10.1016/j.janxdis.2021.102490

Morgan Thompson
CEO, Prevention Links

Trauma and Recovery

Morgan Thompson

CEO, Prevention Links

September 11, 2025

Stay Safe	• Trauma can feel like a danger zone, which makes being “out of it” feel safer than being in it.
Escape memories	• Unwanted and unresolved memories have a way of popping up incessantly after trauma; addictions offer the mind a different area of or reduced capacity for focus that helps suppress reminiscing.
Soothe pain	• Substances or the adrenalin rush of self-destructive behaviors change body chemistry, releasing endorphins and other mood enhancers that reduce discomfort.
Be in control	• Sometimes, engaging in addictive behaviors can lead to feeling strong, resilient and courageous, an experience that is tremendously alluring when trauma from the past intrudes on the present.
Create a tolerable world	• The intense feelings brought on by fear, memories and anxiety can make any moment seem overwhelming. The release of tension brought on by addiction-oriented behavior helps facilitate a manageable experience.
Create alignment	• Trauma can leave you feeling less than, worthless, hopeless, and damaged. The more self-destructive one behaves the more it can feel like they’re living in alignment with who they truly are. While this is false it can help reduce feelings of otherness and disconnection.
Redefining Oneself	• Engaging in addictions can help create a sense of community by connecting to others who feel, see, think and behave the same. Or, addictions can help by allowing one to engage in and act out behaviors that allow one to feel stronger, more courageous, capable, etc.,

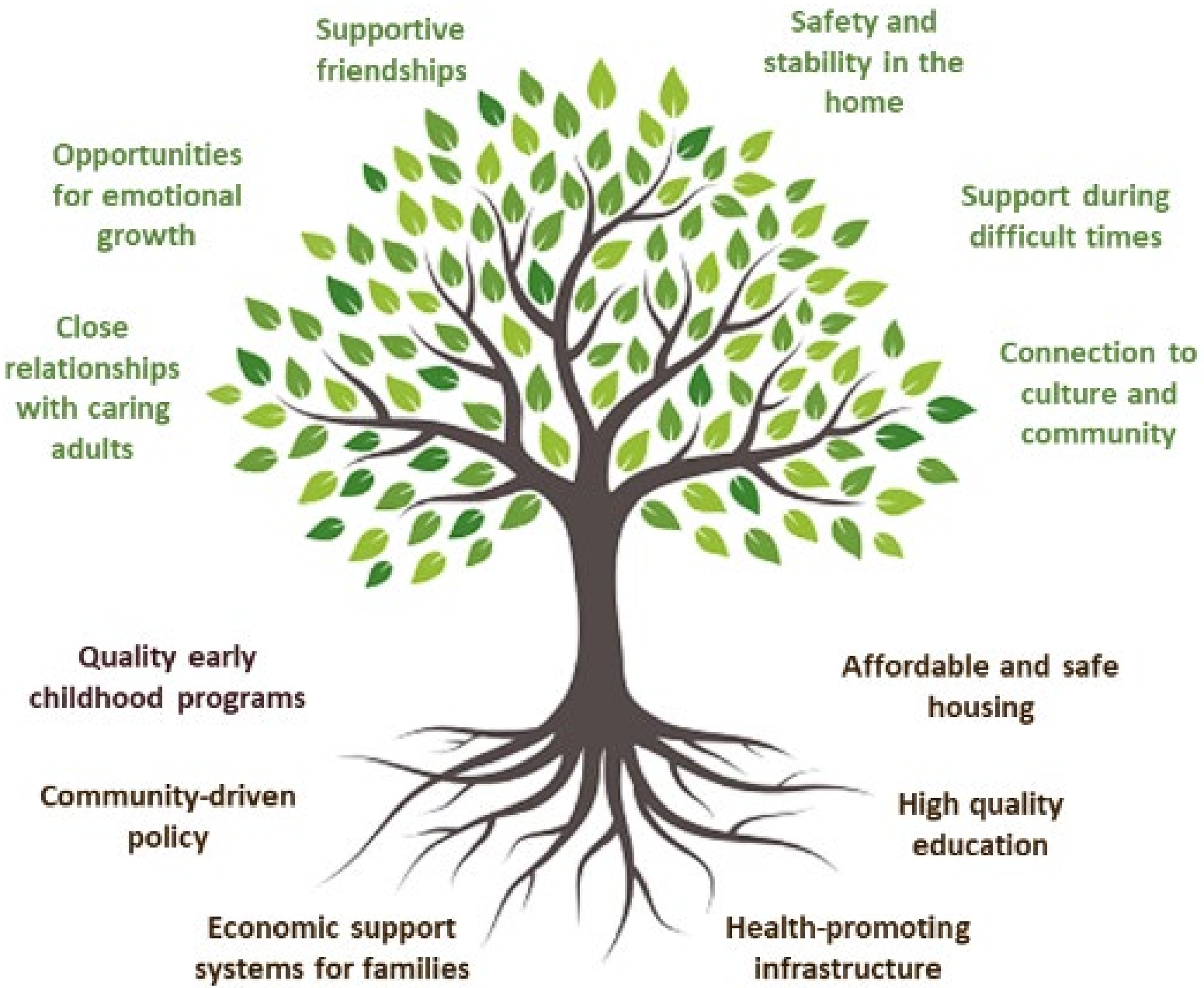
What is a Trauma-Informed Approach?

Realizes	• Realizes widespread impact of trauma and understands potential paths for recovery
Recognizes	• Recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system
Responds	• Responds by fully integrating knowledge about trauma into policies, procedures, and practices
Resists	• Seeks to actively resist re-traumatization

From SAMHSA's Concept Paper

Crosswalk: Values and Principles

RECOVERY	TRAUMA-INFORMED
Authenticity of recovery experience and voice	Empowerment, voice, and choice Safety
Recovery visibility and accountability	Trustworthiness and Transparency
Leadership development	Peer Support
Cultural diversity and inclusion	Cultural, Historical, and Gender Issues
Participatory process	Collaboration and Mutuality
Strength-based perspectives	Empowerment, Voice, and Choice
Peer support, volunteerism, and service	Peer Support



Adapted from Center for Community Resilience, Community Resilience Tree

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YOU ARE INVITED TO ATTEND

NJ Healthy Aging Summit: Opioid Safety & Alternatives

9:30am to 3pm
Friday, September 26, 2025

Golden Nugget Hotel & Casino
Huron Avenue & Brigantine Boulevard
Atlantic City, NJ

PLEASE REGISTER for this important FREE conference at NJHealthyAging.org

Why Attend?

New Jersey's aging population has become increasingly vulnerable in the opioid crisis.

- Opioid overdose deaths for people 65 and older are up 300% since 2002
- Emergency department visits by older adults for opioids are up 16%
- 1 in 8 older adults is prescribed opioids every year

Health and Wellness Strategies for the Aging Population

Topics Covered:

- Opioid prescribing and addiction
- Prescribing trends and increased risk of dependency
- Guidelines for safe use, storage, and disposal
- Promoting safer alternatives for pain management
- Accessing resources and services

PLEASE REGISTER at
NJHealthyAging.org

****BREAKFAST & LUNCH WILL BE PROVIDED****
****DOOR PRIZES & A SPECIAL CASINO INCENTIVE****

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In Cooperation with the Governor's Council on Substance Use Disorder and the NJ Dept. of Human Services

Partnership for a Drug-Free New Jersey
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OPIOID EDUCATION FOUNDATION OF AMERICA

OFFICE OF THE ATTORNEY GENERAL STATE OF NEW JERSEY

OFFICE OF ALTERNATIVE & COMMUNITY RESPONSES

NJCARES.gov
New Jersey Coordinator for Addiction Responses and Enforcement Strategies

To register for continuing education for today's webinar:

Physicians, physician assistants, nurses, nurse practitioners, dentists, pharmacists, other: knockoutday.drugfreenj.org/sept11

EMT: KnockOutDay.DrugFreeNJ.org/EMT

Athletic Trainers: KnockOutDay.DrugFreeNJ.org/Trainers

UPCOMING WEBINAR

Knock Out Opioid Abuse Day: Evaluating Recent Progress to Address the Opioid Epidemic

11 a.m. Thursday, October 9, 2025

Register at KnockOutDay.DrugFreeNJ.org/events

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