

In this issue...

*In 2003, the Central East published an article in the Dialogue on the basics of Hepatitis C. In an effort to give our readers the most up-to-date information on issues related to substance abuse treatment, we decided to revisit the issues of Hepatitis treatment and prevention. In this issue we have reprinted a December 2007 article from NIDA's **Addiction Science & Clinical Practice Journal on Hepatitis C.***

Hepatitis C for Addiction Professionals

By Diana Sylvestre, MD

Despite this authoritative guideline, most addiction specialists encounter difficulties in referring patients for hepatitis C viral testing, liver biopsy, or treatment. Indeed, addiction specialists struggle to provide access to basic services such as hepatitis C virus (HCV) screening and hepatitis A and B vaccinations. The discrepancy between expert endorsements for treatment and the reality of treatment unavailability frustrates substance abuse patients and their caregivers all the more, because antiviral therapy for HCV is quite effective. Data suggest that more than 50 percent of treated individuals will produce virus-free blood samples for years (Fried et al., 2002; Manns et al., 2001).

Although lack of access to treatment is a glaring problem, despair appears unwarranted. The natural history of HCV infection is typically more benign than many people realize. With aggressive risk reduction, the majority of patients will remain healthy even without treatment (Thomas et al., 2000). Moreover, an evolving body of data suggests that those addicted individuals who do need treatment can have successful outcomes despite multiple so-called barriers, especially if treatment takes place in a setting that can address their special needs (Backmund et al., 2001; Edlin, 2002; Sylvestre et al., 2005).

Addiction specialists can contribute critically to alleviating the impact of the hepatitis C epidemic. The education and lifestyle stabilization that treatment provides are vital aids to interrupting the chain of viral transmission and helping infected individuals maintain or recover their health. This article aims to familiarize readers with the fundamentals of hepatitis C so that they can maximize their effectiveness on behalf of their patients.

Hepatitis C Treatment Basics

Is there a cure for hepatitis C? Based on what we now know, the answer is, "probably." Approximately 55 percent of patients who complete their prescribed course of antiviral medications have no detectable virus in their blood 6 months later (Fried et al., 2002; Manns et al., 2001). Long-term studies of patients after they achieved this benchmark, called the sustained virologic response (SVR), showed that the vast majority remained virus-free after years of additional follow-up (Lau et al., 1998; Swain et al., 2007). Therefore, hepatologists generally concur that SVR is probably synonymous with cure, much as cancer relapse becomes increasingly less likely as tumor-free years accumulate. The belief that HCV has been eradicated when it does not reappear in blood tests over years is strengthened by the fact that it is an RNA-containing virus. As such, it lacks the ability of HIV and some other viruses to hide inside human cells by integrating itself into human nuclear DNA. Although some researchers have reported that viral genetic material may persist in the white blood cells or livers of sustained responders, the clinical data look very promising—so yes, antiviral therapy probably can cure hepatitis C. The mainstays of hepatitis C treatment are interferon and ribavirin. Interferon is a natural cytokine produced by the body in response to viral infection. When taken in pharmacologic doses, interferon enhances the body's immune response to hepatitis C and may lead to viral eradication. Interferon is now available as a long-acting conjugate with polyethylene glycol, called pegylated interferon, which allows for weekly dosing via subcutaneous injection. Ribavirin, a nucleoside analog, does not work as a mono-therapy. Instead, it works in synergy with interferon and approximately doubles the SVR rate. Patients typically take two or three 200-mg ribavirin pills twice daily.

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As mentioned earlier, the genotype is the primary determinant of treatment duration and medication dosing:

- HCV genotype 1, found in about 75 percent of U.S. patients, is relatively resistant and requires 48 weeks of treatment with interferon and 1,000 to 1,200 mg of ribavirin daily. SVR rates obtained with this genotype are around 40 to 45 percent.
- Most of the remaining patients have genotype 2 or 3, both of which are much more responsive to therapy. They generally require only 24 weeks of treatment with interferon and 800 mg of ribavirin per day. New data suggest that some patients may achieve satisfactory outcomes with only a 12- to 14-week course of medication (Dalgard et al., 2004; von Wagner et al., 2005).
- Patients who have one of the less common genotypes 4, 5, or 6 receive regimens like that for genotype 1 and exhibit similar SVR rates. Unfortunately, many patients will not achieve complete virologic clearance with the current treatment regimens. Even so, a sizeable fraction of these patients experience stabilization or even reversal of their liver damage while on treatment (Poynard et al., 2001). There are a number of options for patients who remain actively infected following treatment, such as extending the duration of therapy, increasing the medication dosage, or using different interferons. Patients may also benefit from a low-dose maintenance regimen of interferon, which preliminary studies indi-

cate may inhibit the progress of liver damage. Lastly, because HCV-mediated liver damage often proceeds slowly, many patients may reasonably wait for the new hepatitis C treatments that are expected to improve outcomes in the coming years. These patients can be monitored every 6 to 12 months, and their livers biopsied every 4 to 5 years.

Medication Side Effects

Unfortunately, combination therapy with interferon and ribavirin is very costly and has an onerous side effect profile. First, it shrinks the wallet. Although free interferon and ribavirin are readily accessible through programs for indigent patients, the cost of \$15,000 to \$25,000 per treatment course dictates careful consideration of each patient's treatment need and readiness. Interferon causes flu-like symptoms. Although they can be distressing, they seldom threaten patients' commitment to treatment, because they peak in the early weeks when patients are the most motivated. The medication's more insidious neuropsychiatric symptoms, including fatigue and insomnia, are much more likely to wear the patient down and lead to early treatment discontinuation (Gish, 2004; Kim and Saab, 2005).

In addition, interferon lowers the platelet and white blood counts, a concern particularly when the patient is an active injector because of the risks of bleeding and infection. Ribavirin can produce potentially severe hemolytic

The Course of Hepatitis C

Hepatitis C is the most common blood-borne illness in the United States (Alter, 1999; Sulkowski, 2001). More than 4 million Americans have been exposed to the virus, and 2.7 million are thought to be chronically infected, making this disease four to five times more widespread than HIV infection. Hepatitis C is the most common reason for liver transplantation in the Nation and causes 10,000 to 12,000 deaths annually (Centers for Disease Control and Prevention (CDC), 1998). Because HCV transmission occurs primarily through exposure to infected blood, injection drug use is now responsible for the majority of new and existing cases of hepatitis C (Alter and Moyer, 1998). Some 70 to 96 percent of long-term injectors have been exposed, about half of them during their first year of injecting (Garfein et al., 2000). Blood-to-blood contact transmits HCV from person to person very efficiently; thus, people can acquire it through sharing not only

needles and syringes, but also other injection equipment, including cottons, cookers, and rinse water (Hagan et al., 2001). Risk may also attend sharing or reuse of:

- Cocaine-snorting paraphernalia such as straws or tubing, because the drug produces intranasal bleeding (Conry-Cantilena et al., 1996);
- Tattoo needles, razors, and toothbrushes used by infected individuals. Sexual transmission occurs in fewer than 5 percent of stable monogamous relationships (CDC, 1998). However, sex with multiple partners or sex when either partner has a sexually transmitted disease raises the transmission risk (CDC, 1998). Vertical transmission is uncommon, affecting about 5 percent of children born to infected women. Fortunately, hepatitis C does not usually lead to significant clinical problems during the first two decades of infection. Although estimates vary widely according to the

population studied, overall only about 10 to 15 percent of chronically infected persons develop cirrhosis, with the associated risks for end-stage liver disease and hepatocellular carcinoma, after 20 years (National Institutes of Health, 2002). Disease progression occurs more commonly in males, individuals who acquired their infections at older ages, and those with concurrent hepatitis B or conditions associated with immunosuppression, such as HIV infection (Thomas et al., 2000). In addition, alcohol ingestion of 30 g/day in men or 20 g/day in women accelerates liver damage (Poynard et al., 2001; Schiff, 1997). Interestingly, some evidence suggests that hepatitis C may follow a more benign course when contracted via injection drug use, despite the potential risks of ongoing injecting behaviors and alcohol consumption (Wilson et al., 2006).

anemia. To keep hemoglobin levels in a tolerable range while maintaining a therapeutic ribavirin dosage, many patients take weekly—and expensive—injections of the red blood cell promoter erythropoietin. In susceptible patients, hepatitis C treatment can promote the development of autoimmune thyroid disease and the exacerbation of other autoimmune conditions such as rheumatoid arthritis, lupus, and psoriasis. Patients should be monitored for signs and symptoms of these diseases and conditions (e.g., thyroid blood tests every 12 weeks). Approximately one-third of patients experience interferon-mediated psychiatric reactions, including severe depression, mania, and psychosis (Fontana, 2000; Hauser, 2004). Treatment-related suicides have been reported. In light of these risks, many clinicians understandably hesitate to treat patients for hepatitis C if they have a history of psychiatric illness. This practice imposes a major barrier to treatment access for drug abusers, many of whom have co-occurring mental illnesses. However, a number of small studies have demonstrated that, with monitoring and appropriate medications, patients with pre-existing mental illness have side-effect profiles and treatment outcomes similar to those who do not (Pariante et al., 1999; Van Thiel et al., 1995).

Prospects for New Medications

What about new treatments? An impressive pipeline of less toxic HCV-specific medications, including protease and polymerase inhibitors, is in the works. Patients who can wait for them to become available should do so. However, patients who need treatment now should not delay in anticipation that miracle drugs will arrive in the very near future. The first new medications are not expected to be approved until [late] 2009 or 2010 at the earliest. Moreover, these drugs will probably be used in combination with interferon, at least initially.

Managing Hepatitis C in Drug Abusers

The data from large-scale clinical trials of hepatitis C treatment, while robust, tell us little about the sorts of outcomes HCV-infected individuals with addictive disorders can anticipate. These trials routinely excluded active drug users; most made psychiatric illness a cause for ineligibility; and many would not even admit patients maintained on methadone. However, a growing body of data suggests that drug abusers, even those with multiple potential barriers, can participate successfully in hepatitis C therapy. In the first reported study of its kind, Backmund and colleagues (2001) recruited 50 heroin injectors for hepatitis C treatment at the time of their enrollment in a methadone detoxification program in Germany. Using standard interferon mono therapy or interferon-ribavirin combination therapy, the group attained an SVR of 36 percent, with no significant hepatitis C outcome differences among those who

relapsed and returned to treatment, those who relapsed and did not return to treatment, and those who did not relapse. In another study of hepatitis C treatment in methadone-maintained patients, Mauss and colleagues (2004) prospectively treated HCV infection in 100 individuals, half in a methadone program and half either having no history of addiction or addicted but not using methadone for at least 5 years. Although those in the methadone group were more likely to stop taking their medications and discontinue treatment during the first 8 weeks, both groups ended up with similar SVR rates, and no participants in either group developed serious psychiatric events.

Similarly, this author and colleagues (2005) at the University of California, San Francisco, showed that in 76 methadone-maintained patients, SVR rates did not differ significantly between the following groups:

- Those with less than 6 months of abstinence from opioids other than methadone (22 percent) and those with more than 6 months of abstinence (30 percent); and
- Those who remained abstinent (35 percent) and those who abused drugs intermittently (21 percent).

Our analysis showed that among these methadone patients, individuals with pre-existing psychiatric conditions were less likely to attain SVR (22 percent) than those without such a disorder (35 percent). Both groups adhered equally to treatment; their SVR differential may have been related to interactions with psychiatric medications or to poorly understood endocrine factors (Sylvestre et al., 2005). Finally, Robaey and colleagues (2006) conducted a retrospective multicenter cohort analysis of 406 treatment-naïve hepatitis C patients. The researchers found no significant differences between participants who had histories of injection drug use and those who did not in terms of treatment compliance (91 percent vs. 92.3 percent) or SVR (46.6 percent vs. 34.6 percent) when the latter comparison was adjusted for genotype. About one-quarter of the drug abusers in this study were maintained on methadone, and a similar proportion injected drugs while on antiviral therapy. Additional encouraging data indicate that, although injection drug use can lead to HCV re-infection after treatment, it is not likely to do so. Dalgard and colleagues (2002) followed 27 injectors who had been treated and attained SVR. Even though 9 returned to injecting drugs, only 1 became re-infected during 5 years (45 person-years) of follow-up. Similarly, Backmund, Meyer, and Edlin (2004) noted that only 2 of 12 injectors treated for hepatitis C reverted to HCV-positive status in 6 months of post-treatment follow up a rate that is comparable to typical rates of post-treatment virologic relapse in non-injecting patients. Although some of these cases may have represented re-infection, the genotype in each case was the same one that the patient had contracted originally, suggesting relapse due to incomplete viral clearance during treatment.

(Hepatitis C, cont. on page 4)

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Why, given these data, does the decision to provide hepatitis C treatment to addicted patients remain controversial? The truth is, successful treatment is possible, but it is not easy. Positive outcomes require expertise in infectious diseases, addiction medicine, and psychiatry preferably in an integrated setting. Few physicians have such comprehensive training, and few sites have structured their programs to integrate all these services effectively. In addition, addicted individuals are more likely than others to be uninsured or under insured and to have additional barriers to access, such as unstable housing or lack of transportation.

Role of Addiction Professionals

Addiction professionals belong on the forefront of efforts to help individuals infected with HCV and to contain the epidemic. Beyond the lifestyle stabilization that is integral to drug abuse treatment, education is usually the most important intervention we can provide. The two critical areas for teaching are avoiding infection and staying healthy if infection occurs. Addiction professionals also are well positioned to help patients negotiate the obstacles to care. We can assist at-risk and infected patients in obtaining a proper diagnostic assessment and treatment when needed. Success in these efforts sets the stage for an additional important dimension of help: support for those who fear liver biopsy and those who face the unpleasantness of medication side effects.

Educate for Prevention

The first, absolutely crucial message to give drug abusers is that all injection equipment, needles, syringes, cottons, cookers, and rinse water—can pick up and transmit the

virus. No part of an injection outfit should ever be shared. Offer this information to non-injecting drug users, who risk rapid seroconversion if they begin injecting, as well as to past or current injectors. Inform drug-using and addicted patients about any programs in your state to make sterile injecting equipment available, either via syringe exchange programs or through direct purchase at local pharmacies without a prescription. Sexual activity is a relatively inefficient way to transmit HCV. According to the CDC recommendations, persons with hepatitis C who are in long-term, stable, monogamous relationships do not need to use condoms, even when one partner is infected and the other is not. However, patients who have other sexually transmitted diseases and multiple sexual partners, factors that increase the risk of sexual transmission of HCV, should always use condoms. We advise patients in these groups to adopt the following policy: no glove, no love. Other hepatitis C prevention measures include covering open wounds and cleaning up spilled blood with bleach. Razors, toothbrushes, and other items that may acquire small amounts of blood, including the straws and pipes used for snorting or smoking drugs, should never be shared.

Finally, every patient confronting the challenges of hepatitis C treatment needs to hear messages of hope. This is doubly true for our more marginalized and needy patients who do not have a circle of supportive friends and family. Regular moral support from within the structure of an addiction treatment program can go a long way toward helping our patients stay the course of treatment and reap the best possible results.

Message from “the Liver Lady” *By Thelma King Thiel*

Motivating messages for your clients that could save their life.

Did you know that your liver is your “Guardian Angel,” your internal chemical power plant? It is also your “silent partner,” working 24 hours a day performing over 5,000 vital functions that keep you alive, alert and healthy. It doesn’t have a “voice” so it can’t tell you it is in trouble until it is badly damaged. You have only one liver and when it goes ... so do you.

Did you know everything you eat, breathe and absorb through your skin has to be refined and detoxified by your liver? It serves as your source of energy and food processor. It filters and removes toxins from drugs, alcohol and environmental pollutants and protects you from

germs that surround you. It makes bile to help you digest your food and absorb vitamins and minerals that make your muscles and bones strong and healthy.

How is your liver doing? Most likely you don’t know because it is a non-complaining organ. Trillions of hardworking liver cells serve as the employees in your liver, your personal power plant. Alcohol, drugs, and hepatitis viruses can destroy those liver cells replacing them with scar tissue, called cirrhosis. In essence, they are making drones out of the employees in your own internal factory. With fewer and fewer employees to do the job, productivity of the liver is reduced and many vital body functions are affected. The first, and

maybe the only sign of liver trouble, is feeling tired all the time. If your liver could warn you, it would put out a sign saying “Going Out of Business.” You are the only one who can assess how quickly that may happen. Now is the time to begin **damage control**.

Drinking more than two drinks a day, using drugs in combination with alcohol, especially acetaminophen, a drug found in Tylenol, Datril and Nyquil, can cause serious trouble. Are you mixing prescribed and over the counter drugs without your doctor’s advice? Do you ever breathe in toxic fumes or get them on your skin? Have you ever shared a toothbrush or razor with anyone? Have you had a tattoo or any part

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of your body pierced? Have you ever used IV drugs or snorted cocaine (even 15–20 years ago)? Do you or have you had unprotected sex with multiple partners?

If you answered YES to any of these questions, you should ask your doctor to test your blood for hepatitis B and C ... and HIV.

Hepatitis B virus is 100 times more infectious than AIDS and is easy to transmit sexually. The virus can live outside of the body for a week or more. Anything that may have infected blood on it that touches your mucous membranes or punctures your skin, can transmit this serious liver disease to you. This disease can lead to cirrhosis and cancer of the liver. Current treatments attempt to hold the virus at bay in those who are chronically infected holding off the development of cancer until a cure can be found. The good news is: there are safe and effective vaccines that can provide protection for 20 years and possibly a lifetime. The Center Disease Control and Prevention recommends that all newborns, 11- and 12-year-old children and adults who

participate in risky behaviors be vaccinated for hepatitis B.

Hepatitis C, also found in blood, is not as easily transmitted sexually. However, snorting cocaine and using injection drugs are frequent modes of transmission. There are 3.9 million Americans infected with Hepatitis C (HCV), most of whom are unaware that they are infected and capable of spreading their infection to others. Treatment of hepatitis C, a combination of interferon and ribavirin, is effective in about 50 percent of cases. HCV is a very slow progressing disease that may take 30 or more years to cause serious liver damage. Unfortunately, there is no vaccine for hepatitis C, so preventive measures are very important especially for anyone who is co-infected with HIV.

Hepatitis A is found in feces. Hepatitis A (HAV) contaminated water and food, such as the frozen strawberries served to children in Michigan and California not too long ago, or raw shellfish harvested from contaminated waters, can cause HAV infection. Another way the disease is spread is through anal/oral sex. Once exposed to hepatitis A, an injection of immune globu-

lin within 14 days of exposure can provide a temporary protection. Vaccines are available for hepatitis A that provide long term protection for 20 years or more. Individuals traveling to countries where the sanitation is poor should be vaccinated 2–4 weeks prior to their trip. It is important for individuals who are HIV infected to be vaccinated against hepatitis A as this co-infection can be life threatening.

Hepatitis C causes about 8,000–10,000 deaths a year in the U.S., hepatitis B, 5000; hepatitis A about 200 deaths.

Unfortunately, most of us don't think about health until something hurts or causes us some kind of distress. Hepatitis and HIV can be silent killers. Check the risk you have taken or are taking and make some healthful decisions about avoiding liver damaging activities. Check with your doctor or call the Hepatitis Foundation International at 1-800-891-0707 for more information. Knowledge is the key to maintaining good health. We owe it to ourselves and our children.

Thelma King Thiel is the president of the Hepatitis Foundation International.

Delaware News

National Expert to Lead Division of Substance Abuse and Mental Health

Governor Jack Markell and DHSS Secretary Rita M. Landgraf have appointed Kevin Ann Huckshorn, RN, MSN, CAP, ICADC, Director of the Division of Substance Abuse and Mental Health. Throughout her distinguished career, Ms. Huckshorn has gained national prominence in the field of behavior health as the Director of the Office of Technical Assistance at the National Association for State Mental Health Program Directors (NASMHPD) and the National Coordinating Center for Seclusion and Restraint Reduction.

“Kevin Ann will work with the dedicated staff at the Delaware Psychiatric Center to provide the quality care that its patients deserve,” Markell said. “She is also committed to giving Delawareans with substance abuse problems the opportunities to receive they need to begin turning their lives around. She is the right person to lead the division during the historically challenging times Delaware is facing.”

“Mental health and substance use services have been much more than just a career or job for Kevin Ann; it has been her life’s mission,” said DHSS Secretary Rita M. Landgraf. “With Kevin Ann, the Division and the DPC will have a level of expertise and support to advance our human efforts in trauma based and recovery care. She is committed to ensuring that effective treatments result in positive outcomes for the individuals we serve.

“As a licensed and certified mental health nurse and substance abuse clinician, Ms. Huckshorn brings a practical

knowledge from 26 years of professional frontline experience working in a variety of public and private mental health organizations and systems and substance abuse programs.

“She possesses a rare understanding and experience in the field of behavioral health care and seclusion and restraint reduction, as well as the ability to ensure that best practice methods are common throughout our system,” explained Landgraf. “With Kevin Ann on our team, Delaware will be in the forefront of behavioral healthcare and substance abuse treatment and prevention practices.”

Kevin Ann Huckshorn is a recognized national and international thought leader in mental health and substance use, has numerous published works, and is a recognized keynote speaker at industry functions on such issues as the prevention of violence and the use of seclusion and restraint in mental health settings. She also represents the state mental health agencies on the Joint Commission Professional Advisory Committee for Behavioral Health and is on the editorial boards of three U.S. peer reviewed mental health journals.

Delaware Health and Social Services is committed to improving the quality of the lives of Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations.

Washington, D.C. News

The Addiction Prevention and Recovery Administration (APRA) collaborated with the Central East ATTC to coordinate the Addiction Severity Index (ASI) and Treatment Planning M.A.T.R.S. training for the District of Columbia providers participating in the Drug Treatment Choice Program and other community based programs. The primary goal was to transform required data into individualized treatment plans and make referrals match to client needs. The collaboration extends to the DSM-IV, ASAM, a second round of the Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT) trainings for the District of Columbia. Also, the GAIN I will be conducted for providers participating in the Adolescent Substance Abuse Treatment Expansion Project (ASTEP). By incorporating evidence-based practices in their clinical

programs, ASTEP participants will strengthen their service delivery infrastructure and improve treatment outcomes. APRA will continue to support the dissemination of evidence-based practices to ensure that District residents have access to quality treatment services.

NOTE: APRA has on-going HIV/AIDS training with emphasis on Ora-Quick Advance testing. APRA has also collaborated efforts with the Office of GLBT Affairs to introduce a 2-hour training “Creating a Diverse, Harassment-Free Environment” which covers the Human Rights Act of DC and how it applies to the workplace as well as interacting with customers. It also includes information on GLBT (Gay, Lesbian, Bi-sexual, and Transgender) sensitivity and sexual harassment.

Maryland News

In the report, *Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment*¹, a panel of experts unanimously adopted six recommendations. One of these was to sustain State focus and attention on substance abuse issues: "State advisory councils should be created or revived with enough staff and authority to hold elected officials accountable for providing needed leadership..."²

The Maryland State Drug and Alcohol Abuse Council was re-authorized by Governor O'Malley in July 2008, affirming his administration's dedication to eliminating this major health and safety problem in Maryland. Recognizing the cross cutting nature of substance abuse and its consequences, this Council brings together multiple stakeholders with the intent of promoting collaboration and coordination in improving and sustaining a comprehensive substance abuse service delivery system for Maryland citizens.

A central task of the Council is to prepare, for submission to the Governor, a two-year, statewide, strategic plan that addresses the priorities, gaps in service delivery, and prom-

ising practices in substance abuse services in Maryland. To achieve this end, the Council has established three workgroups. The Safer Neighborhoods Workgroup is responsible for making recommendations for the strategic plan to address service delivery issues for the criminal justice and juvenile justice populations. The Healthier Maryland Workgroup is to do the same for the general public and individuals with co-occurring problems. The third workgroup, the Planning and Coordination Workgroup, is to review the recommendations of the other two workgroups, review the plans submitted by the jurisdictions for input into the state-wide plan, conduct a state-wide survey of available resources for substance abuse services, and prepare the final version of the plan to be submitted to the Governor.

Please visit the Council's website: www.maryland-sdaac.org for more information.

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²Ibid, p. 5.

New Jersey News

A DAS initiative that began in the fall of 2008 provides funding to two New Jersey universities, Rutgers (at both the New Brunswick and Newark campuses) and William Paterson, in Wayne, to enable them to provide recovery and substance-free housing to students in recovery, students at risk of a SUD, and students not in recovery who choose not to misuse alcohol and illicit drugs, with a supportive community that promotes physical, psychological, social, and spiritual health. By providing this support, it is easier for a student that is in recovery to thrive in the college setting and work toward their academic goals. It also provides comfort to families who have to deal with the fears and reservations of letting their recovering loved one enter an environment that is well-known for drinking and partying.

The program at Rutgers, New Brunswick has been in existence for 25 years, and, in addition to housing for up to 22 students, provides an array of evidence-based recovery support services. The program in Newark provides housing for eight students. William Paterson University has dedicated an entire dormitory for the program with the first floor reserved for students in recovery and the second and third floors designated as substance-free. In addition, William Paterson also provides extensive services to students in recovery.

Programs at Rutgers are overseen by Lisa Laitman, MSED, LCADC the Director of Alcohol and Other Drug Assistance Program for Students, while Glen Sherman, Ph.D., Associate Vice President and Dean of Student Development, directs the program at William Paterson.

(Hepatitis C references cont. from page 5)

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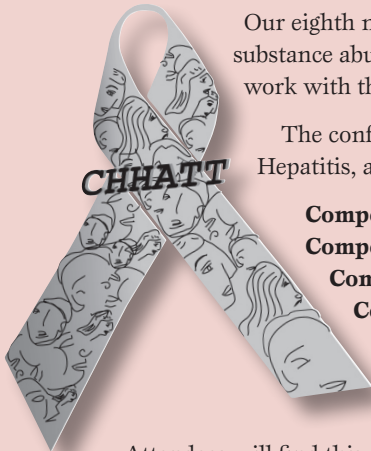
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 - Competency 2** – Understanding Chemical Dependency
 - Competency 3** – Understanding Disease and Wellness in the Context of Drug Use
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