NATIONAL ASSOCIATION OF LESBIAN AND GAY ADDICTION PROFESSIONALS

NALGAP Reporter

Serving the Lesbian, Gay, Bisexual, and Transgender Communities since 1979

Volume. XVV, No. 1 Spring, 2007

NATIONAL AND REGIONAL ACTIVITIES

NALGAP Holds 2006 Annual Meeting in California

NALGAP's 2006 Annual Meeting, held conjointly with the NAADAC-CAADAC Annual Conference in Burbank, CA, September 28-October 1, was an all-around success.

NALGAP BOARD MEMBERS WELCOME RECEPTION SPEAKER, ACTOR MALCOLM GETS.From Left to Right, Rear: President Joe Amico, Ralph Rynes, Michael Ralke, Malcolm Gets, Phil McCabe Front: Dr. Margaret Charmoli, Dr. Penelope Ziegler, Edwin Hackney, Cheryl Reese

NALGAP presented seven Workshops, all of which were well-attended and generated active audience participation and lively discussion.The seven workshops are listed in the box below.

Joe Amico, MDiv, CAS, NALGAP President, Cheryl Reese, LPC, NALGAP Secretary, and two other NALGAP Board members, Marge Charmoli, PhD and Penny Ziegler, MD, participated with members of NAADAC and CAADAC on a plenary Diversity

Seven Workshops presented by NALGAP:

- What Every Counselor Needs to Know When Working with GLBT Clients- Joseph Amico, MDiv, CAS, LISAC
- HIV/AIDS: The Alcohol and Other Drugs Connection- Ralph Rynes, PhD, NCAC
- Clinical Issues in Assessing Client Sexual History-Edwin Hackney, MSW, LCSW, CADC
- Sex Addiction- Neva Chauppette, PsyD
- Addicted Gay and Lesbian Clients with Co-Occurring Psychiatric Disorders- Penelope Ziegler, M.D., FASAM
- From Party and Play to Clean and Sober - Joe Amico, MDiv, CAS and Phillip McCabe, SW,CAS
- Sexual and Spiritual Recovery for GLBTs- Scout Ponder McNamara, LPC, LISAC and Jean Ponder Soto, PhD

NALGAP leadership and members attending felt this year's Conference was a great success and that we were able to generate new energy and new direction for the organization.

Panel on Thursday morning, discussing a broad range of special interests and needs in the treatment of addiction. On Thursday evening, NALGAP presented a dessert reception with special guest Malcolm Gets, star of TV's *Caroline in the City* and the film *Adam and Steve.* Malcolm spoke with deep emotion and humor about his personal experiences in addiction and recovery. The reception attracted a standing-room-only crowd, and was one of the highlights of the conference's social events.

At the NALGAP Membership Meeting Luncheon on Saturday, a number of new members joined our organization, and former members renewed their interest in the work of NALGAP. One physician who attended expressed his need to learn more about the special issues of the addicted GLBT health care professionals with whom he works in his practice of addiction medicine and in his work with the California Diversion Program for impaired physicians. International attendees from Canada and Australia were enthusiastic about networking and becoming involved in our organization's activities. One new NALGAP member from a Midwestern state, who had not been aware of our existence previously, was enthusiastic about getting to know more transgender addiction professionals and stated, "I'm very excited to learn that there is an organization that promotes scientific research as well as networking among professionals who are dedicated to meeting the special needs of addicted persons in the gay, lesbian, bisexual, transgender, intersex, queer, etc., communities."

At the President's Dinner on Saturday night, NALGAP presented its Finnegan-McNally Founder's Award to Robert Cabaj, M.D. The award was presented by NALGAP President Joe Amico and Vice President Phil McCabe, since founders Dana Finnegan, PhD, CAC and Emily McNally, PhD, CAC were unable to be with us to present the award themselves. However, the founders sent their warm regards and congratulations to Dr. Cabaj, a long-term friend and fellow pioneer in recognizing the critical role of alcoholism and

NALGAP BOARD MEMBERS WITH FOUNDERS AWARD RECIPIENT BOB CABAJ. Left to Right Standing: Cheryl Reese, Joe Amico, Bob Cabaj, Phil McCabe, Ralph Rynes, Michael Ralke Sitting: Marge Charmoli, Edwin Hackney

other drug dependencies in the mental health concerns of the GLBTQ community. Bob Cabaj accepted the award with fond memories of his many years of association with NALGAP and his efforts to increase awareness of the need to recognize sexual diversity and diverse sexualities in the fields of addiction and psychiatry.

During his acceptance speech, he made reference to his role as "agent provocateur," making the addiction field uncomfortable and stirring it out of its complacency. He proceeded to do so again by challenging members of the audience to examine their attitudes and their silence in several important areas: the spread of HIV/AIDS and other STDs in minority communities; the increase of unsafe sexual behaviors among young gay and bisexual people associated with use of alcohol and drugs; the risks of rigid definitions and compartmentalization; and the encroachment of politics and moralization into scientific research and medical practice.

Overall, the NALGAP leadership and members attending felt this year's Conference was a great success and that we were able to generate new energy and new direction for the organization. Joining with NAADAC and utilizing the networking opportunities, enthusiasm, and social justice momentum of that national organization can help NALGAP to overcome some of the negative influences of recent political trends as well as to broaden our membership base. Next year's NALGAP Annual Meeting will also be in concert with NAADAC's Annual Conference, in Nashville, TN, September 5-8, 2007. ◆

Tribute to Bob Cabaj from NALGAP'S Founders

Bob–We're really sorry we can't be there to celebrate with you, but we wanted to say a few words to you via our satellite reporter, Joe Amico!

We are thrilled that you are receiving the Founders Award.

As the award states: The Finnegan-McNally NALGAP Founders Award will be given, at the discretion of the NALGAP Board of Directors, to individuals whose professional and/or volunteer activities over a period of 25 years or more reflects the examples set by NALGAP's co-founders, supports and furthers NALGAP's mission, and improves opportunities for LGBT individuals to benefit from substance abuse prevention treatment, and recovery support programs and services.

Given this description, we can think of no one better qualified or more deserving than you. In addition, we wanted to note some of your achievements and our ongoing relationship with you.

We first met you in 1986 when you and Dana became Co-Chairs of the PRIDE National Advisory Board. Little did we know then how gifted you were and how much you would accomplish.

Psychiatrist; Lecturer, Teacher, Educator, Mentor, Supervisor; Researcher, Writer, Editor; Speaker, Presenter; Activist; Board Member; and Good Friend. WOW!

Currently, you are: Director of Community Behavioral Health Services of the San Francisco Department of Public Health; in Private Practice; and an Associate Clinical Professor in Psychiatry,

"You are a man of great integrity and fierce devotion to the causes and concerns of the LGBT communities"

School of Medicine at UC San Francisco.

After you graduated from Harvard Med School in 1974, it seems like you never looked back! Just to name a few positions you hold or have held (many of them volunteer positions)—1987-91 Medical Director, Mental Health & Addictions, Fenway Community Health Center, Boston; Member since 1992, and President from 1994-95 of the Gay and Lesbian Medical Association; Member since 1983, President from 1985-87, of the Association of Gay/Lesbian Psychiatrists; Member since 1985, Board Member from 1990-96, and currently serving on the National Advisory Board of NALGAP.

These are just a few of your activities and contributions. We've read your CV with awe and cannot hope to do justice to your contributions and accomplishments. But we can say this with perfect conviction—you are a man of great integrity and fierce devotion to the causes and concerns of the LGBT communities. And you are a loyal and loving friend.

Thank you for being in our lives. Dana and Emily ◆

Federal Aging Report Explicitly Includes LGBT Elders

The long-awaited Final Report of the 2005 White House Conference on Aging (WHCoA), released by the Administration on Aging, marks a milestone in the fight for the rights of lesbian, gay, bisexual and transgender (LGBT) elders. Months of intensive organizing, including the Task Force-convened Make Room for All diversity summit last December — a counterpoint to the WHCoA — and town hall meetings held around the country have paid off in the explicit inclusion of LGBT elders in the report.

Resolution 34, for example, includes the following implementation strategy: "Expand the definition of minority populations to include — gays, lesbians, bisexuals and transgenders and seniors with disabilities, and increase federal funding to NIH, CDC, Title 3 and other federal agencies to reduce health disparities and promote health promotion programming for all minority populations."

"We refuse to sit on the sidelines and watch as the needs of our community go ignored," said Amber Hollibaugh, a Task Force senior strategist and the nation's premier specialist on LGBT aging issues. "Our community's inclusion in this final report reflects this unwavering principle." ◆

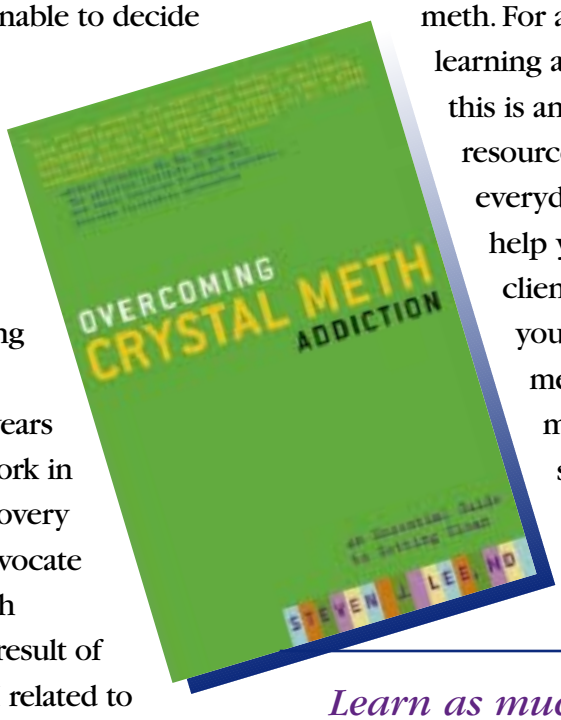
Another Book on Crystal Meth?

By: Mike Rizzo, Program Director: Frank's House/Alternatives

Do we really need another book on crystal meth? " That's what I thought when I was asked to read this book and write this review and the answer is yes, we need this book! Dr. Steven Lee's *Overcoming Crystal Meth Addiction* is a well written and thought out book on this subject. Not only is it accurate in describing what crystal meth is, but it also does a very good job of explaining the dynamic of the drug and why it is so addictive. The book addresses many issues that an addict faces and needs to know in order to obtain and maintain sobriety, such as understanding crystal methamphetamine and addiction, and answering questions such as

what if you don't want to stop, and once you have stopped how do you stay clean, etc.

As I began to write this article I found myself unable to decide from what perspective I should approach the review. I am a gay male with HIV, a recovering crystal meth addict with 9 years of sobriety, I work in the field of recovery and I am an advocate for Crystal Meth Recovery. As a result of all these roles I related to this book on many levels; having both personal and professional experience with the substance, I disagree with Dr Lee on some of the issues brought up in the book and I appreciate his candor and accuracy on others.



Lee states in his introduction that he has written this book from a broad perspective, "because many people use meth," and in trying to reach these audiences the book may be a little too widespread. At times I found myself having to shift gears from addict to counselor; if I did not understand the drug as well as I do, would I relate to what Dr Lee was saying?

As a drug and alcohol counselor this book excited me. I liked many of the concepts that Lee discusses. It does a very good job providing the basics about meth. For a counselor learning about this drug, this is an excellent resource, written in everyday language to help you and your client educate yourselves about meth. One of the most powerful statements that Dr Lee makes in his introduction is that he has five fundamental strategies to overcoming meth, the first one being "Learn as much about crystal meth as you can." Meth is like no other substance and learning how it works is key to combating and overcoming this addiction. Dr. Lee goes on to talk about dealing with the underlying issues around why someone would pick up the drug and continue to use. He addresses self-esteem, social anxiety, depression, crystal and sex, their relationships to HIV and other stressors that would interfere with one's recovery. Dr. Lee supports these chapters with practical exercises that would help an individual discover and resolve these issues.

Learn as much about crystal meth as you can. Meth is like no other substance and learning how it works is key to combating and overcoming this addiction

For an individual who is contemplating sobriety, the book sometimes does not reach them. Specifically when Dr. Lee talks about how meth affects the brain and medications that would be helpful during detox, the narrative gets a little too technical. In my experience, due to poor attention span, if an addict lacks understanding he loses interest, gets easily distracted, may put the book down and not pick it up again. Conversely, if a client finds the book confronting and attempts to deal with issues he may not be ready to face, he may reject the book and become resistant. Another issue to consider is that sometimes even talking or reading about meth may cause some romanticizing of the drug and lead to triggering the client. For that reason this book would be best used in conjunction with structured treatment.

Harm reduction is a controversial issue. As an advocate for

Yes, we need this book; because it not only identifies the problems surrounding meth, it talks about practical solutions to resolve the problem.

Crystal Meth Recovery and what I know about the addictive nature of this drug, I believe in harm reduction as it leads to abstinence. Dr Lee's chapter on harm reduction, in my opinion, is the weakest in content in the book. Dr Lee outlines steps an individual could use to curtail their use such as mapping out how much you want to use and how long you plan to party; setting and knowing your limits; stopping use before you become paranoid; when going out don't take money to buy meth; leave credit cards or ATM cards at home. Dr Lee also states in the book that the very nature of the drug is designed to take the brain hostage and convince it to keep using. I do not know a meth addict who can successfully use harm reduction techniques long term. Addiction is a progressive disease and because of the highly addictive qualities of meth it only speeds this progression up.

I realize I have some bias in this issue, so I decided to read this chapter to my clients without them knowing why I was reading it to them and then I asked them for their thoughts. These clients ranged in time from a few days of sobriety to a few months, most of them under 90 days. The following is what they reported, " I didn't like it, it made me feel I could use and control it"; "It sounds so Pollyanna, following a recipe."; " I don't know my limits."; "It's a way to convince myself I could do it for a week."; " If he's aiming for addicts, he's talking to normies"; " I can't control it."

A final point about the book is that it also talks to the family and friends of a meth user and gives some practical guidelines for dealing with them. Dr. Lee suggests that an individual take a strong stand when dealing with a meth addict and outlines strategies to do that. Though this is a powerful statement to make, it is important for addicts to experience the consequences of their using.

For the most part, this book is an important basic text for learning about meth and how to recover from it. The versatility of this book is that it can be used as a reference guide and the chapters are organized so that you can turn to any part of the book and reference it to deal with any issue you are facing.

Yes, we need this book; because it not only identifies the problems surrounding meth, it talks about practical solutions to resolve the problem. In the last few years advocates have done an excellent job identifying the problem and now it's time to get into action. My hat is off to Dr. Lee for writing the book that takes that step. ◆

Harm Reduction: A Provider's Perspective

By: L. Donald McVinney, MSSW, M. Phil., ACSW, C-CATODSW, CASAC, National Director of Education and Training Harm Reduction Coalition

The Concept of Harm Reduction

Harm reduction is a contemporary perspective, or frame-

work, for understanding drug use and drug users that can guide providers through a broad range of available interventions to meet the needs of diverse clients who use an array of psychoactive substances. A harm reduction perspective allows providers of services and drug users together to establish goals and objectives to reduce drug-related harm that is based on the notion of a client's right to self-determination. Harm reduction has emerged over the last decade in the United States as the new paradigm for intervening with substance users. Harm reduction offers an alternative approach to the moral model (zero tolerance), criminal justice model (the war on drugs), and the biomedical model (sickness and disease) that have dominated drug policy and drug treatment for the last quarter of a century.

Harm Reduction Terminology

Various terms are used to define the concept of harm reduction, some of which have regional currency in different parts of this country and the world and also have differing nuances of meaning. However, for all practical purposes, the terms harm minimization, risk reduction and harm elimination are all captured within the concept of harm reduction.

Historical Context

Historically, harm reduction as a perspective initially grew out of the HIV/AIDS and Viral Hepatitis epidemics in Western Europe. HIV prevention strategies for at-risk injection drug users (primary prevention) and their needle-sharing and sexual partners (secondary prevention) were developed to reduce or eliminate new HIV infection rates. The first application of the harm reduction approach historically was with injection drug users and the first widely publicized interventions targeted behavior change through education and expanded access to sterile syringes through needle-exchange programs. As a form of intervention, needle exchange programs have been extensively researched for outcome effectiveness, among other variables. Published research studies for the last decade have overwhelmingly found needle exchange programs effective as a model of intervention. While many states in the U. S. have changed, or are changing, syringe prescription and possession laws based on this data, resistance and opposition continues to be based, not on science (empirical evidence) or recognized public health principles, but rather on the strident rhetoric of politically-motivated ideologists who claim "it sends the wrong message."

"Harm reduction is an approach that aims to reduce the negative consequences of drug use through utilizing a full spectrum of strategies from safer drug use to moderation management to abstinence."

EDITORS' NOTE: Harm Reduction has long been a controversial concept and treatment approach in the alcohol & drug abuse field, but has slowly gained some acceptance over time. The controversy has often been heated and unclear and sometimes not very rational. Because this is a serious and important topic, we have asked NALGAP member Don McVinney to provide a reasoned and clear explanation of harm reduction, its history, relevance, and applications.

A Working Definition Of Harm Reduction

The definition of harm reduction has changed through time in order to meet the contemporary challenges of public policy and service delivery. Initially, harm reduction was defined broadly in an attempt to allow for its application in diverse settings and communities. However, the original rather vague definition was reworked and the Harm Reduction Coalition developed a more useful and specific working definition, as follows:

"Harm reduction is an approach that aims to reduce the negative consequences of drug use through utilizing a full spectrum of strategies from safer drug use to moderation management to abstinence. Oriented toward working with the whole person, harm reduction programs and policies create environments and develop strategies for change that are practical, humane and effective. These programs meet consumers 'where they are at' to help them become more conscious of the harm in their lives and identify options for reducing those harms. The goal of these interventions and policies is to help people and communities maximize their health and potential while simultaneously reducing harm. While harm reduction is most commonly thought of as an approach to reducing drug-related harm, its philosophy and practice have applications for all professions and communities."

Because the word harm is sometimes lost in the ongoing debates over the meaning of harm reduction and its practical applications, it deserves to be pointed out that it is the first word in harm reduction. Both the definition and the concept of harm reduction equally and explicitly acknowledge the fact that drugs can and do cause harm. The goal of intervention, while intended to reduce, minimize or eliminate entirely the potential for drug-related harm, does not necessarily imply the cessation of drug use. This perspective is clearly consistent with codes of ethics for the helping professions.

Four Prevailing Harm Reduction Strategies

There are four strategies for implementing a harm reduction approach across systems. These are:

1) Education and training for and by clients/consumers (popular education) and for service providers (professional training seminars and conferences);

2) Provision of direct services and programs for individuals, couples, families and groups;

3) Modification of the environment to reduce drug-related harm through coalition building, social action/social justice, and community organizing (for example, the "treatment on demand" campaign); and

4) Changes of public policies to reduce drug related harm to individuals, families, and their communities.

Contemporary Applications of Harm Reduction

Models of intervention and applications of a harm reduction approach are currently broad in scope. Encompassed within the perspective of harm reduction is the belief that the user is the agent of change. When drug users seek help and guidance to reduce drug-related harm, the interventions and goals should be mutually agreed to with the informed consent of the client/consumer and tailored to meet the unique needs of every

(continued from page 12)

Addiction Psychiatric Help: The Doctor is Out...

Dear Dr. Penny:
I'm getting close to 40, and I've been hanging on the club scene for more than a few years now. Several of my friends have gotten into serious medical trouble with crystal, GHB or X recently, having mental breakdowns, heart problems, and breathing difficulties. What's going on here? This stuff didn't used to happen. Are we getting too old to party, or is there something different about the drugs?

— Too Young for the Rocking Chair

Dear Too Young:
I think several factors are operating here. First, these drugs are different from what you were probably using 20 years or even ten years ago. Let's look at methamphetamine, known as "crystal", "Tina", "meth", "ice", etc. As far back as 1969, this drug has been recognized as dangerous and deadly, as indicated by the posters seen around Haight-Ashbury that summer: SPEED KILLS. And the methamphetamine that is being snorted, smoked or injected today is purer and stronger than ever. It can cause vasocon-striction (spasm in blood vessels) in any organ in the body, leading to heart attack, stroke, blood clots, and other medical crises. It also causes elevation of blood pressure and pulse, leading to irregular heart rhythms, strokes and seizures. In many people, the intense overload of dopamine caused by methamphetamine causes psychotic symptoms, especially paranoid ideas. Tactile hallucinations can cause a person to believe that bugs or other creatures are crawling on or under the skin.

The cocaine and marijuana being sold today is also much more potent than a decade ago. Smoking "crack," methamphetamine and/or marijuana is more toxic to lung tissue than smoking cigarettes, although since most people don't smoke crack or pot all day every day, the cumulative effects are less. However, when someone is out of control with one of these drugs and is smoking around the clock, he or she can develop a severe lung disorder known as "crack lung", which restricts breathing and causes constant coughing and wheezing. Pneumonia and other complications are common.

Heroin, being used on the club scene in many areas, is likely to be 10 or more times as pure as it was just a few years ago, and overdoses are much more frequent these days. As for the "street" sedatives like GHB or Rohypnol, there's no telling what you might get when you buy this stuff from a dealer. One law enforcement survey of "Roofies" bought on the street in San Francisco showed that most were diazepam (Valium), some contained other prescription sedatives and/or GHB, and some were over-the counter antihistamines. MDMA (Ecstasy, X), which is both a stimulant and a mild hallucinogen, has been shown

to cause long-lasting, treatment-resistant depression and memory problems, which may be related to impairment or destruction of serotonin neurons in the brain.

Then let's consider the fact that few people today use just one drug. In the clubs or at circuit parties, weekend fetes, etc., most people are mixing alcohol, multiple other brain-active drugs (known as "stacking" or "roles"), and also adding sexual-performance enhancing substances such as "poppers" (amyl nitrite), "Rush" (butyl nitrite) and Viagra. These combinations are often the cause of the serious medical complications. Their chemical actions can cause additive side effects in the brain, and they can block each other's breakdown in the liver, leading to toxic levels of one or more of the drugs.

Dr. Penny

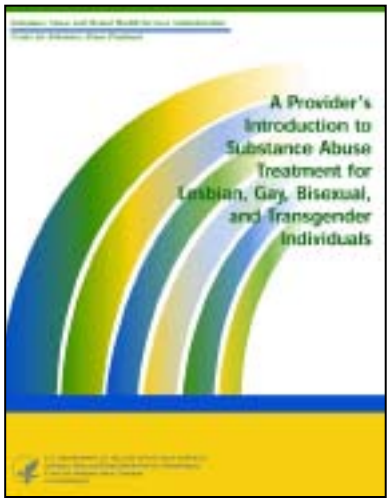
Another factor that may come into play as we get older is the possibility that one is taking other prescription drugs for such health problems as high blood pressure, elevated cholesterol, diabetes, prostate enlargement and glaucoma, to name a few. Drugs used to treat these conditions are very likely to interact with alcohol and other party drugs, causing unpredictable but dangerous results. Of course, if one is taking antiretroviral medications and other treatments for HIV, drug-drug interactions become even more risky.

The relationship between club drug use and HIV transmission and unsafe sexual behavior in the gay community has been studied extensively in the past decade, and the findings are alarming. These drugs impact on judgment and impulse control, frequently resulting in unplanned, unprotected sexual encounters. For more information about club drugs, suggestions for avoiding some of the risks discussed here, or help in getting off these drugs, the following web sites may be useful:

www.lifeormeth.com
www.tweaker.org
www.crystalrecovery.com
www.freevibe.com
www.crystalneon.org

Training Manual for "A Provider's Introduction" finally off to the Presses!

NALGAP received a review copy of *Training Curriculum: A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals* just as this issue of *The Reporter* was going to press!



This is great news! NALGAP was instrumental in getting SAMHSA/CSAT to publish *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals* back in 2001. That document has gone into subsequent reprintings and has become the standard for conference workshops and agency in-services on GLBT issues. The government had promised to publish a training curriculum and to train trainers.

President's Corner

We've come to the end of another year and have begun a new one. It's a time for taking stock, giving thanks, and making resolutions.

2006 was a phenomenal year for NALGAP. We have many reasons to be thankful.

Here are just a few of mine:

• the busiest and best conference season for our small organization

• a new and improved look for The NALGAP Reporter

• thanks to the Cape Cod Symposium for including us as a partner

• thanks to NAADAC and CAADAC for including a NALGAP track throughout a very successful conference and sharing the stage for our Founder's Award

• thanks to Alternatives for providing the NALGAP Receptions, publishing and mailing the Reporter

• thanks to Haworth Press for

sponsoring this issue of the Reporter

• thanks to Rodger Beatty who, after many years on the Board including a long tenure as President, has now stepped down

• thanks to Marty Perry for joining the board and including Pride as an active organization in NALGAP once again

• thanks to Marge Charmoli for rejoining the board and making us more "bi"

• thanks to all my fellow board members who work diligently throughout the year making time for conference calls, answering emails, speaking at conferences, doing regional trainings, representing us at other national organizations, writing and editing The Reporter, etc.

• thanks to CSAT who has announced work on the long awaited Training Manual for *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*

• thanks to a donor who has made a generous $500 donation to NALGAP

• thanks to you for keeping your membership active and supporting the vital work of this organization

That's my short list. I hope as you look over the past year, you will be thankful for the role NALGAP has played in your life or in others' lives as a result of our being in existence. Please examine ways you can be thankful in your own life and then resolve to include NALGAP in 2007 with your membership renewal, extra gifts where possible, volunteering for projects, attending our conference, or serving on the board!

With gratitude,
Joe Amico, President
Joecd1@aol.com

However after years of waiting and non response to phone calls and emails, our Secretary, Cheryl Reese, attended a public hearing last year and asked SAMHSA: "What have you done for the LGBT community lately?"

Longtime NALGAP member and supporter Barbara Warren wrote this training manual and it was reviewed by President Joe Amico at press time. It will be a very useful curriculum complete with Power Point presentation.

Another NALGAP member, Ed Craft, who is Senior Program Analyst in the Division of Services Improvement for SAMHSA is working with NALGAP to have this curriculum premiered at our September Conference in Nashville. Be sure to come to the conference and get the training and the curriculum hot off the press! If you can't come to the conference, stay tuned on our NALGAP website and we'll have info on how to obtain it as soon as it becomes available. ◆

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individual. Not all interventions are embraced by all harm reduction advocates. Among the interventions aimed at reducing drug-related harm as well as drug-related harmful-behaviors are: encouraging consumers to alter their mode of administration of drugs ("switching"); substi-tution therapy (methadone maintenance); drug use manage-ment strategies (moderation and controlled use); "binge" reduction and safety planning (avoiding dehydration; "pay your rent first"); overdose prevention strategies ("learn rescue breathing"); abstinence; and relapse prevention strategies. Harm reduction principles are also currently being used widely and effectively with numerous other contemporary social problems, for instance such self-identified problematic behaviors as compulsive sex, compulsive overeating, compulsive gambling, as well as in the field of intimate partner and domestic violence through contingency safety planning.

The Harm Reduction Coalition is committed to solidifying this movement in order to continue to expand the definitions and applications of harm reduction and protect and enhance our health and well being into the future. ◆

How can we make our treatment facilities safe?

By: Dana Finnegan, PhD, CAC, NALGAP Board Member

SAFETY is the number one issue for anyone struggling to recov-er from the trauma of addiction and for anyone who struggles to deal with and recover from homo-bi-transphobic oppression.

Ways to make treatment facilities safe:

1. Set forth an official policy of ZERO TOLERANCE for homo-bi-transphobia and all forms of oppression.

2. Ensure that every program/ agency conducts an organization audit and adheres to the findings.

a. Especially, agencies/ programs need to review their admissions process from the perspective of LBGT people. Who greets them? How are they welcomed?

b. What is the initial intake like? Is it sensitive? Does it ask as a routine matter what a person's sexual and gender orientation is? Does it ask who the Significant Other is, rather than asking "Are you married?

c. What is family/significant other program like?

d. Are counselors—and all staff, including the maintenance people—trained re stereotypes, diversity, homo-bi-transphobia?

e. Is there zero tolerance for homo-bi-transphobia in the agency? Does the staff know how to deal with intolerance amongst the patients? DOES staff deal with it?—A woman who went to an in-pt. program that provided a "gay group" reported that most of the gays didn't feel safe going to that group because of the homophobia amongst the patients which staff didn't address or deal with.

f. Is the atmosphere welcoming? Are there lists of Special Interest AA/NA meetings displayed? Are books and and other written materials about lgbt people displayed? ◆

NALGAP

Want to Join NALGAP?
Visit our website and register online: www.nalgap.org

NALGAP REPORTER
Published and Edited by:

Dana G. Finnegan, PhD, CAC
drdanafinn@comcast.net

Emily B. McNally, PhD, CAC
emcnally@psychoanalysis.net

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