Preliminary Outcomes of a Model Program for Increasing Treatment Access for African American Women Who Use Crack Cocaine and Are at Risk for Contracting HIV

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Okpaku, S., MacMaster, S.A., Dennie, S., Toliver, D., Cooper, R.L., Rasch, R.F.R. (2010) Preliminary outcomes of a model program for increasing treatment access for African American women who use crack cocaine and are at risk for contracting HIV. *Journal of Evidence-Based Social Work, 7(1-2)*, 41-57. doi: 10.1080/15433710903175871

Abstract:

In the United States, the threat of HIV/AIDS to African American women's health has become the focus of much concern. This paper describes a federally funded community-based program that provides services to African American women at risk for HIV/AIDS in Nashville, Tennessee. The program provides a culturally relevant set of interventions specific to crack cocaine users aimed at reducing substance use and HIV/AIDS risk behaviors. The model is important for the continued development of culturally relevant interventions aimed at reducing the disproportionate rates of HIV/AIDS within the African American community by ensuring treatment access to all populations.

Keywords: HIV/AIDS | African Americans | women | treatment access

Article:

Introduction

There is a growing racial disparity in HIV/AIDS incidence rates that primarily affects African American women. While representing 12.3% of the U.S. population, African Americans represent 49% of all persons living with HIV/AIDS (PLWHA) (CDC, 2007a). For African-American women this disparity is significantly increased, as African Americans represent 64% of all female HIV cases (CDC, 2007b). In Tennessee African Americans represent 16% of Tennessee's population, but account for 72.8% of all HIV cases among women; and, HIV rates were 13.7 times greater for African American women compared to Caucasian women, and 4.8

times greater than other women of color (Tennessee Department of Health, 2007). Within the Nashville MSA, African Americans represent 14.5% of the population, and almost half (46.9%) of the PLWHA. Of greater significance, African Americans represented the majority (53.4%) of AIDS cases diagnosed in the past two years, and the number of African Americans diagnosed with AIDS has risen 16.3% over the past five years in comparison to a 5% rise for Caucasians. The incidence rate for AIDS over the past two years for African American women (31.7%) is nearly twelve times the rate for Caucasian women (2.7%); and the number of both African American and Caucasian women with AIDS is rising. In the past five years the cumulative number of women with AIDS has risen 57.1% in comparison to a 6.8% rise for men (Tennessee Department of Health, 2007). Currently AIDS is the leading cause of death of young (25–34 years old) African American women in this country (NCHS, 2002).

Drug use represents a well-established risk behavior for HIV, primarily as it relates to injection drug use. Other drug users are also increasingly at high risk for contracting HIV due to high risk sexual behavior. Specifically, crack cocaine smokers have been found to be three times more likely to be infected with HIV than non-smokers (Friedman et al., 2003), are less likely to adhere to medical care (Sharpe, Lee, Nakashima, Elam-Evans, & Fleming, 2004), and more likely to continue high-risk sexual behaviors after being diagnosed with HIV (Campsmith, Nakashima, & Jones, 2000). Use of crack cocaine can contribute to the spread of the epidemic when users trade sex for drugs or for money or when they engage in risky sexual behaviors that they might not engage in when not under the influence (Sharpe, 2001; Weiss, Kluger, & McCoy, 2000; Ross, Ywang, Leonard, Teng, & Duncan, 1999;Cottler et al., 1998). Women appear to be at particular risk for HIV infection due to the nature of their role both in the larger society and the crack-using subculture (Evans, Forsyth, & Gauthier, 2002; Mallory & Stern, 2000). Importantly, substance abuse treatment can be effective in reducing HIV risk among crack cocaine users (Hoffman et al., 1998).

However, before an individual can benefit from substance abuse treatment services they must first gain access to, and become engaged with, these services. Without said opportunity, many women are unable to access treatment and engage in treatment once accessed. These women continue to use, contract HIV, and die. Currently AIDS is the leading cause of death of young (25–34 years old) African American women in this country (National Center for Health Statistics, 2002).

There is also a growing awareness of the disproportionate health care disparities affecting African Americans (Institute of Medicine, 2003). While these disparities are important to the larger community of African Americans, there appear to be other factors that primarily affect African American women who use crack cocaine. These women are often in unique environments with specific individual and environmental stressors that have dramatic effects on health outcomes, specifically related to HIV/AIDS.

Only a small percentage (18.2%) of the women who identify a need for substance abuse treatment are able to access it, and there is a definitive gender difference in rates of treatment admissions (National Survey on Drug Use and Health, 2004). Although women use illicit drugs less frequently than men (6.4 versus 10.3 percent of the population) (NSDUH, 2004); analyses of the Treatment Episode Data Set found that from 1992 to 1998 women represented only about thirty percent of all admissions. Importantly, women are also more likely than men to designate cocaine as their drug of choice (DASIS, 2001).

Racial discrepancies also exist, but are less definitive. African-Americans experience substance dependence and abuse at rates slightly higher, but generally comparable to Caucasians, (9.5% versus 9.3%) (NSDUH, 2004). Despite these comparable rates, African Americans, 12% of the population, enter treatment at disproportionately higher rates (24% of treatment admisssions) than the general population (TEDS, 2004). However, the rates for substance abuse treatment admissions for African Americans steadily declined fifteen percent between 1994 and 1999, while rates for admissions for the total population increased three percent (DASIS, 2002). One possible explanation for the higher rates of African Americans in treatment is that a higher percentage (?) of African Americans are involved in the criminal justice system and the criminal justice system is the most frequent source of these referrals (37% of all admissions) (DASIS, 2002). The disparities in treatment access are primarily among African Americans *not* involved in the criminal justice system.

Barriers to treatment access can be thought of as either individually or environmentally based. Individually based barriers to treatment access are often associated with treatment readiness or treatment motivation (Zule, Lam, and Wechsberg, 2003;Joe, Simpson, & Boome, 1998), the lack of desire for treatment, inadequate income, inadequate insurance, and cultural or peer norms. Environmentally based barriers are associated with the structure of the system which prevents access to treatment, such as high fees and long waiting lists for treatment (Wechsberg et al., 2001), even when there is a willingness to enter treatment (MacMaster & Vail, 2002). For African American crack cocaine users, barriers also include lack of transportation, lack of appropriate and affordable childcare, and/or the ability to pay for services (Wechsberg et al., 2003; MacMaster, 2005).

Issues of race and gender that impact the target population may further impact treatment access. African Americans often have unfavorable views of traditional and available approaches to HIV prevention and substance abuse (Longshore, Hsieh, & Anglin, 1993) coupled with a distrust of mainstream social services (Aponte & Barnes, 1995). Models of intervention and treatment developed for middle-class Euro-Americans and may be inappropriate for many African Americans (Cochran & Mays, 1993) as these models assume that people have the necessary resources for accessing care and do not address the barriers to prevention and intervention services. Afrocentric models have been developed which address these barriers to care. These models attempt to provide a framework for preventing HIV, decreasing substance use risk and facilitating treatment access and engagement (Belgrave, Brome, & Hampton, 2000; Belgrave,

Reed, Plybon, & Corneille, 2004;Belgrave, Townsend, Cherry, & Cunningham, 1997). In addition to an African American culture based on race and ethnicity, there appears to be both a drug using culture and a culture of substance abuse recovery (Holleran & MacMaster, 2005). Perceptions of this cultural congruence may also influence treatment access and engagement.

Traditional HIV and substance abuse services have not met the needs of many women. Despite the increasing rate of HIV infection among women, interventions aimed at reducing the spread of HIV have not been developed which address the specific needs of women. In national, cross-sectional studies of perceptions of cultural congruence, the findings suggest that racial and ethnic minority respondents are more likely to perceive bias and lack of cultural competence when seeking health care (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004). These issues of cultural disconnection appear to be particularly problematic for African American women in the Southeast who use crack cocaine when accessing substance abuse treatment services (Brown, Hill, & Giroux, 2004). African American females appear to desire service providers who are able to relate to them as individuals, in trusting, non-judgmental manner and based on their personal experience and/or understanding of the use of crack cocaine and the context of that use (MacMaster, 2006). It is the perceptions of these cultural congruencies that ultimately may influence treatment access and engagement.

PROGRAM DESCRIPTION

The Treatment Access Project (TAP) for African American Women is designed to provide a coordinated continuum of services to individuals at risk of contracting HIV/AIDS. The program builds on the core strengths of three existing and collaborating programs, the Lloyd C. Elam Mental Health Center of Meharry Medical College, which has provided substance abuse outreach and treatment services since 1972, the Metropolitan Interdenominational Church's First Response Center, an African American, faith-based case management program for persons living with or at risk for HIV/AIDS, and Street Works, an outreach program which targets substance users at risk for contracting HIV with late-night and weekend services. The purpose of this community-based collaboration is to facilitate: (a) increased access to comprehensive substance abuse treatment through the removal of current barriers; and (b) an enhanced culturally relevant treatment program which include an intensive treatment program designed to improve retention in services by enhancing treatment readiness and motivation for change. The programs include specific educational interventions focused on HIV/AIDS and Hepatitis C.

Purpose and Goals of the Program

The primary goal of the program is to strengthen the existing collaborative partnership among participating organizations to provide a foundation for a coordinated continuum of culturally competent HIV risk reduction, substance abuse treatment, and other related services to African-American female substance abusers. Ultimately this strengthened collaboration is intended to improve the health and HIV/AIDS risk status of the target population through (a) the removal of

barriers to entering and remaining in substance abuse treatment, (b) reduce the use of alcohol and other drugs, (c) increase motivation to adopt risk-reduction strategies (both substance abuse and sex-related risks), and (d) increase self-sufficiency and psychosocial functioning through improved employment stability, improved housing stability, decreased involvement with the criminal justice system, and improved mental health status.

Framework for Interventions

The program model is based upon an enhancement of the strategies developed as part of the extensively evaluated National AIDS Demonstration Research program and the National Institute on Drug Abuse (NIDA) Cooperative Agreement for AIDS Community-Based Outreach Intervention Research Program, both of which are regarded as the best practice models for reaching out to treatment substance users (Needle & Coyle, 1997; Needle & Coyle, 1998). The intervention approach used in TAP is also rooted in the Trans-theoretical, or “stages-of-change” model (Prochaska & DiClemente, 1992), viewing changes in addictive behaviors as a process requiring movement through a series of five stages of behavior change. The state of the art outreach intervention implements a protocol that takes into account that not all at-risk individuals will be at the same stage of change with regard to their substance abuse or sexual risk behavior. The content of the street intervention is tailored to the participant's current stage of change. Street outreach implies that most at risk individuals are not in treatment and many will be at the pre-contemplation and early contemplation stages. For these individuals the key challenge is to create the motivation for change. Initial outreach contacts are structured to employ motivational interviewing strategies.

Outreach is followed by pretreatment services, which are an enhancement to existing treatment services. The design utilizes a motivational interviewing approach (Miller & Rollnick, 1991) to delivering pretreatment services, and borrows heavily from the experience of Wechsberg and colleagues (2005) in North Carolina. Motivational interviewing is a directive, client-centered counseling style for achieving behavior change by facilitating exploration and resolution of ambivalence. This is a focused and goal-directed approach. Change is encouraged by assisting clients to identify and capitalize on their own intrinsic reasons for change.

Components of the Program

Outreach activities target African American women who use substances, specifically crack cocaine. Meharry Outreach teams (from Project Community Outreach Prevention and Education [COPE] and SISTER) target African American women who live in public housing and who are currently using alcohol and/or other drugs or who are in early recovery. Street Works targets sex industry workers, many of whom are also using alcohol and other drugs. From the front-end of the continuum (outreach activities), this program addresses access related obstacles of timing and trust. Outreach-efforts can be severely handicapped because many members of the population are simply not out in the community during the agencies' hours of operation. Synergy created

between Meharry and Street Works Outreach teams allow for a much-increased probability that the target population is reached, because of the 24-hour-7-day-week capabilities of the collaborative. Each agency has established trust in the community relative to specific locations and general times of day/night. Through cooperation, obstacles of timing and trust are overcome. Larger numbers are reached through expanded human resources, while the chances of engagement are increased through established and trusting relationships between the agencies and community.

Pre-Treatment Services: Once the client is engaged through outreach efforts she is recruited to pretreatment services. Collaborative efforts continue to address issues of trust by beginning to establish a support network for the client both by the providers and the clients themselves. The competency the SISTER Program has developed over the years in the area of building support among African American female substance abusers is legendary. The fact that the majority of SISTER's staff members are themselves recovering African American females helps enormously in trust and support building efforts. This, coupled with Street Works' reputation as a street savvy agency (with staff that have been-there-and-done-that), facilitates an environment that engages this population in pretreatment interventions. Proven pretreatment intervention techniques such as brief intervention, prescreening, and motivational interviewing, combined with street smarts, support-building experience, and trust facilitate clients' entry into treatment and improve their prognosis for treatment and recovery. Here the goals of access and retention are addressed simultaneously. Motivation for treatment facilitates hope and the desire to access treatment while planting the seeds needed to become engaged in the treatment process.

Case Management: Once the client decides to enter treatment a First Response Center case manager is assigned to her. The case manager provides continuity between outreach, pretreatment, and treatment. Case management is based on an alcohol and drug abuse services coordination model and is customized to address the specific needs of African American women, while simultaneously integrating HIV/AIDS services. The case manager performs a needs assessment, and develops a case management plan to facilitate the removal of obstacles to the treatment and recovery process, which is directly linked to the goal of retention.

Substance Abuse Treatment: Women have been transitioned to a number of community substance abuse treatment providers, however the majority has entered treatment at the Elam Center. To remove obstacles to access for a subset of the target population, pregnant and postpartum women and their children, the capacity of the Elam Center's Rainbow program was expanded. Some of the most difficult substance abuse treatment services to access include long-term residential services for pregnant and postpartum women. The Rainbow program is the only such program in the middle Tennessee area, thus continuously operates with a waiting list. Expanding Rainbow's capacity and designating the expansion to African American women clearly addresses the goal of treatment access as it pertains to this subset of the target population.

METHOD

Design

This study involved a single group design (aggregating program participants over the duration of the project), with repeated measures of program outcome indicators at program intake (baseline) and at 6-months post-intake that examined changes over the course of program participation (Cook & Campbell, 1979). The major strengths of the evaluation for establishing program effectiveness were (a) using program participants as their own controls with data from baseline, 6-month follow-up interviews and (b) basing the evaluation upon a centralized management information system to allow program monitoring and outcome evaluation. Within the first three and a half years of the project a total of 207 individuals received services, and data for 153-paired individuals who completed both an intake and a six-month interview is available for analysis. Yielding a response rate of 73.9%.

Sample

Demographics: Over the three and a half years of the project, 207 individuals completed an initial interview and provided their own demographic information (see Table 1). In line with the focus of the project, all participants are women and reported their race as African American or multi-racial; one of the participants indicated that her ethnicity is Hispanic/Latino. As a group, the participants were young, average age is 36.4 and almost all (78.1%), of respondents, were below the age of 45. Average educational attainment was below the high school level and averaged 11.65 years. More than half (50.7%), of the respondents have received a high school diploma, however an additional proportion (3.4%), reported obtaining a GED. The majority (79.7%), of the respondents, were housed, with more than a third (35.7%) of these individuals, housed in their own apartment or home. Those individuals who were permanently housed, but did not live in their own home or apartment (34.3%), lived in someone else's home. Almost all (89.4%) of the respondents, were unemployed.

Table 1. Demographics

Demographic	Categories	N = 207
Age	18–24	12.1%
	25–34	29.6%
	35–44	36.4%
45–54	20.4%	
55–64	1.5%	
Gender	Female	100%
Ethnicity/Racial Background	African-American	94.7%
	Multi-Racial	4.8%
Hispanic/Latina	0.5%	
Housing Status	Housed	79.7%
	Homeless	9.2%
	Shelter	3.9%
	Institution	7.9%

Questions regarding parenting were added in the second year of the evaluation. The majority of respondents who were asked the question (89.4%), reported they were mothers. A total of 374, an average of slightly more than two and a half (2.87) per participant in the program were reported. Additionally, 12 respondents reported being pregnant. One hundred and thirty-eight of the mothers who were asked (40.9%), had children in someone else's custody due to a child protection court order. Additionally 32 of the children had the experience of their mother having her parental rights terminated. It is important to note that due to changes in data collection, these questions were only asked of women entering the program in the last two years.

Reasons for Seeking Services: All of the participants reported that they sought treatment on their own and were not coerced into services by the criminal justice system, an employer, or any other entity. All program participants were referred through the street outreach programs described in the collaboration.

Drug Use Characteristics. In concert with the focus of this project, cocaine was the most frequently reported substance used in the last 30 days prior to accessing services (81.2%) (Table 2). High levels of alcohol (62.3%), and marijuana (37.8%), accounted for almost all of the remaining reported drug use. There was very little reported use of heroin and methamphetamines.

Procedures

Research protocols included procedures to ensure that all individuals were providing informed consent to be interviewed. After the outreach worker made initial contact and the individual agreed to seek substance abuse treatment, he/she was introduced to the intake worker. The intake worker explained what the project was about and what services were available through program participation. The participant was introduced to the evaluation component of the project as involving a baseline interview with follow-up interviews at 6 and 12 months. Confidentiality procedures were explained and informed consent obtained. An additional incentive ($20 food voucher) was offered specifically for completion of the follow-up interviews but not the initial intake interview. Participants were assured that they could refuse to participate in the interviews and still receive services. Consenting participants were interviewed in privacy in a separate room to maintain confidentiality.

Table 2. Characteristics of Drug Use in the Last Thirty Days

Categories (used the following in 30 days)	***N* = 207**
Cocaine	81.2%
Alcohol	62.3%
Marijuana	37.2%

Benzodiazepines	4.7%
Tylenol 2,3,4	3.4%
Codeine	2.9%
Heroin	1.0%
Methamphetamines	0.5%

To facilitate the follow-up interviews, participants provided contact information for themselves as well as two family members or friends who would know how to reach them. Follow-up interview dates and available contact information on respondents was provided to outreach and peer counselor staff who contacted program participants. Where initial efforts were not successful, contacts were attempted through peers, family, or friends in the community. If there was an indication that participants may have died or entered the criminal justice system, efforts were made to confirm their current status through official channels. Institutional Review Board approval for research with Human Subjects was applied for and obtained through Meharry Medical College.

Measures

The Government Performance Results Act Instrument (GPRA) was used to document changes in participant behaviors. The instrument is originally based on items found on the Addiction Severity Index (McLellan et al., 1980) and the NIDA Cooperative Study Risk Behavior Assessment (NIDA, 1991) both instruments have high levels of both standard reliability and validity, and have been used extensively with similar samples.

Data Analysis

Descriptive statistics were analyzed to characterize the study sample in terms of demographics; drug use and prior drug treatment; HIV risk behaviors; HIV knowledge, attitudes, and behavioral intentions regarding risk reduction; prior STD history; psychological functioning; and employment and housing stability. These analyses provided a baseline description of the study sample from which changes over time could be assessed.

Analyses of changes from baseline on principal program outcomes (frequency of substance use, HIV risk behavior frequency, entry into substance abuse treatment) and changes from baseline on intermediate outcomes (knowledge, attitudes, and behavioral intentions regarding risk reduction) were assessed using *t*-tests. The important analytic questions regarding program effectiveness involved the magnitude of changes from baseline on outcomes (to be assessed not

only in terms of significant contrasts on means but also through consideration of effect size estimates of changes from baseline).

Table 3. Cumulative Mean Number of Days Using Within the Past 30 Days

Substance	Baseline	6-months	% Decrease
Alcohol*	7.61	2.29	69.9%
Cocaine*	12.02	2.99	75.1%
Marijuana*	4.05	2.04	49.6%
Heroin	0.20	0	100%

*Statistically significant difference on paired samples *t*-test

RESULTS

Substance Use Behaviors

In terms of self-reported substance use, change in substance use rates within the last 30 days is depicted in Table 3. Not surprisingly, these rates fall, however the level that they are reduced to is significant as almost all respondents reported abstinence or near abstinence six months after entering the program. In line with the stated target of the project, the most frequently used substance at baseline was cocaine, which also experienced the largest decrease in frequency of use.

HIV/AIDS Risk Behaviors

Injection Related Risk Behaviors. Only three individuals involved in the project reported the injection of any substances, prior to or after program entry, and no one reported sharing any injection equipment.

Sexual Behavior Related Risk Behaviors. Sexual risks are summarized in the following Table 4. More than half of the respondents (52%) reported engaging in sexual activity in the prior 30 days at baseline. As shown in the graph below, the number of sexual contacts increased significantly, in part due to a few individuals who reported high numbers of sexual partners. More importantly the number of times an individual reported having sexual contact without using a condom decreased. The incidents of high risk sex without a condom (with a PLWHA or an injection drug user), were reduced to zero, and the number of sexual contacts with individuals who were high also dropped significantly.

Self-sufficiency

Table 4. Cumulative Mean HIV Sexual Risks Within the Past 30 Days

Risk factor	Baseline	6-months	% Change
Number of Sexual Contacts	4.91	8.64	−75.9%
Number of Contacts Without a Condom:	3.80	3.54	6.8%
With HIV Positive Individual	0.07	0	100%
With an IDU	0	0	0%
With an Individual High on Drugs	2.38	.83	65.1%

Improved Employment Stability. Almost all of the respondents reported being unemployed within the prior 30 days at the baseline interview, and employment rates increased significantly within the evaluation timeframe from 15% to 39.3%. A percentage of increase of 161.9% shows a dramatic rise in the number of individuals reporting that they were either employed or involved in job training at the time of the follow-up interview.

Income. For all participants, the amount and percentages of money earned in the past 30 days from legal and illegal sources changed significantly with treatment entry. The average amount of money earned from wages was $75.30 at baseline. The average amount of money earned from illegal sources was $95.62. The average amount of money earned from wages at follow up more than doubled to $210.65 with some case management assistance in linking TAP clients with methods and resources for them to independently follow through with employment opportunities. Money from illegal sources was reduced to $17.27.

Housing Stability. For individuals with data at both points in time, the number of individuals with a permanent place to live in the community improved from 32.9% to 42.9%.

Involvement with the Criminal Justice System. About a tenth (11.4%) of respondents with data available at baseline and follow-up interview were involved in the criminal justice system at baseline, and there was involvement by only about a third of that number (4.3%) at the six month follow-up. Similarly, specific instances of arrests and incarcerations were reduced from the rates seen among all participants in the Table 5.

Mental Health Status

All self-reported psychiatric symptoms were at higher levels at baseline and all levels improved with the receipt of services. The largest reduction was experienced with serious depression, followed closely by concentration. These improvements are in line with both the nature of the psychopharmacology of cocaine (as a stimulant) and the social realities of its use. The decrease in anxiety occurred to a lesser magnitude. This can also be attributed to ceasing the use of cocaine. It is also important to note that attempts at suicide were eliminated, and improvement

was noted in all areas. Further inquiry can take place regarding the increased reported use of psychiatric medications and the relationship to TAP participant awareness of the benefits of adherence and improved outcomes.

Table 5. Cumulative Incidence of Criminal Justice Involvement

	Baseline	**6-months**	**Improvement**
Average number of arrests	0.16	0.05	68.7%
Average number of drug related arrests	0.20	0.09	55.0%
Average number of nights in jail	2.12	1.18	44.3%
Average number of self-reported crimes committed	11.5	5.1	55.6%

Table 6. Mean Number of Days Experiencing Psychiatric Symptoms in the Past 30 Days

Symptom	**Baseline**	**6-months**	**Improvement**
Serious depression*	14.50	9.02	37.7%
Serious anxiety	10.86	9.06	16.5%
Hallucinations*	3.08	1.90	38.3%
Trouble understanding, concentrating or remembering*	10.75	6.13	42.9%
Trouble controlling violent behaviors*	3.17	2.03	35.9%
Suicide attempts*	0.11	0	100%
Prescribed psychiatric medications*	7.05	9.86	39.8%

*Statistically significant difference.

Implications for Practice

Clients with complex problems need comprehensive holistic services that help people reassemble their lives, thus access to substance abuse treatment is truly only the tip of the iceberg. Some individuals are so severely traumatized by poverty, family issues, and arrested psychological, social, and spiritual development that any change requires intensive interventions. Individuals need tremendous, long-term support because of their sense of hopelessness. Immediate services are needed or the transitory motivation to change is lost. Immediate treatment and housing are needed to start the process of change and later, long-term support, resource identification, and

acquisition are necessary. The movement from hopeless to hopeful is much more than simple access to services, rather it requires a reorganization of that individual's relationship with their environment.

Of significance is the model of services that was developed by the aforementioned project. This project was also able to develop a non-coercive model for providing culturally competent services to chronic African-American female crack cocaine users who have not had their needs met by other service delivery models. The project was able to connect with these individuals, retain them in intensive case management services, transition them to substance abuse services, and provide continual supports as they became productive members of the community. While there has been much discussion about the need for culturally competent and faith-based services targeted for African-American substance users, this project provides data that supports the efficacy of the use of this method.

CONCLUSIONS

This paper has offered a description of the Treatment Access Project, a community-based program providing a comprehensive set of services targeted to an African American female population of active cocaine users. While previous research has shown that targeted outreach efforts can be effective, this article provides a description of an array of services designed to be culturally relevant within the African American community by incorporating a gender specific approach to service delivery. Active drug users, as a group, are often reluctant to connect with services. The program described in this article provides an example of how services can be provided to individuals in a culturally relevant and non-coercive manner.

Notes

This project was carried out with funding from a Substance Abuse and Mental Health Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) grant from the Targeted Capacity Expansion Program for Substance Abuse Treatment and HIV/AIDS Services (TCE/HIV). The views and opinions contained in the publication do not necessarily reflect those of the Center for Substance Abuse Treatment, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services, and should not be construed as such.

*Statistically significant difference on paired samples *t*-test.

*Statistically significant difference.

REFERENCES

1. Aponte, J. F. and Barnes, J. M. 1997. “Impact of acculturation and moderator variables on the intervention and treatment of ethnic groups”. In *Psychological interventions and cultural diversity*, Edited by: Aponte, J. F., River, R. Y. and Wohl, J. 19–39. Boston: Allyn & Bacon.

2. Belgrave, F. Z., Townsend, T. G., Cherry, V. R. and Cunningham, D. M. 1997. The influence of an Africentric world-view and demographic variables on drug knowledge, attitudes, and use among African American youth.. *Journal of Community Psychology*, 25(5): 421–433.

3. Belgrave, F. Z., Brome, D. and Hampton, C. 2000. The contributions of Africentric values and racial identity to the prediction of drug knowledge, attitudes and use among African American youth.. *Journal of Black Psychology*, 26(4): 386–401.

4. Belgrave, F. Z., Reed, M. C., Plybon, L. E. and Corneille, M. 2004. The impact of a culturally enhanced drug prevention program on drug and alcohol refusal efficacy among urban African American girls. *Journal Drug Education*, 34: 267–279.

5. Brown, E. 2006. Why rural African-American women who use cocaine mistrust women.. *Journal of Psychosocial Nursing in Mental Health Services*, 44(4): 36–41.

6. Brown, E., Hill, M. and Giroux, S. 2004. A 28-day program ain't helping the crack smoker—perceptions of effective drug abuse prevention interventions by north central Florida African Americans who use cocaine.. *Journal of Rural Health*, 20(3): 286–295.

7. Campsmith, M., Nakashima, A. and Jones, J. 2000. Association between crack cocaine use and high-risk sexual behaviors after HIV diagnosis. *Journal of Acquired Immune Deficiency Syndrome*, 25: 192–198.

8. Centers for Disease Control and Prevention. 2007a. *HIV/AIDS Surveillance Report: 2005* 17(2)

9. Centers for Disease Control and Prevention. 2007b. *CDC HIV/AIDS Fact Sheet: HIV/AIDS among African Americans*

10. Cochran, S. D. and Mays, V. M. 1993. Applying social psychological models to predicting HIV-related sexual risk behaviors among African-Americans. *Journal of Black Psychology*, 19: 142–154.

11. Cook, T. D. and Campbell, D. T. 1979. *Quasi-experimentation: Design and analysis for field settings*, Boston: Houghton Mifflin.

12. Cottler, L. B., Leukefeld, C., Hoffman, J., Desmond, D., Wechsberg, W., Inciardi, J., Compton, W. M., Ben Abdallah, A., Cunningham-Williams, R. and Woodson, S. 1998. Effectiveness of HIV risk reduction initiatives among out-of-treatment non-injection drug users.. *Journal of Psychoactive Drugs*, 30(3): 279–290.

13. Drug and Alcohol Service Information System (DASIS) Report. 2001. *Women in substance abuse treatment*, Washington, DC: DHHS.

14. Drug and Alcohol Service Information System (DASIS) Report. 2002. *Black admissions to substance abuse treatment: 1999*, Washington, DC: DHHS.

15. Evans, R., Forsyth, C. and Gauthier, D. 2002. Gendered pathways into and experiences within crack cocaine cultures outside of the city. *Deviant Behavior*, 23: 483–510.

16. Friedman, S. R., Flom, P. L., Kottiri, B. J., Zenilman, J., Curtis, R. and Neaigus, A. 2003. Drug use patterns and infection with sexually transmissible agents among young adults in a high-risk neighbourhood in New York City.. *Addiction*, 98(2): 159–169. et al

17. Hoffman, J. A., Klein, H., Clark, D. C. and Boyd, F. T. 1998. The effect of entering drug treatment on involvement in HIV-related risk behaviors. *American Journal of Drug and Alcohol Abuse*, 24: 259–284.

18. Holleran, L. K. and MacMaster, S. A. 2005. Cultural competent practice with 12-step groups.. *Alcoholism Treatment Quarterly*, 23(4): 107–120.

19. Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial & Ethnic Disparities in Health.*, Portland, OR: National Academy Press.

20. Joe, G. W., Simpson, D. D. and Broome, K. M. 1998. Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction*, 93: 1177–1190.

21. Johnson, R., Saha, S., Arbelaez, J., Beach, M. and Cooper, L. 2004. Racial and ethnic differences in patient perceptions of bias and cultural competence in health care.. *Journal of General Internal Medicine*, 19(2): 101–110.

22. Longshore, D., Hsieh, S. and Anglin, M. D. 1993. Ethnic and gender differences in drug users' perceived need for treatment..*International Journal of the Addictions*, 28(6): 539–558.

23. MacMaster, S. A. and Vail, K. V. 2002. Demystifying the injection drug user: Willingness to be involved in traditional drug treatment services among injection drug users involved in a needle exchange program.. *Journal of Psychoactive Drugs*, 34(3): 1–13.

24. MacMaster, S. A. 2005. Experiences and perceptions of barriers to substance abuse and HIV service access among African American women who use crack cocaine.. *Journal of Ethnicity in Substance Abuse*, 4(1): 53–75.

25. MacMaster, S. A. 2006. Social service delivery preferences among African American women who use crack cocaine: What women say they need before they can be open to HIV prevention services.. *Journal of HIV/AIDS and Social Services*, 5(3–4): 161–179.

26. Mallory, C. and Stern, P. 2000. Awakening as a change process among women at risk for HIV who engage in survival sex..*Qualitative Health Research*, 10(5): 581–594.

27. McLellan, A. T., Luborsky, L., Woody, G. E. and O'Brien, C. P. 1980. An improved diagnostic evaluation instrument for substance abuse patients: The Addiction Severity Index.. *Journal of Nervous and Mental Disease*, 168(1): 26–33.

28. Miller, W. and Rollnick, S. 1991. *Motivational interviewing: Preparing people to change addictive behavior*, New York: Guilford Press.

29. National Institute on Drug Abuse. 1991. *Risk Behavior Assessment Questionnaire (RBA)*, 625National Institute on Drug Abuse, Community Research Branch (ADM).

30. National Center for Health Statistics (NCHS). 2002. *Health, United States, 2002*, Hyattsville, Maryland: Public Health Service.

31. National Survey on Drug Use & Health (NSDUH). 2004. *2002: Latest National Survey on Drug Use & Health.*, Washington, DC: DHHS.

32. Needle, R. and Coyle, S. 1997. "Community-based outreach risk-reduction strategy to prevent HIV risk behaviors in out-of-treatment injection drug users". In *NIH Consensus Development Conference: Interventions to Prevent HIV Risk Behaviors*, 81–86. Rockville, MD: NIH.

33. Needle, R., Coyle, S., Normand, J., Lambert, E. and Cesari, H. 1998. HIV prevention with drug-using populations—Current status and future prospects: Introduction and overview.. *Public Health Reports*, 113: 4–18.

34. Prochaska, J. O., DiClemente, C. C. and Norcross, J. C. 1992. In search of how people change. *American Psychologist*, 47: 1102–1114.

35. Ross, M., Ywang, L., Leonard, L., Teng, M. and Duncan, L. 1999. Sexual behavior, STDs, and drug use in crack house population. *International journal of STD and AIDS*, 10: 224–230.

36. Sharpe, T. 2001. Sex for crack cocaine exchange, poor black women, and pregnancy.. *Qualitative Health Research*, 11(5): 612–630.

37. Sharpe, T., Lee, L., Nakashima, A., Elam-Evans, L. and Fleming, P. 2004. Crack cocaine use and adherence to antiretroviral treatment among HIV-infected Black women.. *Journal of Community Health*, 29(2): 117–127.

38. Tennessee Department of Health. 2007. *HIV/AIDS/STD Section Epidemiological Profile, 2005*, Nashville, TN: Tennessee Department of Health.

39. Treatment Data Episode Set (TEDS). 2004. *Treatment Data Episode Set (TEDS) 1992–2001*, Washington, DC: DHHS.

40. Wechsberg, W. M., Zule, W., Perritt, R., Roberts, A., Middlesteadt, R. and Burroughs, A. 2001. “Women-Focused HIV Prevention for African-American Crack Users”. In *Problems of drug dependence 2000: Proceedings of the 62nd annual scientific meeting*, Edited by: Harris, L. S. 33–34. Bethesda, MD: US DHHS. The College on Problems of Drug Dependence, Inc. NIDA Research Monograph 181, 2000

41. Wechsberg, W. M., Lam, W. K., Zule, W., Hall, G., Middlesteadt, R. and Edwards, J. 2003. Violence, homelessness, and HIV risk among crack-using African-American women. *Substance Use and Misuse*, 38: 671–701.

42. Wechsberg, W. M., Lam, W. K., Zule, W. A. and Bobashev, G. 2004. Efficacy of a woman-focused intervention to reduce HIV risk and increase self-sufficiency among African-American crack abusers.. *American Journal of Public Health*, 94(6): 1165–1173.

43. Weiss, L., Kluger, M. and McCoy, K. 2000. *Health care accessibility and acceptability among people that inject drugs or use crack cocaine*, New York, NY: New York Academy of Medicine.

44. Zule, W. A., Lam, W. K. and Wechsberg, W. M. 2003. Treatment readiness among out-of-treatment African-American crack users.. *Journal of Psychoactive Drugs*, 35(4): 503–510.