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Evaluation of a Faith-Based Culturally Relevant Program for African American Substance Users at Risk for HIV in the Southern United States

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Abstract:
Objective: This article provides an evaluation of a federally funded faith-based program that serves African Americans who use heroin and cocaine and are at risk for HIV/AIDS in Nashville, Tennessee.
Methods: Data were collected from 163 individuals at baseline and 6- and 12-month follow-up interviews. A subset of participants (n = 51) completed all three interviews.
Results: Results suggested that this culturally relevant set of interventions was successful in reducing substance use and HIV/AIDS risk behaviors. The program was able to show data that supported the efficacy of a faith-based approach emphasizing spirituality rather than directive, aggressive, authoritarian, or coercive counseling techniques.
Discussion: The model is important to the continued development of culturally relevant interventions that are vital to decreasing the disproportionate rates of HIV/AIDS within the African American community.
Keywords: HIV/AIDS; substance use; African Americans; faith based

Article:

While representing 12% of the U.S. population, African Americans represent more than one third of all cumulative AIDS cases and the majority of all new AIDS cases in the United States (Centers for Disease Control, 2005). Despite this disproportionate representation by African Americans, traditional approaches to both substance abuse (Longshore, Hsieh, & Anglin, 1993) and HIV/AIDS (Cochran & Mays, 1993; Jones, 2004; O'Connell & Langley, 1997) prevention and treatment continue to be problematic given unfavorable views of available treatments and distrust of mainstream social services (Wright, 1998). Furthermore, traditional middle-class European American intervention and treatment models do not address the barriers to prevention and intervention facing African Americans and ignore the idea that individuals engage in behaviors that are functional for the environment in which they exist (McNair & Prather, 2004). Research has increasingly emphasized the need for promoting prosocial motives (i.e., reentry into a moral community, renewed spirituality, collective and individual self-esteem, and establishing or reestablishing roles in family) to increase service utilization among African American service recipients (Longshore, Grills, Anglin, & Annon, 1997; O'Connell & Langley, 1997).

The integration of a faith-based and/or spiritual component is an important component for providing culturally relevant services to African Americans. Spirituality has been a fundamental aspect of the African American experience (Constantine, Lewis, Conner, & Sanchez, 2000; Frames & Williams, 1996), and therefore the integration of spirituality is an important component in the provision of culturally competent services and practices. This article includes an overview of the program, its theoretical orientation, and outcome data documenting the success of the services in reducing substance use and HIV/AIDS risk behaviors. Specifically, this article provides the results of an evaluation of a federally funded faith-based program that serves African Americans who use heroin and cocaine and are at risk for HIV/AIDS in Nashville, Tennessee.

BACKGROUND

Metropolitan Community AIDS Network (Metro CAN), affiliated with Metropolitan Interdenominational Church, was developed in response to the growing number of African American substance users who were at

risk for HIV/AIDS. Culturally relevant modes of service delivery specific to HIV/AIDS risk were specifically included in the development of Metro CAN to best meet the needs of the community. The program model is based on an enhancement of the strategies developed as part of the extensively evaluated National AIDS Demonstration Research (NADR) program and the National Institute on Drug Abuse (NIDA) Cooperative Agreement for AIDS Community-Based Outreach Intervention Research Program (NIDA/NADR Outreach Model), which is regarded as the best practice model for reaching out-of-treatment substance users (Needle & Coyle, 1997; Needle, Coyle, Normand, Lambert, & Cesari, 1998). The program combines elements of the NIDA/NADR Outreach Model with extensive supportive case management.

Although the definitions of *faith-based programming* have varied throughout the literature, within this program the conception of spirituality employed in implementing a spiritual perspective is derived from Okundaye, Smith, and Lawrence-Webb (2001), which describes spirituality in terms of a search for meaning and fulfillment in life and relationships that is experienced throughout the process of human growth and development. Spirituality is viewed within the program as the totality of what it means to be human and encompasses the biological, mental, social, and spiritual aspects of an individual that cannot be reduced to any single component. As a result, regardless of one's faith tradition, progress is made toward a healthy spirituality, allowing one to accept and give love and forgiveness. Within this perspective, healthy spirituality reconnects one with one's inner power and enables one to release shame and guilt and become reengaged in the process of consciously developing new attitudes and behaviors. Spirituality initiates, supports, and sustains the changing of attitudes and behaviors that limit an one's potential for living a fulfilling, high-quality life. This experience of "reawakening" increases a sense of self-acceptance, self-love, and self-care behaviors. Self-condemnation, judgment, and alienation are replaced with a growing sense of personal power evidenced by increasing self-acceptance, self-trust, and motivation derived from reframing life experiences to discern lessons learned and strengths developed as a result of the experiences.

The primary goal of Metro CAN is to serve the target population through the provision of a coordinated continuum of outreach, HIV/STD testing services, case management, HIV risk-reduction interventions, substance abuse treatment, and health or mental health ser-vices from a faith-based perspective. The components of the program included (a) street outreach and risk reduction interventions, (b) HIV/STD testing and counseling, (c) alcohol and drug coordination services, which transition participants to substance abuse treatment, (d) on-going long-term intensive case management, (e) support groups, and (f) spiritual nurture activities. A unique focus of the Metro Can program is the integration of spirituality and the delivery of culturally competent services. The program is grounded in the principles of spirituality, love, and community to create a service-oriented environment where participants are not condemned or judged. Staff serve participants' needs through the provision of support, nurturing, and positive affirmation to aid persons in choosing healthier, life-enhancing behaviors.

The infusion of spirituality is approached from three perspectives (i.e., environment, individual interactions, and education). First, all staff work to create an environment where program participants feel safe, accepted, and not judged. Emphasis is placed on how program participants are greeted when they enter the building and on making the space inviting and esthetically pleasing. Second, all staff are trained to understand how the Metropolitan Interdenominational Church body under-stands spirituality and how to translate spiritual under-standing into spiritual care. Staff are trained to be deliberate in communicating to individuals their value and worth by acknowledging positive characteristics and accomplishments, acknowledging change, providing feedback about failures with a focus on a teaching moments, making visits to the home or hospital, and so on. For this project, the staff represented a diverse group of individuals with differing life experiences, educational backgrounds, and substance use backgrounds; however, each member of the team was similar in his or her ability to communicate to the individuals whom he or she served in his or her intrinsic value and worth. Finally, planned group activities focusing on spirituality, life transaction, and decision making provided opportunities for program participants to learn about and begin to identify how spirituality operates in their own lives and its relationship to life's challenges, individual changes, and hopes. Spirituality was interwoven throughout all aspects of Metro CAN programming. For example, in working with women in groups, emphasis

was placed on addressing the biological, mental, social, and spiritual components. In terms of the biological component of spirituality, interventions were specifically created to speak to the uniqueness of each individual. In a group experience, participants were provided with information that affirms gender differences (e.g., how alcohol affects women differently than men). The group activities and exercises enabled men and women to grow in self-understanding and self-acceptance. An aspect of the mental component of spirituality focused on providing information and stimulating dialogue that reduced the stigma associated with mental health diagnosis, substance abuse, HIV, and other stigmatizing traumas or experiences and enabled participants to be open to and more consistent in not only taking medications, getting treatment, and getting medical care but also in becoming more sensitive in listening to their body's signals and responding with care. The social aspects of spirituality were addressed through exploration of the qualities of healthy relationships and in finding relationships the aid in the process of living healthy lives free of drugs and other behaviors that place them at risk.

This study was conducted to determine the potential benefits of this model (i.e., Would it lead to improvements in substance use, HIV risks, and other measures of self-sufficiency for individuals with long-term chronic and multifaceted challenges?).

METHOD

Design

This study involved a single group design (aggregating program participants during the duration of the project), with repeated measures of program outcome indicators at program intake (baseline) and 6 and 12 months postintake that examined changes during 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 base-line, 6-month, and 12-month follow-up interviews (combined with data on their service use) and (b) basing the evaluation on a centralized management information system to allow program monitoring and outcome evaluation. A total of 13,230 outreach contacts were made during the 3-year course of the project. Of these contacts, a total of 193 individuals were served with additional services beyond street-based outreach, 163 completed the initial intake process and became active clients, 116 received ongoing intensive case management, and 51 completed additional follow-up evaluation interviews at both 6 and 12 months.

TABLE 1: ***Demographics of Participants***

Demographic	*Categories*	*Total Sample* *n*	*%*
Age (in years; *M*, *SD*)		39.8	9.9
Gender	Female	85	52.5
Marital status	Married or remarried	35	21.5
	Separated or divorced	49	30.4
	Never married	78	48.1
Ethnicity/racial background	African American	131	80.8
	Caucasian	29	17.9
	Latino/Hispanic	2	1.3
Education (in years; *M*, *SD*)		11.39	3.9
Housing status	In own home	52	31.9
	Someone else's home	52	31.9
	Homeless or shelter	36	22.2
	Institution or halfway house	17	10.5
	Rooming house	6	3.5

NOTE: *N* = 163.

Sample

Demographics. A total of 163 individuals completed an initial interview and provided demographic information (see Table 1). Slightly more than half (*n* = 84, 51.6%) of the respondents had at least a high school diploma, and an additional proportion of the group had obtained a GED (*n* = 23, 14.1%); however, very few (*n* = 6, 3.7%) had a college degree. The average length of time at present address was almost 5 years (*M* = 4.96); however, there was great variability (*SD* = 9.6), and almost two thirds (*n* = 10 1, 61.6%) of the respondents had been in their residence for only a year or less. The majority (*n* = 86, 52.7%) of the respondents reported no income from

any source, and most (*n* = 110, 68.0%) were unemployed. Only a small percentage (*n* = 21, 12.9%) reported being employed full-time. Many (*n* = 75, 46.0%) of the respondents had no source of insurance, including Tenncare (Tennessee's universal Medicaid waiver). Very few of the respondents were on probation or parole (*n* = 13, 8.0%) and/or waiting charges, trial, or sentencing (*n* = 7, 4.4%).

Reasons for seeking services. Everyone within the program was self-referred in the sense that in contrast to some other substance abuse programs, none of the service recipients were coerced into services by the criminal justice system, an employer, and so on. Outreach workers were a frequently cited source of information about the program (*n* = 52, 32.2%); however, almost half (*n* = 73, 44.7%) of respondents were informed of the program through informal networks of friends and family members or other Metro Can participants. Other community agencies (*n* = 28, 17. 1 %) and churches (*n* = 10, 5.9%) accounted for the sources of information about the program for the remainder of the population. Outreach workers were cited as "playing a major role" in the decision to seek services for the majority (*n* = 85, 52.0%) of the consumers. The most frequently cited reasons for seeking services were substance use related (i.e., drugs or alcohol problems). Respondents could identify more than one reason, as most members of the population presented with multiple issues. These issues tended to be chronic in nature. The majority (*n* = 96, 58.9%) of respondents reported experiencing the presenting problems for more than 5 years.

Drug-use characteristics. Cocaine (56.0%) and heroin (36.9%) accounted for almost all of the primary drugs of choice. A significant proportion (41.4%) had sought treatment in the previous 6 months, but a much smaller percentage (28.8%) had actually obtained it. About one fourth (24.5%) of the respondents used injection drugs. More than one third (34.5%) reported engaging in sex when high without using a condom in the past month, and a smaller percentage (12.7%) reported trading sex for drugs within the past month. Respondents reported spending an average of $724 on drugs and $56 on alcohol within the past 30 days. The majority (73.8%) reported that they had never stayed clean and sober for more than a month in their adult lifetime. More than two thirds (69.2%) reported that obtaining substance abuse treatment was "extremely important" to them.

Procedures

Research protocols included the following procedures to ensure that all individuals were providing informed consent to be interviewed. After the outreach worker brought the individual to Metro Can offices, he or she was introduced to the intake case manager who explained what the project was about and the services 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.

To facilitate the follow-up interviews, participants pro-vided contact information for themselves and 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 participants was applied for and obtained through the University of Tennessee.

Measures

Alcohol and other drug use. The Addiction Severity Index (ASI) (McLellan, Luborsky, Woody, & O'Brien, 1980) was used to document lifetime drug use and frequency of use within the past 30 days. The ASI is a standardized interview widely used to determine treatment needs and to assess improvement during and after treatment. High levels of interrater agreement have been reported for the ASI (*r* = .74-.99). Supplemental probe

questions from the NIDA Cooperative Study Risk Behavior Assessment (NIDA, 1991) were added to the drug-use checklist to obtain further data on age at first use, days used, and days injected in the past 30 days (for each drug).

Entry into substance abuse treatment. Substance abuse treatment entry was measured by a review of clinical records. Entry into treatment included both residential and intensive outpatient treatment programs. A participant was counted as entering treatment if he or she completed the treatment program's intake process and participated in the program's activities.

HIV/STD risk behaviors. Injection and sexual-risk behaviors were assessed with modifications of the NIDA Risk Behavior Assessment (NIDA, 199 1), which includes a series of items tapping both injection risk (needle use, needle sharing, needle disinfection procedures) and sexual behavior risk (frequency of oral, vaginal, anal sex with males or females; frequency of condom use during each type of sexual activity). These items have been used in the NIDA cooperative study, and Needle et al. (1995) present test-retest reliability statistics for crack (r = .69), cocaine (r = .78), and heroin (r = .78) use in the past 30 days, indicating high levels of reliability for self-reported drug use. Reliability for sex-risk behaviors was high for "days having sex in the past 30 days" (r = .83), "number of partners in past 30 days" (r =.80), and "number of times had vaginal sex in past 30 days" (r = .82). Reliability of reports of "needle and 'works' sharing activities" was somewhat lower. Diagnosis or treatment of STD infections during the past 6 months was based solely on self-report data. This is similar to measures used in NADR by Bonito, Bohlig, Dennis, Fairbank, and Rachal (1993).

Self-sufficiency and psychosocial functioning. The Problem subscales of the ASI were used (with some modification to gather supplemental information) to address changes over time in psychosocial outcomes. To provide a more reliable assessment of psychological functioning, we supplemented the ASI measures using Derogatis and Spencer's (1982) Brief Symptom Inventory (BSI), a 54-item questionnaire designed to reflect psychological symptom patterns. The BSI produces a global severity index and assesses 9 dimensions of psychological symptoms: anxiety, depression, hostility, obsessive-compulsive, paranoid ideation, phobic avoidance, psychoticism, somatization, and interpersonal sensitivity. Internal consistency coefficients for the subscales range from .71 to .85, and test-retest reliability coefficients range from .68 to .9 1. The global severity index has a test-retest coefficient of .90. The BSI has been validated against the Minnesota Multiphasic Personality Inventory scales, with correlation coefficients ranging between .30 and .72. Only subscales measuring depression and anxiety were used in the study. Because of the nature of the program, an additional measure of spiritual well-being was used to assess change in this area. A 20-item questionnaire, the Spiritual Well Being Instrument (Ellison, 1983), was used. The items are scored on a 6-point Likert-type scale ranging from *strong agreement* to *strong disagreement*.

Data Analysis

Preliminary analyses of data (factor analysis and internal consistency reliability analyses) were con-ducted to examine the psychometric properties of multi-item measures. 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 analysis of variance (ANOVA) techniques. The basic research design was a single factor repeated measures ANOVA with three levels (baseline, 6-month follow-up, and 12-month follow-up). 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) and the maintenance or stability of changes from baseline, at 6 months, and at 12 months.

TABLE 2: ***Mean and Standard Deviations Number of Days Using Within the Past 30 Days***

	Baseline		6 Months		12 Months		
Substance	*M*	*SD*	*M*	*SD*	*M*	*SD*	*% Decrease*
Alcohol	8.5	(11.4)	3.2	(8.1)	2.2	(6.4)	74
Alcohol to intoxication	6.0	(10.2)	1.2	(4.3)	0.96	(4.5)	84
Cocaine	10.7	(13.1)	3.1	(7.2)	2.2	(6.9)	79
Heroin	7.0	(12.4)	2.4	(7.4)	1.3	(5.1)	81
Marijuana	4.8	(9.9)	2.3	(6.7)	1.8	(6.5)	63
Multiple substances	6.9	(10.6)	2.6	(6.6)	2.0	(6.0)	71

NOTE: $N = 51$.

RESULTS

Substance-Use Behaviors

Alcohol and other drug use. Self-reported substance use decreased significantly for all of the major sub-stances used by the target population (see Table 2).

Entry into substance abuse treatment. Of the 163 individuals, 79 (49%) were transitioned to treatment. This rate is within the targeted range, as the projected goal for the project was a 44.0% to 70.0% substance abuse entry rate for the individuals involved in the program. A total of 110 substance abuse treatment transitions were made during the course of the project, as some participants required multiple treatment episodes. Of the 51 individuals who completed evaluation interviews at all three periods, a treatment entry rate was significantly improved (72.5%).

HIV/STD Risk Behaviors

Injection risk behaviors. HIV risk related to injection drug use was difficult to assess given the changes in reporting by the respondents. In the baseline interview, 11 individuals reported ever using injection drugs. This later decreased to 6 in the 6-month follow-up and 5 at the 12-month follow-up. Reported risk did decrease. The number of individuals reporting sharing syringes decreased from 5 to 3 to 2, and the number of individuals reporting not using a clean syringe within the past 30 days decreased from 3 to 2 to 1. However, the numbers are really too small to draw any realistic conclusions.

Sexual risk behaviors. Sexual risks are summarized in Table 3. There were significant changes in all sexual risk measures. None of the respondents reported partners of the same sex. The largest decrease in the number of partners was among women, with the largest change occurring between baseline and 6 months. Condom use also increased significantly during the three periods.

HIV and STD infection. The percentage of service recipients reporting STD diagnoses (syphilis, gonorrhea, chlamydia, and herpes) decreased during the 12 months. Aggregated, the number of non-HIV STD diagnoses shows a significant change; however, the numbers are so small within any single category that they could easily be related to chance. The number of reported diagnoses did decrease or remain the same in all four categories. HIV rates increased at both periods but need to be viewed differently, as a recent diagnosis may not indicate a recent infection.

Self-Sufficiency and Psychosocial Functioning

Employment status and financial support. The data on financial support all provides evidence of prosocial changes. The average number of days paid for work doubled between baseline and 6 months. The percentage of the amount of total income from work increased from 34.2% at baseline to 91.0% a year later. At baseline, the average amount of money spent on drugs was 205% of reported monthly income, and this decreased to 31% a year later. Likewise, the average amount of money spent on drugs decreased by 90%, and the average amount of money spent on alcohol decreased by 77%.

Housing stability. There was little difference in the average length of time that the participants reported being at their current residence, but there was a great deal of variability in these scores, as standard deviations for the

three means were between 75 and 82 days. However, satisfaction with living situation increased to a statistically significant level ($F = 6.45$, $p \leq .001$), based on a one-way ANOVA. Post hoc analyses utilizing a Scheffe test found the significant difference to be between baseline and both 6- and 12-month intervals. The number of reported close friends increased from 1.9 at baseline to 6.1 at 6 months and then leveled off to 3.2 at 12 months.

TABLE 3: ***HIV/STD Risk Behaviors Within the Past 30 Days***

Risk Factor	*Baseline*		*6 Months*		*12 Months*	
	M	*SD*	*M*	*SD*	*M*	*SD*
Mean number of sex partners	3.2	(12.3)	1.2	(1.8)	0.75	(0.8)
Mean number of male partners	2.7	(12.3)	0.8	(1.6)	0.53	(0.7)
Mean number of female partners	0.63	(1.6)	0.42	(1.0)	0.29	(0.7)
Mean number of times had sex without a condom:						
Vaginal sex	2.9	(7.1)	2.3	(5.1)	1.4	(4.4)
Oral sex	2.4	(6.8)	1.4	(3.5)	0.39	(0.9)
Anal sex	0.03	(0.1)	0.0	(0.0)	0.0	(0.0)
When trading sex for drugs	2.6	(12.6)	1.0	(3.6)	0.04	(0.2)
	n	*%*	*n*	*%*	*n*	*%*
Total non-HIV STD diagnoses	7	(12.8)	1	(2.1)	2	(4.2)
HIV diagnoses	2	(4.3)	4	(8.5)	3	(6.4)

NOTE: $N = 51$.

Legal problems and criminal justice involvement. Individuals reported a significant decrease in the average number of days involved in illegal activity, from 10.8 to 0.3, a drop of 97.2%. There was an even more significant drop in the reported amount of money made from these activities, an almost complete decrease from $878 to $8 per month, or 99.1%.

Despite the significant changes in self-reported illegal activities, there were increases in the number of drug-related arrests, the number of nights in jail, and the number of individuals awaiting trial, awaiting sentencing, and/or serving time on parole or probation. The numbers of individuals is relatively small but important. One interpretation could be the lag time between the end of illegal activities and the criminal justice system's penalties. In discussions with program staff, it became apparent that the majority of the criminal justice activity that the participants experienced was related to criminal charges that were incurred prior to treatment entry. For instance, several participants were arrested on warrants that had been issued several years prior to their involvement with the program. As participants began to work in legitimate jobs and live in mainstream society, they became more vulnerable to being picked up for these outstanding warrants.

Psychological functioning. The BSI Anxiety and Depression scales were used to provide additional information. Although the ASI provided data on the number of individuals experiencing anxiety or depression, the BSI provided data on the severity of the symptoms (see Table 4). The BSI is scored on a 5-point Likert-type scale, from 0 (*not at all*) to 4 or (*extremely*). Scores fell between *moderately* and *a little bit* for all points but did show a significant decrease between baseline and 6 months and then maintenance of that change at 12 months. The results of a one-way ANOVA were statistically significant ($F = 4.07$, $p \leq .020$) for depression; a post hoc Scheffe analysis found the significant difference to be between baseline and 12 months. There was little change in the psychiatric symptoms reported on the ASI items, with the exception of depression, which decreased by 12%. It is also interesting to note that there was an increase in the number of individuals taking psychiatric medications between baseline and 6 months, but this leveled off significantly at 12 months.

Spiritual well-being. Spiritual well-being was scored on a 6-point Likert-type scale of *strong agreement* to *strong disagreement*. Lower scores indicate higher levels of spiritual well-being. The average scores during the 6-month period decreased from 2.7 at baseline to 2.4 at 6 months and to 2.1 at 12 months. The differences were statistically significant ($F = 6.97$, $p < .001$) on a one-way ANOVA; a post hoc Scheffe found the significant difference to be between baseline and 12 months. It is interesting to note that the level of change was the same among all three measures. This differs from most of the other measures that tended to change at significant rates

between baseline and 6 months and then level off and maintain the initial change. All three sets of scores are on the positive side of the well-being continuum at all three points.

TABLE 4: ***Self-Sufficiency and Psychological Functioning in the Past 30 Days***

	Baseline		*6 months*		*12 months*	
Financial self-sufficiency						
Average number of days paid for employment	3.7	(8.2)	7.6	(10.6)	7.9	(10.5)
Average amount of money made through employment ($)	193		295		328	
Average amount of money made from all sources ($)	563		412		362	
Average amount of money spent on drugs ($)	1,153		564		112	
Average amount of money spent on alcohol ($)	97		26		22	
Involvement in illegal activities						
Average number of days involved in illegal activities for profit	6.0	(10.8)	2.9	(8.7)	0.3	(0.9)
Average amount of money made through illegal activities ($)	878		715		8	
Criminal justice involvement						
Average number of arrests	0.14	(0.6)	0.12	(0.3)	0.10	(0.3)
Average number of drug-related arrests	0.04	(0.2)	0.06	(0.2)	0.08	(0.2)
Average number of nights in jail	1.2	(5.2)	0.78	(3.0)	2.8	(8.0)
Number of individuals awaiting trial	3		7		6	
Number of individuals on parole or probation	2		6		7	
Psychological symptoms measured with the Addiction Severity Index						
Serious depression	30	(59.0%)	53	(27.0%)	24	(47.0%)
Serious anxiety	25	(50.0%)	26	(51.0%)	53	(27.0%)
Trouble controlling violent behaviors	15	(30.0%)	14	(28.0%)	14	(28.0%)
Suicidal thoughts	6	(11.7%)	6	(11.7%)	7	(13.7)%
Suicidal attempts	1	(2.0%)	3	(5.8%)	2	(3.9%)
Taking psychiatric medications	12	(23.5%)	18	(35.2%)	14	(27.4%)
Psychological symptoms measured with the Brief Symptom Inventory						
Anxiety	1.8	(1.1)	1.2	(1.1)	1.2	(1.2)
Depression	1.9	(1.1)	1.2	(1.1)	1.1	(1.2)

NOTE: $N = 51$.

DISCUSSION AND APPLICATIONS TO SOCIAL WORK

The findings from this project provide data that may be useful in improving substance abuse treatment in other areas. Specifically, the results (a) document a faith-based approach emphasizing spirituality rather than directive, aggressive, authoritarian, or coercive counseling techniques as an important component in providing culturally competent and relevant services to a population of long-term chronic drug users and (b) suggest that this approach may be beneficial in reducing substance use and high-risk sexual behaviors among this population. As a nonexperimental design, these results are only suggestive of this possibility, and programs of this type need to be further evaluated through a study with more rigorous design.

The possible efficacy of a faith-based approach would be an important finding, particularly for this population and for this type of faith-based approach. Spirituality has long been considered an important component in the treatment of substance users. The emphasis on a noncoercive, nonjudgmental, spiritual approach as a necessary factor in providing culturally competent services is an important finding. Although the professional literature has emphasized the importance of incorporating spirituality within the service delivery model for African American substance users, this evaluation provides some data suggesting that this is both effective and necessary. Similarly, these results provide data showing the need for, the willingness and motivation to connect with, and the effectiveness of appropriately provided intensive case management services for this population. All of the service recipients in the program were there voluntarily. They maintained contact with the program

not because they were coerced but because they chose to maintain contact. Although intensive levels of social need are often documented, improvements of these needs and the willingness of members of the population to remain in services are less well documented.

Significant improvements in HIV risk behaviors for individuals involved in substance abuse–related out-reach and treatment programs are documented in the literature. However, these improvements are usually related to high-risk behaviors associated with injection drug use. This evaluation provides data showing the effectiveness of these services for high-risk behaviors associated with sexual risks. The program appeared to be particularly effective for African American women, the fastest growing risk group for contracting HIV.

The generalizability of the findings from this evaluation are limited. This was not a random sample, and the results from this study are only truly generalizable to the individuals who participated. Evaluation research based on similar types of sampling runs the risk of sampling bias, as those individuals who were in the sample may not have accurately represented the pool of potential service recipients. Further weakening the ability to apply these results in other situations is the lack of a counterfactorial. This is a nonexperimental design, and a comparison or control group was not utilized to allow for comparisons with a similar group of individuals who did not experience the intervention. In addition, the number of individuals who participated in the evaluation at all three periods ($n = 51$) is a relatively small group and represents slightly less than one third of the total population of service recipients. Although there are numerous reasons why this number is relatively small (e.g., difficulty in tracking a transient out-of-treatment substance using population during a period of 1 year), it is important that the results are viewed with this limitation in mind.

Despite all of these limitations, the results of this evaluation cannot be overlooked. With a few minor exceptions, all of the measures showed significant improvements in the lives of the individuals involved in the project. Despite the previously mentioned limitations, these results and the lessons learned through the development of the project can be used to develop and/or enhance the services to similar individuals in other areas. The project clearly demonstrated that a continuum of intensive faith-based and noncoercive out-reach, case management, and substance abuse treatment services can be implemented and may be effective for the target population (i.e., African American substance users who have long histories of chronic drug use and multiple related psychosocial problems). This is a population that has been historically described as hard to reach and/or noncompliant with traditional models of service delivery. By developing and providing a treatment model that is culturally relevant, highly effective, and transferable to similar populations, the most relevant piece of knowledge that was demonstrated by the project was the importance of the faith-based, noncoercive model that was developed, implemented, and utilized by the program.

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