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Exploring Community-based Alcohol Rehabilitation in India: A case study of a community rehabilitation and support centre

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Substance dependence and addiction continues to be a growing problem globally, with India being no exception. Despite the availability of patient-centred services, accessibility remains a challenge, especially in terms of community-based treatment centres for substance abuse. Through a series of case studies, this study examines the Community Rehabilitation and Support Centre (CRSC), a therapeutic community-based de-addiction centre in Delhi, India. Via thematic analysis of in-depth interviews with eight male patients and observational data, it explores the rehabilitation programme's structure, relapse management, and the role of communal living. The findings reveal the effectiveness of the centre's approach in fostering holistic recovery. Key elements contributing to its success include structured programming, extended stays, and a nurturing environment. The study highlights the advantages of CRSC's methods and enriches the literature on therapeutic community frameworks in addiction recovery. It underscores the significance of structured programmes and communal living for successful rehabilitation while offering insights for enhancing substance abuse treatment outcomes in India.

INTRODUCTION

The global rise in substance use, particularly alcohol dependence, has become a pressing concern, including in India, where socio-economic and cultural factors influence patterns of addiction. Rapid lifestyle changes and associated stressors contribute to increasing substance use, leading to significant health and social consequences. According to the Health and Family Survey (2019–21), alcohol consumption rates among urban Indian men and women stand at 18.8% and 1.3%, respectively (Ministry of Health & Family Welfare Government of India, 2021).

However, alcohol-related harm is not evenly distributed across populations. The alcohol-harm paradox suggests that individuals from low socio-economic status (SES) experience greater alcohol-related problems despite similar or even lower consumption levels compared to higher SES groups (Probst et al., 2020). Gender disparities further compound these risks, with women from low SES facing a 27% higher likelihood of alcohol-related harm (Porth et al., 2020). These inequalities limit access to healthcare and treatment services, exacerbating the challenges in addressing substance dependence.

While substance abuse treatment centres exist, they have often been criticised for limited accessibility (Bashara et al., 2014). Research suggests that community-based interventions, particularly therapeutic community models, can help bridge this gap by offering patient-centred support that includes vocational training, group therapy, and counselling (Balhara et al., 2014; Allen & Campbell, 2011). Despite their potential, such community-based models remain underdeveloped in India, with limited literature exploring their effectiveness and operational mechanisms (Porthe, 2020).

This study aims to address this gap by examining the Community Rehabilitation and Support Centre (CRSC), a therapeutic community-based substance abuse treatment centre in Delhi, India. Through an in-depth analysis of its rehabilitation processes, with a focus on communal living and relapse management, this research provides new insights into how structured, community-driven approaches can foster holistic recovery and social reintegration. By highlighting the effectiveness of such models, this study contributes to the ongoing discourse on accessible and culturally relevant addiction treatment frameworks in India.

LITERATURE REVIEW

Impact of Alcohol abuse in India

Alcohol abuse, according to the American Psychological Association, is characterised by a pattern of compulsive alcohol consumption that persists despite recurring consequences stemming from an individual's personal, social or financial activities (APA Dictionary of Psychology, n.d.). A report by the National Drug Dependence Treatment Centre and All-India Institute of Medical Sciences (2019) highlighted that 5.2% of 473,569 individuals surveyed were affected by harmful or dependent alcohol use, raising concerns about the health and social consequences of excessive drinking in India.

Despite the availability of treatment programmes, access and engagement remain significant challenges. Many individuals do not seek help, even when treatment options are available, due to psychological barriers, lifestyle factors, and physiological stressors (Barman et al., 2011; Ahmed, 2009); however, these studies often fail to consider the socio-cultural contexts in which these barriers manifest. Anderson's conceptualisation of healthcare utilisation serves as a helpful paradigm for understanding these challenges (Anderson, 1995; Barman et al., 2011), highlighting systemic stressors such as financial limitations and restrictive admission criteria; however, this model overlooks the unique struggles of rural and marginalised populations in India, where low socioeconomic status,

lack of education, and stigma further restrict access to care (Appel et al., 2004; Barman et al., 2011). These limitations underscore the need for alternative, community-based models that address practical barriers to treatment, and highlight the importance of developing holistic care frameworks tailored to India's diverse socio-economic and cultural landscape.

EVOLUTION OF TREATMENT FOR SUBSTANCE ABUSE: FROM ALTERNATIVE PRACTISES TO COMMUNAL PRACTICES

The treatment for substance abuse in India evolved from spiritually rooted traditions to modern, evidence-based approaches. Historically, addiction was stigmatised as a spiritual weakness or moral failing, leading to treatment through ritualistic healing practices (Church et al., 2018, p. 220). Many communities relied on practices administered by a spiritual healer like chanting or herbal remedies to restore the imbalance between one's spiritual and emotional well-being (Winkelman, 2001). These methods, although lacking scientific validation, provided holistic care that encompassed not only the individual but also communal support, playing a vital role in recovery.

While the Western medical model dismissed these traditional practices, it led to a missed opportunity to integrate culturally significant therapeutic methods into addiction treatment. As biomedical frameworks become more dominant, traditional healing was replaced with clinical practices, which often failed to address the emotional and communal dimensions of addiction. This oversight contributed to gaps in holistic care, which modern rehabilitation systems are now beginning to address by reintegrating communal and culturally relevant practices (Ray et al., 2020). The shift toward Community-Based Rehabilitation (CBR) reflects an effort to balance scientific rigor with psychosocial aspects of recovery, ensuring culturally attuned treatment options.

Non-governmental organisations (NGOs) have played a critical role in developing these models, which emphasise participation, communal healing, and accessibility, particularly in areas where government rehabilitation services are insufficient (Thara & Patel, 2010; Balhara, 2011). Over time, CBR programmes have transitioned from a medical focus to a rights-based approach, advocating for community inclusion and mental health awareness (Pande & Dalal, 2004). Countries such as Italy, Finland, and Australia have successfully reduced alcohol consumption-related harm by implementing community mobilisation strategies (Porthé et al., 2020).

The central premise of these interventions is that substance abuse affects the whole individual, requiring an approach that addresses all dimensions of their life. Treatment models emphasising structured activities, social integration, and personal development foster long-term recovery (Bunt et al., 2014). Winkelman (2001) argues that traditional healing practices offer valuable insights into the emotional and spiritual dimensions of addiction, aspects often overlooked in biomedical models. By integrating these elements into modern rehabilitation frameworks, treatment programmes can better address the complex needs of individuals, particularly in culturally diverse contexts like India.

INSIGHTS FROM COMMUNITY-BASED INTERVENTIONS AND THE NEED FOR COMMUNITY-BASED CENTRES

Despite the growing recognition of community-based interventions for addiction treatment, India continues to face significant gaps in implementation and accessibility (Balhara, 2014). Much of the existing research has focused on the prevalence and causes of alcohol abuse (Singh et al., 2007), while studies evaluating the effectiveness of community-based rehabilitation (CBR) models remain scarce. This lack of empirical evidence limits the ability of policymakers and practitioners to scale and refine these interventions to better serve individuals with substance use disorders.

Balhara (2014) examined a "soft-entry" (p. 2) approach that integrated treatment services into community settings, offering both pharmacological and psychosocial interventions such as motivational enhancement and family sessions. The programme showed a high retention rate (67.03%), attributed in part to the close proximity of services to patients' residences; however, Balhara also highlighted that many individuals, particularly in urban slums, were not actively help-seeking and required treatment delivery at their doorstep (Singh et al., 2007). He further emphasised how physical distance, limited awareness, and motivational barriers could undermine the effectiveness of community interventions.

Furthermore, most existing models failed to accommodate the needs of rural populations or dual-diagnosis cases, highlighting the need for comprehensive frameworks that integrate accessibility, inclusivity, and holistic care. This study builds on these limitations by examining CRSC's community-based rehabilitation model, which integrates residential care, communal living, and structured interventions to address barriers identified in previous research. Unlike many urban-centric or fragmented approaches, CRSC's approach prioritises accessibility, relapse management, and family reintegration, creating a sustainable model of rehabilitation. Importantly, this study redefines "community" not just as an external support structure, but as a core element embedded within the methodology and therapeutic interventions of residential rehabilitation (Balhara, 2011; Porthé et al., 2020).

Thus, expanding research on CBR models is essential, as these frameworks hold great potential for improving addiction treatment outcomes in India. By addressing existing gaps in the literature, this study contributes to the ongoing discourse on the role of community-based approaches in rehabilitation, with the goal of informing future interventions.

METHODOLOGY

Design

This qualitative case study examined CRSC's rehabilitation framework, focusing on its structure, processes, and outcomes. Data was collected using semi-structured interviews and direct observation; chosen to provide a comprehensive understanding of both the lived experiences of patients and the Centre's operational environment.

Semi-structured interviews were conducted with patients to explore their experiences with the rehabilitation programme. This method allowed for flexibility in questioning while ensuring key themes were addressed (Yin, 2018), provided first-hand narratives on the programme's impact, and perceptions of the therapeutic community model.

Direct observation documented real-time interactions, communal activities, and the overall structure of the Centre's environment. This method captured implicit behaviours, such as social dynamics, peer interactions, and adherence to daily routines, providing deeper insights into the communal support structures shaping recovery. The observational report provided context for the interviews, ensuring a comprehensive analysis of the rehabilitative environment.

Sample

This study employed purposive sampling, selecting eight male participants aged 25–50 based on their time at the Centre and active involvement in its operations. As the Centre caters exclusively to men, the sample reflects the programme's gender-specific nature.

Methodological and observational notes were maintained throughout data collection, and findings are context-specific, not intended for broad generalisation.

Ethical considerations included informed consent, privacy, and confidentiality. Participants were fully briefed on the study's aims, given the opportunity to ask questions, and informed of their right to withdraw at any time with the option to request data deletion. Given the sensitive nature of discussing addiction and rehabilitation, steps were taken to minimise distress. Interview questions were structured to avoid triggering emotional discomfort, focusing on the rehabilitation process rather than personal trauma. The researcher remained attentive to verbal and non-verbal cues, pausing or redirecting the conversation when participants exhibited signs of distress. Pseudonyms are used to

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ensure anonymity in all direct quotes.

Figure 1

Participant Pseudonyms and Corresponding Interview Numbers

Interview Number	Pseudonym
Interview 1	Arjun
Interview 2	Rohan
Interview 3	Vikram
Interview 4	Kabir
Interview 5	Rahul
Interview 6	Kiran
Interview 7	Amit
Interview 8	Sameer

Method of Analysis

Data analysis, concurrent with the data collection phase, was an iterative process whereby initial observations were reflected upon and shaped through subsequent data collection. The data was analysed through "thematic analysis" utilising epistemological frameworks to provide comprehensive data accounts. Thematic analysis was well-suited for several key reasons, providing a robust framework to examine the multifaceted processes within the therapeutic community-based substance abuse treatment centre. By focusing on recurring themes correlated to one another, it allowed for a more nuanced understanding of the research position, while also understanding the positive impacts this programme had on its participants. Thematic analysis also allowed for delving into the personal narratives which could be further linked to the comprehensive overview of the programme's effectiveness from the observational data as well (Braun & Clarke, 2006).

RESULTS

The following section presents the findings from the case study of the CRSC, focusing on the key themes that emerged from the data. The results are organised around the following areas: (1) the structure and duration of the programme, (2) the management of relapse and the role of family involvement, (3) behavioural changes and habit formation fostered by the programme, (4) the benefits of communal living, and (5) the participants' subjective understanding of success. Each theme highlights how CRSC's approach contributes to holistic recovery and long-term rehabilitation. Additionally, the study underscores the importance of cultural relevance in treatment frameworks, particularly in the Indian context, where family and community play central roles in an individual's recovery journey.

Rehabilitation Programme Structure and Duration

A key theme that emerged was the structured four-stage approach undertaken to facilitate a holistic recovery and reintegration into society. Bahara (2011) substantiates the structured approach by highlighting the importance of tailored, comprehensive set-ups within community-based intervention models. The programme's success lies in its ability to address addiction through a combination of personal accountability, communal support, and gradual reintegration, which are embedded in its four-stage framework.

The first stage (forty-five days), focuses on self-improvement where patients engage in input sessions and receive feedback from each other. These foster self-awareness, emotional healing, and accountability, with counsellors tracking progress and updating families. Subsequent stages are completed within a discretionary period of time up to the progress of the patient.

In the second stage, patients take on entry-level roles, such as managing housekeeping or laundry, before progressing to leadership positions like Heads of Department (HoDs). This structure instils a sense of responsibility and purpose, as noted by Rahul: "First, an individual is made a general member in a department… after that individual has been with that department for a while, the counsellors will consult one another and make him the HoD of that department". By gradually increasing responsibilities, the programme helps patients rebuild their self-esteem and develop skills that are essential for long-term recovery.

The third and fourth stages of the programme introduce increased responsibilities and volunteer opportunities for patients, including mentoring new members and engaging in external tasks such as procuring supplies for the Centre. These activities serve as a bridge to reintegration, allowing patients to step outside the Centre while remaining within a supportive framework. Many patients emphasised that the fourth stage provided a crucial transition period, enabling them to navigate real-world triggers with confidence and reduced risk of relapse. This structured yet flexible approach ensures that patients are not abruptly forced back into society but are instead gradually prepared to handle the challenges of daily life without reverting to addictive behaviours.

With the completion of the four stages, patients can transition into staff or outreach roles, further supporting their reintegration; however, participants expressed concerns that the current six-month duration is insufficient, advocating for at least eighteen months to reinforce growth and ensure sustained recovery. Additionally, they highlighted the importance of flexible durations and greater biological family involvement to further their recovery journey before reintegrating into society.

The findings underscore the importance of structured, staged approaches to rehabilitation, demonstrating how communal responsibilities, and gradual reintegration contribute to sustained recovery. By addressing the physical, psychological, and social dimensions of addiction, the programme creates a supportive environment that not only rehabilitates the individual but also empowers individuals to rebuild their lives. This highlights the need for further research into multi-stage frameworks within Indian rehabilitative contexts, particularly those that prioritise holistic and community-driven approaches.

Relapse Management and Family Involvement

Managing relapse is a critical aspect of the Centre's rehabilitation process. While the programme does not differentiate based on their substance use history or dual diagnoses, it employs specific interventions to support those undergoing relapse or struggling with complex psychological needs. As Rohan noted, "the treatment is the same for everyone, and everyone is treated together;" however, additional measures are in place to help relapsed patients reintegrate into the programme and address the underlying causes of their relapse.

One of the primary interventions for relapsed patients is the provision of "detoxification beds," specialised spaces where patients can rest and receive medical supervision during withdrawal. Located in the main hall, these beds allow relapsed patients to receive peer and counsellor support, reinforcing a sense of belonging and accountability. The "caring department," comprising patients further along in recovery, assists with medication management and emotional support, fostering mutual responsibility.

Another significant intervention is the use of companions for both relapsed and new patients. Companions help newcomers acclimatise to the Centre's routines and communal living, ensuring they understand the workings of the "family" structure. Reflecting on the arrival of new patients at the rehabilitation centre, Rohan explained that a newcomer "has no idea how the house works or how the family functions. So basically, the companion is important to introduce him to the workings of the household and the family." This fictive kinship (Osborne & Leone, 2024; Wang, 2023) modelled after a family dynamic, fosters a supportive environment where patients learn to care for one another and take collective responsibility for their shared space.

Individual counselling further aids relapse management with in-house counsellors dedicating additional time and effort to relapsed patients, providing them with the motivation and guidance needed to

re-engage with the programme. Despite setbacks, relapsed patients quickly reintegrate, demonstrating the effectiveness of structured communal support.

Family involvement, both within the CRSC "family" and the patient's biological family, is integral to the recovery process. CRSC educates biological families on the risks of premature programme withdrawal, since premature withdrawal significantly increases relapse likelihood (Rolová et al., 2023). Through this integrated approach, the Centre not only addressed the immediate challenges of relapse but also equipped patients with the tools and relationships needed for sustained recovery and reintegration into society.

Behavioural Changes and Habit Formation Fom the Programme

The Centre's structured daily routines significantly impacted patients' behaviour and lifestyle, and fostered mutual respect and accountability, which are essential elements for long-term recovery and personal growth.

A typical morning began with a fixed wake-up time, followed by a morning session with in-house counsellors to address communal problems. Patients then engaged in a series of structured activities, including group therapy, individual counselling, and skill-building workshops, as well as assigned tasks such as cleaning, or managing supplies. These tasks are not merely chores but integral to the programme's philosophy of fostering responsibility and self-reliance. Throughout the week, patients participate in varied activities, such as vocational training, creative workshops, and family visits, ensuring they remain engaged and purposeful.

Interviews with patients revealed how these routines helped them realise the differences in their attitudes and lifestyles compared to their lives before joining the Centre. Small but impactful habits, such as waking up on time and actively participating in assigned tasks, allowed patients to regain a sense of structure and direction, elements often missing in their lives prior to treatment. Patients were also allocated duties and responsibilities in roles not initially skilled at or interested in, which helped them appreciate and hone new abilities. By participating in chores, participants became aware of their shortcomings prior to treatment. For example, Vikram reflected on how participating in chores made him aware of his previous selfish behaviours:

"If my sister is mopping and yelling that I am walking around, I'm not really paying any attention to her. Today, I tend to understand that if I'm mopping the floor and someone is walking over it, then you are going to be irritable. The smallest things are basic manners that are recently forgotten when you are so addicted are what are taught here."

Counsellors regularly remind patients to consider not only their own needs but also the well-being of those around them, further reinforcing this sense of communal accountability.

The programme's interventions also worked to address the root causes of addiction, emphasising behaviour and personality modification. Patients struggling with impulsivity are taught to pause and reflect before acting, often through mindfulness exercises and role-playing scenarios. Those with low self-esteem are given opportunities to take on leadership roles, such as Heads of Department, which helps rebuild confidence and a sense of purpose. As Kiran noted, "the main aim of the treatment is towards your behaviour…working towards correcting those [behaviours] that had gone astray during your [substance] using."

These changes aligned with Mamba et al.'s (2020) argument that while medication-assisted treatments (MAT) are effective in reducing opioid use, many individuals with opioid use disorder also have complex psychological and social needs that MAT alone cannot address. Behavioural interventions, like those employed at the Centre, provide a more comprehensive approach by tackling the underlying psychological and social factors contributing to addiction. By instilling habits and creating a supportive environment, the programme equips individuals for long-term recovery, offering a model for enhancing rehabilitation frameworks.

Benefits of Communal Living

Communal living, within this context, refers to a shared structured environment where patients reside together in a family-like setting. This model emphasises mutual support, accountability, and collective responsibility, creating a nurturing space for individuals to recover from addiction. By engaging in communal activities, patients learn to cooperate, and develop a sense of mutual accountability. As Rahul noted, "Here, they are teaching you to eat with one another, take care of one another—be aware of things happening around you…All of these things are something you start to consider when living with one another."

One of the key benefits of communal living is the connection it fosters between patients and the outside world. Through community-based activities, patients gradually reintegrate into social norms and responsibilities, preparing them for life beyond the Centre. Tasks such as cooking and managing supplies are not just chores but opportunities to practice teamwork, responsibility, and accountability, helping patients re-establish a sense of purpose and direction, often lost during addiction.

The findings underscore the significance of communal living in creating a supportive and accountable environment, where patients develop a sense of responsibility and connection. While existing research highlights the importance of peer support in addiction recovery (Horvath et al., 2019; Eddie et al., 2019), there is limited evidence on how communal living facilitates such support within structured rehabilitative frameworks. At the Centre, the communal living model is designed to replicate a family dynamic, where patients take on roles and responsibilities that mirror those of a household. This fictive kinship (Osborne & Leone, 2024; Wang, 2023) structure fosters mutual care and accountability, creating a sense of belonging that is crucial for long-term recovery.

The support provided by this community-rehabilitation system is particularly vital for patients recovering from addiction, as it helps them remain focused and motivated throughout their journey. Participants reported that living in communal settings allowed them to move beyond self-centred behaviours, which they often associated with their addiction. By taking on roles such as caring for others, managing household tasks, and supporting peers, patients developed a sense of empathy and responsibility. As Kiran explained, "Living here has allowed me to look beyond myself and take care of others. It's made me think about how I can care for my own family and children in the future."

Communal living also connects patients to the outside world through activities that mirror real-life responsibilities. This fosters a sense of ownership and reliance on peers, creating a network of support critical for overcoming addiction. Research by Beaudoin et al. (2022) supports this, showing that peer engagement significantly promotes treatment adherence.

Understanding of Success

The concept of success within the CRSC's rehabilitation programme is deeply personal and subjective, reflecting individual rather than collective definitions. Moving beyond conventional metrics (e.g., sobriety rates), success is framed as an abstract and ongoing process, encompassing milestones like living in the present, gaining familial recognition, and reintegrating into society. This shift away from outcome-driven measures aligns with the programme's holistic approach, which prioritises the emotional, social, and psychological dimensions of recovery over rigid clinical benchmarks.

A recurring theme among interviewees was the importance of living in the present, with many defining success as the ability to navigate one day at a time. As Rohan noted, "Success is the passage of one day." This focus on the here-and-now reflects the programme's emphasis on mindfulness and self-reflection, which help patients avoid repeating past mistakes.

Others highlighted self-awareness and the willingness to seek help as pivotal moments of their recovery. For some, success also meant the ability to replicate structured routines in their daily lives after leaving the programme.

Familial acceptance also emerged as key markers of success. Amit explained, "I put more focus on improving myself so that my family can be confident enough to say that I am much better." This emphasis on familial acceptance aligns with the cultural values of collectivist societies like India, where family plays a central role in an individual's

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identity and well-being.

By framing success as an abstract and personal concept, CRSC empowers patients to define their own paths to recovery, fostering a sense of ownership. This approach enhances the programme's effectiveness reinforcing broader goals of community-led, holistic rehabilitation.

A key point that emerged through direct observation was the absence of women patients at the Centre, highlighting broader systemic issues relating to the availability and accessibility of treatment for women in India. Discussions with in-house counsellors revealed that societal barriers, such as stigma, privacy concerns, and familial opposition, often prevent women from seeking treatment. Counsellors also expressed a preference for working with male patients, citing past experiences where female patients were perceived as more likely to manipulate systems to leave treatment prematurely. This observation aligns with Balhara's (2014) findings, which report higher dropout rates among female patients due to societal stigma and restricted access to care. The underreporting of female substance abuse and its consequences, such as domestic violence, further exacerbates the issue (Singh et al., 2007). These findings underscore the urgent need for gender-sensitive interventions that mitigate stigma and create inclusive, supportive rehabilitation models for women.

DISCUSSION

The findings of this study offer new insights into the effectiveness of community-based rehabilitation models, especially in the Indian context, where such research is scarce. While existing literature (Gururaj et al., 2020; Balhara, 2011) document the prevalence of substance abuse and the barriers that exist to treatment, few explore the operational mechanisms of these community-based rehabilitation models. This study addresses this gap by providing a detailed examination of CRSC's therapeutic community model, highlighting how structured routines, communal living, and family involvement contribute to holistic recovery.

One of the key contributions of this research is its emphasis on the cultural relevance of the rehabilitation framework. Unlike many Western models, prioritising individualistic approaches to treatment, CRSC's model aligns with India's collectivist social structure, where family and community play central roles in an individual's identity and well-being. This differs from previous research (Hubbard et al., 2003; Kleber, 2008; Balhara, 2014), which often overlooked cultural dimensions of treatment, particularly in non-Western contexts. By demonstrating then, how communal living and "family" involvement can foster a sense of belonging and accountability, this study provides a nuanced understanding of how culturally relevant frameworks can enhance treatment outcomes.

The subjective definitions of success within CRSC also are important aspects of the research. While existing literature tends to prioritise measurable outcomes such as sobriety rates (Bunt et al., 2014), this study highlights the importance of personal growth, self-reflection, and reintegration into society as markers of success. This perspective allows us to better understand addiction recovery that goes beyond clinical metrics, emphasising the emotional and social dimensions of healing. For example, participants in this study defined success in terms of living in the present, gaining familial recognition, and developing a sense of responsibility, elements that are often overlooked in traditional outcome-driven models.

That said, the study's reliance on a small sample size, many of whom were batch-holders (e.g., Heads of Departments), limits the generalisability of the findings. As Degenhardt et al. (2019) and McKnight et al. (2018) highlight, smaller sample sizes in addiction research can restrict the ability to generalise findings and detect significant effects. Additionally, the potential for social desirability bias among participants, who may have felt pressured to present the Centre positively, could lead to an overestimation of the programme's effectiveness. Furthermore, the study did not account for confounding variables such as co-occurring mental health issues or socio-economic differences, which can significantly influence treatment outcomes. For instance, Kelly et al. (2020) found that individuals with co-occurring mental health issues were less likely to complete addiction treatment programmes and more likely to experience relapse. These limitations underscore the need for future research with larger, more diverse samples and robust methodologies to validate these findings.

Despite these constraints, the study sheds light on the role of communal living in fostering long-term recovery, an area that has received limited attention in existing research. While peer support is widely recognised as a key factor in addiction recovery (Eddie et al., 2019; Horvath et al., 2019), few studies have explored how communal living environments facilitate such support within structured rehabilitative frameworks. The Centre's use of a family dynamic, where patients take on roles and responsibilities that mirror those of a household, provides a unique model for fostering mutual care and accountability. This differs from previous research, which often focuses on individual therapy or medication-assisted treatments without considering the broader social context of recovery.

This study also brings to light the systemic barriers faced by women in accessing rehabilitation services, a critical issue that has been under-researched in the Indian context. While existing studies have documented the stigma and societal challenges that prevent women from seeking treatment (Balhara, 2014; Singh et al., 2007), few have explored the practical implications of these barriers within community-based rehabilitation centres. By drawing attention to the absence of female patients at the Centre and the counsellors' preference for working with male patients, this study underscores the urgent need for gender-sensitive interventions and inclusive rehabilitative models.

CONCLUSION

This study contributes to the field of substance abuse and community-based rehabilitation by offering insights into how culturally relevant frameworks can enhance addiction recovery. It highlights how communal living, family involvement, and structured routines foster long-term recovery within the Indian context, where collectivist values shape individual well-being.

By examining the Community Rehabilitation and Support Centre's therapeutic community model, this study underscores the importance of social integration in rehabilitation, moving beyond only clinical, outcome-driven approaches. The findings suggest that community-based interventions, when effectively structured, can address emotional, social, and psychological dimensions of addiction, offering a more holistic alternative to traditional treatment models.

However, the study also reveals systemic barriers to accessibility, particularly for women seeking treatment. The absence of female patients at the Centre highlights gender disparities in rehabilitation access, emphasising the need for inclusive, gender-sensitive interventions that account for stigma, privacy concerns, and familial opposition. Addressing these barriers is critical for ensuring equitable access to addiction treatment.

Moving forward, future research should focus on scaling community-based rehabilitation models, evaluating their long-term effectiveness, and adapting them to diverse populations, including rural communities

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