Innovative Interventions with Alcohol Problems in Rural Areas: An Indian Experience and its Relevance to Rural America

***Kala Chakradhar**, Murray State University, USA*

Summary
Conventional interventions used to address the complex problems of substance abuse call for multifaceted approaches reflecting the diverse backgrounds of affected populations. In this paper the rural context is highlighted as an asset in contributing to sustainable recovery from alcohol problems. Against the background of comparing two international rural contexts and recognizing shared identities, a case is made for transfer of knowledge east to west. The success elements of a unique approach to intervention with problems associated with excessive drinking in rural areas of South India, based on the experiences of Community-Based Rehabilitation camps is described. Spanning two decades of systematic implementation, the camps utilize existing community resources for planning, execution, and follow-up of treatment while simultaneously creating greater awareness about alcohol abuse through community education. After a critical examination of prevailing treatment options for problem drinking in rural America, inter-country analysis reveals contextual similarities between rural America and rural South India based on community-orientation, cost-containment, and social capital formation with implications for rural social work intervention with alcohol problems in the United States.

Introduction

Interventions to address the complex problem of substance abuse (including alcohol) have necessitated 'multifaceted' context-sensitive approaches reflecting the intricate diversity in client backgrounds (Ell and Vourlekis 2005; Gundy 2006). Community oriented interventions to work with alcohol problems date back to the 1970s, with a renewed focus in the past two decades. The key themes driving this approach have been first, the strengths accrued through community involvement and participation and second, prevention. Achieving efficient outcomes and sustainability through local availability amidst limited resources has been yet another motivating factor (Midford et al. 2006; Ormond et al. 2000; Saxe et al. 2006). For the purpose of this paper, the focus is the rural context and addressing intervention for alcohol problems tailored to the assets and limitations of rural populations.

The rural population of the United States shares the disadvantages ubiquitous to rural communities elsewhere, namely deficits in 'financial, physical and human capital' (Belanger 2005, 75). It also shares strengths characterized as typically rural: face-to-face contacts, community cooperation and willingness to know and intervene in crises involving others in the community (Harley et al. 2005). The latter characteristic is increasingly recognized as an asset to be capitalized, 'social capital' based on the qualitative relationships and interactions and the wealth inherent in social connections and informal networks within the community (Belanger 2005, 77; Gundy 2006). There is also an inherent rural diversity in keeping with the primary source of economic base with implications for policy and practice (Davenport and

Davenport, 1995). Today, three distinct 'rural Americas' have been identified: amenity-rich, declining resource-dependent and chronically poor communities (Rural America in…., 2007). In the welfare sphere, prevailing health care disparities are constant concerns with challenges that include limited public funding, paucity of personnel, wider geographic area coverage leading to access problems, smaller hospitals with restricted budgets and scattered distribution of limited resources (Berkowitz 2004; Galambos 2005).

Karen Van Gundy's (2006) report on 'Substance Abuse in Rural and Small Town America' surmises that though use of illicit drugs is less in rural areas than urban, alcohol abuse is a serious problem especially among rural youth and young adults. Alcohol-related problems are also more marked in individuals with less education and those who are unemployed or unmarried. This report was based on a critical review of The 2003 National Survey on Drug Use and Health (NSDUH) report. Her report urges the need for alcohol abuse treatment services, especially community interventions developed with and for rural communities through use of local resources. Stressing the limitations encountered in existing infrastructure, the report advocates tailoring treatment programs to the uniqueness and inherent strengths of rural communities.

The purpose of this analytical paper is (1) to review the current situation in rural America with regard to the treatment infrastructure for alcohol problems, (2) to present evidence of a time-tested treatment model that has proved successful in rural South India and the philosophy backing the model, and (3) to critically examine the suitability of adapting this experience from the East to address treatment for alcohol problems in rural America.

What follows is a literature-backed critical examination of the treatment situation for problem drinking in rural America and the advocacy for rural community development and community-based practice. The paper then examines the rural South Indian experience in combating problem drinking using Community-Based Rehabilitation camps. This unique approach to alcohol intervention has had about twenty years of successful implementation in rural India. The final part of the paper presents a cross-cultural analysis of the parallels that can be drawn between contexts (South India and United States) for rural social work practice in intervention with alcohol problems.

Literature Review

Rural America

A brief examination of the status of health care delivery for alcohol problems in rural America lends credibility to considering alternate intervention approaches drawn from the experiences of rural South India. Rural Americans comprise one-fifth of the total population (Dillon and Savage 2006). A recent compendium reviewing health services utilization by individuals with substance abuse and mental disorders draws attention to the rapid change in the behavioral health care delivery system in the United States in terms of clients served and the organizational structures utilized. Daunted by demands of cutting costs, quality maintenance, reaching care to the needy and optimum care and outcomes, the system has witnessed changing trends in substance use/abuse, demographics of affected populations, an array of available interventions, and last, but not the least, the indomitable role of managed care in making cost issues a barrier to client access to services (Council and Bray 2004).

The following review of problems related to alcohol consumption within rural areas in the USA reveals some interesting details:

- Higher rates of Alcohol Abuse and Dependence than in urban areas (52% vs 40%: SAMHSA 2005) (Lorenz et al.2004; McAuliff et al. 2003; Schoeneberger, et al. 2006).

- Compared to urban areas, rural admissions for alcoholism treatment more likely to be from criminal justice system (47% vs 35%) (Schoeneberger, et al. 2006.)

- Compared to urban treatment seekers, Younger, White or American Indian/ Alaskan Native, first time treatment seekers, abstinent in past month, no daily use (SAMHSA 2005)

- Adults from non-urban areas have to travel almost 6 times the distance than those from large metro areas to reach the nearest facility (SAMHSA 2002).

- Among rural older adult admissions to substance abuse treatment half were for alcohol abuse only; more likely than other admissions to enter treatment for first time. Among rural retirees, alcohol only admissions more likely to be retired than other older adult admissions (26% vs. 9 %) and less likely to have some form of health insurance (SAMHSA 2006).

- Higher proportion of rural treatment seekers is older than younger (Glasgow 2004).

- Rural physicians reported greater difficulty getting mental health services to patients and fewer mental health visits in rural areas compared to urban (Reschovsky and Staiti 2005).

Managed care and its accompanying policies have not only brought a drastic reduction in inpatient services but also have transferred financial risk to providers who may avoid expensive care options. This could reflect insufficient motivation to attempt best practices (Council and Bray 2004). Apparently, though substance abuse treatment is covered by almost all private insurance plans, less than half provide the same coverage for inpatient and outpatient services on par with that for other illnesses (Kronson as cited in Cornelius, 2002). Finally, inequities exist in federal allocations, leaning largely towards criminal justice than substance abuse prevention and treatment (Cornelius 2002). In rural areas, apart from federal/state allocations, local government spending on health services is a distinct entity. Nevertheless, health providers' dependence on Medicare and Medicaid reimbursement or the patients' ability to pay is substantial. Yet another disadvantage cited is uncompensated care, namely charity care or bad debt. Wealthier or insurance- covered residents prefer to seek care in metro areas in their region. The combined effect of these and the need to maintain a 'safety net' is seen as a burden on rural service providers (Zimmerman et al. 2004). For the substance abuse population inability to pay could mean postponing help. The lack of adequate infrastructure and personnel results in treatment-seeking individuals becoming a statistic in a waiting list.

Community-based Interventions

Researchers who have made critical analyses of this state of affairs consistently call for a serious switch to new treatment options that is of shorter duration and more cost effective. These alternatives need not necessarily involve only professional teams, and should seek to exploit inherent strengths of rural communities and involve communities to proactively determine health care needs (Cornelius 2002; Galambos 2005). Social work professionals

have been particularly urged to take 'a proactive stance' both at micro and macro levels, initiate and test best practice options and harness the growth and utilization of both human and social capital (Abbott 2003; Belanger 2004; Galambos 2005, 180). Abbot (2003) in her editorial cites SAMHSA administrator Charles Curie's keynote address to the 2003 Annual Program Meeting (APM) of the Council on Social Work Education (CSWE) highlighting problems in substance abuse services and SAMHSA's commitment to community-based services and evidence-based practice.

In essence here, a strong case has been made for a deliberate change in the way intervention for alcohol problems is addressed in the rural context in America. Given that problems related to excessive alcohol consumption are influenced by environments, a need to focus on context driven solutions is seen as key (Humphreys and Tucker 2002; Moskalewicz 2002; Ojesjo 2002). Complementing these recommendations is the widely acknowledged distinguishing feature that the community is a fundamental aspect of social work practice (Coulton 2005). Can these give us stepping-stones to forge new directions? What could be the answers and how? The following paragraphs present potential answers by highlighting the value of community based practice and rehabilitation especially in keeping with the characteristics and resources that govern rural contexts.

When examining rural contexts as practice settings for social work, the overriding theme that dominates the literature is that of community development and community-based practice (Murthy 2005). Community development has been lauded as the most appropriate approach for rural practice with its emphasis on resource utilization and development and ushering social change. The nature of the rural context characterized by its close-knit complex social networks, self-reliance, low population density, against the backdrop of restricted funding and resources has an impact on approaches to practice (Green 2003). The rural community profile requires innovative skills that exploit knowledge gained about the community through a gradual dynamic process that only community development can provide (Green 2003; Ersing et al. 2007). A necessary component of this progressive change process is the role played by interdisciplinary community collaboration established by stakeholders both within and outside the community, voluntary, professional and nonprofessional as well (Ersing et al. 2007; Murthy 2005).

Major issues related to health care debates in rural areas center on cost, access and quality; collaborative efforts are being tried and tested to address critical needs as well. Increasingly social work will need to concentrate on high-risk groups including those with substance abuse problems. In this scenario there is an urgent need for social workers to initiate and implement practice evaluation research that is interdisciplinary, cost-effective and culturally sensitive to rural areas (Ell and Vourlekis 2005). Recent chronological reviews have highlighted the ebb and tide of social work's relationship with community practice, beginning with the settlement house movement, with a resurgence of interest in the last two decades (Korazim-Korosy et al. 2007; Yan 2004). With due sensitivity to political and economic flux, interdisciplinary community collaboration and development (ICCD) and community-based rehabilitation are seen as the way to proceed in order to address health and social needs towards sustainable outcomes. The key assumption cited is the "synergy created with a diverse group of actors [that] will result in more creative outcomes" (Korazim-Korosy et al. 2007,19) and the opportunity to indigenize practice and promote self-help (Green 2003).

Various models of community development have been reported that focus on building and/or enhancing community assets, including financial, social, human, physical and political capital

(Ersing et al. 2007). In the realm of social capital, voluntary participation is seen to offer a form of collective action enhancing citizenship and creating supportive and sustainable communities (Kenny et al. 2008; Ryan et al. 2005).

Community-Based Rehabilitation (CBR) is one such model that was introduced by the World Health Organization in 1976 in the field of physical disabilities, especially for implementation in low-income countries with scarce resources (Chatterjee et al. 2003; Twible and Henley 1993). This has grown into a social model to overcome the gap in services to rural areas with an emphasis on inclusion, right to access and equal opportunities (Eldar 2000). Apart from encouraging active participation from the community and a sense of ownership through use of existing community infrastructure, this approach aims at 'demystifying' disability, promoting leaders to facilitate change for the better and educating communities through an experiential process. Central to this model is the focus on cultural relevance and simplification of strategy, complemented with a referral system and follow-up services (Eldar 2000; Twible and Henley 1993). The CBR model has been subsequently adapted to various contexts including India where it has been termed the 'Camp Approach'. In India, the CBR (camp) approach has been utilized to provide community-based services for issues beyond physical disability through eye camps, immunization camps, family planning camps and camps to address substance abuse (Chavan et al. 2003; Ranganathan 1994).

In the current global era the "retrenchment of welfare states" (Yan 2004) reflects the difficulty faced by governments in dealing satisfactorily with the existential aspects of community concerns. This in turn poses challenges to human service professions and the need for building alternative service options amidst a paucity of such practice evidence (Korazim-Korozy et al. 2007). Multi-country comparisons are seen as crucial in selecting new strategies to enhance skills, address client needs adequately and develop adequate delivery systems (Daley 2005) with the concepts of interdisciplinary community collaboration and CBR being at the forefront of this comparison (Korazim-Korozy et al. 2007). The following sections execute this comparison exercise to draw out strategies that would be amenable for transfer and duplication across national boundaries with due consideration to differences in context as well. What follows is the presentation of a community-based treatment model that has been in place in rural South India for the last two decades and indicates promise for an option to emulate.

The Indian Context and Rural Treatment experience

Generally described as an abstinent culture, prescribed by both the Hindu and Muslim religions, a review of historical reality presents a more ambivalent image of the drinking culture in India (Benegal 2005). Though the post-independence Prohibition movement catalyzed by the center, the federal government, proved a major preventive force for a major part of the twentieth century, effective enforcement of abstinence has been elusive (Chakradhar 1992). With the ushering in of a free market economy, socioeconomic flux and growing disposable incomes, there is not only increased alcohol production but also attitudes favoring alcohol use and a corresponding escalation in consumption (Benegal 2005).

Scientific recognition at the governmental level for intervention for alcohol problems originated only in the 1980s. Treatment for alcohol/drug problems across the country is offered mostly in public mental health institutions, psychiatric departments of government hospitals, private psychiatric clinics and substance abuse treatment centers. The treatment itself ranges from individual/group psychotherapy with family involvement to behavioral methods in both inpatient and outpatient settings. Remedial interventions that include dietary

regimens, religious indoctrination and those offered by alternative medicine and indigenous healers also add to the gamut (Chakradhar 1997). Of the substance abuse treatment-seeking population 45-50 percent is for alcohol dependence (Satyanarayana as cited in Ranganathan, 2001; Benegal 2005).

A stark realization in this evolution of formal services for alcohol problems was the need to focus on rural areas. Nearly three-quarters of India's population of more than one billion live in villages (Pasupuleti et al. 2004) with a larger share of drinking problems than in urban areas (Ranganathan 2001; The Extent….2004). India's health care system was envisioned and implemented as a tiered de-centralized system, a logical viable alternative to reach the people locally rather than having them travel to urban hospitals. The dismal reality, however, is that the rural health centers are plagued by a shortage of doctors and drugs, absenteeism, inadequate referral services and rampant spread of communicable diseases amidst rural poverty (40% of the population) and illiteracy (Pasupuleti et al.2004). Thus people from rural areas often have to travel to urban locations, with the accompanying disruptions to work and family life (Benegal 2005).

Against this background, in the year 1989, emerged the initiative for rural camps to combat alcohol problems. This is a 15-day in-patient program conducted in villages within locally available infrastructure such as schools, community centers or wedding halls, with each camp serving 20-30 clients. The initiative was taken by the TTK Hospital, Chennai in South India (see Chakradhar, 1993; Society for the Study of Addiction, 2005 for details of their treatment program). The discussion of the program below is based on both published and unpublished reports by the hospital and interviews and correspondence with Dr. Shanti Ranganathan, the founder of the hospital.

The unique features that went into initiating the rural camps were the adaptation of the concept of 'Community- Based rehabilitation' involving intervention in the community, using available community resources. This initiative included a cost effective intervention within rural communities with attention to the appropriateness and acceptability of the model to the community. This also involved conducting the intervention at no cost to clients, making it accessible to the clients. In addition, therapeutic sessions that are offered are tailored to the community context, e.g., the use of narrative stories and the language and its nuances that are familiar to the community. The responsibility of intervention is shared between the professionals and the members of the community, with the community providing the physical infrastructure and aftercare help. Education provided to the community by treatment personnel, including orientation to the recovery process, empowers the community and creates a sense of ownership. Apart from knowledge acquisition and attitudinal change, community support for recovering alcoholics and continuity of care is ensured.

Recognition and repeated acknowledgement of the benefits of the community approach both internationally and nationally, not only with alcohol and other drug problems but also with other health and environmental issues, was an added impetus to this initiative. Treatment camps have been a viable alternative to supplement healthcare in rural settings in India from preventive screenings and immunization to secondary and tertiary preventive interventions since the '70s. For substance abuse in particular, opium treatment camps were pioneered in the '80s and have been in operation sporadically, sponsored by psychiatric departments of public teaching hospitals. Such community based initiatives had also been reported from other countries in South East Asia and Canada (Ranganathan 2001; Lok Raj et al. 2005). The camp

approach model presented here, however, has been the most long-standing one of its kind in India.

Camp Approach[1]

Rural clients (in contact with the urban treatment center) or their collateral contacts or community representatives often identify the need for a campsite. The campsite is the village where they feel the camp needs to be to be conducted. Identifying and initiating a partnership with a host organization which are often schools, rural development societies, self-help organizations, churches and the like is the next crucial step. The host organization, which is a pivotal component of this program process, is described as "any local nongovernmental agency, which enjoys the trust and respect of the community" (Ranganathan, 2001, 65). Some of this host organization's responsibilities include identifying and motivating potential alcoholic clients for treatment, organizing infrastructures to conduct the camp and mediating in the educational, therapeutic and after care initiatives of the program. The camp is scheduled in consultation with the host organization avoiding peak harvest and/or business seasons, school events, or other community events that would hamper camp attendance.

Apart from intensive preparation of the community and volunteer resources, clients who are recruited for alcohol intervention are primarily detoxified at home, supervised by local physicians. Voluntary abstinence prior to the camp is encouraged as an incentive for admission. Disulfiram is prescribed with signed informed consent of the consequences and always under contracted supervision from the family or employer (see Ranganathan 2001; Ranganathan, in press). The treatment team includes a nurse and two counselors (social worker/ psychologist) from the urban center. A ward boy and a driver also support the team. They live in the camp premises and tailor the program and interactions with the camp participants to the comfort of the contextual rural environment, e.g., accent of the language, predominant community characteristics. The psychological therapy phase that marks the beginning of the camp consists of daily prayers, re-educative interactive sessions, group therapy sessions, individual and family sessions, sharing by recovering alcoholics and recreational activities (Ranganathan 1994; Ranganathan 2001).

The program includes 10 half-day sessions for the families and a two-hour education session for key support members independent of the sessions for clients with alcohol problems. Monthly follow- up visits for the first year following the camp are an important program entity. For more than a decade, the host organizations have taken over the follow-up responsibility, with the treatment team having to go only for the yearly treatment camps. There have been about 96 camps in the past 18 years and they have been held at distances ranging between 150 and 800 miles from the urban center (S.Ranganathan 2006, pers.comm., 4 July).

The critical components to which the program's success can be attributed include (Ranganathan 1994): the preparatory work initiated before the camp, the invaluable role of the host organization, a holistic treatment approach, community empowerment, the role of religion, and maintaining the momentum through follow up. Specifically drawing attention to the assets of intervention in the rural context is the close-knit structure of the community that helps in spreading the benefits of recovery from alcoholism among the people: "Each camp

[1] A detailed description of the camp approach as implemented by this treatment center beginning in 1989 is available elsewhere (Ranganathan 2001; Ranganathan, in press).

creates the publicity required for the next camp" (1075). The distinction of the salient features of successful treatment between urban and rural settings is that in the rural camp, participants are not strangers to each other, giving limited scope for denial. There is a high degree of trust in the treatment agency, the treatment group is often homogenous and confidentiality is not expected. The role of religion in one's life is often a given and narrative stories take on immense value. The follow up visits are often handled worked through with clients meeting in a group to review progress (Ranganathan 1994).

The treatment initiative is partly funded by the Ministry of Social Justice and Empowerment, which covers the cost of staff allowances, transportation and mediation. The host organization provides the physical facility, utilities and food. Sober recovering alcoholics or the participating community members often contribute meals. Health insurance as a formal entity governing treatment access is almost non-existent in India. Treatment providers are often seen as experts with authority (by clients) and can be directive in counseling in the best interests of the clients. This approach is seen to be effective in achieving favorable outcomes especially in villages and illiterate populations (Nimmagadda and Cowger 1999). Outcomes after one-year post-treatment in two separate assessments revealed an 83 percent and 67 percent abstinence rate respectively, with evidence of qualitative life-style change (Ranganathan 1994; Ranganathan 2001).

Some essential lessons learned in conducting these camps have been the need to: schedule camps in keeping with the community's work/occupational commitments; and exert caution with home detoxification and screen for specific medical and /or psychiatric conditions well in advance of the camp. An added lesson was that attitudes of the community towards clients who relapse and towards alcohol/drugs needed to be examined (Ranganathan 1998). Another observation worth incorporating was that it is important to steer clear of caste/class/geographic differences within the treatment group through modeling positive barrier-free interactions, especially during more informal events like dining, prayer sessions and recreation (Society for the Study of Addiction 2005; S. Ranganathan 2006, pers. comm., July 2). The time involved in forging community connections and receptivity to the intervention initiative could pose a constraint as well (Ranganathan 1998).

Important tenets of the Community-Based Rehabilitation approach were realized in the intervention experience in South India: It was a community-based initiative resulting from an expressed need, using community assets in the form of 'host organizations' and utilizing knowledge acquired from community members in program planning. The intervention took place in the community using community identified resources. Community participation formed an integral component in utilizing community members to contribute to the program (food, follow-up, support) and thus building social capital. Cultural relevance was achieved through sensitivity to timing and duration of the program and adapting program delivery to the context through the use of narratives, religious elements and flexible and creative use of professional markers like confidentiality. Education of the community at large including active program participants created the human capital necessary for sustenance and follow-up activity. Simplification of treatment strategies like detoxification and building social networks addressed not only fiscal efficiency but community self-efficacy.

The following section brings together the two national rural contexts, their commonalities and differences to examine emulation and innovation in intervention possibilities in rural America.

Analysis of the Two Rural contexts for Alcohol Intervention

A distant parallel to the South Indian camp experience can be found in the publicly funded, nonprofit social model programs in California that began five decades ago. Though not examined in the rural context, this model offers valuable lessons. Supported by the understanding that alcoholism is a multifaceted disease, these programs constitute a continuum of care from social setting detoxification (nonmedical) to residential recovery homes, non-residential neighborhood recovery centers and sober living houses. They are staffed exclusively by recovering alcoholics, follow AA guidelines, encourage participant involvement and experiential learning and have minimal hierarchy. The staff also acts as advocates for participants in providing liaisons to appropriate sources in the social network. Cost effectiveness data reveal that they almost halve the cost of other residential approaches achieving similar outcomes. Oxford Houses (Polcin 2006) and the Ohlhoff Skip Byron Primary program (Polcin et al. 2002) are examples of this success story. Despite initial opposition towards its meeting accreditation standards, this model received sustained recognition through an alternate review system, the California Association of Alcoholic Recovery Homes (CAARH). This model, however, faced rough times in the move towards medicalization and professionalization of what? through federal and state actions. The absence of these very elements gave this program its uniqueness and enabled cost savings (Borkman et al. 1998). Recent reviews of this model highlight an urgent need to systematically evaluate and establish its efficacy despite noticeable "erosion" since it has held its ground in not only being successful, but also getting increasing referrals from the criminal justice system. The reason for the erosion or decreasing adherence to social model principles has been attributed to the dominance by managed care and mandated treatment referrals from court systems (Kaskutas et al. 1999, 607; Polcin 2001; Kaskutas et al. 2003-2004).

Recapitulating the rural intervention experience in South India and its supportive features will be a worthwhile exercise to draw comparisons with the rural context here in the United States in order to estimate the possibility of transferring various aspects of the experience across nations.

CBR Parallels and Possibilities in Rural America

Community-based initiative and community participation: The rationale proposed earlier in this paper through the available literature has established favorable ground that such an initiative is possible. Rural America is a well recognized existing asset including its rich rural networks (formal & informal). Messinger's (2004) account of a comprehensive community initiative in rural North Carolina addressing issues like health, housing and education is a case in point. Ushering the inclusion of 'indigenous nonprofessionals'/'community guides' as an important element of postmodern social work practice, Ungar et al's (2004) study of indigenous non- professional helpers underscores the need to combine formal and informal resources in a community. Their research surmises that indigenous community helpers (non professional) "can be a catalyst for change and a bridge to inclusion, but only when operating from a position of immersion" (p.560). The successes in involving community leaders and use of natural community networks have been reinforced by other researchers as well (Harley et al. 2005).

Ryan et al (2005) make a convincing case for the potential that voluntary participation has in rural community improvement projects. They cite literature through the 20th century in which the passion for volunteering is presented as unique to American society and even a precursor to its stability. Backing their theoretical analyses is both their citation of the systemic model of community attachment of Kasarda and Janowitz and a survey by the authors of 9000

citizens across 99 small (500-10,000) Iowa communities. They argue that the combined influence of interest and sentiment nurtures social capital and the likelihood of residents working together for common purposes. These key observations closer to home provide fertile ground for tapping this resource to forge initiatives in alcohol intervention.

The national asset of voluntary participation (Ryan et al. 2005) can be exploited to enlist the support of health professionals within the community to volunteer their time and expertise towards such a camp initiative. Merwin et al's (2006) report of an experience from rural Southwestern Virginia offering free health services using volunteers in a Remote Area Medical (RAM) clinic through health fairs offers immense potential for innovative implementation. The replication of the California experience despite 'medicalization' and managed care challenges is a worthy possibility that needs consideration (Borkman et al. 1998; Kaskutas et al. 2003-2004). Funding possibilities for such low-cost initiatives have been cited, as well (Zimmerman et al. 2004).

Murthy (2005) offers alternatives for a revival of rural social work through a list of community-based initiatives. Advocating for decentralization of services, she recommends that service providers begin with a community needs assessment. Social workers in such regional programs (targeting various issues) could be assigned the valuable task of studying the community and its resources to better plan intervention efforts. Introducing the idea of 'travelling specialists,' rural one-stop multiservice centers hosted by the community in which workers from diverse programs visit and implement services, is another possible innovation. Funding concerns and directions have also been included.

Cultural Relevance: Though in the Indian context a high degree of trust in the treatment agency and collective decision-making (family/community members) serve as advantages in steering the individual towards treatment commitment (Nimmagadda and Cowger 1999; Ranganathan 2001; Society for the Study of Addiction 2005), the context in the United States is one of encouraging individual choice and self-determination at every phase of intervention (Bischoff et al. 2003). Though both these dynamics are culturally driven, the latter may pose some barriers depending on the individual's stage of readiness for change.

The de-emphasis of professional markers like credentials, documentation and absence of managed care pressures in India is seen by this author as a precursor to diffusing barriers and enhancing relationships between professionals and the community (including clients and families). One would seldom find framed display of professional credentials in social workers' offices in India. This is a viable possibility in rural contexts here in the United States since "rural people tend to evaluate social workers based on help delivered or problems solved rather than on their degrees, years of education or areas of specialization" (Davenport and Davenport, 1995, 2081) and are suspicious "of professional jargon" (Gumbert and Black 2004, 158).

While in the Indian context the absence of or limited anonymity in the rural milieu was identified as an asset in diffusing denial of alcohol problems (Ranganathan 1994; Ranganathan 2001), limited anonymity features here as both an asset (Harley et al. 2005) and a stigma (Lo and Stephen 2002) especially when considering problem drinking and alcoholism. Stronger ties within the community could be a cause for stigmatization, discouraging employed and older residents from seeking treatment for fear of a threat to social status (Lo & Stephen 2002). Fortney et al's (2006) study of at-risk drinkers (n=733) confirms this perceived stigma as a pervasive phenomenon. They recommend educational

programs directed both at affected individuals, their networks and the community since the stigma poses a major barrier to seeking treatment.

Whereas the Indian cultural context does not expect or demand confidentiality, in the American context confidentiality is a treatment/profession-driven ethic with legal stipulations and implications (Code of Ethic 2006). However, the tricky nature of adherence to it in rural practice is also being increasingly acknowledged, along with a need for a culturally sensitive approach to suit the rural environment (Gumpert and Black 2005; Strom-Gottfried 2005). Croxton et al (2002), reporting on their empirical study of urban and rural practitioners in Michigan, find that the value of confidentiality is held high in both contexts though the problem of dual relationships is inevitable in rural areas. They add that "absolute positions are unrealistic and unnecessarily restrictive" (121) and that "therapist(s) need to exercise judgment and not always follow the rules" (122). In the rural context, the positive aspect of observing clients in non-clinical contexts needs to be seen as an asset, according to these authors. This need for 'elasticity' with due regard to the uniqueness of practice situations is further affirmed by social workers in rural Australia (Green et al. 2006).

Respect for institutions, which is part of the rural fabric, places religion as a significant entity that can play a key role in the treatment and recovery process (Brown et al. 2004; Hodge et al. 2001). Rural Americans are more likely than their urban counterparts to attend church and identify as "born-again Christians," though there are regional differences and denominational preferences (Dillon and Savage 2006). Churches are key community assets. Some intervention programs especially with older populations could be planned, such as church retreats that may counter the role of stigma.

Finally, delivery of educative inputs through use of narratives and storytelling to promote understanding of drinking condition, which had high value in the rural camps in South India, has been reported to have favorable potential especially for rural clients in this country too. In one such report, storytelling was used within a social skills group to help members in addiction treatment deal with negative thinking. It is seen to generate enthusiasm in the group and provide an avenue for group members to examine their personal issues related to their addiction (Leukefeld et al. 2002).

Simplification of intervention strategy: In the Indian rural camp experience, as cited by Ranganathan 2001, medical barriers were overcome through home detoxification, de-dramatizing withdrawal, de-mystification of the need for drug support and empowerment of natural support systems in enabling recovery. Bischoff et al (2003) highly recommend a similar approach, i.e., social setting detoxification, especially for the noninsured and people with limited financial resources. Sharing their positive experiences at a community mental health center they present a balanced account of the strengths of treating clients in their own environments, using the resources available in the community including AA and other agencies. While in rural South India, the camps were a necessary precursor to forming AA groups, this process may be less difficult with the already existing AA network in rural America.

Building social capital through homogeneity: The homogeneity of the treatment group (a specific village/ rural area) in South India was seen as favorable, enabling bonding through the sharing of common experiences and events within the community (Ranganathan 1994; 2001). Rural communities in the United States, though diverse, depending on their geographic distribution and changing demographic characteristics, in and of themselves are seen to have

distinct common features (Murthy 2005). Homogeneity in treatment groups could also be created through common demographic characteristics like gender, age, race, criminal justice referral and the like.

Conclusion

In conclusion, amidst the backdrop of a growing recognition of the disparity of health services delivery between urban and rural populations, we see the evolution of a strengths perspective that can auger new and fruitful directions. Mental health services, including help for substance abuse problems, face additional challenges in rural contexts due to their obvious effect on the psyche, prolonged duration of treatment/recovery and associated stigmae. This paper, in recognizing the growing push for community-oriented, cost-containing, social-capital-focused alternatives to current substance abuse interventions, draws attention to one such successful movement in rural India for intervention with alcohol problems. In analyzing its applicability to rural populations in the United States, we see a substantial possibility for its appropriate replication in rural America. Reports of valuable experiments in relation to community oriented initiatives (Julia and Kondrat 2005; Leukefeld et al. 1999; Messinger 2004; Veysey et al. 2004), along with the analysis presented in this paper, help to begin our exploration of further implementations of Community-Based Rehabilitation in rural America.

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Author´s Address:
Dr Kala Chakradhar
Murray State University
101S Applied Science Bldg.
USA-Murray, KY., 42071
United States
Email: kala.chakradhar@murraystate.edu