

## Conversation with Shanthi Ranganathan



In this occasional series we record the views and personal experience of people who have especially contributed to the evolution of ideas in the Journal's field of interest. Dr Ranganathan founded and developed in South India a nationally influential centre to respond to alcohol and drug problems. What has given her work special interest and authority is her sensitivity to the Indian cultural context.

*Addiction (A): You have been working in the area of addiction treatment and rehabilitation for over 25 years. Tell us about your family background and how you happen to get into this field during a period when this subject was relatively unknown in India.*

*Shanthi Ranganathan (SR):* I come from a very traditional family. No one in my family drank. Also, during a decade or so following India's independence, when I was in my school and college, 'prohibition' was in force in this state of Tamil Nadu. Drinking alcohol was an offence punishable under the law. There were no bars or wine shops. To me, any one who drank alcohol was a villain or wicked. By the time I graduated, prohibition had been scrapped.

*A: So how did you come to develop an interest in alcohol problems?*

*SR:* I got married when I was 20. It was a traditional, 'arranged' marriage. I married into a wealthy household

where drinking was considered quite common. When guests were entertained, alcohol was served. My husband started drinking at a fairly young age. Over a period of time, he became an alcoholic. We did not know how to handle this problem. My mother-in-law pleaded with him, shouted at him, and even stopped talking to him for some time. We did whatever we thought should be done, but he did not give up drinking. He would often give up drinking for a period of time and start again. At that point in time, we learnt that treatment for this was available in the United States; we took him to America for treatment. He was in a centre for 1 month and I attended a few sessions for family members. That was the first time I understood that addiction to alcohol was a treatable condition. I also observed that there was no centre available in the entire region not only in India, but also in other Asian countries.

My husband died when he was hardly 33 years old. I had suffered in the process of being victimized by alcoholism. At the same time, I did not suffer too long to have become bitter about the whole thing, and I had the energy in me to do something constructive after his death. My in-laws were supportive. My mother-in-law felt that the family should do something to deal with the problem of addiction. We started the TT Ranganathan Clinical Research Foundation with funding from the companies owned by our family. The rest is all history.

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### THE TT RANGANATHAN CLINICAL RESEARCH FOUNDATION

*A: How did the work of your Foundation then progress?*

*SR:* We started the centre in a modest way in our own ancestral bungalow near the Santhome beach. It was a fairly big house. Before I started offering the services formally, I went to Hazeldon in the United States for training and I also visited several other centres. After coming back, I started offering help through an out-patient programme. I was not satisfied with the way I was providing

the therapy. Hence, I went to Broadway Lodge in England, which was started by Hazeldon; I stayed there for a period of 1 month. I acquired a great deal more clarity on how to conduct group therapy and issues to be dealt with in counselling.

*A: Then you broadened your programme?*

SR: When we started receiving patients from other cities in India, we felt the need to start an in-patient programme wherein we could offer both detox and psychological therapy under the same roof. In 1987, we were able to build our own centre. Here the patients could undergo treatment along with their spouses. Now we have completed 25 years and what we have today are:

- A 65-bed primary care centre: the patients stay here for a month. We provide detox as well as psychological therapy. We have a family ward wherein the spouse can stay for 15 days to attend the mandatory family therapy programme.
- A 20-bed 'after-care centre'—patients who need long-term care, mainly drug addicts; patients who have had repeated relapses are admitted for 3 months.
- A vocational therapy unit called TEJAS—patients who have completed treatment, if they have no skills, are given computer training and family members receive training in tailoring. We have a packing unit wherein they learn work ethics—to arrive on time and leave on time, work with the team and take up responsibilities, An outreach centre for intravenous (i.v.) drug users—a community programme; we have so far treated 500 i.v. drug users. We provide medical and nursing care, buprenorphine substitution therapy, counselling and help to deal with HIV.

Besides this, we conduct treatment camps in villages. We have been conducting camps for the past 16 years in six villages.

*A: Your centre treats mainly alcoholics or also drug dependents?*

SR: Initially, we treated only alcoholics. In 1987, brown sugar (heroin) addiction showed up as a serious problem, and there was a need to accommodate these patients in our centre. At some point in 1999, we felt that there was a large number of i.v. drug users and they were HIV positive. We started treating i.v. drug users by providing care and support.

*A: How many people has your programme benefited?*

SR: Around 18 000 families. When we treat a patient, it is not only that patient who recovers. The entire family recovers from the trauma. We are helping his spouse, children and parents as well.

*A: Well, Shanthi, how many really recover?*

SR: When we say 'recovery', we talk not only about giving up alcohol or drugs completely, but also improvement in other areas of life—improvement in work life, relationships, and so on.

*A: But your programme has total abstinence as its goal?*

SR: Yes, we believe in total abstinence. Because of addiction, every area of his life will have been affected—strained family relationships, violence at home, loss of job and 'spiritual bankruptcy'. When we say recovery, the person *has* to make efforts toward positive changes in life-style; 45–50% of them recover completely, and stay away from alcohol and drugs as well as make improvements in their lives.

*A: What about those who do not do so well?*

SR: Some of them go back to alcohol or drugs, some of them do not make any positive changes in their lives. But we do not give up. We recognize some relapse as an inevitable part of recovery and conduct a relapse prevention programme. Here, we educate them to recognize the relapse symptoms, methods to deal with them, and the need to improve their quality of life. We believe in long-term follow-up. Any such major change is a process. It does not happen overnight. We provide follow-up support for a period of 5 years. After a year, we expect them to come back to the centre once in 3 months. If they do not come we make efforts—call them over the telephone, send letters, make home visits and so on. Even if the patient is not willing to come, we contact the family members. We provide support to them. We help them to intervene. There are many patients who do recover and lead a quality life after a few relapses

*A: What kind of people come to your Centre—poor, middle-class or rich?*

SR: Addiction has no bar for religion, community or economic status or educational background. We receive patients from various economic backgrounds. We provide free treatment for those from the lower strata of society—conservancy workers, casual labourers, fishermen and the like. We have seven special rooms for those who can afford them. In the campsites, where the treatment is free, all of them are from the lower strata of society. Even in the outreach centre, again a free service, all of them are from poorer communities.

*A: Do any particular class or classes of clients respond better?*

SR: The typical 'middle class'. Their response is often gratifying. A clerk in a private firm or, for instance, a supervisor in a power supply undertaking or the manager of a hotel and so on. When they make an effort, there is a sea change in their life-style. I must say a good number from

the lower strata also benefit. The children go back to school. If they have lived in a house without electricity, now they will have a dwelling place with a power connection and a television set. There is economic improvement leading to life-style changes for the better.

*A: In what way is treating addiction in India different from how they do it in other countries?*

SR: In most of the Asian countries, the TC (Therapeutic Community) model is the method used by many centres. There are disadvantages to this model—the treatment period is too long (9–12 months). In a country such as India, the number of people seeking help is so high, if we have to keep them for long periods of time we can treat only a small number of patients. In India, they are not covered by any insurance. No individual can afford to stay in a treatment centre for a long period of time. They are expected to work and take care of their families. So we have a short in-patient programme and a long-term out-patient programme. We maintain an effective contact with the patient through the out-patient care.

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*A: Is that all the difference—the duration of treatment?*

SR: Some of the issues such as cocaine are a major problem in the United States. Fortunately, it is not a problem in our country. In other Asian countries, amphetamine-type stimulants are abused—Thailand, Philippines. In India, we do not have problems of amphetamine addiction. In India, some of the commonly abused drugs are alcohol (the foremost), marijuana, heroin, etc. We also have prescription drugs.

*A: In India we do see much poverty. At the same time, the government itself is directly selling alcohol—as in our state, Tamil Nadu. What do you do about it while being involved in prevention initiatives? Is it not frustrating?*

SR: Well, this paradox has become a social reality. Alcoholism leads to poverty. Work is available, but the majority of them work, earn and spend it on alcohol. The amount of money spent by government for alcohol-related medical problems, accidents, poverty alleviation and so on, is much more than what they may earn as excise duty revenue.

*A: Is there any kind of national policy on alcohol?*

SR: In the entire country, there seems to be no organization, which is concerned about the policies related to

availability of alcohol. The World Health Organization (WHO) has been emphasizing that the availability of alcohol has to be curtailed. There have to be many regulations regarding the minimum age for providing alcohol, responsibility of the server in the bar and so on. These are some of the methods to reduce the impact of alcoholism. Policy has never been looked into. Western countries face a declining market growth with regard to the sale of alcoholic beverages. So, most of the large liquor companies are focusing on India and China who have a huge untapped population of non-drinkers. These two countries are booming economically. Because of this reason, there are several ties up with liquor industries to produce alcohol. Recently, an organization has been launched called the 'Indian Alcohol Policy Alliance', which is part of the Global Alcohol Policy Alliance in England. They monitor the liquor industries and advise the government on policy issues.

*A: But your Foundation has an advocacy presence?*

SR: We make our best endeavours, through our research projects and studies, to make the government aware of the implications of high availability of alcohol. We make them aware of the amount of money spent for taking care of these people.

*A: Have you faced any ethical dilemmas in your work?*

SR: Yes. You know our programme has always been an abstinence-based model. When HIV became an issue with i.v. drug users from the streets, they were not willing to quit drugs totally. The option given was harm minimization. The dilemma began as to whether to adopt harm reduction strategies as an alternative to abstinence. We looked into harm reduction as an option in order to curtail the spread of HIV. After many deliberations, we decided to provide sublingual buprenorphine for i.v. drug users for a period of time so that they could be taken off i.v. use and when they are ready to go in for abstinence, we provide them all support.

*A: What was the real dilemma in this issue?*

SR: The issue is to give another drug as a substitute. That was the dilemma. On one hand, we promote total abstinence, and on the other hand, we provide drugs. The problem is, if we ask them to quit completely we are not going to get even one patient. Providing substitution was one way of attracting patients. Harm reduction is a way of attracting patients. They can be taken off i.v. drugs; hence the HIV issue is dealt with. Over a period of time, when they are in the right frame of mind through counselling and group interaction, we motivate the patients. We call it a low threshold programme. We provide what they want with minimal constraints or conditions.

*A: And such policies can produce benefit.*

*SR: We do see some improvements. We used to receive a large number of patients with abscesses. Now the incidence has reduced a great deal. We are offering many services, such as medical, nursing care, sublingual. We are able to attract many more i.v. drug users. We are willing to give 'whatever they want' to minimize harm, even though they do not fit into our criteria or regulations.*

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*A: How do you measure the quality of your service?*

*SR: I must say it is difficult to measure the quality of service. The attributes on which we measure are: the patient needs to give up alcohol or drugs completely, improve his life style—is he able to get back to work; is he able to strengthen relationship with family and extended family network; is he able to manage his life; does he involve himself in recreational activities; is he able to relate to a higher power? Other outcome measures are—do people come for regular follow-up, do they value the services provided? Yesterday it happened. The patient had taken treatment in 1988. He has been sober for more than 13–14 years. Recently, his daughter fell in love with a boy 'outside her community' and wanted to marry him. He suffered many conflicts and had a relapse for a day or two. He immediately came to the centre with his wife and daughter, shared his problems and learnt to accept the situation. This happened 4–5 months back. He came back again yesterday. For him, to come back after several years to resolve his conflicts, we must be providing quality service. We do not give publicity to what we do. Our main referral is through old patients bringing new patients. To me, it is an indication of the quality of service.*

*A: You are a Hindu. But a large number of your counsellors and other staff are Christians.*

*SR: True. Many of them are Christians. Even in social work education, half the students are Christians. That could be one of the reasons for many counsellors to be Christians.*

*A: Your Centre, is it an all-women show?*

*SR: The majority of the staff and almost all professionals are women. The resident counsellors who take care of the patients during the night are men; ward boys in the detox ward are men; a few administrative staff are men. This is true of most of the centres in India. The entire patient population is men.*

*A: And this gender situation is satisfactory?*

*SR: Being a woman, I think we are a great deal more empathetic. We have not faced any problems so far with this mix.*

*A: Nowadays there are many religious conflicts in society. Does that create any problem in your Centre?*

*SR: So far, no. Like Alcoholics Anonymous (AA), we believe in a Higher Power. We do not talk about any religion or specific God. All of us believe in a Higher Power. It is also important for the clients to get into a spiritual mode—the right kind of values, the ability to relate to a Higher Power. We start the day with the serenity prayer. There are no religious conflicts in our organization.*

*A: When I was walking past your centre, I noticed several pictures of 'Gods', both Hindu and Christian. You have specific higher powers? I hope this question is not offensive!*

*SR: Not at all. In India, many of them pray to a specific God. It is a common practice. The room where you saw the pictures is called *pooja* room. We hang the pictures of a wide repertoire of Gods belonging to the main religions. Whichever the God to which the patient would like to pray, he can sit quietly for a few minutes in the morning after a shower. We also encourage the patients to celebrate festivals. Festivals are important—they provide an opportunity to be with relatives and friends. It is also a way of learning to have fun without chemicals. At the centre, we celebrate all festivals.*

## HIGHS AND LOWS

*A: Two great moments in your life?*

*SR: As the President of FINGODAP—the body where all non-governmental organizations (NGOs) in the country are members, I visited several NGOs. When I visited, some were doing good work. Some had good intentions, but no skills or knowledge. I felt that there should be minimum standards of care for the entire country. We should provide some guidelines for the NGOs. Our centre as a team developed the documents—counselling sessions, group therapy, family therapy, follow-up counselling, etc. When we developed this, we had a meeting with 300 NGOs. We discussed minimum standards of care issues with them. To our surprise and satisfaction, the majority of them accepted the minimum standards of care. With minor modifications, we gave a shape to the document and submitted to the Government of India. The government accepted the document and made it mandatory for the NGOs, who are receiving financial support from the Ministry of Social Justice and Empowerment. A total of 380 NGOs are receiving grants from the government. Because they are using this as a mandate, the quality of service is*



bound to improve. Government did not stop with that. They felt that we have given them standards. How do they achieve these standards? The next step was that the government established regional resource and training centres (RRTCs) in five regions. Organizations who have been working for a longer period of time and who have the expertise were chosen as RRTCs. Under each RRTC a certain number of NGOs are there. Our centre is the RRTC for the South, catering for Tamil Nadu, Kerala, Karnataka, Andhra Pradesh and Pondicherry (80 centres). Our role is to provide knowledge and skills and help them comply with minimum standards of care through training and on-site training in local languages. I am sure that with all these efforts the quality of service will improve. It is a major achievement at the national level.

*A: Another high point?*

SR: One of our clients who came as a young boy of 18 with multiple addictions, after 15 years, with sobriety and financial success, gave us a big donation to build one wing to provide vocational training to our patients and their family members. It was a touching moment in my life. The boy clearly said, 'I don't want my name anywhere in the building. It is one way of showing my gratitude'. Even for the inauguration, he did not come. His father inaugurated the building.

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*A: You have not mentioned the awards you had received. Don't you see them as your high points? What do they really mean to you?*

SR: They do mean a lot. The Government of India honoured me with a 'Padma Shri' award in the year 1992, presented to me by the President of India. In 1999 Dr Kofi Annan, United Nations Secretary General, gave me the UN Vienna Civil Society award at Vienna, in the very first year of its introduction. These two awards increased the visibility of our institution at a national and international level, and helped us to network with many organizations working for the same cause.

*A: What have been the two most agonizing moments in your life?*

SR: In the community project for i.v. drug users, many of them are very young people. In this group, 45% of them are HIV positive. They are young, the majority of them are married and they cannot access antiretroviral drugs. Sometimes when I go there, the staff talk about the death

of one or two patients. It is very sad. We did something about it. People with HIV are given a kit every week. The kit has antibiotics, vitamins and medicine for ulcers in the mouth, medicine to control loose motions, condoms, gloves and some food, such as porridge. By providing them, we feel that we can help them to be functional, go to work and extend their life-span to some extent. When they come there to collect the kits, we also give them a medical check-up. Overall, this makes one feel sad.

*A: Other difficult moments?*

SR: In our second year of conducting camps in villages, we were conducting a camp at Kanyakumari—the southern tip of India. A patient with severe withdrawal symptoms was admitted because of pressure from the host organization. He had several medical problems and he went into delirium tremens and died on the third day. That was a very agonizing moment for all of us. At that time, the wife of the dead patient told all the other 24 patients not to leave the programme just because her husband died. Whatever has happened to him should not happen to you later, she said. She requested all of us: 'just because my husband died, do not go back'. A person who has just lost her husband to give a word of encouragement to other patients—it was the most touching as well as agonizing moment. We were very confused. We did not know whether to continue or discontinue the treatment. She gave us the direction and we continued with the camp and completed it.

*A: Did you learn something from this?*

SR: Yes, certainly. We sat together, modified our norms for conducting the camps. Some of the changes we made were contacting the patients 3 months ahead, providing medical check-ups and dealing with the medical problems, home detoxification with the help of a local physician before the camp, motivating the patient and the family members. Even if there is a 1% possibility of developing delirium, we shift them to TTK hospital. We made many changes and made our programme totally safe. This happened 15 years ago in our second year. Since then, we have not lost any lives in the rural camps.

*A: Most of your counsellors seem highly qualified with bright academic records and clinical experience—how do you retain them on salaries which, compared to industry, may seem unattractive?*

SR: It is the grace of God that they stay with me. The work itself gives us much satisfaction. We work as a team, and at the same time we have a great deal of independence. We encourage the patients to celebrate their new birthdays—the day on which they quit drinking or taking drugs. They come with their entire family—wife, children, parents—and share sweets with us. They share

with the new patients and are given a medal from the counsellor. The gratitude of the patient and improvements he has made gives us a great deal of happiness.

*A: What part of work gives you lot of joy?*

*SR:* Attending camp programmes gives me a sense of fulfilment. In every 15-day camp, I try to spend at least 2 days. Once a year I am part of the team which is conducting a camp at a village called Manjakkudi. I experience a 'flow' in the camp process and the interaction with the patients and the community. I have been going to the campsite for the past 17 years. Patients who were treated earlier also come back and share their joys and sorrows. We touch many lives in the community. We not only provide support to the patient but to the family members. When we go to Manjakkudi, in every second house we have a patient. We seem to know almost everyone in the village: we are connected with them in one way or another. The next year, when I see them with improvements in their life-style, I feel really happy.

*A: Your Centre does some publishing?*

*SR:* Preparing manuals and workbooks mainly on our own experiences is also gratifying. We work as a team and develop these manuals. So far, we have published four manuals for the Government of India, five manuals for the UNODC and six workbooks for the Colombo Plan. This work gives me a lot of stimulation.

*A: Which part is tiring or boring?*

*SR:* Administrative work, preparing reports for government, donor agencies, making the records available and so on. I think the creative components of my job form the 'artist' component. All these administrative procedures form the 'slave' component. Well, we *have* to do that also!

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