

EXPERIENCING HIETALINNA COMMUNITY

Stories of participation of the Service Users

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ABSTRACT

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The aim of the research is to identify what kind of narratives are the service user constructing about their participation in a therapeutic community. The target group is service users in the therapeutic community Hietalinna. The aims of the research were to analyze how service users have experienced their participation in the therapeutic community Hietalinna. I focused on identifying the weaknesses, strengths, possibilities and difficulties of the participation of the service user.

The study utilises qualitative research methods. The research was conducted by five narrative individual interviews. The material has been analyzed with the use of the narrative analysis method.

The analysis of the research resulted with three different identifiable story types of participation; the very active participant; the co-operative participant; the neutral participant. The interviewees discussed various different topics in the interviews. By analyzing the way how they discussed different topics I was able to identify the different story types.

With the results of this research there is new knowledge about the experiences of participation of the service users in a therapeutic community. This knowledge can be used in order to improve services.

Keywords: participation, addiction, narrative, therapeutic community

CONTENTS

1 INTRODUCTION	4
2 BACKGROUND AND THEORETICAL FRAMEWORK	6
2.1 Addiction.....	6
2.2 Therapeutic communities	11
2.3 Participation.....	13
2.4 Aims and research question	18
3 METHODOLOGY.....	22
3.1 Data Collection	23
3.2 Process of Data Collection	25
3.2.1 Therapeutic Community Hietalinna.....	27
3.2.2 Interviewing and analyzing data in a different language.....	29
3.3 Analysis Method	30
4 EXPERIENCING HIETALINNA.....	33
4.1 Arriving in Hietalinna.....	33
4.2 Experiencing Hietalinna.....	35
4.3 Second time in Hietalinna.....	37
4.4 Commitment to Hietalinna	38
4.5 Levels of service user participation	38
4.5.1 The dependent service user	40
4.5.2 The co-operative service user	41
4.5.3 The neutral service user	42
6 DISCUSSION.....	44
6.2 Ethics and validity.....	45
6.3 Further Studies.....	46
6.4 Professional Development.....	46
REFERENCES	49
APPENDIX 1 SUOSTUMUS	54
APPENDIX 2 CONSENT	55

1 INTRODUCTION

The aim of my research is to analyze what kind of narratives the service users construct about their experiences of participation in the therapeutic community Hietalinna.

The thesis is research oriented and will be used in the therapeutic community Hietalinna for development and improvement purposes in their community. My target group is the services users from the therapeutic community Hietalinna.

The research is work-life oriented as I have done it in close cooperation with the staff of the therapeutic community Hietalinna. The aim is to help the therapeutic community Hietalinna to develop its services and the participation of the service users. The aspect of service user participation means that the concept of community development is at the core of this research. By giving the service users a possibility to tell about their experiences and make their experiences visible for the workers, the results of this research aim to benefit the therapeutic community Hietalinna.

With this research I aim to provide valuable information about how the service users experience their participation in the therapeutic community Hietalinna. This knowledge might be used in order to improve the treatment of the therapeutic community Hietalinna or to develop the services of any other treatment organization.

During my studies I have implemented my practical placements in organizations such as Tapolan Kyläyhteisö ry, Youth house Harakkamäki, Vailla Vakinaista Asuntoa ry and the therapeutic community Hietalinna. In most of these placements I was confronted with the issue of substance abuse and the issue of community development. Especially during my placement in the therapeutic

community Hietalinna I developed interest towards the issue of addiction and the issue of the participation of service users.

I chose this topic as I am very interested in the work with substance abusers and the issue of the participation of service users in their treatment. The therapeutic community Hietalinna does community development work by empowering their service users to become independent and by supporting them to obtain a structured life. These factors increase the service users' participation into the society.

The participation of service users is a topical issue which is in need of more research. Knowledge about the service users' point of view is needed. It is important to gather knowledge about the experiences the service users have in their treatment and especially how they experience participation during the treatment.

With this paper I display my results of my study about the experiences of participation of the service users of the therapeutic community Hietalinna. In the following chapters I will at first describe the background and the theoretical framework of my work; the issues of addiction, in detailed substance abuse and gambling addiction, as well as the issue of service user participation and the therapeutic community model are discussed. Further on, the data collection method, the data collection process and the analysis method and process are explained. After I described my findings of my work, a general discussion chapter about the ethics and the validity of my work are discussed, as well as the possibility of further studies and I present my own professional development of this study.

2 BACKGROUND AND THEORETICAL FRAMEWORK

The following chapter introduces background information and the theoretical concepts of the research. In the following subchapter, the theoretical concept of addiction and participation is presented.

2.1 Addiction

As my aim is to study the experiences of participation of substance abusers who are in treatment in the therapeutic community Hietalinna, it is necessary to define what is meant by addiction. As my main interest lies in the addiction to substances and gambling, these issues will be discussed in the following.

According to Hakkarainen, Hankilanoja, Kuussaari, Partanen, Rönkä, Salminen, Seppälä & Virtanen (2007) in the year 2005 0.4% to 0.7% of the population aged 15 to 54, 12,000 to 22,000, have been amphetamines problem users. Opiates problem users have been in the same year 3700 to 4900, 0,13% to 0,18% of the population. (Hakkarainen et al. 2007.)

In Finland there are approximately 110,000 problem gamblers (Avellan 2013). More adolescents are problem gamblers than adults and per year one person spends averagely 239 Euros on gambling in Finland. Finland's problem gambling rate exceeds 3%; gambling prevalence in Finland was in the year 2008 at 74% and the problem gambling prevalence at 5.5%. Most popular were lotteries and scratch cards, most likely to seek treatment were electronic gaming machine gamblers, which are 66% of gamblers in Finland. (Griffiths 2009, 62.)

Drug-related treatment focused on problem users of opiates and poly-drug users. Opiates users are more expected to have severe issues and to request

help than cannabis users. The data of the year 2010 from the drug treatment Information System shows that 59% of clients requesting help at drug treatment units listed opiates as their main problem drug, 13% stimulants, 10% cannabis, 11% alcohol and 6% pharmaceuticals. Over 50% of the clients had a problematic use history with no less than three intoxicants. 80% of the problem drug users in the age group 25 to 34 have been men. Synthetic and pharmaceutical opiates were involved in most of all the opiate use recorded recently in Finland. (Forsell, Perälä, Tanhua, Varjonen, Vili 2012.)

The amount of clients seeking for treatment because of cannabis was highest in the youngest age groups. Actually, under 20 years old users sought treatment mainly because of cannabis. Alcohol is seen as the main problem substance and a very new social problem is problem drug use. The comparatively young age of users and fairly little record of drug use are typical factors of the problem drug use in Finland. Although over the past ten years the average age of drug users has increased significantly. (Forsell et al. 2012.)

In the 1960s and 1990s, Finland experienced two key drug waves. Starting as a small underground movement, the techno culture arrived in the end of the 1980s followed by an increase of experimenting with drugs in the 1990s; especially above the adolescents between the age of 15 and 34 years. The occurrence developed from a minor means of partying amongst metropolitan adolescence and became more diverse. The tendency to drug tasting in the 1990s has been shown to be a gender-specific variation and started from men; women just followed late 1990s. After the late 1990s this fashion obviously cleared off. However, nowadays drug experimentation and use is more common than it has been in the beginnings of the 1990s. Recently experimentation is increasing yet again within the age group of 25 years to 34 years. (Forsell et al. 2012, 26.)

The use of alcohol and substance has a variety of negative consequences on a person's physical and mental health, additionally on society in general. Those negative consequences conclude physical diseases, crashes and issues linked

to intoxication and addiction. At the resident level the most severe damage develops from impaired actions under intoxication, for example, accidents, violence and traffic accidents. Additionally the most severe damage develops from chronic diseases, like liver cirrhosis, brain damage, foetal abnormalities and pancreatitis. (Academy of Finland 2007, 2.)

In the year 2011 the national institute for health and welfare planned a survey called "Suomalaisten rahapelaaminen 2011"/"Finnish Gambling 2011" (Halme, Järvinen-Tassopoulos, Mervola, Ronkainen, Turja 2012) with the aims of studying the gambling behaviour of the Finns, their attitude towards problem-gambling and the frequency of problem-gambling. The survey was conducted by Taloustutkimus Oy. The research included 4484 participants aged 15 to 74 years old; which were interviewed via phone. According to the study, 78% of the Finnish population, 3.1 million Finns between the age of 15 years and 74 years, has gambled in some way during the year 2011. From those 78% Finns 12% have gambled at least twice per week and 34% once per week. Further on, two-thirds of the participants stated a severe problem in Finland is problem-gambling. (Halme et al. 2012.)

Although drug use and gambling differ from each other in terms of the addictive substance; in one case it is an actual substance to which a person is addicted, in the other case it is an activity the a person is addicted to; both of these may be considered very addictive. The world health organization (WHO 2013) defines alcohol or drug addiction as followed:

"Repeated use of a psychoactive substance or substances, to the extent that the user (referred to as an addict) is periodically or chronically intoxicated, shows a compulsion to take the preferred substance (or substances), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means."

In case of a gambling addict, the addict uses repeatedly slot machines, or other gambling activities in order to be "intoxicated"; is forced to play on, for example,

slot machines whenever near one; not able to control and reduce playing on slot machines and does everything in order to be able to play on slot machines. These can lead to high debts of the gambler, as in order to be able to play gambling games the gambler borrows money and even sells everything of his belongings. It can also cause eviction, as the gambler stops paying rent in order to finance the addiction.

According to Peele and Brodsky (1975/1991) every influential exercise can be addictive in which individuals are able to forget themselves. As well as while using substances, gambling also is able to start a series of emotions; sadness and failure will follow after enthusiasm, as also dependence on paranormal thoughts. (Cited in Peele 2001). Peele (2001) continues the vital factor of addiction to gambling is that individuals grow to be entirely wrapped up in an action, pursuing it in an obsessive behaviour with the result of enormously unconstructive life outcomes (Peele 2001). Also Griffiths (2009) states that problem gambling might have a negative influence on a individual's wellbeing, employment, savings or interpersonal relations; and that depression, alcoholism and obsessive-compulsive behaviour may worsen or be deteriorated by problem gambling (Griffiths 2009, 3).

There are many different definitions for addiction, which transformed over the years. Nowadays substances known as highly addictive substances and illegal have been some centuries ago used in medicine and have then been some kind of magic medicine. Even still nowadays many substances that we know as drugs are originally for use in medical treatment and in regulated use helpful. It is the wrong, irrepressible use of these substances that make them harmful. These days the term "drug addiction" has been changing to "substance abuse", this is caused by the wide variety of substances which have an addictive profile. Thus, the term "substance abuse" has become more popular, also activities have to be added. Gambling is not a substance, but it is an activity that can be for some people as addictive as a substance like heroin can be. Peele (2001) states that not only substance addicts experience the loss of control over their own behaviour and experience harm, hence are also problem gamblers.

According to Coombs (2004, 129) initiation, escalation, maintenance, discontinuation, relapse and recovery are the usual developmental stages of physical and psychological dependence; a person is not straight away addicted after one time use. The initiation is the first time use of any substance, does not necessarily mean followed by repetition. The escalation means the use of any substance with possible severe consequences. The user still has the possibility to discontinue. The maintenance is the phase when the use of a certain substance has become regularly; developing to use on a daily-basis. The discontinuation stage consists of first attempts of discontinuing regular use of substances. The user might try on its own or with support to stop using substances. The discontinuation stage is followed by the relapse stage, the user relapses and is using again. The last stage is the recovery stage; the user is able to stop the substance abuse and manages to live life without the use of any substances.

Coombs (2004, 39) recognises five different types of addicts, according to their different stages of drug use; abstainer, social user, addict, physical addict, physical and psychological addict. The first type is barely ever using drugs. The second type is only using drugs in collective happenings. The third type is not yet chemically dependent. The fourth type is physically dependent, but not yet psychologically. The fifth type's life is dominated by his addiction, as he is physically and psychologically addicted.

According to Cherry, Dillon and Antoine (2002, 9) drug addiction or abuse, is not a usual or constant use of any chemical substance to change the mood for a medically justified reason, but for any other reason. Nowadays, the permanent and obsessive drug use despite physical and psychological damage to the consumer and the general public is defining addiction; including legal and illegal drugs (Cherry, Dillon, Antoine 2002, 9-10). They define psychological dependence as the personal sensation of upholding a well-being sensation the addict desires from the drug. The want for gradually larger amounts of the drug to nourish the addiction and the experiencing of withdrawal symptoms while the

addict is abstinent are characteristics for physical dependence. (Cherry et al. 2002, 10.)

From the previous definitions we can therefore conclude that addiction is most of all not only focusing on substances, but also certain activities can be addictive. It is also important to realise that addiction occurs on different levels: psychological, physiological and social. The psychological level of addiction is characterised by the feeling of the user to the need of a substance, for example, in order to function or to be in a good mood. The physiological level is reached when the user's body adjusts to the constant existence of the drug and needs growing portions of the substance in order to reach the wanted state of mind. If the body does not receive the substance, the user experiences undesirable consequences; the user experiences withdrawal symptoms. Also the user at a social level of addiction can experience withdrawal symptoms. This user uses substances within a certain group of level at certain happenings, but not alone and not beyond these happenings. (Coombs 2004, 8.)

2.2 Therapeutic communities

As has been mentioned earlier, drug use and gambling are highly addictive; it is difficult for a user to discontinue the addictive behaviour without any support. There are different types of treatment available; inpatient treatment in withdrawal clinics, outpatient treatment as therapy or counselling sessions. One way of treating and supporting people who suffer from addiction is engaging them in therapeutic communities. By therapeutic communities we mean organizations which offer a communal drug treatment.

The most striking element that distinguishes the therapeutic community from other treatment options and communities is the *“purposive use of the peer community to facilitate social and psychological change in individuals”* (De Leon 1997, 5). The treatment process is collaborative, but the goals of the treatment are for every service user unique. The division of labour between the workers

and the service users is well established and clearly visible. The primary task of the workers is to maintain the structures and control the actions of the service users. *“The service users take care of the service users and the community takes care of the service users.”* This implies that the service users have a great influence in their own care, as well as in the treatment planning, implementation and evaluation of other service users. The service user participation happens in the care and treatment at community level, additionally coaches for social inclusion. (Ikonen 2006, 70-79.)

Every member of the TC is seen as a role model; if representing the expected manners and reflecting the principles and knowledge of the community. This ensures the maintaining of the reliability of the community and the increase of social learning effects. Also the workers are seen as a role model; idyllically, the workers consist of recovered and traditional professionals. The roles of staff are defined as rational authorities, role models, catalysts and guides in the self-help community method. (De Leon 1997, 7-9.) The community care structure and method supports service user participation in their rehabilitation as well as the implementation of the society. All functions of the therapeutic community is thought and designed to the service user’s recovery and social attachment. All community members are active participants within the community and the rehabilitation process. (De Leon 1997, 3-9.)

The therapeutic community defines substance abuse as a disorder of the whole person; affecting a person’s whole life. In order to rehabilitate, the individual does not only have to stop using the drugs, but also the individual itself has to go through changes. The goal of the recovery process is an overall transformation of the individual’s way of life. As a person enters a therapeutic community to stop substance abuse, he is knowingly or not entering to change his whole life. (De Leon 1997, 4.) The objective of the community is to support the individual in its well-being and its phase of transformation. The community-based approach is build upon the life change of an individual through the support of the peer group. The aim of the therapeutic community is recovery and an overall change of the lifestyle. (Ikonen, Kallio & Ruisniemi 2012.)

The elementary principle of the therapeutic communities is the users' participation in all roles and action of the community life. De Leon (2000) continues the community activities and relationships can only have a therapeutic and educational effect on the user if he is participating. Further on De Leon explains that the vibrant essentials of the transform development are the participation within the program and the level of involvement in the community. (De Leon 2000, 347-348.)

The community structure and principles strengthen the inclusion of communal care and rehabilitation methods which basic idea is the holistic view of human beings. In the community not the substance abuse itself is being taken care of, but the addiction is seeing as a problem of the whole person. The individual is seen as a whole, it is not solely defined for substance abuse or mental illness. In the community care model issues are approached with the mindset that the individual is a part of the community it is surrounded by. (Ikonen, Kallio & Ruisniemi 2012.)

2.3 Participation

As was mentioned earlier, participation is a key value in therapeutic communities. Therefore this chapter focuses on service user participation in general and how it is implemented in therapeutic communities. Service user participation has been and still is a highly discussed topic; especially in the case of drug users as service user. There has been more focus on the use and the effectiveness of the treatment services, than has been on the clients' point of view on the treatment (Baker and Hunt 1999, 129-131).

Brafield and Eckersley (2007) define user participation as following in their book "Service User Involvement: Reaching the Hard to Reach in Supported Housing":

“User participation [is] a generic term, although narrower than ‘service user involvement’, suggesting that users are taking part in some aspect of the organization’s work and therefore have some influence in decision-making.”

Hart (1992, 8) developed a ladder of participation in order to categorize and analyze children’s participation. The steps of the ladder are; manipulation, decoration, tokenism, assigned but informed, consulted and informed, adult-initiated shared decisions with children, child-initiated and directed, child-initiated shared decisions with adults. With the aid of this ladder, Hart explains the different levels of participation. According to his definition, the first three steps stand for non-participation and the other ladders for participation. The ladder on top; child-initiated, shared decisions with adults; stands for the most possible participation of children; the children initiate their own activities and the decisions are decided together with the adults.

In order to project Hart’s ladder of participation to the participation of service users, it is possible to “switch”. Instead of talking about the children’s participation, we can talk about the service user participation. The first three steps can be seen as non-participation of the service user. Within these steps, the power lies in the hands of the professionals and the service users have no possibilities to engage actively in the process. The fourth step stands for activities led by the social worker, but the service user received information hence the service user understands the reason for the activities, the decision-making process and plays a role in the activity. The following step describes a level of participation in which the activities are led by the social worker, but the service user has been informed and consulted about how his ideas will be used and to what kind of decision the social worker came. The next step explains the participation level where the decision is made in cooperation of the service user and the social worker, either way the activity is led by the social worker. Those three steps mentioned before were combined under the topic of tokenism. The next to last step shows a level of participation in which the activity is led by the service user and with a little input from the social worker. The last step is the highest level of participation. In this level the activity is led by the service user,

the decision making process happened with service user and social worker together on an equal basis. Those last two steps were identified by Hart as levels of real participation.

McPhail (2007, 2) arguments that the patient and professional participation is an activity which is highly consuming in time and money, thus verifications of efficient transformation are essential to substantiate the inputs. However the risk of lack of trust and of undertaking a huge damage to clients and professionals is present, if the participation happens in a shallow or tokenistic way. Thus it is very important to ensure full knowledge to the service users in every step of the service they are using.

Collins, Britten and Ruusuvoori (2007) argue that currently a change in the direction of health care professionals occurred; encouraging health care service users to see themselves in an active role in consultations and providing services which aim to accomplish this. In government policy demands for enlarged patient and public participation are apparent. According to Collins et al. (2007), patient participation, or comparable occurrences, has been examined. The reasons for the interest lie on the one hand in the interest of promoting patient participation "in its own right". On the other hand, others interests lie in the arguments of patient participation leading to profits, for example, the improvement of patient satisfaction, the enhancement of trust and the relationship between patients and professionals. (Collins et al. 2007, 4-5.)

Within my project placement, which took part between February 2013 and March 2013 in the therapeutic community Hietalinna I conducted a brainstorming method with the service users about what they associate with participation or what it means to them. Their answers were amongst others sharing responsibilities, openness, democracy, taking responsibilities, to be attentive towards others, interaction, adaption and honesty.

Peräkylä and Ruusuvoori (2007) present five main elements of user participation in their article "Patient Participation in health care consultations:

qualitative perspectives". The main elements are *"the patient's contribution to the direction of action, the patient's influence in the definition of the consultation's agenda, the patient's share in the reasoning process, the patient's influence in the decision-making and the emotional reciprocity between the patient and the provider of the care"* (cited in Collins et al. 2007, 168).

The first key element for user participation is the role of the patient either as an initiator, as by asking a question or asking for advice, or as a responder, as by answering to a question of the service provider. Peräkylä and Ruusuvoori (2007, 169) suggest that the client participates more in the controlling of a consultation the more possibilities the client has for incipient procedures. The influence of a client on the characterization of the plan of the meetings is the second key element for user participation. Hereby it is important for the professionals to offer space for the client to express worries and for the client important issues. The third element is the distribution of the client in the interpretation procedure. The main concentration of this element is the client's role within the discussion of the causes and possible solutions to the client's issues. The fourth element concerns the client's power in decision-making. The client has several possibilities to influence this process, by suggesting different treatments and by having a certain attitude towards the suggestions of the professional. The fifth element concerns the possibilities for the clients to express their feelings and how the professionals respond. It also concerns the experiences of the meetings and the behaviour of the professionals made by the clients. (Peräkylä & Ruusuvoori 2007 cited in Collins et al. 2007, 168-175.)

According to McPhail (2007) the intention of client and professional participation is the development of approachable, incorporated services benefiting the clients and professionals. He continues that there is the possibility of participation to change the basis of the relationship between social work scholars and specialists and clients and workers on the ground of reciprocal advantage and an equivalent influence background. (McPhail 2007, 2-3.)

Drug users are repeatedly considered as inactive receiver of support or regulations of control, punishment and discipline; they have no rights, no voice and no identity. Because they are using illicit substances, drug users are defined as criminals. (Anker, Asmussen, Kouvonen 2006.)

According to Asmussen (2006) for a successful and functional service user participation a trustful and democratic relation between the user and the social worker is inalienable. Within this relation the social worker assists to make alterations possible in the user's life. The user and his awareness of troubles are situated by the empowerment perspective into the centre and the user receives the control to modify his circumstances. (Cited in Anker, Asmussen, and Kouvonen 2006.)

Health professionals are more and more fortified to offer patient-centred care, to communication with their clients and to promoting user participation. Nevertheless, facts imply that those intentions are not being implemented; due to lack of skills and guidance of the health professionals and the barriers within the environment of the health care. In order to achieve patient participation these barriers have to be tackled. (Collins et al. 2007, 5.) Baker and Hunt (1999, 30) argument the drug user himself knows best about his illness and the life around substances, he is the expert. Concluding drug users should be able to choose which treatment and medication they prefer.

In Finland the National Plan for Mental Health Care and Substance abuse work was planned in the year 2008 and its goal is to improve mental health care and substance abuse work between the years 2009-2015 in various fields. One aim is the strengthening of the position of the clients. (Bergman, Moring, Nordling, Partanen 2010.) There are many discussions nowadays about how to offer clients more say in their treatment, about how to improve their participation. In Denmark user participation became statutory in the year 1998 with the new Act on Social Service 1998 entering into force. This act made following two techniques mandatory for user participation; user councils and social activity plans. (Anker et. al 2006.)

Adams (1996) argues there has to be acknowledged difference between the definition of user and client. The user is seen as an expert of his problems and is actively working together with the social worker. On the contrary the client inactively receives the help from the social worker and waits for the solution the social worker offers him. This empowerment perspective puts the user in the middle of attention and hence he receives back the power to adjust his life situation. The relationship between user and social worker is democratized and offers the user more influence than the client has. Being active, to participate in any kind of activity means to be a part of something. (Cited in Anker et. al 2006.)

In substance abuse work different methods are required for different service users. As an alternative for a rehabilitation option it is important to maintain a drug-free community care model which is focusing on the service users as a whole. The community care model provides substance abuse and mental health care clients an effective and profitable opportunity to a good life. (Ikonen et al. 2012.)

2.4 Aims and research question

As mentioned before the importance of participation of the service users for recovering drug addicts, I am interested in the experiences of participation of the drug addicts. I am interested in the narratives of experiences of participation constructed by the service users in the therapeutic community Hietalinna. The research question is; what kind of narratives are the service user constructing about their participation in the therapeutic community Hietalinna? The aim of the research was to identify how the service users of the therapeutic community Hietalinna are experiencing participation.

The participation of the service users plays a very important role in the therapeutic community Hietalinna and has been discussed within the mental health care and substance abuse work in the scope of the national plan for

substance abuse work and mental health care. With this research I aim to provide a new insight to the experiences made by the service users. This insight might be used in order to improve services for the service users. The participation of the service users is not only connected to the wellbeing and functionality of the therapeutic community Hietalinna; but also to the home community of the service users. Thus, the service users are empowered to an active membership within a community, the participation of service users can be seen as community development work.

Service user participation has been studied earlier by Minna Hekkala and Saira Ohranen; they have been conducting a case study of user participation with injection drug users; and Heli Valokivi, who conducted a study regarding the role of the individual as service users within the social and health care system.

Minna Hekkala and Saira Ohranen (Hekkala&Ohranen 2010) conducted a case study of user participation with injection drug users. Their case study took place in the Lyhty peer training programme. This programme has been conducted in the spring of 2010 in the drop-in centre Stoori. The aim of their case study was to develop an evaluation and description about the Lyhty peer training programme. With this evaluation they intended to increase knowledge about the possibilities of involving drug users in the services and to envision an example of a peer training programme with injection drug users. They found out that the Lyhty peer training programme was making it possible for service users and workers to discuss on an equivalent rank. Additionally, as the group members wanted to support other drug users, they had motivation to take part in the training programme. Field work supervision, the intoxication of the participants and overall the shortage of resources, like for example time, were identified as the major difficulties of the training programme. Their research is an evaluation of a programme which has been initiated by social workers but in which the service users have an equal role and the decision making process is shared.

Schulte, Moring, Meier and Barrowclough (2007) conducted a study about service user involvement in drug treatment in Northern England. Their study is a

part of a larger project which took place from the year 2001 to the year 2003 and consisted of semi-structured interviews with 46 service users and 51 service providers. Their aim was to examine the obtainable level of user involvement at chosen organizations, to study opinions about user involvement from both service user and provider perspectives and to evaluate preferred service developments. They discovered that the level of service user involvement was not high generally, as 16% of the services did not have any user involvement. However, the service users wished for a higher level of user involvement in contrast to the low ambition which was expressed by the service providers. They recommend development towards better understanding and balancing users' and providers' needs, because of the enhancement of treatment efficiency by user involvement and closer partnerships between service users and service providers. (Schulte et al. 2007.)

Ikonen, Kallio and Ruisniemi (2012) discuss in their report "Elämänmuutos rakentuu toiminnasta ja osallisuudesta yhteisöhoidossa" about the National Plan for substance abuse work and mental health care, and about one of its main policy; which is to strengthen the position of the client. Community-based treatment and rehabilitation for the client start off on an equal footing in the community. Each client has its own place in the community and the opportunity to influence the community. (Ikonen, Kallio & Ruisniemi 2012.) Ikonen et al. (2012) talk about the importance of community-based treatment as an option for substance abuse work and mental health care; they emphasize the importance of empowerment of the service users' participation during the treatment as a possibility to improve the service users' status in the social community.

Heli Valokivi's research "Citizen as a client- A research on participation, rights and responsibilities of elderly people and offenders" (2008) concerns the role of the individual as service users within the social and health care system regarding its participation and citizenship; focusing on the concourse of the social work expert and the service user (Valokivi 2008).

The main concern of the research is the way how the participation of an older or criminal person might be achieved as a service user of social and health care services. Further on, it states an issue about the composition of the citizenship of the person in the status of service user. The person's participatory personality in the situation of a service user represents a scale; from very vigorous and arrogating citizenship to a citizenship which has abandoned and has dissented. In between are consulting and cooperating citizenships, citizenships that surrender and pull out, are utilizing independently from services. (Valokivi 2008.) Valokivi's research displays the differences of service users about their possibilities and motivation to participate within social services. Her research offers a measurement for the level of participation of service users within social services.

3 METHODOLOGY

The following chapter will explain the process of the collection of the data for my research and what kind of techniques I have been using. The difference between qualitative and quantitative research will be discussed; as well as the narrative interview and analysis approach.

As Hirsjärvi and Hurme (2008) discuss in their book "Tutkimushaastattelu - Teemahaastattelun teoria ja käytäntö" the decision between conducting qualitative or quantitative research cannot be made upon personal preferences. Following aspects have to be considered before making a decision. First the form and the aim of the research have to be defined and depending on these the kind of research can be set. For example, researching a wider topic which is concerning a great amount of people, maybe even a whole society cannot be researched by interviewing a small amount of people from within this society. Or of course it can be researched, but the result of the research cannot speak for the whole society. For this kind of research a quantitative approach would be more suitable. (Hirsjärvi & Hurme 2008, 21-24.)

In contrast, a research about, for example, experiences made by a certain kind of group may be best researched by a qualitative approach, such as interviewing these people. Thus by qualitative research an individual's voice is being heard. Characteristic for quantitative research is also that the research object is independent from the researcher, whereas in qualitative research, the research object is in direct interaction with the researcher. (Hirsjärvi & Hurme 2008, 21-24.) According to Silverman (2005, 9-10) qualitative research means have a tendency to work with little quantity of matters and can offer a detailed insight of social appearances.

3.1 Data Collection

I conducted narrative interviews in order to gather material for my research. In the following I will describe why I have chosen to gather my material through conducting interviews and the narrative interview approach. This decision is based upon the aim of my research to identify the experiences of the service users. As I am interested in individual's experiences, it was clear to me not to conduct group interviews. As within group interviews interviewees might tend to agree on one reality and leave their own, may different, reality out.

As the service users in the therapeutic community are used to tell their own story, or to speak about issues within the group, I saw it as useful for my interviews. A normal structured interview with fixed questions seemed to me not useful for analysing their experiences. With a structured interview, the interviewer leaves not much space for the interviewee to develop and argument his ideas or his story.

As Kvale and Brinkman (2009, 155) state, narrative interviews resemble more storytelling. The interviewer asks the interviewee to tell him a certain story, or the story develops within the interview without the interviewer knowing the topic of the story. Narrative offers possibilities for persons to understand the past as it also similarly represents past incidents. By telling stories or happenings from the past, the storyteller might find some solutions to problems, or begins to understand his past and certain choices better. These narratives are purposive, efficient and calculated; they can be organized cyclically and by telling stories persons build identities. Through narratives the listeners or readers receive an insight to the viewpoint of the narrator. (Riessman 2008, 4-9.)

Czarniawska (2007, 61) states the timeframe of the accounts of the interviewees are chosen by them, and they might choose chronological, cyclical or cerotic timeframe; even though the interviewer might wanted them to start from a certain point. The decision lies with the interviewee, at what point the narrative begins.

The aim of the narrative interviews in this research was to offer the interviewees the possibility to express their experiences in the therapeutic community Hietalinna. They were giving a chance to tell their story of their experiences in the therapeutic community Hietalinna. Each interview, story, tells about one individual how he has coped and what he has learned.

In contrast to structured interviews, for conducting narrative interviews a researcher does not have to prepare a list of interview question that will be shortly answered. I have made a mind map with themes relating to my topic and which I thought to be important. As Riessmann (2008) states the aim in narrative interviewing is not to generate short answers or universal proclamations, but to generate in depth descriptions. Riessmann (2008) continues in order to develop narratives the interviewer has to resign from his power and offer the interviewee more freedom and bigger turns at talk. Further on, the interviewer has to follow the interviewee and where he takes the interview, and not the aim of the research. For this it is important not to be fixed upon what the interviewer wants to hear, but what the interviewee wants to talk about. In order to begin such an interview, it might be helpful to state an open-ended question. But as important an open-ended question is, it is also important for the interviewer to be open-minded, emotional attentive and engaged for the interviewee to feel empowered to tell his story. (Riessman 2008, 23-25.)

Johanna Mykkänen (2010) conducted narrative interviews in her research about men who were becoming a father for the first time. Mykkänen uses an open-ended question in order to start her interviews. The question was for every interview the same; hence it was possible for her to compare the answers of the interviewees. During the interview she only asks follow-up questions, or just nods or in any other way shows the interviewee that she listened and understood. (Mykkänen 2010.) Important for this opening question is to open up subjects and to encourage the interviewee to start at the beginning and that the interviewee can relate in chronological order to the happenings (Riessmann 2008, 25). Fulfilling these requirements I developed following question for the interviews: *"I am interested in your thoughts, experiences and feelings of your*

time in Hietalinna. What kind of feelings and thoughts did you have when you came to Hietalinna and how have they been developed from then until now? Tell in your own words, as soon as you are ready." By stating what I am interested in and encouraging the interviewee to start at the beginning of his stay in Hietalinna and to continue until the day of interview, the interviewees were offered the possibility to go back in time and relive their stay in Hietalinna.

I conducted five narrative interviews in Finnish. My thesis proposal states that I planned to interview five to ten interviewees, but after the fifth interview I realized that I reached the level where I do not have to conduct more interviews, as there will not be different and more knowledge than what I have reached by now; I reached the saturation point. The saturation point means, in qualitative research, that the researcher decided, upon personal view, not to be able to gain new material than has already been gained (Kumar 2005, 165).

3.2 Process of Data Collection

The process of my thesis started in the beginning of 2013 while I planned my project placement in the therapeutic community Hietalinna. The goal of this placement was to plan, conduct and evaluate a project within an organization. As I conducted already in the spring of 2012 a placement within the therapeutic community Hietalinna I was familiar with their organization, and already since then thinking about conducting my thesis in cooperation with them.

During the process of planning the project placement I developed the topic of my thesis to be the experiences of participation of the service users in the TC Hietalinna. The main goal of the project was to develop in cooperation with the personnel of the therapeutic community Hietalinna a questionnaire. The aim of the questionnaire was to analyse the service users' point of view of their participation and the participation of the personnel in the therapeutic community Hietalinna. Further on, I aimed to provide ideas for improvement of the participation in the therapeutic community Hietalinna.

Additionally I aimed to create a good basis for my interviews I was conducting for this thesis. By first filling out the questionnaire and discussing about participation, the service users and interviewees got already some ideas about the topic, and moreover they got to know me. This project gave me a lot of insight knowledge, some kind of basic knowledge, about what the service users think about their own participation and the participation of the staff within the TC Hietalinna.

The research question for my thesis however is; what kind of narratives of participation are the service users constructing? With the questionnaire from my project I got some general knowledge about the service users' definition and thoughts about participation, but no detailed explanation. The project was to prepare the service users for the interviews and to offer me more ideas for the thesis process.

Before starting the research process within the therapeutic community Hietalinna I applied for the research permit from the A-clinic foundation; it was granted in February 2013. After finalizing the project and presenting the results to the service users and the staff of the therapeutic community Hietalinna, I started the process of gathering volunteers for the interviews. I explained to the whole community the aim of my research and was handing out the consent for the interviews. We went together through the consent and I was answering upcoming questions as well as I explained the meaning of the consent and its contents.

After only two days, five service users agreed to participate in my research and returned the signed consent to me. I conducted five narrative interviews in the time frame from March 2013 to April 2013. They have been conducted within the premises of the therapeutic community Hietalinna. The interviews lasted from ten up to 35 minutes and have been recorded with a voice recorder. The interviewees were notified about the recording within the signed consent and also directly before the interview; the voice recorder was placed visible for all participants.

The appointments for the interviews were made by me personally with the service users. I gave them different dates on which I would be able to come to the TC Hietalinna and they could choose when it would fit them. After agreeing on those dates we did not have to rearrange the interviews, every interview happened on the agreed date to the agreed time. As the consent says, the interviewee has at any time the possibility to withdraw from the research, I told the interviewees if this should be the case, they are supposed to contact the staff of the therapeutic community Hietalinna, who will then inform me.

I have not collected personal data of the research participants, as it is for the goal of my research not relevant if the participant was male or female or how old s/he was. The only relevant requirement for the participants was to have been a service user in the therapeutic community Hietalinna for longer than three days. I decided upon a limited time of three days, as it was in my opinion possible to have after this time certain knowledge and experiences about the therapeutic community Hietalinna.

As the material has been gathered I started the process of transcription. The transcribing of the interviews was finished by August 2013. As the duration of the interviews differed, also the length of transcription differed; the total amount of transcription was 26 pages. The next step was analyzing the interviews and writing the thesis.

3.2.1 Therapeutic Community Hietalinna

The therapeutic community Hietalinna in Järvenpää is situated next to the Järvenpää addiction hospital. It has its own building in which are 17 places for substance abuser and gambling addicts. The therapeutic community Hietalinna offers rehabilitation for drug and multi-drug addiction and gambling addiction; drug detoxification without medication and consultation. (A-klinikka Säätiö 2013.)

The duration of the treatment depends upon the service user's situation and needs. The motivational period is one to three months and the advanced period from two up to four months of duration. They offer also strengthening periods and crisis periods, which in general are approximately two weeks long. Additionally they offer the possibility of work placement within the community and after-care support visits. (A-klinikka Säätiö 2013.)

The treatment in the therapeutic community Hietalinna is a total drug-free treatment. This means service users in the Hietalinna community do not receive any central nervous system medication for possible withdrawal symptoms. The Hietalinna community offers a communal method of treatment, this includes a communal solution-and resource-orientation; cooperation with families, networks and other services; encouraging and honest atmosphere; responsible and respectful behaviour; education, training and peer support; processing addiction from mental, psychological, physical and social aspects. (A-klinikka Säätiö 2013.)

The workers in the Hietalinna community consist of the unit manager, a doctor as also of nursing and social work professionals. Service users have the possibility to receive services of physiotherapists, occupational therapists, psychiatrists, psychologists, a pastor and hospital. (A-Klinikka Säätiö 2013.) The community house offers common space for meetings or other sessions for the whole community. The terms of philosophy of the community, its rules or regulations, the daily schedules and names of the service users are displayed on the walls of the communal room. The activities are planned in shared formats; at least one shared and self-prepared meal for the whole group, structured free time, on a daily basis programme of groups, meetings and seminars. (De Leon 1997, 7.)

Every day has its own schedule; consisting of varied therapeutic and educational activities with set times, regular actions and prearranged designs. Through this schedules days, the service users themselves learn to structure their everyday life eventually and more over it prevents upcoming boredom or

negative thinking; which might lead to drug use. (De Leon 1997, 8.) The daily running of the facility, for example, cleaning or preparing food, is the responsibility of the service users. Through these different activities and responsibilities lies an essential educational and therapeutic effect. In addition to the daily schedule, these activities help the service users to train their structuring of everyday life and prepare for a drug-free, independent life. (De Leon 1997, 6.)

3.2.2 Interviewing and analyzing data in a different language

Pietilä (2010) discusses in his article “Vieraskielisten haastattelujen analyysi ja raportointi” the issue of interviewing and analyzing data in a different language than the researcher’s mother tongue. He discusses the importance of considering how the analysis of data in a foreign language is differing from an analysis of data in the mother language. The researcher has to be aware of possible challenges in understanding the material; especially if the researcher has not collected the data. It is very important for the researcher to have enough language skills. Further on, it is important that the researcher is conscious about certain dialects or colloquial language, which might be used. If the researcher collects the data in a foreign language, he has to consider if the interviewees might speak to him differently than they would speak to an interviewer with the same mother tongue. The translation of interviews can be much work and can be difficult; especially as the fine nuances of meaning not always stand the translation and important parts can be lost. (Pietilä 2010 cited in Ruusuvoori, Nikander and Hyvärinen 2010, 411-423.)

Considering Pietilä’s article, I decided to conduct the interviews only after I have been for some time present in the Hietalinna community. In doing so, I was able to make myself comfortable with the colloquial language the service users were speaking. Additionally, I wanted to offer the service users the impression, that even if my mother tongue is not the Finnish language, but the German language, I am able to speak and understand it. Through this I wanted to

reduce the risk of them speaking to me differently than they would speak to a researcher with the Finnish language as his mother tongue. In consideration of the translation of the interviews I had decided to only translate those parts that were for me difficult to understand or that I wanted to quote directly in this thesis paper.

3.3 Analysis Method

As was mentioned before narrative interviews resemble more storytelling. In order to be able to identify those different stories, narrative analysis is used as the analysis method of the interview material. According to Kvale & Brinkmann (2009, 222) *“Narrative analyses focus on the meaning and the linguistic form of texts; they address the temporal and social structures and the plots on interview stories.”* In the analysis I focused on the different stories told by the interviewees; the focus was on what they were telling and not how they were telling their stories. Bernard (2011, 416) defines narrative analysis as the exploration for constancies in the way people, inside and transversely cultures, tell narratives.

According to Mishler (1986, 91) the diverse stages of understanding and the complexity in specifying story limitations that might be needed to connect subplots with each other and to the main focus of a story, can be issues in narrative analysis. Mishler continues that *“telling stories is a significant way for individuals to give meaning to and express their understandings of their experience.”* (Mishler 1986, 93). Mishler (1986, 93) states that systematic analysis of narrative stories in order to produce significant and capable conclusions is possible. Narrative analysis consists of a theoretical and methodological perspectives requiring detailed attention to what and how interviewees and interviewees tell each other. Additional, within narrative analysis the researcher cannot distance themselves from the interview material, as it is possible for researchers conducting a statistical analysis. The researcher

is connected to the interview material on a quite personal basis. (Mishler 1986, 93.)

The aim of narrative analysis is to identify certain stories which appear in the interview material. With my narrative analysis of the interview material I have collected with the five narrative interviews, I aim to identify the different stories the interviewees were conducting about their time in the therapeutic community Hietalinna. I especially focus on how they express and construct their story of participation in the therapeutic community Hietalinna. I focus on the stories themselves that came up within the interviews.

Riessman (2008) presents three different approaches of narrative analysis; structural, dialogical and thematic analysis. In contrast to the structural or dialogic analysis approach, the thematic analysis focuses primarily on what has been said and not how it has been said. The main focus lies not on analyzing the language used by the interviewee, but only on what the interviewee has said. Researchers using this approach believe that the interviewee meant what has been said. The researcher analyzes the contents of the interviewees and extracts from it the main stories. Consequently, the transcript of the interview does not necessarily have to be very detailed. I decided for the first version of the transcripts to keep them as original as possible, which means I wrote them as they have spoken, in colloquial language; but I did not mark pauses or other noises. For my own and also future readers' better understanding I cleaned out the transcripts before analyzing. I translated from colloquial language into literary language. I felt confident in doing so as I am not analyzing the language but merely the contents. (Riessman 2008, 53.)

After I finalized the process of transcription, I started with the main analysis process. I read through the interview material several times. The first times I only read through them to be sure to understand everything and made some notes about questions that came up, but also reoccurring topics. Later on I marked in the interview material the different topics that came up and started to compare the different interviews with each other.

Finally I identified the different stories which came up in the interviews. I was able to identify following stories from the interviews; arriving in Hietalinna; experiencing Hietalinna; second time in Hietalinna; commitment to Hietalinna. With support from the ladder of participation of Roger Hart (1992, 8); which I explained earlier; I was able to identify three different main story types of service user participation; depending on the level of participation the service user experiences in the therapeutic community. I named those story types; the dependent service user, the co-operative service user and the neutral service user. In the following chapter I explain more detailed the different stories.

4 EXPERIENCING HIETALINNA

As was mentioned before, I identified different stories from the interview material; arriving in Hietalinna; experiencing Hietalinna; second time in Hietalinna; commitment to Hietalinna. In addition to that I was able to analyze different levels of service user participation. These types I named the dependent service user, the co-operative service user and the neutral service user. In the following I will discuss the identified stories and the three different story types of service user participation.

4.1 Arriving in Hietalinna

The reason for the interviewees to be in Hietalinna is for all the same; they all have problems with some kind of addiction and want to quit it. For why they chose Hietalinna to be their place of treatment varies. Some did not know anything beforehand about Hietalinna and others could not imagine or comprehend what kind of place the therapeutic community Hietalinna will be like. For others it was a more clear decision to go to Hietalinna. (Interviewees 1-5.)

“The treatment here is drug-free; this is for me a really good aspect. If this would be a medicated withdrawal clinic or some other kind of treatment place, the service users would be much more different and less motivated” (Interviewee 1).

The knowledge, thoughts and feelings about Hietalinna before the first treatment differ between the interviewees. Some have some kind of knowledge about the therapeutic community Hietalinna, others have not ever heard about the therapeutic community Hietalinna before it got introduced to them as their therapy place and they were already on the way to the therapeutic community

Hietalinna. A few heard about the therapeutic community Hietalinna in other treatment institutions for substance abuse from other addicts who have been in treatment in the therapeutic community Hietalinna or from their social workers. But their idea about Hietalinna diverges. (Interviewees 1-5.)

Some interviewees imagined the therapeutic community Hietalinna to be similar to a hospital or prison. With long, sterile floors and the staff wears clothes similar to what staff wears in hospitals. They imagined the patients to be most of the time in their rooms, only for meals they group together and the staffs serve them food. The patients are inactive in receiving the treatment, most of the time lying in their beds, tired from the medicines. Some other interviewees were told before about the responsibilities they have to take and the role of the staff as being more in the background. Some other interviewees were not able to imagine what Hietalinna would be like, because of their bad condition. (Interviewees 1-4.) Some interviewees did not care really to what kind of place they are going. They just wanted to start with therapy and do something for their drug addiction. (Interviewees 1-5.) The interviewee explains that he did not care about in what kind of circumstances he has to live in Hietalinna; he just wanted a break from his life and restart fresh. He did not have any ideas beforehand about Hietalinna (Interviewee 5).

In general for all of the interviewees, regardless of what kind of picture they had before about Hietalinna, the first impression they actually made in Hietalinna was positive. Quickly they realized the relationship between the workers and the service users and what kinds of role both are playing within the community.

“In the very first meeting when I arrived in Hietalinna, there were not only workers present, but also one of the service users. Straight from the beginning I was introduced to the service users in Hietalinna.” (Interviewee 4.)

4.2 Experiencing Hietalinna

The relationship between the staff and the service users was for most of the interviewees a little bit confusing at first; as they expected to come to a more institutional environment. For others it was not a surprise at all for the service users being so active and it was one of the main reasons, why they decided to go to Hietalinna.

The interviewees describe the daily life rhythm in the therapeutic community Hietalinna as a little bit of scaring at first, but the other service users helped to adjust. For the interviewee 5 *“the daily routines make the days go by very fast”*. The interviewees are motivated to see that the other service users have the will to succeed. An individual therapy would not be suitable and wanted. *“All those people, if you see their motivation, it is also growing for you.”* (Interviewee 4-5.)

The interviewees see the therapeutic community Hietalinna as a place to build up a ground for a life without drugs and possibilities to find friends and support for the future. (Interviewee 1) Through the daily routines it is for the interviewees possible to relearn important daily life routines. The daily meetings are described as tough but helpful, they demand a lot of thinking. According to the interviewees' experiences, people with the same goal and motivation come to Hietalinna and those not *“fitting the Hietalinna profile”* (interviewee 1), soon leave again. For the interviewees it is more than helpful, it enables the search for peers and friends who can be supportive during life of abstinence. (Interviewees 1, 4)

The interviewees talk about learning to be able to accept themselves again. The interviewees learned that there are many more people, who suffer from the same problem. *“There are other people in my age who suffer from using drugs. In the outside world I always somehow assumed that everyone only enjoys using drugs and I am the only one for who it became a problem.”* (Interviewee 3) The interviewee also experienced that no one is judging someone if the service user does not know something nor did something unwillingly wrong.

Because everyone is there to learn, everyone came more or less from a similar background and all have the same goal. It is inalienable to speak with the others and tell if something is wrong, there is some kind of problem or need help with anything. (Interviewee 3.)

“The earlier you open up to people, tell your problems and ask for help, the sooner it gets better” (Interviewee 3).

Moreover the interviewees told to have learned that it is possible to enjoy a sober life. Being in Hietalinna and being active in all different kind of activities with the other service users and finding new and also old interests showed the interviewees that there is more to life than using drugs. The Interviewees continue that as long as the service users stay open minded when they arrive and are open to new people and possibilities; you only can take something good from Hietalinna. (Interviewee 1, 3, 5.)

According to the interviewees the responsibilities are just good. There is enough to do every day, so that there is no time for being bored and coming up with bad ideas. But still they have enough private time. According to the interviewees to be committed to the treatment is a very important, if not the most important factor for being successful in Hietalinna. (Interviewee 3.)

The interviewees received new will and motivation for handling daily life routines and other issues, which tend to be left aside. For example, during the treatment in Hietalinna the interviewees found motivation and power to tackle problems like repaying debts. (Interviewee 2.) *“I have started to enjoy things again; learned to enjoy the small things of life”* (Interviewee 2).

The interviewees' horizon has been narrowed and reduced down to just so few things and how it widened, was made possible to look further into the future now and be able to hope for something better in the future; to be able to believe in the future again (Interviewee 2). *“Now I feel again like I have felt before, before my problems have grown too big. I feel like myself again, like my normal*

self. I came back to what I have been once before. And what I wanted to be.”
(Interviewee 2.)

4.3 Second time in Hietalinna

As the interviewees have been for various durations in Hietalinna, and some have been before already in Hietalinna, the amount, or depth, of experiences they have made in Hietalinna varies; and of course as experiences are subjectively. (Interviewee 1, 4.) For some interviewees it was the second treatment in Hietalinna while I conducted the interviews. The interviewees often referred to their experiences from the first treatment and how it effects the treatment now. For them the first treatment ended or did not have the positive follow up that they wished for and both had a relapse. Now being for the second time in treatment in Hietalinna they are able to see, what they have done differently in the first run and what they have to change not to have the same result this time. (Interviewee 1, 4.) The interviewees talk a lot about how closed up and how self-contained they have been and how little the actual own motivation was at that time. The interviewees want to stop using drugs. Moreover, the interviewees did not offer themselves enough time to let the change happen but were waiting it to happen right away. And when it was not going as fast and easy as accepted, the treatment ended. (Interviewee 1, 4.) The interviewees are able to reflect the last treatment and make conclusions on what went wrong, or what they now want to do differently. Further on, the interviewees see their previous experiences also as a possibility to help other service users in Hietalinna not to make the same mistakes. (Interviewee 1, 4.)

“The first time I did not know so well myself what I came to get from here. Now the second time it was much clearer to me what my main goal is” (Interviewee 1). For the interviewees it was also easier the second time to emerge to the responsibilities and what the tasks will be. The first time the interviewees had more difficulties with them. The pressure is not there so much anymore, as the

interviewees have experienced that no one is judging. *“Now the second time I knew what I came for”* (Interviewee 1).

4.4 Commitment to Hietalinna

Further on, the issue of commitment was mentioned in all the interviews. All interviewees agreed upon how important it is to fully commit to the treatment and especially to the regulations and the life in the therapeutic community Hietalinna. According to the interviewees it is more than necessary to commit, as if a service user is not able or does not want to commit fully to the treatment in the therapeutic community Hietalinna, he will have troubles and might not be able to go through the treatment successfully. Moreover, the service user who does not commit will have negative influence on all the others service users and the whole community. For a functioning, liable and rehabilitative community the commitment of all service users and also workers is needed.

4.5 Levels of service user participation

As Heli Valokivi (Valokivi 2008) categorized the service users by their level of participation into categories; I aimed to do it for the service users from the therapeutic community Hietalinna. Valokivi stated that the level of participation of service user differ from very active service users, which are actively involved in their treatment and honestly interested and more over very able to participate. But there are also service users which, for some reasons, do not want or are not capable to participate. In between are service users which might choose when to participate and when not to. (Valokivi 2008.)

The service user from the therapeutic community Hietalinna can be categorized as more, if not even very active service users. It is important to say, this categorization mostly depends upon the treatment that is offered in the therapeutic community. The service users have to be active. Those who are not willing to be as active as it is needed from them will not stay in the treatment. So

in some way the therapeutic community Hietalinna picks already from the beginning, before the treatment even starts, the more active service users into their treatment and those less active service users most probably will not begin treatment or will fall out quite soon after the start of the treatment.

According to the ladder of participation by Roger Hart (1...) I was able to categorize the level of participation of the service users varying between level seven and level eight. The seventh level describes a participation of the service users as them being the initiator and actor of an activity. The eighth level describes the highest level of participation a service user can achieve. In this level the activity is initiated by the service user and the decision making process happens in co-operation with the social worker, in this case with the workers of the therapeutic community Hietalinna.

But it is important to say, that even if the level of service user participation is very high in the therapeutic community Hietalinna, there are certain decisions, in which the level of participation is lower. As was mentioned before, the service users take care of the service users and the community takes of the service users; the workers take care that the structured is in order. So in any case of decisions which consider the structure, the overall regulations of the therapeutic community; the power lies with the workers. So the level of participation of the service users might be at level four or five. At those levels, the service users are informed about any decision, or might be consulted and their opinion can be taken into account in the decision-making process, which is initiated and guided by the workers.

However, according to the interview material I have gathered I was able to identify three different stories of participation; the very active participant; the co-operative participant; the neutral participant. These story types I developed after I completed the first part of my analysis, where I identified the different topics the interviewees mentioned in the interviews. These following types are mostly a combination from all the interview material, and no interviewee stands exactly for one story type. I developed these types by focusing only on the different

aspects or issues the interviewees mentioned about participating in the therapeutic community Hietalinna. The following types display different levels of participation the service users have in the therapeutic community Hietalinna.

4.5.1 The dependent service user

The dependent service user's level of participation was first quite low, and only developed to a higher level. This depended mainly on the service user, on the level of commitment to the treatment. At its peak the level of participation swings between level six and eight; the dependent needs from time to time assistance from the workers in case of the decision making process, but is able to initiate alone an activity and consult the workers in the decision making process.

The dependent participant was in the therapeutic community Hietalinna for treatment before and the first time might did not meet the participant's expectations, nor the participant was able to commit to the treatment as much as it would have been needed. Consequently, the first treatment is not as successful as the dependent participants wanted it to be and it ends more or less abruptly. The dependent participant realizes while being out of the therapeutic community, that those factors that annoyed or disturbed him; strict timetable, everyday group meetings, the responsibilities, talking about your feelings; are actually things that the participant now misses in his daily life and the participant might even realize that they have been supporting in some way.

After some time apart from the therapeutic community Hietalinna the dependent participants wants to go for a treatment again and wants to try it once again in the therapeutic community Hietalinna; even though the first time went not as planned. As the dependent participant appreciates to be welcomed back again, and the strict timetables and responsibilities, which have been a problem before, are now much easier to handle and the participant is able to see their therapeutically meaning. The responsibilities do not seem so much as a burden

anymore and the group meetings are more interesting and helpful than exhausting and annoying. It is easier for the participant to talk openly about issues and what the participant has gone through.

The participant is able to open up about the first treatment in the therapeutic community and is able to see what went wrong the first time and how much the therapeutic community Hietalinna is actually able to help the service users, if they are committing to the treatment. The participant realizes how helpful the treatment in the therapeutic community Hietalinna is for starting a new life and to stop using drugs. The participant feels the need to help other service users, who are having the same issues and wants to help with the experiences and mistakes the participant has made.

The dependent participant realized it is not possible to change your life while just being passive and waiting for others to solve your problems. The participant realized everyone has to be active in order to make changes in one's own life. The dependent participant sees the level of participation of the service users in the therapeutic community Hietalinna at a very high level, and especially because of this fact the dependent participant sees the treatment as very effective.

4.5.2 The co-operative service user

The co-operative participant appreciates the treatment in Hietalinna and sees it as very helpful for people who have problems with certain substances. The co-operative participant really enjoys and participates actively in all activities the therapeutic community Hietalinna offers. In the beginning, the co-operative service user might be a little bit quiet, especially during the group meetings, but after a short period of time he becomes more and more active. The co-operative service user benefits from listening to other service users' stories and their problems, and giving feedback. For the co-operative service user this is a very important and necessary part of the treatment and is learning a lot from it.

The co-operative service user is very critical about everything and inquires different treatment services and decisions. Decisions made by the staff and the service users have to be discussed through with the whole community. Especially decisions made by the workers the co-operative service user wants to have detailed explanation, why the workers made this certain decision. The other service users respect and like the co-operative service user; as the co-operative service user has always something to say to them and always has some advice.

The level of participation of the co-operative service user can be defined at first as a more inactive level of activities initiated by the workers but with input from the co-operative service user in the decision making process. As the co-operative service user first needs to become acquainted with the therapeutic community Hietalinna and its rules and regulations. Later on the level of participation develops into a level where the co-operative service user develops own activities, but consults the workers in the decision-making process.

4.5.3 The neutral service user

The neutral service user's level of participation can be set at the same levels as the other types mentioned before. He participates in the community life and handles his responsibilities. He enjoys the peer-group support offered in the therapeutic community Hietalinna and uses it in order to improve his treatment.

However, the relationship between the neutral user and the workers is not as developed as it might be with the other service users. He appreciates the support the workers offer and the work that they are doing. But for him it is more important to spend time with the other service users and to discuss with them his issues.

Moreover, the neutral service user does question the treatment in the therapeutic community. For him it is very therapeutic to be in a group of people who suffer from the same problems and with whom he can discuss different

topics and to whom he can relate. He does not question the therapeutic community Hietalinna, for him it is as it is and he is fine with it. Possible conflicts with the workers or other service users he tends to solve rather sooner than later and if needed, he draws back.

The neutral service user does not care a lot about the circumstance of his place to stay during his treatment; he is satisfied to have a place to stay and to be able to work on his addiction. He has no problems in getting to know the other service users and is very open-minded.

6 DISCUSSION

This chapter consists of final discussions about the research. Following is a summary of my results; as well are discussions about ethical issues and the validity of the research. Additionally the possibility for further studies is discussed and finally my professional development I gained during the process of my first own qualitative research.

6.1 Summary of results

In this subchapter I aim to answer following two questions; how will the therapeutic community Hietalinna and the service users benefit from my research? How can the results be used?

I asked myself these questions during the whole research process. The aim of my research was to identify what kind of narratives the service users construct about their participation in the therapeutic community Hietalinna. The results showed they constructed quite different narratives. With these narratives, the workers in the therapeutic community Hietalinna received now an insight view to the opinions, thoughts of the service users. These results might broaden the knowledge about the service users to the workers. Also, these results can be helpful for other service users to identify themselves, their role within the therapeutic community Hietalinna. Phases they are going through, thoughts they thought; there were other service users who went through the same and who thought the same.

I aimed with this research to construct possibilities for the therapeutic community Hietalinna, but also for other organizations, to improve the level of participation of their service users. At least I aim with this research to inspire workers, service users or student of the substance abuse treatment

organizations to think about the level of participation of their service users and how they are able to improve it.

6.2 Ethics and validity

In this chapter, I talk about the ethical principles and issues concerning research. I make obvious the importance of ethics while conducting a research. Additionally I will present the ethical factors I had to consider in my research process. *“In all research involving the collection of data from human beings, there is a fundamental moral requirement to treat those people in accord with standards and values which affirm their essential humanity”* (Oliver 2010, 12).

According to Oliver (2010, 9) it is significant to reflect on ethical issues starting from the opening of the research process. He continues that every interactive situation with people requires respect, no threat of damage in any way to the participants and the participants have to receive full information about the research. (Oliver 2010, 22.)

The selection of participants should happen according to the aims of the research and the research questions. It is inalienable to provide full knowledge about the research's goals to the participants before they agree on participating to the research. Especially if the research aims to analyze experiences of a relatively small amount of individuals; it is more necessary to guarantee that they understood everything about the research before approving to take part. (Oliver 2010, 10 & 26.)

According to Rubin and Rubin (1995, 85) the reliability of quality research is evaluated by its intelligibility, regularity, logic and communicability. A transparent report displays every aspect of the research. The reader is not only reading the wished outcomes and the positive aspects of the research, but also the weaknesses of the research, and the interviewer's prejudices, assiduousness.

Within this thesis I displayed all aspects of my research; I made clear what kind of aims and goals I had and how I planned to achieve them. I explained detailed various steps of my research and the results. Furthermore, I showed the problems I faced.

6.3 Further Studies

There are possibilities to take this research further. For example, by conducting more interviews in different treatment places for substance abusers. There would be the possibility to compare the experiences made by the service users in the different organizations; thus producing knowledge and opportunity to develop and improve different treatment organizations.

It would also be possible to conduct a series of interviews with the workers in substance abuse work organizations in order to receive their point of view about the participation of the service users and their ideas if it is needed to be improved and how it could be improved. I would be personally quite interested to conduct interviews in different substance abuse treatment organizations, as I am very interested in the experiences of the service users about their participation. In my opinion, it would be really fruitful and empowering for substance abuse work.

6.4 Professional Development

The thesis has been my first wider research, so there was a great learning progress. In the beginning I read literature about possible methodology methods and literature concerning my topic of research in order to receive some general understanding about what I was planning to do. The methods I used I learned by doing.

The time-management was in the beginning no problem for me and the interviews have been conducted in the planned time table. Due to different

factors, I came to some difficulties to keep up with my schedule. Now afterwards I have realized that I did not count enough time for certain steps of the research, because I was not aware about how much time it takes, for example, to transcribe the interviews. Also I underestimated the workload in general of the thesis and took a too big workload from my work placement. That is why I had to extend the process of my research for six months. I informed the therapeutic community Hietalinna, the interviewees and the A-clinic foundation about this situation. A bachelor of social services is able to evaluate the theoretical points of departure for their actions and, as required, to implement alternative approaches so as to change their actions. (Degree-specific analysis of competences.)

I learned through this thesis process the importance of self-initiative and determination. I have developed the topic and the methodology for the research and during the process I was responsible for carrying out the research. I guaranteed to follow the thesis work guidelines and that I received the support from my supervising teacher and the staff of the therapeutic community Hietalinna when needed. I was capable to discover literature about the methods I have been using in my research process and applied it on my data supporting the results. A bachelor of social services is able to create an interactive, professional relationship with the client which enables client participation. A bachelor of social services is able to implement a variety of theoretical approaches and working methods in an appropriate way and to assess their success. (Degree-specific analysis of competences.)

I gained knowledge about addiction and participation of service users, as well as about conducting narrative interviews, narrative analysis and writing a thesis. Through the literature and the results of the interviews, I especially gained knowledge about the experiences of the service users in the therapeutic community Hietalinna. A bachelor of social services understands the functional principles and characteristics of communities; is able to cooperate with concerned parties to strengthen and create community spirit and participation. (Degree-specific analysis of competences.)

Through the whole thesis process in general I learned a lot about myself and the future professional challenges I might be facing. Even though, I did not meet my original schedule, I am satisfied with the result and I am convinced that all in all this progress has a positive outcome.

As English is not my mother tongue, but German is; I practically developed this research using three different languages. I conducted the interviews in Finnish, in English I wrote the notes and finally the thesis; but thinking and developing my thoughts I did in my mother tongue. This was quite interesting and also challenging for me. At first I had difficulties to translate my ideas for the research and especially for the interviews from English to Finnish. But after I was for a few weeks working in the Hietalinna community, and so mostly or only speaking Finnish, I had some difficulties to gather my thoughts and think again in English and to write my thesis in English.

I faced two challenges within this research process; first the risk of not enough service users volunteering to participate and secondly the risk of the dropping of the interviewees out of the research progress. As I conducted my fifth interview and arrived at the saturation point, I was quite alleviated. The risk of participants dropping out was still there, but as I discussed this issue with the service users themselves and also the staff; all participants assured me that they could not think about any reason why they should withdraw from the research. This assured me, but I was still cautious and ensuring with the staff of the therapeutic community Hietalinna, that if needed I was able to conduct more interviews.

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APPENDIX 1 SUOSTUMUS

Hei!

Nimeni on Anneli Roski ja opiskelen sosionomiksi Diak Järvenpään Ammattikorkeakoulussa. Olen tekemässä opinnäytetyötä aiheesta asiakkaiden osallisuus Hietalinna-yhteisössä.

Tavoitteena on selvittää, miten asiakkaat kokevat osallisuutensa yhteisössä, miten sitä hyödynnetään asiakkaiden kuntoutusprosessissa ja missä sen voisi vielä parantaa.

Opinnäytetyön aineisto kerätään haastattelemalla asiakkaita yksitellen nyt kevään 2013 aikana. Ja lopullisen työn tulisi olla valmis tämän vuoden syksyllä.

Haastattelut nauhoitetaan, mutta haastattelunaineistoa käytetään opinnäytetyön raportoinnissa niin että yksittäistä tutkittavaa ei voi tunnistaa.

Tutkimukseni on anonyymi, mitä tarkoittaa sitä, että henkilöllisyytesi ei tule ilmi työssäni.

Pyydän nyt Sinulta suostumusta tutkimukseeni osallistumiseen. Osallistuminen on vapaaehtoista ja Sinulla on mahdollisuus keskeyttää osallistumisesi milloin tahansa ilmoittamalla minulle.

T. Anneli Roski

_____ Suostun osallistumaan tämän opinnäytetyön haastatteluun kevään 2013 aikana. Haastattelun saa nauhoittaa ja haastattelunaineistoa saa käyttää opinnäytetyön raportoinnissa, mutta kuitenkin niin, että minua ei voi tunnistaa. Olen ymmärtänyt että osallistuminen on vapaaehtoista ja että voin keskeyttää osallistumieni milloin tahansa ilmoittamalla tutkijalle.

Aika ja paikka

Nimi

APPENDIX 2 CONSENT

Hello!

My name is Anneli Roski and I study at the polytechnic university Diak in Järvenpää Social Services. I conduct my bachelor thesis about the participation of the service users in the therapeutic community Hietalinna.

My goal is to clarify how the service users are experiencing participation within the community, how participation is benefitting the service users' rehabilitation process and how it could be improved.

I collect the data for my bachelor thesis by interviewing individually service users during this spring of 2013. And the bachelor thesis would be finished this spring of 2013.

The interviews will be recorded, but the interview material will be used in the thesis so that it is not possible to identify the individual interviewee.

My research is anonym. This means that your identity will not be exposed within my thesis.

I ask now for your consent to participate in my research. Your participation is voluntary and you have at any time the possibility to withdraw from the research.

Greetings,

Anneli Roski

____ I agree to participate in this study for an interview during the spring of 2013. The interview can be recorded and the interview material can be used in the thesis. But it will not be possible to identify me. I understand that my participation is voluntary and that I can withdraw at any time from this research.

Time and Place

Name