“No one bothers you here”

Clients’ experiences on the psychosocial support and the services in a maintenance treatment community

Degree Programme in Social Services
Final Thesis
28.10.2010

Saija Puhjo
Eeva-Liisa Yli-Mattila

Metropolia

Helsinki Metropolia University of Applied Sciences

Degree Programme in	Degree
Social Services	Bachelor of Social Services

Author/Authors

Saija Puhjo and Eeva-Liisa Yli-Mattila

Title

"No one bothers you here." Clients' experiences on the psychosocial support and services in a maintenance treatment community

Type of Work	Date	Pages
Final Project	Autumn 2010	65 + 4

ABSTRACT

This study was realised in cooperation with the Helsinki Deaconnes Institute's Maintenance Treatment Community. The objective of this study was to explore the opioide addicted clients' experiences and feelings about the treatment and the psychosocial support offered in the community, and whether there had been a change in their psychosocial ability. The theoretic framework of the study addresses different methods of psychosocial support especially in drug abuse treatment. The study also discusses maintenance treatment as a part of harm reductionist drug policy.

This study was a qualitative study. The data was collected by interviewing nine clients using semi-structured interviews. Elements of psychosocial support and psychosocial ability formed the basis for the interview. The data was analysed by using content analysis.

The results showed that there had been mostly positive changes in the clients' lives and in their psychosocial ability. These changes concerned housing, mental health, physical condition, personal economy, relationships, substance abuse and crime. The medical treatment alone was experienced as an important factor in the improved life situation, but also the community's services were valued. Especially the personnel's role and the non-judgemental atmosphere at the clinic were highlighted. Criticism was principally directed towards the clinic doctor and also towards the one-dimensional way the clients felt that their problem was seen.

The clients hoped more stability in the staff and that the pesonnel would delve deeper into the clients' situation. The clients also expressed a need for more holistic type of treatment, such as therapeutic methods and treatment also for their somatic symptoms. Many suffer from mental health and social problems and therefore the opiate addiction is not the only problem, but the situation is more multidimensional and calls for a holistic type of treatment both from the clinic doctor and the personnel as a whole. The results indicate, that the clients would benefit from a key worker system that would secure that at least one personnel member would be familiar with each clients' case. Attention should be paid also to the stability of the staff. Longer relationships between the personnel and the clients would improve the effectiveness of psychosocial support and develop the method towards a more therapeutic one.

Keywords

opiate addiction, maintenance treatment, harm reduction, psychosocial support

Metropolia Ammattikorkeakoulu
Hyvinvointi ja toimintakyky

Koulutusohjelma	Suuntautumisvaihtoehto
Sosiaalialan koulutusohjelma	Degree Programme in Social Services

Tekijä/Tekijät

Saija Puhjo ja Eeva-Liisa Yli-Mattila

Työn nimi

"Täällä saa olla rauhassa!" Korvaushoitoyhteisön asiakkaiden kokemuksia ja tuntemuksia yhteisön tarjoamasta hoidosta sekä psykososiaalisesta tuesta.

Työn laji	Aika	Sivumäärä
Opinnäytetyö	Syksy 2010	65 + 4

TIIVISTELMÄ

Tämän kvalitatiivisen tutkimuksen tarkoituksena oli kartoittaa Helsingin Diakonissalaitoksen korvaushoitoyhteisön asiakkaiden kokemuksia yhteisön tarjoamista palveluista ja psykososiaalisesta tuesta, sekä heidän näkemyksiään omasta psykososiaalisesta kuntoutumisestaan.

Tutkimuksen teoreettinen viitekehys käsittelee psykososiaalisen tuen metodeja etenkin päihdehuollossa. Tämän lisäksi tutkimuksessa esitellään korvaushoitoa osana haittoja vähentävää huumepolitiikkaa. Tutkimusaineisto kerättiin haastattelemalla korvaushoitoyhteisön asiakkaita teemahaastattelun avulla. Tutkimukseen osallistui yhdeksän asiakasta. Psykososiaalisen tuen elementit sekä psykososiaalisen toimintakyvyn osa-alueet muodostivat pohjan haastatteluille. Aineisto analysoitiin noudattaen sisällön analyysiä.

Tutkimusaineisto osoitti, että kaikkien haastateltavien kohdalla oli tapahtunut eriasteista psykososiaalista kuntoutumista. Muutoksia oli tapahtunut muun muassa asumisessa, henkisessä hyvinvoinnissa, ihmissuhteissa, taloudellisessa tilanteessa, päihteiden oheiskäytössä, rikollisuudessa sekä fyysisessä kunnossa. Jo pelkän lääkehoidon koettiin parantaneen elämäntilannetta, mutta yhteisön palvelut saivat myös kiitosta. Erityisen paljon painoarvoa annettiin osaavalle ja ymmärtäväiselle henkilökunnalle sekä yhteisössä vallitsevalle rennolle ilmapiirille. Asiakkaat kokivat, ettei heitä tuomittu ja että he voivat olla rehellisesti omia itsejään. Pelkkään narkomaniaan keskittyvä yksipuolinen hoito koettiin negatiivisena. Myös klinikan lääkäri sai juuri tästä syystä kritiikkia osakseen.

Henkilökunnan merkitys osoittautui erityisen tärkeäksi ja asiakkaat toivoivat henkilökunnalta pysyvyyttä sekä asiakkaiden asioihin paneutumista. Haastattelujen myötä ilmeni myös, että asiakkaat toivovat saavansa kokonaisvaltaisempaa hoitoa, sillä päihdeongelma on paljon monisyisempi kokonaisuus kuin pelkkä huumeriippuvuus. Asiakkailla oli sosiaalisia ja mielenterveydellisiä ongelmia joiden hoitoon he kaipasivat entistä enemmän apua. Hoitoon toivottiin terapeuttisempaa otetta ja lisäksi lääkärin toivottiin hoitavan myös somaattisia oireita. Omahoitajajärjestelmä voisi parantaa asiakkaiden tilanteisiin paneutumista sekä tehdä asiakassuhteesta terapeuttisemman. Henkilökunnan pysyvyys on myös avainasemassa parempien asiakassuhteiden luomisessa.

Avainsanat

opiaattiriippuvuus, korvaushoito, haittojen vähentäminen, psykososiaalinen tuki

CONTENTS

1 INTRODUCTION

Substitute and maintenance treatment have an established place in the present-day Finnish drug treatment system. According to Hakkarainen and Tigerstedt (2005: 12), five explanatory factors led introducing substitute (and maintenance) treatment to Finnish drug rehabilitation system. Firstly, there was significance increase in drug-related harms in the late 1990's, which led politicians and government authorities to revise the national drug strategy. Secondly, there were public disputes concerning two doctors describing buprenorphine at private clinics. In addition, a vast number of professional groups, non-governmental organisations, the media and ordinary citizens stood up for substitute treatment. International trends also affected and advocated substitute treatment in Finland. Lastly, substitute treatment became an important part of a current socio-medical reframing of the drug issue in Finland. (Hakkarainen & Tigerstedt 2005: 154.)

Psychosocial methods are often mentioned in the discussion concerning substitute treatment. Psychosocial support is also included in the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products (33/2008) and is therefore a central part of the treatment. "Current care" recommendations state that psychosocial treatment exclusively is inefficient when treating an opioide addict, but that together with medical substitute treatment it has proven successful. This study discusses the role of psychosocial support within maintenance treatment for opioide addicted people from the clients' point of view. Moreover, it studies whether the clients see psychosocial support as a relevant treatment method.

Helsinki Deaconess Institute's Drug abuse Treatment Centre in Munkkisaari, Helsinki, offers its opiate dependent clients maintenance treatment in a communal setting with low threshold, where psychosocial support is a part of the overall service together with the medical treatment. This client group is challenging, as many of them have not been able to commit to other types of treatment and therefore need specialized services. The main

objective in the institute's maintenance treatment is harm reduction, as leaving drugs completely is no longer likely or expected with the client group in question.

The research interest of this study is the clientele of the Maintenance Treatment Community. The aim is to explore their views, feelings and experiences on the overall services and especially the psychosocial support that the clinic offers alongside the medical maintenance treatment. The initiative for the study came from the Helsinki Deaconess Institute's Drug Abuse Treatment Centre. Saija Puhjo has completed her second practice placement at the Institute's Drop-in Centre and later on worked for Deaconess Institute in various positions and thus has a connection with the institute.

Chapter 2 presents the Helsinki Deaconess Institute's Maintenance Treatment. In chapter 3, maintenance treatment in the Finnish drug policy is discussed. Chapter 4 outlines different explanations on addiction and discusses opioide addiction in a more detail. Chapter 5 introduces the main theoretical framework; methods of psychosocial support. Chapter 6 shows earlier studies about similar subject areas. Chapter 7 concentrates on describing the methodology used in this study. This study is a qualitative research and the data is collected using semi-structured interviews. The results of this study are presented in chapter 8 and conclusions are made in chapter 9. The last chapter is dedicated for critical discussion about the study in question and the subject area in general. Later in this report, the Maintenance Treatment Community will be referred to as KoHo, the clinic or the community.

2 HELSINKI DEACONESS INSTITUTE'S MAINTENANCE TREATMENT COMMUNITY

Helsinki Deaconess Institute offers advice and treatment for drug addicts of all ages, and to their families and close friends as well as public authorities. The services include a drug addiction clinic for acute care, detoxification ward, a drug rehabilitation day clinic, a drop in centre Stoori, maintenance treatment community KoHo, substitution treatment, support centre Salli, family treatment, short term accommodation, a walk in clinic for HIV positive

drug addicts, non-institutional care, a mobile harm reduction unit and a laboratory. (Drug Abuse Treatment 2010.)

The values that guide the Institute's work with drug addicts are based on the general values upheld by the Institute. Its operation is steered by the Christian ethics and love for one's neighbour. This means that everyone's needs are responded to genuinely. The institute strives to always develop and regenerate its operations and services, and thus retain its vitality. It recognises its responsibility in the society and the environment, also globally. (Values Upheld by Helsinki Deaconess Institute 2010) The services for drug users are targeted to those, whose human dignity is threatened and where other help is not available. Values based in Christian altruism, such as human dignity, righteousness and communality are realised as work that advocates life worthy of a human being. (Huume- ja mielenterveystyön palvelualue 2010.)

The Maintenance Treatment Community KoHo has been operating since 15.8.2005 (Vehviläinen 2010). It offers rehabilitating maintenance treatment services for opiate addicted clients who are probably not able to give up drugs completely and who find it difficult to commit themselves to other substance abuse therapies. The objective is to prevent the spreading of contagious diseases and other health problems, and to improve the quality of life for the clients. This harm reduction principle is stated in the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opiate addicts with certain medicinal products and is the main aim of the treatment at KoHo. (Maintenance Treatment Community 2009.)

2.1 Services

The therapy at the Maintenance Treatment Community is based on methadone or buprenorphine treatment, psychosocial support and communality. It is a drop-in centre that is open from 9 am to 2 pm. In addition to receiving their medication, the clients can spend time for example by watching television and reading newspapers and magazines. The

clients are offered breakfast, lunch, and the possibility to do laundry and take care of their personal hygiene. They can make official calls and use the Internet. Services of a nurse and a social instructor are provided. The working methods include individual tutoring, institutional visits, group activities, community support and networking. When necessary, the community personnel make also home visits. (Maintenance Treatment Community 2009.) During the first years of operation, the community was divided in two units. Those behaving in a more unsocial matter and regarded as benefitting more from communality were treated in the other unit and those, who came to the clinic primarily for the methadone dose, in the other. Due to limited resources and personnel the Institute needed to unite the two units into one unit on 1.11.2009. (Vehviläinen 2010.)

The community does not offer the services of a social worker, but the clients are instructed to their local social office or Astu which is the social services for homeless people. Nevertheless, the clinic does offer help in dealing with officials by filling forms with the clients and accompanying them to different institutions. This kind of support is important, as many customers do not have the necessary persistence and ability to concentrate when dealing with official matters. (Vehviläinen 2010.)

The clinic doctor's job description mainly concerns treating the clients' addiction and very little any somatic symptoms. The doctor does, however, treat for example acute infections that are common with the client group in question. Also, referrals and statements can be applied for. Prescriptions for psycho pharmaceutical drugs may also be obtained from the clinic doctor. The nurses offer health education, treat cuts and bruises, measure blood pressure and blood sugar and work in cooperation with the doctor. During autumn 2010 the clinic starts to use electrocardiogram when monitoring the clients' health status. The clinic has its own laboratory. If a client is too ill in order to come to the clinic for their methadone dose, the personnel visits the client at their home. Some personnel members are educated to give acupuncture. The health services are essential, as using the local health centres may be challenging for many clients due to their substance abuse problem. (Vehviläinen 2010.)

The KoHo community does not offer actual therapy, but the personnel are ready to discuss the clients' private matters with them and help them to seek further assistance. The institute priest offers spiritual support. Also the community itself plays an important role in maintaining psychosocial ability: now the clients have contacts outside the drug world and have the possibility for peer support. A community meeting assembles once a week. There the clients may discuss community matters and make proposals. The participants vote for a community host(ess) who has the responsibility over the kitchen the week to come. Small allowance is paid to the host(ess). This procedure aims at strengthening the communality among the clients and the self-esteem of the host(ess). In addition to the community meeting there is also the possibility to join a discussion group. Every Thursday all volunteers may participate on a recreational trip, for example bowling. (Vehviläinen 2010.)

2.2 Clientele

The clientele constitutes from forty-six adult opiate addicts of whom a vast majority are men, in total thirty-nine persons. Mean age of the clients is 38.5 years. The clients come from the capital area, majority being Helsinki citizens. Of the total forty-six customers, thirty-three are from Helsinki, eight from Espoo, three from Vantaa, and two from Kauniainen. (Vehviläinen 2009.) All the clients fill one or more of the following criteria; the client does not benefit from rehabilitative maintenance treatment; the client has excessive additional substance abuse; the client has not been successful in other treatments due to inability to commit and/or behavioural problems; the client benefits from harm reduction, which stands for degreasing crime and preventing infectious diseases. (Päihdehoitoyksikön laatuarvio 2009.)

Most of the clients have a long history of opiate abuse. Many have difficult social back ground and together with abuse problems from an early age, this has resulted in an impaired psychosocial ability. In addition, multiple prison sentences and homelessness are important factors in their situation. Many suffer from mental health problems and use illegal drugs as self-medication. Therefore, the opiate addiction is not the only problem, but the situation is

more multidimensional and calls for a holistic type of treatment. It also explains why giving up drugs completely is no longer a feasible goal for many clients and why the clinic concentrates on reducing the drug related harm in the clients' own life and in the whole community. (Vehviläinen 2010.)

2.3 Rules and practices

The community has set rules that determine desirable behaviour. It is prohibited to use any illegal substances or alcohol in the premises, deal drugs or collect depths, use an offensive language or behave violently. Legal substances, such as coffee and cigarettes are allowed, although smoking has to take a place in a premises reserved for smoking. The maintenance treatment medication is consumed in the medication room only. Failure to meet these rules leads to a temporary ban from the premises. The ban can last from one day to several weeks according to severity of the offense. During the ban, the client can collect methadone and other medication from the medication room. (Vehviläinen, 2010.)

It is stated in the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opiate addicts with certain medicinal products that the medicine may be only given to the patient under the control of the care unit. There is an exception to the rule; if the patient's adherence to treatment is good, the patient may receive at most eight daily doses, exceptionally up to 15 doses at his/her possession. This procedure is called a vacation by the KoHo clients. Usually at KoHo, those clients who have successfully committed to the treatment receive the weekend's medication before hand. After the weekend, the clients need to bring back the empty bottles unharmed. Failure to do so will result in losing the right for a vacation the following week. Other impediments are ban from the services and worsened mental status. The personnel have experienced that frequent vacations often lead to worsening of the clients' mental wellbeing. Therefore each vacation needs to be applied for and granted separately. Common reasons for applying vacation are family reasons and juridical proceedings. (Vehviläinen 2010.)

The Deaconess Institute sees addiction as an illness. The clients are also referred to as patients, depending on the situation. As patients suffering from an illness, the clients are seen as needing care, attention and support. However, the clients are also seen as rational and liable, and therefore their right to self determination is respected and supported. If the client has not been able to function within the community rules, he will be excluded from the services for a limited time, but even in such cases the client's illness (addiction) will be treated with medicinal means. Even after a long ban, the clients are welcomed back to the services according to the Institute's values and the harm reduction principle. (Vehviläinen 2010.)

3 MAINTENANCE TREATMENT IN THE FINNISH DRUG POLICY

This chapter discusses maintenance treatment as a part of harm reductionist drug policy in a more detail. First, the concepts of substitute and maintenance treatment are explained. Then the chapter gives an overview on the development of the Finnish drug policy and on the legislation concerning maintenance treatment. Lastly, the concepts of harm reduction and low threshold services are looked deeper into.

3.1 Maintenance treatment

The difference between the concepts of substitute and maintenance treatment causes confusion in Finnish discussions. Substitute treatment aims to drug free life and integration back to the society, whereas maintenance treatment concentrates on harm reduction and enhancing the clients' quality of life when detoxification is no longer a realistic goal to reach. (Holopainen, Fabritius & Salaspuro 2003: 478.) In this study, the focus is on maintenance treatment aiming at harm reduction.

In maintenance treatment the patient is given methadone or bubrenorphine in order to inhibit illegal opioides from entering the opioide receptors and in order to prevent

withdrawal symptoms and craving for opioides (Huumeongelmaisen hoito 2010). Methadone is a synthetic opioide that was developed in 1940's. It is a morphine-like substance which causes euphoria, sedatation, pain relief and addiction. Methadone is thus used for relieving severe pain for example in cancer treatment, and since 1960's for treating opiate addicts. Methadone decreases withdrawal symptoms for from twelve to twenty-four hours. (Holopainen et al. 2003: 475.) Buprenorphine is a synthetic opioide, which has effects from both methadone and naltrekson. Compared to heroin or methadone, buprenorphine is relatively safe, as it does not cause the respiration to slump. It reduces symptoms of withdraw and additionally the desire for opioides. Moreover, it weakens the euphoric effect of heroine. Buprenorphine is the best medication for those opiate addicts who have relatively short substance abuse history. (Holopainen et al. 2003: 473.)

The main objective of maintenance treatment is to attach the patient to the treatment system. Maintenance treatment aims at preventing crime, marginalization and illegal substance abuse as well as enabling psychosocial treatment, physical and social rehabilitation, education and employment. It also aims at preventing the spread of HIV and hepatitis C. The treatment is regulated by the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products (33/2008). The prerequisite for maintenance treatment is opioide addiction and failed detoxification treatment due to interruption or continuous use of illegal opioides despite of the treatment. Use of other substances does not inhibit maintenance treatment or result in termination of the treatment. (Huumeongelmaisen hoito 2010.)

Maintenance treatment is said to be considerably more successful than detoxification for opioide addicts. It significantly improves the continuity of the treatment. As maintenance treatment decreases the use of illegal opioides, crime against property, mortality of patients and hazardous behaviour concerning HIV, it is provided when harm reduction is of specific importance. Providing maintenance treatment thus results in fewer expenses than providing no treatment at all. (Huumeongelmaisen hoito 2010.)

3.2 Policy development from prohibition to harm reduction

Before the 1990' the Finnish drug policy was one of the strictest in western countries and mainly based on criminal control. Possession and use were criminalised initially in 1966 during the first drug wave. The drug users were primarily seen as the police's problem instead of the health care professionals'. (Tammi 2007: 252-253.)

During the 90's, however, the drug situation in Finland worsened considerably and opiate use was increased in the larger cities. This resulted in a notable increase also in serious drug-related problems, such as deaths, overdosing, and virus diseases such as the HIV. The changed situation offered a chance for a change in the policy. The criminal aspect in drug policy has maintained but in 1994 the Criminal Code was revised so that criminal sanctions were waived in cases where the subject commits him/herself to treatment or when the criminal act was minor. This could be seen as a shift towards harm reduction measures from the earlier total prohibition and welfare policy, with both still remaining strong. (Tammi 2007: 252-253.)

Tammi (2007: 254) explains the reasons behind the policy development further; the Finnish drug policy committee stated in Drug strategy 1997 that the spread of drug abuse related infectious diseases would be combated even in the case of continuing use, and that necessary measures include counselling, sexual education and the exchange of syringes and needles. Tammi (2007: 254) continues, that the next year, one of the targets of the Government Resolution on drug policy was to "minimise the costs and harms caused by drug use and related public measures". On the other hand it also stated that drug control measures based on total prohibition must be intensified and availability of and access to treatment improved (Tammi 2007: 254). Tammi (2007: 256) also refers to the Governments policy statement on drug policy 1998 where it is stated that "efforts are made to minimise the individual, social and economic harms caused by drugs and related prevention, treatment and control measures". Total prohibition and harm reduction thus exist simultaneously in the Finnish drug policy (Tammi 2007: 256).

The needle and syringe exchange programmes started in 1997 (Rönkä & Virtanen 2008: 38) when the first counselling centre, Vinkki started its operations. In 2001 there were altogether nine counselling centres in the largest cities. (Tammi 2007: 260) The trend is to develop low threshold services. The most challenging clients' treatment is centralized in specialized service units. Nevertheless, problem users are often at risk of being excluded from the service system altogether. (Rönkä et al. 2008: 38.)

3.3 Legislation

The care for substance abusers is based on Act on Welfare for Substance Abusers (41/1986). According to the first paragraph, the aim is to prevent and decrease the problem use of intoxicants and the social and health related harm. It also aims at improving the problem users' safety and capacity. The third paragraph states, that it is the municipalities' responsibility to provide substance abuse services that meet the needs both in content and in coverage. (Päihdehuoltolaki 41/1986.) There are, however, also other activators on the field organising services for substance abusers, from which the municipalities purchase the services. Deaconess Institute is one of them and can be seen as a forerunner in developing low threshold services for the most marginalised substance abusers. (E.g. Törmä, Huotari & Inkeroinen 2003)

As a practical expression of harm reduction, maintenance and substitution treatment for opiate addicts were officially integrated in the Finnish service system for substance abusers after the directive number 1997:28 of the Ministry of Social Affairs and Health was issued in 8.7.1997. After this the directive has been altered three times with ministry decrees in order to expand the availability of maintenance treatment services to meet the continuously increasing demand, first in 2000 (Decree 607/2000), and then in 2002 (Decree 289/2002). (Hakkarainen & Tigerstedt 2005: 144.)

In 2008, the decree on pharmacotherapy for opiate addicts (289/2002) was abolished by a new decree, Decree of the Ministry of Social Affairs and Health on the detoxification and

substitution treatment of opioide addicts with certain medicinal products (33/2008), in order to meet the constantly increased need (Päihdetilastollinen vuosikirja 2008: 48). According to the recent act, substitution treatment means “treatment of an opioid addict by using medicinal products containing buprenorphine or methadone in which the objective is rehabilitation and a lifestyle free of illegal drugs, or harm reduction and improved quality of life of the patient” (Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products No 33/2008). The Deaconess Institute’s maintenance treatment community’s objective is the latter; harm reduction and improved quality of the patient’s life.

According to the third paragraph of the Decree 33/2008, substitution treatment can only take a place for a patient who has not been detoxified from opioides. The objective of the treatment must be specified prior starting the treatment and adjusted when necessary. For those persons who are probably not able to completely refrain from illegal drugs, the objective must be harm reduction. Through harm reduction, the patient’s quality of life can be improved and thus the person may be prepared for more demanding rehabilitative substitute treatment. (Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products No 33/2008.)

In the fourth paragraph of the decree 33/2008, it is stated that the treatment as well as the assessment of the need for treatment must be provided at a health care centre or a treatment unit that has a physician in charge who is familiar with the treatment together with other necessary staff and prerequisites for provision of treatment. As substitution treatment is long-term in nature, it should be provided as near to the patient’s place of residence as possible. (Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products No 33/2008.)

According to the fifth paragraph of the Decree 33/2008, the treatment should be based on a treatment plan, where the objective of the treatment, pharmacotherapy, other medical and psychosocial support, rehabilitation and follow-up of the treatment are specified. The sixth

paragraph of the Decree 33/2008 states that the medical treatment has to be implemented solely under the surveillance of the care unit. In the case of good adherence to the treatment, up to eight daily doses can be administered to the patient. For a special reason, exceptional fifteen daily doses can be administered. (Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products No 33/2008.)

3.4 Harm reduction policy

Toivo Hurme (2002: 417) presents the concept of harm reduction and states that it can be examined on two levels. First, it can be understood as a general strategy for national drug policy. On the other hand, it is also described as pragmatic, reactive and situational work with no general ideals or principles. This work consists of needle exchange services for users of intravenous drugs, health counselling, medical substitute and maintenance treatment and intensified interference by the police to the locations where drugs are used. (Hurme 2002: 417.)

Two different perspectives can be identified in the discussion. The human rights perspective concentrates on the rights of drug users and understands harm as something that is caused by the strict policy of control to the abusers. Public health perspective on the other hand emphasises the harm that drug abuse causes to the population for example by spreading of HIV. (Hurme 2002: 417.)

According to Bernadette Pauly (2007: 6), harm reduction proposes a value neutral shift in attitudes towards drug use, both in policy and practise. Moreover, value neutral approach has been acknowledged as one of the strengths of harm reduction, as it does not include moral judgement. However, harm reduction is not value free even though moral judgement is lifted from it. (Pauly 2007: 6.)

There are five underlying principles outlined by the Canadian Centre on Substance Abuse Working (1996).

1. Pragmatism, that recognises that many activities in life carry risks.
2. Humanism, that highlights values of respect, worth and dignity of all persons including substance abusers.
3. Promoting the reduction on negative consequences of substance abuse, not only for individuals but also for communities and societies, rather than focusing eliminating or degreasing substance abuse.
4. Balancing the tension between promoting individual and common good.
5. Focusing on the priority of immediate goals, and enhance fairness and justice.

Pauly (2007: 6) explains that harm reduction as a philosophy values the worth of individual and no harsh judgements are implemented upon substance abusers. On contrary with the disrespect often associated with a stigma of drug abuse, everyone is seen as deserving of care, and each person is respected. This attitude has the potential to open opportunities for promoting health and enhance access to health care services. Harm reduction could be seen as a set of various interventions that aims at reducing negative consequences of substance abuse, and as a creator of a new moral order where a person is responsible for staying healthy through the use of clean needles and proper injection technique. (Pauly 2007: 6.)

3.5 Low threshold services

Low threshold services generally mean easily accessible services for clients who have difficulties in committing to a treatment programme. Usually these clients are either substance abusers or persons with mental problems. (Kaakinen, Törmä, Huotari & Inkeroinen 2003: 59.) In this study, low threshold services will be discussed from substance abuse point of view.

There are certain criteria that a service has to fulfil in order to be called a low threshold service. Firstly, there should be no system of appointment because they do not work with

substance abusers who have problems in committing to services and keeping appointments. Neither should referrals be required. A low threshold service should be accessible straight from the street without referrals from other service units or authority. Access should be granted also regardless of habitual residence in a case of crisis. (Kaakinen et al 2003: 60.) Nuorvala (1999) interviewed problem users in his study about social and health care services through the eyes of a drug abuser and many of the interviewees stated that the need to enter the services emerges suddenly and if there is no help available straight away, the motivation may not last for long waiting periods. Also, Törmä (2003) has found similar opinions among the most marginalised substance abusers.

Low threshold service units do not set high goals for the treatment. Already the first contact is seen as an accomplishment itself that can lead to attempting sobriety. In low threshold services intoxication should not deny access and also relapses should be allowed. All motives count, whether it is temperance or just needing a break from the street and the drug abuse world. (Kaakinen et al 2003: 60-61.)

Anonymity and confidentiality are important principles in low threshold services. At least the first contact should be possible anonymously and treatment should be possible without any danger of authority involvement. Fear for the authorities can often be a significant barrier between the service user and the services. For example parents may be afraid of losing the custody of their children if they search for treatment for their substance abuse problems. (Kaakinen et al 2003: 60-61.)

4 ADDICTION

Often addiction is considered meaning dependence solely on substances. However, according to Elster and Skog (1999: 4-5), addiction may occur with any powerful experience which provides a great deal of satisfaction. People can be addicted to romantic relationships, working, reading, food, television, masturbation et cetera. These addictions are considered as behavioural addictions and are not based on the intake of a substance. A

chemical addiction includes addiction to nicotine, alcohol, opiates, cocaine, caffeine and amphetamines and is considered as “core addiction”. Characteristics for core addictions are symptoms of withdrawals and cravings. At the basic level, addiction can be seen as weakness of will and losing control, a habit that has gotten out of hand. Addiction could be seen also as a person’s inability to see the consequences correctly or underestimating the future consequences. (Elster & Skog 1999: 4-5.)

Addictions have a characteristic developmental sequence. An initial stage includes moderate or controlled use, the next stage is loss of control which often goes along with a desire to quit, and finally there is relapse from a shorter or longer period of abstention. Addiction could be defined in terms of objective factors that are:

1. Tolerance. This means that more substance is needed in order to obtain the same effect as the first time.
2. Withdrawal. This is often considered the most important feature of addiction, as it means simply occurrence of unpleasant consequence.
3. Objective harm. Addiction, particularly to substances, ravages lives and communities and is therefore the most striking aspect of addiction
4. Craving. A person has a desire to get rid of withdrawal symptoms and escape from a miserable existence.
5. Desire to quit. This is an important indication of addiction; a person knows that a habit is harmful but is unable to quit. Simply, to be addicted is to be subjected to craving of such strength that it is difficult to quit. (Elster & Skog 1999: 3-8.)

Matela and Väyrynen (2008: 230) name also sixth factor; narrowed social relationships. Due to the substance abuse, the person’s social relationships consist mainly of other users.

4.1 Opiate addiction

This study concentrates on opiate addiction and as opiates are considered especially addictive, they should be paid more attention in this context. Ahtee (2003: 151) explains

that opiates are made from opium poppy *(Papaver somniferum)* or synthetic compounds. Opioides is a designation that refers to all morphine like compounds, including endogenous, opium, and synthetic morphine like compounds. Morphine has been until date an important pain reliever, where as heroine, codeine and synthetic opiates are used for intoxication purposes. (Ahtee 2003: 151.)

Opiate abuse creates rapidly tolerance and bigger dosages are required in order to experience the desired effect. Along with the tolerance, a physical dependence is created and the body is adjusted to the opiate use and the user suffers from withdrawal symptoms in case of interruption of use. A big enough dose eliminates the withdrawal symptoms. This creates a situation where an opiate abuser's body can tolerate dosages that are more than hundred times bigger than the first one. Opiate tolerance is unique compared to other substances where the daily dosage raises maximum ten to twenty times bigger. In addition, tolerance towards euphoria builds up rapidly and thus even a big dose does not lead to the pleasure experienced originally. A big enough dosage is, however, always toxic. Therefore, an overdose can result to death. Physical dependence is linked to the strong euphoria caused by opiates and is the most important reason for compulsive opiate use. (Ahtee 2003: 154-155.)

4.2 Opiate abuse in Finland

Heroine was a popular pain relief in Finland already during 1920's and 1930's but drug abuse as such occurred only in small circles. Actual problem abuse in Finland started during the first drug wave in the late 1960' and early 1970' when the number of problem users rose significantly. During that time drugs were criminalised and therefore became a part of organised crime. This led to marginalisation and exclusion among the drug users. (Onnela 2001: 30-38.) Socio-economic problems during the 90's led way to the second drug wave. Hard drugs such as opioides were now more available than before and the number of marginalised problem users rose. Drug related crime became more commonplace and more brutal in nature. Problem use reached all areas, all social classes

and also younger age groups. (Saarto 2003: 69.) In 1995, larger quantities of smokable heroin emerged to the Finnish drug market. This lowered the prices and as a result, as young people as 14-year-olds started to experiment with opiates. Since then opiates have had an established position in the Finnish drug scene. (Salaspuro et al. 2003: 470.)

The following presents how opiates are represented in the Finnish drug treatment system today. Partanen (cited in Rönkä & Virtanen 2008: 33) refers to the 2007 data of the drug treatment system and state that 0.1-0.2% of the whole Finnish population abuse opiates. Opiates were the main reason (46%) for clients entering drug treatment. Bubrenorphine was the primary drug for 33% of those entering a drug treatment program. (Partanen cited in Rönkä & Virtanen 2008: 33.) Kuussaari and Ruuth (cited in Rönkä & Virtanen 2008: 34) refer to the same data and state that the proportion of bubrenorphine as the primary substance has been increasing over the past years. The data also shows that the mean age of clients in drug treatment was 28.7 years. According to Hakkarainen and Tigerstedt (2005: 144), the number of patients receiving maintenance treatment was 600-700 in 2004.

5 PSYCHOSOCIAL SUPPORT IN SUBSTANCE ABUSE REHABILITATION

Psychosocial support is an essential part of maintenance treatment as stated in the Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioide addicts with certain medicinal products (33/2008), and accordingly is a concept that has settled into professional vocabulary in substance abuse work in particular. Weckhroth (2007: 433) explains that it is based on an idea that being a human being can be divided in biological, psychological and social dimensions that are brought together with the help of psychosocial concept. In medical science and psychology, this is self-evident and practical but creates difficulties in social sciences. The term “psychosocial” in substance abuse work is used with a variability of methods and lacks shared meaning in other fields. As a term, psychosocial is useful when discussing any phenomenon related to humanity. Humanity contains various attributes that may otherwise be difficult to explain. (Weckhroth, 2007: 433.)

Treating an opiate addict is a long term process, where pure medical treatment is not often enough to lead to successful results. Substance addiction is a complex condition and constant chemical self regulation can hardly be treated and fixed with new chemicals. This would be purely treating the symptom. Clients need psychosocial rehabilitation and support alongside the medication. (Juurinen, 2008: 8.) Mental health problems and substance abuse include deteriorating in psychological and social abilities. This could lead to exclusion, which further more endangers for mental health issues and substance abuse. (Kettunen, Kähäri-Wiik, Vuori-Kemilä & Ihalainen 2009: 79.) Clients may have several overlapping problems such as substance abuse, social exclusion, risk behaviour and mental health problems. Thus, it may be beneficial to treat also social and psychosocial problems alongside the substance abuse. This is particularly true with people who are suffering from multiple problems. (Havio, Inkinen & Partanen 2008: 127.)

5.1 Aims of psychosocial support

Psychosocial support aims at restoring the person's psychosocial ability. Psychosocial ability includes capability to manage normal situations encountered in everyday life and in communities, such as the ability to interact and create relationships, survive from problematic situations and function in one's own environment. Psychosocial ability is dependent on experience, living environment, background and personal history. (Kettunen, Kähäri-Wiik, Vuori-Kemilä & Ihalainen 2002: 53, 64.) According to Matela and Väyrynen (2008: 231), psychosocial rehabilitation refers to the interaction between the person and the environment. The psychosocial environment includes other people, language and culture. Psychosocial support aims at locating the client's own resources so that (s)he could survive in his/her everyday life and understand his/herself.

Vehviläinen (2004:7) states in her report, that psychosocial support includes all support that is provided to the client whose ability to take care of one's own life is threatened, in both interactional and actionable means. With psychosocial support, the client is able to practise

skills needed in everyday life, create new relationships, learn to take care oneself and develop in social skills. Psychosocial support enables opportunity to experience meaningfulness in life, also without substances. (Vehviläinen 2004: **7**)

5.2 Psychosocial support in practice

Opioide addiction often includes problems in various aspects of life such as psychiatric and somatic illnesses, unemployment, homelessness and criminality. Psychosocial support as a holistic form of treatment aims to intervene in these issues. The Ministry of Social Affairs and Health had set a working group to develop medical treatment for opioide addicts in 2001. In their memo, the working group classifies three types of psychosocial support in research. These are supportive treatment, cognitive and behaviour therapy, and psychotherapy. In supportive treatment, the emphasis is on network between the patient, the relatives and the worker. Their network may also include police, school and housing officer et cetera. Supportive treatment concentrates on improving problematic areas individually. There are no written instructions in these types of therapies and their content has not been clearly described in the studies. Cognitive and behavioural treatment on the other hand usually requires education from the therapist. However, when written instructions are available, education is not essential. This type of treatment includes AA-based 12 steps programmes. The aim is to locate and improve problem areas in the client's life, such as supporting the ability to restrain from drugs and general life management. The third type of psychosocial support, psychotherapeutic methods include family therapy, large scale cognitive and behavioural therapy, and dynamic and reconstructive therapy. Formal education is required with these types of therapy. (Ministry of Social Affairs and Health 2001)

The working group refers to 23 studies concerning patients receiving methadone substitute treatment. Based on these studies, even the most intensive supportive type of treatment had no effect on the patients' drug abuse or in their commitment to the treatment when compared to normal methadone substitute treatment. Cognitive therapy proved to have a

low but statistically significant positive effect on the treatment's efficiency. Psychotherapeutic treatment appeared to have the strongest influence on the patients' commitment to the treatment. In studies on family therapy the influence was significantly high. Later studies have however shown that different types of psychosocial treatment, even the supportive type, do improve the patients' life quality. Some of the indicators were working capacity, crime, mental state and lower methadone dosages. (Ministry of Social Affairs and Health 2001.)

Duodecim administered "Current Care" web pages state that psychosocial support in practice means support with various aspects of life, such as housing, income, work and social relationship. Focus is on the client's overall life situation rather than only concentrating on substance abuse. Successful psychosocial support requires professional competence, consistency on the treatment and client commitment and motivation. However, even the most intensive non-medical psychosocial treatment is apparently inefficient when treating patients with opioide addiction. Without medical substitute treatment the patient's commitment to the treatment is so weak that psychosocial treatment's effectiveness has not been able to be studied alone but only alongside the substitute treatment. Studies have shown that learning theory based therapy and some extensive psychotherapies such as family therapy and motivational therapy, do decrease the occurrence of heroin abuse among patients in methadone substitute treatment. Also incentive and restriction based programs seem to decrease the use of illegal drugs. Supportive therapies such as acupuncture seem ineffective. (Huumeongelmaisen hoito 2010.)

The Current Care pages classify eleven different examples of psychosocial methods: dynamic psychotherapy, the twelve step treatment, cognitive-behavioral therapy, motivational interviews, service counseling, solution centered therapy, community care, community reinforcement approach CRA, relapse prevention, systems theory model and general support. Dynamic psychotherapy discusses the patient's life phases. This helps the patient to explore his mind and images and to develop them into a meaningful direction. The twelve step treatment sees addiction as an illness. The aim is to cure the addiction with

cognitive means and with the support of peer support groups such as AA and NA. Cognitive-behavioral therapy processes the patient's core beliefs and aims at changing the patient's feelings and behavior. Motivational interviews concentrates on tackling conflicting feelings. Service counseling is a working method where the worker estimates the client's need for treatment, makes the care plans and instructs the patient accordingly. Solution centered therapy aims at solving concrete problems, locating resources and thus increasing the patients self knowledge and ability to function in problematic situations. Relapse prevention uses cognitive methods in order to identify risk situations and to help to maintain the set goals. Systems theory model is a holistic form of treatment that considers all aspects of the whole and their relations with each other. In community care, the clients learn to live in a drug free environment with other patients and the personnel and practice skills needed in everyday life and bearing responsibilities. Community reinforcement approach, CRA, uses incentives, family, work and free time as a support system. Psychosocial methods are the basis for treatment and they strive to enhance the quality of the patient's life. (Huumeongelmaisen hoito, 2010.)

Psychosocial support at KoHo community falls into categories of Service counseling and Supportive treatment. The support consists of discussions, peer support and service counseling. KoHo does not execute therapeutic methods as this client group does not have the necessary perseverance for long-span and goal directed treatment. The aim of the treatment at KoHo is mainly harm reduction and improving the quality of life, even though rehabilitation does occur. The Institute also runs a rehabilitative substitution treatment where the aim is to eventually come off the replacement medication. In this unit more therapeutic methods are used. (Vehviläinen, 2010.)

According to Kettunen et al (2009: 58) all psychosocial support is based on relationship between worker and client and at its best form, the relationship is filled with understanding and dynamicity. Kettunen et al (2009: 59) continue that at its worst worker and client relationship can turn to power struggle, one-sided and non-understanding rehabilitation by force. Attitude towards substance abuser are commonly rather negative and rejecting. Client experiences this negative attitude as feelings of shame, guilt, inferiority and lack of

support. These feelings lead client's behaviour and instead of using his/her capacity the client is condescend. (Kettunen et al 2009: 49-50.)

Also Granfelt (1993: 180-181, 183, and 212) and Raunio (2004: 140, 142-144) stress the importance of the worker-client relationship. In psychosocial work the worker needs to be skilled in delving deeply into the client's situation and in understanding the world as the client experiences it. The communication between the worker and the client and the worker's intuition play an essential role. (Granfelt 1993: 212.) Psychosocial approach is a hermeneutic approach that sees the client as a whole. (Sipilä, 1989: 226-228.) This may be difficult if the worker cannot really understand the client due to the difference in their positions. Sipilä (1989: 201-206) lists three conditions for mutual understanding: shared experiences, shared language and meeting in time and place. These conditions may be hard to meet when working with marginalised people even if the last condition feels self-evident. Differences in class, culture and life style may result in different meanings in language even if the native tongue is the same. (Sipilä 1989: 201-206.) The worker rarely has personal experiences about marginalisation and the social difficulties related to it, but Granfelt (1993: 212) points out that understanding the client is possible by using one's own experiences if they are processed properly. The experiences do not need to be identical. The main point is that the client feels being understood. (Granfelt, 1993: 212.)

Although psychosocial work requires working closely together with the client, such a relationship can be consuming both for the client (Granfelt 1993: 211) and the worker (Raunio 2004:145). Raunio (2004: 145) explains that this can be avoided by keeping a professional distance. This may seem as contradictory with the intensive working method that aims at understanding the client, but may be necessary so that the worker maintains his/her own working ability. (Raunio 2004: 145.) This is particularly relevant when working with challenging client groups such as drug addicts.

The concept of psychosocial support in literature is relatively vast and versatile in meaning and it has not been defined in detail in legislation. Similar to Harju-Koskelin's study (2007: 14), psychosocial support is understood in this study as supporting the client's ability to

integrate into the society and as improving the client's life quality. Examples of integration and improved life quality may be positive changes in the following life sectors: housing, physical condition, mental wellbeing, work and personal economics, substance abuse, crimes and convictions, social life and relationships and general life management.

6 EARLIER STUDIES AROUND THE SUBJECT AREA

The maintenance treatment community KoHo has not been studied before, but researches about other Deaconess Institute's drug rehabilitation units have been made. "Mäkin oon ihminen!" (Törmä et al, 2002) is an assessment study about the service centre for HIV positive drug addicts. In that study also the customers' viewpoint were taken into consideration and therefore we found it useful regarding our own study. The study found out that from the customers' point of view, the most important aspects about the services were the possibility to eat and rest and use the services of a social worker. Also the empathetic and respectful attitude of the staff was valued. The health care services came later on the list. It seems that satisfying the most basic needs enables other positive changes to occur in the clients' life. In addition, another assessment study about the Institute's drug addiction clinic called Kurvi 24h (Törmä et al 2003) studied the Institute's services also from the customer's point of view.

A-klinikkasäätiö's project OHJAT examined and developed psychosocial rehabilitation in substitute and maintenance treatment. A follow-up study "Kuntoutuuko korvaushoidossa" (Harju-Koskelin, 2007) studied the changes that occurred in the patients' quality of life and in their social and mental state.

Yrjö Nuorvala (1999) has studied drug abusers' opinions and experiences on the addiction regimen on a more general level. He found out that there are negative attitudes towards drug abusers in the service system and this makes it difficult for the clients to use and commit to the services. Also Nuorvala addressed the need for low threshold services.

Tuulikki Forssèn has made her Licentiate thesis about opiate addicts' maintenance treatment in a day centre. The thesis is a case study that studied the matter primarily from the personnel's point of view. Forssèn argues that maintenance therapy services should be studied further as their supply will have to increase in front of growing drug abuse problems. She stresses further the importance of analysing what psychosocial support means in maintenance therapy is and how it is being realised.

Matti Mäkelä, Jarmo Nieminen and Sinikka Törmä (2003) have studied the service thresholds that substance abusers face as a part of a development project for low threshold services. Törmä (2009) has studied thresholds experienced by the most disadvantaged drug addicts further in her doctoral dissertation Kynnyskysymyksiä through four case studies.
Tuukka Tammi's (2007) doctoral dissertation "Medicalising Prohibition" examines the evolution of Finnish drug policy. It focuses on the changes and development that led to adopting harm reduction policy alongside the repressive prohibition policy.

7 METHODOLOGY

This chapter discusses the aim of the study, the methodology used and the research process. Information needed for the reader to assess the believability of results is provided alongside with information needed by another researcher to replicate this experiment. Furthermore, this chapter describes materials, procedure of the study and used theories and ponder limitations, assumptions and range of validity.

7.1 Research problem and research questions

The aim of this study is to find out how the clients of KoHo community experience the treatment offered at the community. Moreover, different aspects of their lives before and after the KoHo services and whether there have been either positive or negative changes in their psychosocial ability are also discussed. Focus is set on the following aspects of life;

housing, physical condition, work and personal economics, substance abuse, crimes and convictions, relationships and general life management.

The main research question is:

How do the clients experience the services and the psychosocial support of the maintenance treatment community?
Sub-questions are:

1. What kind of changes has occurred in the clients' lives and in their psychosocial ability during the treatment?
2. What kind of matters the clients value and consider as important at KoHo?
3. What kind of shortcomings and developmental needs do the clients experience concerning the services?

This study concentrates on the clients' point of view. The clientele of KoHo community consist of approximately 45 people. Instead of studying the whole group, the first nine volunteers who happened to be at the premises at the time of the interviews and willing to participate were interviewed. Some clients were suggested to be interviewed by the personnel. This type of research focus hinders the results from being generalized to the whole clientele but it can give valuable information about the services for the service provider. The Deaconess Institute may use the results of this study in developing their services in the maintenance treatment community. According to Vehviläinen (2010), this study may also be used when the Institute negotiates with Helsinki city on providing maintenance treatment services.

7.2 Research method

Our study is empirical and qualitative. The criteria for choosing qualitative approach can be found in the characteristics of qualitative research as presented by Hirsjärvi, Remes & Sajavaara (2001: 152-155). Qualitative research aims at describing real life. Qualitative

research uses methods that present the examinees' opinions and view points. It aims at comprehensive data collection in natural, real circumstances. The researcher does not dictate what is important. In qualitative research the research sample is chosen purposefully instead of a random sample. Qualitative research is flexible and the research plan can be adjusted to the circumstances if needed. (Hirsjärvi et al. 2001: 152-155.) This study strives to find out the interviewees real opinions and viewpoints concerning the KoHo community. The interviewees were free to present whatever kind of matters they saw as important. Quantitative research would not have been given deep enough information on the examinees' opinions. Moreover, the personnel suspected that questionnaires may not have been successful form of data collection with this type of client group. The answering rate might have been low and the quality of data poor. In addition, the flexibility of qualitative research was an important factor as it allowed specifying the research questions after seeing what kinds of matters were brought up and seen as important by the clientele.

7.3 Data collection

The data collection method used was semi-structured interviews where the topics were the same for all interviewees but the compositions and the arrangement of the questions may change. Semi-structured interviews follow the central topics and gives voice to the interviewees' thoughts and opinions. Therefore, the interviewees' interpretations and meanings they give to the matters become central. Meanings often arise in interaction. (Hirsjärvi & Hurme 2004: 48.) Open ended questions were used in order to avoid directing the interviewees' thoughts (Hirsjärvi et al. 2001: 188). This way it was possible to obtain deeper and more individual information than with ready made options. Follow up questions were posed when needed.

The interview themes were treatment history, housing, physical condition, mental wellbeing, work and personal economics, substance abuse, crimes and convictions, social life and relationships and general life management. Possible changes under these themes were discussed as well as the support that the clients had experienced and needed.

The interviews were conducted at the community facilities. There was a separate room available which was both safe and gave privacy. Recorders were used on the interviewees consent. In the beginning of the interviews, the aim of the research was discussed together with conditions concerning anonymity, the voluntary nature of the participation, keeping and handling the data and publishing the results. All this information was written down in an announcement (Appendix 1) that was distributed at the clinic one month before the first interviews. Before the interview, the interviewees signed a written consent of their participation (Appendix 2). The interviews took from seven minutes to an ample hour.

The first preliminary interviews took place 11.2.2010 at the community facilities. The first two interviews were conducted with a list of set questions (Appendix 3). Conducting the first two interviews showed that having structured questions in a pre-set order hindered the interview from flowing freely and therefore it was decided to abandon the list of questions and run the rest of the interviews with the help of simple interview themes. Further interviews were conducted the 22nd and 26th of April. Interviewees were given a complimentary box of cigarettes for their participation. It might have had some impact on client's motivation to participate on interview. There were more volunteers willing to participate that it was possible to interview. However, some of the interviews were hasty and vain as the clients were motivated only by the possibility of obtaining a free box of cigarettes. More than half of the interviews were, however of good quality and all the interviews gave answers to the research questions. Nine service users in total were interviewed. Eight of them were males and one was a female, age range from 27 to 54. The interviews took from seven minutes to one hour. After transcribing the tapes, there were 57 pages of raw data, which consisted of three hours fifty-nine minutes and thirty-eight seconds of speech.

7.4 Data analysis

Qualitative data analysis aims at understanding the data whereas quantitative data is rather explained (Hirsjärvi et al. 2001: 210). When analyzing qualitative data, the aim is to bring clarity to the data and produce more information about the research subject. The analysis aims to condense the data without loosing its central information. It makes incoherent data clear and meaningful. (Eskola & Suoranta 1998: 138.) The data is examined based on the theoretic framework (Alasuutari 2001: 40).

Categories used in presenting the findings were outlined from the data by following the interview themes and research questions but also new categories appeared. The findings are organised under the following sub-headings: experienced changes (housing, physical condition, emotional and mental status, relationships, substance abuse, personal economics and crime) general atmosphere, personnel, medical treatment, rules and practises and criticism. Conclusions were made by comparing the findings with the theoretical framework of the study.

7.5 Reliability, validity and ethical consideration

The concepts of validity and reliability used in quantitative research do not apply per se when considering the reliability of qualitative research. Qualitative research is based on the researcher's open subjectivity. The researcher is a central research instrument and therefore the most important criterion for the reliability and validity of the research. Thus, the whole research process is assessed. (Eskola & Suoranta 1998: 211-212.) Hirsjärvi et al (2007: 227) argue that the reliability and validity can be best assessed when all the details concerning the research process are reported clearly and truthfully. This way the reader can evaluate the research and its results independently (Eskola & Suoranta 1998: 211-212). In order to give the reader the possibility to asses the reliability and validity of the study and also in order to verify it, all the steps that were made during the study process are explained in chapter 7 which explains the methodology and also in the last chapter that

discusses the study process. The last chapter also critically discussed the subject area and thoughts awoken by it.

The interviews were conducted in Finnish. The report is written both in English and in Finnish. The findings were translated into English language before the analysis stage. The authors of this study are not professional translators and thus translating the results may have caused some further interpretations, which has to be taken into account. In order to eliminate this possibility, quotations from the interviews were entered using the original language in both reports. Quotations also strengthen possibility to asses the validity of the study. The Finnish language version was translated after finishing the English one.

The ethical principles of this study concern mainly the collection and handling of data and the publication of the results. The examinees approved consent is essential and they were made aware of the possible risks. When collecting the data, the examinees' anonymity was be safeguarded. The data were appropriately and confidentially recorded. (Hirsjärvi et al 2001: 25 - 27.)

The Ethical Committee of Helsinki Deaconess Institute has set clear instructions on the principles for all research implemented in cooperation with the Institute. All research projects must respect the principle of human dignity and integrity. The examinees' advantage and wellbeing are essential to all research and all possible risk and harm must be prevented at all cost. The examinees were asked for a written consent on participation (Appendix 2). They were made aware that the participation is voluntary and that refusal or suspension does not affect their services. (Lausunnon hakeminen eettiseltä lautakunnalta 2009.) Research permit was applied for in autumn 2009 from the ethical committee. The committee was in favour of granting the permit, which was then granted the 15th of December 2009 by Pekka Tuomola, the director of substance abuse and mental health work (Appendix 4).

The research material was handled only by the authors of the final project. Also, the interviews were conducted by the authors personally. As Saija Puhjo has worked at the

KoHo community and is familiar with many of the clients, this may bring up ethical dilemmas. She may have some reservations concerning some of the interviewees, which may affect the interview situation and therefore the quality of data. Also, interviewees may have problems to maintain neutral attitude as some male clients have indicated interest which is inappropriate. Moreover, Ms Puhjo's familiarity could be either beneficial so that it was e easier for the clients to agree to be interviewed, or hindrance so that they are evading as she may know too much about them. In order to prevent this, Eeva-Liisa Yli-Mattila conducted interviews with those clients who Saija Puhjo knows well. Furthermore, sharing the responsibility over the study secured objectivity at times when it might have been in jeopardy due to Ms Puhjo's familiarity with the interviewees.

It is a common practise that when studying substance abusers, the examinees are given some kind of incentive to motivate them to participate. It has been the practise at the Deaconess Institute before and thus it was followed when making this study. Therefore, one has to consider the possibility that this incentive may have had an impact on the number of volunteers and on the quality of data. With two interviewees, it seemed obvious that the only motivation to participate was the possibility to obtain a free box of cigarettes and those interviews produced poor quality data. The data was no, however, totally useless, and therefore the data was not excluded completely. For another two interviewees the incentive was not an issue as they did not smoke, and therefore it can be assumed that the gesture did not have an overly strong impact on the reliability of the study.

In order to assure ethicalness, the interviews or interviewees were not discussed with any outsiders, exceptions being the study seminars. All collected and printed material alongside the form of consents was stored separately so that they could not be linked and hence clients recognised. Material that might lead to recognition of a particular client was excluded and focus was on presenting the data in the matter that secures the interviewees' identity. All material was handled with grave confidentiality and email was not used in order to avoid material falling into wrong hands. After receiving the final evaluation for this study, all material was destroyed. Printed documents were fed to a shredder and recordings were deleted.

8 FINDINGS

This chapter presents the main findings from the raw data. All nine interviewees had a long personal history of opiate abuse, which started mostly during adolescence. However, one of them had started using heroine during childhood and had an abuse history lasting for over forty years. Majority had history of several other treatments that had failed due to substance abuse alongside the maintenance treatment. Two eldest interviewees had no previous treatment history, yet their history of substance abuse were considerable longer and severe as compared to the other interviewees.

8.1 Experienced changes

Clients had experienced several, mainly positive changes in their lives after entering their treatment at KoHo. Those changes were both concrete changes such as housing, and emotional changes such as peace of mind and less experienced stress. These changes are presented in a more detail under the corresponding subheadings.

8.1.1 Housing

Most interviewees had experienced the burden of homelessness and were homeless prior to the substitute treatment and had stayed at fellow users' flats, with their girl friends, on the street, in prison or with their parents. Only one interviewee reported that he never been homeless. None of the interviewees was homeless at the time of the interviews. Most clients had their own apartment and only three were living in a dormitory. Some interviewees had been able to hold on to their apartments they had obtained during the client ship, and felt proud of it, as this was not possible before. Two of the interviewed clients had the same apartment as before the treatment. Some had obtained an apartment during treatment and one had lost his apartment and ended up in a dormitory. One client's housing situation had improved considerably:

> I3:*”Mä olin täysin koditon. Ja sit mä muutin asuntolaan, nykyään mulla on perhe. Asun hienossa kodissa…”*
>
> I3:*”I was completely homeless. And then I moved into a dormitory, and nowadays I have a family. I live in a nice home…”*

One interviewee had attained an apartment only two weeks before the interview but reported that otherwise:

> I4:*“… tää on ollut yhtä kadulla asumista.”*
>
> I4:*”…this has been nothing but living rough.”*

One of the interviewees lived at his parents' house but could not leave due to a problematic situation in the family. Otherwise, he would be willing to find an apartment of his own and felt that when the time comes he would get support from the KoHo personnel.

8.1.2 Physical condition

Most clients felt that their physical condition had improved and many reported having gained some weight due to methadone treatment. This, on the other hand, was a problem for some interviewees as weight had increased excessively: one client reported having doubled his body weight after the beginning of the methadone treatment. Considerable weight gaining had led to various problems with joints and knees with one interviewee:

> I1:*”… yleisterveys on parempi kun ennen hoitoa, mutta … hoidon myötä… [tullut muita huolenaiheita] …esimerkiksi … aika huomattava painonnousu… oon lihonut ainakin tota kolkyt kiloo… painon kasvuun liittyy et mulla on ruvennut polvet prakaan…”*
>
> I1:*”... generally my physical condition is better than before the treatment but... after the treatment… [other problems have occurred]… for example… a quite considerable weight gain… I've put on at least like thirty kilos… because of the weight gain my knees have started to break…”*

Some associated aches and pains with the ill-effects of methadone. Other methadone ill-effects mentioned in addition to the weight gain were chronic heart burn, loss of teeth and also extreme fatigue. One client explains the ill-effects as follows:

> I7:*"… ensinhän mä lihoin hirveästi [metadonista]. Nythän mulla on tippunut paino ihan normaalille, lähes normaalille tasolle. Mut se johtuu siitä et mä oon myös tiputtanut annostakin… se auttaa, myöskin se ettei, ettei mee sellaseen kuntoon et tipahtelee tonne että, niinku jumalauta pystyyn, seisaalteen niinku. … Mä niinku nukahdin seisaalteen, niin on se kyllä aika outoo."*
>
> I7:*"... first I put a lot of weight [due to methadone]. By now weight has gone down to quite normal, almost normal level. But it's also because I have decreased my dosage… It help, it also helps, because you don't get in to a state when you just drop off, goddammit standing up, from your feet. I, like, fell asleep standing, and that was like quite weird…"*

One client reported having stopped using hard drugs and started to drink more alcohol. This led to pancreas infection and diabetes. Four interviewees had started to do some exercising, and were getting more interested in their own health and diet. Despite of the ill-effects, most clients saw methadone treatment as positive. Many stress the fact that they are still alive and that they would have died by now without the substitute treatment.

8.1.3 Emotional and mental condition

Majority of clients mentioned that stress level had gone down since they started maintenance treatment. There was no urgent need to make money every day in order to obtain drugs anymore. This had given the clients a more peaceful and positive state of mind. One interviewee told how the quality of his life had improved since there was no insecurity about the next dose anymore:

> I7: *"… mä nautin siitä rauhasta ja siitä, tiätsä siitä, ennenkaikkee siitä mielenrauhasta kun, ei tarvinnut lähtee mihinkää… ku ei tarvinnu aatella sitä seuraavaa aamuu ja… se stressi katos. Se stressi ku katos niin sillon mulla vast elämä kato niinku aukes."*

> I7:”*... I enjoy the peace and, that, you know, above all that peace of mind, when you do not have to go anywhere... when you don’t have to think about the next morning and… the stress disappeared. That stress when it disappeared only then my life opened up.”*

Several clients also brought up the fact that having to come to KoHo had brought structure and regularity in their lives that had never occurred before. In addition, this had reduced the level of stress and brought peace of mind. One client told how after being treated at KoHo he has had the possibility to try to do normal things that people do, such as go bowling with the community. He felt that he has never been so close to normal life before. He compared coming to KoHo as coming to work like everybody else are doing. Moreover, many interviewees told that the possibility to talk with the personnel who are not addicts made them feel closer with the “normal world”.

8.1.4 Relationships

One client had established a family during the client ship. Another on the other hand had lost contact with his young child, but most clients reported improved relationships with parents and other relatives after starting the treatment. One interviewee felt more accepted among his relatives and another one felt that he is being trusted more now than before the treatment:

> H7:”*… sukulaisetkin on jo hyväksynyt mut… Nyt kun on hoidossa ni nyt mut otetaan kyl vastaan ihan joka paikkaan et aiemmin mua ei otettu vastaan sukulaisille mut nyt otetaan.”*

> H7:”*... even my relatives have already accepted me. Now that I’m getting treatment I’m accepted everywhere, like before I was not accepted at relatives’ but now I am.”*

Also another one reported improved relationships with the relatives:

> I8:*”…[sukulaiset] on tietty hirveen tyytyväisiä siitä että mä oon niinku hoidossa… kaikki sukulaiset on ollu siitä niinku tyytyväsiä ja …. pikkusen on välit parantunut sinne päin.. ja ehkä on ruvennut se luottamus palaamaan…”*

> I8: *"[the relatives] are off course very pleased that I'm like in treatment… all relatives are like really pleased over it and… our relations have become a little better… and maybe the trust has started to come back…"*

On the other hand, three clients reported increased loneliness, because they do not know other people but other drug addicts and having left that world behind after starting the treatment. One of them states:

> I4:*"… melkein kaikki kaverini jätin ja yksin oon saanu olla. Eikä mitään hyötyä ole ollut siitä. Yksin kuljet tuolla..."*

> I4:*"... almost all of my friends I have left and alone I've been ever since. And it didn't do me any good. You just walk alone in there…"*

Another one thinks along the same lines and stated that he has no other option than befriend with addicts or to be alone:

> I6:*"Mun vanhemmat on kuollu, kaikki omaiset kuollu. Mun suhteet on poikki mun entisiin kimmakavereihin. …mä en tunne ketään muuta ku näitä nistejä. Jos mä en oo näiden seurassa niin mä oon melkein yksin. Et se on oikeastaan sellanen juttu mitä mä en välttämättä kaipais, mut siihen on vaan pakko myöntyy… itse mä tilanteen oon aiheuttanut seurustelemalla nelkyt vuotta samanlaisten kanssa … ei siinä jää tilaa paljon muuta tehdä"*

> I6:*"My parents are dead, all my relatives dead. I've lost contact with all of my ex-girlfriends. I don't know any other people but these drug addicts. If I'm not with them I'm almost alone. It's not something you would long for at but you just have to give in… I've brought the situation to myself after associating forty years with the likes of me... it won't leave much space for doing anything else."*

Two clients reported having made friends at KoHo. The personnel were also seen as a valuable contact:

> I1:*" …oon mä [KoHossa] muutamiin [uusiin ihmisiin]tutustunut. Ja henkilökunta on kans tärkee"*

> I1:*"... I have met a few [new people] [at KoHo]. And the personnel are also important. "*

Many on the other hand saw other clients negatively, as a reminder of the world they were struggling to leave behind.

8.1.5 Substance abuse

All clients said that there has been noticeable change in their substance abuse. Seven out of nine reported having stopped using intravenous drugs completely. Most clients used cannabis occasionally alongside the maintenance treatment. One interviewee explains the changes in his substance abuse:

> I5:*"… etten oo vuoteen pistänyt itteeni neulalla, mut oon mä kerran vetänyt pirii nokkiin ja muutaman kerran spiidinappeja, ja tollast noin. On mul sattunut retkahduksii ja tollee noin, mut pääasias polttelen pelkästään pilvee."*

> I5:*"... for one year I have not shot with a needle, but I have taken speed up my nose and a couple of times speed pills, and stuff like that. I've had relapses, and stuff like that, but mainly I just smoke weed."*

Two reported smoking cannabis regularly but they did not consider cannabis as a drug. Many did not seem to consider using other drugs than opiates as using drugs at all:

> I7:*"Oheiskäyttö on lähes minimissään, lähes minimissään. Aika ajoin mä repsahdan mut se on vaan amfetamiinii tai jotain hassista tai tämmöstä mut ei muuta. Ei heroiinii, ei mitään… no joo morfiinipillereitä mä vedin yks yks kausi oli, semmoset pari kuukautta mä vedin, niinku mä myin niit samal sitte kanssa."*

> I7:*" Additional use is almost minimal, almost minimal. Every now and then I relapse but it's only amphetamine or hash or stuff like that but nothing else. No heroine, no nothing… well a couple of morphine pill I took one period, like two months as I was also dealing those."*

Amphetamine was mentioned by many interviewees. Other drugs mentioned were magic mushrooms, GHB and ecstasy. One had problems with alcohol that had led to severe health problems such as pancreas infection.

8.1.6 Personal economics and crime

Everyone said that they were not doing as much crimes anymore or had stopped completely, as there was no need to make money in order to obtain drugs from the street. Most clients regarded this as a positive change in their life, apart from one who felt it was a negative change. Negative as he had less money now than before when he was a professional criminal:

> I4:*"[talous] on [muuttunut] huomattavasti huonompaan suuntaan. Sen takia kun ei tuu tehtyy rikoksii niin ei tuu rahaakaan mistään. Eli ei mitään järkee tässä periaatteessa, rahan kannalta."*
>
> I4:*"[personal economy] has gone a lot worse. When I don't do crime I don't get money. This does not make any sense, economically."*

One client reported a need to do shoplifting for food, as the benefits received were not enough to cover the basic needs. He has however stopped committing heavier crime and associating with the criminal world.

> I8:*"Nytten oo ollut enää tekemisissä, niinku raskaan rikollisuuden kanssa, tai tehnyt raskaita rikoksia…. välillä niinku näpistän ruokaa."*
>
> I8:*"These days I am not rubbing elbows with hard criminality or done stodgy crimes… occasionally I like nick some food."*

Another client however told that he has not been stealing anything anymore as he would find it too embarrassing to be caught stealing a bottle of beer at his age.

It seemed hard to get rid of the criminal lifestyle even when there was less need to commit crimes. Many interviewees reported not committing any kind of crimes anymore but spoke

about recent drug dealing and assaults in another context. Minor crimes were not considered as actual crimes. Violence was often seen as a normal part of their everyday life, not a criminal offence. In addition, committing crime and being convicted seemed to be separate from each other's in one interviewee's mind:

> I7:*"Vuonna kaheksanyks jäin viimeks huumausaineiden, öö, myynnistä kiinni. Sen jälkeen mä en oo jääny."*
>
> I7:*"I was caught in year 81 dealing drugs the last time. After that I have not been caught."*

In another context, the same interviewee ends up admitting having dealt illegal substances, but felt that it was not a criminal activity but rather surviving under difficult circumstances:

> I7:*"Mulla on koko ajan rahaa. Joo, mä en oo koskaan perse auki. Ja mä pärjään sil pienellä rahalla, plus pientä, snadii bisnestä. Joo joo, pakkohan se on, kuka pärjää neljäl sadalla kuukaudes?"*
>
> I7:*"I always have money. Yeah, I'm never broke. And I get by with that little money, plus some minor dealing. Yeah, yeah, one has to, who get's by with four hundred a month?"*

Most clients felt that their personal economics had improved and they had money to spend on other things than drugs from the street. There was no strong urge for criminal activities as they receive their medication from the clinic. One interviewee saw a direct connection with methadone treatment and doing less crime:

> I1:*"... olin yhes vaihees niin sanottu taparikollinen, jotain kaikkee pientä, et tota, kun mä pääsin tähän hoitoon, niin mä en oo pöllinyt kaupasta edes purkkapakettia…. et kiitos metadonihoidon."*
>
> I1:*"... at one point I was a so called habitual criminal, always a little bit of something, and like, when I got into this treatment, I have not shoplifted even a pack of gum… thanks to methadone treatment."*

Many have not been able to stay out of prison as long periods before as they have been after starting the substitution treatment.

> I6:*”Kaheksan vuotta mä oon ollut vapaana, sitä ennen mä en oo ollu ku kaks kuukautta korkeintaan vapaana, kaks viikkoo. Et mun rikokset pysähty ku seinään siinä, kun metadonhoito alkoi.”*
>
> I6:*”Eight years I have been out of prison, before that it was maximum of two months or weeks. My criminal activity stopped completely after the methadone treatment. “*

It seems that for most interviewees the criminal activity in the past was tied to the need to obtain drugs. After starting the maintenance treatment that need had considerably decreased. Leaving the habit appeared to be difficult for others even though the daily methadone dosage was secured.

8.2 General atmosphere

Clients in general felt that it is easy to come to the services; they felt welcomed and safe. It was often mentioned that in KoHo one gets to be at ease. The personnel were considered important. It was mentioned that the personnel brought peace to the community. It was also valued that at KoHo the clients could spend time after receiving their treatment. They could stay and drink coffee, watch the TV and read the paper or just rest. The good atmosphere was described aptly by one client:

> I7:*”Hoito. Se on parasta. Se on se. Oleellisin. Sen takia mä käyn. Niin niin, et mä saan sen annoksen ja se annetaan niin pyyteettömästi ja niin positiivisesti vielä. Hyvät huomenet ja tuttavallisesti ja ”rovasti on hyvä ja jatkaa matkaa” ja se on oikeen, mä pidän sitä arvossa kyllä.”*
>
> I7:*”The treatment. It’s the best. That’s it. The most essential. That’s why I come. Yeah, yeah, I get the dosage and it’s given in such an unselfish and yet positive way. Good morning and in a familiar way ‘You’re welcome Dean and get going, and it’s like, I value that a lot.”*

KoHo was seen as a non-judgmental place where the clients are allowed to act in somewhat free a manner. As most clients had additional substance abuse alongside the maintenance treatment, it was important that personnel did not have judgemental attitude

towards them. Also, many clients felt that personnel encouraged them to reduce or stop altogether drug abuse. One client saw that coming to KoHo felt like coming to work:

> I6:*"… tää on suht koht inhimillinen ympäristö. Ja sit tää systeemi tapahtuu tääl aika vapaasti kuitenkin, et tääl ei kävele koko ajan joku nenä perseessä, mihin mä meen, tiätsä, ja seuraa mua niinku ja, mä tuun vähän niinku himaan niinku äsken mä menin suoraan jääkaapille, otan sieltä pari jugurttii, kukaan ei sano mitään, avaan hesarin. Ihan ku joku duunari tulis duunipaikalleen, meikäläinen tulee. Vaik mä oon vaan poka täällä näin niin. Se muistutti aika paljon niinku joku duunari tulis hommiin tiätsä, mun tuleminen tänne. Mä voin lähtee tulla niinku huvittaa täällä näin. Voi istuu safkaan asti. Tietynlainen vapaus täällä niinku päättää tekemisistään."*
>
> I6:*"... this is somewhat humane environment. And this system evolves in a quite free matter, like nobody walks after your their noses up your ass, where am I going, you know, and like follow me, and I come like home like I just went straight to the fridge, took a couple of yoghurts , nobody says anything, open the Hesari paper. Like a worker would come at his work place, that's how I come. Even though I'm just a John here. It resembled a lot the way a worker comes to work, you know, the way I come here. I can come go as I please here. I can sit until lunch. A certain kind of freedom to choose what to do."*

The non-judgmental atmosphere had built trust towards the personnel and encouraged the clients towards honesty:

> H6:*"Tääl uskaltaa niinku sanoa miten asiat suunnilleen on... Voi olla rehellinen, aika pitkälle rehellinen."*
>
> H6:*"Here you don't have to fear to tell how things really are... You can be honest, pretty far honest."*

Clients felt that it was easy to come to the services also due to the location and facilities:

> I6:*"Ei kukaan tost ohiajava tiedä millä asioilla mä täällä käyn, mistä ovesta mä meen sisään, miks mä tuun tänne."*
>
> I6:*"Nobody who drives by knows why I come here, which door I use, why I come here."*

The non-judgmental atmosphere was in a way expanded even beyond the immediate clinic facilities and the client did not feel stigmatized by coming there. It was both mentally and emotionally easy to come to the services.

8.3 Personnel, experience of:

The personnel were mostly seen as empathetic and approachable. The interviewees felt that they could receive help and assistance from the personnel in an acute situation. The personnel were always ready listen if the clients had something on their mind. Even when concrete help was not available, often just talking to someone was seen as helpful. Many told that the personnel at the clinic were their only contact to people who were not drug addicts. As they felt that some issues could not be discussed with other users, the personnel as listeners were irreplaceable. One client describes the personnel exhaustively:

> I7:*"[Henkilökunta on] ihan superii, ihan superii, ihan superii. Joka ikinen, ihan superii."*
>
> I7:*"[The personnel is] just super, just super, just super. Each and every one of, them, just super."*

Many felt that the support received from the personnel was comprehensive and sufficient. Others wished that the personnel would not pay attention only to their substance abuse problems but other areas of life as well. One client mentioned receiving mental support for giving up cigarettes and decreasing alcohol use. Even short substance free periods were encouraged and given positive attention. Many reported the personnel having given help when making difficult phone calls or filling official forms and applications.

One interviewee brought up the importance of personnel who are familiar with the drug scene and users' life style. That kind of knowledge does not come from books but through experience, and experienced personnel members were rather valued and respected. Stability

and life experience of the personnel was also seen important. Trust builds over time and can not be created with rapidly changing staff.

> I6:*” Mun mielestä on tärkeetä et tääl ei vaan mee ja tuu läpi porukkaa. Ei ne ehdi tuntee mitään, ei ne ehdi tajuta mitään, ei ne ehdi oppia mitään. Ei kirjois lue kaikkee, todellakaan, mitä tää elämä on. Sen huomaa ku tulee tänne hommiin, semmoset ku tulee tänne hommiin ja harjottelijat, neki on suu auki täällä. Niiden käsitys nististä on ihan toinen. Ne luulee et on aivoton ääliö, ettei osaa mitään tehdä, sen suusta ei tuu ku paskan jauhantaa, et se ei osaa ajatella ollenkaan.”*
>
> I6:*”I think it’s important that people just don’t come and go. They don’t get to know anything, they don’t get to understand anything, and they don’t learn anything. You can’t read everything, seriously, from the books, what this life is all about. You see easily when they come to work here, such and student, they are open-mouthed. Their idea of a junkie is different. They think that one is brainless moron who can’t do anything, who talks only crap and can’t think at all.”*

Two interviewees missed one worker who had already left the clinic. They felt that this person really delved deeply into the client’s case and did not leave matters unsolved.

> I2:*”Joo, heti kun hän lähti niin ei tääl oo kukaan mitään jeesannu. Ei sinne päinkään.”*
>
> I2:*”Yeah, once she left, nobody here has helped. Not even close.”*

The community rules and the personnel’s supervision brought safety. Many clients saw it as a positive thing that the personnel would monitor that the rules were obeyed and that they would be disciplined for problem behavior. One mentioned that a personnel member managed to avert stabbing.

Personnel also received some criticism. Some clients felt that personnel labelled them without a reason and were spiteful. Also, it was mentioned that at times there were incidents that were perhaps meant to be friendly teasing from the staff, but was experienced

as a public humiliation by the client. Moreover, some clients felt that different clients were treated differently, according to face value.

8.4 Medical treatment

All clients considered medical treatment as the most important issue:

> I5:*”Mä haluun käydä hoidossa. … Mä tartten tätä hoitoo, mä tartten sitä joka päivä, mä tartten ne aineet mitä täältä saa.”*
>
> I5:*”I want to go to the treatment. I need this treatment, I need it every day, I need that stuff that I get from here.”*

In addition to methadone, the clients received other medication, prescriptions and advice for various problems such as diabetes, rashes, head aches, anxiety and nicotine addiction. Nurses’ services were valued as minor infections, cuts and bruises were common.

Opinions towards maintenance treatment in general were positive. A common remark was that they would not be alive anymore if they had not started receiving maintenance treatment:

> I8:*“… ihan konkreettisesti pelastanut mun elämäni tai ainakin antanut sille huomattavan paljon jatkoaikaa…”*
>
> I8:*”... in a quite concrete way this has saved my life or at least given me considerably more time...”*

They felt that for a user with a chronic addiction maintenance treatment was the only reasonable option and that it substantially decreases crime. However, it was also mentioned that some patients receive medical treatment groundlessly and exploit the system for intoxication purposes or sell their medication at the street. Methadone as the choice of medicine received some criticism due to the side-effects. Many would prefer bubrenorphine.

8.5 Community rules and practises

Most interviewees considered community rules as sensible and that they were obeyed and controlled sufficiently. Rules brought sense of safety and eliminated arbitrariness. Rules were the same for all, and adjusting to them was considered rather effortless. However, some felt that consequences should be harder than what they were at the time of the interviews.

Collective consequences were considered as unfair. For example, if someone had smoked cannabis and the guilty one was not caught by the personnel, everyone lost their weekend methadone vacation. Clients felt that they should not be punished from mistakes made by others, as they are not "their brother's keepers".

The medication distribution times changed in January 2010. The shortened opening hours were criticised and many clients felt that the personnel was too strict, even "fascist" about following them. Two clients reported having lost their weekend vacations because of being a couple of minutes late. That was considered unreasonable. In addition, the need to bring a doctor's certificate in case of illness was seen as ridiculous:

> I6:*"Mun mielestä on aika järkeenkäypää, et semmonen ihminen on aika helposti kipee joka täällä käy. Oikeen vitsi toi juttu et pitää hankkii lääkärintodistus."*
>
> I6:*"I find it quite reasonable, that a person who comes here is quite easily ill. That one has to bring a doctor's certificate is a proper joke."*

Most of the interviewees reported about taking part to the weekly community meetings. They did not, however, experience having any kind of power regarding the community's daily functions and rules and did not think that the matters they brought up at the meetings were taken seriously. Generally, the interviewees felt their possibilities to influence very little and were questioning the purpose of taking minutes at the meetings, if no action was taken based on them.

> I2:*“Kyllähän mä niissä istun mut ei niistä mitään apuu ole, järkeviä ratkasuja, kunhan on noit palaverei. ”*
>
> I2:*”I do sit at them, but they are not of any use, reasonable solutions, they are just meetings.”*

It was also a common opinion that some matters were off limits at the meetings, for example criticism towards the doctor:

> I3:*“Itseasiassa ne tuntuu aika turhauttavilta noi yhteisökokoukset, me ei esimerkiks saada ottaa lääkäriä puheeks kokouksissa, joka on hyvin outoo, koska sehän on meidän yhteisökokous, meidän yhteisöpuhumisesta meidän asioista ja ongelmista, meillä on ongelmana lääkäri, mut me ei saada puhua lääkäristä. Et tääl on aika diktatuuri ja tää on kuitenkin diakonissalaitos.”*
>
> I3:*”In fact they seem quite frustrating, those community meetings, we are not allowed for example to bring up the issue of the doctor at the meetings, which is really strange, because it’s our community meeting, our community discussion about our issues and problems, and our problem is the doctor and we are not allowed to talk about the doctor.“*

Before November 2009 the KoHo community was divided in to two different departments. Now they are united and some interviewees reported problems that had roused after the merger. According to one interviewee, the more unpredictable and aggressive clients were treated before in a separate unit so that the calmer clients did not have no associate with them. Now after the merger it was seen as disturbing that certain clients would come in to the clinic under arms and in an unpredictable state of mind. One interviewee experienced that the personnel was incapable to intervene and even afraid. Several interviewees also reported that personal chemistry was creating problems after the fusion of the two clinics and that they tried to avoid attending to the clinic at the same time as certain other clients. Also the fact that the clientele consists of problem users was seen as troublesome:

> I4:*” No ne on käyttäjiä, mä en hirveesti haluu olla niiden kaa tekemisissä”*

> I4:*" Well they are users; I don't really want to hang out with them."*

Before the unification of the two communities, when KoHo was located elsewhere in the facilities, the clients were allowed to leave their pet dogs at the hall. Now there is no such possibility and also this was seen as negative and even discriminative practice.

The medical treatment was considered as the most important service, but also the possibility to eat, use phone and the internet, play pool, do the laundry, participate on the recreational trips, use the nurses services and just hang out were mentioned.

Most interviewees said that the possibility for weekend vacations, receiving the weekend's medication beforehand, motivated to come to the clinic regularly. Many wished for more possibilities for these vacations. Two interviewees reported being allowed days off due to personal issues, such as loss of a family member or in order to run errands. This kind of flexibility was valued. It was also valued that at KoHo, additional substance abuse did not result in refusal of the weekend vacations, as it would at other substitution treatment clinics. The absence of urine test was largely valued:

> I6:*"Muissa pisteissä ei niin annetakaan lomia ku täällä. Muissa pisteissä tehdään vaan kusikokeita. Tää on ainoo paikka missä ei tehdä kusitestejä..."*

> I6:*"At other clinics you don't get vacations like you get here. At other clinics, all they do is piss tests. This is the only place where they don't do piss tests…"*

Two interviewees told that having to come to the clinic daily makes them feel chained to the clinic physically which makes it difficult for example to run errands and try to find work. Therefore they wished for more days off. One felt that it was difficult to get days off and criticized the need to give a specific reason for applying for vacations.

8.6 Criticism towards the clinic

The KoHo community received also some criticism. Physical location of the clinic was regarded improper by two interviewees; they found it difficult to get there. Several however told that the communal traffic made it easy to commute to the clinic.

Many interviewees stressed that their addiction is only one of their problems and therefore needed support in other areas of life. Lack of social advisor, therapy and psychological services were often mentioned. The clients often stated that they would need weekly discussions with a key worker. There was also a need for a personnel member to help sorting out practical problems such as housing et cetera. The clients wished for support also in other problematic life situations and in relations with the authorities. More specific examples of expressed need for support were domestic help, housing and getting psychiatric help. The interviewees felt that the treatment at KoHo concentrated too much on treating the addiction on the expense of psychosocial aspects of life:

> I6:*"Tää juttu ei oo pelkästään tätä, narkomaniaa, niinku sanan täydellises merkitykses aineiden himoa, vaan myöskin sitä, et kun asiat on tarpeeks päin vittuu ni niit ei haluta enää itsekään nähdä, vaan sitä tulee vetäneeks verhon itsensä ja maailman väliin, toisin sanottua vedettyä taulu täyteen. Et unohtuis edes vähän kuinka helvetin sekasin omat asiat on."*

> I6:*"This thing is not merely this, addiction, like in its full value; craving for stuff, but also that when things are fucked up enough you don't want see those anymore but rather close the curtains, by other words you get wasted. So that you could forget even for a while how messed up your life is."*

Many interviewees hoped that the personnel would get thoroughly oriented in a single client's case. They admitted that they could start a conversation with the personnel anytime but what they longed for were regular conversations with a specific nurse who would be familiar with the case of the concerned client. It was suggested, that each client would be assigned to one nurse that would be more familiar with the client's case. In this context, several clients mentioned a nurse that had already stopped working at KoHo. It was said

that this particular nurse had delved deeply into the client's case and would not leave things unfinished.

> I2:*"Se kerto niinku tommosia asioita mihin nää toiset ei viitti saatana vääntää. …. Heti kun se lähti pois niin lähti matto alta. Saman tien. Se kumminki pureutu niihin asioihin, ettei se niinku jättäny roikkuun"*
>
> I2:*"She told like the kinds of things the others can't be freaking bothered. As soon as she left, it was like a carpet was pulled under me. Straight away. She got into those issues, didn't leave them hanging."*

On the other hand, the interviewees understood that the nurses did not necessarily have enough time and resources for more personal involvement and the number of clients was considerable. They also understood that the personnel would get easily frustrated and tired as many clients seemed to be in a vicious circle of problems. Nevertheless, the interviewees hoped for more involvement from the personnel due to the complexity of substance abuse problem:

> I6:*"Ne ei oikeen kelaa et ne kulkee käsi kädessä nää ongelmat. Sosiaalinen vaikeus ja sitte tää näin [huumeriippuvuus], ne kulkee ihan käsi kädessä. Tätä ei jaksa kattoo tätä paskaa selvin päin."*
>
> I6:*"They don't really twig that they go hand in hand these problems. Social difficulties and this [drug addiction], they go hand in hand. One can't look at this shit sober."*

Many interviewees mentioned the need for psychological and psychiatric support. Also spiritual support was mentioned in one interview. They hoped that the personnel would pay more attention to the client's mental health. Many reported having mental health problems such as depression and anxiety that had been attended to only by medical means. This was seen as insufficient as medication does not solve the problems causing the symptoms. Many had suffered from a personal crisis and felt that they were not given enough support at the time of the crisis. Even just the possibility for a psychiatric evaluation would help taking the matter forward independently. The need for therapy was often mentioned.

Some wishes were more specific and concrete. One client wished that the personnel would offer support in order to be accepted to a rehabilitative course. Another hoped that the clinic would offer an opportunity for physical exercise. He told that there had been discussion about building a gym at the clinic facilities but so far the issue had been put aside.

Most of the criticism was directed towards the clinic's doctor. They felt that it was difficult to get an appointment with the doctor and that many times the appointment was cancelled. It was mentioned that maybe the doctor had too much on her plate, working at two different clinics. The interviewees also found it strange, that first they needed to tell their issues for the nurses, who would forward the information to the doctor and then distribute the medication based on the doctors feedback. They would want to see the doctor personally in order to make sure they were treated properly.

It was also criticised that the doctor would refuse to treat any somatic symptoms. They felt that the clinic doctor's job description should be broadened due to the complexity of substance abuse problem. Instead of only focusing on treating the addiction, also the other health problems caused by the lifestyle should be attended to.

The interviewees also reported communication problems with the doctor, caused by both the lack of language skills and poor knowledge of human nature. They felt that they literary spoke a different language and "walked on different soil". One interviewee put it this way:

> I2:*"Tänne kuulemma haluu kukaan lääkärikään tulla töihin tähän paikkaan, sen takii meillä on tommonen lääkäri joka ei osaa suomee, siin sit tulee kaiken maailman ongelmii siinä niinku miten se käsittää niinku asiat.."*
>
> I2:*"For all I know, no doctor wants to work here either, and that's why we have that kind of a doctor who cannot speak Finnish, and then all kind of problems occur in the way she like understands things."*

The communication problems made them feel that they had poor possibilities to influence on their own treatment. They felt that the relationship between the doctor and the patient was autocratic instead of being equal. The importance of the issue was stressed in many ways:

> I8:*"…koska lääkäri on se ihminen jolla tavallaan on mun elämä kämmenellään, että se pystyy niinku tekemään mun elämästä todella kurjaa, tai sitten niinku korjaamaan sen."*
>
> I8:*"... because the doctor is that person who in a way holds my life on her hand and therefore can like make my life really miserable or to like fix it."*

It was also mentioned that the doctor categorically saw the clients as liars that should not be trusted and whose only motivation was to get as intoxicated as possible, when in many cases they only wanted to...

> I8:*"…saada niinku omat asiansa hoidettua parhaalla mahdollisella tavalla. "*
>
> I8:*"... have like your own issues taken care of in the best possible way."*

The interviewees also reported that they were not allowed to pose any kind if criticism about the doctor at the community meetings and that the nurses try to absorb any negative discussions concerning the issue. Some criticism posed against the doctor was personal and irrelevant and it was decided to exclude it from the study results.

9 CONCLUSIONS

This chapter aims at answering how the clients experience the services of the maintenance treatment community. More specifically, it aims to present what kind of changes has occurred in the clients' lives and psychosocial ability during the treatment, what kind of matters the clients value and considers as important at the community and finally what kind

of shortcomings and developmental needs do the clients experience concerning the services.

There was some fluctuation in the data, but primarily the clients saw the treatment at KoHo community as positive and effective. All clients had experienced some kind of changes, both positive and negative, in their lives after starting the maintenance treatment. The non-judgmental atmosphere and the actual medical treatment received most of the praise. Criticism was principally directed towards the clinic doctor and also towards the one-dimensional way the clients felt that their problem was seen. They wished for a more holistic type of treatment that would also consider their social and mental issues.

All clients reported several kinds of changes that had taken place after entering the maintenance treatment program. In this report the changes have been classified under the following themes: housing, emotional and mental status, physical condition, relationships, substance abuse, personal economics and crime. Changes in these sectors of the clients' lives can indicate a change in the clients' psychosocial ability (Kettunen et al, 2002: 53, 64; Harju-Koskelin, 2007: 14). The data suggests that the psychosocial ability had improved for most clients. None of the interviewees was homeless during the interview, but most reported having experienced homelessness at some point of their lives. They had not obtained their apartments with the help of the clinic but many stated that they would not have been able to hold on to their apartments if they were not receiving maintenance treatment.

Majority of the clients had obtained structure and regularity in their lives, which had brought sense of normality and thus improved their mental status. Also, communality and community activities, such as playing pool and making trips, were creating possibilities to experience life as so called normal people do. For majority, KoHo was the only place to engage in such activities. These types of activities may seem trivial but were experienced as important form of interacting with others, both other clients and the personnel. Furthermore, the possibility to stay at the clinic facilities without being bothered was valued by most of the client and had brought tranquility in their lives. The medical

treatment alone was also mentioned as an important factor in the improved mental status as the clients had no stress over the next dosage anymore.

Most clients felt that the regularity that KoHo had introduced to their lives had led to improved physical status. Regularity had brought more possibilities to take care of themselves and many had even started or continued doing physical exercise. Methadone treatment had however brought weight problems for many. However, most of those who reported weight problems seemed motivated to lose the excess weight. One client brought up a wish for a gym at the clinic facilities so that it would be easier to keep fit. It might be a good idea to support physical exercising as it is a healthy leisure time activity and improved physical state promotes better mental health and quality of life. Exercising at a common gym may be difficult for some clients due to lack of money or social skills. Even a small scale gym would offer the clients something positive to do at the clinic alongside with the pool table, which was also valued by many interviewees.

Many interviewees reported positive changes also in their social life and thus in their ability to engage in meaningful relationships. After starting the treatment, the relationships with relatives had improved for most. One client had even started a family that is a positive change mostly from the client's own perspective. Some clients also experienced loneliness after having left the "gangland" world. Communality and peer support are among the methods of psychosocial support at KoHo. The data however showed that the interviewees generally saw the other clients in a negative way as opposed to an asset or a resource. Many referred to the other clients as "the others", strikingly nobody used the word "us". The other clients were often seen as trouble and as drug users that one did not want to associate with anymore. Only two interviewees reported having made friends at KoHo. It did not become clear whether uniting the two KoHo communities had resulted in worsened personal relationships among the clients. Only one interviewee complained about the unification, others did not think it played any kind of a role. The lack of trust in the fellow clients may result from the previous drug abusers life style where people generally only attempted to benefit on the others' expense. Also bad self-esteem and social stigma may arouse negative image of other drug addicts as well. One client replied when asked for an opinion about the

recreational trip, “there are only so many places where you can go with this kind of a lot”. Other causes for the mistrust towards other users were past experiences, dept and mere clashes of personality. Communality could be an asset at KoHo, but at present the community does not seem to work properly. Maybe after a longer period of time the one single KoHo community will form in to a more whole and people will find their own place. Placing more effort in discussion groups and togetherness could bring positive outcomes.

Other indicators of improved psychosocial ability were reduced substance abuse and change in criminal activity. Most clients said that they used fewer drugs, and also criminal activity had reduced. However, prolonged association with the police and the legal system appeared to lead blurring of the sense of justice. If they were not caught or given a sentence, criminal act, such as minor assault, was not considered as a crime at all. The same applies to dealing drugs and driving under influence. Therefore, it cannot be concluded that criminal activity has considerably degreased in reality. The number of hard crimes, however, seems to have decreased.

Regardless the fact that there had been positive changes in the clients’ psychosocial ability, it is however dubious whether the positive changes and improved psychosocial ability were due to the psychosocial support offered or merely resulted from the medical treatment. It may be the combination of both, as also other studies suggest (Ministry of Social Affairs and Health, 2001, Huumeongelmaisen hoito, 2010). Mere substitute treatment was mentioned as a provider of peace of mind due to the lack of stress of the next dosage by many interviewees. This supports the assumption that medical treatment plays an important role on the overall change in the clients’ lives. Clients’ do not have to commit crimes in order to obtain drugs and thus criminal activity has degreased.

On the other hand, the data pointed out the importance of psychosocial support. The relationship between the personnel and the clients was seen as pivotal by many interviewees. The non-judgmental attitude was valued as well. Also, Sipilä (1989: 201) stress the importance of mutual understanding in the worker-client relationship, more precisely meeting in time and place, sharing experiences and speaking a common language.

Even if the personnel would not be able to relate to everything that has happened in the client's life, it is possible to understand the client from one's own point of view especially if the relationship has been forming over time. Forming this kind of relationship is a long term process, whereby stability of the personnel is crucial. This was also suggested by the data; the rapid changing of staff members provoked criticism. Many hoped that there would be even one staff member who would be especially familiar with their case. This indicates that a key worker system would be a welcomed improvement in the community's services. It might be worthwhile to consider why the turnover rate of the personnel is so high, and how to make employment more permanent. Good client-worker relationship is beneficial for both parties as it is a foundation for trust and therefore creates safer environment for all. For example, according to a client, a familiar worker was able to cease an act of violence before it even started properly. This was due to their long term relations, a worker less familiar might have not been able to interfere in the matter successfully. Although the client-worker relationship is of great importance, the workers should maintain professional distance as described by Raunio (2004: 145). This client group is demanding and can easily consume the worker's resources, both personal and professional. The clients tend to have rather traumatic backgrounds and mere listening to them can be burdensome.

The personnel were the only human contact with non-users for many clients. As Kettunen et al (2009: 49-50) point out, the public attitude towards drug users is commonly harsh and rejecting and therefore the approving atmosphere at KoHo was valued. Nuorvala (1999) found out that negative attitude especially within the service system made committing to the treatment difficult, which emphasizes the meaning of the non-judgmental atmosphere at KoHo even more. The interviewees stated that the attitude at the KoHo in general was positive and that they were treated equivalently. Clients reported that it was easy to come and stay at KoHo, unlike previous substitute treatment faculties which were experienced negatively; clients felt that they had been kept a stricter eye on their doings by the personnel at other treatment places. This may be resulting from different treatment objectives. At KoHo the objective is harm reduction, as opposed to giving up substances, as in substitute treatment in general. Many valued the positive and straightforward

atmosphere. This seemed to be something that was experienced rarely elsewhere and something unique that the personnel could take pride in creating it.

The psychosocial support offered at KoHo falls into categories of supportive services and service counseling. However, clients stated a need for more holistic form of treatment. As the clients' problems are multidimensional, also the treatment should address more than just one problem, the addiction. Many reported a need for therapy or even just a psychiatric evaluation in order to search for these services elsewhere. As substance abuse is not detached from mental health problems, they should be treated simultaneously. Regular discussions with a key worker could answer to the need of psychiatric help to some extent. In addition to mental support, many clients hoped for practical support with everyday errands. Having led the addict's lifestyle for most of their adulthood, many lacked of basic housekeeping skills and needed support.

A holistic approach was also expected from the clinic doctor. At the time of making this study, the clinic's doctor's job description did not include treating somatic symptoms, only the addiction. With other symptoms clients needed to turn to their local health center, which was seen as problematic by many. Making and keeping an appointment is difficult and daily visits to KoHo already made their schedules tight. A full service clinic would be ideal but a utopia with limited resources. On the other hand, a full service clinic could make the clients too dependent on the services of KoHo and marginalize the clients even more, as they would not have to associate with other service providers.

The clinic doctor received also plenty of personal criticism from the clients. This could be expected as the study was targeted at people with difficult addictions and who are therefore dependent on the doctor who prescribes the medication. The doctor is clearly in a position of power and the arrangement might have been be difficult to bear for some clients. Two clients, however, expressed difficulties in the doctor-patient communication in an emotionally neutral context and therefore the matter deserves some attention. As Sipilä (1989: 205) states, common language is one prerequisite for mutual understanding. Many clients felt that the doctor did not understand them because she was not native Finnish

speaker. In order to avoid misunderstanding, the nurses' involvement could be secured in all doctor-client relations, even though one client did criticize the doctor for delegating her work for the nurses. At the most times, the nurse is present at doctor's meetings, so language issue could be a mere pretext to complain and claim that their needs are not met. The personnel probably has received criticism towards the doctor regularly and therefore it might have been easily ignored even when was justified. Many clients reported that they were not allowed to talk about the doctor at the meetings which made the power distance between the doctor and the clients even greater.

Both incentives and restrictions were used at KoHo and both practices were either valued or criticized. The possibility for vacations from the clinic could be seen as incentives; if the client attends regularly and is adhered positively to the treatment (s) he is allowed to have several days' medication at his/her possession. This possibility was seen as a positive incentive by the clients and it incited the clients to come to the clinic regularly. Ban from the services due to misbehaving or losing the possibility for vacation for one reason or another are on the other hand restrictions that help regulating the client's conduct. The clients generally saw the rules in a positive light and felt that restrictions were given with justice. Only one client felt having been treated wrongly and also only one felt that coming to KoHo daily was too difficult and that vacations should be allowed even if the client misses a day from the services. Therefore one could argue that for most clients incentive/restriction based methods work well at KoHo and bring positive outcomes in committing to the treatment and in behaving properly. In addition, Current Care recommendations acknowledge incentive and restriction based methods as effective, but in decreasing the use of illegal drugs (Huumeongelmaisen hoito 2010).

Overall, it could be argued that KoHo has improved the quality of clients' life, although the clients experienced need for improvements. Yet, the clients' needs are a bottomless dwell which most probably can not be filled. One also has to bear in mind that the results presented here are the clients' own experiences and assumptions, not objective facts.

10 DISCUSSION

There was need for this study and the initiative came from the Deaconess Institute. This was the main motivator when working on the study. This made the entirety final thesis process worthwhile and meaningful; it was made for a purpose, not just for the sake of graduating or filling the school library. The study process gave possibilities to learn about the policies related to substance abuse, and how they relate to general welfare.

The principle of harm reduction justifies substitute treatment well. It reduces drug-related crime, marginalisation and the spread of infectious diseases such as HIV. The again, substitute treatment is an expensive treatment and thus heavy for the national economy. Although studies have shown (Huumeongelmaisen hoito 2010) that providing maintenance or substitute treatment results in fewer expenses that not providing any treatment at all, one cannot help but wonder whether this is true. Would the drug related harm without maintenance treatment really be greater in costs than providing several years' of treatment for citizens who have never contributed to the national economy?

Maintenance and substitute treatment also cause problems. Some clients abuse the treatment and manage to sell their medication on the street. This may lead to unnecessary deaths, as methadone is dangerously strong for inexperienced user. Methadone and bubrenorphine are also attractive for young people as they may be consumed orally as opposed to injecting heroine and as a result young people that might not otherwise experience with opiates get addicted. Partanen (cited in Rönkä et al. 2008: 33) states that 33% of those who seek treatment for substance abuse seek it because of Subtext which is a buprenorphine product. Kuussaari and Ruuth (cited in Rönkä et al. 2008: 34) report bubrenorphine being the primary drug of those starting treatment. It seems paradoxical that their problem might be treated with the very same drug that was the cause of the problem in the first place or even with a drug that is even more dangerous and addictive.

Many clients had started experimenting with substances at the very early age and therefore had no knowledge of so called normal life at the time of the interviews. One could say

that many of them were victims of the situations rather than rational subjects intentionally engaging in harmful activities. For that reason, it feels justified that the responsibility is lifted from the individual and help is offered by the society. The responsibility thus lies partly on the society: as methadone maintenance treatment is often a treatment method designed to last for the rest of the patient's life, the treatment should not be started by weak grounds. Some of the interviewees had started the treatment relatively young and many criticised methadone maintenance treatment because young people are easily accepted to the program. Before, clients had to have recorded history of opiate abuse from a period of ten years. Methadone is a heavy drug and causes numerous ill-effects as represented in the data. Buprenorphine would be better suited and less dangerous for younger patients (Holopainen et al. 2003: 473) and above all, would it not be reasonable to try all possible non-medical methods before starting a lifelong medical treatment that is almost impossible to come off. There has even been discussion on giving up non-medical methods in substance abuse rehabilitation. (Kallio, 2009) This tells about the medicalization of the modern society. All illnesses and symptoms are mainly treated with drugs without paying attention on the cause of the symptoms. Big drug companies market their products aggressively and many drugs are prescribed unnecessarily. As one interviewee said, the problem is more complex than just the drug addiction: it involves also many social and psychological problems which cannot be treated with medications. This speaks strongly for the psychosocial methods: non-medical methods should be used at least alongside the medical ones.

This was authors' first study of this scale and if given the opportunity many things would have been made differently. The study arrangement changed on the course of the study and thus some of the work done was unnecessary. As making, this study was a learning process throughout. This concerned especially the interviews; the quality of data obtained during the last interviews was better than during the first ones because of improved skills as interviewers to some extent. The research focus became clearer on the course of the study. This affected also the theoretical framework. At first, it was considered adding motivation and motivational interviews in the theoretical framework but concentrating on methods of psychosocial support served the purpose of the study the most. Also, the

research questions sharpened all the way the study process and were worked on even after collecting the data. This is common in qualitative research and allowed to utilize the data to the fullest.

The data and the study process gave ideas for future studies. Future studies could be conducted on the clients' right to self-determination and their possibilities to influence on their treatment. This was suggested by the fact that many clients saw their possibilities to influence their treatment and the communal matters poor. Clients also seemed to experience a great power distance between the clinic doctor and the patients. As psychosocial support is vast in meaning and the term is used in connection with different kinds of methods, it would be interesting to study how the personnel at KoHo understands psychosocial support and how they experience its meaning in the KoHo treatment. This kind of additional study would also strengthen the validity of this study. Also conducting a quantitative study on the changes that have taken place in the clients' life during the treatment with the help of the clinic's, the social services' and the police's reports could support or contradict the results of our study. This study relies solely on the clients' own experiences and feelings and thus the results cannot be seen as solid facts.

REFERENCES

Ahtee, L. (2003). Opioidit ja kannabinoidit. In Salaspuro, M., Kiianmaa, K. & Seppä, K. (2003) *Päihdelääketiede*. Jyväskylä: Gummerus Kirjapaino Oy.

Alasuutari, P. (2001). *Laadullinen tutkimus*. Gummerus Kirjapaino Oy, Jyväskylä.

Elster, J. & Skog, O-J. (1999) *Getting Hooked; Rationality and Addition*. Cambridge University Press, United Kingdom.

Eskola, J. & Suoranta, J. (1998) *Johdatus laadulliseen tutkimukseen*. Gummerus Kirjapaino Oy, Jyväskylä.

Forssèn, T. (2005) *Huumehoidon asiantuntijuuden rakentuminen päiväkeskuksessa*. Raportteja 1/2005. Stakes, Helsinki.

Granfelt, R. (1993) Psykososiaalinen orientaatio sosiaalityössä. In Granfelt, R., Jokiranta, H., Karvinen, S., Matthies, A -L.& Pohjola, A.(1993) *Monisärmäinen sosiaalityö*. Jyväskylä: Gummerus. 175-252.

Hakkarainen, P. & Tigerstedt, C. (2005) Korvaushoidon läpimurto Suomessa. *Yhteiskuntapolitiika 70, 143-154*.

Harju-Koskelin, O. (2007) *Kuntoutuuko korvaushoidossa?* Järvenpään sosiaalisairaalan julkaisuja nro 37.

Havio, M., Inkinen, M. & Partanen, A. (2008) *Psykososiaaliset menetelmät*. Päihdehoitotyö. Helsinki: Tammi 127–132.

Hirsjärvi, S. & Hurme, H. (2004) *Tutkimushaastattelu : teemahaastattelun teoria ja käytäntö*. Helsinki: Yliopistopaino.

Hirsjärvi, S., Remes, P. & Sajavaara, P.(2007) *Tutki ja kirjoita*. Helsinki: Tammi.

Hirsjärvi, S., Remes, P. & Sajavaara, P.(2001) *Tutki ja kirjoita*. Helsinki: Tammi.

Holopainen, A., Fabritius, C. & Salaspuro, M. (2003). Opiaattiriippuvuus. In Salaspuro, M., Kiianmaa, K. & Seppä, K. (2003) *Päihdelääketiede*. Jyväskylä: Gummerus Kirjapaino Oy.

Hurme, T. (2002) Harmin paikka? Haittojen vähentämisen ongelmallisuus huumepolitiikassa. *Yhteiskuntapolitiikka 67, 415-422*.

Juurinen, R. (2008) Korvaushoitoko ainoa oikea hoito? *Tiimi* 6/2008,*7-9*.

Kaakinen, J., Törmä, S., Huotari, K. & Inkeroinen, T. (2003) *Raha-automaattiyhdistyksen rahoittaman huumeiden vastaisen työn ja matalan kynnyksen palvelujen merkitys*. Sosiaalikehitys Oy, Helsinki.

Kettunen, R., Kähäri-Wiik, K., Vuori-Kemilä, A. & Ihalainen, J. (2002) *Kuntoutumisen mahdollisuudet*. Helsinki: WSOY

Kettunen, R., Kähäri-Wiik, K., Vuori-Kemilä, A. & Ihalainen J. (2009*) Kuntoutumisen mahdollisuudet*. Helsinki: WSOY.

Koivisto, M-V. (2007a) *Mihin opiaattiriippuvaisten korvaushoidolla pyritään*. Järvenpään sosiaalisairaalan julkaisuja nro 38.

Koivisto, M-V. (2007b) Korvaushoitojen kehittämiseksi tarvitaan tavoitteiden ja käsitteiden selkeyttämistä. *Tiimi 2/2007*.

Matela, K. & Väyrynen, S. (2008) Huumeongelmat. In Rissanen, P., Kallanranta, T. & Suikkanen, A. (eds.) (2008) *Kuntoutus.* Otavan Kirjapaino Oy, Keuruu.

Ministry of Social Affairs and Health (2001). *Opioidiriippuvaisten lääkkeellisiä hoitoja kehittäneen työryhmän muistio*. Työryhmämuistioita 2001:21.

Mäkelä, M, Nieminen, J. & Törmä, S. (2005) *Hoito- ja palvelujärjestelmän kynnykset päihdeongelmaisen kannalta*. Sosiaalikehitys Oy, Helsinki.

Nuorvala, Y. (1999) *Sosiaali- ja terveydenhuollon palvelut huumausaineiden käyttäjien silmin*. Helsinki: Stakes.

Onnela, T (2001) Huumausaineet historiallisesta näkökulmasta, katsaus huumeidenkäytön ja huumepolitiikan historiaan. In Onnela, T (2001) *Pyhä Huumesota*. Vihreä sivistysliitto ry, Uusikaupunki.

Pauly, B. (2007). Harm reduction through a social justice lens. *International Journal of Drug Policy* 19 (2008) 4–10.

Raunio, K. (2004). *Olennainen sosiaalityössä*. Tammer-Paino, Tampere.

Rönkä, S. & Virtanen, A. (eds) (2008) *Finland - Drug Situation 2008. National report to the EMCDDA*. Stakes, Helsinki.

Saarto, A. (2003). Huumeet suomalaisessa yhteiskunnassa. In Salaspuro, M., Kiianmaa, K. & Seppä, K. (2003) *Päihdelääketiede*. Jyväskylä: Gummerus Kirjapaino Oy.

Seppälä, T. & Virtanen, A. (2007). Amfetamiinien ja opiaattien ongelmakäytön yleisyys Suomessa 2005. *Yhteiskuntapolitiikka 72 (5), 553–561*.

Sipilä, J. *Sosiaalityön jäljillä*. Helsinki: Tammi.

Tammi, T. (2007). *Medicalising Prohibition, Harm Reduction in Finnish and International Drug Policy*. Tammi, Vaajakoski.

Törmä, S., Huotari, K. , Kinnunen, R. & Nieminen, J. (2002) *"Mäkin oon ihminen!" Erityispalvelut hiv-positiivisille huumeiden käyttäjille. Kluuvin palvelukeskuksen toiminnan arviointi.* Sosiaalikehitys Oy.

Törmä, S., Huotari, K. & Inkeroinen, T. (2003) *Kurvi 24H. Helsingin Diakonissalaitoksen Kurvin huumepoliklinikan ulkoinen arviointi.* Sosiaalikehitys Oy, Helsinki.

Törmä, S. (2009) *Kynnyskysymyksiä. Huono-osaisimmat huumeiden käyttäjät ja matala kunnys.* Sosiaalikehitys Oy, Hämeenlinna.

Vehviläinen, R. (2004) *Asumisen ja elämisen tuki – projekti 2001-2004. Kotihoitomallin kehittäminen HIV-tartunnan saaneille huumeidenkäyttäjille*. Diakonissalaitos.

Wecroth, A.(2007*)* Mitä merkitsee "psykososiaalinen" päihdehoidossa? *Yhteiskuntapolitiikka 72 (2007):4, 426-436.*

OTHER SOURCES

Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioid addicts with certain medicinal products No 33/2008. Issued on 17.1.2008. Internet document. <http://www.finlex.fi/en/laki/kaannokset/2008/en20080033.pdf> Read 21.9.2009.

Drug Abuse Treatment. Internet document.< http://www.hdl.fi/en/drug-abuse-treatment> Read 21.9.2009.

Huume- ja mielenterveystyön palvelualue. Internet document. <http://www.hdl.fi/fi/huumetyo> Read 10.10.2010

Huumeongelmaisen hoito. Internet document
<http://www.kaypahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/hoi50041#s8_30>
Read 25.3.2010

Kallio, L. (2009) *Korvaushoidosta hyötyy vain osa huumeriippuvaisista*. Internet Document. <http://www.kalliola.fi:8080/Lists/Viestit/Post.aspx?ID=4> Read 20.10.2010

Kuussaari, K. & Ruuth, P. (2008). *Päihdehuollon huumeasiakkaat 2007*. Internet Document. <http://www.stakes.fi/tilastot/tilastotiedotteet/2008/Tt21_08.pdf.> Read 24.9.2010

Lausunnon hakeminen eettiseltä lautakunnalta. Internet Document. <http://www.hdl.fi/en/research/eettisen-toimikunnan-lausunto> Read 24.9.2009.

Maintenance Treatment Community. Internet document. <http://www.hdl.fi/en/drug-abuse-treatment/maintenance-therapy> Read 21.9.2009

Päihdehoitoyksikön laatuarvio. Internet document.
<http://neuvoaantavat.stakes.fi/tietokannat/pdf/Korvaushoito_avo.pdf> Read 21.9.2009.

Päihdehuoltolaki 17.1.1986/41. Issued on 17.1.1986. Internet document. <*http://www.finlex.fi/fi/laki/ajantasa/1986/19860041*> Read 25.9.2009

Päihdetilastollinen vuosikirja 2008. Alkoholi ja huumeet. Internet document. <https://www.stakes.fi/tilastot/tilastotiedotteet/2008/paihde/Paihdetilastollinen2008.pdf> Read 24.9.2009.

Tutkimuslupa. Internet document. <http://www.hdl.fi/fi/tutkimus/tutkimuslupa> Read 24.9.2009.

Values Upheld by Helsinki Deaconess Institute. Internet document. <http://www.hdl.fi/en/group/163> Read 10.09.2010

Vehviläinen, R. (2010) Interview 10.09.2010

Vehviläinen, R. (2009) Interview 09.09.2009

Appendix 3

Research permit in the printed version

Appendix 1

HAASTATTELURUNKO KOHON ASIAKKAILLE

1. Sukupuoli?
2. Syntymävuosi?
3. Kotikunta?
4. Kuinka kauan olet ollut KoHon asiakkaana?
5. Miten päädyit KoHon asiakkaaksi?
6. Oletko ollut korvaushoidossa ennen KoHon asiakkuutta?
    a. Jos olet, missä?
    b. Mikä oli syy hoidon keskeytymiseen?
7. Kuinka pitkään käytit opiaatteja ennen korvaushoidon aloittamista?
8. Onko päihteiden käytössäsi tapahtunut muutoksia sen jälkeen kuin aloitit KoHossa?
9. Asumisolosuhteet?
    a. Ovatko muuttuneet KoHon asiakkuuden aikana? Miten?
10. Fyysinen terveydentila?
    a. Onko muuttunut KoHon asiakkuuden aikana?
11. Psyykkinen kunto; oma mielipide ja onko muuttunut asiakkuuden myötä. Jos on, miten?
12. Ihmissuhteet?
    a. Ovatko muuttuneet KoHon asiakkuuden aikana? Miten?
    b. Miten koet muut KoHon asiakkaat?
    c. Kokemukset henkilökunnasta?
13. Muut muutokset, esimerkiksi harrastukset, mielenkiinnon kohteet, turvallisuuden tunto, jne
14. Taloudellinen tilanne ja mahdolliset muutokset KoHon asiakkuuden myötä?
15. Sakot ja tuomiot, ennen ja nyt? Onko muutoksia esim. tuomioiden määrässä?
16. Miten usein käyt KoHossa?
17. Viikonloppulomat; kannustavatko ne käymään KoHossa säännöllisesti?
18. Mitä mieltä olet rajauksista ja rajausten perusteita?
19. Osallistutko KoHon yhteisökokouksiin?
    a. Koetko, että voit vaikuttaa asioihin?
20. Mitä KoHon palveluista käytät? Miksi?

21. Onko mielestäsi KoHoon helppo tulla?
    a. Jos vastasit kyllä, mitkä asiat tekevät asioimisesta erityisen helppoa?
    b. Vaikeuttavatko jotkut seikat KoHossa asioimista?
22. Saatko KoHossa sellaisia palveluita joita tarvitset?
    a. Jos ei, minkälaisia palveluja tarvitsisit?
23. Mistä saat tukea ongelmatilanteissa?
24. Saatko KoHOsta tarvitsemaasi tukea esimerkiksi asioiden hoidossa (esim. sakkojen maksu, hammaslääkärikäynnit, jne)
25. Mikä on parasta Kohon palveluissa?
26. Mitä asioita pitäisi mielestäsi parantaa tai muuttaa?
27. Mitä mieltä olet yleisesti ottaen korvaushoidosta?
28. Mitä muuta haluaisit ottaa esille; sana on vapaa.

TIEDOTE KORVAUSHOITOYHTEISÖSSÄ TEHTÄVÄSTÄ TUTKIMUKSESTA

Hei!

Opiskelemme Metropolia ammattikorkeakoulussa sosiaalialan koulutusohjelmassa. Olemme tekemässä opinnäytetyötä koskien Korvaushoitoyhteisö KoHon asiakkaiden kokemuksia yhteisön palveluista. Tavoitteenamme on tuottaa Diakonissalaitokselle tietoa asiakkaiden omista käsityksistä yhteisön tarjoamasta hoidosta ja sen vaikuttavuudesta.

Haluaisimme haastatella Teitä opinnäytetyöhömme. Haastatteluun osallistuminen on vapaaehtoista ja tapahtuu kasvotusten. Haastattelusta kieltäytyminen tai haastattelun keskeyttäminen ei vaikuta saamaanne palveluihin millään tavoin. Haastattelut suoritamme KoHon tiloissa erikseen sovittavana ajankohtana. Haastattelun lisäksi emme käytä tutkimuksessamme muita asiakkaita koskevia tietoja. Haastatteluun osallistutaan nimettömänä. Haastattelut nauhoitetaan suostumuksellanne.

Tutkimusaineistoa käsitellään ja säilytetään niin, etteivät ulkopuoliset tahot saa niitä tietoonsa. Tutkimuksen valmistuttua haastattelunauhat ja muu tutkimusaineisto hävitetään. Tutkimustuloksia tulkittaessa varmistamme, etteivät yksittäiset henkilöt ole tunnistettavissa.

Toivomme osallistumistasi!

Terveisin,

Saija ja Eeva-Liisa

SUOSTUMUS TUTKIMUKSEEN OSALLISTUMISESTA

Tutkimus: Metropolia ammattikorkeakoulun sosiaalialan opiskelijoiden opinnäytetyö korvaushoitoyhteisö KoHon asiakkaiden näkemyksistä yhteisön palveluista: Motivaation merkitys korvaushoidossa.

Minulle on selvitetty yllä mainitun tutkimuksen tarkoitus ja tutkimuksessa käytettävät tutkimusmenetelmät. Olen tietoinen siitä, että tutkimukseen osallistuminen on vapaaehtoista. Olen myös tietoinen siitä, että tutkimukseen osallistuminen ei aiheuta minulle minkäänlaisia kustannuksia, henkilöllisyyteni jää vain tutkijan tietoon ja minua koskeva aineisto hävitetään tutkimuksen valmistuttua.

Suostun siihen, että minua haastatellaan ja haastattelussa antamiani tietoja käytetään kyseisen tutkimuksen tarpeisiin. Voin halutessani keskeyttää tutkimukseen osallistumisen milloin tahansa ilman, että minun täytyy perustella keskeyttämistäni tai että se vaikuttaa hoitooni tai asiakassuhteeseeni.

Päiväys

_____

Tutkittavan allekirjoitus ja nimenselvennys

_____

LIITE Tiedote

Metropolia Ammattikorkeakoulu
Hyvinvointi ja toimintakyky klusteri
Sosiaaliala

TYÖELÄMÄN LAUSUNTO
Sosiaalialan opinnäytetyöstä

Hyvä yhteistyökumppani, Pyydämme ystävällisesti arvioimaan opinnäytetyötä erityisesti työelämälähtöisyyden kannalta sekä opiskelijan kykyä toimia yhteistyössä sosiaalialan ammattilaisten kanssa ja hänen valmiuksiaan nähdä alan kehittämishaasteita.

TYÖPAIKKA/TOIMINTAYKSIKKÖ: Helsingin Diakonissalaitos/Korvaushoitoyhteisö(haittoja vähentävä korvaushoito). Hylkeenpyytäjänkatu 5, 00150 Helsinki

---

ARVIOITAVA OPISKELIJA/T: Saija Puhjo ja Eeva –Liisa Yli-Mattila

---

OPINNÄYTETYÖN AIHE/ NIMI: ”Täällä saa olla rauhassa !” Clients experiences on the psychosocial support and services at a maintence treatment community

---

Arvioitavat alueet:
1.Aiheen merkittävyys sosiaalialan asiakaslähtöisen ammatillisen työn kehittämisen kannalta.

Korvaushoitoyhteisön asiakaskunta edustaa kaikkein syrjätyneimpiä korvaushoidossa olevia opioidi riippuvaisia huumeidenkäyttäjiä. He ovat useimmat käynteet läpi vuosien varrella erilaisia päihdehoitoja. Hoitomallin tulee olla nimenomaan asiakaslähtöinen ja asiakkaan ihmisarvoa kunnioittava. On erityisen tärkeää saada kuulla asiakkaan näkemyksiä psykososiaalisesta tuesta, jota korvaushoitoyhteisö voi tarjota. Tämän opinnäytetyön avulla saamme uutta tietoa jotta voimme kehittää asiakaslähtöistä hoitomallia. Olemme tehneet hiljattain asiakastyytyväisyyskyselyn korvaushoitoyhteisössä ja onkin nyt mielenkiintoista verrata näitä kahta.

2. Opiskelijan kyky rakentavaan, innovatiiviseen ja tulokselliseen yhteistyöhön työelämän edustajien kanssa.
Yhteistyö molempien opiskelijoiden kanssa on ollut koko opinnäytetyöprosessin ajan hyvin rakentavaa ja ammatillisuuden kehittyminen on näkynyt työn edetessä.

3. Opinnäytetyön hyödynnettävyys työelämässä, sen tarjoamat näkymät alan kehittämisen näkökulmasta kts.kohta 1.

4. Opiskelijan ammatillinen kasvu; kyky reflektiiviseen ammatilliseen työotteeseen, kyky tunnistaa omia voimavarojaan ja kehityshaasteitaan
Työelämäohjaajan kanssa käydyt keskustelut ja sähköpostikirjeenvaihto on osoittanut kummankin opiskelijan kykenevän ottamaan vastaan palautetta ja korjaamaan sen perusteella työtään.

Paikka ja pvm: Helsinki 8.11.2010
Työelämän edustaja: Riitta Vehviläinen, osastonhoitaja, Korvaushoitoyhteisö

Ehdotus arvosanaksi : 4