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ETHNIC SENSITIVE SUBSTANCE ABUSE WORK

Services for Non-Finnish Speaking Clients in Substance Abuse Treatment Units in Finland Today

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ABSTRACT

The purpose of this study was to examine the current situation in substance abuse treatment units in Finland in taking non-Finnish speaking clients into consideration. The initiative for this research came from the Development of Alcohol and Drugs Intervention group at Stakes (National Research and Development Centre for Welfare and Health). Their aim was to gather information about the functioning and relevance of the quality assessment forms based on the quality recommendations for substance abuse work, filled in by substance abuse treatment units. The ethnic issue was chosen as the main approach in the study. The aim of this research was to answer the following questions: what is the readiness and competence in substance abuse treatment units in Finland to receive and encounter non-Finnish speaking clients, how is the quality of these services assessed and/or developed in the units, and what has been the role and functioning of the quality recommendations and quality assessment forms in working with non-Finnish speaking clients.

The research methods used in the study were both quantitative and qualitative. The information concerning language services provided in the units was gathered from the quality assessment forms and basic information forms found in the database maintained by Stakes. The total amount of units found in the database was 267. In addition to that, semi-structured theme-interviews were carried out in four substance abuse treatment units in order to get a more deep understanding of how the services function in practice.

The few number of non-Finnish speaking clients in the units may explain to a certain degree the results of the research. The results however showed that there is still space for improving the services. In the light of quality recommendations, the degree of language options provided in substance abuse treatment units in Finland today is low. Also the quantity of interpreter services provided in the units is scarce. There could also be unified guidelines specially tailored for substance abuse treatment units on how to work with ethnic minorities, as the knowledge is currently adopted from several different instances. The quality recommendations as well as quality assessment forms were valued and applied in the units appropriately and were also perceived to have an effect on the functioning, and quality, in the units.

Keywords

Substance abuse work, non-Finnish speaking clients, language, cultural and linguistic competence, quality recommendations, quality assessment forms

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TIIVISTELMÄ

Tämän tutkimuksen tarkoituksena oli tarkastella Suomen päihdehoitoyksikköjen tämänhetkistä valmiutta ottaa ei-suomenkieliset asiakkaat palveluissaan huomioon. Aloite tähän tutkimukseen tuli Stakesin päihdetyöryhmältä jonka tarkoituksena oli saada tietoa päihdepalvelujen laatusuosituksiin perustuvien laatuarviolomakkeiden toimivuudesta ja tarkoituksenmukaisuudesta yksiköissä. Itse valitsin näkökulmaksi etniset kysymykset. Tavoitteena tässä tutkimuksessa oli vastata seuraaviin kysymyksiin: mikä on yksiköiden valmius ja kompetenssi vastaanottaa ja kohdata ei-suomenkielisiä asiakkaita, miten näiden palvelujen laatua arvioidaan ja tarvittaessa kehitetään yksiköissä, ja mikä on ollut laatusuositusten ja laatuarviolomakkeiden rooli ja toimivuus yksiköiden toiminnassa.

Tämän opinnäytetyön tutkimusmenetelmät ovat sekä kvantitatiivisia että kvalitatiivisia. Tiedot yksikköjen palvelukielistä keräsin perustietolomakkeista sekä laatuarviolomakkeista jotka löytyvät Stakesin ylläpitämästä tietokannasta. Näiden yksikköjen kokonaislukumäärä oli 267. Tämän lisäksi tein puolistrukturoidut teemahaastattelut neljässä päidehoitoyksikössä saadakseni syvempää tietämystä näiden palvelujen toimivuudesta käytännön tasolla.

Muunkielisten asiakkaiden vähäinen määrä yksiköissä voi omalta osaltaan selittää tutkimuksen tuloksia. Tulokset kuitenkin osoittavat että varaa näiden palvelujen kehittämiseen vielä on. Laatusuositusten valossa yksiköiden tarjoamat kielivaihtoehdot ovat vähäiset, kuten ovat vähäiset myös yksiköiden tarjoamat tulkkipalvelut. Päihdehoitoyksiköille voisi olla tarjolla myös yhtenäinen ohjeistus työskentelyyn etnisten vähemmistöjen kanssa, sillä tällä hetkellä tarpeellinen tieto saadaan hajanaisista lähteistä. Laatusuositukset sekä laatuarviolomakkeet koettiin yksiköissä tärkeiksi ja niitä arvostettiin sekä käytettiin hyväksi asianmukaisella tavalla, ja niillä koettiin olevan myös vaikutusta yksiköiden toimintaan ja sitä kautta laatuun.

Avainsanat

Päihdehoito, muunkieliset asiakkaat, kieli, kulttuurinen ja kielellinen kompetenssi, laatusuositukset, laatuarviolomakkeet

PREFACE

This whole research process has been highly interesting and educational for me at the same time being a tremendous amount of work. I was happy to see that all the substance abuse treatment units participating into the interviews were extremely interested in the research and considered it to be important, and genuinely and without hesitation participated into the process. Also Stakes has been extremely helpful in the making of the present study by continuously offering help and support whenever needed. The A-Clinic Foundation participated in the making of the present study by assisting in the process of acquiring the research permit, as well as being ready to help also in other issues. Stadia has also contributed in the making of the study by offering SPSS-guidance, proofreading as well as help through discussions.

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Tiia Louko

CONTENTS

1. INTRODUCTION

This final thesis is a study about the current state of substance abuse treatment for non-Finnish speaking clients in Finland. The study was carried out in cooperation with the Development of Alcohol and Drugs Intervention group at Stakes (National Research and Development Centre for Welfare and Health). Their aim was to gather information about the functioning and relevance of the quality assessment forms based on the quality recommendations for substance abuse work, filled in by each substance abuse treatment unit. The ethnic issue was chosen as the main approach for the study.

The main objective of this study was to examine how, according to the quality assessment forms and basic information forms and interviews done in the units, ethnic minorities are taken into consideration in substance abuse work in Finland, i.e. does the service system provide adequate, high quality and culturally sensitive services to special groups such as immigrants and other non-Finnish speaking clients. Services provided in the mother tongue of the clients are the main interest of the study as well as culturally competent practices in the units and how intercultural competence among the workers is emphasized and developed. Also, as the number of immigrants, as well as alcohol and drug abuse among them, especially among young immigrants (Jouhki 1998), is growing, attention was paid to how the need for these special services is acknowledged in substance abuse treatment units. The information was gathered from quality assessment forms and basic information forms aimed to substance abuse treatment units in Finland concerning their functioning. These forms are found in the database maintained by Stakes. Interviews were also carried out in four substance abuse treatment units to get a more deep understanding about the issue.

The first part of the study introduces the concepts and theories relevant in understanding why intercultural competence/communication and culturally competent practises are extremely important in social- and health care services in our society today. The second part of the study concentrates on the research methods and findings.

Finnish society is rapidly changing in the pressure of global markets and diffuse boundaries allowing more free migration. There are more and more non-Finnish speaking people in Finland, which demands awareness of cultural differences and development of cultural competence among staff members in health care settings, as

well as in other spheres of our service system. Substance abuse work makes no exception. In order to recognise the need for such services as well as meeting this need properly and with high quality, more studies concerning substance abuse among immigrants have to be made. Today the number of such studies is extremely scarce and statistics are not made (e.g. in the units) concerning the level of substance abuse among immigrants. This fact well justifies the present study.

2. CENTRAL CONCEPTS AND THEORIES

The framework of the study is built around the concepts of equality, quality, cultural and linguistic competence and intercultural communication and mindful intercultural communication, all important aspects in working with people from different cultures. The importance and meaning of language and mother tongue in social- and health care settings are also acknowledged as well as patterns of communication in general. These terms are introduced briefly below, yet clarified and discussed more in detail in the upcoming subsections.

2.1 Equality

Equality in this context means equal opportunities for people in relation to access to education, employment and different services. It is often falsely assumed that equality is guaranteed if people are given same opportunities. It has to be acknowledged that different individuals have different situations and possibilities and thus different needs. On the other hand, equality does not mean putting someone into a better position but making same opportunities possible for everyone. At its simplest equality is accepting difference and respecting others the way they are. (www.yhdenvertaisuus.fi)

There are several laws and agreements to secure equality and non-discrimination, the most important being the *Non-discrimination Act (Yhdenvertaisuuslaki)* (21/2004). This Act prohibits discrimination based on age, racial or ethnic origin, citizenship, language, religion or belief, conviction, opinion, state of health, disability, sexual orientation or other personal characteristics (such as financial position, pregnancy, and family situation). The Non-discrimination Act also states that a municipality may not treat people differently on the basis of ethnic origin, for example when organising social work, day care for children, hospital care and occupational safety and health services (www.yhdenvertaisuus.fi). There has been debate about the term “treating differently”, because being “colour blind” may even hinder the client’s situation. Ethnic, religious and cultural differences have to be acknowledged, but not at the expense of good and adequate services. Laws and regulations are handled more closely in Chapter 3.6.

2.2 Quality

Quality is a central issue in the present study, as the quality recommendations for substance abuse treatment units are the foundation of the study. But what is quality? There is no one core definition of quality, but the definition must be defined according where it is accustomed to. (Ovretveit, J. 1998:235) In order to evaluate quality in public health services, definitions suitable to that specific area are needed. Donabedian (1980) defines three aspects of quality in health care: the goodness of technical care, of interpersonal relationships and of the amenities of the setting of care. (Ovretveit, J. 1998:235) Maxwell (1984) defines quality in the following six dimensions: accessibility (distance, time, social barriers), relevance to need (appropriateness), equity (equal services for equal needs, unequal services for unequal needs), social acceptability (acceptability of what is provided and how it is provided), effectiveness (desired effects are produced in everyday conditions) and efficiency (produces the desired effect with the least waste). (Ovretveit, J. 1998:235) The Joint Commission for Accreditation of Healthcare Organisations (JCAHO) has a similar definition, but adds continuity into the list and gives a different emphasis to some of the dimensions: efficacy (is the treatment useful?), appropriateness (is it right for this patient?), accessibility (if it is right, can the patient get it?), effectiveness (is it carried out well?), efficiency (is it carried out in a cost-effective way?) and continuity (did the treatment progress without interruption, with appropriate follow-up, exchange of information and referral?). (Ovretveit, J. 1998:236)

But, as Ovretveit states, in both of these definitions the usual emphasis on quality as patient satisfaction has been lost. (Ovretveit, J. 1998:236) He offers the next definition of quality as: meeting the health needs of those most in need at the lowest cost, and within regulations. (Ovretveit, J. 1998:236) This definition can be broken down to three dimensions: patient quality (whether the service gives patients what they want), professional quality (professionals' views of whether the service meets patients' needs as assessed by professionals and whether staff correctly select and carry out procedures which are believed to be necessary to meet patients' needs), and management quality(the most efficient and productive use of resources to meet client needs, within limits and directive set by higher authorities). (Ovretveit, J. 1998:236) Which one of these is used by the evaluator, depends on the purpose of the evaluation and whom it is for. (Ovretveit, J. 1998:236)

2.3 Cultural and Linguistic Competence and Intercultural Communication

Cultural and linguistic competence refers to an “ability by health care providers and health care organisations to understand and effectively respond to the cultural and linguistic needs brought by clients to the health care encounter.” (Andrews, M. 2003:16)

Intercultural communication (ICC) is: ”a discipline that studies the interaction between individuals and/or groups with different backgrounds. ICC aims to enhance intercultural awareness, encourage the use of a double-perspective approach and offer a systematic method for analysing cultural differences in order to increase the effectiveness of communication between these individuals and/or groups.” (Pinto, D. 2000:15) It is closely connected to intercultural awareness which acknowledges cultural differences and recognizes how they affect thoughts, feelings and actions, but is not sufficient enough by itself in intercultural encounters. This issue is further discussed in Chapter 4.3.5.

Stella Ting-Toomey writes in *Communication Across Cultures* (1999) about mindful intercultural communication: “The feelings of being understood, respected, and intrinsically valued form the outcome dimensions of mindful intercultural communication. Mindful intercultural communication emphasizes the appropriate, effective, and satisfactory negotiation of shared meanings and desired goals between persons of different cultures. Mindful intercultural communicators are resourceful individuals who are attuned to both self-identity and other-identity negotiation issues. They are mindful of the antecedent, process, and outcome factors that shape the dynamic interplay of the intercultural communication process. They are also able to adapt to intercultural differences, flexibly and creatively, in a diverse range of communicative situations.” (Ting-Toomey, S. 1999:54) This issue is discussed more in detail in chapter 4.3.5.2.

2.4 Language

Language is an extremely important aspect of the present study, as language is a central part of our identities and of our whole culture. As Gaisfor (1981) has stated: “Since language is cultural, the product of human interaction, then it can be said that it is through language that humans define themselves and their world.” (Gaisford (1981)

cited in Baldwin, E. et al. 1999:45) Baldwin et al. continue: "The knowledge and information that is communicated in language is an artefact of language itself since language is constituted to identify and give meaning to human experience. Thus the events, objects, persons, emotions and so on that the language identifies are not discrete entities in human experience awaiting a label to be attached to them; they are constituted through language and the meaning given in language. In this way language stands for or **represents** that which it names." (Baldwin, E. et al. 1999:45) The Sapir-Whorf Hypothesis presented below discusses this issue more deeply. Language issues are found again in chapter 4.2.

2.5 Sapir-Whorf Hypothesis

It is easily assumed that everyone in the world thinks and speaks in the same way, just in different languages. But, as Samovar et al. write in *Communication Between Cultures* (2004) this is not the case. "How people think and how they ultimately speak is determined to a large extent by their culture. This process is known as linguistic relativity." (Samovar, L. et al. 2004:143) Benjamin Lee Whorf, an American linguist (1897-1941) suggested that language and thought are so closely connected that one's language determines the categories of thought open to him or her. (Samovar, L. et al. 2004:143) That is, the language one speaks affects on how one thinks. Whorf studied ancient Hebraic, Aztec, and Mayan cultures and went to The U.S in the 1930s to study the Hopi's Uto-Aztecan language and made the following observations: the Hopi do not pluralize nouns referring to time, such as days and years. Instead they viewed time as a duration. They do not use words denoting phases of a cycle, such as summer as a phase of a year, as nouns, and they do not see time as linear in that there are no tenses in the language. He observed that the Hopi did not have words, grammar, construction or expression that refers to time. From all this he made a conclusion that a culture is discoverable in its language. (Jandt, F. 2004:149-150) Edward Sapir, a student of Whorf's, wrote:

> Human beings do not live in the objective world alone, nor alone in the world of social activity as ordinarily understood, but are very much at the mercy of the particular language which has become the medium of expression for their society…The real world is to a large extent unconsciously built up on the language habits of the group. No two languages are ever sufficiently similar to be considered as representing the

> same social reality. The worlds in which different societies live are distinct worlds, not merely the same world with different labels attached.

The Sapir-Whorf hypothesis then argues that: “language is not simply a means of reporting experience but, more important, it is a way of defining experience.” (Samovar, L. et al. 2004:143) In short: culture is controlled by *and* controls language. (Samovar, L. et al. 2004:151)

3. SUBSTANCE ABUSE IN FINLAND AND IMMIGRANTS

In this chapter the current situation of substance abuse and treatment in Finland is discussed as well as the developing of substance abuse work, immigrants in Finland and substance abuse among them, and laws and regulations concerning substance abuse.

3.1 Consumption of Alcohol in Finland

The consumption of alcohol in Finland increased substantially after 1968, when the alcohol policy changed and beer was allowed to be sold freely in grocery stores and cafeterias. During that time, Finland was also hit by the first wave of illegal drugs. Since then, the consumption of alcohol has in turn increased and decreased, but after the 1990’s the total consumption has steadily been increasing and around the millennium it reached the highest point ever. Since then the consumption has increased 5% annually. (Inkeroinen, T., Partanen, A. 2006: 13) In 2004, three things dramatically affected the development of alcohol consumption in Finland: the removal of the contingency in the import of alcohol, the lowering of the taxation of alcohol, and Estonia’s membership in the EU. (Inkeroinen, T., Partanen, A. 2006: 13)

The level of alcohol consumption in a population is usually reported in litres or ethanol (100% alcohol or pure alcohol) ***per capita***, or in litres of ethanol for each person aged 15 or older. (Babor, T. et al. 2003:31) In 2005 the total consumption of alcohol in Finland was 55,2 million litres of 100% alcohol, 10,5 litres per inhabitant. Comparing to the year 2004, the amount rose 2,5 percent. During the last 30 years, the total consumption has more than doubled. The total consumption entails both statistical consumption (e.g. Alko’s sales and wholesale to restaurants, kiosks and service stations) and non-statistical consumption (e.g. import, illegal manufacturing, and consumption

abroad). (Yearbook of Alcohol and Drug Statistics 2006:18) However, the majority of the total consumption is concentrated mainly on the people that use substantial amounts of alcohol. In 2003, the top 10% that used alcohol the most, used 45% of all the alcohol used in Finland. (Mustonen et al. 2005: 247)

According to the Substance research made in 2005 by Stakes, 88% of inhabitants between ages 15 and 69 had used alcohol during the last 12 months. The percentage is even bigger among young people between 30 and 49 years: 92% of males and 91% of females had used alcohol during the last 12 months. Also the amount of teetotallers has decreased from 43% of women and 13% of men (1968) to 13% of women and 12% of men (2005). The estimated amount of inhabitants that use substantial amounts of alcohol is 250 000-500 000, that is 6-12% of the adult population. (Yearbook of Alcohol and Drug Statistics 2006:19)

3.2 Use of Illegal Drugs in Finland

The (regular, occasional, experimental) use of illegal drugs increased in Finland during the 1990's, especially among young people. The increase was so substantial, that we can talk about the "second wave of drugs", after the first one in the 1970's. (Hakkarainen & Metso 2003:252) After the year 2000 the increasing seemed to stop, and now there can even be seen signs of a slight decrease. (Yearbook of Alcohol and Drug Statistics 2006:23)

Cannabis is the most common illegal drug experimented and used in Finland. (Inkeroinen, T., Partanen, A. 2006: 14) In 2004, approximately 12% of inhabitants between ages 15 and 69 reported to have used cannabis at some point of their life (14% of men, 10% of women). The figure is the same as in year 2002. The amount of people that reported to have used cannabis during the past year was 3%. From young adults (15 to 34) every fifth reported to have used cannabis at some point of their life. (Hakkarainen & Metso 2005:253-254) Many studies (e.g. kouluterveyskysely/School health questionnaire done regularly by Stakes) however have shown that the trend of experimenting illegal drugs seems to be decreasing, although the rate is still higher than in the 1990's. (Luopa et al. 2006 cited in Stakes 2006:23) From the adult population, 5% reported to have used legal drugs (remedies) in the purpose of intoxication at some point of their life (14% of men, 11% of women), and 2% reported to have used them

during the last year. Amphetamines and ecstasy had been used by 1-2% of adults and 0,5% reported to have used them during the last year. 2-3% of people between 15 and 34 reported to have used cocaine and ecstasy at some point of their life. (Hakkarainen & Metso 2005:253) (Source: Päihdetutkimus/Alcohol and Drug Studies 2004, Stakes. 2 526 respondents)

The estimated amount of problem users of amphetamines and opiates in 2002 (latest estimation) was 0,4 - 0,6% of adults (15-69 year olds, whole country). In the capital area the estimated amount was 0,7 - 1,1%. Problem users of amphetamines were the majority of all problem users. (Partanen P. et al. 2004:279-280) The use on illegal drugs is mainly concentrated on the capital area, but during the 2000's, Tampere, Turku and Oulu have effectively been catching up. (Nuorvala&Metso 2004 cited in Inkeroinen, T., Partanen, A. 2006: 14)

3.3 Substance Abuse and Treatment in Finland

Services providing care for substance abusers are part of the basic social welfare and health services which include outpatient care (health care centres, occupational health services, student health services, mental health services, social services) and inpatient care (psychiatric/hospitals and service housing) as well as specialised services and treatment which includes outpatient care (A-clinics, youth centres, day centres) and inpatient care (rehabilitation units, detoxification units and service housing) (Services for substance abusers 2005). In addition there are also organisations and peer groups based on voluntary action (e.g. Alcoholics Anonymous/AA and Narcotics Anonymous/NA) (Recommendations concerning the quality of services for substance abusers 2002:3:28)

The municipalities are responsible for organising services for substance abusers. Most of the social and health care services in Finland are statutory, that is, the law binds municipalities to organise these services. The municipality can organise the services itself, buy the services from other municipalities or private service providers and organisations, or provide them as being a part of a federation of municipalities. Buying the services has become more and more common: in the beginning of the 1990's a third of the special services for substance abusers were organisation based, whereas in the 2000's about a half. (Inkeroinen, T., Partanen, A. 2006: 14) The laws that govern the

social and health care services are divided into central universal laws and special laws. The universal laws concerning social care include *Social Welfare Act (Sosiaalihuoltolaki)* (710/1982) and *Act on the Status and Rights of Social Welfare Clients (Laki sosiaalihuollon asiakkaan asemasta ja oikeuksista)* (812/2000) (Ministry of Social Affairs and Health 2005:7:4-6) Substance abuse work fits under the special laws which are examined more in detail in chapter 3.7. Statutory social services include social work, child guidance and family counselling, home services, housing services, institutional care, family care, support for informal care, child and youth care, child day care, substance abuse work, special care for the disabled and rehabilitative work. (Ministry of Social Affairs and Health 2005:7:7-11) Every municipality should also have a substance strategy which entails preventive work, determines how substance abuse treatment is organised in the municipality and gives guidance to inhabitants how to get help. (Ministry of Social Affairs and Health 2002:3:28) This, or similar strategy, has been done in less than half of the municipalities. (Yearbook of Alcohol and Drug Statistics 2006:20)

The municipality has to ensure that the content and proportion of substance abuse work meets the needs in the municipality. (Ministry of Social Affairs and Health 2005:7:10) According to the National Review of primary social and health care services done in 2004, this need has not been met in the recent years, as the municipalities have not increased the treatment possibilities simultaneously with the increasing substance abuse. (Yearbook of Alcohol and Drug Statistics 2006:20) The service system has to be able to help people with alcohol or drug problem at every point: from general social- and health services to specialised care. The services should be offered on the grounds of the needs of the person, his/her family and other people close to the person. (Ministry of Social Affairs and Health 2005:7:10) Still, it is possible to get into immediate detoxification only in every other municipality, and less than tenth of the municipalities have even arranged detoxification. (Yearbook of Alcohol and Drug Statistics 2006:20)

3.3.1 Outpatient and Inpatient Care

Outpatient care for substance abusers has increased considerably between the 1990's and 2000: over 20 units more were established. Still, this has not increased the possibilities to get into treatment. Only 7 000 more clients are treated annually

comparing to the amount of treated clients in the 1990's. Treatment visits on the other hand have increased with about 140 000 visits. (Kaukonen, O. 2005:315)

Inpatient care has gone through a dramatic shift in its functioning: the number of treatment days decreased about a third between years 1990 and 2003 and the number of clients nearly halved. Also the duration of inpatient care shortened with four days. (Kaukonen, O. 2005:313) Although the treatment periods have become shorter, getting into treatment has got more difficult: only a half of the number of service users treated in the 1990's can get treatment today. (Kaukonen, O. 2005:313). In accordance to the population, clientele or occurrence of substance related harm, inpatient care is been produced today less than before the regression. (Kaukonen, O. 2005:314) Also, although the supply of services, both inpatient and outpatient services, has increased and become more versatile, the services are not reachable to all. (Nissinen 2005:4)

Matti Mäkelä, Jarmo Nieminen and Sinikka Törmä (2005) have studied the thresholds of substance abuse treatment from the client point of view. (Inkeroinen, T., Partanen, A. 2006: 22) According to the results, the biggest thresholds in the basic social and health services were queues, difficulty to speak about substance abuse, workers' negative attitude towards substance abusers and pure absence of knowledge. This absence of knowledge, skills and courage of the workers often leads to ignorance. (Mäkelä et al. 2005:7-8) In specialised services the biggest thresholds were also queues and the location and unreachable nature of the services. The location of the unit is a problem especially in the smallest municipalities, where the nearest unit can be 50-100 kilometres from the client. (Mäkelä et al. 2005:5,9) According to Kaukonen (2005), especially outpatient services favour the most social substance abusers: despite of their problems they have to able to follow and obey the appointment procedures and agreed meeting times, as well as commit to intensive treatment relationships. (Kaukonen 2005:315) In the largest municipalities, the queues in the A-clinic services, the appointment procedures and the weakened functioning capacity of the substance abusers may often be a barrier to seek help. (Hämäläinen et al. cited in Inkeroinen, T., Partanen, A. 2006:22) Those substance abusers with the poorest condition have often the poorest position also in the service system: even if they succeed in getting into treatment, after it they have to, in worst cases, return back to "the streets" and try again to get into some other unit. (Mäkelä et al. 2005:9-10)

These results raise a question about the situation of immigrants and other non-Finnish speaking clients in getting help. When it is so difficult for Finnish people to get help, how difficult it must be to people who do not even speak Finnish or are not familiar with the Finnish service system. In those cases the thresholds must multiply, as language barriers and other cultural issues are there to make the seeking of help even more difficult. This issue is further discussed in Chapter 3.5.1.

3.3.2 Need for Services According to Province

The high level of alcohol consumption, alcohol-related deaths (especially in the Kymenlaakso region and South Karelia) and drug problem are issues that challenge the substance abuse work in **Southern Finland**. (Nissinen, R. 2005:5) Also the queues are a problem: the queuing time to rehabilitative inpatient care can be as long as 15-30 days. Needle exchange services are not arranged in 37 municipalities and 24 hour access to services is not possible in over 60% of the municipalities. (Peruspalvelut Etelä-Suomen läänissä 2004:138) Also the costs of substance abuse services are the highest when compared to other provinces. Especially in the capital area the costs (33,6 euros/inhabitant) exceed the whole country's average (20 euros/inhabitant). (Nissinen, R. 2005:6)

In **Western Finland** the level of substance use is the lowest in the country but the alcohol related harm has been rising. Scarce resources and the ending of allowances in the middle of the year make getting into treatment difficult. The services are multifaceted but they have not been developed simultaneously with the growing demand. Queues are a problem in the biggest cities. The amount of service users has not grown in the 2000's, which indicates the prolongation of treatment periods and worse condition of the clients. The health care sector has taken more and more responsibility in providing substance abuse treatment. Detoxification is available in health care centres 24 hours/day and in A-clinics during office hours. (Nissinen, R. 2005:8; Peruspalvelut Länsi-Suomen läänissä 2004:128-130)

Despite of the fact that the level of substance use in **Eastern Finland** is average compared to other provinces, the substance related harm is rising (excluding drug related crimes). The impact of "Itäviina" (Spirits from the east) can be seen in the services. (Makkonen 2005 cited in Inkeroinen, T., Partanen, A. 2006:25) The effort put

into substance abuse services seems to be insufficient in Eastern Finland, but in those municipalities where effort is good, also the services are good and available. The service system concerning substance abuse work is quite scattered and responsibility for organising it seems to be missing. (Nissinen, R. 2005:8) The allowances for substance abuse work are insufficient. The number of service users in detoxification units halved between years 2000 and 2004, but the treatment periods prolonged. Half of the municipalities arrange 24 hour detoxification and compensation treatment for Opiate addicted people. There are only few needle exchange services. In some municipalities there are no detoxification services or rehabilitative inpatient care at all, and in some municipalities the allowances aimed for substance abuse work were still intact in September. (Nissinen, R. 2005:8; Itä-Suomen läänin peruspalvelujen tila 2004:77-82)

In 2004, the level of alcohol consumption was below the average in **Oulu.** The number of alcohol related deaths was remarkably lower than in other provinces. Between years 2000 and 2004, the amount of service users in detoxification units lowered as well as the amount of treatment days. Detoxification was mainly organised in health care centres. The number of service users in rehabilitative units on the other hand grew. The scarce number of low threshold services as well as units aimed for young substance abusers is a challenge in Oulu. The costs of substance abuse work were lower than average. (Oulun läänin peruspalvelujen arviointiraportti 2004:107-108; Nissinen, R. 2005:9)

In **Lapland** the sales of alcohol is above the average and the level of consumption seems to be growing. These levels can be explained by tourism and the purchasing of alcohol by people arriving from Sweden and Norway. Alcohol-related diseases and accidents are in the same level as in other provinces. (Lapin läänin peruspalvelujen arviointiraportti 2004:101-106) The use of services according to the amount of service users in rising, but the treatment periods are considerably shorter than in other provinces. Substance abuse work is mainly organised in health care centres, where the knowledge concerning these issues may be inadequate. The municipalities have little experiences in treating people with drug problems. The services are estimated to function moderately and accessibility to treatment is good. There are no queues or other thresholds preventing the access to treatment. (Lapin läänin peruspalvelujen arviointiraportti 2004:101-105; Nissinen 2005:9) The allowances for substance abuse

work are often insufficient and do not last the whole year. (Lapin läänin peruspalvelujen arviointiraportti 2004:101-105)

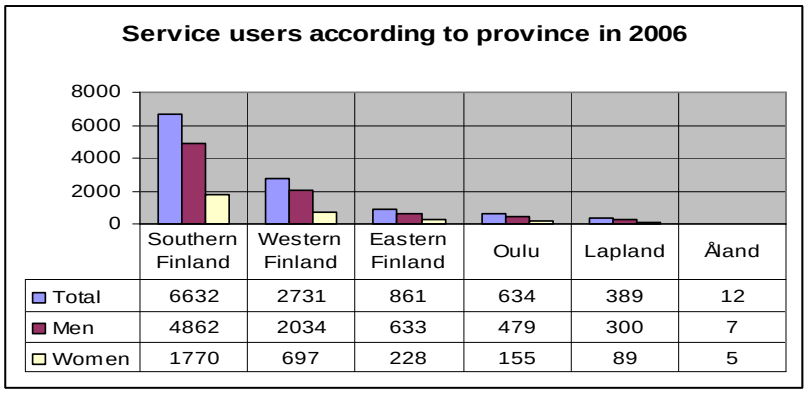
3.3.3 Service Users

In the end of the year 2006 there were 5 276 955 inhabitants in Finland. (www.stat.fi) The table below shows how they are divided between each province. (www.kaupunkiopas.com)

Province	Number of inhabitants	Population density
Southern Finland	2 141 866	71 inhabitants/m2
Western Finland	1 854 735	26 inhabitants/m2
Eastern Finland	578 864	12 inhabitants/m2
Oulu	463 424	8 inhabitants/m2
Lapland	185 791	2 inhabitants/m2
Åland	26 784	17 inhabitants/m2

Table 1 Number of inhabitants in Finnish provinces

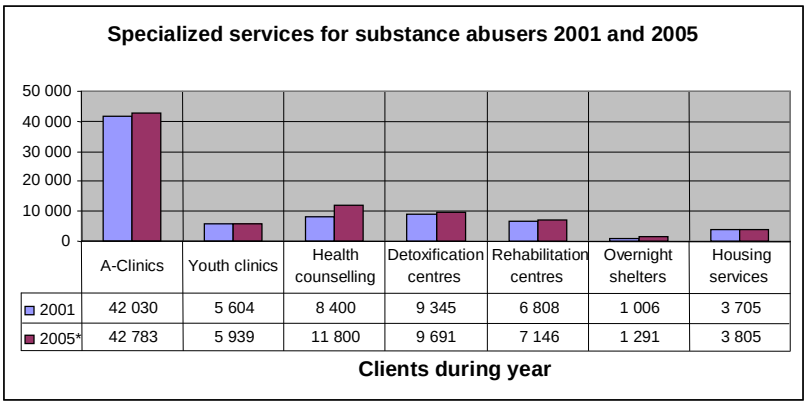
The number of clients in substance abuse treatment units in Finland in 2006 was 11 269, from which 8 320 were men and 2 949 women. Comparing to the year 2005, the total amount of clients decreased by 2,2%. (Sosiaalihuollon laitos- ja asumispalvelut 2006/Institutional Care and Housing Services in Social Care 2006, Taulu 6, Stakes) The total amount is divided regionally as shown in Figure 1.



(Source: Sosiaalihuollon laitos- ja asumispalvelut 2006, Taulu 6, Stakes)

Figure 1 Service users according to province 2006

The number of service users in specialised services for substance abusers divided according to the units in 2001 and 2005 was as follows:

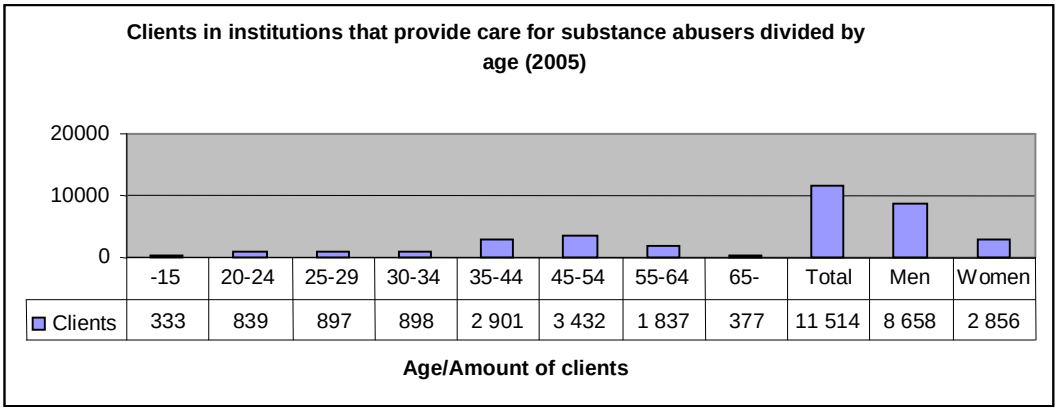


(*: Preliminary data)

(Source: Yearbook of Alcohol and Drug Statistics 2006, Stakes)

Figure 2 Specialized services for substance abusers 2001 and 2005

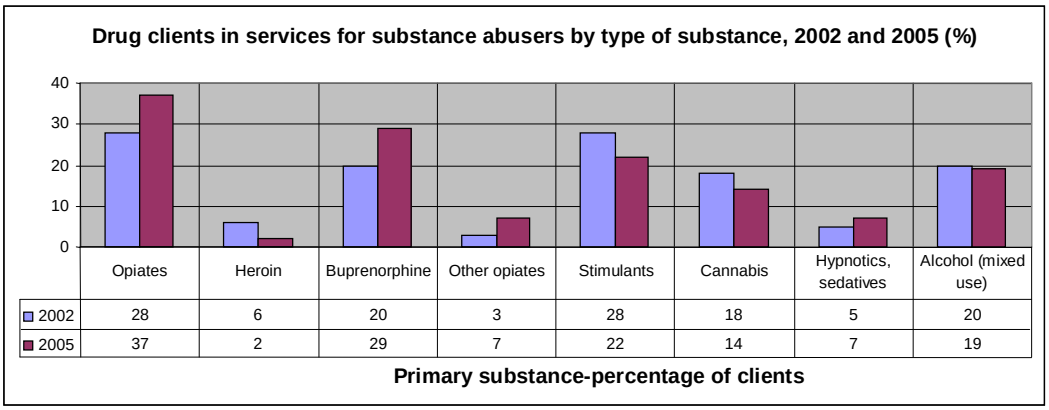
The number of clients in institutions that provide care for substance abusers divided by age in 2005 was as follows:



(Source: Yearbook of Alcohol and Drug Statistics 2006, Stakes)

Figure 3 Clients in institutions that provide care for substance abusers divided by age (2005)

The amount of drug clients in services for substance abusers in 2006 was 4 865, from which first timers 655, men 3 361 and women 1 493. From these, in outpatient care were 3102 clients and in inpatient care 1 682 clients. (Päihdehuollon huumeasiakkaat 2006, Taulukko 4, Stakes) (Voluntary and anonym information acquire method for substance abuse treatment units, does not necessarily illustrate the actual situation) The percentage of drug clients in services for substance abusers divided by type of substance in years 2002 and 2005 (%) was as follows:



(Source: Yearbook of Alcohol and Drug Statistics 2006, Stakes)

Figure 4 Drug clients in services for substance abusers by type of substance, 2002 and 2005 (%)

3.4 Developing Substance Abuse Care

Several development programs and projects have been established in order to improve the situation in substance abuse work. The National Development Project for Social Services 2003-2007 (Sosiaalialan kehittämishanke), Alcohol Programme 2004-2007 (Alkoholiohjelma), Drug Policy Action Programme 2004-2007 (Huumausainepoliittinen toimenpideohjelma), National project to secure the future of health care 2002-2007 (Kansallinen terveyshanke), Quality recommendations for substance abuse work (Päihdehuollon laatusuositukset) and also the Project to restructure municipalities and services, which creates pressure for development in substance abuse care, are all examples of these. (Inkeroinen, T., Partanen, A. 2006:36)

The aim of the National Development Project for Social Services is to safeguard the availability of services in every part of Finland. The means to achieve this are to renew the structure of services, safeguard the professional skills and sufficiency of workers, produce social services effectively and strengthen the funding. The project also supports municipalities in reforming and producing permanent services. (Development Project for Social Services 2005:documentation page) Its purpose is also to bring substance abuse care meet the recommendations stated in the Quality recommendations for substance abuse work. Development areas of the project include the improvement of the availability of detoxification as well as low threshold services, ability to recognise and treat people misusing several substances and also improve cooperation with the police in directing people into care. (Development Project for Social Services 2005:36)

The aim of the Alcohol Programme is to bring all the actions taken in reducing alcohol related harm into structured whole where cooperation with different service providers will help in achieving mutual goals. Cooperation between the municipalities, parishes, organisations and the economic life is steered by the Ministry of Social Affairs and Health. The core aim of the programme is to develop the means in reducing alcohol related harm. (Alcohol Programme 2004-2007 2004:3-4)

The aim of the Drug Policy Action Programme is to diminish permanently the drug related harm in Finland. The purpose is to improve the opportunities in getting into treatment by reducing the barriers now existing. Improving the availability of non-medical as well as medical care, bettering opportunities for rehabilitation and after care, and preventing the spread of drug related illnesses are all aims of the programme. The treatment given should also be appropriate, high quality and versatile. (Valtioneuvoston periaatepäätös huumausainepoliittisesta toimenpideohjelmasta vuosille 2004-2007 2004:18-21)

The aim of the National project to secure the future of health care is to safeguard proper health care for all Finnish citizens. Everyone should be able to get treatment regardless of their place of residence or financial state. The cooperation between municipalities and the state is stressed in order to achieve this goal. (Kansallinen hanke terveydenhuollon tulevaisuuden turvaamiseksi)

3.4.1 Quality Recommendations for Substance Abuse Work

In addition to the stated above, the Ministry of Social Affairs and Health in cooperation with Local and Regional Government Finland has drawn up quality recommendations for substance abuse work. The recommendations were outlined in an expert team set by Stakes. This expert team consisted of representatives from The Ministry of Social Affairs and Health, Local and Regional Government Finland, National Research and Development Centre for Welfare and Health Stakes, communal and private service producers and also client representatives. (Recommendations concerning the quality of services for substance abusers 2002:3) The national recommendation on developing the quality of services for substance abusers was a part of the government-approved Target and Action Plan for 2000 – 2003. (Recommendations concerning the quality of services for substance abusers 2002:13)

The aim of these recommendations is to build a solid base for high-quality services for substance abusers and support the planning, organising, producing and developing of these services in the municipalities. The recommendations include the substance abuse care done in the general social and health care sector as well as specialized services. (Recommendations concerning the quality of services for substance abusers 2002:14) These recommendations give general guidelines which can be modified to better respond to the actual situation in the municipality. (Recommendations concerning the quality of services for substance abusers 2002:9)

According to these quality recommendations, the baseline for substance abuse care is as follows: the inhabitants in the municipality have the right for appropriate and high quality substance abuse care given at the right time despite of the place of residence of the person; intervention is done in as early stage as possible in all levels of services, and information, support and help is offered; the services are arranged in a manner that the basic- and human rights as well as legal protection of the client are not endangered; the starting point is the client's and his/her family's need for care; autonomy and independent initiative of the client and confidentiality are the basic principles; clients participation into the planning and decision making is safeguarded; the client's physical as well as mental state of health are taken into consideration in rehabilitation; the services are developed in cooperation with the client, organisations representing the client and peer groups. (Recommendations concerning the quality of services for substance abusers 2002:15(translated from Finnish by the author)

In these recommendations, special attention has been paid to special groups which are more and more visible in substance abuse care today: minors, women (especially mothers), families, the most unfortunate people with multiple problems, and **immigrants and other minorities.** (Recommendations concerning the quality of services for substance abusers 2002:3) In section 2.1.3, the quality recommendations state that: *services should be available in Finnish and in Swedish and also in other languages when needed. Special attention should be paid in the mother tongue of the client, his/her cultural background and prerequisite for using the services.* (Recommendations concerning the quality of services for substance abusers 2002:16(translated by the author) Section 2.1.5 states that: *the client's existential as well as religious needs should be taken into account in the services.* (Recommendations concerning the quality of services for substance abusers 2002:20(translated by the

author) Section 3.4.3 states that: *there are more and more immigrants and ethnic minorities in substance abuse care. Special services that take cultural and ethnic needs into account are required from the service system*. (Recommendations concerning the quality of services for substance abusers 2002:40(translated by the author) This part of the quality recommendations is crucial as to the present study and chapters 8 and 9 will show how these recommendations are actually met in practice.

3.4.2 Quality and Assessment of Quality

Quality in social and health care can be defined as the ability to recognise, determine and fulfil clients' needs professionally and ethically with low costs and according to laws and regulations. Also the ability to steer the resources for those who need them the most is a sign of quality. (Recommendations concerning the quality of services for substance abusers 2002:23) Quality can be assessed from three different perspectives: from the client perspective, from the professional's perspective and from the management perspective. **Client** is always the fundamental assessor of quality as the quality experienced from his/her point of view tells if the service has been what the client needed. The **professional** quality tells if the service has fulfilled the needs of the client and if the results are good from the professional's point of view. **Management** quality tells if the service has been implemented eloquently without errors or loss-usage, economically and following the laws and regulations. As all these parties emphasize different aspects of quality, it is essential to agree what is meant by the quality that is pursued in the organisation. Quality recommendations and quality criteria help in making the content of quality more concrete and clear, at the same time being helpful in planning and assessing quality. Follow-up of the results as well as long term effects, and using them in developing the services, is essential. That is why it is important to agree on quality indicators which work as a baseline in follow up and assessment. (Recommendations concerning the quality of services for substance abusers 2002:23) In the study both professional quality and management quality are present, as the aim is to examine if clients' needs have been met from the workers' point of view and how the services follow the laws and regulations.

The quality in substance abuse care should be examined both technically (e.g. facilities) as well as according to processes (e.g. practices). This study concentrates on the processes. In addition to this, the care should be examined as part of the general social-

and health care services but also as special services aimed specifically for substance abusers. The services should be high quality from the point of view of the client, the municipality and the whole society. The criteria should also be measurable. (Recommendations concerning the quality of services for substance abusers 2002:24) Wilding (1994) has presented criteria for services, and in the next figure they are adjusted to fit in the Finnish service system.

CLIENT	QUALITY CRITERIA
Inhabitant in the municipality	Attainability, acceptability, transparency, effectiveness
The municipality	**In addition to previous** Compatibility with other services within the municipality, sufficiency of the whole service system, right allocation and equality, predictability of costs, taking care of the workers capacities, general satisfaction.
Society	**In addition to previous** General aims of social- and health policy Political acceptability Maintaining social security

Figure 5 : Quality criteria for services according to the service user
(Source: Päihdepalvelujen laatusuositukset 2002:25, translated by the author)

According to this model, the attainability is the central prerequisite for the other criteria to even come true. In addition to physical attainability, also mental attainability is stressed. As mentioned in chapter 3.3.1, queues are one threshold of getting into treatment. That is one aspect that makes the attainability of services inadequate. Also the processing times of decisions, difficult opening hours and service fees are include in this (Recommendations concerning the quality of services for substance abusers 2002:25) Language barriers also contribute to the attainability of services, as inadequate language services may prevent clients from different linguistic background to seek help. As seen in the model, the inhabitant in the municipality is the central client of the services: if the criteria do not come true in the inhabitant level, they can not be measured in the other levels. (Recommendations concerning the quality of services for substance abusers 2002:24)

3.4.3 Quality Assessment Form

Based on the quality recommendations for substance abuse work, a quality assessment form for substance abuse treatment units has been drawn up. With the help of this "self assessment" form, municipalities, professionals working in the field, the actual substance abuse treatment units and also the people with alcohol/drug problems can evaluate the quality of different service providers. The filled in forms are published in a data base maintained by The Development of Alcohol and Drugs Intervention group at Stakes. (www.stakes.fi) (Basic information forms of all the substance abuse treatment units in Finland can be found in the data base, only some of the units have also filled in the actual quality assessment form as seen in the results in chapter 12.1). The aim is that as many substance abuse treatment units as possible would fill in the form, therefore the empty forms are found in the internet and can also be sent in electronic form. This makes the filling in them more convenient for the respondents. There is also free access into the data base, so anyone can read the filled in forms. Also, the information given in the form should be checked annually (at least once a year) and required changes have to be made.

A sample of a basic information form found in the data base:

Units that provide interpreter services	**Yes/ No**
Does the unit provide interpreter services?	Yes

In which languages is treatment related material available? Finnish, English

In which languages it is possible to participate into treatment? Finnish, Swedish

[Freely translated and filled in by the author, imaginary answers]

Figure 6 A sample of a basic information form found in the data base

A sample of the actual quality assessment form (blank):

Service languages	Finnish ☐	Swedish ☐
	other(s):	
	Is it possible to get interpreter services?	
	Yes ☐	In which languages?:
	No ☐	

Other support services	
Accessibility	

[Freely translated by the author]

Figure 7 A sample of the actual quality assessment form (blank)

3.5 Immigrants in Finland

In 2006, there were 121 739 people living in Finland with a different nationality than Finnish. Below are shown the numbers and countries of origin. (Source: Statistics Finland)

Country of origin	Amount
Russia	25 326
Estonia	17 599
Sweden	8 265
Somalia	4 623
China	3 382
Former Republic of Serbia and Montenegro	3 340
Irak	3 045
Thailand	2 994
Germany	2 978
United Kindom	2 910
Turkey	2 886
Iran	2 602
United States	2 199
Afganistan	2 011
India	1 990
Vietnam	1 811
Bosnia and Hertsegovina	1 599
Others	32 179
Total	**121 739**

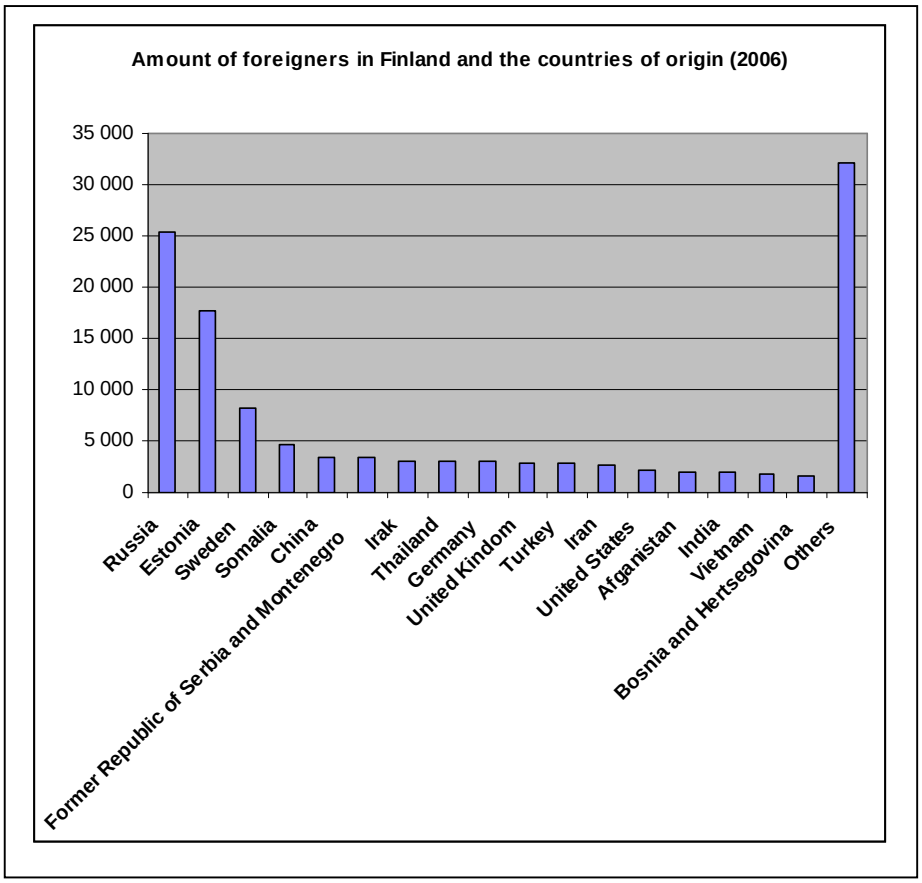


Figure 8 Amount of foreigners in Finland and the countries of origin (2006)

The proportion of foreigners in each province (foreigners/number of inhabitants) is shown below. (Sisäasiainministeriön julkaisuja 7:2005)

Province	Percent
Southern Finland	3,08 %
Western Finland	1,56 %
Eastern Finland	0,97 %
Oulu	0,86 %
Lapland	1,00 %
Åland	5,29 %

Table 2 A percentage of foreigners in Finnish provinces

The proportion of foreigners in the biggest municipalities is presented below, also shown the units taking part in the interviews: Helsinki, Espoo, Tampere and Kotka. (www.vaestorekisterikeskus.fi)

City	Number of inhabitants	Of which foreigners
Helsinki	565 881	33 196
Espoo	236 505	11 609
Tampere	206 378	6 207
Vantaa	191 211	8 687
Turku	174 795	7 560
Oulu	130 283	2 417
Lahti	98 919	2 735
Kuopio	90 869	1 168
Jyväskylä	84 410	2 151
Pori	76 230	792
Lappeenranta	58 968	1 688
Rovaniemi	58 120	844
Vaasa	57 501	2 228
Joensuu	57 408	1 115
Kotka	54 658	1 582

Table 3 The proportion of foreigners in the biggest municipalities

3.5.1 Services for Immigrants and Substance Abuse among Them

The Substance Abuse Prevention Unit of Vantaa made a report in 2004 concerning the situation in substance abuse treatment in the city. It stated that: *there are very little substance abuse services aimed for immigrants in Finland. In the substance abuse treatment units located in Vantaa immigrants are naturally served, but as long as this clientele does not get services with its own mother tongue or with cultural competence from the staff, it is clear that they do not seek help.* (Salin, M. 2005:27)

According to *Drug situation in Finland 2001* (Virtanen, A. 2002. Stakes), all health care services in Finland are, basically, available to all, but the knowledge of different languages and/or cultures create obstacles for immigrants to seek help. However, according to Virtanen (2002), in 2001 there were specially tailored substance abuse services for the Roman people, and in Järvenpään Sosiaalisairaala they had a special programme for Russian people with a drug problem (Jouhki, M. 1998 cited in Virtanen, A. 2002:108) . In Vinkki, a health counselling centre situated in Helsinki, a nurse has been employed who is specialized in serving the Ingrian people (Kullat, M. 2001 cited in Virtanen, A. 2002:109), and in 2001 Helsinki Deaconess Institute launched a program called Venpro-Pycnpo, which aim was to assess the need and plan for services for Russian immigrants with a drug problem. (Hakkarainen, P. et al. 2000 cited in Virtanen, A. 2002:109) Irti Huumeista ry (Free from drugs association) and Inkerikeskus ry (the Ingrian centre) also trained people to act as support persons for immigrants with a drug problem, as well as working on a emergency phone line. In 2004, the A-clinic Foundation and Pro-tukipiste launched a peer support- and substance abuse service project called *Aura-Aypa* which lasted for 3 years. One of its aims was to find out how to lower the thresholds for Russian immigrants with substance abuse problem of seeking help. In Pro-tukipiste there are currently 2 workers that speak Russian and in Eastern-Vinkki, which also was a part of this project, one worker. (Salin, M. 2005: 27) Immigrants can also get services from A-clinics, but the amount of foreign clients in them is minimal. In 1998, in the capital area where 40% of all immigrants in Finland live, there were 190 foreign clients in substance abuse treatment units, most of then Russians. (Virtanen, A. 2002:109)

According to many international surveys, due to their lower use of health services and treatment received being worse in quality, immigrants from outside the western countries are in a more vulnerable situation than others when it comes to health issues. (Gissler et al. 2006:3) Statistics Finland has made a research concerning the use of health care services and institutional care provided by the social services in Finland, with 15 600 immigrant participants between ages 15-64, who have moved to Finland during years 1989-2003. The comparison group was 80 212 Finnish people belonging in the same age group. (Gissler et al. 2006:3) The information on their use of the services was based on the Care Register on health and social care institutions kept by the National Research and Development Centre for Welfare and Health (Stakes), material

on the productivity of hospital care activities and the visit records of the primary health care services in 11 municipalities. (Gissler et al. 2006:5)

According to the results, immigrants use primary health care services 8% less than Finnish people, and 27% less specialized health care services. (Gissler et al. 2006:3) Immigrants from refugee countries (Yugoslavia, Somalia, Iraq and Iran) use health care services the most. (Gissler et al. 2006:5) Inpatient care periods among male immigrants due to substance abuse is 3,6/1000 follow-up years, and among women 1,2/1000, when among Finnish people the numbers are 8,0/1000 and 2,9/1000. (Gissler et al. 2006:39) Male immigrants have a substantial amount less substance related inpatient care compared to Finnish males, when among women the difference is much smaller. The majority of substance abuse treatment is alcohol based, but among immigrants, treatment due to the addiction to illegal drugs and/or legal drugs (medicine) is greater than among Finnish people. The proportion of treatment days due to the use of legal/illegal drugs is 14% among immigrants, when among Finnish people it is 5%. Also inpatient care periods among immigrant males addicted to legal/illegal drugs is 10/1000 follow-up years, when among Finnish males it is 7/1000. Among women the numbers are 2/1000 and 4/1000. (Gissler et al. 2006:40)

According to the information concerning specialized health care services, immigrants have less mental health problems than Finnish people. Treatment related to alcohol abuse (ICD-10-code F10: brain syndromes due to alcohol abuse and behavioural disorders) is 70% less among immigrants than among Finnish people. This diagnosis has however been the 11th common primary diagnosis among immigrant males in bead wards and in day-surgery between years 2001-2003 (25 patients). Among immigrant women this diagnosis is not in the top ten. However this diagnosis is in the top ten also among Finnish people. The occurrence of this diagnosis during 2001-2003 among immigrant males was 4,7/1000 person years, while among Finnish males it was 16,5/1000. Among women the numbers were 1,7/1000 and 5,8/1000. (Gissler et al. 2006:62) Schizophrenia is 50% rarer among immigrants than among Finnish people, and depression 15% rarer. (Gissler et al. 2006:42)

The number of treatment days or visits of male immigrants in inpatient treatment due to alcohol abuse was 77/1000, whereas the equivalent figures for women was 29/1000. Among Finnish males the figure is 126/1000 and among women 41/1000. Treatment

days due to legal/illegal drug abuse was 13/1000 among immigrant males and 7/1000 among Finnish males. Among women the figures were 1/1000 to immigrants and 4/1000 to Finnish women. (Gissler et al. 2006:69)

Although it is known that ethnic minorities are in a vulnerable situation when it comes to substance abuse, the amount of studies concerning substance abuse among immigrants is extremely scarce in Finland, as it is scarce also in other parts of the world. EMCDDA (The European Monitoring Centre for Drugs and Drug Addiction) is one of the European Union's decentralised agencies which monitor the drug situation in Europe. It was established in 1993 and based in Lisbon, and it is the central source of comprehensive information on drugs and drug addiction in Europe. It states in an announcement published in 2003 that there can be seen a risk sensitive model within ethnic groups in drug abuse. These risk factors include low socio-economic status, social exclusion, low level of education and scarce societal participation. (Drugs in Focus 10, 2003) However, the relation between ethnic minorities and drug abuse is unclear, as information concerning this issue is scarce. There is no scientific evidence of drug abuse being more common among immigrants than among the dominant population in European countries, even though it is estimated that in Finland drug abuse, especially heroin abuse, is more common among the Ingrian people (estimated 1-2%) than among the dominant population. (Annual report 2003: the sate of drugs problem in the European Union and Norway)

Mika Jouhki (1998) wrote in Tiimi-magasine about substance abuse among immigrants. He stated that according to the treatment visits in substance abuse treatment units substance abuse can be considered to be scarce among immigrants. (Jouhki, M. 1998) The results of the present study however show that conclusions drawn from the visits in substance abuse treatment units are questionable and do not necessarily provide a truthful picture about the actual situation. (See Chapters 8.2.1 and 8.2.6)

3.6 Laws and Regulations

Along with the Equality Act, there are also other laws and regulations that safeguard the services for immigrants and other non-Finnish speaking clients in the Finnish society as well as substance abusers.

The Constitution of Finland (Suomen perustuslaki) (731/1999) states in Section 6, that: "Everyone is equal before the law. No one shall, without an acceptable reason, be treated differently from other persons on the ground of sex, age, origin, language, religion, conviction, opinion, health, disability or other reason that concerns his or her person." In section 11 is stated that: "Everyone has the freedom of religion and conscience. Freedom of religion and conscience entails the right to profess and practice a religion, the right to express one's convictions and the right to be a member of or decline to be a member of a religious community."

Administrative Procedures Act (Hallintolaki) (434/2003) states in section 22, that: "The authority shall arrange for interpretation and translation in cases where a concerned party in a matter that may be initiated by the authority does not know the language to be used before the public authority pursuant to the *Language Act (Kielilaki)* (Act no. 148 of 1922), or where he cannot make himself understood due to a sensory handicap or speech disorder. For a special reason, the public authority may also arrange for interpretation and translation in cases. The public authority shall ensure that citizens of the other Nordic countries receive the necessary interpretation and translation assistance in matters considered by the said public authority." In this act, by public authority is meant the administrative authorities of the State, the public authorities of municipalities and federations of municipalities and the organs of the Social Insurance Institution and the University of Helsinki. The Act shall also govern the consideration of matters of judicial administration in courts of law.

The purpose of the *Non-Discrimination Act (Yhdenvertaisuuslaki)* (21/2004) is to: "foster and safeguard equality and enhance the protection provided by law to those who have been discriminated against in cases of discrimination that fall under the scope of this Act." In section 2 it states that: "The Act also applies to discrimination based on ethnic origin concerning: social welfare and health care services; social security benefits or other forms of support, rebate or advantage granted on social grounds; the performance of military service, women's voluntary military service or non-military service; or the supply of or access to housing and movable and immovable property and services on offer or available to the general public other than in respect of relationships between private individuals." In section 4 of the act is stated that: "In all they do, the authorities shall seek purposefully and methodically to foster equality and consolidate administrative and operational practices that will ensure the fostering of equality in

preparatory work and decision-making. In particular, the authorities shall alter any circumstances that prevent the realization of equality." According to the act, stated in Section 13, in a case of ethnic discrimination (other than working related when it is a matter of the public law), a Discrimination Board is entitled to: "confirm a conciliation settlement between the parties; (…) A conciliation settlement confirmed by the Discrimination Board and involving an agreed sum in compensation may be enforced in the same way as a legally valid judgement." The Ombudsman for Minorities may bring a case concerning ethnic discrimination before the Discrimination Board. The Finnish legislation related to discrimination and equality has its basis in international laws and agreements of human rights, such as Social and Cultural Rights, European Convention on Human Rights and Fundamental Freedoms, European Social Charter, and ILO Discrimination Convention no 111. (www.yhdenvertaisuus.fi)

The purpose of the *Language Act (Kielilaki)* (423/2003) is: "(…) to ensure the constitutional right of every person to use his or her own language, either Finnish or Swedish, before courts and other authorities. The objective is to ensure the right for everyone to a fair trial and good administration irrespective of language and to secure the linguistic rights of an individual person without him or her needing specifically to refer to these rights. An authority may provide better linguistic services than what is required in this Act." This right is also stated in *The Constitution of Finland (Suomen perustuslaki)* (731/1999).

Act of Welfare for Substance Abusers (Päihdehuoltolaki) (1986/41) states in section 3 that the municipality is responsible of the content and scope of substance abuse care answering the need in the municipality. In section 6 it states that the services should be easily attainable and versatile. The services should also be arranged in a manner in which the client can easily seek care by his/her own initiative. (Section 8)

Social Welfare act (Sosiaalihuoltolaki) (1982/710) states in section 17 (2) that municipalities are: "responsible for organizing child and youth welfare, daycare for children, special care for the mentally handicapped, services and support for people with disabilities, **services related to care for substance abusers**, the statutory functions of child welfare officer, other measures related to the investigation and establishment of paternity, ensuring child maintenance, adoption counselling, family conciliation and conciliation concerning the enforcement of decisions on child custody and visiting

rights, and provision of support for informal care and other social services, and for the duties laid down in the Act on Rehabilitative Work (189/2001) in accordance with any additional specific provisions concerning these services." In section 40 of the act it is stated that: "In a unilingual municipality or joint municipal board social welfare shall be provided in the language of the municipality or the joint municipal board. Provisions on the client's right to use and to be heard in Finnish or Swedish and to obtain documents containing a decision concerning him/her in Finnish or Swedish and the client's right to interpretation when using these languages before authorities are laid down in sections 10, 18 and 20 of the Language Act (423/2003)." And: "Social welfare in a bilingual municipality or joint municipal board whose member municipalities are bilingual or include both Finnish and Swedish speaking municipalities shall be provided in both languages of the municipality or joint municipal board, so that clients are provided with services in the language of their choice, either in Finnish or Swedish. Furthermore, municipalities or joint municipal boards shall see to it that citizens of the Nordic countries can, as necessary, use their own language, i.e. Danish, Finnish, Icelandic, Norwegian or Swedish, when using social welfare services. In such cases, municipalities or joint municipal boards shall, as far as possible, see to it that citizens of the Nordic countries are provided with the necessary interpretation and translation assistance."

The Act on the Status and Rights of Social Welfare Clients (Laki asiakkaan asemasta ja oikeuksista) (2000/812) states in section 2, 4§ that the client is entitled to receive high quality social services without discrimination. His/her privacy and beliefs should not be insulted. Client's wishes, opinions, welfare, individual needs, **cultural background and mother tongue** must be taken into account. If the staff does not understand the language of the client, interpreter services must be provided.

4. ISSUES IMPORTANT IN WORKING WITH CULTURALLY DIVERSE CLIENTELE

In this chapter issues that are important to acknowledge and take into consideration when working with culturally diverse clientele are presented and discussed. These include cultural and linguistic competence, communication and language.

First, the concept of culture. What is meant when talking about culture or someone being from another culture? The term *culture* is a complex term and can refer to multiple of things and has fascinated scholars through centuries. In the early 1950s, Kroeber and Kluckhohn identified more than 160 different definitions for the term. (Ting-Toomey,S. 1999:9). The term comes from the Latin word *cultura* or *cultus* as in *agri cultura*, the cultivation of the soil. "From its root meaning of an activity, culture became transformed into a condition, a state of being cultivated." (Freilich cited in Ting-Toomey, S. 1999:9) Later, "the term had developed an important next stage of meaning, by metaphor, and was extended to the process of human development" (Lago, C.1996:29). It is also forth of recognising how the word culture has evolved in the French and German languages. According to Lago the word *couture* (now associated with fashion) was the original French name for culture. In the mid-eighteenth century the word culture became linked to the word *civilication*. In German, the term *culture* (later *kultur*) was also a synonym for the word civilisation. (Lago, C. 1996:29)

Milton J. Bennett (1998) divides the term culture to *objective culture* which includes art, literature, theatre, music and other aspects of culture what also can be called the "high culture", and *subjective culture*, which refers to the "…psychological features that define a group of people-their everyday thinking and behaviour-rather than to the institutions they have created." (Bennet, M. 1998:3) According to Bennett, a good definition of subjective culture would be "*the learned and shared patterns of beliefs, behaviours, and values of groups of interacting people*." (Bennett, M. 1998:3). He concludes that the understanding of subjective cultures leads to intercultural competence, which will be further discussed in Chapter 4.1. Ting-Toomey, on the other hand, states that: "(…)the term culture refers to a diverse pool of knowledge, shared realities, and clustered norms that constitute the learned systems of meanings in a particular society(…)these learned systems of meanings are shared and transmitted through everyday interactions among members of the cultural group and from one generation to the next(...)culture facilitates members' capacity to survive and adapt to their external environment." (Ting-Toomey, S. 1999:9) This definition is the one we usually come to think of when faced with the word *culture*.

Samovar et al. (2004) distinguishes five basic elements of culture: history, religion, values, social organization and language. (Samovar et al. 2004: 31-32) According to Samovar, culture's history is passed on from generation to generation and offers the

members a part of their identity which shapes them. (Samovar et al. 2004:31) The influence of religion is seen in the entire fabric of culture:"both consciously and unconsciously, and in vary degrees, religion impacts everything from business practices (…) to politics (…) to individual behaviour." (Samovar et al. 2004: 31) The relationship between culture and values is tight: "The connection between values and culture is so strong that it is hard to talk about one without the other." (Samovar 2004:31) Values are "culturally defined standards of desirability, goodness, and beauty that serve as broad guidelines for social living" (Macionis cited in Samovar et al. 2004:31) According to Samovar, values are the ones that determine how one ought to live and behave. **Social** organizations (or structures) "help the members of the culture to organize their lives. "(Samovar et al. 2004:32) As Samovar continues: "These social systems establish communication networks and regulate norms of personal, familial and social conduct. How these organizations function and the norms they advance are unique to each culture." (Samovar et al. 2004:32). Language is also common to each culture and allows the members to communicate with each other. Language allows the members to "share ideas, feelings, and information, but it is also one of chief methods for the transmission of culture. Whether it be English, Swahili, Chinese, or French, most words, meanings, grammar, and syntax bear the identification mark of a specific culture." (Samovar et al. 2004:32) How all of these can affect the intercultural encounters, also in a social and health care setting, is discussed more in chapter 4.3.6.

4.1 Cultural and Linguistic Competence

As many as there are different cultures, there are definitions of the term cultural competence. The concept refers to "…a complex integration of knowledge, attitudes, and skills that enhance cross-cultural communication and appropriate/effective interactions with others." (American Academy of Nursing (1992,1993) cited in Andrews, M. 2003:15) One definition, which concerns social- and health care, is that cultural (or intercultural) competence refers to the worker's process and ability to work more effectively with people from diverse cultural backgrounds. (Andrews, M. 2003:15) Also *culturally congruent care* is used by some in referring to cultural competence. It is defined as "the provision of care that is meaningful and fits with cultural beliefs and lifeways." (Andrews, M. 2003:17-18) This definition (Leininger's) is more holistic, as, among many things, it takes the complex interrelation of religion,

politics, language, environment and worldviews into consideration, factors that all contribute to culturally congruent care. (Andrews, M. 2003:18)

Cultural competence can also be defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross et al.., 1989; Isaacs & Benjamin, 1991 cited in King et al..). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997 referring to health outcomes cited in King et al..). According to King et al., there are five elements that contribute to the system of being culturally competent: “The system should (1) value diversity, (2) have the capacity for cultural self–assessment, (3) be conscious of the "dynamics" inherent when cultures interact, (4) institutionalize cultural knowledge, and (5) develop adaptations to service delivery reflecting an understanding of diversity between and within cultures. Further, these five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies, and services.” (King et al..)

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited language proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. This may include, but is not limited to, the use of: bilingual/bicultural or multilingual/multicultural staff, cross-cultural communication approaches, cultural brokers, foreign language interpretation services including distance technologies, materials developed and tested for specific cultural, ethnic and linguistic groups, translation services, and ethnic media in languages other than Finnish (e.g., television, radio, Internet, newspapers, periodicals). (Goode, T., Jones, W. 2004) Linguistic competence by health care providers has, according to some experts, an impact on the client’s access and response to health care services. (Andrews, M. 2003:15-16)

4.2 Language

There are approximately 6,912 known living languages in the world today, sign languages not included. In Europe the amount of spoken languages is 239. (www.ethnologue.com) It is difficult to estimate the total number of languages due to controversies in the understanding of the term *language*. Language can be defined purely on linguistic grounds, but also, and increasingly, on social, cultural and/or political grounds. There is also a difficulty to draw a line to where language begins and where it ends. Also different dialects cause confusion in separation of languages. How different the dialect must be from the core language in order to be considered as a separate language? (www.ethnologue.com) The fact also is that we know so little about some languages, that it is impossible to say if it is a single language, one language and one dialect or two separate languages. Also, languages are constantly decaying and new languages are born.

According to Statistics Finland (www.stat.fi) there are 13 languages spoken as mother tongue in Finland (Statistic made in 2003). Finnish and Swedish are the national languages in Finland. Below is shown the number of people with Finnish or Swedish as their mother tongue.

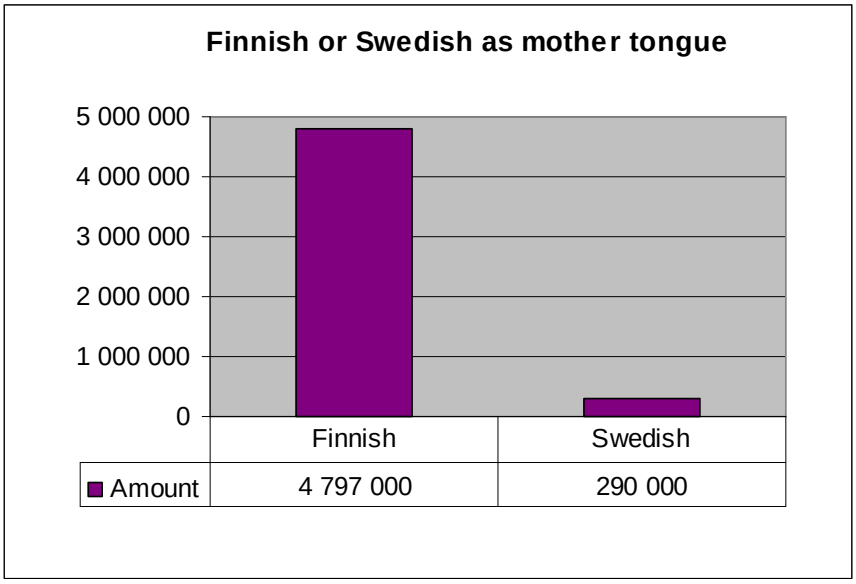


Figure 9 Number of people with Finnish or Swedish as their mother tongue, 2003

Other languages spoken in Finland as mother tongue are divided as follows:

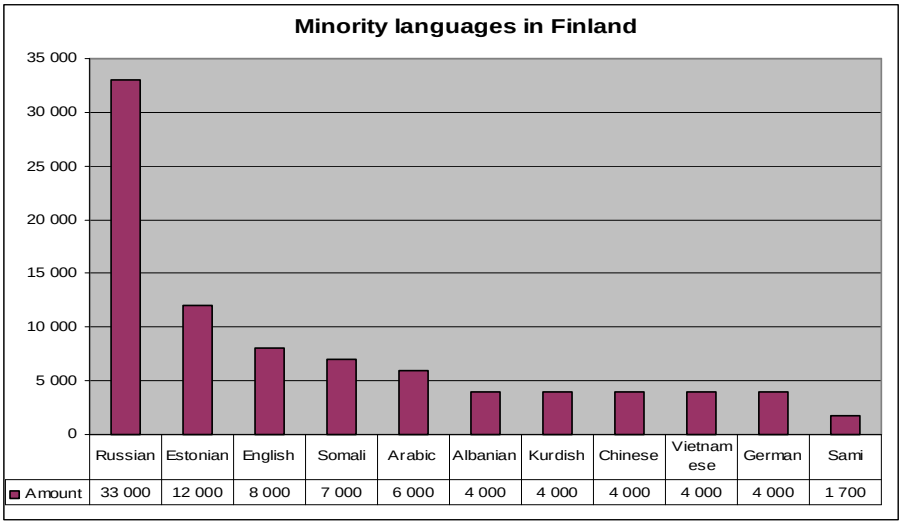


Figure 10 Minority languages in Finland, 2003

But what is language and why is it important to know about the characteristic of language in working with people with different linguistic background?

All languages in the world are coherent, logical systems and they all share similarities, but evident differences exist in the sounds, written symbols, grammars and nuances of meaning. (Ting-Toomey, S. 1999:85) It is important to understand the basic features of language in order to understand and cope with the differences and become more mindful of the causes that contribute to verbal frictions across cultures. (Ting-Toomey, S. 1999:85) Stella Ting-Toomey, a Professor of Speech Communication at California State University and the author of 11 books, defines language as: "…an arbitrary, symbolic system that names ideas, feelings, experiences, events, people, and other phenomena and that is governed by the multilayered rules developed by members of a particular speech community". (Ting-Toomey, S. 1999:85)

Ting-Toomey distinguishes three distinctive features of each human language: arbitrariness, multilayered rules and speech community. "All human languages are arbitrary in their phonemic (i.e., sound unit) and graphic representation (i.e., alphabets or characters)". The multilayered rules of language are present to us at all times but we are seldom aware of them. Only when we hear a foreign language we do not understand, we notice that it does not make any sense to us, that is, its rules appear random and nonsensical. Still, according to Ting-Toomey, all human languages are structured according to the rules of phonology, morphology, syntax, semantics and pragmatics. (See Ting-Toomey, S. 1999:86)

According to John E. Joseph, the author of *Language and Identity*, linguists and philosophers have traditionally identified the primary purposes of language as one or both of the following: communication with others and representation of the world to ourselves in our own minds - learning to categorise things using the words our language provides us with (Joseph, E.J. 2004:15). He continues: "In Plato's Cratylus, Socrates says that the purpose of words is for discriminating things from one another, and for teaching each other about those things. Discriminating things from one another is what is meant by representation. Teaching each other about things is communication-where what is being communicated is, as it happens, representation. Socrates makes clear that communication is rather a poor and vulgar thing, whereas representation is a communion with the Ideal Forms of things as they exist in heaven". (Joseph, E.J. 2004:15) This view of Plato's is still the core of the views of linguistics and philosophers today, but in the Western culture, a third function has been traditionally recognised, the function of expression. "…what is expressed are the feelings, emotions and passions, usually of an individual, sometimes of an entire ethnicity or gender or other grouping." (Joseph, E.J. 2004:16) In the late 1950's, Jerome Bruner wrote about language: "…it is a systematic way of communicating to others, of affecting their and our own behaviour, of sharing attention, and of constituting realities to which we then adhere just as we adhere to the `facts` of nature". (Bruner, 1983:119-20, in Joseph, E.J. 2004:88)

4.2.1 Language, Identity and Culture

A different language is a different view of life.
Federico Fellini

Stella Ting-Toomey distinguishes five diverse functions of languages across cultures: the group identity function, the perceptual filtering function, the cognitive reasoning function, status and intimacy function, and creativity function. Ting-Toomey writes about the group identity function: "Language is the key to the heart of a culture. Language serves the larger cultural/ethnic identity function because language is an emblem of "groupness". In speaking a common tongue, members signal group solidarity and connectedness." (Ting-Toomey, S. 2002: 91) She continues: "Since language is learned so early in life and so effortlessly by all children, it permeates the core of our cultural and ethnic identities without our full awareness of its impact. Until we encounter linguistic differences, we may not develop an optimal mindfulness for our

cultural-based “linguistic-naming” process. Our construction of our own identities and the identities of others are closely tied with the naming or labelling process.” (Ting-Toomey, S. 2002:92) Ting-Toomey also states that language and culture can never be separated as language “infiltrates so intensively the social experience within a culture”. (Ting-Toomey, S. 2002:93)

The cognitive reasoning function refers to the way how grammatical structure of language shapes our thought process. This is also known as the Sapir-Whorf hypothesis, which states that “the grammars of different languages constitute separate conceptual realities for members of different cultures. We experience different cognitions and sensations via our linguistic systems.” (Ting-Toomey, S. 2002:95) Although there is an ongoing debate about this hypothesis, its major premis is that it links language, thoughts and culture. “Language serves as a mediating link between thoughts and our cultural reality. It acts as a window between the internal mindscape, on the one hand, and the external landscape, on the other.” (Ting-Toomey, S. 2002:97)

The status and intimacy function refers to the notion that we can use language to indicate status by selecting either formal or informal pronouns (in French *vous* or *tu*, in German *sie* or *du*, in Finnish *Te* or *sinä* etc.), or regulate intimacy by verbal means of signalling friendship and relational bonding (Ting-Toomey, S. 2002:97). In more formal encounters we naturally use more formal language, whereas with friends our use of words is more informal.

Language, and the way we humans use it, is highly creative. But as Ting-Toomey states, we humans are many times so accustomed to our linguistic systems that do not even realise what kind of power our language can have. By changing certain language habits we can even change long lasting cultural norms and attitudes. (Ting-Toomey, S. 2002:98) Ting-Toomey offers the male generic language as an example (e.g. words chairman, businessman, and fireman). This use of male generic language “tends to elevate men’s experience as more valid and make women’s experience less prominent.” (Ting-Toomey, S. 2002:99) Ting-Toomey continues: “Language can simultaneously be a hacking and a healing instrument: it can be used to “cut down” or degrade others’ primary identities; it can also be used mindfully to uplift and support their desired group-based or personal identities.” (Ting-Toomey, S. 2002:100) “(…) Individuals can

garner their creative potential to use language mindfully for mutual gain and collaboration across gender and cultural groups." (Ting-Toomey, S. 2002:99)

4.2.2 Mother Tongue

The concept of mother tongue can be described in many ways. The most common description is that mother tongue is the language child learns first. This description is however problematic in situations where the parents speak different languages. Another description is that mother tongue is the language the child masters the best or what he/she uses the most. This also is problematic, as linguistic minorities are very often forced to use another language than the one they learned first. (Lukkarinen, M. 2001:1) There is also a description where mother tongue is perceived as the language by which the person has acquired the norms, rules and values of the culture he/she is a part of. In this description the language does not necessarily have to be the most used or even the first learned language. (Lukkarinen, M. 2001:1)

The opportunity to use one's mother tongue is extremely important, especially in social- and health care settings where language is more an emotional tool than verbal. The more difficult the situation is with the client, the more important is the opportunity to use one's mother tongue. Adults that have used their mother tongue all their lives and are now forced to communicate with a new foreign language, can very often withdraw in these situations. The person tries to avoid making mistakes and can not fully and fluently think with the strange language. That is, when the person states his/her thoughts in a strange language, he/she first thinks them in the mother tongue and then translates them into the foreign language. (Lukkarinen, M. 2001:1) This naturally has an effect on the outcome of the message. Using one's mother tongue thus has a direct effect on the quality of care. (Lukkarinen, M. 2001:1)

4.2.3 Interpreting

When there is no mutual language between the participants in a conversation, especially in a social and health care setting where the terms used can be extremely difficult even to the natives, the use of an interpreter is crucial in getting messages across.

An interpreter is a person that has a proper education on interpreting and who has practical experiences from working as an interpreter. (Koivisto-Junni, A. 1998:51) The interpreter does not only transfer a language into another, but his/her aim is to transmit the message forward in a manner that cultural borders are crossed and the receiver of the message can understand the full message despite of his/her own cultural background. (Koivisto-Junni, A. 1998:51) As Schulte (1995) writes about translators: "Translators build bridges not only between languages but also between the differences of two cultures. We have established that each language is a way of seeing and reflecting the delicate nuances of cultural perceptions, and it is the translator who not only reconstructs the equivalencies of words across linguistic boundaries but also reflects and transplants the emotional vibrations of another culture." (Samovar, L. et al. 2004:160) Unfortunately there are cases, where the client's spouse, relative or even child is used as an interpreter. Usually their language skills are insufficient and they do not understand the neutral and objective role, or confidentiality, of the interpreter. The spouse can also censor the information given: in Sweden there has been a case, where an abortion was made to a woman whose husband acted as an interpreter. This woman wanted the child, but her husband did not. (Koivisto-Junni, A. 1998:51) So, using an interpreter may also promote gender equality, as women are entitled to get neutral information face-to-face. (Koivisto-Junni, A. 1998:51)

In Finland there have been cases where the force of using an interpreter has been avoided as long as possible and insufficient Finnish or English has been used. In these cases the client may have had to revisit the location just because he/she did not understand the instruction in the first visit. Also the fact that the client can not use his/her mother tongue may create a barrier of talking about one's issues. (Koivisto-Junni, A. 1998:50) There are many advantages in using an interpreter: their use infers respect for the client's preferred language, they signal to the clients the counsellor's wish to understand fully the client and their predicament, and they acknowledge that the client will be able to be maximally fluent and descriptive of their situation in their own language. (Lago, C. et al. 1997:61) The use of interpreters promotes also the immigrants' integration to the Finnish society, for then they have an equal opportunity of using the services offered for each inhabitant in Finland. It does not hinder the learning of Finnish, but is necessary before, and also after learning the language, especially in social- and healthcare services where expressing one's problems and

understanding the procedures and treatment instructions is crucial. Using interpreters also promotes the legal protection of the workers. (Koivisto-Junni, A. 1998:50)

There are also problems in using an interpreter. Firstly, the use of them immediately reduces the possibility for direct communication between the client and the counsellor. Secondly, the interpreter is also a human being with a persona of his/her own, and thus subject to the same difficulties as the counsellor in terms of attitudes, assumptions and cultural origins. (Lago, C. et al. 1997:61) As Lago states: "In short, the messages that leave both the counsellor and client have the potential to be modified and indeed changed through the translator. (…) The extent to which each of the participants in this three-way relationship are able fully to trust the other two persons may determine the capacity to which the client is helped." (Lago, C. et al. 1997:62-63)

In Finland interpreter and translation services are offered in approximately 100 languages. The most common languages used are Arabic, Kurdish, Persian, Somali and Vietnamese (outside Europe) and Russian, Albanian, Bosnia, Estonian, French and Turkish (inside Europe). Also the international Romani language has been common in the recent years. Some rare languages are still not interpreted. In those cases a third language can be used (e.g English or French). (Lukkarinen, M. 2001:1)

4.3 Communication

In order to fully understand the complexity and importance of intercultural communication, especially in the social and health care setting where effective communication is crucial, the basic principles of communication must be understood. What is communication? The term itself can refer to many forms of information transmission and thus can be applied to information transmission between animals, humans, humans and animals and even between machines. (Pinto, D. 2000:19).

Over thirty years ago, Dance and Lawson (1972) scanned through literature about communication and found 126 definitions of the term. (Samovar, L. et al. 2004:15) I chose two quite new basic and informative definitions to be used here. In his book *Culture and Psychology* (2000), David Matsumoto defines communication as the: "exchange of knowledge, ideas, thoughts, concepts, and emotions among people". (Matsumoto, D. 2000:360) Ruben and Steward (1998) define communication as

"(…)the process through which individuals-in relationships, groups, organizations, and societies-respond to and create messages to adapt to the environment and one another". (Samovar, L. et al. 2004:15)

4.3.1 Models of Communication

In order for communication being possible, three basic components are required: a *sender*, a *message* and a *receiver*. (Ellis, R. et al. 2003: 4) Below a diagram of these three basic components is shown.

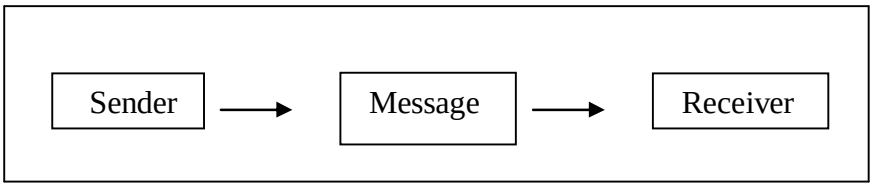


Figure 11 The basic components of communication
(Ellist, R. et al. 2003:4)

But, as one can clearly see, this is an extremely simple view of communication. The diagram is thus an example of *one-way communication*, where it is assumed that the receiver does not respond to the message he/she is receiving. In two-way communication, the response of the receiver is being taken into consideration, as shown below:

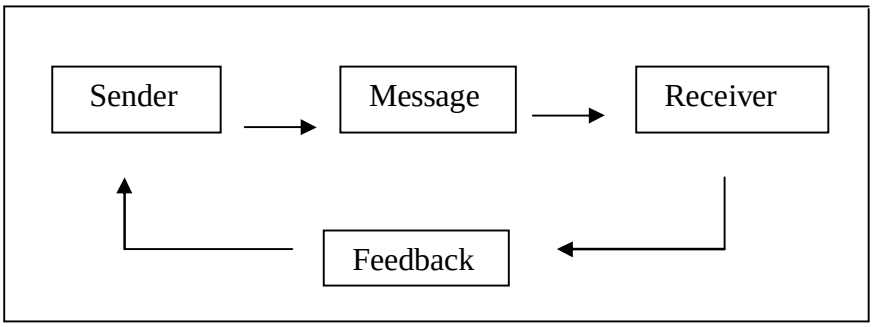


Figure 12 Basic components of communication with feedback
(Ellis, R. et al. 2003:5)

In working with people, especially in health and social care and therapeutic settings, the two-way communication is naturally the desired one. Taking turns the sender is either the client or the professional and both give feedback to each other. This is the core idea of *dialogue*, which is essential in helping professions.

David Berlo (1960), a famous communication theorist, has a similar idea of the process of communication (transmission model). He emphasised that "communication is a dynamic process, as the variables in the process are interrelated and influence each other" (Jandt, F. 2004:30). The actions of receivers influence the process.

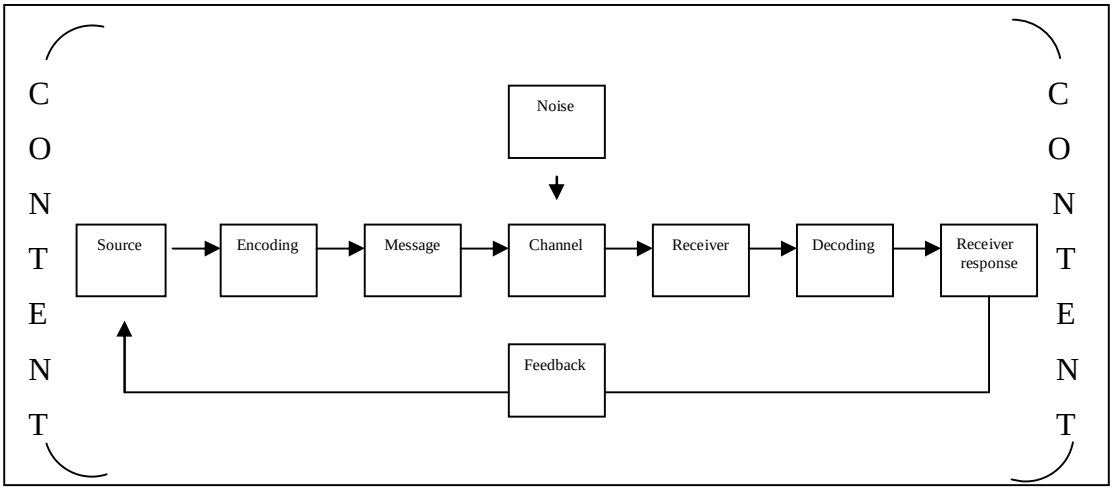


Figure 13 Ten components of communication.
(Jandt, F. 2004:30)

The noise in the diagram can refer to either background noise during the communication process or disturbing thoughts of the sender that might influence the transition of the message. But not to make it too simple, Roger Ellis (2003) introduces a more complex diagram of communication, where all the aspects involved in a communicative situation are presented.

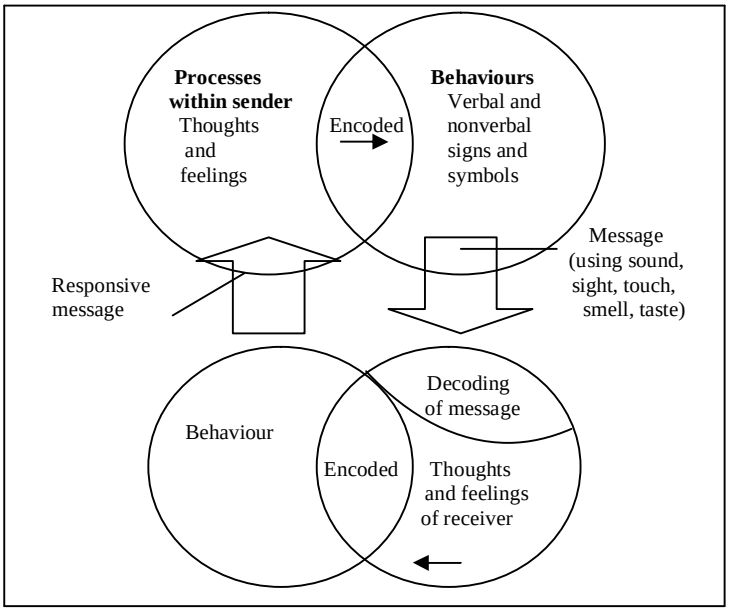


Figure 14 A model of communication
(Ellis, R. et al. 2003:7)

Encoding, (appearing between the spheres in the diagram above), refers to the process by which people select, consciously or unconsciously, a particular modality and method by which to create and send a message to someone else (Matsumoto, D. 2000:361). Decoding (appearing on the top of the lower right sphere) refers to the process by which a person receives signals from an encoder and translates those signals into meaningful messages (Matsumoto, D. 2000:361). As Matsumoto writes in *Culture and Psychology* (2000): "Just as "proper" encoding depends on understanding and applying the rules of verbal and nonverbal behaviours, "proper" decoding depends on those rules in order for messages to be interpret in the manner in which they were meant to be conveyed." (Matsumoto, D. 2000:361) But, as mentioned earlier, communication is not a one-way street with an encoder sending a message and another person decoding the message. As Matsumoto states: "Communication is a vastly complex process of encoding and decoding in rapid succession, overlapping in time so as to occur almost simultaneously. […] During this process, individuals switch roles from moment to moment, from encoder to decoder and back again." (Matsumoto, D. 2000:361)

Also Roger B. Ellis writes in *Interpersonal Communication in Nursing* (2003) about this complex communication process: "[the process] starts with the thoughts and feelings of the sender, i.e. the intrapsychic world, and acknowledges that these have to be encoded into some form of behaviour (the message) if they are to leave the internal domain and be communicated to another person (the receiver)". Ellis, R. 2003:7) The message is sent through verbal or nonverbal signs and symbols and it has to reach one or more senses of the receiver. The receiver then decodes the message, resulting thoughts and feelings. But, as Ellis writes, these thoughts and feelings may not match with the original message, that is, the receiver may misinterpret the message and make own conclusions from his/her own standing point. Especially in communicating with foreign people, when there is no common language and/or knowledge about the culture and its characteristics, especially communication style, the likelihood of misinterpreting the message multiplies.

There are also communication models that emphasize a more humanistic approach to communication, one of them being the transactional model. It takes the relationship of the participants into considerations and believes that exact same words can be spoken to different people with different meanings. (Jandt, F. 2004:34) As Jandt writes in his book *An Introduction to Intercultural Communication* (2004): "Recognising that

communication is transactional allows us to understand, for example, that the source can know the intended receiver well enough to incorporate that personal knowledge into the encoding of the message" (Jandt, F. 2004:34).

Different cultures also define communication in different ways and value and stress different aspect of the communication process. The rules of communication may also vary a great deal. One good example of this is China, where balance and social harmony are highly valued in all communication. This Confusian tradition has influenced also their vocabulary, as they have developed many verbal rituals in order to maintain good interpersonal relationships. (Jandt, F. 2004:37) The different communication styles between cultures, and problems these differences may create are discussed more deeply in chapter 4.3.6.

4.3.2 Actual Message

We do not communicate solely by words. Even the words we say may have different meanings in different times and to different people, as mentioned above. We are rarely aware that most of the information we sent to other people comes from entire other things than words and sentences.

In order to get our message across, the receiver has to understand what we are saying. Even if the receiver speaks our language, we may use such words that are not familiar to him/her. This often happens when a doctor describes a diagnosis to the patient who does not understand a word from it. This kind of usage of words can also be intentional; people may want to appear wise, literate, interesting or part of a group. People also may want to dominate, humiliate and give clues of our social position. In such cases, the words themselves are the "surface meaning", which is secondary to the disguised meaning, the actual "point". (Ellis, R. 2003:8)

The paralinguistic features of spoken message appear aside of the actual words: pitch, tone, intonation, rhythm and pace of the talking (Ellis, R. 2003:8). In some languages these are very important and an essential part of the whole language. These features also give tools for the receiver to interpret the speaker's state of mind, but again, it is only the interpretation of the receiver and thus confusions may result. Also accents and dialects tell a lot about the person and these can also be used in bringing fort, and

maintaining, the identity of the person. “The learning of another’s language is not enough … unless you understand the subtle cues implicit in language, tone, gesture and expression…you will not only consistently misinterpret what is said to you, but you may offend irretrievably without knowing how or why”. (Hall 1976b:66-74 cited in Lago, C. et al. 1997:64)

4.3.3 Non-verbal Communication

According to David Matsumoto in *Culture and Psychology* (2000), nonverbal communication can be divided into two general categories: nonverbal behaviours and nonbehaviours. (Matsumoto, D. 2000:337) Nonverbal behaviours occur during communication and include facial expressions, movements and gestures of the hands and legs, posture, lean and body orientation, tone of voice and other vocal characteristics (also silence!), interpersonal space, touching behaviours, gaze and visual attention. (Matsumoto, D. 2000:337) Nonbehaviour refers to other messages and signals we send without actually behaving in any way. These include the use of time, the clothes we wear, our make-up and hair-do and also the house we live in or our work place. (Matsumoto, D. 2000:338)

Ekman and Friesen (1969) divide nonverbal behaviours into five major categories: illustrators, adaptors/manipulators, emblems, emotion, and regulators. (Matsumoto, D. 2000:339) Illustrators are used when we want to highlight our point, to make the words more powerful. Usually we use our hands, but also other body parts are handy. We Finnish people are not so accustomed using our hands in conversations, but people in southern Europe are masters in this area. Their behaviour may seem to us to be quite funny, or even hostile, whereas in their eyes we may seem reserved or even numb. Adaptators/manipulators are not so important in communication, but extremely important to us in our everyday lives, as they include scratching, picking the nose, rubbing our eyes or biting our lips. The purpose of these is to help our body to adapt to the external environment. Every culture also defines when these are appropriate to use. Emblems refer to gestures that have a clear message in them, the simplest ones being the nodding or shaking our head meaning “yes” or “no”. The universal sign of lifting up our middle finger at someone is also an emblem and sure does send a clear message! These too are culture specific, and using them in foreign country or with people with different cultural background, may cause confusion. Emotions are indeed expressed

nonverbally. Our facial expressions convey extremely effectively what we are thinking and feeling. Facial expressions in signalling emotions are both universal and culture-specific. With regulators we regulate the flow of speech during a conversation. We signal through our facial expression when we are done talking or when we invite someone else to speak. In many cultures glance has a powerful force in regulating the conversation. (Matsumoto, D. 2000:339-340)

In a helping profession, as important and helpful it is to learn to "read" nonverbal signs of the client, it is as important to learn to read and understand our own nonverbal signals. When dealing with clients from different culture, the awareness of nonverbal signs in that specific culture, and mastering our own nonverbal behaviour in that situation, is extremely important. One may accidentally insult someone with a behaviour that is normal to them but out of the question for the client.

4.3.4 Effective Communication

David Pinto (2000) has written about the prerequisites of effective communication. According to him, five prerequisites are essential: technical prerequisite, cognitive prerequisite, interpretative prerequisite and affective prerequisite. The technical prerequisite refers to the fact that in order for the communication to be effective, each party should understand the language of the other party and each party should also see/hear the other party in order to understand the message. Distance and noise can disturb the understanding. Interpreters are also included in this prerequisite, for they have to do a good job in order for the participants to understand the message fully. Cognitive prerequisite refers to the fact that both parties must communicate at an intellectual level acceptable for both and also the subject must be somewhat familiar for both in order for the communication to be effective. Even if they speak the same language (technical prerequisite) the communication can fail if both parties are not familiar with the subject. The interpretative prerequisite refers to the fact that even if the language and the intellectual levels are the same among the parties, both parties must also have the same interpretation to the words used. As every language has idioms, references and analogies of their own, non-native speaker can interpret these with a literal meaning on the contrary to the figurative meaning and misunderstand the whole point. The affective prerequisite refers to the fact that despite all of the stated above, also the gestures and actions chosen must be familiar to both parties, and evoke the

same emotions and emotional interpretation in both parties. (Pinto, D. 2000:23) As mentioned in Chapter 4.3.3, some gestures that are natural in our culture may be offensive to people from other cultures. Even if the other person has the same cultural background, some gestures are better left undone with some people (a pat on the head or a pinch in the cheek). The other person's personality, status and age have also to be taken into account.

4.3.5 Intercultural Communication

The best way of understanding the concept *intercultural communication* is to compare it with *monocultural communication* which is the way of communicating constantly used in everyday surroundings.

Monocultural communication is *similarity-based*: it entails common language, values and behavioural patterns of the participants sharing the same cultural background. (Bennett, M. 1998:2) Milton J. Bennett, the co-founder of the Intercultural Communication Institute and director of the Intercultural Development Research Institute in the US and author of many books concerning intercultural communication, states in his article *Intercultural Communication: A Current Perspective* that "These similarities generally allow people to predict the responses of others to certain kinds of messages and to take for granted some basic shared assumptions about the nature of reality. (…) difference represents the potential for misunderstanding and friction. Thus, social difference of all kinds is discouraged." (Bennett, M. 1998:2)

Intercultural communication on the other hand is *difference-based*. "Intercultural communication-communication between people of different cultures-cannot allow the easy assumption of similarity. By definition, cultures are different in their languages, behaviour patterns, and values. So an attempt to use one's self as a predictor of shared assumptions and responses to messages is unlikely to work." (Bennet, M. 1998:3)

According to Gudykunst (2003) intercultural communication is conceptualized as "communication between people from different national cultures, and many scholars limit it to face-to-face communication." (Gudykunst, W. 2003:163) David Pinto writes in his book *Intercultural communication* (2000) that the literature on intercultural communication has grown steadily since the 1960's, but still authors differ in their

terms, definitions, lines of approach and objectives. (Pinto, D. 2000:13) He continues that: “Today, there are studies on intercultural communication from the viewpoint of anthropology, communication science, art, history, sociology, management, social psychology, psychiatry, music, theology, literature and language. (Pinto, D. 2000:14) But, despite of all mentioned above, he arrives to the following definition: “Intercultural communication (ICC) is a (developing) discipline that studies the interaction between individuals and/or groups with different backgrounds. ICC aims to enhance intercultural awareness, encourage the use of a double-perspective approach and offer a systematic method for analysing cultural differences in order to increase the effectiveness of communication between these individuals and/or groups.” (Pinto, D. 2000:15)

Bennett (1998) offers a simple definition of the term intercultural communication: *intercultural communication can be defined as face-to-face interaction between people whose cultures are significantly different from one another* (Bennett, M. 1998 cited in Launikari, M. 2005:152)

4.3.5.1 Intercultural Communication Competence

Definitions of intercultural competence (or intercultural communication competence) stress usually the development of skills that transforms one from monocultural person into a multicultural person. (Jandt, F. 2004:44) Multicultural person is “one who respects cultures and has tolerance for differences” (Belay, 1993;Chen&Starosta, 1996 cited in Jandt, F. 2004:45) Chen (1989,1990) identifies four skill areas in order to achieve this: personality strength, communication skills, psychological adjustment and cultural awareness. (Jandt, F. 2004:45) Personality strength entails four personal traits: self-concept (how person views the self), self-disclosure (willingness to openly and appropriately reveal information about oneself to others), self-monitoring (using social comparison information to control and modify one’s self-presentation and expressive behaviour), and social relaxation (ability to reveal little anxiety in communication). (Jandt, F. 2004:45) According to Jandt, in order to be an effective communicator, one must know oneself well and through this knowledge initiate positive attitudes. (Jandt, F. 2004:45)

Communication skills refer to the competency in verbal and nonverbal behaviours, and can be divided into four skills: message skills (ability to understand and use the

language and feedback), behavioural flexibility (ability to select an appropriate behaviour in diverse contexts), interaction management (ability to handle the procedural aspects of conversation and being other-oriented), and social skills (ability to be empathetic and maintaining identity). Identity maintenance is "the ability to maintain a counterpart's identity by communicating back an accurate understanding of that person's identity. (Jandt, F. 2004:45)

Psychological adjustment refers to the ability of acclimating to new environments and to handle feelings of "culture shock" (e.g. frustration, stress and alienation). (Jandt, F. 2004:45) In order to be culturally aware, one must understand the social customs and social systems of the other culture, as well as their thinking and behavioural patterns. (Jandt, F. 2004:46)

According to Bennett (2003), intercultural competence (or intercultural communication competence) consists of a *Mindset* (cognitive variables), a *Skillset* (behavioural skills) and a *Heartset* (affective variables). (Bennett, J. 2003 cited in Launikari, M. 2005:153) The *Mindset* includes cultural self-awareness, culture-general and culture-specific frameworks and identity development patterns and understanding of cultural adaptation processes. (Launikari, M. 2005:153) The *Skillset* includes behavioural skills relating to interaction management, stress and anxiety management, listening, observation, social adaptability, empathy, relationship building, problem definition and resolution. (Launikari, M. 2005:153) The *Heartset* includes attitudes and motivation comprising curiosity, open-mindedness, patience, tolerance, perseverance, flexibility, initiative to explore other cultures, respect for others' values and beliefs, confidence to take appropriate risks, and attention to group and interpersonal harmony. (Launikari, M. 2005:153)

4.3.5.2 Mindful Intercultural Communication

The *Mindful intercultural communication* model derives from the *Identity negotiation theory*. The identity negotiation perspective is an integrative theory which draws from the work of social identity theory (social psychological discipline), symbolic interactionism (sociological arena), identity negotiation and relational dialectics (communication discipline). (Ting-Toomey, S. 1999:27) As Ting-Toomey writes in *Communicating Across Cultures* (1999): "The identity negotiation theory focuses on the

motif of identity security-vulnerability as the base that affects intercultural encounters". (Ting-Toomey, S. 1999:26) According to Ting-Toomey, understanding this motif in any intercultural encounter is important because of the following reasons: individuals bring their sense of self-image (or identity), which is shaped by cultural, personal, situational and relational factors, into communicative encounters. Culture plays the primary shaping role in our self-image, and through cultural values and practices the meanings of identities such as ethnicity, gender, and age are defined and differentially valued. (Ting-Toomey, S. 1999:26) Individuals also shape their identities in interaction with other people in their culture. How an identity role is performed is defined by the consensual norms developed by people in the particular culture. What is competent interaction in one culture, may be incompetent in another and vice versa. In order to be an effective communicator in intercultural encounters, it is important to understand how cultural norms shape communication ideals. (Ting-Toomey, S. 1999:26) In addition to these, individuals also tend to feel secure when they are communicating with people who are somewhat similar to them, and insecure (identity vulnerability) when they interact with people who are unfamiliar. Common values and norms are shared in encounters with similar others, but with dissimilar other these norms and values are constantly questioned or contested. (Ting-Toomey, S. 1999:26)

As ting-Toomey states: "The identity negotiation theory emphasizes that identity or reflective self-conception is viewed as the explanatory mechanism for the intercultural communication process. Identity is viewed as reflective self-images constructed, experienced, and communicated by the individuals within a culture and in a particular interaction situation." (Ting-Toomey, S. 1999:39) Identity negotiation refers to the notion that in interaction, while the communicators attempt to evoke their own desired identities in the interaction, they also attempt to challenge or support the others' identities. (Ting-Toomey, S. 1999:40) The theory has 10 core assumptions, form which assumptions 9 and 10 entail the outcomes, criteria and components of intercultural communication. Assumption 9 states that *satisfactory identity negotiation outcomes include the feeling of being understood, respected, and supported.* Assumption 10 states that *mindful intercultural communication emphasizes the importance of integrating the necessary intercultural knowledge, motivations, and skills to communicate satisfactorily, appropriately, and effectively.* (Ting-Toomey, S. 1999:41)

The components of the mindful intercultural communication model are: knowledge factors, motivational factors and skill factors. “Without culture-sensitive knowledge, cultural communicators may not be able to match cultural value issues with identity-related behaviours. Knowledge here refers to the process of in-depth understanding of certain phenomena via a range of information gained through conscious learning and personal experiences and observations.” (Ting-Toomey, S. 1999:50) “The motivations in intercultural communication competence refer to our readiness to learn about and interact with people who are different.” (Ting-Toomey, S. 1999:52) “Skills in this context are our operational abilities to integrate knowledge and motivations with appropriate and effective intercultural practice.” (Ting-Toomey, S. 1999:52) The knowledge factors include: cultural/personal values, language & verbal communication, non-verbal communication, in-group & out-group boundary, relationship development, conflict management and intercultural adaptation. The motivational factors include: mindful of identity domains, mindful of identity needs, and mindful of ethnocentric tendencies. The skill factors include: mindful observation, mindful listening, verbal empathy, nonverbal sensitivity, mindful stereotyping, constructive conflict skills, and flexible adaptive skills. (Ting-Toomey, S. 1999:49)

The **criteria** of all of the mentioned above to be appropriate are: appropriateness, effectiveness and satisfaction. “Appropriateness refers to the degree to which behaviours are regarded as proper and match the expectations generated by the culture.” (Ting-Toomey, S. 1999: 48) “Effectiveness refers to the degree to which communicators achieve shared meanings and desirable outcomes in a given situation.” (Ting-Toomey, S. 1999: 48) The desired **outcomes** are: *being understood, being respected and being supported.* (Ting-Toomey, S. 1999: 49)

4.3.6 Possible Problems

What then are the problems that may occur in intercultural encounters and why do they so easily occur? As Colin Lago writes in *Race, Culture and Councelling* (1997), the process of counselling is “based upon sensitive, understanding and accurate communication between counsellor and client.” (Lago, C. 1997: 38) He continues: “While communication constitutes part of the visible and audible aspects of people’s behaviour, the inner origins of such messages come from the complex inner workings of our minds, our emotions, our memories, our relationships and so on.” (Lago, C. 1997:

38) According to Lago, issues that are potentially present, and affecting, in any meeting between two people who are culturally and racially different are: language, time, context, purpose of meeting, views/attitudes towards other, location of meeting, customs and rituals, smell, age, touch, disability, decoration, adornment, jewellery, personal/institutional power, expectations of the other, perceptions of the other, previous personal history, fear of the other, the context within which they are meeting, conventions of greeting and meeting behaviour, gender, notions of acceptable/unacceptable behaviour, system of ethics/morals, status/authority, belief system/religion, interpersonal projections, political differences, personal theories of communication, physical appearance and non-verbal behaviour. (Lago, C. 1997:40) As Lago continues: ”The complexity of this situation is further realized when one takes into account that person A, already having all these aspects, attitudes and attributes is trying to communicate with person B, also possessing these aspects, though differently constituted. Each is different to the other. Each also then proceeds to see, perceive, attribute and project on to the other from their own understanding of the world.” (Lago, C. 1997:39) Below shown this in a concise form:

> A perceives B
> A judges B on A’s system of categorizing people
> A’s behaviour and communication is thus likely to be affected.
>
> B perceives A
> B judges A on B’s system of categorizin people
> B’s behaviour and communication is thus likely to be affected.
> (Lago, C. 1997:39)

From all the mentioded above, Lago arrives to a conclusion, that if these two (A and B) meet each other in a counselling situation as a counsellor and a client, the counsellor’s capacity to be accepting of and non-judgemental towards the client, is already limited in the very beginning of the encounter. (Lago, C. 1997:41) The Sapir-Worf hypothesis presented in Chapter 2.7 is very close to Lago’s ideas, although it concentrates mainly on the linguistic issues.

Samovar et al. (2004) have also written about the major barriers to successful intercultural communication. They are: avoidance of the unfamiliar, the desire to reduce uncertainty, withdrawal, stereotyping, prejudice, racism, misuse of power, culture shock, and ethnocentrism. (Samovar, L. et al. 2004:300) LaRay M. Barna has a similar

view: he has written about the six stumbling blocks in intercultural encounters that include most of these barriers. His ideas are presented in Chapter 4.3.6.2.

4.3.6.1 The Golden Rule

> *Therefore all things whatsoever ye would*
> *that men should do to you,*
> *do ye even so to them…*
> **-Matthew 7:12-**

The Golden Rule is usually used when we are unsure how to treat other people. In those situations we then imagine how we would like to be treated and then act in accordance. (Bennett, M. 1998:191) Although the golden rule sounds graceful and embodies a basic truth of us all being equally human, it actually denies differences and thus does not work. We are all different from one another. (Bennett, M. 1998:192) As Bennett states: "Not only are [we] individually different, but [we] are systemically different in terms of national culture, ethnic group, socioeconomic status, age, gender, sexual orientation, political allegiance, educational background, and profession, to name but a few possibilities. Associated with these differences in people are differences in values-values which cannot easily be generalized to all people from those of any given group." (Bennett, M. 1998:192) In addition to denying differences, the rule actually hinders effective communication: "Assuming that others are like ourselves when we talk to them is tantamount to talking to ourselves. We fail to recognize the crucial differences to which our communication must be accommodated, and our efforts to understand and be understood are subverted by a façade of uniformity." (Bennett, M. 1998:192)

Sympathy is most closely allied with the Golden Rule. Sympathy means "the imaginative placing of ourselves in another person's position". As Bennett states: "Following the assumption of similarity, we merely assume that the other person is like ourselves and therefore inpute to him or her our own thoughts and feelings. In its least sophisticated form, sympathy projects both the self and the circumstances of the sympathizer onto the perceived situation." (Bennett, M. 1998:197) The advantages of sympathetic strategy are: it is easy, it is credible, it is often accurate and it may be confronting. The disadvantages are: it is insensitive to difference, in the face of difference it is patronizing and breeds defensiveness, and it helps perpetuate the assumption of similarity. (Bennett, M. 1998:201-202)

As in sympathy one attends to the suffering of another but the feelings are one's own, in *empathy* one attends to the feelings of another. Empathy concerns "how we might imagine the thoughts and feelings of other people from their own perspective." (Bennett, M. 1998:197) Bennett defines empathy as: "the imaginative intellectual and emotional participation in another person's experience". (Bennett, M. 1998:207) On the contrary to sympathy, empathy holds in it the assumption of difference. (Bennett, M. 1998:207) Bennett offers six ways of developing empathy: assuming difference, knowing self (not "loose ourselves" to the other person), suspending self (temporary expansion of the boundary of self), allowing guided imagination (allowing our imagination to be guided into the experience of a specific other person), allowing empathic experience and re-establishing self (remember the way back to our selves). (Bennett, M. 1998:209-212) As Bennett states: "With empathy, and only with empathy, we are privileged to live briefly in the least accessible land of all-another person's experience." (Bennett, M. 1998:212)

4.3.6.2 Six Stumbling Blocks in Intercultural Communication

LaRay M. Barna has written about the six stumbling blocks in intercultural communication in Basic Concepts of Intercultural Communication, edited by Milton J. Bennett (1998). According to him, they are: assumption of similarities, language differences, nonverbal misinterpretations, preconceptions and stereotypes, tendency to evaluate and high anxiety. (Barna, LaRay 1998: 173-183)

As already stated in the above chapter of the Golden Rule, the assumption of similarities prohibits us the see the other person as unique and different form us. Barna states: "(…) why misunderstanding and/or rejection occurs is that many people naively assume there are sufficient similarities among peoples of the world to make communication easy." (Barna, LaRay 1998: 173) Vinh The Do has written: "If we realize that we are all culture bound and culturally modified, we will accept the fact that, because unlike, we do not really know what someone else "is"." (Barna, LaRay 1998: 174)

Language difference is an evident stumbling block in intercultural encounters. In addition to the differences in vocabulary, syntax, idioms, slang and dialects, even greater problem is the tenacity with which "some people will cling to just one meaning of a word or phrase in the new language, regardless of connotation or context. The

variations in possible meaning, especially when inflection and tone are varied, are so difficult to cope with that they are often waved aside." (Barna, LaRay 1998: 179)

Verbal language is often regarded the only barrier to understanding. "People from different cultures inhabit different sensory realities. They see, hear, feel, and smell only that which has some meaning or importance for them. They abstract whatever fits into their personal world of recognition and then interpret it through the frame of reference of their own culture." (Barna, LaRay 1998: 180) As Barna continues: "The misinterpretation of observable nonverbal signs and symbols-such as gestures, postures, and other body movements-is a definite communication barrier." (Barna, LaRay 1998: 180)

The function of stereotypes is to reduce the threat of the unknown by making the world around us predictable but they create an obstacle to communication because they hinder the objective viewing of stimuli. (Barna, LaRay 1998: 181) According to Barna, steretypes are sustained and fed by the "tendency to perceive selectively only those pieces of new information that correspond to the image held." (Barna, LaRay 1998: 181)

The tendency to evaluate, to approve or disapprove the statements and actions of other people is the fifth stumbling block. As Barna states: "Rather than try to comprehend thoughts and feelings from the worldview of the other, we assume our own culture or way of life is the most natural. This bias prevents the open-mindedness needed to examine attitudes and behaviours from the other's point of view." (Barna, LaRay 1998: 181)

According to Barna, high anxiety, also known as stress, is common in cross-cultural encounters due to many uncertainties present. (Barna, LaRay 1998: 183) Some degree of anxiety is needed in new situations in order to meet challenges with energy, but too much anxiety can lead to the use of defences, such as withdrawal or even hostility. (Barna, LaRay 1998: 183) As Young Y. Kim has stated: "Stress, indeed, is considered to be inherent in intercultural encounters, disturbing the internal equilibrium of the individual system. Accordingly, to be interculturally competent means to be able to manage such stress, regain internal balance, and carry out the communication process in

such a way that contributes to successful interaction outcomes." (Barna, LaRay 1998: 183-184)

5. MATERIALS AND METHODS

The aim of this research was to answer at least the following questions: what is the readiness and competence in substance abuse treatment units in Finland to receive and encounter non-Finnish speaking clients, how is the quality of these services assessed and/or developed in the units and what has been the role and functioning of the quality recommendations and quality assessment forms in working with non-Finnish speaking clients.

The quality assessment forms and basic information forms found in the database maintained by Stakes built a solid base in research question number 1, but also interview was used in order to get more detailed information about the culturally and linguistically competent practices in the units. Question number 2 touches the quality of the services and the assessment and development of quality, and question number 3 deals with how the quality recommendations and quality assessment forms have influenced the working with non-Finnish speaking clients and have they been appropriate, functional and adequate. Answers to these questions were sought mainly through interviews.

5.1 Methodology

This research is both qualitative and quantitative, containing statistical data as well as data gathered through interviews. The quantitative data was gathered from the basic information forms and filled in quality assessment forms found in the database maintained by The Development of Alcohol and Drugs Intervention group at Stakes. These forms clearly show which substance abuse treatment units provide services also to minority groups (basically language services), including immigrants and other non-Finnish speaking clients, and which do not. Also the possible languages are listed. The qualitative data was gathered from interviews done in four substance abuse treatment units.

5.2 Treatment Units

The study was narrowed down to substance abuse treatment, including outpatient services (specialised services such as A-clinics and youth clinics and other similar services) and intensive/residential treatment and rehabilitation centres (inpatient care and treatment). Daycentres and service housing units are not included (support services), mainly to keep the quantity of data in reasonable proportions. The units to take part into the interviews were chosen according to the following criteria: one can participate in treatment in Finnish, Swedish or English, the unit has filled the quality assessment form, and interpreter services are provided. These criteria were set in order to get detailed and experience based information about the functioning of the services. The criteria helped in focusing on units that had actual experiences about these issues and/or had put on effort on them and thus could provide information relevant to the research questions.

The units chosen to participate into the interviews all functioned under the A-clinic Foundation. The units situated in Helsinki, Kotka, Espoo and Tampere. The reason for choosing these units along with the demand that they fulfil the main criteria was to get information not only from the capital area, but also from other parts of Finland. Also the amount of foreigners in the area was one reason for choosing these units (see Table 3) as well as the fact that these units were among the few ones that actually fulfilled the criteria. The aim was also to get a variety of units, that is, both inpatient units (one unit) and outpatient units (three units) and both units that concentrate mainly on alcohol abuse (two units) and units that concentrate mainly on drug abuse (two units). Random sample is usually recommended in choosing the interviewees, but some also protest it. Lazarfeld (1967), just to mention one, recommends choosing the people that know the actual topic well. (Hirsjärvi, S., Hurme, H. 1979:72) This “purposive sampling” was used in the study as the aim was to get experience based information from the units.

5.3 Research

After choosing the units taking part into the interviews, the A-Clinic Foundation was contacted to get information how to proceed in order to get the research permit. After that the area managers of the particular units were contacted by e-mail in order to get recommendations for the research permit. The information concerning this research was

then put into the research database of the A-clinic Foundation. This is required from all studies concerning its units. At the same time the units were contacted and presented the research by email. The research permit was affirmed in 12 September 2007 accompanied with the confidentiality agreement. After this the units were contacted again to set up the dates for interviews. Prior each interview directional information concerning the content of the interview by e-mail was sent to each unit and the persons taking part into the interviews. This allowed the participants to get acquainted with the themes beforehand and thus be better prepared. During the research process continuous contact with Stakes was kept. The completed study will be sent to Stakes as well as to all the units that took part in the interviews. Also the information concerning this study will be updated in the database of the A-Clinic Foundation.

5.3.1 Quantitative Research

The data concerning the language services offered in substance abuse treatment units found from the basic information forms and filled in quality assessment forms was transferred into SPSS-program and analysed. In order to do this properly, the author participated three times into SPSS-guidance offered by Stadia. This helped in formulating the data and making appropriate tables and figures. The variables in the data were: province (the location of the unit), type of treatment (outpatient care or institutional care), filled in quality assessment form (has the unit filled it in), service languages according to the quality assessment form (in which languages service is provided), interpreter services (does the unit provide interpreter services), material languages (in which languages does the unit provide material to clients) and treatment languages (in which languages does the unit provide treatment).

5.3.2 Qualitative Research

The qualitative part of the study was realized in the interviews. They took place in four substance abuse treatment units functioning under the A-clinic foundation and were aimed for head supervisors or managers of those particular units. The aim of the interviews was to gain information about how the services for non-Finnish speaking clients function in practice, how the quality of these services is assessed and /or developed in the units, what has been the need for these kinds of services, and what has

been the role and functioning of quality recommendations and quality assessment forms in the units.

Interview as a research method has been criticised, but it also has several benefits. It is extremely flexible, as the interviewer has the opportunity to repeat questions, make corrections, clarify the questions and words used, and present the questions in an order the researcher feels is justifiable. Also the quiz-like nature of forms is not present in face-to-face contact. (Tuomi, J. Sarajärvi, A. 2002:77) One benefit of an interview is also the fact that refusal rate is much smaller than it is when using forms. (Tuomi, J. Sarajärvi, A. 2002:77) In addition to these reasons affecting in choosing interview as a method, it was beneficial to actually visit the places as well as discuss with the workers about intercultural issues in substance abuse work as they see it. The visits helped in getting a more deep understanding about the situation.

The interviews performed were semi-structured theme interviews. Theme interview is a half structured interview method where the interview proceeds under certain themes but there is also room for clarifying questions. (Tuomi, J. Sarajärvi, A. 2002:77) In theme interview it is not necessary to perform all the questions planned or even present them in the same order for all interviewees. The range of theme interview can be from extremely structured interview with certain questions planned ahead to almost entirely open type of interview. (Tuomi, J. Sarajärvi, A. 2002:77) Naturally one cannot ask whatever one pleases even in theme interview, but try to find meaningful answers that would answer the research questions. The themes are based on the theoretical foundations of the research, that is, what is already known. (Tuomi, J. Sarajärvi, A. 2002:77)

The questions in the interview were loosely organised by themes with accurate questions that were same for all units. The themes rose from the central concepts used in the study. The themes were: non-Finnish speaking clients in the units, the readiness of the units to receive and encounter non-Finnish speaking clients, staff's readiness and competence of working with non-Finnish speaking clients, assessment of quality and developing services, and quality recommendations and quality assessment forms. The questions were the same and presented in the same order to every interviewee, but clarifying questions were added when in order. The interviewees also occasionally answered the up-coming questions before they were presented, so the order of the

questions was flexible. Also free discussion was possible. All of the interviews were taped, but notes were also made in case the taping should fail or something else go wrong. The interviews were then transcribed from word to word. This took 6-8 hours per interview. The material concerning the interviews was kept by the author during the whole process and no-one had access to them. All the material will be destroyed after finishing the study. The interview questions are seen in appendices 1 and 2.

The interviews lasted from ½h to 1/½ hour. In every unit the reception was extremely welcoming and warm and there could be seen a genuine interest towards the ongoing study and a deep wish for participation. The atmosphere in every interview was relaxed and informal, which made the situation more comfortable to the interviewer as well as to the interviewees.

5.4 Analysis

The purpose of analysing the research data is to create a verbal and clear picture of the phenomenon under research. Analysing qualitative data aims to increase the information value, as coherent information is sought from the scattered data. By creating clarity to the data, reliable and clear conclusions can be drawn from the phenomenon. (Tuomi, J. Sarajärvi, A. 2002:110) The forms of qualitative analysis can be divided into material based, theory directive or theory grounded analysis. (Tuomi, J. Sarajärvi, A. 2002:97-99) The theory directive approach has certain theoretical connections which are not necessarily directly based on a theory, but theory can function as a guide in the analysing process. The impact of previous knowledge can be seen in the analysis, but its purpose is not to test the theory but open new thinking possibilities. (Tuomi, J. Sarajärvi, A. 2002:98)

The approach in the present study was theory directive, as there were certain concepts and theories that guide the analysis and have steered this whole research, but they were not considered as the whole truth, as a lot of space has also been given to the material gained from the interviews. Content analysis is a basic analysing method that can be used in all traditions of qualitative research. (Tuomi, J. Sarajärvi, A. 2002:93) The aim of content analysis is to organise the material into solid and clear form without loosing its information. (Tuomi, J. Sarajärvi, A. 2002:110) Content analysis was utilized in this thesis.

Analysing the data followed the framework presented by Timo Laine concerning the progression of qualitative analysis. According to him, the process starts with selecting relevant issues from the material, then sorting out and collecting these issues together, thematising or classifying the material and writing the summary. (Tuomi, J., Sarajärvi, A. 2002:94) After transcribing the interviews, They were read several times in order to get a deep understanding about what had actually been said. Already at this stage, issues relevant for the research stood up from the text and preliminary coding was done. Then, the text was coded by underlining the relevant issues for the research with coloured pencils, certain colour for certain theme/question, and left irrelevant material out. Also similarities and differences were found this way and coloured with similar colours. After this theme-cards were made with the computer, which included the themes already present in the interviews as a heading and space for relevant issues found from the texts. Then the sections, sentences or phrases that fitted under a certain theme were sought and added to the appropriate theme-card accompanied with a code given to the interviewee (U1-4, U being the unit). This part was easily done with the "copy-paste" function in the computer, where the relevant (already coloured) issues were copied from the text and pasted under the theme they fitted in. Issues that did not fit under any theme but were relevant for the research were also found and added to a card made for this additional information. After this, work continued with the theme-cards, still pruning the material and making general concepts of the sentences or phrases. The summarising of the results and writing them down was done after this.

5.5 Reliability, Validity and Ethics

The aim of a scientific research is to produce as accurate and reliable information as possible about the phenomenon under research. In evaluating the trustworthiness of a research, the truthfulness and accuracy of the information produced is examined. (Kylmä, J. et al. 2007:127) The trustworthiness of a qualitative research can be evaluated with general reliability criteria for qualitative studies or with criteria that is connected with the methods used. (Kylmä, J. et al. 2007:127) The concepts of validity (the research has examined what it promised to examine) and reliability (the repeatability of the results) have usually been used as the criteria for trustworthiness. However, the use of these concepts in qualitative research has been criticised, as they derive from the domains of quantitative research. There are no unambiguous guidelines

how to evaluate the trustworthiness of a qualitative research (Tuomi, J., Sarajärvi, A. 2002:135), but one way is to follow the next criteria which is a synthesis of views presented by multiple researchers: the research and its results should be credible, dependable, transferable and reflexive. (Kylmä, J. et al. 2007:128)

In order to strengthen the credibility of a research the researcher can use triangulation or discuss the results with the participants in the research, or with someone who is studying the same topic. (Kylmä, J. et al. 2007:127) During this research process the author has been in continuous contact with a representative at Stakes who is a member of the Development of Alcohol and Drugs Intervention group (PÄDE). The mission of PÄDE is to support the developing of substance abuse work in the local as well as regional level. These discussions have strengthened the credibility of the research. Also the fact that material was collected from several different sources (methodological triangulation) has affected on the validity and credibility of the results. Triangulation means combining different methods, researchers, information sources and theories in the research in order to strengthen its validity. (Tuomi, J., Sarajärvi, A. 2002:140)

Dependability refers to the documentation of the whole research process, so that another researcher is able to follow the course of the research on the whole. (Kylmä, J. et al. 2007:129) The aim is that the researcher explains in detail the different phases of the research process, utilises notes e.g. from the interviews and shows how and why the methods used were chosen and how the conclusions were achieved. (Kylmä, J. et al. 2007:129) However, it is acknowledged and accepted that in qualitative research it is almost impossible for another researcher to end up to the same conclusions than the original researcher even with the same data. On the other hand, different interpretations concerning the phenomenon do not necessarily mean a problem in the trustworthiness of the research, as they might simultaneously increase the understanding about the phenomenon (Kylmä, J. et al. 2007:129) The study reports the course of the process accurately and in detail and the reasons for methods used are also explained. Also the conclusions and how they were drawn and ended up with has been examined. If this research should be repeated, similar, if not exactly the same, results would no doubt emerge.

In order for the research to be reflexive, the researcher should be aware of one’s starting-points as a researcher and evaluate his/her own impact on the data and the

whole research process. (Kylmä, J. et al. 2007:129) Reflexivity can be divided into personal reflexivity (the researcher's effect on the research) and epistemological reflexivity (how the methods or assumptions have shaped the research). Objectivity has been maintained as the leading idea during the whole process, although the results gained from the basic information forms and quality assessment forms found in the database provided some preliminary information about the situation in the units which naturally had an affect on the interview questions. Also in the analysing of the interviews only the issues relevant for the research questions were concentrated on, resulted in leaving a lot of information out. However, the data gained has been presented in the study exactly how they were first presented to me and analysed in an appropriate and ethical manner. As the data was collected only from four substance abuse treatment units which have taken linguistic issues very well into consideration in their functioning, the results can not be generalised into the situation in all the units in Finland. That would have required more units to take part into the study and thus, due to the great amount of units in Finland, a different method. But, as the aim of the interviews was to gather information about the functioning of linguistic services in the units, and at the same time support the information already gained from the database, that aim was reached considerably well. Also, as the quantitative data was gathered from 267 units, it can be said to reflect the overall situation in Finland very well.

In order for the research to be transferable, the results should be able to be transferred into other similar circumstances. The researcher should give enough information about the participants in the research as well as the environment in the research in order for the reader to evaluate the transferability of the research. (Kylmä, J. et al. 2007:129) The present study gives the relevant information concerning the units that took part into the interviews as well as the circumstances surrounding the interview situations. The course of this study as well as the results have also been reported in detail.

The trustworthiness of a research can also be evaluated through the different phases of the research. The phenomenon under research has to be identified and named clearly in the research, the relevance of the research has to be justified, the purpose of the research and naming the research questions have to be visible in the research, the description of the data collecting process should be sufficient, analysing the data should be appropriate in relation to the aims of the research, the analysing process should be described in detail, relevant original quotations should be presented, the data should be adequate in

relation to the purpose of the research, the report of the research has to be clear and reader friendly, the thinking processes of the researcher should be visible, the data, results and conclusions should interact, and the results should be beneficial for (in this case) the social- and healthcare field. (Kylmä, J. et al. 2007:130-133) As the nature of this research has been described in detail and its meaning as well as importance in substance abuse care is reflected, the data collecting processes as well as the methods used are well described, the themes in the interviews are presented, relevant information concerning the units that took part into the interviews is visible, the results of the study are beneficial for the substance abuse treatment units as well for Stakes, the data is effectively combined with the analysis and results and the form of this thesis is also kept as reader friendly as possible, this criteria has been fulfilled in the study.

The quality of the data collected through interviews can be improved in several ways. Prior to the interviews it is essential to conduct a solid framework for the interview questions and think of additional questions to be used if needed. It is also essential to make sure that all the equipments work (e.g. tape-recorded, tapes, pencils), and take supplement batteries and pencils to the interview. During the interview the functioning of the tape-recorder should be checked, and also notes should be made to help in the upcoming analysis (and also make sure that if the taping goes wrong, there is still material from the interview). After the interviews the data should be transcribed as soon as possible when the information is still fresh in the interviewers mind. (Hirsjärvi, S., Hurme, H. 2000: 184-185) All of these aspects were taken into account in making and analysing the interviews for this thesis. The questions were prepared carefully, several tape-recorders, batteries, pencils and tapes were taken into the interviews, notes were made during the interviews and the tapes were transcribed soon after the interviews. In order for the data gained through an interview to be reliable, it has to be good quality. If the taping is bad, transcribing is done without a unified method or classification is random, the data is not reliable. (Hirsjärvi, S., Hurme, H. 2000:185) The data used in this thesis was high quality and a unified transcribing as well as classification method was used with every interview data.

Ethical issues and good scientific practice were acknowledged throughout the research process. The Academy of Finland (1998) has described what is good scientific practice: “Good scientific practice means following the procedures affirmed by the scientific community, general cautiousness and accuracy in the research process and in presenting

the results, taking the work done by other researchers appropriately into consideration, presenting own results in the right light, and respecting the principles of openness and controllability of science." (Tuomi, J., Sarajärvi, A. 2002:130) In the making of the present study these issues were studied, taken into consideration and applied in every step of the process.

The anonymity of the interviewees has also been secured and the interviews were conducted by following good manners and with respect. All the data has been handled only by the author and will be destroyed after finishing the study. Confidentiality agreement has been signed and obeyed accordingly.

6. RESULTS

The amount of units found in the database and analysed in the SPSS-program was 267. The information found in the quality assessment forms and basic information forms was collected during spring 2007, so the information may have changed since then. The amount of units that took part into the interviews was four.

6.1 Database Findings

The results show, that from the 267 units found in the database (=had filled the basic information form), 145 were outpatient services and 122 were intensive/institutional services.

Type of treatment	Amount of units	Percent
Outpatient services	145	54,3
Intensive/institutional services	122	45,7
Total	267	100,0

Table 4 Type of treatment

How the units are divided between provinces is seen in Appendix 3, Table 4.1, and how they are divided regionally according to the type of treatment is seen in Appendix 3, Table 4.2.

From the 267 units, only 76 (28,5%) had filled in the quality assessment form. Six units report to have filled in the form, but it could not be viewed.

Filled in quality assessment form	Amount of units	Percent
No	185	69,3
Yes	76	28,5
Yes, but not available	6	2,2
Total	267	100,0

Table 5 Filled quality assessment form

How the filling in the quality assessment form is divided according to the type of treatment is seen in Appendix 3, Table 5.1, and how the units that have filled in the quality assessment form are divided according the province is seen in Appendix 4, Table 5.2.

Only 28,1% of the units reported to provide interpreter services and 23 units had mixed information concerning this issue (in the basic information form interpreter services are mentioned, but in the actual quality assessment form they are not):

Interpreter services	Amount of units	Percent
No	169	63,3
Yes	75	28,1
Mixed information*	23	8,6
Total	267	100,0

* Information given in the quality assessment form is different than in the basic form

Table 6 Interpreter services

Interpreter services offered in each unit divided according to the province is seen in Appendix 4, Table 6.1.

According to the filled in quality assessment form (76 units have filled in the form and the question *in which languages service is provided*, is only available in the form), in 74 units Finnish is mentioned as one service language. In Swedish service is provided in 26 units and in English in 23 units. Other languages in which service in provided are as follows:

Filled in quality assessment form (76)	Finnish	Swedish	English	Russian	Norwegian	German	Polish	Spanish
Service language	74	26	23	3	2	3	1	1

Table 7 Service languages

In which languages service is provided (according to the quality assessment form) divided by province is seen in Appendix 5, Table 7.1.

Only 180 units out of 267 reported to have treatment related material available even in Finnish. Material in Swedish is available in 41 units and in English in 34 units. Material in other languages is available as follows:

Total amount of units (267)	Finnish	Swedish	English	Norwegian	Russian	German	Polish	Spanish	Arabic	Estonian
Amount of units	180	41	34	1	7	2	1	1	1	1

Table 8 Material offered in different languages

How this is divided between provinces is seen in Appendix 5, Table 8.1.

From 267 units, only 186 reported it to be possible to participate into treatment with Finnish language. This may be an indication of Finnish language being taken for granted in the units and thus not separately mentioned. The same assumption can also explain the low amount of treatment related material offered in Finnish in the units. In Swedish it is possible to participate into treatment in 75 units and in English in 69 units. Other possible languages are seen below:

Total amount of units (267)	Finnish	Swedish	English	Norwegian	Russian	German	Somali	Arabic	Polish	Spanish	Persian	Estonian
Amount of units	186	75	69	4	10	10	3	4	4	3	2	1

Table 9 In which languages it is possible to participate into treatment

How this is divided between provinces is seen in Appendix 5, Table 9.1.

6.2 Interview Findings

From the units that took part into the interviews, one was an inpatient unit and three were outpatient units. Some of the findings are presented from this point of view. The interviewees were: (U1) substitute manager, (U2) manager, (U3) planner, (U4) manager and psychologist. In unit 3 the manager was unable to participate in the interview, so the planner answered the questions. The quotations are freely translated into English by the author, the original quotations are found in Appendices 6 and 7.

6.2.1 Non-Finnish Speaking Clients in Units

None of the units had made statistics concerning the amount of their non-Finnish speaking clients, but they all stated that it was extremely low. In two units the estimated amount of foreign clients has been less than five clients per year, and in one unit it has been approximately 5% of the whole clientele. There was no difference in the number of foreign clients between outpatient and inpatient units, nor with units that concentrate more in drug abuse and units that concentrate on alcohol abuse.

In two units it was stated that there could be seen a slight increase in the number of non-Finnish speaking clients in the recent years, both of them outpatient units, and in one unit it was stated that the number has stayed quite the same. However, in two units it was mentioned that the number of non-Finnish speaking clients varied a great deal from month to month and even from week to week so making generalisations of the situation was difficult. In one given month there can be many clients with different cultural backgrounds, when in the next there is none.

Russian, Swedish and English speaking clients were mentioned in three units. Turkey as a country of origin was mentioned in one unit, as well as clients with an African background, not separately mentioning the countries. Kurdish clients were also mentioned in one unit, and in one unit there had been clients from Somalia, Afghanistan, Kampuchea, Sudan, England and Former Yugoslavia, along with the Russian, Swedish and English speaking clients.

6.2.2 Readiness of Units to Receive and Encounter Non-Finnish Speaking Clients

Every interviewee felt the readiness, and willingness, to receive non-Finnish speaking clients being good in their unit, which was mainly explained by the ability to serve clients with several languages and providing interpreter services. However, interpreter services were not used much in any of the units. Two interviewees also reported the unit being ready to take the client's family members to take part in the appointments, which is not a general way of working in the units but can be a common manner of functioning in another culture. The Romani people were mentioned in two units to be known to have such special features in their culture which have to be taken into consideration in the practice, and one unit also mentioned the Kurdish clients in this context.

> *…the Romani people come to my mind, as they usually come together to the appointment and so and it is ok. (…) and so, because, that is not the thing anyway. The thing is that the person would get help. From somewhere. (U1)*

> *And and it is of course known that if here should come, come someone like a young Kurdish, that half of the family could come along, so we do have a negotiation room there that has space, that we are ready to take also family members along with in that…(U2)*

One interviewee also mentioned that they are willing to take the client's special diet into consideration, and have also done so in the past with one Jewish client who was given the opportunity to get kosher food on the expense of the unit.

Every interviewee also stated that the services provided for the non-Finnish speaking clients in their unit had been adequate and functional. When asked about possible problems that may have occurred when working with these clients, one interviewee mentioned following self-evident issues (agreements/rules/manners) being such, as well as racist tendency among some other clients. One interviewee mentioned linguistic problems.

> *(…)the only thing is just that such excessive making sure that have you like understood, so entirely like this kind of linguistic(…)(U1)*

> *(…) following self-evidences so that, that can have been sometimes a little difficult, for example if there is a group situation then you can not all of the sudden go and do something else or…(…) Or then such agreed (…) like such can be then that the message might not have been gone, that is, that it is really this way.(U3)*

Every unit reported to attempt to take cultural issues into consideration in the best way possible, two interviewees mentioned clients' wishes and requests concerning cultural issues being heard and acted on if the clients state them. Two interviewees from outpatient units however mentioned that in their services the cultural differences are not as visible as they could be in inpatient services (religious issues, rituals, diet etc.), as the clients just briefly visit the places.

6.2.3 Readiness and Competence of Staff with Non-Finnish Speaking Clients

None of the interviewees were familiar with the concepts *inter/cultural competence* or *intercultural communication*, but after explaining what they meant, every interviewee identified some similar working methods in their units. Two interviewees stated that admitting to the client if the culture is not so familiar and/or asking about their culture is a good way of working and may soften a situation where something has been done wrong from the client's point of view. One interviewee felt that the interpreters are also helpful in situations were the client's culture is not familiar, for a good interpreter interprets also the culture and may explain more in deep the certain ways or traditions important in that specific culture. (See Chapter 4.2.3 about interpreting) In one unit there was a worker from Irak, who was felt to be a good example of a foreign culture, and many of the workers there had also been working abroad. Discussions in the working community, having an open mind and being sensitive, reading a guide about the special features of the Romani culture, and the subtle nature of the whole substance abuse work and the variety of clients were also mentioned as having been helpful in facing people also from other cultures.

> *(…) as we have, have then indeed a nurse from Irak working here (…) s/he like in a way with his/her own being all the time reminds us about that, so it is to us in that way internalized…(U2)*

> *(…) I think there is some kind of wisdom still in that we have, should we say if Finnish clients are so different from each other that, that should I say working with people as such already qualifies then to encounter if the other now talks a bit different language so that is not necessarily…that common denominators yes, and what unites us, those surely exist. (U3)*

The similarities rather than differences being important in working with non-Finnish speaking clients in substance abuse work were stressed also in another unit:

> *(…) why should there be anything special? (…) well who has come as a refugee or like this, probably gets enough special treatment already. Like if, these are just minor things, like if one notices that is treated like anyone else so that can be a uniting experience. (…) Like, this is just that, that if them, with a foreign background are treated in the same way so, maybe that relates to them in the same way, it is for my self that way that if one must start to do something differently then it suddenly becomes something special…don't know. Maybe there are pros and cons. (U1)*

In all four units training was offered and encouraged, and the workers could choose their training very much according to their interest, but none of the units had had training concerning multicultural issues, at least the interviewees did not remember anyone taking part in such training. Two interviewees stated that in their unit there had not been activity in that area or requests for such training. Different kinds of seminars or lectures which had handled these issues were mentioned in one unit, but nothing major in that area had been provided. However, every interviewee stated that training would be possible if the workers were interested.

Two of the units had workers with different cultural background than Finnish and two did not. When asking about the language proficiency of workers, English was mentioned in all four units and Swedish in three units. Other languages that were mentioned were Russian, Deutsch and Polish (one unit), Norwegian and Arabian (one unit) and French (one unit).

6.2.4 Assessment of Quality and Developing Services

In every unit the quality of services for non-Finnish speaking clients was assessed in the same way as the quality of services for the Finnish speaking clients. This included discussions in team meetings, implementing and following successfully the care plan, having feedback questionnaires for clients or getting feedback from them through discussions. One interviewee emphasized the importance of letting the clients be a part of the assessment for they are the core of the whole functioning of the unit. This interviewee also stated that in their unit assessment was done in daily basis when interacting with the clients, not necessarily even using the term "assessment" but that it was built in the whole functioning of the unit. Two interviewees also stressed that achieving the goals and ending up to the desired outcome in the care process are

indicators of good quality. However, one interviewee felt that maybe there should be a different method used in assessing the services aimed especially for non-Finnish speaking clients and that such methods could be developed.

None of the units had any special plans for developing the services for non-Finnish speaking clients. However, one interviewee mentioned that as their aim was to get new clients, they were planning to go more into the field and spread the word about their unit (jalkautuminen), as the information, and good experiences, concerning services is very often spread via mouth-to-mouth method among the clients. That way they could possibly also reach the now missing non-Finnish speaking clients. In another unit they had a similar idea, as they continuously reflected the messages coming from the field and were prepared to develop their services according to the need. One interviewee estimated their upcoming move to new facilities offering a possibility to get more non-Finnish speaking clients. Only one interviewee clearly stated that there should be special plans for developing the services for non-Finnish speaking clients, and that the city should also be involved in the planning of these services.

6.2.5 Quality Recommendations and Quality Assessment Forms

In two units the quality recommendations for substance abuse work were seen extremely helpful in planning and organising the services, and were discussed and examined in regular basis by the staff. The recommendations were experienced as setting the limits for the work and bringing respect as well as emotional support for the work already done.

> *Well yes like, in that way they affect, that they in a way hold the bar, that that, really like, although it is self evident to us workers, that what, what like is a good quality substance abuse work, but but, that it also concretely is like that, and it is seen in people's education, it can be seen in that whoever pleases can not come here and like do this work, that that's just the way it is. (…) The quality recommendations are that they also prevent this kind of thinking, that who cares who works there, as long as there is someone present. (U1)*

> *Well yes, there was a lot of such which supported again, like strengthened what has been already done, and it is truly important that it, should I say that even from the point of working ethics, that what has been done, is supported also from the, should I say, most formal direction, in a way. (…) this has confirmed what we have already done. But this is not like, sometimes people talk about a*

> *zero-study, so this is not a zero-study to us this quality recommendation but it is truly important. That we have been in the right track. Emotional support. (U3)*

In one unit the quality recommendations were examined and used especially during the establishment of the unit. In one unit the recommendations were examined mainly during the filling in the quality assessment forms, but otherwise it was felt that they were aimed more for municipalities and their decision makers than the actual units. However, through the municipality then certain small parts of the recommendations could be seen in the unit.

> *And they go through the municipalities, so they are not like, they are not the things we have to ponder with, but of course little things come to us from there, for example how quickly one can get into our service, so that is grounded from there. (…) Like for example in this way they can be seen in here, but do not truly concern that way us than they concern the decision makers in the municipality. (U4)*

In three units the whole working community was involved in the process of filling in the quality assessment forms. The issues in the form were handled and discussed in meetings, small groups and working groups. In one unit the workers also had the opportunity to fill in certain parts in the form by themselves. The final version was put together and transferred into the database by the managers/area managers or the manager with another worker. In one unit the filling in the form was mainly the responsibility of the manager alone. Two interviewees stated that the filling in the form was a big and time consuming process. One interviewee also stated that it was nice to answer this question concerning the filling in the form as it was taken very seriously in the unit, and the interview was experienced as a feedback for the work done.

When asked about the functioning of the quality assessment form in bringing forth the language services in the units, none of the interviewees had any major improvement ideas. One interviewee however felt that the section concerning the interpreter services can be misleading as the “yes” and “no” alternatives are in a different row with the actual question, but this also was considered to be a minor defect. From the most part the form was experienced as clear, revealing the relevant and being adequate. One interviewee felt that as the amount of non-Finnish speaking clients was so small, and one interviewee felt that as the stream of clients was at the time being so strong, it would not even have been wise to go and advertise something in the form that cannot be

provided. In a nutshell, as one interviewee stated, as a compromise the quality assessment form was considered fairly good.

6.2.6 Further Findings

Already in the two first interviews a question emerged why the non-Finnish speaking clients are not seen in the units, when it is known that the problem exists also among them. After the second interview it was then decided to take the thresholds of seeking help to be one of the questions also in the following two interviews. Possible reasons offered by the interviewees for this phenomenon were cultural issues (settling possible problems inside the family instead of seeking help from authorities, or even different comprehension of what problem is), stigma, language barriers, ability to seek help, fear of eviction or being marked into some kind of a register, and getting the help needed from other services offered by the city. The statements about culture affecting the seeking of help correspond to what Tracey Powers-Erkkilä has written in her study about how Finnish alcohol culture affects the low risk immigrants' integration process. (Powers-Erkkilä, T. 2005: Moving into Finland's Drinking Culture. Published in Clarke K. 2005) She states: "Cultural differences strongly factor into the identification of problem consumption rates and an individual's inclination to seek help for excessive alcohol use. Different levels of tolerance, acceptance and social drinking standards do exist between cultures, religious traditions and historical periods, but are these differences great enough to have a serious impact on newcomers' lives here? Furthermore, does the Finnish drinking culture have a negative impact on the acculturation process and lives of immigrants?" (Powers-Erkkilä, T. 2005:197) Every respondent taking part in the interviews agreed that the thresholds immigrants might have in seeking help would be worth further studies.

7. DISCUSSION

A lot of valuable information was gained both from the quality assessment forms and basic information forms as well as from the interviews. As the aim of this research was to find out what is the readiness and competence in substance abuse treatment units in Finland to receive and encounter non-Finnish speaking clients, how is the quality of these services assessed and/or developed in the units and what has been the role and

functioning of the quality recommendations and quality assessment forms in working with non-Finnish speaking clients, the aim was reached as a lot of information answering these question was collected. In the next chapter the results of the research are viewed more in deep and in relation to the research questions.

7.1 Readiness and Competence in Substance Abuse Treatment Units to Receive and Encounter Non-Finnish Speaking Clients

When drawing conclusions about the information found in the quality assessment forms and basic information forms two things have to be borne in mind: the low amount of non-Finnish clients in the units and the fact that there were also units that have taken these issues into consideration extremely well. The low amount of language options provided in the units (see Tables 7 and 9), material in different languages (see Table 8) as well as interpreter services (see Table 6) could tell us that especially the linguistic readiness in the units to receive a variety of non-Finnish speaking clients was inadequate, but how it responded to the actual need is another thing. Unfortunately, as mentioned earlier, the number of studies concerning substance abuse among ethnic minorities is scarce, and some of the units, if not all, do not make statistics about the non-Finnish speaking clients in their unit. Thus strict generalisations from the results cannot, and will not be made. However, the low number of non-Finnish speaking clients in the units also raised the question if there was a correlation between the low amount of language services and the low amount of non-Finnish speaking clients in the units? Can it even be a threshold for the clients in seeking help? This would be in conflict with the *Act of Welfare for Substance Abusers (Päihdehuoltolaki)* (1986/41) which states in section 6 that the services should be easily attainable and versatile. The services should also be arranged in a manner in which the client can easily seek care by his/her own initiative. (Section 8). Also Maxwell's (1984) definition of quality could be worth mentioning in this context (see Chapter 2.2). If language creates a barrier for seeking help or getting into treatment, is the dimension of accessibility fulfilled? Also the dimensions of relevance to need, equity, social acceptability as well as effectiveness can be endangered if this actually is the situation. The reason why non-Finnish speaking clients are not seen in substance abuse treatment units, although it is known that these kinds of problems among them exist, is without a doubt an important issue to study in the future. Some suggestions made by the interviewees were reflected in Chapter 6.2.6.

When looking these results in the light of the quality recommendations (Chapter 3.4.1), where it is stated that: *services should be available in Finnish and in Swedish and also in other languages when needed. Special attention should be paid in the mother tongue of the client, his/her cultural background and prerequisite for using the services.* (Quality recommendations for substance abuse work/Päihdepalvelujen laatusuositukset 2002:16), the inadequacy of language services in substance abuse treatment units becomes clearer. Also, when the *Non-discrimination Act (Yhdenvertaisuuslaki)* (21/2004) prohibits discrimination based on language, among other things, we can think if inadequate language services fit under the concept of discrimination. *The Act on the Status and Rights of Social Welfare Clients (Laki asiakkaan asemasta ja oikeuksista)* (2000/812) again states in section 2, 4§ that the client is entitled to receive high quality social services without discrimination. His/her privacy and beliefs should not be insulted. Client's wishes, opinions, welfare, individual needs, cultural background and mother tongue must be taken into account. If the staff does not understand the language of the client, interpreter services must be provided. The stated low amount of interpreter services provided in the units contradicts with this law.

As the number of the units that took part in the interviews was small, comprehensive conclusions cannot be drawn from the results. However, they provide valuable information on how the situation was seen and acted on in the units. The readiness to receive non-Finnish clients was felt to be good in every unit taking part in the interviews, which, as mentioned earlier, was mainly explained through providing language services. The services were also considered to be adequate and functional. Cultural competence of the workers was also perceived to be adequate, although in none of the units training concerning cultural issues was made use of it however being offered if needed. The terms intercultural competence and intercultural communication were not familiar in any of the units although similar working methods were identified. There was no need, or plans, to develop these services, which can also be explained by the low amount of non-Finnish speaking clients in the units.

Ting-Toomey wrote about the components of mindful intercultural communication (Chapter 4.3.5.2), and especially the component of motivational factors could be seen in all the units. "The motivations in intercultural communication competence refer to our readiness to learn about and interact with people who are different." (Ting-Toomey, S. 1999:52) In every unit there was a genuine effort to learn and take cultural issues into

consideration and respond to the needs and wishes accordingly. Also some of the skill factors (mindful observation, mindful listening, verbal empathy and flexible adaptive skills) could be seen in the units, as empathy, asking and listening, approaching the client sensitively, as well as observing were mentioned important in working with non-Finnish speaking clients. (More about the importance of empathy in intercultural encounters in Chapter 4.3.6.1). To some degree the knowledge factors were also present in the units, as the competence was felt to be acquired also from other things than training, such as team discussions, having a worker with different cultural background, reading manuals, asking the clients and through experience. Also learning by doing and making mistakes was mentioned to be a good teacher. Knowledge factors refer to "the process of in-depth understanding of certain phenomena via a range of information gained through conscious learning and personal experiences and observations." (Ting-Toomey, S. 1999:50)

However, also stumbling blocks, presented by LaRay M. Barna (1998) (Chapter 4.3.6.2) could be seen present in working with non-Finnish speaking clients. Language differences were mentioned to create problems. Also, to some extent, the assumption of similarities could be seen, as two respondents felt that concentrating more on similarities rather than differences was important in working with this clientele.

As one definition of cultural competence is that it is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross et al.., 1989; Isaacs & Benjamin, 1991 cited in King et al..), the scarce concentration on these issues in the units revealed that cultural competence was not yet fully developed. Also, as cultural competence can be understood as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997 referring to health outcomes cited in King et al..), the fact that there was no coherent and constant guidelines or policies, or even plans to develop these, in working with non-Finnish speaking clients in the units show that in order to develop cultural competence, these issues should be taken more into account not only in the units, but also in the municipalities. According to King et al., there are five elements that contribute to the system of being culturally competent: "The system should (1) value

diversity, (2) have the capacity for cultural self–assessment, (3) be conscious of the "dynamics" inherent when cultures interact, (4) institutionalize cultural knowledge, and (5) develop adaptations to service delivery reflecting an understanding of diversity between and within cultures. Further, these five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies, and services." (King et al..) This also contributes to the fact that these issues should be acknowledged and developed more in every level of the service delivery system. (See Chapter 4.1 Cultural and linguistic competence) The interviews indicated, that the knowledge, although apparently good knowledge, about these issues was gained from multiple, and many times scattered instances. There was no unified working policy, nor guide or training how to handle these issues. This defect is evidently worth repairing, especially in the substance abuse care where the amount of non-Finnish speaking clients is estimated to grow.

7.2 Assessing and/or Developing the Quality of Services in Units

In every unit taking part in the interviews the quality of services for non-Finnish speaking clients was assessed in the same way as the quality of services for the Finnish-speaking clients. The internal assessment of quality was carried out very well in all four units (see Chapter 6.2.4), but as chapters 4.2 and 4.3 of this study show, in working with non-Finnish speaking clients there are special characteristics present which have to be taken into account. In addition to the issues common to all the clients and issues characteristic to each client individually, also issues concerning language and culture differences should be taken into account when working with non-Finnish speaking clients. Naturally, in evaluating services aimed for this clientele and in order to develop them if needed, special attention should be paid into these issues. However, in this context the Aura-Aypa project which concentrated on Russian immigrants (Chapter 3.5.1) must be mentioned, as its aims were to find out how to lower the thresholds for Russian immigrants with substance abuse problem of seeking help and develop multicultural and ethnic sensitive working methods. (See www.a-klinikkasaatio.fi – hanketietokanta)

There were no special future plans in developing these services as such, although general developing plans had been made in the units which could also involve non-

Finnish speaking clients (see Chapter 6.2.4). The plans mainly concentrated on the acquiring of new clients, not necessarily developing the services already in use.

7.3 Role and Functioning of Quality Recommendations and Quality Assessment Forms

Quality recommendations were considered to be an important general guideline for the work, especially in setting a bar for what can be considered a good quality in substance abuse work and what is demanded from the work in order to fulfil these criteria. The quality recommendations were also perceived important in giving mental support and justifying the working methods already in use. The recommendations were also studied and discussed in the units in regular bases, although in one unit they were perceived to be aimed more for the decision makers in the municipality than the actual units. However, also in this unit they were used, especially during the filling process of the quality assessment form. In one unit the recommendations were mainly examined more in deep during the establishing process of the unit. A conclusion can be drawn from these statements that the quality recommendations were experienced as a valuable tool to be used also in the units in developing and assessing the functioning of their services. (See Chapter 3.4.1 about the quality recommendations).

The process of filling in the quality assessment forms was multifaceted in three units. The contents of the form were discussed in team meetings among the whole working community and also the workers had the opportunity to fill in segments of the form by themselves. The final draft was checked and transferred into the database maintained by Stakes usually by the manager, area manager or manager with another worker. Only in one unit the filling in process was mainly the responsibility of the manager only. A lot of effort was also put into the filling in the form, and one respondent even stated to be pleased that someone is interested in the filling in process of the form, as it was taken extremely serious in the unit. The whole filling in process was also considered to be highly demanding and time-consuming in two units. Every unit considered the quality assessment form to be adequate and none had any major improvement ideas concerning the appearance of the form (see Chapter 6.2.5).

As the purpose of the filling in the form, which takes place once a year, is also to reflect these issues among the whole working community, and that way possibly evoke new ideas or developmental areas in the workplace, it was delightful to see how many units

actually utilised the form in that way. Including the whole working community into the filling in process may also be a step towards better quality in the units, as everyone is a part of the assessment process and thus a part of the development of quality.

8. CONCLUSION

As the results show, there is still room for developing the services for non-Finnish speaking clients, but there can also be seen a genuine interest, readiness and willingness to work with this clientele in the units. What seemed to be missing was a unified working tool and information on how to encounter this clientele. This opportunity should not be missed. A suggestion is that working tool/guide/training concerning ethnic issues could be developed to reach all the substance abuse treatment units in Finland. In addition to the general information concerning ethnic issues and intercultural communication, this guide/training should specifically concentrate on these issues in connection to substance abuse among immigrants. The making of such guide could be a great opportunity for someone making his/her final project/thesis in the near future.

More attention should be paid also to linguistic issues, that is, provide treatment in several languages either through linguistic competence of the staff or through providing interpreter services. Working with interpreters also requires appropriate training and/or knowledge how to work in such situation where interpreting is needed. There should also be more material available in different languages in the treatment units. This could also include the information provided in the internet.

Also the low amount of studies concerning substance abuse among immigrants raises a lot of questions. When making the research, several sources were found, originated even from the 1990's, where substance abuse among immigrants was considered to be a problem, but still today adequate research is missing concerning this issue. Are we facing here the assumption of similarities, the Golden Rule or a fear of stigmatisation? What ever the reason should be, in order to help this clientele properly and with high quality, this issue has to be fully acknowledged in the service system as well as in our whole society. In order to do this, appropriate studies have to be made. Also, in addition to the studies and statistics hopefully made concerning the need of services among this

clientele, the units should also make statistics concerning the amount on non-Finnish speaking clients in the units in order to answer to their needs in appropriate way.

In addition to the mentioned above, as the question of the low amount of non-Finnish speaking clients seen in the units emerged without asking already in the two first interviews and only hypotheses were made why the situation is such, this issue would be worth studying in the future. What are the actual thresholds that prohibit non-Finnish speaking clients in seeking or getting help? Could language be perceived to be one of these thresholds? Answers to these questions are waiting to be answered.

Unified assessment criteria which would take cultural and linguistic issues into consideration should also be developed in substance abuse work, or include cultural/linguistic issues to be a part of the assessment tools presently used. In assessing services in the light of cultural issues, developmental procedures are enabled, needs are better met, and thus quality of these services improved. It could also be beneficial for the workers to know what the possible stumbling blocks are when working with this clientele, what issues should be taken into consideration in assessing the working methods and what the service should be in order to be appropriate and effective. But, in order to do this, information should be provided to people working in substance abuse care field as well as to social and health care/substance abuse care students about these issues. In order to assess something, it has to be clear what is being assessed, why it is being assessed, and what the ideal situation where the assessment is aiming for should be. As the amount of non-Finnish speaking clients in substance abuse treatment units is estimated, and even hoped, to grow, this issue is worth considering.

As the quality recommendations for substance abuse work as well as the quality assessment forms were found highly beneficial in the developing of services in the units that took part into the interviews, it can be recommended that all substance abuse treatment units in Finland would take the recommendations to be part of the functioning in the units and, more importantly, fill in the quality assessment forms. As linguistic and cultural issues are separately mentioned in both of these, the awareness concerning the importance of these issues could increase.

All of these suggestions aim for improving the situation not only from the point of view of the non-Finnish speaking clients but from the point of view of the workers as well. In

fact, cultural awareness, intercultural communication competence and ethnic sensitivity benefit everybody in our multicultural society today.

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APPENDIX 1

Questions for the interviews

Non-Finnish speaking clients in the units

1. What has been the amount of non-Finnish speaking clients in your unit and how has this amount developed in recent years?
2. The profile of the clients (country of origin, language, religion)

The readiness of the units to receive and encounter non-Finnish speaking clients

3. What is the readiness of your unit to receive foreign clients?
4. How are ethnic minorities taken/ready to take into consideration in your unit? (language, rituals, diet)
5. What has been the functioning and sufficiency of these services?

Staff's readiness and competence of working with non-Finnish speaking clients

6. Are the concepts inter/cultural competence and intercultural communication familiar terms in your unit?
7. How is the ability of workers to face clients with different cultural background (cultural competence, intercultural communication competence) assessed and developed if needed in your unit?
8. Are the any workers with different cultural background than Finnish?
9. The ability of worker's to serve clients with other languages than Finnish?

Assessment of quality and developing services

10. How is the quality of services for ethnic minorities assessed in your unit?
11. Are there any future plans for improving these services? If so, what kind?

Quality recommendations and quality assessment forms

12. How have the quality recommendations for substance abuse treatment units affected the functioning of your unit?
13. How and by whom was the quality assessment form filled in your unit?
14. Has the quality assessment form been appropriate and adequate in measuring your unit's services for non-Finnish speaking clients?

APPENDIX 2

Haastattelukysymykset

Ei suomenkieliset asiakkaat yksiköissä

1. Mikä on ollut ei-suomenkielisten asiakkaiden määrä yksikössänne ja miten tämä määrä on kehittynyt viime vuosina?
2. Asiakkaiden profiili (kansallisuus, uskonto, kieli)

Yksiköiden valmius vastaanottaa ja kohdata ei-suomenkielisiä asiakkaita

3. Mikä on yksikkönne valmius vastaanottaa ei-suomenkielisiä asiakkaita?
4. Miten etniset vähemmistöt otetaan/ollaan valmiita ottamaan yksikössänne huomioon? (kieli, mahdollisuus suorittaa kulttuuriin/uskontoon liittyviä rituaaleja, uskontoon/kulttuuriin liittyvät ruokailutottumukset)
5. Mikä on ollut näiden palvelujen riittävyys/toimivuus?

Henkilökunnan valmius ja kompetenssi työskennellä ei-suomenkielisten asiakkaiden kanssa

6. Ovatko käsitteet inter/kulttuurinen kompetenssi (inter/cultural competence) ja interkulttuurinen kommunikointi (intercultural communication) tuttuja yksikössänne?
7. Miten työntekijöiden osaamista kohdata muun kulttuuritaustan omaavia asiakkaita (kulttuurista osaamista ja interkulttuurista kommunikointikykyä) arvioidaan, pidetään yllä ja tarvittaessa kehitetään yksikössänne?
8. Työskenteleekö yksikössänne eri kulttuuritaustan omaavia henkilöitä?
9. Työntekijöiden valmius palvella muulla kuin suomen kielellä? (lukumäärä, kielet)

Laadun arviointi ja toiminnan kehittäminen

10. Miten yksikössänne arvioidaan ei-suomenkielisille suunnattujen palvelujen laatua?
11. Onko tehty tulevaisuuden suunnitelmia näiden palvelujen kehittämiseksi? Jos, minkälaisia?

Laatusuositukset ja laatuarviolomake

12. Miten päihdehuollon laatusuositukset ovat vaikuttaneet yksikkönne toimintaan?
13. Miten ja kenen toimesta päihdepalvelujen laatuarviolomake täytettiin yksikössänne? Prosessi?
14. Onko laatuarviolomake mielestänne ollut tarkoituksenmukainen ja riittävä tuomaan julki erikoisosaamistanne tällä alueella?

Table 4.1 Number of units according to province

Province	Amount of units	Percent
Southern Finland	108	40,4
Western Finland	90	33,7
Eastern Finland	36	13,5
Oulu	23	8,6
Lapland	8	3,0
Åland	2	,7
Total	267	100,0

Table 4.2 Type of treatment and province

Province	Type of treatment		Total
	Outpatient services	Intensive/ institutional services	
Southern Finland	57	51	108
Western Finland	50	40	90
Eastern Finland	16	20	36
Oulu	15	8	23
Lapland	5	3	8
Åland	2	0	2
Total	145	122	267

Table 5.1 Type of treatment and filled quality assessment form

Type of treatment	Filled quality assessment form			Total
	Yes	No	Yes, but not available	
Outpatient services	34	110	1	145
Intensive/residential services	42	75	5	122
Total	76	185	6	267

Table 5.2 Filled quality assessment form according to province

Province	Filled quality assessment form			Total
	Yes	No	Yes, but not available*	
Southern Finland	25	77	6	108
Western Finland	26	64	0	90
Eastern Finland	15	21	0	36
Oulu	8	15	0	23
Lapland	2	6	0	8
Åland	0	2	0	2
Total	76	185	6	267

* Quality assessment form could not be opened in the database

Table 6.1 Interpreter services according to province

Province	Interpreter services	Frequency	Percent
Southern Finland	No	64	59,3
	Yes	34	31,5
	Mixed information*	10	9,3
	Total	108	100,0
Western Finland	No	63	70,0
	Yes	21	23,3
	Mixed information*	6	6,7
	Total	90	100,0
Eastern Finland	No	20	55,6
	Yes	12	33,3
	Mixed information*	4	11,1
	Total	36	100,0
Oulu	No	14	60,9
	Yes	7	30,4
	Mixed information*	2	8,7
	Total	23	100,0
Lapland	No	6	75,0
	Yes	1	12,5
	Mixed information*	1	12,5
	Total	8	100,0
Åland	No	2	100,0

* Information given in the quality assessment form is different than in the basic form

Table 7.1 Languages in which service is provided (according to the quality assessment forms) divided regionally

Province/ (filled form)	**Finnish**	**Swedish**	**English**	**Russia**	**Norwegian**	**German**	**Polish**	**Spanish**
Southern Finland (25)	23	7	9	2	0	0	1	0
Western Finland (26)	26	12	7	0	2	1	0	0
Eastern Finland (15)	15	4	4	0	0	1	0	0
Oulu (8)	8	3	3	1	0	1	0	1
Lapland (2)	2	0	0	0	0	0	0	0
Åland (0)	0	0	0	0	0	0	0	0

Table 8.1 Material languages according to province

Province/ (total)	**Finnish**	**Swedish**	**English**	**Norwegian**	**Russia**	**German**	**Polish**	**Spanish**	**Arabic**	**Estonian**
Southern Finland (108)	72	20	16	0	6	2	1	0	0	1
Western Finland (90)	55	16	11	1	0	0	0	0	1	0
Eastern Finland (36)	32	3	4	0	0	0	0	0	0	0
Oulu (23)	17	2	2	0	1	0	0	1	0	0
Lapland (8)	4	0	1	0	0	0	0	0	0	0
Åland (2)	0	0	0	0	0	0	0	0	0	0

Table 9.1 Languages in which one is able to participate into treatment divided by province

Province/ (total)	**Finnish**	**Swedish**	**English**	**Norwegian**	**Russia**	**German**	**Somali**	**Arabic**	**Polish**	**Spanish**	**Persian**	**Estonian**
Southern Finland (108)	76	35	30	3	7	4	3	3	4	2	1	1
Western Finland (90)	56	25	20	1	2	3	0	1	0	0	0	0
Eastern Finland (36)	32	7	11	0	0	2	0	0	0	0	0	0
Oulu (23)	18	8	7	0	1	1	0	0	0	1	0	0
Lapland (8)	4	0	1	0	0	0	0	0	0	0	1	0
Åland (2)	0	0	0	0	0	0	0	0	0	0	0	0

8.2.2 The readiness of the units to receive and encounter non-Finnish speaking clients

(…)tulee just niinku romanei mieleen et et hehän tulee niinku yhdessä vastaanotolle ja ja näin ja se on ihan ok. (…) ja näin, koska, ei se oo se juttu kuitenkaa. Vaan juttu on niinku se et ihminen sais apua. Jotain kautta. (U1)

Ja ja tiedetään tietysti että jos tänne nyt tulisi, tulisi joku sitte semmonen nuori kurdi, ni sieltä vois tulla sitten puoli sukua mukana, että kyllä meillä tossa sitten on neuvotteluhuone johon mahtuu että, että ollaan valmiit ottaa siis myös perheenjäsenet tossa kyllä mukaan(…) (U2)

(…)ainut totani just se et semmonen ylenpalttinen varmistaminen et oletko ymmärtäny niinku, siis ihan tämmöne kielellinen(…)(U1)

(…) itsestäänselvyyksien ni noudattaminen ni se, se on voinu olla joskus vähä vaikeeta että esimerkiksi jos on ryhmätilanne ni siitä ei niinku ei yhtäkkiä jos siltä tuntuu ni lähetä johonki muihi asioihi tai… (…) Tai sitte semmoset sovitut (…) tämmönen saattaa olla sitte et se ei oo ehkä menny se viesti välttämättä et on, että tuota se on oikeesti näin.(U3)

8.2.3 Staff's readiness and competence of working with non-Finnish speaking clients

(…) meillä kun on, on sitten sitten tosiaan Irakista syntysin oleva sairaanhoitaja töissä (…) hän meitä, meitä niinku tavallaan sillä omalla olemassaolollaan koko ajan muistuttaa siitä, siitä jo että, että kyl se meillä sillai on sisäistyny(…)(U2)

(…) musta siinä on jonkunlaista viisautta kumminki et meil on, siis sanotaanko että jos suomekieliset asiakkaat on keskenään niin erilaisia että, että sanosinko että ihmistyö sinänsä jo pätevöittää sitten kohtaamaan jos toinen nyt puhuu vähän eri kieltä ni se ei välttämättä oo…et niitä yhteisiä nimittäjiä kyllä, ja mikä meiät yhdistää sitä varmasti on. (U3)

(…) miks pitäis olla erityistä? Jos puhutaan niinku et et tasavertasuutta ja ja ettei niinkun ois jotain, et heist tehtäis erityisempiä. (…)no vaikka ketä on niinkun tullu pakolaisena tai tai näin niin, varmaan saa sitä erityist kohtelua niinku ihan riittävästi. Et et, sit jos nää on ihan pieniä asioita, et et huomaa et kohdellaan ihan samanlaisena ku ketä tahansa muuta ni se voi olla taas vähän sellanen eheyttävämpi…juttu. (…) Niinku et just tätä, et et et jos he, sit näit meiän ulkomaalastaustasii ihan samalla tavalla kohtelee ni, ehkä se et et suhtautuu ihan samalla tavalla se on itelle nii et jos pitää alkaa tekee jotain erillistä ni sillonhan siihen helposti niinku sit tulee jotain erityisyyttä yhtäkkiä…en tiiä. Varmaan puolensa ja puolensa. (U1)

No kyllä sillee niinku, sillätavallahan ne vaikuttaa, et ne tavallaan pitää niinku sitä rimaa, et et, et oikeesti niinku, vaik se on kyl meille työntekijöille ihan selvää, et et mitä, mitä niinku on laadukas päihdetyö, mutta mutta, et se on myös konkreettisesti niin, ja se näkyy niinku ihmisten koulutuksessa, se näkyy siin että et kuka tahansa ei voi tulla tähän ja alkaa tekee niinku tätä työtä, et se vaan on niin. (…) Et ne laatusuositukset on et estää myöskin tämmösen ajattelun, että et mitä välii ketä siellä on kuhan joku on paikalla. (U1)

No joo, täällä oli paljon semmosta mikä tuki taas, siis vahvisti sitä mitä oli jo tehty, ja se on oikeesti tärkeetä että se, että sanosinko että työmoraalinki kannalta että se mitä on tehty, tehty ni saa saa saa tukea myös myös sitten sanosinko virallisimmalta mahdolliselta taholta, tietyssä mielessä. (…) tää on vah-vahvistanut sitä mitä me on tehty. Mut, mut ei tää oo niinku, joskus puhutaan nollatutkimuksesta, ni ei tää meille nollatutkimus oo tää laatusuositus vaan se on oikeesti niinku tärkeä. Et oikeilla jäljillä ollaa oltu. Et ainaki se et on hyväksyttävää tehdä asiat näin. Henkistä tukea. (U3)

Ja ne menee kuntien kautta, ne ei oo niinku, ne ei oo niit asioita joita me joudutaa hirveesti pohtii, mut totta kai sieltä tulee meille hyvin paljon semmosia pieniä osioita esimerkiks kuinka nopeesti teille pääsee, ni ni se pohjaa kyllä sinne. (…) Ni et et esimerkiks tällä tavalla ne saattaa näkyy meillä, mut ei varsinaisesti kosketa sillätapaa meitä kun ne koskettaa kuntien päättäjiä. (U4)