Operating between recovery and desistance

Researching substance use treatment in Norwegian prisons

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Introduction

In recent decades, policymakers within the Nordic countries and elsewhere have been increasingly called upon to address a wide variety of public health and social issues resulting from substance use (hereby referring to harmful use of both licit and illicit drugs, including alcohol), in the face of the ongoing global drugs crisis. Criminalisation and subsequent penalties for illicit substance use have also been called into question. Recent public discourse around substance use in Norway has largely been concerned with debating the potential merits and consequences of decriminalisation of controlled substances, or alternative methods of liberalising drug legislation. From an international perspective, moves towards drug law reform have arisen out of a growing body of evidence supporting harm reduction initiatives, and a wider recognition of the problems associated with traditionally punitive reactions such as imprisonment. This essay will discuss specifically prison-based substance use disorder (hereafter SUD) treatment in Norway, in the wider context of the discourse around the criminalisation of substance use. The increasing trend towards harm reduction and 'evidence-based' drug policy frameworks reflects also greater historical and political discourses about health, human rights, and the responsibilities and limitations of criminal justice systems, as well as shifts in societal attitudes towards controlled substances and people who use them.

1. Merging medical and penal spheres

Scholars have identified two traditionally dominant and competing discourses operating within Norwegian drug policy: a health or "harm reduction" discourse, versus a moral and abstinence-oriented, penal discourse (Olsen, 2019, Skretting, 2014). While not novel, these perspectives have become increasingly prominent during the gradual move towards harm reduction after the opioid crisis of the 1980s (Olsen, 2019, Skretting, 2014). This conflict

can be seen as rooted in a long history of traditionally restrictive drug policy and diverging societal attitudes towards substance use and substance users in Norway. Christie and Bruun (2003) have pointed to the country's prohibition on the sale of alcohol in the early twentieth century as a move heavily informed by US-style teetotalism, which would again influence the drug policy of the coming decades. The arrival of cannabis amidst countercultural influence from abroad during the sixties, coupled with increasing amphetamine use in neighbouring Sweden, have been identified as contributing factors to the merge of these two previously disparate discourses (Skretting, 1991; Tallaksen, 2017). The seventies and eighties' rhetoric of repression and zero-tolerance strategies, influenced by the global 'war on drugs', was seen expressed in increased sentence length, an increase in imprisonments for substance-related offences and an expansion of police powers. The latter resulted in 'crackdowns' on street use before the turn towards harm reduction, increased focus on treatment and 'medicalisation' of substance use against the backdrop of the opioid and AIDS crises of the eighties (Skretting, 1991, Tallaksen, 2017, Olsen, 2019). Both this historical backdrop and the charged political climate around punishment and treatment of substance use in Norway today reflect that this merge overall has not been a harmonious consolidation of differing perspectives resulting in a unified approach, but rather a conflict of ideologies resulting in a complex working relationship.

This conflict is evident in the ongoing debate in Norway around potential drug law reform (*rusreform*), which was one of the dominant political issues during the 2021 parliamentary election. As stated previously, the movement towards harm reduction is partly characterised by the increased medicalisation of substance use. Within this context, illicit substance use represents illness requiring treatment, with the potential for recovery, as from a "disease perspective", rather than a break with social norms and a danger to public health, necessitating tough penalties, as from a traditional penal perspective (Skretting, 2014).

2. Substance use disorders: Nordic and international contexts

SUDs have a substantial social and public health cost, and are a major contributor to the worldwide burden of disease. Longitudinal research also shows that rates of overdose deaths within the Nordic countries are reliably among the highest in Europe (Simonsen et al., 2020). In Norway specifically, SUDs are among the three most common mental health disorders among adults, with SUDs and mental illness more generally ranking second for all non-fatal declines in health. Despite relatively robust welfare systems in Norway, as in other Nordic countries, remarkably few individuals with SUDs and related health issues are in regular contact with the Norwegian health service (Reneflot et al., 2018). Although the Nordic nations are often regarded as politically alike,

control of illicit substance use between the countries varies greatly. Moeller (2019) demonstrates that Norway and Sweden have consistently been more restrictive in both drug policy and practice (i.e. seizures and arrests) than their Nordic neighbours. In addition, Norway currently holds the overall position of having the highest control intensity of illicit substances, given that rates of drug seizures among the proportionally larger Swedish population have in fact decreased (Moeller, 2019). Although concepts like 'recovery' and 'harm reduction' have become more commonplace in Norwegian policy documents since the nineties, concrete harm reduction initiatives in the community, such as safe injecting rooms and the introduction of opioid maintenance therapy, have in turn met with considerable opposition before their eventual adoption (Skjælaaen, 2019, Olsen, 2019).

Ultimately, both internationally and in Norway, the burden of disease resulting from substance use weighs heaviest among society's most disadvantaged, including people currently and formerly imprisoned. People who have been incarcerated are far more likely to have a background of harmful substance use, which for many will be also related to their history of offending. Moreover, individuals either waiting to be or whom have been incarcerated are far more likely to experience extensive socioeconomic disadvantage and precarious life circumstances than the majority population (Bukten, 2016). It is important to separate causality from association here: using substances does in no way guarantee that an individual will be incarcerated, and many people who enter the prison system never experience substance use problems. However, incarceration, substance use, social and economic marginalisation and overall poorer physical and mental health are all shown to be associated with each other to a greater or lesser degree (Revold, 2014). The complex and often symbiotic relationship of these issues, in addition to the weight of stigma and discrimination faced by individuals experiencing one or more of these issues simultaneously, makes addressing these problems a complex and sensitive issue for criminal justice systems, healthcare providers and communities.

3. Substance use treatment within the context of prison: drug recovery wards

Nordic penal systems have often been regarded as "exceptional", this is attributed partly to more "humane" and overall less punitive prison conditions and (relatively) lower rates of imprisonment across the region (Smith & Ugelvik, 2017). This "humane" focus is partly reflected in what Hammerlin (2021, p. 22) describes as the "three pillars" of security, rehabilitation and care that make up the ideological foundation of the Norwegian correctional system. According to this model, the two central perspectives are that of, firstly, discipline, control and protection of society, and secondly, rehabilitation and treatment, concerned with minimising the harms of imprisonment, promoting desistance, and

enabling recovery from SUDs and/or other problems. The conflicting political discourses around specifically substance use, discussed earlier in this paper, are clearly reflected within this model. Criminal justice actors are tasked with the responsibility of attempting to reconcile these objectives – to uphold both the 'retributive' and 'disciplinary' ideal, minimise harms and promote rehabilitation simultaneously. This calls into question how such actors should operate ideologically when it comes to the issue of substance use as both crime and illness within the context of prison, and how to navigate competing retributive and rehabilitative foci, if this is in fact possible.

Kolind et al. (2013) describe how modes of substance use treatment have steadily been integrated into prisons across the Nordic region since the turn of the millennium, including, among other methods, methods for managing withdrawal symptoms, opioid agonist therapy and specialised "drug recovery wards" (hereafter DRWs). Ideally, the positive outcomes of these types of measures would be an improvement on immediate health and overall life quality of people with SUDs in prison, such as by minimising harms of withdrawal and reducing the risk of relapse or overdose. Long-term, these types of initiatives may have several potential positive effects from a community health perspective, in terms of improving overall health outcomes for individuals transitioning back into society. The Norwegian prison system has incorporated several forms of SUD treatment, including (as of 2021) thirteen specialised DRWS (Tyrilistiftelsen, 2020). Under the Norwegian system, health services are "imported" from the municipal health sector. The idea behind this is to provide access to healthcare in prison which is equivalent to that available to the rest of the community. Despite progress made with the establishment of DRWs in selected prisons, prior studies suggest that providing adequate, or equivalent, healthcare and treatment for SUDs in prison is challenging in practice (Tyrilistiftelsen, 2020). Some of the most common obstacles to in-prison SUD treatment are limited resources earmarked for SUD initiatives, few staff with adequate competence on SUDs in relation to the size of the population, communication issues between health services and between the health services and prisons themselves, and a lack of suitable premises (Tyrilistiftelsen, 2020). The latter concern is particularly visible in older facilities such as Oslo prison, which amongst its towering stone blocks houses prisoners held on remand awaiting trial together with others serving sentences of various lengths, on the same grounds as a dedicated DRW. While the presence of dedicated DRWs in thirteen prisons points towards the influence of the aforementioned "care" and "rehabilitative" ideologies within a typically security-focused environment, a key issue is that the numbers of people in prison with SUDs far outweigh the capacity and resources currently available. In previous self-report studies on experiences with 'in-house' SUD treatment measures, people in prison who reported that they had not received adequate help for their SUD were also more likely to be repeat offenders, and self-reported high rates of substance use prior to entering prison (Revold, 2014). The substantial remainder of the

prisoner population who have a SUD but whom for various reasons, do not meet the criteria for completing part of their sentence at one of the thirteen DRWs, would seem to have reasonably limited options left over (Tyrilistiftelsen, 2020). There is a need for critical examination of these 'leftover' routes of treatment, and where they lead for the large proportion of the Norwegian prison population who have a substance use disorder, but do not serve part of their sentence on a DRW.

4. Prison-based treatment: implications for recovery and desistance

There is a clear need to examine how SUD treatment measures such as the ones described in this paper are implemented and integrated into, and thus also shaped by, the context of prison. Qualitative data is needed to explore how these measures actually function in practice, i.e. beyond policies and white papers, and how they are experienced by those they are designed for: both people in prison who have SUDs, and those involved in implementing said strategies, such as prison officers and healthcare personnel. In this way, one can analyse the phenomenon of in-prison SUD treatment by seeking to articulate the norms, mechanisms and processes associated with different treatment initiatives. Secondly, there is a need to investigate the implications in-prison SUD treatment has on recovery, release and life after imprisonment, and engage critically from a criminological perspective with what successful recovery and desistance may actually look like in the reality of former prisoners' lives. Looking beyond to the broader socio-political context discussed elsewhere in this essay, it is important to identify both 'obstacles' and 'opportunities' that arise in within the context of in-prison drug treatment, and their subsequent effect on both recovery from SUDs, desistance from crime and transitioning back into the community post-release.

The context of prison and the structured framework of a prison sentence present, theoretically, both 'obstacles' and 'opportunities' for recovery and desistance. Other scholars have already highlighted the potential for operationalising the prison environment and demonstrated how for some individuals, new habits and routines may be more effectively formed in prison than otherwise (Bukten and Lobmaier, 2013). A caveat, however: lifestyle changes established in prison may not exclusively be health-promoting (Bukten and Lobmaier, 2013, Muller et al., 2018). Prisons are not naturally positive environments in themselves. It has been demonstrated that both conditions associated with imprisonment, the physical environment within prisons, and social isolation and stigma associated with incarceration can both cause and exacerbate somatic and psychiatric illness (Martin et al., 2020). It is evident that prison can be a negative turning point for many people's lives, where existing problems are exacerbated, or new ones are created. In Norway, many

individuals begin using substances for the first time in prison, or find that an existing SUD worsens (Revold, 2014). One can also ask the question as to whether recovery under such circumstances is realistic, and to what extent specialised medical treatment actually belongs, or can be effective in, in this context.

However, on the side of 'opportunity', entering prison may represent in a break with substance use in a practical sense, whether this is actually the desired outcome or not, and provide room for reflection. Crewe and Levins (2020) have explored the potential of prisons to be "reinventive" and a positive, rather than destructive, turning point in certain cases. One potential hypothesis worth exploring is that for people with SUDs in prison, the structured existence and somewhat predictability that is an inevitable part of a prison sentence can provide a window of opportunity for recovery, which for some individuals was not available prior to imprisonment. This window may have been unavailable due to unstable life circumstances, lack of regular contact with health services or other reasons, or it simply may not have been the 'right' time. We should not overlook the fact that individual motivations and reasons for why someone uses substances at certain times play a major role, and not assume that recovery, and indeed, a drug-free existence is right, or possible at all times. This is a topic beyond the scope of this essay, but has been discussed by others such as Skjælaaen (2019, pp. 154-164.

5. Potential drug law reform and practical solutions: evidence of a paradigm shift?

The societal and public health impact of substance use and addiction is plainly apparent. Increasing criticism of the 'war on drugs' and zero-tolerance approaches and sobering statistics on substance use and overdose has in part forced nations to critically reassess how people who use illicit substances are treated, not only in a clinical sense, but in the wider socio-political sphere. The ongoing debate about exactly where and how substance use should be addressed – under the authority of the healthcare system or the criminal justice system – reflects that in Norway, a "time of breakthrough" is imminent, as Skjælaaen (2019, p. 129) puts it. The Norwegian government appears to be at a crossroads as to deciding the future of drug policy.

As of today, the outcome of the debate around decriminalisation in Norway is as yet unclear, as are the potential effects of liberalisation of drug policy on the criminal justice system. The most significant results of a potential reform in Norwegian controlled substance legislation, may not be strongly felt amongst the prison population, given that the types of lesser offences primarily involved in the suggested reforms (possession and personal use) are already often met with non-custodial reactions. Decriminalisation is neither a particularly novel discussion, nor a purely Eurocentric issue. Some countries, both Nordic and

elsewhere, have had progressively liberal policies in place since the early 1970s, whereas in other parts of the world substance use is still grounds for capital punishment (Greenwald, 2009). Enacting drug decriminalisation requires reassessment of typically longstanding policies that are rooted in cultural and historical contexts of their own, and not least demands the recognition of not only the ubiquity of substance use despite punitive efforts, but also the inefficacy of the latter in the face of considerable social costs. Development of new international and state-level drug policy frameworks reflect ongoing discourses around health, human rights and the simultaneous responsibilities and limitations of criminal justice systems. Meanwhile, the debate around substance use and substance users is often tinged with appeals to social justice, emotion, and moralistic overtones, together with sobering rates of mortality, illness and crime. It is clear that this debate and existing ideological conflicts will not find an easy resolution in Norway. The potential, however, for increasing the quality of life of individuals with SUDs both in and out of prison by researching newer methods of SUD treatment and harm reduction within the context of prison, looks promising. The questions raised through researching SUD treatment methods within penal systems are relevant for both criminologists and drug researchers, and will hopefully provide new insights that can have both theoretical and practice relevance, not least providing an important scientific contribution to the current political and social discourse around substance use.

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