



## Research paper

## The paradox of control: An ethnographic analysis of opiate maintenance treatment in a Norwegian prison

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## ABSTRACT

**Background:** Opiate maintenance treatment (OMT) is increasingly being offered in prisons throughout Europe. The benefits of OMT in prison have been found to be similar to those produced by OMT in community settings. However, prison-based OMT has been a controversial issue because of fear of the diversion of OMT medications and the development of black markets for prescription drugs such as buprenorphine and methadone. Prison-based OMT thus involves a delicate balance between the considerations of control and treatment.

**Methods:** This article reports on an ethnographic study of a prison-based OMT programme in a closed Norwegian prison. The data include field notes from eight months of participant observation in the prison as well as qualitative interviews with 23 prisoners and 12 prison staff. Midway through the fieldwork, the prison authorities established a separate unit for OMT-enrolled prisoners to reduce the widespread diversion of buprenorphine. This “natural experiment” is explored in the analysis.

**Results:** The prison-based OMT programme was characterised by strict and repressive control to prevent the diversion of buprenorphine, and the control became even stricter after the establishment of the OMT unit. However, the diversion of buprenorphine increased rather than decreased after the establishment of the OMT unit. To understand this “paradox of control”, the article engages with theories of legitimacy, power and resistance. The excessive and repressive control was perceived as illegitimate and unfair by the majority of study participants. In various ways, many prisoners protested, confronted and subverted the OMT programme. The increase in buprenorphine diversion is interpreted as a form of collective resistance towards the perceived unfairness of the OMT programme.

**Conclusion:** The article demonstrates that an unbalanced and control-dominated approach to prison-based OMT may have the opposite effect of what is intended.

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## Introduction

Opiate maintenance treatment (OMT) is increasingly being offered in prisons throughout Europe (European Monitoring Centre for Drugs and Drug Addiction, 2012), reflecting a general “rehabilitation renaissance” in correctional institutions (Ward & Maruna, 2007, p. 10). The benefits of OMT in prison have been found to be similar to those produced by OMT in community settings (Hedrich et al., 2012), and studies have documented that prison-based OMT programmes reduce participants’ in-prison drug use, risk-taking behaviour and other subcultural activities

during imprisonment (see Stallwitz & Stöver, 2007; Stöver & Michels, 2010, p. 3 for reviews). However, prison-based OMT has been a controversial issue because of fear of the diversion of OMT medications and the development of black markets for prescription drugs such as buprenorphine and methadone (Stöver & Michels, 2010, p. 3). Studies indicate an increase in illegal buprenorphine use in prisons in several jurisdictions (Doyle, 2013; Plugge, Yudkin, & Douglas, 2009; Tompkins, Wright, Waterman, & Sheard, 2009). Prison-based OMT thus involves a delicate balance between the considerations of control and treatment. Based on a larger ethnographic study of drug rehabilitation in a closed Norwegian prison, this article details the way these two considerations play out against each other in the everyday workings of the prison’s OMT programme. The article’s empirical point of departure is a measure that was implemented in the prison during the study period with the intention of reducing

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the diversion of buprenorphine through increased control and supervision. To the author's knowledge, this article is the first to report ethnographic findings from a prison-based OMT programme.

The article engages with theories of power, legitimacy and resistance in the analysis of the ethnographic data (Bosworth & Carrabine, 2001; Buntman, 2003; Crewe, 2009; Mathiesen, 1965; Rubin, 2014; Scott, 1990; Sparks, Bottoms, & Hay, 1996). These theories, although with different emphases, suggest that the degree to which prisoners comply with institutional rules, values and expectations is contingent upon how they experience the power to which they are subjected and how they perceive its legitimacy. Based on this theoretical assumption, the article seeks to answer the following research questions: how do participating prisoners experience the treatment and control to which they are subjected in the OMT programme, and how do they react towards it?

### Power, legitimacy and resistance

How prisoners perceive and experience the power to which they are subjected in prison and how they address this power has been a main concern in the study of captive society (e.g., Crewe, 2009; Mathiesen, 1965; Sykes, 1958). While Foucault's works (e.g., 2008) have constituted a major influence on studies of modern forms of penal power, an alternative research tradition has been concerned with the issue of legitimacy (Liebling & Arnold, 2004; Mathiesen, 1965; Sparks & Bottoms, 1995; Sparks et al., 1996; Tankebe & Liebling, 2013; see also Tyler, 1990). Inspired by the work of Beetham (1991), Sparks and Bottoms (1995, p. 47) argue that "all systems of power relations", including those within prisons, "seek legitimation". This perspective entails a critique against those commentators who claim that prisons can be nothing other than entirely non-legitimate. These authors agree that prison authority may be based on force, control and coercion rather than consent and that prisons may produce violent disorder, but, they claim, "they do not do so equally always and everywhere" (Sparks & Bottoms, 1995, p. 51). Prisons may be perceived as *more or less* legitimate by the confined, and, according to these authors, the degree to which power relations are perceived as legitimate affects the way prisoners react and adapt to their subordinate position: "Considerations of fairness and respect are not just normatively desirable, they are central to the achievement and reproduction of social order itself" (ibid. 59). A related argument lies at the heart of Tyler's (1990) theory on procedural justice. Legitimacy is achieved most effectively when criminal justice institutions act according to principles of procedural fairness (e.g., respectful treatment, fair and consistent decisions). When principles of procedural justice are followed, Tyler (1990) claims, people are simply more willing to comply with the law.

One sociological problem that has been discussed in this literature concerns why reactions to "legitimacy deficits" (Beetham, 1991) are individually performed in some institutions and circumstances and collectively performed in others (e.g., Mathiesen, 1965; Sykes, 1958). This sociological problem is at the heart of Mathiesen's (1965) ethnography of the Ila detention centre in Norway. The prisoners Mathiesen studied accused prison staff of an arbitrary use of their wide discretionary powers, a lack of consistency and predictability in decisions of importance to prisoners (rewards and punishments), and a lack of adherence to the principle of non-discrimination. However, the prisoners did not confront this illegitimate use of power through collective and subcultural opposition, as Sykes (1958) had described some years earlier, but rather through an individualised defensive approach defined as "censoriousness": the prisoners criticised prison staff for not adhering to their own values and principles – or those

widely held and shared by society at large – when making decisions (Mathiesen, 1965, p. 12). In explaining the lack of peer solidarity and collective reactions, Mathiesen points to the treatment-oriented regime of the prison, a regime in which power was exercised through individual discretionary considerations, undermining the basis for solidarity and leading prisoners to pursue their interests individually rather than as a group. In a recent contribution, Crewe (2009) addresses this problem in a related way. He argues that "the institutional environment structures the meanings of and motives for resistance" (2009, p. 234). The "institutional environment" Crewe (2009) analyses in his comprehensive ethnographic work in an English prison is also characterised by individualisation, albeit in a somewhat different form. He describes how the introduction of incentive schemes, progression in sentencing and individualised discretionary arrangements have become the primary means of achieving compliance with institutional rules in "the late modern prison". In this context, he argues, "the kind of solidary subculture that might engender overt, collective resistance is unlikely to be realized" (2007: 265). Such changes in the way power operates may explain a more general trend in the literature on prisoners' reactions towards penal power: scholars increasingly investigate the small, hidden and *individually performed* "everyday practices of resistance" (e.g., Bosworth & Carrabine, 2001; Ugelvik, 2011). Inspired by Scott (1990), studies of everyday acts of resistance point to the agency of prisoners and the way that small or seemingly trivial rule-violating behaviours are important for prisoners in maintaining a sense of autonomy, identity and self-respect despite their subordination. The motivations for engaging in such behaviour, Bosworth and Carrabine argue (2001, p. 507), are not only "anger, rage, exploitation and injustice" but also "pleasure, play and boredom".

An important issue that has been addressed in this literature is how to conceptualise the reactions to (illegitimate) power. Very often, these reactions are described as "resistance". However, the concept of resistance (particularly "everyday practices of resistance") has been criticised for being vague, all encompassing, romanticising and loosely defined (Buntman, 2003, pp. 250–253; Crewe, 2009, p. 97; Rubin, 2014; see also Ortner, 1995). According to Rubin (2014), it is problematic that the concept covers diverse acts ranging from hunger strikes and riots initiated to bring about political change to everyday practices of "microresistance" such as disobedience, argot or quiet subversion. She argues that the label of resistance should be reserved for "consciously political, grievance- or justice oriented (and often collective) behaviour" (Rubin, 2014, p. 5). Despite differences in approach, these scholars seem to agree that subversive acts are best understood along a continuum, from individually performed "everyday acts of resistance" on one end to collective, organised and political actions on the other.

In the analysis that follows, I first describe how prisoners perceived the OMT programme and then how they reacted towards it. In the discussion, I return to the issue of legitimacy and discuss the reactions in light of the problems outlined above.

### Context

Approximately 60% of Norwegian prisoners report having used illegal drugs the month prior to incarceration (Friestad & Hansen, 2005), and up to half of the Norwegian prison population is considered to have a serious drug problem (Ødegård, 2008). Partly in response to this situation, OMT is one of the drug treatment and rehabilitation services now offered in Norwegian prisons. The national OMT programme was introduced in Norway in 1998 (Waal, 2007). In 2004, OMT became part of the Norwegian health care service, and participants in OMT obtained status as patients with patient rights. The new national guidelines that were

introduced in 2010 strongly emphasised that patients in OMT should receive individually accommodated rehabilitation (Directorate of Health, 2010). OMT patients are not charged for their medications. Norwegian OMT has been described as “high-threshold” and being rather restrictive (Waal, 2007), characterised by a tight control regime in an effort to prevent the diversion of medications (Havnes, Clausen, & Middelthun, 2014). Nonetheless, the number of participants in the national OMT programme has grown rapidly every year; as of 2013, approximately 7000 individuals were enrolled, 57% of whom are prescribed buprenorphine (Subutex/Subuxone) and 43% of whom are prescribed methadone (Waal, Bussesund, Clausen, Håseth, & Lillevold, 2014, pp. 6, 28).

If patients in OMT are imprisoned, their treatment is continued in prison, and opioid-dependent individuals may also enter the national OMT programme while incarcerated. The Regional Health Authorities are responsible for admissions to (and dismissals from) OMT, whereas the primary health care service in each prison is responsible for the follow-up of patients including the dispensing of medications.

“Kollen prison”,<sup>1</sup> a closed Norwegian prison where the ethnographic fieldwork discussed in this article was conducted, lies on the outskirts of a large Norwegian city (pop. <500,000) and has a capacity of a couple hundred prisoners. The prison comprises a handful of closed wings in separate buildings, all of which are enclosed by a concrete wall. Each wing holds approximately 50 prisoners. In most wings, prisoners serve their time in living units that consist of six or twelve cells and a shared living room with a kitchen where meals are prepared.

An OMT unit was located in wing 3 of the prison and consisted of one large living unit with approximately 10 cells and a shared kitchen and living room. It was established midway during my fieldwork in an effort to prevent the widespread diversion of buprenorphine in the prison. Before the OMT unit was established, prisoners enrolled in OMT were eligible to serve their time in all of the prison’s wings, and they had to be escorted to the prison health care service every morning to receive their medication. Health care staff was responsible for dispensing the medicines, but prison officers supervised the dispensing. During my research period, the number of incarcerated OMT patients varied between 20 and 30. With the establishment of the OMT unit, all prisoners enrolled in the OMT programme were placed there, and those who refused had to serve their time in the most restrictive wing of the prison.<sup>2</sup> The dispensing of OMT medications was also moved to the OMT unit. By locating all OMT-enrolled prisoners in one unit and limiting their contact with prisoners in other wings, the prison authorities aimed to reduce the diversion of buprenorphine, save resources by making the dispensing of medications less time consuming, and generally improve services to the prisoners enrolled in the OMT programme. Thus, the establishment of the OMT unit introduced two changes to the operations of the OMT programme that will be important in the analysis that follows. First, the OMT-enrolled prisoners were *separated* from other prisoners, and second, prison officers were delegated *more responsibility* for dispensing OMT medications.

## Method

The article reports findings from a larger ethnographic study of prison-based drug rehabilitation in Kollen prison. The ethnographic fieldwork consisted of observations and open ended interviews with prisoners and prison staff, and lasted for eight months. It was

mainly conducted in a drug rehabilitation unit in wing 2 of the prison, but when the OMT unit in wing 3 was established the prison authorities allowed me to pursue my research interests here as well. I thus spent considerable time in the OMT unit during the last three to four months of my fieldwork. The data utilised for the analysis that follows are derived mainly from observations and interviews conducted during these months at the OMT unit, but interviews and observation notes covering the subject of OMT conducted before the establishment of the OMT unit are also used.

Typically, I spent three days a week at the prison, mostly “hanging around” and talking informally with prisoners. I wrote observation notes in the evening or the following day. The observation notes covered informal conversations between prisoners (and between prisoners and myself) as well as descriptions of practices I observed (e.g., dispensing practices). In addition to observational field notes, qualitative interviews were conducted, first with prisoners (23) and later with staff members (12). In this article, I mainly rely on the interviews with the prisoners. The majority of prisoners interviewed were enrolled in the OMT programme, were in the process of applying for OMT, or used illegal buprenorphine regularly at the time of the interview. The interviews were open and semi-structured but shared some common themes. Views on and experiences with the treatment and control in OMT were covered in all interviews with the OMT-enrolled prisoners, and the topics of drug use, drug distribution and buprenorphine diversion in prison were addressed in all of the interviews, irrespective of status as an OMT patient. The prisoners interviewed were all men, typically between 25 and 45 years old, and nearly all were ethnic Norwegians from or living in the nearby city. Most of them were serving (or expected to serve) a sentence of between 6 and 18 months, and most of them had considerable experience as injecting drug users of either heroin or amphetamine. The interviews were fully transcribed and coded thematically in NVivo 10.

## Perceptions of control and power relations in OMT

The field note extract below describes the first day I was allowed to observe the dispensing of buprenorphine in the newly established OMT unit:

It is 10:05 in the morning, and the dispensing is about to start. Renate, a female prison officer in her thirties, brings out the prisoners one by one. She knocks on the cell door, the prisoner comes to the door, shows his hands, takes both his hands up to his mouth, inserts two fingers from each hand into his mouth, turns cheeks and lips inside out in a rhythmic movement: first the prisoner opens wide and stretches out his tongue, then the cheeks are turned inside out, then the lower lip, then the upper lip. When this procedure is repeated for all the five prisoners present on this floor, the prisoners have to take a sip of water from the glass provided by Renate. Then, the prisoners must find their seats opposite the three prison officers present to supervise the dispensing. Some of the prisoners express more pronounced discontent than others. Hogne is the one protesting the most: he overdramatises every movement, he groans, sighs and shakes his head, and he repeatedly comments on the procedure. Hogne is the prisoner who has been particularly eager to get me to observe the dispensing, and he turns to me a lot: “Do you see all the things they make us do? How we have to open wide and turn our cheeks inside out?” When all the prisoners are seated in front of the officers, the dispensing starts. Vibekke, also a prison officer in her thirties, has already prepared the medicine. While the prisoners are watching, she carefully crushes the tablets of buprenorphine. She pours the pieces of buprenorphine in a vial and hands it to Hogne as the

<sup>1</sup> The proper names of the prison and the city are withheld for ethical considerations. Similarly, all names of prisoners quoted below are pseudonyms.

<sup>2</sup> When there were more OMT patients than cells in the OMT unit, patients on buprenorphine had to stay in the most restrictive wing of the prison until a cell became vacant in the OMT unit.

first in line. He raises the vial to his mouth with large and pronounced movements and almost throws the tablets into his mouth. The procedure is then repeated with the four other prisoners. Now, they have to sit in a straight line for twenty minutes, all the while supervised by the three prison officers. They are instructed not to raise their hands up to their mouth or head. Most of the prisoners look down or stare emptily into space during the next twenty minutes while Hogne does the talking. The tablets are supposed to be dissolved after twenty minutes, and the dispensing comes to an end. They get up one by one, and they receive a glass of water from Renate. They have to drink it in front of her. Then, they have to open wide for inspection and repeat the procedure of turning their cheeks and lips inside out before being locked up in their cells. When all the prisoners are locked up, the prison officers pack up the equipment. The prisoners are then locked out again, and one by one they come out, shaking their heads, asking me for my opinion and if by now I realised what they had meant when telling me about the unfair dispensing procedure. (Field note, January 2012)

According to the prisoners as well as my own observations on several occasions, the highly controlled, supervised and ritualised character of the dispensing described here was not an exception but rather the normal and intended procedure at the OMT unit. The clear majority of the OMT-enrolled prisoners I came to know disapproved of the dispensing procedures. One of the most frequent criticisms was the fact that the prisoners had to insert their fingers into their mouth to facilitate the prison officers' inspection. This action was perceived as particularly degrading:

I find it disgraceful to insert my fingers into my mouth and things like that. However ... what can we do? We need our medication. (Interview, Tor)

A second frequently voiced criticism was the collective aspect of the dispensing and the presence of prison officers. This topic came up during an informal conversation between a small group of prisoners (including Arne and Bjarte), me, and a prison officer:

Arne: It shouldn't be like that. It ought to be a personal thing between the one dispensing the medicine, which is the health care service, and you. Like when you see the doctor or the health care service outside [prison]. I don't like that the prison has got anything to do with it. And how can you address things when you're surrounded by prison officers and a crowd of others? Like, in terms of adverse effects or things like that, if it is things you would like to address. Who would like to share when you have a group of people listening?

Bjarte: I would not. (Field note, November 2011)

The supervised and collective aspect of the dispensing was also a core concern for prisoners before the establishment of the OMT unit. However, the frustration increased after the establishment of the OMT unit as prison officers were delegated increased responsibility for dispensing medicines. The majority of the enrolled prisoners considered it wrong that the prison officers were so heavily involved in their medical treatment, and several prisoners questioned the legal basis for infringements of their right to confidentiality and privacy. Because the prison had more or less taken over the dispensing of medicine in the OMT programme, the frustration and criticism from prisoners were primarily directed towards the prison and the prison officers representing it, not the health care service.

A third frequently raised criticism concerned an unintended consequence of locating the OMT-enrolled prisoners in a separate unit. According to several prisoners and prison officers, this separation had resulted in increased stigmatisation of drug users in general and prisoners in OMT in particular (see also [Havnes et al., 2014](#)).

During the entire fieldwork for this study, many of the enrolled prisoners were frustrated by the level of control in the OMT programme. This frustration increased with the establishment of the OMT unit. The majority of the enrolled prisoners noted severe "legitimacy deficits" ([Beetham, 1991](#)) in the operations of the OMT unit. They particularly emphasised the amount of control and supervision during the dispensing of medicine, the procedures used by staff when controlling and supervising the dispensing, and the stigmatising effect of being separated from other prisoners. Contrary to recent governmentality inspired analysis of modern penal power (e.g. [Crewe, 2009, 2011](#); [Ugelvik, 2011](#)), the mode of power that prisoners perceived through these control practices could be described as more "modern" than "late modern", more "hard" than "soft", and based more on authoritarian and repressive dictates than enticement and self-regulation. A minority of prisoners, however, disapproved of the control measures without questioning the overall legitimacy of the OMT programme (see below). What type of reactions followed from these perceptions of the legitimate and illegitimate use of authority?

## Reactions to power in OMT

### Compliance

For a minority of the prisoners I interviewed and came to know, the diversion and distribution of buprenorphine were considered so problematic that they accepted the excessive control regime in the OMT programme. This position was apparent when they expressed their views on the OMT unit, as Dag does below:

Researcher: Why did they place you at the OMT unit?

Dag: It's because of the rules they've made. I don't know. It's to prevent diversion of medicine. I think they exaggerate. However, I, I do think things work out all right here, I really do. (Interview, Dag)

Although Dag finds the level of control to be exaggerated, he still says that things "work out all right". For Dag and the few other study participants who shared his opinion, this position was influenced by negative experiences from former prison sentences in which fellow prisoners had bullied and threatened him to divert his buprenorphine (see also [Penfold, Turnbull, & Webster, 2005](#)). He experienced less pressure to divert buprenorphine in the OMT unit simply because he socialised less with non-OMT-enrolled prisoners. Other prisoners, who were far more critical about the OMT programme in prison, also highlighted this as one of the few positive effects of the establishment of the OMT unit (see also [Havnes et al., 2014](#)).

The reaction chosen by these prisoners may be seen as a form of normative compliance ([Crewe, 2007, 2009](#)). The prisoners disapproved of the excessive control and complained about lack of rehabilitation and purposeful activities in the OMT programme, but they complied with institutional rules because they accepted and approved of the goals that the prison sought to accomplish (reducing the diversion of buprenorphine and related bullying).

### Righteous critique

Many of the education, employment and rehabilitation programmes recruited prisoners from all wings of the prison. With few exceptions, the prisoners in the OMT unit were denied access to these programmes to limit the possibility of distributing diverted buprenorphine. Prisoners lamented that their access to rehabilitative services and educational programmes was restricted because of the fear of diversion. These restrictions were perceived as highly discriminating, and the lack of access to meaningful activities such as work or education was the single most important source of frustration in the months following the establishment of the OMT unit. Thus, the most common reaction among the study participants was to protest against the OMT programme by public critique and written complaints. This criticism was raised particularly with reference to the prospect of rehabilitation, which is the primary aim of OMT (Directorate of Health, 2010) as well as an important principle according to Norway's penal legislation (The execution of sentences act, § 2):

What I find worth criticising is that people are not given a chance to be rehabilitated in here, even if they want to. They don't, they don't get the opportunity, even if they want to. [...] If a young guy comes in here, in his early twenties, and he wants to do something with his life, be a chef or whatever, well, today it's not possible if he's on Subutex. And that's the worst thing about it. You know, you are discriminated because you get medicine because you are in OMT. And that's wrong; you are, after all, a patient! (Interview, Hogne)

When the prisoners confronted staff with this critique, as Hogne did above, they often made reference to their patient rights, their right to rehabilitation, their right to work and education, and the principles of non-discrimination and equal treatment. This form of reaction could thus be described as a *righteous critique*. The righteous critique resembles Mathiesen's (1965) concept of "censoriousness" in that prisoners accused prison officers and prison authorities in public for not adhering to widely held and shared values (and rights) regarding the operation of the OMT unit. However, whereas the censorious critique described by Mathiesen (1965) was directed towards the arbitrariness caused by individual treatment, the righteous critique was directed towards discriminatory *collective* treatment.

### Confrontation

A rather small group of prisoners reacted in a more confrontational way to protest against the OMT regime. One prisoner, highly frustrated by the lack of opportunities and the tight control at the OMT unit, refused to take his buprenorphine and succeeded in this way to be transferred from the OMT unit. Another claimed to be threatened by fellow prisoners to achieve a transfer. A more rights-oriented protest came from Arne. He refused to insert his fingers into his mouth before and after dispensing because he found it degrading and he was convinced that prison staff had no right to demand it. In the field note below, Arne instructs a fellow prisoner who is about to begin OMT on how he should reject this procedure during dispensing:

Arne: I simply refused because I knew they weren't entitled to. They're allowed to ask you to open your mouth. And that I'll do. However, they want you to insert your fingers into your mouth as well, to do a more thorough inspection, but that they are not entitled to. So I simply refused. That pissed them off, and I was

thrown straight down [to the most restrictive wing]. (Field note, November 2011)

Even though Arne was respected by prisoners and even some of the prison officers for his uncompromising attitude, very few prisoners followed his line of conduct. They simply had too many privileges to lose, and they had too many bad experiences serving under conditions equivalent to isolation in the most restrictive wing of the prison.

### Subversion through diversion

A substantial number of the prisoners enrolled in the OMT programme, both before and after the establishment of the OMT unit, reported diverting some of their medicine. The motivations for diverting buprenorphine among participants in this study were many and varied. The buprenorphine-enrolled prisoners in Kollen who diverted their medication did so partly because they could (they received a higher dosage than they felt they needed), partly because they felt obliged to do so (to "help out" other prisoners), partly out of self-interest (they received something in return), and partly because they were bullied to do so (they feared sanctions if they did not divert) (see also Havnes, Clausen, & Middelthun, 2013; Penfold et al., 2005; Winstock, Lea, & Jackson, 2009; Yokell, Zaller, Green, & Rich, 2011). However, buprenorphine diversion from prison-based OMT should also be analysed in relation to programme characteristics. An OMT-enrolled prisoner responded in the following way when I probed into why he diverted and distributed his buprenorphine:

Arne: ...No, it's just the fact that it feels good to help others, and... that you can play a trick on these prison officers. To prove to others and yourself that it's doable.

Researcher: Yes. That's important?

Arne: Yes, it is important. It actually is important. It may sound bloody childish, but...

Researcher: No, I don't think it sounds childish.

Arne: However, it's, it's just, if you can play a prank on them, then you do it. Yes. (Interview, Arne)

He admits that his motivations to divert buprenorphine sound childish when he articulates them during the interview, but he insists on the importance of "playing a trick" on the prison officers. Another prisoner, regarded as and respected for being the most skilful "hustler" of buprenorphine in Kollen prison, said something similar regarding his motivations to divert buprenorphine:

Researcher: However, how much of it, how much of it is motivated by the pleasure of tricking the system in here?

Knut: Very much.

Researcher: [chuckles] Very much? Is it really?

Knut: Yes, the more you trick them, the better it is [chuckles]. It has become quite a hobby for some of us, you know [chuckles]. [...] It's kind of childish, but it's just the way it is. (Interview, Knut).

He laughs several times during this sequence, almost embarrassed, and excuses himself in the last sentence when he admits

that the whole thing is quite childish. The language here is also playful; for instance, he describes diversion as “tricking them” and says that it has become “a hobby”. Unquestionably, for these prisoners, diversion of buprenorphine is an enjoyable, subversive activity. This finding is thus in accordance with Bosworth’s and Carrabine’s claim that counter-conduct activities “will be motivated as much by anger, rage, exploitation and injustice, as by *pleasure, play and boredom*” (2001, p. 507, italics added). Non-OMT-enrolled prisoners who used and distributed buprenorphine expressed similar motivations for involvement in the contraband activities. Independent of each other, they repeatedly used the phrases “to fuck them” or “to fuck the system” when describing their motives for engaging in these activities. For many, although not all, buprenorphine diversion and its related illegal activities were related to a *defiant desire* to subvert institutional rules and expectations.

### Increased control and increased subversion

The main purpose of the establishment of the OMT unit was to put a stop to the extensive distribution of diverted buprenorphine by increased use of various forms of control and supervision. According to the research participants in this study, however, the distribution of diverted buprenorphine *increased* rather than decreased in the months following the establishment of the OMT unit, and the supply to the other wings, according to prisoners, became more organised and reliable. The following quote is from an informal conversation with a group of prisoners in one of the communal wings two months after the OMT unit was established:

Rune: There are many drugs in this prison right now. It’s never been as much as now. It’s crazy. I have never seen drugs as accessible before, and I have spent my time in prison, so to speak. People have hid away drugs all over the place! (They laugh)

Researcher: So the establishment of the OMT unit has not been effective?

Rune: Effective? There has never been more Subutex than is in here right now!

Researcher: Okay? How long does it take before you have the Subutex here? When does it come?

Rune: I would say approximately 11 a.m. [one hour after the dispensing]. You have to be tough to stay clean now. (Field note, February 2012)

By creatively and collectively using the few openings and opportunities the prisoners in the OMT unit had to get out of the unit, they managed to establish distribution lines between the wings of the prison with the assistance of various carriers, middlemen and hiding places. Several prisoners claimed, as Tor does below, that these efforts had been so effective that, in some sense, the prisoners had gained control over the dispensing of buprenorphine in prison:

Everybody knows someone in the other wings. Based on that, we make arrangements, we talk to each other. We know how things are in wing 2, we know how they are in wing 5, we know how things are in wing 4, we know how things are in wing 3. We don’t know how things are in wing 1. We haven’t achieved access in wing 1. It’s the only wing they control. We control the rest. [...] To sum it up, you may say that the OMT unit feeds the rest of the prison. It’s almost like that. (Interview, Tor)

Tellingly, Tor constantly refers to the collective “we” in the excerpt above, as did many other prisoners in related conversations. Furthermore, these conversations showed the pride the prisoners took in having managed to establish distribution lines of diverted buprenorphine that, in effect, circumvented the OMT programme. During the last three to four months of my fieldwork, prisoners in wing 2 and 3 repeatedly (and often triumphantly) declared the ease with which they obtained and used buprenorphine.

Surely, the self-confident tone in many of these statements could be interpreted as indications of a certain “resistance narrative” among these prisoners. I did however probe the issue in great detail, particularly with the prisoners I had come to know well and some of the prisoners who were most heavily involved in the hustling and distribution of diverted buprenorphine. One of these was Jacob, a prisoner who initially was suspicious of me and the research I was conducting, but who gradually became one of my key contacts in the prison. In one of the many informal conversations we had in his cell, he detailed his tasks as a middleman, responsible for collecting diverted buprenorphine from the OMT unit and distributing it to other prisoners in his wing:

Jacob: Things are sorted out now. Everything works out the way it’s supposed to, it’s predictable. We have our places, you know [lists the hiding places where the diverted buprenorphine is stored and then picked up]. We never know for how long it will last. But right now it works out fine. In a year or so they might know in there [points in the direction of the guardroom]. But hopefully I’ll be out by then.

Researcher: Alright. But how predictable is it, in terms of when the drugs arrive and by whom?

Jacob: It’s predictable. The stuff is often still wet when we get it [laughs]!

Researcher: [laughs] But it’s quite an accomplishment to keep such a steady operation going?

Jacob: Yeah, but it’s also fragile. I don’t know what they know in there [the officers]. I guess they know a little. I guess they know more than we think they do. But I don’t think they know this particular route, and this particular routine. But you know, it’s enough that one guy in here talks a little bit too loudly, and then the route is down [...]. But for the moment it is reliable, very reliable. (Field note, February 2012)

Jacob’s descriptions of the practices are nuanced and detailed (I have left out specific details on hiding places and the routine in order not to compromise the confidentiality of research participants), and they suggest that the distribution of diverted buprenorphine from the OMT unit had become organised, coordinated and stable in the months following the establishment of the OMT unit. Although some of the claims by the prisoners may be exaggerated, a uniform judgment by the prisoners I probed the issue with was that the distribution of buprenorphine had become more extensive after the establishment of the OMT unit.

When the OMT unit was established, it initially became more challenging to distribute diverted buprenorphine across the prison estate.<sup>3</sup> At the same time, however, it made the diversion and

<sup>3</sup> In the immediate aftermath of the establishment of the OMT unit I noticed a change in the behaviour of some of the prisoners in wing 2 of the prison. They were louder and more restless than before. I suspected first that they were high on some different kind of drug, but it turned out that they were suffering withdrawal because of a decline in the supply of buprenorphine. Soon after, the supply chain of buprenorphine from the OMT unit was established and the behaviour of prisoners and the atmosphere in the wing went back to “normal” again (see also Crewe, 2005: 475 on the relation between fluctuations in drug supply and social order in prison).

distribution of buprenorphine *a more symbolically rewarding activity to pursue*. The increase in buprenorphine diversion and distribution can be seen as a *reaction* towards the increase in control and supervision that was introduced with the establishment of the OMT unit. This interpretation was shared by some of the prisoners involved in the illegal activities as well as some staff members who were critical of the level of control in OMT. For instance, a nurse with extensive experience who held a leading position in the prison health care service reported the following during an interview:

It is necessary to have some control with the dispensing of medicine. However, the correctional services are hysterical. They are hysterical. [...] And I think they are way too concerned with security. [...] And, and I believe that the more we prioritise security, the more we offend the patient, and the more they feel like tricking us. Like, they just get more creative in that direction. (Interview, nurse, prison health care service).

Her argument echoes *Scott's (1990)* assertion that acts and practices that are perceived as offensive and that represent “slights to human dignity” (1990, p. 7) provide particularly fertile soil for the development of resistant and subversive practices. She considered the control and supervision in the OMT programme offensive and was not surprised to see buprenorphine diversion flourishing in the prison.

## Conclusion and discussion

The available literature reports a low prevalence of methadone and buprenorphine diversion from prison-based OMT programmes (*Kinlock, Gordon, Schwartz, & Fitzgerald, 2010; Magura et al., 2009*) and documents that OMT reduces participants' in-prison drug use, risk-taking behaviour and other subcultural involvement during confinement (see *Stallwitz & Stöver, 2007; Stöver & Michels, 2010*, p. 3 for reviews). The ethnographic analysis presented above, however, reports a different finding: diversion of buprenorphine from the prison-based OMT programme was extensive and contributed to a vibrant drug subculture in the prison, in which a substantial number of prisoners were involved in the use and distribution of prescription opioids (see also *Mjåland, 2014*). Furthermore, the analysis suggested that the diversion of buprenorphine *increased* during the study period following the establishment of a separate unit for OMT-enrolled prisoners that was intended to *reduce* the diversion of buprenorphine by means of various control measures. The data that supports this finding is primarily based on statements from prisoners and could be seen to reflect a “resistance narrative” among prisoners involved in such subversive practices. The issue was however pursued in great detail with a substantial number of prisoners – from two different wings of the prison – among whom were the prisoners most heavily involved in the illegal activities. I also spent considerable time with prison staff during the entire period the fieldwork lasted, and I never had the impression that they considered the establishment of the OMT unit as successful in reducing the distribution of diverted buprenorphine. Furthermore, if indeed the supply of buprenorphine had gone down as a result of the establishment of the OMT unit, I most certainly would have noticed this due to the increase in withdrawal symptoms that would have occurred among prisoners I knew quite well by then. These considerations of the data and the study as a whole, I argue, lend support to the prisoners' claims of an increase in buprenorphine distribution following the establishment of the OMT unit. How can we then understand this “paradox of control”?

Theories on legitimacy, power and resistance may provide some answers. *Sparks et al. (1996)* claim that there is a strong relation

between legitimacy and social order in prisons. A related argument is proposed by *Tyler (1990)*, who has convincingly argued that increased compliance with the law is most effectively achieved when criminal justice institutions follow principles of procedural fairness. However, the majority of the prisoners in Kollen prison perceived the OMT programme as illegitimate and based on procedural unfairness. Based on the prisoners' testimonies, the following “legitimacy deficits” (*Beetham, 1991*) are identified in this article: (a) prison officers were not considered lawful or competent authorities to govern the prisoners' medical treatment; (b) the control measures were considered degrading and disrespectful, and the legal validity of these measures was questioned; and (c) the prisoners' rights to rehabilitation were violated as a consequence of the control measures, most prominently by the separation that was introduced with the establishment of the OMT unit. Apart from the prisoners who perceived the OMT programme as legitimate (because it spared them from being bullied for their medications), a substantial number of the study participants responded to the procedural unfairness of the OMT programme with various forms of protest (e.g., righteous critique), confrontation (e.g., refusal to comply) and subversion (e.g., buprenorphine diversion). These are very different reactions, but, I argue, they should all be seen as acts of resistance towards the illegitimate and repressive use of power in the OMT programme.

To substantiate this interpretation, I draw from discussions on how to define resistance (*Buntman, 2003; Crewe, 2009; Rubin, 2014*). A consensus among these scholars seems to be that some type of (political) intentionality is needed to define acts as resistance. The righteous critique was explicitly political; prisoners accused prison staff of discrimination, stigmatisation and poor treatment. They raised concerns because they wanted improvements to the OMT programme. The reactions I describe under the heading of “confrontation” are internally very different and differ in the degree of political intention. However, the prisoner who refused to follow what he perceived as degrading dispensing practices and who claimed that prison staff violated visitation rules by demanding that he insert his fingers into his mouth to facilitate inspection, clearly had political intentions with this behaviour. He was, I argue, resisting power despite the consequences of having to serve his sentence under conditions equivalent to isolation. The subversive act of buprenorphine diversion, as the last reaction considered here, is a complex phenomenon, and prisoners report a range of different motivations for their actions (see *Yokell et al., 2011* for a review on diversion from community-based OMT programs). For instance, an important explanation for the increase in diversion after the establishment of the OMT unit was very practical: because they were located in the same unit, it became easier for the prisoners to advance the techniques and skills necessary for diverting buprenorphine as well as to plan and organise the distribution of the drug across the wings of the prison. However, the increase in control associated with the establishment of the OMT unit also added new political meanings to the practice of diverting buprenorphine – political in the sense that many prisoners came to share a common desire to *undermine* a measure of which they disapproved. The prisoners who diverted their medications did so for a number of reasons, but subversion became increasingly important after the control measures were intensified with the establishment of the OMT unit.

The collective nature of the diversion and further distribution of buprenorphine requires explication. Not only are such collective acts of subversion scarce in the recent literature, but heavy drug users are also commonly described as a rather isolated group of prisoners who are low in status in the prisoner community (*Crewe, 2009; Ugelvik, 2011*). To understand this surprising finding, we should attend to the sociological problem outlined in the theory

section above. Mathiesen's (1965) main argument was that the reactions to power that he found among prisoners – that is, a defensive and individually performed censoriousness – served as a functional alternative to peer solidarity. He explains the development of censoriousness (and the lack of peer solidarity) by highlighting the individualised and treatment-oriented character of the institution. The individual, and thus differential, treatment of prisoners undermined the basis for solidarity among prisoners. Crewe (2007, 2009) highlights a similar point when he argues that solitary subcultural resistance is unlikely to flourish in prisons where order is sought through incentive schemes, progression in sentencing and individualised discretionary arrangements. In the OMT programme I studied, power relations were characterised by the absence of such individual treatment. Prisoners were, to a large degree, treated in the same susceptible manner, and order was sought through degrading and collective control measures. An unintended consequence of these procedures was that they helped to create the kind of “cultural dissensus” between prisoners and staff that is important for the development of group cohesion around subcultural norms and activities (Mathiesen, 1965, pp. 132–134). The shared sense of being treated equally unfairly helps to explain how the diversion of buprenorphine increasingly became a collective practice.

Are the findings and analysis presented in this article generalisable beyond the specific context studied? The generalisability of the empirical findings is difficult to assess because there are very few other (ethnographic) studies of diversion from prison-based OMT programmes on which to rely (but see Kinlock et al., 2010; Magura et al., 2009). However, a recent overview shows that OMT is increasingly being offered in European prisons (European Monitoring Centre for Drugs and Drug Addiction, 2012), and studies suggest that buprenorphine has become a popular prison drug in countries such as Norway (Mjåland, 2014), England (Tompkins et al., 2009) and Australia (Doyle, 2013). I thus consider it likely that the empirical findings presented in this article will have relevance beyond the specific prison studied here, but this relevance can only be determined through future research efforts. Furthermore, the literature on community-based OMT programmes does, I argue, substantiate the generalisability of the analysis presented in this article. Several studies have highlighted how non-compliant behaviours (e.g., diversion of medications) should be seen in relation to programme characteristics (Bourgeois, 2000; Harris & Rhodes, 2013; Havnes et al., 2014). In particular, procedural unfairness through degrading control and supervision measures in community-based OMT programmes is found to produce similar forms of subversion and resistance, as I have shown in the analysis above (Dahl, 2007, 2008; Harris & Rhodes, 2013). More generally, the analysis of the “paradox of control” is also consistent with the argument put forward by Foucault (2008) in *Discipline and Punish*, where he claims that repressive and authoritarian forms of power can be ineffective as they might produce resistance that undermines institutional aims. I thus hypothesise that this article highlights important aspects of the relation between “control and conduct” in prison-based OMT that may have relevance beyond the specific prison studied here.

Given that the analysis is relevant to other contexts, future prison policies should discuss how to identify less harmful ways of balancing the concerns of drug treatment, on the one hand, and drug control, on the other (see also Stevens, Stöver, & Brentari, 2010). As a contribution to these discussions, this article demonstrates that an unbalanced and control-dominated approach to prison-based OMT may have the opposite effect of what is intended. The widespread diversion, distribution and use of buprenorphine across the prison were, however, not the only unintended consequences of the repressive features of the OMT

programme. The extensive and partly degrading control during dispensing of medicines, the stigmatisation involved when OMT patients were separated from other prisoners in a separate unit, and the lack of confidentiality and intimacy in the delivery of treatment, clearly worked against the rehabilitative aims of both the OMT programme and Norwegian penal policy as such (Directorate of Health, 2010; White Paper No. 37, 2007–08). The control practices were detrimental to the development of trust and relational intimacy between staff and prisoners, thus undermining factors that research have shown to significantly affect the success of rehabilitative interventions (e.g., Ward & Maruna, 2007). These anti-therapeutic effects of the control practices may be seen to represent a greater concern than the widespread diversion of buprenorphine. One way to approach both issues, and here I draw from Tyler's (1990) arguments presented above, would be to encourage prison managers, prison staff and treatment providers to plan for and execute control in ways that prisoners perceive as humane, fair and respectful.

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### Conflict of interest

None.

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