

11. Drug-related health policies and services in prison

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11.1 Prison systems and prison population: contextual information

11.1.1 Characteristics of the population, health and social status

The average number of inmates in Norwegian prisons was just over 3,700 in 2010.¹ This is an increase of almost 400 from the year before. The total number of inmates during the year was 14,606, which is slightly fewer than the year before. The number of new inmates in 2010 was 11,700, 3,900 of whom were held on remand.

Of the sentences imposed in 2009, sentences for crimes of violence accounted for 25 per cent, followed by driving under the influence (22 %) and drug crimes (15 %). Three per cent were sentenced for sexual offences. Around ten per cent were between the ages of 16 and 20, while 17 prisoners were below the age of 16 in 2010. Most stays in prison are relatively short: In 2010, four out of ten were released within 30 days, while 75 per cent were released within three months.

The proportion of foreign inmates (both on remand and serving sentences) has increased strongly in recent years, from 18 to 32 per cent of the average number of inmates in Norwegian prison from 2006 to 2011. Foreign inmates also

serve longer sentences than Norwegian inmates, most often for drug crimes (about 40 %). Foreign inmates are a complex group. Most of them are from countries in Eastern Europe and North Africa. Inmates in this group are entitled to necessary medical help in prison, but they will normally not be returned to Norwegian society after serving their sentences.

Several surveys show that the level of morbidity among inmates is generally higher than among the population at large.² This applies to drug and alcohol addiction, mental health problems and somatic illnesses. A survey conducted by the research foundation Fafo on the basis of interviews with 260 inmates shows that four out of ten have chronic illnesses that affect their everyday lives (Friestad & Skog Hansen, 2004). The corresponding figure in the general population is 25 per cent. Two out of ten inmates have financial problems. Outside prison, this was the case for around six per cent of the general population. Four out of ten inmates have no education after lower secondary school, while the same applies to fewer than one in ten of the general population. This may say something about an accumulation of several living-condition problems, and it shows that there is a connection between a high number of previous prison sentences and several problem areas (Ibid).

11.1.2 The extent of drug and alcohol use in Norwegian prisons

The three biggest surveys available on drug and alcohol use and prisons are all based on figures from the early 2000s:

¹ Annual statistics 2010. The central administration of the correctional services. <http://img3.custom-publish.com/getfile.php/1640752.823.befyrrfee/årsstatistikk+2010+bruk.pdf?return=www.kriminalomsorgen.no>

² Bjørngaard et al. 2009. The prisoner as patient – a health services satisfaction survey. BMC Health Services Research 2009, 9:176.: <http://www.biomedcentral.com/1472-6963/9/176#B3>

- Skardhamar (2002)³ has interviewed 247 inmates from a cluster sample of some prisons in a region (the Eastern Norway prison district) since the year 2000.
- Friestad and Skog Hansen (2004)⁴ have data from 260 interviews of convicted persons from all prisons in 2003.
- Ødegård (2008)⁵ uses data from a questionnaire survey of all convicted persons in 2002.

All the surveys ask about drug and alcohol use during a period of two to three months prior to imprisonment. The results vary from almost 60 per cent to 76 per cent reporting that they had used drugs in the period prior to imprisonment. The first two surveys focus on living conditions in general, while Ødegård focuses more specifically on the difference between alcohol and drugs. Ødegård also differentiates the results by type of use, i.e. the type of drug used, the frequency and the method of taking the drug (e.g. by injection). Here, the proportion of inmates displaying *serious problem drug use*⁶ prior to imprisonment was estimated to be 45 per cent, while 23 per cent had *less serious drug use*.⁷ Another finding in this survey concerns the consumption of alcohol prior to imprisonment. The findings stand out from the rest of the population, both in that a greater proportion report high-frequency alcohol consumption and in that more people abstain from alcohol than in the general population.

Several things can be said about whether the results of the surveys are representative of the situation in prisons today. This applies in particular to the proportion of inmates serving short sentences. On an average day in 2003, 20 per cent⁸ of all inmates were serving a sentence shorter than three months. In Friestad and Skog Hansen's survey, this group was eleven per cent.⁹ Over the whole year, 75 per cent of those who were released had served less than three months. The proportion of inmates who serve short sentences in the course of a year is therefore higher as a proportion of all inmates than figures based on measurements taken on a single day. This is a weakness of sample surveys, which are often based on the proportion of inmates on a given day. Moreover, Friestad and Skog Hansen only include inmates serving sentences, not those held on remand. The number of persons held on remand has increased in recent years and it now accounts for almost 30 per cent of the number of days served in prison. There are no good studies of drug use among persons held on remand, but this group of inmates is challenging in relation to systematic follow-up of possible drug or alcohol problems. Skardhamar found no differences in drug/alcohol use between inmates serving sentences and inmates held on remand.¹⁰

11.2 Organisation of prison health policies and service delivery

11.2.1 Drug-related health policies targeting prisoners

The white paper on the correctional service, *Punishment that works – less crime – a safer society* (Report no 37 (2007–2008) to the Storting),

³ Skardhamar, T. 2002. Levekår og livssituasjon blant innsatte i norske fengsler ('Living conditions and life situation among inmates in Norwegian prisons' – in Norwegian only). Master's degree thesis in criminology. The Department of Criminology and Sociology of Law, the University of Oslo.

⁴ Friestad, C. and Skog Hansen, I.L. 2004. Levekår blant innsatte ('Living conditions among inmates' – in Norwegian only) in Fafo report 429. Oslo <http://www.faf.no/pub/rapp/429/429.pdf>

⁵ Ødegård, E. 2008. Narkotika- og alkoholproblemer blant innsatte i norske fengsler ('Drug and alcohol problems among inmates in Norwegian prisons' – in Norwegian only). Published in the Nordic Alcohol and Drugs Journal (NAT) no 3 2008: p. 169-185.

⁶ By serious problem drug use is meant the reporting of frequent use of heavy drugs.

⁷ By less serious drug use is meant the reporting of sporadic use of heavy drugs or frequent or sporadic use of cannabis.

⁸ Length of sentences for inmates serving sentences of less than three months as of 16 May 2003. Taken from Kompis KIA report v-02-10a as of 19 September 2011.

⁹ Length of sentences for inmates taken from Table 2.2, Friestad and Skog Hansen 2004 p. 17.

¹⁰ Skardhamar, T. 2002. Op. cit. p. 86

sets the direction for work on drug and alcohol problems in prison. The correctional service shall execute sentences while at the same time facilitating changes in the individual inmates and preparing their return to society in collaboration with ‘imported services’¹¹ and external partners. The correctional service has developed a drug and alcohol strategy (2008–2011) that contains three sub-goals for this work: 1) Motivate and facilitate, 2) Reduce the use of drugs and alcohol during prison sentences and 3) Strengthen the cooperation between drug and alcohol measures and collaborative partners.

Inmates have the same rights as the general population. This is particularly the case in relation to health, and drug and alcohol users in prison are entitled to treatment and follow-up by the health service. The municipal health service is present in all prisons. It is the municipality in which a prison is located that is responsible for health services in the prison. GPs are the most important resource for those serving sentences under the supervision of the probation service. *The Administrative Alcohol and Drugs Treatment Reform* in 2004 (see more details in Chapter 5.3)¹² and *the Norwegian Action Plan on Alcohol and Drugs* (2008–2012)¹³ emphasised in particular the health service’s responsibility for collaborating with the correctional service during the serving of sentences and for following up inmates upon release.

When the Administrative Alcohol and Drugs Treatment Reform transferred responsibility for detoxification, assessment and specialised treatment for drug and alcohol use to the public health service, drug and alcohol dependency became a more limited category. The health service’s assessment of drug and alcohol dependency and of treatment needs became a medical assessment (the ICD-10 and DSM IV classification systems). It is an important point that it is this assessment of the patient’s condition/situation that constitutes the treatment order, which in turn triggers a right to treatment.

One of the sub-goals of the Action Plan is to *improve accessibility of services for prisoners and convicts*. It lists six measures that are also followed up in the correctional service’s strategies:

- Improve collaboration between the municipal health service, the specialist health services, the municipal social services and the Norwegian Correctional Services.
- Increase the number of prison days served in an institution pursuant to section 12 of the Norwegian Execution of Sentences Act.
- Establish units for people with problem drug/alcohol use in prisons.
- Improve the services for prisoners about to be released.
- Evaluate the trial scheme Drug Rehab Programme under Court Supervision and assess continuation and expansion.
- Develop a coordinated strategy to combat substance use in the Norwegian Correctional Services.

¹¹ Imported services are services provided in prison by persons/agencies not employed by the prison. Teaching, health services, library and other services are examples of such services. The health service has been an imported service in prisons since 1988, and the municipalities took over this responsibility in 1994.

¹² Information about the Administrative Alcohol and Drugs Treatment Reform is available on the Directorate of Health’s website: <http://www.helsedirektoratet.no/rusmidler/behandling/rusreformen/>

¹³ Information about the Government’s escalation plan for the drugs and alcohol field is available on the Directorate of Health’s website: <http://www.helsedirektoratet.no/rusmidler/opptrappingsplanen/>

11.3 Provision of drug-related health services in prison

11.3.1 Treatment in the health service

From a social service and health perspective, prison is a good arena for starting change processes, since inmates are available and motivated for change. All inmates are entitled to the same medical treatment in prison as other users. This also applies to the right to an individual plan, a

right to participation and a right to information, the informed consent requirement and the right to referral to the specialist health service, if relevant.

The correctional service carries out basic assessment of inmates on arrival in prison. This assessment is intended to provide information about matters with a bearing on the prison term and to form the basis for referral to collaborative partners for a more detailed assessment. In spring 2012, the correctional service will start testing an electronic assessment form. Participation in this assessment will be voluntary for the individual inmate.

Inmates who are in opioid substitution treatment and/or have been prescribed other addictive medicinal drugs (class A and B drugs) will be able to continue this treatment in prison. For persons held on remand, it is their GP who has medical responsibility, if relevant in collaboration with the prison health service. The prison health service and the prison doctor take over responsibility for convicted persons and consider continuation of the treatment during the stay in prison.

Although the prison health service is part of the municipal health service, the extent to which it is integrated with the municipality's other health care varies. The prison health service staff are mainly nurses and doctors, while some units also have a physiotherapist and a psychologist. The average time health services are available per inmate in all prisons in Norway is one hour and ten minutes per week, but there are great variations between prisons. There has been an increase in the number of nurses and doctors from 2007 to 2010, but not as great as the increase in the number of inmates during the same period.¹⁴

¹⁴ Kartlegging av fengselshelsetjenesten i Norge 2010 ('Survey of the prison health service in Norway 2010' – in Norwegian only). Synovate Norge. 21 March 2011.

In the health service's report for 2007, 15 out of a total of 45 prison units express concern about capacity. Several units are also concerned about inadequate provision of specialist health services. The Directorate of Health's assessment points out that *the need for health services in prison is probably much greater than in the rest of the population...* and that *the provision varies so much that a survey of the coverage of health personnel in prisons should be considered.*¹⁵ In a survey conducted by Synovate Norge on assignment for the Directorate of Health in 2010, eight of out ten health departments report that the prison health service provides adequate health services, while one out of ten disagree. The health departments were also asked whether the prison health service had sufficient resources to provide the necessary health services. More than half agreed that they did.

Collaboration with the prison health service is one of the most important measures in the correctional service's drug and alcohol strategy. It is regulated in a separate circular,¹⁶ which is intended to contribute to improving coordination and strengthening local and regional cooperation. The circular has also been important in collaboration on the Action Plan, which also focuses on measures aimed at drug and alcohol users during and after the serving of sentences. Among other things, it emphasises follow-up of individual plans, which are the users' own plans, in order to coordinate treatment and rehabilitation, and collaboration between the prison health service and the specialist health service in order to offer treatment during the serving of sentences.

¹⁵ The Directorate of Health 2009. Helsetjenester til innsatte i fengsel ('Health services for inmates in prison' – in Norwegian only). Report 2007.

¹⁶ Rundskriv G-8 2006 om Samarbeid mellom kommunehelsetjenesten, spesialisthelsetjenesten, kommunenes sosialtjeneste og kriminalomsorgen overfor innsatte og domfelte rusmiddelavhengige ('Circular G-8 2006 concerning collaboration between the municipal health service, the specialist health service, the municipal social service and the correctional service in relation to inmates and convicted problem drug or alcohol users' – in Norwegian only).

The units for mastering drug and alcohol problems, which are also part of the correctional service's drug and alcohol strategy, are one such collaboration measure (see Chapter 11.3.2).

A proposed new health and care act (expected in 2012) will transfer responsibility for more health tasks from the specialist health service to the municipalities. The consultative paper discusses in particular services relating to people with mental illnesses and people with drug/alcohol dependency.¹⁷ The municipalities will also be assigned clearer responsibility for following up individual plans and for coordinating the measures before, during and after treatment. This also applies to the prison health service's responsibility for providing health care for convicted persons.

11.3.2 Measures and treatment provision for inmates

A description of the most important measures for drug prevention, information and educational activities follows below. They are part of the correctional service's overall drug and alcohol strategy and aim to motivate and facilitate abstinence from drugs and alcohol by convicted persons/persons on remand during imprisonment and better control of drug and alcohol use after release.

Units for mastering drug and alcohol problems

The units for mastering drug and alcohol problems are a rehabilitation service for inmates who are being assessed for entitlement to interdisciplinary specialised drug or alcohol treatment. Entitlement to such treatment may confer a right to treatment beyond the duration of the sentence. In the course of 2011, 13 units for mastering drug and alcohol problems will be established in Norway, in addition to two corresponding units that have already been established. Eight units

have been established in high-security prisons, and five in prisons with lower levels of security. The precursor to the units for mastering drug and alcohol problems was the collaboration on the Pathfinder Programme between Oslo prison and the Tyrili foundation. In the units for mastering drug and alcohol problems, prison staff work together with health professionals from the specialist health service on a treatment-enhancing measure aimed at further treatment in prison, either pursuant to the Execution of Sentences Act section 12 or by the specialist health service after release.

A separate circular is being prepared on the organisation of the collaboration in the units for mastering drug and alcohol problems. It will contain guidelines and procedures for reporting on the collaboration and the development of the units.

Suspended sentence with drug courts

Suspended sentence with drug courts is a separate penal sanction based on the model of Drug Courts in Ireland and Scotland. The programme was established as a three-year trial scheme from 2006 with two units in Oslo and Bergen. It has since been extended until the end of 2014 (see Chapter 9.3.3). The correctional service's education centre has completed a follow-up evaluation of the start-up of the project.¹⁸ SIRUS is now collecting data from two years' follow-up of 115 persons who have been included in the project. Admission to the programme has taken more time than expected, which will delay the evaluation by up to two years.¹⁹

Serving of sentences pursuant to section 12

The Execution of Sentences Act section 12 gives inmates who have drug or alcohol problems and/or mental health problems the possibility of serving their sentence in a treatment or care institution (see

¹⁷ Consultative paper; draft new municipal health and care act. <http://www.regjeringen.no/nb/dep/hod/dok/hoeringer/hoeringsdok/2010/horing2/horingsbrev.html?id=621193>

¹⁸ Johnsen, B. and Svendsen, M. Narkotikaprogram med domstolskontroll ('Suspended sentence with drug courts' – in Norwegian only). Start-up of the teams and centres 2006. <http://img3.custompublish.com/getfile.php/502689.823.wcquuyytdf/dok22007.pdf>

¹⁹ Personal correspondence, Astrid Skretting, SIRUS 19 September 2011.

Chapter 9.3.1). Many of those who are transferred pursuant to section 12 are under assessment for entitlement to interdisciplinary specialised drug and alcohol treatment in the specialist health service. The number of convicted persons who are transferred has remained stable at around 500 per year, following an increase since the early 2000s.²⁰ More measures are now being initiated to increase the number of convicted persons serving their sentence this way. In order to achieve this, collaboration with the health service must start as early as possible. In April 2010, the correctional service took over responsibility for summoning convicted persons to serve their sentences. One of the advantages of this is the opportunity it offers to include information about measures such as serving sentences pursuant to section 12. It is also important that the health service and the municipalities make use of this opportunity to continue or start treatment in prison.

The return-to-society guarantee

The Government's return-to-society guarantee was launched in Report no 37 (2007–2008) to the Storting. It entails that all inmates who lack housing, employment or training, who need social services, treatment for drug or alcohol dependency or other health services, shall be offered this when they are released from prison. It is a goal that all agencies with which the correctional service cooperates shall offer their services in all large prisons. Today, schools and health services are established in all prisons, while social services, labour and other welfare services that are organised under the Norwegian Labour and Welfare Service (NAV), and the specialist health service, are only present in a few prisons.

The qualification programme is a measure organised by NAV that aims to help more people to find employment and engage in activity through closer and more binding collaboration. Seven

prisons are included in this programme to test the collaboration between NAV and the correctional service. It is the NAV office in the municipality in which a prison is located that takes part in the collaboration instead of the office in the inmate's home municipality. This is modelled on the collaboration with the health service. Of the seven prisons taking part in the qualification programme, five are establishing units for mastering drug and alcohol problems.

11.3.3 The correctional service's overall drug and alcohol strategy

The correctional service is implementing several measures as part of its drug and alcohol strategy. The prison officer, acting as contact officer, is the most important resource in this context. All permanently employed prison officers in Norway act as contact officers. The contact officer has day-to-day contact with the inmate and is responsible for motivating and facilitating contact and follow-up of plans with the inmate. Interviewing methods such as motivational interviewing, assessment and sentence planning are tools used in this process. The contact officer usually participates in the inmate's individual plan or other plans for the period in which the convicted person is serving his/her sentence.

The drug and alcohol coordinator or the prison's social counsellor shall contribute to coordinating collaboration between the inmate, the contact officer and collaborative partners that work in or outside the prison. In connection with the implementation of the return-to-society guarantee, dedicated reintegration coordinators have been appointed who will assist in planning reintegration after sentences are served.

A substance abuse interview is an alternative to sanctions for violation of the prohibition on drug and alcohol use in prison. It can also be used as a rehabilitation measure to create motivation to change drug and alcohol habits. The interview consists of three structured conversations based on motivational interviewing and cognitive methodology. All prisons shall offer such interviews as an alternative to sanctions for violating the

²⁰ An evaluation of the section 12 scheme by Ploeg, G. 2006. *Straff i institusjon* ('Punishment in institutions'). (English <http://img3.custompublish.com/getfile.php/327910.823.aqavswtdyu/rapport32006.pdf>)

prohibition on drug and alcohol use. This entails closely linking control and rehabilitation measures.

Measures and cognitive programmes in prison

The purpose of measures and cognitive programmes carried out under the auspices of the correctional service is to motivate or prepare the inmate for treatment or follow-up. Some programmes are offered as a result of criminal offences, such as the most comprehensive programme *Trafikk og rus* ('Driving under the influence'), which is a cognitive programme targeting persons convicted of driving under the influence who are serving their sentences in prisons with a lower level of security. In 2010, 350 inmates completed this programme. More specific programmes are offered to inmates with an acknowledged drug or alcohol problem, such as the Canadian National Substance Abuse Programme (NSAP).²¹ To ensure quality, programmes that are organised under the auspices of the Norwegian correctional service must be approved following an assessment by a dedicated accreditation committee. Following a trial period of three years, NSAP is now being implemented in several prisons on a permanent basis. In several prisons, NSAP is part of the service offered by the units for mastering drug and alcohol problems. Up to 100 inmates took part in such programmes in 2010.

A special penal sanction is being implemented under the auspices of the probation service as an alternative to prison for persons convicted of driving under the influence. The penal sanction includes participation in a cognitive programme over a period of ten months and it entails the convicted person being referred to an assessment for drug and/or alcohol treatment in the specialist health service. The number of participants per year is approximately 500.

11.3.4 Quality and scope of the services

There are two important questions relating to the collaboration between the correctional service and the health services: How extensive services must be offered in order to ensure equal right to treatment in and outside prison, and how shall the services be adapted to ensure that the individual inmates can make use of this service?

Most prisons have procedures for basic assessment on arrival, and several of them involve the health and school departments. There is no uniform system for such assessments today, but a trial project aimed at identifying inmates and convicted persons' needs is scheduled to start-up in Halden prison and at Østfold probation office in 2012. The assessment is intended to identify needs relating to the person's housing situation, education, work, finances, health and other factors that are important in the rehabilitation context. Participation in the assessment is voluntary, and it will not replace the collaborating agencies' own mapping or evaluations.

Subject to the patient's consent, the prison health service will obtain information from the patient's GP and from any treatment facilities by which the inmate was being treated prior to imprisonment. Subject to the client's consent, the municipal social services will contact the correctional service to establish contact with the prison and maintain contact with the inmate during his/her stay in prison. A right to specialised interdisciplinary drug or alcohol treatment is conferred following a medical assessment.

11.3.5 Adaptation of the services

It is the inmate/convicted person who, together with the health service, decides how much and to what extent the prison shall be informed about his/her health situation and treatment. Persons held on remand can continue to use their GP outside the prison. For convicted persons, this responsibility is transferred to the prison doctor during the serving of the sentence. The health service shall continue work on individual plans or start such work for those who wish and are entitled to such a plan.

²¹ Correctional Service Canada, SubstanceAbuseProgrammes, NSAP. <http://www.csc-scc.gc.ca/text/prgrm/sub-eng.shtml>

A survey of the prison health service from 2011 shows that procedures have been established for collaboration with the specialist health service in all prisons. This applies in particular to collaboration on psychiatric treatment and treatment for drug or alcohol problems, but also to somatic treatment to some extent. There is also extensive collaboration with the correctional service during the serving of sentences, but to a lesser extent after the transfer of inmates to another prison or upon their release. Procedures for collaboration with the home municipality (GP) upon imprisonment and release have only been established to a small extent. The prison health service has to some extent established collaboration with NAV during imprisonment, but to a lesser extent upon release.²²

In some prisons, the specialist health service also offers outpatient treatment for inmates with mental illnesses. The goal is that convicted persons who are included in the units for mastering drug and alcohol problems will be transferred to treatment in an institution during serving of their sentence pursuant to section 12, or to treatment in an institution or outpatient clinic upon their release.

As mentioned above, both NAV and the correctional service contribute to the qualification programme in the form of staff and facilitating collaboration in prison. The health service and, if relevant, the unit for mastering drug and alcohol problems, are also part of this collaboration.

11.3.6 Coordination of planwork

Individual plans are the most important tool for coordinating planwork in the health and social services. The legal basis for them is set out in both health and social services legislation. Problem drug and alcohol users in prison will usually be entitled to have an individual plan prepared if they do not already have one. It is expedient that the prison (the contact officer) participates in the

work on the plan and at meetings about the plan, so that it can facilitate meetings and implementation of the plans during the serving of sentences.

An evaluation was carried out in the period 2006–2008 following a trial involving the coordination of planwork at eleven correctional service units.²³ The units that succeeded in finding solutions were the ones that started by holding a meeting with the inmate at which all the relevant parties were present and involved in the information that was given.²⁴

11.4 Control in prisons

The fundamental principle underlying the correctional service's overall drug and alcohol strategy is to see control measures in conjunction with motivational/rehabilitation measures. It shall always be possible to follow up control measures with motivational and rehabilitation measures. The substance abuse interview (cf. Chapter 11.3.3) is an alternative to a sanction following violation of the prohibition on drug and alcohol use for inmates with drug or alcohol problems. Other sanctions can include loss of privileges such as watching TV or participation in social activities.

Control measures such as urine tests, breathalyzer tests (alcohol) and searches are carried out on a regular basis with a view to discovering drugs and user equipment. There has been a slight downward tendency in the use of drugs and illegal medicinal drugs uncovered by urine tests in recent years. There are great difference between the units and regions, however, in the proportion of positive tests.

²² Synovate 2011. Survey of the prison health service in Norway 2010.

²³ Rokkan, T. 2006. Samordning av planarbeid: Fra kaos til orden ('Coordination of plan work: From chaos to order' – in Norwegian only). Final report with comments and recommendations. KRUS. http://www.krus.no/upload/Samordning%20av%20planarbeid_evaluering.pdf

²⁴ Often called a 'responsibility group meeting', but is has no legal basis in legislation or regulations.

Over the last three years, 75,588 urine tests have been carried out, and illegal drug use was found in 8,857 samples, including those who refused to give samples (11.7 %).²⁵ The ten prisons with the most finds of illegal use are mainly large prisons (more than 50 inmates), and high-security prisons. Prisons with few finds of illegal use are often small prisons and prisons with lower security levels.

11.5 Training of prison staff

Competence-raising is an important tool in the correctional service's drug and alcohol strategy. This applies in particular to the sub-goal of *motivating and facilitating abstinence from drugs/alcohol by convicted persons during imprisonment and better control of drug/alcohol use after release*. It includes the development and use of new mapping tools that combine mapping on a broad basis with knowledge about finds from controls and observations to form a complete picture of convicted persons/prisoners on remand. Training in planwork is also crucial for all correctional service staff if they are to be able to cooperate with the health service and other partners on the convicted person's own plan during and after the stay in prison.

The correctional service's education centre (KRUS) provides staff training. All correctional service staff must be conscious of their own use of drugs/alcohol, they must be knowledgeable about drug and alcohol dependency, have the ability to identify drug and alcohol problems, and be able to assess motivation, motivate for change using motivational interviewing (MI), carry out controls and recognise signs and symptoms of drug and alcohol use, be aware of the connection between drug and alcohol dependency and mental illness, and be familiar with

the support system and treatment available to drug addicts and alcoholics.

This comprehensive goal is linked to a two-year basic education and/or further education for all correctional service staff. The goal is that all staff shall be able to evaluate and implement measures as a reaction to finds or suspicion of drug or alcohol use during the serving of prison sentences. This also includes specialised control functions, such as the drug service dog handlers, who also need skills in motivation, assessment and change work.

KRUS also offers training to partners in the prisons: the health service, the social services and the municipalities. This training is currently focused in particular on training in substance abuse interviews, the training and certification of programme leaders in the National Substance Abuse Programme (NSAP), the training of staff at the units for mastering drug and alcohol problems and professional conferences aimed at strengthening the collaboration on reintegration, collaboration at the units for mastering drug and alcohol problems, with the focus on inmates with mental illnesses.

11.6 Further issues

There are several challenges relating to the coordination of plan work between collaborative partners and the correctional service. Many prisons are small and have limited capacity. In the smallest prisons (15–25 inmates), there are only one or two permanent staff members at work during daytime due to work rotas. Work rotas may also be an obstacle to continuity of collaboration in larger prison units.

The difference of approach between the correctional service's vision of fully drug-free prisons and the health service's treatment and harm-reduction measures is a challenge in relation to collaboration. This applies to substitution treatment, the distribution and use of other addictive medicinal drugs and to the use of needles. As

²⁵ Calculated on the basis of statistics from controls carried out using urine tests (drugs and medication) or breathalyser tests (alcohol) in all prisons in Norway for the years 2008, 2009 and 2010.

regards treatment with methadone, Subuxone and Subutex, which is permitted, the distribution and administering of the medicines could be a challenge, especially in prisons with few prison health service staff.

This conflict of interest is most apparent in the discussion about the use of needles in prison. In a report from 2009, the Directorate of Health recommended giving inmates access to clean needles.²⁶ Previous practice has been to grant access to chorine for sterilisation purposes. The Norwegian Board of Health and the Norwegian Medical Association endorsed the recommendation, while the prison officers' unions, the prison health service and the police were against it. In 2010, the Ministry of Health and Care Services decided to reject the proposal, stating that there was little need to change the current practice, that the safety of prison staff was important and that the distribution of needles in prisons could undermine work on motivating inmates for change and treatment.²⁷

Another critical factor in connection with collaboration is the fact that many inmates serve relatively short sentences. Three out of four convicted persons released in 2010 had served up to 90 days. The average duration of sentences was 123 days. Almost half were released after 30 days on remand and one of three after 60 days. The average time spent on remand was 79 days. This means a high turnover and a short time frame in which to implement measures during the serving of sentences.

²⁶ Ekeid, S.E. 2009. Tilgjengelighet i norske fengsler til sterile sprøyter og spisser for injiserende rusmiddelavhengige. Forslag til en ny tilnærming. ('Access to sterile needles and syringes for injecting drug addicts in Norwegian prisons. Proposal for a new approach' – in Norwegian only). The Directorate of Health

²⁷ The Ministry of Health and Care Services. Press release 28 July 2010: Nei til utdeling av sprøyter i fengslene ('No to the distribution of needles in prison' – in Norwegian only). <http://www.regjeringen.no/nb/dep/hod/aktuelt/nyheter/2010/nei-til-utdeling-av-sproyter-i-fengslene.html?id=611770>

In several prisons, the prison health service describes the increasing number of foreign inmates as a major challenge, both in relation to access to interpreting services and in relation to the provision of necessary help. This emerges from a qualitative survey of the prison health service in four selected prisons (Synovate, 2011).²⁸

Some prisons have better health resources than others, and they also seem to be allocated new resources through the focus on units for mastering drug and alcohol problems, collaboration with NAV and the correctional service's own drug and alcohol strategy. However, if we compare the location of the units for mastering drug and alcohol problems with the overview of finds of illegal drug use in connection with control measures, there is little correlation between units with a high proportion of finds of illegal use and the establishment of units for mastering drug and alcohol problems. There does not seem to be a connection between prison health services and the prevalence of illegal use detected through controls. There are as many units with extensive resources as units with few resources that have a high proportion of finds of illegal use.

Equal right to treatment is an important principle in the Norwegian health service. The basis for such equal treatment is an individual assessment of needs. It is therefore important that the health departments in all prisons have the resources they require to be able to refer inmates for assessment, and that the prison is capable of facilitating any necessary treatment in collaboration with the specialist health service and NAV. In order to plan such collaboration, a common knowledge base is required of the scope of drug and alcohol dependency among inmates and convicted persons. In a consultative paper on new national professional guidelines for the assessment, treatment and follow-up of persons with concurrent drug and/or alcohol problems

²⁸ Synovate 2011. Op. cit.

and mental health problems,²⁹ it is proposed that the prison health departments be given responsibility for screening all inmates on admission to

prison. Such screening, both in prisons and in the probation service, would be a good starting point for designing appropriate measures.

²⁹ The national professional guidelines for assessment, treatment and follow-up of persons with concurrent drug or alcohol problems and mental health problems are available online: http://www.helsedirektoratet.no/vp/multimedia/archive/00316/H_ringsversjon_av_r_316179a.pdf