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“I’m Not Like That”

How People with Opioid-Use Disorder are Affected by and Manage Stigmatisation Before and After Entering Heroin-Assisted Treatment

Heloise Sverdrup Lund

Master Thesis in Criminology
Department of Criminology and Sociology of Law
University of Oslo

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Summary

Title: «I'm Not Like That»
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Research question and aim: My research question for this thesis is "*How are people with opioid-use disorder impacted by and manage stigmatisation before and after entering heroin-assisted treatment?*" My study aims to understand how people with opioid-use disorder (OUD) experience and manage stigmatisation, and whether and how being in HAT changes this. The objectives of the study are to explore 1) How the participants experience stigmatisation, 2) How they manage stigmatisation, and 3) Whether and how being in HAT changes how they experience and manage stigmatisation. My study links the stigmatisation, social exclusion, and criminalisation of people who use drugs to Norway's contemporary debate on whether hard drug use should be met with help or punishment, and I argue that having a knowledge base on the individual and social effectiveness of harm-reduction initiatives like HAT as alternatives to punitive drug policies is essential for criminology to partake in this debate.

Theoretical framework: I use Goffman's (1963) stigmatisation theory as my overarching theoretical perspective, supported by Sykes and Matza's (1957) neutralisation theory. I define stigma as a trait that goes against the norms of a particular social group and by that leads to experiences of discrimination and social exclusion. The theories are used to gain an understanding of the participants' experiences with stigmatisation through analysis of their encounters and awareness of it, and how stigmatisation is managed through analysis of their responses to it.

Methods: My research is a qualitative study that took an inductive and iterative approach towards exploring the participants' experiences and management of stigmatisation. I visited the HAT-clinic in Oslo somewhere between 15-20 times to conduct participant observation, interview the purposively sampled participants, and get insight from the staff on how the clinic works and who the patient group is. The interviews were audio-recorded, transcribed in f4transcript, and coded in NVivo. I used thematic analysis for the categorisation and coding of the data. The thematic analysis resulted in three themes that are linked with the study's objectives, and are explored in chronological order through sub-themes.

Data: Nine transcripts from interviews with patients that had been enrolled in the HAT-program in Oslo for 1-3 months. The participant group consists of six male and three female patients with OUD and the age group is 38-54 (average age 47). Seven of the participants inject the medication at the clinic in liquid form and two consume it in solid tablet form.

Findings: Institutional stigma was experienced through rules and regulations in MAT and/or HAT that restrict the patients' agency, which further lead to the internalisation of stigma. Stigma was managed through neutralisation techniques that demonstrate control and rationality, and symbolic boundaries that alter the perspectives on delinquent acts. The patient-centred approach in HAT has a mediating effect on how the participants experience stigma and facilitates feelings of coherency to the conventional society, improved self-efficacy, and a positive self-perception. Overall, my findings suggest that HAT can be an effective harm-reduction strategy for mediating how patients are affected by stigmatisation, but that the patient-centred approach is an essential element of this success.

Conclusion: Stigmatisation of norm-breaking individuals with substance-use disorders may have adverse consequences where the formation of sub-groups creates a community where deviant behaviour is accepted and contextually justified, which in turn can promote neutralisations of guilt and shame related to delinquent behaviour. Stigmatisation may also reinforce expectations and fears of social exclusion and discrimination, which further promotes the use of neutralisation techniques that justify or rationalise deviant and/or delinquent behaviour before, during, and after engagement. HAT challenges the stereotyped idea of a person who uses drugs as deviant, criminal, and dangerous and can reduce the impact of stigmatisation and facilitate successful recovery for people with OUD through a patient-centred approach where the staff play a key part in the patient's recovery process. The medical discourse from seeing illicit drug use as a behavioural issue to a health issue also includes some critiques where this group's challenges related to structural and social factors may be overlooked. Increasing the public's understanding of OUD may contribute to reducing the stigmatisation towards this group.

Key words: Heroin-assisted treatment, opioid-use disorder, stigma, neutralisation techniques

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On a more personal level, I want to thank my partner - and my dog - for lifting me up when I have felt like there is no end in writing this thesis and making sure that I get home to joy, smiles, and hugs. My family, although they live too many hours away, has always felt close and I never would have gotten to this stage in my life if I did not have you. My peer students at IKRS have been absolutely essential for motivating me to come to Domus Juridica and write, and my friends (you know who you are) have been the best cheerleading squad a girl could dream of.

Heloise Sverdrup Lund *Oslo, 21.05.2023*

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1 Introduction

Before you start reading through my thesis, I will take you to one of Norway's first heroin-assisted treatment clinics. The following two paragraphs are my first field notes from visiting the Oslo-clinic on April 4, 2022:

I am sitting in one of the sofas in the inner corner of the observation room. The room has two corner sofas with a table each, two lounge chair stations, a patient bed that is on the way out of the room, a large dining table that has a fruit basket with bananas, and a food station where the staff has served a simple breakfast. There is a huge bookshelf with anything from novels to a book on tractors that separates the sofas, and newspapers by the dining table. The door to the room where the majority of the staff are is wide open, and a window on the wall makes it easy to observe and communicate between these two rooms. The first patients of the day enter the observation room after having injected their medicine the injection room. They say hello to a nurse who notes their time of entry and gives them both a multivitamin tablet, and they give me a smile and a nod but seem as if they are in a hurry. Their clothes are worn-out and way too big, but one of them has brand new Nike-shoes. One lays down on the patient bed and seems to fall rapidly asleep, the other sits down to relax in an armchair. The person who just sat down in the chair stands back up like he has forgotten something, before he mumbles something to himself and goes to the food station where he shakily pours himself a cup of coffee. He grabs a banana from the fruit basket on his way back and sits down in the armchair again. He falls asleep with the banana in one hand and the coffee cup in the other. A nurse has to wake him up and tell him to put the coffee on the table as it keeps spilling on the floor when he falls asleep.

Three more patients enter the room. Same procedure with the nurse and they all say hello to me before they grab some bread with cheese, jam, or liver pâté. One of them puts three portions of jam on one slice of bread. They pour themselves some coffee and juice before they approach me and ask if it is alright that they sit down next to me. I smile and say "of course", and all three patients sit down in the sofa. I introduce myself and they introduce themselves, and we start talking. They are dressed as many ordinary citizens are – nothing particular about their appearance stands out to me, except for their faces, which look somewhat rough, and their eyes, which are very blank. The conversation flows easily and I am surprised by *how personal many of the things they tell me are, considering that we just met. Four new patients enter the room. Same procedure with the nurse and saying hello to me, before they grab some food and sit down around the dining table. Two of them start talking to each other, one reads the newspaper, and one grabs another newspaper and starts solving Sudoku. They small talk and make jokes with the staff, and seem to be comfortable with each other. A nurse says to the person who laid down on the patient bed that he is good to go. The patient does not want to wake up, so she approaches him to check that he is okay. He is fine, but explains that he does not want to go out in the rain again and that it is cold outside. All the patients who have entered the observation room have given me a smile, and many have been very curious about who I am. Some seemed insecure and hesitant about looking me in the eyes though, as they quickly looked away after giving me a smile and saying "hi". If any of the patients did not like my presence there, they did not show it.*

I arrived at the clinic at 8 am to participate in the staff's morning meeting and introduce myself and my purpose for being there, as well as to get an introduction and tour of the clinic. This is one of Norway's two first HAT clinics, both opened in 2022 – one in Oslo which opened in January and one in Bergen which opened in March. The patients enter the clinic twice daily to get their medication; first between 8:15-12:00, and then between 14:00-17:00. The medication that the patients receive during these opening hours is medical heroin[1], which they have to inject or take in tablet form at the clinic. The great majority injects and the patients' wishes regarding which dosage they want be on is taken into consideration. At the end of their afternoon visit, they get a take-home dose of methadone. The patients have to enter the clinic at least 30 minutes before it closes to have enough time to do the following procedure:

The patients have to be let into the clinic by staff at the reception desk, at which they enter a waiting room where they can have some coffee while they wait for their turn in the assessment room. In the assessment room, which has closed doors and is shielded from other patients and staff, they talk to a nurse about which substances they have taken since their last visit to the clinic and whether there are any new health-related issues that the staff should be aware of. The

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[1] Medical term: diacetylmorphine (DAM). Referred to in this text as 'medical heroin' whereas heroin acquired outside the clinic is referred to as 'street/illicit heroin'. The patients at HAT can choose to receive DAM in liquid or tablet form.

nurse then gives them a score based on an opioid score table (see *Appendix 1*) and they have to score 1 to be allowed into the injection room. The patients walk into the injection room where there are seven stalls which each has a desk and a chair, placed in front of a large mirror that arches across the whole wall. The patients collect their labelled trays with personal injection supplies and get their medication from a nurse who monitors the injection room. Nurses in another room measure each patient's prescribed medicine dose before it is given to the injection room, and the dose can be adjusted based on what the patient reported during the assessment. Each patient's dose has been calculated and tailored beforehand by doctors at the clinic who follow up every individual's medical needs. The patients are given 20 minutes and a maximum of three attempts to inject the medicine, and posters clearly state that they are not allowed to inject into their neck or groin. The room has a vein scanner that the patients can use to identify their veins and the staff is ready to guide the patients if they struggle, but are not allowed to physically inject the medicine for them. After injection, the patients clean up and sanitize the desk before they put their tray back in place and walk into the observation room. Here, a nurse welcomes them and notes their time of entry as they have to wait 20 minutes before they are allowed to leave the clinic. This is to ensure that the patients are stable and well after they have received their medication. The nurse gives the patients a multivitamin tablet and there is a simple breakfast buffet for the morning visits. The patients who receive their medication in tablet form do not have to go through the injection or observation room, and are free to go after swallowing their tablet by the opening next to the reception. They can still choose to enter the observation room if they want to socialise, have food, or need to talk with someone from the staff.

HAT is a trial project that will last for five years, the first two being the start-up phase, and is going to be evaluated by the health authorities after the trial to decide whether it shall continue or not. Christie and Bruun (2003: 13) argue that the war on drugs is partially lost because of the punitive approach that continues to produce the same defeated outcomes, and the implementation of this harm-minimisation program occurred whilst the contemporary debate was polarised on whether drug use should be met with help or punishment. The project was initiated by the Norwegian health authorities who saw a need to expand the traditional offer in medication-assisted treatment (MAT)[2] as one out of ten patients did not benefit from the treatment, which was strongly supported by advocacy from stakeholders such as PWUD, organisations, and politicians (Oslo University Hospital 2022). HAT has been tested abroad for more than 25 years and is considered an evidence-based approach due to the research that has been conducted internationally, and the clinics in Oslo and Bergen are aimed at treating 150-300 patients (Eide et al. 2019: 6; Madden et al. 2021: 2181). It is a harm reduction initiative that is aimed at providing patients with a better quality of life and improved health, and must be understood accordingly without being confused with programs that aim at full abstinence from drugs (Eide et al. 2019: 10, 11).

HAT is an extension of the traditional MAT, which has been in operation in Norway since 1998 (Eide et al. 2019: 10). A main difference between these programs is that the patients in HAT receive medical heroin and methadone instead of buprenorphine and methadone, which share similarities with morphine (Eide et al. 2019: 6). Another difference is that HAT aims at treating patients that they refer to as ‘hard-to-treat’ or ‘hard-to-reach’, which means that they must have tried less intense drug treatment without achieving adequate treatment outcomes, or that they have been challenging for these treatments to reach. The patients in HAT enter the program through referral from their doctor, NAV[3], or MAT. A report from the Norwegian Institute of Public Health (Steiro et al. 2020: 5) on qualitative studies on traditional MAT found that common challenges in MAT were that both patients and staff experienced that the program contributed to higher stigmatisation as negative attitudes from the society included that the patients were still seen as ‘drug addicts’, not patients. Being in MAT meant that the patients had to publicly acknowledge that they had opioid-related issues, hence strengthening the stigma because they could no longer hide it. It was also found that limited knowledge amongst the staff reduced the patients’ quality of care and that the patients had expectations about receiving support regarding non-health related issues, such as employment and living conditions, which were not met.

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[2] Legemiddelassistert rehabilitering (LAR), translated to medication-assisted treatment (MAT). HAT is an extension of and part of the traditional MAT, see https://www.helsenorge.no/rus-og-avhengighet/legemiddelassistert-behandling-lar/ for more information.

[3] Norges arbeids- og velfedsforvaltning (NAV) (The Norwegian Labour and Welfare Administration), see www.nav.no for more information.

Each patient in HAT is appointed a primary care nurse that acts as their substance-use coordinator, and a clinically certified social worker as their point of contact regarding health and social services such as dental health and accommodation. Both of these contacts are present at the clinic as well as senior doctors who can follow up on acute issues and make referrals for follow-up help on different health-related problems. This provides a closer and more intensive treatment regime than MAT. The close and easily available contact with the primary care nurse, social worker, and doctors is assumed to provide a therapeutic component that can facilitate tailored help for the patients and enable further treatment for comorbidities and other health or social issues (Bell et al. 2017). This is an important element of this treatment program as many of the patients have complex issues related to their health, such as very poor dental health, severe vitamin deficits, and mental health issues, and many do not have stable living arrangements. OUD is a medical condition that places this patient group's challenges in a different category than the ones of more recreational PWUD. However, poor knowledge and misbeliefs regarding the complexity and physiological aspect of OUD contribute to added burdens for these individuals in the form of social exclusion and marginalisation through punitive drug policies (Goffman 1963: 147; Madden 2019: 324; Romo et al. 2009). Research has found that this patient group identifies most of their stigmatising experiences to occur in public institutions such as hospitals, and stigma has been found to pose significant barriers to seeking and receiving care as well as reducing the quality of care that they do receive (Adams and Volkow 2020: 702; Burgess et al. 2021). The patient group that HAT treats is complex. They do not only face physical and psychological issues, but also carry a heavier burden than other patient groups as they are argued to be one of the most stigmatised worldwide (Cheetham et al. 2022; Eide et al. 2019: 2019; Luoma et al. 2008; Skatvedt 2020: 22).

Goffman's stigmatisation theory has been widely recognised as a framework for understanding how those who deviate from conventional society are labelled and treated. As this thesis will demonstrate, the consequences of living with a stigmatised condition can be severe, but stigma can be reduced with the right initiatives (Stevens et al. 2022: 42). However, this brings the question of what stigma is. Is it a physical mark that exposes a person's immoral status, like the Greeks believed – or perhaps a bodily mark that identifies physical disorders as opposed to bodily signs of the holy grace, as the Christians assumed (Goffman 1963: 10)? Or is it norm-breaking characteristics that separate someone the conventional society because of the cultural expectations general citizens have to each other (Ahern et al. 2007: 189)? The different definitions and conceptualisations of stigma depend on which discipline and circumstance the concept is applied to and has varied greatly since it was first theorised by Goffman who in 1963 defined the contemporary stigma as an undesirable attribute, such as drug use or crime, which leads to exclusion from conventional society (Link and Phelan 2001: 364, 365). This definition is broad and by that, often easily applicable at first glance, but this also brings some challenges. For instance, Goffman's definition excludes structural factors and places the stigma as a personal characteristic, hence creating the risk of overemphasising individuals' responsibility and undermining the social and political forces that contribute to stigmatisation. Another noteworthy critique of this theory is that those who apply it in their studies are not in the stigmatised group, hence are the findings often uninformed by the lived experiences of the stigmatised groups that are the core of the studies (Link and Phelan 2001: 365). This creates a paradox where our understanding of what stigma is and how it affects those who are stigmatised is severely uninformed as it is understood through the perspectives of non-stigmatised individuals. I therefore argue that it is essential to include the lived experiences of those who are (arguably) stigmatised for criminology to understand the concept of stigma, the process of stigmatisation, and how it affects people who are stigmatised because of their drug use. This understanding may further contribute to knowledge on how stigma can be reduced, hence improve marginalised individuals' quality of life. Moreover, it can generate insight on the true effectiveness of harm-minimisation strategies, such as HAT, as alternatives to punitive drug policies. This thesis will contribute to knowledge on these matters through exploring how people in heroin-assisted treatment are impacted by and manage stigmatisation and I argue that this knowledge is important for criminology to partake in the debate of whether problematic drug use should be met with punishment or help.

1.1 The Thesis' Aim

This thesis's research question is: *How are people with opioid-use disorder impacted by and manage stigmatisation before and after entering heroin-assisted treatment?* (see *Appendix 2* for table of research question, aim, and objectives). The participants in my study are nine patients from the HAT-clinic in Oslo and the data material is transcripts from interviews with these patients, which were examined through thematic analysis. Field notes from participant observation is used as supporting data in cases where they can provide additional insight into the interview data but were not used in the thematic analysis. The purpose of the research question is to examine the participants' experiences with stigmatisation before and after they entered HAT, and also whether their mechanisms for dealing with stigma change by being in a treatment program that focuses more on the therapeutic component than for instance MAT. I took an inductive approach when writing this thesis and decided to explore stigmatisation as I in the thematic analysis of the data material quickly discovered that my themes could be related to stigma. Based on the literature I read about HAT and OUD, it was also firmly argued by several scholars that OUD is the most stigmatised health conditions in the world as illicit drug use is often seen as a choice rather than a medical condition (Cheetham et al. 2022; Luoma et al. 2008). Hence, Goffman's (1963) stigmatisation theory is applied as the overarching theoretical perspective in this thesis. The aim of this thesis is to understand how patients with OUD experience and manage stigmatisation and whether and how enrolment in HAT changes this. I will explore this aim through a three-fold research objective that explores; how the participants experience stigmatisation, how the participants manage stigmatisation, and whether and how being in HAT changes how the participants experience and manage stigmatisation. By doing so, this thesis will contribute to generating knowledge about the function and impact of stigmatisation by pointing out some exact experiences from the individuals who are on the receiving end of this process. This may further be used as evidence-based knowledge for policy makers and service providers who work with this group, as well as for the public who gain an insight into how it is to live with a stigma. The hope is that this can contribute to reducing stigma towards people with OUD, hence also improving their quality of life.

I have chosen to explore stigma through a criminological lens by looking at stigmatisation's function of social control which generates social exclusion and institutional vulnerabilities, and how this affects those who are stigmatised. The social exclusion means that stigmatised individuals are prevented from participating in the conventional society with regular citizens, whereas institutional vulnerabilities are formed through penalising drug policies that restrict the affected individuals' resources in terms of social and health services (Cheetham et al. 2022: 2; Goffman 1963: 147). Existing literature argues that legal systems that generate beliefs about heroin, addiction, and criminal behaviour have a considerable impact on the individuals who use criminalised drugs as these beliefs also impact the public's view on the matter (Boyd and Norton 2019: 265; Cheetham et al. 2022: 2). Consequently, the stigmatising effect of these legal systems is intensified as they shape the public's perception and by that also generate support for drug policies that are aimed at punishment rather than help. This is worrying as research has found that the specialist healthcare is better equipped and more suitable for managing and treating drug use than the criminal justice system (Stevens et al. 2022: 41). Consequently, the political and public debate regarding how heavy drug use should be approached is divided between the opinions on whether they should receive punishment or help. There is extensive research on the outcomes of criminalising drug use both in the national and international context, whereas the outcome of HAT as a harm minimisation strategy in Norway is yet to be explored. Hence, the results from taking this exact therapeutic approach towards treating OUD is not known, which makes it reasonable to suggest that both sides of this debate lack fundamental insight. For criminology to participate in this debate, I argue that it is necessary to have a knowledge base on how laws, regulations, and norms contribute to stigmatisation and structural vulnerability for people with substance use disorders as this has been found to be vital elements of their recovery process (Cheetham et al. 2022: 1). How this group is affected by and manage stigmatisation is the focus of my analysis, whereas how this is related to laws, regulations, and norms is the broader context and will be discussed in Chapter 6.

When reading through the literature on stigmatisation, HAT, and substance use, I found that the various definitions of 'stigma' were either too narrow or too broad to capture what I wanted to explore in this study. I therefore had to establish a definition that was beneficial for addressing my research question, whilst trying not fall under the previously mentioned critiques of the original definition. For the purpose of this study, I have defined stigma as a trait that goes against the norms of a particular social group and by that leads to experiences of discrimination. This definition is inspired by Stafford and Scott (1986), and by 'norms' I refer to common beliefs about how individuals in a social group should behave (Ahern et al. 2007: 189). Seeing stigma as a trait makes it possible to include the participants' diagnosis of OUD as a stigma, whilst my definition also includes that stigmas may be related to behaviour and not just individualistic characteristics. This is highly relevant due to the strongly argued institutional stigmatisation that this patient group encounters as disclosure of their diagnosis impacts their resources related to healthcare, social services, and in criminal justice processes (Skatvedt 2020: 22). I found it particularly interesting that the participants often justified and/or rationalised deviant behaviour, and that some even shared stigmatising beliefs about other patients at HAT that were in the same position as them whilst at the same time discouraging use of stigmatising language and attitudes. However, Goffman's theoretical perspective only enables an analysis of whether and how the participants in my study are affected by stigmatisation as well as an indication of to what extent they are aware of it. Neutralisation techniques are argued to provide individuals with tools that mitigate the fear of being stigmatised and the impact of it in social interactions as they through these techniques can alter the perspective through which their behaviour is seen (Askew 2016: 21; Sykes and Matza 1957: 666). To facilitate an analysis of how the participants respond to and manage stigmatisation, Sykes and Matza's (1957) neutralisation theory is included as a supporting perspective as neutralisation techniques have been found to be common responses that stigmatised individuals utilise to protect and maintain a positive self-identity (Dickinson and Jacques 2019). This is explained further in Chapter 3.

1.2 The Thesis' Structure

My thesis has seven chapter, this introduction being the first. The introduction has given the reader a way into the core of the thesis by first explaining the HAT-clinic I have visited and sampled my participants from, and who the patients at HAT are. It then provided a short summary of my theoretical framework as I considered this understanding as a necessary foundation for reading the following background chapter. The thesis' research question, aim, objectives, how I approach them, and the thesis' criminological relevance were described in Chapter 1.1.

The second chapter will introduce background information based on existing literature on the political developments that lead to HAT, explanation of what OUD actually is, the link between stigmatisation and OUD, the social exclusion and grouping of people with OUD, and how a thereapeutic approach can be a harm-miminsation strategy. The chapter will by that provide the necessary knowledge to understand central concepts in this thesis.

The third chapter will provide the reader with the theoretical knowledge that is necessary to understand this thesis' analysis and discussion. I start by explaining Goffman's (1963) stigmatisation theory and how I have chosen to define and understand stigma for the purpose of this thesis, before I explain Sykes and Matza's (1957) neutralisation theory and how neutralisation techniques work. An important part of the theoretical framework is how stigma and neutralisations contribute to the participants' identity construction. I finish the chapter by demonstrating how these two theories may generate answers to this study's research question as they, when combined, are able to answer whether and how the participants experience stigmatisation, their awareness of it, and how they construct a positive self-perception through neutralising stigma and deviant behaviour.

The fourth chapter will describe the qualitative methods I used in this thesis. I explain how I sampled the participants for this study, the processes with participant observation and interviews, and the challenges I encountered during the data gathering process. I describe how I started with an open-ended research question and took an inductive approach when categorising and coding with thematic analysis, provide some strengths and limitations with my study, and the ethical considerations that were made.

The fifth chapter will present and explore the results from the thematic analysis. The analysis is split into three parts where each headline represents a theme whereas the secondary headlines represent a sub-theme. Part one analyses experiences that I interpret as stigmatising based on my definition of stigma, as well as how the participants reacted to these experiences. The first part will try to identify whether and how the participants experience stigmatisation, as well as to what extent they are aware of and have internalised their stigma. Part two takes a deeper look at how the participants utilise neutralisation techniques to distance themselves from a stigmatised and/or delinquent label and how this demonstrates a certain coherence to conventional norms and values, despite being excluded from the mainstream society through the process stigmatisation. Part three explores how being in HAT contributes to changes and differences from the stigmatising experiences that the participants described in part one, and whether being in HAT changes how they are impacted by and manage stigmatisation, which was explored in part two.

The sixth chapter will provide a summary of the main findings from my study before it moves on to discuss them in relation to previous studies, the importance of these findings in a wider context, and point to areas that future studies should address. I will discuss the adverse and unintended consequences stigmatisation can have both for individuals and society, how deviancy can be rational and contextually accepted, and some issues in interpreting this topic through a theoretical lens. I will also review some challenges in the discourse of seeing OUD as a medical rather than behavioural or social issue.

The seventh chapter sums up the overall implications of my study and how they contribute to valuable insight in the contemporary debate on whether hard drug use should be met with help or punishment.

2 Background

2.1 Drug Reform – From Punishment to Help

20 years ago, Christie and Bruun (2003: 14) encouraged the government to appoint a committee that could evaluate what they refer to as the war on drugs. They argued that the penalty level for drug use should be evaluated as the consistent punitive approach towards it continued to produce the same defeated results, such as increased social and health-related harms amongst PWUD. They also argued that drug policies and initiatives should be aimed at helping rather than punishing people who use drugs (PWUD) and that it should be made easier for doctors to prescribe drugs that were only distributed on the black market, such as street heroin, as this could free people from dealing drugs to support their own use. The Norwegian drug reform from 2004 contributed to changing the way we see PWUD as they could now be treated as patients, hence challenging the dominant stereotype of a 'drug user' as purely criminal (Ravndal 2009: 75). This reform legislated that people who need long-term and coordinated services regarding drug use have the right to an individual plan that also considers their opinions and needs, and that the service providers are obliged to offer holistic healthcare offers (Rådahl and Flydal 2003). It also moved the responsibility for drug treatment from the county municipality to the national specialist healthcare services. 15 years after Christie and Bruun (2003) had published their encouragements, they were somewhat answered by the Solberg-government (2013-2021) which in 2018 appointed a Drug Reform Committee with the task of making a proposal for a second drug reform. This proposal should explore and evaluate how Norway could implement a decriminalising and destigmatising drug policy that improved PWUD's healthcare offer, for instance by directing possession of user-doses from the criminal justice system to the healthcare sector (Torgersen et al. 2019). The reform was voted down when it was presented for the Norwegian parliament in 2021 as there was disagreement as to whether possession of user-doses of illicit drugs should be decriminalised, but there was common agreement that PWUD should be met with help rather than punishment.

The political development from 2004 to 2021 might suggest that the general understanding of heavy drug use and addiction has taken a more medical approach than before by increasingly transferring how it is treated from the criminal justice system to the public healthcare. This includes that heroin can be used as prescribed medicine for people with OUD who are in treatment, rather than being limited to a street drug that is used for recreational purposes (Johansen and Johansen 2013: 113). It is not given that every person who uses illicitly acquired opioids, such as street heroin, is in need of treatment and nor is it given that this political development means that all PWUD will, or can, be treated as patients. However, treatment may be necessary when the pursuit for opioids is prioritised over other activities and dominates someone's life (Radcliffe and Stevens 2008: 1066). It is also important to note that a person who receives medical heroin in treatment is not given a free pathway for delinquent behaviour, like some scholars have argued, as the use of illicit steet drugs – including heroin that is acquired outside of a clinical setting – is still illegal (Maruna and Copes 2005: 291). Similarly, drug dealing is still a criminal offence regardless of whether you are a patient in HAT or not. Illicit drug use is therefore not decriminalised or depenalised in Norway as it can still be reacted to with criminal sanctions, but there has been a diversion of it as PWUD are directed towards health and social services, such as HAT, rather than the criminal justice system (Stevens et al. 2022: 30). This does not mean that criminal sanctions against illicit drug use are no longer used, but rather that they are no longer the primary and first step on how to approach PWUD that have health problems related to drugs.

The reform from 2004 could be considered an important step towards reducing the stigma towards people with OUD where there is a polarised and stigmatising view of the legitimate and physically ill person, who is a 'patient', versus the one that is illegitimate, mentally ill, and weak, who is seen a 'drug addict' (Cheetham et al. 2022: 1; Werder et al. 2022: 10). The legitimate person utilises medical heroin and other hard drugs to deal with physical illnesses such as cancer and is therefore considered responsible, whereas the illegitimate consumes hard drugs for recreational purposes, or as tools to deal with mental issues, and is considered irresponsible (Cheetham et al. 2022: 1). Hence, the illegitimate person is considered deviant and becomes stigmatised and socially and politically excluded from the general society (Cheetham et al. 2022: 1). This exclusion encompasses that the stigmatised are not welcome in the social life and normative coherency of the conventional society, and rather than being treated by the healthcare system and social services, they are criminalised and further marginalised by policy makers through the criminal justice system (Goffman 1963: 147; Madden 2019: 324; Romo et al. 2009). Patients in HAT are a group that have been directly influenced by this political shift as they were given patient status and rights when they were diagnosed with OUD, which give them the merit to being treated by the healthcare system rather than being transferred directly to the criminal justice system. However, the majority of this group has already been treated as patients for their OUD by their general practitioner or in MAT, where studies found that the stigma was strengthened rather than reduced (Steiro et al. 2020: 5). This might suggest that becoming a legitimate PWUD in the eyes of the law does not necessarily mean that you are considered legitimate by the conventional society. To what extent and how stigmatisation impacts these patients when they enter HAT is unclear and the current literature may give indications, but not answers as this issue has not been addressed in the Norwegian context. There is also a gap in the literature on how they respond to and manage it, which is worrying as stigma has been found to be a barrier for people with OUD who need and seek care (Adams and Volkow 2020: 702). My study will seek to fill these gaps through insight from patients at HAT who describe what these stigmatising or discriminating experiences are, and identify how they respond to and manage it. This can uncover whether HAT produces the same adverse consequences of strengthened stigmatisation that were found in MAT.

2.1.1 Heroin: From Illicit Street-Drug to Prescribed Medication

The UK started to use medical heroin to treat opiate dependence in the 1920s and introduced HAT in the 1950s in an uncontrolled social experiment (Farrell and Hall 2015: 3). However, poor evaluation of the outcomes of the experiment led to limited support for this form of treatment until a British psychiatrist advocated for heroin treatment in the 1980s and 1990s (Farrell and Hall 2015: 3; Fischer et al. 2002: 231). As a result of this advocacy, Switzerland introduced strictly controlled and clinic-based HAT in the 1990s where the patients were supervised during medical heroin injection several times daily throughout the week (Farrell and Hall 2015: 3). The Swiss model has now become the most standard HAT-model internationally and several European countries have introduced HAT-programs during the last century, where people who use opioids are prescribed medical heroin that they administer at a clinic under medical supervision (Fischer et al. 2002: 231; Löbmann and Verthein 2009: 83). In 2019, HAT was offered in at least 58 clinics across eight countries; Canada, Denmark, England, Germany, the Netherlands, Spain, Switzerland, and Belgium (Eide et al. 2019: 14).

Australia, Belgium, Canada, Spain, Switzerland, and the United Kingdom have substantially researched the national effects of HAT with different methods (Farrell and Hall 2015: 3; Fischer et al. 2002: 231). Studies have found that HAT significantly reduces the patients' health risks as it prevents the use of contaminated street heroin and illicit drugs in general (Gartry et al. 2009 in Jozaghi 2014: 6; Löbmann and Verthein 2009: 83; Romo 2009: 186). Supervised and controlled injections also reduce the patients' risk of overdose as they get access to stable, pure, and constant doses of medical heroin rather than shooting adulterated and big doses when they can (Mayer et al. 2020: 3). Additionally, they get more money to spend on things like clothes, proper food, and shelter, which is not only positive for the patients' health but also contributes to a reduced need to commit crime (McCall et al. 2019: 47). It might also be suggested that having these basic needs covered and not having to commit crime to achieve them has an impact on stigmatised individuals' self-perception. Having a daily routine, such as attending at HAT-clinic, has also been found to provide individuals with stability and reducing crime by directing them away from the street community (Smart and Reuter 2021: 2). Be that as it may, these findings and studies are all based outside of the Norwegian context and it is being argued that the ways in which HAT works must be understood by taking into consideration the surroundings where the treatment is given and how this affects the participants (Johansen and Johansen 2013: 114). Because of that, findings from international studies can be used to guide the research and treatment on HAT in the Norwegian context, but not be generalised to it as the same conditions cannot be replicated here. This includes the program's delivery form, the layout at the clinic, and the treatment provided by the staff, and findings from studies in other clinics may not necessarily be applicable to the Norwegian context as these factors will be different between HAT-clinics abroad and those that are located in Norway (Johansen and Johansen 2013). Henceforth, there is a need to explore HAT in the context that is applicable for Norway's stakeholders. One approach towards doing so is to explore how the patients manage and are affected by stigmatisation before and after entering HAT as this has an impact on both the patients and society, which is what my study will do.

Whilst the effectiveness of HAT on the patients' health and well-being is highly documented, there are still some issues and concerns related to this treatment in addition to stigma and limited social support. A common concern amongst patients in Mayer et al.'s (2020) study was uncertainty regarding their chances and opportunities for leaving the program, much due to their former experiences of withdrawal. This has also been found in other studies, where participants have been critical towards the lack of exit strategies from the program as this leads to fear of having to return to a life with crime (Jozaghi 2014: 4). It is also noteworthy that Eide et al. (2019: 25) list 'stigma' as a specific challenge that is related to drug treatment with medical heroin specifically. It might be reasonable to suggest that this is a valid concern considering that Steiro et al. (2020: 5) found that both patients and staff reported increased stigmatisation with MAT, which is a treatment aimed at less complex patients than HAT. In studies that have interviewed the staff at HAT-clinics, two of the main concerns were overdoses if the patients were already intoxicated and the diversion of prescribed medications (Demaret et al. 2012: 563; McCall et al. 2019: 45). There have also been reported challenges regarding busy clinics that are pushed to their limits in terms of physical and spatial capacity, which is a challenge that is amplified by the big personalities that this clinical setting includes as this increases the risk of conflicts (McCall et al. 2019: 47). As argued by Johansen and Johansen (2013), 'place' is not limited to the physical surroundings – it also applies to how humans interpret and experience the room that they are in. Hence, it is a social construct that has an impact on the social interactions that happens in that place as well as the cognitive processes, and may therefore have a significant impact on the quality of treatment a clinic is able to offer (Fletcher 2006 in McCall et al. 2019: 47). For instance, a small clinic may limit the staff's ability to provide comprehensive patient care, such as wound care and other basic needs (McCall et al. 2019: 47, 48). Studies have also found that some clinics experience a high staff turnover as a result of the personnel not being sufficiently prepared for the work and challenges that occur in the clinic (McCall et al. 2019: 48). Moreover, the attitudes from the staff have been found to have a signiciant impact on this group's experiences of institutional stigmatisation as the patients' fear of stigmatising views from service providers has been found to be prevalent in HAT abroad (Werder et al. 2022: 10). This suggests that there are many components that are important for HAT to be a successful initiative, but several studies argue that the relationship between the staff and the patients is one of the most important factors for facilitating positive treatment outcomes because it improves the patients' social functioning (Jozaghi 2014; Ravndal 2009: 78).

2.2 Opioid-Use Disorder – Not Just an Addiction

The increased medicalisation and diversion of the drug field from the criminal justice system to the healthcare sector may be argued to reflect a change in how drug use is seen and responded to both by the public, and the authorities (Ravndal 2009: 76). This might further suggest that there is a need to understand why and how substance use can be more than just an addiction or deviant behaviour. The reason for this is that the stigma related to substance use is argued to be rooted in beliefs about PWUD being dangerous as they are violent when they undergo withdrawal, steal to support their need for drugs, and that they choose to use illicit substances for illegitimate reasons (Adams and Volkow 2020: 703; Ahern et al. 2007: 191; Cheetham et al. 2022). The stereotypical beliefs about substance use, which give life to the process of stigmatisation, are argued to be rooted in poor knowledge, misinformation, and ignorance towards the medical aspects of substance use (Cheetham et al. 2022: 2). Henceforth, to confront the stigma towards opioid-related substance use at its core, it is necessary to provide information and generate more knowledge about what happens when a person has OUD. Note that this is not the same as to argue that all individuals who use illicit drugs have a medical health condition that changes curiosity or desire for a drug to a physical and medical need, but for the group that is included in this thesis, the medical perspective is important as it applies to every patient in HAT.

OUD is defined as a chronic brain-related medical disorder with symptoms that are listed in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and patients live with a significant risk of disability, relapse, and death (American Psychiatric Association 2022; Pinn 1998: 1936). The disorder means that individuals experience significant symptoms of withdrawal when their needs for opiates are not met, caused by functional brain changes after repeated exposure to opiates (Adams and Volkow 2020: 702; Buchman et al. 2010: 36). As a result, these changes impact how the person responds to rewards, regulates their behaviour, and their emotional state, which are all essential elements of their well-being and how they function in society (Adams and Volkow 2020: 702). These changes are often used to explain why a person with a substance use disorder continues to engage in harmful behaviour despite the adverse consequences that the behaviour lead to (Buchman et al. 2010: 36). Symptoms of withdrawal may start as early as six hours after intake and include generalised pain, diarrhoea, restlessness, anxiety, nausea, insomnia, significantly intense cravings, and chills (American Psychiatric Association 2022; Wolfe and Scharp 2022: 1). Risk factors for developing the disorder are mental illness, genetic factors, exposure to drugs, market availability, and traumatic experiences in the childhood (Strang et al. 2020: 1). It seems reasonable to argue that one must have awareness of these medical aspects of OUD in order to understand why health and social services are better equipped for dealing with it than the criminal justice system, and hence, why penalising policies directed towards this group continue to produce the same defeated results as they do not consider the medical impact of OUD (Christie and Bruun 2003: 13; Stevens et al. 2022: 41). On the contrary, it is being argued that such policies attack the scapegoats of the war on drugs, which are PWUD, rather than the true enemy, which is the misguided nature of these policies (Christie and Bruun 2003: 14). The establishment of OUD as a medical disorder is formalised and clear, and that the symptoms of it go beyond those of recreational drug use, seems evident. Be that as it may, this group is argued to be one of the most stigmatised worldwide as the general society has limited understanding of how OUD differs from recreational drug use (Cheetham et al. 2022; Luoma et al. 2008). In addition to OUD's medical burdens, this stigmatisation adds hardship through social exclusion and criminalising drug policies which cause further marginalisation (Madden 2019; Skatvedt 2020: 22). In turn, this compromises the help that individuals with OUD receive as initiatives aimed at helping rather than punishing them may gather limited public support (Brown et al. 2022).

There has not been found a permanent cure for OUD, the goal of treatment is to provide individuals with a better quality of life by reducing the burdens associated with the disorder and effectively managing the symptoms of illness (Eide et al. 2019: 9; Olsen and Sharfstein 2014: 1393). It has however been concluded by an expert panel with representatives from several fields, such as medicine, drug use, and psychology, that OUD can be effectively treated with results that produce significant benefits both for the patients, and the society (Judd et al. 1998: 1936). Treatment of OUD with medications is an initiative that has been empirically proven to be effective in reducing the risk of both overdose and relapse, in contrast to other treatment initiatives such as detoxification and programs that aim at complete opioid abstinence (Olsen and Sharfstein 2014: 1393; Strang et al. 2020: 1). Patients in drug treatment may also become less subject to discrimination and prejudice as they, through seeking medical help and intervention, abide by social norms that require those with medical issues to seek help (Madden 2019: 325). OUD is estimated to affect more than 16 million people worldwide and 120,000 deaths are attributed to opioids annually, which makes it reasonable to suggest that the severity and extensive prevalence of this disorder calls for research to address the effectiveness of initiatives that are aimed at treating it (Dydyk et al. 2022). Madden (2019: 325) argues that research often portrays medical interventions, such as MAT and HAT, as destigmatising initiatives as they reframe physical and mental deviance as a medical problem and that being in treatment may provide individuals with the moral ground that they were derived of through stigmatisation. Although the previously mentioned studies on the Norwegian MAT to some extent proved Madden's arguments wrong (see Steiro et al. 2020), this thesis can provide insight on whether HAT is a more suitable and efficient destigmatising initiative.

2.2.1 The Personal Costs of OUD

Studies have found that between two and three percent of those who are addicted to heroin manage to quit and that this group has a high prevalence of mental illnesses (Amundsen 2008: 6). There are several physical harms that are directly associated with heroin use, besides the significant pain patients feel when they experience withdrawal. These harms include overdoses, infections, abscesses from unclean syringes, and high risks related to the use of contaminated heroin acquired on the streets (Boyd et al. 2017: 1; Löbmann and Verthein 2009: 83; Smart and Reuter 2021: 2). It is also a well-known issue that many of those who are fined for possession of illicit drugs, intended for personal use, do not have the financial capacity to pay and have to do a short sentencing instead (Oslo Economics 2020: 26; Rasmusen 1996: 536). People with OUD therefore face high risks of criminal sanctions when their need for opiates is not covered because of their need to acquire these drugs illicitly, which is worrying as criminal sanctions make them more even more disadvantaged and stigmatised (Hadjimatheou 2016). Nevertheless, the harms associated with OUD and illicit heroin use are not limited to the physical. It is being argued that PWUD are centrally influenced by the recognition of negative attitudes from others and shame as they may consider themselves as lacking the ability to meet their own moral standards and act effectively (Flanagan 2013 in Matthews et al. 2017: 275). The element of shame is argued to stem from stigmatisation and is linked with their beliefs about being incapable of acting as responsive and rational agents who adhere to their moral compass, which has a negative impact on this group's self-perception and treatment outcomes (Matthews et al. 2017: 275; West et al. 150). The ways that people with OUD violate social norms is also argued to alienate them from their family and friends, which adds significant social and emotional burdens to the disorder (Adams and Volkow (2020: 703). These burdens are strengthened through stigma from family, friends, service providers, and society, which has been found to produce considerable barriers towards these individuals' development of a desired and positive self-perception (Doukas 2011: 408, 409). The personal harms and challenges associated with OUD strongly suggest that there is a need for effective treatment initiatives for this group, which also entails that it is necessary to explore whether these initiatives – such as HAT – are successful in reducing the mentioned harms.

2.2.2 The Societal Cost of OUD

The opioid crisis is a global issue that causes significant challenges to individuals, communities, and healthcare systems, and people with OUD are argued to disproportionately contribute to high socioeconomic costs as their criminal activity leads to considerable costs for the criminal justice system (Cheetham et al. 2022: 1; Graham et al. 2022: 375; Smart and Reuter 2021: 2). It is estimated that there are 12,500 people in Norway with a problematic use of heroin and that only 7,000 of these are in MAT (Norges forskningsråd 2011: 18). The Norwegian government has not been able to estimate the productivity loss associated with criminal justice process related to drug-related crimes, but the ways in which people with OUD are affected by the disorder includes a significant productivity loss for society through low employment rates for this group (Fischer et al. 2002: 230; Graham et al. 2022: 375; Oslo Economics 2020: 33). Mayer et al. (2020: 6) found that the majority of this group's income stems from governmentally funded economic assistance, hence suggesting that financial support from the welfare state is used to support a significant proportion of the economy in the black market. These findings are strengthened by other studies which have found that the majority of this group support their drug use through crime, such as drug dealing, or funds that they receive in social support (Fischer et al. 2002: 230). In that sense, HAT may be considered an initiative that reduces crime by regulating heroin as medicine in an alternative arena to the black street market (Wakeman 2015: 582). If so, HAT could also be considered an answer to Christie and Bruun (2003) who advised that regulating certain drugs as medicine could reduce its prevalence and value on the street market. However, to know whether HAT has this function on crime, it is first necessary to know the prevalence and nature of crime amongst the patient group at HAT. This study can contribute to this knowledge through insight on the patients' daily lives, such as whether it is true that the majority of their illicit drug use was, or is, supported by drug dealing. This could also give indications on whether harm reduction strategies regarding drug use not only reduce harms that directly affect individuals, but potentially also reduce the extended harms caused to society.

2.3 A Dangerous Delinquent, or a Stigmatised Patient?

OUD is argued to be the most stigmatised health condition worldwide and is often considered a weakness or fault in character, and the people seen as dangerous and unpredictable (Cheetham et al. 2022: 1; Grønnestad and Sagvaag 2016: 2). The conventional paradigms and stereotypes of PWUD are that they are liars, fabricators, and manipulators with limited self-control, and the stigmatisation that follows from this is argued to be formed through associations and expectations of crime (Ning 2005: 249, 350; Radcliffe and Stevens 2008: 1065). The result of this stigmatisation is that PWUD who need help are socially excluded and considered unworthy of government assistance in terms of housing, food supply, sufficient healthcare, and economic assistance (Cheetham et al. 2022: 1; Löbmann and Verthein 2009: 83). The literature makes a distinction between the discrediting and thereby visible stigma, and the discreditable stigma that is invisible or hidden (Corrigan et al. 2017: 60). It is being argued that the visibility of a stigma is a central element of how it is perceived, managed, and reacted to, both by the stigmatised group and those who inflict stigma (Ragins 2008: 196). Entering drug treatment means that individuals have to both acknowledge and expose their stigma, hence making a hidden stigma become visible (Radcliffe and Stevens 2008: 1065). Former research has also found that stigma – or even just the fear of it – has a negative impact on the completion of treatment for PWUD as it affects how they manage their recovery process (Burgess et al. 2021; Cheetham et al. 2022; Earnshaw 2020: 4; Madden et al. 2021; Palamar et al. 2013: 516). Recovery for this groups involves successfully navigating symptoms of withdrawal and implementing coping strategies that minimise the risk of relapse to behaviour that is damaging for their mental and physical health (National Institute on Drug Abuse 2021 in Wolfe and Scharp 2022: 1). Stigma from family, friends, society, and professionals has also been found to produce significant barriers towards the development of the patients' positive and desired self-identity (Doukas 2011: 408, 408). Furthermore, research has uncovered that participants identified most of their stigmatising experiences to occur in hospitals, government agencies, and pharmacies (Burgess et al. 2021). Henceforth, stigma acts as a barrier for people who need and seek care as well as compromising the care that they do receive (Adams and Volkow 2020: 702). It may therefore be argued that it is essential to address how laws, regulations, and norms affect and segregate PWUD, and how these practises contribute to criminalisation, stigmatisation, and social exclusion of a group that according to research benefits more from help than punishment (Cheetham et al. 2022: 1; Stevens et al. 2022: 41).

2.3.1 The Link between Stigma and Delinquency

It is being argued that the stigmatisation and stereotyping of PWUD are formed through associations and expectations of uncontrolled heroin use and crime (Radcliffe and Stevens 2008: 1065). The stereotypical pathway in these associations is that heroin leads to crime as people have to commit crime to satisfy their innate craving for a specific drug, hence making 'heroin' a stigma as it assists in norm-breaking behaviour (Burr 1987: 333). However, the relationship between stigma, drug use, and crime is far more complex due to stigmatisation's function of informal social control where unwritten norms establish the boundaries between acceptable and unacceptable drug use (Decorte 2001: 297; Ugelvik 2019: 109). Moreover, contexts where the conventional society has limited informal social control, such as amongst people who are homeless or unemployed, have been found to significantly increase a person's likelihood of delinquency and crime by reducing the constraining effect of norms that establish offending as wrong whilst also increasing the incentive to offend (Sigfusdottir et al. 2012: 118). On the other hand, formal social control is sanctioned by written rules such as legislation on drug dealing and the boundaries between illicit and legitimate drug use, and operates through agents like the police and the state (Ugelvik 2019: 106). Topalli's (2005) study demonstrates that the absence of both formal and informal social control has a significant impact on the criminal behaviour of street offenders who operate in areas where their delinquency is in concurrence with other offenders, and their contact with agents of social control – such as police or law-abiding citizens – is limited. Additionally, several scholars have argued that deviance and criminal behaviour are results of stigmatisation as the person's self-image is adversely affected, and hence creates a self-fulfilling prophecy (Burr 1987: 334).

Rasmusen (1996: 536) suggests that stigma only works as a deterrent incentive to crime for people who have something to lose and that this effect also increasingly wears off each time a person faces criminal sanctions. Individuals with discreditable and hidden stigma may therefore use different coping mechanisms to avoid being stigmatised, such as living with the condition in secrecy, which may have an adverse effect due to the psychological distress and negative emotions this may inflict (Ragins 2008: 196). Crime and delinquency are argued to be common responses to negative emotions such as fear and anger because of the choices people are more likely to make under the influence of these emotions (Barbieri 2019: 1; Capowich et al. 2001: 445). Fear and shame, both arguably negative emotions, are also common responses to stigmatisation as individuals fear how other may perceive them and feel shame if the stigma is internalised (Burgess et al. 2021; Earnshaw 2020: 9; Topalli et al. 2008: 149). Additionally, responding to stigma with anger has been argued to strengthen the negative consequences stigmatisation has on the stigmatised's health (Ahern et al. 2007: 189). Public stigma has also been found to be linked with support to criminalising drug policies and initiatives (Corrigan et al. 2017: 62). This demonstrates that public stigma and crime has a reciprocal relationship, as criminalising and labelling a behaviour as 'criminal' also has a stigmatising effect (Hadjimatheou 2016). Whilst previous studies have been successful towards measuring and documenting whether drug treatment reduces crime, they have failed to explore which mechanisms that influence this decline and whether it is linked with changes in stigmatisation (Löbmann and Verthein 2009: 84). Hence, there is also limited knowledge as to which factors and circumstances that are responsible for crime and stigma reduction when patients enter HAT or MMT programs (Smart and Reuter 2021: 1). Due to the well-established link between stigma and crime, it may be reasonable to suggest that exploring this group experiences of stigmatisation whilst in HAT is a reasonable first step towards understanding these mechanisms.

2.3.2 Self-Protection from Stigmatisation

Radcliffe and Stevens (2008: 1065) found that some of the participants in their study navigated stigma by managing information about themselves, hence excluding themselves from the stigmatised categorisation. Although these participants did not associate with or see themselves as the stigmatised stereotype, they also acknowledged the categorisation's validity by placing others in it. Copes (2016) argues that this group may create symbolic boundaries to create a difference between themselves and stigmatised others, even though they belong to the same subgroup. These boundaries are usually applied to separate the functional PWUD from the dysfunctional ones and is particularly important for members of stigmatised groups as they are aware of the powerful and discrediting narratives that are often associated with them. Through drawing upon a greater cultural context, PWUD may effectively create these boundaries through recognising differences between them and others in the same context (Copes 2016: 201). This is also referred to as intra-group stigmatisation, where comparison to highly stigmatised others in the same group has been found to be a management technique that mitigates stigma (Furst and Evans 2015: 140). Copes (2016: 194) further argues that maintaining symbolic boundaries to stigmatised others can contribute to demonstrating control over their own drug use, in contrast to their social position which they have limited control over. Making references to the boundaries that separate them from what they consider dysfunctional PWUD can provide a sense of agency and control, and they may legitimise their drug use when they face the risk of stigmatisation through articulating and demonstrating control and functionality (Askew 2016: 112; Copes 2016: 207). Functional PWUD may therefore tell stories that demonstrate core differences between them and those they consider dysfunctional as a way of rejecting the labels of being a 'junkie', 'meth head', and so on (Copes 2016). These are key features of what distinguishes the functional PWUD from the dysfunctional one and is often demonstrated through, for instance, pointing out that they know how to consume the drugs properly and how they control the effects of it (Copes 2016: 200). Henceforth, symbolic boundaries may be used as a mechanism for associating with a desired group whilst also dissociating with the less desirable (Gueta and Chen 2021: 1).

Studies have found that one way that PWUD and drug dealers distance themselves from the negative label is through using neutralisation techniques about themselves and their behaviour (Dickinson and Jacques 2019: 16). By distancing themselves from a particular role, they may avoid feelings of guilt and blame through neutralisation of delinquent acts such as by explaining that they have to sell drugs to satisfy basic needs (Dickinson and Jacques 2019: 18). By doing so, they may justify and rationalise that delinquent behaviour are contextually justified and rational acts (Miller 2005: 246). This was found in Miller's (2005: 246) study where risks associated with injecting street heroin were neutralised through the participants placing the risks in a different context. Additionally, Askew's (2016) study on recreational illicit drug use found that PWUD legitimised and neutralised their consumption through articulating control of their drug use and demonstrating that they either maintained or gained functionality of their lives through the consumption of drugs (Askew 2016: 112). It is therefore being argued that people can reject parts of societal values and norms whilst still adhering to the majority of them by enacting these techniques as they act as important tools for maintaining a positive self-conceptualisation, henceforth protecting individuals from internalisation of stigma (Aldridge et al. 2011 in Askew 2016: 114; Dickinson and Jacques 2019: 21). It is therefore being argued that neutralisation theories should be applied to explain the persistence or desistence from crime as they enable insight into how individuals rationalise and justify their behaviour (Maruna and Copes 2005: 221). However, although studies have found a link between drug dealing and neutralisations, there is limited knowledge as to whether these techniques maintain the same function when people go from illicit drug PWUD to patients in drug treatment. This could be addressed through studying how patients in treatments such as HAT manage internalisation of stigma, which is what my research will do.

2.4 Social Grouping of Stigmatised Individuals

The consequences of stigma often has the adverse effects of individuals feeling shame and living in secrecy with low self-esteem, and that they therefore socialise with other PWUD rather than non-using friends and family (Palamar et al. 2013: 517). Previous findings on the benefits of HAT include that the patients got time to do meaningful things, such as reconnecting with family and friends, as their lives were no longer purely dominated by the search and need for heroin (Jozaghi 2014: 5; McCall et al. 2019: 47). Other studies have found that the medical discourse from ‘substance addiction’ to ‘chronic illness’ enables PWUD to become a part of society again after being rejected and excluded for a long time (Romo et al. 2009: 186). Additionally, it has been demonstrated that medical heroin in treatment programs can contribute to transforming the public perception of heroin from street drug to medicine, and in doing so, also transforming the perception of heroin use from pleasure-based to a need (Johansen and Johansen 2013: 113). These findings answers to literature which argues that drug policies and regulations should be focused on enabling people to manage their relationships and personal commitments (Chang 2023: 1). However, other studies have found that patients who have successfully recovered and overcome withdrawal, which was a big personal achievement, still experienced stigma from family, healthcare services, and society due to their history of drug use and/or relapse (Kelly and Westerhoff 2010 in Wolfe and Scharp 2022: 1). Additionally, the taboo related to medical heroin use has been found to be implemented and demonstrated in the behaviour of both patients and staff at HAT-clinics in Denmark (Johansen and Johansen 2013: 113). The literature therefore provides ambivalent answers regarding the presence of stigma in HAT-clinics and drug treatment centres in general, which is an issue that my study addresses through exploring how stigma is perceived by patients in HAT.

2.4.1 A Divided or United Sub-Group?

Studies have found that HAT facilitated advocacy and a collaborative identity for the patients (Boyd et al. 2017: 1; Jozaghi 2014: 8). However, it has also been found that having to attend a drug treatment centre may have a contradictory effect on recovery and the reduction of internalised stigma as the patients are forced to be in a social setting with other patients who may not share the same goals of being in treatment (Doukas 2011: 411). Participants in qualitative studies on methadone maintenance treatment reported that they found it unpleasant being forced to socialise with other clients due to the nature of the conversations that often took place, as well as feeling that their safety was compromised as these other clients were considered dangerous (Fraser 2006 in Doukas 2011: 411). This might demonstrate an intra-group stigmatisation, where patients in drug treatment considered other patients to be dangerous. Moreover, these findings represent a discrepancy in the former literature as some studies suggest that attending a drug clinic contributes to a collaborative identity, whereas other studies suggest that the participants find the setting to be challenging for their self-image (Doukas 2011: 411;

Jozaghi 2014: 8). Fine (2012: 159) suggests that groups both constitute and are constituted by social orders, and it is being argued by Leighton (1988) that a ‘community’ should be seen as a web of personal networks rather than a local and territorially bounded phenomenon. Furthermore, it is being argued that the interdependence of people in a society means that they also rely on each other and that social groups provide individuals with collective and emotional support, trust, and adherence (Fine 2012: 164; McGloin and Kirk 2010: 178). Henceforth, being in a group contributes to social capital by providing valuable social and emotional resources, regardless of whether that group is stigmatised or not (Fine 2012: 164). Be that as it may, there is a gap in the literature as studies have primarily focused on group adherence of people with OUD based on theoretical perspectives, whilst not sufficiently addressed which social group people with OUD personally feel like they belong to. If social interaction with other patients in drug treatment clinics reduces the management of self-stigma, does this mean that stigmatised individuals feel more coherency to conventional society than their sub-group? And what does this say about how these individuals are affected by being socially excluded? This knowledge gap suggests that there is limited insight on the extent of stigmatisation’s function of social exclusion, whilst also demonstrating the critique of the application of stigmatisation theory where the perspectives of those who are stigmatised are underexplored. This is a knowledge gap that my study can contribute to filling through identifying how patients with OUD feel in society when they become patients in HAT as compared to before.

2.5 The Power of Therapeutic Approaches in Drug Treatment

Studies have found that the administration of medical heroin in the therapeutic context of HAT contributes to breaking the habit of illicit heroin use amongst patients, and that the relationship between staff and patients has a significant impact on the behaviour of the patients (Jozaghi 2014: 1; McCall et al. 2019: 45; Romo et al. 2009: 186). Jozaghi (2014: 15) found that the relationships between the patients and the social workers, nurses, and doctors at HAT enabled help with needs and comorbidities that went beyond the patients’ OUD as they received support to deal with both health issues, and social issues. It was also found that the friendly and relationship building efforts from staff improved the patients’ social functioning and that the staff’s high levels of expertise and knowledge reinforced the safety and security that the patients felt at the clinic. However, other studies have discovered that the staff in HAT-clinics experienced that they did not get sufficient preparation before and during their work at the clinic as their education was directed towards substance ‘misuse’ and not substance treatment (Marcellus

2007 in McCall et al. 2019: 48). This should be seen in light of studies that have found the setting of drug treatment to be stigmatising because of limited knowledge amongst the staff, and it seems reasonable to suggest that an educational focus on ‘misuse’ rather than ‘use’ or ‘treatment’ is a stigmatising approach (Madden et al. 2021).

Getting to know and understand the patient has been argued to be an essential factor towards providing good patient centred care, yet including patients in the decision-making in drug treatment has been found to be challenging and there is argued to be a general lack of trust between patients and service providers regarding opioid use (McCall et al. 2019: 48; Werder et al. 2022: 10). It is further argued that most of a patient’s opportunity for growth and development lies in their one-to-one relations with service providers, but if the service provider’s power increases, the patient’s power decreases (Ravndal 2009: 78). It is being argued that patients in drug treatment have limited agency, but as the literature also demonstrates that HAT provides the patients with more freedom and agency, the conclusion to this topic is ambiguous (Chang 2023; Holt 2007: 1942). An important step towards getting this knowledge would be to explore how the approach taken by staff impacts the patients’ self-perception (Doukas 2011). This suggests that studies should not only address the therapeutic relationship between patients and staff at HAT, but also whether the power dynamics in those relations affect the patients’ agency. My study will address this issue through including the relationships between patients and staff when exploring whether and how being in HAT changes how the participants experience and manage stigmatisation.

The importance of agency and perceived self-efficacy has been found to be vital in drug treatment as people who do not believe that they can achieve the desired outcome of treatment have limited motivation for participating in the different aspects of treatment (Bandura 1999: 214). The patients’ self-efficacy is therefore vital in every stage of the recovery process as it affects their commitment to initiate changes as well as their belief in their capability of successfully performing these changes (Bandura 1999). Studies have also found that diminished self-efficacy is a common outcome of internalised stigma, which provides some explanation as to how stigmatisation negatively impact treatment outcomes because it affects the patients’ beliefs in successful treatment (Luoma et al. 2008: 150). Although stigma’s function of informal social control may have a deterrent effect on non-users towards trying illicit drugs through establishing it as norm-breaking behaviour, this also demonstrates that it has a adverse impacts on those who are stigmatised as it contributes to poorer treatment outcomes with high drop-out rates rather than having a deterrent effect (Palamar et al. 2013: 517). This might further show how stigma causes social inequalities by being what the literature refers to as a ‘moral determinant of health’ as it affects the treatment and recovery processes of stigmatised patients, such as those with OUD (Werder et al. 2022: 10). It has been suggested that enabling patients in drug treatment to exercise agency over controlled and strategic use may facilitate greater independence and treatment stability (Holt 2007: 1945). It seems reasonable to suggest that one of the most important efforts that can be done towards providing positive treatment outcomes for patients with OUD is to facilitate the development of a positive self-efficacy through reducing stigma. However, towards doing so, it is important to know how drug treatment may generate these outcomes and an important brick of this knowledge-base can be provided through exploring whether HAT’s therapeutic approach changes the patients’ internalised stigma.

3 Theoretical Framework

This chapter will explain the two theoretical perspectives that are used in this thesis; Goffman's (1963) stigmatisation theory and Sykes and Matza's (1957) neutralisation theory. While the term 'theory' can be interpreted in various ways, a common definition of it within research is that they provide explanations for observed patterns (Bryman 2016: 18). I developed my theoretical framework by modifying existing theories based on their relevance to my data material, hence being data-driven as this enabled explanation rather than just description of the phenomena I explored (Hennink et al. 2020: 258, 259). I will start this chapter by explaining the overarching theoretical perspective which is stigmatisation theory, before I move on to the supporting perspective, neutralisation theory. After explaining both theories and the concepts that are central to my research topic, I describe how they are used and conceptualised for the analysis of this thesis.

Stigmatisation theory is used to analyse negative experiences that the participants had with drug treatment both before and after enrolment in HAT. This theoretical perspective was useful towards exploring whether these experiences could be related to the stigmatisation process that the literature argues this group is strongly influenced by (see e.g. Cheetham et al. 2022 or Luoma et al. 2008). Central concepts that are relevant in this theory are institutional stigmatisation and internalised stigma as my data material included many descriptions of experiences related to social exclusion and discrimination, as well as how the participants were impacted by this. The processes of institutional stigmatisation and how they lead to internalised stigma were useful tools for analysing the connection between these experiences and the personal impact they had on the participants. Another central element of this theory is how to define stigma and what stigma is, which I had to modify because I wanted to use a definition that was more suitable for my research than the original by Goffman, and the existing literature uses various definitions. Whilst stigmatisation theory may contribute to understanding the mechanisms that influence the behaviour that I, in the following chapter, define as part of the participants' stigma, this theory alone did not enable an analysis of how the participants manage stigmatisation. Towards gathering an understanding of not only how these participants are affected by stigma but also how they manage it, I added Sykes and Matza's (1957) neutralisation theory as a supporting perspective. This theory is often used to explain how individuals protect themselves from labelling and negative responses that may affect their self-perception as neutralisation techniques enable distance to a stigmatised identity (Askew 2016: 113).

These techniques involve the use of language that justifies or rationalises deviant behaviour, or responses that mitigate the impact of negative responses from others. I found this theory to be very useful towards analysing how the participants managed and navigated stigmatisation, and it also enabled insight into how affected the participants were by internalised stigma because of the variety and the extent of how they used these techniques. Key words that link these two theories are identity, self-perception, norms, deviance, social control, and behaviour.

3.1 Stigmatisation Theory

Goffman's theory of stigma became instrumental in criminology with his publication *Stigma: Notes on the Management of Spoiled Identity* in 1963, and remains both influential and applicable today. 'Stigma' is defined by Goffman (1963: 11) as an attribute that is considered undesirable, such as criminal behaviour or drug use, and by that deeply discredits a person from an established social group. This further results in a reduced and discounted identity for the stigmatised. Stigma used to be something that the Greeks referred to as physical marks that exposed the immoral status of certain individuals, such as burns or cutes on slaves, criminals, or traitors (Goffman 1963: 10). Later, in Christian times, these bodily marks were used to identify physical disorders that contrasted to bodily signs of the holy grace (Goffman 1963: 10). However, today's view often refers to stigma as disgrace that may be rooted in concern or fear associated with a person regardless of whether or not there are any bodily marks or other physical evidence (Bos et al. 2013: 1; Goffman 1963: 10). Consequently, some stigmas may be visible and discrediting to some, such as the participants in this study's medical records which expose their OUD, whilst they are hidden and discrediting for others. As a result, scholars have applied various and elaborated definitions of stigma depending on which phenomena they explore, but have also been criticised for defining it too vaguely and individualistic (Link and Phelan 2001).

3.1.1 How Stigma is Defined in This Thesis

For this thesis, I have taken inspiration from Stafford and Scott (1986) to define and contextualise 'stigma' as a trait that goes against the norms of a particular social group and by that leads to experiences of discrimination and social exclusion. A 'norm' is further described as a common belief about how individuals in a social group should behave, hence do these traits (or stigmas) also include behaviour (Ahern et al. 2007: 189). The stigma associated with drug use is therefore, for this purpose, mainly focused on identifiable markers such as demeanour and behaviour, but also includes the patients' OUD diagnosis as their disorder is exposed when they enter healthcare or social services. To include OUD as a stigma in and of itself is relevant due to the well-established institutional stigmatisation of this patient group where this diagnosis impacts their resources in terms of social services, healthcare, and in criminal justice processes (Skatvedt 2020: 22). Henceforth, this definition may be argued to be beneficial as it contributes to explaining both how the public, government agencies, and the patients are able to identify stigma both with and without bodily marks, hence also being in line with Goffman's (1963: 10) definition of a stigma as a disgrace that is associated with a person. This conceptualisation also answers to Goffman's (1963: 11) encouragement of understanding stigma as '*a language of relationships, not attributes*' as it enables interpretations of stigmatisation in human interactions where the stigma is not a physical mark, whilst still being something that stems from the physical – namely, behaviour.

3.1.2 The Process of Stigmatisation

The process of stigmatisation is complex and defined variously in the literature, but for this thesis, I conceptualise stigmatisation as the process in which an individual is excluded from the conventional society and discriminated because of their stigma (which I defined in the introduction to this chapter). The process of stigmatisation occurs when those who adhere to conventional rules and norms within a social group place the stigmatised individual outside their social group based on the normative expectations and anticipations they form towards this person (Goffman 1963). Henceforth, this process of categorisation, exclusion, and infliction of stigma is what is referred to as stigmatisation. Scholars have presented various components that are necessary for stigma to be enacted, and Link and Phelan (2001) suggest that the execution of power is a core element for stigmatisation to occur. This leads to why the stigmatised are also discriminated, as those who stigmatise may use their power to discriminate for instance by not wanting to hire them, avoid renting their properties to them, or providing a reduced quality of care in primary care services (Corrigan et al. 2017: 61). It is furthermore being argued that there are two fundamental components of enacted stigma, namely the recognition of difference, and devaluation (Dovido et al. 2000 in Bos et al. 2013: 1). Stigma therefore becomes apparent through social interactions rather than being something that resides consciously in each person, which explains why it is a socially constructed phenomenon that is activated through social context (Bos et al. 2013: 1). Additionally, this means that a behaviour that is stigmatised in one social context may be considered contextually appropriate in another (Bos et al. 2013; Cheetham et al. 2022: 2).

Bos et al. (2013: 2) argue that there are three functions of stigmatisation: to maintain a disproportionate power-relationship, social norm enforcement, and disease avoidance. The first function includes that the inflictor of stigma exerts power to keep the stigmatised person down and thereby maintain inequality between them as persons, and between their social groups. The second function of social norm enforcement is that the grouping of the stigmatised and non-stigmatised encourages the deviants to forms groups and convey to norms that are contextually accepted within that group, rather than adhering to the mainstream and conventional society. The third function of disease avoidance stems from an evolutionary perspective where social exclusion and stigmatisation protects the health and wellbeing of healthy by keeping the sick individuals at a distance, hence contributing to survival of the fittest. It is being argued that there are three types of stigma towards people with OUD; institutional, public, and internalised (Cheetham et al. 2022: 2). All types of stigma interact with each other, where for instance public stigma will impact service providers and policy makers and create institutional stigma (Cheetham et al. 2022: 3). The different forms of stigmatisation are therefore complex and it seems reasonable to argue that they must be understood individually in order for the reader to understand their interactive relationship. As most attention is given to institutional and internalised stigmatisation in this thesis, these will also be most thoroughly explained.

Institutional Stigmatisation

Institutional stigmatisation operates on a macro level by restricting the opportunities and resources for a group through policies, rules, and practises (Cheetham et al. 2022: 2). This form of stigmatisation occurs through societal and institutional conditions such as underfunding and poor service delivery, penalising policies and regulations, and treatments initiatives and responses that are of a discriminatory nature (Cheetham et al. 2022: 2; Werder et al. 2022: 10). As a result, individuals who seek help and care related to their substance use are constricted in their available treatment resources (Werder et al. 2022: 10). It also includes the use of stigmatising language in these practises, which has been found to still be prevalent both in the public, private, and clinical context, and can act as both a cause and consequence of stigmatisation (Cheetham et al. 2022: 3; Graham et al. 2022: 375; Werder et al. 2022: 10). It has been suggested that neither the healthcare system nor the public routinely refer to OUD and its treatment as medical care, but rather uses stigmatising and judgmental terms such as ‘clean’, which gives indirectly gives the association that the person was dirty before (Olsen and Sharfstein 2014: 1394). The use of such language is argued to be dehumanising and stigmatising, and contributes to reducing the effectiveness of treatment for people with OUD as well as increasing the barriers to both seeking and staying in treatment (Werder et al. 2022: 9). Institutional stigma associated with OUD is therefore argued to be mediated by healthcare professionals adopting destigmatising language to describe this disorder, those it affects, and the interventions (American Psychiatric Association 2022; Olsen and Sharfstein 2014: 1394). The structural barriers institutional stigmatisation causes for people with OUD is argued to cause structural vulnerability with increased risk factors related to crime, such as the need to commit theft to get food or clothes (Boyd et al. 2020; Mayer et al. 2020). This vulnerability is highlighted by the economic costs and burdens associated with OUD and illicit drug use as it negatively affects the group’s ability to get food and shelter (Mayer et al. 2020: 6). In turn, institutional stigmatisation contributes to making hidden stigmas become more visible and by that increasing the likelihood of further discrimination as the stigma also becomes more identifiable to the public.

Public Stigmatisation

Public stigmatisation operates on a meso level where the public endorses negative attitudes towards a person and by that also creates a negative stereotype (Cheetham et al. 2022: 3; Corrigan et al. 2017: 62). This form of stigmatisation is particularly important for stigmatisation’s function of informal social control and may occur overtly through refusal to socially interact with stigmatised individuals, discriminating language, or other discrediting and dehumanising actions that are easy to identify (Bos et al. 2013: 1). It may also be expressed in a subtle manner through lack of eye contact, raising of eyebrows, or other nonverbal expressions of disapproval and discomfort in social interactions between stigmatised and non-stigmatised individuals (Hebl et al. 2000 in Bos et al. 2013: 1). The stigmatised is through these mechanisms subjected to prejudice and discrimination from citizens in the conventional society, and can also occur in interactions between service providers and patients in drug treatment (Cheetham et al. 2022: 3). Public stigmatisation impacts an individual in three ways; through enacted stigma in the form of negative treatment, felt stigma through experienced or anticipated stigmatisation, and internalised stigma where the individual experiences a psychological distress and reduction of their self-worth (Bos et al. 2013: 3). Public stigmatisation is also argued to be closely linked with criminalisation as it influences which policy initiatives the public decides to support, and its main source is argued to be lack of knowledge (Corrigan et al. 2017: 62; Madden et al. 2021: 2181). This stigma is argued to affect individuals with OUD through facilitating support for penalising drug policies, hence being a contributor to restricted resources for this vulnerable group (Corrigan et al. 2017: 62). Furthermore, this stigmatisation significantly impacts people with OUD through the social norm enforcement that the public exercises, which encourages stigmatised individuals to form groups and convey to norms that are contextually accepted within their sub-group but rejected by the conventional society (Bos et al. 2013: 2). The prejudice and discrimination that this stigma inflicts may result in feelings of shame and reduced self-esteem amongst stigmatised individuals, which is the final stage of the stigmatisation process – the internalisation of stigma (Corrigan et al. 2017: 62; Matthews et al. 2017: 275).

Internalised Stigmatisation

Internalised stigmatisation, also referred to as self-stigma, operates on a micro level and is recognised by individuals feeling that their self-worth is reduced and experience psychological distress as a result of internalising prejudice from institutional and public stigmatisation (Bos et al. 2013: 2; Cheetham et al. 2022: 1). Self-stigma is closely linked with feelings of shame as the individual perceives that they violate a social group's norms and values (Matthews et al. 2017: 276, 277). Corrigan et al. (2017: 62) argues that this process occurs in four stages: 1) awareness of the stigma, 2) agreement with the stigma, 3) self-application and internalisation of stigma, and 4) negative impact on self-esteem and self-efficacy. This process includes that individuals self-identify with peers that are also in the stigmatised group, which acts as a barrier towards the internalisation of a positive self-image and identity and contributes to maintaining the social groupings between stigmatised and non-stigmatised individuals (Luoma et al. 20008: 150). This form of stigmatisation therefore occurs as a result of stigmatised individuals absorbing negative attitudes about them, their drug use, and their behaviour, or in short; when they that the society's negative beliefs about them are true (Matthews et al. 2017: 276; West et al. 2015: 150).

It is being argued that individuals who try to meet normative standards are likely to be affected by social norms when trying to personally care for themselves as these social norms and normative standards are incorporated through social learning where we are taught that by letting ourselves down, we also let down people who rely on us (Matthews et al. 2017: 276). This contributes to why low self-efficacy and self-worth poses barriers to treatment-seeking behaviour as it impacts how patients evaluate the value and potential outcome of treatment (McCradden et al. 2019 in Werder et al. 2022: 10). Several studies have found that stigma has a considerable impact on the psychological processes and well-being of the stigmatised individuals as it negatively affects their cognitive and affective processes (Bos et al. 2013: 3). The stigmatised individuals experience negative thoughts and feelings from identifying with a stigmatised group, which further impacts their mental health, well-being, and behaviour as they because of the fear of being stigmatised may socially withdraw and avoid seeking treatment (Cheetham et al. 2022: 3; Luoma et al. 2008: 150). Because of these negative feelings, self-stigma has been found to be associated with both depression and anxiety (Corrigan et al. 2017: 62). It must be noted not all individuals who use drugs are affected by socially induced shame or self-stigmatisation, but it does apply to a significant proportion of those who are in a stigmatised group (Matthews et al. 2017: 276). Moreover, it seems reasonable to argue that it is understandable that these individuals often have a need to protect themselves from the internalisation of stigma.

Reactions to Stigma

People with substance use issues may, like other marginalised groups, react to stigma and discrimination in ways that can either intensify or moderate these challenges through their emotional reactions, psychological traits, or behavioural approaches (Ahern et al. 2007: 188). The coping strategies for internalised stigmatisation can either be problem-focused where the individual alters their relationship with the environment, for instance hiding their stigma or avoiding certain situations, or emotion-focused by regulating negative emotions and responses (Bos et al. 2013: 3; Major and O’Brien 2005: 404). The problem-focused approach may be particularly relevant for individuals with hidden stigmas as they often live with their condition in secrecy (Ragins 2008: 196). However, responses such as anger or strategies aimed at hiding the stigma have been suggested to have the opposite effect as they exacerbate how the stigma impacts the individual’s health and well-being (Ahern et al. 2007). Stigma management is argued to play an important role in the recovery process to people with substance use disorders because of the significant impact internalised stigma has on their treatment outcomes, and it has been suggested that detachment from the stigmatised identity is one emotion-focused coping strategy that vulnerable individuals may utilise (Bos et al. 2013: 3; Gueta and Chen 2021). One way of exercising this detachment is by the use of neutralisation techniques.

3.2 Neutralisation Theory

Sykes sand Matza's (1957: 669) neutralisation theory argues that neutralisation techniques are essential for individuals to shield themselves and their internalised values from self-blame and feelings of shame. These techniques enable individuals to excuse, rationalise, or justify their behaviour both through their language (Topalli et al. 2005: 798). The dual meaning of crime has made criminologists scratch their heads for decades whilst trying to figure out whether their studies should be limited to violations of the criminal law or include immoral acts that are not – per definition – illegal, but violate the conventional norms of society (Michalowski 2016: 184). Neutralisation theory by Sykes and Matza (29157) is a theoretical development within criminology where deviance is conceptualised as a socially constructed phenomenon as it is based on society's response to a certain behaviour, rather than an indication of personal dysfunction within an individual (Askew 2016: 113). This theory criticises subcultural perspectives that assume that offenders reject conventional values and norms, and argues that offenders are unavoidably aware of these social constraints as being a part of a subculture also indirectly suggests that someone is aware of the conventional rules of society (Topalli 2005: 799). These conventional rules are internalised and as this also implies that deviant and delinquents have to acknowledge that their acts are morally wrong in the eyes of society, they employ neutralisation techniques before and after committing crime to achieve their desired self-image (Topalli 2005: 799). Whilst the theory was originally developed to explain juvenile delinquency, it is being argued to have become one of the most applicable theories both within criminology and other disciplines as it can be used to explain a wide variety of norm-breaking behaviour (Maruna and Copes 2005: 222, 223). This theory has also been found to be an important tool for individuals who wish to protect themselves from public labelling and stigma (Maruna and Copes 2005: 255).

Neutralisations have been found to be frequently used by both PWUD and dealers to avoid feelings of guilt and blame regarding their illicit behaviour, and it is being argued that PWUD constantly have to negotiate risks related to criminality and health as well as stigma and moral condemnation (Askew 2016: 113; Dickinson and Jacques 2019). Rationalising deviant behaviour is therefore considered an essential tool towards protecting and maintaining a positive self-image, and this cognitive process is argued to demonstrate that deviants are aware of – and to some extent adhere to – conventional norms and values (Askew 2016: 113; Miller 2005: 246).

Neutralising illicit behaviour may limit the effectiveness of the social restraint of conventional norms and values, hence may they be considered adaptations that enable individuals to continue deviant behaviour whilst maintaining a positive self-image (Miller 2005: 246). These neutralisations and adaptions are both behavioural and cognitive as the offenders adapt their behaviour whilst also adjusting their beliefs (Miller 2005: 246, 247). Sykes and Matza's (1957: 666) argue that neutralisations may be utilised as a mechanism for rendering the functions of social controls inoperative, hence enabling individuals to continue in deviant behaviour without feelings of guilt and harm to their self-image. However, this also demonstrates that they to some extent adhere to conventional norms and values as they feel shame and guilt when they do not adhere to them and wish to maintain a positive self-perception (Askew 2016: 113; Topalli 2005: 798).

3.2.1 The Utilisation of Neutralisation Techniques

Sykes and Matza (1968: 667, 668) suggested that there are four main techniques of neutralisation that either justify, rationalise, or excuse deviant behaviour. First, the denial of responsibility. By considering himself or herself as more acted upon than acting, the actor prepares the way for deviance from the dominant normative system without the necessity of a frontal assault on the norms themselves. Second, the denial of injury, where the actor considers the act not to cause any significant harm despite it being a breach of the law. Third, the denial of the victim, where the actor hold a belief that the act was not wrong under those circumstances and that the injury that may have been caused to a victim was considered to be a rightful retaliation or punishment. And finally, the condemnation of the condemners where the deviant shifts focus from their own deviant acts to the motive of those who disapprove. This technique includes that the actor uses their language to attack the person who questions their acts, rather than defend them. Sykes and Matza (1957: 667) further argue that these techniques enable deviants to stay committed to the social order by framing their behaviour as acceptable, although they may not be morally or legally right. Whilst Sykes and Matza interchangeably used excuses, justifications, and rationalisations regarding these techniques, Scott and Lyman (1968) make a distinction between excuses and justifications for drug use. They explain that justifications mean that the user accepts responsibility for their behaviour, but not that it is wrong. Excuses mean that the user accepts that their behaviour is wrong, but rejects responsibility for it. Rationalisations mean that the user rejects the deviant label as they consider their behaviour to be contextually accepted. Askew (2016: 117) suggests that the use of justifications rather than excuses is a fundamental component of framing drug use as acceptable because rejection of responsibility may be associated with lack of control, which does not reason with having a functional lifestyle. Like Scott and Lyman (1968), I deliberately rather than interchangeably use the distinctions between these techniques for exploring how and which neutralisations the participants use for managing stigma.

It is being argued that the purpose of neutralisation techniques is for the protection of a desired self-image and that delinquents and deviants need to avoid feelings of guilt and self-blame to achieve this (Topalli 2005: 799). It is furthermore being argued that just as law-abiding citizens are motivated and influenced by their self-conceptualisation, there is no reason to assume that deviants are different (Higgins 1989, 1987 in Topalli 2005: 799). Neutralisation theory may therefore contribute to understand the persistence of deviance from the deviant's perspective (Maruna and Copes 2005: 221). However, recent literature on this theory also suggests that deviants who do not experience guilt from norm-breaking acts still utilise neutralisation techniques as a tool to maintain a positive social identity and self-image (Dickinson and Jacques 2019: 17). This process is suggested to occur through altering their perspectives and motives, hence creating a distance to the role of being deviant, delinquent, or other forms of stigmatised (Dickinson and Jacques 2019: 18, 20). The motivation for doing so lies in their desire to align the person they believe that they are, namely their actual self, with the person they would ultimately like to be, which is their ideal self (Topalli 2005: 799). Neutralisation theory therefore conceptualises identity as the ways in which individuals view themselves and how they would ultimately like to be (Dickinson and Jacques 2019: 21. This identity construction has a reciprocal relationship with behaviour as the responses they receive both from themselves and others can have an impact on their self-perception (Dickinson and Jacques 2019: 21). For instance, individuals who consider themselves moral persons but receive negative reactions to their action may re-think whether their personal morality (Dickinson and Jacques 2019: 21). Henceforth, a person's identity is used to guide and dictate their behaviour as it both shapes and mediates social interaction (Maruna and Copes 2005: 253).

3.3 Neutralisation of Stigma

Towards trying to understand how the participant group is affected by and manage stigmatisation, it is necessary to acknowledge that we are all influenced by how our preconditioned perceptions form our social interactions and that we may – although unwillingly – contribute to stigmatisation through social norm enforcement in these interactions (Bos et al. 2013: 2). As a response to this, stigmatised individuals may utilise neutralisation techniques when talking about their own actions and experiences to create a mediating effect on the fear of experiencing stigma from the person they talk to as these narratives are reflections of their identity (Askew 2016: 21; Sykes and Matza 1957: 666). This is also applicable in an interview setting, such as in the data gathering process of my study. There is a close relationship between stigmatisation and disapproval, and it being argued that the recipient of public disapproval or stigma may counter their effects through neutralisations or by deflecting it in advance (Sykes and Matza 1957: 666, 667). The need to justify or rationalise deviant behaviour may not only be a defence mechanism that enables individuals to maintain a positive self-conceptualisation and avoid blame, but also a way of deflecting the possibility of enacted stigma from the person they talk to (Dickinson and Jacques 2019; Sykes and Matza 1957: 666). Additionally, it could be interpreted as a confirmation regarding previous studies which have argued that people who commit crime – or are stigmatised – are aware of conventional norms and values (Topalli 2005: 799). Using neutralising language regarding deviant behaviour may therefore be considered as something that enables individuals to continue with deviant behaviour and reject parts of societal norms and values, whilst still adhering to most of them (Aldridge et al. 2011 in Askew 2016: 114). These neutralisations may therefore be both behavioural and cognitive as deviants adapt their behaviour whilst also adjusting their beliefs about themselves and the world around them (Miller 2005: 246, 247).

3.3.1 Identity Construction and Management

Feelings of shame, guilt, and poor self-image are central concepts in both stigmatisation and neutralisation theory as the consequences of stigma often has the adverse effect of individuals feeling shame (Palamar et al. 2013: 517). It is being argued that feeling of shame may compromise individuals' identity as it impacts their self-perception, and that when shame is experienced as stigmatising, unresolved, or displaced, it may have a criminogenic effect (Maruna and Copes 2005: 255, 256). Furthermore, it is being suggested that the need to protect one's identity from stigma seems to be universal and that the primary motivation for neutralisation is therefore the establishment of an internal consistency where the actual and ideal self align (Maruna and Copes 2005: 259). It is therefore being suggested that these techniques protect individuals not only from feeling of guilt, but also shame, public labelling, and stigma (Maruna and Copes 2005: 255). Consequently, neutralisations are argued to be particularly applicable for individuals who experience shame from stigma as they enable protection from a negative label and the negative experiences that may occur from this (Maruna and Copes 2005: 259, 259). Moreover, several scholars have argued that the internalisation of stigma is the most harmful form of shame that an individual can experience (Maruna and Copes 2005: 291). Shame and other devaluing thoughts are also argued to be the emotional core of self-stigma in people with substance use disorders, such as OUD (Luoma et al. 2008: 150; Matthews et al. 2017: 275). Matthews et al. (2017) suggest that the element of shame is connected to a person's belief in self-efficacy and stems from public stigmatisation of addiction. I argue that neutralisation techniques that protect an individual's self-image and contribute to maintaining a positive belief in their self-efficacy are valuable tools for the management of stigma.

Individuals may limit the effectiveness of informal social control that stems from conventional norms and values through neutralisation techniques, hence may they also be considered adaptions that enable individuals to continue with norm-breaking behaviour whilst maintaining a positive self-perspective (Miller 2005: 246). Henceforth, it seems reasonable to suggest that neutralisation techniques may be a natural response to stigma as they provide individuals with protection from the internalisation of stigma. Neutralisation techniques may therefore be proactive tools that protect individuals from negative responses. Whilst stigmatisation theory suggests that those who are stigmatised are aware of their status as norm-breaking when the stigma becomes internalised, possibly even sooner, neutralisation theory suggests that those who deviate from conventional norms and values demonstrate awareness of their deviance through their need to neutralise their acts (Bos et al. 2013: 3; Copes 2016: 194; Topalli 2005: 797). I therefore argue that these two theories are beneficial towards gaining an understanding of 1) How people with OUD are affected by stigmatisation as they enable analysis of their awareness of it, and 2) How they manage stigmatisation as they enable analysis of their responses to it.

4 Methods

My thesis is written in cooperation with RusForsk, who are responsible for the qualitative research on the HAT-trial project. The qualitative method of research aims at gaining an understanding of different phenomenon through the perspectives and experiences of those who experience them and acknowledge that these stakeholders' contribution is essential towards gaining such understanding (Castleberry and Nolen 2018: 807, 808; Kiger and Varpio 2020: 846). Henceforth, a qualitative study seemed most appropriate for exploring the experiences of patients in HAT as these would be challenging to explore through a questionnaire with pre-conditioned answers (Oviedo-Joekes et al. 2014: 2). I took an inductive approach as I wanted to explore what HAT entails for the patients with an open mind and allow the findings to direct me towards a theoretical framework for the analysis (Braun and Clarke 2006: 83; Bryman 2016: 21; Hennink et al. 2020). This approach was also iterative as I continued to collect relevant material from my data that was related to theories I decided to use based on the initial coding (Bryman 2016: 23). I used the software program f4transcript to transcribe the interviews verbatim and then transferred the transcripts to the software program NVivo for coding. The data material that was coded for this thesis was 9 transcripts from interviews with patients at HAT in Oslo, whereas notes from participant observation at the clinic were used to get a picture and understanding of the clinic environment and diversity amongst the patients at HAT. The quotes were translated from Norwegian to English because I did my bachelor's degree in Australia and feel more confident in English when it comes to academic writing. I used thematic analysis as a strategy for analysing the data as this method includes inductive steps where the themes are found from identifying and analysing patterns within the data, which enables the themes to be found as biased-free from pre-existing theoretical knowledge as possible (Castleberry and Nolen 2018: 808; Kiger and Varpio 2020: 847). However, it should be noted that I acknowledge that this process is likely to have been influenced by my pre-existing knowledge and ideas to some extent.

4.1 Sampling

The participants in this study consisted of nine patients from the heroin-assisted treatment clinic in Oslo and were purposively sampled based on their enrolment in the treatment program. The participants' age ranged from 38 to 54 with the average age being 47, and the group consisted of six male and three female participants. Seven out of nine participants injected the medicine whereas the remaining two consumed it in solid tablet form. I started visiting the clinic in early

April 2022 and conducted the interviews in May and June. I conducted in-depth semi-structured interviews with three patients who had been enrolled in the program for 1-3 months and received six transcripts from RusForsk that contained relevant data for my study, as well as sharing the transcript from my interviews with them. Studies suggest that data saturation is usually reached between 9 and 17 interviews, and I assume to have reached saturation as I have combined data from my interviews with data collected by the other researchers (N=9) (Hennink et al. 2020: 108; Kvale 2007: 44).

4.1.1 Participant Observation

I wanted to get a wholesome understanding of the HAT-clinic and the setting that the participants were in as I did not have any prior experience with drug treatment, and therefore conducted participant observation in addition to interviews. Fieldwork is aimed at gaining knowledge about people and their lives by identifying the world in which the people of interest are through observing their behaviour and speech in natural situations (Hastrup in Brinkmann and Tanggaard 2022: 46; Krumsvik 2014: 142). Participant observation includes that the researcher goes beyond just observing the study object by being open for conversation (Leseth and Tellmann 2018: 91). This enabled me to gain insight from patients I did not interview as well as from the staff, hence creating a better understanding of the group at HAT than what could be achieved through interviews alone. Additionally, I wanted to utilise my time at the clinic as much as possible considering that recruiting for interviews was a challenging and time-consuming process. It must in that respect be noted that the emotional and physical state of the patients at HAT could vary significantly from day to day and it was therefore not always appropriate to approach the interview candidates. This could be for instance if they were busy, upset, expressing that they wanted to be alone, or heavily affected by the medication they had received at the clinic. Because of my limited experience with this setting, I always started my visits to the clinic by talking with the staff and asking them if it was appropriate to approach the different candidates at that given time. The staff's hospitality, experience, and knowledge were therefore essential at every stage of my data gathering process.

By conducting participant observation, I was able to use my time at the clinic meaningfully and effectively as I could focus on the patient group as a unit rather than just the possible interview candidates when they were unavailable or unapproachable. By doing so, I got to have conversations with and get to know the majority of the patients despite only interviewing three. The process of recruiting for interviews and participant observation therefore occurred simultaneously by talking to several patients, including the participants, and I visited the clinic somewhere between 15-20 times. Observing and talking with the staff and patient group beyond my participants enabled me to get a better understanding of my research topic and prepared me to better understand what the patients referred to and said during the interviews. Additionally, these conversations gave me the necessary knowledge to understand the cultural codes and jargon used by this group (Krumsvik 2014: 145). The goals of participant observation are to gain an understanding of how life affects people by looking at how they interact with each other, how they behave and presents themselves, and to get an impression of their values through participating in their daily lives (Spradely 1980 in Leseth and Tellmann 2018: 91, 93). Towards doing this, I observed the room, the different people in the room (including staff), the activity that occurred, the different objects (such as the serving of food), the events that happened, how much time the patients spent at the clinic, their purposes of being there, and the emotions that were expressed (Leseth and Tellmann 2018: 94). I wanted the patients to see me as approachable and made sure that I was casually dressed whenever I visited the clinic, introduced myself and my purpose of being there when I got in conversation with the patients, and took summary notes after the conversations. Not taking notes during the conversations with the patients was an intentional approach as I wanted to be present and attentive to what they were saying, and by that also able to follow the conversation.

4.1.2 Interviews

For the data gathering process, the researchers at RusForsk created an interview guide designed to examine the patients’ former experiences with drug treatment programs, their expectations of HAT before enrolment, their current experience of HAT, and how they are affected by the program. With guidance from my supervisor, I designed an interview guide that documented the same concepts as the original and included many of the same questions, but also added questions that enabled me to take a more criminological approach (see *Appendix 3*). I erased about 10 questions from the original guide and replaced them with questions directed towards crime, economy, use of illicit drug before and after enrolment in HAT, experiences with law enforcement, and whether the patients had noticed any changes in these areas after starting the treatment program. I wished to examine the participants’ experiences linked with crime, particularly in relation to illicit drugs, but understood that there might be barriers such as the patients not being comfortable sharing that information. Semi-structured interviews were therefore applied as this method enabled me to adjust according to how much the patients felt comfortable sharing and thereby gather useful data, and build rapport (Hennink et al. 2020: 116; Tjora 2021: 172). In doing so, I got interviews with useful data even if the participants were hesitant towards sharing certain information as it allowed me to explore other areas of interest that were of a less sensitive or invasive nature. Using interviews for data collection was considered appropriate as this method enables insight into individuals' personal and lived experiences by allowing them to answer questions fully and without being limited to pre-conditioned answers (Brinkmann and Tanggaard 2012: 19). The interview setting is strongly influenced by the interaction between the interviewer and the interviewee, and this relationship is instrumental towards which knowledge and empirical data the interview can produce (Brinkmann and Tanggaard 2012: 22). I therefore spent about three days at the clinic before I started recruiting for the interviews to establish a connection with the patients and get to know them, as well as letting them get to know and trust me. Getting their trust was something I considered essential as some of the interview questions were sensitive, and it was also important that they trusted that what they shared in the interviews would not affect their treatment. In total, I visited the clinic somewhere between 15-20 times to get acquainted with the patients and staff, conduct the interviews, and do participant observation. All my interviews were conducted during the opening hours when the patients are allowed to come into the clinic. Two of my interviews took place inside the clinic, and one in a park outside the clinic as the patient wanted to enjoy the sunny weather. These three interviews lasted for 18 minutes, 1 hour and 19 minutes, and 1 hour and 42 minutes. I borrowed a recording device and a storage stick from RusForsk and utilized the recording device during the interviews before I transferred and saved the audio recording on the password-protected storage stick. I evaluated each interview before I started a new one as this allowed me to adjust the following interviews according to recurring themes, and according to which questions that had shown to be challenging for the patient to answer and which ones that were fitting (Tjora 2021: 181). Additionally, it allowed me to evaluate my performance as an interviewer, and by that adjust and improve before the next interview.

Challenges

The main challenges of the data-gathering process were related to recruitment. There were 30 patients in HAT when I first started visiting the Oslo-clinic in April 2022, and the clinic had at that stage planned to continue the intake of new patients. It was therefore assumed that the access to potential participants for my study would be rather large. However, when I was ready to start with the interviews, the clinic had to pause the patient intake because of limited staff capacity. It was therefore only 10 potential candidates to recruit, whom I also had to share with researchers from ProLAR Nett, as the RusForsk-team had already interviewed the 20 first patients who entered the program. Out of my five potential candidates, one dropped out of drug treatment completely and one transferred back to MAT, which is why I ended up interviewing three patients and receiving six transcripts from RusForsk.

Another challenge related to the recruitment process was that many of the patients wanted to talk to me in the observation room, but were hesitant towards agreeing to a formal interview. This was often related to the patients not wanting to spend more time at the clinic than necessary, especially considering that the interviews took place in late spring and early summer with warm and sunny weather. A related challenge was to meet up with the participants at the coordinated time for the interviews. Only one of the participants that I interviewed, Lisa, wanted to do the interview immediately, whereas Mary and Mark wanted to schedule a more suitable time either later that week or sometime in the future. Mark encountered health issues so we had to postpone several times, and Mary simply did not feel like doing the interview when we met at the agreed time. It therefore took several visits to the clinic even after recruiting these participants before the interviews took place, but it must be noted that Mary and especially Mark were eager to do the interview even though they postponed on several occasions.

A reoccurring challenge during the interviews was to keep the participants on the right track when they were answering questions. This was also an experience that Sandberg and Copes (2013: 185) encountered in their study where participants who were under the influence of marijuana or street heroin tended to slumber during the interview. Both Mary and Mark had a strong tendency to drift off and start talking about subjects that were irrelevant to my study, and it was difficult to guide them back as they often led the conversation towards topics that were sensitive such as trauma and vulnerable experiences. The difficulty was therefore to guide them back to the right topic without breaking the rapport that had been established before and during the interview as I did not want to come across as insensitive or dismissive of their feelings and experiences. This was particularly challenging because I simultaneously had to pay attention to whether they still appeared to be on opioid score 1 (see *Appendix 1*). Additionally, Mary dismissed almost every question related to drugs and delinquent behaviour by either distancing herself from the topic, changing the subject, or arguing that she did not have a problem with drugs. It was therefore particularly challenging to interview Mary about her experiences with HAT, crime, and illicit drug use, as she did not seem to acknowledge that she had drug-related issues.

4.2 Approach

The reflexive approach of coding in a thematic analysis entails the following six steps; Getting familiarised with the data through reading the transcripts, generating initial and broad codes, searching for initial themes, reviewing and further developing these themes, defining and naming themes, and writing them up (Braun and Clarke 2006: 87; Braun and Clarke 2021: 39; Castleberry and Nolen 2018: 808; Kiger and Varpio 2020: 846). This approach is data-driven, meaning that I found the categories through analysis of the coded data material before they were deconstructed and conceptualised into overarching themes by looking at common and shared meanings amongst the data (Braun and Clarke 2021: 39; Hennink et al. 202: 247, 250: Kiger and Varpio 2020: 847; Kvale 2007: 104, 113). By doing so, I found overarching themes that functioned as umbrellas for the sub-themes (Hawkins 2018: 3). Each code was given descriptions that functioned as inclusion or exclusion criteria that captured the essence of the phenomena that were eventually explored in this study (Castleberry and Nolen 2018: 809, 812). The development of themes was reflexive as they were developed in an unstructured coding process where I read the transcripts and generated codes by engaging with the data (Braun and Clarke 2021: 39). This process included making visual representations of the codes and themes in the form of drawing thematic maps as this enabled me to identify patterns both within and across the data (Castleberry and Nolen 2018: 812). This also included reflexivity where the labels of the themes were changed according to the patterns that were found between the codes.

Using an open-ended research question was considered suitable for this qualitative study as it allowed me to explore the perceptions and experiences of the participants beyond pre-conditioned yes/no questions (Oviedo-Joekes 2014: 2). This also allowed the empirical data to direct me towards the the theoretical development of the conclusion rather than working from a hypothesis, which is a central element of the inductive process (Bryman 2016: 23). I decided to approach the thematic analysis with the research question '*How are people with opioid-use disorder impacted by and manage stigmatisation before and after entering heroin-assisted treatment?*' (see *Appendix 2* for table of research question, aim, and objectives). When I was reading through the transcripts and creating themes, I was initially looking for quotes and themes that could be analysed through a criminological lens and that they were related to my research question. I had not decided what the themes would be and was prepared to adapt my research question as it was an inductive process, but data related to crime (e.g. drug dealing or conflicts), the participants' opinions and experiences of HAT, what they expected from the treatment versus how they found it, and descriptions of their daily lives and relationships with staff or peers were of particular interest. The first theme I found was labelled 'Experiencing Stigma' with the sub-themes 'Limited Agency' and 'Stigmatising Language and Attitudes'. The second theme I found was 'The Management of Stigma' and got the sub-themes 'Symbolic Boundaries', 'The Exhibition of Control', 'Neutralising Delinquent Behaviour', and 'Meaningful Delinquency'. The third theme was labelled 'HAT's Impact on Stigmatisation', and the following sub-themes were 'Becoming a Part of Society' and 'The Importance of Trust in Treatment'. The aim I decided for the thesis was to understand how patients with opioid-use disorder experience and manage stigmatisation, and whether and how being in HAT changes this. The themes were analysed in three parts of the analysis chapter through thematic analysis as this method enables flexibility where patterns can be identified both within and across the datasets by looking at the participants' lived experiences, perspectives, and behaviours (Clarke and Braun 2017: 297; Kiger and Varpio 2020: 846). Towards answering my research question, aim, and creating a logical narrative of the analysis, I decided on the following three-fold objectives; to explore 1) How the participants experience stigmatisation, 2) How the participants manage stigmatisation, and 3) Whether and how being in HAT changes how the participants experience and manage stigmatisation.

The analysis of the data was latent where deeper and underlying ideas, assumptions, and conceptualisations were identified and explored (Braun and Clarke 2006: 84; Kiger and Varpio 2020: 847). The exploration of the themes included interpretive work where I analysed how the themes work together towards forming an understanding of my open-ended research question (Braun and Clarke 2006: 84; Hawkins 2017: 5). The analysis was interpreted from a constructionist framework as I wanted to explore and interpret how both the meanings and experiences described in the interviews may be socially produced and reproduced due to the well-known stigmatisation of the participant group (Braun and Clarke 2006: 85; Madden et al. 2021: 2182). Henceforth, the analysis went beyond being purely descriptive by making arguments that were related to the research question through an interpretive and analytic narrative description of the transcripts and illustrative data extracts (Braun and Clarke 2006: 93; Kiger and Varpio 2020: 853). Some of the claims that were made in the write-up of the analysis were theoretical and interpretive as were they seen in relation to existing literature that explores relevant topics, whilst others were empirical when based on what was said by the participants. The final analysis does not only represent how I as the researcher interpret the data, but also include criminological theories to demonstrate how and why these interpretations may be accurate (Kiger and Varpio 2020: 853). The merging of findings in the analysis is a distinguishing feature that is often found in thematic analyses and connecting the findings to existing literature provides the reader with an understanding of how my data relates to what is already known about the researched phenomenon (Hawkins 2017: 5; Kiger and Varpio 2020: 852, 853).

4.3 Strengths and Limitations

Strengths of the study include that the data could be re-tested throughout the study due to access to several potential participants, hence it can be argued that the study can produce reliable findings as the consistency can be measured and documented (Bryman 2016: 157). Additionally, there is extensive literature on heroin-assisted treatment and experiences from other countries, which enabled me to measure the convergent validity as my findings could be compared to those of other studies (Bryman 2016: 159). Field notes that record other patients at HAT describing the same phenomena contribute to strengthening the validity of the data from the interviews (Krumsvik 2014: 145). Experiences from other countries and former studies helped me during the analysis by conceptualising and using the theories by looking at similarities and differences in our findings, which can be argued to have contributed to improving the validity of my study (Hennink et al. 2020: 250). It should also be noted that a strength of this study is that it enables policymakers to create efficient and informed drug treatment policies by providing patients with the opportunity to evaluate the treatment they receive. The participants' opinions and experiences gathered in this study are essential towards reducing stigma and improving their health care as this is a stigmatised and vulnerable group that might otherwise be challenging to interview (Cheetham et al. 2022: 1). Additionally, the analytic strategy of thematic analysis is argued to produce work that is both trustworthy and credible as the steps of the analysis are thoroughly documented, hence can they also be re-tested (Castleberry and Nolan 2018: 814). Whilst previous studies have explored how this vulnerable group is affected by stigma in other countries, this study fills a gap in the literature by covering the management of stigma for this group in a Norwegian context. The participants in this study are also a hard-to-reach group that it has been encouraged that research includes, hence does this study provide insight that has been found challenging to acquire (Torgersen et al. 2019: 71).

Limitations of the study include challenges when recruiting participants for interviews and therefore also the possibility of not being able to gather valuable information that omitted participants might have contributed to (Tjora 2021: 147). Participant observation also includes the risk of documenting and interpreting subjective behaviour (Hennink et al. 2020: 198). The participants in this qualitative study are a vulnerable group which also promotes some unique challenges when it comes to the interview setting, largely due to their influence of medication during the interviews. Whilst influence of drugs during interviews may be a threat to the study's validity, Sandberg and Copes (2013: 184) found that their participants – who were drug dealers – argued that the influence of drugs is what made them function normally as they would be under distress if they had not taken drugs. They do however argue that the pressure to collect useful data may include errors from the interviewer as the level of intoxication may be overlooked, which is a scenario that could be applicable to this study as well. Additionally, some participants may have been hesitant about sharing information due to the recording device used during the interview, or not being confident that the information would not be shared with authorities or affect their treatment if the rapport that was established before the interview was not good enough (Hennink et al. 2020: 134; Tjora 2021: 182). It must also be acknowledged that the findings from this study are not considered generalizable as the conditions cannot be replicated, although they can still function as guidance for future research and policy-making regarding similar participant groups (Castleberry and Nolen 2018: 812; Hennink et al. 2020: 316).

4.4 Ethical Considerations

The formal considerations for my study were granted through RusForsk and I did not have to personally apply to have my study approved by The National Committee for Research Ethics in the Social Sciences and the Humanities. I signed a confidentiality statement and an agreement on which terms that apply for writing my thesis with RusForsk. The participants in my study are not believed to have been caused any harm by their participation and the information they shared did not affect their treatment (Tjora 2021: 187). Whether patients that receive medical heroin can give informed and voluntary consent has been debated in several articles, and a previous study on HAT excluded patients from participating as an ethical concern because of the influence of medical heroin during the interviews (Cheetham et al. 2022: 4; Uusitalo and

Broers 2015). However, excluding these perceptions and experiences from research may result in significant knowledge gaps and faulty service models where structural barriers experienced by the patients are not taken into consideration. Ethical considerations were made throughout the data-gathering process by only interviewing patients that score 1 on the opioid score (see *Appendix 1*) after they had taken the drugs at the clinic. This is the same score as the staff uses to evaluate the patients before and after the medication handout. The score ranges from 1 (best) to 6 (worst), and rates the patients based on their cognitive and physical functions, such as whether their eyes are open, their speech is clear, and whether they can stand upright or if keep falling asleep. Using this score was considered a useful instrument towards deciding whether the patients could be interviewed or not as it includes detailed descriptions of what each score means and gives a good indication of their present state. As the staff has significantly more knowledge and experience with the patients than me, I made sure to confer with them about each participant's mental and physical state before I approached them.

Each interviewee had to sign a consent form and are free to withdraw from the study at any point (see *Appendix 4*), and I guaranteed that whatever they said during the interview would not be shared with anyone other than the researchers that are on the project and that they would be anonymised and not identifiable in our studies. The content of the consent form was explained to each interviewee at the beginning of the interview and they were offered to take a copy that they could read in their own time. The interviewees were shielded from staff and other patients by interviewing in a separate room at the clinic with closed doors, where I was still able to get help from the staff if needed. I paid close attention to how the interviewees reacted to the questions and avoided questions that were believed to potentially bring up old trauma or information that was not necessary for the study. I was prepared to finish the interview if the participant got upset or seemed to be on a higher opioid score than at the beginning of the interview. My field notes did not contain personal information that could be used to identify the patients and the physical notes were stored in a place where others could not obtain them (Tjora 2021: 95). The digital notes were also free from identifiable information and password protected, and the participants were given pseudonyms that do not necessarily reflect their gender.

The ways I speak about OUD, heroin, and HAT is something I reflected on before, during and after my visits to the clinic because I wanted to reduce the possibility of unintentionally causing distress to the patients through hurtful and uninformed language (see e.g. Bech 2023). It was necessary to make several ethical considerations regarding language and terms when writing this thesis as the patients and the existing literature made me more aware of my language. It is necessary to acknowledge that like the general population, I am influenced by learned behaviour when it comes to the social forces behind the stigmatisation of people with OUD (Graham et al. 2022: 375). Nevertheless, I wanted to use this thesis as a tool to change the underlying mechanisms that influence this learning process by writing something that contributes to changing the stereotypical and negative associations that are linked with OUD. The use of destigmatising language is one of these tools. The stigma associated with OUD is argued to be mediated by the use of destigmatising language, and I have paid significant awareness to using non-judgemental and accurate language when writing this thesis (Olsen and Sharfstein 2014: 1394). For instance, I refer to the medical heroin that the patients receive at the clinic as ‘medicine’ rather than a ‘drug’; to the people at HAT as ‘patients’ rather than ‘addicts/drug (mis)users’; to the committal to opioids as a ‘need’ rather than a ‘desire/choice’; to the intake of heroin as ‘use/consumption’ rather than ‘misuse’. I do however use the word ‘addiction’ sometimes, which is because the patients' OUD in its medical meaning means that their bodies are addicted to opiates. I am aware of the discussion on addiction versus dependency, but I consider this term fitting and not stigmatising when used appropriately and with consideration as OUD was explained in that same manner by several patients that I talked to. By that I do not mean that the patients’ OUD is simply an addiction. I also use person-centred language, such as describing the group I study as ‘PWUD’ rather than objectifying and reducing them to a ‘drug addicts’ (Bech 2023; Cheetham et al. 2022: 3).

5 Analysis

This chapter is divided into three parts according to the themes that were found in the thematic analysis of the data material. In the first part, I analyse how experiences that restricted the participants' agency in drug treatment are linked with institutional stigmatisation through disempowerment and how stigmatising language and misinterpretations of OUD lead to internalisation of stigma. In the second part, I explore how the participants utilise neutralisation techniques and symbolic boundaries to manage stigmatisation, and how this management also facilitates deviant behaviour. In the third part, I analyse whether and how being in HAT changes how the participants feel in society and how HAT improved their self-esteem and self-worth. In doing so, the analysis thematically and chronologically addresses 1) The participants' experiences of stigmatisation, 2) How they manage it, and 3) Whether and how being in HAT changes this.

5.1 Part 1: Experiencing Stigma

The first part of the analysis will address the first research objective: To explore how the participants experience stigmatisation. I found that the participants' experiences before and after enrolment in HAT demonstrate examples of institutional stigmatisation that have led to feelings of agency loss, limited autonomy, and disempowerment. They described encounters with rules and regulations in drug treatment that did not align with their wishes and needs, and experiences where service providers had taken a "*top-down attitude*". Stigmatising language and discriminating attitudes therefore played vital roles in the process of stigmatisation as these elements contributed to feelings of shame and dehumanisation for the participants (Werder et al. 2022: 9). This first part of the analysis will therefore explore how coercive or restrictive treatment policies, stigmatising language, and misinterpretations of OUD lead to internalisation of stigma and reduced self-efficacy.

5.1.1 Limited Agency

Experiences of limited agency and disempowerment was particularly prevalent in the participants' previous experiences from MAT, but also applicable to certain parts of their treatment at HAT. Several participants wished to quit methadone and having this as the only option for their take-home dose was working against their purpose of being at the clinic, and the result of the dislike for methadone was side-use of other illicit drugs and that the bottles of methadone stacked up at their homes. Some of the patients that I talked to during participant observation also thought it possible that other patients might be selling their evening doses or trading them with street drugs. There was an evident dislike for not being allowed to inject the medicine into the groin and the result of this was that some of the patients still did it, but tried to hide it. It is being argued that planned drug use should be considered an autonomous decision where the individual has agency and responsibility for this action, whilst limited agency in drug treatment is a stigmatising form of formal social control as it would not be acceptable in other healthcare settings (Askew 2016: 118; Chang 2023). Receiving prescribed methadone and medical heroin in drug treatment can be considered a form of planned drug use, but the agency of these actions may be questioned when the patients feel uncertainty towards the medication and agitation regarding the practises of how the medication can be taken. This might suggest that agency loss within drug treatment can be a form of discrimination because the diagnosis or symptoms of OUD leads to less favourable treatment than other patient groups.

> **Lisa**: But methadone ruins my kidneys really, and I’m so annoyed with… With… The methadone in general, that it’s… No, that’s something I want to get away from.

Lisa found it meaningless to be treated with methadone when heroin was her addiction and said that “*the methadone ruins my kidneys,*” and that she wanted to get off it. Phil discussed how he found his dosage of methadone to be “*not even close to enough*” as the staff at HAT did not understand that his prior dosage, which his current prescription was based on, was in addition to his side-use. This caused him a lot of frustration and he had to acquire other drugs for the evenings instead of methadone. Sue explained that she did not like the methadone because it was “*very harmful for the body and it’s kind of like… Like pushing the speed and the break at the same time, taking methadone and then coming here to take heroin.*” Kevin was worried because he suspected that his girlfriend’s back issues were related to methadone, and Mark said “*methadone made me very drowsy and I could barely do anything, just having a shower was tiring*” and that he found it ridiculous to have his dose of methadone increased in HAT when he intended to quit using it. A patient I talked to in the observation room said that he had to pull himself together for not taking more drugs as he could always have more, and that suitable medication at the clinic would make it easier and more motivating to abstain from street drugs. Two of the patients, one of them being Mark, expressed concern that they were a “*lost cause*” if they failed to improve their health whilst being in HAT as they considered it to be the last resort for improving their quality of life, and the evening dose with methadone was a major source of this concern. This demonstrates a reduced belief in self-efficacy and hence, agency, as this is argued to be constituted by a person’s self-efficacy beliefs (Bandura 1999: 214). These participants, as well as several others, therefore called out for other options as their take-home dose or the possibility of a third visit to the clinic during the evening.

Chang (2023) argues that rigid drug treatment programs compromise the patients' agency and that the status quo of these treatments is that clinicians and policy makers make decisions on behalf of the patients. These patients have limited agency regarding protocols and treatment options, hence being subject to forms of social control that are stigmatising as they would not be acceptable in other healthcare settings (Chang 2023). Luke suggested that there should be regular meetings at the clinic where these issues could be discussed, or a letterbox where the patients could write and submit both positives and negatives about the treatment. Joint meetings was also advocated by Phil, who said that "*having a patient representative that can attend meetings so you feel included and get to speak about the things that might be on your mind.*" The absence and need for a platform where the patient group is included might strengthen Chang's (2023) argument as it highlights that the patients' feel like their agency to influence protocols and decisions is limited. It is being argued that an individual's perceived self-efficacy, namely their belief in their capacity to produce a specific outcome, is a key factor for human agency and has a significant impact on which changes they can make in drug treatment, as well as being a key factor for human agency (Bandura 1999: 214, 215). Lisa said that the methadone is "*something I want to get away from*" which demonstrates a discrepancy between her goals of being in drug treatment and the treatment options HAT provides, hence also limited agency regarding both her treatment and drug use. Bandura (1999: 214) argues that personal agency is influenced by both social and structural factors, and it might be suggested that this limitation of the treatment is a structural factor that limits Lisa – and the other participants' – agency. Being treated with a drug that is considered harmful and not desirable may be argued to be a form of treatment that patients in other settings would not have to accept, henceforth may it also demonstrate a form of institutional stigmatisation.

> **John**: What I find a bit odd is that rule about not being allowed to inject in the groin and those kind of stuff. Because I can't understand… I mean, I kind of get the feeling that that rule is more for you than it's for us, really. […] Personally, I don't have any trouble hitting in the arms at the moment, because they've been given rest for quite some time, but like, you probably get to a point where you… Where I'm starting to struggle, and I know several others here who swear and struggle and almost stab themselves to death, and get really frustrated because they… Yeah, like they could've had had it over with [injecting

> medical heroin] in 10 seconds, right. So… I've tried to work that bit [laughs], but we'll see.

John said that "*I kind of get the feeling that that rule is more for you than it's for us, really*" when he talked about the rule against groin injection and explained that other patients struggled significantly with this rule as other veins were severely damaged and nearly impossible to find. Adam explained, "*I don't like it when others make decisions over my body*" as he had been injecting into the groin for 20 years without getting any scars because he was cautious about the hygiene. Sue on the other hand, who was also used to injecting in the groin, said that "*there have to be some rules here too, [...] I'm thinking that's part of being in society and having to adhere to certain rules, that's just how it is.*" Henceforth, groin injection was a common route of administration for many of the participants and not being permitted to do so was particularly challenging for some of them. This was also highlighted as a common frustration by several patients I talked to in the observation room. Studies have found that although this practice is severely damaging to the femoral vein that they inject into, the behaviour seems to be persistent regardless of the consequences the users may experience and research has therefore called out for interventions that promote behaviour change regarding this practice (Rhodes et al. 2007; Senbanjo et al. 2011). This was also reflected in my study, as Phil said that this rule lead to patients still doing it but trying to hide it, and despite having experienced significant health issues as a consequence of injecting in the groin, he still found the rule to be "*stupid.*" This might also suggest that HAT's approach to promoting behaviour change regarding groin injection is not fully successful, although some of the patients accept the rule.

Although the damaging effect groin injection has on the femoral vein is well-documented, many of the participants' views regarding this rule share similarities with a stigmatising and devaluing experience, such as Adam who felt like others were making decisions over his body (Rhodes et al. 2007; Senbanjo et al. 2010). The process of stigmatisation is argued to enable differentiation of power through the devaluation of people with certain attributes and behaviours, and it seems reasonable to suggest that Adam feeling that someone else is making decisions over his body is a form of disempowerment (Taylor et al. 2021: 1752). Groin injection is considered a strategic area to inject as others rarely see the marks and studies have found that for those who only inject into the groin, the most common reason is that it is discreet (Hope et al. 2015: 240). It has also been found that symptoms of injuries and infections are less prevalent amongst these users, possibly because it is considered a 'sure hit' where the person needs fewer attempts for successful injection, hence less contamination (Hope et al. 2015: 243; Shorter et al. 2022; Wright et al. 2016). This does not align with the other studies that found that groin injection is a considerably damaging practice, and it might be suggested that the participants in my study demonstrate the discrepancy between these former findings. Additionally, their experiences of this rule as something that "*is more for you than it's for us*" might demonstrate Chang's (2023) previously mentioned argument that service providers' fear of misuse and diversion compromise the patients' autonomy and empowerment.

One of the ways in which institutional stigma is enacted is through limited and restrictive treatment policies, which further constrains the stigmatised group's opportunities, resources, self-efficacy, and agency in treatment (Chang 2023; Cheetham et al. 2022: 2). Several participants called out for being prescribed other drugs instead of methadone due to unwanted side effects and uncertainty towards the drug. However, their beliefs in their agency to influence this part of the treatment at the time of the study was absent[4]. It might be reasonable to suggest that these experiences pose challenges to the participants' alignments of their actual and virtual social identities as their agency to remove an attribute, namely their use or association with methadone, and increase their self-efficacy in treatment is reduced (Goffman 1963: 10; Topalli 2005: 779). Henceforth, so is their agency to reduce both structural and self-stigma regarding their use of drugs. The participants' self-conceptualisation is strongly influenced by the stigmatisation of them as consumers of illicit drugs, and therefore an important aspect of their treatment process where the consequences of inflicted stigma reduce their autonomy and self-image (Bos et al. 2013: 1; Topalli 2005: 799). Hence, it may be suggested that the restrictions regarding the participants' take-home dose and route of injection act as barriers to the participants' personal needs in treatment – namely, to have agency over their drug use, which is also one of the overarching aims of HAT (Eide et al. 2019: 10, 11). It is being argued that the exercise of power is a condition for stigmatisation to take place, which might also suggest that disempowerment and reduced agency can be the end results of stigmatisation (Link and Phelan 2001: 363). Holt (2007: 1939) challenges the stereotypical and stigmatising view of PWUD as having a desperate need for drugs by suggesting that they share the same anxieties as the general population regarding the use of drugs in treatment that are not their choice, which is demonstrated by my

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[4] As a result of new guidelines in MAT, the patients at HAT can now choose whether they want to receive methadone or dolcontin as their take-home dose. This change was implemented a few months after my data gathering process and my participants were critical towards whether it would happen.

participants. This also demonstrates that due to their limited ability and agency to influence protocol and treatment decisions, these participants are subject to stigmatising forms of social control (Chang 2023).

5.1.2 Stigmatising Language and Attitudes

Several of the participants described how previous experiences in MAT were stigmatising because of the language and approach used by the service providers, but also highlighted that their experience with the staff at HAT was completely different in a positive way. While some participants encouraged others to refrain from using stigmatising language, others used terms like "*junkie*" and "*heroinist*" about both themselves and others. Several participants had negative experiences with MAT, much due to the stigmatising culture and attitude they had encountered there. The participants also emphasised that they encountered HAT as completely different to MAT because of the culture at the clinic, and because the staff seemed like they had good knowledge about OUD and drug-related behaviour and treated them respectfully.

> **Phil**: Well, I think that here, it's like… It's a better culture here [in HAT], I think. I think it's a better culture… Seems like there's a better culture amongst the staff and that culture meets you when you come here. I think that you're welcomed with more respect, and that they have a different approach to us as drug addicts. I think that… Well… Epistemology is a nice thing. It's interesting, important things. The choice of which terms to use and stuff. Just the term 'drugged' in and of itself is very… Kind of misleading. Like, 'drug addict', I partially think that I am a drug addict, yes, but first and foremost, you're addicted to not feeling sick. You're 'opiate dependent', right, so… You're addicted to a drug in order to simply function in an ordinarily manner, not to get high … Still, everything about drug addiction is slightly misleading, in my opinion. I think people should be more aware of that, really.

Phil discussed the use of stigmatising language as he primarily needed opiates as medication, not to get high. The use of terms like "*drugged*" and "*drug addict*" were therefore misleading as they did not reflect how the heroin worked for him, nor his need for it. Stigmatising language has been found to be prevalent both in the public, private, and clinical context, and the stigma of opioid use is associated with delay in seeking treatment and premature exits from treatment programs (Graham et al. 2022: 375). In light of this, the participants' prospect of long-time treatment in HAT may be more optimistic compared to other treatment programs as they experienced the staff as compassionate and user-focused as compared to stigmatising. Phil's reflections on stigmatising language also demonstrate that his self-perception is different to what he sees as the stereotype of the stigmatised opiate user, seeing that he considers the general knowledge regarding drug addiction to be slightly misleading because the medical and physical need rather than lust for opiates is rarely acknowledged. Due to the high stigmatisation of this group, it might be suggested that many might interpret Phil's explanations as neutralisation techniques of drug use as he applies both justifications and rationalisations to explain his addiction (Sykes and Matza 1957). However, it seems reasonable to suggest that one would not interpret his testimony as neutralisation techniques if his addiction was related to pain relief for a disorder that the general public has more knowledge of and acceptance for, such as anxiety or post-traumatic stress disorder which, on a side note, many of these participants also have. Problems in knowledge, such as ignorance or misinformation, are argued to be a key source of opioid-related stigma (Cheetham et al. 2022: 2). It seems reasonable to suggest that insight and empirical evidence from the perspectives of patients like Phil may contribute to reducing this source of stigma as he stresses the misleading nature of the language that is being used regarding opiate addiction. The quote from Phil do not only provide insight into how a person with OUD experiences their disorder, but is also an interesting example of the internalisation of stigma as he earlier in the interview said "*Considering that I am a heroinist right, and drug addict, it's not so unnatural that my impulse control is not the best*." Here, Phil refers to himself as both a "*heroinist*" and a "*drug addict*." However, after that, he said that the term '*drug addict*' was misleading and that people should be more aware of how they describe people who are addicted to drugs, as his primary concern was to recover from his OUD – not to get high. Henceforth, by referring to himself in the same manner that he encourages others to refrain from, Phil unknowingly demonstrates how he has internalised what he considers to be a misleading stigma.

> **Mark**: But I was hoping for the best, so… The expectations I had [to HAT] were really… Like MAT, with little listening and lots of top-down attitude.
>
> ***
>
> **Sue**: Yes, a very positive difference. Like kind of hard getting used to not having to hide and lie about everything, and having to give out the wrong information just to keep living alright.

Mark said that his expectations towards HAT were "*like MAT, with little listening and lots of top-down attitude*." Similarly, Sue said that her experience at HAT was very different from MAT, and that it was hard to adapt to no longer "*having to hide and lie about everything*." Although Mark and Sue did not mention the language used by the service providers in their former treatment programs, they both described stigmatising experiences where the demeanour and attitudes towards them signalised disinterest in their issues (Skatvedt 2020: 18). Cheetham et al. (2022: 2) argue that attitudes and prejudice is one source of opioid-related stigma, and Mark's description of MAT "*with little listening*" might demonstrate an example of experiencing a stigmatising attitude where he was not being heard and respected by the healthcare system. In another part of the interview, Sue described how the ways she had been treated previously had made her feel ashamed regarding her situation and it is being argued that feelings of shame stem from both public stigmatisation, and from the internalisation of this (Matthews et al. 2017: 275). Additionally, Sue said that she felt like she had to "*give out the wrong information*" to maintain her functionality, which confirms previous studies that have argued that the general lack of trust between patients and service providers often leads to patients hiding their opioid use as they fear judgement, stigma, and reduced quality of care (Werder et al. 2022: 10).

Phil, Mark, and Sue describe experiences where language and "*top-down attitude*" play vital roles in the process of stigmatisation as these elements have previously contributed to feelings of shame and dehumanisation when they have been in drug treatment (Werder et al. 2022: 9). Stigmatising language and restrictive or coercive treatment policies are examples of institutional stigmatisation and it seems reasonable to suggest that this is well demonstrated in my participants' experiences (Cheetham et al. 2022: 2). The use of stigmatising language is argued to still be prevalent in the public, private, and clinical context and stems from learned behaviour, hence is it necessary to change the underlying mechanisms that influence this social learning process (Graham et al. 2022: 375). As several participants pointed out, they needed opiates as medicine and explained that they were only functional when this need was covered. This is why it is encouraged to use destigmatising language when talking about OUD, such as by referring to the drugs that are used in treatment as 'medicine' as this aligns with how other psychiatric medications, like antidepressants and antipsychotics, are understood and function in the patient's treatment plans (American Psychiatric Association 2022; Olsen and Sharfstein 2014: 1394). This aligns with what Phil suggests when he calls for people to be more aware of the language and terms they use regarding opiate dependency, as using the wrong terms causes misleading interpretations of OUD and the people who have this disorder. Language is argued to communicate which attitudes someone holds towards an attribute, hence also enabling or disabling feelings of respect and inclusion (Werder et al. 2022: 10). As the participants in my study explain, being met with respect and positive attitudes contributed to a positive experience at HAT where they felt respected and valued. Henceforth, it may be suggested that they demonstrate that healthcare professionals adopting destigmatising language and attitudes towards the disorder, the patients, and their treatment can mediate the stigmatisation of OUD (Olsen and Sharfstein 2014: 1394).

5.2 Part 2: The Management of Stigma

This part of the analysis aims at gaining a deeper understanding of how the participants manage stigma associated with drug use and opiate dependency and addresses the thesis' second objective: To explore how the participants manage stigmatisation. My research found that many of the participants frequently utilised neutralisation techniques as a way of creating a distance and demonstrating differences between themselves and other patients at HAT, for instance by claiming that they were not "*like that*" or explaining how they opposed and disapproved of stereotypical "*junkie"* behaviour. Many of the participants explained their drug use through the perspective of having control and making rational choices, often contrasted to other PWUD or patients at HAT, and that neutralisation techniques were used as a way of rationalising and justifying delinquent behaviour related to drug dealing. They also found meaning and value in delinquent behaviour by focusing on the social role they had in their sub-group.

5.2.1 Symbolic Boundaries

I found that the participants often ridiculed or condemned the behaviour of other patients at HAT or similar peers and that instead of explaining how their own drug use and lifestyles were functional, they often focused on why others were dysfunctional. By doing so, the participants were able to maintain a positive self-image through rationalising that at least they did not behave in a certain dysfunctional way, hence creating symbolic boundaries between them and stigma. The employment of symbolic boundaries have been found to be an effective tool for creating a distance to an undesirable group and attachment to a desired group (Gueta and Chen 2021). This is argued to be particularly important for stigmatised individuals, such as PWUD, as it enables intra-group differentiation where individuals can place themselves in a functional category (Copes 2016: 193). Henceforth, this boundary work enables management of stigmatisation's function of social exclusion as individuals resist being categorised in a stigmatised subgroup of the conventional society.

> **Interviewer**: […] Am I understanding you correctly, that you haven't necessarily used drugs like diligently, consistently?
> **Mary**: No, I'm not like that. Before, I could quit and start whenever I wanted to really. I laughed my pants off when they [other PWUD] were whining and all of that 'ooh I'm so sick and I'm all sweaty and ooh help, painful'. I took it head on, I did.

Mary, as quoted above, said that she was "*not like that*", and Phil expressed strong feelings of dislike and agitation towards patients that acted too intoxicated after receiving their medication at the clinic. Copes (2016) argues that as a way of characterising themselves as functional PWUD create symbolic boundaries between themselves and the users that they consider dysfunctional. By distancing themselves from stigmatised behaviours, PWUD actively resist the stereotypical stigma that they fear might be associated with their identity through the symbolic boundaries they use to categorise appropriate versus inappropriate behaviour within the group (Copes 2016: 194). The employment of this boundary work may therefore aid individuals in establishing their connection to their desired social group, whilst distancing themselves from the groups they consider less desirable (Gueta and Chen 2021). Mary demonstrated this categorisation on several accounts, such as in the quote above where she ridicules other users' behaviour and contrasts it to herself who "*took it head on*". By doing so, she may avoid the shame and stigma associated with her personal substance use by portraying how the 'real' addict behaves in contrast to her (Copes 2016: 199, 200). Henceforth, the symbolic boundaries may contribute to how Mary manages stigmatisation as they enable her to protect and differentiate herself from the stigmatised identity.

> **Mark**: […] And I've been nagging her for all those years that we've been together, 'Can you please just try to pretend like you're a bit awake and not like completely distant and junkie-like when we're walking around in our neighbourhood', right. And she's got it now, finally.

Another demonstration of symbolic boundaries and detachment from other PWUD was Mark who did not like it when his partner Sarah (also diagnosed with OUD) blatantly acted like a "*junkie*" when they were walking around in their neighbourhood. This demonstrates Goffman's arguments regarding the contamination of stigma through association with stigmatised others, where Goffman – like Mark – uses the example of walking down the street alongside a stigmatised person and in doing so, becomes contaminated by the visible stigma this person bears through association and suspicion (Goffman 1963: 55). Stigma is argued to become apparent through social interactions and the social context rather than residing consciously within an individual (Bos et al. 2013: 1). Furthermore, demonstrating core differences between yourself and other stigmatised identities is argued by Copes (2016) to be particularly important for individuals who are either physically or socially close to people in stigmatised groups as these demonstrations are used to categorise which group an individual associates with. It might therefore be suggested that this pattern of rhetoric regarding other peers with OUD has some roots in the contextual social process of stigmatisation, where the participants do not want to be associated with other PWUD who act a certain and stigmatised way. The participants are part of a sub-group of individuals due to their OUD. However, these findings demonstrate the social constructiveness of stigmatisation by implying that there are further stigmatised groups even within this sub-group where someone's behaviour is considered socially unacceptable and not coherent to the groups' cultural norms and values (Bos et al. 2013: 1; Cheetham et al. 2022; Ragins 2008: 196). This may also be indicative towards an intra-group separation and stigmatisation amongst the patients in HAT. Matthews et al. (2017) note that the socially induced shame or self-stigmatisation does not apply to all individuals with an addiction, but it might be suggested that the participants who express dislike for the intoxication and associated behaviour of other patients are highly aware of this shame and self-stigmatisation as they do not wish to be affiliated with it.

> **Interviewer**: Are you guys thinking of dealing less and stuff? Get rid of that stress when you no longer need all that [money for drugs]... Then there's kind of no point anymore, except the cash?
> **Kevin**: No, exclusively to not feel sick. Not any… You know what? The way we look at people who are dealing for the sake of the money, that's real ugly. It just doesn't cut it, that's just a thing you don't to, really. [laughs]

"*The way we look at people who[…]*" demonstrates another interesting symbolic boundary and stigmatisation amongst the individuals in this group of patients where informal social control is exerted through making a distinction between '*we*' and 'them' (Palamar et al. 2013: 517). It also presents a neutralisation technique where Kevin can distance himself from the stigma of being a drug dealer by rationalising that at least he is not doing it for what he considers immoral reasons. Feelings of guilt are thereby neutralised through constructing an identity contrasted to those of 'bad' drug dealers, a form of neutralisation that has been found to apply to PWUD and dealers alike as neutralisations are incorporated into their self-identities (Dickinson and Jacques 2019). It seems reasonable to suggest that the need to neutralise this behaviour stems from the stigmatisation of both drug use and dealing, as discrediting other drug dealers' motives may be a way of regulating Kevin's own negative emotions and hence feeling detached from a stigmatised identity (Bos et al. 2013: 3; Ragins 2008: 196). Creating a symbolic boundary between him and other drug dealers might enable him to indirectly increase the morality of his dealing by highlighting the immorality of another's (Hitlin 2007 in Copes 2016: 195). In doing so, Kevin demonstrates that he inhibits two roles as he is both the inflictor of stigma and the stigmatised. It might be suggested that he feels more adherence to social norms and values by inflicting stigma on drug dealing that is based on economic profit, as he may – in that context – be considered as not stigmatised through exhibiting a motive for dealing that is deemed contextually acceptable, namely, "*exclusively to not feel sick*" (Bos et al. 2013: 2). Doukas (2011: 409) argues that for a PWUD to successfully transform a stigmatised identity and self-image to a social identity that is not stigmatised, they must publicly announce which choices they make that have a life-changing effect on their addiction. It is not known whether the participants who expressed a dislike for the motive of economic profit have always thought this way. However, it seems reasonable to suggest that their need to highlight their disapproval could be interpreted as a public statement of their desired self-image and an attempt to align this desire with their ideal self – namely, how they would ultimately prefer to be (Higgins 1989, 1987 in Topalli 2005: 799).

Information management and symbolic boundaries are argued to be common mechanisms of how stigmatised individuals protect themselves against stigmatisation, and manage the internalisation of it (Copes 2016; Radcliffe and Stevens 2008: 1065). This was particularly prevalent amongst the patients I talked to in the observation room as they often started the conversations by telling me their stories and explaining the reasons for why they ended up in HAT, hence starting our relation by taking control of which information they wanted me to have about them. Neutralisation techniques have been argued to create a boundaries between an individual and their stigma, and it might be suggested that the boundaries that these participants create between themselves and others therefore provides both protection and management of stigma (Covington 1984 in Maruna and Copes 2005: 256). Like previous findings suggest, the participants in my study acknowledged the stigmatised stereotype's validity by categorising what they considered dysfunctional users to be like and stressing that they did not approve of such behaviour (Radcliffe and Stevens 2008). They also demonstrate that there are norms within their subgroup as they explained boundaries between acceptable and unacceptable behaviour (Askew 2016: 112). This shows that stigmatisation not only occurs between the conventional society and stigmatised individuals, but also within stigmatised groups. LeBel (2008: 417) argues that stigmatised individuals often try to conceal their stigma by portraying themselves as “normal”, and it might be suggested that explanations of deviant or unwanted behaviour in others may also be interpreted as a way of framing the ‘abnormal’. Henceforth, the utilisation of symbolic boundaries may contribute to the management of stigma by limiting the extent of it social exclusion. These findings may also demonstrate that individuals who exhibit what the conventional society often consider deviant behaviour are invested in maintaining a positive self-perception and bond to society, as both the participants and the other patients seemed to have a need to express themselves as good people (Topalli 2005: 798).

5.2.2 The Exhibition of Control

I found that many of the participants tried to express control regarding their drug-related behaviour by condemning the lack of control in other users. PWUD’s ability to demonstrate control and rationality is argued to contribute towards legitimising their drug use and that by doing so, they may avoid blame and protect their self- image by rationalising that their behaviour is ‘better’ than comparable other’s (Askew 2016: 112, 113; Copes 2016: 200). Decorte (2001: 297) argues that PWUD who can demonstrate that they have control maintain a positive identity and adherence to the conventional society through the establishment of a meaningful role where their lives are not centred on drugs. The participants in my study demonstrated that there are psychological processes related to control and rationality involved in their decision-making regarding the side-use of illicit drugs. Sue explained that she was concerned regarding the development of highly concentrated street drugs and that she was aware of how much drug-related crime cost society; John said that he felt proud when he had been at a festival without smoking weed; Adam knew that his cocaine addiction was purely psychological and not physical; Phil acknowledged poor impulse control, especially regarding drug use; and Lisa was very pleased with how little time she had spent in prison, considering that she had been using street heroin for 35 years. Hence, may it be argued that they demonstrate awareness and acknowledgement of the consequences of illicit drug use, hence therefore a certain adherence to societal norms and values despite their exhibition of acts that are considered deviant (Askew 2016: 113; Dickinson and Jacques 2019: 17; Sykes and Matza 1957). This might furthermore be interpreted as a way in which the participants manage the consequence of being stigmatised, namely through narratives of self-control, rationality, and accomplishments (Copes 2016: 193, 194).

> **Phil**: [...] and there's some people here that have been way too… Quite a few who are way too high, in my opinion. And that's disrespectful, I think, and fucking annoying because… I mean, I know that I too have been way too high here sometimes right, but I get annoyed by that kind of stuff. Like, I really disapprove of people who act like that, that people come here and you can't even talk to them after they've hit their shot. Then I'm like, 'hello', that's not what this… That's not the point of this, right.

It seems reasonable to suggest that using stigmatising or discrediting language when referring to other people with OUD demonstrates that Phil to some extent adheres to conventional norms and rules as clearly states a way of acting that he considers socially unacceptable, even amongst patients in HAT (Topalli 2005: 799). When Phil talked about his dislike for too intoxicated patients, he also noted that "*I know that I too have been way too high here sometime*s," before continuing to express his dislike towards patients who "*act like that*". This may be a form of neutralisation that is applied with the intent of achieving his desired self-image, namely by stating a difference between himself and others regardless of how big or small this difference may be (Topalli 2005: 799). It is being argued that the identity of PWUD is complexly constructed by a variety of social worlds where people are linked through communication and common interests, connected through their experiences and perspectives on the world (Doukas 2001: 409). Phil's internalisation and self-definition are therefore argued to reflect the contextual norms of his social group, which may be why he was so determined not to be associated with these other patients' social identity as it does not align with his desired identity and self-image (Doukas 2011: 409). Former studies have found that there is a bidirectional relationship between identity, addiction, and involvement, for example, that involvement in addictive behaviour influences someone's identity (Walter 1996 in Doukas 2011: 409). Henceforth, it seems reasonable to suggest that the participants distancing themselves from the unwanted behaviour of others is a way of limiting and constraining their own addictive behaviour and thereby also the impact the addiction has on their identity. It might also be argued that participants like Phil to some extent use stigmatising language about people he considers worse than himself as a neutralisation technique for his own drug use. By condemning the behaviour of others, participants may manage and reduce the impact of stigmatisation as they can place the shame on someone that they consider worse (Copes 2016: 207, 208).

5.2.3 Neutralising Delinquent Behaviour

I found that many of the participants had a neutralised perspective on crime and delinquency, especially drug dealing. Several of the participants reported that before HAT, most of their days were spent acquiring street heroin and other illicit drugs. For many, this entailed what the participants referred to as ‘pushing’, more commonly known as ‘drug dealing’, and they explained that heroin on the streets was sold in balls of five grams and that the act of ‘pushing’ meant that they bought one ball of street heroin before splitting it into smaller portions. By doing so, the participants were able to finance their drug use by getting a small income on each party of heroin that they bought. According to Dickinson and Jacques (2016), drug dealers employ neutralisation techniques to separate themselves from the negative connotations associated with the ‘drug dealer’ label and the resulting social stigma by changing their motives for drug dealing. Whilst some of the participants, like Mark, took full responsibility for dealing drugs, others – like Adam and Luke – considered it to be because of pressure from external forces, such as the obligation to pay fines or because other people came to them for drugs.

> **Interviewer**: What does a regular day look like now, then? If you compare to how it was before you entered HAT, do you hang around with different people? […] More time and such, as you’ve said. And things you don’t have to do… With dealing, maybe […]
> **Adam**: Not as much. Yeah, or… It’s more like… It’s not that I actively try to get drugs to sell and stuff like that. It’s more like it’s suddenly happened, if you know what I mean? Yeah, cause it… Maybe it… But compared to before, it’s nothing. Before, it was kind of the engine of my whole existence, to be able to do anything. […] Whereas now… It’s pretty much… It’s closer to nothing than anything, if you know what I mean? Like dealing. It’s… I don’t give away my phone number if anyone asks. If I’m [inaudible] a ball… Like, that’s five grams of heroin, which is like the least you can buy. So if I get someone a ball, coincidentally, then… I don’t leave my phone number and stuff. That… No, I think… I can pretty much say that I’ve completely stopped, really. And I’ve been selling a lot through the years.

An interesting phenomenon I found in this study was that dealing small amounts of drugs was considered almost equal to dealing nothing at all, as explained by Adam. This is similar to other statements in the interviews, such as when Kevin described how he was still selling drugs but later in the interview stated, “*I don’t do crime at all anymore, I don’t like it.*” Correspondingly, using and buying illicit drugs were not considered crimes, which may be rooted in the perspective and experience of opioids as a medicine that they need rather than an illicit street drug that they choose. Altering one’s motive and perspective on drug dealing has been found to be a rather common neutralisation technique amongst drug dealers as a way of distancing themselves from the ‘drug dealer’-label and the negative stigmatisation that follows with it, and it seems plausible to argue that this form of neutralisation is demonstrated in Adam (Dickinson and

Jacques 2016: 18). Using the phrase "*closer to nothing than anything*" shows that he is still dealing drugs to some extent, whereas the word "*coincidentally*" suggests that he does not take responsibility for it and "*I can pretty much say that I've completely stopped"* is contradictory to his affirmation of dealing. The denial of responsibility is considered the only neutralisation technique that is being used as an excuse rather than a justification, however, neutralisation theory argues that this also includes accepting that one's behaviour is morally wrong (Scott and Lyman 1968 in Askew 2016: 113). How an individual frames events and circumstances when speaking about their lives is argued to bear many implications regarding that individual's psychology, and Adam's neutralisation is a complex meeting of both awareness and denial (Maruna and Copes 2205: 222). Whilst his behaviour rejects conventional values and norms, Adam's language suggests a desire to adhere to the moral values of society as he does not wish to take responsibility or blame for dealing drugs (Aldridge et al. 2011 in Maruna and Copes 2005: 144). It might therefore be argued that Adam to some extent adheres, or at least wishes, to adhere to conventional rules and values, but that he neutralises their restraining effect (Peretti-Watel 2003). This might demonstrate stigmatisation's functionality of social norm enforcement, where deviants are encouraged to form groups and convey to norms that are contextually accepted in that group considering that Adam's words "*if I get someone a ball*" is suggestive towards adhering to someone else's expectations of him (Bos et al. 2013: 2). Furthermore, it seems reasonable to suggest that Adam's neutralisation techniques are central towards his persistence in crime as they enable him to maintain his ideal self – that being, how he ultimately wishes to see himself (Maruna and Copes 2005: 221; Topalli 2005: 799).

> **Luke:** It's kind of the same. I still do a lot of the same stuff as before, and that's dealing, but I spend way less time on it, and have money left over which, paradoxically, will go to paying fines from the police. So, I sell narcotics to pay fines for possession of narcotics. Logics put in system [laughs].

Another element of this sub-theme was that (as indicated by Luke) some of the participants did not consider themselves to have the financial capacity to pay off their fines through legitimate means. The financial burdens related to both their prior and current drug use therefore made the habit of dealing hard to break, demonstrating an example where the burdens both lead to and assist in the continuity of delinquency as Luke's path towards a goal – namely, paying his debt – is blocked by his financial means (Agnew 1985: 153; Broidy 2011). It might be argued that taking this perspective is a neutralisation technique that enables guiltless sales through the ’defence of necessity', which has been found to be one way in which drug sellers neutralise guilt (Broidy 2011: 10; Dickinson and Jacques 2019: 18). Seeing that both the consumption and distribution of hard drugs is considered physically, mentally, and socially harmful, it might be reasonable to suggest that Luke (like Kevin) alters his perspective on drug dealing through rationalising his motive as a way of maintaining a positive self-image and social identity (Dickinson and Jacques 2019). Luke using the terms “*paradoxically*” and “*logics put in system*” may suggest that he considers his drug dealing to be a response to external forces and sanctions. In that sense, he seems to consider himself more as acted upon by an illogical system rather than acting, demonstrating a technique of neutralisation and, at least to some extent, denial of responsibility (Sykes and Matsa 1957: 667). This technique is by Sykes and Matza (1957) considered to be further extended if the person can explain their act of delinquency in a manner that makes it out of their control. This is demonstrated in Luke who says that he will spend the money he earns from selling drugs to pay fines for possession, whilst also indicating that he finds it to be an odd situation. The ways Luke decides to frame his acts of dealing point towards putting the blame on the fines he has received for possession of drugs – not himself for being in possession of illicit drugs. In doing so, Luke justifies his offending through a condemnation of the condemners, or rejection of the rejectors, where the focus is shifted from the deviancy of dealing drugs to the motive of the actors he considers responsible for indirectly forcing him to do so (Sykes and Matsa 1957: 668).

Dickinson and Jacques (2019: 17) argue that neutralisation techniques are either consciously or subconsciously constructed explanations individuals use to protect their self-image and avoid condemnation both from themselves and others. In this internal process and dialogue, the effect of social control is significantly reduced (Sykes and Matza 1957: 669). Henceforth, it may be suggested that by considering their acts of dealing drugs as the result of factors that are beyond their control, or as something they do because of things others do to them, they are to some extent able to deny responsibility for these acts (Sykes and Matza: 667). It must be noted that this is not the same as arguing that the participants neutralise their acts of dealing drugs because they consciously want to profit from delinquent behaviour without guilt, but rather an analysis of how the acts of dealing are seen and experienced from the perspectives of the participants. Dickinson and Jacques (2019: 21) also argue that someone’s identity is conceptualised through how an individual sees themselves, or at least how they would like to be. Furthermore, someone’s identity and behaviour are interchangeably linked as the identity forms the foundation for how an individual should behave, whereas behaviour in and of itself may lead someone to reconsider their morality based on the response these actions may receive (Dickinson and Jacques 2019: 21). Additionally, Goffman (1963: 14) argues that a stigmatised individual can protect their identity through their personal beliefs about themselves and the world, hence alienate themselves from the effects of stigmatisation and consider those who inflict the stigma to be the ones that are in the wrong. By incorporating neutralisations and creating a distance to the responsibility regarding the illicit act of selling drugs, Adam and Luke may protect their identity and avoid feelings of guilt as their perspectives and motives for these actions are redirected away from the morality of the act. Henceforth, the link between their self-conception and behaviour may be weakened and their ideal identity protected. This significantly reduces the effectiveness of restraint and social control that stems from disapproval both from themselves and others, often applied through stigmatisation (Sykes and Matza 1957: 667). Adam and Luke's neutralisations therefore free them from stigmatisation's function of informal social control and enable them to continue to engage in crime without feelings of guilt and harm to their self-image.

5.2.4 Meaningful Delinquency

Several of the participants had trouble getting out of the criminal drug scene because they had established a good reputation as drug dealers over a significant period of time. This entailed that participants had found a role in a community where they felt valued and meaningful as opposed to stigmatised. Many of them had been dealing drugs for so many years that they had built a good reputation on the streets as stable and trustworthy suppliers, and they often sympathised with other PWUD who turned to them for drugs. Consequently, they still experienced being approached on the streets, at home, and through the phone by buyers in need of illicit drugs. The need to buy and sell drugs decreased after they started the treatment at HAT as the participants' need to acquire illicit heroin was significantly reduced, but my study found that the majority of the participants still traded drugs in their spare time. When asked questions related to this, they responded in manners that neutralised the delinquency of this behaviour through denial of responsibility. Again, this may be considered a way in which the participants neutralise feelings of shame and guilt related to the social and moral condemnation of behaviour that is stigmatised (Askew 2016: 113). This may be related to experiences of stigmatisation as the labelling of a behaviour as 'criminal', which applies to the act of drug dealing, is argued to have a stigmatising effect (Hadjimatheou 2016).

> **Luke**: And I'm not in it so deep that… Of course, I would probably miss that part about people being happy to see me, because they know that I always have good drugs with good measurements, and… Yeah, that was a part of that class I took, and… As August [lecturer] said, 'The greatest risk of cannabis is to be pulled into the criminal economy,' because you have high status within the [street] community, whereas outside in the society, you're just a petty criminal or big criminal, all thereof, and that has a low status, and that could make many feel rather comfortable in the [street] community.

As a result of Luke's good reputation and arguably high status as a drug dealer, he still experienced being approached on the streets, at home, and on the phone by buyers in need of illicit drugs because they knew that he had "*good drugs with good measurements*". Hence, Luke found drug dealing to still be a normalised part of his day, and the interviews showed that he considered dealing drugs in a small amount to be the equivalent of dealing nothing at all. It was also found that all nine participants used neutralisation techniques when they talked about their drug dealing. Although this role includes delinquent behaviour as the sale of illicit drugs is a mala prohobita crime that is specified in the Norwegian legislation because of its immoral nature, Luke explains how it still contributes to feelings of accomplishment and contextual social acceptance in a community where he has high status, as opposed to in the conventional society (Dickinson and Jacques 2019: 18). "*I would probably miss that part about people being happy to see me*" may be argued to demonstrate the contrast between how he is welcomed in the street community versus the conventional society, considering Luke's use of the word "*happy*" when describing drug buyers' reaction to seeing him. Henceforth, Luke expresses a problem-focused coping mechanism to the experience of stigma by self-identifying and entering a sub-group with peers that share the same characteristics as this provides him with social support and feelings of acceptance (Bos et al. 2013: 3; Luoma et al. 2008: 150). Like Luke, Kevin seemed to value that he and his partner had a good reputation as stable and empathetic suppliers as he was proud of his partner for being so kind, despite being in a position where they wanted to stop dealing drugs. He also considered his acts of dealing to be outside of his control as desperate buyers were "*coming in bulks*" to their own home in the middle of the night, which he found distressing as both he and his partner looked forward to not having to deal drugs anymore. As explained by Jozaghi (2014: 587), some communities may consider 'the real addict' to be resourceful and strong whereas a person in HAT is a 'patient'. It might be suggested that being a valued and trustworthy supplier presents the possibility of having a meaningful role for the participants (Cheetham et al. 2022; Luoma et al. 2008: 149, 150).

5.3 Part 3: HAT's Impact on Stigmatisation

The last part of the analysis will address the thesis' third research objective: To explore whether and how being in HAT changes how the participants experience and manage stigmatisation. This final part of the analysis will explore whether becoming a patient in HAT affects the stigmatisation that was identified in Part 1 and whether it changes how this is perceived and managed, which was examined in Part 2. By doing so, I explore whether HAT facilitates positive changes for the reduction of both institutional and internalised stigma, which the existing literature on HAT firmly argues.

5.3.1 Becoming a Part of Society

Entering HAT contributed to feelings of adherence to conventional society as the participants felt like they became "*a legal person*", that they were a part of a project instead of being a "*junkie*", and that they suddenly had time to do ordinary activities like going shopping and getting appliances for their homes. As Phil explained, it was "*cool*" to feel and act like a normal person when he did these things. Several participants considered going to HAT their job and said that it was nice to feel like they were missed if they failed to show up. Whilst some found it challenging to attend the clinic two times daily, especially in the beginning, others argued that it was beneficial and positive that they now had a daily routine. Several participants highlighted that receiving medical heroin meant that they did not have to steal and lie to support illicit drug use, which contributed to a major change in how they felt when they were walking around in the society.

> **Sue**: Yeah, it's like a new situation and like… It's a very big life change. You stop sneaking around and being ashamed and forced to lie and steal. And you can walk with your back straight as you're part of a project in society, you kind of get this 'certified' stamp. You don't have to steal and everything's suddenly like… Yeah, and then there's honesty and trust and other things that are important too right. It's like a completely different mentality… It's very hard to explain the great difference that makes. I almost think that you need to have some sort of experience with being disempowered to see how big that is. […] And you're treated like a human, right, after having been thrown from wall to wall for so long, and that's a very strong feeling.

Like Sue, many of the patients described how being in HAT had a transformative effect on their self-esteem and dignity by making them feel like they were part of society and given a "*certified stamp*" rather than a deviant. As Sue explained earlier in the interview, receiving medical heroin transformed her from feeling like an “*addicted idiot”* to becoming “*a part of the society*.” As a result, Sue felt like she had become a “*legitimate person*” after starting her treatment in HAT because it enabled her to “*stop sneaking around and being ashamed and forced to lie and steal.”* Similarly, a patient I talked with in the observation room explained that he did not want to lie and be a “*crook*”, and now that he was in HAT, he no longer had to be because the stable access to medical heroin meant that he did not have to spend his days acquiring illicit drugs. These findings align with Higgins (1989, 1987 in Topalli 2005: 799) who argue that individuals have a strong desire to align their actual, ideal, and ought self, and that there is no reason to assume that offenders or delinquents are any different to law-abiding citizens when it comes to how they are influenced and motivated by their self-conception. My study shows that has a significant impact on this cognitive process due to the new and strong experience of being “*treated like a human*.” Former studies have found that participants who experienced that their drug problems were discredited by authorities also experienced that their virtual and actual identities did not align as the severity and consequences of their drug problems were not acknowledged (Andersen and Kessing 2019: 277). My study confirm these previous findings as the participants explained how having their problems taken seriously and being treated respectfully in HAT contributed to a major change in their self-conception. Stigma from professionals can produce significant barriers towards the development of patients’ desired self-identity, and it seems reasonable to suggest that HAT contributes to reducing these barriers as the testimonies from the participants indicate that HAT reduces the shame and guilt associated with their stigma by making them feel included in the society. This also suggests that HAT is successful in reaching its aims, which are to provide the patients with a better quality of life, improved health, and an autonomous life (Eide et al. 2019: 10, 11). Biernacki (1986 in Doukas 2011: 411) found that people who use heroin must selectively choose new elements to incorporate into their new construction of a non-stigmatised identity. However, based on the changes described by Sue and several other participants, it seems reasonable to suggest that it is equally important for patients to deconstruct their former identity by choosing elements that need to be removed. For instance, the reduced need for stealing and lying was frequently argued to be of significant importance towards the participants’ increased self-esteem, demonstrating examples of stigma-related elements in the participants’ lives that were now either significantly reduced or entirely removed and contributed to a more positive self-conceptualisation. Henceforth, HAT may be argued to mediate the consequences of stigmatisation by empowering the patients and reducing their feelings of shame and guilt.

> **Kevin**: But my body wouldn't… I mean, a rehab for me, it's so… What I then have to go through, it's so heavy that… I mean, I can't handle it. And I don't want to be depressed. Now, I'm loving life so much. I've been depressed for so many years that I can't believe how it's even possible. But I love life. Love rainy days, love bad days. Yeah, even yesterday. Oh, I wouldn't be without it. So… Yeah, HAT to me… It really means… I had no idea that it would come to means as much as it actually does. I realise that it actually does. And especially since there are two of us. That we can both… We can get a life with routines, like we can go to bed at night, wake up in the morning, and be a part of society and the rest of the world around us. Yeah.

Kevin was also one of the participants who highlighted how he felt that he and his partner Liz (also struggling with a drug addiction) became part of society after entering HAT. After suffering from both depression and anxiety for many years, he now felt gratitude even on rainy days and loved his life. The changes described by Kevin align with previous studies which have found that HAT has a positive effect on patients' mental health, reduces depression, and makes patients experience that they fit more into society by feeling more like an ordinary person (Treloar et al. 2007 in Doukas 2011: 411; Jozaghi 2014: 5). Kevin, being part of the most stigmatised group in the world, is argued to have been socially disqualified due to a specific attribute or flaw which in turn has become his stigma (Goffman 1963). However, it may be suggested that his treatment in HAT limits the extent to which he is socially disqualified as it reduces the appearance of these discrediting flaws or specific attributes that are associated with his substance use. This seems reasonable to suggest given that Kevin, and other participants, argued that they felt like they had become a part of society after starting their treatment. As both Sue and Kevin explain, they experienced a transformative effect on how they feel and act in society now as compared to before HAT. Sue described that it changed how she carried herself because she could now "*walk down the street with my head held high*" and Adam said, "*we can go to bed at night, and wake up in the morning, and be a part of the society and the rest of the world around us.*" Individuals with addictions are argued to self-stigmatise as a result of internalising negative social attitudes regarding their addiction and behaviour, but participants in my study also demonstrate how being in a legitimate program can counter and mediate the internalisation of stigmatisation by making individuals feel like they become a part of the conventional society (Matthews et al. 2017: 276). The visibility of a stigma is argued to be a central element towards how it is perceived, managed, and reacted to, both by the stigmatised group and those who inflict stigma (Rasmusen 1996: 196). However, it may be reasonable to suggest that the reduced self-stigmatisation that the participants describe also has a reductive effect on how visible their stigma is through how they externalise their stigma (Jozaghi 2014: 5).

The participants demonstrate that they have a strong bond to conventional society and its normative values and norms as they experience positive changes through being in a legitimate drug treatment program (Topalli 2005: 798, 799). Hence, it may be suggested that HAT acts as a mediator in reducing stigma towards individuals with OUD as it addresses laws, regulations, and rules that segregate them from mainstream society (Cheetham et al. 2022). This positive element of the treatment became apparent already during my first day of participant observation when a patient said that his life had become so much better after starting HAT as the routines meant that there was less time during the day to commit crimes and more time to relax and take care of himself. This patient also said that this had made him appreciate his value more as he no longer saw himself as an 'addict', but as a patient worthy of healthcare and that this made it easier to accept the help offered at HAT than in MAT. The great majority of the patients referred to the drugs they received at the clinic as "*medicine*", and being in HAT may be considered to change both their own and the public's perception of their drug use from being an illegitimate choice, to a legitimate need (Cheetham et al. 2022: 1). If so, this confirms previous studies which have found that the use of medical heroin in drug treatment programs contributes to transforming the general perception of heroin as a pleasure-based street drug, to medicine (Johansen and Johansen 2013: 113). It also confirms Palamar et al.'s (2013: 516) arguments that stigma can be reduced by treating drug use as a behaviour related to health rather than deviancy and morality.

5.3.2 The Importance of Trust in Treatment

HAT's mediating effect on stigmatisation was largely rooted in the participants' experience of trust between them and the staff. All participants had negative experiences with former drug treatment programs and said that the major difference between MAT and HAT was that the staff at HAT treated them with respect, hence creating a clinical setting that was not stigmatising. This facilitated a relationship between the patients and the service providers that was built on trust as the ways in which they were treated enabled the participants to be honest about their prior and current drug use.

> **Interviewer**: So how's your experience with HAT been so far, compared to your experience from MAT?

> **Adam**: Oh, completely different. I can really say that, I feel like they have knowledge. Well, perhaps not all of the staff. Some of them are new to this, but even they are acting professionally towards us. And those who are in charge seem like they have a very good understanding of the problem, and they adapt the treatment to us instead of us having to adjust to a system [...]. For some people it will be too much [the medicine], for others it won't be enough. That sort of stuff. It's way less rigid, no use of sanctions, and that's also why I don't have any trouble telling them when I've taken stuff like cocaine, or amphetamine, because if I then on the third day in a row say that 'I took some cocaine yesterday', I can hear it in my own head too, and they'll probably point out like 'what's going on?'. And instead of urine samples, because urine samples just make you try to manipulate the tests… Trust is way better, so I feel like this is way more based on trust, more based on the patient's needs, and my voice is being heard. It's user involvement, as it's so nicely being called.

Adam and several of the patients argued that trust between patients and staff was essential towards making HAT an effective treatment program and that the understanding they experienced from the staff had a positive impact on their self-esteem and sense of dignity. As explained by Adam, the patients' former experiences with other treatment programs were that they compromised their treatment and well-being by the use of sanctions if the patients were honest about their side-use of other illicit drugs, which they did not experience at HAT. The staff at HAT did not impose any sanctions such as decreasing the participants' medicine dose unless they found it unsafe to provide their regular measurements, and the participants expressed acceptance that sanctions under those circumstances were appropriate. This supports findings from previous studies which have found that the approach taken by the staff has a positive impact on patient satisfaction in opiate-assisted treatment, and it might also be suggested that the patients' safety is better at HAT than in MAT as the patients felt safe about disclosing the extent and content of their side-use (McCall et al. 2019: 45). Previous studies have found that HAT is effective in reducing the risk of overdose, and it may be suggested that the trust between patients and staff a key factor to this reduction as it enables honesty and therefore also control over the patients' drug use (Boyd et al. 2017; Jozaghi 2014: 6; Mayer et al. 2020: 3; Wakeman 2015: 581). It is also worth noting that the participants considered the staff to have surprisingly good knowledge and insight about the effects of drug use, whereas other studies have found that the staff often did not have sufficient education and knowledge about opiate use and its impact on the patients' health (Marcellus 2007 in McCall et al. 2019: 48). It might be suggested that the staff's knowledge and understanding of the problems related to the patients' drug use contribute to reducing stigma by treating their use of opiates as something they need rather than something they choose, hence also contributing to their establishment as responsible patients rather than irresponsible 'drugs users' (Cheetham et al. 2022: 2). If so, this would also be an example of what Palamar et al. (2013: 516) calls for – namely, to reduce stigma through treating drug use as a health behaviour rather than deviance.

> **Sue**: The difference here [from MAT] is basically that you're met with trust and as a human. Whilst MAT is centred around rules and control measures and punishment, this [HAT] is more like, well, needs and trust and… [...] Yes, it's a very big difference. Great difference and it takes time getting used to it because you're not used to being met and treated with openness and trust and humanity, really.
>
> ***
>
> **Sue**: And a bit of peace [when joining HAT] to look at yourself too, right? You start to think, 'Who am I without all this lying and chasing and hustling all the time? Who am I then? Who am I without all this illegality', right?

Sue thoroughly explained how much she appreciated the hospitality she received from the staff and that she had noticed that they tried to facilitate a comfortable and safe environment at the clinic. This experience was a common finding amongst the participants in my study. Examples included setting up a sheltered area in the injection room where the patients could inject without an audience, and in general making the patients feel like they were being cared for and that their opinions regarding their treatment plan mattered. In another part of the interview, Sue explained that being in HAT made her think about who she was "*without all this illegality*". That Sue has started to consider who she is without all the "*lying and chasing and hustling all the time*" may suggest that until recently, these were the traits that she considered to be personal characteristics. Similarly, another patient I talked to in the observation room said that he had learned to use drugs as tools for dealing with his problems and trauma, and that being in HAT meant that his tools for coping to some extent disappeared. This patient, like Sue, explained that it was challenging and hard to face the reality of the life he had been living for the last 10 years and that it was shameful to accept the person he was, but that HAT provided a safe place for facing these feelings.

The participants were surprised by how kind and understanding the doctors at HAT were towards OUD as previous experiences with professionals had been of a different nature. This might be argued to strongly suggest that the patients have experienced significant structural or institutional stigma, as the service providers of other treatment programs were experienced as punitive and with a lack of understanding of the participants' situations (Cheetham et al. 2022: 2). Furthermore, it seems reasonable to suggest that these experiences demonstrate the structural vulnerabilities and disadvantages that are associated with being a highly stigmatised group in the society as even treatment programs are experienced as dehumanising and discrediting (Andersen et al. 2013: 1; Boyd et al. 2022; Luoma et al. 2008: 149). PWUD are not only impacted by stigma enacted by others and society, but also through the processes of self-stigmatisation in the form of shame, fear of stigma, and evaluative thoughts as the recognition of stigma becomes internalised (Luoma et al. 2008: 150; Matthews et al. 2017: 275). Self-stigma is therefore argued to be a significant barrier towards the internalisation of a positive self-image and identity (Luoma et al. 2008: 150). Kellogg (1993 in Doukas 2011: 411) suggests that stigma associated with substance disorders may lead to experiences and internalised feelings of rejection for PWUD, and it seems reasonable to suggest that this theory applies to the participants in my study. Be that as it may, it might also be relevant to argue that being in HAT has a mediating effect on these stigmatising experiences through providing the patients with a treatment program that is based on trust and dialogue between patients and providers.

As discussed in Part 1 of the analysis, the participants had several experiences with institutional stigmatisation in the form of having their agency restricted or through meetings with stigmatising language or beliefs. However, my study also found that HAT functioned as a counterweight to this. Lisa said that being in HAT made her feel like she "*was taken seriously, at least by the healthcare system. And that was valuable*." Similarly, Luke felt like his "*voice was being heard*", and Mark was "*completely shocked, I've been given a hope that I didn't have*." The participants often expressed dislike for previously tried treatment programs with an emphasis on the use of sanctions and lack of knowledge amongst these service providers. In HAT, they experienced the opposite. The staff was experienced as both knowledgeable and respectful towards the patients, and several participants highlighted that they finally felt like their voices were being heard. This might strengthen former findings which argue that the high stigmatisation of opioid use is rooted in the three interrelated sources of insufficient knowledge, prejudice, and discrimination, and that initiatives that address these issues have the potential to reduce stigma (Cheetham et al. 2022: 2).

6 Discussion

This chapter will first summarise the main findings from my study in chronological order according to how the themes were addressed in the analysis chapter, before it moves to a discussion of these findings in a broader context where I also point to areas that future research should address. I will use this opportunity to discuss what the extended consequences of stigmatisation entail for both people with OUD and society, and how a trait that is a stigma in one cultural context can be appreciated and accepted in another. I will also discuss how drug treatment initiatives that are patient-centred may be a counterweight to stigmatisation and some challenges that are linked with the medical discourse on drug use. I want to emphasise that my discussion is with relevance to the type of drug use that is described in this thesis, which is in a context that goes beyond recreational drug use.

Summary of Findings

The participants' experiences with stigmatisation were described as mostly institutional and often stemmed from having their agency restricted through rules and regulations in drug treatment that they did not agree with or understand the reasons for. They had experienced the use of stigmatising language in clinical contexts and encouraged use of appropriate and destigmatising terms. Some participants used stigmatising terms when describing themselves and other people with substance use issues which demonstrated internalisation of stigma.

The participants frequently used symbolic boundaries and neutralisation techniques to create a difference and distance between themselves and other people in their sub-group who exhibit what may be considered norm-breaking, or deviant, behaviour. This was often done by demonstrating that they had control over their drug use or drug dealing. These techniques were also utilised for altering their perspective and motives for delinquent behaviour. Drug dealing was also found to provide the participants with the feeling of having a valuable and respected role in their community as they had built a good reputation as trustworthy suppliers of illicit drugs.

Being in HAT had a mediating effect on how the stigmatisation processes affect the participants as the staff treated them with trust and understanding, which they explained was very different from their previous encounters in MAT. This made them feel like they became a part of the conventional society and facilitated improvements in their self-perspective and efficacy.

6.1 Consequences of Stigmatisation

A function of stigmatisation is to place norm-breaking individuals into sub-groups that are not a part of the conventional society, but it has also been suggested that neutralisations regarding delinquent behaviour mitigate the anticipated shame and guilt individuals feel when they violate social norms (Topalli 2005: 797). Additionally, the association with delinquent peers is a commonly acknowledged risk factor for crime (Warr 2002 in McGloin and Kirk 2010: 169). I want to suggest that this makes it reasonable to question the effectiveness of excluding and grouping stigmatised individuals from conventional society as a form of informal social control that protects society from undesirable behaviour, as the criminogenic effect in that respect might be doubled. Firstly, it creates a sub-group where deviants may find acceptance for behaviour that violates conventional norms, values, and formal legislation as they experience that this behaviour is contextually justified and accepted in the sub-group. This might further facilitate neutralisations of guilt and shame for violating conventional norms, as their peers in the stigmatised sub-group do not condemn their behaviour the same way as the conventional society. Stigmatisation's function of informal social control thereby contributes to facilitating deviant behaviour rather than deterring and preventing it, such as for Luke who explained that it was nice to feel appreciated and wanted by people who approached him for illicit drugs. Secondly, this grouping may contribute to expectations and fears of stigma, which further promotes the utilisation of neutralisation techniques both before, during, and after deviant or delinquent behaviour. Again, the restraining and deterrent effect of stigmatisation's informal social control on deviant behaviour may be reduced as negative responses are rendered inoperative (Sykes and Matza 1957: 667). The application of neutralisation techniques both before and after drug dealing was seen in many of my participants as they often justified drug dealing through the perspective of helping others who needed illicit drugs rather than from the perspective of them as drug dealers. This may demonstrate that stigmatisation's function of social exclusion can have the adverse effect of facilitating rather than deterring undesired behaviour. Moreover, it can also explain why punitive approaches that criminalise, stigmatise, and socially and politically exclude this group are inefficient in deterring illicit drug use and unwanted behaviour, and hence, why harm-reduction strategies that facilitate social and political inclusion may be a more appropriate response. The suggested drug reform from 2021 emphasised that Norway should implement a decriminalising and destigmatising drug policy, and I suggest that this could be a more efficient approach than punitive responses towards this group (Torgersen et al. 2019).

Romo et al. (2009: 186) argue that a society that sees the need for drugs as a chronic illness can reintegrate a stigmatised, rejected, and excluded group. My study may be argued to confirm these statements, as several participants explained how being in HAT made them feel like they became a part of the conventional society as it made them legitimate and allowed them to live a life where they had routines and time to do other things than acquire illicit drugs around the clock. However, it is important to remember that HAT is only one part of their daily lives and its scope regarding the lives of the participants is therefore limited. Adams and Volkow (2020: 703) argue that the stigmatising attitudes towards people with substance use disorders are challenging to break because of the severity of the social norms that this group breaks, such as lying or stealing to support their needs for drugs. This should be discussed in relation to the social norms that this group violates as that behaviour is why OUD can be considered a stigmatising trait. For people with OUD, opioids may be considered a basic need because of the severe symptoms they experience when their needs for it are not met. However, it might be suggested that a person who is lying or stealing to support generally acknowledged basic needs, such as food, would not be considered as violating social norms to the same extent because their motive for doing so is something that most people can understand and associate with. Although hunger can be painful and dangerous, withdrawal from opioids can have an even stronger behavioural impact as the person experiences a similar craving, but with additional symptoms such as generalised pain, anxiety, chills, nausea, and more (American Psychiatric Association 2022). Perhaps the perception of which social norms people with OUD violate would change if the public had more knowledge of how this group is affected by this disorder. I want to suggest that although HAT does not directly impact how its patients are treated by the conventional society, it can still be an important step towards reducing public stigmatisation as it may contribute to challenging the perceptions of which norms that the trait of OUD is considered to break. Furthermore, the implementation of HAT could be seen as a result of a development where the Norwegian society moves in a less stigmatising and more socially inclusive direction regarding drug policies and treatment, as Romo et al. (2009: 186) calls for.

On a societal level, uncontrolled drug use has been found to pose significant costs to the healthcare system, social services, and criminal justice system, and it is well known that many of those who are fined for possession of illicit drugs are unable to pay and have to do a short sentencing instead, hence generating societal costs rather than incomes (Fischer et al. 2002: 230; Graham et al. 2022: 375; Oslo Economics 2020: 26; Rasmusen 1996: 536 Strang et al.

2020: 1). The political development in the recent years regarding PWID and the debate of help versus punishment has included that possession of user-doses of illicit drugs[5] may be eligible for a waiver of sentencing (Supreme Court of Norway 2022). However, examples from the Supreme Court also show that formalising a limit for when a user dose can be penalised and not brings challenges for which guidelines to follow when it comes to PWUD who are in possession of illicit drugs intended for personal use, but barely exceed the limit. What my study adds to this knowledge, is that fines for possession of illicit drugs that are intended as user-doses but exceed the indicative limit, not only contribute to increased costs for the criminal justice system when individuals are unable to pay their fines or have to do a sentencing. Moreover, it can facilitate more crime if these individuals consider crime the best method to collect this money, such as when Luke explained that he sold drugs to pay fines for possession of drugs. This is a valid point to raise in the debate of whether hard drug use should be approached punitively as it shows that, at least under these circumstances, it does not prevent crime, nor illicit drug use – on the contrary, it may facilitate even more. My study found that the great majority of the participants were only dealing drugs to support illicit drug use and that they wished to stop, which might suggest that the prevalence of drug dealing amongst this group should decrease with time as HAT continues to treat people from this group. This could potentially have a great impact on the black street market economy, considering that several patients in the observation room said that they spent between 45.-60.000 Norwegian kroner each month on illicit street drugs before entering HAT. The extent of the costs associated with illicit drug use or dealing after entering HAT is something that future studies should address. To get an understanding of the full picture, I also want to encourage future studies to explore whether the previously mentioned institutions experience changes in their expenditures related to PWUD during HAT's trial period.

6.2 Rational Deviancy

Warr (2002 in McGloin and Kirk 2010: 169) argues that criminal behaviour is social behaviour as most offenders belong to groups where their peers also violate the law, and that having delinquent peers is the strongest predictor of crime that is known to criminologists. The participants in my study to some extent confirm these statements, such as when Adam described how

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[5] The judgment case HR-2022-731-A in the Supreme Court of Norway has set an indicative limit of five grams for personal use of heroin, amphetamine, or cocaine. PWUD who are in possession of this quantum may be eligible for a waiver of sentencing. See Tre nye avgjørelser fra Høyesterett: Mildere reaksjoner for rusavhengiges befatning med narkotika til egen bruk (domstol.no)

dealing small amounts of drugs qualified him as having "*almost completely stopped.*" Adam's perspective might not only be a form of incorporated neutralisation that protects a positive self-identity, but compared to the behaviour of peers that he might compare himself with, it might also be experienced as true. This seems reasonable to suggest as the criminal behaviour that Adam might associate with drug dealing is on a much more extensive level than he now explains that his drug dealing is, hence making his behaviour different from what he considers the criminal behaviour of drug dealing to be. This might also demonstrate that criminal behaviour is social behaviour for two reasons. First, it demonstrates that Adam's criminality has changed now that he is in HAT and no longer as deeply embedded in the culture of his stigmatised sub-group as before. Secondly, it is suggestive towards the social constructiveness of what different individuals may consider a 'crime' because people may have different thresholds for labelling a behaviour as 'criminal'. Adam's description of drug dealing could also be discussed in light of my definition of stigma as a trait that goes against the norms of a particular social group and by that leads to experiences of discrimination and social exclusion. Adam and several other participants framed their current drug dealing as something they did as a favour to others in need, hence showing that the general stigma of delinquent behaviour is a trait that in some contexts is desired and leads to inclusion, acceptance, and even appreciation. Managing stigma through rationalising behaviour that is deviant may therefore not only be because the participants believe that their drug use or dealing is contextually accepted, but also because they have found a context where it is (Askew 2016: 113). As Miller (2005: 246) suggests, certain deviant behaviours may therefore be considered rational acts in the right cultural context.

The existing literature argues that the exhibition of control and rationality, combined with moderation, are distinct key features that separate functional users from those who are dysfunctional (Copes 2016: 200). This separation is often constructed through symbolic boundaries which was a prevalent pattern in my study, such as Mary who said that "*I'm not like that*" when she described how other people behave when they experience withdrawal. Based on the theoretical perspectives, I interpreted this as neutralisation techniques and symbolic boundaries that Mary could use to separate herself from dysfunctional users. Similarly, Kevin explained that he and his partner were only dealing drugs "*exclusively to not feel sick*", which I interpreted as a neutralisation of guilt and informal social control within their sub-group as it established them as moral drug dealers who did it to support a need in contrast to immoral dealers who did it for profit. However, I also want to suggest that this may not only be neutralisation techniques that protect Mary and Kevin from guilt and stigma, or that symbolically separate them from dysfunctional users. Several studies, including mine, have found that their participants experienced that heroin – regardless of whether it is acquired on the streets or in a clinical setting – enabled a functional lifestyle as this is the only thing that helped for not feeling sick (see e.g. Bos et al. 2020: 5). Interpreting people with OUD's descriptions of this as symbolic boundaries and neutralisation techniques may, regardless of how well-intended and theoretically sound it may be, undermine the function that opioids have for these individuals through only interpreting it as an *expression* of control – not *actual* control. In that sense, even my study on the stigmatisation of people with OUD may be seen as stigmatising because of this interpretation. Copes (2016: 200) argues that individuals who are successful in demonstrating that they are rational, have control, and show moderation may feel like they have agency over their drug use, which is in contrast to the social position that they have limited control over. To this, I want to add that the participants' verbal expressions of these key features should not only be interpreted as neutralisation techniques and symbolic boundaries that make them feel like they have control, but that they could also actually be true.

Whilst existing literature argues medical intervention and treatment act as markers of stigma and by that contribute to barriers in the patients' recovery process due to fear of further stigmatisation, findings from my study suggest an alternative outcome (Burgess et al. 2021; Cheetham et al. 2022; Earnshaw 2020: 4; Madden et al. 2021; Palamar et al. 2013: 516; Radcliffe and Stevens 2008: 1065). Several of the participants in this thesis demonstrated examples of how entering HAT contributed to reduced impact of stigmatisation as they experienced that their drug-related issues were taken seriously and that the program contributed to improved self-esteem and self-efficacy, much because of the respectful treatment they received from the staff. In that respect, it might be suggested that drug treatments that are patient-centred – such as HAT – can produce positive outcomes for this group where similar initiatives, like MAT, have failed. Moreover, this demonstrates that a patient-centred approach can be used as a successful alternative to criminal justice processes as it may increase the likelihood of successful recovery rather than contribute to increased stigmatisation, marginalisation, and disadvantage. Whilst my study found that the participants still experienced that their agency was limited because of certain policies and rules at the HAT-clinic, such as regarding methadone and groin injection, they also highlighted that being in HAT was a very positive difference to their former drug treatment experiences. An important element of this experience was that they felt like they became a part of the conventional society again. This might strengthen previous studies which have found that initiatives that treat drug use as a medical issue can reduce stigmatisation towards this group (Madden 2019: 325). Additionally, these findings may suggest that harm reduction initiatives like HAT may not only reduce the stigmatisation towards this group, but also mediate how it impacts them.

6.3 The Medical Discourse’s Challenges

Scholars have worried that the medical discourse on OUD, which constructs addiction and drug use according to medical criteria, excludes the possibility of uncovering whether any of the symptoms may be linked with contextual and structural factors (Ben-Ishai 2012: 39; Boyd et al. 2020: 1). Ben-Ishai (2012) expresses concern regarding the medical discourse as drug use becomes individualised and treated without consideration of how stigmatisation and criminalisation impacts a person’s drug use and behaviour, whilst also arguing that putting healthcare and drug use under the same category contributes to humanising rather than alienating this group from conventional society. An element of stigmatisation is that individuals are discriminated against and socially excluded because of a norm-breaking trait, and it seems reasonable to argue that humanising stigmatised individuals could change the general perception of this trait. For instance, having a different sexual orientation than heterosexual used to be a norm-breaking and highly stigmatised trait that led to social exclusion and discrimination. Increased humanisation and a general understanding of what sexual orientation is have led to greater social acceptance and less stigma towards it, although this is still a work in progress. This could be seen as an example of how more knowledge contributed to changing something that used to be a stigma that violates social norms, to being just a trait. Sexual orientation and OUD are by no means the same, but it may be reasonable to suggest that the same destigmatising process could apply to substance use disorders if they receive enough attention and stakeholders manage to convey information to the public about it. The analysis of my thesis mostly concerned institutional and internalised stigmatisation, which I found was mediated by entering and being in HAT. Public stigmatisation was not addressed and it may be reasonable to suggest that this form of stigma is the one that is most challenging for initiatives like HAT to impact as the public sphere to a large extent falls outside the clinic’s reach. However, the implementation of HAT indicates that there has been development in how the public sees PWUD as they have given support to policy makers that have initiated this program. The policy makers themselves are a part of the public, which may also suggest that this reflects a change in the public's opinions. Nevertheless, future studies are therefore needed to address whether initiatives like HAT also mitigate the meso level of the stigmatisation process. This can be done by, for instance, exploring whether the public's perceptions of heroin use change over time as harm minimisation initiatives, like HAT, are implemented.

Although the establishment of OUD as a medical disorder seems to be beneficial towards reducing stigma and increasing the support for people with OUD, Lie et al. (2022: 104) argue that the portrayal of PWUD as incapable of having choice and agency because of their chronic, relapsing brain disease includes the risk of causing further marginalisation. They assert that the social, economic, and political exclusion of this group may risk being justified through the focus on how the brains of people with substance use disorders are 'damaged'. This seems like a valid critique if the treatment of this group is solemnly focused on the medical aspect of these disorders and limits the programs to medication. However, that is not what HAT intends to do as the program also facilitates close contact and support from points of contact in the staff that can help the patients with health and social issues that go beyond their OUD (Eide et al. 2019). The health-related harms associated with both legitimate and illicit drug use are argued to be rooted in the stigmatisation and criminalisation of these drugs as this impacts the care that dependent individuals are entitled to and receive, regardless of whether they have patient rights or not (Ben-Ishai 2012: 41). But, as Boyd et al. (2020) argue, a person with a medical substance use disorder is entitled to different services and treatment than a person who does not have this diagnosis. This is also reflected in the patient rights that the patient at HAT become entitled to when they are diagnosed with OUD. However, it seems plausible to think that this may pose another challenge for the medical discourse on hard drugs as there are individuals who are significantly impacted by opioid-related issues without qualifying for being diagnosed with OUD because the criteria for OUD also result from a certain stereotype of who this patient is. In a broader context, the discourse could fail to pick up PWUD who fall between two chairs if their drug-related challenges are too extensive to be effectively addressed and treated in MAT, but do not qualify for HAT. It may also suggest that the medical discourse will not reach its full potential if it is not accompanied by initiatives that are more directly aimed at reducing public stigma and criminalisation of substance use disorders (Lie et al. 2022: 105). Henceforth, this discourse is a positive step towards providing better treatment for people with OUD but needs to be supported by other initiatives to successfully improve PWUD’s quality of life (Stevens et al. 2022: 41).

It is being argued that the medical discourse regarding drug use may contribute to undermining this group’s vulnerabilities related to stigma and criminalisation by defining societal issues as medical (Ben-Ishai 2012: 39; Boyd et al. 2020: 1; Ravndal 2009: 76). Ravndal (2009: 76) argues that seeing substance use as a defined disorder that should be managed by the specialist healthcare sector is completely different from seeing drug-related issues as a complexity of behavioural issues with major medical and psychological burdens. This might, in some circumstances, be true as the separation of initiatives such as MAT and HAT from the general healthcare may lead to social problems and what this group experiences outside of the clinical setting being overlooked by service providers and policy makers as they enter a service that is specialised in seeing and treating their medical issues (Olsen and Sharfstein 2014: 1393). However, I suggest that this is particularly applicable in circumstances where the drug treatment is generalised and not patient-centred. In my study, the participants highlighted that they appreciated that the treatment they now received was adapted to them and that the staff helped them beyond their drug-related needs, rather than them having to adapt to a treatment regime that was not tailored for them and their issues. This does not align with previous statements where the discourse undermines this group’s vulnerabilities, but I will use it to point out a potential explanation as to why the discourse may be interpreted that way by simply suggesting that if research does not explore these vulnerabilities, they will also be overlooked and by that also undermined. This might make it reasonable to suggest that this group’s vulnerabilities related to stigma and criminalisation are undermined not because of the discourse, but because there is not enough knowledge on what these vulnerabilities are, how they work, and how they impact this group. Without this knowledge, little attention will be given to the matter, which is why research needs to focus on this marginalised part of the population.

7 Conclusion

As I mentioned in the introduction, Christie and Bruun (2003) argue that although the current punitive initiatives do not work, the war on drugs continues to be fought with the same approach. The Drug Reform from 2004 and the suggested reform from 2021 show that Norway's approach to the war on drugs has taken a less punitive approach than before, but as the results from MAT demonstrate, stigmatisation continues to impact people who struggle with drug use even though they get patient status (Steiro et al. 2020: 5). I want to suggest that the final stage of the stigmatisation process, namely the internalisation of it, is equally harmful as the institutional and public stigma that people with OUD experience because of how it affects their self-perception and beliefs in successful treatment (Luoma et al. 2008: 150). If so, this provides some explanations as to why stigmatised individuals are still affected by stigma when they become patients in treatment programs such as HAT or MAT because although the infliction of stigma first becomes apparent through social interactions with others, it continues to be inflicted through the internalisation of it. Additionally, being in drug treatment does not mean that PWUD do not encounter criminal sanctions from agents of formal social control or social sanctions from agents of informal control. I therefore want to add to Christie and Bruun's argument that one of the punitive initiatives that continues to be used in the battle of the war on drugs, is stigmatisation. My study found that the participants experienced HAT to have a different culture than MAT, mostly because of the approach taken by the staff as this made them feel like their voices were being heard and that they did not experience unfair sanctions at the clinic that impacted their treatment. This might suggest that the expectations and norms about how patients should behave in these two programs are different and that HAT is successful in treating OUD as a health issue rather than unwanted behaviour that can be regulated with sanctions. Nevertheheless, my data material is from the first 1-3 months after the patients enrolled in HAT, and it may be reasonable to suspect that the patients experience different challenges than what they reported in my study when they have been in the program for a longer period. Studies that follow up on this group over time are therefore needed to know whether the participants continue to experience the same positive development and changes, or whether these are just immediate effects that wear off.

Hadjimatheou (2016: 569) argues that being stigmatised is a burden and needs legitimate justification. However, it seems reasonable to question to what extent it can be justified to criminalise and stigmatise people with OUD as the deterrent effect is limited and becomes saturated over time, and because harm reduction strategies are more effective than criminal justice processes in reducing the consequences of illicit drug use (Olsen and Sharfstein 2014: 1394; Radcliffe and Stevens 2008: 1065; Room 2005: 150; Stevens et al. 2022: 41). This is also something that could be interpreted from my study as the participants demonstrate that they manage stigma by neutralising the deviancy of criminal behaviour, such as drug dealing, through altering their motives and perspectives. Lisa even said that she found it rather impressive that she had spent so little time in prison despite using street heroin for 30 years, which shows that her expectations of criminal sanctions are not enough to contribute to any changes in how she lives her life or deter her from using illicit drugs. That is not the same as saying that I consider it realistic that Lisa, who has OUD and was deeply affected both emotionally and physically by it, could simply choose to change her life if only she had the right motivation. Criminalising drug policies could however be interpreted as following that line of thought as they direct PWUD into the criminal justice system rather than social or healthcare services, despite extensive empirical evidence from numerous studies which demonstrate that this has the opposite effect. I argue that the existing literature and my study demonstrate that this group needs help rather than punishment as the expectations of punitive, discrediting, or socially excluding sanctions do not work.

The contemporary debate on how Norway should approach drug use has been centred on the slogan ‘help versus punishment’. In the introduction of this thesis, I argued that criminology needed to gain insight into the effectiveness of initiatives aimed at helping rather than punishing PWUD as it cannot partake in the public debate if it is uninformed about the outcomes that both approaches produce. In the background chapter, I described how the Drug Reform from 2004, and the proposed second reform from 2021, have contributed to directing PWUD from the criminal justice system to the specialist healthcare services. However, stigma is a common obstacle towards positive treatment outcomes for these patients as well as to public support for the implementation of harm-reduction drug policies. It has been suggested that OUD-related stigma largely stems from the impression of this group as dangerous and unpredictable people that make bad choices, hence growing from associations and expectations of links between uncontrolled heroin use and crime (Cheetham et al. 2022: 1; Radcliffe and Stevens 2008: 1065). HAT challenges the association and expectation of heroin use as uncontrolled by providing patients with medical heroin in a controlled setting with prescribed doses that have to be injected or consumed under supervision from qualified health personnel, and findings from my study suggest that it can be an effective harm-reduction initiative that also reduces how stigma is experienced. I therefore argue that destigmatising drug policies are important towards providing people with OUD a better quality of life, but that they must be supported by initiatives aimed at addressing how this group is treated by the conventional society as well because the barriers to seeking help and treatment will also apply to entering HAT. These barriers will make it especially challenging to help people with OUD who consider the consequences of stigma to outweigh the benefits of being in treatment. Henceforth, it seems reasonable to suggest that HAT needs assistance from society and policy makers to reduce the barriers and vulnerabilities that stigmatisation creates for this group.

My thesis aimed to explore how patients with OUD are affected by and manage stigmatisation before and after entering HAT. Most of the participants described their encounters with stigmatisation to occur in MAT before they entered HAT because of stigmatising language and attitudes from service providers. Their experiences with institutional stigmatisation in HAT were linked with having their agency limited regarding their options for take-home medication and not being allowed to inject into the groin. My study also shows that the participants managed stigma through neutralisation strategies and symbolic boundaries, which suggests that stigmatisation's function of social exclusion and the deterrent effect of punitive drug policies has a limited effect on changing drug-related behaviour for individuals where the need for drugs is stronger than the adverse consequences this behaviour entails. Overall, my findings suggest that HAT is an effective harm minimisation strategy for reducing how patients are affected by institutional and internalised stigma and that the patient-centred approach is a fundamental element of this. The literature argues that there is a separation of the legitimate and physically ill PWUD versus the illegitimate and recreational, and HAT could be considered an initiative that changes someone's label from illegitimate 'user' to legitimate 'patient' (Cheetham et al. 2022: 1).

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9 Appendix

9.1 Appendix 1

OPIOIDSCORINGSSKJEMA Ved tvil noteres høyeste skår				
Øyne	Bevegelse og respirasjon	Bevissthet, tale, orientering	Eksempler	**SCORE**
Øynene er åpne.	Habituell kroppsholdning og bevegelsesmønster.	Våken, klar og orientert. Svarer adekvat med normal tale.	Reagerer som et normalt, våkent menneske.	**1**
Øynene er åpne. Åpnes og lukkes langsomt.	Litt tregere kroppsbevegelser.	Våken, klar og orientert, men mer langsom tale/oppfattelse.	Fremstår «trøtt». Kan reise seg.	**2**
Øynene er lukket. Åpnes ved tiltale.	Langsomme bevegelser. Synker sammen i kroppen, men lar seg fint korrigere.	Våken, klar og orientert, men tydelig cerebralt påvirket. Langsom tale, svarer adekvat.	Vil gjerne ligge ned. Tvilsomt om pasienten kan reise seg.	**3**
Øynene forblir lukket etter tiltale, åpne i høyst 10 sekunder.	Tydelig langsomme bevegelser. Synker litt sammen i beina. Går lett «i stå». Må korrigeres flere ganger. Nedsatt finmotorikk.	Våken, men ikke klar og orientert. Snøvlete tale.	Klarer ikke å orientere seg i rommet. Klarer for eksempel ikke å legge fra seg sprøyte og kanyle på forsvarlig vis etter injeksjonsbehandling.	**4**
Øynene forblir lukket ved tiltale.	Klarer ikke reise seg. Ukoordinert finmotorikk. Nedsatt respi-	Sovner hen, men kortvarig vekkbar ved kraftig berøring	Legger hodet på bordet. Kan eventuelt falle ned fra stolen.	**5**

	rasjonsfrekvens/ utsettende innpust, men trekker pusten på oppfordring.	og/eller smertestimuli.	Forstår ikke beskjeder. Uforståelig tale.	
Ingen reaksjon på tiltale.	Ingen spontane bevegelser. Svak eller ingen spontan respirasjon.	Svarer ikke. Komatøs.	Bevisstløs.	**6**

9.2 Appendix 2

Research Question	Aim	Objectives
How are people with opioid-use disorder impacted by and manage stigmatisation before and after entering heroin-assisted treatment?	To understand how people with opioid-use disorder experience and manage stigmatisation, and whether and how being in HAT changes this	To explore… 1) How the participants experience stigmatisation 2) How the participants manage stigmatisation 3) Whether and how being in HAT changes how the participants experience and manage stigmatisation

9.3 Appendix 3

Guide for intervju (masteroppgave): Pasienter

Spørsmål kun til første intervju:

- Status (enslig/samboer/gift)
- Boligsituasjon (eier/leier/kommunalt tilbud/uten fast bolig)
- Er du førdt i Norge?
- I jobb, studerer, Nav-tiltak, kurs, uføretrygdet e.a.?
- Hvorfor ønsket du deg til HAB?
    - Var det noen barrierer som gjorde deg nølende til å bli med på prosjektet?
- Hva slags forventninger har du til HAB?
    - Hva håper du at HAB kan bidra med i livet ditt?
- Hvordan har den første tiden vært i HAB?
    - Hva er du mest fornøyd med?
    - Hva er du minst fornøyd med?
    - Noe som har overrasket deg eller vært annerledes enn forventet?
- Hvordan opplever du HAB så langt, sammenliknet med tidligere erfaringer fra LAR?

Generelle spørsmål (gjentas over tid):

1. Hvordan har HAB vært for deg siden sist vi snakket sammen?
2. Er du i annen behandling nå – i tillegg til HAB?
3. Hva er det viktigste du har fått ut av HAB så langt?
    a. Hva har vært mest utfordrende?
4. Hvordan virker medikamentet for deg?
    a. Noe som har blitt annerledes med HAB enn det du forventet? Hva?
5. Hvordan opplever du å være i HAB-klinikken?
    a. Hvordan blir du møtt og forstått av de som jobber der?
6. Hvilken hjelp har du har fått i HAB med å få på plass andre tjenester (NAV o.a.) og den oppfølgingen/behandlingen som du trenger (utover heroinen)?
7. Er det personer, pårørende eller andre utenfor HAB som har vært spesielt viktige for at du har fått til positive endringer mens du har vært i HAB? Hvilke og hvordan?
8. Hvordan opplever du at de rundt deg reagerer på din deltakelse i HAB?
    a. Er du åpen med de rundt deg om ditt rusbruk, og nå deltakelse i HAB?
        i. Hvorfor/hvorfor ikke?

    b. Hvis du har relasjoner til andre i rusmiljøet, hvordan reagerer de på din deltakelse i HAB?

9. Har det at du jevnlig får heroin endret hvem du omgås med, og hva du gjør i hverdagen?
    a. Hvordan var en typisk hverdag for deg før HAB? Og: Hvordan er den nå?
    b. Har bruken av illegale rusmidler endret seg for deg?
    c. Har det påvirket hva du opplever av fordommer fra folk som ikke bruker illegale rusmidler?
10. Føler du at det inntrykket andre har av deg, stemmer overens med hvordan du ser deg selv?
    a. I hvilken grad påvirkes du av hvordan andre ser på deg?
    b. Tror du at det inntrykket andre har av deg kommer til å endre seg nå som du er med i HAB?
    c. Hva har det å delta i HAB å si for din selvfølelse?
11. Hvor mye penger brukte du daglig på illegale rusmidler før HAB?
    a. Hvor mye bruker penger bruker du daglig på illegale rusmidler nå som du er i HAB?
    b. Hvordan har du skaffet penger til rusmidler før din deltakelse i HAB?
    c. Hvilke metoder har du brukt for å få tak i illegale rusmidler når du ikke har hatt nok penger?
12. Hva slags erfaringer har du med politiet, fengsel og straffereaksjoner på grunn av ulovlige ting du har vært involvert i?
13. Har rusavhengighet ført til at du har begått ulovlige handlinger? Hvordan da, og hvilke?
14. Er det ting i hverdagen din nå som bidrar til at du føler at du må begå ulovlige handlinger for å oppnå det du ønsker, eller å være trygg? I så fall, hva da?
    a. Ønsker du å få hjelp til å slutte med disse aktivitetene? Eventuelt: Hvorfor ikke?
        i. Hva tror du skal til for å lykkes med dette?
        ii. Hvordan tror du at HAB kan hjelpe deg med å oppnå disse målene?
15. Hvilke ulovlige handlinger tror du det blir vanskelig å slutte med, til tross for deltakelse i HAB?
    a. Hvorfor blir det vanskelig?

16. Har du fått advarsel om at du kan miste plassen i HAB, blitt nektet dose eller fått redusert dose ved HAB noen gang? Beskriv hendelse/r.

Avsluttende spørsmål:

- Ser du for deg at du vil gå i HAB på lang sikt eller har du et mål om å gå over til annet medikament, en annen behandling eller annet på sikt? Hva er målet og hvorfor?

- Hva er det viktigste HAB kan gjøre for å hjelpe deg med å unngå kriminalitet?
  - Hvilke tilbud benytter du deg foreløpig av, ved siden av HAB, for å unngå å måtte benytte kriminalitet for å oppnå det du trenger?
  - Hvilke tiltak gjør du selv for å minimere kriminell aktivitet?
- Har du vurdert å gå ut av HAB? Hva var i så fall årsaken?
- Noe annet du vil legge til om HAB og denne behandlingen som vi ikke har snakket om?

Spørsmål dersom pasienten har falt ut av HAB:

- Hvorfor er du ikke lengre i HAB? Mistet du plassen eller valgte du det selv?
- Hvordan er situasjonen din nå?
- Ønsker du deg inn i HAB igjen? Hvorfor/hvorfor ikke?
- Var det det at du var misfornøyd med behandlingsopplegget, medikamentet eller oppfølgingen for øvrig som gjorde at du valgte å gå ut av HAB/mistet plassen?
  - Spesielle hendelser? Gi eksempler.
- Hva kunne vært annerledes i HAB for at du ikke skulle ha trukket deg ut/mistet plassen?

9.4 Appendix 4

Evaluering av heroinassistert behandling (HAB)

Kvalitativ delstudie

Forespørsel om deltakelse i forskningsprosjekt

Dette er en invitasjon til deg som er pasient i klinikken for heroinassistert behandling (HAB) om å delta i et forskningsprosjekt for å evaluere denne behandlingen. Formålet med dette delprosjektet er å undersøke holdninger og erfaringer til HAB blant pasienter, pårørende og behandlere. Prosjektet som helhet er forventet å gi en bedre samlet forståelse av viktige spørsmål som bør undersøkes frem mot en eventuell anbefaling om videreføring av HAB etter prøveperioden. Som deltaker vil du bli invitert til flere intervjuer over tid. Vi ønsker i tillegg å kunne intervjue dine pårørende dersom du samtykker til det. Ved å bidra i disse intervjuene gir du oss et godt grunnlag for å kunne evaluere prøveprosjektet med HAB, og du kan bidra til at fremtidens rusbehandling i Norge vil kunne bli bedre.

Forskningsprosjektet gjennomføres av Senter for rus- og avhengighetsforskning (SERAF) ved Universitetet i Oslo, i samarbeid med erfarne forskere, kliniske virksomheter i Oslo og Bergen, og brukerorganisasjonen for LAR-pasienter (ProLAR Nett).

Hva innebærer prosjektet?

Dette delprosjektet går ut på at du deltar i intervjuer og oppfølgingsintervjuer i løpet av den tiden prøveprosjektet med HAB pågår. Intervjuene vil omhandle temaer knyttet til dine forventninger til og erfaringer fra behandlingen. Intervjuene gjennomføres av forskere og prosjektmedarbeidere i HAB-prosjektet to eller tre ganger (i løpet av en to-års periode) etter din oppstart i HAB. Intervjuene kan ta opptil en time. Dersom du samtykker til det, så vil dine pårørende bli spurt om å bli intervjuet om deres erfaringer som pårørende til pasient i HAB.

Mulige fordeler og ulemper

Deltakelse i prosjektet vil ikke få noen konsekvenser for din behandling i HAB eller andre tilbud du får. En mulig fordel med deltagelse i evalueringen av HAB er at du bidrar til en systematisk gjennomgang av viktige områder som vil ha betydning for evalueringen av prøveprosjektet HAB. Slik sett vil du bidra til å utvikle bedre rusbehandling i fremtiden. Det forventes ingen konkrete ulemper for deg knyttet til din deltagelse i prosjektet. Noen av temaene som inngår i kartleggingen kan være vanskelige å snakke om. Du kan når du vil si i fra dersom det er tema du ikke ønsker å snakke om i intervjuene.

Frivillig deltakelse og mulighet for å trekke sitt samtykke

Det er frivillig å delta i prosjektet. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Du kan når som helst og uten å oppgi noen grunn, trekke ditt samtykke. Dersom du samtykker til at vi kan kontakte dine pårørende for intervju, så kan du når som helst også trekke dette samtykket. Dersom du skulle trekke samtykket ditt, så vil det ikke få noen konsekvenser for din videre behandling i HAB eller andre tilbud du får. Dersom du trekker deg fra prosjektet, kan du kreve å få slettet innsamlede opplysninger, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Dersom du har spørsmål til prosjektet eller senere ønsker å trekke deg, kan du kontakte prosjektleder: …, telefon … eller epost …

Hva skjer med OPPLYSNINGENE om deg?

Opplysningene som registreres om deg skal kun brukes slik som beskrevet i hensikten med prosjektet. Du har rett til innsyn i hvilke opplysninger som er registrert om deg og rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Du har også rett til å få innsyn i sikkerhetstiltakene ved behandling av opplysningene. De innsamlede data vil bli lagret i Universitetet i Oslos løsning for sikker datalagring (TSD) og sikre datalagringsområder ved Oslo universitetssykehus. Du kan klage på behandlingen av dine opplysninger til Datatilsynet og Universitetet i Oslo sitt personvernombud.

Alle opplysningene om deg vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger i datafiler som forskere jobber med. En kode knytter deg til dine opplysninger gjennom en kodeliste. Det er kun prosjektleder Thomas Clausen og annet autorisert personell knyttet til prosjektet som har tilgang til denne listen.

Mulighet for registerkoblinger beholdes frem til prosjektslutt i 2032. Opplysningene om deg vil bli oppbevart i fem år etter prosjektslutt av kontrollhensyn. Det vil ikke være mulig å identifisere deg i resultatene fra prosjektet når disse publiseres. Dine data vil i anonymisert form kunne inngå i sammenligningsstudier innen rusfeltet også med data fra andre prosjekter som ikke ennå er planlagt i løpet av prosjektperioden.

Deling av data og overføringer til utlandet

Dine data vil kun oppbevares i sikre datalagringsområder som beskrevet ovenfor, og ikke deles med forskere i utlandet.

Forsikring

Alle pasienter er på generelt grunnlag forsikret med hjemmel i pasientskadeloven. Det forventes imidlertid ingen skader eller komplikasjoner som følge av deltakelse i evalueringen.

Oppfølgingsprosjekt og intervju med pårørende

Du vil bli kontaktet for å delta i flere intervjuer underveis mens prøveprosjektet med HAB pågår. Vi ønsker også å intervjue dine pårørende over tid (to eller tre ganger i løpet av 24 mnd), og du velger selv hvilke pårørende vi kan kontakte dersom du samtykker til dette.

Godkjenning

Regional komité for medisinsk og helsefaglig forskningsetikk har vurdert og godkjent prosjektet (REK saksnummer 195733).
Etter ny personopplysningslov har behandlingsansvarlig Universitetet i Oslos Tjenester for Sensitive Data (TSD) og … et selvstendig ansvar for å sikre at behandlingen av dine opplysninger har et lovlig grunnlag. Dette prosjektet har rettslig grunnlag i EUs personvernforordning artikkel 6 nr. 1a og artikkel 9 nr. 2a og ditt samtykke. Du har rett til å klage på behandlingen av dine opplysninger til Datatilsynet.

Kontaktopplysning

Dersom du har spørsmål om forskningsprosjektet generelt eller ønsker å trekke deg fra deltakelse, kan du kontakte prosjektleder …, telefon … eller e-post …
Har du spørsmål som omhandler intervjuene spesielt eller om du ønsker å trekke ditt samtykke til at vi kontakter pårørende for intervju, kan du kontakte … ved RusForsk (Oslo Universitetssykehus), telefon … eller epost …

Dersom du har spørsmål om personvernet i prosjektet, kan du kontakte personvernombudet ved Universitetet i Oslo e-post: personvernombudet@uio.no Kontaktadresse til Datatilsynet er post-kasse@datatilsynet.no

SAMTYKKE TIL Å DELTA I PROSJEKTET

Jeg samtykker til å delta i det kvalitative delprosjektet og til at mine personopplysninger brukes slik det er beskrevet ovenfor.

Sted og dato Deltakers signatur

Deltakers navn med trykte bokstaver

Deltakers fødselsdato

☐ Jeg samtykker til at den/de pårørende jeg har oppgitt nedenfor kan kontaktes for å bli intervjuet.

Pårørende 1:
Navn:.. Telefon:................. Epost:................................. Relasjon:...........................

Pårørende 2:
Navn:.. Telefon:................. Epost:................................. Relasjon:.............................

Pårørende 3:
Navn:.. Telefon:................. Epost:................................. Relasjon:.............................

For den som intervjuer:

Jeg bekrefter å ha gitt informasjon om prosjektet til deltakeren

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Sted og dato Signatur

Rolle i prosjektet

[Evaluering av heroinassistert behandling; en tverrfaglig fler-tematisk undersøkelse, v. 4 – januar 2022]