Julie Holeksa

Varying drug policies and unequal access to harm reduction

Experiences, mobility, and risk management of people who use drugs
VARYING DRUG POLICIES AND UNEQUAL ACCESS TO HARM REDUCTION
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Experiences, mobility, and risk management of people who use drugs
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VARYING DRUG POLICIES AND UNEQUAL ACCESS TO HARM REDUCTION

Experiences, mobility, and risk management of people who use drugs

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To my parents
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ABSTRACT

Sweden has a history of a restrictive drug policy, with a national policy focus on achieving a “drug free society.” This has led to a relatively slow development of “harm reduction” services, those services which aim to reduce risk and vulnerability for people who use drugs (PWUD), without requiring drug abstention. The harm reduction services which do exist are inequitably distributed across the country. In this context, this project aims to explore the attitudes of social work professionals (SWP) towards harm reduction, and the experiences of Swedish PWUD. The data consist of a survey of SWP (208 responses), interviews with PWUD in an area of limited harm reduction (11), and interviews with PWUD who had travelled to Denmark, a country with a less restrictive drug policy approach (17).

Article I utilizes survey data to explore the perspectives of Swedish SWP regarding the philosophy of harm reduction and specific harm reduction initiatives. The study reveals a generally positive attitude towards harm reduction, albeit with significant geographical variances. There were low levels of support concerning the adoption of newer harm reduction strategies. Less positive attitudes and negativity regarding new interventions were significantly associated with SWP in areas with lesser exposure to harm reduction practices.

Article II examines how PWUD in a small urban center handle the absence of local harm reduction services. The participants’ experiences are interpreted using the theoretical concept of “risk environment” which highlights how various environmental factors interact to produce risk of drug-related harm. Strategies ranged from traveling to external needle exchange programs, relying on unofficial secondary distribution, to risk behaviours such as stealing, reusing, or sharing injection equipment. Many were homeless, articulating a continuous struggle to find temporary shelter. They injected drugs in unsafe places, such as public toilets, increasing risk of overdose or infection. They also expressed
feeling stigmatized and excluded from society which compounded their stress, risk of disease transmission and overdose, and poor overall wellbeing.

Article III explores the motivations behind the mobility of PWUD from Sweden to Denmark. The “risk environment” framework was used to contextualize decision-making and risks, based on the physical, social, policy, and economic environments. The study identifies harm reduction service availability, stigma, social networks, the drug scene, and policing practices, as key drivers for relocation. Despite the perceived benefits of moving, such as improved access to harm reduction services, participants also reported exposure to new risks, including violence, potential exclusion from a range of services, and exposure to new drugs.

Article IV analyzes the reflections of PWUD on their experiences in Sweden and Denmark in the context of each nation’s drug policy. The analysis explored experiences of stigma and coupled these to concepts of identity and social exclusion. In daily interactions, participants felt ignored and dehumanized in Sweden’s zero-tolerance environment, whereas in Denmark, a country with a harm reduction approach, they felt visible and valued as individuals. This, combined with more developed services and a less punitive policing approach, led participants to feel included in society in Denmark. Contrasts between experiences in the two countries were also echoed in participants’ interactions with the healthcare system, relating to feeling controlled in Sweden, or being given autonomy and trust over their care in Denmark.

Collectively, this thesis highlights the interplay between drug policies, care formats, policing practices, social interactions, the attitudes of SWP, and the lived experiences of PWUD. While overall positive, the attitudes towards care goals and interventions differ between different areas, among professionals who provide care to PWUD. PWUDs’ movement to and experiences in different settings can be used to offer an insight into their own policy preferences. The project demonstrates the role of constructions, and resulting drug policy, in how they influence PWUDs’ experiences of stigma and exclusion, and their risk environments.
ARTICLE OVERVIEW

**Article I:** Holeksa J., Richert T. Attitudes towards harm reduction amongst social work professionals in three geographical areas in Sweden. (manuscript provided).


**Article III:** Holeksa, J. (2024). “I knew it was different there”: a qualitative study of the motivations and risks of drug policy migrants going to Denmark from Sweden, Drugs: Education, Prevention and Policy, DOI: 10.1080/09687637.2024.2307477

**Article IV:** Holeksa, J. “In Sweden you are worthless. In Denmark you get an identity again” – the perspectives of people who use drugs on being perceived and received in two countries with different approaches to drug policy. (manuscript provided).
INTRODUCTION

People who use drugs (PWUD) are at a high risk of complex, interrelated physical, psychological, and social harms (Armoon et al., 2021; Couto E Cruz et al., 2018; Darke et al., 2008; Degenhardt et al., 2013). These include but are not limited to: overdose, blood-borne infections, mental health or psychiatric issues, homelessness, legal concerns, and social exclusion (Armoon et al., 2021; Bourgois et al., 1997; Couto E Cruz et al., 2018; Kemp et al., 2006). More intensive substance use, such as injection, polysubstance use, and more frequent use indicative of a substance use disorder, significantly heighten the risk of morbidity and mortality (Bohnert et al., 2018; Coull et al., 2014; Hayden et al., 2014; Larney et al., 2017; McCabe et al., 2017). These elevated risks are reflected in global figures relating to drug-related harms reported by the UN Office on Drugs and Crime (UNODC) (UNODC, 2023). They reported that opioid use, injection, and substance dependence are the primary drivers of drug-related harms, resulting in nearly 18.4 million healthy years of life lost and 500,000 deaths globally in 2019. These mortality figures include deaths occurring directly, such as through overdose, as well as indirectly, such as through infectious disease like hepatitis C virus (HCV) (UNODC, 2023).

The multitude of approaches to reduce drug-related morbidity and mortality have evolved over decades. The different approaches reflect diverse societal and scientific perspectives, and lack of consensus, on addressing the multifaceted issue of drug-related problems (Keane, 2016; Klingemann & Storbjörk, 2016; Stevens et al., 2019). Debates persist over policy goals and their effectiveness. Some suggest that strict laws and social deterrents against substance use will effectively limit use, while others debate this (Caulkins et al., 2014; Hughes et al., 2018; McKeganey, 2011). Critics to strict approaches also highlight the potential of these strategies to compound harms for those involved in substance use (Caulkins et al., 2014; Scher et al., 2023; Wakeman & Rich, 2018). Most
“drug policies” (i.e. the collection of policies, programs, and interventions aimed to address issues relating to drug use) will encompass a combination of elements to address both substance use and related harms. These may for example, aim to reduce overall usage through preventing initiation and providing treatment (demand reduction), limiting trafficking and sales (supply reduction), or addressing specific risks associated with substance use (harm reduction) (Hedrich & Rhodes, 2010; Ritter et al., 2016). Choices of which interventions to employ are driven by the variety of policy goals and conceptualizations of the underlying reasons for substance use, which are based on research, culture, and political or ideological positions (Babor et al., 2018; Klingemann & Storbjörk, 2016; Ritter et al., 2016). While some interventions are employed relatively commonly, others are only delivered in certain settings (Babor et al., 2018; Ritter et al., 2016).

Strategies based on the pillar of “harm reduction” are considered controversial in many contexts. Harm reduction is defined as “policies and programs which aim at reducing drug-related harm without requiring abstention from drug use.” (Riley et al., 1999, p. 11). This leads to concerns by some that harm reduction programs are overly permissive, and even promote drug use (McKeganey, 2011; Stöver, 2016; Tryggvesson, 2012). Others consider it to be a pragmatic, as well as realistic and humane approach (Pauly, 2008; Vakharia & Little, 2017). Thus, there are varied levels of acceptance of this philosophy with regards to illicit drug use, leading to highly inconsistent formation and implementation of harm reduction strategies. This results in a situation where responses to address substance use differ substantially both between and within countries.

Some of the harms of drug use derive directly due to physiological impacts of drugs themselves, while others stem from social responses to drug use. For example, adequate access to clean injection equipment and opioid substitution treatment (OST) programs can significantly reduce risks such as blood-borne virus transmission and mortality (Platt et al., 2017; Santo et al., 2021). Studies have shown that providers’ views of the goals of drug treatment – goals which are often driven by policy – influence their care recommendations (Brown, 2022; Javadi et al., 2022). That drug use is criminalized, and considered to be stigmatized, or negatively viewed, in many settings, also has an influence on risk of harm. The legal status of drugs, and approach of policing, can undermine access to harm reduction services (Cooper et al., 2005; Rhodes et al., 2003), and stigma against PWUD leads to discrimination and their exclusion from society (Couto E Cruz et al., 2018; Lloyd, 2013). Negative attitudes towards PWUD in care settings may act as a deterrent to their accessing care services (Crapanzano et al., 2018; Paquette et al., 2018) as well as leading to worse care outcomes,
when care is accessed (Van Boekel et al., 2013). Therefore, the policy context can play a critical role in producing or reducing exposure to risks, where many drug harms can be averted or, alternatively, amplified by both policy approaches as well as environmental factors.

The case of Sweden presents a relevant example with regards to the development of drug policy and variable implementation of harm reduction. Sweden is among the countries in Europe with the highest recorded rate of overdose mortality, several times the EU average (EMCDDA, 2020). However, given different data collection and reporting procedures, the comparison of such statistics across national settings should be done cautiously. Since the 1980s, Sweden has pursued an abstinence-driven goal of a “society free from drugs” showing reluctance towards harm reduction and favouring punitive measures, prevention, law enforcement, and abstinence-oriented treatment. Personal drug use is criminalized, and there is a strong and enduring social stigma towards drug use, elements believed to, and promoted by, the Swedish government to prevent drug initiation and usage (Ministry of Health and Social Affairs, 2016). Several studies have mapped the role of political, not purely scientific, influence in the development of Swedish drug laws, policy, and services (Eriksson & Edman, 2017; Karlsson et al., 2021; Tryggvesson, 2012). Although there have been many changes in the offering of harm reduction strategies in the last decade (Andersson & Johnson, 2020; Karlsson et al., 2021), where harm reduction does exist in Sweden, it has done so largely in a limited format, and (relatively) within the confines of a zero-tolerance policy.

Despite the national context of a drug-free policy aim, regional disparities in service provision are evident in Sweden, where there are significant differences in the approach towards and resources available to PWUD in distinct areas. For instance, in the region Skåne, there are four needle and syringe exchange programs (NSP), two of which have been providing sterile injection equipment since the late 1980s. This contrasts with other regions where NSP facilities are fewer (often only a single regional facility) and more recent, with one region opening their first NSP as late as 2024. Sweden’s neighbour, Denmark offers an interesting comparative case, highlighting a markedly different approach towards drug-related harms. To provide a point of comparison, in Denmark sterile injection equipment may be distributed at pharmacies, by mail, by NGO actors, among others, leading to a more geographically equal access across the country. This example regarding accessibility of injection equipment does not explore the important complexities of the differing programmatic requirements in both settings, which will be surveyed in a later chapter. In Denmark, harm reduction
has been much more definitively incorporated into drug policy and services, as well as drug-related laws and policing (Houborg & Møller, 2021). Denmark has even implemented a number of services not offered in Sweden, such as supervised drug consumption rooms and heroin-assisted treatment programs.

Individuals with higher risk substance use, who constitute the primary focus of this study, face heightened vulnerability and also bear the brunt of drug-related harms (UNODC, 2023), and are therefore disproportionately affected by variations in policy choices. They are especially vulnerable to variations in programs emphasizing harm reduction, given the pivotal role these programs play in addressing the extensive drug-related risks (Hedrich & Rhodes, 2010), especially in light of the societal marginalization that PWUD often face. The widely varying approaches to drug-related harms results in a situation of unequal access to care. The different approaches may also reflect differing attitudes towards PWUD as well as the goals of their treatment, which can play a role in indirectly influencing risk of harm. In some cases, it has even been reported that the differences in policy contexts may lead individuals to move or travel to access care elsewhere (Fast et al., 2009; Hayashi et al., 2019; Schreiber et al., 2018; Sjölander & Svensson, 2008). This underlies the importance of studying how national drug policies are implemented and how they influence PWUD, as well as how they are understood by professionals on the local level. For those who relocate, this movement between settings can even be indicative of policy and care preferences.

**Purpose and aims**

The presence of variations in drug policy environments and service delivery, both within and between countries, underscores the need for an in-depth examination of such disparities and their impact on PWUDs’ life situation and experiences. Considering the diverse drug policy landscape, some individuals may choose to relocate or travel in pursuit of improved access to services. Conversely, others might opt not to, or be constrained in their ability do so, remaining in areas characterized by limited service provision, and a more restrictive policy environment. Policy environments impact not only PWUDs’ access to services, but can also affect interactions and encounters with care providers, police, and even the general public. Further, the policy environment can influence professionals’ attitudes towards various services or treatment goals, which in turn can influence which services these professionals suggest or grant to clients.
Therefore, this project has two aims. The first is to examine social workers’ assessments of access to various interventions for PWUD in different areas, and ascertain if there is a linkage between local harm reduction development and the attitudes of social workers towards harm reduction. The second is to analyze PWUDs’ experiences of, and strategies in relation to, variations in policy approaches and harm reduction service formation both within Sweden and between Sweden and Denmark. The overarching research questions are:

1. What are social work professionals’ attitudes towards harm reduction in different areas of Sweden, and how may these attitudes relate to local service landscapes?

2. How do people who use drugs experience and navigate low access to care, as well as locally differing approaches to drug policies? And, 

3. How might varying policy approaches be linked to the mobility of PWUD – and what influence does this have on wellbeing as well as risk?

Disposition

In this chapter I have explained the overarching rationale and aims of the research project. In chapter two, I will explore in to the background and cover the relevant previous research on the thematic topics covered in the project. I will highlight areas where there is a research gap, and how the current study can assist in addressing that gap. Chapter three will cover the theoretical disposition of the project. This will comprise the overarching theoretical standpoint I take in approaching the subjects of the study, as well as specify how these theories will be used in the individual articles and contribute to the project as a whole. In the fourth chapter, I will specify the methodological approach to the studies, including ethical considerations, decision-making processes in data collection methods, reflections on my position in the research process, and the limitations of the study’s procedures. Chapter five provides a summary of the main findings of the four articles. This is followed by chapter six, the discussion, which examines these main findings in reference to each other, and in relation to the existing literature and chosen theory. This chapter also presents the proposed implications of the project. This will be followed by reflections of the project’s potential implications. These six chapters are subsequently followed by the manuscripts which make up the basis of the dissertation.
This chapter will explore the literature on several themes which have relevance to the project, and reflect on how these studies specifically relate to the project in question. First it will give an overview of some of the major risks and harms related to drug use – both somatic and psychosocial. This will be followed by a section explaining the key policy elements to address drug-related challenges, with a subsequent emphasis on the concept of harm reduction, as well as critiques of that concept. It will then give a more focused overview of drug policy and harm reduction development specifically in Sweden and Denmark. This is followed by a section which gives an overview of the literature on service providers’ attitudes and how they are connected to care outcomes for clients. Finally, there will be a section outlining the role of geography in health and wellbeing, with a focus on mobility of PWUD.

**Drug related harms …**

As described in the introduction, PWUD are in a vulnerable situation to a variety of negative health and wellbeing outcomes. The harms from substance use transpire at several levels. These include “drug-specific” physical harms and mortality, such as stroke and respiratory failure (Darke et al., 2008; Degenhardt et al., 2013; Nutt et al., 2010). Factors such as the amount and frequency of use, the substances used, and the route of administration may amplify risks. Polysubstance use leads to higher mortality, more emergency department presentations, and poorer treatment outcomes (Bohnert et al., 2018; McCabe et al., 2017). There are also “drug-related” harms and mortality, which tend to be associated with the conditions of use (Nutt et al., 2010). Injection drug use is associated with the highest levels of risk, increasing potential for soft tissue
infections, endocarditis, transmission of infectious diseases such as HCV and HIV, as well as overdose (Coull et al., 2014; Degenhardt et al., 2013; Larney et al., 2017). Many of these harms (excluding overdose) relate to hygienic conditions such as sharing or re-using injection equipment, not the direct effects of substances on the body per se. Further, substance use, particularly addiction, is strongly associated with a co-occurrence of psychiatric problems, which present an increased complexity of both concerns, difficulty providing effective treatment, and worse treatment outcomes (Morisano et al., 2014). Use of drugs carries the risk of addiction – defined broadly by an increasing tolerance, inability to control use, and persistent use despite harmful consequences (American Psychiatric Association, 2013). Addiction implies greater health risks and often leads to prioritizing drug-related activities, resulting in employment loss, housing instability, and deterioration of interpersonal relationships.

The somatic harms of drug use are often compounded by the negative social status of drug use in society. Many of the potential harms are linked, rather than to the drug itself, to stigma and discrimination related to drug use. Stigma is classically defined as an, “attribute which is deeply discrediting,” (Goffman, 1963, p. 3) which can lead to exclusion from broader society. Illicit drug use is considered to be one of the most stigmatized behaviours across many societies (Barry et al., 2014; Lloyd, 2013). Injection specifically is particularly stigmatized, associated with negative stereotypes (Crawford et al., 2012; Lloyd, 2013). Stigma has been suggested to serve a social function, by discouraging certain behaviours, and creating in- and out-groups (Ahern et al., 2007). Stigma and negative conceptions of PWUD present themselves in practice as discrimination, fostering negative interactions and exclusion on both interpersonal and institutional levels. However, it has also been seen that internalization of stigma – i.e. the belief that one aligns with the stigmatized characteristics associated with the stigmatized group one belongs to – can be related to increased substance use (Cama et al., 2016; Kulesza et al., 2017). Therefore, while stigma is meant to play a role in limiting substance use, it may also amplify the risks of addiction for some.

Stigma, and related discrimination, is not benign, and in fact has been demonstrated itself to have serious health and wellbeing implications. PWUD face discrimination in their encounters with medical and social care workers leading to worse treatment outcomes (Van Boekel et al., 2013), which will be discussed in detail in a later section. Experiences of stigma are one of the reasons for which many PWUD report avoiding accessing medical care, which can lead to them presenting later in an illness course, with more serious symptoms, and
therefore experience worse outcomes (Chan Carusone et al., 2019; Farhadian et al., 2022). Stigma may amplify specific drug-related harms. Levels of reported discrimination have been linked with increased injection-related risks and overdose (Ahern et al., 2007; Couto E Cruz et al., 2018). Studies have also shown a linkage between internalization of a stigmatized identity with poorer self-esteem, and lower use of certain harm reduction services (Rivera et al., 2014). Stigma is also associated with poor mental health, such as depressive symptoms, as PWUD are often excluded by family and close social networks (Ahern et al., 2007). Ahern et al. (2007), for example, found that 65% and 75% of the PWUD they surveyed reported being rejected by friends and family, respectively, due to their drug use. An Australian study found that the relationship between poor mental health and discrimination were especially pronounced for women as well as people reporting Aboriginal or Torres-strait background (Couto E Cruz et al., 2018). This highlights the intersectional aspects of stigmatizing experiences, how they are mediated by other aspects of one’s identity, in some cases leading to a multiplicative effect of stigma and discrimination (Collins et al., 2019; Couto E Cruz et al., 2018).

…and how to address them

Risks for the above-named harms of drug use are dependent on individual vulnerabilities and drug-related factors, as well as legal and sociocultural conditions, which in turn are shaped by social processes. Drug policies, consisting of programs, interventions, and laws, serve to mediate some of the potential negative outcomes of drug use. They may aim to address (limit) the use of drugs, as well as the consequences of use (Babor et al., 2018). Due to the variety of risks, there is a critical need to provide high quality interventions, but the format of implementation of drug policies and laws are highly varied both within and between different settings (Ritter et al., 2016). This section aims to provide a brief overview of the key features of a drug policy, described by Babor et al., (2018) and Ritter et al. (2016), shedding light on the diversity of these policies and their relevance to PWUDs’ lives, experiences, and risks.

Contemporary responses to drug use represent a complex interplay of sociocultural, historical, scientific, and political forces. Drug policy can be seen as a “part of societal management of risks” (Bjerge et al., 2019, p. 34). A major element which shapes the foundation of a drug policy is the goal of the policy (Babor et al., 2018; Ritter et al., 2016). This goal may be to eliminate drug use or to eliminate drug-related harms and accept some drug use as a feature of society (or most often, the goal may encompass elements of both). A focus of this thesis
is the influence of the overarching goal of a drug policy (in this case, a goal of drug-freedom, or a goal of harm reduction), on intervention availability, provider and public attitudes, and PWUD experiences. An element which can influence the chosen policy goal is the conceptualization of the issue. Different scientific and cultural traditions will inform how the “drug problem” is framed, “where” the problem originates from, which will thus influence the formation of appropriate responses (Klingemann & Storbjörk, 2016), particularly in relation to what consequence this response will have in serving the policy goal. The influence of framing will be considered in more detail in the Theory Chapter.

Deriving from this foundation, there are three elements of approach which represent the higher-level goals and conceptualizations in practice (as previously described in the Introduction) (Ritter et al., 2016):

1. Demand reduction – including interventions which are aimed to reduce uptake and overall levels of drug use in society. For example, preventative educational interventions and legal restrictions/law enforcement, as well as treatment for those involved in substance use already.

2. Supply reduction – involving interventions which aim to limit the production, trafficking, and distribution of drugs.

3. Harm reduction – encompassing programs which aim to limit the potential harms and improve the quality of life for people who for various reasons cannot or will not stop using drugs. The inclusion of harm reduction is a more recent development within the context of drug policy.

The mix, weight, and precise formation of these elements is driven by the programmatic goals and conceptualizations of the drug problem (Ritter et al., 2016), and result in vastly different conditions, interventions, and risk of harms for PWUD in different places. A clear example of this can be provided by Houborg et al. (2022), compared the risk conditions of PWUD in Malmö, Sweden, and Copenhagen, Denmark, showing how national policies impact PWUD’s risks. The concrete influence of the policy goal, especially its effect on harm reduction service availability and formats, will be further clarified in the sections on Swedish and Danish drug policy.

While national policies set overarching guidelines, major criteria, and frameworks such as financing, local settings can in some cases mediate these on

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1 A note that there may not always be total coherence between policies in different sectors in the same setting, where for example the legal sector may criminalize drug use and have a law enforcement focus on punitive measures, whereas the health and social sectors may focus on harm reduction.
the practical level. As Houborg et al. (2022) describe, at the local level, “one can find development of interventions which have concrete impacts on PWUD daily life” (own translation) (p. 159). The authors later emphasize that if the national and local policies deviate, it is the local which may be more directly relevant to, and impactful on, PWUD themselves. These local adaptations can be referred to as “street level” or “grassroots” bureaucracy, leading to a diversity of practices on the ground, and can result in different implementation or interpretation of top-level policy.

In Sweden, drug policy itself and related guidelines are developed and communicated from the national level. Health care is organized and delivered regionally. Social services are organized and delivered on the municipal level. Each of these levels offers an opportunity for nuances in the implementation of the national policy, or the development of a “local” policy environment in how they interpret and carry out services, as compared to the national level. For example, Sweden’s Skåne region allows clients to choose their own provider for OST, in a move to improve empowerment and access to care (Andersson & Johnson, 2020), a policy which does not exist in other regions. These intra-national differences are important as the current study investigates both two distinct national settings, as well as nuances in more localized policy conditions. Thus, in this thesis, the term “drug policy” can be seen both as relating to national guidelines, as well as how these guidelines are operationalized in practice at different levels. Still, though, the national policy and legal frameworks ultimately restrict the realization of certain forms of care. For example, legal restrictions such as the Syringe Exchange Act (SFS 2006:323) in Sweden mean that needles and syringes for drug use can only be provided at a NSP, making it the only country in the EU which does not offer free or for-purchase needles and syringes at pharmacies without a prescription. This example represents how legal limitations can constrain more radical local nuances in service development. Where settings have different approaches, as is the case in this study, it can be useful to understand how people experience these different systems, and what their own perspectives on some of these issues are, which are of pressing importance to their own wellbeing.

Harm reduction

As this study explores experiences of those who are currently involved in drug use, harm reduction stands out as the most relevant element of drug policy to concentrate upon, due to its direct impact on those most at risk. This section introduces harm reduction, emphasizing its relevance to the project, while more
specific information about its development in Sweden and Denmark follow in a later section.

As stated by Riley et al. (1999), “all drug policies and programs aim to reduce the harm associated with drug use,” (p. 11). However, harm reduction as a strategy encompasses specific principles. Emerging during the HIV/AIDS crisis of the 1980s and 1990s, harm reduction is founded on the principle of minimizing drug-related harms, without necessarily compelling the cessation of substance use. It is based on: pragmatism (that some use of drugs will always be a feature in society), humanism (that all people are worthy of dignity, and a person’s decision to use drugs should be respected), a focus on harms (prioritizing reducing negative consequences of drug use over reducing drug use itself), balancing cost and benefit (evaluating the direct and indirect effects for the individual and society), and prioritizing immediate goals (meeting pressing needs first) (Riley et al., 1999). Global bodies such as UNAIDS and the WHO have endorsed care based on these principles as essential (UNAIDS, 2019; World Health Organization, 2022). Harm reduction can encompass a vast array of interventions aimed to address many levels of the social determinants of health and/or risky drug use, including health and social services, housing, education, outreach services, and more.

In an overview of available scientific evidenced published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), harm reduction strategies have demonstrated success in reducing risk behaviours, morbidity, and mortality associated with drug use (Hedrich & Rhodes, 2010). Their direct goals may be, for example, to prevent overdose death, offer tools for safer drug use, change the route of drug administration, or even reduce overall illicit substance use. They may achieve those goals by:

- Offering regulated substitute substances: Opioid substitution therapy (OST) has been shown in a systematic review by Santo et al. (2021) to significantly reduce all-cause mortality. A Cochrane review has shown reduced HCV transmission, particularly when combined with comprehensive NSP (Platt et al., 2017). Benefits extend to reduced morbidity, criminality, and enhanced social functioning (Heilig, 2019).
- Two related subcategories with promising results but which are provided on a smaller scale in some countries are Heroin Assisted Treatment (HAT) and Safe Supply. HAT involves providing prescription heroin to those with refractory opioid addictions, reviews find improved treatment retention and potentially improved health compared to
traditional OST (McNair et al., 2023). *Safe supply* offers prescribed alternatives to illicit drugs for those not served by traditional OST, showing reduced all-cause mortality among participants compared to matched controls accessing the illicit market (Slaunwhite et al., 2024).

- Providing sterile equipment for drug use (needles, syringes, water, pipes, alcohol swabs): *Needle and syringe exchange program (NSP)* effectively reduce HIV transmission and risk behaviours like needle sharing, according to a Cochrane review (Platt et al., 2017).

- Providing a safe space to ingest substances to avoid overdose and police and public interference: *Supervised consumption sites (SCS)*. A review by Kennedy et al. (2017) found that SCS prevent overdose deaths, facilitate linkages to care, reduce amounts of publicly discarded injection equipment, and do not increase crime in the surrounding areas.

- Distributing a substance which can reverse an opioid overdose: *Take home naloxone*. According to a systematic review, take home naloxone programs have high levels of success in reducing overdose-related mortality, with very few adverse events (McDonald & Strang, 2016).

- Not excluding PWUD from government funded housing: *Housing First*. Based on the principle that housing is a fundamental human right, these programs do not exclude PWUD and have shown high levels of housing stability, quality of life improvements, improved social relations, and for some, reduced or ceased substance use (Knutagård & Kristiansen, 2018; Tsemberis et al., 2004).

- Offering testing strips or mass spectrometry to determine the composition of illicitly purchased substances: *Drug checking services* allow for people to alter their drug using behaviour based on testing results – for example to reduce their dose (Maghsoudi et al., 2022).

- Reducing or removing criminal sanctions with regards to small, “personal” amounts of drugs. *Decriminalization*. Criminalization has been seen to undermine some of the positive benefits of harm reduction programs. It can make people reticent to present to services for fear of arrest, can lead to perpetuated stigma, as well as promote criminal networks which create other, indirect harms (Babor et al., 2018). Decriminalization may reduce the impacts of these harms, and allow for a focus on social and medical harms (Hughes & Stevens, 2010).

- A policing focus on maintaining public safety, order, and wellbeing rather than a punitive focus on drug-related crimes. *Harm reduction policing* can also be offered in the context of continued drug
criminalization, in order to reduce some policing-specific harms, and may also aim to divert PWUD out of the criminal justice system (Beckett, 2016). These include informed training efforts and partnerships with harm reduction sites, and have been found to improve police understanding of harm reduction, readiness to respond to overdose, as well as relationships between police and harm reduction sites (Khorasheh et al., 2019). They also may aim to symbolize to PWUD that they have rights as citizens in the event of crime victimization (Kammersgaard, 2019; Kammersgaard et al., 2024).

- Offering “low threshold” forms of care – any of the above services, or others, which are provided in a manner which prioritizes accessibility, with strategies like extended opening hours, interdisciplinary services, minimal entry criteria, and a high threshold for program removal, leading to positive outcomes in motivation, satisfaction, retention, recovery, and health (Eckhardt et al., 2022; Jakubowski & Fox, 2020; Snow et al., 2019).

Beyond the direct link to reduced risk behaviours, harm reduction services can play an indirect role in reducing drug-related harms and poor health and wellbeing outcomes. Such services can act as a link to referral to other health and social services, including drug treatment (Kennedy et al., 2017). Studies show that well-developed and non-discriminatory services can have a positive impact. They may lead to improved self-efficacy, provide a sense of being supported, and combat previous experiences of stigma and discrimination, which contribute to people accessing care where they otherwise may not (Jozaghi, 2012; Lee & Petersen, 2009; Macneil & Pauly, 2011). As stated previously, there is even a link between self-esteem and drug-related risks (Cama et al., 2016; Rivera et al., 2014). The theme of developing hope and experiencing calm, is commonly reported in qualitative studies on experiences of harm reduction services (Jozaghi, 2012; Macneil & Pauly, 2011; Nordstedt, 2023). For example, research in Sweden has demonstrated the social meanings of NSP, where, “countless material and relational exchanges that foster positive experiences of the needle exchange program, turning it into a place of social hope and a changed future,” (Nordstedt, 2023). Also in the Swedish setting, Stenström (2008) found that clients visited the NSP not only to access sterile injection equipment but also for “social” visits, and that these contacts in turn predicted lower incidence of HCV infection. Therefore, it is both the services themselves, as well as the relationships and environment they promote, which can have positive impacts on psychosocial and medical outcomes of PWUD.
The benefits of harm reduction are maximized when programs are comprehensive, accessible, and provided in an integrated fashion (Hedrich & Rhodes, 2010). It must therefore be noted that not all services which purport themselves to be harm reduction fully embody its principles. High thresholds such as strict rules may deter people from accessing care – where this was one of the most commonly reported reasons to avoid some OST programs (Prami et al., 2023; Richert & Johnson, 2015). Additionally, some genuine harm reduction may be undermined by other environmental factors. For example, punitive and/or targeted policing practices around harm reduction sites may undermine access (Cooper et al., 2005; Rhodes et al., 2003). This leads to a situation where accessibility in theory does not mean accessibility in practice.

Harm reduction accessibility is affected by a variety of factors, including legal frameworks, policies, and the attitudes of both politicians and care providers. The debate surrounding mandatory drug cessation has created significant political resistance, which has, in part, led to the slow and uneven implementation of harm reduction programs (Eriksson & Edman, 2017). This variation results in care inequities that require analytical attention. Furthermore, this project examines experiences of not only differing harm reduction, but also the impact of law enforcement practices and drug legislation differences, which are closely tied to the development of harm reduction strategies. The array of health risks associated with drug use highlights the consequences of care disparities, particularly for those at elevated risk. By investigating PWUDs’ perspectives on, and navigation of, these disparities, we can gain insight into their effects on the lived experience of those in need of such care.

Critiques of harm reduction

While harm reduction has gained recognition as a pragmatic approach to addressing substance use issues, it is not without its critiques and challenges. These critiques will be outlined in the following section, including a focus on how these arguments have been used in the Swedish context. Some of the major critiques come from an ideological perspective, focusing on how harm reduction has been interpreted and implemented (Moore & Fraser, 2006; Roe, 2005). Other criticisms relate to concerns about the effectiveness and overall goals of harm reduction (Eriksson & Edman, 2017; McKeganey, 2011).
Ideological critiques

Neoliberalism, responsibilization, medicalization, and fatalism

Neoliberalism is based on ideas of reduced government spending and regulation, as well as incorporation of market principles, into the care sector. This is related to the notion of New Public Management (NPM) – creating competition and incentives in the public sector – with a primacy placed on quantifiable, measurable interventions and outcomes. Critics argue that the manner in which harm reduction is developed today is bolstered by a neoliberal economic system, in that it addresses immediate individual risks but often neglects the broader social, political, and economic context of substance use (Moore & Fraser, 2006; Roe, 2005). A reflection on this sentiment has been confirmed in studies of PWUD themselves. One study of young PWUD found that they appreciated the well-developed existing harm reduction services in Vancouver, Canada but felt that they offered “little meaningful support to improve young peoples’ broader life chances” (Bozinoff et al., 2017, p. 33). Bozinoff et al.’s (2017) findings emphasize the criticism above, that harm reduction interventions are frequently viewed as standalone solutions without addressing the wider social determinants of health. Similarly, von Reis & Wendel (2022) explore the challenges that Swedish social workers face when navigating individualized and outcome-based measures for clients in need of long-term care. These clients may not meet outcomes defined by the system, which are frequently based on economic considerations rather than the clients’ own needs (von Reis & Wendel, 2022).

Works by Rhodes (2002) and Bourgois et al. (1997) are applicable here in highlighting how harm reduction programming has been built on the rationality of public health officials. The notion of rationality similarly links to the concept of “responsibilization” i.e. how health policy shifts the care burden to individuals to make healthy or “correct” choices, and blame them if they do not (Fraser, 2004). The responsibility of action is placed on the individual, which downplays the state’s role in addressing the underlying issues which drive not only harm, but also substance use itself.

The development of rationality and responsibilization have justified an increasing medicalization of addiction, where interventions and outcomes are largely quantifiable, rather than addressing its more distal root causes. This shift is reflected in findings from Andersen & Järvinen (2007), where Danish treatment practitioners viewed abstinence as an impossibility for most opioid using clients. This stance underscores the critique of responsibilization, highlighting a system where individuals are expected to initiate and take charge of their treatment journey, rather than being met with proactive support from care providers.
Andersen & Järvinen (2007) as well as Roe (2005) have even suggested that harm reduction services could inadvertently perpetuate a sense of fatalism amongst clients, dampening their belief in recovery by setting low expectations for client engagement. Similar arguments have been used in the Swedish context regarding social workers’ resistance towards the development of both OST and NSP (Christensson & Ljungberg, 1991; Johnson, 2007), where politicians suggest that such interventions will “prolong the suffering” (Eriksson & Edman, 2017, p. 117). These critiques were visible in Denmark as well, during the initial pushback to methadone as OST, due to concerns that it obscured the fundamental social causes of addiction (Houborg, 2010).

The focus of these critiques remains primarily on the provision of “direct” harm reduction services, rather than the philosophy of harm reduction itself. The critiques centre largely around the notion that issues related to drug use must simultaneously be managed by broad, holistic social reforms, but that these would require expensive, long-term investments from the state, and thus are not politically attractive.

Normalization

The normalization thesis proposed by Parker et al. (1998) relates to the idea of the signaling of norms to society. Normalization is based on the belief that norms towards drug use have changed, that a “cultural accommodation” of some illicit drug use will lead to, or possibly has already led to, widespread experimentation and use among people who would historically have viewed it as an unacceptable activity (Parker et al., 1998). Some, like McKeganey (2010), have used these arguments to suggest that harm reduction sends the “wrong message” and may lead to increased normalization. This is very much aligned with some of the arguments which are used in the Swedish contexts against the expansion of harm reduction services (Eriksson & Edman, 2017, Johnson 2003). Research has been dedicated to evaluating the normalization thesis, with mixed results (Bahora et al., 2009; Duff, 2005; Shildrick, 2002; Shiner & Newburn, 1997). Bahora et al. (2009) and Duff (2005) found for example that increased visibility and availability of ecstasy led to a normalization and reduced risk perception for recreational users. Others question the link between permissive attitudes towards recreational drugs and subsequent heavier drug use, emphasizing decreasing trends of injection drug use as evidence (Shildrick, 2002; Shiner & Newburn, 1997). It is also worthwhile to consider and balance potential increasing youth experimentation (which of course has potential for harm and trajectories towards addiction), with the previously mentioned negative influences of stigma on PWUD.
**Critiques of effectiveness**

Finally, some critiques of harm reduction programming direct themselves towards the effectiveness of specific programming. Babor et al. (2018) succinctly describe the complexity of evaluating harm reduction’s effectiveness. For some interventions, such as OST, it is relatively easy to perform randomized controlled trials, considered to be the gold standard of scientific evidence. For others, such as NSP, randomized trials are difficult or impossible and instead other forms of evidence are used, such as natural experiments, and observational studies. These are considered to produce less reliable forms of evidence, due to the inability to have control groups, and given the possibility for confounding factors. It is thus fundamentally impossible to have the best forms of evidence about every intervention. Importantly, as previously mentioned, on a global level, governing bodies have concluded that there is sufficient evidence for certain services, such as NSP, OST, and naloxone distribution (UNAIDS, 2019; World Health Organization, 2022). However, the lack of “gold standard” evidence opens up for the (sometimes intentional) misinterpretation of research findings, or ascribing evidence “different relevance” (p.118) by opponents (Eriksson & Edman, 2017). This strategy was seen by Eriksson & Edman (2017) in their study of the political arguments for and against expansion of NSP in Sweden. They found that opponents questioned the applicability and impact of NSP, argued that there was insufficient local evidence, and claimed that NSP send negative societal signals. The uptake of these arguments can result in a catch-22 where the evidence is considered insufficient, but relevant evidence cannot be created.

There is also a tension in various forms of competing outcomes. Defining success in harm reduction can be contentious, with high threshold OST programs showing high retention, but potentially excluding those most at risk of disengagement, seen in both Sweden and Norway (Gunne et al., 2002; Waal, 2007). Balancing accessibility with avoiding negative outcomes, like drug diversion, requires a nuanced approach, developed in concert with the perspective of PWUD themselves on the matter. The current study can help provide additional insights into these viewpoints, where the thresholds of certain services in Sweden remain too high and “push” people out. There can be competing concerns regarding program-level versus community- or society-level effects. For example, while SCS has good evidence regarding intervening directly on overdoses occurring on-site, they tend not to be used exclusively by participants for all injections, have low total attendance, and there are uncertainties regarding population-level effects on overdose rates (Caulkins et al., 2019).
These critiques explore the ideological and evidential challenges facing harm reduction. Despite strong evidence for certain interventions, ideological resistance and context-specific considerations complicate harm reduction’s implementation and political acceptance in Sweden. It can be difficult to make political decisions regarding which interventions should be developed, how, and on what scale. Interventions are not always directly translatable from one setting to another and must respond to local needs. Additionally, there is a persistent question regarding what interventions should be prioritized in a context of limited resources. All of these limitations have influenced the development of harm reduction in practice, the practical experience of which will be outlined in the following section. How these limitations are then experienced by PWUD themselves, the environment they give rise to, and how they may even influence provider attitudes, is yet not known in this context.

**Drug policy and harm reduction in the Swedish context**

Looking at a national or regional situation can give interesting insights into how the elements of drug policy work and are utilized in practice. Sweden is known, and presents itself, as a progressive, rational society, upholding human rights (Carlson-Rainer, 2017; Simons & Manoilo, 2019; Swedish Institute, 2023). However, this image contrasts with its drug policy trajectory. In 2007, the UNODC praised Sweden’s low youth cannabis use as a sign of a successful drug policy (UNODC, 2007). By 2015, however, Sweden was criticized by the UN for human rights violations in relation to criminalization of drug use and insufficient harm reduction (The Local Sweden, 2015). What caused this drastic shift in opinion was not associated to any changes in Swedish drug policy during that time, as harm reduction actually expanded during this period, but likely rather to evolving perceptions towards harm reduction and drug policy goals.

Since the 1980’s, Sweden has had an official policy goal of achieving “a society free from drugs” (Prop. 1983/84:100; Skr. 2021/22:213). This goal and its associated policies are intended to communicate that using drugs is an unacceptable behaviour, with the aim of deterring initiation and use (Ministry of Health and Social Affairs, 2016; Tham, 2021). The policy centred around the idea that an acceptance of substance use will lead to widespread drug use in society (Tham, 2021). Substance use has been described by politicians and experts as a social contagion, a threat against the nation, the people, and the welfare state (Edman, 2013; Tham, 2021). It is also conceptualized as being “alien” or external,
to Swedish society and values (Bjerge, Houborg, et al., 2016; Tham, 2021). Personal drug use is criminalized in Sweden. A noteworthy feature of this is the legal power to compel urine drug testing on individuals suspected of having taken drugs, and the ability to charge them based on having illicit drugs “in their bodies.” The stated aim of this is to specifically allow for early detection and intervention for young people involved in drug use (Ministry of Health and Social Affairs, 2016). The country has historically focused on abstinence-based goals, and rehabilitation-oriented treatment (Johnson, 2007). The policy aim was also to simultaneously address the social conditions which give rise to substance use (Prop. 1983/84:100).

In many countries, harm reduction has been adopted, scaled up, and made an explicit pillar of drug policy, with an increasing focus on incorporating individuals’ perspectives and experiences on care which is directed at them (Bjerge, Brown, et al., 2016; Lago et al., 2017; Rance & Treloar, 2015). Sweden has been resistant to these changes, and the influence they may have. The document which steers Sweden’s approach to alcohol, drugs, doping, tobacco, and gambling (ANDTS) (Skr. 2021/22:213) cautions against the influence of foreign drug policies on Swedish attitudes towards drugs. Instead, the document advocates for “a line where restrictiveness fits within the frame of a public health-based policy” (own translation) (Skr. 2021/22:213, p. 75). Until the most recent version of the ANDTS, the words “harm reduction” have rarely made an appearance in this guiding document.

Sweden’s policy goals have limited the development and proliferation of harm reduction activities (Eriksson & Edman, 2017). Much of the opposition to the development of harm reduction has come from, among others, social work (Christensson & Ljungberg, 1991; Johnson, 2007; Tryggvesson, 2012). When various harm reduction interventions have been introduced, they have initially been encumbered with strict regulations, high entry barriers, and are justified with goals of rehabilitation or motivational work. In some cases, like OST, they have even had low thresholds to be expelled from the program. The goal of motivational work is still a requirement of NSP under the Syringe Exchange Act SFS (2006:323) which has been a point of contention, with some PWUD finding such requirements discouraging (Nordstedt, 2023). These sorts of rules and formats of Swedish harm reduction also may play an important role in why people choose to access care in another country such as Denmark, when that movement is an option. However, as stated in the introduction, the official policy line of zero-tolerance has been interpreted, weighted, and put into practice differently in different regions in Sweden. Two examples of this include NSP and OST.
The first NSP in Sweden opened in 1986 and 1987 in neighbouring cities in Skåne, Lund and Malmö. Karlsson et al. (2021) chart the history of Swedish NSP, where further development essentially stalled for two decades. NSP establishment was especially hindered by a municipal “veto” option (removed in 2017), compounded by the prevailing belief that such programs undermined the ultimate “drug free society” goal of Swedish drug policy (Eriksson & Edman, 2017; Tryggvesson, 2012). Even after 2017, there have still been delays to development of this service. Sweden’s second largest city, Gothenburg, did not open a location until late 2018. Västernorrland was the last region in Sweden to establish an NSP, inaugurating its first location in February 2024 – almost 40 years after the first location was established in Skåne. Figure 1 demonstrates the protracted development of NSP across Sweden’s regions over a 30-year period, followed by a more recent period of rapid development.

Even in the face of swift change, most regions only operate one location, meaning some individuals have to travel up to several hundred kilometers to gain access. Service users must identify themselves, regularly engage in testing for HIV and HCV, and are limited to business hours (or less) to access sterile injection equipment. There is an age limit of 18 (previously 20), and there are limits on total amounts of equipment distributed to each individual at a time. However, variations exist, where the Malmö NSP offers a pilot program where personal identification is not required to access the service for the first month, in order to promote trust and a therapeutic relationship for individuals who are reticent to engage.
Similarly, the rollout of OST programs has been uneven, with early programs facing resistance and strict controls that limited access for many, including regulating total programmatic capacity. The first OST programs in Sweden began in 1966 in Uppsala. This intervention faced significant resistance from various groups – including social workers – to more extensive development (Johnson, 2003). Programs were built with strict controls, documentation of an extended addiction history, previous attempts at abstinence-based forms of care, and suspension or expulsion upon evidence of concomitant drug use (Andersson et al., 2021). In the face of high overdose rates, the threat of HIV/AIDS, and, later, the introduction of buprenorphine as a treatment option, the program participant cap expanded steadily from the 1980s, while the strictest form of admission regulations began to relax in 2005 (Johnson, 2007). In the meantime, many PWUD died on waiting lists for treatment (Johnson, 2007). Since 2014, OST in Skåne has been reformed to allow for increasing client choice over care, to improve retention and patient empowerment (Andersson et al., 2021; Andersson & Johnson, 2020). Other regions have not made such reforms. Figure 2 displays the rate of OST registration by region in 2021. The stark disparities between the
top and bottom regions are due to the slow establishment of programs, different regional drug profiles, as well as system differences which promote or hinder access (SOU 2023:62). The number of those in treatment in Skåne, for example, may be inflated, where individuals from neighbouring regions may seek care there due to the more relaxed rules (SOU 2023:62). Additionally, attitudes of those working in health and social services may differ, something which is a focus of this project, leading to different referral patterns. Notably, Sweden has approximately half as many OST patients per 100,000 as compared to neighbours Denmark and Norway (Gedeon et al., 2019).

As demonstrated above, there are significant differences in availability of key forms of care and treatments, such as NSP and OST, in different regions of Sweden. These differences mean that there are highly unequal conditions for PWUD, for risk or for wellbeing and health, dependent on where in the country they are located. Sweden is a geographically large country with low population density, especially outside of major population centres, where care tends to be centralized. Thus, care disparities in drug-related treatment access also reflect...
broader inequities in healthcare access across Sweden. The National Board of Health and Welfare compiles and publishes open comparisons (öppna jämförelser) of availability of care interventions in a number of different domains – including addiction-related care, with the hopes of trying to provide a basis to address differences. These have identified the lack of harmonization of care across Sweden (Socialstyrelsen, 2023). A look into these open comparisons can give a picture into how widely care varies across municipalities and regions. For example, 62 out of 290 municipalities report offering Housing First (Socialstyrelsen, 2023). However, in reality it is unknown how many of these municipalities currently offer Housing First in practice, as well as on what scale. Swedish researchers such as Eriksson & Edman (2017) and Karlsson et al. (2021) have identified and critiqued the lagged harm reduction development in general, as well as unequal development across the country. Some projects have traced the processes by which these differences have come about (Karlsson et al., 2021), as well reporting as statistical data on the impacts on PWUD, such as above, rates of access. This project instead investigates the issue from the client perspective, exploring how these differences are navigated and experienced.

There are several other interesting features of Sweden’s approach to drug policy and harm reduction which make it stand out from neighbouring countries. The scope of criminalization has recently expanded – for example engaging in ordering of drugs and attempting to break personal drug use laws has now been criminalized (SFS 2023:258). The criminalization of drug use may potentially lead to people not calling emergency services during a suspected overdose event. In one study 40% of the sample expressed either concerns or total resistance to engaging emergency services in a hypothetical overdose event for concerns of stigma and legal interference (Soussan & Kjellgren, 2019). Criminalization has also been a major hinder for development of certain services such as SCS and drug testing, where those sorts of services would require a change to existing legal frameworks (SOU 2023:62). Another notable aspect of the Swedish system is that there is the possibility to compel PWUD to undergo involuntary treatment for up to six months, if they are judged to be at a major risk of harm to themselves or those around them (under SFS 1988:870). These “compulsory care” evaluations are driven by the social services. Although compulsory care is not unique to Sweden, it is relatively uncommon to compel care on the basis of social laws, rather than within the criminal or psychiatric systems (Israelsson et al., 2015).

Currently, Sweden could be characterized by an emphasis on demand-reduction, including prevention and deterrence strategies (Tham 2021, Johnson
Amidst ideological and political debates, there is tension regarding the country’s future direction in drug policy. Johnson (2021) suggests that Sweden could be developing towards a “dual track paradigm”, a term coined by Tammi (2007), with a restrictive drug control policy coupled with comprehensive care and harm reduction interventions. However, two recent public inquiries could lead to radical shifts in Sweden’s approach, if they are taken up into official policy. These are the Comorbidity Inquiry (Samsjuklighetsutredning) (SOU 2021:93) as well as the Drug Commission of Inquiry (Narkotikautredning) (SOU 2023:62). These commissions propose significant changes that could enhance care, reduce stigma, improve client influence over care, and lower access thresholds for programs like NSP, OST, and naloxone, and integrate harm reduction more explicitly into policy aims (SOU 2021:93; SOU 2023:62). The aim of ensuring proper “harm reduction” is central to the latter commission, suggesting a change of the overarching policy message from “a society free from drugs” to “a society with reduced harm from drugs.” The Drug Commission of Inquiry also recommended to implement new programs such as SCS and drug checking (SOU 2023:62). Importantly, they make the recommendation to review legal frameworks, especially those concerning the criminalization of drugs, however, they have been restricted in their ability to recommend any actual changes to the legal system. These restrictions were heavily critiqued as being on moralistic and ideological grounds (DN, 2022). The extent to which these recommendations will be adopted, given the constraints of existing legal frameworks, remains uncertain.

Beyond the policy and care sphere, public and private discourses of drug use often carry stigmatizing tones in Sweden (Ekendahl, 2012; Eriksson & Edman, 2017; Ministry of Health and Social Affairs, 2016). However, as von Fessem (1996) states, as cited in Tham (2021), “Public opinion doesn’t appear out of the blue. Opinions are shaped by history and previous experiences. And in the Swedish case, opinions are shaped through ‘opinion formation’ by the government institutions.” (p. 148). Swedish government documents report the low level of social acceptance of drug use as an important policy element to maintain low levels of use (Ministry of Health and Social Affairs, 2016). PWUD are mostly excluded from the media debate about drug policy – while other stakeholders “mould opinions” and set the agenda about them (Lerkkanen & Storbjörk, 2023). A recent example of the stigmatized position of PWUD in Sweden was the response to the “Swishlist” scandal, occurring in the small northern-Swedish municipality of Sundsvall. This was a list of individuals who had electronically transferred (“swished”) money to a drug dealer, made public
as part of a pretrial investigation. Individuals were publicly shamed and faced repercussions such as firing, despite that they were not charged with any crime nor was it confirmed that they had even sent money in a drug-related transaction. This situation is illustrative of the stigmatization faced by PWUD in Swedish society.

This project therefore seeks to explore the impact of this slow and uneven development of harm reduction, as well as how the associated narratives of criminalization and stigmatization, play out in the lives of Swedish PWUD. It will examine how these developments may play a role in compelling mobility, the risks PWUD encounter due to service gaps, tradeoffs which are made, and linkages to experiences of stigma and exclusion.

The role of the social services in addiction-related care in Sweden

It is also relevant to explain how addiction-related care is organized in Sweden, and what role social workers take within this framework. Under the Social Services Act (Socialtjänstlagen) (SFS 2001:453), social services bear the primary responsibility for care to individuals with addictions. Municipal social services manage non-medical addiction care (missbruksvård), including social supports (employment, housing, financial aid). Social services share the responsibility for care with regional healthcare services who handle the medical aspects of addiction care (beroendevård), such as detox, OST, and psychiatric comorbidities. The social services are collaborative partners in most harm reduction sites. Even at those primarily driven regionally, there may be social workers present. For example, regional requirements for OST in Skåne state that social workers should be employed at OST clinics (Socialstyrelsen, 2020).

With regards to non-medical addiction care, the social services (with the client) determine eligibility, treatment goals, and settings for care (in- or out-patient) (Ekendahl, 2011). In the Social Services Act (SFS 2001:453) it is stated that social workers should work to give the person the support they need to recover from addiction (“komma ifrån missbruk”). However, there is a level of discretion afforded. It has been seen by von Reis & Wendel (2022) that social workers can interpret these guidelines differently or weigh different aspects of various guidelines in relation to each other. In the context of the key role that social workers play in addressing addiction, as well as the discretion afforded to them, it is important to examine social workers’ attitudes, as their perspectives can significantly influence the care options available to clients. An overview of the literature on the impact of provider attitudes towards PWUD and various care interventions will come in a later section.
Drug policy and harm reduction in the Danish context

Denmark’s approach to substance use markedly diverges from Sweden’s. Houborg & Møller (2021) trace the development of Danish drug policy, with key divergences from the Swedish example occurring around the 1970s, where Danish lawmakers implemented a “dual” drug policy. This policy imposed stringent penalties on drug traffickers and distributors, while effectively exempting drug possession for personal use. These policy decisions were based on a belief that drug-related issues were emerging from “inside” Danish society, due to rapid social changes occurring, and that it was associated particularly with people from deprived social positions (Bjerge, Houborg, et al., 2016). Despite a trend toward more punitive measures in recent years, such as the reintroduction and increase of fines for drug possession in 2004 and 2007 respectively, these measures target recreational and experimental users to deter drug use (Houborg, 2010). However, fines are waived for people who have legitimate addictions issues and economic vulnerabilities, as opposed to recreational users – leading to a de facto decriminalization of personal use for this group. This difference is built on a view of drug use which distinguishes different groups of users – whereas individuals who are casual users consciously break the law, individuals with genuine addictions are unwilfully breaking the law and should not be punished as such (Houborg, 2010). The aim is to discourage drug experimentation and use among the broader population, while continuing to treat those who have addictions from a health and welfare perspective, and not one of criminal justice.

With this foundation, Danish harm reduction has taken a different route to development than Swedish, and with different outcomes for service formats and goals. Like in Sweden, there was initial controversy over the use of methadone, seen as an overly medicalized response to a problem believed to derive from social issues (Houborg, 2012). However, once implemented, Danish OST programs have expanded more rapidly and with lower barriers to access than their Swedish counterpart, shifting focus from abstinence to maintenance and harm reduction (Houborg 2012). Following the realization that many PWUD were unable or unwilling to pursue abstinence, Denmark adopted a “graduated” approach, aiming to improve general life conditions without requiring abstinence, which today would be seen to align with harm reduction (Houborg & Møller, 2021).

Harm reduction programs offered in Denmark include OST, NSP, SCS, HAT, and take home naloxone programs. NSPs were introduced in the same year as Sweden, but are more equally distributed throughout the country, with sterile
injection equipment available at pharmacies, drop-in centres, treatment organizations, and other such services. A local NGO (Brugernes Akademi) offers mail-order harm reduction equipment – sending packages of hundreds of needles, syringes, smoking equipment, sterile water, and more, across the country. This helps assist spatial inequalities in resource access, as well as for those who may be reticent to access in-person sites. In addition to being more numerous, these programs are also lower in threshold, not requiring identification or engagement with blood-borne virus testing.

In 2010, HAT programs were initiated for treatment refractory opioid users, now running five such programs nationally, two of which are within the greater Copenhagen area. HAT participants in Denmark are subject to strict controls, especially with regards to scheduling and appointment attendance. In fact, there are criticisms of these programs by service users in other settings as being overly restrictive and not user-friendly, leading programs which are not running at capacity, despite the provision of legal heroin (Ellefsen et al., 2023). In 2011, an unsanctioned, mobile SCS began operation, being run by local NGOs in Copenhagen.

In 2012, the first legal SCS was opened, of which there are now five in four municipalities. Citizens within the neighbourhood of Vesterbro, known for its prominent drug scene, supported the opening of an SCS in order to reduce public injection and discarding of injection equipment. There is ongoing consultation with local stakeholders such as residents, businesses, SCS workers and clients, in the neighbourhoods surrounding Danish SCSs to ensure continuing support of the local community (Bancroft & Houborg, 2020). There is also a “non-enforcement” zone surrounding these SCS, where police focus on safety rather than drug possession enforcement, embodying “harm reduction policing” principles, shown to improve relations between PWUD and police (Kammersgaard et al., 2024). The most recent available data, in 2017, over 8,000 clients utilized Danish SCS programs, totaling more than 400,000 drug consumption events in one year (EMCDDA, 2019).

Danish drug policy even includes provisions made for individuals of non-Danish citizenship, acknowledging the draw of its liberal drug policies, stating: “The group of foreigners account for approximately every fifth of all users. Copenhagen Municipality is aware that the drug consumption rooms in themselves attract foreign citizens to Vesterbro’s open street scene. However, as long as movement across the boarders is free and there are different social programs in the different countries, it is highly likely that marginalised
foreigners will walk the streets of Copenhagen and take advantage of the drug consumption rooms.” (Danish Health and Medicines Authority, 2014)

However the ultimate goal of the policy is to repatriate those who are not official Danish residents (Danish Health and Medicines Authority, 2014). Furthermore, accessing most care services without official resident status remains a challenge, with only a few low-threshold services like SCSs and limited overnight shelters available to non-residents.

Why look at these two countries?

The previous sections have detailed the distinct drug policy approaches in Sweden and Denmark, highlighting how these differences manifest in the availability and structure of harm reduction services. Table 1 outlines key harm reduction formats and indicators in both countries, to illuminate how the policy goals and developments described have influenced service availability and nuances within service formats.

The results of these different offerings and formats can be seen in practice in Houbourg et al.’s (2022) survey study of PWUD in Malmö, Sweden and Copenhagen, Denmark. The authors found similar access to resources such as access to food, clothing, social workers and outreach work, housing, and similar financial situations. However, PWUD in Copenhagen engaged in significantly less risky drug-taking behaviours, frequently utilizing SCS and shelters, contrasting with those in Malmö who often resorted to public spaces, like public toilets, parks, cellars, and stairwells for drug intake. Those in Malmö reported receiving more informal help from their social networks, whereas significantly more of those in Copenhagen reported feeling that a social worker or doctor was a support in their life. Also relevant was that those in Malmö reported having more concern about police, as well as overdose and other drug-related harms, than their counterparts in Copenhagen. Both cities in focus of the project have arguably the most liberal harm reduction landscape in their respective countries, however the Houborg et al. (2022) study, together with Table 1 and the section above, reflects the more liberal harm reduction landscape in Denmark and underscores the challenges still facing Swedish PWUD due to policy, service development, and policing approaches.
Table 1: Harm reduction landscape comparison, Sweden vs. Denmark

<table>
<thead>
<tr>
<th></th>
<th>Sweden (pop 10.42 mil)</th>
<th>Denmark (pop 5.86 mil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needle and syringe exchange (NSP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NSP identification requirement</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacy NSP</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Supervised consumption</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heroin-assisted treatment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Take home naloxone</td>
<td>Yes, with prescription</td>
<td>Yes, no restrictions</td>
</tr>
<tr>
<td>Low threshold shelters</td>
<td>Limited</td>
<td>Widely available</td>
</tr>
<tr>
<td>Total opioid substitution therapy (OST) clients*</td>
<td>7,500</td>
<td>7,500</td>
</tr>
<tr>
<td>OST clients per 100,000 **</td>
<td>72</td>
<td>127</td>
</tr>
<tr>
<td>Overdose deaths per 100,000 **</td>
<td>6.46</td>
<td>4.56</td>
</tr>
<tr>
<td>Criminalization of personal drug use</td>
<td>Yes</td>
<td>Yes, with possible exemptions for those with addictions</td>
</tr>
</tbody>
</table>

* – data from (Gedeon et al., 2019; SOU, 2023:62)  
**– data from (Wiese Simonsen et al., 2020)

These policy dissimilarities, coupled with their geographic proximity and ease of travel (including a 30-minute train linking Malmö, Sweden and Copenhagen, Denmark), and similar languages, facilitate mobility between the two settings. In fact there are reports that 10% or more of the clients of Copenhagen’s main SCS are of Swedish origin (Sandin, 2014). Previous research in the Swedish/Danish setting has highlighting cross-border movement for better access to services like methadone and a less stigmatizing environment (Sjölander & Svensson, 2008). This mobility constitutes not only movement to a new physical setting, but also a new environment for drug use. This setting presents a unique opportunity and lens through which to explore the lived experiences of PWUD across divergent policy landscapes.

**Service provider attitudes and care experiences**

The goals of drug policy extend beyond merely care formats and physical access for clients; they are also delivered or mediated by the people who carry out care – professionals such as doctors, nurses, and social workers. Stated by Boyle et al., (2011) as cited in Pillay et al. (2014), “Clinician attitudes can be influenced by the organizational philosophies, values, and norms of the program they work for,” (p. 377). Negative perceptions towards PWUD and harm reduction may
stem from insufficient knowledge, outdated education, or organizational values (Brown, 2022; Javadi et al., 2022). A review by Brown (2022) found that education on OST, exposure to OST in clinical settings, and a clinical treatment orientation were the most important factors enhancing willingness to provide OST. A variety of studies have demonstrated that, for instance, lower knowledge about the evidence of methadone as a treatment option is correlated to stronger support for abstinence-oriented policies (Aletraris et al., 2016; Gerlach & Caplehorn, 1999; Russell et al., 2011). Similarly, Javadi et al. (2022) found that substance use professionals who reported prioritizing abstinence, and who reported lack of knowledge of certain interventions, were less supportive of harm reduction measures such as NSP, OST, and overdose prevention sites. Many of these findings underscore how exposure and knowledge influence care provision. Many studies tend to focus on single settings, or alternatively do not analyze attitudes based on, or place them into, their distinctive local policy contexts. Therefore, it is not known how nuances in policy landscapes, such as are present in Sweden, may lead to different formation of attitudes towards goals of care, which may ultimately unfold in care interactions.

Research has also demonstrated that professional attitudes are often driven by politics and personal morals (Hoffmann et al., 2000; Johnson et al., 2015; Murphy & Russell, 2021). For example, political orientation has been identified as a significant determinant of medical students’ policy preferences, more so than their level of education or beliefs about treatment efficacy, with conservative students favoring stricter user sanctions and liberals supporting harm reduction measures (Hoffmann et al., 2000). A vignette study of health care professionals found that positive depictions can play a role in decreasing stigma towards and increasing desire to work with PWUD, indicating susceptibility to societal messaging (Kennedy-Hendricks et al., 2022). It could be inferred that a context of criminalization, stigmatization, and a zero-tolerance policy is likely to lead to a larger proportion of providers who harbour subconscious or even overt negative views about PWUD and non-abstinence treatment goals. Importantly, stigmatized views by providers has been shown to influence both the atmosphere of interaction, as well as potential treatment recommendations or outcomes (Brown, 2022; Javadi et al., 2022; Van Boekel et al., 2013).

Despite their crucial role in addressing substance use issues, the research on Swedish social work professionals’ (SWP) perspectives in relation to overarching drug policy and treatment objectives is limited. Von Reis & Wendel (2022) interviewed a small subset of Swedish SWP and found mixed views to the country’s zero-tolerance policy. They noted efforts to adapt policy to better meet
client needs, however some showed ambivalence towards harm reduction strategies like OST, viewing them as substituting one illicit substance with another. This indicates a fundamental misunderstanding of OST as well as a stigmatizing attitude towards this intervention – something seen as an additional realm of stigma (intervention stigma), as well as a barrier to care in other studies (Andraka-Christou et al., 2022; Richard et al., 2020).

Richert et al (2023) reported positive views among SWP in Malmö, but noted that requirements such as motivational work could create a barrier in relationship development and deter potential clients from accessing care. Notably, those SWP in the Richert et al. (2023) study reported advocating and pushing for new harm reduction interventions locally, showing also that their attitudes may influence service design and availability. Considering their workplace in Malmö within broader Swedish context outlined in a preceding section, it also prompts speculation as to whether similar initiatives for enhanced harm reduction are underway elsewhere. These qualitative studies establish the influence of Swedish policy messages and institutional framework requirements, on how they hinder or promote certain forms of care, as well as potential for local nuances which may determine what is accessible for clients, leading to inequities in individuals’ access to care. There is a need for quantitative studies to explore the connection between attitudes and local policy conditions, which could provide a complement to these qualitative findings, as well as enable a larger number and possibly a broader spectrum of respondents.

The research covered in this section has demonstrated that policy can be influential over professional attitudes – through influencing moral judgements, educational curricula, care formats, and organizational norms. Ultimately, these attitudes influence clientele (Neale, Sheard, et al., 2007; Neale, Tompkins, et al., 2007; Paquette et al., 2018; Van Boekel et al., 2013). Constructive provider-client relationships are crucial for encouraging care engagement and must be free from discrimination to avoid negative self-conception and reduced care-seeking behaviour (Crapanzano et al., 2018; Neale, Sheard, et al., 2007; Ostertag et al., 2006; Paquette et al., 2018). Provider stigma can adversely affect health outcomes, patient empowerment, and the therapeutic relationship (van Boekel et al., 2013), making the role of care providers, such as SWP in Sweden, particularly important to study. As there are differing local conditions within Sweden, the current project will contribute to an understanding of how the development of the drug policy approach, nationally, as well as local interpretations and resulting service landscapes could be related to nuances in attitudes towards the philosophies and goals of care. This project will also, in a different setting,
explore how these attitudes and interactions may contribute to shaping PWUDs’ experiences. As will be explored in the current project, and will be described in detail in the next section, differing policy and service landscapes may even lead to movement of service users (Deren et al., 2003; Schreiber, 2014; Tibi-Lévy et al., 2020).

**Geography, service access, and mobility**

Finally, a central aspect of the project focuses on differing geographical service landscapes, as well as people’s mobility in response to differing contexts, including drug policy and treatment landscapes.

**Geographic barriers to care, and strategies to address them**

There exists extensive global literature exploring healthcare access, geography, and their impact on individual and population health outcomes (Glinos & Baeten, 2006; Schærström et al., 2011). Much of the research in health geography may involve assessing area characteristics or physical distance and their influence on care access and health outcomes (Schærström et al., 2011). Similar research has been conducted in relation to drug-specific services, where there have been studies demonstrating that geographic distance or rurality is a barrier to accessing harm reduction services in Atlantic Canada, and rural/Northern British Columbia, Canada (Harvard et al., 2008; Mema et al., 2019; Milloy et al., 2010; Parker et al., 2012; Spittal et al., 2007). Travelling distance and/or commuting time, known as “distance decay” significantly limits service accessibility (Gibson et al., 2014). Mapping PWUD’s willingness to travel, several studies have demonstrated a direct relationship between geographic proximity and harm reduction service utilization (Allen et al., 2015; Parker et al., 2012). Service inaccessibility is associated with higher levels of risk-taking behaviours (Milloy et al., 2010; Spittal et al., 2007), and associated negative health outcomes (Spittal et al., 2007), underscoring the importance of equitable distribution of harm reduction services – even in less populated areas.

Policy formats, zoning restrictions, and “not in my backyard” (NIMBY) attitudes have limited the proliferation of services into a greater diversity of settings (Bernstein & Bennett, 2013), perpetuating the burden on individuals who are located further from services. Strategies to address unequal resource distribution include mobile, mail, and pharmacy-based services (Gibson et al., 2014; Peterson et al., 2007; Torres-Leguizamon et al., 2020), all of which have been found to be particularly suited to marginalized populations such as PWUD.
Physical distance is not the sole barrier to accessing services; socioeconomic factors also impede care access, as lower-income individuals face travel expenses and income loss when seeking care (Caldwell, 2015). Thus, other formats, as above, can help address spatial access issues, without placing the resource burden on the individual. Limitations of mobile clinics are that they are generally not standalone and thus require additional linkages to fixed clinical settings (Yu et al., 2017). There also can be issues of privacy, and concerns with the care continuum and follow ups with marginalized patients (Yu et al., 2017). Mail resources are limited to providing items like injection equipment and cannot offer other care. Pharmacy services encounter challenges due to stigmatization from pharmacists and other customers (Lawrie et al., 2003; Peterson et al., 2007).

**Mobility patterns among PWUD**

In response to lack of equitable service provision, research has found that populations reliant on specific services may relocate to cluster around these services. This was particularly evident as mental health and homelessness services shifted to community-based (rather than institutionalized) services (Culhane, 2010; Somers et al., 2016). PWUD have been noted to be a particularly mobile population – which relates to both international, domestic (regional), or more local, intra-city mobility (Deren et al., 2003; Hayashi et al., 2019; Rachlis et al., 2008; Schreiber et al., 2018; Sjölander & Svensson, 2008; Tibi-Lévy et al., 2020). Understanding the motives and impact of traveling for service access is crucial, especially regarding changes in exposure to risk.

A variety of push and pull factors drive PWUD movement. Ideas of geography and place are about physical space, but also context. Some studies have found the pull of different drug policy environments or service availability, such as diverse treatment options or avoidance of punitive policing practices (Deren et al., 2007; Hayashi et al., 2019; Perez Torruella, 2010; Sjölander & Svensson, 2008; Tibi-Lévy et al., 2020). Research participants have cited reasons such as escaping repressive drug policies (Tibi-Lévy et al., 2020), seeking care related to drug use (Perez Torruella, 2010; Tibi-Lévy et al., 2020), or fleeing adverse situations such as punitive policing (Fast et al., 2010). In the Swedish context, reports have shown Swedish PWUDs’ movement within the country as well as to Denmark, in part in search of service access (Alanko Blomé et al., 2017; Sjölander & Svensson, 2008; SOU, 2023:62). As previously noted, OST in Skåne has drawn people from other regions (SOU, 2023:62). As noted, there has even been a report mapping the presence of Swedish people experiencing homelessness in Copenhagen, which in part focused on movement relating to drug and treatment
access in Sweden and Denmark (Sjölander & Svensson, 2008). Given the extensive changes in the drug policy landscape on both sides of the border since this study was undertaken, this phenomenon merits a renewed and expanded investigation. Limited other studies have explored in detail how movement relates to reflections on aspects such as stigma and social inclusion (Perez Torruella, 2010), nor how this may link to identity. Identity can be understood as a reciprocal social process relating to individuals’ conceptions of their selves, as reflexively informed by social categories and contexts (Lawler, 2014). This study makes a primary focus of the meaning and effects of this movement in the context of the drug policy systems.

Migration’s impact on risk varies based on individual circumstances, and new settings offering both risks and opportunities. PWUDs’ movement has often been related to entering or leaving drug scenes and accessing different drug markets (Deren et al., 2007; Hayashi et al., 2019; Wagner et al., 2012). Moving into a drug scene has been associated with risks such as “entrenchment” i.e. becoming inexorably involved in the day-to-day process of existence in the context of drug use and homelessness, and increased drug-related harms such as infectious disease transmission (Deren et al., 2007; Fast et al., 2010; Paschane & Fisher, 2000; Rachlis et al., 2010; Schreiber et al., 2018; Wagner et al., 2012). Rachlis et al. (2008) found that migration out of urban areas was associated with a lowering of overall drug use and risk behaviours, likely in part due to reduced access to illicit drugs. Conversely, Schreiber et al. (2018) noted that despite that moving away from a drug scene was an important migratory factor for individuals in their study, migration in general was associated with an increase in risks, such as lack of harm reduction access and unstable housing. Migration among PWUD is often associated with various marginalized social positions, including Indigenous ancestry (Hayashi et al., 2019; Schreiber et al., 2018), engagement in sex work (Schreiber et al., 2018), unstable housing (Rachlis et al., 2008), loss of access to resources (Schreiber et al., 2018), and HCV positivity (Ti et al., 2019). This could indicate that those who move are particularly vulnerable to risk. While migration can disrupt social networks and care access (Paschane & Fisher, 2000; Tibi-Lévy et al., 2020), it can also lead to reconnection with family and social ties, or returning “home” (Schreiber et al., 2018). It may also lead to increased access to concentrated drug-related services (Hayashi et al., 2019; Schreiber et al., 2018). There are therefore many distinct situations which may produce or reduce risks for any one person moving between settings.

In this project, geography relates not only to the physical such as distance, but to contextual differences. Schærström et al. (2011) discuss the intangible aspects
of areas where people achieve better health, emphasizing positive sentiment and a sense of belonging. However, the authors caution, to live somewhere does not automatically mean one is included – which ties back to the subject of this study. Some places may be associated with negative experiences. Addressing this requires us, “to listen to the individual about how they practically experience a place and being included, which places give them the best support,” (Schærström et al. 2011, p. 73). This aspect is central to this study, to offer insights into people’s own perspectives on different systems. Particularly in light of the associated risks, it is valuable to understanding decision-making processes and the factors people prioritize, including the potential trade-offs they are willing to make. This study addresses another gap by focusing on a distinct aspect: many studies examining international mobility centre on settings characterized by significant structural and/or cultural disparities—such as those explored by Tibi-Lévy et al. (2020) of moving from post-USSR states to France, and by Wagner et al. (2012) of border crossings between the USA and Mexico. In these cases, there are a multiplicity of additional factors which influence risk and wellbeing. Alternatively, studies of domestic movement do not imply the same level of potential dislocation from the care system, nor the degree of difference in drug policies. The settings of Articles III and IV of the current study provides a unique perspective on settings which share many similarities, as previously described, as well as being situated within the EU which entails some levels of support, albeit diverging drug policies. Therefore, such a study has the potential to say something distinctive about PWUDs’ own preferences for drug-related policy and care, which can help in informing policy decisions.
This chapter examines the theoretical perspectives underpinning this project, their application to the project overall, as well as how they are used in the individual articles. The literature of the previous chapter demonstrated, the politicized nature of the drug policy arena, various approaches to drug use and how they shape service development, care inequities, the influence of attitudes on care experiences, and the phenomenon of PWUD mobility. In this chapter I will introduce the theoretical tools used for analyzing and interpreting my findings. These include theories on the social construction of social problems, deviance, stigma, identity, and the “risk environment” framework. These theories can help articulate the diverse perceptions and treatments of substance use issues across different contexts. I relate these varying constructions to their practical implications for PWUD, as well as attitudes of SWP towards care philosophies and offerings.

Social construction of social problems

This thesis adopts a social constructionist lens, which frames my choice of, as well as approach to, the subsequent theoretical concepts. Therefore, I will give a brief overview of social construction, and how it relates to the framing of social problems, before getting into the more direct theoretical approaches used in the thesis and its associated articles. Social constructionism is the belief that our knowledge and understandings of the world, as well as our experiences within it, are created through social processes (Berger & Luckmann, 1991; Hacking, 1999). This is a collective process in which we participate, which in turn produces our reality through a reinforcing process of internalization and institutionalization (Berger & Luckmann, 1991; Hacking, 1999). Based on history, as well as values, knowledge production, norms, and beliefs, these social processes create
categories, certain “kinds” of people, which ultimately shape policies and, “material interactions with things and other people,” (Hacking, 1999, p. 31). These may become reified in a cyclical process (Hacking, 1999). People existing in a category may be treated, and view themselves, as that “kind” of person (Hacking, 1999). This process can be seen in drug policy, in that policy responses such as criminalization has significant consequences for individuals categorized as “drug users.” Policies may compel them to use in unhygienic conditions, limit their access to health and social care, as well as can impact their interactions with those around them and their self-perception. Hacking (1999) views this perspective as crucial in questioning the status quo and understanding the subjective nature of our interpretation of problems, but the tangible impacts that these subjective understandings have on people’s lives.

The development of “social problems” illustrates the case of social construction. Loseke (1999) argues that there are innumerable conditions which could be viewed to be problematic, but conditions only become “social problems” when constructed, proposed, defined, and accepted as such, which is reliant on subjective perception. Social problems are conditions viewed to be troublesome, that affect a large number of people, which need to be changed, and which we think can be changed (Loseke, 1999). The labeling of a condition as a social problem not only shapes our perceptions of the proper ways to address it but also exerts significant influence on the lives of those affected by this condition. Loseke (1999) does not deny the fact that a problem may exist, with real and negative impacts on the lives of those affected. Instead, the author argues that the framing of a problem determines the response it receives and thereby affects those it concerns. Loseke (1999) emphasizes the “diagnostic frame”—the interpretation of the problem’s nature and causes— which influences the “prognostic frame” or the solutions which are viewed to be appropriate to address it. This framing process shapes our comprehension of the issue and dictates how the public and policymakers respond to the problem and those people associated with it.

For example, substance use was seen as an individual and medical problem in Sweden until the 1960s (Edman & Olsson, 2014). The reframing of illicit drug use as a “social problem” (and specifically one coupled to “deviance”, a term which will be defined below), led to the mobilization of a specific type of response. The development of a condition as a “social problem” can also be seen as an expression of power (Becker, 1963; Loseke, 1999). Often, it was when drug use was associated with already stigmatized groups, that certain drugs became a social problem, which then reinforced stigmatization (Edman & Olsson, 2014).
It is widely accepted and evidenced by the vastly ranging approaches to substance use issues that these are socially constructed problems (Dingelstad et al., 1996; Matza & Morgan, 2017). Matza & Morgan (2017) compare the inconsistent approach to alcohol as compared to other psychoactive drugs. Alcohol policy distinguishes between casual and problematic drinking, attributing this to beliefs about individual capacity to manage intake, which is not seen in relation to other substances (Matza & Morgan, 2017). In alcohol policy, sanctions tend to relate to the consequences of alcohol consumption – such as drunk driving accidents – rather than the act of consumption itself. Conversely, in many countries, including Sweden, it is merely the possession or consumption of any “illicit drug” which is the problem, and is penalized, regardless of any specific consequences. A study by Nutt et al. (2007), attempted to provide insight into this by conducting a “neutral” assessment of various drugs. Two expert panels rated and classified substances based on a number of categories relating to harms to both the individual and society. One was a panel of psychiatrists with addiction specialties, the other a panel encompassing experts in a range of disciplines including pharmacology, forensic science, and epidemiology. The study found that some substances currently classed as illicit, such as MDMA and LSD, were found to have lower levels of societal and individual harms than alcohol. This challenges the criminalization of drug use and illuminates the cultural and historical factors influencing drug policy.

It can be argued that it is in fact the construction of some substances as a criminal social problem which exacerbates harms. Criminalization compels illicit production and thus inconsistent and unregulated ingredients (Maghsoudi et al., 2022; Reuter & Caulkins, 2004), violence over the control of unregulated drug markets (Werb et al., 2011), reluctance to seek emergency services (Soussan & Kjellgren, 2019), and delay in presentation to care (Biancarelli et al., 2019). Criminalization has also hindered or even prevented the development of harm reduction interventions, where in many cases legal frameworks must be changed to accommodate such interventions (Chatterjee et al., 2023; Kerr et al., 2017). The next section will discuss the literature on how PWUD are constructed and labelled. It will also explore how these constructions impact their experiences and the perceived acceptable responses from the care sector.

Deviance, stigmatized identity, and substance use

The construction of deviance, stigma, and identity demonstrates how societal norms dictate what is considered deviant behaviour. That substance use is defined as deviant is a specific construction which implies a particular experience and
response (Becker, 1963). Becker (1963) classically described that deviance emerges not inherently from an action or individual themselves, but from social reactions and imposed penalties. This process is proposed to play a role in social control, in creating “in” and “out” groups (and thus group solidarity) and signaling “unacceptable” behaviours in a society (Link & Phelan, 2001). This process can result in both formal and informal exclusion from society. This is, in part, meant to limit the spread of such behaviours like drug use, viewed to have negative societal consequences (McKeganey, 2011). Certain traits or assumptions are then associated with this category, known as stereotyping (Link & Phelan, 2001).

Ascription of deviance may be “applied” in practice in the form of stigma and discrimination. The definition of stigma was provided in a previous section, where I also outlined some of the health and wellbeing impacts of this experience. This section instead discusses the processes by which this occurs. Pryor & Reeder (2011) suggest the following four domains of stigma: “public stigma” such as discriminatory interactions, “self-stigma” the internalization of negative narratives and stereotypes leading to negative psychosocial wellbeing impacts, “associational stigma” relating to the negative reactions to being associated with a stigmatized person, and “structural stigma” how stigma is both made legitimate and further perpetuated through its institutionalization and integration into public ideology. This project investigates both interpersonal (public and self-stigma) as well as structural levels of stigma. It is worthwhile to note that the levels and degree of stigma faced are variable, based on a number of different factors. These include for example, the visibility, the severity, and/or the dangerousness of the issue, as well as one’s perceived responsibility for one’s own circumstances (Bos et al., 2013).

Stigma leads to what Goffman (1963) called a “spoiled” identity2, one’s identity and self being “discredited” due to association with a stigmatized status. The concept of identity can be approached from many different theoretical and disciplinary angles. There are a number of useful definitions found in the literature, for example, Lawler (2014) describes identity not as an individual but instead as a collective and social process, but also that the internalization of this process (how one begins to identify with the collectively-created identity) has an impact on the self. Similarly, Katovich (1986) as cited in Anderson & Mott (1998) describes identity as how “individuals construct and re-construct their realities and pattern their behavior within the larger societal background.” (p. 300). These

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2 A term critiqued by Neale et al. (2011) as being dated and stigmatizing in itself
definitions highlight the fluidity and context-bound nature of identity. The term identity therefore reflects the interplay between how people see themselves and how others respond to them—in relation to specific features of the world around them. The concept of identity and how it relates to constructions of drug use are elements of Articles II and IV.

Framing of drugs as criminal, dangerous, and deviant then carries on to the people who use them, and vice versa. In a society in which drug use is highly criminalized, PWUD then become labeled themselves, as criminals, deviants, and a danger to society (Becker, 1963; Scher et al., 2023). And, as stated, this process can also occur in reverse, in that drugs become deviant in their association with certain groups (Edman & Olsson, 2014), then leading to a reinforcing cycle. There is a wealth of research describing the fluidity of these categories and how people associated with various deviant behaviours “manage” that experience and their resulting stigmatized identities—trying to resist, re-categorize, differentiate themselves, or advocate for that identity (Brookfield et al., 2019; Erickson, 2022; Rødner, 2005). Some authors discuss the ascription and acceptance of a deviant identity as a key aspect in a persistence or subsistence of substance use (Anderson, 1998; Anderson & Mott, 1998; Brookfield et al., 2019; Gueta & Chen, 2021; Plumridge & Chetwynd, 1999).

In addition to interpersonal aspects, this thesis also explores how institutional structures produce and reproduce “problems” as they are so-defined. The notion of construction of social problems is the theoretical underpinning which informs my interpretation of the results of Article I. This standpoint can provide an understanding of the mechanisms behind differing of service provider attitudes. Governments have the ultimate power to design and organize the provision of services and resources to deal with certain issues. They set agendas and goals—dependent on the diagnostic and prognostic frames—what “type” of problem something is, and what solutions are therefore appropriate to deal with it. Criminalization of drug use allows the care system to be imbued with control over the lives of PWUD (Loseke, 1999). Thus, social constructions are extremely salient to care providers such as social work professionals, as they become ingrained in the “doxa” (Bourdieu, 1977) of the field. The “doxa” are the uncritically accepted norms guiding professional practices. Blomqvist (2004) discusses how the messaging of drug use in Sweden has created a “doxic field.” The relationship between the provider and the client can reinforce inequality, through the ongoing labelling of the client as having a certain deviant or discredited identity. The construction of deviance provides an explanation to
understand the relationship between agenda setting, institutionalized goals, and how this may feed back into providers’ attitudes about care options.

Differing forms and shapes of criminalization of drug use, such as exist between Sweden and Denmark, may lead to a different level of ascription of a “deviant” or criminalized, lesser identity for participants. Anderson, (1998) specifies that “the salience or degree of stigma attached to each [marginalizing experiences, traits, or statuses one has] also matters” and acknowledging that “this also varies geographically” (p. 244). This highlights the importance of local context in the dynamic experience of shaping identities and interactions with care services and law enforcement. I explore the variations in local care services, which I see as distinct “local” policy environments, with their own institutional agendas. I am therefore applying the concepts of construction of social problems, and its linkage to deviance and stigma, to provide a theoretical background for the local differences in opinions about treatments like harm reduction (discussed in Article I), as well as variations in experiences of care interactions themselves (explored in Articles III and IV).

The focus on social construction is also valuable when examining the potential for “de-stigmatization.” Lavin & Barnes (2020) describe how recent decades have seen major shifts of which groups are defined as deviant in some places – what they define as a “de-stigmatization movement.” This project draws attention to changing societal norms and their impact on the framing of deviance, suggesting avenues for improving conditions through a critical examination of social constructions.

Despite that stigma is recognized as resulting from social processes (Goffman, 1963; Link & Phelan, 2001), and as having severe consequences for those being stigmatised (Kulesza et al., 2017; Latkin et al., 2010), institutional structures continue to reproduce stigmatising narratives of certain groups. The strength or value of the theoretical perspectives described in this chapter is that they provide a basis for why people have different experiences in different places, and this project then investigates what impact this has on them. This project focuses on the experiences, how these framings shape many aspects of the individuals’ environment – from mobility, legal interactions, care, service formats, interpersonal interactions, stigma, even views of self. The following section, on the “risk environment” integrates many of the concepts utilized in this section, but also provides a framework with other important factors to examine risk and wellbeing for PWUD.
Risk Environment

Schærström et al. (2011) link social constructions to geography, illustrating how spatial processes, reflected in the localization of society’s institutions, can contribute to social exclusion. This project centres around the interplay between physical and social spaces, utilizing the “risk environment” framework. This is a form of social-ecological model, i.e. one which considers, “intrapersonal (e.g. knowledge, attitudes, behaviour), interpersonal/network (social networks, social support), community (e.g. relationships among organizations/ institutions), and public policy (e.g. local, state, national laws),” (Baral et al., 2013, p. 2). These dimensions are considered when analyzing and addressing individual risk behaviours. Rhodes (2002, 2009) defines the risk environment as, “the space—whether social or physical—in which a variety of factors interact to increase the chances of drug-related harm,” (p. 88). This perspective highlights the importance of considering the unique characteristics of physical spaces (such as drug scenes), but also the social and policy contexts, and how individual behaviour and decision making is shaped within these contexts. The risk environment is a theoretical concept which provides a practical framework to apply and understand risk for harm, or potential for wellbeing, for PWUD. To contextualize this within the previous section, it encompasses aspects of constructionism, but also promotes to look at risks, harms, and wellbeing, beyond solely the experience of socially constructed categories. In practice in this project, it provides a frame for understanding the results of Articles II and III.

The risk environment categorizes risk influences at two levels – macro (national or global-level systems and policies) and “micro” (interpersonal, individual, and local circumstances). These influences then span different types of environments (physical, social, economic, and policy). “Physical” denotes place and setting, such as a drug scene itself, certain neighbourhoods, or even trade routes. “Social” refers to norms, interpersonal interactions, and peer groups. “Policy” indicates laws and national or local guidelines. “Economic” relates to costs (for example cost of living, cost of healthcare access), resources, or financial circumstances (individual and national). Table 2 provides a visualization of the risk environment framework, with examples.

<table>
<thead>
<tr>
<th>Micro</th>
<th>Physical</th>
<th>Social</th>
<th>Economic</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The local drug scene</td>
<td>Interpersonal relationships</td>
<td>Individual unemployment</td>
<td>Local interpretations of guidelines</td>
<td></td>
</tr>
<tr>
<td>Macro</td>
<td>Transnational border regions</td>
<td>Societal stigma towards drug use</td>
<td>Welfare state provisions</td>
<td>National drug policy and care guidelines</td>
</tr>
</tbody>
</table>
The factors above can either mitigate or amplify risk, and they often intersect, creating complex dynamics. These could support each other, where a macro-level legal policy which allows for non-punitive focus of policing could be supported by the micro-level provision of low threshold services. Both of these levels together align for a reduced risk environment. Or, they could contradict each other, where a more punitive policing can interrupt this access to harm reduction services, undermining any local attempt to create an “enabling” environment and circumvent risk (Rhodes et al., 2003). An “enabling environment” (Duff, 2010) is one which supports the access to various enabling resources, to reduce harm and improve wellbeing. Social construction is one key element that influences the risk environment, through shaping policy development, social interactions, and access to services.

The value of the risk environment concept is its emphasis on the uniqueness of each individual, situation, and environment, and simultaneous differing elements which may reduce or produce risks or wellbeing. Another point of value is that the risk environment critiques “traditional” harm reduction which tends to focus on the individual and whether or not they access services. Instead, it looks at the other factors to understand how the individual’s choices are formed and influenced by the physical, social, economic, and political environment around them. Examples from existing literature highlight this framework’s value in practice. For instance, as was mentioned in a previous chapter, studies have demonstrated that urban habitation may influence levels of drug use due to better access (increased risk), but also have influence on levels of access to harm reduction supplies and services (reduced risk) (Rachlis et al., 2008). Or, services such as needle exchange have a concrete, immediately measurable impact on the context in which local persons use drugs. Additionally, impacts extending beyond immediate clients – due to the carry-on impact of education and clean equipment provision (Cooper et al., 2009). Furthermore, by modifying their local access to health and social services, such services are important in less concrete outcomes, because of impact on individual perception of marginalization, and impacts on belief in personal future and self-efficacy (Ezard, 2001). A cycle of exclusion from society can influence increased risk-taking behaviours, while the offering of a service such as a needle exchange can interrupt that cycle, by having a psychological impact on PWUD views of themselves, their opportunities, and life chances (Lee & Petersen, 2009; Macneil & Pauly, 2011; Nordstedt, 2023).

This approach extends to analyzing structures and circumstances beyond immediate substance use issues, such as cost of living, general access to the health care system, national economic circumstances, and gender equality. It is flexible,
allowing for practical applications in a number of different ways. Rhodes (2002, 2003) provides examples about how the economic transition in the post-USSR period led to increased risks, compounding with the lack of drug-related services in Russia. Nowotny et al., (2017) places the substance use trajectory and HIV risk of female sex workers within the political context of deportations, social context of gender roles, economic context of limited opportunities, all within the physical context of a politically contentious border region between the US and Mexico. Abadie & Dombrowski (2020) use the framework to link HCV transmission in Puerto Rico to its colonial status as an unincorporated territory of the US – with worse economic conditions but simultaneously being subject to US patent laws regarding HCV pharmaceuticals which limits treatment possibilities. This perspective is revealing, in shifting the blame and responsibility from the individual and highlighting the otherwise often obscured, “role of social and risk environments in shaping drug sharing arrangements,” (Abadie & Dombrowski, 2020, p. 8).

The risk environment framework has also been used to understand differences in risk outcomes in two settings within the same country (Platt et al., 2006), or neighbouring cities in different countries (Houborg et al., 2022; Lechuga et al., 2023). Or, for example, to understand why rates of harms are high, even in the context of developed harm reduction programs, offering insights into what additional service needs current formats are missing, due to changes in the drug market or policing practices (Bastani et al., 2019; Rhodes, 2002). It can also inform the adoption of new services, to understand what the existing risk environments are, and how they may best be mediated by implementation of an intervention (Shaw et al., 2015). The framework can also be used to investigate the experiences of certain populations, such as women (Mayock et al., 2015), or sex workers as above (Nowotny et al., 2017), or how different aspects of identity may converge to mediate or produce risk or wellbeing (Collins et al., 2019). The risk environment concept allows for the teasing out of the unique aspects of settings within their context to address and understand what shapes risks and wellbeing.

How the risk environment will be used in this project

The risk environment framework is specifically applied in Article II to frame the discussion, and in Article III to frame the results. The framework offers a lens to examine the interplay between social construction and environmental factors in Sweden and Denmark. This will enable a nuance discussion that extends beyond substance use, considering broader influences of risk and decision making, such
as social networks, bureaucracy, employment. The framework facilitates a
detailed examination of how different environments impact individuals’
experiences and risk profiles. As above, Rhodes emphasizes looking towards
factors like national economies, drug trade routes, social norms and stigma
towards drug use, gender (in)equality, and health system organization, which can
steer individual risk and risk management (Rhodes, 2002).

Interestingly, Sweden has been considered to have a generous welfare state
with many of the macroeconomic features which would be believed to support an
“enabling” environment, with regards to distribution of resources and achieving
the broader social determinants of health. Utilizing the risk environment in
Article II can in fact draw attention to the risk-engendering features relating
specifically to drug-related constructions and policy decisions, policing of
PWUD, and lack of services. The two settings of Article III also bring an
interesting dimension to the analysis considering that on the many of the macro
levels, Sweden and Denmark take similar approaches to many welfare provisions,
being classified as “social democratic” welfare states (Esping-Andersen, 1990;
Ferragina & Seeleib-Kaiser, 2011; Horn & Kersbergen, 2022). They both offer
universal health care coverage, strong income supports, free tertiary education,
and highly subsidized childcare coverage, benefits which tend to receive wide
popular support (Frederiksen, 2018; Horn & Kersbergen, 2022). Additionally,
they share a similar sociocultural context built on a highly intertwined history and
development, including similar norms regarding gender equality (European
Institute for Gender Equality, 2023), religion (Pew Research Center, 2018), and
egalitarianism (Frederiksen, 2018). While on other norms, such as relating to drug
policy and laws, they differ. This provides a unique setting when looking between
them to “neutralize” some of the similar macro elements and provides an
opportunity to in fact focus on the impact of drug-related policy and services.

This framework can allow for a focus on what separates the settings, including
those which may lay outside of the realm of social construction of drug problems
and deviance. It allows for a nuanced analysis – for individual settings, as well as
individual participants’ experiences, and promotes a complexity in the range of
environmental features considered. For example, moving to a new country
involves navigating bureaucratic and administrative processes for registration and
accessing services. Additionally, certain areas may present unique risks or
enabling elements such as an open drug scene (Fast et al., 2009; Rachlis et al.,
2008), like that seen in this study in Vesterbro, a neighbourhood in Copenhagen.
Utilizing this as a framework for analysis will be valuable in the current study, as
it prompts a multilevel and multidimensional assessment of the different benefits
and drawbacks of environmental, as well as personal, features. The framework will allow to look beyond the offering of harm reduction, but also differences with regards to social norms and stigma, policy choices, and formation of specific services. It is also advantageous as it provides a structure for analyzing, organizing, and systematizing findings.

One major critique of the risk environment framework is that it places too much emphasis the environment and not enough on individual agency. To address this, this study analysis will explore how environmental features shape individual agency, choices, and experiences.
METHODS

This chapter will give an overview of the general methodological choices of this thesis. The project as a whole is made up of four individual articles, and utilized multiple methods in order to capture several aspects of the phenomena I was investigating. The methodology for each individual article has been described in the respective manuscript and is listed in Table 3. This chapter instead accounts for overarching considerations. The first section will describe and discuss my methodological choices specifically for Article I. This article took a quantitative approach, utilizing data from a survey with social workers. This will be followed by sections on Articles II-IV, which were qualitative in approach. These articles’ data were derived from semi-structured interviews with PWUD.
Table 3. Overview of studies and data

<table>
<thead>
<tr>
<th>Sub-study</th>
<th>Data collection method</th>
<th>Scope of data material</th>
<th>Analysis method</th>
<th>Outcome measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Survey</td>
<td>208 social work professionals. Malmö (79), Gothenburg (82), Gävleborg (47) Collected: May – Aug 2020 (Malmö), April-November 2021 (others)</td>
<td>ANOVA with post-hoc analyses, ANCOVA, and pairwise chi-square comparisons</td>
<td>Differences in alignment with harm reduction philosophy and treatment goals, views of harm reduction initiatives, perceived care access for clients</td>
</tr>
<tr>
<td>II</td>
<td>Semi structured interviews</td>
<td>11 people who use drugs in an area with limited harm reduction services Collected: Jan-March 2021, Avg length 49 mins, range: 21-73 mins</td>
<td>Thematic analysis</td>
<td>Strategies to cope with low access to harm reduction</td>
</tr>
<tr>
<td>III</td>
<td>Semi structured interviews</td>
<td>17 people who use drugs with a history of travel from Sweden to Denmark Collected: Aug 2022-Jan 2023 Avg length 58 mins, range: 25-111 mins</td>
<td>Thematic analysis</td>
<td>Motivations and risks with travel and movement to Denmark</td>
</tr>
<tr>
<td>IV</td>
<td>Semi structured interviews</td>
<td>17 people who use drugs with a history of travel from Sweden to Denmark Collected: Aug 2022-Jan 2023 Avg length 58 mins, range: 25-111 mins</td>
<td>Thematic analysis</td>
<td>Reflections on identity, interactions, experiences in different policy systems</td>
</tr>
</tbody>
</table>

Methodological considerations for quantitative study – Article I

Article I utilized data deriving from a survey. The first wave of data collection was completed in Malmö from May to August 2020, prior to my involvement, as part of the project “Urban drug scenes as risk environments: how do police and social welfare institutions intervene and how are people who use drugs impacted?” (funded by Riksbankens Jubileumsfond, grant number P18-0892:1). The project was carried out by Torkel Richert, Johan Nordgren, and Anke Stallwitz. The aim of the project was to study everyday life, social marginalization, and risks for PWUD who spend time in Malmö’s open drug scenes, as well as responses of police and social welfare actors. A survey targeting social work professionals (SWP), developed by Torkel Richert and Johan
Nordgren, sought to understand SWP’s views on risk, vulnerability and intervention access for PWUD, and their attitudes towards harm reduction. I became involved with the project after the survey’s completion in Malmö, and utilized a subset of the data.

This paper was co-authored with my supervisor Torkel Richert, who conceived the idea. A second wave of data collection occurred in two additional sites: Gothenburg and Gävleborg. The study sites were chosen to compare with Malmö. The survey was adapted for local conditions, particularly changing verbiage to reflect that Gävleborg is a region, rather than a municipality. I performed the initial analyses, with Torkel Richert and my second supervisor Björn Johnson providing guidance and contributing to further analyses. I developed the initial draft of the manuscript, where they supported through ongoing input and revisions.

**Study settings**

The different settings are described in detail in the article, but will be explained briefly here. The settings were chosen due to their very different development histories of harm reduction, relative to the Swedish context, and are therefore categorized as “high” “medium” and “low” development. In exploring and subsequently comparing attitudes of SWP in these sites, we aimed to map and begin to explore a relationship between harm reduction development and provider attitudes.

**High development**

Malmö, Sweden’s third-largest city, is located in Skåne, a region as a whole which can be seen as largely taking a pioneering role in introducing and/or liberalizing harm reduction measures in Sweden, which has previously been described. At the time of the survey, Malmö itself operated the only housing in Sweden with a clear “low threshold” and harm reduction approach, allowing for on-site substance use.

**Medium development**

Gothenburg is Sweden’s second largest city, located in Västra Götaland. Gothenburg did not open their first NSP until late 2018. OST was introduced relatively late in Gothenburg, in the beginning of the 2000s. At the time of sampling for this study, there was an intake stop of OST patients due to limited system capacity (Lerjestedt Walka, 2022).
Low development

Gävleborg was one of the last regions in Sweden to implement NSP, where no NSP was offered here during the time of study, though one has now been implemented in the main city of Gävle (with remote/mobile operations in Hudiksvall one time per week). OST access is limited, and only available in two cities (Gävle, Söderhamn). Gävleborg was the region which had Sweden’s highest average rate of overdose-related death over the period 2017-2021.

Recruitment process and sample

Our sampling method was a hybrid of convenience and purposive approaches. Since a comprehensive database of SWP does not exist, we targeted those who were easily accessible, available, and willing to participate, typifying convenience sampling (Etikan, 2016). The approach also had characteristics of a purpose sample as we identified, “individuals or groups of individuals that are proficient and well-informed with a phenomenon of interest,” (Etikan, 2016, p. 2). We identified section unit managers (“enhetschef” in Swedish) who specifically work with substance use. We reached out to them via email, found on municipal websites, asking them to distribute the survey within their departments. This method relied on their judgment for further dissemination. We also leveraged contacts in local universities and social services to extend the survey’s reach. Notably, an average of 86% of respondents across settings reported working with individuals with heavy drug use, affirming the relevance of our sample. The inclusion criteria for the survey were that the respondent worked in social work, and self-defined as working with PWUD, specifying that the survey was aimed at those who, “in your work meet clients with substance abuse or addiction problems in [location] or who otherwise work with drug issues,” (own translation).

A notable limitation of our study is the lack of data on the response rate, as specific figures on the number of SWP in the substance use field are unavailable. However, informal estimates suggest a high engagement rate among targeted professionals in Malmö, with around 80% participation. A related issue is that the respondent groups differ in size. However, the population sizes of the three areas also differ – with Gothenburg’s population approximately double that of Gävleborg, the response rates were considered proportionate to each area’s characteristics. The lower, less urban population of Gävleborg, for instance, still could represent a comparable sample of SWP.
Variables and measures

This study sought to measure two major themes: attitudes to harm reduction and perceived access to care. The variables used to measure these will be described below.

Attitudes

We used two separate measures to assess attitudes towards harm reduction, made up in total of five variables, in order to measure both alignment with the treatment goals and philosophy of harm reduction, as well as attitudes towards specific interventions.

The first measure was a modified version of the Harm Reduction Acceptability Scale (HRAS). The modified scale is available in Appendix One. The HRAS utilizes a 5-point Likert scale, in which 1 is strongly agree, 3 is neutral, 5 is strongly disagree. A lower score indicates acceptance of harm reduction, where some items (indicated with an asterisk) are reverse scored. The scale was originally developed by Goddard (2003), and has been used to assess changes in attitudes following an education intervention for drug and alcohol treatment professionals in the US. A confirmatory factor analysis indicated a high Cronbach’s alpha (0.80) for the modified scale, indicating high internal consistency.

We then assessed the acceptability of three specific harm reduction measures which are not available in Sweden currently: supervised consumption sites, heroin-assisted treatment, and decriminalization of drugs for personal use. To measure acceptability, we utilized a 3-point Likert scale, where 1 indicated that the intervention “should absolutely be implemented”, 2 indicated “should maybe be implemented”, and 3 indicated “should not be implemented”. These three interventions were chosen as they have been implemented in other countries, but not yet in Sweden. In one setting (Gävleborg) we added an additional question, asking about NSP implementation, as NSP had not been implemented there at the time of the survey.

In measuring both alignment with philosophy and real interventions, we aimed to explore if there would be differences in support of harm reduction as a philosophy as compared to as a reality. This contributed to nuance the findings.

Perceived access for clients

We also sought to measure perceived access for clients to specific interventions. The aim of this was to make possible inferences for (in)equity of care accessibility
in different areas, which possible can reflect different traditions of care. It also served to confirm the breakdown of “low”, “middle”, and “high” access settings. This was measured by 19 different items which related to perceived availability of various services and harm reduction interventions for PWUD, available in Appendix One. Participants were able to respond through a 3-point Likert scale, where 1 indicated low access, 2 indicated medium access, and 3 indicated high access.

Analyses
There were several analyses performed as a part of this study. Firstly, the different settings’ participant characteristics were compared using pairwise comparisons, utilizing chi-square tests to assess for significance, with Malmö as the reference category.

To compare the HRAS score, we calculated a mean score for each participant, and then performed a one-way analysis of variance (ANOVA) with Bonferroni post-hoc correction to compare means between settings. This allowed us to examine if there were differences in score mean between settings, as well as to which setting the differences could be attributed. Particularly given the slightly different demographic makeup in each location, we performed an analysis of covariance (ANCOVA) to control for the influence of demographic factors, including age, education as a social worker, and official decision-making capacity. We then performed Pearson’s chi-square tests to examine the significance of the geographic setting with each of the individual HRAS questions. This allowed us to find individual questions which had significant differences in respondent attitudes. We also performed an ANOVA with Bonferroni post-hoc correction to assess the acceptability of new interventions.

For questions regarding perceived access for clients, again, a mean score was created, grouped based on location. Using this mean score, an ANOVA with Bonferroni post-hoc correction was performed to analyze differences.

Methodological considerations for qualitative studies – Articles II-IV

Study design
The aim of the second aspect of the project focused on PWUD experiences. Therefore, I decided on a qualitative approach to data collection for Articles II-IV. Qualitative research, “seeks to contribute to a better understanding of social
realities and to draw attention to processes, meaning patterns and structural features,” (Flick et al., 2004, p. 3). I utilized semi-structured interviews due to their flexibility, and adaptability to topics that my participants found important and focused on, rather than prescribe strictly what sorts of questions would have to be asked (Brinkmann & Kvale, 2018) The qualitative interview is a tool to understand not only what people have experienced, but also how they have perceived that experience (Brinkmann & Kvale, 2018). This is both a limitation and a benefit, as interviews rely on perceptions and recollections. Much of the project is about the impacts of experiences, which are subjective, finding the exact objective reality was not the aim of the project. I did, however try to, as much as is possible, confirm these experiences with support of other interviews, as well as knowledge of official policies (which may have guided the experiences).

In addition to the above reasoning for my choice of data collection, a larger impetus also guided me. Research can play an important part in improving the lives of individuals who are marginalized or vulnerable (Lahman, 2018). Qualitative methods can specifically be used to allow for the participants’ voices to be presented (Creswell & Poth, 2018). Often portrayed negatively in media and popular culture, PWUD are among the most highly marginalized persons in society, who benefit from groups such as researchers making an active effort to understand them and present their experiences. However, it is important to simultaneously recognize that, “the interview is an instrumental dialogue … A good conversation is no longer a goal in itself, but a means for providing the researcher with descriptions, narratives and texts, to interpret and report according to his or her research interests.” (Brinkmann & Kvale, 2018, p. 19). Therefore, while I aim to present my participant’s stories and experiences, I do not wish to understate my role in interpreting and presenting these perspectives.

**Ethics**

Ethical considerations were highly relevant to this project, from design to publication, especially given the sensitive nature of research involving PWUD. Under Swedish law (2003:460) on ethical review of research involving people, projects meeting certain criteria, such as involving sensitive personal information, information regarding criminal acts, and involving potential for psychological harm to participants, must obtain ethical approval through the Swedish Ethical Review Authority (*Etikprövningsmyndigheten*). This project, involving such sensitive elements, necessitated review and successfully received approval (Dnr 2019-06509). The application included a thorough description of
the project, an assessment of potential risks to participants, and strategies to mitigate harm to protect participants effectively. In this section I will explain my project in relation to the process of ethical conduct in research in general, as well as specific considerations when researching the population I was interested in engaging. Some of the ethical concerns are discussed here, while others may be also reflected on in the sections on positionality and interview conduct. This reflects the notion of “ethics-as-process” (Cutcliffe & Ramcharan, 2002) where ethical behaviour cannot be delimited to one specific section, but should involve all actions throughout the project.

When undertaking any scientific research, especially on vulnerable human participants, it is of the utmost importance to ensure that these persons are treated safely, compensated fairly, understand their participation, and that their participation is beneficial to them, and not harmful. Confidentiality is a fundamental ethical principle, as discussed by Shamoo & Resnik (2009). Measures to maintain confidentiality were rigorous, involving anonymizing names, locations, or any identifying personal details, in interviewing and transcribing. In addition to the basic measures normally taken to ensure confidentiality, even more substantial efforts were made during the data collection and reporting phases. I decided to obscure the name of the city (and region) of data collection for Article II, to further reduce the likelihood that someone may be able to find a specific individual in the data. Interview recordings were stored on two encrypted USB drives. In all interview cases, participants provided informed consent to participate in the study, and to have the interviews be audio recorded. I went through the information sheet with each participant, and highlighted the aims of the study to ensure they understood specifically to what they were consenting, as well as emphasized their rights as participants (e.g. to withdraw at any time, to not answer individual questions). I allowed them to keep the information sheet if they wished to, which had both mine and my supervisor’s (Torkel Richert) contact information on it in case of any concerns.

The study also considered various categories of potential participant vulnerabilities and the ethical considerations necessary to ensure their fair treatment. PWUD could be classified as a vulnerable group who are at risk of exploitation – categorized as having “allocational” vulnerability (Lahman, 2018). Compensation for research, discussed by Fry et al. (2006) may “equalize the power imbalance between investigators and drug user participants, and provide a simple way of ensuring direct benefits to this participant group and acknowledgement of their expertise and efforts.” (p. 31). Aligning with this, I
provided a gift card in compensation to participants (value of 200 SEK or 100 DKK depending on the setting) to a grocery store chain. However, especially where compensation is involved, this may give rise to questions regarding genuine willingness to participate, rather than participation being driven by compensation. In an attempt to address this, I provided gift cards upfront when interviewing in person, at the same time verbally reinforcing their right to discontinue participation at any time. This can be seen as an example of “ethics-as-process”.

Another practical example of “ethics-as-process” relates to ensuring that the interview experience itself is not harmful to participants, who in many cases are discussing sensitive and difficult topics. This was something I kept in mind when conducting interviews, trying to allow my participants to speak freely, being aware of my wording, tone, and body language. This meant having an open posture, such as keeping my arms uncrossed. It also meant maintaining a welcoming facial expression and non-judgmental verbal choices. I was expressly aware that I did not want to reproduce any stigmatizing interactions or responses which participants may have faced previously. My ability to maintain a safe atmosphere to the interviews was supported by my previous work experiences such as conducting clinical research with PWUD in Vancouver, Canada. Of course, this would also serve to improve the quality of the interviews, and thus the data that were produced (Brinkmann & Kvale, 2018). Some research has found that the ability to share their story in a nonjudgmental atmosphere, has the potential to have a positive impact on participants (Brinkmann & Kvale, 2018). The potential for exploitation or harm in research involving PWUD necessitates a careful balance of the importance of learning and understanding about their experiences for the purpose of the research study, while also ensuring that no mental distress or harm comes to participants. This reflects a broader ethical consideration in research, where the potential for participants to be viewed as “raw material for the extraction of surplus value” (Culhane 2011, p. 256), without meaningful long-term benefits, must be critically examined. It is imperative that researchers take particular account of our own motivations and actions, as well as the eventual outcomes, when undertaking research with this group (Shamoo & Resnik, 2009). While this was not something I particularly felt I encountered, I still feel it important to reflect on and always keep in mind in the interview setting.
Fieldwork
During the process of the project, I “entered” the field on two separate occasions, firstly online, and secondly, in person.

Article II:
Fieldwork for Article II was conducted online due to COVID-19. I was connected with “gatekeepers” at two local agencies serving PWUD, who assisted in setting up online and phone interviews. One agency provided overnight shelter and food, while the other provided drug treatment. The sampling locations were chosen based on their relevance to the project, established contacts, as well as gatekeepers’ willingness to support the project. Sample inclusion criteria for this sub study specified individuals over 18, engaged in “hard” drug use (such as heroin, amphetamines, and cocaine) or in drug treatment. Gatekeepers advertised the study on my behalf, and scheduled interviews at their office (online), or provided participants’ contact information (with their approval). Data collection ended due to operational pressures on gatekeepers. I conducted 11 interviews, averaging 49 minutes, with a range of 21–73 minutes. Participant demographics are detailed in the corresponding article.

A scoping review by Davies et al. (2020) discusses the potential benefits and challenges with conducting online data collection methods (including both interviews and focus groups). The authors highlight the difficulties, including rapport-building. This may relate to, for example, difficulties developing “virtual eye contact” (Salmons, 2014) and difficulty observing nonverbal cues (Ogden & Cornwell, 2010). The review of online data collection found that online formats might facilitate discussions on sensitive topics but could also yield shorter, more direct and “concrete” answers to questions (Davies et al., 2020). Aware of these issues, I aimed to counter them by asking more exploratory questions and being prepared with more follow up questions. I also intentionally employed larger, more overt verbal and nonverbal gestures, such as head nodding and verbal confirmation of comprehension (yes, mhmm, uh-huh, etc.), so that participants knew I was there (and not digitally “frozen”) and was following what they were saying. Overall, my experience with online interviews was largely without issues, with only one instance of technological disruption which was quickly rectified.

Articles III and IV
Recruitment and data collection for the final two articles were primarily in-person, with one interview over the phone. I undertook a mix of convenience
sampling and snowball sampling. Snowball recruitment was limited in its success due to difficulties making contact with those whose contact information I was given. I had the opportunity to shadow staff at a supervised consumption room and an overnight shelter in Copenhagen, as well to sit in the waiting room of a needle exchange in southern Sweden. In Copenhagen, the sites were established for having Swedish clients, and offering services not available in Sweden. There is no supervised consumption in Sweden, and the shelter was very low in threshold shelter for access – including providing sterile injection equipment on site. The shelter was one of the only shelters in Copenhagen that, within certain parameters, allows clients without a Danish social security number, therefore the clients tend to be nonofficial Danish residents. This allowed me to meet Swedish people who were perhaps more transiently in Denmark. The NSP in Sweden was chosen owing to established contacts there, as well as its relative proximity to Copenhagen.

In all cases, I was introduced to staff, and also to their clientele. This established my credibility within the organization. I displayed posters advertising my study. Given that all clients to these three organizations are required to register upon access, staff could promptly notify me when eligible participants arrived. This allowed me to approach potential participants. Alternatively, in some cases staff made introductions for me. I conducted 17 interviews for these two sub-studies. Interview durations averaged 58 minutes, ranging from 25 to 111 minutes. Sample inclusion criteria specified individuals over age 18, who had ongoing use of “hard” drugs such as heroin, amphetamines, and cocaine, or were in drug treatment, and had been in both Sweden and Denmark in the past five years. An exception was made for one individual who hadn’t traveled to Denmark for over a decade. Their inclusion offered valuable historical perspectives on drug policy changes, enriching the study’s contextual understanding. Demographic information regarding the participant group is available in the related articles.

Wolff (2004) discusses considerations and challenges in accessing “the field”. For example, highlighting the role of gatekeepers as both facilitators and barriers. My access to field sites was confined to specific, predefined times. For example, at the consumption site, this was mainly during the day, and rarely during evenings when the shifts were busier. In part, this related to security concerns, and to minimize disruption during busier evening shifts. To be allowed to attend a later shift required demonstrating my familiarity with the population and affirming that my presence would, “only disturb normal daily business in an acceptably limited way,” (Wolff, 2004, p. 200). Especially in the context of health and social care organizations with limited time and resources, I did not wish to
be an additional burden. I tried to be of assistance in small tasks such as making coffees. Simultaneously I wished to maintain a distance from being perceived as “part” of the organization hosting me, over concern this may bias results. Therefore, I did not engage in certain actions, in order to set myself apart. For example, as the door to the injection room at the SCS must be unlocked with a keyless fob for every client entry, I did not unlock this door for clients. Although the staff could give my presence credibility, it also may have limited some peoples’ interaction with me, depending on the potential participant’s own relationship with the organization (Wolff, 2004). I also emphasized my role as an outsider to the organization during the interviews in order for the participants to be able to critique the organization if they wished to.

Frequently, individuals approached me upon hearing from service staff about my project and I experienced that they were very motivated to share their experiences. For others, I was alerted to their presence, approached them, and explained the purpose and rationale of the study. If the individual seemed interested, I would inquire if they wished to participate, then or at a later time, and assessed those interested for their eligibility. I also sought referrals for the purpose of snowball sampling. Interviews were conducted in a private office within each organization for those interviewed immediately. When not conducting on-site interviews, interviews took place either over the phone, at a private room at the university, or at cafés/restaurants. I allowed the participants to dictate where it would be best for them to be interviewed, always offered a phone interview, as well as an interview at a room which was not at my office space. This was done with confidentiality in mind.

**Overall interview conduct and considerations**

Hermanns (2004) describes the importance of the researcher’s ongoing role in setting and managing the interview environment, facilitating a comfortable space for participants to share intimate details of their life. Of course, interviews varied in their style and atmosphere. Overall, people seemed largely happy to have the chance to talk about their experiences. It is possible that experiences of stigma and discrimination from persons in authority positions may limit participants’ comfort in disclosing such sensitive personal information. However, the participant’s position as having information that they can choose to share with me equalizes, in some way, this power balance (Brinkmann & Kvale, 2018). Establishing a trusting and open interview environment starts even from the approach, or earlier, in how I presented myself, and in gaining relevance by being referred by trusted sources. My prior experience working with PWUD supported
my ability to avoid stigmatizing language or questions, and maintaining welcoming body language, as previously mentioned.

Reflecting on the above discussion of online versus in-person interviews, I relate to Brinkmann & Kvale’s (2018) indicators of quality interviews. One of the signs listed is that of short questions (interviewer) and long answers (interviewee). When looking at the transcripts and reflecting on the interviews, my impression is that the online interviews were equally as successful (as well as varied in their success) as my in-person interviews. Some participants provided shorter more direct responses, but this did not seem tied to the method used. Three of my interviews took place over the phone. Given the complete lack of visual cues, some researchers have suggested that telephone interviewing is an inferior method, due to lack of “naturalness” of the circumstance and reduced rapport-building through small talk (Shuy, 2001). Others have suggested that in fact the partial anonymity can improve interview quality, especially on sensitive subjects (Sturges & Hanrahan, 2004). Similar to the online interviews, I mindfully employed more verbal affirmation cues throughout, to demonstrate my presence, engagement, and understanding to the participant, in absence of body language and physical cues. All three interviews were very long and rich, and I do not feel that conducting them over the phone compromised their quality.

I did not conduct pilot interviews per se however I did actively refine the interview guide throughout the interview process, particularly in response to how the first few interviews functioned. The interview guides are available in Appendix Two. I began the interviews with asking participants descriptive details about their lives, in order to begin an easy dialogue. I then asked participants to tell me about their initiation into drug use, how it developed, then onwards. I tried to ask direct, clear, and single-topic questions, avoiding jargon. I practiced active listening, reflecting back to participants what I had understood them say. This included confirming what was said, and confirming my understanding or interpretation of what was said, for example asking: do I understand you correctly, is this what you mean, so you are saying it is about this, can I go back and ask again about this? (Brinkmann & Kvale, 2018).

Challenges

One of the primary challenges faced throughout the study was the effects of COVID on recruitment possibilities. These became apparent in several ways. Firstly, it required for me to engage in online interviews, which has been discussed already.
Secondly, when finally gaining access to the field in person for data collection for Articles III and IV, I encountered significantly fewer individuals from my target demographic at the sites than were reported in previous years. This decline was attributed to the COVID-19 pandemic’s impact, with personal communications revealing a drop from an average of 500 unique monthly visits by Swedes to the consumption room to just 50 in the post-COVID period. This drastic reduction was largely due to strict border controls between Sweden and Denmark during COVID-19, which hindered cross-border movement. Consequently, my initial goal of conducting 20-30 interviews became challenging. There is no consensus on the exact number of interviews considered to be “sufficient”, and the decision to finalize data collection is up to the researcher’s discretion in how the data material suit the study’s aims (Brinkmann & Kvale, 2018). The extended data collection period (August 2022-January 2023), allowed for transcription, reflection, and review of interviews, facilitating an understanding of the data. Thus, I ended data collection when I felt that the interview data had yielded a sufficiently rich data set.

As will be discussed in the limitations section, participant demographics were relatively homogenous, with regards to gender, and nationality. This raises concerns about potentially unexplored perspectives from more diverse backgrounds. In an attempt to rectify this, I included snowball sampling in recruitment for Article III/IV, which did produce two of the three of the female participants. This may confirm that alternative approaches might be necessary to reach underrepresented groups. Attempts were made to access female-specific services, though these efforts faced significant challenges.

Interviews – language

Reflecting on language use in interviews is important, highlighted by Resch & Enzenhofer (2023) as often overlooked in multilingual research studies. After moving to Sweden in April 2019, my first interview with a PWUD took place in January 2021. During this time, I worked steadily on learning Swedish, and had a rather strong grasp on it by the time of the interviews, especially in my listening comprehension. I discussed the issue of language with all participants, allowing them to choose the interview language. I was aware of the potential challenges: in Swedish, I might not fully grasp some nuances, whereas in English, participants could be restricted in expressing themselves as richly as in their native language. I decided against involving a translator or interpreter, considering the possible impacts on interview dynamics (Resch & Enzenhofer, 2023). Interpreters can play a critical role in assisting with interviews, but can
also modify meanings and reduce content in their translations. This, in addition to the ethical considerations in interviewing my participant group, led me to conclude that it may be easier for the participants to speak openly, without the presence of an interpreter.

In the first round of interviews (for Article II), I primarily posed questions in English, and participants responded in the language of their choosing. When needed, I repeated questions in Swedish for clarity. I expressed that my grammar and pronunciation were imperfect and to let me know if they could not grasp what I was trying to communicate. In reviewing the transcripts, I can confirm mutual understanding during interviews. My comprehension was supplemented by the ability to audio record interviews, as I could replay for anything missed. In data collection for Articles III and IV, there was more use of Swedish on my end, with about half the interviews conducted in each language, often mixing both. When producing quotes for my article drafts, I presented both the original Swedish alongside my English translation to my supervisors, who reviewed for accuracy.

Interviewing in a non-native language posed challenges but also offered some possible benefits. The ability for the participants to choose which language they were interviewed in may have lent itself to an increased equality of the researcher-participant relationship, which is often described as uneven (Brinkmann & Kvale, 2018). Expressing my lack of Swedish fluency may have contributed to a more balanced power dynamic, positioning interviewees as experts, something which I tried to emphasize subtly.

Analysis

I transcribed the majority of the interviews (seven in Article II, and 14 in Article III/IV). A transcriptionist was employed for the remaining interviews, specifically those in Swedish that were challenging due to fast speech or poor audio quality.

The analysis processes were guided by Braun & Clarke’s (2006) approach to thematic analysis. As interviews took place, I kept memos of initial impressions. Interview transcripts were reviewed several times in order to familiarize, and preliminary notes and interpretations were made. The coding schemes in each paper took a both inductive and deductive approach – in that grounding in the literature and theoretical frameworks informed the selection of some codes, but other, novel ideas were also searched for and permitted to be developed as codes directly from the data themselves. The presence and application of theory in informing the coding and thematizing process is explained in more detail within each individual paper. In short, in Article II, the theoretical framework was used
to frame and organize the discussion. In Articles III and IV, theory in part guided the coding and interpretive processes. Coding was an open, fluid, and flexible process, in which initial ideas viewed to be relevant or of interest were noted. They were subsequently developed, refined, combined, separated, and so on, through a process of continual revision. This process of continuous refinement aimed to identify codes with shared meanings to create initial themes. New codes were applied retrospectively to earlier transcripts to ensure comprehensive theme development. Themes were then checked against each other, as well as the whole data set, for consistency and representativeness. The aim of developing themes was not merely to summarize the data, but to interpret in order to find core, central, unifying concepts (Braun & Clarke, 2006). Themes were finalized when they were judged to be internally coherent, consistent, and distinct from each other. Data extracts were chosen to elucidate analytic claims.

The analysis process reflects how I as the researcher conceptualize meaning within the data, where the researcher “has a monopoly on interpretation” (Brinkmann & Kvale, 2018, p. 7). This process is influenced by my cultural, social, and theoretical positions and lenses, and my positionality is discussed below. I thus may interpret seemingly unrelated pieces of data to have a common message. As data analysis, in this case, can be understood as a process of finding what is interesting and relevant in the data, it is clear that I am an active participant in producing the knowledge in the analysis. Where possible and relevant, or if necessary, (as was mentioned above) I tried to check my interpretation with participants during the interviews (Brinkmann & Kvale, 2018). As before, I did not aim to find a single “truth” of the data, but to explore the how and the why, the experiences of my participants, and how these experiences may share patterns on some level. My analytical process may also relate to positionality (discussed below).

Positionality
Examining one’s positionality has become a common practice in qualitative research, and entails reflecting on how a researcher’s identity and background influence every stage of their study, from conceptualization to presentation of results (Brinkmann & Kvale, 2018). There are several aspects to my position, both my identity and my approach to the process, which may have shaped this study.

A first aspect of my position is that I am not from Sweden. I found this to benefit my recruitment and interviews, allowing me to adopt the role of an outsider within the Swedish context. This positioning may have helped mitigate
participants’ concerns about my potential biases or stigmas I might hold, enabling them to freely share their experiences. I leveraged this outsider status, positioning participants as experts, something which I tried to emphasize when asking follow-up questions or for further details on a response.

I come from Canada, specifically Vancouver, where the approach to drug policy is very different than in Sweden. As mentioned, I have worked with a similar population in Vancouver. Having experience in a setting with comprehensive harm reduction services and a more lenient legal policy towards drugs could potentially have an impact on my understanding of the data and how I queried and interpreted my participants’ experiences. As stated by Brinkmann & Kvale (2018), “the personal perspectives of interviewees and interviewer can provide a distinctive and sensitive understanding of the everyday life world,” (p. 99), and is not necessarily a negative. This foundation also offers me competencies in interviewing on sensitive topics as well as sufficient background knowledge to form relevant lines of questioning and discussion with participants. Acknowledging my own preconceptions, I made concerted efforts to challenge assumptions. In practice, this meant focusing questions and questioning lines towards prompting and exploring experiences which would be contrary to my expectations, and critically examine the data to ensure a balanced representation of participant experiences.

More broadly, in most cases my social position was quite different relative to participants’ – marked by differences in societal status. This could potentially affect the research dynamics, particularly in how participants may be willing or unwilling to share certain experiences in the interview, as well as in their perceived power to, for example, end the interview (Brinkmann & Kvale, 2018). I have already described several aspects which may have addressed this power balance. It could also be that my age (younger or similar age to participants), attire (informally but respectfully dressed), and communication style (with regards to language, and tone), would alleviate some of participants’ preconceptions of my status.

**Method discussion and limitations**

In this section I will reflect on how my research design and decisions align with to common metrics of research quality, and the potential limitations of the project. Collecting both qualitative and quantitative data presents an opportunity for the two aspects of the project to complement as well as corroborate each other (Plano Clark & Ivankova, 2016), in that they can provide a comprehensive exploration
of Swedish drug policy. Consequently, a benefit of this study is that it can serve to integrate the perspectives of different groups.

The quality of qualitative research specifically is often queried (Brinkmann & Kvale, 2018). Various criteria such as validity, reliability, rigor, credibility, confirmability, trustworthiness, transferability are applied (Kitto et al., 2008; Leung, 2015; Lincoln & Guba, 1985; Patton, 2015), suggesting different philosophies on how to assess and discuss quality. I will speak to a few of the main issues which I view to be common across these works, specifically examining the appropriateness of the method, bias, systematic reporting, interpretive validity, and transferability of results. Some of these topics, specifically the methodological choices as well as my positionality and biases, have already been addressed in the methodology chapter. For process reporting, I largely adhered to the COREQ criteria (Tong et al., 2007) to allow for transparency and replicability of the methods. To provide support for my interpretive validity, participant quotations serve to justify my interpretive claims (Eldh et al., 2020; Lincoln & Guba, 1985). Additionally, although this project was undertaken as a primarily independent work, I had ongoing contact with my thesis supervisors (both with many years of qualitative research experience, as well as research specifically with PWUD) throughout the entire process, from development of the research question and method, interview guide, interviews, transcription, and analysis. This allowed for me to present ideas, codes and themes, findings, and pose analytical questions, serving as a form of “analyst triangulation” (Patton, 2015). This was utilized to critique, strengthen, confirm, and validate my interpretations. Given the nature of the recruitment process, in which no ongoing contact with participants was maintained, and in most cases no contact information was given, there was no possibility for “member-checking” of my analysis. This, along with reliance on a single form of data, could be viewed to impact the credibility of my findings (Lincoln & Guba, 1985; Nowell et al., 2017; Patton, 2015).

The qualitative studies had small sample sizes, which means the perspectives represented in this project may not reflect the diversity of experiences in the settings which were studied. The results of the study should be transferred and generalized on to other populations or settings with caution. However, (as is stated in Article II) resistance to harm reduction, and variations in care, are not unique to Sweden, nor only to the specific areas of Sweden which I researched. Therefore, the results could be cautiously used to inform understandings of experiences of PWUD in similar settings, where there are large variations in service access or drug policy, or what strategies are being used to solve low levels
of access. With regards to Articles III and IV specifically, I focused my recruitment on people with experiences of leaving Sweden. This aspect of the project did not include the perspectives of the many who choose to stay in Sweden, who are satisfied with the care and services they have access to.

I encountered recruitment challenges, including difficulty engaging, or better representation of, “hard-to-reach” groups – including women and non-Swedish people (i.e. those residing in Sweden without citizenship/residence status). The vast majority of the interviews were with male, Swedish citizens. When understanding the multiplicative, intersectional impact of additional marginalized identities in producing drug-related harm that has been discussed in the literature (Collins et al., 2019; Couto E Cruz et al., 2018), it must be acknowledged that these nuances may have been missed in this study. Another limitation of the recruitment strategy is that PWUD are in a highly vulnerable position, and some may not wish to present themselves to certain services, for a variety of reasons. Some people, such as those more vulnerable, those without an official status in the countries, as well as those who don’t want to be seen as “drug users” may not attend. Therefore, as I mainly recruited through services (in addition to a small amount of snowball sampling), the studies may be biased.

In relation to the quantitative element of the project, the main criteria of quality quantitative research are: validity, reliability, and generalizability (Bryman et al., 2008; Dale, 2006). Relating to validity, survey data such as the utilization of scales are a popular social scientific approach used to assess attitudes, and this is seen as an appropriate and effective method, as long as they are well designed (Abelson, 1992; Krosnick et al., 2005). The survey tool utilized (the HRAS) is a validated scale, supporting its application in this study. Regarding reliability, the procedures to collect and analyze data have been clearly and rigorously reported upon. The statistical work of myself and my co-author was supported by additional researchers, both within and outside of the project at hand, substantiating the statistical analyses.

Potential issues with the different size of the samples in each setting have previously been discussed. With that said, the survey covered a relatively high percentage of SWP in the substance use field in one setting (Malmö), and thus it is possible to make some inferences that a similar proportion of SWP responded in the study’s other settings. Notably, the study accessed a purposive, not random, sample, so it would only be seen as generalizable to those within a similar group.

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3 "hard-to-reach" is a term which can be critiqued for implying a blame on the individual, rather than framing them within barriers to care, or a system which is “hard to access” for some see for example: (Flanagan & Hancock, 2010; Freimuth & Mettger, 1990)
The study risks the potential for social desirability bias in the results, as well as potential that only those interested and involved in the research question answered, therefore skewing the data. Another limitation of the study’s method is that an attitude may have different strength and meanings at different times and to different people, and attitudes do not necessarily translate directly to action or behaviour (Krosnick & Abelson, 1992).
The following section outlines the main results of the studies, while the comprehensive results can be found in the individual articles. Together, these results provide an insight into the uneven development of harm reduction in Sweden, as well as differing approaches to drug policy between Sweden and Denmark. Findings demonstrate how local differences in harm reduction’s implementation are reflected by care providers’ attitudes, confirming inequities in care access and professionals’ attitudes. The results also reveal the influences of locally differing social constructions of drug use on the lives and wellbeing, mobility, self-conception, risk, and service access of PWUD. Results speak to how these constructions play a role in shaping PWUD substance use trajectories – sometimes exacerbating use and other times contributing to reduction. These findings point to the fact that the broad policy messaging in the Swedish system may in fact undermine broad policy goals, at least for some of those people who are most vulnerable to negative outcomes. Service formats deterred participants from accessing care, excluding them, burdening them with finding strategies to access inaccessible services, or even driving them to another country. The implications of these findings, in relation to theory and previous research will be discussed in the next chapter (Discussion).

**Article I**

Preliminary Title: “Attitudes towards harm reduction amongst social work professionals in three settings in Sweden”

The first article aimed to address the first research question of the project: What are social work professionals’ attitudes towards harm reduction in differing areas of Sweden, and how may these attitudes link to local service landscapes? Specifically, we aimed to explore social work professionals’ (SWP) attitudes
towards harm reduction philosophy and measures in three areas of Sweden with high, medium, and low harm reduction development: Malmö, Gothenburg, and Gävleborg, respectively— as described in the previous chapter. We also explored their views on the accessibility of care interventions for their clients, linking these views to local harm reduction traditions.

There were 208 valid survey responses, Malmö: 79, Gothenburg: 82, Gävleborg: 47. Table 4 provides an overview of participant characteristics. The respondents background characteristics were largely similar. Respondents from Gävleborg were significantly older and significantly less likely to have a bachelor’s degree in social work than those in Malmö. Those in Gävleborg and Gothenburg were significantly more likely to have “decision-making” power (*myndighetsutövning*) than those in Malmö.

<table>
<thead>
<tr>
<th>Table 4. Descriptive statistics</th>
<th>Total % (n=208)</th>
<th>Malmö % (n=79)</th>
<th>Gothenburg % (n=82)</th>
<th>Gävleborg % (n=47)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age – mean (std. dev)***</td>
<td>43 (11.5)</td>
<td>39 (10.7)</td>
<td>43 (12)</td>
<td>46 (10.7)*</td>
</tr>
<tr>
<td>Gender - Woman</td>
<td>76.2</td>
<td>81</td>
<td>72.3</td>
<td>75</td>
</tr>
<tr>
<td>Education – bachelor’s in Social Work</td>
<td>66.3</td>
<td>70.1</td>
<td>75.9</td>
<td>43.8*</td>
</tr>
<tr>
<td>Work with clients - yes</td>
<td>90.8</td>
<td>93.6</td>
<td>90.2</td>
<td>87.2</td>
</tr>
<tr>
<td>Decision making power - yes</td>
<td>45.9</td>
<td>26.6</td>
<td>56.1**</td>
<td>60.4**</td>
</tr>
<tr>
<td>Managerial role - yes</td>
<td>14.9</td>
<td>14.1</td>
<td>12</td>
<td>21.3</td>
</tr>
<tr>
<td>People with heavy substance use as target group for work</td>
<td>86.2</td>
<td>86.1</td>
<td>84.3</td>
<td>89.5</td>
</tr>
</tbody>
</table>

*significant at the 0.05 level
** significant at the 0.001 level
*** utilized ANOVA test for this variable

Attitudes towards the goals and philosophy of harm reduction differed significantly by location. The overall mean HRAS score of 2.209 indicated positive attitudes towards harm reduction, where a score of 1 would indicate total alignment with harm reduction, and a score of 5 would be total rejection of this philosophy and related treatment goals. ANOVA with Bonferroni post-hoc correction indicated that Malmö and Gothenburg scores (2.046 and 2.159 respectively) were significantly more positive than those in Gävleborg (2.572) (p <0.001).

Opinions on implementation of new harm reduction measures such as HAT, SCS, and decriminalization of drugs for personal use were more negative overall (Figure 3). A score of 1 would indicate total acceptance (should be implemented), where a score of 3 would indicate non-acceptance (should not be implemented).
Therefore, as many of the score means were above 2 (neutrality, “should possibly be implemented”) this indicated mostly negative views towards these three interventions. In fact, only 9% of total participants supported implementation of HAT. These opinions followed the above trend, with regards to differences based on geographical location.

Differences could indicate a relationship between exposure to harm reduction and acceptance of it. While results were overall positive – as stated, they differed based on geographical location. The lower support for specific harm reduction interventions demonstrated a discrepancy between the philosophy of harm reduction, and the reality in terms of programming. The fact of lower support for programs not-yet-implemented may indicate that exposure to harm reduction precedes acceptance of it.

![Mean score per group on HAT, SCS, and decriminalization](image)

Figure 3. Mean score per group on HAT, SCS, and decriminalization of drugs for personal use

Perceptions of care access for clients also revealed disparities in access to care and treatment in the different settings. For example, detoxification was perceived to be more available, while overdose prevention and OST less available, in Gävleborg as compared to Malmö. The differences indicate that national policies and guidelines are implemented differently. The differences can also confirm the categorization of the areas into the “high” “medium” and “low” categories.
It can be inferred from the results that care for PWUD clients will be different (inequitable) based on geographic location. The results of the subsequent articles will explore PWUDs’ experiences of care disparities. Differing attitudes and inequities in care access may ultimately affect social vulnerability, risks, and opportunities for PWUD.

**Article II**

*Dealing with low access to harm reduction: a qualitative study of the strategies and risk environments of people who use drugs in a small Swedish city*

Article II investigated the experiences of PWUD who were living in an urban area with limited harm reduction infrastructure, notably lacking NSP and a Housing First policy, leading to exclusion from municipal housing for those actively using substances. Housing and NSP are municipal and regional services, respectively, but are influenced by municipal politics, such as veto power over the development of NSP until recently. They also represent both social and medical services, aiming to reduce drug-related harms both directly and indirectly. This study examines how PWUD navigate and respond to local drug policy variations, revealing both adaptive strategies and the significant consequences of service gaps. This paper contributes to the thesis in answering the research question: How do people who use drugs navigate and experience locally differing approaches to drug policies?

**Strategies**

To solve lack of local NSP, participants reported: travelling up to 200km to access services in an adjacent region, forming and relying on informal secondary distribution networks, stealing, buying online, reusing, and sharing injection equipment.

The lack of stable housing forced many into makeshift solutions, including sleeping outdoors, in vehicles, or in unconventional places like storage units. Utilizing social networks for temporary lodging, they continually sought short-term accommodations and some used stimulants to remain awake and mobile during the night. Those who were housed faced a constant concern of eviction.

**Consequences**

The burden of insufficient access to housing and NSP extended beyond the immediate challenges above. For some, accessing distant NSP services meant
sacrificing family time. Others were unable to consistently travel for services, leading to unsafe practices like sharing injection equipment, and using unsanitary water for drug preparation, increasing the risk of severe infections. Homelessness and the absence of safe injection sites compelled drug use in unsafe places, such as public toilets or parks, heightening overdose risk. It also reflected other sorts of low access to the medical system, where some reported avoidance of general medical care due to fear of stigmatization. The lack of municipal investment in services like NSP not only heightened health risks but also exacerbated participants’ stress and sense of exclusion, adversely affecting their mental wellbeing.

**Articles III and IV**

Collectively, Articles III and IV investigated the impact of differing harm reduction and drug policy provision in Sweden and Denmark. The research questions answered here were:

1. How do people who use drugs navigate and experience locally differing approaches to drug policies? And,
2. How might differing policy approaches be linked to mobility – and what influence does this have on wellbeing as well as risk?

**Article III “I knew it was different there”: a qualitative study of the motivations and risks of drug policy migrants going to Denmark from Sweden**

Article III PWUD mobility between Sweden and Denmark, utilizing the risk environment framework to categorize the factors influencing mobility and its associated risks. The unique setting provided an opportunity to look into how and why PWUD reason regarding their experiences and preferences of different drug policy elements, and what they are willing to compromise for a more favourable environment. The primary motivations for were categorized into the: policy, social, physical, and economic environments, with most participants (16/17) citing multiple motivations, and these motivations were seen to evolve over time. An overview of these motivations is presented in Table 5 (all names are pseudonyms).
In the context of this project, the most important categories to reflect on are the policy and social environments. Motivations under the policy category including the desire to escape high-threshold care in favor of more harm reduction-oriented services and to avoid a control-centric care system. Policing practices also play a significant role, with the punitive approach in Sweden driving individuals to Denmark, where interactions with police are perceived more positively. Similarly, the non-judgmental atmosphere in Copenhagen contrasts stigmatizing interactions which occurred in Sweden motivated movement between settings.

However, this movement introduces additional risks. For some, relocating results in homelessness in a new location, compounded by limited access to comprehensive social and healthcare services due to non-resident status. A lack of familiarity with the harm reduction landscape in Denmark means that many do not access available services. The open drug scene in Copenhagen, while attractive, poses risks of increased or different forms of substance use. Despite criticisms of the Swedish system’s restrictiveness, some reflections on harm reduction services, like NSP interactions, are positive. Participants highlight
benefits such as more frequent, meaningful contact with service providers, which can foster supportive relationships. It is the combination of these motivators with their associated risks which shape a risk environment for any individual participant in the study. They balance improved conditions like less punitive policing and more accepting care interactions against the constraints of limited long-term welfare access.

Article IV preliminary title “In Sweden you are worthless. In Denmark you get an identity again” – the perspectives of people who use drugs on being perceived and received in two countries with different approaches to drug policy”

This paper explored how Sweden's and Denmark’s contrasting approaches to PWUD affect their experiences, focusing on stigma and its impact on identity, inclusion, and empowerment. This included reflections on experiences in public spaces, policing, as well as within the realm of addiction-related care. Participants’ narratives were anchored in two primary themes: perception and interaction in public spaces, and the influence of the treatment system on identity.

In public spaces, participants felt criminalized and dehumanized in Sweden, encountering behaviours like avoidance, that rendered them invisible or as “ghosts.” Contrastingly, in Denmark, they felt their presence was acknowledged, which participants associated with societal valuation, feeling recognized as individuals despite their drug use. This was related to how public interactions, policing practices, and availability of services, shaped participants’ sense of their own legitimacy within in public spaces. The negative interpersonal interactions in Sweden became a reinforcing experience, where participants felt they did not have the “right” to be out – leading to self-imposed isolation. Participants equally reported that positive interactions in Denmark, alongside a more lenient policing practice and service accessibility, indicated they were symbolically included in society.

The second theme related to how care formats and service interactions influenced the building of trusting and open therapeutic relationships. In Sweden, anticipated stigma and punitive measures hindered open communication with care providers. These experiences force participants to hide relapses to avoid consequences such as dose reductions and associated senses of shame, which ultimately impaired the therapeutic alliance. Denmark’s less punitive approach fostered open, empowering relationships, enhancing participants’ self-trust and optimism about recovery and the future.
The paper explored the dynamic between policy, public perception, care, and individual identity among PWUD. It provides insights into how the construction of the drug problem and drug-related policy goals can have real potential for impact on addiction-related trajectories, both including and beyond the offering and format of services themselves. Importantly, the results also demonstrated that these stigmatized identities are highly context-bound, and can be shed or applied with relative fluidity in different settings.
DISCUSSION

This chapter will discuss and relate the project’s findings to previous research, theory, and to their implications for policy. This project sought to explore the acceptance of the harm reduction philosophy and goals, the implications of limitations in service offerings within Sweden, as well as differing policy approaches between Sweden and Denmark. It considered the experiences of those directly affected by these policies — namely, PWUD — as well as the attitudes of SWP. SWPs’ attitudes towards the harm reduction philosophy were positive, but varied in reflection of their locality’s harm reduction development. They were more negative towards specific harm reduction interventions. From the perspective of PWUD, inequities in harm reduction development and restrictive care formats increased risks of drug-related harms. These inequities led to strategies to address care shortages and, in some cases, movement between regions or to Denmark to seek other care options. PWUDs’ movement was influenced by service formats, stigma, and policing. Moving to a setting with integrated harm reduction philosophies was seen as beneficial for wellbeing, trust with care providers, social inclusion, and even identity formation. However, movement also exposed participants to additional risks, such as lack of access to or knowledge of some services, and a riskier drug market.

This chapter will focus on exploring themes common among the articles, examining first how policy shapes risk through care availability and formats, and social interactions, and then discussing environmental factors affecting risk. This will be followed by potential policy implications. Finally, the project’s limitations will be discussed, as well as suggestions for directions for future research.
How policy shapes risk through influencing service availability and formats

Articles II-IV revealed that participants employed various strategies to mitigate harm in high-risk environments. The responsibility largely falls on individuals to navigate structural inequalities, through mobility or other means. There were many risks stemming from the lack of geographic equity in care, where some individuals, in the absence of housing, resort to increased drug use—a scenario which has been described as “double jeopardy” (Neale, 2001). The necessity to share, reuse, steal, or travel to injection equipment because it is not being offered in a reasonable geographic distance directly opposes both WHO goals for hepatitis elimination (World Health Organization, 2016), and the Swedish national hepatitis C elimination strategy (Sveriges Kommuner och Regioner, 2022).

Moreover, restrictive policies precludes the proliferation of certain services and care formats, further exacerbating risky situations for study participants. Turner et al. (2023) found that 29% of NSP attendees in Sweden began injecting before age 18, thus lacking legal access to NSP due to age restrictions. This cohort of injectors had specifically more vulnerable social and health situation compared to adult initiators (Turner et al., 2023). For those who can physically and legally access services, policy-imposed barriers such as restricted opening hours or identification requirements compel some to seek services abroad. Nordstedt (2023), too, illustrated the lengths to which individuals go to bypass Swedish NSP controls, such as arriving just before closing to avoid engagement in motivational work or mandatory blood testing. Sweden is the only country in the EU which has prescription restrictions on needles and syringes.

Results from Articles II and III also demonstrated that participants often used drugs in risky ways due to service inadequacies, expressing a strong desire for safe, secure, and supervised settings for drug ingestion. These findings are supported by Houborg et al. (2022), who noted that PWUD in Malmö were significantly more concerned about overdose, psychosis, or other drug-related harms than their counterparts in Copenhagen, and tended to use drugs in riskier settings. Nordstedt (2023) discussed the challenging, life-dominating pursuit to find safe places to use drugs and suggested the implementation of SCS to alleviate some of these pressures.
Mobility and risks

Inequities and variations in care access are one of the primary foci of the study, especially in how they relate to mobility of PWUD. Globally, individuals often travel or relocate to access care unavailable locally. Often referred to as “medical tourism”, this phenomenon can be more accurately described as “patient mobility” (Glinos & Baeten, 2006). Patient mobility encompasses a spectrum from short-term commuting to permanent relocation, with both patterns, as well as variations in between, present within Articles II and III. Importantly, when considering equitable distribution of services, it must be understood that such services are provided within a context of finite resources. It is imperative to keep in mind that some individuals or groups will inherently reside geographically further from various services (Rosenberg, 2014). However, inequities in access in this case instead related to the fact that the goal of a drug free society has hindered the development of many harm reduction interventions in Sweden. A similar phenomenon is seen with regards to cross-border travel for services such as abortion or other reproductive services, where legal disparities are highlighted as a primary reason for such movement (Oliveira da Silva, 2009; Zanini, 2011).

Within the EU, rights of free movement enable, to an extent, healthcare access abroad (Glinos et al., 2010). However, these rights of free movement are not universal, and are often constrained by residence or employment status (Stan et al., 2021). This reflects a broader discourse on EU patient mobility, including whether and/or how to format insurance schemes to allow for better international access (Glinos & Baeten, 2006; Stan et al., 2021). Currently, insurance schemes are based nationally and are defined in such a way that they inherently privilege those with a specific type of agency and resources. Access tends to be reliant on highly bureaucratic systems, and it takes resources to both take oneself to and benefit from international services. In the case of Articles II and III, individuals were often (though not always) constrained in some way due to both limited resources, as well as their stigmatized position in society, restricting full system access. This exacerbated participants’ vulnerability – to the health and social care system (whether they were able to access it or not, and in what ways their access may be restricted), to individual providers, and to their social networks.

The discussion of patient mobility also brings up larger points about equity, agency, and constraints, as some people do but others do not have those opportunities or ability to seek out care elsewhere (Lunt & Mannion, 2014). These inequities between groups can be seen practically for example in a study of inter-city patient mobility in China, where Yan et al. (2022) found that women,
people of older age, and those with non-employment based medical insurance were less likely to travel long distances to seek care as compared to younger people, men, and those with insurance based on employment. A similar phenomenon could therefore be inferred by the presence (or lack thereof) of women and non-EU citizens in the datasets for Articles II-IV, something which will be returned to later.

Ultimately, PWUD may move to seek out care elsewhere, to places with more comprehensive care provision. This has raised concerns about concentrated harm reduction services creating “a paradise for drug users” (own translation) (Nilsson & Abbas, 2023), or how they are referred to in the academic literature as “social services ghettos” (Dear & Wolch, 1987, p. 8). Such criticisms, often based on NIMBY attitudes, fail to critically examine the fundamental reasons driving individuals towards these services, which is most often that they are not being provided in their area of origin. Providing equally accessible services, could potentially limit these sorts of negative reactions and perceptions, preventing clustering in specific locations. Resistance to new services may also stem from lack of awareness, or even fear, among local residents. Therefore it is critical to engage local community stakeholders in the development of new services to understand their opinions and reservations, and help them comprehend the benefits of intervention implementation (Bancroft & Houborg, 2020; Kolla et al., 2017).

Movement placed participants in Article III in a different, but not always better, risk environment. Harm reduction access, care provider attitudes, and policing practices were technically more favourable in Denmark. However, exposure to a different drug scene carried risks, and some of the larger factors which influence social determinants of health, such as the full welfare state and related care services, were often inaccessible to the participants in the new setting. The nuances in exposure to risk or enabling factors also emphasizes why the risk environment is such a useful framework for analysis. Given the previously noted risks of moving, also seen in the literature (Paschane & Fisher, 2000; Rachlis et al., 2010), it is ideal for people to have the opportunity to remain in their own communities, as long as they feel this is in their interest. This allows them to stay linked to family, social networks, and care. Notably, it was not only care access but also stigma and negative interactions from care providers and the general public which were a driver of PWUD mobility, topics which will be discussed later. This project sheds light on the difficult choices faced by PWUD, in the face of need for care, despite the possible risks or requirement for tradeoffs.
Shaping the care that providers can offer, and how clients receive it

Article I demonstrated SWP are generally positive towards harm reduction. However their working formats continue to be constrained by lack of national-level support for the values of harm reduction (Richert et al., 2023; von Reis & Wendel, 2022). This disconnect can deter clients from seeking care and increase exposure to risk. An abstinence-orientated system has been described as acting as an “invisible barrier” to uptake of harm reduction (Heller et al., 2004). This barrier was evidenced in Article I, where the setting (Gävleborg) which reported more access to abstinence-oriented treatment services also had lower acceptance for the harm reduction philosophy, as well as less willingness to implement certain harm reduction services. This pattern aligns with other research, which indicates that care providers with an abstinence orientation are less inclined to recommend or provide harm reduction services such as OST, NSP, and overdose prevention (Brown, 2022; Gerlach & Caplehorn, 1999; Javadi et al., 2022).

Qualitative studies with SWP in Sweden has found support for harm reduction, aligning with core tenants of social work like autonomy, self-determination, human rights, and social justice. At the same time, tensions arise where guidelines state that care should be voluntary “as much as is possible” (own translation) (Socialstyrelsen, 2021, p. 75), yet individuals should be motivated towards interventions. Social work in many cases has a mission to work towards lifestyle changes and social integration. This tension reflects the abstinence and control orientation embedded within Sweden’s drug-related care system. Providers reflect on how goals of treatment and mandatory treatment aspects, like urine drug testing, can hinder therapeutic alliances and potentially stigmatize clients not aiming for abstinence (Månsson et al., 2021; Richert et al., 2023). These reflections are consistent with the results of Articles II-IV, highlighting how a controlling atmosphere can undermine genuine, open therapeutic relationships and even disincentivize people from accessing care at all. Several Swedish and international studies have reported sentiments on strict criteria and controlling care formats representing a barrier to accessing care (Deryabina & El-Sadr, 2017; Nordstedt, 2023; Richert & Johnson, 2015; Stöver, 2010). Some participants perceived care as controlling and punitive in Sweden, leading to deceiving providers to avoid repercussions, which could impact other important outcomes like relapse. Participant concerns were not only about the restrictive care formats but also about stigmatizing interactions, which will be discussed in a section below.
Conversely, on experiences of liberalized care models, clients report a sense of empowerment (Andersson & Johnson, 2020). Reflections from participants in Articles III and IV on their encounters with more supportive, flexible, and trusting care formats in Denmark illustrate the positive impact of honest interactions with providers, and increased willingness to engage in care. Trust in the health and social care system has been previously found to be a key indicator for facilitating PWUD access and creating an “enabling” environment (Harris et al., 2013; Stöver, 2016). This trust and willingness to engage are often attributed to system-level attributes like care flexibility, as opposed to rigid guidelines and controls (Harris et al., 2013; Lee & Petersen, 2009; Neale, Sheard, et al., 2007). Care features that promote trust are fundamentally linked to the broader framing of substance use issues.

How policy shapes risk through influencing interactions

Provider attitudes towards PWUD can also influence interpersonal interactions, which themselves are important for clients (Van Boekel et al., 2013), and can mediate aspects of the risk environment in a more indirect manner. For example, while NSP in Sweden is operationally constrained, many participants had largely positive reflections on interactions with staff at this service. This aligns with findings by Nordstedt (2023) and Stenström (2008) who underscore the role of social visits and interactions in compounding the benefits of NSP offerings. The inherent requirement of engagement as is driven by Swedish policy also offers a chance to develop a therapeutic alliance for those who are willing and able to access such services.

The results of Articles II-IV contribute to the existing literature which demonstrate the negative impact of stigma on PWUD, affecting engagement in care and self-perception (Biancarelli et al., 2019; Cama et al., 2016). Reflections of participants echo findings of a review by Crapanzano et al. (2018), which found some evidence for the direct and indirect role of stigma on treatment outcomes. This included stigma’s role in shaping treatment perceptions and contributing to negative self-conception and poor mental wellbeing, both of which may affect the recovery process. Articles II-IV sheds further light on the processes which drive some of those findings, by offering a look at how people perceive stigma in different contexts, and how that relates to surrounding social structures. This suggests a need to address not only harm reduction but also the social frameworks that shape risk or enabling environments. As was previously described, a connection has been found linking perceived and experienced stigma and discrimination with alienation, as well as poor mental and physical health.
outcomes (Ahern et al., 2007). Latkin et al. (2010) found that self-reported stigma was associated with risk behaviours for HIV and HCV, such as sharing injection equipment. Furthermore, Latkin et al. (2019) also found a positive association between perceived stigma and experiencing a non-fatal overdose event in the past year, compared with those who had never had an overdose.

Research also conducted in a Swedish/Danish setting demonstrated that Swedish PWUD report higher levels of loneliness than their Danish counterparts (Houborg et al. 2022). Articles III and IV provide a qualitative complement to this finding, offering insights in the mechanisms behind this phenomenon. These articles highlight how everyday interactions, such as passersby avoiding eye contact or crossing the street, can reinforce feelings of invisibility among Swedish PWUD. These articles demonstrate the influence of the policy context, such as one which constructs PWUD as deviants and criminals, and how it is reflected in their everyday lived experiences.

Anderson (1998) discusses how the influence of different dimensions of marginalization impact people with stigmatized traits. The author defines marginalization as, “various events that change the individuals’ social status in a negative fashion,” (Anderson, 1998, p. 302). The author proposes that the subjective experience of marginalization (“perceived/affective” marginalization), which refers to negative feelings stemming from being placed in a stigmatized social category, may have a more significant impact on how people form their identities than any actual, measurable changes in social status (which is termed “objective/real” marginalization). The distinction made by Anderson (1998) acknowledges that much of the identity development occurring, for example as described in Article IV, may be a self-reflective process of perceptions of experiences in different contexts, but that it still has real consequences. The results of Article IV also demonstrated that reflections on stigma and identity were part of a dynamic process, and that the stigma does not necessarily permanently adhere to participants’ self-conception and was highly variable in different settings. These findings imply how a stigmatized identity can be shed by changing environments. Given other research on importance of identity change on outcomes like recovery (Anderson & Mott, 1998; Best et al., 2016; McIntosh & McKeganey, 2000), the findings linking the policy environment to identity provide an interesting perspective into implications for formation of policy and societal messaging.

The idea which drives drug criminalization is that social control, potential for punishment, and the resulting stigma will coalesce to deter drug use (Babor et al., 2018; Becker, 1963; Goffman, 1963). What this logic rarely takes in to account
is that the more serious forms of substance use, such as addiction, are most often preceded by variety of difficult life and social conditions (Leza et al., 2021). Social control and resulting exclusion disproportionately affect those already in difficult positions, compounding issues (Anderson, 1998). There is evidence which suggests that for individuals with addictions, the negative outcomes of criminalization and stigma intensify the harms of drug use itself (Beletsky et al., 2015; Bonn et al., 2020; Cooper et al., 2005; Scher et al., 2023). Instead of negatively framing drug use itself (and the people engaging in it), focusing on negative outcomes, such as death from overdose, may be more fortuitous. Alternative approaches to substance use, including decriminalization and depenalization, have been suggested (Stevens et al., 2019).

The European Values Study may give insights into how different legal and social framings of substance use may influence public attitudes towards PWUD. The survey found that only 38% of Portuguese respondents considered having a neighbor with a drug addiction to be unacceptable, the lowest level of disapproval recorded across the dataset, marking a steep decline from over 60% in 1990. Gilroy (2023) relates the changes in Portuguese attitudes to the influence of policy changes, where Portugal famously decriminalized drugs for personal use in 2001 and has focused on approaching drug-related issues with a health and social welfare focus. Over the same time period, Sweden had increasing rates of reported unacceptability (65% to 70%) (European Values in Education). The survey’s results could imply how the differing policy environments (institutional stigma) and their associated public rhetoric, may influence interpersonal stigma (public stigma).

**Other environmental factors which shape risk**

Beyond drug policy itself, other environmental factors contribute to maintaining the status quo, or even reinforcing existing policy goals. Many of the ideologically-informed geographic inequities are enabled or heightened by devolved decision making in Sweden. The country has a devolved power system, which grants localities autonomy to tailor care to local needs (Storbjörk et al., 2019). This decentralization has resulted in “diversity ... now so vast that basically every municipality/region has a unique organisation, uses various hybrid forms and continues to change.” (Storbjörk et al., 2019, p. 13). Although the national setting has a certain strategy, results of Articles I and II showed how localities have interpreted this policy differently, leading to unequal conditions. For example, while evidence-based housing interventions like Housing First,
recommended by Socialstyrelsen (2019b) and the new national homelessness strategy (S2022/03255), Housing First has only been adopted in only a few municipalities. While devolved power may allow for innovation, such as Skåne's patient choice in care provider as described in Andersson & Johnson (2020), it also results in significant disparities. In the most extreme cases, self-governance has allowed for ongoing political, moral influence on care, which is responsible for many of the delays in development of interventions such as NSP.

Examining the macro aspects of the economic environment are also important when it comes to drug-related harms. Research has suggested that robust welfare systems are linked to fewer drug-related harms (Stevens, 2010) – indicating some relationship between the macroeconomic welfare context and risk environments. Sweden, known for its strong social supports compared to many nations (Horn & Kersbergen, 2022; OECD, 2022), offers “enabling resources” aimed at improving lives and wellbeing. However, the Swedish welfare state, is facing a trend of reduced generosity and increased privatization (Burström, 2015). Some of this privatization may even be responsible for driving some of mobility of PWUD (Nilsson & Abbas, 2023). The shift towards NPM, has led to a greater focus on individualized care and quantifiable outcomes, at the expense of long-term or more intangible psychosocial benefits (Dennis et al., 2020; von Reis & Wendel, 2022). This shift has created conflicts between organizational goals, service demands, and performance incentives in Sweden (Storbjörk et al., 2019).

Social workers in von Reis & Wendel’s (2022) study reflected on the difficulty justifying Housing First as an intervention for PWUD. This challenge was framed as an example of the conflict between the principles of harm reduction in comparison with those of NPM. As Housing First is a resource-intensive, long-term investment, which does not mandate drug abstinence – nor necessarily produce that as a measurable outcome – this intervention was suggested to be difficult to motivate (von Reis & Wendel, 2022). This has resulted in uneven implementation of Housing First, affecting the availability of housing for individuals with substance use issues and potentially leading to increased substance use or relocation, seen in Articles II and III. NPM’s influence extends beyond drug policy, promoting a results-oriented approach that may neglect clients needing more comprehensive support (Dennis et al., 2020; Moore & Fraser, 2013; von Reis & Wendel, 2022). Service providers may avoid engaging with clients perceived as less likely to progress quickly, such as those more prone to relapse (Dennis et al., 2020). This can lead to rigid program structures (for example only allowing a certain number of care sessions), and a focus on specific problems and necessitating ignoring others (Moore & Fraser, 2013). This is a
sentiment also mentioned by Storbjörk et al. (2019), that the NPM focus can “undermine long-term support; and marginalise less profitable people with multiple needs by selecting customers” (p. 4). Therefore, this economic environment which deters from investment in long term goals or interventions which prioritize process over quantifiable results, amplifies risk for PWUD.

Implications

This section will explore the policy implications of the project’s findings. This will include both direct policy implications, as well as broader reflections on the influence of the system of drug policy on those at the highest risk of drug-related harms.

Direct implications

This project gives a practical look into the implications of an overall restrictive as well as unequal development of harm reduction in Sweden. The reliance on individualized strategies to address lack of harm reduction illustrates structural barriers, underscoring the need for state-sponsored solutions – both nationally, and by regions and municipalities. This also emphasizes the necessity to re-examine the policies and legal frameworks which limit a more liberalized format of harm reduction programs. The positive aspects of policy which functions for some, such as promoting depth of engagement, should be balanced with a desire for lower thresholds and higher engagement of the most vulnerable to risk.

There are a number of successful, evidence-based interventions which could be implemented to alleviate the burden of having to move or travel for care, or to miss out on care due to geographic limitations. Evidence-based interventions for distribution of injection equipment, including postal (Torres-Leguizamon et al., 2020), mobile (Mema et al., 2019), and pharmacy based services (Yang et al., 2015), are all viable strategies which should be considered to address geographical service gaps, or other deterring restrictions of the current service format. The Drug Commission of Inquiry has proposed prescription-free injection equipment in pharmacies (SOU, 2023:62). It remains to be seen if this evidence-based practice will be taken up. Pharmacy-based services offer an opportunity to improve access to certain types of services, but must be done so correctly in order to ensure quality of care (Deryabina & El-Sadr, 2017; Lawrie et al., 2003). Other currently unimplemented services in Sweden, could include drug testing check points and/or distribution of fentanyl testing strips, as well as supervised consumption rooms which would reduce other drug-related harms, in alignment
with the ANDTS strategy’s “zero-mortality vision of narcotic overdose” (own translation) (Skr. 2021/22:213, p. 65). Absence of these interventions partly stems from legal framework constraints (SOU, 2023:62), likely as well as a perceived conflict with the zero-tolerance policy, which has historically hampered harm reduction efforts in Sweden.

The decentralization of decision-making poses a challenge for care harmonization. While keeping in mind the desire to maintain local autonomy, there must be a movement towards improved coordination of service delivery, and ensuring services are located at accessible distances, or otherwise can be supplemented with other forms of distance-based services. Local authorities should be disincentivized for noncompliance with national guidelines. The “open comparisons” which are already compiled by Socialstyrelsen could be used as a format to follow up on (lack of) service delivery in municipalities.

There are also implications for policing practices in Articles II-IV. Where Houborg et al (2022) confirmed quantitatively that PWUD in Malmö, Sweden, had more concerns about police than those in Copenhagen, Denmark. Articles II-IV explore some of the qualitative reasoning behind, and impacts of, those results. Participants reflected on confiscation of injection equipment, in addition to a general sense of being targeted by police in Sweden, in some cases driving them away from Sweden completely. Punitive and targeted police encounters have been found in a number of studies, including this one, to undermine service delivery (Beletsky et al., 2015; Cooper et al., 2005; Rhodes et al., 2003). These encounters therefore drive risks such as HCV, HIV, overdose, as well as dislocation from the Swedish welfare state and care systems. Articles III and IV in particular provide a unique perspective on these experiences, where many participants were able to make direct comparisons of their experience with police in the different settings. While there is resistance to drug decriminalization, adopting a harm reduction policing approach (described previously) could mitigate risks within existing legal frameworks. Already some areas in Sweden may practice harm reduction policing (Nordgren et al., 2022), but per results of Article II, geographic disparities in policing practices persist, contributing further to different risk environments in different locations.

**Broader implications**

The implementation and equitable distribution of harm reduction strategies such as SCS, pharmacy-based NSP, and harm reduction policing are important steps in mitigating immediate drug-related risks. However, most of these strategies inherently relate to a logic of responsibilization and individualization over care,
without addressing the other structural elements which drive risk for PWUD. Scholars such as Rhodes (2002), Roe (2005), and Tempalski & McQuie (2009), highlight that these strategies cannot fully counteract the broader context of criminalization of substance use, and a zero-tolerance policy. Thus, the practical strategies mentioned in the previous section should be considered, but also in the context of more comprehensive policy and legal changes. This also speaks to the different levels of the risk environment, where improved service access can address micro level risks, but where the macro level policy still hinders the transformation into a truly “enabling” environment.

While there is resistance against deviating from Sweden’s restrictive drug policy, which should not be seen to “promote” drug use, Sweden’s viral hepatitis strategy, or new ANDTS “zero mortality” goal could be used to validate and politically motivate the liberalization of services directed at PWUD. Aligning with these existing goals can assist in development of new service formats, which can even have an influence in evolving provider attitudes. The project also contributed a contextualization of the motivations for movement (in Article III), which can provide insights into representing the desires of PWUD themselves. Client influence is increasingly valued in health and social care, including relating to substance use, however there remains some continued pushback in this field specifically due to moralistic notions and power structures (Bjerge, Brown, et al., 2016; Storbjörk, 2012).

As previously stated, the rationale for criminalization of drug use is predicated on deterrence through sanctions and stigmatization of deviant behaviours (Becker, 1963). This has also been the argument for example of the Swedish government (Ministry of Health and Social Affairs, 2016). This approach has been cited as a factor in Sweden’s purportedly low youth cannabis use rates and perceived “success” of its drug policy (UNODC, 2007). However, recent alternative data collection methods suggest an underestimation of youth cannabis use rates (Andersson et al., 2023). Estrada et al. (2023) evaluated global research on criminalization of substance use, and question the efficacy of criminalization in reducing drug use and its negative consequences. The research presented across Articles II-IV unveil the broader implications of policy decisions. Policies not only influence service formats, but other aspects of the environment such as provider attitudes, stigma, and social exclusion. Many drug-related harms stem from its framing as a certain kind of a “social problem” and responded to in a corresponding manner (Loseke, 1999), and these harms are often disproportionately borne by the most marginalized. The lived experiences of PWUD in Articles II-IV in this study, should also be considered as an outcome.
of a drug policy. In the context of this project, it is worthwhile to consider whether the potential function of a restrictive policy outweigh the consequences for those who are at highest risk of harm.

**Directions for future research**

This project utilized several cases in order to examine the research questions. The findings here could be confirmed, strengthened, or built upon with further research. This section explores ideas of studies to follow up the existing project results.

As certain groups were not sufficiently represented in the recruitment process, Future studies could address representation gaps by focusing on underrepresented groups. This will help to better understand and ultimately address the intersectionality of experiences and risk.

It will be important as well as interesting to examine the influence of the recent proposals of the Drug Commission of Inquiry (SOU 2023:62), as well as potentially changing norms towards drugs in Sweden, on PWUD experiences and provider attitudes. This could include, for example, studies on context-specific willingness to utilize proposed new services, such as SCS or pharmacy-based NSP. It will be important to engage Swedish PWUD in the design of such interventions, to ensure they are appropriately adapted to their needs, and address specific barriers to care. Similarly, the new homelessness strategy may lead to changes, it will be important to follow this and how it relates to harm reduction and the circumstances of PWUD. Therefore, these developments should be closely tracked.

There are also a variety of relevant potential applications of the Harm Reduction Acceptability Scale (HRAS), alongside other measures, to provide insights into various service providers’ attitudes, how they may change over time, as well as geographic differences in attitudes. Conducting the HRAS across Sweden could comprehensively map the full range of attitudes of SWP. Conducting a baseline measure would allow for exploration of any shifts in attitudes in the face of policy changes. These findings may even give clearer insights into a direction of causation of attitude change and harm reduction development. Studying the attitudes of pharmacy workers and police would also be useful, in assessing their willingness to be involved in harm reduction. Furthermore, linking attitudes to behaviours, possibly through vignette studies, could be useful to explore to the relationship between attitudes and actions in harm reduction settings. Additionally, extending the HRAS to Denmark could
offer a provider-focused complement to some of the PWUD experiences expressed in Articles III and IV. These could help to continue to explore, compare, and confirm the role of the national- and local-level policy landscape on provider attitudes which was suggested in Article I.
I denna studie undersöks hur Sveriges narkotikapolitik samt utvecklingen och utförandet av olika insatser upplevs av och påverkar personer som använder droger. Även socialarbetares attityder till policy- och behandlingsmål undersöks. Sverige utgör ett intressant exempel på hur narkotikapolitiska mål påverkar införandet av olika insatser och även deras utformning. Inte minst gäller detta så kallade skadereducerande insatser, alltså insatser som syftar till att minska olika typer av risker för personer som använde droger, polisens arbete mot narkotika samt professionellas uppfattningar om vilka behandlingsmål som bör eftersträvas.

Skadereducering är den del av narkotikapolitiken som syftar till att minska skador som är förknippade med droganvändning, utan att samtidigt kräva att individer slutar använda droger. Exempel på skadereducerande insatser är sprutbytesprogram, substitutionsbehandling (i Sverige ofta kallat LARO, läkemedelsassisterad rehabilitering vid opioidberoende), överdosprevention samt lågtröskelboenden. Skadereducering har varit kontroversiellt i Sverige, och därför har införandet av insatser med en skadereducerande inriktning kommit att variera stort mellan olika regioner. Detta innebär att människor som använder droger har ojämlig tillgång till skadereducerande insatser beroende på var de bor. De geografiska skillnaderna kan också innebära att personal inom sjukvård och socialtjänst har olika inställning till behandlingsmål och behandlingsfilosofi, vilket i sin tur kan påverka samspelet med klienterna och de resurser som klienterna får tillgång till.

I den första delstudien undersöks socialarbetares attityder till skadereduktion i tre geografiska områden i Sverige. En enkät som bland annat innehöll frågebatteriet ”Harm Reduction Acceptability Scale”, som mäter i vilken grad en person håller med om principerna och behandlingsmålen för skadereduktion,

Analyserna visar att över 80% av de yrkesverksamma socialarbetarna hade en positiv syn på skadereduktion, både som övergripande princip och när det gäller konkreta behandlingsmål. Vid en jämförelse mellan de olika områdena hade socialarbetarna i Gävleborg en mer negativ inställning till skadereduktion än socialarbetarna i Malmö och Göteborg. Dessa resultat ligger i linje med hur områdena kategoriserades när det gäller utvecklingen av skadereduktion.

Resultaten kan tyda på att personal som är mer exponerade för skadereduktion, och därmed har mer kunskap och erfarenheter av skadereducerande arbetssätt, också är mer positivt inställda till skadereduktion. Det geografiskt varierade utbudet av skadereducerande insatser, i kombination med skillnader i socialarbetares attityder, kan innebära att klienter får ojämna tillgång till insatser och därmed olika förutsättningar för en god hälsa.


att bostadsproblemen även ledde till att de använde droger under natten, för att hålla sig vakna och stå ut i kylan. Avsaknaden av säkra platser för att kunna injicera sina droger innebar att de använde droger på platser som ökar risken för overdoser och dödsfall, exempelvis offentliga toaletter. Deltagarna rapporterade också om mer generella konsekvenser för deras liv, till exempel att de inte ville uppsöka sjukvården på grund av oro för stigmatisering och att de kände sig utestångda från samhället. Sammantaget utgjorde den undersökt regionen en tydlig ogynnsam riskmiljö för personer som injicerar droger.

De tredje och fjärde delstudierna baseras på samma datamaterial, 17 intervjuer med personer som använder droger och som rest eller flyttat från Sverige till Danmark. Danmark har en annorlunda narkotikapolitik än Sverige och har anammat skadereducerande principer och arbetssätt i betydligt högre grad. Detta innebär att länderna skiljer sig åt när det gäller vårdutbud, typer av skadereducerande insatser och polisarbete, vilket gör dem intressanta att jämföra. Åtta av studiedeltagarna var baserade i Danmark och nio var baserade i Sverige. Av de senare nio reste två regelbundet till Danmark, sex reste periodvis medan en inte hade några aktuella resplaner.

Den tredje delstudien syftar till att förstå vilka motiv människor som använder droger har för att resa till Danmark, och vilka risker detta kan föra med sig. Begreppet ”riskmiljö” används för att analysera individers beslutsfattande och potentiella risker i sitt sammanhang. Resultaten visar att det finns en mängd olika motiv för att resa. Policyrelaterade skäl tycks dock dominerar, många deltagare nämnade det större utbudet av olika typer av skadereducerande insatser i Danmark som ett viktigt motiv för att resa, samt att det är enklare att få tillgång till insatser på grund av att danska vårdinsatser ofta har lägre (eller inga) inträdeskrav jämfört med svenska.

Deltagarna uppgav också att den svenska polisens repressiva arbetssätt drev dem till Danmark. Den sociala miljön var också en motivationsfaktor, både när det gällde deltagarnas sociala nätverk och när det gällde stigmatiserande upplevelser i kontakter med vårdgivare, vilket uppgavs vara mindre vanligt i Danmark än i Sverige. Skillnader i drogscenerna var också en framträdande motivationsfaktor, där den öppna och koncentrerade drogscenen i Köpenhamn motiverade många deltagare i deras beslut att resa. Slutligen spelade ekonomiska faktorer en roll; inkomstmöjligheterna upplevdes vara bättre i Danmark, bland annat på grund av att brottsregister i Sverige begränsar möjligheterna till anställning. Delstudien ger sammantaget viktiga insikter om fördelar och nackdelar med olika narkotikapolitiska inriktningar ur droganvändarnas egna perspektiv, liksom om komplexiteten i att hantera narkotikarelaterade risker.
I den fjärde delstudien analyseras vilken betydelse den nationella narkotikapolitikens övergripande mål har när det gäller droganvändares mellanmänskliga kontakter med vårdgivare, polis och människor i allmänhet. Analysen utgår från ett socialkonstruktionistiskt perspektiv där begreppen stigma och identitet används för att tolka det empiriska materialet. Deltagarna uppgav att mellanmänskliga kontakter ofta fick dem att känna sig osynliga och avhumaniserade i Sverige, medan de kände sig mer sedda i Danmark, vilket innebar att de kunde återvinna sin mänsklighet.

Tillgången till vissa insatser i Danmark, exempelvis drogkonsumtionsrum, och den danska polisens mindre repressiva arbetssätt fick dem också att känna sig mer inkluderade i samhället. När det gäller vårdkontakter uppgav deltagarna att de ofta kände sig kontrollerade eller till och med skambelagda av behandlingspersonal i Sverige, vilket ledde till att de inte vågade berätta om återfall. Ett mindre bestraffande förhållningssätt i Danmark upplevdes leda till mer öppna och stärkande relationer, vilket förbättrade deltagarnas självförtroende och gav dem mer optimism inför framtiden.

Tillsammans visar studierna i denna avhandling på de mångfacetterade sätt som narkotikapolitiken kan påverka individer som använder droger, och deras tillgång till resurser, risker och välbefinnande. Avhandlingen visar att attityderna till vårdmål och interventioner skiljer sig åt mellan olika regioner, bland yrkesverksamma som ger vård till personer med narkotikaproblem. Den visar också hur vårdkontakter, polisarbete och mellanmänskliga relationer kan formas av såväl nationella som lokala policy- och vårdstrategier. Sådana policies och strategier påverkar människornas tillgång till vårdresurser, deras rörlighet mellan olika miljöer, deras identitet och deras möjligheter att inkluderas i samhället.

Avhandlingen pekar på behovet av att ett bättre utbyggt och geografiskt mer jämnt fördelat utbud av skadereducerande insatser. Därförkan kan bördan minska för dem som behöver flytta eller resa för att få tillgång till vård, eller som utsätts för orimliga risker på grund av ett begränsat vårdutbud.
ACKNOWLEDGEMENTS

As many who have gotten to this point will say, doing a PhD was both professionally and personally challenging. In my case, it was not just an intensive work process, but also involved moving to a new country and establishing a new life. I received support from an incredible number of people throughout the past five years was on many different levels, who celebrated my successes (and more importantly, helped during my struggles). Whatever I can write here will be insufficient to express my gratitude for everyone who has helped me along the way, in all of the small and large ways people have been there for me.

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I have so many colleagues who welcomed me with open arms and helped me adapt to life and working in Sweden, who must be thanked. There were numerous people who gave me opportunities to help me build competencies working with students, which has been so valuable to me: Johan Nordgren, Mikael Boregren, Jonas Christensen, Marie Karlsson, My Lilja, and Anna-Karin Ivert. Thank you to Carin Cuadra for helping me and looking out for me. Lisa and Kristina, who were some of the driving forces for me learning Swedish – tack. To the whole “missbruksgrupp” for offering perspectives, discussion, and lunch meetings
which I always look forward to! Nada, who has been there to commiserate and support on international student issues. Olivia, for being my desk mate. To all of my doctoral colleagues and colleagues at ISA for feedback, retreats, fikas, lunches (and second lunches), and puzzling, for including me, and for speaking Swedish to me and, accepting that I won’t speak Swedish back, I thank you.

I am fortunate to have friends all over the globe who have helped me go this distance! It can be difficult to start over (and over), I am so thankful for each friend who has helped make somewhere feel like home. Thank you to my amazing friends who I have met in Sweden, who have included me, and added joy to my life – as well as all of those around the globe in Canada, the UK, and wherever else you may be. Regardless of how far we are from each other, I never doubt that when we see each other, we are right back in step. Whether it was through dinners and cycling across Skåne through COVID, or voice notes and FaceTime, I feel privileged to be surrounded by such amazing, intelligent, and supportive people.

Oscar, thank you for being a daily support, a source of calm, and levity. You can always tell exactly how I am feeling, and have helped me when I have been stressed. I promise now I really will unload the dishwasher. And to the Larsson/Lucander families for being so generous and welcoming to me – I am so grateful!

Thank you to my entire extended family for the unending support, which has helped get me to this point. Thanks to my siblings, Zack, Maddie, and Duffy, who through life have guided me down a steep mountain slope – literally, but also at times figuratively. Though distance from family can be difficult, the 9-hour time change means there is always someone awake to talk to. Thank you, Maddie for always being there for me. To my parents, who were the ones who suggested I do a PhD over a decade ago, which I thought was a ridiculous idea at the time. Thank you not only for the infinite moral support, but the career support, too. Dad, you gave me the tools to get here, by reading and editing my papers throughout university, and encouraging curiosity. And mom, you inspired my interest in this subject. I am so appreciative to you for patiently listened to me practice countless presentations and always giving me helpful feedback.

Finally, I would like to thank the participants of this study. To the hundreds of social workers who took time out of their day to respond to the survey, despite the so many different pulls on their time, thank you. And to the 28 individuals who I interviewed. I had the privilege of speaking to you throughout my fieldwork. I can only hope that through this project, I am able to adequately represent the experiences shared with me.
REFERENCES


APPENDIX ONE

This appendix displays the survey questions relating to perceived service access for clients, and the modified Harm Reduction Acceptability Scale.

Hur bedömer du generellt tillgängligheten vad gäller följande insatser för personer med narkotikaproblem som vistas i din kommun?

<table>
<thead>
<tr>
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<th>Låg tillgänglighet</th>
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<tr>
<td>Strukturerad öppenvård (planerade, tidsbegränsade och regelbundna insatser)</td>
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<td>Annan öppenvårdsverksamhet (kontakt, stöd eller rådgivning)</td>
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<td>Medicinsk beroendevård</td>
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<td>Eftervård och uppföljning (efter behandlingshem eller annan behandlingsinsats)</td>
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<td>Insatser kring sysselsättning via Arbetsförmedlingen (statligt)</td>
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<td>Insatser kring sysselsättning via socialtjänsten (kommunalt)</td>
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<td>Överdosprevention</td>
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<td>Diakonal verksamhet</td>
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Nedan finns ett antal påståenden som handlar om skadebegränsning. Markera i vilken utsträckning du håller med respektive tar avstånd från varje påstående

<table>
<thead>
<tr>
<th>Val av mål med behandlingen (till exempel avhälsamhet, minskad användning av droger eller alkohol, säkrare användning av droger eller alkohol) bör diskuteras med alla personer som söker hjälp för drog- eller alkoholproblem.</th>
<th>Instämmer starkt</th>
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<tr>
<td>*Personer som bor i offentligt finansierade bostäder måste vara drog- och alkoholfria.</td>
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<td>Läkare bör tillåtas att förskriva heroin och liknande substanser för att behandla narkotikamissbruk så länge som det minskar problem som brottslighet och hälsorisker.</td>
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<td>Drogen användare bör få ärlig information om hur olagliga droger kan användas säkrare (till exempel hur överdoser eller relaterade hälsorisker kan undvikas).</td>
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<td>Personer med narkotikaproblem som inte är villiga att acceptera avhälsamhet som mål för behandling bör erbjuda insatser som syftar till att minska skador i samband med deras fortsatta narkotikavändning.</td>
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<td>Det är acceptabelt att förskriva substitutionsläkemedel som metadon/buprenorfin för att minska brott och andra sociala problem förknippade med narkotikamissbruk.</td>
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<td>Så länge klienter gör framsteg mot sina behandlingsmål, bör LARO-program inte skriva ut klienter ur behandlingen på grund av sidomissbruk.</td>
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<tr>
<td>*Åtgärder för att minska skador i samband med narkotikamissbruk eller alkoholanvändning är acceptabla endast om de på sikt leder till att klienten avstår från narkotika eller alkohol.</td>
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*Personen som bor i offentligt finansierade bostäder måste vara drog- och alkoholfria.
Personer med narkotika och alkoholproblem kan vara mer benägna att söka professionell hjälp om de erbjuds åtminstone några behandlingsalternativ som inte fokuserar på drogfrihet.

Personer vars narkotikaanvändning är stabil bör utbildas för att kunna lära andra användare hur man använder narkotika säkrare (till exempel hur man injicerar säkrare).

Det är möjligt att använda droger utan att missbruka droger.

*Opioid användare bör endast förskrivas metadon/buprenorfin under en begränsad tid.

Personer med injektionsmissbruk som inte är villiga att acceptera avhållsamhet som behandlingsmål bör ges enkel tillgång till ren injektionsutrustning för att minska spridningen av HIV och andra blodburna sjukdomar.

*Drogfrihet är det enda acceptabla behandlingsmålet för personer som använder olagliga droger
APPENDIX TWO

This appendix displays the guides which informed the semi-structured interviews.

Article II

Background
Personal history (age, sex, place of birth)
Current living/life situation – Employment, housing, social network, family, perceived health.
Experiences of being homeless? If homeless currently, where sleeping? Other solutions?

Substance use
Drug use career – when started to use drugs? Which drugs? Main drugs used now
Main route of use?
How often injecting?
Where get needles? Where get other things – e.g. pipe for smoking?
Reuse needles? Share needles?
Where use drugs (e.g. home? Street?)
Ever stopped? If yes, how?

Treatment experience
Which types of treatment accessed?
Experiences on OST? If so, ever been removed? If currently on OST, how often urine drug screening? What is the process if positive? Experiences with staff there – how do they treat you?
Any choice of provider?
12 step treatment? Zero tolerance approach?
What harm reduction/drug-related services being used in current location?
What is the process to use services?
Perception of adequacy of services to meet needs?
What other services might be offered to better meet needs?
Knowledge of/attitudes towards services offered elsewhere
Desire or thought to go elsewhere for services? Or internet? Why yes/no?

**Other services/encounters**
What other (non- harm reduction, -drug related) health and social services connected to?
Employment, housing, income assistance, food, shelter, etc. services?
What kind of interaction with social services?
What has your experience been with getting medical/social care – e.g. with doctors, nurses? Perceptions of attitudes of service providers
Perception of societal view of drug use – day to day interactions with regular citizens

**Risk behaviours**
Perception of personal risk behaviours
How handle drug-related risk currently
How handle low availability of services
Is there any secondary, bridging distribution system?
Willingness to attend a local needle exchange?
What impact might a needle exchange opening have on behaviours/life?
Overdose prevention/naloxone – access? Education on how to avoid overdose?
User union? Any organization for users where they try to change policy, etc.? advocacy?
View on SCS? HAT? Will it happen? Perception?
Police – how do they treat you? What do they do re: open drug use in city? Are there open drug scenes?
What services do you think are missing?
Future plans?
Articles III/IV

Background
Personal history (age, sex, place of birth, place of current residence)
Current living/life situation – employment, housing, social network, health, family.
Experiences of being homeless? If homeless currently, where sleeping? Other solutions?

Substance use
Drug use career – when started to use drugs? Which drugs? Main drugs used now
Main route of use?
How often injecting?
Where get needles? Where get other things – e.g. pipe for smoking?
Reuse needles? Share needles?
Where use drugs (e.g. home? Street? Consumption room?)
Ever stopped? If yes, how?
Treatment history and experiences of treatment?

Why in Denmark and practicalities
Motivations for movement – why are you here/where else have you been/why did you go (t)here?
Practicalities of movements: i.e place of origin, timing of leaving, who of personal network remains in place of origin, life situation factors at home (employment, housing)
Challenges/barriers to movement – how has it been to move between places?
What was it like?
Problems based on rules of accessing services in Denmark?
Risks of being here/elsewhere? Travelling?
What was involved in the journey (t)here? Direct? Stopping over places? Was/is this the end destination?
Process to access different services regarding civil registration in the municipality?
Any services can’t access?

Services and experiences in Denmark
Experiences of since they moved, began accessing services in destination/current region.
What services used, how are they, good/bad experiences with them? How do they compare to other services elsewhere?
Other life circumstances – how have they changed since moving?
Experiences with police
Experiences with health and social care

Services and experiences in Sweden
What services used, how are they, good/bad experiences with them?
Experiences with police. Have police taking drugs or needles taken away?
Experiences with health and social care

Long term plans
How long intended to stay here? Short term, indefinite, permanent? Why stay?
Intentions to return home?
Questions focusing on ability or barriers to actually accessing services in their destination

Reflections on different settings
Reflections of services in different areas accessed?
Comparison/reflection of attitudes of service providers, general public in different areas
Barriers to returning home (if desired)/return to Denmark if in Sweden
Preferences with each system?
Experience or understanding of differences in drug policy between the two/several places? Perspectives on this?
Ross, M. W. Typing, doing and being. A study of men who have sex with men and sexuality on the Internet. 2006:1
Stoltz, P. Searching for meaning of support in nursing. A study on support in family care of frail aged persons with examples from palliative care at home. 2006:2
Gudmundsson, P. Detection of myocardial ischemia using real-time myocardial contrasts echocardiography. 2006:3
Holmberg, L. Communication in palliative home care, grief and bereavement. A mother’s experiences. 2007:1
Ny, P. Swedish maternal health care in a multiethnic society – including the fathers. 2007:2
Schölin, T. Etnisk mångfald som organisationsidé. Chefs- och personalpraktiker I äldreomsorgen. 2008:1
Svensson, O. Interactions of mucins with biopolymers and drug delivery particles. 2008:2
Holst, M. Self-care behaviour and daily life experiences in patients with chronic heart failure. 2008:3
Bahtsevani, C. In search of evidence-based practices. Exploring factors influencing evidence based practice and implementation of clinical practice guidelines. 2008:4
Andersson, L. Endocytosis by human dendritic cells. 2009:1
Svendsen, I. E. In vitro and in vivo studies of salivary films at solid/liquid interfaces. 2009:2
Persson, K. Oral health in an outpatient psychiatric population. Oral status, life satisfaction and support. 2009:3
Hellman, P. Human dendritic cells. A study of early events during pathogen recognition and antigen endocytosis. 2009:4
Baghir-Zada, R. Illegal aliens and health (care) wants. The cases of Sweden and the Netherlands. 2009:5
Stjernswärd, S. Designing online support for families living with depression. 2009:6
Carlsson, A. Child injuries at home – prevention, precautions and intervention with focus on scalds. 2010:1
Carlson, E. Sjuksköterskan som handledare. Innehåll i och förutsättningar för sjuksköterskors handledande funktion i verksamhetsförlagd utbildning – en etnografisk studie. 2010:2
Sinkiewicz, G. Lactobacillus reuteri in health and disease. 2010:3
Tuvesson, H. Psychiatric nursing staff and the workplace. Perceptions of the ward atmosphere, psychosocial work environment, and stress. 2011:1
Ingvarsdotter, K. Mental ill health and diversity. Researching human suffering and resilience in a multicultural context. 2011:2
Hamit-Eminovski, J. Interactions of biopolymers and metal complexes at biological interfaces. 2011:3
Mellgren, C. What’s neighbourhood got to do with it? The influence of neighbourhood context on crime and reactions to crime. 2011:4
Pooremamali P. Culture, occupation and occupational therapy in a mental care context— the challenge of meeting the needs of Middle Eastern immigrants. 2012:1
Gustafsson A. Aspects on sepsis: treatment and markers. 2012:2
Lavant, E. Multiplex HLA-DR-DQ genotyping. For genetic epidemiology and clinical risk assessment. 2012:3
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Dealing with low access to harm reduction: a qualitative study of the strategies and risk environments of people who use drugs in a small Swedish city

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Abstract
Background: The development of harm reduction has been limited in many areas of Sweden. This study aims to understand the implications that this has for the life circumstances and risk management of people who use drugs in areas of low access.

Methods: Eleven qualitative, semi-structured interviews were undertaken with people who use drugs in a small urban centre with no needle and syringe exchange program (NSP) or Housing First policy.

Results: Participants reported many solutions to lack of NSP, including travel to an external NSP, creating bridging distribution networks, stealing, borrowing, reusing, ordering online, and smuggling injection equipment. They were at risk of having their equipment confiscated by police. Participants were mostly homeless, and to address exclusion from housing services, were forced to frequently find new temporary solutions, sheltering themselves in public places, with friends, in cars, among others. Participants felt the lack of services reflected stigmatized notions of drug use and heightened their exclusion from general society. For example, they avoided accessing other health care services for fear of discrimination. These issues caused high levels of stress and anxiety, in addition to serious risk for many somatic and psychological health conditions, including HIV and HCV transmission.

Conclusion: Lack of harm reduction services placed a great burden on study participants to develop strategies due to gaps in official programming. It also contributes to a vicious cycle of exclusion from services. The implementation of such evidence-based programs will reduce this burden, as well as provide the indirect, symbolic effect of inclusion.

Keywords: People who use drugs, Harm reduction, Needle exchange, Housing first

Background
The use of illicit drugs is associated with an increased risk of a number of intersecting health [1, 2], psychological [3, 4], and social vulnerabilities [5, 6]. This is especially true of injection drug use, and for those who have substance use disorders [1, 7]. There is a good evidence basis for programs and policies based on the paradigm of harm reduction, such as needle and syringe exchange programs (NSP), opioid substitution therapy, supervised consumption rooms, among others, in mitigating some of these concerns [8–11]. Various forms of well-developed harm reduction programing demonstrate effectiveness in reducing risk behaviours [8, 9], blood-borne virus transmission and bacterial infections [8, 10, 11], serving as the basis for other health interventions [12], improving referral to other health and social services [13–16], and...
quality of life [17]. Furthermore, they may promote positive engagement with the healthcare system more generally, and qualitative studies on people who use drugs experience of these services demonstrate that they view such interventions as a “safe haven” or “a little heaven in hell” [13, 18–21]. However, how or if these programs are developed and implemented varies greatly both across and within countries.

Sweden has been widely noted to have a restrictive, deterrence-based drug policy, and an aim to have a “drug-free society”, stemming from the early 1980s [22]. Policy responses are built on this notion, and drug use in Sweden is criminalized and highly stigmatized, with a law enforcement focus on street-level drug use and a history of low access to harm reduction. The zero-tolerance approach has been criticized, due to its ineffectualness and negative impact on the lives of people who use drugs [22–24]. Notably, Sweden has consistently been at the top end of European drug-related deaths reports [25] (though these can be faulted for lack of common methodology). In recent years, there has been a general shift towards increased focus on harm reduction; however, these changes have not been uniform across the country.

Sweden operates a universal healthcare system, which is mostly free at the point of access. Health and social care offerings are decided at the regional and municipal level, respectively, leading to local service variations. Harm reduction offers a prime example of this variation. While the first NSP were opened in two neighbouring cities in the Skåne region in Southern Sweden already in 1986 (Lund) and 1987 (Malmö), debate surrounding these programs limited their continued development [26–28]. In the Swedish context, NSP have been controversial because it is seen to directly contravene the goal of a “drug free society”. Outside of this region, the first NSP was opened in 2012. In 2017 a policy change led to more widespread development than before, and now NSP operate in 17 of 21 regions. The development of harm reduction, and NSP specifically, in Sweden are well described in Eriksson and Edman [27] and Karlsson et al. [28].

Where offered, the practice of NSP in Sweden, has a specific, rigid characterization, as described by Alanko-Blomé et al. [29]. NSP are located within the healthcare system, often at a hospital [29]. This limits the number of physical locations. They have high entry requirements, including identifying oneself, a minimum age of 18 (previously 20) years, and taking part in mandatory HCV and HIV testing [29]. They are only offered during business hours [12]. NSP offer a full staff of an infectious disease specialty physician, nurses, and social workers [29]. The positive aspects of this structure are access to a wide range of cohesive services and efforts, including social work, sexual health, basic medical care, help to enter drug treatment, among others. Consequences of this programmatic structure include excluding people from care due to time or geographic limitations, or their desire to be anonymous, especially in the previously described context of drug use criminalization. Consequently, the provision of such a program does not mean access in practice. Official NSP are the only place in which sterile injection equipment can be legally obtained by people who use drugs. In contrast, in many other nations, particularly in Europe, needles and syringes are often offered freely or by purchase through, for example, pharmacies, vending machines, and/or NGOs, among others, in conjunction with NSP locations, with no requirement of participation in other aspects, or identifying oneself [30].

The recent improvements in the breadth of NSP coverage also reflect other recent positive changes in the Swedish harm reduction landscape. However, these changes vary substantially on a regional and municipal level. For example, the Skåne region, recently improved access to opioid substitution therapy, which has, until recently, been characterized by a high-threshold model. This involved long waiting lists, with strict criteria regarding an extensive documented history of substance use, regular urine drug testing with expulsion or suspension upon a positive test, high age limits, and limited personal agency/preference of the service users. Some regions have undergone reforms in recent years, which have led to increases in access and patient numbers [31], as well as increase in patients’ sense of empowerment over their own care [32].

Broader harm reduction programming, such as Housing First policies, is also unevenly implemented in Sweden. The predominant model to address homelessness in Sweden can be referred to as a “staircase” or “treatment first” model [33]. This model requires individuals to have stopped all drug use and undergo monitoring to ensure that they can maintain an apartment “adequately” [33]. Conversely, Housing First, as the name implies, offers a stable home as a primary support, where abstinence from substance use is not a requirement to receive or maintain housing, but with the belief that any attempt to address such concerns would be better done concurrently, rather than in a successive manner [33]. The focus is on the stability that a permanent home can give someone as a basis for other interventions, and harm reduction is considered to be a key feature of such programs [33]. Housing First programs were first introduced in Sweden in 2010,

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1 Patient fees of 200kr–300kr (20–29 EUR/23–34 USD) for visits with doctors, up to a cap of 1100kr (108 EUR/127 USD) per twelve-month period.
beginning in the capital area of Stockholm, as well as in the municipality of Helsingborg, which is in the Skåne region previously noted for its early implementation of harm reduction efforts. The development, interpretation, and implementation of the first Swedish Housing First programs are reported upon in detail by Knutagård & Kristiansen [33]. Evaluations of such projects in the Swedish context have demonstrated positive results, such as improved quality of life and social relations, as well as reduced or terminated substance use [34, 35].

Housing First has been promoted by the Swedish Association of Municipalities and Regions (Sveriges Kommuner och Regioner) [36] and is in the National Board of Health and Welfare’s (Socialstyrelsen) national guidelines since 2017 [37] but has only been taken up by a limited number of municipalities. As of 2020, approximately 40 of Sweden's 290 municipalities had validated such a policy [38], although it is unknown how many of those actually offer Housing First accommodation in practice. In those municipalities which offer it, Housing First is not an exclusive policy in many cases, and may be offered in parallel with other models [33].

Additionally, take-home naloxone (THN) has recently been made available, but has restrictive access criteria. Since 2017, it is only available to individuals who are themselves deemed to be at risk of an opioid overdose, by prescription [39]. Friends, family members, or individuals who use non-opioid substances cannot be given THN, though they may attend training with the view to administer THN to someone in their network [39]. The legislature states that “the patient [needs to] make sure that the medicine is available to the person who may need to give it” (translated by author) (p. 16) [39]. THN is often distributed through, for example, opioid substitution programs and NSP. There are no supervised consumption rooms or heroin assisted treatment programs currently in Sweden.

The current case: operationalization of “low” provision of harm reduction

While Sweden continues to move in the direction of harm reduction, some regions and municipalities continue to lag far behind due to the influence of the zero-tolerance approach. There are a number of different ways to operationalize what “low” harm reduction may be. In this case, I have chosen the lack of two programs—NSP, and a Housing First policy—as the primary criteria. These can be seen to encapsulate both a “direct” and “indirect” harm reduction approach.

Despite recommendation by the Swedish Public Health Agency (Folkhälsomyndigheten) [40] and National Board of Health and Welfare (Socialstyrelsen) [41], at the time of study, four regions remain completely unserved by a NSP. The current study takes place in a city in one of these four regions. The city and region of study remain unnamed out of concern for the anonymity of participants in a setting of criminalization of illicit substance use. One hypothetical defence that could be used to not open a NSP in the Swedish context would be lack of population density, relating to the above-described high administrative demands of the program. However, NSP are open in several cities in Sweden with significantly smaller populations than the current case. Therefore, this setting is particularly interesting due to the fact that it is primarily municipal political actors who have constrained this development.

Additionally, while some of the municipalities in this region do have a Housing First policy, the particular city in focus lacks such a program, meaning that individuals who are currently using drugs are excluded from accessing government housing programs. Knutagård and Kristiansen [33] have suggested that the limited take-up of Housing First in Swedish settings could in part relate to the fact that “the core element of harm reduction within the Housing First philosophy challenges the traditional substance abuse work in Sweden, which is based on the requirements of abstinence and control” (p. 102).

Other well-evidenced interventions, such as opioid-substitution therapy, are provided in a limited fashion, in the region, with very few clinics and no choice or agency over care provider from clients. Despite that Sweden in fact was one of the first countries in the world to provide methadone maintenance therapy (1966), proliferation across Sweden was slow, and this region did not begin such provision until several decades later [42]. As stated above, take-home naloxone is often distributed by NSP. The lack of NSP in this region means access is limited, especially for individuals who are not engaged in addiction care, or who do not access other health care services. Together, these factors can be used to demonstrate this region’s reluctance to embrace evidence-based harm reduction practices, leading to low access for the population.

Place is an important determinant of health [43–45], and research has demonstrated the influence of geographic proximity and utilization of harm reduction services and/or engagement in risk behaviours. Studies which have mapped the willingness of people who use drugs to travel for services have demonstrated a direct relationship between distance to and use of services [46–48], syringe sharing [49, 50] and thus associated health outcomes. Harm reduction-based strategies have developed and expanded in many countries in the past few decades. However, as can be seen in a case study by Clarke [51], due to the moralized nature of drug use, some of the programs and services associated with it are
seen as controversial. As stated, this means that there are significant variations of service offering and provision both between and also within countries, which mediate access on an individual level.

Studies on regional-level variations or deficiencies in harm reduction provision have taken place in settings such as Canada and the United States. These are often characterized by the urban/rural divide and low population density as the primary factors behind lack of service provision [47, 52–56]. Another group of studies demonstrate that people who use drugs will travel or migrate, in part to access better services [57–61]. The existing studies have also primarily focused on service needs, barriers to care, and potential solutions [47, 52–54, 56]. Fewer studies have focused on urban areas lacking services [52] or about how people who use drugs who choose to stay in areas of limited service-provision experience and cope with this, and the broader implications this has for their social vulnerability and health risks.

The purpose of this study is to investigate the life situation, risk exposure, and risk management for people who use drugs who live in an urban area of a region with low access to harm reduction. It asks the question: what does it mean to people who use drugs to have low access to harm reduction measures, in terms of their lives, health, risks, and social exclusion, and what strategies do they employ to contend with this?

Methods
Study design and recruitment
A qualitative study was carried out, consisting of semi-structured interviews. The primary recruitment target for the current study was people with an extended history of substance use, with a focus on people who inject drugs. However, one individual with a history of non-injection substance use was also included, due to their history of engagement in harm reduction programs. Recruitment took place in a small but urban area in a specified region of “low” harm reduction service coverage, as described above.

Interviews were conducted over the phone or on Microsoft Teams, between January and March 2021. Due to COVID-19-related complications, a convenience sampling method was adopted. I was unable to travel to recruit for this study in person. Instead, I came into contact with individuals (henceforth referred to as “recruitment partners”) who worked at two organizations locally whose services were primarily aimed at people who use drugs. One organization provided overnight shelter and meals, and the other provided treatment for substance use. I provided them an information sheet digitally, and these recruitment partners assisted me in advertising and recruiting for this study. At one service, I was given the phone numbers of individuals who indicated their interest in participating, with whom I conducted a phone interview at their convenience. At the other service, the recruitment partners set up video calls in their office. The limitations of this recruitment strategy are addressed in a later section.

Data collection
The interview guide was designed to explore participants’ accounts, key topics included: perceptions of Swedish and local drug policy and its impact on them as individuals, injecting equipment access and use, risk behaviours, experiences of accessing other harm reduction and health services, how lack of access to certain services is dealt with, as well as perceived health and social care needs. Structured questions, with relation to sample characteristics and life circumstances, such as housing and income, and information on history of drug use, were also asked.

In total, 11 semi-structured interviews were conducted, ranging from 21 to 73 min in length (mean duration 49 min). Interviews were recorded with the permission of participants. Participants chose which language (English or Swedish) they preferred to be interviewed in. Interviews were transcribed verbatim. Completed transcripts were proofread and checked for accuracy. Data coding took place in the original language of the interview, and I translated excerpts used for display in the current report. These excerpts were checked for accuracy by two bilingually fluent individuals.

Analysis
Thematic analysis, as described by Braun & Clarke [67], was chosen as the method to guide the analysis of the interview data, due to its flexibility and theoretical malleability. Qualitative data analysis software (NVivo 12) was used to assist in this process. As interviews took place, I kept memos of initial impressions. Interview transcripts were read and re-read in order to familiarize, and preliminary notes and interpretations were made. I employed an abductive coding method, where some of the codes came from preconceptions and backing in the literature, and others came from the data themselves. Coding was an open, fluid, and flexible process, in which ideas viewed to be relevant or of interest were noted. Codes which were decided upon throughout the initial reading process were then developed and refined through a process of continual revision. Codes (and the data excerpts they represented) which were interpreted to have shared meanings were grouped together to create initial themes. Themes were then checked for consistency and representativeness, and revised as necessary. The aim of developing themes was not merely to summarize the data, but
to interpret in order to find core, central, unifying concepts [67]. This allows for the deeper meaning of the data to be clarified. Data extracts were found and chosen to elucidate analytic claims.

The risk environment as a theoretical framework

Several authors have critiqued individual behavioural orientations to reducing drug-related harm [62–65]. Many harm-reducing programs require that individuals actively seek out care and reduce their own risk, but in reality are limited by “the material constraints on individual human agency” [65] (p. 3036). Rhodes [63, 64] suggests a more contextual, “risk environment” approach to understanding the engagement in ongoing risk or health-seeking behaviours [59, 60]. This approach investigates the systems surrounding the individual, and acknowledges the multiple competing priorities that play a role in risk management [64]. Understandings of drug harms must be seen to be mediated by the interplay of social, policy, economic, and physical dimensional factors [66]. The current study employs these dimensions of the risk environment to assist in interpreting themes and organizing them within the discussion. These may be further examined at the micro- (individual, interaction), meso- (group norms, community level access to services), and macro- (national level policies and laws) levels [66]. Participants’ experiences are situated within their contexts, and where applicable, the role of their environments in producing or reducing risks is examined.

Ethics

The project on which the current study is based was approved by the Swedish Ethical Review Authority (Dnr 2019-06509). All participants gave their informed consent to participate. All study procedures complied with relevant laws and institutional ethical guidelines. Given the nature of the topics involved, extreme caution was taken regarding exact names, locations, and other identifying personal details when both interviewing and transcribing. Any such specifying personal information was removed from the final transcribed product, in order to ensure confidentiality. Participants were remunerated with a 200SEK gift card for their time.

Results

Participant characteristics

Eleven individuals took part in this study, of which ten were male and one was female. The age range was 31–55 years, with an average of 43 years. All but one had injected drugs. Most (eight of 11) had ongoing daily or near-daily injection use. The remaining three had a history of substance use and were linked to the recruiting organizations, as above, treatment for their substance use or a shelter and meal program, and thus were knowledgeable about harm reduction interventions. Ten of 11 reported at least a decade of substance use, and eight reported use beginning in teenage years, or earlier. The primary drug of choice was amphetamines, followed by heroin and other opioids, and benzodiazepines. Alcohol and cannabis use were also reported. Four of 11 reported current polysubstance use. Seven were homeless or unstably housed. One participant was regularly employed, the rest reported a mixture of income generation from state pension, income assistance and/or disability payments, casual employment, begging or busking, and criminal activities.

Findings

In this section, I present the two overarching, interrelated themes developed through the process of analysis: how individuals in the study addressed their needs in the face of lack of access to harm reduction services, and the health, psychological, and social consequences of this lack of access. These themes are first presented on the direct level, reporting NSP and Housing First individually, followed by presentation of the broader-level consequences and implications of the absence of services.

Strategies and consequences related to the lack of NSP

The participant population as a whole was made up of individuals with a very high level of consistent need of sterile injection equipment—as noted, most were injecting daily or near daily—which was not being met by formal solutions in their immediate physical environment. They reported that their current city was their home, where their families and social networks were, where they were connected to other services, so, for most, permanent movement to a city with better service access was not an ideal option. They reported a number of different ways in which they got around the lack of access to care in their region. Almost all noted that they had at some point travelled to another region of the country, approximately 100 km away in each direction, to collect a large number of syringes and needles at a formal NSP:

"And then we gather [the used injection equipment] all together. I think I left a hundred syringes and needles that I had at home in a box... And those at the syringe exchange program, they know what situation we're in up here. So they have been nice... always provided extra tools as well. And I think that is- it makes me really happy." (Participant 8)

"Yes... it's far. I live in [town], yes but, it's a long way there. So it takes a while. But it's going well, they have nice staff. You are treated well, you're just anyone. They aren't like 'Oh, an addict!'" (Participant 7)
Despite the effort to travel there (some participants noted doing so on a weekly basis), several participants highlighted the additional, psychosocial impacts of such services, further to receiving sterile injection equipment. For example, when discussing the external NSP and the staff there, another participant remarked:

“How soft and welcoming they are and what service they stand for… it’s beautiful.” (Participant 6)

However, not everyone was able to consistently visit an external NSP. Instead, they reported gaining access to equipment “in lots of different ways. From friends, maybe in a burglary… at the veterinary clinic and such. I can order them online” (Participant 4). Among other strategies reported by participants, one reported accessing the hospital ER in hopes that a member of staff would give them spare syringes, one reported fashioning injection equipment out of household items, and a number reported smuggling them from other countries where they are more easily accessible, such as Norway. Another commonly stated solution was secondary syringe and needle distribution, that is, working together amongst a small network to distribute legally obtained syringes to each other. Participants reported both giving and receiving this equipment, either for free or in exchange for drugs, the below accounts demonstrating the concern these individuals have for access in their wider network:

“I have many of my friends, or yes, acquaintances… they do not think because they are addicted. They don’t care if they’ve used a needle for three or four weeks then…. I just – ‘What the hell, why didn’t you call me? You know I’m sitting on my tools. How hard is it to call me and ask me, do you have any tools? Because you know I’ll say yes. … Yes, come and pick me up then. Replace your old ones that you have, so I can take them. So you can take new ones from me instead.” (Participant 6)

“There are many who do not dare to go there [the external NSP], or who cannot. And then I think they have as much right as I do, so then I go there and pick them up for us… I get it for free, they get it for free… You should not have to pay to get well, or stay healthy.” (Participant 7)

This sort of community cooperation was key in maintaining their health and wellbeing, and was found both for syringe distribution, as well as finding places to sleep and inject together. In this case, their social environments functioned as a manner to mitigate risks at the micro-level. Many noted the importance to them of ensuring that people in their network were using sterile equipment, as “we addicts have a special belonging to each other. We actually take extra care of each other a lot” (Participant 6). However, while this may reduce the hindrance of travel and time for some, it may increase the burden for others, placing them into a sort of informal, uncompensated provider role. It also may lead to inconsistency in equipment access.

Despite their efforts, participants faced a number of challenges to consistently accessing new, sterile injection equipment. For those who did report going over distances to access an external NSP, personal compromises were made, for example, noting:

“If there was a NSP in my city, I wouldn’t have to go so damn far, spend a whole day in another city, which I don’t even like…. And then yes, more children, grandchildren I could spend my time with. So it’s a lot. So I would get a lot of time for other things.” (Participant 7)

The hidden costs of health risk management included travel time, money for transportation, general discomfort in a different setting, and lost time with loved ones. Compromises were being made between accessing the NSP and other important priorities, including important social connections with family.

Unsurprisingly, a primary consequence of lack of NSP and other low threshold services was the extensive reuse of injection equipment, sharing with others, and the acquisition of used injection equipment. One participant explained:

“I have to use the same syringes for like, well, at least 5 days… like 15 times, it’s no problem … Some people are going on travels to [town with NSP]. But I’m not in that capable to go on busses or trains or like that.” (Participant 3)

Another participant’s comments illustrated the issues with insecure access and relying on others for injection equipment:

“… And now I order or I get from others.”

(Interviewer) “Yeah so you always get clean ones?”

(Participant 9) “Not always.”

(Interviewer) “… When you get them from other people do you pay for them? Or do you give them for free?”

(Participant 9) “No [I don’t] pay for them, I think we pay enough to chance if you’re going to get HIV or something else just by using it.”

Thus, relating to the dimension of the physical environment, the geographic impediment to access has clear and important implications on engagement in risk behaviours for this population. This has important impacts on health outcomes – including blood-borne viruses such as HCV,
for which Sweden provides free treatment – which then “goes around and around like a hamster wheel” (Participant 3) due to ongoing lack of sterile equipment access leading to repeated HCV reinfection.

**Strategies and consequences related to the lack of stable housing**

As noted, this area offered a “treatment first” model of housing and, accordingly, people who use drugs were excluded from housing programs. Participants reported a number of strategies in which they addressed this themselves. Most were homeless or unstably housed, and found more or less temporary housing through shelters or by friends and family. Others reported solutions such as “sleeping in my car, and a storage unit” (Participant 5). For those who had apartments, any ongoing substance use meant that “it hangs by a thread whether I can keep it or not” (Participant 8).

Due to the lack of formal solutions, they reported moving frequently, often faced with short-term solutions, unable to settle in any one place. Those who were actively homeless in particular faced a nightly struggle. One participant’s description of their everyday existence exemplified this effort:

“So then I have been at the train station until half past two... Then they close there, then I was out walking in town then. And I have a pretty heavy pack... just because I never know what’s coming. So I probably have a 50 kg pack, which I go and carry. So it becomes a little hard there to carry... But it will be like carrying on a home as well. But yes, I went from there down to the town, the public toilet, so we stood in a public toilet... And there we still stood until five o’clock this morning, approximately. Because then we knew that by then the train station had opened, they open at a quarter past four... So you could go there again then...until eight, before I came here.” (Participant 6)

Similarly to how they addressed lack of NSP, harnessing community contacts was one strategy to facilitate short- or long-term housing. Here again we can see how micro-level social environments can reduce harms. However, it also may lead to issues for those friends and family who must provide space for them, seen in an example by a participant who was asked to leave housing which was being provided by a friend because “I started with the amphetamine. And then people came in, and he [the friend providing housing] did not really want any people there running around, he wanted peace and quiet. And it ended up being a lot of running around. And so, I lost that one too” (Participant 5). This illustrates the tension between wanting to assist a friend, and the issues with trying to deal with some of the lifestyle factors surrounding substance use.

The further stress that this instability and patchwork of informal strategies causes may exacerbate the health and social issues related to both substance use and homelessness. Housing was seen as one of the foundational elements of wellbeing because “you need a home, you need a safety” (Participant 9), but in this case “the help network, it starts in the wrong end” (Participant 9), referring to the fact that cessation of substance use was required in order to get housing, when in fact the participant felt that housing would help support the achievement of abstinence. The needs of the local authorities, rather than the needs of the participants themselves, dictated what services they received.

Lack of housing options for people who use drugs is a particular problem in cities such as the one in focus, where average winter temperatures may be well below freezing, and is highly problematic for the participant population. This, in addition to persistent housing insecurity, gave participants a high level of stress about their futures and in some cases contributed directly to their ongoing substance use as a way to cope. This strategy is one which then may cause a vicious cycle of exclusion from housing services. As one individual described this dilemma:

“If...I’m homeless, well then I have to find a way to survive, and that’s with the drugs. ... That’s the only way I know to survive in the rough I mean. You have to take something to, it’s like 11 degrees below zero now, so it’s cold here, so the only way to keep awake is by using something.” (Participant 5)

Those who were homeless and using substances were excluded from municipal housing, and some of those who were housed noted avoiding injecting at home over concerns of eviction. Thus, lack of low-threshold housing programs free of abstinence requirements (as well as lack of a supervised injection facility) led to public injecting “usually in the toilet. Often in the toilet so you can get water. Sometimes with Coca-Cola, or something like that. Once out in the woods, I took water from the ground. Yes, there have been some shady situations at times. But that’s how it’s been” (Participant 8). This was reported by almost all participants, particularly occurring in public toilet facilities. One participant noted that they were potentially going to lose their housing due to their substance use, and described public injection as a way around this, but coming with its own risks, stating:

“I use in public toilets sometimes. Well of course I’m getting vulnerable, if I’m using in a public toilet abusing and then going out from the toilet and the
cops are coming or something. Then you get problems.” (Participant 2)

In this case, the participants had to weigh the options of potential arrest versus the possibility of losing their home. This has implications for overdose and bacterial infections in particular, as well as consequences for social issues, such as public persecution, arrest, and stigma.

Broader consequences for health and social exclusion
Beyond the direct concerns reported by participants, there were several notable references to the indirect impacts of the lack of these services on their health and wellbeing. These largely stemmed from the macro, policy-environment, and how this affects attitudes towards and inclusion of people who use drugs. The development of both Housing First and NSP in the current municipality is primarily a political question, as the National Board of Health and Welfare and/or the Public Health Agency have promoted their development, while municipal actors have delayed their implementation. Seizure of (legally or illegally obtained) injection equipment by law enforcement was commonly reported. In regions with NSP services, staff work with and educate law enforcement on the program, to limit such practices. In this region, this cooperation does not exist and participants had limited recourse to address these confiscations, citing “what shall I do? I go to the needle exchange again” (Participant 1). The presence of harm reduction in the policy environment may lead to cooperation and bargaining between different actors (particularly official actors who have legitimacy over such concerns in the eyes of law enforcement), improved understanding of such issues, and consequently better relations between all groups.

In contrast to the above-reported high quality and non-judgmental services accessed at the NSP externally, participants “have as little to do with healthcare as possible” (Participant 6) in their own region, because of lack of trust, or a poor therapeutic relationship. Participants felt that the lack of low threshold harm reduction programs was reflective of other, stigmatizing features of healthcare locally:

“Doctors usually think that I am a drug addict who lives dangerously.” (Participant 4)

More broadly, participants were keenly aware of their deviant position, and reflected that general society made them feel that “if you are homeless, a drug addict, then you are dirt” (Participant 7). Mirroring that sentiment, another individual discussed how they resisted that identity when possible:

“I wash and maintain my hygiene, and so on. I know that it is difficult for many who end up on the streets. I want to keep my hygiene, so that no one can think ‘Oh but [they], [they abuse]. You see, [they smell] disgusting’. Or yes, I do not want to be that kind of person. I want to be this person, I have an image that I have to maintain.” (Participant 6)

They also felt that the possibility to access certain services would signal a macro-level inclusion and acceptance in society in a different and hopeful way, in the words of one participant:

“The people are thrown in the wind. They are sleeping in the train station, people are outcasts. They are not feeling a part of the society. Involved in the society. [Such services would] inform them, ‘this is what works, this is what we can afford you.’ Then they are getting closer to the society and then they are maybe someday they are thinking again.” (Participant 3)

Ultimately, this level of exclusion, the multiple competing priorities which it causes, and overall lack of knowledge of what might happen in both the immediate and distant future. Several of the individuals who were interviewed reflected that this was a constant stress and negative influence on their mental wellbeing:

“I may not be feeling really well up here [points to head] ... You think a lot, what will my life look like? How will it end? Where should I get money from? How do I solve certain things? And-, yes, where will I sleep? ...It's so much, like, and that's something that takes a lot of energy.” (Participant 5)

“You get very lonesome. You can't go talk to anyone, and also because of the policy in Sweden, it's very hard. If you go try to seek help you self-incriminate yourself. ... It was very nerve wracking to go seek [care] because I had kids at that time. So ... I knew [it was possible] that Social Services would take contact with me and, like, investigate me as a parent.” (Participant 10)

The above quote demonstrates the impact of both real and perceived potential discrimination. The punitive consequences of their drug use lead to reticence to access such services which are offered, such as opioid substitution therapy and other substance use treatment programs, or social services. The highly stigmatized and criminalized nature of drug use in Sweden means that the benefits of service access do not always outweigh the potential consequences of identifying oneself as a person who uses drugs. Another participant reflected on the relief they would feel to not be constantly chased:

“[if drugs were decriminalized for personal use] maybe [I'm] gonna take a deep breath, exhale.” (Participant 9)
In addition to the measurable outcomes of harm reduction programs, these comments speak to the non-quantifiable impacts of such policies, how they improve interaction with official authorities such as law enforcement, and improve individuals’ psychosocial wellbeing and sense of belonging in society.

Discussion

Physical environment

Engagement in risk-taking behaviours exists at a nexus between the individual and their broader environment. It is clear that the lack of NSP, as well as a Housing First policy, in the locality of study has a greatly negative impact on the individuals in the study, the risks they take, and the ways in which they address those risks. The onus of the procurement of sterile equipment has been entirely placed on the individual who is injecting. The availability (or lack thereof) of syringes is one of the primary factors leading to syringe sharing [68–71]. Most individuals in the current study reported sharing injection equipment at least at some point, which has important health impacts, such as leading to the avoidable transmission of HCV, other blood-borne viruses, and bacterial infections [1, 2]. By offering easily accessible sterile equipment, this risk behaviour can be significantly reduced. Public injection, too, is highly associated with negative outcomes [72]. Such situations often compel individuals to inject in a rushed manner, in an unsterile setting, with no professional overview in the event of an overdose [73]. In the current study, the threat of eviction due to substance use meant that even some of those who were housed often injected elsewhere from their home, to avoid detection.

Despite a number of barriers in their way to do so, most participants in the current study engaged in active and committed health-seeking behaviours, and tried to reduce the above-stated risks which are being produced or amplified by lack of services in their own community. Participants described numerous important trade-offs that they made in order to consistently use sterile injection equipment. However, these barriers could prove to be too great at any given time, leading to an increase in risk taking. Contrasting from other studies [47, 54, 56, 74], where programs such as mobile, postal, or pharmacy distribution of syringes have been implemented, official solutions to bridge the gap have been limited in this setting, due to legislative limitations. Instead, informal solutions prevail, such as secondary distribution systems. A significant body of literature on both formal and informal secondary, bridging injection equipment distribution systems exists [47, 75–85]. Such arrangements make up a large proportion of needle and syringe distribution in some settings [75, 80], and may allow for more geographically widespread distribution, as well as the engagement of individuals who do not or cannot engage in more formal programs, such as younger people [80, 81, 85]. However, these solutions are not always sustainable or consistent [79], may be limited to social networks [83, 85], and may not reduce risk behaviours as effectively as formal sites [82, 83]. The data from this paper confirm the importance of such practices. However, the data also demonstrate the potential burden this has on those who are seen as “providers”, as well as the imperfect nature of the solution, as recipients have to pay for or rely on the generosity of others for equipment access. Therefore, informal secondary exchange should not be relied on to make up for official service deficits in a long-term manner.

As previously described, longer physical distances from services lead to reduced access and increased risk behaviours [46–50]. As one strategy to address distance-related issues, other studies have highlighted a migratory element with relation to accessing services, with focus on people who use drugs [58, 59, 61, 86–90], as well as the interlinked field of mental health and homelessness services [91–94]. Perez Torruella [59] describes that such migration is encouraged by Puerto Rican authorities, on the basis of improved treatment access. However, there are also risks associated with this. Other studies have found that recent migrants in a period of “transition” were significantly less likely to access harm reduction and social support services, or be more likely to engage in risk behaviours [86, 88, 90, 95]. The individuals in the current study noted having important connections locally to family, children, social networks, social services, among others. Therefore, permanent migration may contribute to their further marginalization in a new location, where they would be lacking social connections and knowledge of the harm reduction landscape, and should not necessarily be encouraged. That being said, the extensive, frequent travel which the participants reported embarking upon also must be solved.

From a micro- (individual, interaction-level) and meso- (community level, access to services) perspective, the physical risk environment in this setting produces a significant amount of risk and harm. These levels were highly intertwined and interacted with each other, for example, that actions at the level of the individual were often found to make up for absence of services on the community-level. However, this creates complications of its own, as seen with the reliance on social networks for secondary distribution.

Social environment

Not only are the direct risks of the physical environment apparent, the setting of limited harm reduction reflects broader social aspects of these individuals’ lives, which
produce, or in some cases mitigate, harms. Goffman [96] describes a process by which certain socially stigmatized attributes or identities, such as that of a person who uses drugs, are ascribed to individuals, creating a “spoiled” or “discredited” identity. It has been suggested that stigma functions on many levels as a social determinant of health, exacerbating processes related to stress, isolation, and reduced access to resources [97]. Phelan et al. [98] posit that stigma against groups such as people who use drugs functions, in part, to enforce social norms. Lack of social acceptance towards drug use on the macro-level is acknowledged as an important part of Swedish drug policy, for precisely this purpose [99]. However, this has a twofold effect of internalization of stigma, as well as the experience of discrimination, and leads individuals with this group’s identity ascribed to them being excluded from society. Some participants in the current study made explicit reference to how they managed and resisted being ascribed this “discredited” identity and the stigma that is attached to it. Research on the importance of such identities—both societally and self-attributed—has shown how they may lead to exclusion from the mainstream and/or retention in a drug-using “subculture” [100–104].

Correspondingly, Bourgois [62] discusses the notion of the “moral economy of survival in fragile networks and marginal communities” (p. 2332), with relation to sharing of drugs and equipment in an effort to utilize micro-level social relations to construct supportive networks, resist arrest, conserve resources, and economize drugs. These statements have been further supported by subsequent studies on secondary equipment distribution [76, 84, 85]. A moral economy can be seen in this study, with the protective and collective nature of these communities. Individuals here utilized and harnessed their social networks as a system to receive and distribute materials and reduce their risks. However, this subcultural reliance also risks what Coumans and Knibbe [104] call “hardening”—an adaptive process of behavioural change and coping strategies, which may reduce ability to fit in with the norms of “general society” in the long run. Programs such as Housing First work to combat this, as they may promote social integration, through their incorporation into standard housing complexes. Reports from the Housing First program in Helsingborg demonstrated that tenants had broadened and diversified their social networks, as well as improved relations with their children or other family members [34].

Stigma against drug use may also result in individuals feeling unworthy of care [105]. This was visible in the self-stigmatizing discourse that these individuals have internalized and use about themselves. Internalized stigma is associated with lower utilization of NSP [106], and negative mental health outcomes [107]. Additionally, real or perceived trusting or discriminatory relationships with healthcare providers also is a factor which mediates outcomes amongst this population, particularly healthcare utilization [108–110]. The impact of these micro-level interactions, as well as macro-level policy context, is reflected in the participants’ reported lack of desire to attend medical services in the region, due to the perceived discrimination they face. Low-threshold services may provide a conduit through which to engage and generate trust, even in the broader context of stigma in society. These programs not only provide a specific service, but also may be a first point of engagement, to “coax NSP clients (quite literally) to a place where they can express, often very strongly, their trust in the service”. [21] (p. 143). Stenström [111] found that many individuals engaged in the NSP in Malmö often participated in “social” visits, without explicitly engaging in services, and that such contacts were a predictor of lower HIV/HCV incidence. This was hypothesized to relate to increasing the integration of clients in care and general society. The development of a trusting therapeutic relationship with social workers has also been reported amongst those in a Swedish Housing First program [34]. This may also lead to a renewed self-esteem amongst participants.

Policy environment
In this setting, the macro-level “public and legal context of risk management” [63] (p. 89), here being the criminalized legal status of drugs and personal drug use, leads to high levels of social marginalization. Though, certain macroeconomic and societal welfare policies may mitigate some level of harm, for example, almost all individuals in the study were benefiting from some form of government-based income assistance programs. Sweden has a wide and relatively well functioning social safety net and operates largely on a social democratic welfare model, which implies high levels of supports [112]. However, the policy context of criminalization justifies the exclusion of people who use drugs from services. Given the primary problematization of people who use drugs as criminals, their agency and ability to steer their own care is limited in this context. Instead, authorities exert punitive control over them by limiting access to certain forms of care. Moraled assessments of “deservingness” influence who has access to such programs, as well as which programs are offered [41, 49, 113].

With relation to exclusion from housing, homelessness and drug use are often described as a situation of “double jeopardy” which serve to reinforce and compound each other [114]. Lack of housing leads to increased risk of HCV and HIV [115], public injection [116], as well as
increased drug use for coping with emotional or physical pain [114, 117], all of which were directly reflected in the participants’ narratives. Housing First policies have demonstrated success in providing housing stability to vulnerable populations [33, 34, 118–120]. Padgett [121] describes housing as providing security in the sense of physical shelter, as well as “ontological security, the feeling of well-being that arises from a sense of constancy in one’s social and material environment which, in turn, provides a secure platform for identity development and self actualization” (p. 1926). It is clear that the participants in the current study would benefit from both forms of security. Conversely, putting the onus on themselves, friends, and family members to solve their housing issues leads to a grey area of “hidden homelessness”—provisional accommodation without the security of official tenancy [122]. Such situations may be tenuous, straining relationships on both ends, and leaving individuals vulnerable to the goodwill of others, at risk of exploitation, among other negative outcomes [123].

The macro-policy context also influences the possibilities and focus of police interventions, which have important impacts on the study population [124]. Institutional contexts shape policing priorities and culture [124]. Studies in various cities have shown that directed police interference and stops led to decreased accessing of NSP [125, 126], increased syringe sharing [127], and led people who use drugs to carry fewer sterile injection materials on themselves [128]. It has also been found that such policing practices lead to unsafe public injection practices, due to the stress of potentially being arrested [128]. These practices, while technically legal, should be reviewed and discouraged.

As a whole, the macro-level policy of zero-tolerance towards drug use, and the stigma it engenders, trickles down to the meso-level of missing services and exclusionary policies. At a micro-level, it also leads to a reticence among some participants to engage in official services, where they do exist, for fear of discrimination, and/or repercussions for themselves or their families. Participants in the current study described stresses and an overall sense of insecurity and uncertainty about their futures. This was reflected in the large proportion of participants who reported using drugs to cope with their current life circumstances. Per Keane [129], “social stigma itself could qualify as a harm of drug use and since illegality produces some of the most obvious harms of drug use, investigation of drug laws is also well within the scope of harm reduction” (p. 228).

Limitations
The current study has a number of limitations. Firstly, due to COVID-19, I was unable to recruit participants directly. I initially had planned to travel to the location of study, and recruit both through relevant organizations, as well as on the street, and through snowball sampling. Instead, I had to rely on recruitment partners from two organizations to recruit on my behalf. This has inherent limitations due to lack of knowledge on how systematically these individuals were advertising or recruiting for the study. I attempted to address this by providing a thorough information sheet and background of my study and having frequent contact with these partners. Ultimately I was limited in my recruitment and was only able to connect with 11 individuals. Attempts to recruit more individuals were unsuccessful due to lack of time resources on behalf of the recruitment partners and their organizations. Nonetheless, the interviews generated rich data of interest and relevance to the study question. Inability to recruit directly or expand beyond the organizational setting has limited my participant population. Individuals who were not participating in either of the programs with which I was in contact would have been missed entirely. This may have included both less marginalized and more marginalized individuals, whose experiences may have been different to the individuals who were engaged in these two programs.

People who use drugs may be reticent to participate in interviews, particularly online, due to the criminalized and stigmatized nature of their activities. This may have also influenced responses due to social desirability biases. Some interviews took place in a private office within the organization of recruitment, which may have limited or discouraged participation for some, due to privacy concerns. Furthermore, interviewing a marginalized population involves building a rapport, often through casual contact, which can begin as early as the recruitment stage in making hesitant potential-participants feel comfortable with participating in an interview, knowing that they will not face judgement or stigmatizing attitudes. As I was unable to recruit individuals directly, those who have faced more discrimination in their life and thus fear this may have opted to not participate. This may be seen particularly in that, despite efforts to reach them, only one female was engaged in this study. It is well documented that women who use drugs (especially who are pregnant or have children) in these situations face additional challenges in identifying themselves to services and accessing care [130–132].

Relating to transferability, the small sample size means that attempts to transfer the results to a different population or setting must be done so with caution. Relating to the above limitations, the findings should be especially carefully applied to the lives of women who use drugs. However, the results may be able to inform the experiences of similar groups (people who...
use drugs) in similar settings (areas without services for this population), and what consequences this has on their somatic health and psychosocial wellbeing. Resistance to harm reduction and variations in such program delivery are not unique to Sweden. Therefore, the current case could elucidate upon the conditions faced by people who use drugs beyond the current context. Especially relevant might be regional or national border areas, commuter towns, and other such settings where policies and services may vary widely in relatively geographically small areas.

Conclusion
Despite decades of evidence, the development of key harm reduction programming has been slow in many Swedish municipalities and regions. The results of this study demonstrate the burden that this delayed, uneven development has had on individuals who are affected by such policies. They must resort to travelling for, buying, stealing, re-using, and sharing their injection equipment. Much of this comes at great personal cost—whether it be time away from family, money for travel, or the potential health impacts of sharing or re-using items. It also reflects further marginalization in other policies, leaving many of the participants in a situation of great insecurity in life, particularly when it comes to housing, as most were unstably housed and many of those who had housing felt constantly at risk of losing it. These participants reflected on their excluded position in society as a whole and internalized their stigmatized identities. NSP and Housing First in particular were focused upon, due to their direct, as well as symbolic, value as interventions of inclusion. Lack of harm reduction services has placed a great burden on individuals to develop strategies to address this, leads them to engage in avoidable risk behaviours, and has created a cycle of marginalization of this population.

Abbreviations
HCV: Hepatitis C virus; HIV: Human immunodeficiency virus; NSP: Needle and syringe exchange program(s).

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Authors’ contributions
JH performed all of the work involved with this project and manuscript. All authors read and approved the final manuscript.

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Availability of data and materials
The datasets generated during and/or analysed during the current study are not publicly available due to privacy concerns.

Declarations
Ethics approval and consent to participate
The project on which the current study is based was approved by the Swedish Ethical Review Authority (Dnr 2019-06509). All participants gave their informed consent to participate. All study procedures complied with relevant laws and institutional ethical guidelines.

Consent for publication
Not applicable.

Competing interests
The author declares that they have no competing interests.

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“I knew it was different there”: a qualitative study of the motivations and risks of drug policy migrants going to Denmark from Sweden

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"I knew it was different there": a qualitative study of the motivations and risks of drug policy migrants going to Denmark from Sweden

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ABSTRACT

Background: This study explores why Swedish people who use drugs (PWUD) relocate to Denmark, in the context of differing drug policy approaches in the two countries. Specifically, the aim was to understand how PWUD experience and value different drug scenes and policy contexts, and reason about the benefits and risks of changing environments.

Methods: We conducted 17 semi-structured interviews with PWUD who moved from Sweden to Denmark, recruiting participants from harm reduction sites in both countries, and through snowball sampling.

Results: Key drivers for relocation included: harm reduction service availability, stigma, social networks, policing, and financial factors. Mobility between settings increased risks such as violence, exposure to new drugs, polysubstance use, and incomplete access to care. Participants presented evolving motivations over time, but one participant reported several motivations.

Conclusion: The study presented a contextual view of the nature and character of PWUD’s movement. The policy environment particularly influenced mobility. While aspects in one setting may promote well-being, other factors can increase potential for risk. Given the rapidly changing drug policy landscape in many parts of the world, this study offers insights into how PWUD navigate these settings, and can offer opportunities to better meet the needs of these individuals.

Introduction

I was living in (a medium-large city in the middle of Sweden). But there is no help for the homeless. (It’s) only available during the day... there was nothing in the nights. And nothing on weekends. So it is extremely difficult to live as a homeless person in Sweden. Especially during the winter. You are terrified every single night. Or every single day, because where am I going to sleep? If I don’t get into a stairwell … or do I have to do amphetamines and walk around all night? It’s different in Denmark. There are so many shelters – you can eat food 24/7 if you want, you can sleep in many places, many shelters in Copenhagen…. Since I just knew, I had all my friends here in Copenhagen, and I don’t get help in Sweden at all. So, I came (to Copenhagen). (Carl)

Carl is one of many individuals who use drugs who travel and/or move from Sweden to Denmark. The above quote illustrates one individual’s reasoning for moving, in pursuit of an easier and safer life amidst substance use and homelessness. His relocation was driven by interpersonal and structural factors, as he sought support from a social network and services. After a period receiving substance use treatment in Sweden he was expelled from care when his home municipality stopped funding his stay, as he was registered in a different municipality. No follow-up care was planned, and he became homeless. Due to his past experiences of homelessness in Sweden, he realized his circumstances would be better in Copenhagen, Denmark. Services like a supervised consumption site (SCS) are offered there, where Carl reported staff had saved his life when he had overdosed, and where about 10% of clients are of Swedish origin (Sandin, 2014). No such service exists in Sweden. However, not all experiences are positive ones, he first tried heroin and cocaine in Copenhagen, ‘and I regret that to this day, because I got totally hooked,’ and the friends who he travelled to stay with were soon evicted, so he ended up back on the street. Though Carl faced challenges, he still believed Denmark offered a more comprehensive range of opportunities, such as low threshold housing with access to food and sterile injection equipment, offering rest and security. The lack of these types of accommodation in his hometown meant that he felt the only viable solution was to use amphetamines to stay awake and mobile to avoid violence or theft. The aim of the study is to explore the motivations and challenges of people who use drugs (PWUD) who move to a different environment and drug policy context.

The case presented here is exemplified by changes to and contrasts between the service and policy landscape on both sides of the Swedish/Danish border. The drug policy landscape is rapidly changing in many areas of the world. It is important to study how PWUD navigate these landscapes and move between different policy settings in order to better meet their own perceived needs. The study presents a contextual view of the nature and character of the...
movement of PWUD. Ultimately it can provide insights for policymakers to better address the needs of this group. By shedding light on the factors that influence their mobility decisions, it can offer an understanding of how policy objectives and service provision directly and indirectly affect the lived experiences of PWUD, as well as what other factors may be of relevance to them. The Swedish-Danish example investigated here provide insights that have not previously been studied in this type of setting. By looking at two countries with broad similarities in welfare state provisions, but differing approaches to drug policy (which will be described in detail below), this study can be used to highlight the real impacts of drug policies.

Background

Danish and Swedish approaches to drug policy

The Öresund region is transnational, spanning Sweden’s Skåne county and Denmark’s Greater Copenhagen area. The countries are linked by a bridge, train lines, and tax treaties, share a similar language, and there is no physical border in place, enabling easy movement. Both Denmark and Sweden are considered to be social democratic welfare states, with relatively strong levels of social support (Esping-Andersen, 1990). Citizens of Nordic nations can more easily acquire social security numbers in each other’s countries (only needing an address) compared to other European Union (EU) citizens, who require an address and job and do not require a passport to cross each other’s borders. Despite these links, significant differences exist in their approaches to drug policy. These similarities and dissimilarities provide an interesting case for examination of the experiences and perspectives of PWUD.

Policies relating to the healthcare, social care, and policing of PWUD, particularly those with substance use disorder, in Denmark are based on the principles of harm reduction (Houborg & Møller, 2021). Sweden has taken a zero-tolerance approach with the aim of a society free from drugs, although Denmark are based on the principles of harm reduction (Andersson & Johnson, 2020). These different approaches have led to a marked impact on the forms and types of services made available to PWUD. Table 1 provides comparative information on key harm reduction availability, as well as overdose rates, in the two countries.

Policing practices also differ, where the Vesterbro neighbourhood in Copenhagen operates a harm reduction approach to policing, focusing on safety and public order (Kammersgaard, 2019). Swedish police have a greater focus on individual drug crimes, and may even compel urine drug testing (Tham, 2021), though they may refrain from enforcement around harm reduction sites in some settings (Nordgren et al., 2022). A recent study found PWUD in Malmö, Sweden had significantly higher levels of risky drug using practices than those in Copenhagen (Houborg et al., 2022).

Table 1. Harm reduction landscape comparison, Sweden vs. Denmark.

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<tr>
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<th>Sweden (pop 10.42 mil)</th>
<th>Denmark (pop 5.86 mil)</th>
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<tbody>
<tr>
<td>Needle and syringe exchange (NSP)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>NSP identification requirement</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pharmacy NSP</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Supervised consumption</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Heroin-assisted treatment</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Take home naloxone</td>
<td>Yes, with prescription</td>
<td>Yes, no restrictions</td>
</tr>
<tr>
<td>Low threshold shelters</td>
<td>Limited</td>
<td>Widely available</td>
</tr>
<tr>
<td>Total opioid substitution therapy (OST) clientsa</td>
<td>7500</td>
<td>7500</td>
</tr>
<tr>
<td>OST clients per 100,000 population</td>
<td>72</td>
<td>127</td>
</tr>
<tr>
<td>Overdose deaths per 100,0002</td>
<td>6.46</td>
<td>4.56</td>
</tr>
<tr>
<td>Criminalization of personal drug use</td>
<td>Yes</td>
<td>Yes, with exemption for those with additions</td>
</tr>
</tbody>
</table>

aData from (Gedeon et al., 2019; Statens offentliga utredning, 2023).

Mobility of PWUD

PWUD are a population who have been noted to be mobile in a number of different settings globally (Deren et al., 2007; Li et al., 2014; Schreiber, 2014; Ti et al., 2019; Tibi-Lévy et al., 2020; Volkmann et al., 2012; Wagner et al., 2012). PWUD generally have poorer access to health care services due to a variety of reasons, including stigma, logistical factors, and limited resources (Ahern et al., 2007; Hewell et al., 2017; Ibragimov et al., 2021). For some, travelling or relocating can be seen as the best opportunity to access the services or resources they need. Travel is reported within countries (Schreiber, 2014; Ti et al., 2019), as well as between countries (Hammett et al., 2003; Li et al., 2014; Wagner et al., 2012). Reported reasons for travel/movement include access to/ prices of drugs, family and social reasons, unstable housing, treatment options, and law enforcement concerns (Schreiber, 2014; Tibi-Lévy et al., 2020; Wagner et al., 2012). Conditions such as social and financial resources, lack of identity documentation, among others, influence PWUDs’ movement opportunities (Schreiber, 2014; Wagner et al., 2012).

Previous research has found that there are both risks and benefits to this movement, including reduced access to harm reduction services/increased risks in injection (Deren et al., 2007; Paschane & Fisher, 2000; Rachlis et al., 2010). An issue which is discussed briefly by Tibi-Lévy et al. (2020) as well as by Wagner et al. (2012), but has not been explored in detail is the relation of different policy environments as a motivation for movement, and how this impacts living conditions, health, vulnerability, opportunities, and access to interventions.

Much of the research on PWUD mobility focuses on their movement in and out of ‘drug scenes’ (Fast et al., 2010; Ti et al., 2019) that is, places where PWUD gather, most often with the purpose of selling or buying drugs (Grønnestad & Lalander, 2015). Hayashi et al., (2019) surveyed people living outside of Vancouver’s urban drug scene, finding that drugs, friends, clinics and services, and employment were the primary influences for going to the drug scene. There are risks of the drug scene itself – what is often referred to as
‘entrenchment’, i.e. becoming ‘consumed by the daily project of ‘staying safe on the streets’ in the context of homelessness, chronic poverty, and involvement in potentially harmful drug use practices and income generation activities’ (p. 5) (Fast et al., 2009), and having difficulty exiting the scene. This can lead to exposure to violence, increasing substance use, increased marginalization, and overdose (Fast et al., 2009, 2010). These scenes are also framed as a nuisance to a broader society, where drug use, dealing, and other related activities take place openly, which can lead to negative perceptions by local residents and businesses (Bancroft & Houborg, 2020).

Relevant to the current study, Copenhagen’s Vesterbro neighbourhood has one of the largest open drug scenes in Europe, but which also has a high concentration of low-threshold harm reduction services. Some of the mobility in the current study may not relate to movement to Denmark in general, but to Vesterbro and the open drug scene specifically.

The phenomenon of Swedes traveling to Denmark for access to substances, different drug scenes, and harm reduction interventions, is not new, and has drawn attention from media and policymakers. A study by Sjölander and Svensson (2008) on Swedish homeless individuals in Copenhagen identified ‘methadone refugees’ as a primary group, seeking easier access to licit or illicit methadone. These individuals reported improved care access, reduced stigma, and more humane interpersonal and service interactions. As stated, about 10% of those accessing the main SCS in Copenhagen are Swedish (Sandin, 2014). Previously, a program was in place whereby Swedish social workers assisted in Copenhagen, assisting Swedish clients. This movement has been discussed in the media, portrayed as problematic and undesirable, but also lifesaving and necessary (Lützen, 2007; Sandin, 2014). Danish policy documents acknowledge that their harm reduction services attract foreign citizens, but they ultimately aim to repatriate them (Danish Health and Medicines Authority, 2014). Since the report by Sjölander and Svensson (2008), the situation on both sides of the border has evolved. Sweden’s access to opioid substitution therapy (OST) has improved, incorporating harm reduction principles (Andersson & Johnson, 2020), and Denmark adopted harm reduction policies, supervised consumption, and heroin assisted treatment.

Against the backdrop of otherwise similar countries with comparable welfare systems, one significant difference that impacts the participant population of the current study is the differing national approaches to drug policy. This case can therefore offer a valuable opportunity to contribute to the existing literature on PWUD mobility, investigating their perspectives regarding decision-making to relocate to a different drug scene and policy environment. Its particular value is that it can emphasize the specific role of the environment that the overarching approach to drug policy produces.

Methodology and analysis

This study was part of a larger project aiming to investigate experiences of differing drug policy approaches and service delivery on PWUD. The data from the study were collected during 17 qualitative, semi-structured interviews. The goal of the sampling process was to speak to PWUD who had gone to Denmark from Sweden, within the past five years. Participants were recruited from both a SCS and an overnight care service there. All except for one participant fit those criteria. One additional participant was included in the study due to particularly relevant historical experiences to give an overview of the changing drug policy landscapes on both sides of the border.

Notably, the recruitment for this study began in August 2022, a few months after most COVID-related restrictions were lifted in Denmark (February 2022). During the COVID period, the border between Denmark and Sweden was highly restricted and services had reduced capacities. For example, the inhalation room at the main SCS was temporarily closed. This led to substantial changes in service access for the target population of this study, and the SCS reported that the number of Swedish-origin individuals accessing recruitment sites remained low in August as compared to previous years.

Interviews were a mean of 58 min long (range 25–111 min), and took place wherever was most convenient for the interviewee, either in person, or over the phone. Interviews were in Swedish or English, and all interviews were transcribed verbatim. The interview guide focused on the motivations and practicalities of movement between Sweden and Denmark, to understand what sort of pull factors this environment had, what drives people away from their home country, experiences of treatment and service, and what difficulties they faced.

This study was approved by the Swedish Ethical Review Authority (Dnr 2019-06509). All participant names are pseudonymised. Participants were made aware of their right to withdraw from the study at any time, as well as not answer any particular question. They provided consent to participate and be audio recorded. Participants were provided a gift card (100 DKK or 200 SEK) in compensation for their time. Recordings were stored on two encrypted USB drives.

Analysis

The analysis comprised a mixed inductive and deductive thematic analysis approach (Braun & Clarke, 2006). During the interview process, notes were taken, and the interview guide was continuously revised. Transcripts were uploaded to NVivo for coding. First, a stage of open coding was undertaken, where anything of interest or relevance to the project as a whole was marked, guided by broad questions related to mobility motivations, experiences in different environments, and additional risks or perceived tradeoffs. The next coding stage focused on policy and service delivery differences reasoned to motivate movement. This was first driven by the literature on PWUD service experiences, for example stigma, low versus high thresholds to care, and policing, as well as circumstantial factors such as social networks, and economic considerations. This was followed by a literature-driven coding stage related to risks, and then further open coding to
find additional risks, not originating from the literature. Through a process of re-reading and continual revision, overarching themes were decided upon. At this point, it was found that the resulting themes aligned well with the dimensions in the ‘risk environment’ (Rhodes, 2002) framework, and this was used to structure the results.

Rhodes (2002) developed the concept of the risk environment, defined as ‘the space—whether social or physical—in which a variety of factors interact to increase the chances of drug-related harm’ (p. 88) to promote a more contextual view of the conditions which are relevant in addressing drug-related harms. The dimensions, namely, the physical, economic, social, and policy environments, frame the results. The risk environment can be contrasted with the ‘enabling environment’. This is one which enables or promotes health, wellbeing, and reduced risk, through the ‘realization of specific enabling practices and processes’ (p. 338) and the distribution of ‘enabling resources’ (p. 339) (Duff, 2010). As Duff (2010) states ‘All such (drug use) settings exhibit diverse risk and enabling factors’ (p. 338).

Utilizing the risk environment framework in this study allows for categorizing the broad, circumstantial factors influencing the mobility of the participants in the study. It also provides an effective framing for the ‘relational push and pull of risk and enabling processes’ (p. 338) (Duff, 2010), risks being amplified or mitigated in different settings. This framework is useful for its nuance in focusing on risk/beneficial factors on several levels and dimensions (Rhodes, 2002) and thus is particularly relevant for this project. Again, taking into consideration the similarities between the two countries, it can emphasize and isolate what motivations and risks relate specifically to drug policy and related issues, as well as which relate to other situational factors.

Participant characteristics

The majority of participants (14) were male and three were female. The mean age was 41 (range 26 to 61). One participant lacked EU citizenship. Four reported current formal employment, eight reported receiving statutory income support, and three reported no formal income source (two respondents did not provide income information). Seven individuals were currently homeless or unstably housed, five reported never having experienced homelessness, the remaining five were not currently experiencing homelessness but had in the past. All but one had a history of substance use beginning in teen years and all had experience of injection. Substances of choice included: amphetamines, opioids (primarily heroin and/or methadone), cocaine, and a mixture of heroin/cocaine. 13 reported active illicit substance use, and four reported being engaged in substance use treatment programs (such as OST) with no current illicit substance use. All had either originated from or had lived in the southern regions of Sweden (Skåne, Småland, and Blekinge), although some reported having lived in different areas of Sweden prior to their travel to Denmark.

Results

Experiences, motivations, and patterns of travelling to or staying in Denmark were manifold. Eight participants were based in Denmark and reported plans to stay indefinitely. Of the remaining nine who were based in Sweden, two travelled on a regular basis to Denmark, six went intermittently with no planning as such, and one had no future plans to go to Denmark. Many who were based in Denmark at the time of the interview reflected that their ultimate goal was to return to Sweden, but only once they were no longer involved in substance use, or only if they could be guaranteed rapid access to care. One individual reported never having used illicit substances in Sweden because of concerns regarding the drug policy and policing.

There were a wide variety of interacting motivational considerations, as well as noted risks of such movement. Where relevant, the motivations for relocation or travel are presented alongside related risks – difficulties encountered or trade-offs being made, consciously or unconsciously, as a results of moving to a new environment.

Policy environment

The differing policy environments influenced both approaches to harm reduction and drug treatment, as well as policing, in both places. Themes related to the policy environment were the most commonly represented in the data. These can be broken down into three categories: the experience of high versus low threshold care, a focus on rehabilitative treatment as compared to harm reduction, and leaving a system based on coercion and control.

Motivation: high versus low threshold care

As noted previously, most interventions in Sweden require registration, identity documents, and are more bureaucratic. They tend to be restricted in hours or days of service, for example if you need injection equipment outside of standard business hours ‘then you have to go to Denmark to get them’ (Axel). For Gustav, the threshold for NSP was too high, discussing that the requirements to do HIV and hepatitis C virus testing resulted in him not continuing to access that service.

Gustav ‘I went there [the needle exchange] once, then they said to me that next time you have to leave blood samples, to test for hepatitis. And I said I don’t want to do that, and I won’t do it. And after that they said to me that absolutely next time you have to do it, so I never went back.’

Despite that this is not the case, Gustav was concerned that the testing would show up on his medical journal and that providers accessing his file in the future would be able to see that he had accessed the NSP, and thus had a history of substance use. While the testing requirement is built to enable the identification and treatment of persons with blood-borne viruses, Gustav’s perception demonstrates the hazard of systems with such prerequisites for entry.

For some, like Axel, the easy access to harm reduction in Denmark served as an initial motivator, ‘because I knew it
was different there,' whereas others did not know about this different approach before they came. For those, such as Bengt, it was a reason that they remained in Denmark, rather than returning to Sweden, 'because I knew that if I did … I would have to sleep outside, it can happen that you have to sleep in public washrooms. There are no night cafes or things like that.' This can also connect to the sentiment noted in the introductory quote, where the lack of low threshold sheltering services can perpetuate further substance use.

**Motivation: rehabilitative focus or harm reduction focus**

Participants perceived that the notion of harm reduction had been engrained more deeply into the system in Denmark, whereas in Sweden 'you have to be clean or not clean,' (Elias). Elias reflected a sense of limited nuances relating to different types of use or agency over one’s own desire for care (or not), 'I don’t want treatment, you know, I just want to figure things out, you know? … But in Sweden you have to… Here [in Copenhagen] there is a difference, you can be what you want.' This quote shows how the notions of harm reduction and drug freedom impact how people felt they are met by the system. Where in Denmark individuals are given more autonomy to make their own decisions over care, even if that means not accessing certain services. Some, like Elias, reported avoiding Swedish services for concern of being forced into rehabilitative treatment which he did not feel interested in or ready for. The lack of such measures in the Danish system allowed for them to continue to access programs of their choosing, such as the SCS.

**Motivation: leaving a system imbued with control and coercion**

Many of the participants experienced that Sweden was a system based on control, and that the Danish system was more humane, reflected in both their approaches to policing as well as care. In Sweden, individuals reported feeling constantly pursued by police or evaluations for compulsory care (in Swedish Lag (SFS 1988:870) om vård av missbrukare i vissa fall, or LVM)¹.

Bengt: ‘I was being chased by the system in Sweden, because of my addiction. Because they don’t help enough, and then when you have gotten in too deep, they say okay we are going to lock you in now, for six months, because they think it helps, but it never does, compulsory care.’ Later remarking, ‘because in Sweden, it’s like, coercion. Coercion, that is, or jail.’

Especially for those, like Gustav, who was on probation, they went to Denmark specifically to avoid police interaction.

Gustav: ‘I only use here [in Denmark]. Use them [drugs] and then go home [to Sweden]. The thing is, when I got out of jail, I decided I’m not going back, so I don’t take even the smallest risk, because I know if I get caught I will go back [to jail].’

Because of the focus on street-level users in Sweden, the fear of police interference and the legal consequences of personal use was a persistent concern. This was compared to Danish police who many reported having more positive interactions with, as ‘you have to be troublesome, against the citizens or violence involved…. Otherwise they do nothing. So it’s nice to have that tolerance,’ (Daniel).

**Risk: requiring a Danish social security number to have full access to the system**

Though participants found care to be much lower in threshold for access, they still reported continued barriers. While the process is relatively easier for Nordic citizens, few had success getting a Danish social security number (Centrale Personregister, or CPR). In the meantime, those without a CPR are limited in which shelters and services they could access. Daniel talked about having experienced being restricted from accessing various services:

Daniel: ‘You are often not allowed to do certain things only because you have a Swedish identity card… like, live at certain places, hostels and things. Then you need to just say your CPR number if you don’t have ID, so it becomes like an ID, but if you don’t have those Danish numbers, so…’

One can get emergency care, such as described by Axel below, but may lack the ability to access long term health or social services.

Axel: ‘I’ve been hospitalized twice for alcohol detoxification. But it doesn’t go so well because I need support before I get out also.’

‘Due to only being able to access emergency services, Axel is released from detoxification without planning for follow up care. This can lead to ongoing cycles of difficulties, where the underlying circumstances which lead to emergency care access are not being addressed.

**Risk: lack of information leading to missed harm reduction opportunities or additional risks**

Several individuals reported no knowledge of the different laws and policies in Denmark during their initial visit or subsequent visits, ‘I didn’t know anything when I went there. I didn’t know where their needle exchange was’ (Marcus). This meant that ‘it was just luck’ (Marcus) or when someone they met shared information with them that they found their way to harm reduction services. This led to potentially missed opportunities and increased risks, described by Felicia, who explained that some shelters required prior contact in order to access them, and not being aware of this system led her to sleep ‘on the streets, sleeping in basements, bike cellars, and what have you.’ Despite there being places available, she was unable to access them and instead was forced to sleep in risky places.

**Risk: the design of Danish services offers less inherent personal interaction than those in Sweden**

While the services were viewed as overall more limited, some participants felt certain services in Sweden offered more inherent personal interaction than those in Denmark, which was highly valued. Thus, in leaving this environment, individuals risk losing this potential for connection. For example, how Pernilla describes the design of Swedish needle exchange,
which requires interaction with service providers, as opposed to pick up from containers anonymously in Denmark.

Pernilla: ‘The difference in Copenhagen, it actually isn’t as personal there. There are just these containers laying there [with injection equipment]. Or you can go in and you can take what you need. And that ... in [Sweden] that would make a big difference, but I think that it is actually more personal in Sweden, at the needle exchange than what it is in Copenhagen. There are staff who are there and talk to you and stuff. There are always the ladies there at the needle exchange who have always been super sweet, and they always have helped [my friend] when [they] need something. As much as they can.’

Pernilla reflected that while a system with anonymous pickup would make a positive difference in Sweden, that the high ambitions and requirements of engagement of the Swedish system also has benefits. While we could see this deterred Gustav from accessing in an earlier section, here we see the extended potential for the development of therapeutic relationships and additional help being offered.

Risk: inability to consistently cross the border
Only one individual in the study did not have EU citizenship. As he had lost his passport and due to potential issues with intermittent border control, he chose not to travel to Copenhagen, despite a desire to, and a sense that his life would be made easier if he could,

Marcus: ‘Now it isn’t so often, it isn’t so much [that I go there]... you see, I would really like to go there, it would be much better, easier for me, but I can’t. Because you have to leave the country. Now mostly I can’t go to Denmark because of my passport, you have to have your passport to go over the border, and that is really difficult.’

The opportunities of the environment are moot if one is unable to access them. Although this is an experience reported only by one participant, it also reflects the difficulty in recruiting other individuals with non-EU citizenship.

Issues with crossing the border, or access to health services without national identity information relate to a much broader policy environment than strictly drug policy itself. These instead relate to the design of healthcare system access, and border control policies. However, these policy decisions still have a tangible impact on the individuals in this study.

Social environment
Motivation: access to a social network and leaving a negative environment behind
Participants commonly reported their social network, such as friends, family, or romantic partners in Denmark, as a motivator for travel. In many cases, these were mentioned as totally separate from substance use itself. However, this is still highly relevant because of the important roles that having a socially supportive safety net can have in substance use, recovery, and mental health in general. As noted in the introductory quote, Carl had ‘all of my friends... here in Copenhagen.’ Friends assisted when people were in situations of need (housing, etc.), provided support, and offered information on how and where to access resources.

In parallel, a consideration which was reported by some participants was the idea of leaving one’s environment and network behind, for a new start.

Pernilla: ‘One thing I can think is, if I go back to Sweden again, it will ruin my whole life, I will start using drugs again. And it will be a danger to my life if I start using drugs again.’

They felt their environment in Sweden would lead to negative outcomes whereas moving to Denmark allowed them to make a break from their previous environment and start over, and separate themselves from existing social networks made up of people still engaged in active substance use.

Motivation: non-judgmental interaction as compared to experiences of stigma
Several participants also mentioned experiences of stigma and discrimination as a reason for travel, that it was not just the services themselves but the view of drugs and PWUD in the two countries being different which made life easier and more secure in Denmark, or more difficult and stressful in Sweden. They described more consistent, positive reception, and non-judgmental attitudes by staff at Danish services, leading to openness and relationship-building. As Gustav reflected,

Gustav: ‘In Copenhagen it feels safe to me, I feel a safety here, there are good staff, I feel welcome when I come.’

Negative and stigmatizing views towards drugs and people who use them were an influential circumstance which pushed many people away from Sweden. Options are limited, and perceived as controlling, per Robert,

Robert: ‘In Sweden it has impacted me because it [drug use] is shameful and forbidden. That has negatively impacted me because there is a stigma, and there is nowhere you can turn, and you can’t get any help, everything takes such a long time.’

This quote demonstrates the comprehensive effect of stigma, in that it causes the participant to feel shame (internalized stigma), be concerned about discrimination (enacted stigma), as well as being a clear reason for difficulties accessing care. Robert here relates the stigma towards substance use as relating to a lack of sufficient resources to ensure efficient care.

Physical environment
Motivation: Copenhagen’s drug scene is open and accessible
For many, the drug scene was the initial and most consistent attraction for visiting Denmark, specifically heading to Vestebro. People had heard of the openness of the drug scene, that ‘when you go buy drugs, you can just buy it off some random [person] off the street. In Sweden you have to know someone who knows someone, you have to have a phone number. You don’t need that here.’ (Felicia). While drugs often began the journey, the other aspects surrounding the drug scene continued to draw people to Copenhagen, as shown in Marcus’s and Axel’s reflections:

Marcus: ‘The reason, it’s easier, what should I say, it’s easier to get [drugs] and more relaxed, the laws, I knew, I was told
that it isn't as illegal… they [the police] don’t do so much, you don’t run into problems as much, you know.’

Axel: ‘Overall, the average value or quality of street drugs is high, so I would have gone there just for quality’s sake. But it is more comfortable in every way. It’s a little bit different there [in Copenhagen] than it is here [in Sweden]. With free distribution of needles. There’s no nagging, you can just take as many as you want….It’s way different with overnight shelters. It is a big difference…’

Both participants do not solely discuss the quality or ease of access to drugs, but also that the laws and rules around drug use, as well as low threshold access to harm reduction services, make transactions and use easier and less risky. It is these auxiliary benefits which provided added motivation to continue to come to Copenhagen. This makes it difficult to draw an analytical boundary between the physical and policy environment. The open drug scene in Copenhagen means easy access to drugs as well as access to a range of different harm reduction and low-threshold activities.

**Risk: potential for violence, which can also deter engagement**

Due to the drug scene in Copenhagen being very open and concentrated, some felt that, ‘in a way maybe here [Copenhagen] its more violent…everyone knows in that environment, everyone knows everyone. Because they’ve seen each other face to face. And in Sweden they don’t because… my hookup might not know my friend’s friend’s hookup and they might have a beef. Here [Copenhagen] it’s like all mixed together in one pot you know.’ (Felicia).

In Felicia’s experience, even if there is a conflict in Sweden, those involved might not know what their rivals look like, or see them out, because interactions and transactions tend to occur behind closed doors, leading to reduced experiences of violence. In some cases, this concern about violence can lead to people not accessing certain services in Copenhagen, like Robert, who reflects on his ambivalence:

‘Now it isn’t so often [that I go to the supervised consumption site], I don’t have the energy anymore. It’s too stressful. At the same time, it’s tempting, you don’t have to, like, give a shit. And I give a shit. I can’t take it anymore, the violence and shit, I can’t take it any more… but it is so appealing, the freedom. And drug users, we can see objectively that it is crazy.’ But he later remarked, ‘but absolutely, if I am going to take an opioid in a risky way, absolutely. Feels safer if there is someone watching.’

On the other hand, the drug scene especially in Vesterbro is more concentrated, stressful, and potentially dangerous. On the other hand, it may be more appealing because of a sense of freedom from police, as well as the security that someone is watching in case one overdoses.

**Risk: a more open drug scene also means new drug offerings**

The easy access to the open drug scene also led to a change in substance use patterns. While many individuals in Sweden were primarily using amphetamines, most reported changing to heroin, cocaine, or a mix of the two when they came to Copenhagen.

Carl: ‘When I came here, I tried heroin for the first time. And I regret that still today, because I became totally hooked. Totally hooked. And now it is mixed, heroin, cocaine, alcohol, hash. Everything possible, uppers and downers.’

This change in drug use patterns is significant as it exposes participants to a wider variety of risks such as the possibility of developing a more severe addiction, or of transitioning to heavier or riskier drug use. Many reported an increase in polysubstance use, which can be more difficult to treat, and lead to increased risk for overdose and blood-borne viruses.

**Economic environment**

**Motivation: limited financial opportunities in Sweden**

Moving to a new place offered participants a new set of financial and employment prospects. Of those individuals who had criminal records or large debts in Sweden, they noted that they had limited opportunities in Sweden to live a comfortable life. They were unable to find legal employment or retain their income if they did, due to Kronofogden (the government agency in charge of debt collection) furnishing their incomes. Per Felicia,

‘And still I have a criminal record in Sweden, so I can’t get a job there, like what the fuck am I gonna do. And that’s also a thing that like, keeps people in criminality and in drugs.’

As Felicia reflects, this system places people in a vulnerable financial situation which may perpetuate engagement in criminality and substance use. The ability to move to a new country with a fresh slate allowed for individuals to accomplish something in their lives in a way not possible in their home country.

Table 2 provides an overview of all the listed reasons which were raised during each individual interview. It demonstrates the wide variety, as well as importance of having several motives, where all but one participant listed multiple reasons for their movement to Denmark, with most having three or more.

**Discussion**

The study’s results reveal diverse reasons why Swedish PWUD relocate to Denmark, related to physical, social, economic, and policy environments in both countries. Key drivers pushing people from Sweden and attracted them to Denmark are social networks, the open drug scene, stigma, policing, and the availability of harm reduction services. Participants showed evolving motivations over time, and all but one participant reported several motivations. Transitioning between settings raised concerns about violence, exposure to new drugs and polysubstance use, and incomplete access to care. Duff (2010) challenges the notion of ‘enabling’ and ‘risk’ environments as finite, exclusive categories, highlighting that drug use settings will always encompass both risk and enabling factors simultaneously. Participants in this study experienced compromises in their moves to what they
considered as a better environment, but which still engendered risks in other ways.

The impact of a policy environment of relaxed drug laws and the physical environment of an open drug scene are often intertwined, making it challenging to separate their effects as motivating factors for movement. Rhodes et al. (2003) for example discusses policing practices as a structural, policy environment mediator for access to and benefit from existing harm reduction services. Harm reduction policing in Denmark has shown positive outcomes in reducing harm and violence, whereas punitive policing measures have been criticized for hampering harm reduction access (Cooper et al., 2005; Rhodes et al., 2003). There are relevant policy implications for rethinking the focus on the individual PWUD in law enforcement, and instead focusing on public order and safety, and reducing harms. However, drug scenes are physical settings which also carry risks, as seen in this study. Escalated or more risky substance use patterns, public disorder, and in some cases continued challenges in reaching harm reduction efforts, especially for vulnerable individuals, have previously been noted (Fast et al., 2009, 2010; Shirley-Beavan et al., 2020; Waal et al., 2014). These scenes are sometimes discussed in the literature as leading to possible ‘entrenchment’ and difficulty exiting (Fast et al., 2010; Knight et al., 2017; Ti et al., 2019). Entering a drug scene is also framed as something which should be avoided or intervened upon (Fast et al., 2009). Conversely, and despite these potential risks, many participants related dynamically moving in and out of the drug scene, for longer or shorter periods of time, often over the span of years or even decades. This did not only produce risks, but in fact conferred some benefits for them, largely due to the different policy environment.

Many expressed a desire to return to Sweden under more favourable conditions, but are hindered by social and structural environmental constraints. The legal system can place people in vulnerable financial situations, perpetuating involvement in criminality and substance use (Knight et al., 2017). Cross-border travel within the EU offers unique opportunities to become employed, as criminal records are not necessarily shared between countries. Knight et al. (2017) identified legitimate employment or education, as well as physical and social distance from the drug scene, as crucial factors for exiting these environments. Leaving negative environments has been cited as a common push factor in previous survey studies (Schreiber, 2014). Certain physical or social environments can trigger drug cravings and increase the risk of relapse, emphasizing the importance of being able to leave such circumstances (Childress et al., 1986).

Participants in this study traveled for their social networks, which is also seen in other studies (Schreiber, 2014; Wagner et al., 2012). While this may not be exclusively related to substance use, it can have important consequences on drug-related trajectories. Social isolation exacerbates substance use (Tomori et al., 2014), while supportive social networks improve treatment retention and reduce relapses (Atadokht et al., 2015; Bathish et al., 2017; Westreich et al., 1997). Social networks were key for people learning about which services were offered and how to access them. However, the benefits to social networks depends on the qualities of the group itself, where group norms such as syringe sharing can influence riskier drug use (Latkin et al., 2010; Umberson & Karas Montez, 2010).

It was not just the services themselves, but also the reception of service providers which influenced mobility decision-making. The study confirms stigma as a motivator, previously posited by Hayashi et al., (2019). Previous studies named ‘adverse situations experienced elsewhere’ (p. 1) (Fast et al., 2009) and repressive drug policies (Tibi-Lévy et al., 2020) as driving factors, but none have explored the impact of this condition of the social environment, service provider attitudes, as a motivator. Perceived and/or internalized stigma deters PWUD from accessing care (Paquette et al., 2018; Rivera et al., 2014). Providers with abstinence-orientations have negative views toward PWUD (Caplehorn et al., 1997; Kapadia et al., 2021) and limit harm reduction referrals/access (Javadi et al., 2022). There are clear implications here, with regards to how top-level policy goals may guide treatment formats, and even provider attitudes. This influences lived experiences of, and actions to leave, the system.

Policy factors such as the availability of lower threshold harm reduction-based programs which focus on engaging

| Table 2. Motivations for going to Denmark from Sweden. |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                 | Harm reduction services + service orientation | Policing/ compulsory care | Stigma | Social network | Physical | Drug scene | Income/employment opportunities |
| Axel            | X               | X               | X               | X               | X               | X               | X               |
| Bengt           | X               | X               | X               | X               | X               | X               | X               |
| Carl            | X               | X               | X               | X               | X               | X               | X               |
| Daniel          | X               | X               | X               | X               | X               | X               | X               |
| Elias           | X               | X               | X               | X               | X               | X               | X               |
| Felicia         | X               | X               | X               | X               | X               | X               | X               |
| Gustav          | X               | X               | X               | X               | X               | X               | X               |
| Hans            | X               | X               | X               | X               | X               | X               | X               |
| Ivar            | X               | X               | X               | X               | X               | X               | X               |
| Jakob           | X               | X               | X               | X               | X               | X               | X               |
| Kjell           | X               | X               | X               | X               | X               | X               | X               |
| Leif            | X               | X               | X               | X               | X               | X               | X               |
| Magnus          | X               | X               | X               | X               | X               | X               | X               |
| Nolan           | X               | X               | X               | X               | X               | X               | X               |
| Olivia          | X               | X               | X               | X               | X               | X               | X               |
| Pernilla        | X               | X               | X               | X               | X               | X               | X               |
| Robert          | X               | X               | X               | X               | X               | X               | X               |
users in the development and design of service programs have high degrees of user acceptability (Bartholomew et al., 2022; Islam et al., 2012; Kappel et al., 2016) which can enhance engagement. It is recommended to include the target population in the development of services (Ti et al., 2012). It is important for low threshold initiatives to meet the needs of those who are at the highest risk of lack of engagement and/or negative outcomes, where lack of such services had real impacts on perpetuation of drug use in the context of homelessness. Some prefer strictly regulated systems, while others prefer lower surveillance and control (Notley et al., 2014). However, harm reduction sites are not always unequivocally beneficial, and can also engender risks (Jakobsen et al., 2022) or be formatted in a restricting way (Kerr et al., 2007), leading to reluctance to use them. Features of the Swedish system which required inherent engagement were sometimes viewed positively, but the criteria and levels of control criteria ultimately drove many away. An attempt should be made to meld the existing positive factors of the system with lower thresholds, to ensure people are not deterred from accessing services. Abstinence- or rehabilitative-oriented treatment is an important tool for some individuals, ideally offered as an option within a wider system also offering harm-reduction focused alternatives and autonomy over care decisions.

PWUD’s movement has been previously linked to specific risks such as potential for lack of full access to a comprehensive health and social care system and inadequate information (Paschane & Fisher, 2000; Rachlis et al., 2010), these issues were also reflected in the results of the current study. It can also raise equity concerns, as certain groups can seek better care, leaving others ‘stuck’ with lower quality care (Lunt & Mannion, 2014). We can see this reflected by the one participant in this study who was limited by their non-EU citizenship, as well as the low proportion of women in the study, who may face different expectations relating to caregiving responsibilities, which could hinder possibilities to move. All participants spent much of their lives in the three southernmost regions of Sweden, facilitating their movement and knowledge of the settings. Others may be forced to travel far within the country for better access, and those who cannot or do not want to travel are at greater exposure to risk (Holeksa, 2022).

The study explores individuals’ considerations when relocating to a new environment, as well as the risks or compromises faced as a result of that relocation. It emphasizes the impact of drug scenes, service delivery, interpersonal contacts, stigma from service providers, as well as the structural conditions which shape these, on decision-making. Limiting factors for the benefits of movement include issues with comprehensive access, violence concerns, and missed engagement opportunities. Given the broadly similar welfare states, the data demonstrate the real consequences that drug policy has for PWUD. There are important implications related to the role of the overarching policy, service delivery, and law enforcement foci, on improving access, inclusion, wellbeing, and safety, as well as reducing stigma. For Carl, his Swedish hometown meant a clear risk environment, and the move to Denmark enabled a safer existence in several, but not all, respects. Features of the policy, economic, social, and physical environments must be appraised jointly to provide an accurate understanding of the motivations for, and benefits or risks of, mobility of PWUD. These data can provide important knowledge in particular about the advantages and disadvantages of different drug policy orientations, and can be part of the work to transform risk environments into enabling environments.

Limitations

The study has several limitations. Firstly, the small sample size limits generalizability of the findings to a broader population. The sample comprises individuals dissatisfied with the environment in Sweden, therefore the data may possibly miss comprehensive insights into positive aspects of that system. The empirical material reflects experiences, which may not always accurately represent the actual system. Some experiences may pertain to historical issues, now alleviated due to policy changes. Only one participant lacked EU citizenship. Additionally, despite attempts to reach more, and although they were approximately proportional to reports of those using recruitment services, only three participants were female. It would have been valuable to engage more individuals from these groups to understand their experiences more thoroughly.

Note

1. This law allows for individuals to be sent to compulsory drug treatment if they are judged to pose a severe danger to themself or others and are not willing to engage in voluntary care. Approximately 350–400 people with illicit substance use are sent to treatment under LVM annually.

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Ethical approval

The project on which the current study is based was approved by the Swedish Ethical Review Authority. All participants gave their informed consent to participate. All study procedures complied with relevant laws and institutional ethical guidelines.

Disclosure statement

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Data availability statement
The datasets generated during and/or analyzed during the current study are not publicly available due to privacy concerns.

References
Kappel, N., Toth, E., Tegner, J., & Lauridsen, S. (2016). A qualitative study of how Danish drug consumption rooms influence health and
Sweden has a history of a restrictive drug policy, with a national policy focus on achieving a “drug free society.” This has led to a relatively slow development of “harm reduction” services, interventions which aim to reduce risk for people who use drugs, without requiring drug abstention. The harm reduction services which do exist are unequally distributed across the country. Sweden’s neighbouring country, Denmark, has a much more developed harm reduction landscape, and a less punitive drug policy. In this context, this project aims to explore the attitudes of social work professionals towards harm reduction in different areas of Sweden, and Swedish people who use drugs’ experiences of differing drug policies. It focuses on people who use drugs’ risk management strategies and mobility, in relation to differing policy and harm reduction service landscapes, as well as their experiences of stigma.

The findings of this project may be used to understand how care varies in different areas, and what impact that may have for people who use drugs. The thesis points to the need for a better-developed and more geographically evenly distributed supply of harm reduction measures. This could lessen the burden for those who need to move or travel to access care, or who are exposed to excess risks due to a limited range of care services. The project demonstrates how national and local policy and care strategies affect people’s access to care resources, their mobility between different environments, their identity, and their opportunities to be included in society.