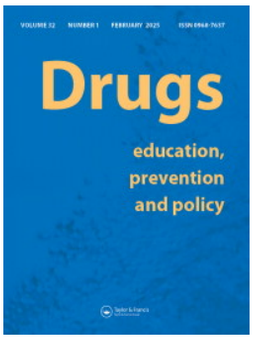

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# "I knew it was different there": a qualitative study of the motivations and risks of drug policy migrants going to Denmark from Sweden

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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, all 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.

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Harm reduction; people who use drugs; drug policy; mobility

## 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

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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 has embraced aspects of harm reduction in recent years (Andersson & Johnson, 2020; Karlsson et al., 2021; Nordgren et al., 2022). 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.

| | Sweden (pop 10.42 mil) | Denmark (pop 5.86 mil) |
|---|---|---|
| Needle and syringe exchange (NSP) | Yes | Yes |
| NSP identification requirement | Yes | No |
| Pharmacy NSP | No | Yes |
| Supervised consumption | No | Yes |
| Heroin-assisted treatment | No | Yes |
| Take home naloxone | Yes, with prescription | Yes, no restrictions |
| Low threshold shelters | Limited | Widely available |
| Total opioid substitution therapy (OST) clients[a] | 7500 | 7500 |
| OST clients per 100,000 population | 72 | 127 |
| Overdose deaths per 100,000[c,b] | 6.46 | 4.56 |
| Criminalization of personal drug use | Yes | Yes, with exemption for those with addictions |

[a]Data from (Gedeon et al., 2019; Statens offentliga utredning, 2023).
[b]Data from (Wiese Simonsen et al., 2020).
[c]Inter-country comparisons on such statistics should be made with caution, due to potential differences in measures and reporting.

### *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 (Gr⊘Nnestad & 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 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 operated 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 policing, 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 shelter in Copenhagen, and a NSP in southern Sweden. This was complemented by a snowball sampling strategy. Inclusion criteria were that the individual was a Swedish citizen/resident, and that they had gone to Denmark and had experiences of accessing harm reduction and other drug-related care services 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 pseudonymized. 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 these 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:

Robert: '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 one 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, up[pers] and down[ers].'

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,

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

**Table 2.** Motivations for going to Denmark from Sweden.

| | Policy | | Social | | Physical | Economic |
|---|---|---|---|---|---|---|
| | Harm reduction services + service orientation | Policing/ compulsory care | Stigma | Social network | Drug scene | Income/employment opportunities |
| Axel | X | | X | X | X | X |
| Bengt | X | X | X | X | | |
| Carl | X | | X | X | | |
| Daniel | | X | X | X | | |
| Elias | X | X | X | | X | |
| Felicia | X | X | X | X | X | X |
| Gustav | X | X | X | | | X |
| Hans | | | | X | | X |
| Ivar | | X | | X | X | |
| Jakob | X | | | | X | |
| Kjell | X | | X | | X | |
| Leif | | | | X | X | X |
| Magnus | | X | X | | X | |
| Nolan | | | | X | | |
| Olivia | | | | X | X | |
| Pernilla | X | X | X | X | X | |
| Robert | X | X | | | | |

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, most 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

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

No potential conflict of interest was reported by the author(s).

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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.

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