AALBORG UNIVERSITY

Rationalities and everyday practices in substance abuse treatment of asylum seekers in Denmark

Thesis, spring 2018

Rebecca Marie Broholm-Little
Student ID: 20162246

Supervisor: Steffen Jensen
Submission date: May 31st 2018
Characters: 143,968

Global Refugee Studies
Department of Culture and Global Studies
Aalborg University, Copenhagen

Abstract

This study seeks to conduct an extensive policy analysis of substance abuse treatment concerning asylum seekers in Denmark structured by Carol Lee Bacchi's approach *what's the problem represented to be?* (2009). The study views the policy through textual documents, as well as everyday practice carried out by street-level bureaucrats. The empirical material is gathered through interviews with health personnel from four different asylum centers and is supplemented with interviews with social and health actors from the open drug scene on Vesterbro, Copenhagen. Apart from identifying implied rationales in the policy and policy practice, the analysis has also been concerned with exploring so-called policy silences, meaning issues unaddressed in the policy. The findings show that an underlying conceptual logic in the policy is that asylum seekers have a lesser right to health care than Danish citizens, including substance abuse treatment. A clash between this critical migration rationale and a health-oriented drug rehabilitation logic is apparent at the asylum centers, and health personnel are left to navigate in this tensional field. Different policy practices are identified among the informants at the asylum centers – some reproducing the policy's rationales and others opposing them. The analysis furthermore illustrates that there is a large prevalence of asylum seekers on the open drug scene in Copenhagen, which is a circumstance unaddressed in the policy. It is discussed how this policy silence may fixate policy practice to the official asylum system, thus impeding action to be taken on the unofficial drug scene. Concerns are raised as to whether the policy favors the most resourceful drug dependent asylum seekers, due to a lack of integrated social and medical treatment together with red tape bureaucracy, thus neglecting the most vulnerable asylum seekers with a substance abuse.

Keywords: Policy analysis, substance abuse, asylum seekers, street-level bureaucracy

Table of Contents

INTRODUCTION 2

RESEARCH QUESTION AND SUB-QUESTIONS 4
STRUCTURE OF STUDY 4

CHAPTER 1 – METHODOLOGICAL AND THEORETICAL APPROACH 6

POLICY ANALYSIS 6
METHODOLOGICAL APPROACH TO POLICY ANALYSIS 8
THE WPR-APPROACH APPLIED IN THIS STUDY 9
THEORETICAL APPROACH 11
DATA COLLECTION 14
TEXTUAL EMPIRICAL MATERIAL 14
INTERVIEWS WITH HEALTH AND SOCIAL WORKERS 15

CHAPTER 2 – CONTEXTUALIZING THE POLICY SPACE 20

DANISH DRUG POLICY 21
DANISH MIGRATION POLICY 23
THE POLICY SPACE OF THIS STUDY 25

CHAPTER 3 – ASSUMPTIONS AND RATIONALES IN THE POLICY 26

ASYLUM SEEKERS' ACCESS TO SOCIAL AND HEALTH BENEFITS 26
"NON-DANISH, VIOLENT, CRIMINAL" 30
THE DEPENDENCY OF ILLICIT DRUGS 32
CLOSING REMARKS 33

CHAPTER 4 – HOW PRACTITIONERS ENGAGE WITH THE POLICY 34

CLASH BETWEEN HEALTH PRINCIPLES AND POLITICALLY MOTIVATED PRINCIPALS 34
A NATURALIZATION OF THE IMMIGRATION SERVICE'S TREATMENT CRITERIA 37
DIFFERING LOGICS IN POLICY PRACTICE 43
CLOSING REMARKS 47

CHAPTER 5 – THE FLIP SIDE OF THE POLICY 48

THE OFFICIAL/NON-OFFICIAL PROBLEM 48
THE (LACK OF) INTEGRATION OF SOCIAL AND MEDICAL CARE 52
CLOSING REMARKS 56

CHAPTER 6 – FURTHER PERSPECTIVES 58

TREATMENT BARRIERS FOR THE HIGHLY VULNERABLE 58
CLOSING REMARKS 61

CONCLUSION 62

LITERATURE LIST 65

WEB PAGES 69

APPENDIX LIST 70

Introduction

> "Some people say that they took drugs at home, because there was war. Others started on the journey up here, because they were forced into prostitution or to box for money – different crazy things. But there are also others who say that they started taking drugs, when they arrived in Denmark." (Michelle, appendix 1)

In the statement above, one of the informants of this study touches upon the fact that traumatic events experienced in the country of origin and/or on the flight to Europe can cause problematic substance abuse among refugees and asylum seekers as a way to cope with trauma and deal with uncertain living situations. Similarly, international research has shown how traumatic experiences can increase the development of substance abuse among refugees (Ezard 2011, Brune et. al. 2003). In recent years there has been an increase in refugees seeking protection in Europe with the highest amount arriving in 2015 with just over 1.25 million refugees (Eurostat 2018). During the same year Denmark received 21,316 asylum seekers (Ministry of Immigration and Integration 2018: 4) and although the number has since been declining, the increase in received asylum seekers over the past years has generated debate over how receiving countries should facilitate and organize the treatment and reception of these newly arrived citizens.

In the summer of 2016, the former Danish Ministry of Social Affairs and the Interior published the report: "An Analysis of the Consolidation Act on Social Services' (Service Act) Applicability in regards to Foreign Nationals with Procedural or Non-Legal Residency" (Ministry of Social Affairs and the Interior 2016). The report was written to clarify the questions that have surfaced after the increased arrival of refugees in Denmark regarding the social services provided to foreign nationals, hereunder treatment for substance abuse. It however seems as if there is still much doubt regarding how such treatment should be organized and facilitated in practice for asylum seekers, as the legislation falls between the Danish Service Act, Health Act and Aliens Act and due to contradictory ministerial responses on the area (Kiørboe 2017).

In early 2017, Research Center for Migration, Ethnicity and Health at Copenhagen University carried out an investigation of the range, patterns and treatment opportunities for asylum-

seekers in Denmark with a substance abuse. The study showed that 5,6 percent of adults and 3,8 percent of minors had a drug addiction at Danish asylum centers. The researchers who conducted the study assessed that these numbers were quite conservative and were somewhat uncertain, as they are based on asylum seekers actively seeking out help in the asylum centers' health clinics. The report also showed that the amount of asylum seekers and refugees on the *open drug scene*[1] on Vesterbro has risen over the past years (Østergaard & Nørredam 2017). The prevalence of asylum seekers and refugees on the open drug scene is also a tendency which has shown itself in several news articles in recent years (Politiken 2017 (1&2)).

Based on these recent developments, I am interested in carrying out an extensive policy analysis of substance abuse treatment concerning asylum seekers. I find it relevant to do so by viewing the policy as a set of textual objects to e.g. zoom in on the abovementioned legislation that falls between different stools, and to look at the language of the policy to explore its imbedded assumptions and rationales. However, I am also interested in viewing the policy as it is engaged with and affected by its practitioners. I employ this perspective based on a Lipskian approach to policy:

> "Most citizens encounter government (if they encounter it at all) not through letters to congressmen or by attendance at school board meetings, but through their teachers and their children's teachers and through the policeman on the comer or in the patrol car. Each encounter of this kind represents an instance of policy delivery." (Lipsky 2010: 3)

Based on this perspective, it is just as, if not more, important to view a policy through its practitioners as through its physical form, as it is here policy comes to have meaning and affect the world, which it is in. Furthermore, in order to understand the entire field surrounding drug dependence treatment for asylum seekers, I find it necessary to also view

---

[1] The open drug scene is a term for a small geographic area of approximately 1 km2 behind Copenhagen Central Station on Vesterbro, where drug users come to buy, sell and take drugs. It is called the "open" drug scene, as drug users are clearly visible in the area to the public surroundings and people (Mændenes Hjem 1). In this area there are several health and social facilities aimed towards drug users and the homeless, among others two injection/smoke facilities, where drugs can be taken under secure conditions.

what is left unmentioned in the policy. This has led to the following research and sub-questions:

Research question and sub-questions

How is public policy concerning drug dependent asylum seekers engaged with in the everyday lives of its practitioners, and what is left unmentioned in the policy?

The research question will be answered through the following sub-questions:

1) What rationales and assumptions are imbedded in public policy concerning asylum seekers?
2) How does health personnel at asylum centers engage with the policy in practice?
3) What is left unmentioned in the policy, and what effects may this have for the treatment of drug dependent asylum seekers?

Structure of study

Prior to the analysis, I will in chapter one demarcate how I will use Carol Lee Bacchi's policy analysis (2009) as a methodological tool to answer the research question, and what theoretical perspectives will be utilized to supplement the policy analysis approach. This will be followed by methodological considerations regarding the collection of empirical data together with a discussion about what the empirical data allows, but also delimits me, to explore.

Chapter two will provide the reader with a contextualization of the world within which the policy under scrutiny came to be, and illustrate how the policy is situated in a highly complex field characterized by competing logics, which provides a stepping stone to chapter three, where underlying assumptions and rationales of public drug policy concerning asylum seekers will be explored, based on the textual documents surrounding the policy.

Chapter four will use the collected data from conducted interviews to analyze how the policy is understood and engaged with by health personnel at asylum centers. The analysis in this chapter will be grounded in Michael Lipsky's work on *street-level bureaucracy* (2010), Dorte Caswell's further development of Lipsky's work (2005) together with James D. March and Johan P. Olsen's theory on *the logic of appropriateness* (1995). Here the policy rationales,

identified in chapter three, will be included to understand how the health practitioners make sense of the policy and its imbedded regulations.

In the two final chapters, it will be critically discussed what is left unaddressed in the policy based on the interviews conducted with asylum center health personnel, but also supplemented with interviews conducted with social and health actors working on the open drug scene in Copenhagen. It will lastly be discussed what effects the unaddressed issues in the policy may have for the treatment of drug dependent asylum seekers.

CHAPTER 1 – Methodological and theoretical approach

This study sets out to conduct a comprehensive examination of Danish drug policy concerning asylum seekers, which includes identifying underlying rationales in the policy, exploring how policy practitioners engage with it, and zooming in on what the policy neglects to address. The methodological framework chosen is thus informed by policy analysis supplemented by interviews with health personnel at asylum centers and health/social workers from the open drug scene on Vesterbro, Copenhagen. In the following chapter I shall elaborate on the methodology and methods used throughout this study and the theoretical lens though which I shall analyze the collected data.

Policy Analysis

In this section a short introduction to the term policy and policy analysis will be presented, followed by a methodological overview of how the policy analysis will be conducted based on Carol Lee Bacchi's approach "what is the problem represented to be? (2009)"

When conducting a policy analysis, it is important to first establish, what is meant by the term policy. This study is concerned with public policy, meaning a policy developed by the Danish government, rather than policies developed by e.g. NGO's or corporations. Policy is furthermore understood as a process, which is not only centered around concrete policy texts, specific outcomes, or implementation strategies, but consists of all of the above together with rationales and logics that together have an agenda-setting function (Rizvi & Lingard 2010: 5). This study thus views public policy as the actions and programs, but also political positions taken by the government, seen as consisting of a large range of collective institutions. Through this lens, a policy becomes a policy through the collectivity of these institutions, and cannot be seen as one individual decision:

> "A policy expresses patterns of decisions in the context of other decisions taken by political actors on behalf of state institutions from positions of authority. Public policies are thus normative, expressing both ends and means designed to steer the actions and behavior of people." (Rizvi & Lingard 2010: 4).

The study thus assumes the perspective that public policies have a governing function.

There can be different purposes for conducting a policy analysis. The analysis can be *of* a policy or *for* a policy, which primarily depends upon who is conducting it (ibid: 50). An analysis for a policy can be done as part of a policy development or as policy evaluation, where the goal of the analysis is to give specific advice relevant to public decision-making by policy advisors, lobbyists or NGO's, as described by Weimar and Vining (2016). With an analysis of a policy, also called policy research (Patton & Sawicki 1986), the purpose is academic exploration and comprehensive research on policy issues. Because of this distinction, it is important to establish my positionality, as this determines the policy analysis I will undertake. The fact that I am conducting the policy analysis as an academic researcher, as opposed to for instance a policy entrepreneur, influences the type of policy analysis that I will conduct. My positionality entails an inherent purpose of general academic exploration and not e.g. policy advocacy, which means that the policy analysis will be an analysis *of* a policy and not an analysis *for* a policy, based on the description above. (Rizvi & Lingard 2010: 46).

When doing an analysis *of* a policy, an array of different approaches present themselves. Carol Lee Bacchi's (2009) approach to policy analysis is termed "what is the problem represented to be"? (WPR), and scrutinizes the *implied* problems, which are inherently lodged in policies. Also concerned with public government policies, Bacchi states that because policies are created to remedy or change a current situation, they also imply that there is a problem that *needs changing*. The mere development of a policy entails a framing of a given situation as something that *needs be dealt with*. This problematization, or *problem representation*, is the implied understanding of a problem in any given policy. Her view on policy "problems" is thus that they are "endogenous - created within - rather than exogenous - existing outside - the policy-making process." (Bacchi 2009: x). Her approach is thus critical towards the notion that policies somehow deal with objective issues, but rather views policies as solutions to problems, which are constructed by the policy itself.

According to Hal K. Colebatch (2006) policy analysis can be separated into three perspectives, namely; authorized choice, structured interaction and social construction. While authorized choice views policy as a "fix" to certain problems that exist in the world, and thereby belongs to a positivist position, structured interaction stresses the importance in

policy definition from a recognition of there being competing political views on what the problem may be. However, due to the idea that there exists a most desirable direction, this perspectives is also placed in the positivist realm. Social construction however views policy as constructed by the policy participants' view of the world. (Colebatch 2006: 6-10). Bacchi's WPR-approach takes a critical stance to both authorized choice and structured interaction, as she views policy "problems" as constructions, and not objective realities (Bacchi 2009: 33).

As such, Bacchi's project is to explicate these constructed framed problems through an analysis, which is grounded in identifying problem representations. As such, the approach builds on the premise that all policies are problematizing activities and contain implicit problem representations. In her approach, this framework theory is understood as "the ways in which *problematisations are central to governing processes"* (ibid: xii), and thus also presupposes that we are governed through these problematizations. A central goal in her approach is thus to problematize the policy problematizations imbedded in government policy, through which society is managed and people are subsequently governed. Through this approach, Bacchi does not only view the state as a central player, but a wider range of players in the running of society, such as doctors, social workers and teachers (ibid: 25-26). Through this wide range of actors, Bacchi, similarly to Rizvi & Lingard views public policy as something carried out by a collectivity of actors and institutions, which inherently contain knowledges, rationales and logics, which are taken for granted and should be challenged.

Methodological approach to policy analysis

The methodological framework for this study will be structured around Carol Lee Bacchi's WPR-approach in an attempt to identify the underlying problematizations and rationales in government policy concerning drug dependence treatment for asylum seekers. The field of policy analysis is fairly broad and many researchers have conducted extensive research within different spheres of it. Where researchers such as David L. Weimar and Aidan R. Vining view policy analysis as a professional activity centered around advice given to clients regarding public decisions (Weimar & Vining 2016), researchers such as Jacob Torfing view policy as a an empirical tool through which to discuss governance (Torfing & Triantafillou 2017). Carol Lee Bacchi on the other hand takes policy seriously as something in and of itself, and turns the focus away from how policies can solve problems to how they frame them. Her conducted policy analyses furthermore belong to the same empirical field as this study ranging from

crime/justice policy, immigration policy to drug policy, thus providing contextual similarities.

Although governance is central to her work, her project first and foremost focuses on exploring and analyzing the problematizations inherent in public policies and to identify the assumptions, rationales etc. that policies produce and represent. At the same time, Bacchi provides a clear methodological framework which can structure my analysis. With this framework, I can explore how the policy is framed when entering the practice field – as represented by health personnel at asylum centers – before examining what happens to the policy when health personnel interact with it. Do the identified assumptions change in practice? What role do heath personnel play in the reproduction of these assumptions? Bacchi's approach allows me to explore such questions. At the same time, her approach directs the analyst to explore what the policy *doesn't* articulate, and thus problematize. The analytical questions, which this poses, allows me to redirect my exploration away from the policy itself to the surrounding circumstances, issues, problems, which the policy neglects to articulate. As such, I can answer sub-question three of this study regarding what is unaddressed in the policy.

The WPR-approach applied in this study

Bacchi has developed a methodological framework based on six key questions, which structures the WPR-analysis, and allows the analyst to examine the premises for the problem representation under scrutiny. These six questions will be applied to the policy analysis concerning drug dependence treatment of asylum seekers, however not in a strict manner, going from question one to question six in a "straight line". I do not view Bacchi's WPR-questions as a step-by-step guideline the analysis must follow, but rather as questions, which can direct reflection. As such, some questions will receive more attention than others, the order of questions will be disrupted, while other questions will be merged and explored together.

The six questions in the WPR-approach are (Bacchi 2009: 2):

1. What's the problem represented to be in a specific policy?

2. What presuppositions or assumptions underlie this representation of the 'problem'?

3. How has this representation of the 'problem' come about?

4. What is left unproblematic in this problem representation?

5. What effects are produced by this representation of the 'problem'?

6. How/where has this representation of the 'problem' been produced, disseminated and defended?

The first question is answered by looking at the goal of the policy, and then subsequently turning it around. If the aim of a policy e.g. is to lower the use of drugs, the problem representation is then that drugs are problematic or bad. The following questions from two to six dig deeper into the premises for this representation.

What presuppositions or assumptions underlie this representation of the 'problem'? looks into the background knowledge that the problem representation is based on and is taken for granted. This taken for granted knowledge could e.g. be that drugs are dangerous. Bacchi uses the term *conceptual logics* to describe the collective meaning or understanding that must be in place for a problem representation to make sense, and not be questioned (ibid: 5). She suggests using a discursive approach to explore these underlying presuppositions and conceptual logics by identifying *binaries*, *key concepts* and *categories* within a policy. Questions such as; what meaning is given to concepts in policy formulation, what dichotomies are inherent in the policy, and how do categories give meaning to the policy? can be asked. (ibid: 5-9). This question will be central to and structure chapter three in order to understand how the policy is framed when entering the policy practice field, as represented by health personnel at asylum centers. As such, this question will be explored through a strictly textual exploration of the legislation, documents, and minister responses, which together make up the textual policy, and will supply an answer to the study's sub-question one.

How has this representation of the 'problem' come about? examines the process for how the

policy was developed. This section will identify which actors had a role to play in the development of the policy, together with which reports, statistics etc. were used in the development (ibid: 10-12). This question will be central to chapter two, where a contextualization of the policy will be undertaken in order to understand what world produced this policy.

The sixth question Bacchi poses, is concerned about how the policy is produced, disseminated and defended (ibid: 19). This section of her approach will serve as a general guideline for the analysis in chapter 4, where I will focus on the policy, as it is understood and practiced by nurses at asylum centers, as they have an essential role to play as policy practitioners, which will be elaborated later on in this chapter. Due to their role, it is interesting to explore how they understand and practice the policy, and how this can perhaps contribute to the policy becoming dominant.

With Bacchi's fourth question; *What is left unproblematic in this problem representation?* the analysis turns the main question around by asking what fails to be problematized. Another question belonging to this section of the analysis is; W*here are the silences in the policy?* By identifying what is not being touched upon in the policy, I can both shed light on how the "problem" can be thought about differently, but also draw attention to possible tensions in the policy. (ibid: 12-14). These questions will structure the analysis of chapter five, and will be answered through interviews with health and social workers on the open drug scene on Vesterbro, Copenhagen. The data collected here will supply a different perspective to the policy's target group – asylum seekers with drug dependency – than the one articulated through the policy, and thereby provide a new way of understanding the "problem".

I will include Bacchi's fifth question in the final chapter concerning the effects of the policy, not to be confused with the term outcome, which implies that there is a quantifiable result of the policy (ibid: 15). These effects will be discussed based on the analytical findings from the previous chapters and open up a space for further perspectives, which could be beneficial and interesting to look at in a future study.

Theoretical approach

Carol Lee Bacchi's WPR-approach will thus provide a methodological framework for the entire study, which is subsequently structured around three sub-questions, each analyzing

different areas of the policy. My theoretical approach to each sub-question will in the following be introduced, while a further elaboration of the theories will be conducted simultaneously with the analyses in each chapter.

Based off Bacchi's second question in the WPR-approach, sub-question one of this study is concerned with exploring what rationales and assumptions are imbedded in drug policy concerning asylum seekers. Following Bacchi's framework, chapter three takes its theoretical grounding in Michel Foucault's work on language and discourses (Bacchi & Goodwin 2016: p. 27-53). Discourses can be understood as "the way in which a particular set of linguistic categories relating to an object and the ways of depicting it frame the way we comprehend that object" (Bryman 2012: 528), meaning that discourses structure and delimit the way we can think and act on certain issues, resulting in language having a governing function (Foucault 1991, Foucault 1973). Bacchi uses and understands Foucault's concept of discourse in her WPR-analysis as "socially produced forms of knowledge that set limits on what is possible to think, write or speak about a "given social object or practice" (Bacchi & Goodwin 2016: 35). By engaging in a discursive analysis, I will explore the language of drug policy concerning asylum seekers through binaries, concepts and categories, allowing me to identify what rationales and assumptions are imbedded in the policy, thus affecting the way the policy is practiced in society and the treatment of drug dependent asylum seekers is structured and facilitated (Bacchi 2009: 7-10).

Central to Bacchi's approach to policy analysis is furthermore a focus on "the role of experts, "that link the conduct of individuals and organizations to the objects of politics"" (Miller & Rose in Bacchi 2009: 26). In this sense, Bacchi moves beyond simply viewing "the state" as an actor in public policy, but widens the lens to incorporate a wide range of professionals in civil society. In alignment with this view, the study's second sub-question is: How does health personnel at asylum centers engage with the policy in practice? Although Bacchi's approach rests on the premise that policy problematisations are influenced by practitioners, her methodological framework does not provide theoretical tools to explore this part of the policy process. Therefore, the theoretical grounding in sub-question two will marry Bacchi's query regarding how the policy is produced, disseminated and defended (ibid: 19) with Michael Lipsky's work on *street-level bureaucracy* (2010), Dorte Caswell's further development of Lipsky's work in a Danish context (2005), together with James D. March and

Johan P. Olsen's theory on *the logic of appropriateness* (1995) in the analysis in chapter four. These theoretical approaches are chosen, as they allow me to explore how policy is influenced by the people who practice it and their experiences of the policy. While Lipsky and Caswell will be used to examine how health personnel at asylum centers – street-level bureaucrats – practice drug policy in the cross-field between political regulations, directives and legislations and their own discretion as professionals, March and Olsen will guide an exploration of how health personnel at asylum centers *make sense* of the political regulations they are subject to and their own role in connection thereto, thus affecting their decided behavior and thereby policy.

The final sub-question will join and collectively view the study's analytical points and will combine the abovementioned theoretical perspectives in an analytical discussion. The aim here is to gain a broader understanding of the issue of drug dependent asylum seekers, and critically discuss what the identified policy problematizations and silences may mean for the treatment of drug-dependent asylum seekers. As Bacchi writes: "The argument here is not simply that there is another way to think about the issue but that specific policies are constrained by the ways in which they represent the 'problem'" (Bacchi 2009: 13). As such, the point in chapter five is to shed light on other aspects of the issue and other ways the policy could be thought about and practiced. This discussion will be informed by data from interviews conducted with social and health workers, who work on the open drug scene of Vesterbro and on a daily basis encounter drug dependent asylum seekers in a realm that is "outside" the policy.

Finally it will be discussed how the policy may affect the lives of the people it concerns. In the examination of policy effects, Bacchi here follows McHoul and Grace (1993) and their argumentation on the connection between discourse and effect:

> [I]f discourses don't merely represent 'the real', and if in fact they are part of its production, then which discourse is 'best' can't be decided by comparing it with any real object… Instead discourses (forms of representation) might be tested in terms of how they can actually intervene in real struggles" (McHoul & Grace 1993: 35).

A discussion on the "real" struggles, or effects, the policy under scrutiny has for asylum seekers will thus be conducted in chapter six.

Data collection

As mentioned previously, the policy analysis in this study will be conducted through textual analysis of policy documents and by viewing the policy as an active process, formed by its practitioners. The empirical data for this study was therefore collected in two rounds and will in the following be elaborated.

Textual empirical material

In the first analytical chapter (chapter three) the policy will be viewed as a textual reality, where the imbedded assumptions and rationales will be explored. The Danish drug policy concerning asylum seekers does however not consist of one single policy text, but several pieces of legislation, parliamentary debates, reports, statements etc.. For this section of the analysis, I collected the material through classic desk research, meaning I gathered a range of different documents and legislations related to the policy, that "exist independently of the researcher's intervention" (Silverman 2006: 201)

In order to have a starting point for the analysis, I have chosen to explore the government report "An Analysis of the Consolidation Act on Social Services' Applicability in regards to Foreign Nationals with Procedural or Non-Legal Residency" (from this point: Analysis of Service Act Applicability). The report was published in the summer of 2016 by the former Danish Ministry of Social Affairs and the Interior (SAI) and expansively goes through which social services must be provided to asylum seekers – among others drug dependence treatment – and is therefore the one policy text, which most directly concerns the question under scrutiny.

In order to shed light on more specific parts of the policy and create a fuller picture, the study will also bring other relevant policy texts and statements into the analysis. These other relevant policy pieces are namely:

- Minister response (SUU 2016-17 question 404) to a query from the Danish Parliament's Health and Elders Board regarding drug dependence treatment of asylum seekers
- Selected sections of the Aliens Act
- Selected sections of the Health Act

- Selected sections of the Service Act
- Selected sections of the Penal Code
- Guidelines written by the Immigration Service for health personnel at asylum centers regarding the treatment process for asylum seekers with drug dependency (appendix 4)

Together with the Analysis of Service Act Applicability these texts and statements form the empirical framework for this study's textual policy analysis. Furthermore, secondary literature on Danish drug policy and surrounding policy areas have been included in order to understand the policy's context in a Danish political landscape.

Interviews with health and social workers

The second half of the empirical data was collected through qualitative interviews with health and social workers working with asylum seekers with drug dependency. In the following section, I shall elaborate on how the interviews were used in the analysis, how they were conducted and what was gained from them.

Access and choice of informants

Throughout a six week period in the spring of 2018 five interviews with three nurses, one physician and one social worker from four different Danish asylum centers were conducted. These were supplemented with three interviews with two nurses working at *Skyen*[2], a smoke/injection room on Vesterbro, and a social worker from *H17*[3], another smoke/injection room on Vesterbro. The interviews conducted on Vesterbro were supplemented by a guided walk-through of the two respective facilities.

The choice of these informants was based on the circumstance that health personnel at asylum centers are the street-level bureaucrats (Lipsky 2010) most directly working with the policy, as their daily work consists of assisting asylum seekers with issues regarded to health, including drug dependency. Furthermore, health personnel are the ones who can – or choose not to – initiate substitution treatment for asylum seekers, and are thereby gatekeepers to the service provided through the policy. The chosen informants thus play an essential role as

[2] http://maendeneshjem.dk/stofindtagelsesrum/
[3] https://h17.kk.dk

policy practitioners, and were therefore deemed as ideal informants in this particular policy analysis to supply an answer to the study's research question. I do however recognize that there are other professionals, who engage with the policy in their everyday work lives, such as civil servants at Immigration Service processing applications for substance abuse treatment and health personnel working at municipal clinics, where asylum seekers receive their medication – both of which could also have provided an interesting insight into the policy in practice. I have however actively chosen to explore how health personnel at asylum centers engage with the policy, as they are the first professionals to engage with asylum seekers in the process of obtaining substance abuse treatment. I am also fully aware and acknowledge that the informants do not represent all health personnel at asylum centers in Denmark. Notwithstanding, the interviews have given me an important insight to access knowledge on how health practitioners engage with drug policy concerning asylum seekers. Besides using the interviews in the analysis, the persons I met also provided necessary contextual information for me to pursue this study.

Over the past years there has been a growing – albeit still small – focus on the presence of asylum seekers taking drugs on Vesterbro (Christensen & Larsen 2017, Politiken 2017 (1), Politiken 2017 (2)). This triggered my curiosity regarding possible issues *not* touched upon by public drug policy concerning asylum seekers. As such, in order to explore the study's sub-question three, I chose to interview personnel from H17 and Skyen, as they are the two main actors working directly with drug users on Vesterbro, Copenhagen and furthermore both offer injection and smoking facilities under complete anonymity, which is presumably appreciated by asylum seekers with a precarious legal status.

I gained access to half of these sources through a contact with whom I have worked with professionally for the past years. This does not mean that I personally knew any of the participants before beginning this study, but however knew a person working in the same field as them, who could "vouch for me". The first few people I spoke to then referred me to other health personnel working within the same field, who I then established contact with. Retrospectively, it seems to have been beneficial for my access to sources that I have previously worked within this field and thereby had a "way in". During one of my conversations with a nurse from an injection room in Copenhagen, she said:

> "There are always so many students just showing up on our doorstep, expecting to come in, talk with the users and take pictures. I mean, what do they expect? First and foremost we have to make sure it's a safe space for the users."

This indicates that this particular injection room has a policy, where they do not let "just anyone" inside for the comfort and protection of their clientele. This is of course natural, given the situation their clientele are in, when they are using their facilities. It is however worth noting that I had relatively easy access in once I had established contact, which is perhaps due to my professional experience from the field.

Interview guide and coding

The interviews were conducted based on two interview guides; one for health personnel at asylum centers and one for the health personnel at injection rooms in Copenhagen (appendix 2). The reason I have used two different interview guides is because the intention for the interviews were quite different. While the interviews at asylum centers sought to explore how health personnel understand and engage with the policy concerning drug dependent asylum seekers, the interviews from the open drug scene on Vesterbro were conducted in order to gain a broader perspective of the issue at hand and possibly see what the policy under scrutiny *doesn't* comment upon.

The interviews were semi-structured, only loosely following the interview guides, in order to establish more of a conversation, rather than strict interview with the participants. The interviews were conducted in this fashion, based on the recognition that the participants are experts in their own professional lives, and therefore could bring up topics or challenges, which I had not thought about prior to the interview.

Immediately after each interview, I wrote either notes and quotes from the conversation or fully transcribed the interview, depending on whether I had recorded it or not[4]. In the transcriptions I have omitted pauses, tone of voice and non-lexical conversation sounds, as the transcriptions were not to be used for linguistic analyses, and in order to have coherent material. All notes and transcriptions can be read in appendix 1 and 3.

[4] Two conversations/interviews were not recorded and therefore not transcribed.

Once all the interviews were conducted, I gathered all of the material and did an open first reading. Here I analytically coded each paragraph, noting down all concepts and themes I could identify. Before engaging in the coding, I had not prepared any categories or concepts, which I would divide the material into. I rather let the material steer the direction of the analysis. This gave me a broad overview of the entirety of the material. During the second reading, I could then move to a more focused coding, where I line-by-line analyzed the material based on the themes and concepts identified as prevalent throughout the entire data set and of particular interest. (Emerson, Fretz & Shaw 1995: 143). During this second reading I therefore looked for patterns, but also dissimilarities in the ways the informants spoke about their work and policy practice. As a result of this process, I ended up with a set of material for each theme, which then established a framework for the analysis.

What is gained from interviews

The qualitative method is characterized by focusing on the experiences and opinions of individuals, and in the qualitative interview, the idea is to get as close a picture of these things from the informant's point of view as possible. It is however important to be aware that interviews will always be affected by the interview situation, both in terms of the questions that are asked, and who is asking them (Bryman 2012: 405-406). This can for instance be exemplified, when some of the informants had a physical copy of the policy guidelines from Immigration Service by their side during the interview, which they referred to several times during our conversation. Due to the fact that I am a researcher, they presumably wanted to be prepared to answer my questions correctly, hence the guidelines. I can however not assume that they look to the guidelines in their daily work, although they had them by their side and referred to them, when talking to me. It is therefore furthermore important to acknowledge that the knowledge gained from the interviews cannot provide an insight into how the informants actually practice the policy. It rather tells me something about how they themselves think about and explain their practice. There is a clear distinction between the two. If I had wanted to identify everyday practices, I could have supplemented the interviews with observations from health clinics at asylum centers to see how the health personnel interact with asylum seekers in the process of getting substitution treatment.

However, according to Cecilie Rubow (2003), interviews and conversations are not as separated from participatory observations as they are sometimes viewed. Rubow suggests that

interviews can also serve a similar function to participatory observation and in fact entails far more than just receiving a message: "In an interview one does not necessarily relate to things from a distance" (Rubow 2003: 227) and the interview "can bring the implicit out into a shared space" (ibid: 234). She furthermore argues that people come to understand and interpret the world, when they are put in a situation where they must deconstruct and then reconstruct it through conversation (ibid: 227-243). Drawing on this perspective, I view the interviews conducted as a way to gain an insight into the informants' understanding of the policy, the world in which it is situated, and their relation to it.

CHAPTER 2 – Contextualizing the policy space

As this study sets out to conduct an analysis of Danish drug policy concerning asylum seekers, it is necessary to understand how this policy came to be and in what political world it is situated. This coincides with Carol Lee Bacchi's third analytical question in her "what's the problem represented to be" approach, upon which this study's policy analysis is structured. The purpose of Bacchi's third question is to uncover how a specific problem representation took shape and assumed dominance (Bacchi 2011: 11). This question somewhat assumes that the policy subject is well-established with clearly defined borders and strategies. While this is not exactly the case with Danish drug policy concerning asylum seekers, which will be elaborated in the following chapter, I still find Bacchi's third question useful to contextualize the policy which I am analyzing.

The concept of drug policy is often associated with a deliberate plan of action worked out by government officials, which formulates a framework upon how to regulate drugs, their use and problems associated with them. Bacchi's analysis of drug policy (2011) e.g. looks into the "Tough on Drugs" national strategy in Australia and similar strategies can be seen with the "War on Drugs" under president Nixon in the United States, but also in Denmark with the "Fight Against Drugs" national strategy, formulated by the government in 2003 and 2010. These strategies appear to comprehensively address the full-range of issues surrounding drug use in one tight policy package. However, in reality these policies comprise a wide range of other policy areas, such as welfare, penal and health policy. These policy areas have different practices for approaching "the drug problem" - such as imprisonment, fines or harm reduction - and different rationales for doing so.

Furthermore, within the policy I am exploring, Danish drug policy only takes up half of the space. The other half comprises of political rationales surrounding asylum seekers, and more specifically asylum seekers with drug dependence. This naturally brings other policy areas into the mix, the most obvious being migration and integration policy.

As such, the policy under scrutiny can be seen as having a multi-dimensional nature, situated in the midst of different policy areas, which in turn are implemented by different actors, ranging from health and social authorities to law enforcement, which furthermore answer to

different political institutions. Due to thus, the policy can beneficially be viewed as a *policy space*. Bagga Bjerge, who has done extensive research on the area of Danish drug policy, suggests the use of this concept, when a range of different political rationalities are mixed together in a policy field, rather than one policy dominated by one single rationality. In an article written with Esben Houborg, they use the term to explore how e.g. welfare and penal rationalities are politically negotiated and thus come to affect drug policy in different ways (Bjerge & Houborg 2016: 185-186).

The following chapter will give an overview of the space in which the policy under scrutiny is situated, and thereby provide an understanding of the policy field as a whole.

Danish drug policy

Danish drug policy has been considered to be relatively liberal, compared to its Scandinavian neighbors. The public debate has since the 1960's viewed drug dependency as a social problem, which should be addressed through the social welfare system, school system and cultural policies. Penal policies were at this point also in place, but only directed towards the supply-side of the issue, and in 1972 drug possession was officially de-penalized. In this time period, methadone substitution was also a commonly used treatment form. In the 1980's the public opinion concerning the role of the welfare state underwent developments, and there was a concern about whether welfare institutions disempowered people and simultaneously made them dependent on the state's help. As a result, recipients of social interventions had to become an integrated part of their treatment, by e.g. making social activity plans, so as to ensure a sense of ownership and responsibility. It was however still politically agreed upon that drug dependence should be addressed through welfare and not penal interventions. This began to change in the late 1990's, when several publications and media reports suggested that illegal drug use had become an accepted and normalized commonality. It was in this context, substantial changes were made to Danish drug policy, somewhat disturbing the image of a liberal Danish drug policy. (Houborg & Bjerge 2011: 18-20). This is mainly due to two events.

In 2004, penalization for drug possession was re-introduced, thus criminalizing drug dependent people (ibid: 16). In an official ministerial statement it was expressed that:

> "(. . .) now, and this is highly needed, a fine is issued as the main rule when you possess hash or ecstasy or the like. No matter if it is 1⁄2 a gram or 2 grams and no matter if it is for personal consumption or not. The law is the law and the law should be respected. This is the way to build a proper society." (The Office of the Folketing Hansard 2003–2004: 7651)

As the quote shows, this development represented a move towards using penal practices as a governing tool in drug policy, and a step away from the welfarist practices, which had somewhat dominated the policy field until then.

The other event can be found in the Danish drug strategy "Fight Against Drugs" in 2003, when it was officially stated that prohibition should always come before harm reduction. The strategy report states: "A strict adherence to harm reduction […] would lead to a direct contradiction of the core of drug policy: The parrying of all non-medical and non-scientific use of drugs" (Danish Parliament 2003: 6). This perspective was re-established in the report "Fight Against Drugs II" in 2010.

These instances appear to represent a true "hard on drugs" approach, but simultaneously with these developments, more liberal advances have been made: Since the mid-1990's there has been an increase in money being spent on drug treatment, in 2003 legislation was passed which guaranteed drug treatment within 14 days of application, and heroin treatment was introduced in 2007 (Houborg & Bjerge 2011: 16). As such, Danish drug policy can be seen as an ambivalent balance between repression and welfare, where "no clear policy exists, [and] different verbalizations of the goals of policy exist side by side" (Laursen & Jepsen 2002: 22).

This ambivalence is due to the fact that drug use is a contentious area, "which both calls upon moral judgements and involves a number of social and health risks" (Houborg & Bjerge 2011: 16). Drug use is thus an area which can be – and is – addressed through a legal, social and medical practice, which in turn is carried out by different institutions. These practices also naturally have different foundations, grounded in different legislations, ranging from the Service Law, Health Law to the Penal Code. Therefore, while the police will look at drug use through a crime control lens and address individuals as legal subjects, nurses will address individuals as biological and psychological subjects, whereas social workers will address individuals as social subjects (ibid.). From a treatment perspective, the system is part of the

general health and social care system. This system is publicly funded through taxes and all Danish citizens have equal access to the treatment facilities, free of charge. The treatment system consists of a range of public and private treatment facilitates (the private facilities also publicly funded). These facilities are divided between rehabilitation centers, where drug users in need of intensive treatment can live for shorter periods of time, and ambulatory clinics, where drug users come to receive substitution medicine, psychological counseling, group sessions etc. (Frank & Bjerge 2011: 203-204).

Danish migration policy

Apart from welfare, health and penal policy, the policy space also includes practices and rationales connected with Danish migration policy, as mentioned previously. Also in this policy area Denmark has moved from being known as a liberal and generous welfare society, to having a reputation as one of the most anti-immigrant countries in Europe (Olwig & Paerregaard 2011).

The current understanding and policies surrounding Danish migration do not go further back than the 1960's, when Denmark received thousands of guest workers from the Middle East, the Balkans, Pakistan and northern Africa. At this point, there was a need for extra laborers, and the immigrants were welcomed. However, in the 1970's there was a recession, which put the Danish labor market under pressure. Although the influx of guest workers was stopped, many of the immigrants who were already in Denmark and had obtained permanent visas decided to stay, and on top of that brought their spouses and children to Denmark. At this point, migration became a topic of public debate. In the 1980's, there was then an increase in the received number of refugees from war-torn countries and in the early 2000's approximately eight percent of the entire Danish population came to consist of immigrants. At this point, migration became a topic of public concern. (Olwig & Paerregaard 2011: 3-13).

In 2014 and 2015, the amount of refugees arriving in Europe – Denmark included – reached numbers, by many referred to as the highest since World War II. Under the V-Government (Liberal Party) from 2015, and since the VLAK-Government (Liberal Party, Liberal Alliance and Conservative Party) from 2016 until today, the carried-out migration and integration politics have been characterized by a consistent adoption of restrictive policies concerning

potential refugees and immigrants as well as newly arrived refugees in Denmark. In fact, on the homepage of the Ministry of Immigration and Integration, one can read the 71 restrictive policies that have been put in place during the government's two and a half year period in power. These policies are divided into categories, such as asylum, economic benefits, deportation of rejected asylum seekers, control & biometrics etc. (Ministry of Immigration and Integration 2018). Some of the most significant restrictions that have been made in this area, include: The decision not to receive 500 UN quota refugees yearly in Denmark, the amendment lengthening the moratorium for family reunification application for refugees from one to three years, the abating of deportation agreements, and the adoption of a new integration benefit, substantially lowering the income of newly arrived refugees (ibid.).

According to Olwig & Paerregaard (2011), there is a general understanding of migration to Denmark as challenging the cultural homogeneity of the country. Rather than being centered around religious or social conformity, homogeneity is in this case understood as a common value-system, shared by ethnic Danes centered around "individual freedom, personal choice and social engagement" (ibid: 7) – in other words, values connected to and upon which the Danish welfare state depends. Similarly Marianne Gullestad (2002, 2006) argues that so-called *egalitarian individualism* characterizes the Scandinavian countries, where the central concept is *lighed,* which can be translated into "equality" or "similarity". In the Nordic countries, Gullestad argues, there has been a tendency to view similarity as a prerequisite to equality, meaning that individuals have to perceive themselves as the same in order to feel of equal value (Gullestad 2002: 68-82). Due to this emphasis on commonalities, problems occur when others are perceived to be "too different" (Gullestad 2006:171). In addition, according to Ruth Emerek (2003), the general view on immigrants and refugees is that they "come from countries, which are very different from Denmark in regards to their understanding of democracy, the labor market, labor participation, family structures etc." (Emerek 2003: 2-3). Immigrants thus come to challenge the very welfare state that Danes so integrally identify to and will have difficulty being perceived as equal to Danes, cf. Gullestad. Due to this perceived challenge, many Danes are today concerned with refugees and migrants posing a threat to the Danish welfare system and as a consequence, the political debate is centered around how to best minimize the burden migrants and refugees represent (Emerek 2003: 4).

As can be seen through the Danish government's 71 political restrictions, mentioned above, the approach to minimizing this burden is either centered around receiving as few

immigrants/refugees as possible, or - if they end up in Denmark anyway – how to minimize the economic burden they inherently pose to Denmark. As such, the policy space also includes rationales from other policy fields, such as economy.

The policy space of this study

As such, the policy under scrutiny can not be seen as streamlined and clearly demarcated, but rather one that emerges in the cracks between different policy fields, including welfare, penal, health, migration/integration and economy. This identification of different fields provides an understanding of the policy space as one characterized by contention and conflicting rationales, which I can draw upon in the policy analysis conducted over the following chapters.

In the following chapter I will explore how these different policy fields with their inherent rationales and practices are mixed and played out against each other in the policy space of "Danish drug policy concerning asylum seekers". The complexity of the policy space is evident in the empirical material that I will analyze, as a comprehensive strategy paper for the handling of asylum seekers with drug dependence does not exist. There exists a wide range of policy papers and legislative documents that say something about the different policy areas, which I will be viewing together in order to understand the textual policy space as a whole.

CHAPTER 3 – Assumptions and rationales in the policy

While the previous chapter explored what policy fields encircle the policy at hand, the following chapter will analyze the imbedded problematizations and the underlying rationales and assumptions inherent in the drug policy concerning asylum seekers based on Carol Lee Bacchi's "What's the problem represented to be" approach (2011). As outlined in chapter one, this section of the analysis will focus on the textual aspects of the policy, while the forthcoming chapters, in turn, will look at the policy engaged with by its practitioners and issues surrounding, but not mentioned in the policy. The following chapter will take its empirical departure from the Analysis of Service Act Applicability, while also including other policy-relevant documents and legislations.

Asylum seekers' access to social and health benefits

The Analysis of Service Act Applicability was published in the summer of 2016 by the former Danish Ministry of Social Affairs and the Interior. The report is 132 pages long and stringently goes through the legal status of foreign nationals in regards to which social services must be provided to them and who has the responsibility to do so. The report is general, meaning that it concerns all service benefits and not specifically drug dependence treatment, which is why the policy analysis must also include other policy texts and statements. The report was written to clarify the legal status of foreign nationals with procedural and non-legal residency, regarding what service benefits they have the right to (Ministry of Social Affairs and the Interior 2016: 4).

The problem representation (Bacchi 2009: 4) must therefore be that foreign nationals with procedural and non-legal residency do not *automatically or naturally* have the same right to service benefits as Danish nationals.

In the report it was concluded that asylum seekers have legal residency in terms of the Danish Service Law, meaning that they have the same rights to the Service Act's benefits as Danish citizens. However, it was also concluded that the Aliens Act is a *special law*, meaning that the Service Act is subsidiary to it, as it is *general law*. The Aliens Act thereby regulates asylum seekers' access to social services. With this conclusion, the Service Act only applies to

asylum seekers, when and if the asylum system's measures, as regulated by the Aliens Act, prove to not be sufficient. (Ministry of Social Affairs and the Interior 2016: 108-109).

According to the report, in practice this means that the asylum center must firstly assess whether they have sufficient measures to provide the necessary help to the asylum seekers. If they assess this is not the case, the asylum center can request a professional assessment from the municipality (ibid: 112-116). In the case of substitution treatment, the asylum center can also write an application for treatment without the involvement of the municipality, as stated in "the guideline for health care personnel regarding drug dependence treatment of asylum seekers" (appendix 4). Due to the Aliens Act being the prevailing law on the area, it is the Immigration Service who has the final say in whether the benefit or treatment can be approved. If approved, the Immigration Service will pay for the service. (ibid: 112-116). According to the report, the Immigration Service's approval "is determined based on a concrete assessment of what is necessary based on the *temporal status* of the individual" (ibid: 115 – own italics). This formulation creates a gray zone concerning to which extent temporality affects asylum seekers' right to social services, but does not receive further attention in the report. If the treatment is approved, the municipality can then go into the case (ibid: 112-115). In the case of drug dependence, treatment will be facilitated through a municipal clinic cf. a ministerial response by the Minister of Immigration and Integration (Ministry of Immigration and Integration 2016 (2)).

Relevant sections of law:

Aliens Act	§ 42a	Article 1. A foreign national, who resides in the country and applies for residency in pursuance of § 7 will receive the costs for provision of means of subsistence and necessary health benefits covered by the Immigration Service (…)
Service Act	§ 2	Article 1. All persons residing legally in the country have the right to help based on this law.
Service Act	§ 101	Article 1. The municipal board must offer treatment of drug addicts.
Health Act	§ 7	Article 1. Persons with domicile in the country have the right to the law's benefits.
Health Act	§ 80	Article 1. The regional council offers acute treatment to

		persons, who do not have domicile in the country, but who are temporarily residing in the region, cf. § 8 (…)
Health Act	§ 142	Article 3. The municipal board offers persons with a drug dependence medical treatment with dependence-producing drugs free of charge.
Law on euphoric substances	§ 2	Article 4. Import and export, sale, purchase, distribution, reception, manufacturing, processing and possession of these substances [as determined by the Danish Health Authority to pose a hazard due to their euphoric qualities] is illegal.
Law on euphoric substances	§ 3	Infringement of this law (…) is penalized by fine or imprisonment of up to 2 years.

This process is applicable for all social services provided through the Service Act, among these drug dependence treatment. Social drug dependence treatment is provided through section 101 of the Service Act, while the actual medical treatment is regulated by the Health Act section 142. Both the social and medical treatment is carried out by a clinic under the municipality, and are closely integrated in the case of Danish citizens (the National Board of Health and Welfare 2016). To clarify, this study strictly looks at substitution treatment of substance abuse. Substitution treatment is a term used when a medicinal substance is given in replacement of a more unsafe drug to treat dependency (Danish Health Authority 2017: 8). An example of substitution treatment is when methadone is provided to a heroin addict. Due to this, the study therefore does not include asylum seekers addicted to e.g. cannabis, as cannabis dependency cannot be medically treated. This delimitation is necessary, as the public policy is also strictly centered around medical treatment, which will be exemplified shortly. Similarly, the study does not concern alcoholic asylum seekers as alcohol- and drug dependency treatment are separated in Danish law, with drug addiction mainly featured in the Danish Service Act and alcohol addiction mainly featured in the Danish Health Act (Thylstup, B. et. al. 2014: 12). This delimitation is thus chosen, as it demarcates and focuses the field of study.

As described above, asylum seekers have the full right to social services under the Service Act - albeit the Aliens Act has precedence over it - while asylum seekers have no claim to health benefits under the Health Act, as this is exclusively for persons with Danish domicile –

a Danish address registered on the national register cf. section 7 of the Health Act and as stated in the Analysis of Service Act Applicability (Ministry of Social Affairs and the Interior 2016: 32-33). However, it is also stated in section 80 of the Health Act that all persons have the right to acute and necessary health treatment, regardless of their status in Denmark. Asylum seekers therefore have access to acute health treatment based on the Health Act, and otherwise health treatment under the Aliens Act.

According to a ministerial response to a query from the Danish Parliament's Health and Elders Board (SUU 2016-17, question 404) regarding drug dependence treatment of asylum seekers, the Minister of Immigration and Integration, defines acute and necessary treatment as pain-relieving or urgent (Ministry of Immigration and Integration 2016 (2)). The question is then, whether drug dependence treatment falls under the category pain-relieving and urgent.

According to section 8 of the "National guideline for medicinal substitution treatment of drug users", drug users in substitution treatment have a lower risk of death than when untreated, and furthermore have a reduced risk of attaining virally transmitted diseases and other diseases linked to drug dependence, such as infections or intoxication (Ministry of Health 2008). Based on this alone, medicinal substitution treatment must be seen as rather urgent. However, in the ministerial response to the query from the Danish Parliament's Health and Elders Board, the Minister of Immigration and Integration stated:

> "The Immigration Service *does not cover expenses for addiction treatment*. This concerns all types of addiction, such as drug addiction, alcohol addiction and gambling addiction. In relation to drug addiction, e.g. dependence to heroin or methadone, the Immigration Service will however be able to approve expenses for proscriptions of methadone, *when it is seen as necessary to avoid criminal, aggressive or self-harming behavior*." (Ministry of Immigration and Integration 2016 (2) - own italics)

The same exact wording from this ministerial response can also be read in the "guideline for health care personnel regarding drug dependence treatment of asylum seekers" (appendix 4), which was distributed to all health clinics at asylum centers in Denmark by Immigration Service. As such, the criteria regarding "criminal, aggressive or self-harming behavior" is a recurring phrasing throughout the policy from political documents to policy implementation guidelines.

According to section 142 of the Health Act, Danish residents with drug dependency are offered medical substitution treatment free of charge. If looking again at the national guideline for medicinal substitution, section 8.1, this treatment must be given, when a person is addicted to opioids, defined by WHO as having mental and behavioral disturbances, and the person has expressed a wish for the treatment themselves (Ministry of Health 2008). The ministerial response therefore clearly establishes that different criteria for drug treatment applies to asylum seekers than for people with residency. What assumptions and rationales lie beneath this distinction, will in the following be analyzed.

"Non-Danish, violent, criminal"

As stated in the section above, treatment of asylum seekers for drug dependence is contingent upon the treatment reducing the risk of criminal, aggressive or self-harming behavior, which is a different set of criteria than those applying to Danish residents. There are two different assumptions this distinction can be understood though; By conditioning substitution treatment on violent, criminal and self-harming behavior, the policy can be seen as implying that asylum seekers with a drug addition typically behave that way, and therefore require treatment. These words can be seen as *categories* placed on asylum seekers with drug dependence that are used as a governing tool, affecting how people come to think about themselves and others (Bacchi 2009: 9). This categorization can be seen as particularly harmful, as it carries within it, the only opportunity for drug dependent asylum seekers to receive necessary health treatment. In other words, in order for asylum seekers with drug dependence to achieve treatment, they must behave according to the category "violent, criminal and self-harming". If they did not already do that, this categorical criteria can be seen as the perfect incentive to start.

The conditioning can however also suggest that the treatment of asylum seekers only becomes important, when and if the lack of treatment negatively affects the surrounding society or other people than the individual themselves. Here the logic will be: *Sure, we can help you out, but only if it benefits us first.* As discussed in chapter 2, a dominant rationale within migration policy in Denmark is that migrants pose a threat to the Danish welfare state. Steffen Jöhncke (2007) argues that this understanding stems from the experience that migrants are "stealing" welfare resources away from rightfully belonging Danes, who have spent their lives

contributing to the collective pool (Jöhncke 2007). As a consequence, recent policy is concerned with minimizing the burden posed to Danish society by migrants through restrictive integration policy. In line with this, the treatment criteria can be seen as affected by this "burden-minimizing" rationale, as it transforms a health care benefit into a service provided only if it will benefit the Danish state.

Regardless of the angle upon which the condition is viewed, the policy disregards the social and health status of the individual, apart from the term self-harming. This leads to the binary, which is explicit throughout the entire Analysis of Service Act Applicability, namely between Danish and non-Danish citizens. This binary is of course not a surprise, as the purpose of the report is to clarify the legal standing of foreign nationals. It is however interesting to explore how it shapes the understanding of the issue at hand.

According to Bacchi "there is a hierarchy implied in binaries. One side is privileged, considered to be more important or more valued than the other side." (Bacchi 2009: 7). There is a hierarchical opposition evident in this policy, as substitution treatment of Danish residents is contingent upon conditions related to a person's health status through words such as medically urgent and behavioral disturbances. These are in direct opposition to the conditions that apply to asylum seekers, which are not related to health status, but rather social/criminal status. By taking this train of thought one step further, we can elucidate that the categories Danish or non-Danish have inherent (dis)privileges attached to them, which determine the health treatment offered. Alas, the temporality of "procedural residents of Denmark", transforms the very definition of acute medical care (urgent and pain-relieving) into something completely different when referring to substitution treatment, and places asylum seekers in the underprivileged position of receiving inferior health treatment in comparison to Danish residents. This is again, perhaps not very surprising, but necessary to mention, as it represents a *conceptual logic* - a rationale not questioned - throughout the entire policy.

As such, although the space, which the policy under scrutiny is situated, consists of a range of several different policy fields and thereby rationales – as discussed in chapter two – it seems as if the penal and strict integration policies of current Danish politics somewhat dominate this policy space, thereby leaving less room for welfare and health policy rationales.

The dependency of illicit drugs

Although the policy's criteria for substitution treatment varies greatly from the criteria for treating Danish residents, the nexus between health benefits and Danish/non-Danish residency cannot be understood as simply as presented above. For the health benefit under scrutiny – substitution treatment - is not of unimportance. If I had been examining asylum seekers' access to prenatal care or the treatment of a broken bone, the conditions for treatment might not distinguish themselves from the conditions that apply to Danes.

The dependency of illicit drugs is a stigmatized health condition and according to an American study from 2009, people with substance dependence are viewed as more blameworthy and dangerous compared to people with e.g. a mental illness or physical disability. This view negatively affected the treatment of drug dependent people, as they were less likely to be offered help than people with other conditions and were more commonly avoided (Corrigan et. al. 2009). British research correspondingly shows that the majority of healthcare professionals, at the time of study, held negative, stereotypical views of people who had drug dependency (McLaughlin & Long 1996). Although substitution treatment is a common health practice in Denmark, drug users themselves still belong to a highly stigmatized group. As stated at a hearing held by the Council of the Socially Vulnerable:

> "Harm reduction hasn't removed the stigmatization of drug addicts, neither generally in society or, in many cases, among those who conduct harm reduction in their daily working lives" (Council of the Socially Vulnerable 2014: 7).

This, coupled with the current political climate and public debate regarding asylum seekers, makes for an extraordinarily vulnerable group of people.

Accordingly, it is as if there is a hierarchy in health conditions, ranging from very deserving of help to less deserving to undeserving. On this scale, drug dependence is on the less deserving side. This view of substitution treatment as less deserving than other health issues is of course not stated explicitly in any policy-related documents, but is nonetheless important to mention, as it can help explain why the Minister of Immigration and Integration stated that "The Immigration Service *does not cover expenses* for addiction treatment" (Ministry of Immigration and Integration 2016 (2) – own italics) in a minister response, before mentioning

the violent/aggressive criteria. Because, as one of the conceptual logics in the policy is; *non-Danish residents do not have the full right to health treatment,* it is natural that asylum seekers have a lower chance of receiving treatment for conditions lowest on the scale, such as substitution treatment. Therefore, the nexus between health benefits and Danish/non-Danish residency cannot be understood alone, but must be seen in relation to the health issue at hand; dependency of illicit drugs.

Closing remarks

This chapter has explored the underlying assumptions and rationales in the policy, identified as; asylum seekers do not have the same rights to social/health treatment as Danish residents, "necessary" health care transforms when the recipient is an asylum seeker, substitution treatment is contingent upon violent and aggressive behavior, and drug abuse belongs to a "less deserving" group of health issues than others.

As such, it can be argued that the formal, textual policy is dominated by the migration, penal and economic rationales explored in the previous chapter, while the welfarist, health and social rationales also tied to drug policy are somewhat placed in the background. This is both in terms of the textual wording of different policy documents, but also in a legal manner, as the Aliens Act has precedence over both the Health and Service Act.

The following chapter will zoom in on how policy practitioners at asylum centers engage with the policy and its imbedded rationales, and what this consequently means for the policy under scrutiny.

CHAPTER 4 – How practitioners engage with the policy

In the following I shall unfold how drug policy concerning asylum seekers is experienced and engaged with by five health care professionals at five different asylum centers in Denmark. In the previous chapters, assumptions in the policy have been explored and it has been discussed how this specific policy space is characterized by contention with imbedded logics ranging from cost-minimizing migration rationales to welfarist and socially-oriented rationales. This chapter will zoom in on how health personnel at asylum centers situate themselves within these logics and how their everyday practice is affected by it.

The first part of the analysis will touch upon some of the clashes that appear between political regulations and health care principles and will be explored through Michael Lipsky's work on street-level bureaucrats in order to understand the conflicts inherent when working in between the state and its citizens. Furthermore, it will be explored how the interviewed health personnel make sense of these political regulations and subsequently choose to act as policy practitioners inspired by James D. March and Johan P. Olsen's theory on the logic of appropriateness. Finally some of the differences in policy practice among the informants will be explored based on Dorte Caswell's action compass, thus informing a discussion of different practice logics among the informants.

Clash between health principles and politically motivated principals

When speaking with the health care professionals working on a daily basis with asylum seekers, I asked them how they determine whether an asylum seeker is eligible for substitution treatment. As a response to this question the informants pointed to the so-called NUP-principle, explained here by May, a nurse at Hanstholm asylum center:

> "We have guidelines within all health issues that we base our work on. We operate after, what we call, necessary, urgent and pain-relieving – the NUP-principle. That's what we look at. [5]"

[5] All quotes from informants are my own translations, as the interviews were conducted in Danish. All original quotes can be read in appendix 1 and 3.

Basing substitution on this principle in practice means that "the resident's general well-being and health condition is so threatened due to the abuse that relevant treatment must be ensued", as Matilde, a social worker at Sjælsmark, a pre-removal center explained.

However, as outlined in chapter three, the Immigration Service, which is the institution that assesses whether substitution treatment can be provided, will only approve treatment if it is deemed as necessary to avoid criminal, aggressive or self-harming behavior. This criteria is clearly stated in the guideline distributed to all health care professionals at asylum centers (appendix 4), and which all informants knew of and had access to. In spite of this, the health care professionals all mentioned the NUP-principle, although the Immigration Service refrains from mentioning this in regards to the eligibility for drug dependent asylum seekers to receive treatment. It can therefore be argued that there exists a clash between the health personnel's professional principles and the politically motivated principles the personnel is subject to, which once again indicates that the policy space is characterized by contention, as both welfarist and migration rationales are imbedded in it, which have different logics concerning the treatment of asylum seekers. This clash will in the following be illuminated by Michael Lipsky's work on street-level bureaucracy.

Essential to Lipsky's work is the view that government policy turns into practice in its meeting with citizens, and that it is through street-level bureaucrats that this meeting is facilitated:

> "Most citizens encounter government (if they encounter it at all) not through letters to congressmen or by attendance at school board meetings, but through their teachers and their children's teachers and through the policeman on the comer or in the patrol car. Each encounter of this kind represents an instance of policy delivery." (Lipsky 2010: 3)

Lipsky is therefore interested in exploring the policy-delivering role of street-level bureaucrats, which he defines as: "Public service workers who interact directly with citizens in course of their jobs, and who have substantial discretion in the execution of their work" (Lipsky 2010: 3). Lipsky's definition thus depends on two premises; that the worker has frequent interaction with citizens and can practice a high degree of individual judgment in each case. This is of course a broad definition and encompasses public service workers across

a wide spectrum of working places, but is in this study used to understand health personnel at asylum centers. According to Lipsky, street-level bureaucrats have a large impact on the lives of citizens and "the ways in which street-level bureaucrats deliver benefits and sanctions structure and delimit people's lives and opportunities" (ibid: 4). This impact and influence makes street-level bureaucrats de facto policy makers in Lipsky's eyes, actively defining politically determined policies through implementation in practice (ibid: 13).

Although discretion is central to the definition, it is important to mention that Lipsky also stresses that street-level bureaucrats have no formal control over their work assignments and the amount of them, which is politically determined. As such, street-level bureaucracy is characterized as situated between political regulations and individual assessments. Their work is determined by "levels of benefits, categories of eligibility, nature of rules, regulations and service" (Lipsky 2010: 14), while it at the same time requires a level of discretion, as when Lipsky writes: "Clearly what does or does not constitute a dirty look is a matter of subjectivity " (ibid: 14), regarding a prisons guard's work tasks. As such, Lipsky states that street-level bureaucracy is characterized as being conducted in the cross-field of what the individual street-level bureaucrat deems is correct, based off their professional integrity, and the structural regulations surrounding their work practice.

In this case, political regulations are represented through the Immigration Service's criteria regarding "criminal, violent or self-harming behavior", and the cross-field is thus situated between those guidelines and the nurses' NUP-principle. Oftentimes, this cross-field will be characterized as inhabiting conflicting and ambiguous goals, as Lipsky exemplifies when for instance the goal to promote health and wellbeing through welfare initiatives is conflicting with the goal to simultaneously make the citizen self-reliant and independent from that same welfare system (Lipsky 2010: 40-42). In this case the two principles have radically different parameters for intervention with the one grounded in strict migration policy and the other in Hippocratic oath ideology. This cross-field can be detected, when Elsebeth, a nurse at Tranum asylum center, was speaking about the Immigration Service's treatment criteria:

> "I think it's grotesque that people have to be so far out where they are forced to commit criminal actions and seriously harm themselves in pure desperation before they can receive help for their abuse."

She goes on to say:

> "I don't like the idea of having to turn someone down and having to say: "I can't help you (…) you'll have to find a way out of this yourself." That doesn't harmonize with the concept of nursing."

It is clear that Elsebeth has some reservations regarding the way drug policy concerning asylum seekers is structured. Regardless of personal opinion, Elsebeth however has to follow the formal guidelines.

In this sense, we can view the nurses' role as policy practitioners to be dual-sided; they both have an important role to play as mediators *of* the policy, but are simultaneously recipients of the effects from the policy, as their daily work is affected by it. Within this cross-field there can thus be differing goals and possibly beliefs, and the degree to which these two things coincide, and the workers see the political regulations as legitimate "will determine whether street-level bureaucrats rigorously apply, creatively adapt, or undermine formal policy goals in their interaction with clients and client groups" (Rice 2012: 1039).

Based on the informants' focus on the NUP-principle, one might believe that the nurses opt to creatively adapt the Immigration Service's guideline to better fit with their professional assessments or directly undermine the guideline. This is however not the case and will be elaborated in the following section.

A naturalization of the Immigration Service's treatment criteria

Once I had talked with the informants about how they determine whether an asylum seeker is eligible for substitution treatment, I moved the conversation on to the Immigration Services' requirements. On all occasions, the informants knew exactly what criteria I was speaking of, and on several occasions the health personnel would have a printed copy of the Immigration Services' guidelines with them during the interview. When probed about the requirements, there was a general tendency for the informants to completely accept the wording and premise of the guideline, although none of them brought it up themselves.

As an example, when Helle, a nurse at Ranum asylum center, was speaking about the process for obtaining substitution treatment, she went on in great length about how she and the doctor

at the center would write a NUP-statement in a person's journal, which they would include in an application and then send off to Immigration Service. At no point did she herself mention Immigration Service's criteria that will determine whether that same application will be approved or disapproved. However, when I asked about her view on those criteria, she said:

> "Well I mean, they are all criminals one way or the other, because it's illegal to buy and possess drugs. And we all know that it's expensive, and they have to finance it somehow. Whether it's from selling to others or by stealing, we don't always know."

This same pattern also repeated itself in my conversation with Matilde, who works at Sjælsmark pre-removal center:

> "My decision [for treatment] depends on, whether the resident is sufficiently motivated to withstand the waiting period, as an application is otherwise unnecessary to send in, as the application will be put on hold if the resident leaves the asylum system. But you can say, (…) that if you have to maintain a drug dependence that is so large that is requires treatment, then you will be getting the money for it from something illegal. (…) So it's not a problem to meet the Immigration Service's requirements."

These views, which are also evident from interviews conducted with the other informants, indicate that the Immigration Service's criteria are not *their* priority, but when asked or probed, are *accepted*. In fact, there is a clear tendency throughout the empirical data showing that the criteria violent/aggressive/self-harming is naturalized in the daily work lives of the informants, neither questioned or seen as dissatisfactory. The criteria are rather seen as something logical; the rationale being that all asylum seekers with drug dependency will be doing criminal activities in order to finance their use. Even Elsebeth, who had reservations about the criteria and structure for treatment, as illustrated in the previous section, said later on in the conversation that:

> "These three criteria, they come automatically. I'm sorry to say that, but it's true. Either they can't get a hold of their drugs, because they don't have the money for it, or they are in such a bad psychological state that they will have volatile or self-harming behavior."

It is thus illustrated how the interviewed health personnel rationalize the Immigration Service's criteria about criminal behavior by saying that drug dependent asylum seekers naturally will be doing criminal activities, because asylum seekers typically will not have the money to finance an abuse, and therefore will have to employ alternative measures. This logic is sound. However, it is worth noting that drug use and possession is also illegal in Denmark, cf. section 2 in the law on euphoric substances, meaning that Danish drug users are also de facto criminals. Following this line of logic, substitution treatment would therefore also prevent criminal behavior among Danes. However, the criminal aspect is not prevalent in "the national guideline for medicinal substitution treatment of drug users", where health factors dominate the wording, as mentioned in chapter three (Ministry of Health 2008).

To shed light on this, I bring the attention back to chapter three, where one of the policy's identified conceptual logics is that drug dependent asylum seekers have a lesser right to health care than Danish citizens, and that, because of this, another set of criteria must be applied to asylum seekers than Danes with a drug dependence. Although this rationale was discussed based on the textual aspects of the policy, the health personnel's naturalization of the crime criteria supports this finding and indicates that the conceptual logic is prevalent throughout the entire policy process. As such, it can be argued that the health personnel's naturalization of the criteria contribute to reproducing the rationales and assumptions imbedded in the policy, thus allowing it to become dominant, cf. Bacchi (Bacchi 2009: 19).

However, although we can summarize that the health personnel accept the politically regulated treatment criteria, they simultaneously have a professional view on when and why asylum seekers should be offered substitution treatment, which are radically different. This discrepancy will in the following be explored by James D. March and Johan P. Olsen's theory on the logic of appropriateness.

The logic of appropriateness is concerned with exploring the behavior of actors within the structures of an institution. According to March and Olsen, human action is driven by rules of appropriate behavior, where rules are followed because they are seen as legitimate, natural and expected within a collective framework, where both formal and informal structures for action exist (March & Olsen 1995, 2009).

The theory poses that an actor, when faced with a decision will have a certain set of choices to maneuver among. These choices will be delimited by institutional rules, personal deliberations and experience, and established roles. Depending on the institutional context and the problem the actor is facing, the actor will make a choice they find appropriate, typically based off the questions: What type of situation is this? What kind of person am I? How should a person like me act in this type of situation? (March & Olsen 2009: 4). March and Olsen thereby view roles as highly influential in people's behavior. These roles can be clearly defined through formal definitions, but are also often demarcated from informal structures and working traditions. Actors will "seek to fulfill the obligations encapsulated in a role, an identity, a membership (…)" (ibid: 31), and will thus base their behavior off of what is expected from them in their current role, and thereby deemed appropriate.

During one of my conversations with Ebbe, a head physician at Red Cross asylum centers, I was telling him about my interest in health personnel as policy practitioners to which he at one point said:

> "You will get nothing from asking about that [how health personnel understand and engage with policy guidelines]. We are subject to the Immigration Services' regulations and this guideline. So that's what we follow. If you ask how nurses work with drug dependent asylum seekers, they will also point to the guideline. That's that."

It is very clear from Ebbe's remark that the correct and natural behavior for health personnel is to the follow political regulations put in place by Immigration Service. If we apply a logic of appropriateness lens to this, we can deem that the informants do not assess it appropriate to question the Immigration Service's treatment criteria, as their role as health care providers at asylum centers includes following the rules and guidelines put in place by them. This is of course natural, as they are government officials compelled to follow the rules and laws concerning their work practice, and oftentimes "Rules [will] prescribe, more or less precisely, what is appropriate action" (March & Olsen 2009: 7). It is however interesting how the interviewed nurses not only follow the regulations, but also accept them as logical, as when May was explaining the process of obtaining treatment for drug dependent asylum seekers:

> “They have to want it themselves, have to contact us directly in the clinic, and then we have to justify treatment with – I think it’s obvious – it preventing them from doing something criminal, becoming aggressive or self-harming.”

The ”it’s obvious” in this quote indicates that May is not only willing to follow the policy guidelines, but also views them as completely legitimate and understandable. The reason I dwell on this analytical finding is the fact that she, along with the other informants, also bases her work on the NUP-principle, which is no where to be seen in the Immigration Service’s guidelines.

Although action is rule and identity driven, according to March and Olsen, this does not mean that behavior is an easily predictable and trivial matter, as the consistency of identities vary just as the appropriate matching rules do:

> “(…) individuals have multiple roles and identities and the number and variety of alternative rules assures that only a fraction of the relevant rules are evoked in a particular place at a particular time. One of the primary factors affecting behavior, therefore, is the process by which some of those rules, rather than others, are attended to in a particular situation, and how identities and situations are interpreted” (March and Olsen 2009: 9).

This perspective brings us one step closer to an exploration of the discrepancy between the differing principles inherent in the health personnel’s practice of drug policy. Based on the logic of appropriateness, we are able to view the interviewed health personnel as having several roles with different imbedded rules within their job, subsequently affecting their behavior. For, as March and Olsen state: “Fulfilling an identity through following appropriate rules often involves matching a changing and ambiguous set of contingent rules to a changing and ambiguous set of situations” (March & Olsen 2009: 8).

Although there will also be other roles the informants step into during their daily lives (colleague, citizen, spouse etc.) we can identify two related to this study based off the empirical data; the role of the nurse, led by an ethical nursing codex (Dansk Sygeplejeråd 2014), compelled to provide health care to all who are in need, and the role of the asylum system bureaucrat, compelled to follow government-sanctioned rules and regulations. These

differing roles each have rules imbedded in them, conducive to appropriate behavior. As such, we can surmise that the nurses alternate between following the NUP-principle and the Immigration Service's guideline depending on which role they see themselves in, in that particular given situation. This alternation is for example illustrated in the interview with May:

> "We have guidelines within all health that we look to. We operate based on what we call necessary, urgent and pain-relieving (…). That's what we look at, when they have meetings with us. Then we talk and evaluate.

Afterwards she says:

> "we [have to] apply the Immigration Service to get the treatment paid for (…) We need approval for that. (…) then we have to justify treatment with – I think it's obvious – it preventing them from doing something criminal, becoming aggressive or self-harming."

This interview segment indicates a practice, where May shifts between different logics, depending on the specific situation she is in. She applies the NUP-principle when she has one-on-one interactions with residents, but uses the Immigration Service's criteria when a treatment application has to be written.

I do not mean to suggest that the health personnel at one moment follow their professional assessment, completely disregarding the government regulations, and the next moment rigidly follow the regulations without including their professional views. It's not that simple. It rather seems as if the nurses alternate between the differing principles in a fluid, almost unconscious manner. Both sets of rule and behavior (to follow NUP-principle and Immigration Service criteria) seem to be so fundamentally integrated in the informants that they do not actively perceive them as different or clashing.

This alternation between differing principles is detected among all four interviewed health/social workers at asylum centers. However, in the following, it will be illustrated how there are also differences in how the informants choose to engage with and practice the policy.

Differing logics in policy practice

As the interviews conducted were semi-structured, this meant that topics and issues came up, which I had not specifically asked about or prepared beforehand. When analyzing the collected data, certain differences in policy practice appeared between the different asylum centers, namely regarding the integration of social efforts with medical practice and the level of outreach work conducted in regards to identifying potential drug dependent asylum seekers, which were subsequently both linked to the way the nurses viewed success criteria for substitution treatment. These issues will be the focus in this last section of chapter four.

In the process of analyzing the collected data it became apparent that there were two different approaches to treating drug dependent asylum seekers expressed by the informants. The first is here explained by Elsebeth:

> "They have to have meetings with this social worker, because oftentimes it's a social problem. We have to treat holistically, and when the treatment can't be conducted here at the center, there has to be some follow-up. We can't just have a doctor distributing substitution medicine to an addict without there being any supervision. (…) So the medicine is not the biggest part. Drug dependence treatment is mainly psychological and 20 percent is medicinal."

This social viewpoint is similarly shared by Matilde, who works at the social care unit at pre-removal center Sjælsmark and previously on the same unit at Sandholm reception center. By virtue of her very position, it is natural that her approach to substitution treatment has a social character, but it does not seem as though this is only her individual perspective. She explains the process of asylum seekers receiving substitution treatment as such:

> "We often become aware about an individual's substance abuse through observations made by many different employees. If an employee is concerned they will write a letter of concern (…) to the social coordinator. The coordinator will then typically arrange an interdisciplinary meeting with the concerned employee and relevant professionals, such as the contact person, network personnel and health personnel. Afterwards, a contact person will be chosen, who, through relational work, will find out whether the individual is interested in receiving help for their addiction."

As such, both Elsebeth and Matilde's work with drug dependent asylum seekers is characterized by viewing the addiction as part of a larger set of issues, and that treatment therefore cannot strictly consist of medicinal care.

Contrarily to this, May and Helle strictly spoke about substitution treatment in terms of a medicinal approach. Here it must be underlined that I did not distinctly ask the informants about their medical and social approach to treatment (see appendix 2), but rather asked about the process for obtaining treatment for asylum seekers on a more general level. It was in response to this question that Matilde and Elsebeth themselves mentioned social care and outreach, while May and Helle's responses were solely concerned with medical care. Regarding the process for obtaining treatment, Helle and May said:

> "They have to come to us and express a wish to get out of their addiction. We don't go and seek them out. Maybe we'll hear some rumors about somebody taking something, but they live here, so it's their home, just like we have our home. So we don't go knocking on their door asking "hello, are you an addict?" No, they have to come to us." (May)

> "Firstly the individual has to seek us out or the network personnel will experience they have a problem. Then we'll tell them [the network worker] to urge the individual to seek us out in the health clinic. Then they come in and talk with us." (Helle)

As these statements illustrate, Helle and May's daily work with drug dependent asylum seekers does not include outreach work. In order for substitution treatment to commence, it requires that the asylum seeker actively seeks out help. This stands in opposition to Elsebeth and Matilde, who both view outreach to potential drug addicts as a natural part of their work and stated: "You just have to keep offering help, and eventually they will accept it" (Elsebeth), and "when working with asylum seekers, you really have to make an effort" (Matilde). Therefore, it can be argued that there are two distinctly different approaches to working with this group, where integrated social/medical care and outreach is situated on the one side and pure medical care and no outreach is on the other. The mere difference in practice is interesting on its own, but is even more so when viewed in connection with the policy under scrutiny, as it tells us something about the different ways the informants engage with it.

In the textual policy the main focus is on medical care with the Immigration Service's wording being: "the Immigration Service will however be able to approve expenses for proscriptions of methadone" (Ministry of Immigration and Integration 2016 (2). This is in spite of substitution treatment traditionally being interlinked with a social effort in Denmark: "Drug addiction treatment is based on both a medical and social effort" (Sundhedsstyrelsen 2017). As such, it can be said that the policy silences social efforts cf. Bacchi[6]. In line with this, a recent research project conducted about drug tendencies, patterns and treatment opportunities among asylum seekers in Denmark illustrated that health practitioners experienced substantial legal barriers concerning treatment opportunities, as they were only able to offer medical treatment without social care, resulting in treatment "walking on one leg" (Østergaard & Nørredam 2017: 7). Therefore it can be argued that Matilde and Elsebeth's approach lies *outside* the policy and is not "policy sanctioned." On the other hand, May and Helle can be seen as following the policy more directly.

Once again this illustrates how the informants navigate within a cross-field between their professional principles and political regulations, cf. Lipsky. However, contrarily to the previous section, where the informants all balance between the NUP-principle and the Immigration Service's criteria, different approaches to social/medical care are here identified. These different approaches can be explored through Dorte Caswell's work on *logics of practice* (2005). With inspiration from Lipsky, Caswell has studied street-level bureaucrats' possible modes of action within social work in a Danish municipal context, where she has identified four logics of practice that are based on different understandings of the client within a system. She has organized these into a so-called *action compass*, illustrated beneath:

[6] Policy silences will be discussed in chapter 5

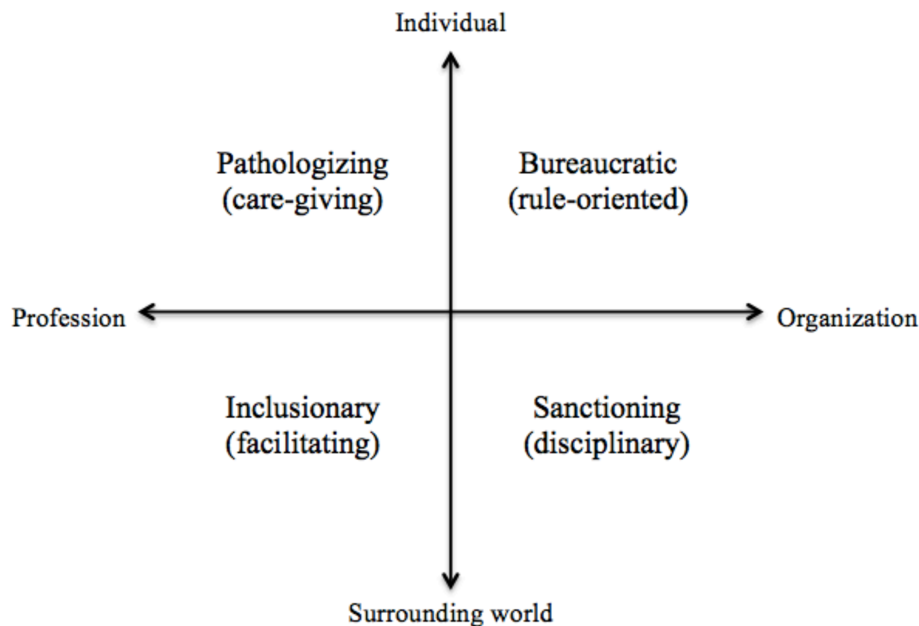

Illustration (Caswell 2005: 289)

Caswell explains the logics of practice as “different ways to view, perform and organize social work” (ibid: 288), which are conditional upon both structural and personal factors concerning the individual street-level bureaucrat (ibid: 290). As illustrated above, the four logics of practice; *care-giving, facilitating, rule-oriented* and *disciplinary* are conducted between the four extremities in the compass, which represent the approach to social work; *individual*, *surrounding world*, *organization* and *profession*. The previous discussion regarding to which extent the informants base their work on political regulations or professional discretion can fruitfully be applied to Caswell’s logics of practice, especially in regards to the axis between organization and profession. For with a organizational approach, action will be based on administrative logics, regulations and rules, and a wish to follow the procedures set in place as correctly as possible. On the other hand, a more professional approach will result in discretion being of greater importance, where practice will be based on “fundamental values and principles within social work”, where the individual’s needs and unique situation will be viewed as determinant for how to proceed (ibid: 290-293).

I do not wish to go into great detail with Caswell’s action compass, but do however believe it to be a useful tool to understand how the informants engage with the policy. As explained above, Elsebeth and Matilde integrate social care with medical care based on the logic that

this approach will be most helpful for the individual asylum seeker. Based on Caswell's logics of practice, their approach to work can therefore be found on the professional side of the axis. As May and Helle on the other hand follow the policy guidelines more strictly, it can be argued that their work practice is situated on the organizational side of the axis.

Two roles were previously identified in connection with March & Olsen's role-based logic of appropriateness, namely the nurse, led by an ethical nursing codex, and the asylum system bureaucrat. In terms of the NUP principle and the Immigration Service's treatment criteria, it was argued that the informants alternated between the two roles. However, based on the differences in practice outlined in this section, these two roles become more explicit and come to represent two ideal types, namely; 1) those who base their work on what they deem is best for the individual, and 2) those who follow policy regulations.

Closing remarks

We have thus reached the pinnacle of this chapter, where the unproblematic connectedness between the informants' professional principles and the policy's politically motivated principles become rescinded through the practice of outreach and social work among two of the informants. Although the public policy is still not questioned, the differences in policy practice indicate that the two separate domains are not as coherent as they may seem. It is in this incoherence that conflicting rationales imbedded in the policy become apparent. On the one hand lies a political migration rationale, reproduced by the Immigration Service and presented to the informants, which poses that asylum seekers shall not receive the same type of treatment as Danish drug users. On the other hand lies drug rehabilitation, grounded in health and social care with subsequent rationales being that all people, regardless of background, must be treated as correctly as possible. In the asylum centers' health clinics, these rationales clash, and the health personnel are caught in the middle. We have seen how the informants sometimes manage to balance between the differing rationales, as is the case with the NUP treatment criteria and the Immigration Service's treatment criteria. We have however also seen examples of the informants' practice landing in favor of one or the other rationale, in the case of social and medical integration. In the following chapter, policy silences will be discussed, and the clash between drug rehabilitation and migration rationales on a street-level will be explored.

CHAPTER 5 – The flip side of the policy

Central to Carol Lee Bacchi's *what's the problem represented to be?* approach is the perspective that "policies *give shape* to 'problems'; they do not *address* them" (Bacchi 2009: x). Implicit in this statement is therefore, that the policy "problem" is not an objective truth about a reality, but rather a certain framing of something in the world. When something is framed in a certain way it means that focus has been placed on a specific area, subsequently meaning that other alternative areas have not received attention.

Throughout this study, conflicting rationales in drug policy concerning asylum seekers have been identified and it has been explored how policy practitioners engage with it. In this chapter the clash between drug rehabilitation logics and migration rationales will be examined, by turning the gaze away from the policy as it is formulated and engaged with by policy practitioners, and rather looking towards what the policy does not address by discussing the fourth question of Carol Lee Bacchi's WPR framework: *What is left unproblematic in this problem representation? Where are the silences? Can the "problem" be conceptualized differently?* (ibid: 2). These silences will be discussed from a new perspective, namely the open drug scene on Vesterbro, where empirical data from interviews with social and health actors working at two injection/smoke rooms will inform the discussion. This data provides a unique insight to the analytical field, as the perspectives here stem from outside the formal policy system, which was represented in the previous chapter. The interviews with health personnel from asylum centers will also be included to provide a rounded understanding of the policy silences.

The official/non-official problem

In 2016, 38 cases regarding substitution treatment of asylum seekers, rejected asylum seekers and foreigners with illegal residence were created in the Immigration Service's filing system and 29 were approved (Danish Parliament 2016 (1)). These 38 instances represent the formal administrative practice surrounding the policy for 2016. During that same year, 6266 refugees arrived in Denmark (Ministry of Immigration and Integration 2018: 4) and Mændenes Hjem, a central social actor on the drug scene of Vesterbro, Copenhagen, started noticing an increase in asylum seekers among their usual clientele, which mainly consists of drug users and

homeless people. Liv, a nurse at Mændenes Hjem's injection room, Skyen, describes it as such:

> "I think it was in the summer of 2016 (…) we began to see many people from the asylum centers. It was a totally new group for us and we had a hard time figuring out how to work with them. On a practical level knowing how to help them. It was a group that clearly – both for us employees and for the rest of our users – was very desperate. They were having a very, very hard time and quickly ended up in a negative downwards spiral."

Since then, Liv describes how asylum seekers have been an integrated part of the drug scene on Vesterbro, and as the two of us are walking around the neighborhood, she stops on several occasions to chat with young men, who she clearly has a good rapport with. Afterwards she will say something like: "oh that's Rami, he's an asylum seeker and came last summer. He's here a couple times a week." Apart from being an integrated part of the Copenhagen drug scene, asylum seekers also make up a large percentage of Mændenes Hjem users as well. In 2017, Mændenes Hjem conducted a systematic count of their clientele, which showed that between 15 to 20 individual asylum seekers visited the organization within a 24 hour time period. Other randomized counts showed that between seven and 20 people from the same legal group visited Mændenes Hjem during the night hours. Although the picture is somewhat fluctuating, Mændenes Hjem estimates that around 10 percent of their clientele consist of asylum seekers. (Christensen & Larsen 2017: 45). Michelle, a social worker from H17, a smoke/injection room on Vesterbro, Copenhagen, does not have a concrete estimation of how many asylum seekers frequent their facility, as it is completely anonymous, but has encountered asylum seekers during her daily night shifts there.

To which degree there is an overlap in clientele within the asylum system in the two injection rooms cannot be determined. Somewhat of an overlap definitely does occur, as Liv, the nurse from Skyen, knew several of the people who were walking in and out of H17, when we were walking around the neighborhood. Oppositely, Liv told me that she "sees many new faces when she is visiting H17", which indicates that some people may frequent one single injection room and not both. However, determining the exact amount of asylum seekers on Vesterbro is not the point, nor relevant, for this study. The main point is that there indeed is a prevalence of asylum seekers on the open drug scene in Copenhagen. Similarly it is not my intention to

make any assumptions on the relationship or scale between the Immigration Service's numbers for asylum seekers getting substitution treatment in 2016 and the prevalence of asylum seekers with a drug use on Vesterbro frequenting injection rooms. However, it is interesting to note that the policy does not mention this "un-official" side of things, given the scale of it.

As we are walking, Liv and I are talking about why so many asylum seekers frequent Vesterbro. She says:

> "[The asylum center] is where they get clothes, food, money, stability, but as soon as they're re-charged and have met their compulsory attendance, then the drugs draw them back. And the drugs are in here. The drugs have a magnetizing function that Istedgade and the open drug scene have. (…) There can be a big wish to change some things, but there is also a big need for the drugs."

Similarly, Michelle, who worked as a social worker at H17 says:

> "If you have a great need [for drugs] you have to cover in order to ease terrible experiences, then you also need to be on Vesterbro to make money. (…) And it's not like you can go back to the center every day. It's not like having an ordinary job. They constantly need to be on Vesterbro to make money and take drugs. They become stuck."

This pattern of getting drawn back to Vesterbro is similarly observed by Matilde, social worker from Center Sjælsmark:

> "Typically people will go in to Vesterbro for a couple of days before returning to the center, where they will get some food and clean clothes, before going back to Vesterbro. They do that for a while, but eventually stop returning to the center. So these people can be affiliated to a center and express that they want to start treatment, but if they can't be maintained at the center, the [treatment] process will be stopped each time you are reported as absent."

Not only Matilde observed these tendencies, in fact all interviewed health personnel from the asylum centers knew of the prevalence of asylum seekers in Copenhagen, and as Helle, a

nurse at Ranum Asylum Center, worded it: “Unofficially we have many addicts, but officially we only have two that are in treatment right now.”

As such, it can be argued that there is a discrepancy between policy formulation and the issue of drug dependent asylum seekers. Throughout the policy, the entire focus is on in what instances asylum seekers are eligible for substitution treatment. By solely focusing on the criteria on which treatment depends, the policy only addresses drug dependent asylum seekers *within* the official system. In other words, there is a large group of people with a health issue that personnel at asylum centers know of, social actors on Vesterbro know of, but which is silenced in the public policy on the area. The idea behind identifying such limitations or inadequacies in the policy is based on the perspective, that the way we frame and talk about issues determines the way we can act on that issue; “the argument here is not simply that there is another way to think about the issue but that specific policies are constrained by the ways in which they represent the ‘problem’” (Bacchi 2009: 13). Therefore, by not actively recognizing this unofficial aspect in the policy, it delimits the opportunities to do something about it and provide help for drug dependent asylum seekers – wherever they may be. Exactly this issue is also expressed by the social actors on Vesterbro. Michelle said:

> “Honestly I don’t feel like I as a social worker am informed enough about what I can do for a guy who is an asylum seeker in terms of treatment. The general information about what options there are isn’t very good. Every single time I’ve stood with somebody, I’ve had to examine what I can do for that person. Because I actually don’t know. (…) H17’s job is to send people onwards in the system, so they can receive treatment. Due to the fact that it’s been approved that asylum seekers can frequent H17, then there is also an obligation for us to be able to help them onwards in the system. But you can really question, whether we can live up to that task, if nobody knows what options there are.”

Based on this, it can be argued that the silencing of the “unofficial” problem consequently fixates policy practice to the asylum system and simultaneously impedes action to be taken in the injection rooms on Vesterbro. This means that actors on Vesterbro, who have daily interactions with drug dependent asylum seekers, do not know how to help, as they do not have structured, outlined opportunities facilitated for them. When Michelle says that the help

she offers is from person to person and from case to case, it illustrates that there are no guidelines or regulations, which she can follow or look to.

The prevalence of asylum seekers on Vesterbro poses the question of why. Why are they on the street instead of receiving help in the asylum system? The answer to this is not easy, and perhaps not even possible to exhaustively supply an answer to. It can however be discussed through another concurrent policy silence, namely the integration of social and medical substitution care. In chapter four the integration of social and medical care was explored through the perspective of how the nurses at asylum centers engage with the policy, and the conflicting rationales inherent in it; migration and drug rehabilitation. In the following section, social and medical integrated treatment will be discussed from a different perspective, namely what this policy silence means for the treatment of drug dependent asylum seekers and how it could potentially be connected to the prevalence of asylum seekers on Vesterbro's drug scene.

The (lack of) integration of social and medical care

As illustrated in chapter four, the main focus in the policy guideline issued by Immigration Service to all asylum center health personnel is on medical substitution treatment. However, the guidelines does at one point mention the integration of social care. The specific wording is:

> "Generally all drug dependence treatment is coordinated based on a psychosocial-medical reference framework. The asylum centers *must however in their coordination of treatment take into account that the residents' time of residency is uncertain* (…) As a rule, Immigration Service does not cover expenses for drug dependence treatment in addition to what is urgent (abstinence treatment). (own italics, appendix 4)

What we can elucidate from this formulation is that although psychosocial and medical integration is the premise for treatment, the *uncertainty* of asylum seekers' length of stay in Denmark obstructs this integration, resulting in Immigration Service only covering urgent, abstinence treatment, meaning medical, cf. the guideline for medical treatment of drug users in substitution care (Ministry of Health 2008). Consequently, the policy guideline is centered

around "the distribution of methadone" (appendix 4). Since the policy disregards psychosocial care, it is interesting that the term is even mentioned in the guideline. The reason for this is perhaps the long tradition in Denmark of viewing drug dependence treatment as requiring both a social, and not just medical, effort. This is clearly illustrated by the fact that the majority of drug dependence treatment legislation is written into the government's Service Act rather than the Health Act (Thylstrup et. al. 2014: 12). Within this tradition, the goal of treatment has been to decrease the individual's drug intake, where an integral method has been to improve the individual's quality of life, living standard and social relations (ibid: 23). In fact; "research has shown that the effect of treatment is increased when social oriented interventions (…) are supplemented with medical services, modified to the individual" (ibid: 30). This tradition is perhaps therefore reflected in the policy guideline, simply because medical and psychosocial care *are* joined in Danish drug dependence treatment. If the term psychosocial was not mentioned, this may raise an eyebrow or two. As such, by including the term, Immigration Service shows that they are aware of the treatment tradition in Denmark, albeit not willing to follow it.

Linked to the two differing approaches discussed in chapter four (integration of social/medical/outreach care), I have furthermore detected a pattern in the empirical material, where the nurses who focused on outreach and social assistance also had more experience with the treatment being successful, while the nurses who strictly provided medical treatment and no outreach did not. Whether or not the nurses experienced success with their treatment, is of course linked to the perception of what successful treatment is. Again, two different perceptions were identified in the empirical material, one shared by Elsebeth and Matilde, the other by Helle and May:

> "Just being able to help them out of their aggressive or inexpedient behavior and no matter what give them methadone, if that means they can live a normal daily life and stay on track (…) We can't have very high success criteria or expectations with this. If we can help them obtain a better everyday life while they are at the center, then that's a goal worth pursuing." (Elsebeth)

> "The result in the majority of cases is positive. The ultimate success criteria is of course that they get our of their addiction. But I've never experienced anybody doing

> that. That's rare. Otherwise the success criterion is always that they gain an acceptable living standard and can function." (Matilde)

> "Treatment is applied based on the individual wanting to get out of their addiction. They have to be ready to phase out of their drugs and completely get out of their addiction. Otherwise we can't help." (May)

> "As long as they're not prepared to stop [their substance abuse], we simply can't help them" (Helle)

During my conversations with the nurses, and exemplified from the interview segments above, it was evident that Helle and May viewed successful treatment as an asylum seekers completely getting out of their addiction, while Elsebeth and Matilde saw treatment as successful if the individual obtained a better living standard. Due to this difference, it is logical that May and Helle might have experienced less success with treatment, as their criteria for success can be viewed as "stricter" than Elsebeth and Matilde's. However, it is not only a question of perception; Helle and May also explained to me that neither of them had experienced any drug dependent asylum seekers having made it through the program. When May was speaking about the process for obtaining treatment, she ended up saying:

> "But they've disappeared before we got to that. We haven't experienced success with getting them out of it [the abuse]. They've been gone, before we could get that far."

Elsebeth and Matilde had experienced some drug dependent asylum seekers leaving the centers, but not to the same extent as May and Helle described to me. I can of course not state anything with certainty about the causality of the link between a lack of social care and the disappearance of asylum seekers from the centers. However, for arguments sake, one might stipulate that since it is recognized in Denmark that substitution treatment must be holistic and cross-integrated with other sectors in order to work, and that asylum centers that do not integrate social and medical care experience a high degree of asylum seekers disappearing mid-treatment process, that the two things in fact are connected.

This leads to the question: If we know substitution treatment is more successful when integrated with psychosocial care, why is it neglected in asylum drug policy? One would

think that it would be in everyone's interest to create as effective a drug policy as possible. In order to answer this, we must go back to the conceptual logics explored in chapter three, namely that asylum seekers are not eligible to the same degree of health/social care as Danish citizens. Following this line of logic, asylum seekers cannot expect to receive the same social and health benefits as Danish citizens with similar problems, as they are somehow less deserving. During one of my meetings with Liv at Mændenes Hjem, she spoke of this rationale:

> "Drug dependent asylum seekers are in an extremely vulnerable position. Far more vulnerable than Danish drug users. But so much is demanded of them, much more than from our Danish users. And it should be the other way around. It's as if we have this idea that they should be grateful. So very grateful, no matter how we treat them (…) And because of this expected gratitude, we can demand things from them that aren't reasonable."

Liv said this in relation to the stringent rules and procedures that asylum seekers must abide by in order to obtain substitution treatment, as experienced by her. The experience of red tape bureaucracy and treatment barriers will be discussed in the next chapter. For now, I would like to dwell on the perspective of asylum seekers as less deserving and therefore expectantly grateful.

As discussed in chapter two, the concept of "Danishness" is closely linked to the welfare state, and cf. Olwig & Paerregaard (2011) being Danish is tied to being in agreement with and maintaining welfarist values, such as social engagement and contribution. Following this line of thought, Steffen Jöhncke (2007) states that welfare Denmark is built upon the collective perspective that everyone contributes and everyone benefits, and that the amount of people receiving benefits, or help, should remain lower than those contributing.

> "In other words, the welfare system works as integrative in the sense that it creates a shared feeling of everybody contributing to a system which everybody benefits from – as long as there are not too many who benefit more than they contribute" (Mogensen 2011: 211).

This perspective leads the thoughts to a Maussian view on exchange, where reciprocity maintains social relations (Mauss 2001). However, the people upon which this thesis is based – drug dependent asylum seekers – cannot live up to these ideals. Due to their precarious legal standing, they can not contribute financially to welfare Denmark, cf. Jöhncke. Instead, they receive services and benefits – such as substitution treatment – without being able to give anything in return, except perhaps, gratitude. This again brings us back to the migration rationale of viewing migrants and asylum seekers as costly for the welfare state, thus resulting in policies and laws aimed at minimizing this cost, as discussed in chapter two. This perspective is further elaborated in the empirical data, when Liv said:

> "I think there's this cost-benefit mindset about these people. It's as if they're only seen as worthy, if they're either making money or at least not costing too much."

Liv stated this when we were talking about the political structures set in place for asylum seekers to receive treatment. We can elucidate from this statement that Liv experiences the formal treatment system as characterized by a quid pro quo mentality, parallel to Jöhncke's analysis of the Danish welfare state. Liv is critical towards this, as her perspective as a nurse is grounded in a Hippocratic oath mentality – or what we can call a profession-based practice logic cf. Caswell's action compass, discussed in chapter four, where social efforts are approached based on what is best for the individual. In Liv's view, there should therefore not be any expectation of exchange in the interaction with drug dependent asylum seekers.

Liv's critique of the formalized treatment system once again illustrates the clash between the logics underpinning drug rehabilitation and Danish migration politics – whether these individuals should be helped however best we can *or* get offered formalized, second-tier treatment based on their uncertain residency in Denmark. It is this clash, which truly characterizes drug policy concerning asylum seekers, as it is essential as to how treatment will be commenced.

Closing remarks

We can thus recapitulate: When the policy's conflicting logics clash in the asylum centers, the health personnel are caught in the middle of this tensional field. As was explored in chapter four, the informants from the asylum centers, depending on the specific situation, either

balance between the two rationales, as was the case with the interweavement of the NUP-principle and the policy's treatment criteria, or lean to one side or the other, based on what practice logic (Caswell 2005) the individual nurse works within, as was the case with social and medical integrated treatment. On the street, the situation is however another. Here social and health workers' practice lies outside of the policy, meaning that they are not confronted with the formalized migration view of the asylum seekers through the Immigration Service's policy guideline. The main point of this chapter is therefore not only that the unofficial issue is silenced in the policy, but that this results in the formalized migration rationale disappearing on the street, because the actors here are not confronted with it, due to the fact that they are unaddressed in the policy. This therefore allows the drug rehabilitation logic with its imbedded health and social rationales to become prevalent, or to use a Lipsky/Caswell terminology, the actors here base their actions on a professionalized practice logic with a high degree of discretion when determining what is best for the individual. However, because the open drug scene is excluded from the formal policy, the social and health actors' are not able to act on this practice logic. For, following Carol Lee Bacchi's approach, action cannot be taken if it is not firstly addressed.

In the final chapter, further perspectives will be discussed, based on what effects these conflicting rationales and policy silences can have for the treatment of drug dependent asylum seekers.

CHAPTER 6 – Further perspectives

This final chapter will move the discussion onwards to include some of the potential effects the policy may have on the treatment of drug dependent asylum seekers guided by Carol Lee Bacchi's fifth question in the WPR-approach concerning lived effects of the policy, which she terms as: "the way in which policies create representations of problems that have effects *in the real* by materially affecting our lives (Bacchi 2009: 18). These effects will be discussed based on the analytical findings from the previous chapters and with the empirical data from the interviews conducted with personnel at asylum centers and with actors on the open drug scene. The purpose of this chapter is not to propose how the policy directly affects asylum seekers with substance abuse, but rather to reflect upon the study's findings in a new light and open up a space for further perspectives.

Treatment barriers for the highly vulnerable

Drug dependent asylum seekers must be said to be a highly vulnerable group of people, both due to their health condition and precarious legal standing. According to the interviewed actors on Vesterbro, the asylum seekers with substance abuse they work with have oftentimes developed their addiction as a coping mechanism to either cope with war, trauma or things refugees have been forced to do on the flight to Denmark, such as prostitution (Michelle). In Michelle's perspective, the struggle does however not end once they arrive in Denmark. Their lives here are also characterized by despair and deprivation:

> "My general picture of people from the centers is that they have nothing to fill up their lives with. They are having a really hard time. Almost none of the people I have met don't wish their lives looked different. But they use the drugs to cope. There is a lot of despair, and a lot of them are walking around with some terrible trauma, it seems like. And they're just sitting there at the center, and somehow need to get the trauma out of their heads, and then they smoke some cocaine or heroin."

On top of addiction, this study has to do with a group of people, who are very skeptical, and for some, quite frightened of authorities, both Liv and Michelle put much emphasis on. Michelle explains that it can be hard enough to convince a person to take an ambulance "even if they're bleeding from the back of their head", due to an aversion and distrust towards "the

system". In spite of these circumstances, experienced from the informants working on Vesterbro, the policy does not address outreach. Due to this silence, it is implicitly expected that asylum seekers actively pursue help themselves. However, to expect this from such vulnerable individuals is unrealistic, according to Liv and Michelle, and Michelle says that "it almost seems inconceivable that they themselves are able to ask for help." Furthermore, experience from Vesterbro shows that asylum seekers oftentimes do not know treatment is an option for them and something they have a right to. Liv explains:

> "Young men have often reached out to me wanting help with their drug abuse, because they want to stop. Because it's stopped being fun, and instead become really, really expensive and incredibly hard to be stuck in the drug scene. And they haven't known that they could actually get help at the health clinics at the asylum centers."

Michelle has experienced many similar situations, where users of H17 have asked her for help to get treatment, not knowing what to do themselves. This lack of knowledge held by asylum seekers regarding their own treatment rights and lack of outreach must presumably result in a group of people being neglected. This observation is not only expressed by actors on Vesterbro, but also among the interviewed nurses at asylum centers:

> "We don't do outreach work. We don't have the resources for that. (…) But there is no doubt that – during the six years I have worked in the asylum system – there have been people with an addiction that we haven't known about. I have no doubt" (May)

> "I am certain there are lots of people who fall all the way down between two chairs. (…) We have no way of identifying or helping the people who don't come near the clinic." (Elsebeth)

As a result of this empirical finding, it appears as if outreach in fact ought to be a high priority within drug policy, if the goal is to support drug dependent asylum seekers, who wish to begin treatment. However, as outreach is unaddressed in the policy, treatment can arguably only be obtained by resourceful asylum seekers, or those who are simply lucky to have been identified at asylum centers through unaddressed-policy activities, such as active outreach.

Conversely, being identified or seeking out help does not necessary result in being "home safe" in regards to treatment. It rather means that the process of applying for treatment through the Immigration Service can begin. Based on the empirical data, many barriers are however also connected to this process. These barriers firstly include a long waiting period from treatment has been applied for until Immigration Service either approves or disapproves the application, which according to the nurses working at asylum centers, can be between four and six weeks. Furthermore, the bureaucratic side of applying for treatment can be experienced as overwhelming. In connection to both barriers, Matilde from Center Sandholm said:

> "Some of the problems we have regarding getting people into treatment is probably that it can be experienced as an arduous and slow process. But I think that an even bigger problem is that we have trouble maintaining them at the center for long enough to start the treatment process."

Matilde furthermore explains that it is somewhat unavoidable for drug dependent asylum centers to go to Vesterbro, while waiting for treatment, as an abuse is not something, which can be paused. She therefore says "it is a question of accepting that the client will have an abuse, while the application is in process." However, it may not be that simple. For as Michelle and Liv expressed in chapter five, Vesterbro is the place where you can get drugs, take drugs and also earn money for drugs and is therefore a place, where people can get stuck. And this can be damaging for people's cases. Diana, a nurse I also spoke with from Mændenes Hjem, explained:

> "We often see that people are here for a few days, before returning to their center (…). But going back and forth in that way is very harmful for their case. If they have reached step five in the treatment process, but then leave for several days, they will be reported absent, and their case will be stopped. When they return to the center, they don't start on step five, but from the beginning – step zero."

As such, although an asylum seeker might have had enough resources to seek out help, they may not be able to follow through on treatment nonetheless, due to experienced red tape bureaucracy and long waiting periods.

Closing remarks

These perspectives indicate that there indeed may be serious treatment barriers for drug dependent asylum seekers, who belong to a highly vulnerable group of people: The informants on Vesterbro point out that many asylum seekers they encounter are not informed about the possibility for substitution treatment, and in their experience too much is expected from them in terms of having to actively seek out help themselves. In a further study, it would be interesting to zoom in on these findings and explore how asylum seekers with substance abuse experience the possibilities and barriers for receiving substitution treatment themselves. Due to this study's focus, I can however only suggest this policy effect based on the informants' professional assessment of the situation.

Furthermore, as explored in previous chapters, the policy under scrutiny only addresses and provides guidelines for policy practice regarding asylum seekers, when they are located in the formal asylum system. This is problematic, as the open drug scene of Vesterbro is where drugs can be bought and taken, meaning that people with a substance abuse will also be prevalent there, as is the case. Here asylum seekers are encountered by social and health actors, who wish to help them overcome these discussed treatment barriers. However, these actors have no formal structure to look to and be guided by, as their work exists in the vacuum of drug policy. As the policy only addresses half of the issue, it may appear as if the less resourceful drug dependent asylum seekers outside of the system, are left behind and neglected on Vesterbro.

Conclusion

This study has conducted an extensive policy analysis of substance abuse treatment concerning asylum seekers in Denmark. The analysis has been informed by Carol Lee Bacchi's what's the problem represented to be? approach (2009), which has provided the methodological framework for the policy analysis undertaken. In line with Bacchi, the study is thus critical towards the notion that policies somehow deal with objective issues, but rather views policies as solutions to problems, which are constructed by the policy itself. As such, the analysis is centered around identifying rationales and assumptions imbedded in the policy, which in turn structure the way asylum seekers with substance abuse are thought about and subsequently treated. The study has thus viewed the policy through textual documents, as well as a practice formed by street-level bureaucrats, whose daily work is regulated by the policy. The empirical material for the latter perspective has been gathered through interviews with health personnel from four different asylum centers.

It has been explored how the policy under scrutiny is situated in the midst of different policy areas ranging from welfare, penal, health, migration/integration and economy. This identification of different fields provided an understanding of the policy space as one characterized by contention and conflicting rationales. The analysis of the textual policy documents indicated that the policy is dominated by migration, integration and economic rationales, while the welfarist and health rationales also tied to drug policy are somewhat situated in the background. In connection with this, several underlying policy assumptions were identified, namely that asylum seekers do not have the same rights to health treatment as Danish residents, "necessary" health care transforms when the recipient is an asylum seeker, substitution treatment is contingent upon violent and aggressive behavior, and drug abuse belongs to a "less deserving" group of health issues than others. It was thus argued that these rationales place asylum seekers in an inferior position in regards to receiving substance abuse treatment in comparison with Danish citizens.

Based on these identified rationales, the analysis moved on to explore how health personnel at asylum centers engage with the policy in their everyday work lives. The theoretical framework for this section of the analysis was informed by Michael Lipsky's work on street-level bureaucracy (2010), Dorte Caswell's further development of Lipsky's work (2005) as

well as James D. March and Johan P. Olsen's theory on the logic of appropriateness (1995). It has thereby been explored how the informants practice drug policy in the cross-field between their own professional assessments and political regulations. A clash is here identified between the principles put in place by Immigration Service regarding the criteria for substitution treatment, which are centered around the asylum seeker exhibiting criminal, aggressive or self-harming behavior, and the informants' professional health principles, where treatment is contingent upon it being necessary, urgent or pain-relieving (NUP-principle). This clash is argued to represent conflicting rationales imbedded in the policy with a political migration rationale, reproduced by the Immigration Service on the one hand, and a drug rehabilitation logic, grounded in health and social care rationales on the other. In the asylum centers' health clinics, these rationales clash, and the health personnel are caught in the middle. It is illustrated that the nurses have different ways of engaging with the policy and its underlying rationales.

Firstly, a tendency is identified of the informants naturalizing the policy's treatment criteria and thus not viewing the opposing principles as an issue in their daily work with drug dependent asylum seekers. This naturalization indicates that the underlying rationales in the policy, such as drug dependent asylum seekers having a lesser right to health care than Danish citizens, is prevalent throughout the entire policy practice. It is therefore argued that the health personnel's policy engagement contributes to reproducing the rationales and assumptions imbedded in the policy, thus allowing it to become dominant. By use of the logic of appropriateness, it is furthermore argued that the informants do not assess it appropriate to question the Immigration Service's treatment criteria, as their role as health care providers includes following the rules and guidelines put in place by them. It is also argued that the informants in their daily work alternate between following the NUP-principle and the policy guideline in a fluid manner depending on which role they see themselves in, in a particular situation. The empirical material however also shows instances of differing policy practice among the informants, either influenced by one or the other rationale, as when two of the informants integrate social and medical care in spite of it being unaddressed in the policy, while two other informants base their work stringently on the policy.

A discussion is hereafter raised on what is unaddressed in the policy. Here the empirical material from the analysis is supplemented by data gathered from interviews conducted with

social and health actors from two injection/smoke rooms on the open drug scene in Copenhagen. It is illustrated that there is a large prevalence of drug dependent asylum seekers frequenting the open drug scene, although this is unaddressed in the policy. The entire focus in the policy is rather on in what instances asylum seekers are eligible for substitution treatment, meaning that the policy only addresses drug dependent asylum seekers *within* the official system. It is argued that the silencing of the unofficial problem consequently fixates policy practice to the asylum system and simultaneously impedes action to be taken in the injection/smoke rooms on Vesterbro. The main point here is not only that the unofficial issue is silenced in the policy, but that this results in the formalized migration rationale disappearing on the street, because the actors here are not confronted with it, due to the fact that they are unaddressed in the policy. This therefore allows the drug rehabilitation logic with its imbedded health and social rationales to become prevalent on the open drug scene.

The integration of social and medical care in substance abuse treatment is likewise unaddressed in the policy, although they are traditionally interlinked in Danish drug policy. Furthermore, the empirical data indicates that the asylum centers that do not integrate the two together with outreach work have difficulty maintaining asylum seekers in treatment compared to asylum centers that do integrate social and medical care together with outreach. Although this study cannot assume anything surrounding the causality of these circumstances, it is suggested that these circumstances may be connected. In connection with this, it is lastly discussed what effects these policy silences may have for the treatment of drug dependent asylum seekers. Concerns are raised whether the policy may favor the most resourceful asylum seekers, who can understand the treatment system and actively seek out help. Following Carol Lee Bacchi's approach, action cannot be taken if it is not firstly addressed. As the policy fails to address the social aspect of substitution treatment and the prevalence of asylum seekers on the open drug scene in Copenhagen, it is argued that this may result in the most vulnerable drug dependent asylum seekers being neglected and left to fend for themselves on the streets of Vesterbro.

Literature list

Bacchi, C. L. (2009): Analysing Policy: What's the problem represented to be? Pearson Australia. 1st edition.

Bacchi, C. & Goodwin, S. (2016): Poststructural policy analysis. Palgrave Macmillan US. New York.

Bjerge, B. & Houborg, E. (2011): Drug policy, control and welfare. In: Drugs: Education, Prevention and Policy.

Bjerge, B. & Houborg (2016): Drug policy in practice. In: Kolind, T., Hunt, G. & Thom, B. (red.): The SAGE handbook of drug and alcohol studies: Social science approaches. Sage Publications. London.

Brune M., Haasen C., Yagdiran O. & Bustos E. (2003): Treatment of drug addiction in traumatised refugees. A case report. Eur Addict Res. Jul;9(3):144–6.

Bryman, A. (2012): Social Research Methods. 4th edition. Oxford University Press.

Caswell, D. (2005): Handlemuligheder i socialt arbejde – et casestudie om kommunal frontlinjepraksis på beskæftigelsesområdet. Roskilde Universitetscenter & akf Forlaget

Christensen, I. & Larsen, L. J. (2017): Asylanter på den københavnske stofscene – set fra Mændenes Hjem. In: KABS Årsmagasin 2017. Trykportalen.

Colebatch, H. K. (2006): Beyond the Policy Cycle: The Policy Process in Australia. Allen & Unwin, Crows Nest.

Corrigan, P.W., Kuwabara, S.A., & O' Shaughnessy, J. (2009): The public stigma of mental illness and drug addiction: Findings from a stratified random sample. Journal of Social Work, 9(2), 139-147

The Council of the Socially Vulnerable (2014): Sundheds- og Ældreudvalget 2014-15 (2. samling) SUU Alm.del, bilag 84. Offentligt.
http://www.ft.dk/samling/20142/almdel/SUU/bilag/84/1551129.pdf

The Danish Health Authority (2017): Vejledning til læger, der behandler opioidafhængige patienter med substitutionsmedicin – Lovkrav og anbefalinger. Sundhedsstyrelsen.

The Danish Parliament (2003): Kampen mod narko – handlingsplan mod narkotikamisbrug. Indenrigs- og Sundhedsministeriet. Copenhagen.

The Danish Parliament (2010): Kampen mod narko II – handlingsplan mod narkotikamisbrug. Socialministeriet, Indenrigs- og Sundhedsministeriet, Justitsministeriet. Copenhagen.

Dansk Sygeplejeråd (2014): De Sygeplejeetiske Retningslinjer. Sygeplejeetisk Råd. 2nd edition.

Emerek, R. (2003): Integration – eller inklusion? Den danske diskussion om integration. AMID, Aalborg Universitet.

Emerson, R. M., Fretz, R. I. & Shaw, L. L. (1995): Writing Ethnographic Fieldnotes. The University of Chicago Press.

Ezard, N. (2011): Substance use among populations displaced by conflict: A literature review. Disasters. Jul;36(3):533-57

Foucault, M. 1991 [1968]: Politics and the Study of Discourse. In: The Foucault Effect - Studies in Governmentality. Eds: Burchell, G., Gordon, C. & Miller, P. University of Chicago Press. Chicago.

Foucault, M. 1973 [1966]: The Order of Things: An Archaeology of the Human Sciences. Vintage. New York.

Frank, V. A & Bjerge, B. (2011): Empowerment in drug treatment: Dilemmas in implementing policy in welfare institutions.

Gullestad, M. (2002): Det norske sett med nye øyne. Oslo: Universitetsforlaget.

Gullestad, M. (2006): Plausible Prejudice: Everyday Experiences and Social Images of Nation, Culture and Race. Oslo: Universitetsforlaget.

Jöhncke, S. (2007): Velfærdsstaten som integrationsprojekt. In: Olwig, F. K. & Paerregaard, K.: Integration: Antropologiske perspektiver. København: Museum Tusculanums Forlag: 37-62.

Kiørboe, E. (2017): Uklar lovgivning og skiftende meldinger om asylanters adgang til stofmisbrugsbehandling. In: KABS Årsmagasin 2017. Trykportalen.

Laursen, L. & Jepsen, J. (2002): Danish Drug Policy - An Ambivalent Balance between Repression and Welfare. Sage Publications.

Lipsky, M (2010): Street-Level Bureaucracy – Dilemmas of the Individual in Public Services. Updated ed. Russel Sage Foundation. New York.

March, G. J. & Olsen, P. J. (1995): Democratic Governance. Free Press.

March, G. J. & Olsen, P. J. (2004): The Logic of Appropriateness. The Centre for European Studies, University of Oslo.

Mauss, M. (1925; 2001 ed.): Introductory in The Gift: The Form and Reason for Exchange in Archaic Societies. London. Routledge. Pp 1-22 (*)

McHoul, A. & Grace, W. (1993): A Foucault Primer: Discourse, Power and the Subject. Melbourne University Press.

McLaughlin, D. & Long, A. (1996): An extended literature review of health professionals perceptions of illicit drugs and their clients who use them. Journal of Psychiatric and Mental Health Nursing , 3(5), 283-288

The Ministry for Children and Social Affairs (2018): The Service Act. LBK nr 102 af 29/01/2018.

The Ministry of Immigration and Integration (2016) (1): Sundheds- og Ældreudvalget 2016-17. SUU Alm.del endeligt svar på spørgsmål 405. Offentligt. www.ft.dk/samling/20161/almdel/suu/spm/405/svar/1383985/1724635.pdf

The Ministry of Immigration and Integration (2016) (2): Sundheds- og Ældreudvalget 2016-17 SUU Alm.del endeligt svar på spørgsmål 407. Offentligt. www.ft.dk/samling/20161/almdel/suu/spm/407/svar/1383989/1724645.pdf

The Ministry of Immigration and Integration (2017): The Aliens Act. LBK nr 1117 af 02/10/2017.

The Ministry of Immigration and Integration (2018): Tal på udlændingeområdet pr. 28.02.2018.

The Ministry of Health (2008): National guideline for medicinal substitution treatment of drug users. VEJ nr 42 af 01/07/2008.

The Ministry of Health (2016) (1): The Health Act. LBK nr 1188 af 24/09/2016.

The Ministry of Health (2016) (2): Law on Euphoric Substances. LBK nr 715 af 13/06/2016.

Ministry of Social Affairs and the Interior (2016): Analyse af servicelovens anvendelsesområde i forhold til udlændinge med processuelt eller ikke-lovligt opholdsgrundlag. Social- og Indenrigsministeriet, Lovkoordinering og Internationale forhold

Mogensen, O. H. (2011): Caught in the Grid of Difference and Gratitude: HIV Positive Africans Facing the Challenges of Danish Society. In: Olwig, F. K. & Paerregaard, K.: The

Question of Integration. Immigration, Exclusion and the Danish Welfare State. Cambridge Scholars Publishing.

The National Board of Health and Welfare (2016): Nationale retningslinjer - for den sociale stofmisbrugsbehandling. Socialstyrelsen.

Olwig, F. K. & Paerregaard, K (2011): The Question of Integration. Immigration, Exclusion and the Danish Welfare State. Cambridge Scholars Publishing.

Patton, C. V. & Sawicki, D. S. (1986): Basic Methods of Policy Analysis and Planning. Prentice Hall. 1st edition.

Rice, D. (2012): Street-Level Bureaucrats and the Welfare State: Toward a Micro-Institutionalist Theory of Policy Implementation. Administration & Society 45(9) 1038–1062, Sage Publications

Rizvi, F. & Lingard, B. (2010): Globalizing Education Policy. Routledge. 1st edition.

Rubow, C. (2003): Samtalen - Interviewet som deltagerobservation In: Hastrup, K.: Ind i verden - en grundbog i antropologisk metode. Hans Reitzels Forlag, København

Silverman, D. (2006): Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction. 3rd edition. Sage Publications. London.

Thylstup, B. et. al. (2014): Misbrugsbehandling. Organisering, indsatser og behov. Forfatterne og Aarhus Universitetsforlag. Samfund og rusmidler, nr. 3.

Torfing, J., & Triantafillou, P. (2017): New Public Governance på dansk. Akademisk Forlag. København.

Weimar, D. L. & Vining, A. R. (2016): Policy Analysis: Concepts and Practice. 5th edition. Routledge.

Østergaard, S. L. & Nørredam, M. (2017): Barriers to Receiving Substance Abuse Treatment for Asylum Seekers: Perspectives from Treatment Providers in Denmark (draft). University of Copenhagen. Department of Public Health.

Østergaard, S. L (2017): Undersøgelse af stofmisbrug blandt migranter. In: KABS Årsmagasin 2017. Trykportalen.

Web pages

Eurostat 2018: Asylum applications (non-EU) in the EU-28 Member States, 2006–2017. Visited on 16.04.18:
http://ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Asylum_applications_(non-EU)_in_the_EU-28_Member_States,_2006–2017_(thousands)_YB18.png

Ministry of Immigration and Integration 2018: Gennemførte stramninger på udlændingeområdet. Visited on 21.02.18:
http://uim.dk/gennemforte-stramninger-pa-udlaendingeomradet

Mændenes Hjem 2018: Vesterbros Stofscene. Visited on 12.04.18:
http://maendeneshjem.dk/vesterbros-stofbrugere/

Politiken 2017 (1): Nogle ryger kokain. Andre ryger heroin. For at dulme nerverne og glemme at de er afviste asylansøgere og misbrugere. Visited on 28.03.18:
https://politiken.dk/fotografier/art6135102/Nogle-ryger-kokain.-Andre-ryger-heroin.-For-at-dulme-nerverne-og-glemme-at-de-er-afviste-asylansøgere-og-misbrugere

Politiken 2017 (2): Restauratører er frustrerede over "svineri" og en "voldsom forråelse" ved Kødbyens fixerum. Visited on 28.03.18:
https://politiken.dk/indland/kobenhavn/art6135242/Restauratører-er-frustrerede-over-»svineri«-og-en-»voldsom-forråelse«-ved-Kødbyens-fixerum

Sundhedsstyrelsen 2017: Behandling af stofmisbrug og skadesreduktion. Visited on 09.04.18:
https://www.sst.dk/da/sundhed-og-livsstil/narkotika/behandling#

Appendix list

Appendix 1 – Transcriptions and notes from interviews with social/health actors on Vesterbro

Appendix 2 – Interview guides

Appendix 3 – Transcriptions and notes from interviews with health personnel at asylum centers

Appendix 4 – Guideline for health care personnel regarding drug dependence treatment of asylum seekers, issued by Immigration Service