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SERAF REPORT 2/2024

Status report 2023

Twenty-five years of opioid maintenance treatment (OMT)

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Foreword

SERAF prepares an annual national status report for opioid maintenance treatment (OMT) on behalf of the Norwegian Directorate of Health. The status report is based on a survey that all opioid maintenance treatment (OMT) units carry out once a year. The purpose is to map the patients' situation, treatment and treatment outcomes in OMT.

The status report summarizes key findings about the situation of patients in OMT, current treatment status, drug treatment (including choice of drug and dosage), psychosocial follow-up (such as treatment goals, individual plan, responsibility group meetings and treatment for mental health problems), mental health, physical health and substance use. In addition, findings on deaths among patients in OMT in the past year are presented.

The 2023 status report marks 25 years of OMT in Norway, and is the second status survey conducted after the introduction of revised OMT guidelines in 2022. The status survey has shown that, over time, OMT has become a well-established, standardized treatment for most people with opioid-dominated addiction. The treatment is constantly evolving, with gradually increased flexibility and focus on user participation through practice and revised guidelines.

In the status survey for 2023, OMT units that use the electronic medical record system DIPS Arena responded to a somewhat further developed version that includes additional information. Patients receiving treatment in these OMT units have provided information on the use of treatment plans, side effects, physical health, illnesses, pain and treatment in the past year, as well as tobacco use. New this year is also a question about whether the patient has received information about the right of appeal in OMT. We hope and believe that these questions can help to further develop knowledge about the patients' situation and important aspects of the treatment.

This report is the result of significant efforts in each OMT unit. We would like to thank the patients in OMT who have responded to the status survey, OMT staff across the country for their work in collecting responses, and for their excellent cooperation with the OMT units and the Norwegian Directorate of Health. We would also like to thank Anne Bukten for her review and input.

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SUMMARY

The results of the 2023 status survey show that the number of patients in OMT was 8467 patients in 20 OMT units. There is generally continuity in the treatment and few discharges. Overall, this suggests good coverage and that the treatment works in such a way that most patients remain in treatment over time. Patients who discontinue treatment do so primarily at their own request. The response rate in this year's status survey was 83%, and patients participated in completing it in 73% of cases.

Participants

- The gender balance in OMT is stable. Women make up approximately 30% of the patient population.
- We continue to see a slight increase in the average age (48 years).
- Most have a stable housing situation, with their own owned or rented home (80%).
- Most are not in work or education (83%).
- Most have disability or retirement pension as their main income (70%).

Drug treatment and medical safety

- In recent years, there has been a development in drug treatment in that a wider range of OMT drugs are offered. Buprenorphine monopreparat is the most commonly used OMT medication (37%), followed by methadone (30%). Buprenorphine/naloxone combination preparations are used to an ever lesser extent (6%). Buprenorphine depot injection, introduced in 2019, has become one of the most used drugs (19%). The proportion with other OMT medications has also increased from previously (8%).
- Overall, 9% of a sub-sample reported side effects of their OMT medication.
- Benzodiazepines were prescribed to 40% of patients.
- Drug tests are gradually becoming less common. Around 45% have no drug testing scheme, while 52% either have an agreement for regular drug tests or random tests.

Psychosocial follow-up

- The OMT treatment is anchored in the specialist health service for most of the patients (78%).
- Most of the patients, 69%, had rehabilitation with abstinence as their overall treatment goal.
- Few, 11%, had an individual plan.
- Responsibility group meetings had been held in the last three months for 28% of patients.
- In one sub-sample, 69% had an active treatment plan.
- Only 14% received treatment for mental health problems.

Processing satisfaction and right to complain

- The majority of patients, 59%, reported satisfaction with the OMT treatment.
- In comparison, clinicians were satisfied with the treatment for 67% of patients.
- Just under half, 48%, had received information about the right to complain about OMT.

Mental and physical health

- Mental health problems are fairly widespread in the patient population: 26% reported severe anxiety symptoms, 16% severe depressive symptoms, and 7% delusions.
- The proportion who had suffered physical injuries or illnesses that reduced their lifestyle or quality of life in the past four weeks was 37%, and the corresponding proportion in a one-year perspective was 43%.
- As many as 69% had had a medical examination in the past year.
- Chronic pain for at least three months was reported for 34% of patients.
- The most prevalent diseases last year were dental problems (19%), chronic lung disease (9%), high blood pressure (6%) and obesity (6%).
- As previously, the proportion with positive HIV status was low (1%). The proportion with positive hepatitis C status was fairly low (6%).

Substance abuse

- The most commonly used intoxicants were benzodiazepines (33%) and cannabis (30%). Opioids other than OMT drugs were used by 9%.

- Approximately half, 49%, had good substance abuse control, and 21% had mixed substance abuse control.

Heroin-assisted treatment (HAT)

- Patients in HAT have many similarities with the OMT population, but are also a sample of OMT patients with somewhat more social instability and more substance use in treatment than the majority in OMT. Compared with ordinary OMT, satisfaction was somewhat higher in HAT. In the coming years, the HAT population and the experiences from the pilot projects in Oslo and Bergen will be evaluated.

Fatalities

- In 2023, 138 people died during OMT treatment. Mortality in OMT is relatively low overall, but dominated by somatic causes of death that increase after the age of 40. Mortality from overdose is low in OMT, as indicated by the purpose of the treatment, if it is possible to sufficiently balance the requirements for safety and accessibility with the quality of the treatment.

In some areas, there is geographical variation between the OMT units. To some extent, this can probably be explained by different patient characteristics, different organization of treatment, and regional challenges and resources. When it comes to the development of OMT, especially in light of the introduction of the revised guidelines in 2022, we tend to see gradual changes rather than drastic, clear changes. This is consistent with the fact that it takes time to implement guidelines in practice.

Contents

25 YEARS OF OMT IN NORWAY

This year's status survey, with national data from 2023, marks 25 years of OMT as a national treatment option for opioid dependence. Prior to the establishment of OMT, there was a period when methadone maintenance treatment was not legal, and the treatment offered was in reality drug-free treatment, usually through long-term inpatient treatment. Even though some people underwent such treatment and became long-term drug-free, the treatment did not have very good results. In the case of severe opioid dependence, treatment results were characterized by both dropout during a treatment episode and relapse to serious drug use after treatment ended.

Throughout the 1990s, overdose mortality caused by heroin was a growing problem. This peaked in 2000 when there were more than 400 fatal overdoses, the majority among injecting heroin users. In the latter part of the 1990s, a couple of small treatment trials were therefore carried out specifically in the target group of heroin users with advanced HIV (HIVMet). The results were good, and the treatment was eventually established as a national service in 1998.

In the run-up to the establishment of a national OMT system, there was both professional and political resistance, and treatment was strictly regulated, partly as a consequence of this. Initially, the new treatment was intended to reach the most seriously affected heroin addicts. An estimate was made of how large the scope of OMT would be in Norway, and this estimate was 600 patients.

The guidelines for who should qualify for the treatment were set strictly, and there was a requirement for more than 10 years of opioid dependence, preferably several unsuccessful treatment attempts (drug-free), and there was a lower age limit of 25 years. OMT was seen as a "last chance" when everything else had been tried.

The treatment framework was also strict. Patients were required to set a goal of abstinence from all illicit drugs, there were frequent supervised drug tests, there was close clinical follow-up, and many patients attended daily appointments to collect their OMT medication. At the same time, the additional prescription of benzodiazepines was not considered to be common clinical practice.

In an international context, we can say that Norwegian OAT got off to a late start, as the treatment was established from the mid-1960s in the USA and came to Sweden as early as the 1960s. Our original OMT model was also referred to as "high-threshold" treatment, meaning that it took a lot to qualify for the treatment, while there were strict requirements for the actual implementation. There was a lot of focus on controlling concurrent substance use. In the first period, people could be discharged from OMT against their will if they had persistent use of illegal drugs while in OMT treatment.

From 1998, treatment centers were established in all of the country's counties and a national treatment system was built up. For the first couple of years, only methadone was available as an OMT drug, but from 2000 buprenorphine was also introduced as an OMT drug. From an early stage, national OMT management meetings were established where both practical, clinical aspects and experiences and formal aspects of the treatment were discussed. These meetings were originally held every quarter. In the future, these have become the semi-annual national OAT network meetings. Furthermore, the OMT conference became an arena that brought together professionals in the field of substance abuse every other year to highlight OMT-relevant topics, as well as to further develop knowledge and expertise about OMT.

As early as 2000, reports were prepared that can be said to be precursors to the Status Reports with a review of the development of treatment nationally. From the early Status Reports, we can read that the focus in the first few years was on increasing capacity and thus the availability of treatment, as well as establishing good clinical routines. However, it soon became clear that the estimated capacity of 600 was too low, and that demand quickly outstripped supply. This resulted in long waiting lists for OMT. At times, there could be more than a year's wait for OMT treatment.

Today, this description of OMT in the establishment phase is fairly distant. What characterizes OMT in Norway today is that, in a European and global context, we are at the top when it comes to coverage of treatment for this target group. We estimate that between 70-80% of the target group in the Norwegian context is in treatment, and today there are approximately 8,500 OMT patients. We also have good retention in OMT in

Norway in an international context, where approximately 70% of patients are in continuous treatment after 12 months in OMT. OMT in Norway currently includes a number of OMT medications, in various forms of administration, which together contribute to a large proportion of patients being able to find a medication that works for them. We can say that OMT in Norway has proved to be a flexible treatment model that gradually changes and adapts as new needs and priorities are identified.

The development of Norwegian OMT has, among other things, been driven by the interaction between research and clinical practice. In addition, user organizations, including ProLAR Nett and Marborg, have played an important role in promoting patients' perspectives and experiences with OMT. The OMT regulations, which came into force in 2010, as well as the OMT guidelines from 2010 and the revised guidelines from 2022, have also had an impact on the direction in which treatment has developed. Today, increased emphasis is placed on patients' involvement in their own treatment, as well as therapists' ability to make individual assessments for each patient, including in the choice of medication, dosage, drug tests and dispensing arrangements. The OAT regulations emphasize improved quality of life and support to change one's life situation as the very purpose of OAT (§2).[1]

In Norway, we have had a unique knowledge of the development of OMT through an annual national status report, together with other OMT-relevant research. This has meant that each year we have been able to monitor developments in the number of patients in treatment and developments in clinical practice. In addition, this has facilitated opportunities to inform and adjust further treatment approaches almost continuously. The findings from the status survey are presented each year at the OAT network meeting so that differences in practice can be discussed. By presenting the findings from the status survey at the OAT network meeting, differences in practice and future priorities can be discussed fairly regularly. It is worth preserving this characteristic of Norwegian OMT, so that course changes can be made along the way and priority areas can be identified through networking and dialogue and prioritized on an ongoing basis.

Priorities and focus areas in OMT have evolved along the way, from the early focus on establishing and incorporating routines, to increasing capacity, and on to quality improvements, including increased emphasis on user participation and individual assessments. In the coming years, we expect age-related somatic health and living conditions in particular to become important focus areas, in addition to opportunities for participation in activities and social networks regardless of age.

[1] Regulations on drug-assisted rehabilitation (OAT regulations). https://lovdata.no/dokument/SF/forskrift/2009-12-18-1641

ORGANIZATION AND MAN-YEARS

OMT is part of interdisciplinary specialized substance abuse treatment, organized in the individual health trusts. OMT is organized as a collaboration between the health trust's unit for substance abuse treatment, the health and social services in the municipality in which the patient lives, and the GP. OAT is intended to ensure the organization of complex and holistic services.

Organization of the OAT treatment

OMT is offered in four health regions: Western Norway Regional Health Authority, Central Norway Regional Health Authority, Northern Norway Regional Health Authority and South-Eastern Norway Regional Health Authority. The latter is divided up in this status report. Helse Vest consists of Stavanger, Fonna, Førde and Bergen. The Central Norway Regional Health Authority consists of Møre og Romsdal, St. Olavs hospital and Nord-Trøndelag. Helse Nord consists of Helgelandssykehuset, Finnmarkssykehuset and Nordlandssykehuset. The Southern Norway Regional Health Authority consists of Drammen, Asker and Bærum, Telemark and Sørlandet hospitals, and the Eastern Norway Regional Health Authority consists of Akershus University Hospital, Oslo University Hospital, Østfold and Innlandet. The OMT services are referred to as OMT units in this report. In total, there are approximately 20 overall OMT units.

SUD units are organized differently, primarily in the form of a separate SUD team that is integrated into a substance abuse clinic or as a separate SUD team or SUD outpatient clinic in addition to other TSB (Table 1). However, some OMT units use different and complex organizational forms internally, where parts of the unit are integrated into a substance abuse clinic and parts of the unit are organized as a separate OMT team or OMT outpatient clinic. This means that it is difficult to provide a simplified presentation of the organization at unit level that adequately describes practice.

Table 1: Organization of OAT unit

	OAT team integrated into substance abuse clinic	Separate OAT team/OAT outpatient clinic
Oslo, Norway		x
Akershus	x	
Østfold	x	
Inland	x	x
Asker and Bærum	x	
Drammen		x
Vestfold		x
Telemark	-	-
Southern Norway		x
Mountains		x
Stavanger, Norway		x
Førde		x
Fonna	x	x
St. Olav	x	
Møre and Romsdal	x	
Nord-Trøndelag	x	
UNN	x	
Nordland Hospital	x	
Helgeland Hospital	-	-
Finnmark Hospital	x	

In addition to the coarse-grained presentation in Table 1, some of the SUD units have further specified their method of organization:

- OAT in Oslo has two separate OAT outpatient clinics, one of which consists of two district teams (treatment teams) and a medication team. In addition, there is HAT in Oslo.

- OAT in Akershus consists of five OAT teams integrated into their respective substance abuse clinics.
- OMT in Innlandet is part of four DPSs, several of which have multiple locations. Each DPS has an OMT team. Innlandet Hospital also has eight Flexible Assertive Community Treatment (FACT) teams. DPS Gjøvik is located at three locations and has its own OAT team. DPS Lillehammer serves OMT patients at two locations, as well as through FACT. DPS Elverum-Hamar serves OMT patients at two locations and works closely with FACT. DPS Tynset has some OMT patients and receives support from DPS Elverum-Hamar in the follow-up of these.
- OMT in Gjøvik (Innlandet) is integrated into the substance abuse clinic, general outpatient clinic and two flexible assertive community treatment (FACT) teams.
- OAT in Vestfold consists of two outpatient clinics in four different locations.
- OAT in Bergen consists of six decentralized outpatient clinics, as well as a separate team that works with patients in need of extended security. In addition, there is HAT in Bergen.
- OAT in Stavanger consists of two outpatient clinics.
- OAT in Fonna has a newly established separate outpatient clinic.
- In addition to the substance abuse clinic, OAT at Nordland Hospital has a low-threshold service that serves all OAT patients in the region.

Annual workforce

There is great variation in the number of OMT patients (59-1127) and the total number of therapist man-years (2-70) across OMT units (Table 2). In addition, there is great variation in caseload per therapist, i.e. the number of patients per therapist FTE, with the lowest caseload in Fonna and the highest caseload at Nordland Hospital. When we separate out HAT (Table 3), we see that the caseload is significantly lower than in ordinary OMT, in line with the intentions and organization of HAT. It must be mentioned that for many OMT units it is challenging to estimate the number of FTEs due to the organizational form.

Table 2: Population base and therapist man-years in OMT

	Population base	Number of patients	Total number of therapist man-years	Number of patients per treatment man-years
Oslo*	523.400	1000	47	21,3
Akershus	618.000	871	21	41,5
Østfold	300.000	565	16	35,3
Inland	340.000	430	16	26,9
Asker and Bærum	118.000	177	6	29,5
Drammen	285.000	333	8	41,6
Vestfold	256.000	413	26	15,9
Telemark	173.000	343	12	28,6
Southern Norway	312.000	620	20	31,0
Bergen*	465.200	1100	70	15,7
Stavanger, Norway	366.800	620	45	13,8
Førde	-	-	-	-
Fonna	184.000	525	39	13,5
St. Olav	237.500	360	7	51,4
Møre and Romsdal	264.500	214	9	23,8
Nord-Trøndelag county	137.000	107	2	53,5
UNN	-	-	-	-
Nordland Hospital	140.000	215	4	53,8
Helgeland Hospital	-	-	-	-
Finnmark Hospital	75.800	59	3	19,7

* Does not include HAT.

Table 3: Population base and therapist man-years in HAT

	Population base	Number of patients	Total number of therapist man-years	Number of patients per treatment man-years
Oslo, Norway	523.400	46	18	2,6
Mountains	465.200	27	18	1,5

Professional groups and access to specialists

Most of the professional groups are represented among therapists in OMT in the various OMT units (Table 4). Some of the OMT units state that, in addition to some OMT-specific therapist man-years, they also have access to therapists in other substance abuse clinics. This applies in particular to access to doctors and psychologists. All OMT units for which information is available have access to both medical and psychological specialists, with the exception of Nord-Trøndelag, Drammen, and parts of Innlandet (Gjøvik), which currently only have access to a medical specialist, and Fonna, which currently has no access to a specialist in the OMT unit.

In addition to the most widespread health and social care professional groups, we also find other therapists in some OMT units, where Akershus and Vestfold have a specialist consultant, Akershus, Innlandet and Vestfold have a child welfare educator, Bergen, Stavanger and St. Olav have occupational therapists, Innlandet has an environmental therapist, and Stavanger has health professionals with and without further education in substance abuse and psychiatry. Innlandet also has an exercise physiologist, and Nordland Hospital has a work and education specialist. Bergen and Stavanger state that they have experience consultants. Most of the units use mercantile staff and managers in other substance abuse clinics for OMT tasks.

Table 4. Professional groups represented in OAT

	Layers	Psychologist	Nurse	social worker	Nurse	Other
Oslo, Norway	x	x	x	x		
Akershus	x	x	x	x		x
Østfold	x	x	x	x	x	
Inland	x	x	x	x	x	x
Asker and Bærum	x	x	x	x	x	
Drammen	x	x	x	x		
Vestfold	x	x	x	x	x	x
Telemark	-	-	-	-	-	-
Southern Norway	x	x	x		x	
Mountains	x	x	x	x	x	x
Stavanger, Norway	x	x	x	x	x	
Førde	-	-	-	-	-	-
Fonna	x	x	x	x		
St. Olav	x	x	x	x		x
Møre and Romsdal	x		x	x	x	
Nord-Trøndelag county	x		x	x		
UNN	-	-	-			
Nordland Hospital	-	-	x	x		
Helgeland Hospital	-	-	-			
Finnmark Hospital	x		x	x		

CAPACITY AND PATIENT FLOW

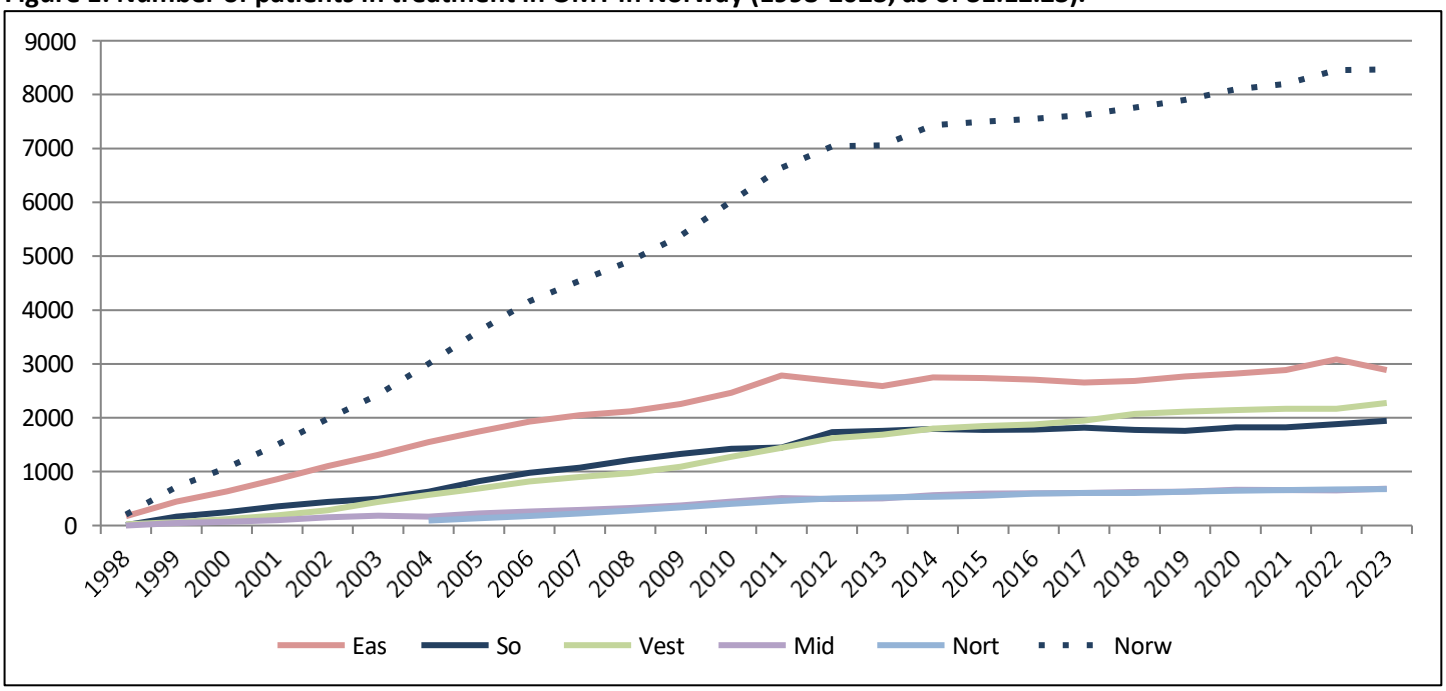
Each OAT unit reports the number of patients and patient flow on December 31 each year. This annual statement describes the number of patients in treatment, the number arriving and the number leaving, and forms the basis for our estimates of need, capacity and circulation throughout the country and in the individual units.

Number of patients in treatment

As of 31.12.2023, there were approximately 8467 patients in OMT. Unfortunately, no figures are available from Nordlandssykehuset and Helgelandssykehuset, but to complete the picture we have chosen to enter the same figures as for 2022 for these OMT units. The total number of patients at the end of 2023 (Figure 1) therefore implies a slight increase from 2021 (8198). 2022 stood out clearly due to the introduction of the health platform in Trøndelag and therefore insufficient reporting from Helse Midt for 2022. In this year's report, we have chosen to even out the graphical presentation by adding missing patient figures for 2022 with the number of patients in treatment as of 01.01.23 for Helse Fonna, St Olav and Nord Trøndelag, which gives 8456 patients in 2022.

Last year, 57.0% of patients received OMT in the South-Eastern Norway Regional Health Authority, 26.9% in the Western Norway Regional Health Authority, 8.1% in the Central Norway Regional Health Authority and 8.0 % in Helse Nord. Figure 1 shows that the growth in the number of patients was strong until 2012. The increase then leveled off, but the number continued to rise steadily from year to year. It is reported that only 9 patients nationwide had not started treatment at the end of the year and can therefore be described as "on the waiting list".

Figure 1: Number of patients in treatment in OMT in Norway (1998-2023, as of 31.12.23).



Admissions and discharges

In 2023, 1,039 patients (including transfers) started in OMT, 35 fewer than the previous year (Figure 2). The figure shows the sum of first-time admissions and re-admissions, including transfers, from 2005, the year when Region North was added. The South-Eastern Norway Regional Health Authority is divided into regions South and East for a better overview.

In 2023, there were 549 first-time admissions and 345 re-admissions. The remaining admissions were transfers between OMT units. Figure 3 shows a fairly stable number of first-time admissions in recent years, with well over 400 annually, while some fewer return after previous discharges. Since 2016, there has been a

stable number of annual admissions

Figure 2. Number of admissions to treatment (2005-2023).

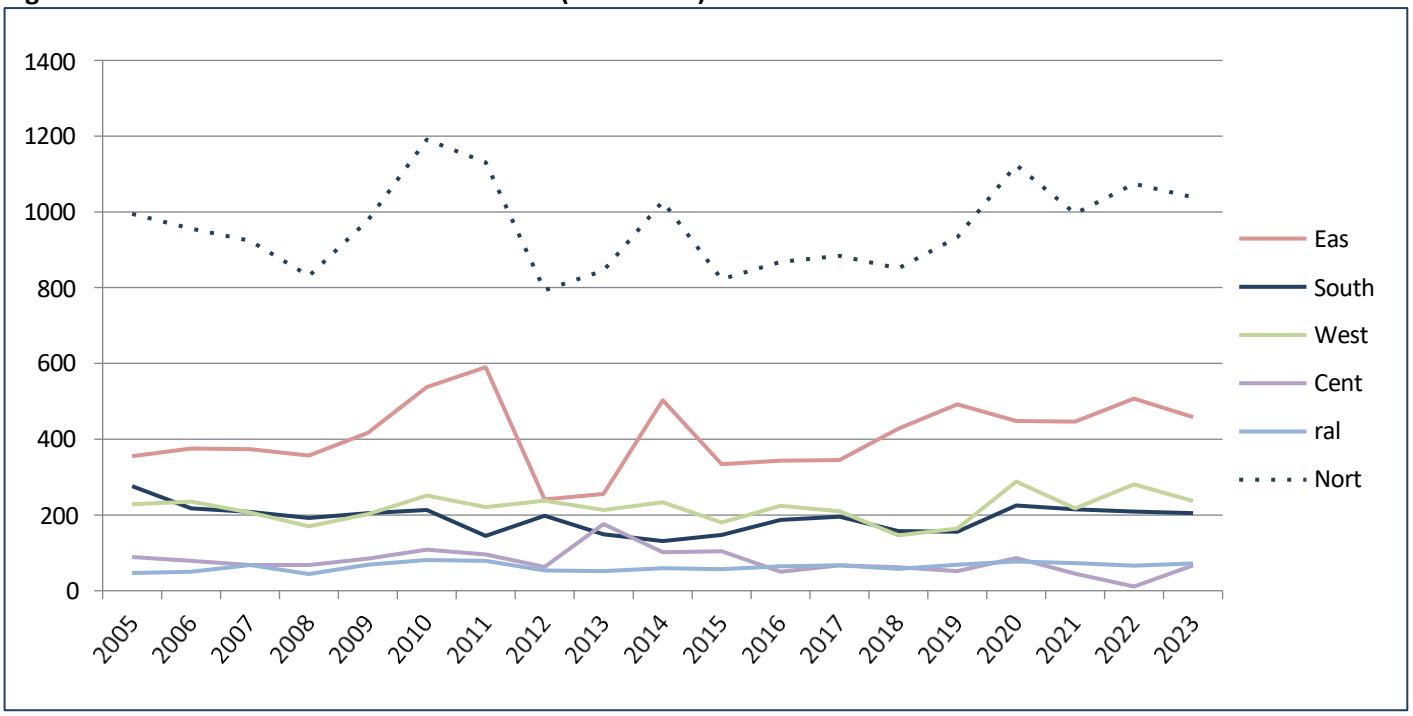
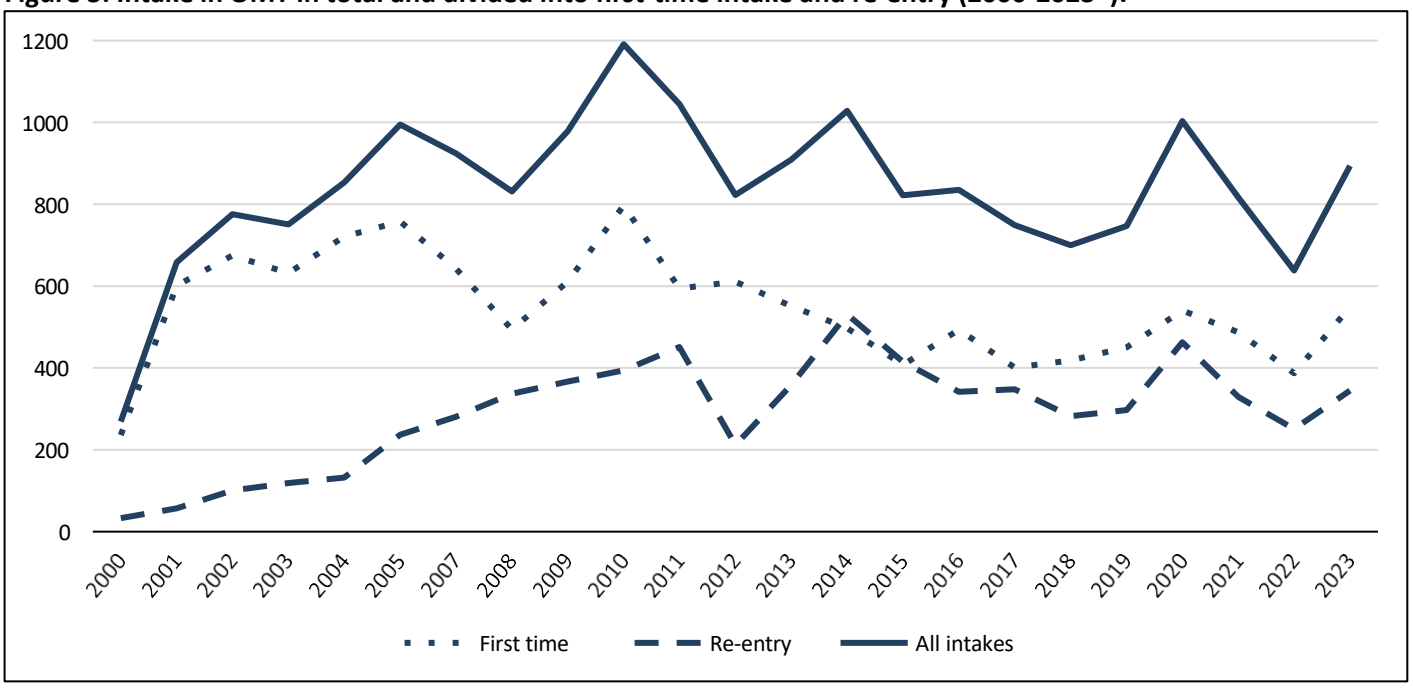


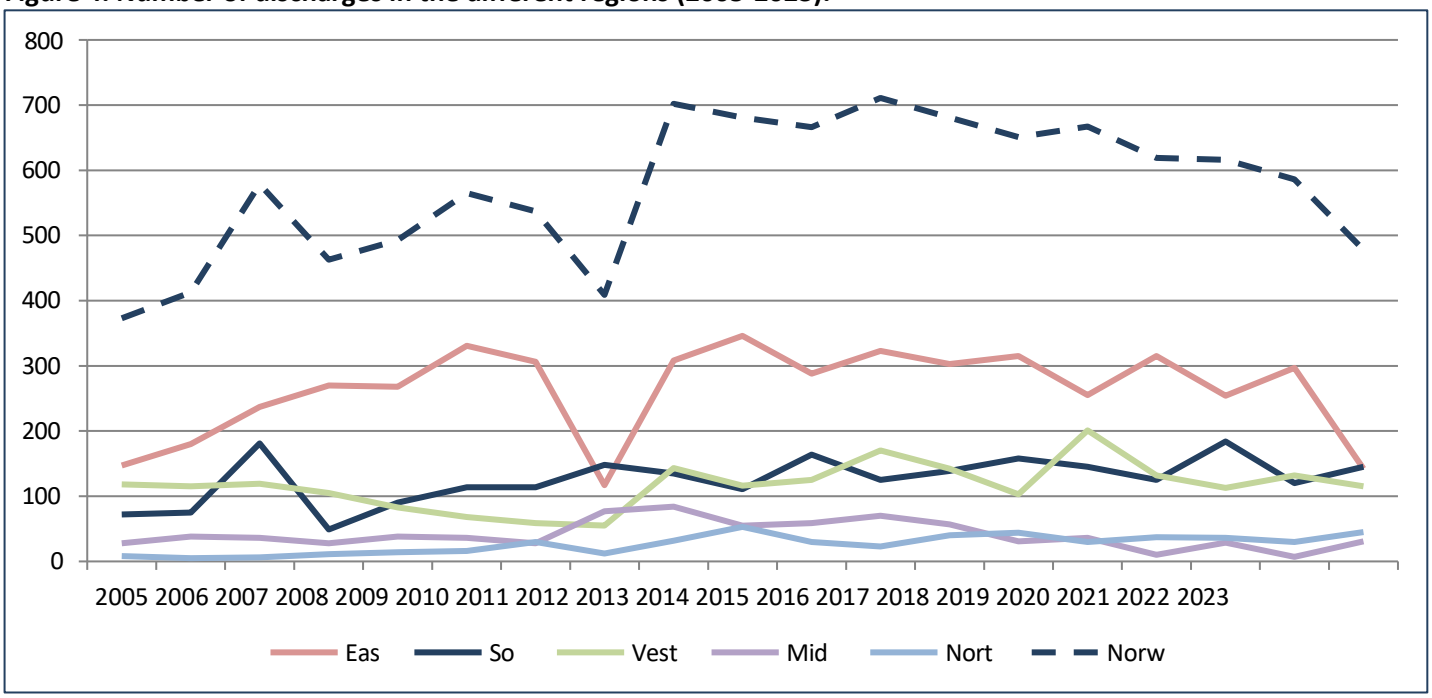
Figure 3: Intake in OMT in total and divided into first-time intake and re-entry (2000-2023*).



*Mangler data for 2006.

Figure 4 shows the development in discharges from OMT. There were a total of 478 discharges in 2023, compared with 581 in 2022. Transfers to another OMT unit are not included. Between 2014 and 2019, the proportion of discharges has remained fairly stable at around 700 per year (approximately 8%), while in the last few years we have seen a trend towards fewer discharges per year. The proportion who remain in SUDs over time continues to be high from one year to the next, with approximately 9 out of 10 patients.

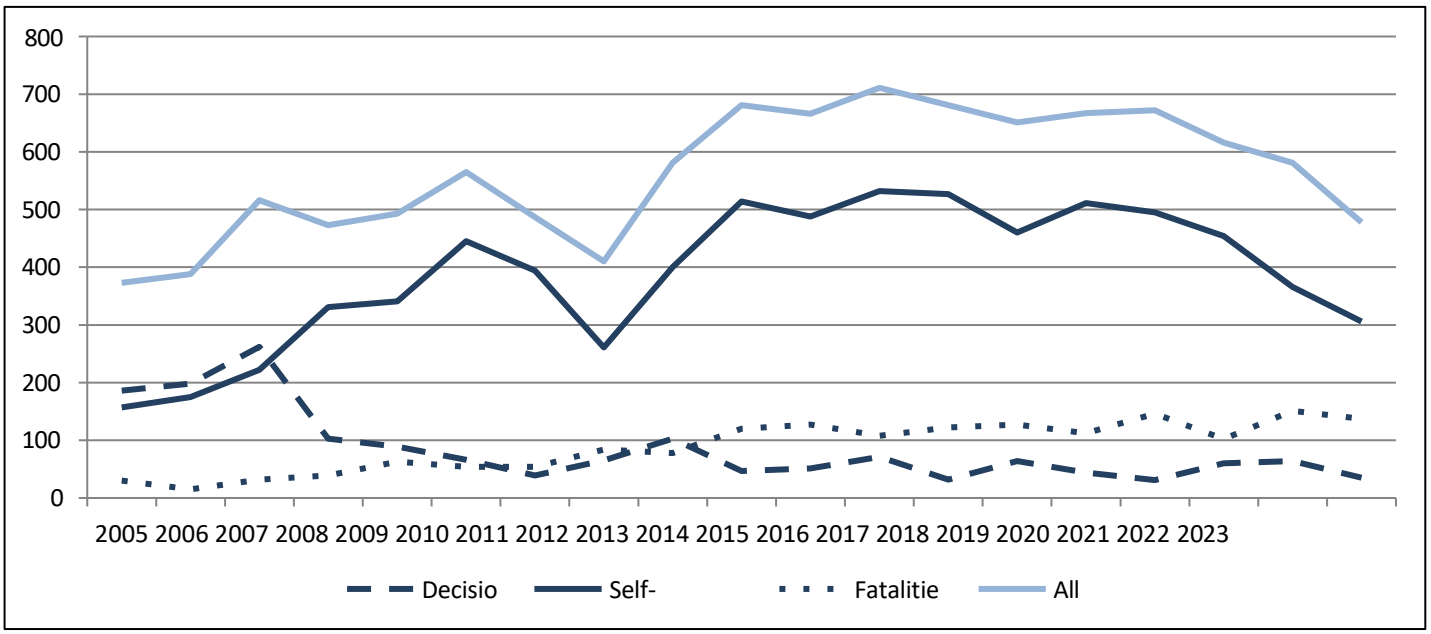
Figure 4. Number of discharges in the different regions (2005-2023).



In principle, OMT is recommended as a long-term and indefinite, possibly lifelong, treatment, but both planned tapering and unplanned interruptions occur. Discharges can take place independently of, and possibly against, the patient's will. The registrations distinguish between discharges decided on the basis of a health professional's assessment (decision of irresponsibility), those controlled by the patient themselves (their own wishes), and those due to death.

The development over time is shown in figure 5. If the patient stops taking the medicine or actively decides to taper off, this is considered a self-determined treatment interruption (green line). Such treatment interruptions have accounted for the majority of the total number of treatment interruptions since 2008, and they appear to have stabilized at around 500 annually between 2014 and 2020, with a clear decline in the last couple of years. In 2023, only 35 patients (7.3%) were discharged following a decision of medical unacceptability, which is lower than in 2022 (64 patients corresponding to 11.0%). In 2023, 137 patients (28.7%) were reported terminated due to death, compared to 151 patients (26.0%) in 2022.

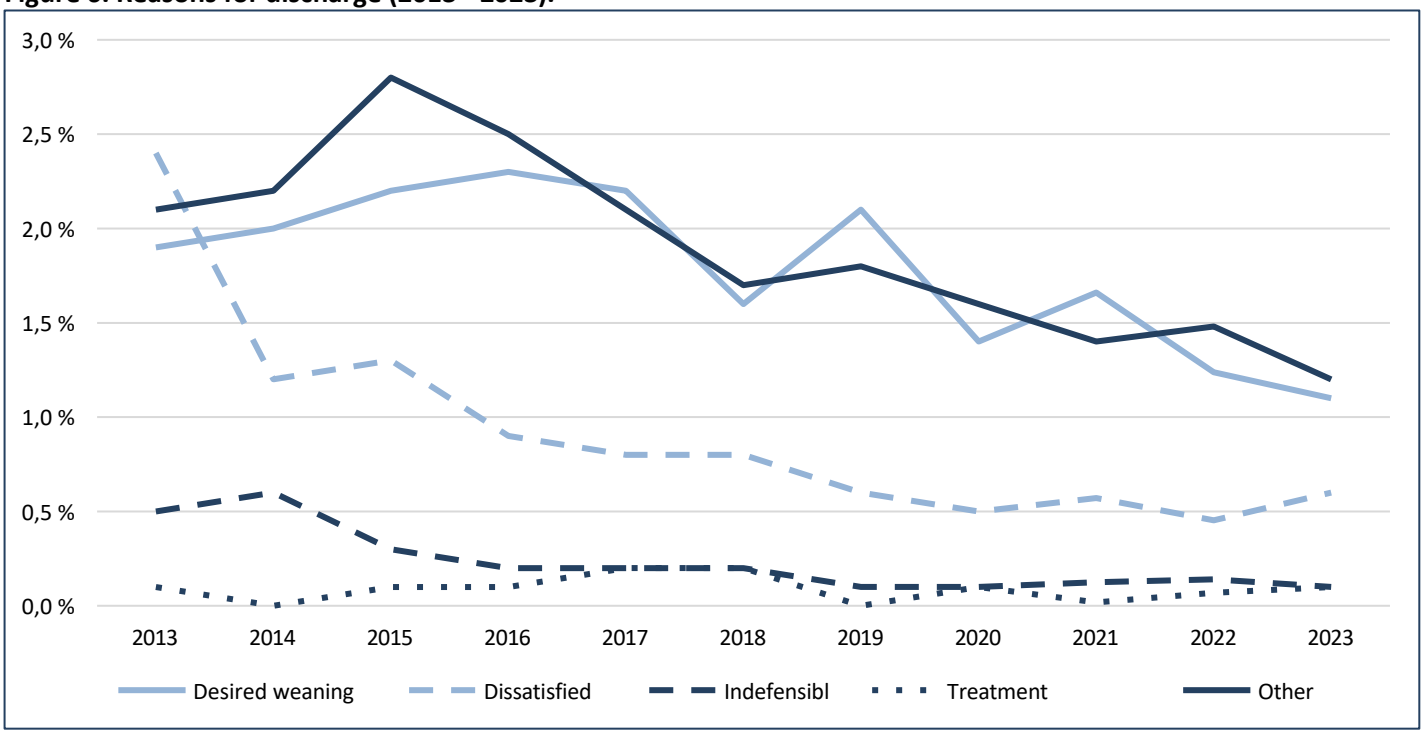
Figure 5. Number of discharges by type (2005-2023).



The number of discharges has increased in line with the increased number of patients in treatment. Very few have been discharged against their will since 2008. The use of discharge decisions has been stably low since 2014 (on average fewer than 60 per year), despite more people receiving treatment. The main reason for treatment interruption is self-determined termination. The proportion of deaths for 2023 is comparable with the previous year (for details, see the chapter on deaths in OMT).

Figure 6 provides an overview of reasons for termination of treatment over time. The proportion of discharges in the period 2013-2023 was stably lower than 5%. The "other" group also includes those who were terminated due to death. The proportion discharged against their will has decreased. Among the rest, it seems that the most common reason for discharge is the patient's desire to reduce or end their OMT treatment, as well as being actively dissatisfied with the treatment. Very few patients are discharged because of difficulties in the treatment or because the therapist considers the treatment to be irresponsible. This may indicate quality improvements over time.

Figure 6. Reasons for discharge (2013 - 2023).



Assessments of developments in admission and discharge practices

The number of patients in OMT appears to have stabilized at around 8,500 patients over the last couple of years, and the steady increase from the years before 2014 has leveled off. Admissions have been somewhat reduced in the years before 2023, while the trend related to new patients joining (rather than re-admissions) seems to remain stable. This confirms that there is still a need to reach new groups that can benefit from OMT. Patients who apply for OMT are assessed for their rights in accordance with the prioritization guide and start treatment quickly. As in previous years, very few patients were not considered eligible for OMT, which indicates well-established application procedures for this part of TSB as well. Discharge practices have changed considerably in recent years in a direction where maintenance is facilitated as much as possible regardless of substance abuse or rehabilitation goals.

STATUS SURVEY 2023

Response rate

Nationally, status forms were reported from 7,026 patients, while 8,467 were receiving OMT at the turn of the year 2022/2023. The response rate was 82.9% (83.8% in 2022). The patient's coordinator or responsible therapist is responsible for completing the forms.

The response option "unknown" is rarely used for most questions about the patients' situation and the drug treatment in OMT. However, the degree of uncertainty was higher for mental health status in the last four weeks (14.6%- 15.2%), physical illnesses or injuries in the last four weeks (10.0%), and substance use in the last four weeks, as well as substance abuse in the last year (13.5%-17.3%). In addition, the percentage of unknown infection status in the past year was 16.4% for hepatitis C and 10.0% for HIV. When it came to psychosocial follow-up, the unknown rate for individual plans was high (13.6%). The unknown rate for offenses in the past year was also quite high (16.8%). The highest unknown rate was 21.1%, similar to the previous years, and thus had the highest unknown rate. This seems to correspond with the fact that in a total of 26.7% of cases, patients did not participate in answering the status survey, which excludes self-assessment of satisfaction. The proportion with unknown status is occasionally higher in larger OMT units. The percentage of unknowns for the questions from OAT units that have DIPS Arena is higher, but this is partly due to the lack of answers to specific questions for DIPS Arena being interpreted as "unknown". The unknown percentages for these questions (e.g., right of appeal and side effects) must therefore be interpreted with caution.

Patient involvement in the status survey

Table 5 below shows an overview of the OMT units that have participated in the status survey, as well as the extent to which patients have been involved in completing the survey. All units reported individually and are grouped as shown in the table. In addition, Figure 7 visualizes the degree of patient involvement by OAT unit.

Table 5: Overview of participating OMT units and degree of patient involvement in the status survey for 2023.

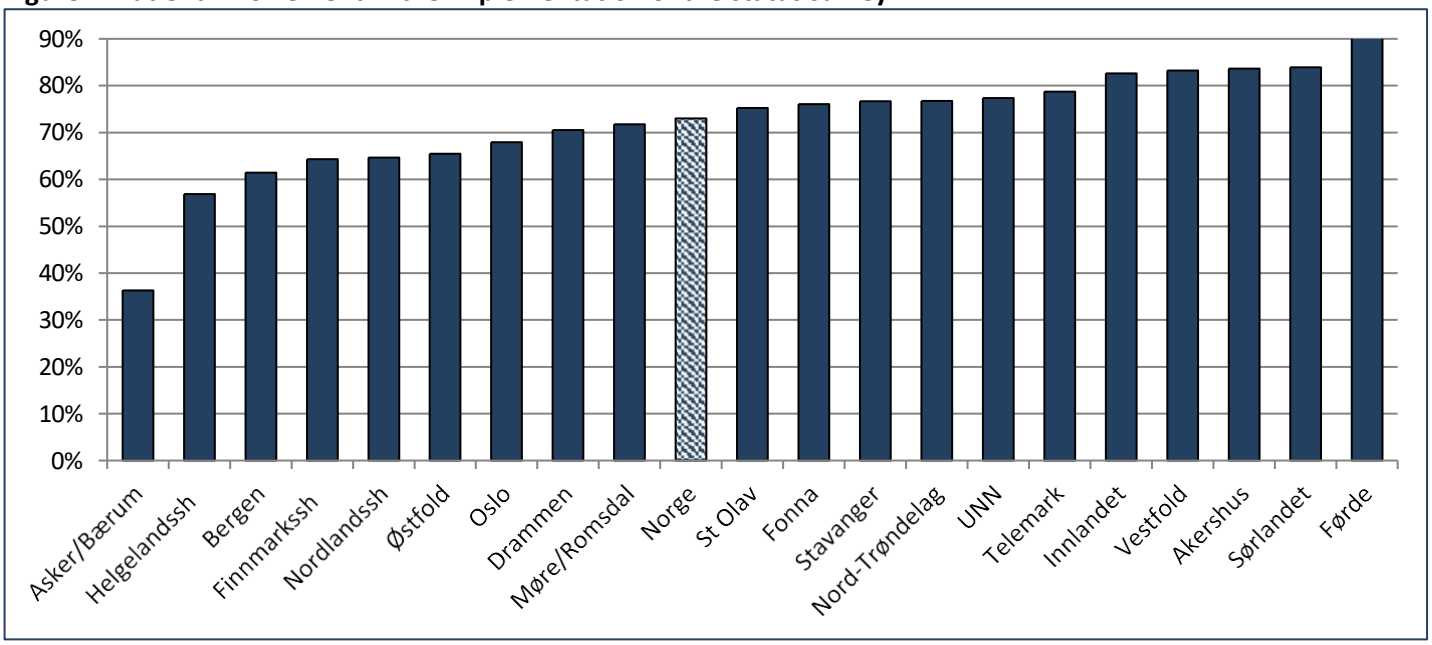
Region (number of participants)	*OAT device*	*Patients reported (number)*	*"Has the patient participated in completing the form?" (%)*	*Trend compared to previous year***
North (338)	UNN	296	64,3	↓↓
	Finnmark Hospital	42	64,3	↓
Middle (665)	Nord-Trøndelag county	99	71,8	Defects
	St Olav	364	75,3	Defects
	Møre and Romsdal	202	71,8	↓
West (1992)	Mountains	865	61,4	≈
	Stavanger, Norway	489	76,7	↓
	Fonna	241	74,6	↓
	Førde	51	97,3	↑
South (1833)	Vestfold	346	83,2	↓
	Telemark	343	78,7	↓
	Drammen	312	70,5	↑
	Asker and Bærum	190	36,3	↓
	Southern Norway	642	84,0	≈
East (2252)	Akershus	545	83,7	↑
	Oslo, Norway	860	67,9	≈
	Inland	386	82,6	↑
	Østfold	461	65,5	↓

* The OAT units are divided into five regions (from four different health trusts) and are presented in the report as these 18 OAT units, in addition to the two OAT units at Helgeland Hospital and Nordland Hospital. Sometimes these follow county boundaries, sometimes hospital catchment areas.

** Approximately the same level is indicated with ≈ and defined within a maximum ± 2% change. Larger changes (10 or more percentage points) are marked with double arrows.

For 2022, we were missing results from the units in the Central Region at St. Olavs Hospital and Nord-Trøndelag due to the introduction of the "Health Platform". In this year's survey, we are also missing complete responses from some units, this time from Region North at Nordland Hospital and Helgeland Hospital. We have chosen to use last year's responses as a basis to allow for comparisons over time.

Figure 7. Patient involvement in the implementation of the status survey.



Assessments of the status survey

The status survey provides a good overview of a number of key areas within OMT. In this way, the status reporting contributes to Norway having a good overview of the organization, treatment results and development of OMT at unit level, regional level and nationally. This appears to be unique to the Norwegian context.

The status survey also has some methodological limitations that should be mentioned. One important limitation is that some questions have a high unknown percentage, which makes interpretation difficult. Another challenge is that slightly different versions of the status survey are used, and that the questions can be interpreted in slightly different ways between patients, therapists and across SUD units.

The response rate is considered relatively good for most of the individual questions in the survey, and most questions are answered with a reasonable degree of certainty (few use the response category "unknown"). In some areas, knowledge of the individual patient's condition is lower, and this applies in particular to assessment questions about mental health and substance use in the last four weeks before completion. Even in the most difficult areas, the respondents thought they knew the condition well enough for assessment in about 85% of cases. Patient involvement in the completion of the questionnaire can help to reduce the proportion with unknown status, as well as being an opportunity for patients to evaluate the treatment and provide feedback on the benefits of the treatment. To some extent, the OMT units have different prerequisites for this, including the number of patients per full-time therapist and the total number of patients.

The conclusion is that there is some uncertainty associated with some questions where a relatively high proportion of the answers are unknown for around 1-2 out of 10 patients. Beyond that, the completers seem to have good knowledge of the patient's situation.

PARTICIPANTS

Gender and age

The gender distribution among OMT patients has remained stable over time, with a female share of around 30% (Table 6). However, there was some variation across OAT units. In 2023, Nord-Trøndelag had the highest proportion of women (40.4%), and Møre og Romsdal and Telemark the lowest (24.3% and 24.4%). In 2023, the average age of OMT patients was 48.1 years, which implies a continued slight increase. Figure 8 illustrates the age distribution in OMT. As in the past, there was a fairly limited difference between the units in terms of average age.

Table 6: Gender distribution among patients in OMT.

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Share of women (%)	30,2	29,3	30,1	30,0	30,4	29,3	30,5	30,4	30,1	29,7	30,4

The proportion of patients over the age of 50 was 43.7% in 2023, compared with 23.7% in 2015 (Figure 8). Only a very small proportion were 30
or younger (4.9%). Furthermore, 20.6% were in the age group 31-40, 30.8% were between 41 and 50, and 30.5% between 51 and 60. As many as 13.3% were over the age of 60. Increased age is an indication that OMT helps to reduce early mortality. At the same time, increased age often leads to somatic co-morbidity, and ageing often has implications for the adaptation of treatment and treatment outcomes. Figure 9 shows the development in age distribution.

Figure 8. Age distribution among patients in OMT (2011-2023).

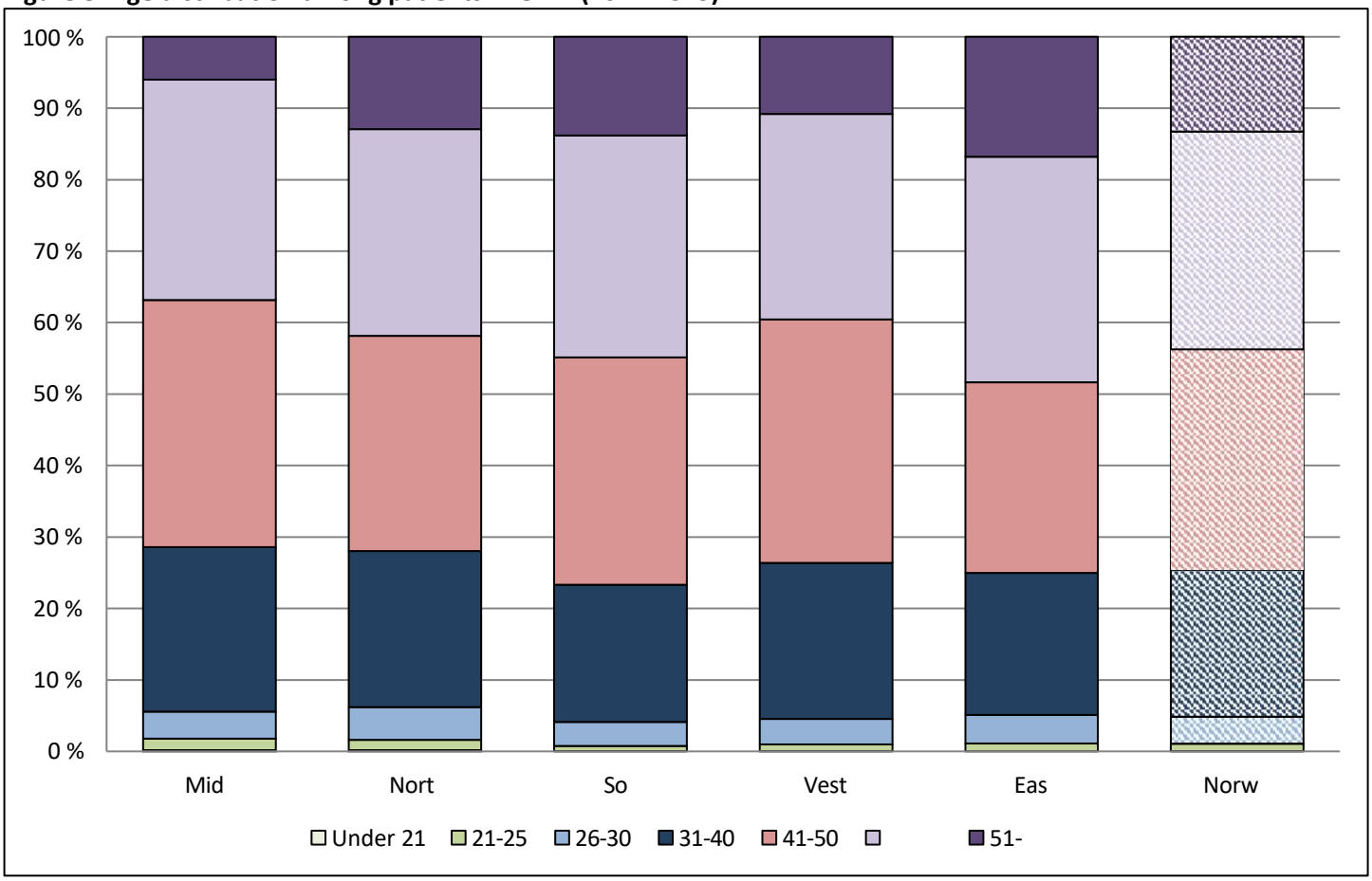
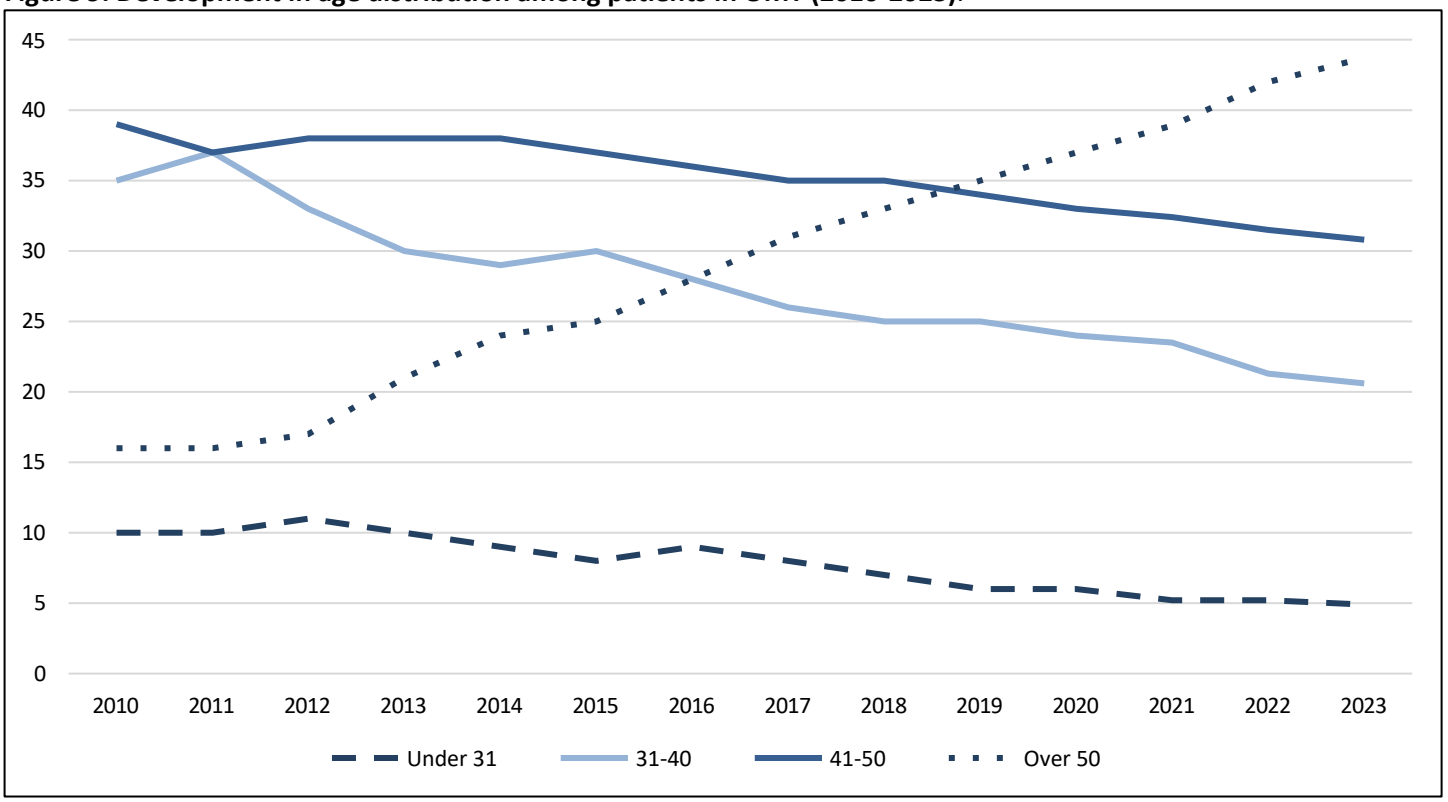


Figure 9. Development in age distribution among patients in OMT (2010-2023).



Living situation

The majority of patients in OMT live in their own home, 79.6% (Figure 10), roughly the same as before (Figure 11). At the national level, 2.3% were homeless, 2.6% lived in hospices/hostels/hotels, 5.9% were in institutions, 1.0% were in prison, 3.6% lived with parents, 2.8% lived with others, and 2.2% had an unknown living situation. The proportion with their own home was highest in Nord-Trøndelag (96.0%) and Fonna (91.8%).

Figure 10. Proportion who rent or own a home (unknown = 2.2%).

Oslo, Norway	67,3 %
Helgelandssh	70,6 %
UNN	75,7 %
Møre/Romsdal	76,2 %
Mountains	77,3 %
Østfold	78,2 %
Akershus	78,3 %
Nordlandssh	79,0 %
Norway	**79,6 %**
Asker/Bærum	80,0 %
Stavanger, Norway	81,1 %
Telemark	81,4 %
Finnmarkssh	82,9 %
St Olav	83,0 %
Drammen	83,2 %
Southern Norway	84,1 %
Vestfold	84,9 %
Inland	86,7 %
Førde	88,2 %
Fonna	91,8 %

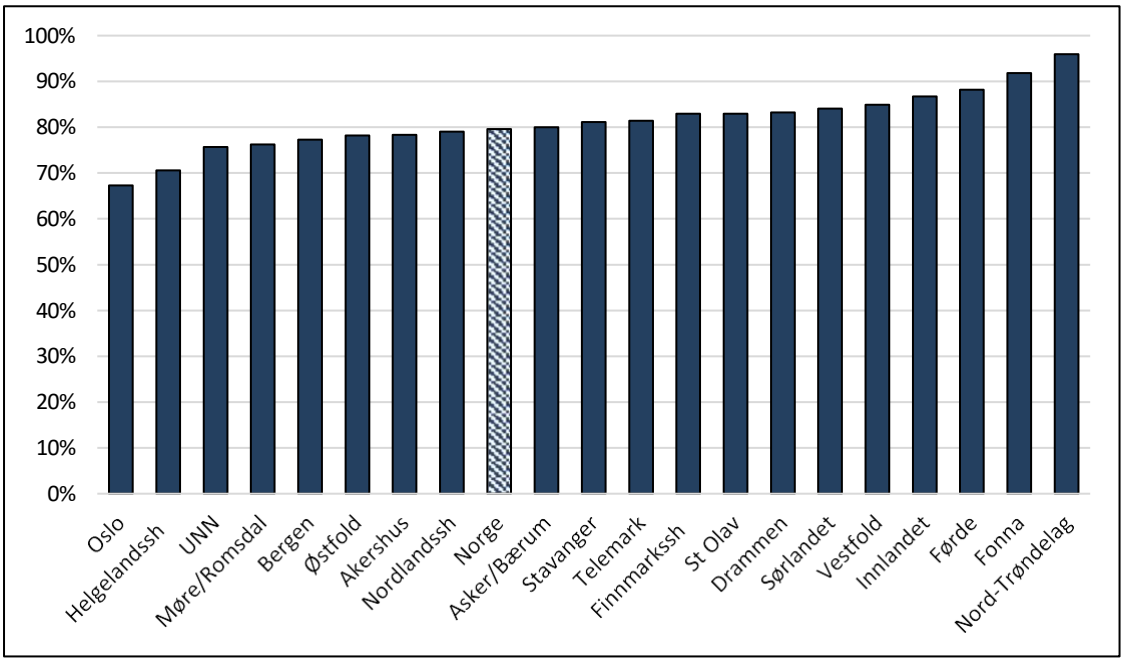
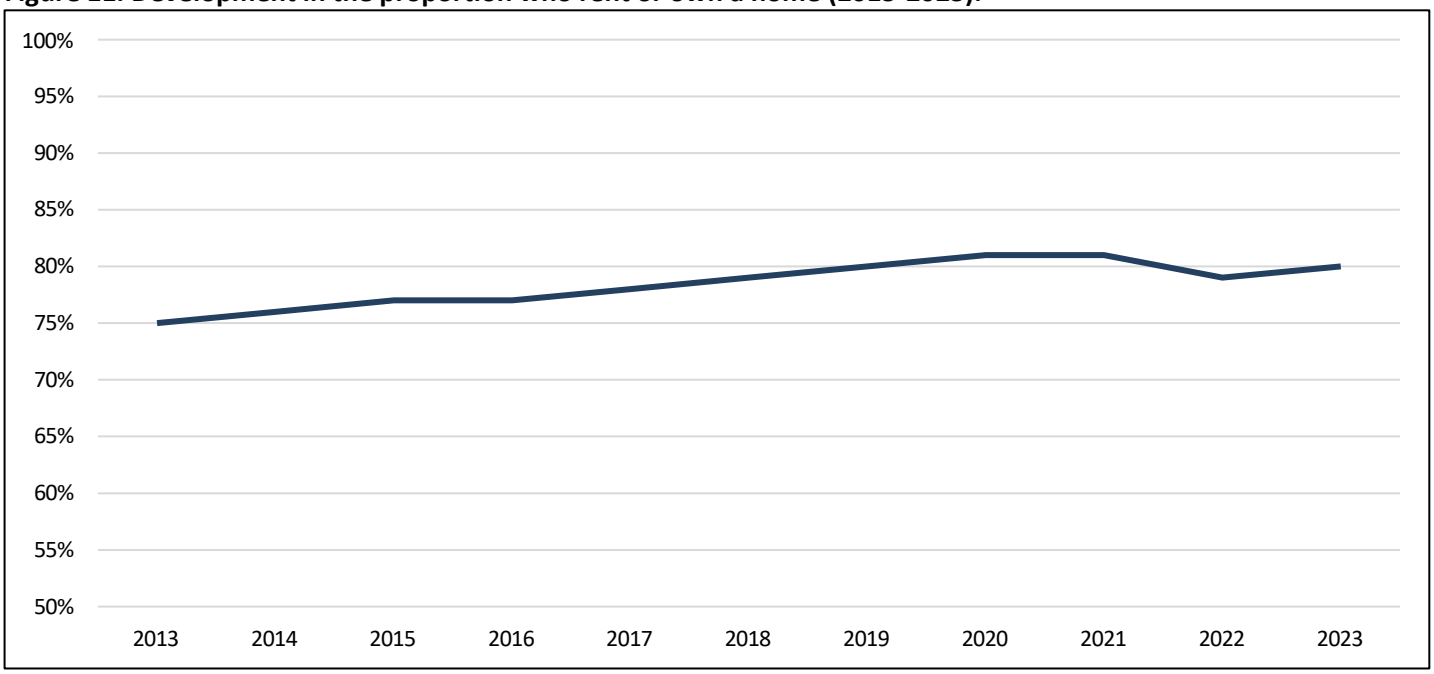


Figure 11. Development in the proportion who rent or own a home (2013-2023).



Main activity

Overall, 82.6% of patients were not in employment or education, 9.2% had a full-time job, 5.4% had a part-time job, 1.0% were in education, and 0.3% had a part-time job and were in education (Figure 12). There was some variation between units and regions. Nord-Trøndelag had the largest proportion of employed patients (26.3% in total), followed by Førde (25.5%). As previously, a larger proportion of patients not in employment or education were in the areas around the larger cities. The proportion of patients without employment or education-related activity has been fairly stable over the past decade (Figure 13).

Figure 12. Main activity (unknown = 1.5%).

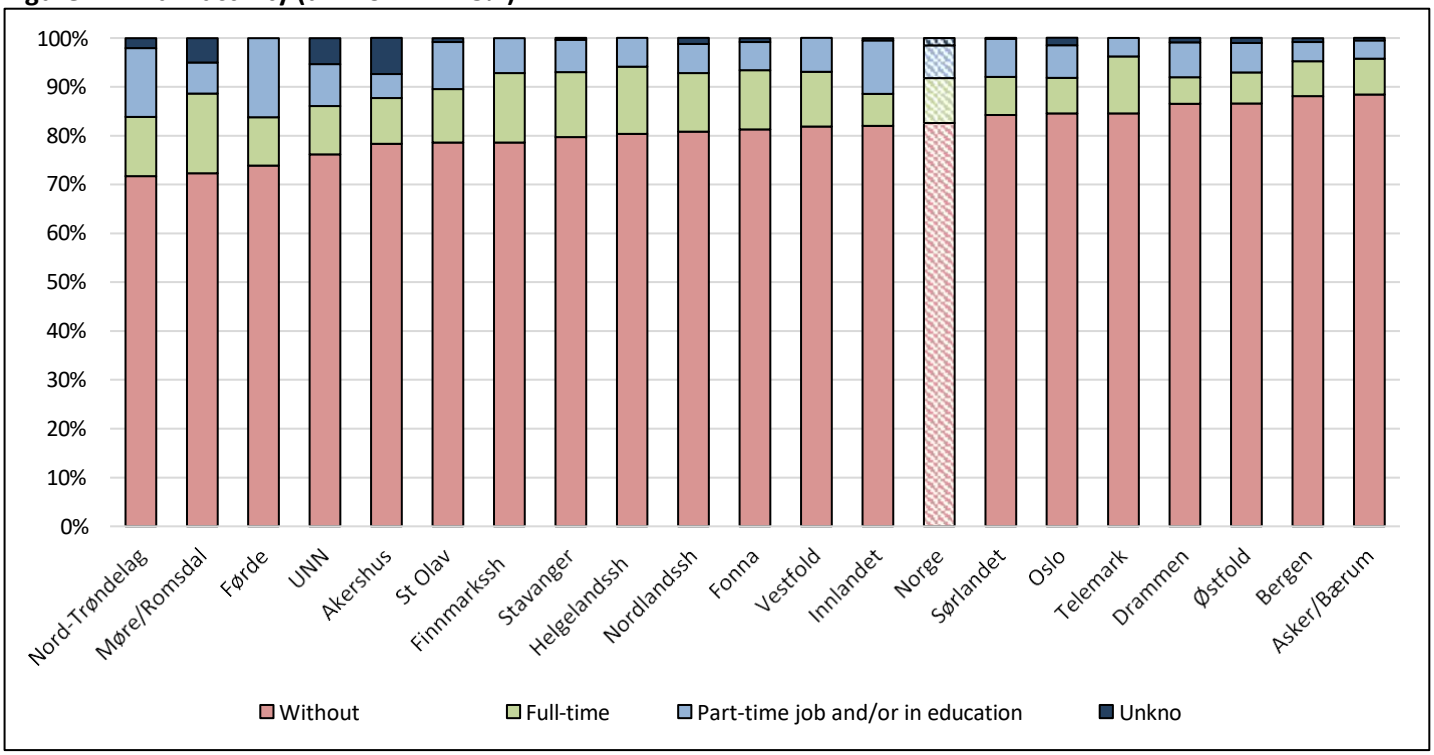
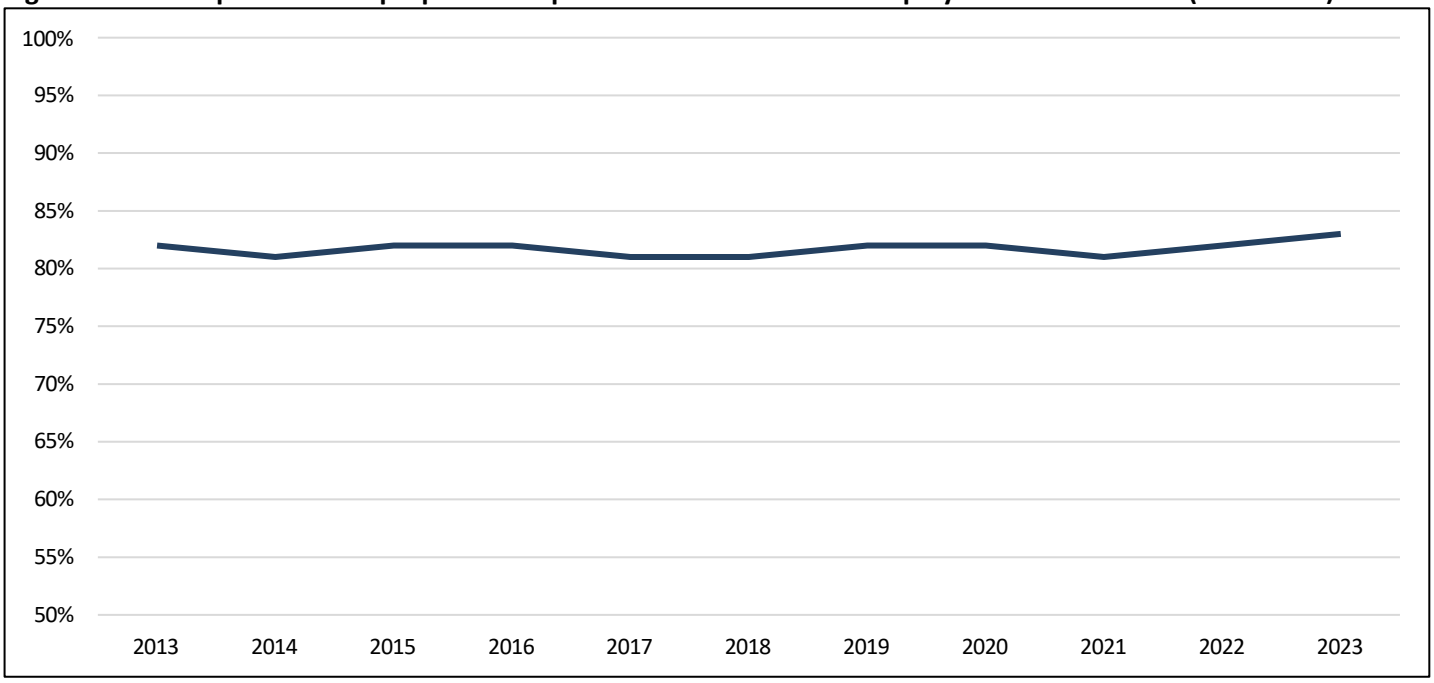


Figure 13. Development in the proportion of patients who were not in employment or education (2013-2023).



Main income

Figure 14 shows main income by OAT unit, and Figure 15 shows main income at national level. In 2023, 70.3% had disability benefit or old-age pension as their main income (compared with 70.2% in 2022), 10.8% had work assessment allowance, and 10.1% had earned income. In recent years, there has been a gradual, cautious increase in disability benefit or old-age pension, in line with the increasing age of the OMT population (Figure 16). For a number of years, disability and retirement pensions have proved to be the most frequent main source of income in the OMT population, while temporary benefit schemes are used to a relatively small extent.

Figure 14: Main income by SUD unit (unknown/other/other = 5.1%).

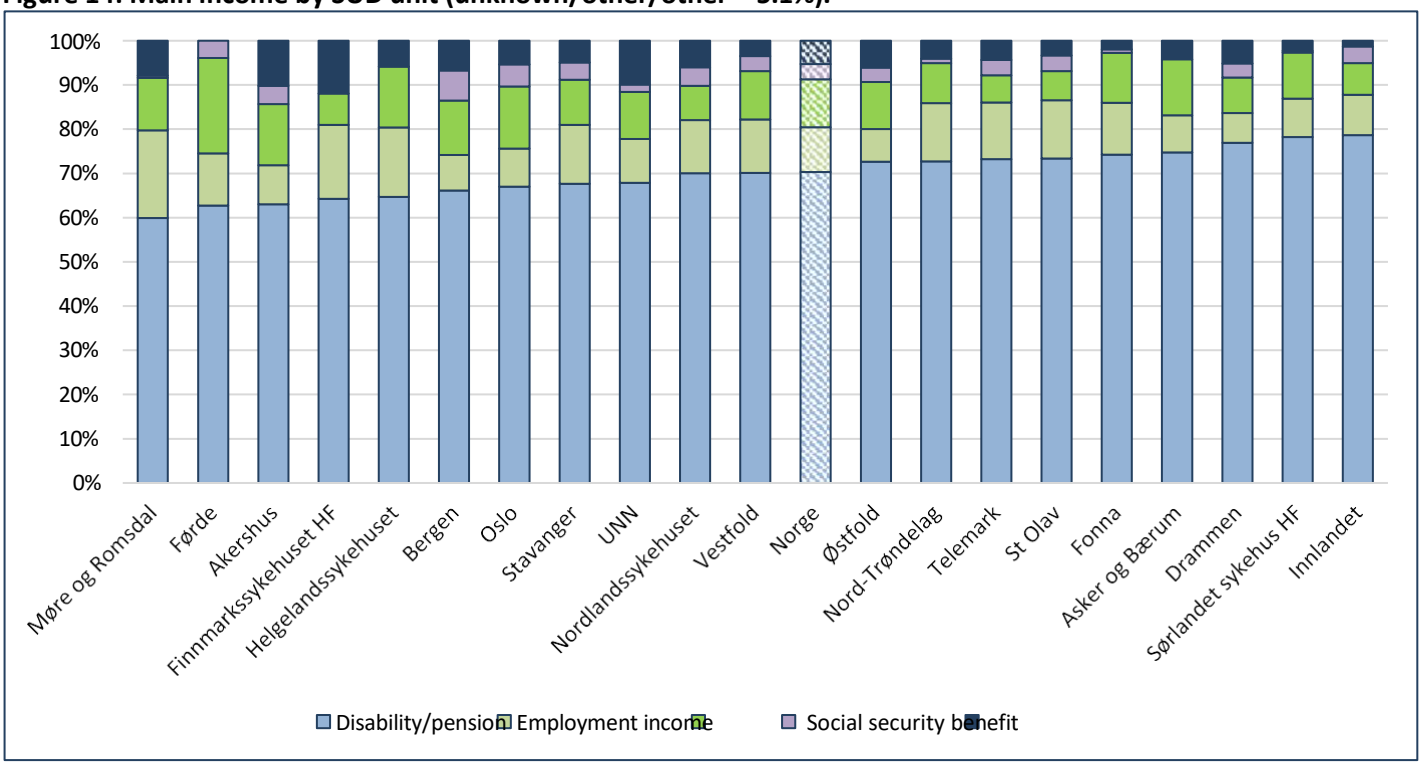


Figure 15. Distribution of main income nationally.

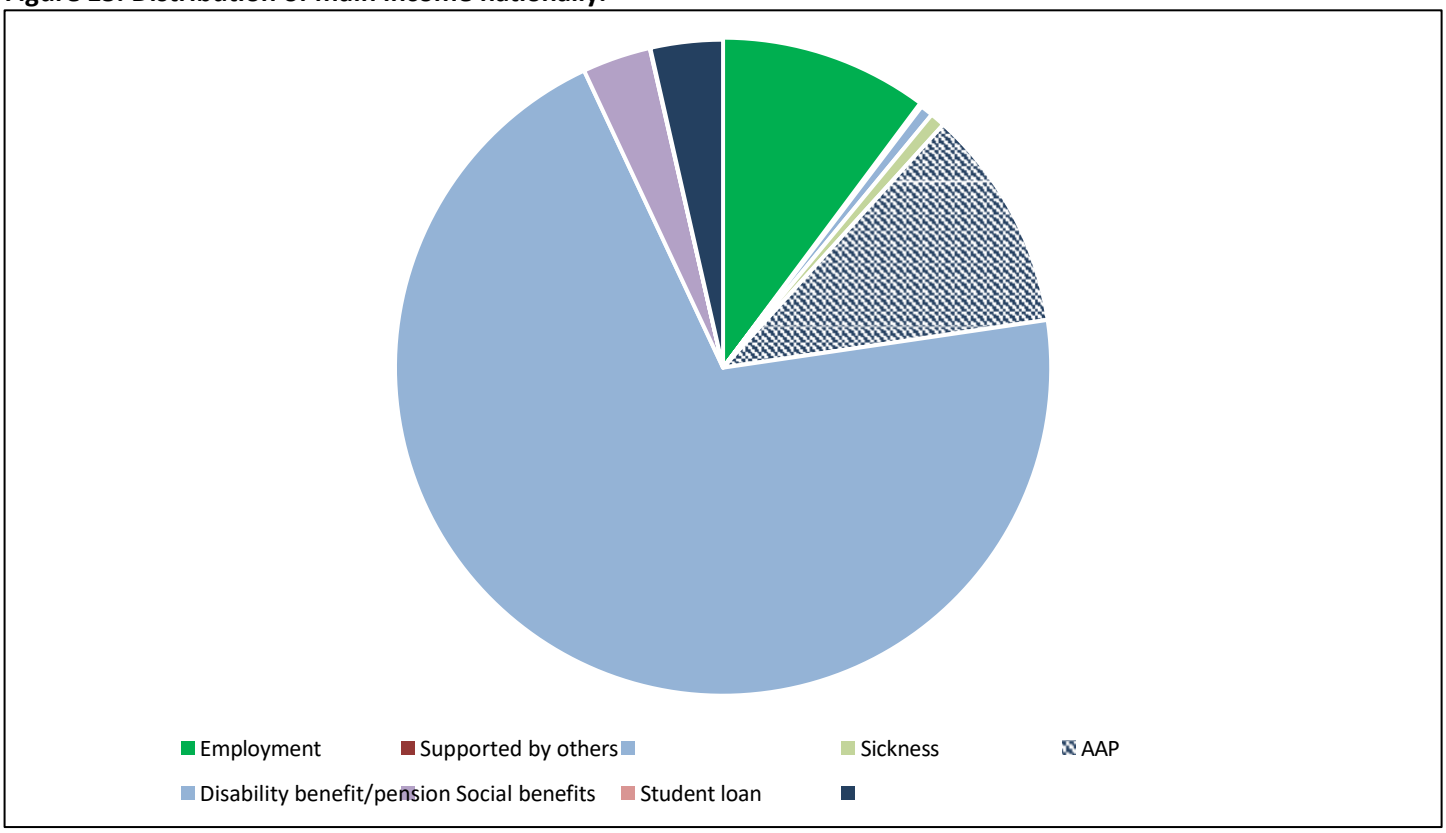
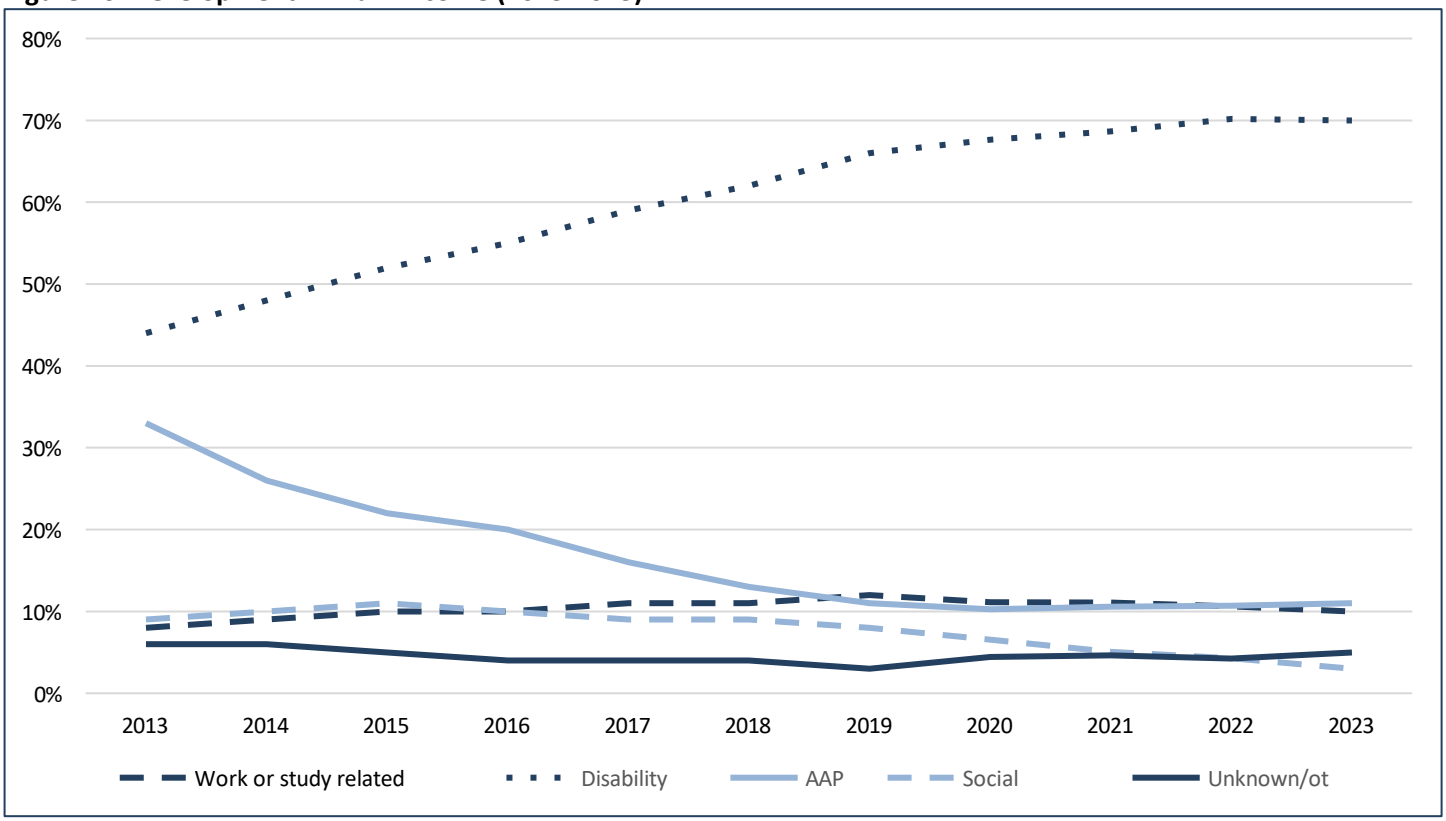


Figure 16. Development in main income (2013-2023).



Assessments of the patients' situation

In the OMT population, the proportion of patients aged 30 and younger continues to be very low, while the proportion over the age of 50 is increasing. More than 40% of the OMT population is now over 50 years old. The increasing age of patients is a marker of the benefit of OMT as a stabilizing and life-saving treatment over time. The gender distribution has remained stable over time, and the proportion of women is roughly the same as in the rest of the population of people with substance abuse problems.

Most patients in OMT have a stable housing situation, with only a minority having temporary housing solutions, and the main impression is that, overall, good work is being done on social housing issues. As before, the status survey shows that the vast majority of the population has a stabilized social situation in several respects. At the same time, very few are engaged in vocational or study-related activities, and by far the most important income is disability and retirement pensions. Few have earned income, and the proportion with work assessment allowance and social assistance is relatively low. In some smaller OMT units, there is a lower proportion of patients without employment, and more with full-time or part-time jobs.

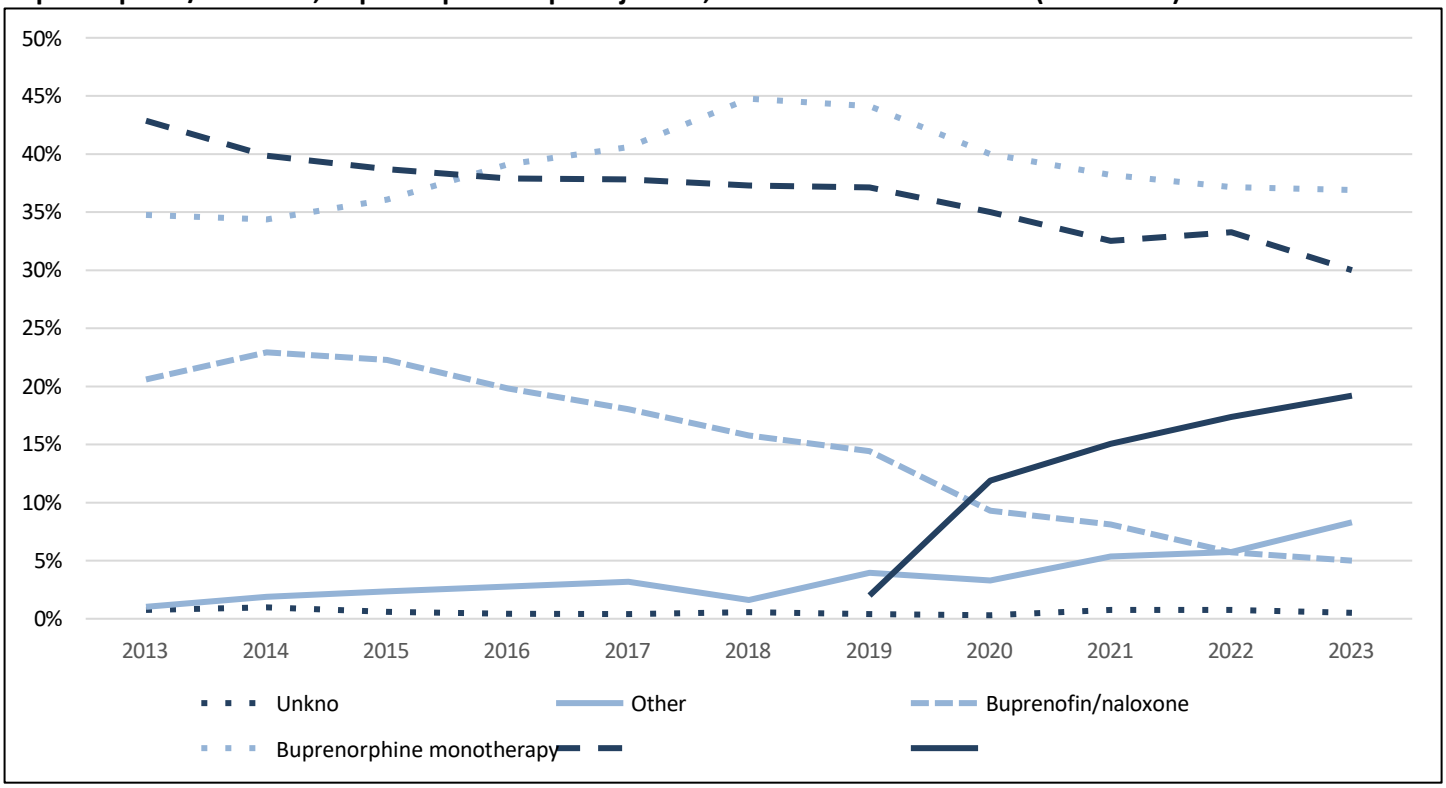
Participation in daily meaningful activities and social contexts is an important issue for OMT, and meaningful activity can be understood broadly. The challenges in practice will be to create and utilize opportunities for participation in various forms of activity to counteract social isolation, and promote social inclusion and quality of life. This will be particularly important in the years ahead, given the ageing of the OAT population.

DRUG TREATMENT

Choice of medication

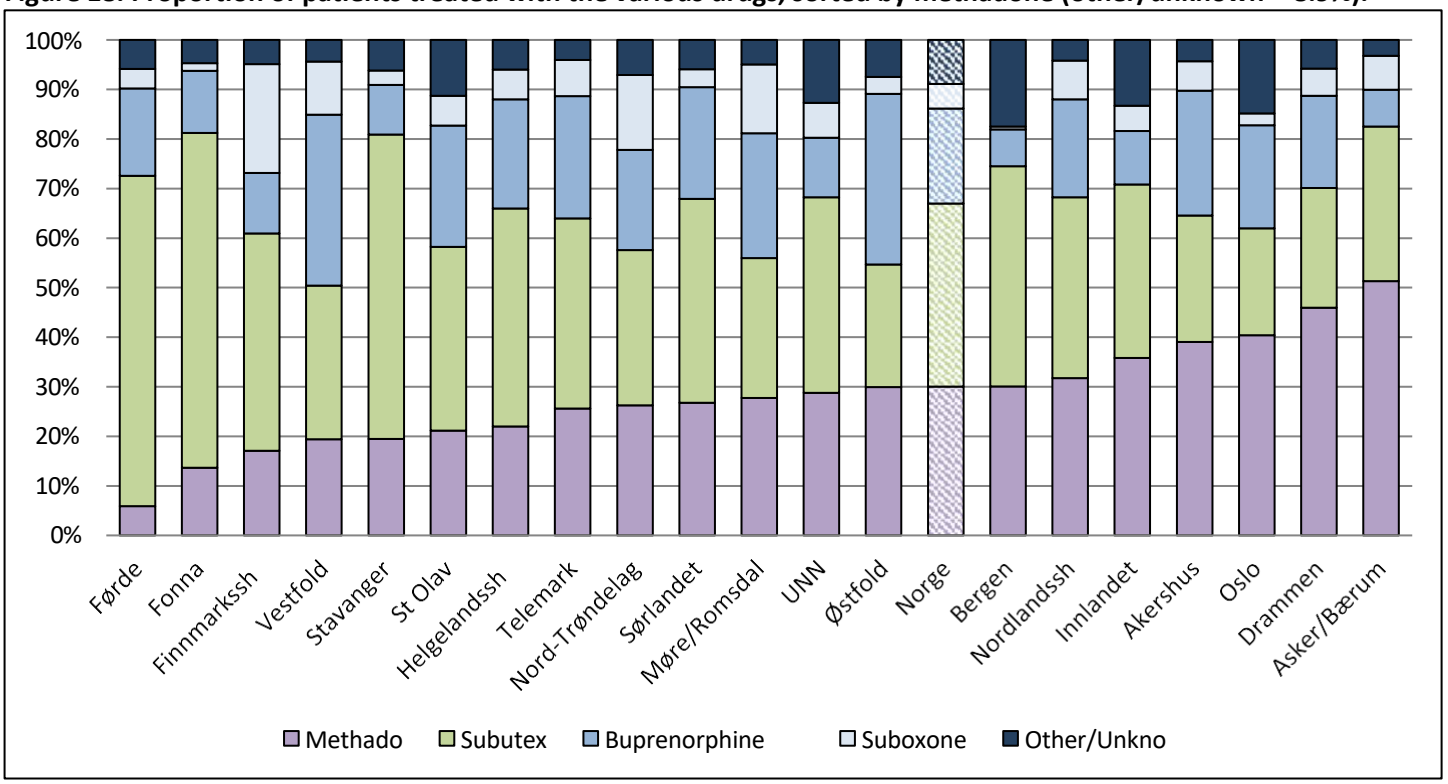
As shown in Figure 17, 30.0% had methadone as their OMT drug (33.3% in 2022), 36.9% had buprenorphine monopreparation (37.1% in 2022), 5.0% had buprenorphine/naloxone combination preparation (5.7% in 2022), and 19.2% had buprenorphine depot injection (17.4% in 2022). Furthermore, 0.8% used diacetylmorphine as their OMT medication, and 7.4% and 0.9%, respectively, used other or unknown OMT medication (including diacetylmorphine). The revised OMT guidelines have allowed for a greater degree of individual assessments related to the choice of OMT medication, which is beginning to be reflected in a greater breadth of OMT medications.

Figure 17. Proportion of patients who were prescribed methadone, buprenorphine monopreparation, buprenorphine/naloxone, buprenorphine depot injection, or other OMT medication (2013-2023).



There are local variations in which OMT drugs are used (Figure 18). As shown in the figure, there are large variations, for example, in the use of methadone as an OMT drug, with Førde as the lower extreme at 5.9%, in contrast to several units in Eastern Norway with a proportion of over 40% using methadone as an OMT drug. In the early phases of Norwegian OMT, virtually all patients were treated with methadone, and buprenorphine only became available as a drug for OMT in 2002. The units that have a significant proportion of their patient population who started treatment in this first period will therefore tend to have more people using methadone as an OMT medication than units that have been added more recently. Furthermore, there are also large variations in the use of buprenorphine monopreparate, with the lowest proportion in Oslo (21.6%) and the highest in Fonna (67.6%) and Førde (66.7%). In some companies, buprenorphine depot was widely used, such as in Vestfold (34.5%). In other places, buprenorphine depot was little used, such as in Asker and Bærum (7.4%). Unlike in 2022, it now appears that buprenorphine depot is used in all SUD units.

Figure 18. Proportion of patients treated with the various drugs, sorted by methadone (other/unknown = 8.9%).

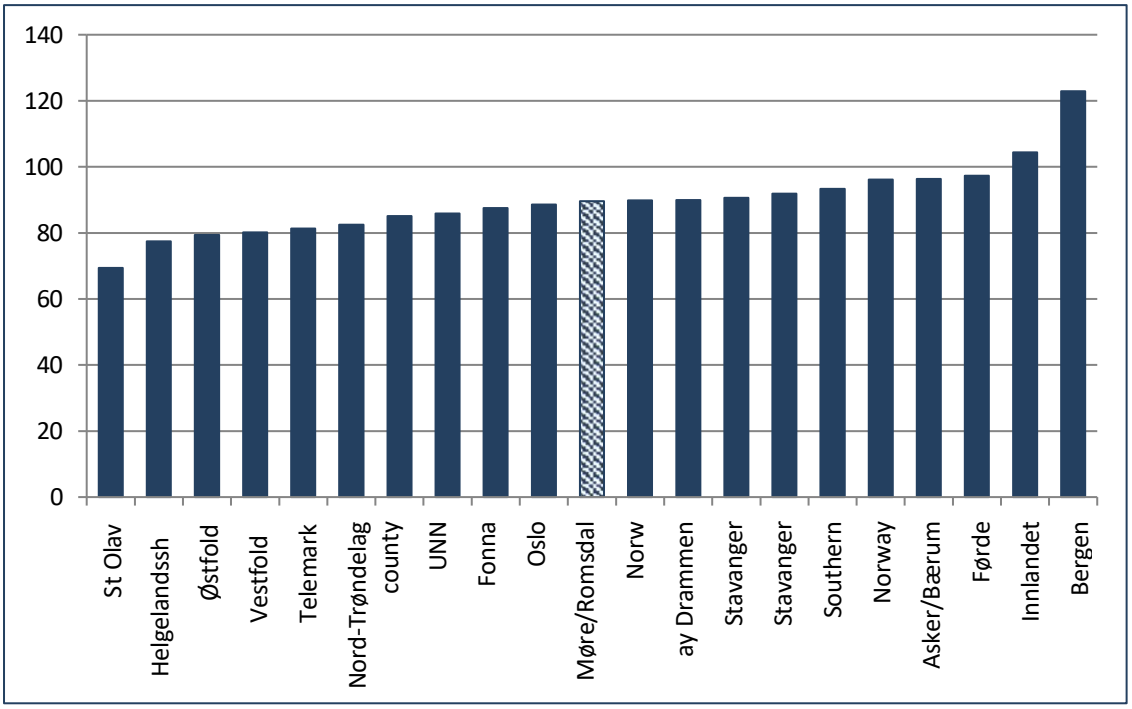


Dosage of OAT medication

For methadone, the average dose was 89.6 mg in 2023 (88.5 mg in 2022) (Figure 19). The average dose has been relatively stable in recent years. However, the last decade shows a steady reduction in methadone dosage levels since 2011 (102.8 mg). There was some variation between OMT units, primarily within the recommended limits of 80-110 mg per day. The lowest doses were reported from St. Olavs hospital (69.4 mg) and the highest doses from Finnmark hospital (122.9 mg).

Figure 19. Average dose of methadone (daily dose, mg).

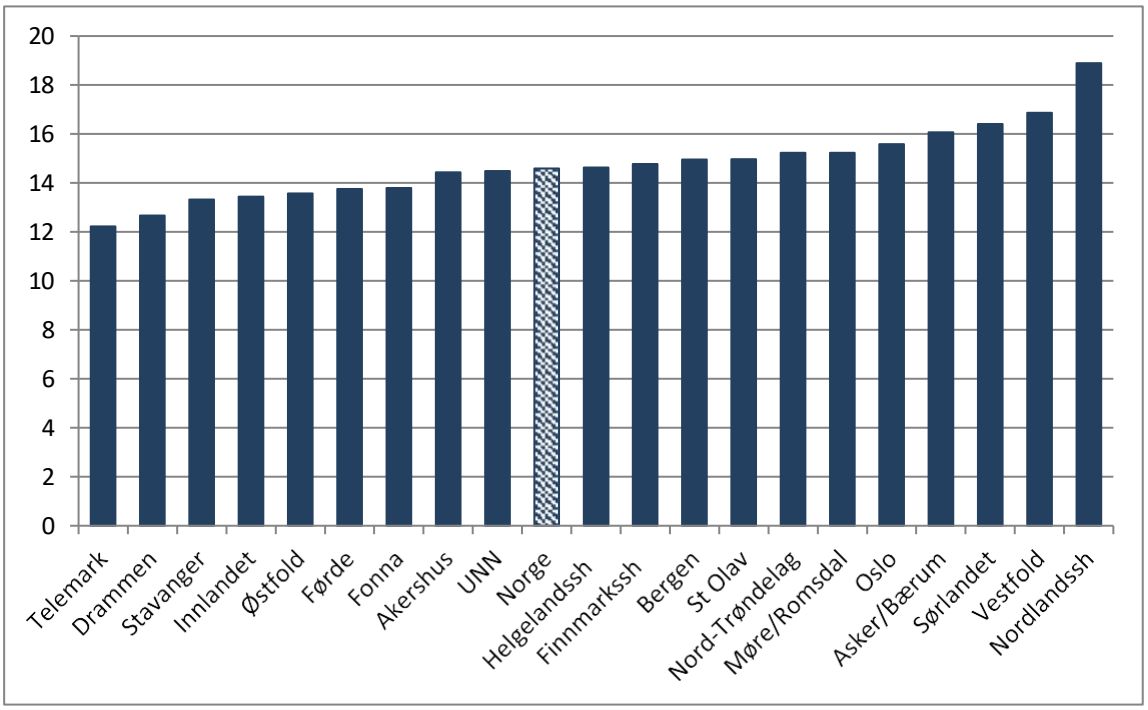
St Olav	69,3
Helgelandssh	77,4
Østfold	79,3
Vestfold	80,1
Telemark	81,3
Northern Trøndelag	82,5
UNN	85,0
Fonna	85,9
Oslo, Norway	87,5
Møre/Romsdal	88,6
Norway	**89,6**
Drammen	89,9
Stavanger, Norway	89,9
Southern Norway	90,1
Asker/Bærum	91,9
Førde	93,3
Inland	96,2
Mountains	96,4
Akershus	97,3
Nordlandssh	104,34
Finnmarkssh	122,86



In the case of buprenorphine, the recommended daily dosage is 12-24 mg for both the monoproduct and the combination product. The average national dosing level was 14.7 mg for the monopreparation (Figure 20) and 13.9 mg for the combination preparation. There was little difference between the OAT units in dosage level.

Figure 20. Average dosage of buprenorphine monopreparation (daily dose, mg).

Telemark	12,2
Drammen	12,7
Stavanger, Norway	13,3
Inland	13,4
Østfold	13,6
Førde	13,9
Fonna	13,9
Akershus	14,0
UNN	14,5
Norway	**14,7**
Helgelandssh	14,6
Finnmarkssh	14,8
Mountains	15,0
St Olav	15,0
Nord-Trøndelag county	15,2
Møre/Romsdal	15,2
Oslo, Norway	15,6
Asker/Bærum	16,0
Southern	16,4



Additional prescribing of benzodiazepines

The status survey reports on whether doctors prescribe medication that can affect the effect of the OMT medication, which particularly applies to the additional prescription of benzodiazepine preparations. As a general rule, benzodiazepines are not recommended in OMT unless there is a clear indication for this. However, the new OMT guidelines allow for a greater degree of individual assessment in relation to additional prescribing of benzodiazepines. Figure 21 below shows a steady increase in the prescription of benzodiazepines, from 24.6% in 2013 to 39.9% in 2023 (38.4% in 2022). There was significant variation in prescribing across SUD units (Figure 22). The lowest prescription figures were found in Møre og Romsdal (18.3%), while Helgelandssykehuset prescribed benzodiazepines to the largest proportion of patients (63.0%).

Figure 21. Proportion of patients nationally with additional prescriptions for benzodiazepines (2013-2023).

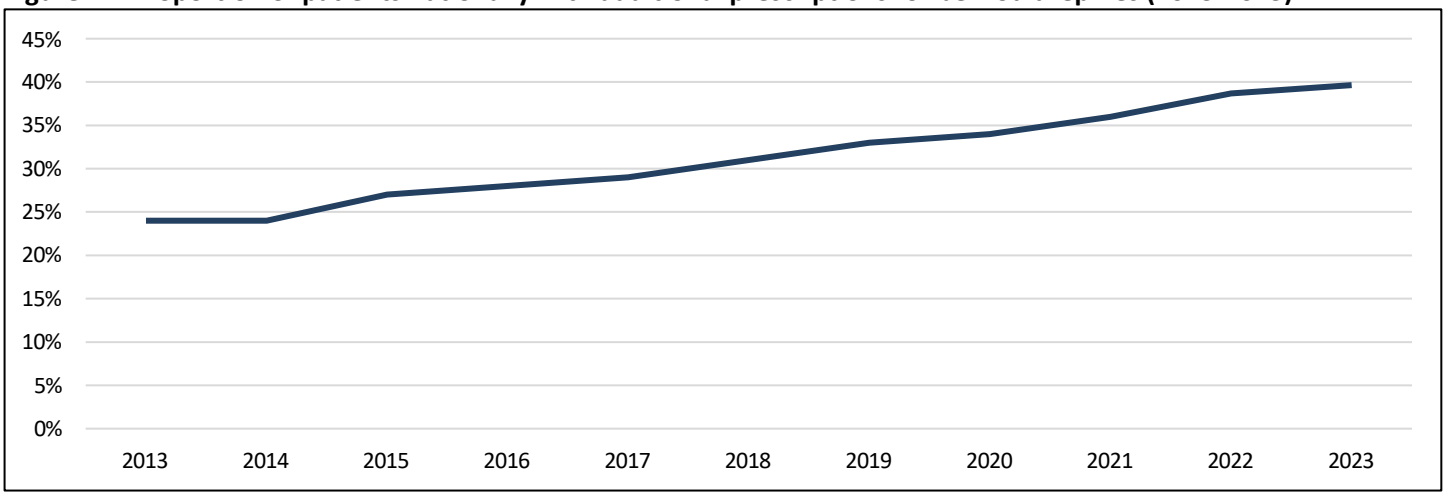
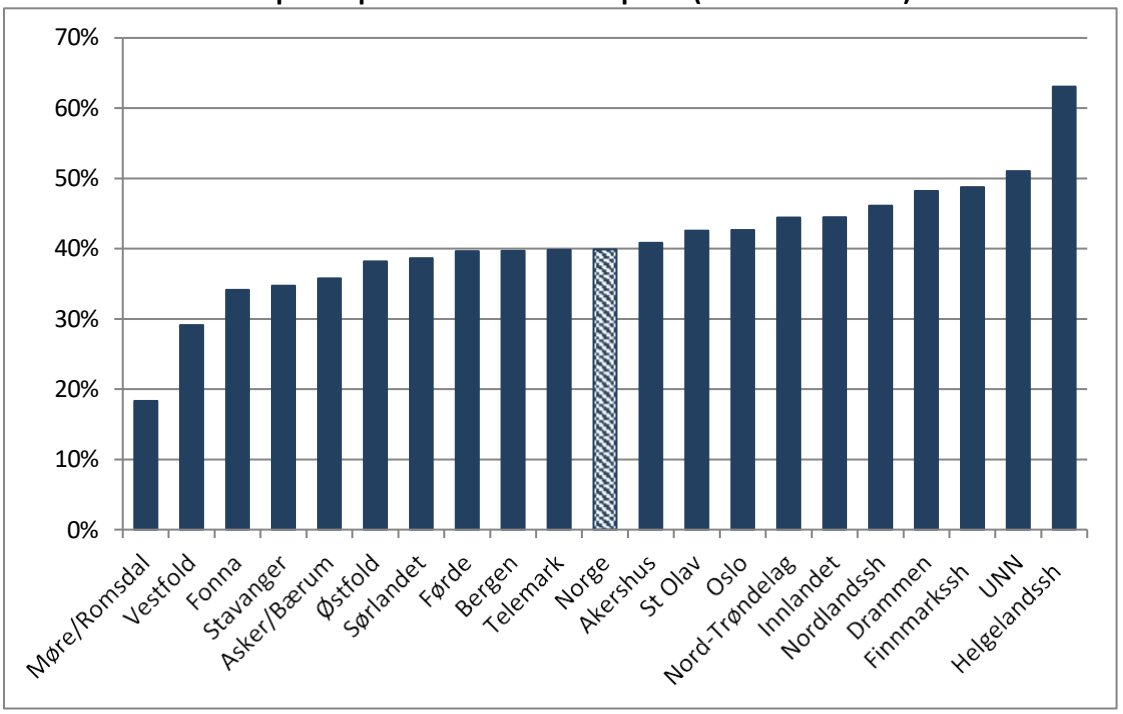


Figure 22. Proportion of patients with additional prescriptions for benzodiazepines (unknown = 4.4%).

Møre/Romsdal	18,3 %
Vestfold	29,1 %
Stavanger, Norway	34,7 %
Fonna	35,2 %
Asker/Bærum	35,8 %
Østfold	38,2 %
Southern Norway	38,6 %
Førde	39,2 %
Mountains	39,7 %
Telemark	39,8 %
Norway	**39,9 %**
Akershus	40,8 %
St Olav	42,6 %
Oslo, Norway	42,7 %
Nord-Trøndelag county	44,4 %
Inland	44,5 %
Nordlandssh	46,1 %
Drammen	48,2 %
Finnmarkssh	48,8 %



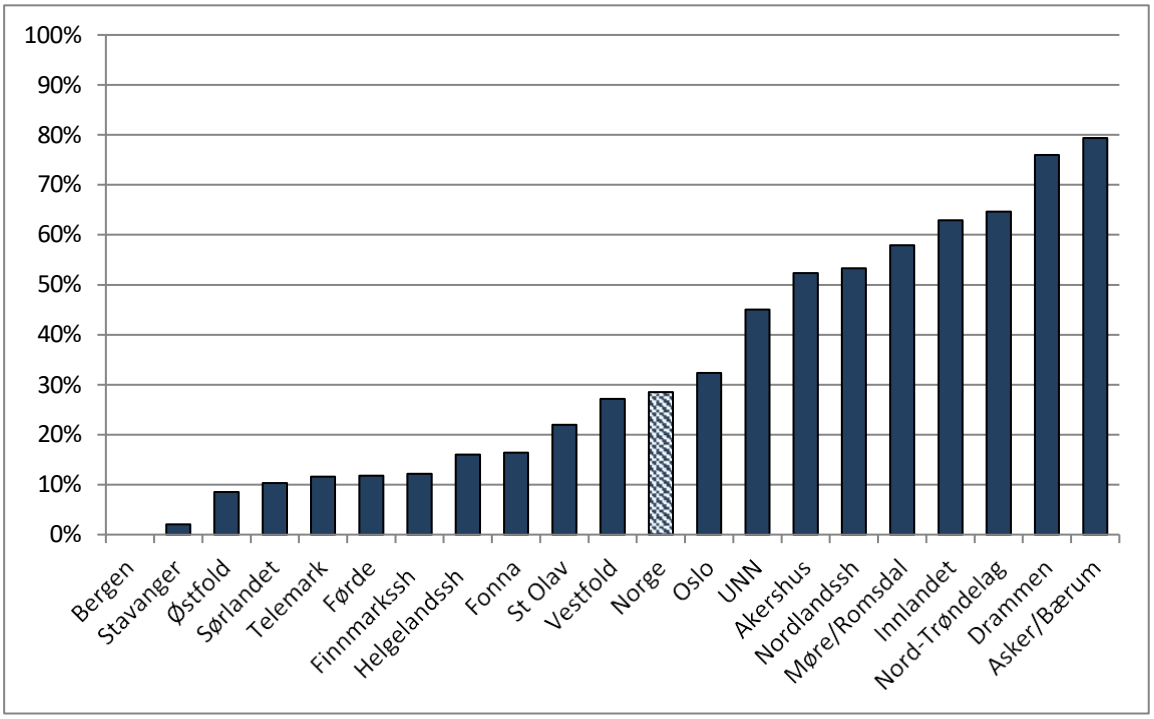
Prescribing physicians

On a national basis, there has been a significant reduction over time in the proportion of people who are prescribed the drug by their GP (Figure 23). In 2023, 28.5% had their GP as their prescribing doctor, compared with 32.7% in 2022. The majority had an OMT doctor as their prescribing doctor (68.5%, compared with 64.3% in 2022). Only a minority were prescribed OMT medication by another doctor (2.2%, compared to 2.4% in 2022).

As in previous years, there were systematic differences between the units (Figure 17). In Bergen, no prescriptions were issued by GPs, and almost all OMT treatment took place in the OMT unit (99.5%). In Stavanger, too, there was minimal use of GPs as prescribing doctors, with almost all prescribing taking place within the OMT unit (97.5%). On the other side of the scale are Asker and Bærum and Drammen, where the majority of patients are prescribed by a GP (79.4% and 76.0%). These clear differences in organizational practices have been stable for a number of years. In addition to the organization of the services, the increased use of other OMT drugs, such as buprenorphine depot injection, plays a role. Buprenorphine depot injection is prescribed by the specialist health service and is one explanation for the reduced use of GPs as prescribers. In addition, some larger health trusts have prioritized a greater degree of dispensing in the OMT unit due to the costs of dispensing in pharmacies. It may seem that tariff schemes and financing schemes in OMT therefore have an impact on the organization of the units.

Figure 23. Proportion of patients who have a prescription for OMT medication from their GP (unknown = 0.7%).

Mountains	0,0 %
Stavanger, Norway	2,0 %
Østfold	8,5 %
Southern Norway	10,3 %
Telemark	11,6 %
Førde	11,8 %
Finnmarkssh	12,2 %
Helgelandssh	16,0 %
Fonna	16,4 %
St Olav	22,0 %
Vestfold	27,1 %
Norway	**28,5 %**
Oslo, Norway	32,3 %
UNN	45,0 %
Akershus	52,3 %
Nordlandssh	53,3 %
Møre/Romsdal	57,9 %
Inland	62,9 %
Nord-Trøndelag county	64,6 %
Drammen	76,0 %
Asker/Bærum	79,4 %



Side effects of OAT medication

In the status survey, some units had an updated status questionnaire with additional information. This applied to those using the DIPS Arena electronic record-keeping system; a total of 3,215 patients in Oslo (860), Bergen (868), Førde (51), Fonna (256), Stavanger (498) and Telemark (344). Of relevance to the drug treatment was a new question about perceived side effects of OMT medication. Below is a presentation of the proportion of patients who experienced side effects, broken down by unit and overall (Figure 24), and medication (Figure 25).

Overall, 8.7% reported experiencing side effects (compared to 8.4% in 2022), 36.1% denied experiencing side effects (35.9% in 2022), 39.4% answered that it was not applicable, and 15.8% had unknown status. The proportion confirming any type of side effects was lowest in Telemark (6.1%) and highest in Førde (14.9%). However, the figures must be understood in the context of the proportion with unknown status, which varied from 13.0 (in Oslo) to 39.2 (in Bergen). No one reported side effects from buprenorphine/naloxone combination products or diacetylmorphine. Otherwise, the proportion with confirmed ADRs was lowest for buprenorphine depot injection (4.3% for weekly injection and 6.1% for monthly injection), and highest for buprenorphine monopreparation (11.0%). It is worth noting that there is a large difference in group size.

Patients who answered in the affirmative had the opportunity to add a description. The side effects experienced by the patients included withdrawal, rash/itching, blisters in the mouth, taste, sweating, headache, nausea, reflux, stomach problems, weight gain, difficulty sleeping, discomfort and anxiety. The reported side effects are symptoms that may be drug side effects, or also symptoms of other conditions that the patient has while receiving drug treatment.

Figure 24. Proportion of patients who have experienced side effects of OMT medication in the past year (unknown = 15.8%).

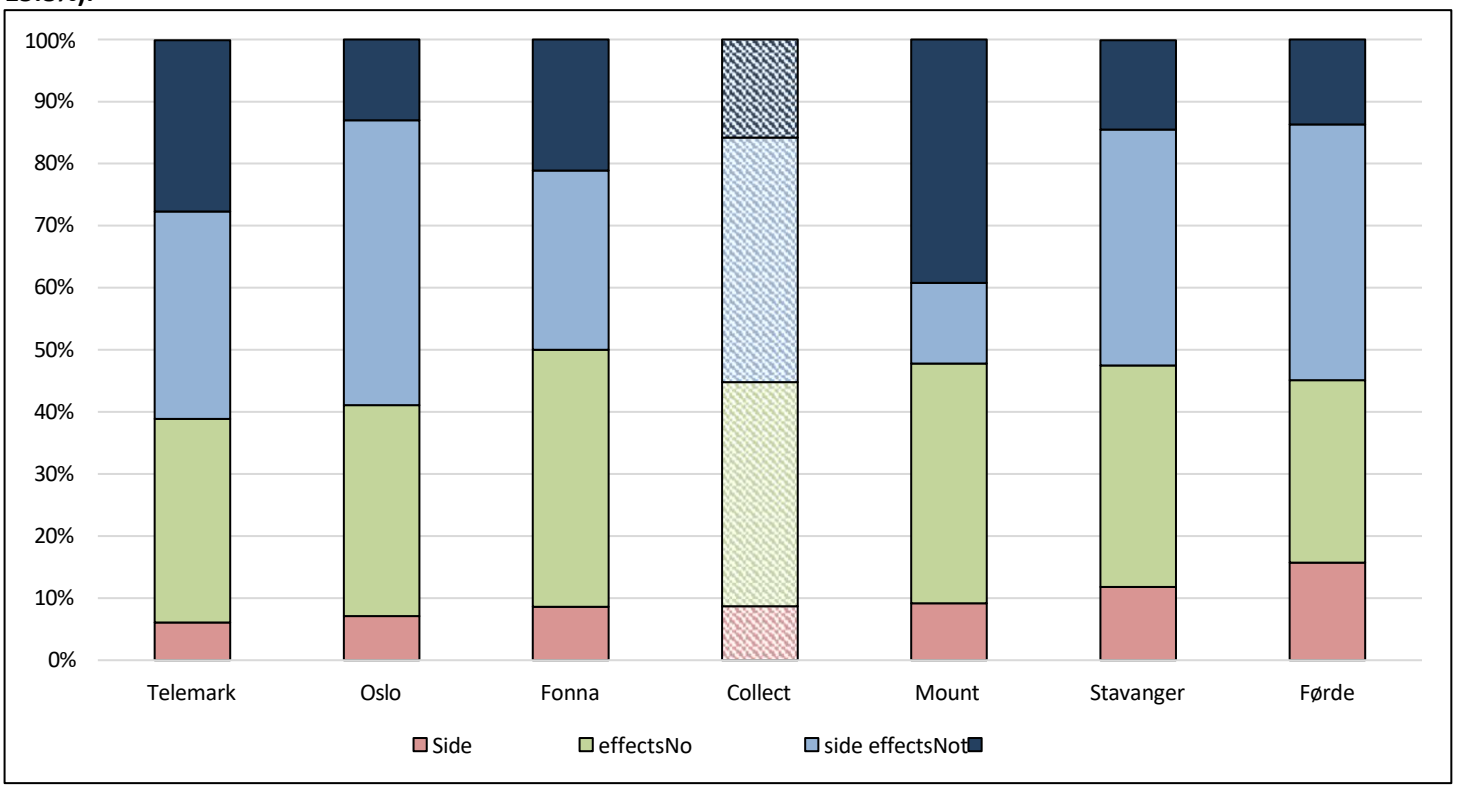
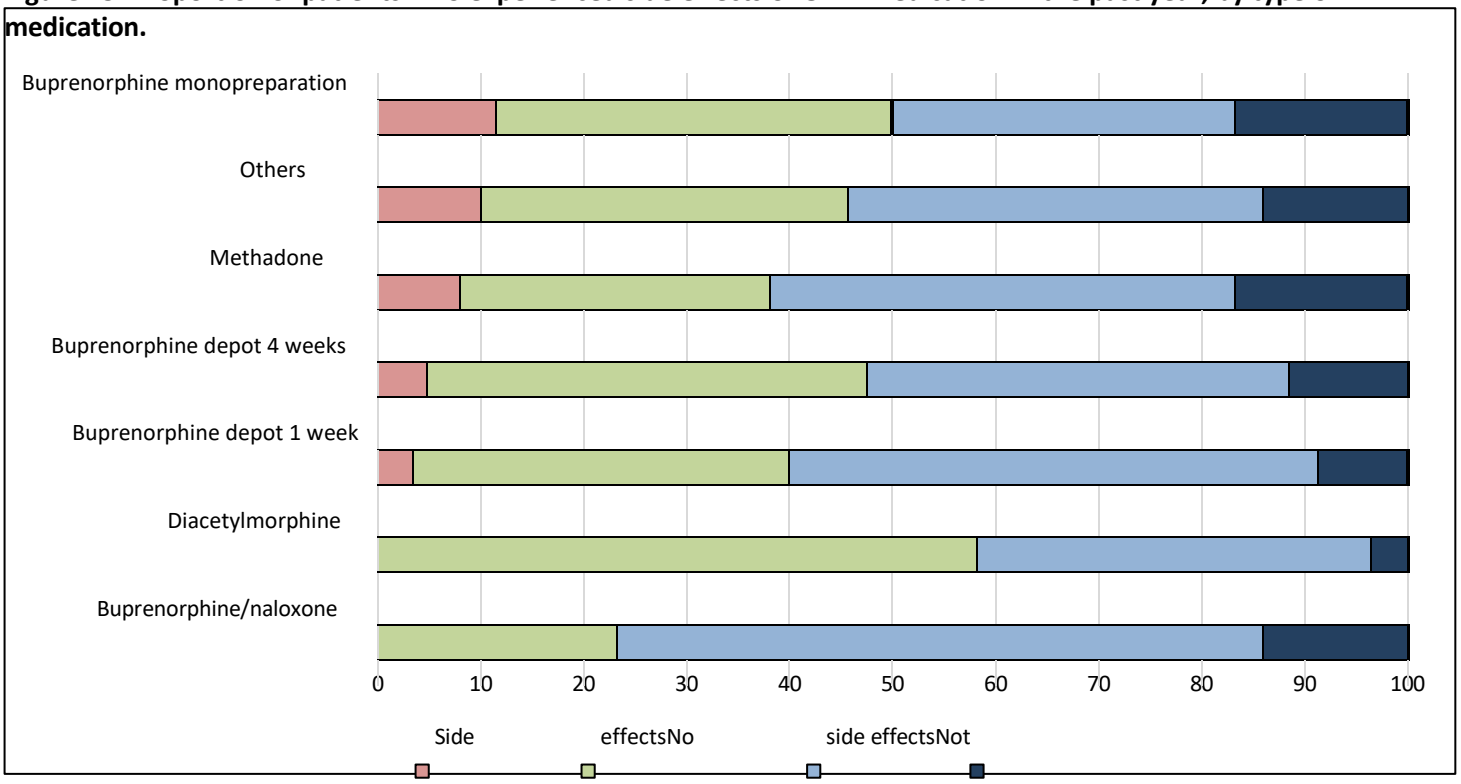


Figure 25. Proportion of patients who experienced side effects of OMT medication in the past year, by type of medication.



Assessments of the drug treatment

Drug treatment in OMT was evaluated in the 20th anniversary report.[2] In line with the recommendations in the 2010 guidelines on buprenorphine as the first choice, there is a high degree of use of buprenorphine in current OMT treatment. The OMT units that use methadone to the greatest extent are also those that started OMT before buprenorphine became available. The clinical experience of therapists and patients' preferences also play a role when it comes to drug choice. With the revised OMT guidelines from 2022, Norwegian OMT today is characterized by an increased degree of individual assessments in drug selection. The increased breadth of use of OMT medication is likely to continue in the coming years, informed by individual adaptation and increased emphasis on information and user participation. Future status surveys will be able to map the breadth of OMT medications to a greater extent.

We see that an increasing proportion of patients are using buprenorphine depot injection as an OMT medication, and at the same time show an increase in the proportion of patients prescribed OMT medications other than methadone and buprenorphine preparations. Buprenorphine depot has a stabilizing effect over one to four weeks for those of the patients who want it, while injections can allow for a more normalized everyday life with reduced treatment burden, without collection arrangements. However, this can also present new challenges, such as maintaining sufficient contact with patients in the periods between injections if there is no concurrent psychosocial follow-up, as well as the dissolution of the routines that previous more frequent drug treatment may have provided for the individual.

Side effects are a key issue to identify in any form of drug treatment, including in OMT. The responses for more than 3,000 OMT patients show that about 1 in 10 experience some degree of side effects, while the unknown proportion is quite high. We see that the proportion with reported side effects varied slightly depending on the OMT drug. Over time, the questions about side effects could be used to obtain a more systematic overview of the degree of side effects experienced in the larger OMT population.

[2] Waal et al (2018). SERAF report 3/2018. Status report 2017. OAT 20 years. Status, assessments and perspectives. Oslo: UIO and OUS. https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2018/seraf-rapport-nr-3-2018-statusrapport-2017.pdf

MEDICAL JUSTIFIABILITY

Medication dispensing

Dispensing of OMT medication must be tailored to the patient's situation and level of intoxication. Most patients in OMT attend several times a week for medication dispensing, often in the form of observed intake on the day of collection. The number of dispensing sessions typically varies from one to seven times a week. Figure 26 shows the average number of weekly dispensations and observed intake for each OMT unit. The average number of medication deliveries in 2023 was 2.9, and the average number of observed intakes was 2.8. Figure 27 shows the number of weekly dispensations over the last decade.

Figure 26. Average number of dispensations and observed intake of medication per week.

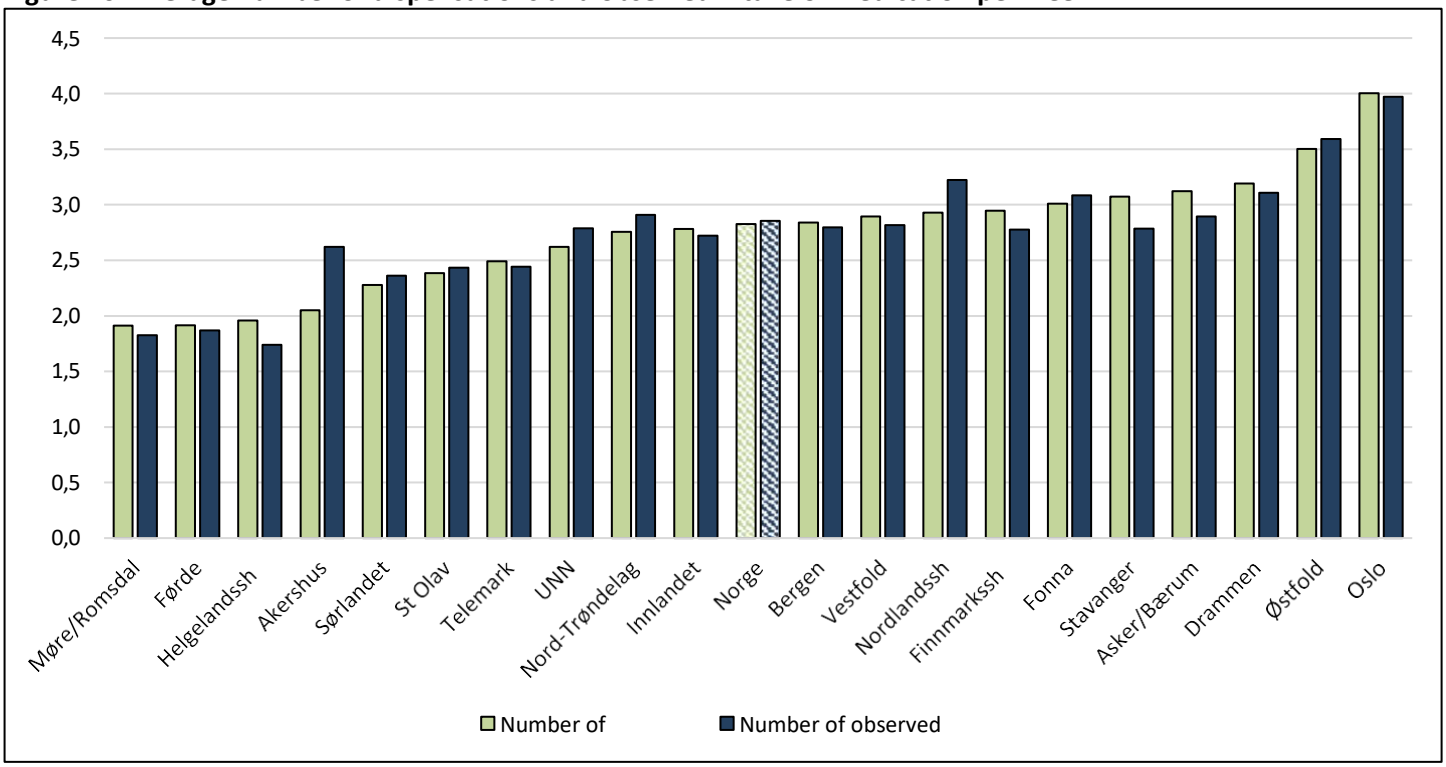
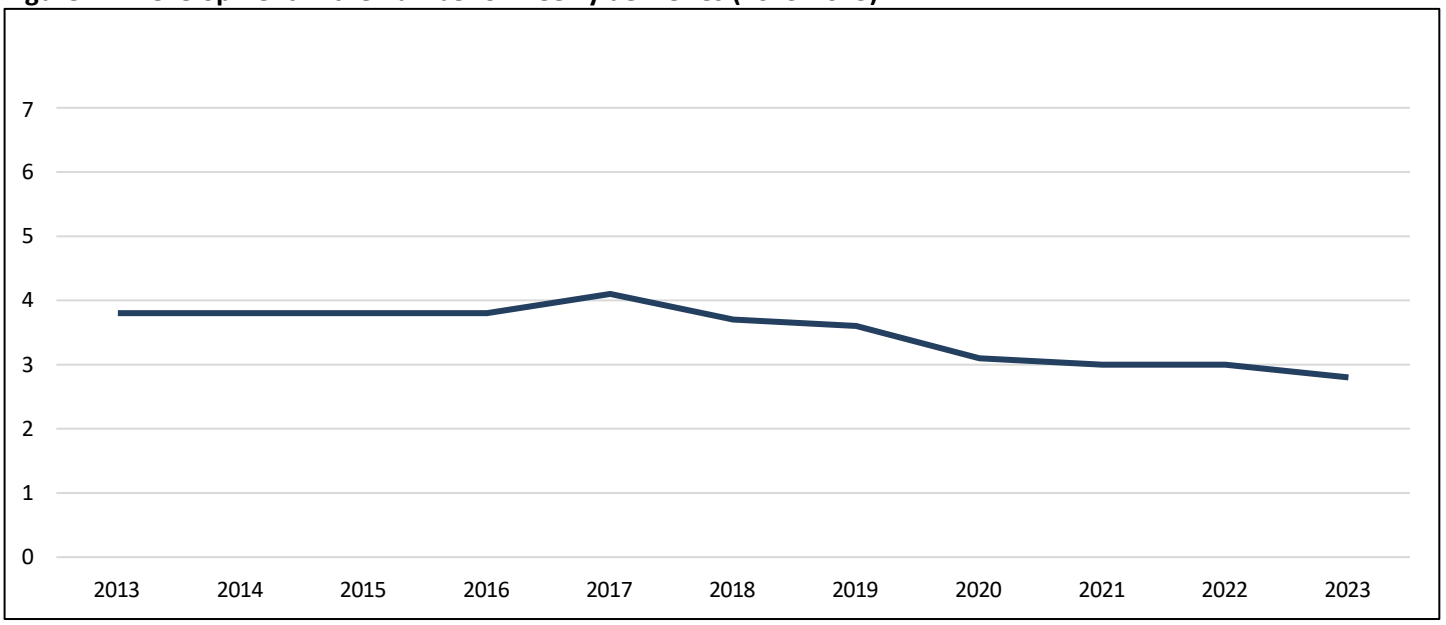


Figure 27. Development in the number of weekly deliveries (2013-2023).

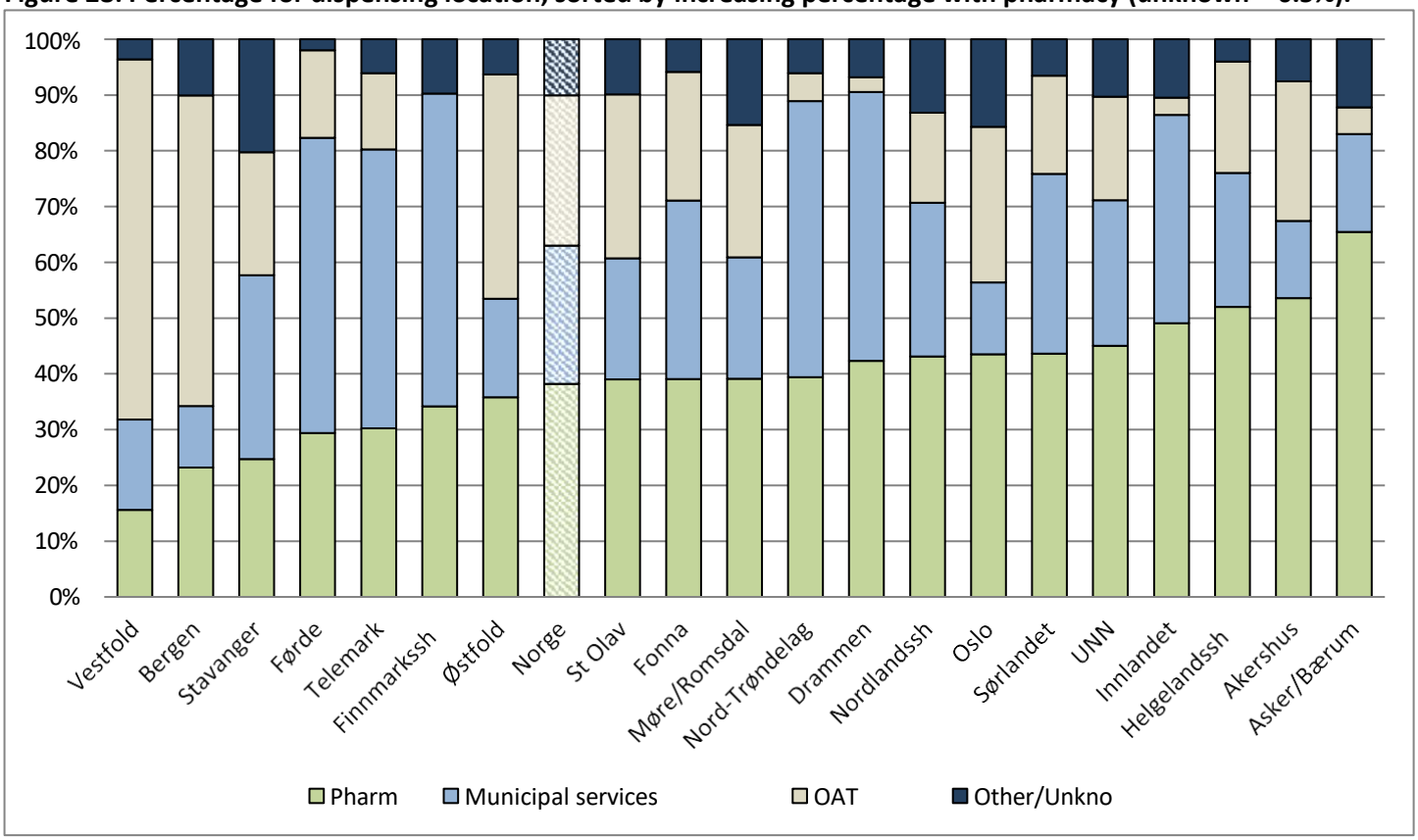


Place of delivery

The proportion using different dispensing locations is shown in Figure 28. In 2023, 38.2% had dispensing at a pharmacy, compared with 39.6% in 2022. In recent years, there has been a reduction in the use of pharmacies as dispensing points (49.4% in 2017). This can be partially explained by the introduction of a wider range of OMT drugs, particularly buprenorphine depot injection, which is administered in the specialist health service. In the long term, increased use of buprenorphine depot injection may lead to a further reduction in the use of pharmacies as dispensing points.

As previously, there were major differences between OMT units in the use of different dispensing points, with some primarily using pharmacies (e.g. Asker and Bærum, 65.4%), while others only use pharmacies to some extent (e.g. Vestfold, 15.6%). In Bergen (23.4%) and Stavanger (24.7%), pharmacies are also only used to a limited extent, as these places have outpatient clinics where most of the drug treatment takes place. In some places, medication dispensing through municipal services, such as home care, is used more frequently. This applies to Finnmark Hospital (56.1%), Førde (52.9%) and Telemark (50.0%). The use of a dispensing site is linked to the overall organization of the OMT treatment.

Figure 28: Percentage for dispensing location, sorted by increasing percentage with pharmacy (unknown = 0.5%).



Drug tests

On average, patients provided 0.3 urine samples per week in 2023. The number of voided urine samples has remained stable in recent years and was 0.2 in 2022. In 2023, 23.1% had regular urine sampling, compared to 24.8% in 2022. Furthermore, 28.8% had random samples from time to time, compared to 29.3% in 2022. There were 45.2% who had no urine sampling scheme, compared to 42.4% in 2022. The proportion that does not have an established urine sampling scheme has increased from 22.8% in 2020. As shown in Figure 29, there were large regional differences in urine testing schemes. At the University Hospital of North Norway, the majority, 67.0%, had no drug testing scheme. The proportion is roughly the same in Akershus, Asker and Bærum, and Vestfold. Figure 30 shows a significant reduction in the use of urine samples over time and suggests that urine samples are only used systematically as a safety measure to a limited extent today. This development must be understood in the light of changes in the types of OMT medication used, as well as increasing age and stabilization in treatment over time.

Figure 29. Use of urine samples (unknown = 3.6%).

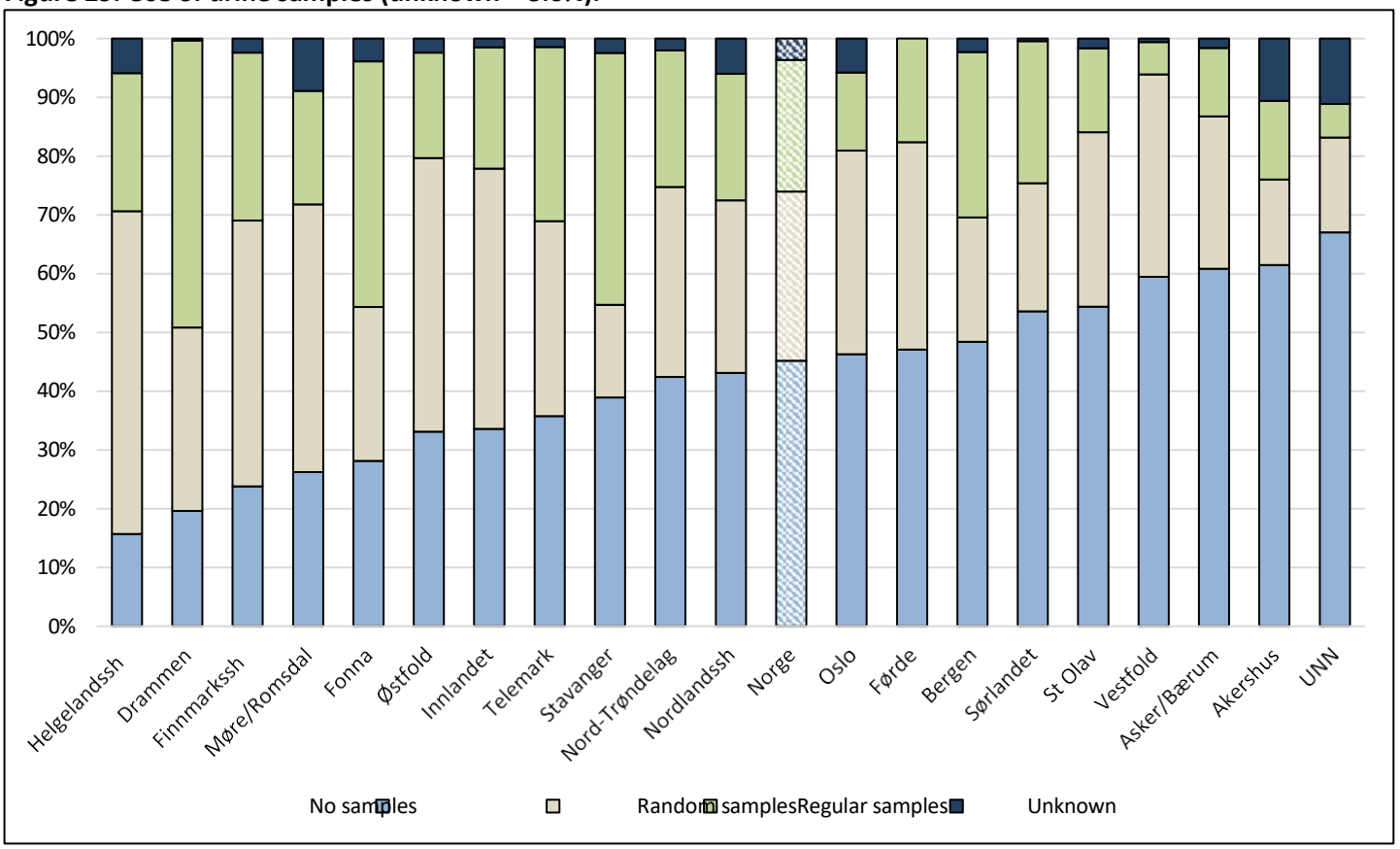
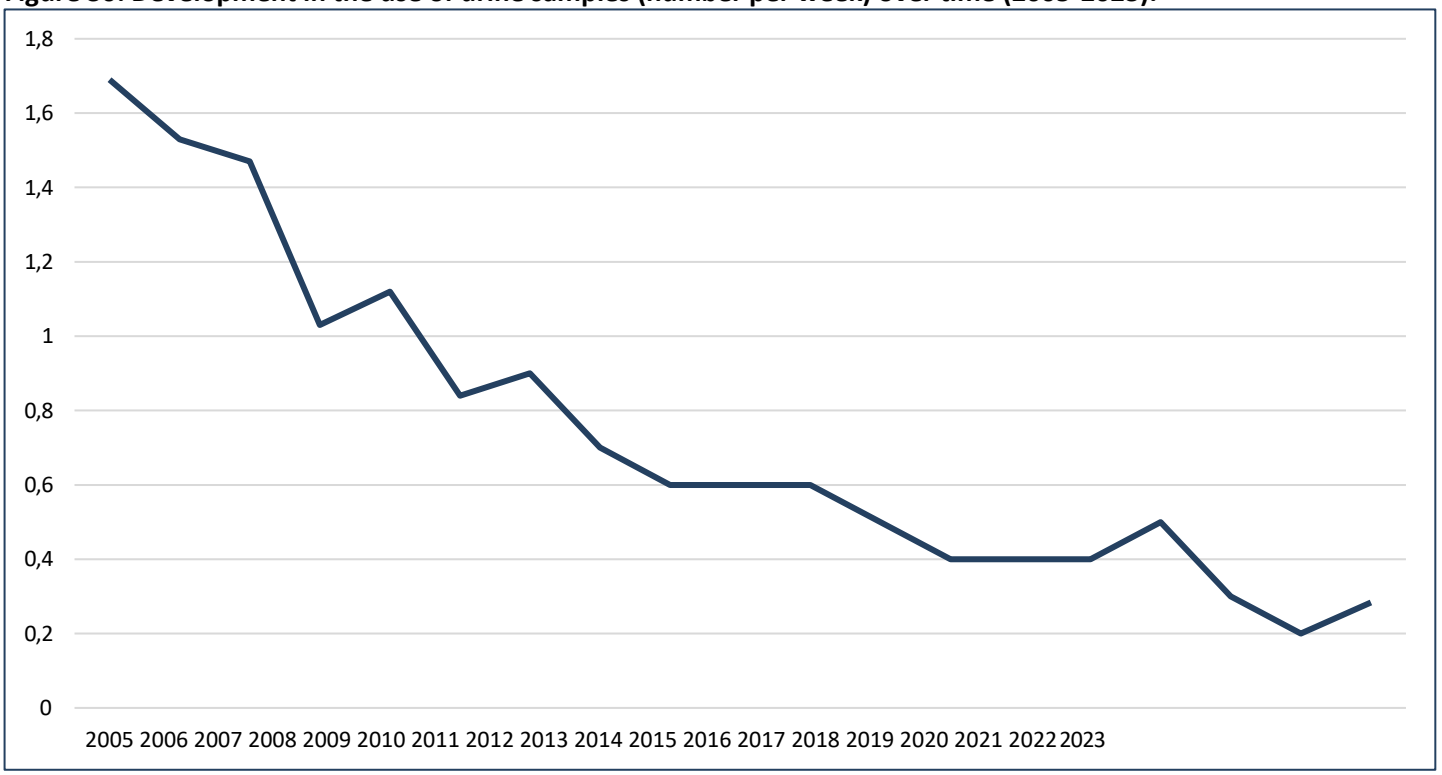


Figure 30: Development in the use of urine samples (number per week) over time (2005-2023).



Assessments of medical justifiability

On average, patients in OMT attended three times a week for monitored intake of medication in 2023. There has been a reduction in the number of weekly dispensations in recent years. The number of weekly drug tests in the form of urine samples, and the proportion that systematically take urine samples, has been significantly reduced in recent years. Agreements on dispensing arrangements and drug tests must be assessed individually based on the patient's goals, what is appropriate in relation to other rehabilitation efforts and adequate soundness in treatment. The new OMT guidelines emphasize dialogue and observation rather than drug tests. In this area, practice is developing in the direction of the wording in the revised guidelines.

Since highly addictive drugs are used in OMT, special regulation is necessary according to the OMT regulations to counteract abuse of the drugs and prevent harm to both patients and third parties. Urine and saliva samples can be used to gain an overview of drug intake and drug use, but should only be used to the extent necessary to ensure professionally sound treatment. The goal should therefore be a balanced use of samples and an adapted dispensing scheme, and thus both a sufficiently high degree of justifiability and the lowest possible threshold for being in treatment over time. Those who prescribe OMT drugs must balance user participation and accessibility against the risk of the drugs being taken by someone other than the patient. Finding this balance can be challenging in practice, but should be a guideline.[3]

Substance use that escalates to the point where it affects everyday functioning, or new substance use in a previously drug-free patient, should preferably be addressed through conversations with the patient. In such conversations, you can discuss the function of the substance use, triggering factors, and how further treatment strategy can be adapted to best meet needs and goals. It may be that the patient needs a higher dose of OMT medication or a change of medication. Urine or saliva samples should, to some extent, be used as a supplement to dialogue and observation in order to monitor the treatment effect and the need to adapt the treatment in collaboration with the patient.

[3] European Monitoring Center for Drugs and Drug Addiction (2021). Balancing access to opioid substitution treatment with preventing the diversion of opioid substitution mediations in Europe: Challenges and implications. https://www.emcdda.europa.eu/publications/technical-reports/opioid-substitution-treatment-ost-in-europe-availability-and-diversion_en

PSYCHOSOCIAL FOLLOW-UP

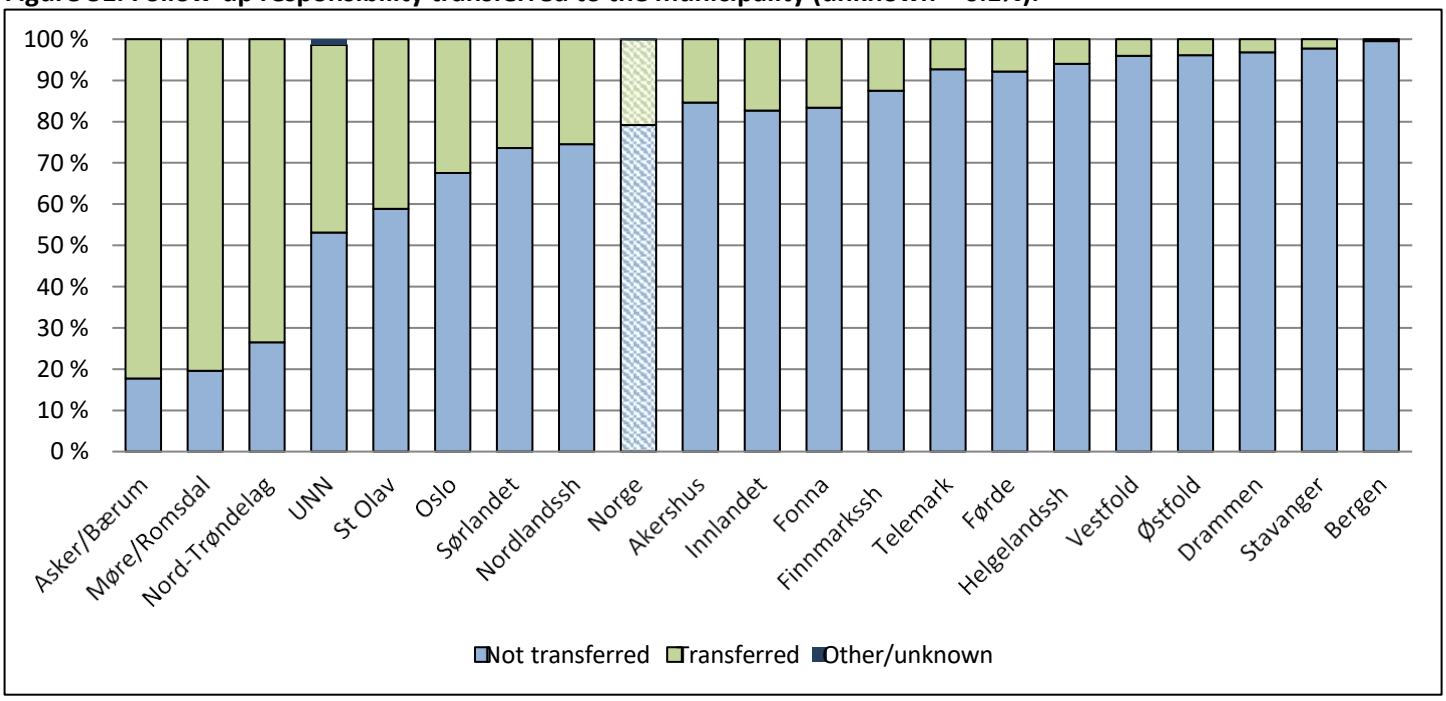
Anchoring of the treatment

OMT has been developed according to a tripartite model with cooperation between municipal health and social services, GPs and the specialist health service. When the patient has achieved a stable and safe prescription with satisfactory function, most of the responsibility can be anchored at the municipal level.

As shown in Figure 31, OMT treatment was primarily anchored in the specialist health service for 78.1% of patients (green bars), similar to 2022 (78.3%). Most OMT units have organized their treatment so that it is primarily anchored in the specialist health service. However, some units have largely transferred the treatment to municipal bodies (blue bars), with Asker and Bærum (81.0%), Møre og Romsdal (77.2%) and Nord-Trøndelag (72.7%) in particular having primarily municipal-based OMT treatment. At the other end of the scale we see Bergen (99.4%) and seven other OMT units that have OMT treatment for more than 90% of patients based in the specialist health service. This illustrates significant differences in organization in practice.

The differences in how follow-up responsibilities are organized have been stable for a number of years. It is not necessarily the case that OMT should be organized in the same way in all health trusts, as factors such as choice of medication, available resources and local needs may mean that it is necessary or appropriate to make local organizational adjustments. However, the organization of the treatment takes place within a common national framework, where the tripartite collaboration, the OMT regulations and the OMT guidelines generally contribute to stability over time.

Figure 31. Follow-up responsibility transferred to the municipality (unknown = 0.1%).



Treatment goals

In the status survey, the individual is asked about the overall treatment goal for the OMT treatment, where the alternatives are rehabilitation with freedom from substance abuse, stabilization, and not clarified. There will be individual variations in the interpretation. Figure 32 shows that rehabilitation with the goal of abstinence was stated as the overall treatment goal for 68.7% of patients (compared to 68.5% in 2022), while 26.5% stated stabilization without the goal of complete abstinence. At unit level, the number of patients with a goal of stabilization was particularly high in Vestfold (38.9%), and particularly low at Finnmark Hospital (9.5%). The proportion without a clear treatment goal, as formulated in the status survey, was generally low, but quite high at Nordland Hospital (20.4%). In most of the OMT units, approximately 7 out of 10 aimed for rehabilitation. The distribution has been fairly stable over the past decade (Figure 33).

Figure 32. Overall treatment goal for OMT treatment (not clarified = 4.8%).

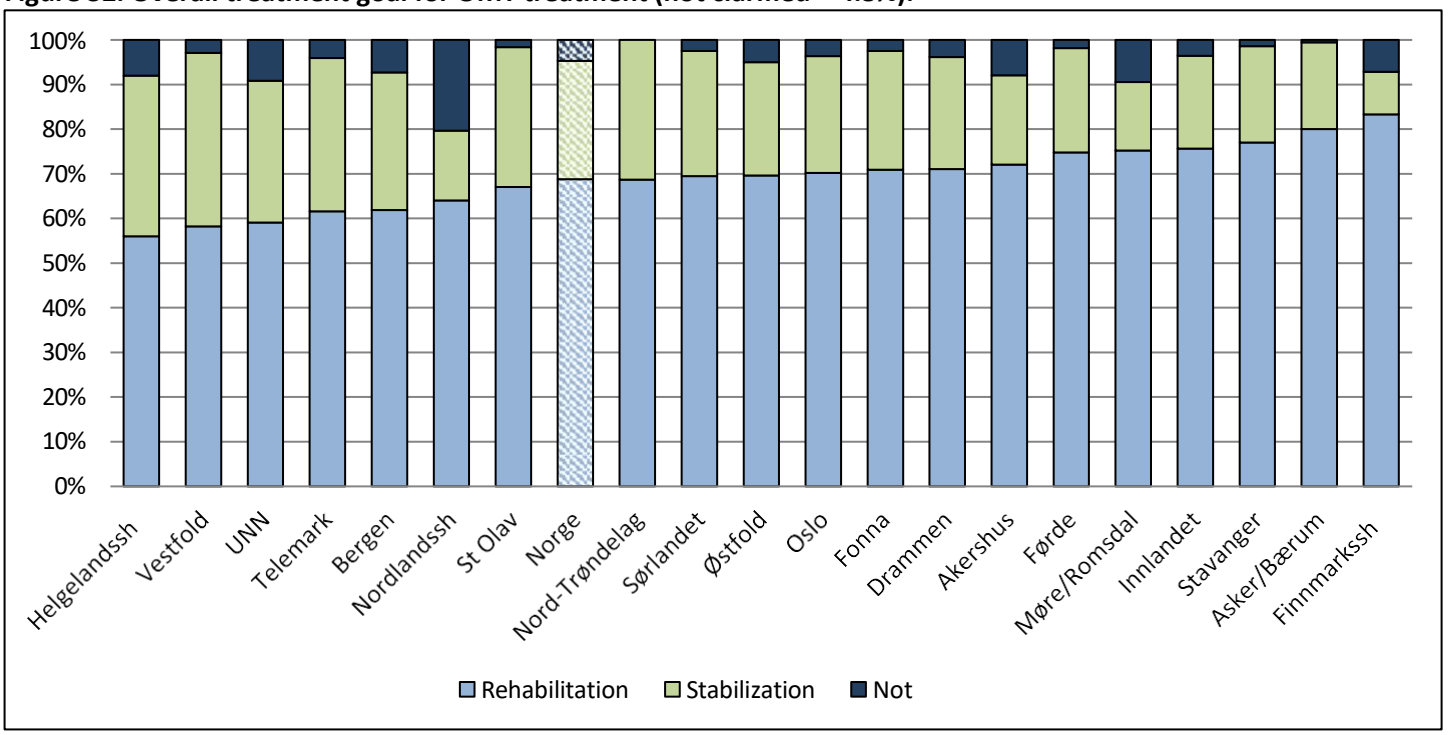
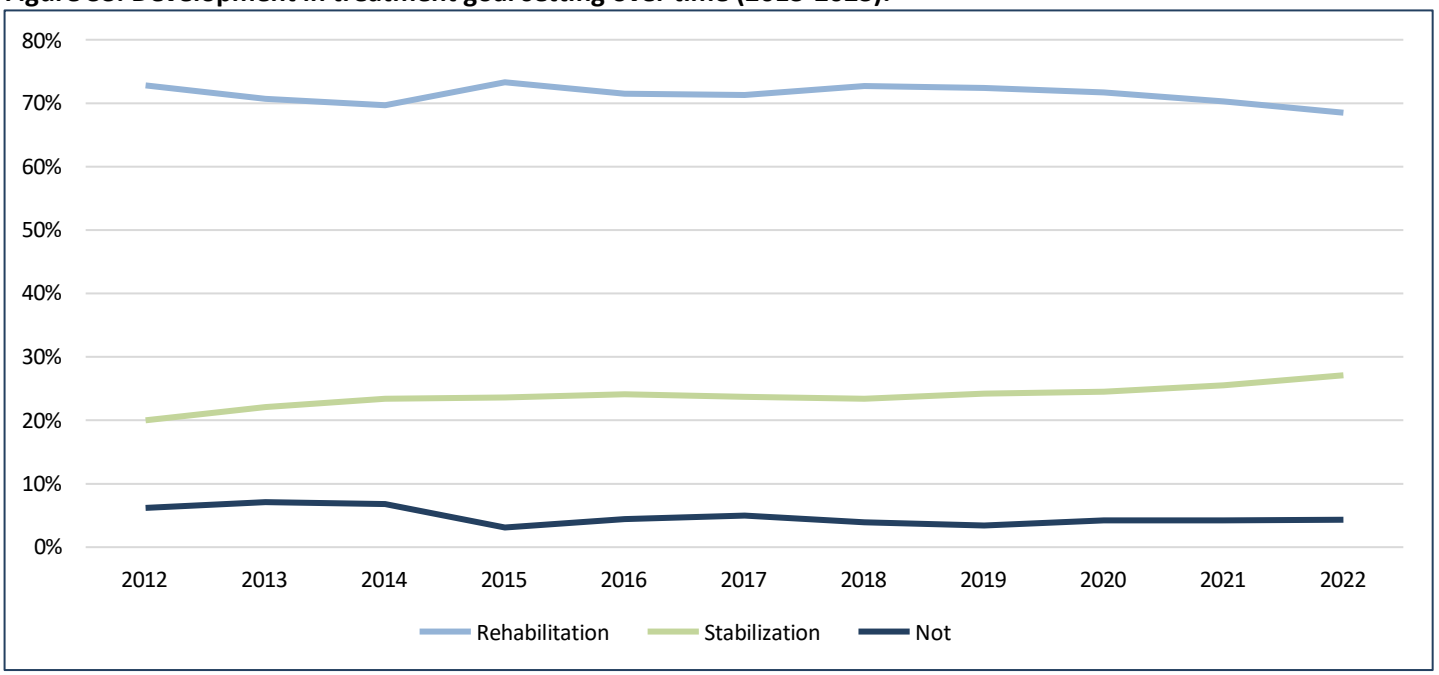


Figure 33. Development in treatment goal setting over time (2013-2023).



In terms of whether the individual had achieved rehabilitation (Figure 34), it was assessed that 44.5% were rehabilitated and only in maintenance treatment (compared to 42.4% in 2022), while 49.2% were in the process of achieving rehabilitation or in a stabilization process. This distribution is roughly similar to the previous year. The highest proportion who had achieved rehabilitation was in Førde (76.5%). At six units, at least half of the patients had achieved rehabilitation. Figure 35 shows the proportion who had achieved rehabilitation over the past decade, showing a gentle but steady rise of about ten percentage points. This suggests that more people had achieved rehabilitation in 2023 than in 2013.

Figure 34. Proportion of patients who have achieved rehabilitation (unknown = 6.3%).

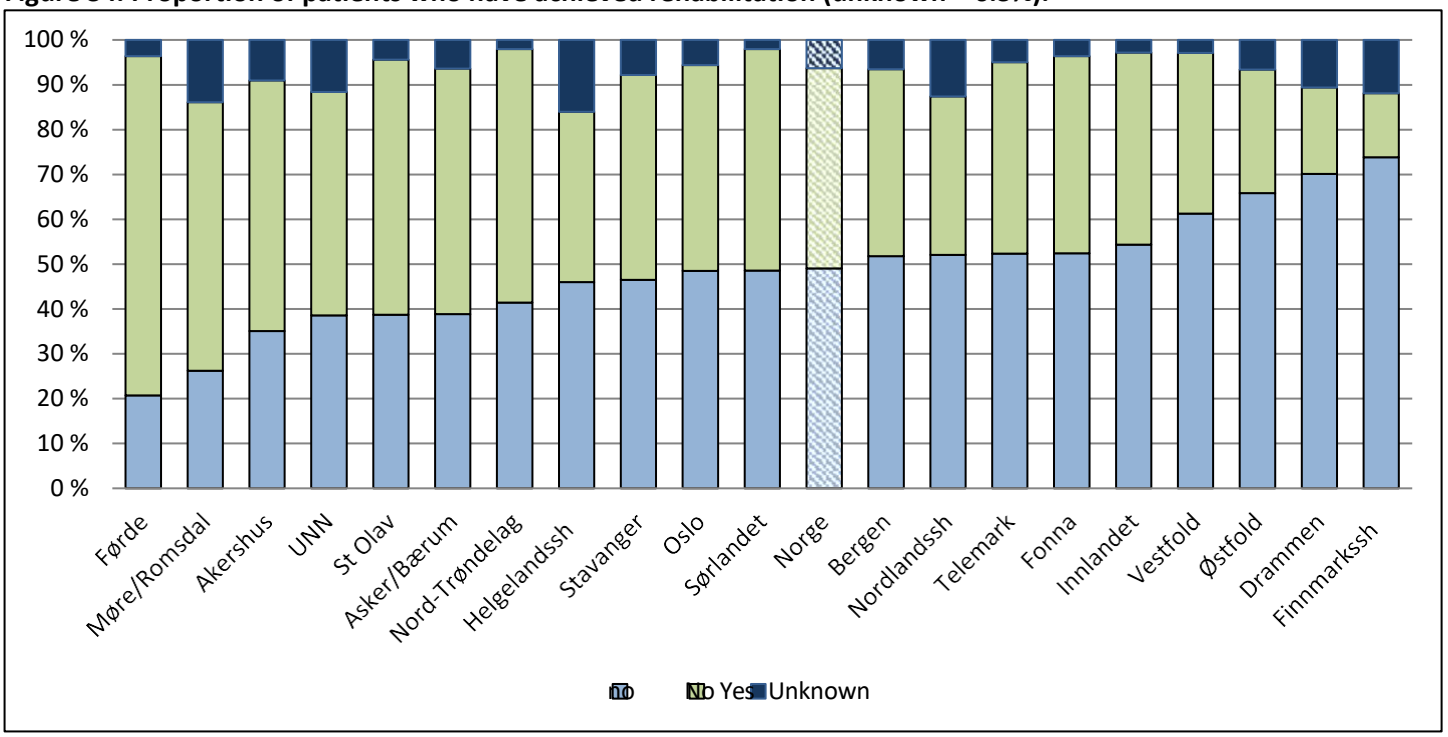
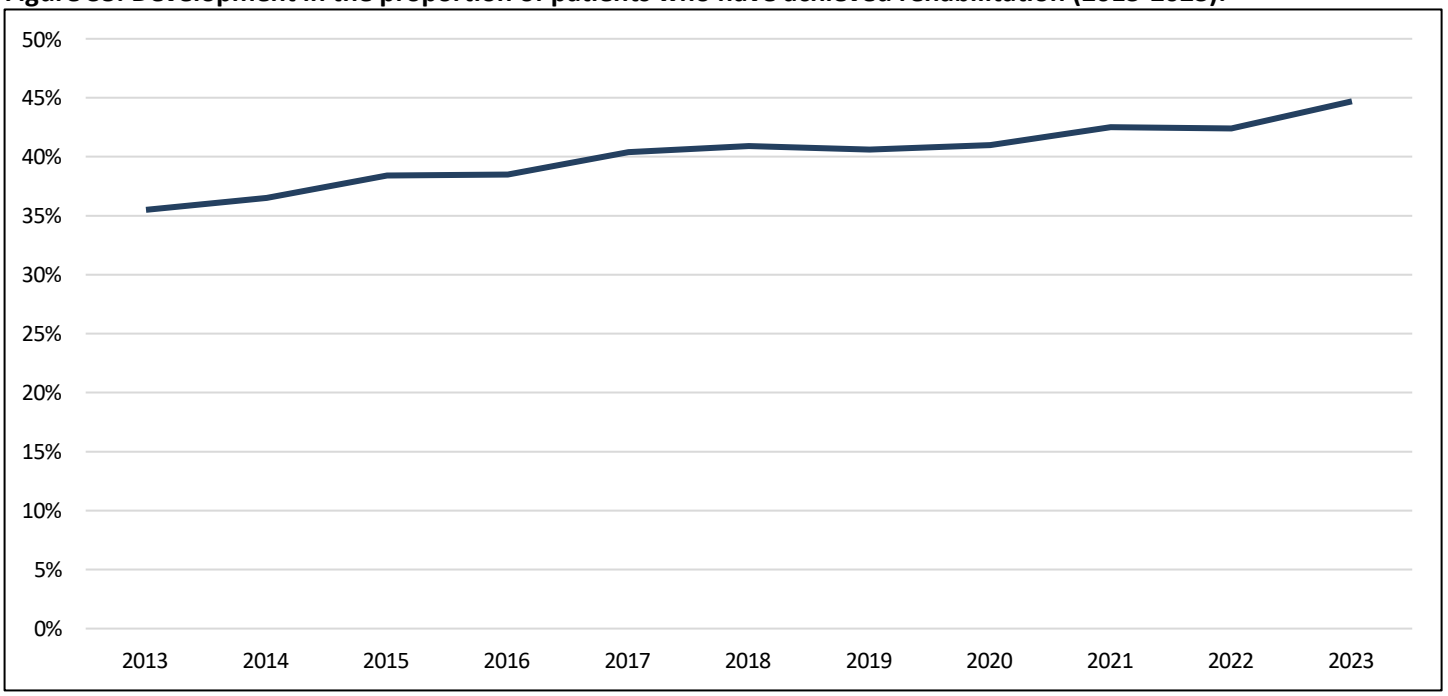


Figure 35. Development in the proportion of patients who have achieved rehabilitation (2013-2023).



Individual plan and responsibility group meetings

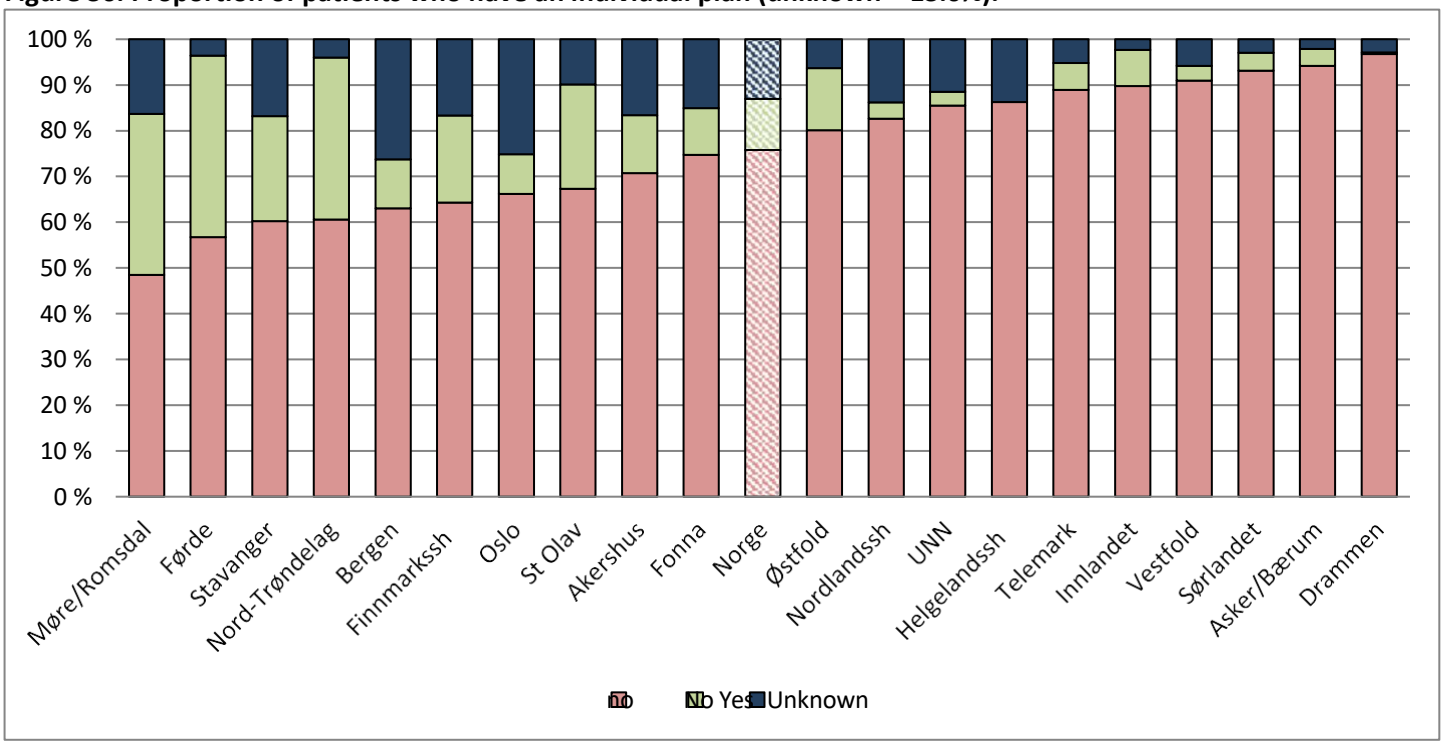
All people in need of long-term and coordinated services are entitled to have an individual plan drawn up, often coordinated through a responsibility group. The specialist health service has a special responsibility for individual plans at the start of OMT, and individual plans must be developed in collaboration with the GP, municipal services and other relevant agencies. This is anchored in the OAT regulations (§6).[4]

[4] https://lovdata.no/dokument/SF/forskrift/2009-12-18-1641

In 2023, 76.0% lacked an individual plan. 11.0% of OMT patients had an individual plan (Figure 36), compared with 10.9% in 2022. As previously, there is some variation in the proportion of patients across SUD units who have an individual plan, with Drammen (0.3%) and Førde (39.2%) as extremes. There is also a certain unknown proportion (13.0%), which indicates that OMT has not necessarily initiated the process of developing an individual plan. Figure 29 shows a gradual decline in the use of individual plans over a number of years.

The reasons for reduced use can be complex, and may be due to a lack of initiative from the services or that the patient does not want an individual plan. This may also be related to the duration of treatment and increasing age among patients in OMT. It may also be that the units use tools other than the individual plan to ensure that they offer individually adapted, holistic services. Given that patients in OMT are entitled to the development of an individual plan, it is still recommended to ensure that the patients' wishes and needs for this are adequately mapped.

Figure 36. Proportion of patients who have an individual plan (unknown = 13.0%).



According to the OMT regulations, drug treatment must be part of a comprehensive rehabilitation process, where responsibility groups consisting of all relevant agencies that collaborate with and about the patient are an important tool for coordinating the services. Like the individual plan, responsibility groups should be a tool for achieving individually tailored treatment. Responsibility groups should be based on the premise that the patient should have the opportunity for active user participation, and the patient's goals and needs should form the basis of the follow-up.[5]

Figure 37 shows the proportion of patients who had a responsibility group meeting in the last three months before participating in the status survey. In 2022, 27.6% of patients had had a responsibility group meeting in the last three months (compared to 32.2% in 2022). Prior to the pandemic, a larger proportion of patients had a responsibility group meeting (42.0% in 2019). There were major differences between OMT units, with the lowest proportion of patients with completed responsibility group meetings in Vestfold (13.3%) and at St. Olavs hospital (14.0%), and the highest proportion in Drammen (64.5%). As with individual plans, the trend for responsibility group meetings has been downward over time (Figure 38).

[5]h ttps://www.helsenorge.no/rus-og-avhengighet/legemiddelassistert-behandling-lar/

Figure 37. Proportion with a responsibility group meeting last month (unknown = 3.0%).

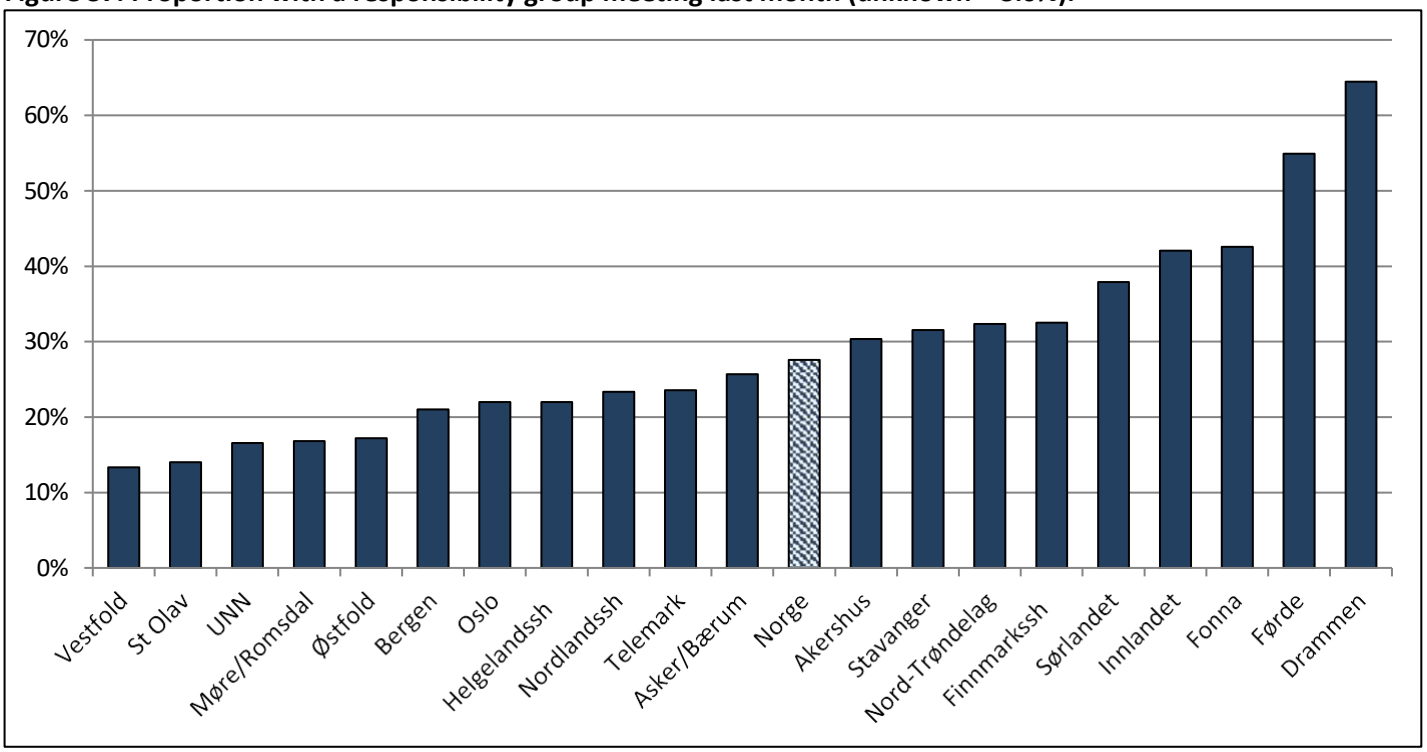
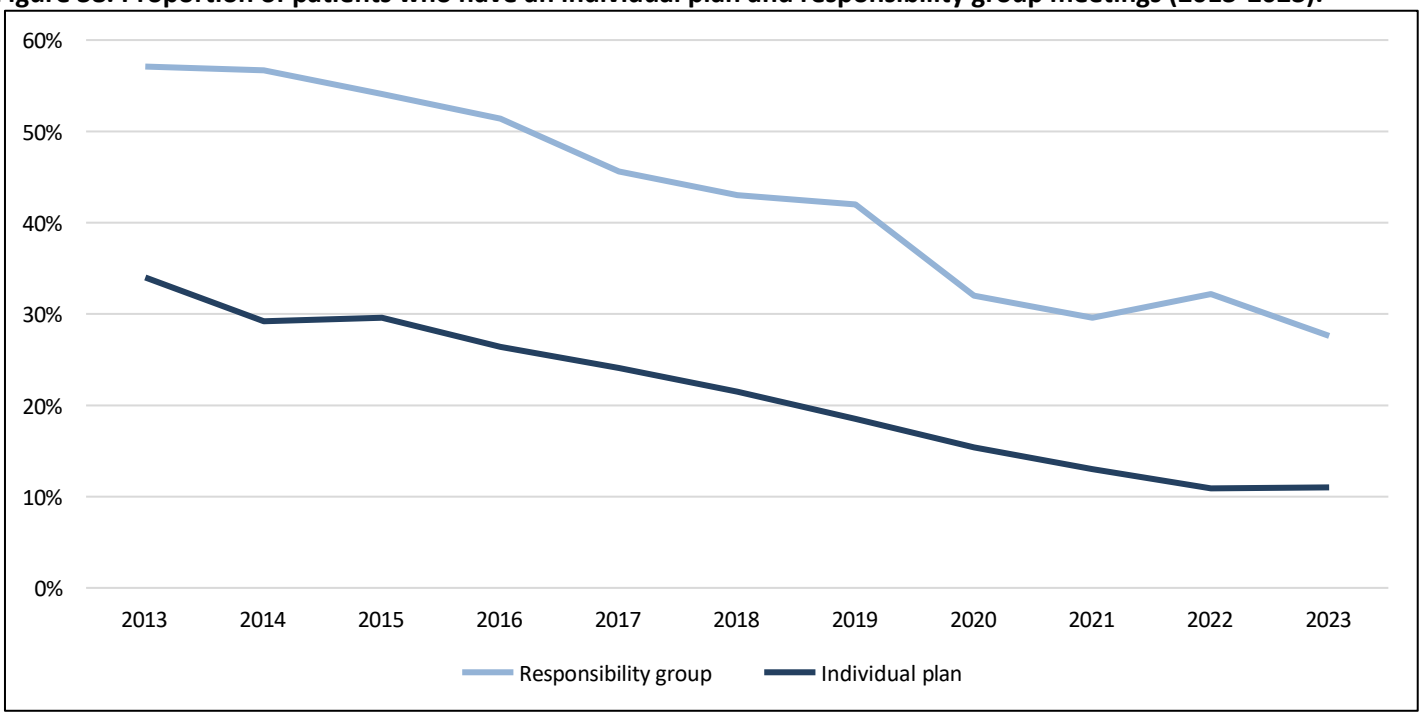


Figure 38. Proportion of patients who have an individual plan and responsibility group meetings (2013-2023).

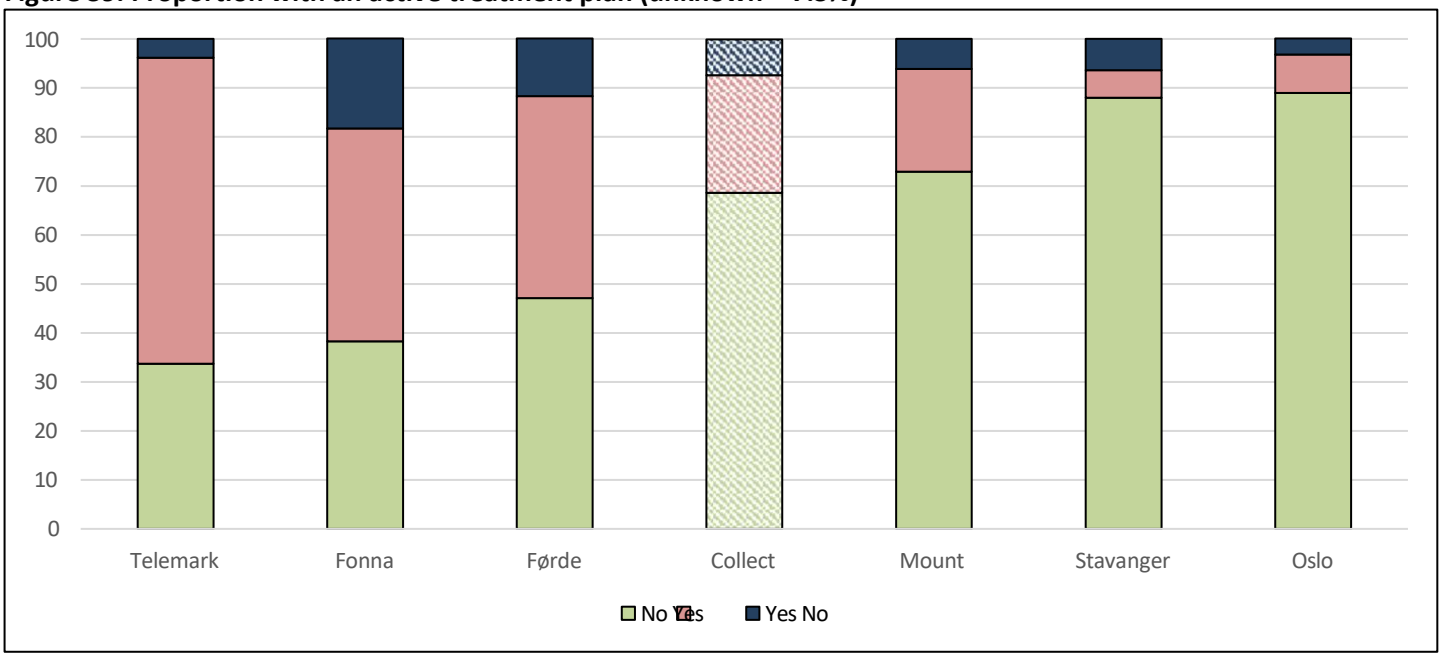


Treatment plan

OAT units that used DIPS Arena answered an additional question about the use of a treatment plan in the past year. The question assessed whether a treatment plan had been developed for the individual patient, which should guide the treatment and be updated at least annually. As shown in Figure 39, the majority of patients, 68.6%, had an active treatment plan. For 24.0%, no treatment plan had been developed, and the unknown percentage was 7.3%. However, there were major differences between the units, with the least widespread use of treatment plans in Telemark (33.7%). Almost everyone in Oslo (89.0%) and Bergen (88.0%) had an active treatment plan. These figures

shows us that some of the OMT units that use individual treatment plans to a lesser extent, follow an individually adapted treatment plan through the use of a treatment plan.

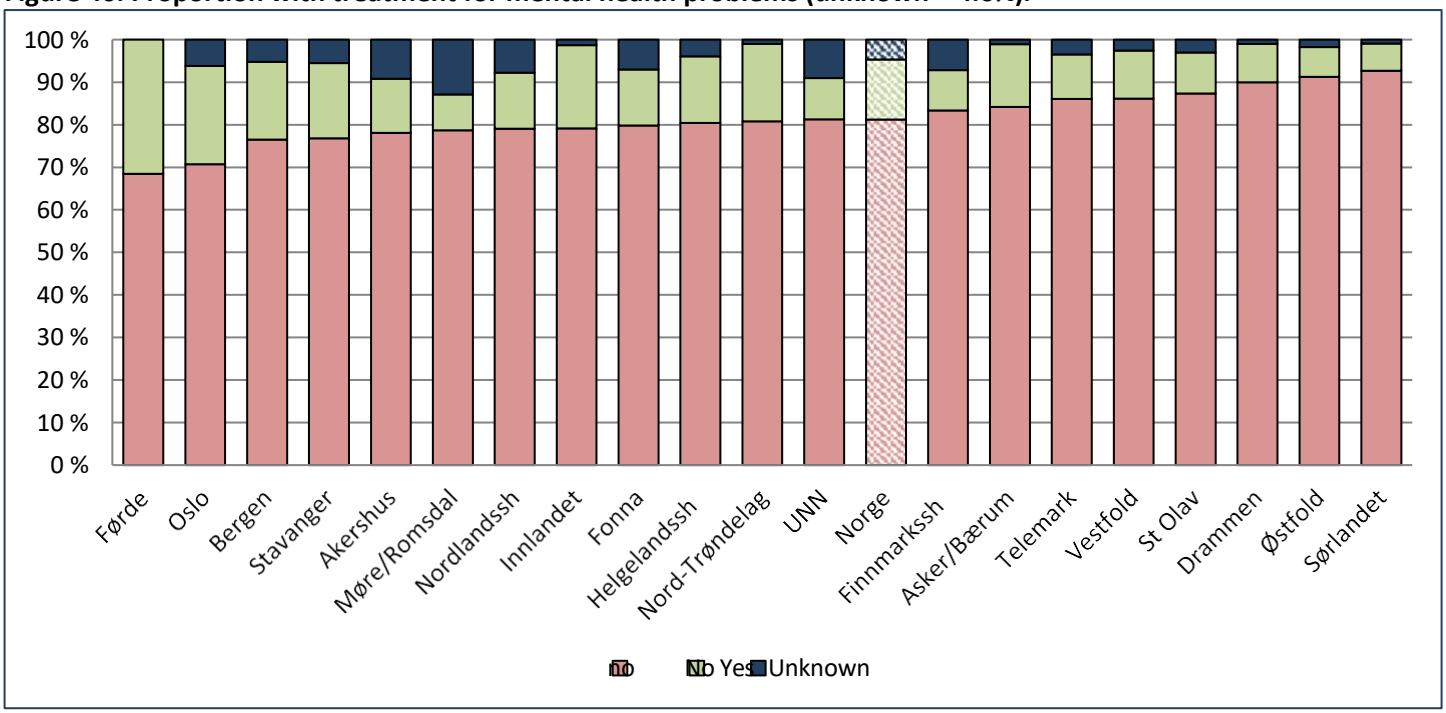
Figure 39. Proportion with an active treatment plan (unknown = 7.3%)



Treatment of mental health problems

Patients in OMT should be able to receive assessment and treatment for mental health problems in the specialist health service if necessary. Only a small proportion of OMT patients received treatment for mental health problems in 2022 (Figure 40). On a national basis, 14.0% received treatment for mental health problems in 2023, compared with 13.3% the previous year. This proportion has been stable over the past decade. Overall, there was little difference between the SUD units. The proportion receiving treatment for mental health problems was highest in Førde (31.4%), followed by Oslo (23.1%).

Figure 40. Proportion with treatment for mental health problems (unknown = 4.6%).



Assessments of the psychosocial follow-up

As in previous years, the treatment in OMT is primarily anchored in TSB, but with great variation between health trusts. The differences in whether OMT treatment is anchored in municipal bodies or the specialist health service have remained stable at unit level over time. The reasons for these differences have not been systematically investigated, but the impression is that traditions in the individual health trusts and resources at municipal level are crucial to the local solutions.

Most patients in OMT have rehabilitation with abstinence as their overall treatment goal, but for a significant group, stabilization without abstinence is the overall goal. These figures show that for many, OMT is an important part of rehabilitation, and for many it is important for harm reduction. Psychosocial follow-up is an important part of OMT together with the drug treatment, and can have a significant impact on patients' ability to achieve their treatment goals.

Over the past decade, there has been a clear reduction in the use of individual plans as a tool for comprehensive, coordinated services. At the same time, we see that a number of patients have an active treatment plan, and that about a third of patients have had responsibility group meetings. Changes in the use of tools for comprehensive, coordinated services may be related to the fact that patients who have been in OMT over time are considered to have less need for psychosocial follow-up. At the same time, increasing age and associated somatic challenges, as well as low access to activities such as work and education, will be important areas to address through psychosocial follow-up. In addition to other psychosocial support, patients in OMT may be in need of treatment for mental health problems, including assessment and talk therapy. The figures for treatment received for mental health problems should be seen in the context of the figures showing recent mental health problems, and thus show some degree of unmet need for treatment.

RIGHT TO COMPLAIN

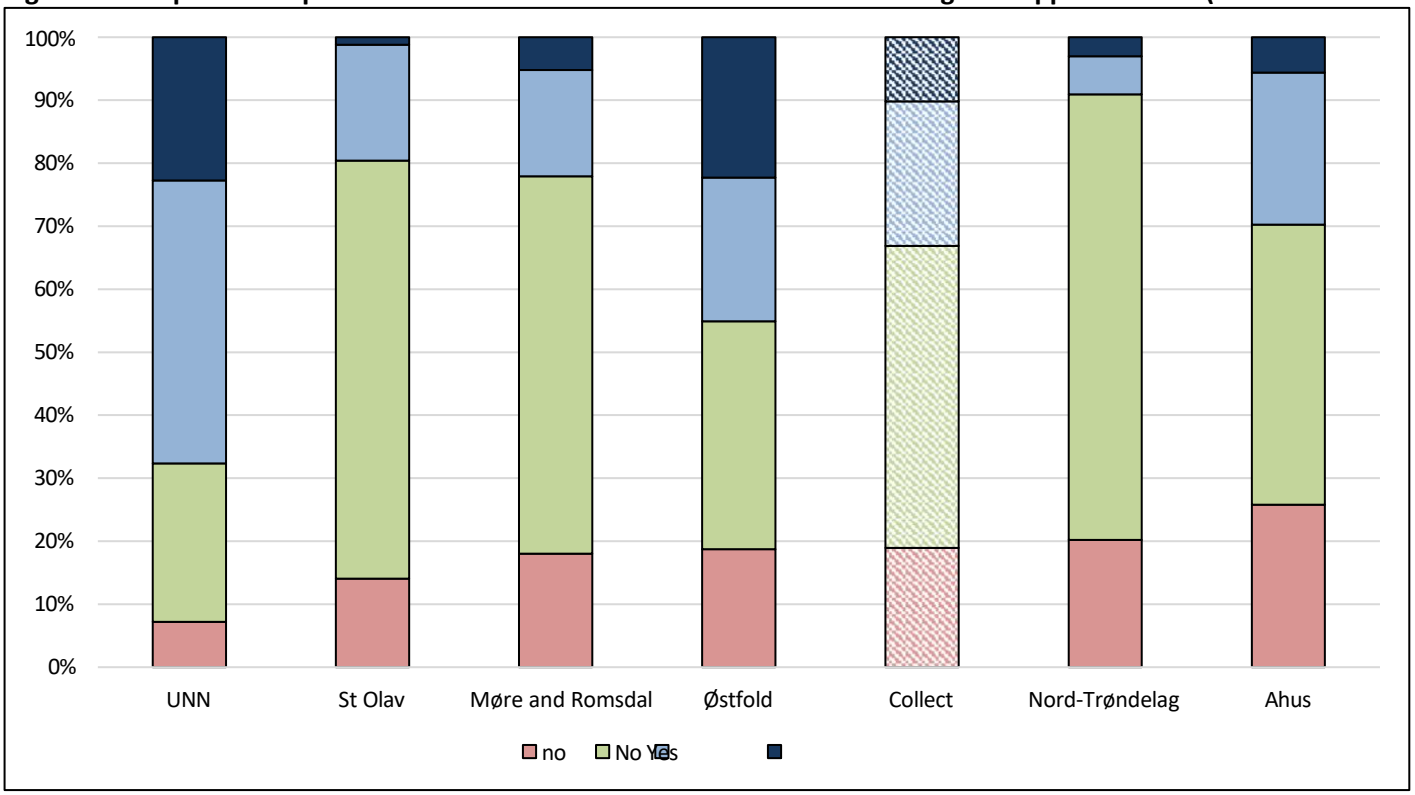
Information about right of appeal

Patients undergoing treatment, including patients in OMT, have the right to complain if they feel that they have not received the health services to which they are entitled. Patients in OMT have had the right to complain since people who were in interdisciplinary specialized substance abuse treatment were given patient rights on an equal footing with other patient groups. Relatives or representatives of patients also have the right to complain.

The Patient and User Rights Act emphasizes that the patient has the right to
"the information necessary to gain sufficient insight into the services offered and to be able to safeguard their rights" (§3-2). It is also emphasized that health personnel must ensure that the information and the implications of the information are understood by the patient and described in the medical record (§3-5)[6] . This means, among other things, that
"the patient shall be informed of the right to appeal, the deadline for appeals and the detailed procedure for appealing" (section 2-2).

Complaints processes typically involve the patient or the patient's representative drafting and submitting a complaint to the treatment center in question or to the state administrator[7] . Complaints may, for example, concern refusal of treatment or treatment measures, inadequate follow-up, or specific decisions. If necessary, health personnel shall
"assist with the recording of the complaint itself"[8] .

Figure 41. Proportion of patients who have received information about the right to appeal in OMT (unknown = 21.6%).



In the status survey for 2023, a question was added about whether information has been received about the right of appeal in OMT. Due to technical challenges at the health trusts, only a selection of OMT units were able to provide information for this question. Information for 1,748 patients is summarized in Figure 41. Overall, almost half of these patients, 47.9%, should have been informed of their right to submit a complaint about their OMT treatment, while 18.9% should not have received this information. There is uncertainty about information about the right to complain for 22.9% of the patients, and furthermore, information about the right to complain was considered not relevant for 10.2% of the patients. We can see from the graph that there are fairly large differences between the different regions

[6]h ttps://lovdata.no/dokument/NL/lov/1999-07-02-63/
[7] https://www.statsforvalteren.no/portal/nyheter/2022/03/hvordan-klage-pa-helse--og-omsorgstjenester/
[8] https://www.helsedirektoratet.no/rundskriv/psykisk-helsevernforskriften-med-kommentarer/skjerming-undersokelse-og-treatment-without-consent-and-coercion/28-complaint

when it comes to whether information has been provided about the right to complain about OMT treatment. The proportion who have not been informed about the right to appeal is lowest at UNN, with 7.2%, and highest at Akershus University Hospital, with 25.8%. Nord-Trøndelag reported the highest proportion who have been informed about the right to appeal, followed by St. Olavs hospital and Møre og Romsdal, at 70.7%, 66.4% and 59.9% respectively.

Assessment of knowledge of right of appeal

The responses suggest that just under half of the patients in the sample will have received information about their right to appeal. At the same time, there are some geographical variations and a fairly high proportion with unknown status, which suggests that there is room for improvement when it comes to ensuring that patients in OMT receive clear information about their right to appeal. The question about the right to appeal is completely new in the status survey, so there are no previous figures to compare these with. There is also a lack of information for most of the OMT units, which represents a weakness in this material, but the answers that are available still apply to a fairly large sample of the patient population. Furthermore, there are probably different interpretations of the question between different units, as well as different approaches to providing information about the right to complain about treatment. It is not known how much focus there is on the right to complain and any assistance in formulating a complaint in the individual unit, and this will be an important area to develop further in the coming years to ensure that patients' rights are adequately safeguarded.

TREATMENT SATISFACTION

Patients' assessments of treatment serve as a measure of the extent to which the individual experiences benefit from and satisfaction with the treatment. Patients' assessment of the treatment is based on a single question, and different aspects of the treatment can be included in this assessment, depending on the individual patient's interpretation and experience of the treatment. Patients' assessment can be seen in the context of the therapist's assessment, as well as any identified need for change.

Patients' satisfaction with the treatment

Below is an overview of overall satisfaction with the treatment among patients in OMT for the previous year (Figure 42). In principle, patients should participate in the implementation of the status survey and also be asked about their satisfaction with the treatment, but despite this, the proportion with unknown satisfaction is quite high (20.9%). In 2023, 58.8% stated that they were satisfied with their treatment in OMT. This is fairly comparable with the figure for 2022 (56.9%). The proportion with mixed satisfaction was 16.1% (17.7% in 2022), and the proportion who were not satisfied with the treatment was 3.9% (4.2% in 2022).

Patients' satisfaction with the treatment was fairly evenly distributed in the different regions. However, the responses show some degree of variation between OMT units, with the highest proportion of satisfied patients in Førde (80.4%) and Vestfold (72.6%), and the lowest proportion who stated that they were satisfied with the treatment in OMT in the north. Mixed satisfaction was most frequently reported at Helgelandssykehuset (25.0%), and least frequently in Drammen (7.1%). Some units have a relatively high proportion of patients who were not satisfied with their treatment (e.g. 9.1% in Nord-Trøndelag and 7.1% at Finnmark Hospital). At a number of units, there is a significant proportion of patients whose satisfaction status is unknown (highest at 32.9% at Nordlandssykehuset, 32.0% in Bergen, and 31.7% in Asker and Bærum). There were none with unknown treatment satisfaction in Førde.

Figure 42. Percentage of patients assessed as satisfied with the treatment program (unknown = 21.1%).

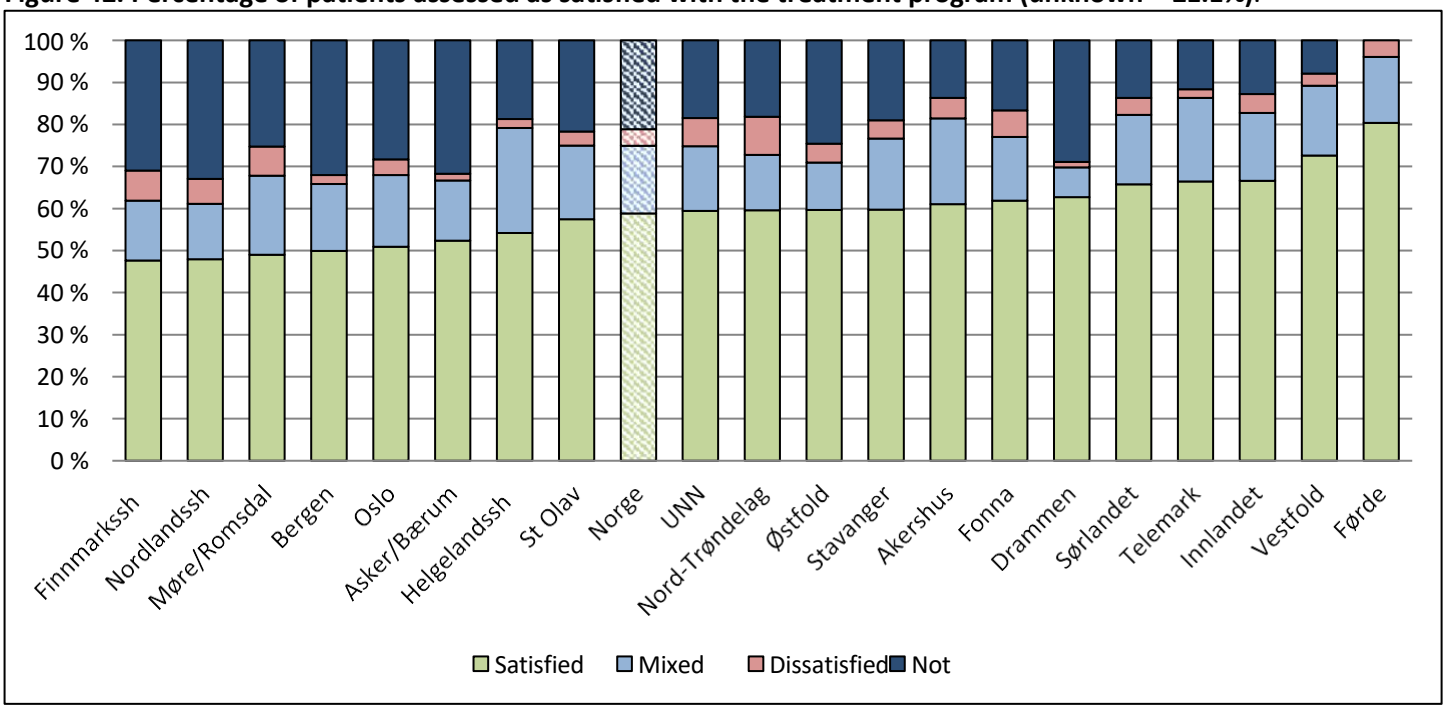
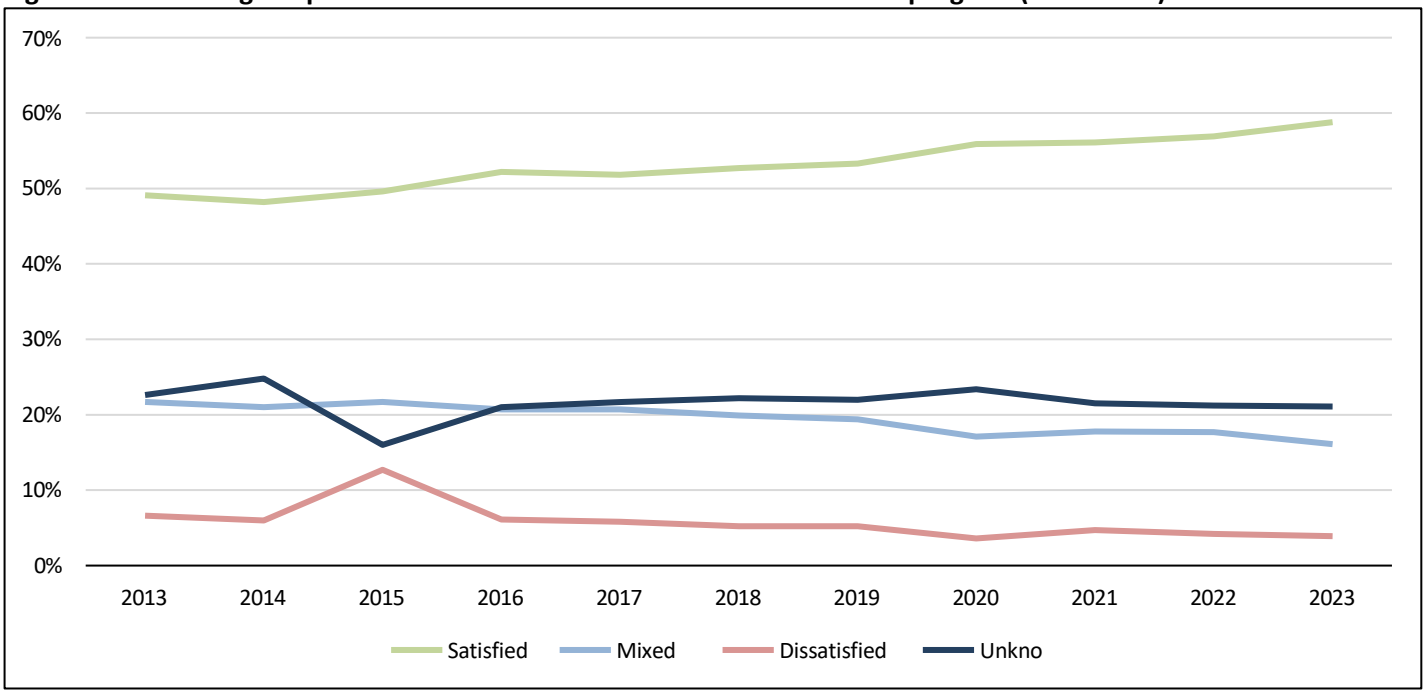


Figure 43 shows the development in patient satisfaction with treatment over the past decade. When a summary graph with an overview of the last decade was produced for the first time in last year's report, regional rather than national figures for 2014 and 2016 were included by mistake, with higher satisfaction for these years than the national figures showed. The correct figures for these years are presented in the figure below. Together with the figures for 2023 and the remaining years, a picture emerges of a gradual slow increase in patient satisfaction, from approximately 50% to 60% satisfied patients over the past decade.

Figure 43. Percentage of patients assessed as satisfied with the treatment program (2013-2023).



Practitioners' satisfaction with the treatment

Figure 44 shows the extent to which the patient's therapist was satisfied with the treatment. On average, therapists were satisfied with the treatment for 67.0% of patients, and partially satisfied for 25.4%. In only 2.6% of cases did the therapist declare themselves dissatisfied with the treatment. Overall, the proportion with unknown status is low. At the regional level, therapists' satisfaction with the treatment was approximately equally distributed. The OMT units with the highest treatment satisfaction were Førde (87.5%) and Innlandet (81.7%). The largest proportion of therapists with mixed satisfaction was at Finnmark Hospital (47.6%). The University Hospital of North Norway had the highest proportion with unknown status when it came to practitioner satisfaction (36.2%).

Figure 44. Percentage of completers who are satisfied with the treatment (unknown = 5.1%).

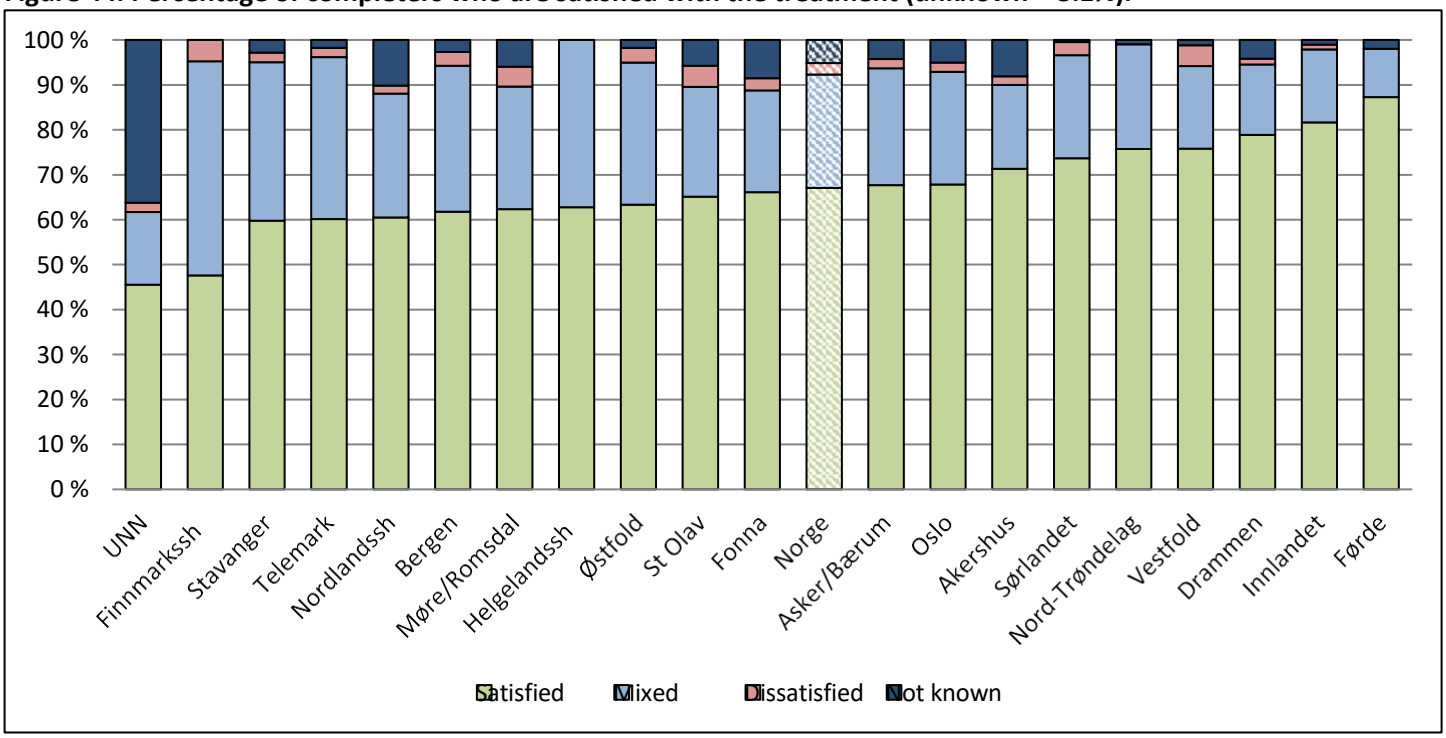


Figure 45. Percentage of therapists who were satisfied with the treatment program (2013-2023).

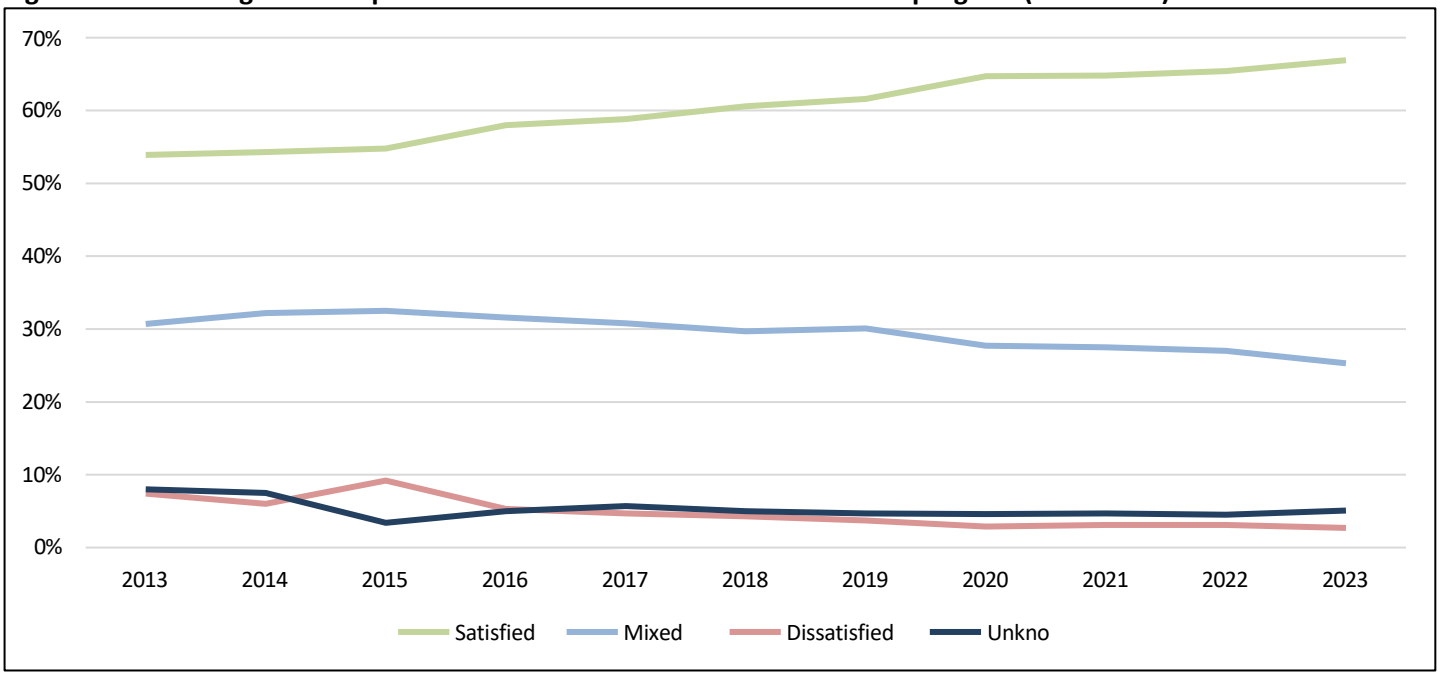


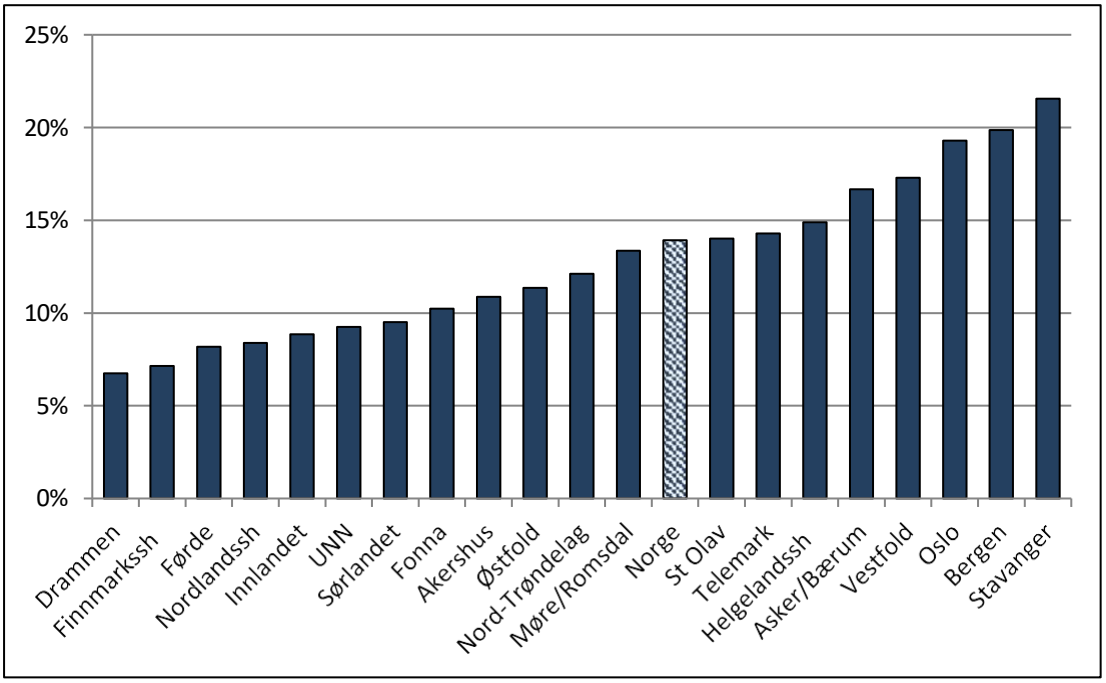
Figure 44 shows a roughly similar development at group level in terms of satisfaction among therapists and patients, with a gradual increase from around 55% to just under 70% satisfaction over the past decade. However, it is uncertain whether there is a correlation between the individual patient's and therapist's reporting.

Need for change

Figure 46 shows an overview of therapists' assessments of whether there is a need to reconsider or adapt parts of the treatment program. In the status survey for 2023, therapists reported possible need for change for 14.1% of patients. In the western region, the highest proportion of patients had identified a need for change in their treatment (17.1%). Stavanger (21.6%), Bergen (19.9%) and Oslo (19.3%) reported the most need for change, while Drammen (6.8%) and Finnmark Hospital (7.1%) reported the least.

Figure 46. Proportion of completers who consider that there is a need for treatment changes (unknown = 6.2%).

Drammen	6,8 %
Finnmarkssh	7,1 %
Førde	7,8 %
Nordlandssh	8,4 %
Inland	8,9 %
UNN	9,2 %
Southern Norway	9,5 %
Fonna	9,8 %
Akershus	10,9 %
Østfold	11,4 %
Nord-Trøndelag	12,1 %
Møre/Romsdal	13,4 %
St Olav	14,0 %
Norway	**14,1 %**
Telemark	14,3 %
Helgelandssh	14,9 %
Asker/Bærum	16,7 %
Vestfold	17,3 %
Oslo, Norway	19,3 %
Mountains	19,9 %
Stavanger,	21,6 %



Assessments of patient and clinician satisfaction

The question about patient and practitioner satisfaction provides an overall and simple estimate that can be used as feedback at unit level. The question is not intended as an objective assessment of the quality of treatment and does not distinguish between different parts of the treatment. With the exception of the patient assessments, the remaining assessments are made by the therapists themselves, so many are therefore invited to assess their own efforts in the treatment processes.

The main impression is that there are limited differences between the various SUD units when it comes to patient satisfaction. The differences that do exist stem primarily from the weighting between satisfied and mixed satisfaction, and from the proportion of missing responses. The various response options should therefore be understood in the context of each other. Perhaps in particular, the proportion of patients who report dissatisfaction should be interpreted in the context of the proportion with unknown status. A high proportion of patients with unknown status may be related to the organization of the treatment services at the SUD unit in question, and it can be assumed that some of the patients with unknown status are in reality probably not satisfied with the treatment. Information about dissatisfaction may also be important for the units to know. Reported dissatisfaction does not necessarily only represent perceived challenges, but also that the patient finds it possible to express their dissatisfaction or perceived weaknesses in the treatment to their therapist. Furthermore, it is interesting to see a gradual, cautious positive development in both patients' and therapists' treatment satisfaction.

There are fairly large differences between the OMT units when it comes to the need for treatment changes. Overall, the therapists see a need for changes in the treatment of 1-2 out of 10 patients. At the same time, this question does not identify how the treatment should be changed, for example, whether this concerns a change of medication, adjustments to the collection system, or other elements related to the medication or psychosocial follow-up. In summary, the questions are intended to help ensure that a conscious status is taken for each individual patient at least once a year, and that this can be followed up with an evaluation of the way forward for the individual patient.

PSYCHICAL HEALTH

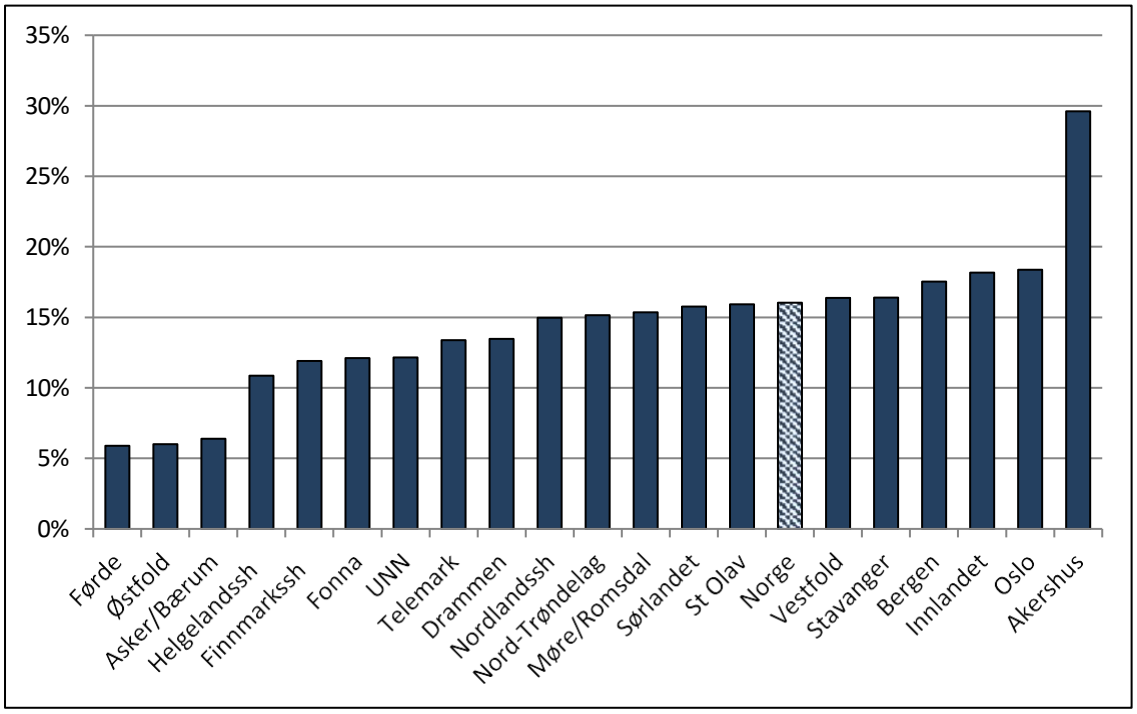
The status survey includes questions about mental health over the past four weeks. The mental health questions relate to whether patients have experienced severe depressive symptoms, anxiety symptoms, and delusions.

Depressive symptoms

Overall, 16.0% reported experiencing depressive symptoms (low mood, lack of energy to carry out daily tasks and activities, and reduced interest) in the past four weeks, compared to 15.3% in 2022 (Figure 47). Furthermore, 60.9% had no depressive symptoms, while 15.2% had unknown status in terms of depressive symptoms. At the regional level, the extremes were North, with the lowest reported proportion with depressive symptoms (12.9%), and East, with the highest reported proportion (18.5%). Most OMT units tended to be around the national average, but Østfold (6.0%), Førde (5.9%) and Asker and Bærum (6.4%) stood out with a lower proportion with depressive symptoms, and Akershus University Hospital with a significantly higher proportion (29.6%).

Figure 47. Proportion of patients with self-reported depressive symptoms in the last four weeks (unknown = 15.2%).

Førde	5,9 %
Østfold	6,0 %
Asker/Bærum	6,4 %
Helgelandssh	10,9 %
Finnmarkssh	11,9 %
Fonna	12,1 %
UNN	12,2 %
Telemark	13,4 %
Drammen	13,5 %
Nordlandssh	15,0 %
Nord-Trøndelag	15,2 %
Møre/Romsdal	15,3 %
Southern Norway	15,8 %
St Olav	15,9 %
Norway	**16,0 %**
Vestfold	16,4 %
Stavanger, Norway	16,4 %
Mountains	17,5 %
Inland	18,2 %
Oslo, Norway	18,4 %

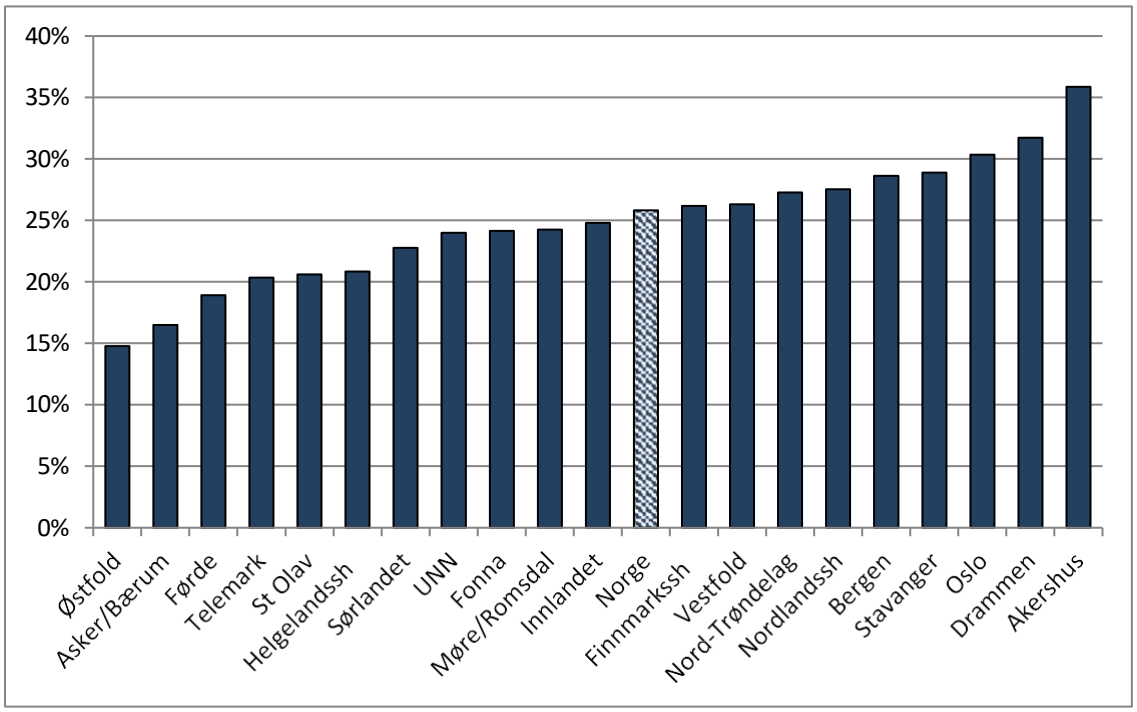


Anxiety symptoms

Overall, 25.9% reported having had anxiety symptoms (persistent nervousness, severe worries, or frequent panic attacks that reduce functioning) in the past four weeks (Figure 48), similar to 2022 (26.0%). However, 59.6% had not had anxiety symptoms, and the proportion unknown was 14.6%. There were fairly small differences between the regions when it came to self-reported anxiety symptoms, with the lowest proportion in Central Norway (22.7%) and the highest in Eastern Norway (27.5%). However, there was some variation between the units, with the lowest prevalence reported from Østfold (14.8%) and the highest from Akershus University Hospital (35.9%).

Figure 48. Proportion of patients with self-reported anxiety symptoms in the last four weeks (unknown = 16.7%).

Østfold	14,8 %
Asker/Bærum	16,5 %
Førde	17,6 %
Telemark	20,3 %
St Olav	20,6 %
Helgelandssh	20,8 %
Southern Norway	22,8 %
UNN	24,0 %
Fonna	24,2 %
Møre/Romsdal	24,3 %
Inland	24,8 %
Norway	**25,9 %**
Finnmarkssh	26,2 %
Vestfold	26,3 %
Nord-Trøndelag county	27,3 %
Nordlandssh	27,5 %
Mountains	28,6 %
Stavanger, Norway	28,9 %
Oslo, Norway	30,3 %

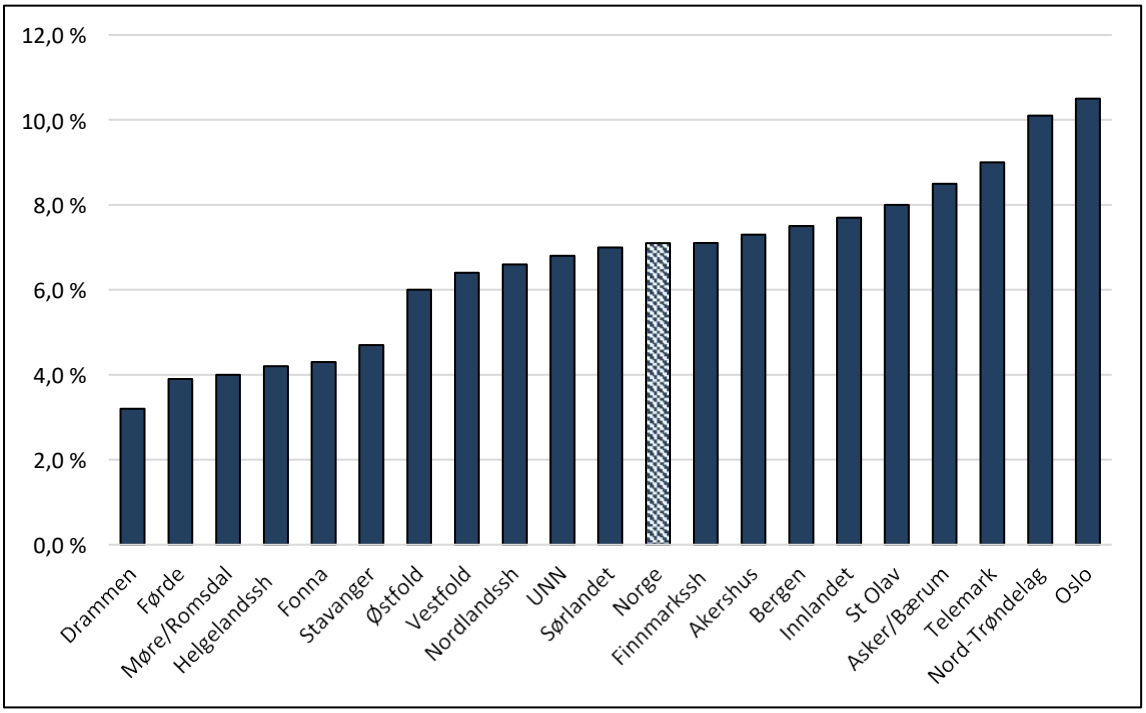


Delusions of grandeur

Overall, 7.1% reported experiencing delusions (unusual sensory impressions that could not be perceived by others, and perceptions that do not correspond to reality) in the past four weeks, compared to 6.9% in 2022 (Figure 49). 78.4% stated that they had not experienced delusions in the past four weeks, and 13.4% had unknown status. The proportion with experienced delusions was lowest in the West (5.9%) and highest in the East (8.3%). The proportion with self-reported delusions was lowest in Drammen (3.2%) and highest in Oslo (10.5%) and Nord-Trøndelag (10.1%).

Figure 49. Proportion of patients with self-reported delusions in the last four weeks (unknown = 14.6%).

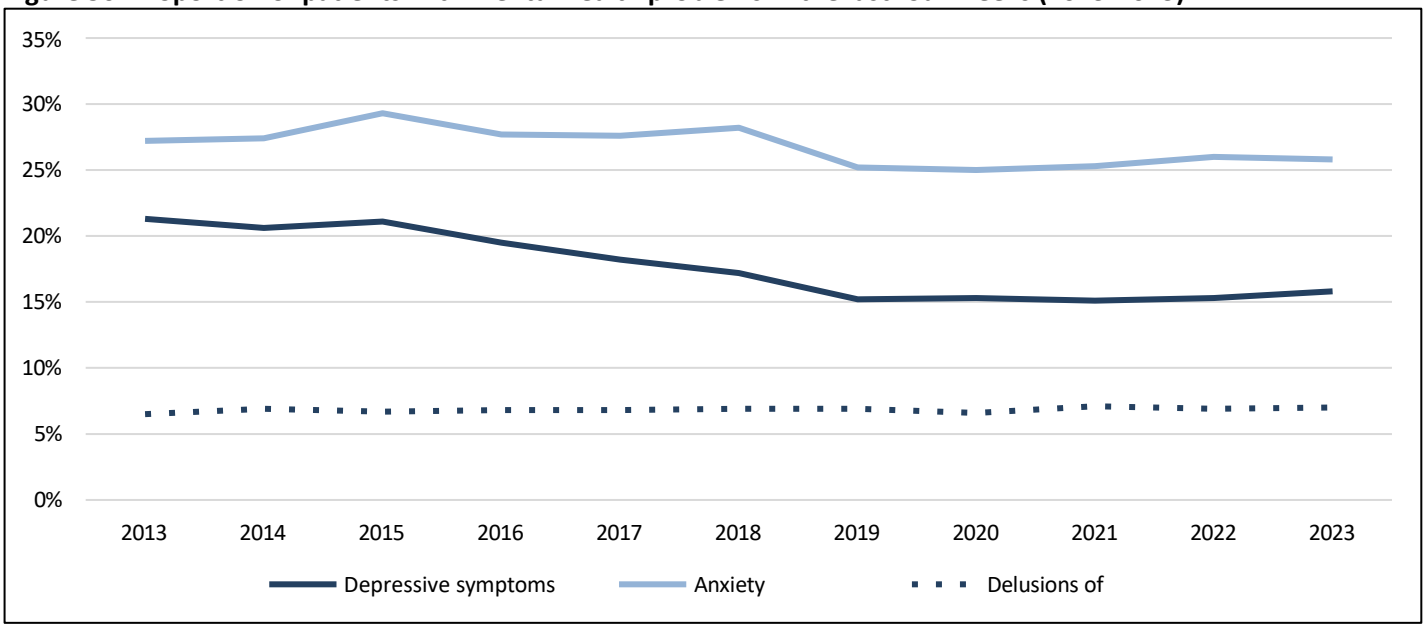
Drammen	3,2 %
Førde	3,9 %
Møre/Romsdal	4,0 %
Helgelandssh	4,2 %
Fonna	4,3 %
Stavanger, Norway	4,7 %
Østfold	6,0 %
Vestfold	6,4 %
Nordlandssh	6,6 %
UNN	6,8 %
Southern Norway	7,0 %
Norway	**7,1 %**
Finnmarkssh	7,1 %
Akershus	7,3 %
Mountains	7,5 %
Inland	7,7 %
St Olav	8,0 %
Asker/Bærum	8,5 %
Telemark	9,0 %
Nord-Trøndelag county	10,1 %
Oslo, Norway	10,5 %



Mental health problems

Figure 50 provides an overview of developments in the proportion of OMT patients who have reported mental health problems over the past decade. Overall, there appears to have been a reduction in the proportion with depressive symptoms and in the proportion with anxiety symptoms over the past five years. The prevalence of symptoms of anxiety and depression is somewhat higher than in the general population, and the prevalence of delusions is clearly higher than in the general population.

Figure 50. Proportion of patients with mental health problems in the last four weeks (2013-2023).



Assessments of mental health status

The questions regarding mental health problems do not shed light on the degree of perceived symptom burden, different forms of symptoms, or whether the ailments are diagnosable. The questions can provide a picture of the patients' experience of their own health situation, but it is not possible to draw clear conclusions about the prevalence of mental disorders and any need for treatment based on this.

When it comes to mental health problems, the status survey shows that anxiety symptoms are the most frequently reported, followed by depressive symptoms and, for a minority, delusions. We do not know how often individual patients experience several of these symptoms, but overall we see that a significant number of patients in OMT experience some degree of mental health problems. Seen in the context of the findings regarding psychosocial treatment, we see that few are receiving treatment for mental health problems. This means that some are probably not receiving adequate healthcare for their mental health problems, while at the same time many are receiving other psychosocial follow-up, particularly through responsibility groups and treatment plans, as well as municipal services.

Some differences are reported between the units in terms of the burden of disease for mental health symptoms, but also some differences in the proportion receiving treatment for this. The explanation may lie in different regional problem burdens, with increased symptom pressure in urban areas, but also different clinical practices. Differences in clinical practice, where some actively assess and refer, while others do so to a lesser extent, may be an area where those with the lowest treatment rate review their own practice and consider whether they can and should assess or refer more people. TSB units must be able to carry out mapping and assessment of mental disorders and cognitive functioning. [9] With regard to particularly vulnerable patient groups, some health trusts and municipalities have set up outreach treatment services for patients with concurrent substance abuse and mental disorders who need closer follow-up.

[9] Norwegian Directorate of Health (2018). Nasjonalt pasientforløp for tverrfaglig spesialisert rusbehandling (TSB). Oslo: Helsedirektoratet. https://www.helsedirektoratet.no/nasjonale-forlop/rusbehandling-tsb

PHYSICAL HEALTH AND TREATMENT

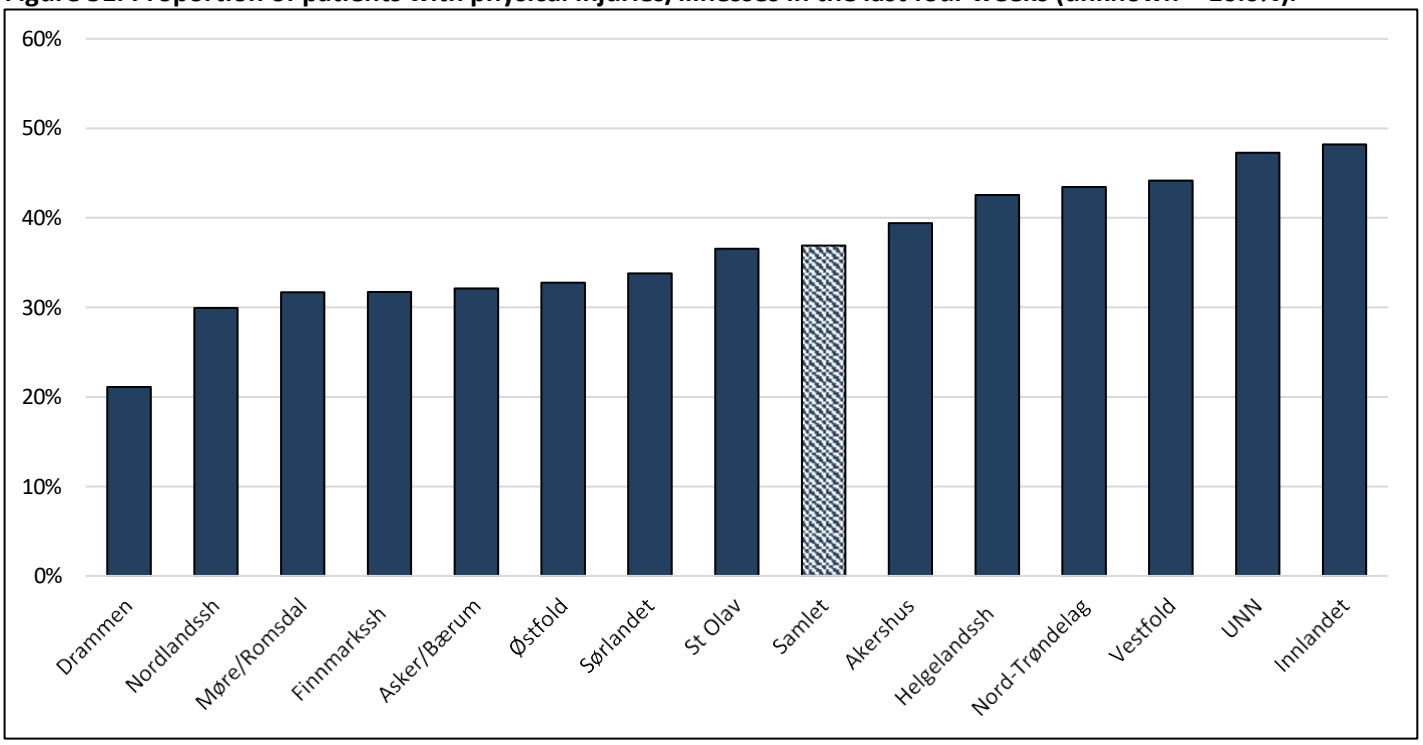
In the status survey, patients are asked about their physical health over the past four weeks, as well as their physical health over the past year. The question about physical health over the past four weeks concerns whether the patient has suffered from physical injuries or illnesses to such an extent that this has reduced their lifestyle or quality of life. For those of the health enterprises that use the DIPS Arena medical record system, the status survey included some new questions about medical examinations in the past year, physical health problems/illnesses in the past year, prevalence of chronic pain and treatment for this, as well as prevalence of various diseases and treatment received for these in the past year. This section is based on responses from 2877 patients in these OMT units. In addition, there is a description of blood infection status for HIV and hepatitis C based on responses from all units.

The patient pathway "Somatic health and living habits in the case of mental disorders and/or substance abuse problems" identifies important areas for mapping and follow-up of somatic health.[10] Some particularly relevant themes that are highlighted are smoking, nutrition, physical activity, sleep, somatic complications related to substance use, and dental health. GPs play a central role in the tripartite collaboration in OMT, and have a particularly important role when it comes to identifying and treating somatic illness. The OMT units should also help to facilitate systematic medical examinations and relevant follow-up.

Physical health last four weeks

The proportion of patients with physical injuries or illnesses that have had a negative impact on their way of life or quality of life in the past four weeks was 36.9% in 2023, compared with 38.8% in 2022 (Figure 51). Most OMT units have a proportion of 35-40% who have reported physical injuries or illnesses, but Drammen stands out with the lowest proportion (21.1%), and Innlandet (48.2%) and UNN (47.3%) stand out with the highest proportion of patients with physical ailments. The overall average for the question about physical injuries or illnesses in the last four weeks does not apply to OAT units that use DIPS Arena, as these have answered questions about injuries or illnesses in the last year. Over time, there has been a slight increase in reported physical ailments, probably linked to increasing average age. At the same time, the proportion has been fairly stable in recent years (Figure 52).

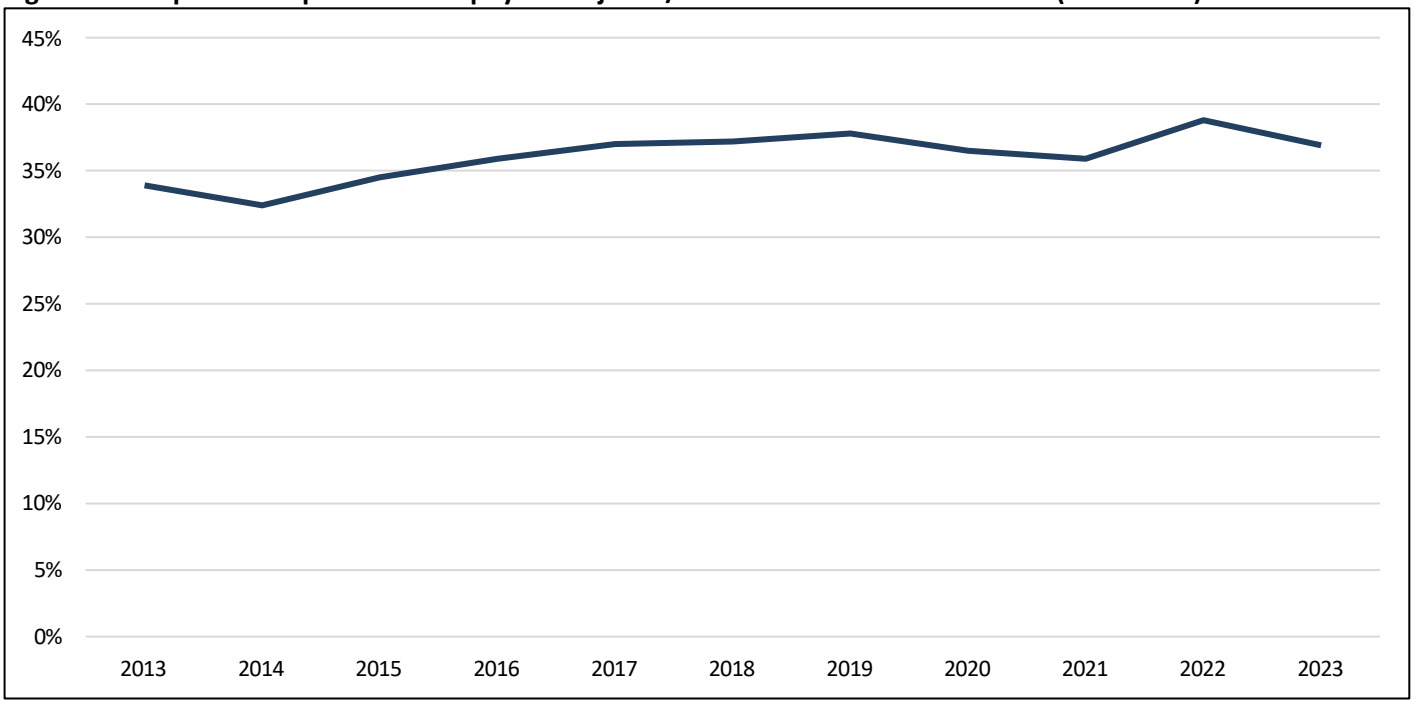
Figure 51. Proportion of patients with physical injuries/illnesses in the last four weeks (unknown = 10.0%).



[10] Norwegian Directorate of Health (2018). Ivaretakelse av somatisk helse og levevaner ved psykiske lidelser og/eller rusmiddelproblemer. Oslo: Helsedirektoratet. https://www.helsedirektoratet.no/nasjonale-forlop/somatisk-helse-og-levevaner-ved-

psykiske-lidelser-og-eller- rusmiddelproblemer

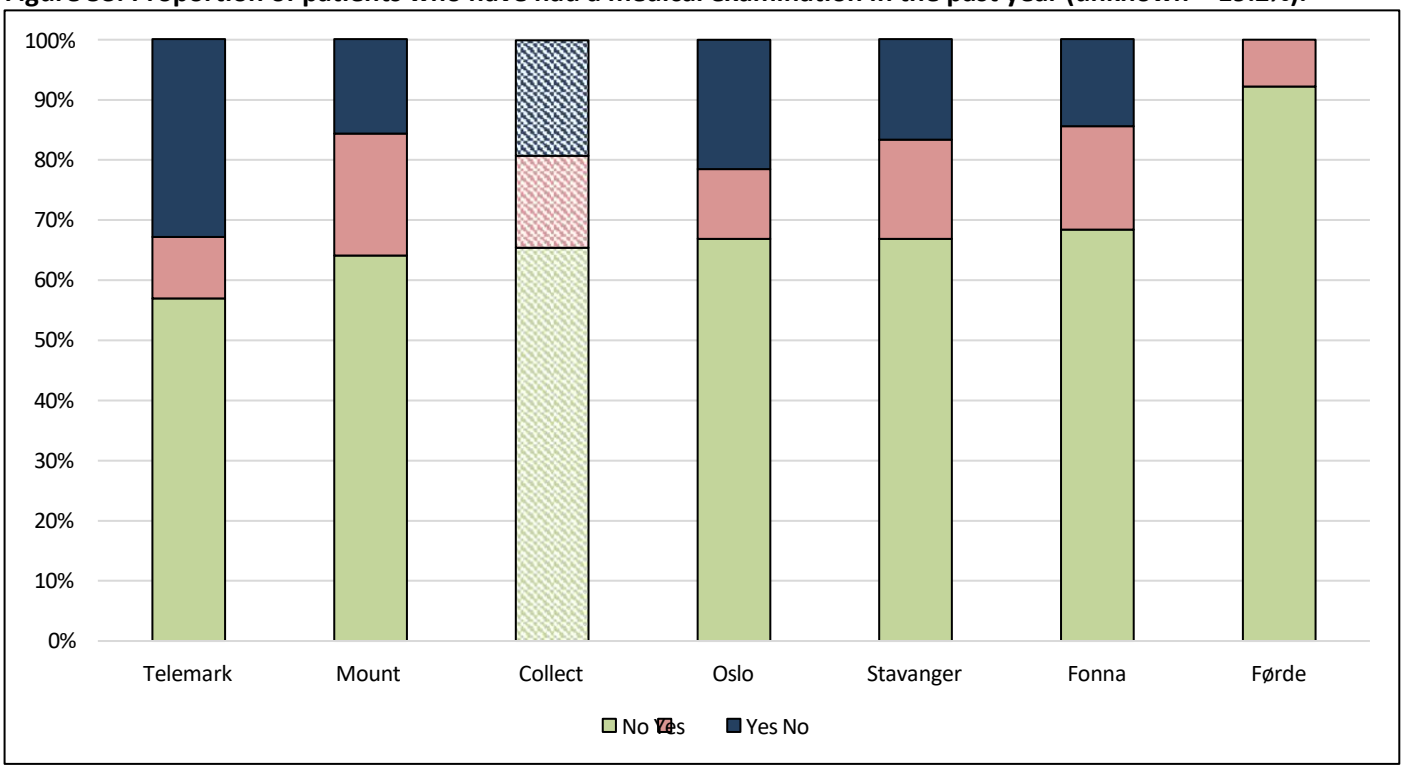
Figure 52. Proportion of patients with physical injuries/illnesses in the last four weeks (2013-2023).



Medical examination

As shown in Figure 53, 68.6% responded that they had been to a medical examination in the past year, compared with 63.8% the previous year. Furthermore, 15.5% had not had a medical examination, and 18.7% had unknown status. The proportion with a completed medical examination was highest in Førde (85.1%). The remaining units were between 57-67%.

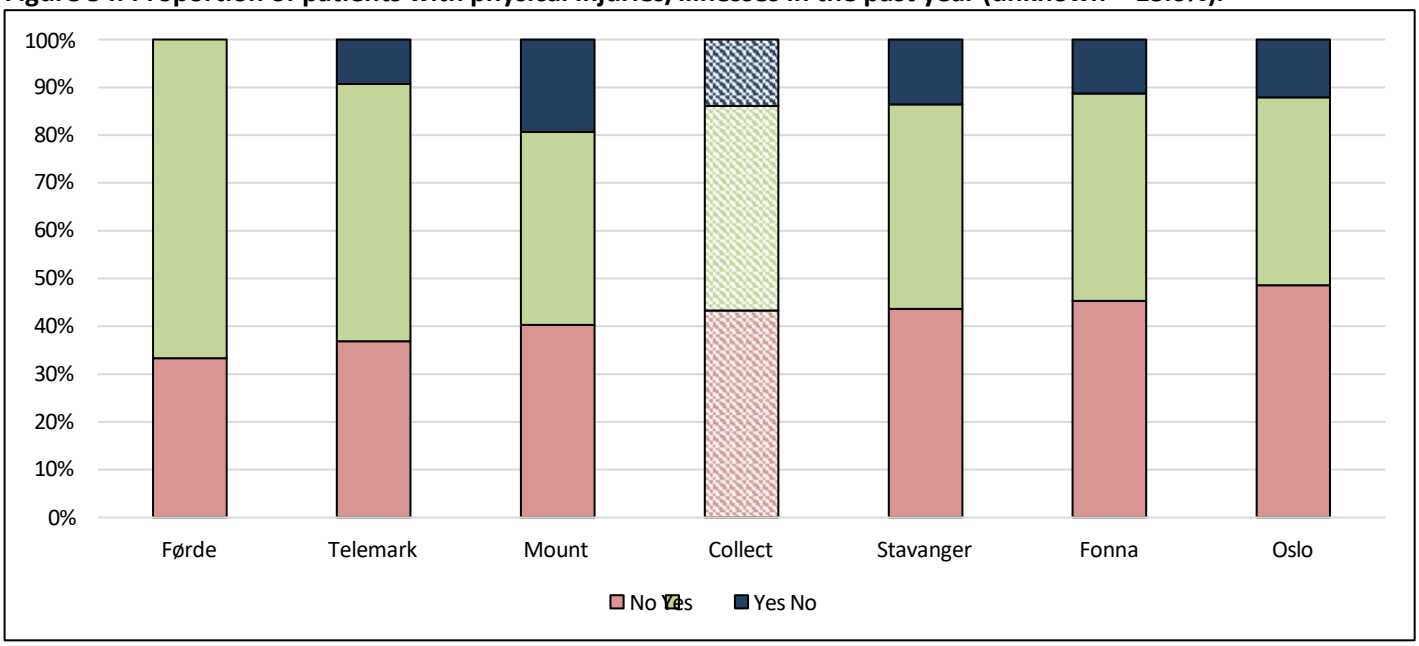
Figure 53. Proportion of patients who have had a medical examination in the past year (unknown = 19.2%).



Physical injuries and illnesses

Regarding the occurrence of physical injuries or illnesses that have affected the way of life or quality of life in the past year, 43.3% responded that they had had injuries, and 42.8% denied this (Figure 54). In comparison, we have shown earlier in the chapter that among the units using the original format, 36.9% reported physical injuries or illnesses in the past four weeks. The proportion in the last year varied from 33-49% across.

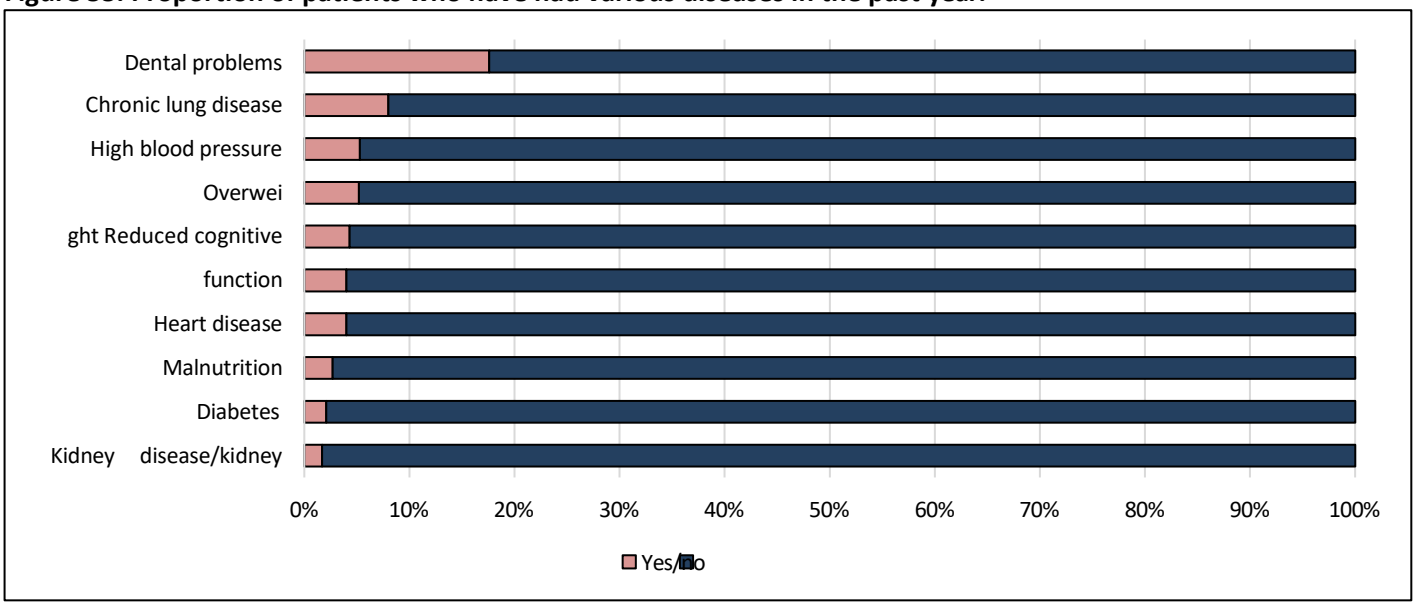
Figure 54. Proportion of patients with physical injuries/illnesses in the past year (unknown = 13.0%).



Prevalence of various diseases

Figure 55 shows an overview of the prevalence of various diseases in the previous year. Of the various diseases identified, dental problems (17.6%), chronic lung disease (8.0%), high blood pressure (5.3%) and obesity (5.2%) had the highest prevalence. For the remaining diseases, the proportions were between 1-5%.

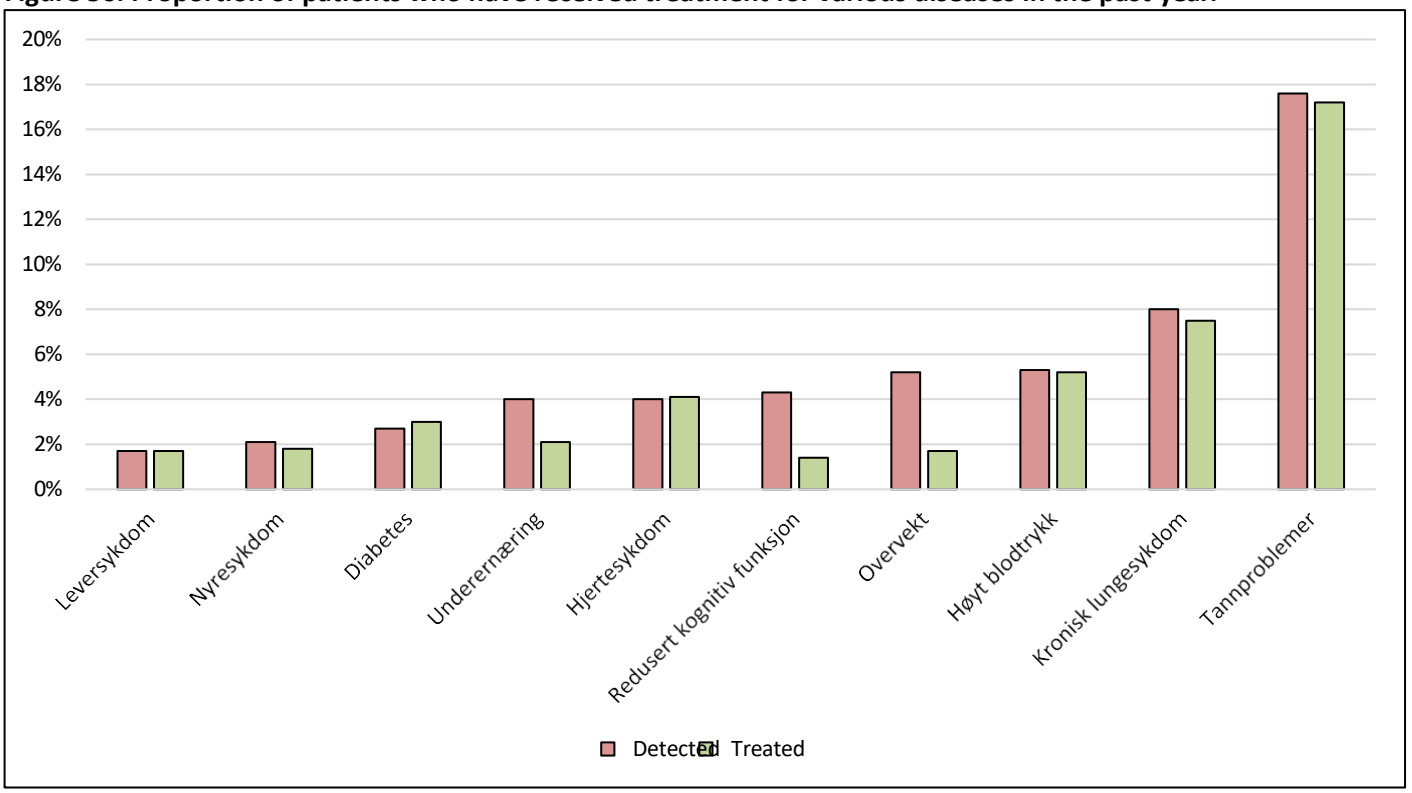
Figure 55. Proportion of patients who have had various diseases in the past year.



Treatment of various diseases

Figure 56 summarizes the treatment carried out for various diseases last year among the patients in the sample. As shown in the figure, there was a high degree of correspondence between various identified diseases or conditions, and mapping, assessment and treatment for these conditions. The exceptions are obesity, reduced cognitive function and malnutrition. The proportion of people who had been diagnosed with reduced cognitive function was clearly higher than the proportion who had undergone assessment and relevant treatment measures for this. Furthermore, a much larger proportion of those who had been diagnosed with obesity or malnutrition had received treatment for this.

Figure 56. Proportion of patients who have received treatment for various diseases in the past year.



Chronic pain and treatment

In addition to the questions about specific somatic diseases and their treatment, questions about chronic pain were also included (Figure 57). Chronic pain was defined here as persistent pain lasting more than three months. Overall, 34.0% responded that they had experienced chronic pain in the past year (compared to 33.4% in 2022). Overall, the proportion who had not had chronic pain was 42.4%, and unknown status was 23.6%. The OMT units were fairly similar in their reporting of chronic pain, but Telemark stood out with the lowest proportion of patients reporting chronic pain (19.5%). In comparison, it is often reported that about a third of the general population report having chronic pain.

Of the 33.4% who responded in the affirmative to experiencing chronic pain (977 people), 21.8% of these had received medical treatment with non-opioid painkillers, 6.2% with opioids in addition to their OMT medication, and 12.5% with non-medical treatment. Almost half of those who reported chronic pain, 45.2%, stated that they had not received treatment for this. The unknown percentage was 14.2%. Figure 58 shows the distribution of treatment for chronic pain overall and by OMT unit. The distribution is approximately the same as in 2022.

Figure 57. Proportion of patients who have had chronic pain in the past year (unknown = 23.0%).

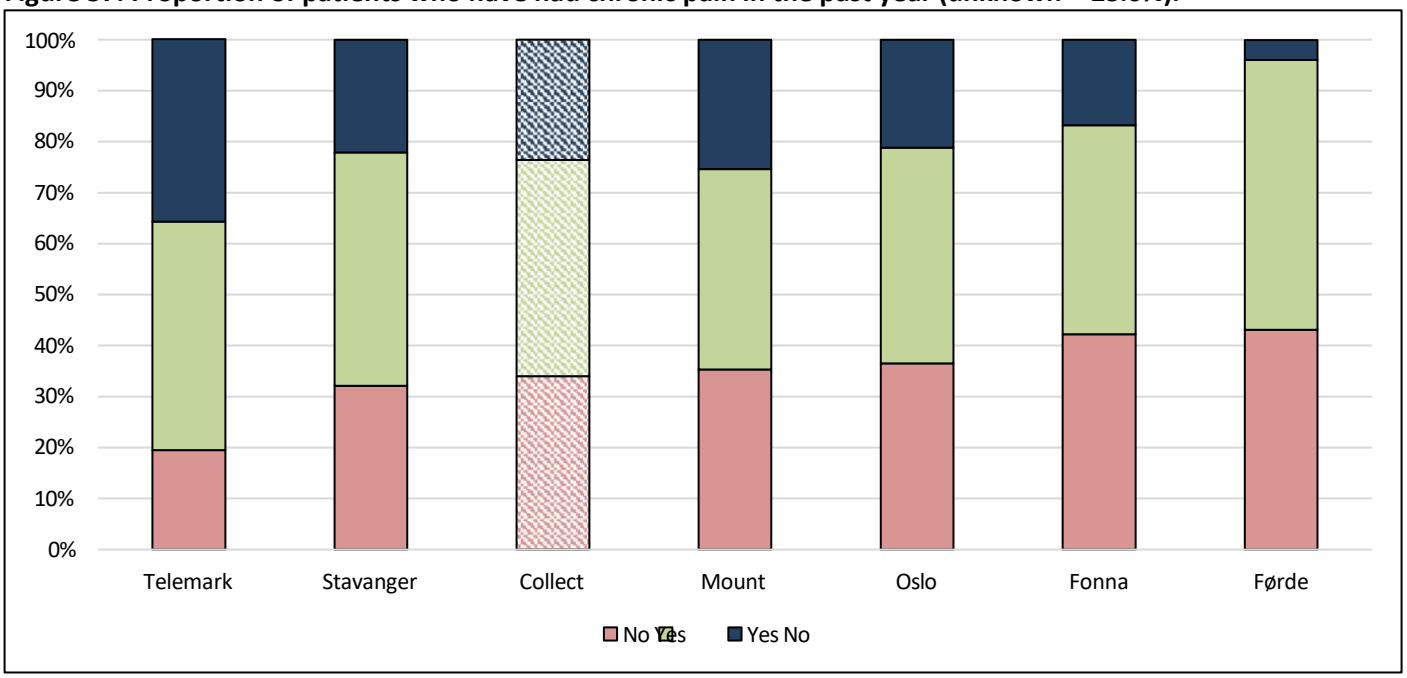
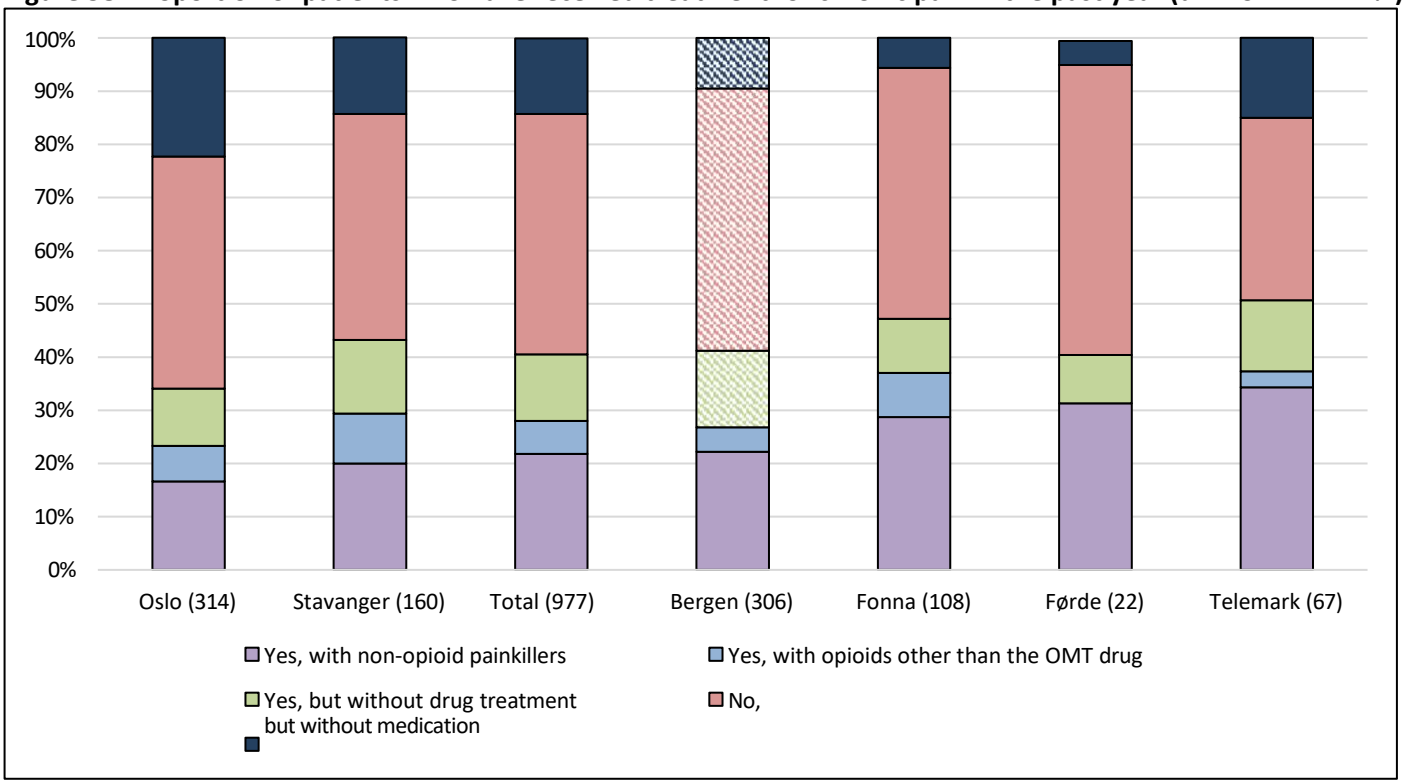


Figure 58. Proportion of patients who have received treatment for chronic pain in the past year (unknown = 14.2%).



Use of tobacco

Regarding tobacco use in the past year (Figure 59), 61.4% answered in the affirmative and 13.5% in the negative. Information was missing for 24.8% of the patients, and the proportion who had used tobacco in the past year was therefore probably higher. For those who had used tobacco (Figure 59), 73.0% reported using cigarettes and 18.4% reported using snus. A small proportion had used e-cigarettes (3.4%).

Figure 59. Proportion of patients who have used tobacco in the past year (unknown = 24.8%).

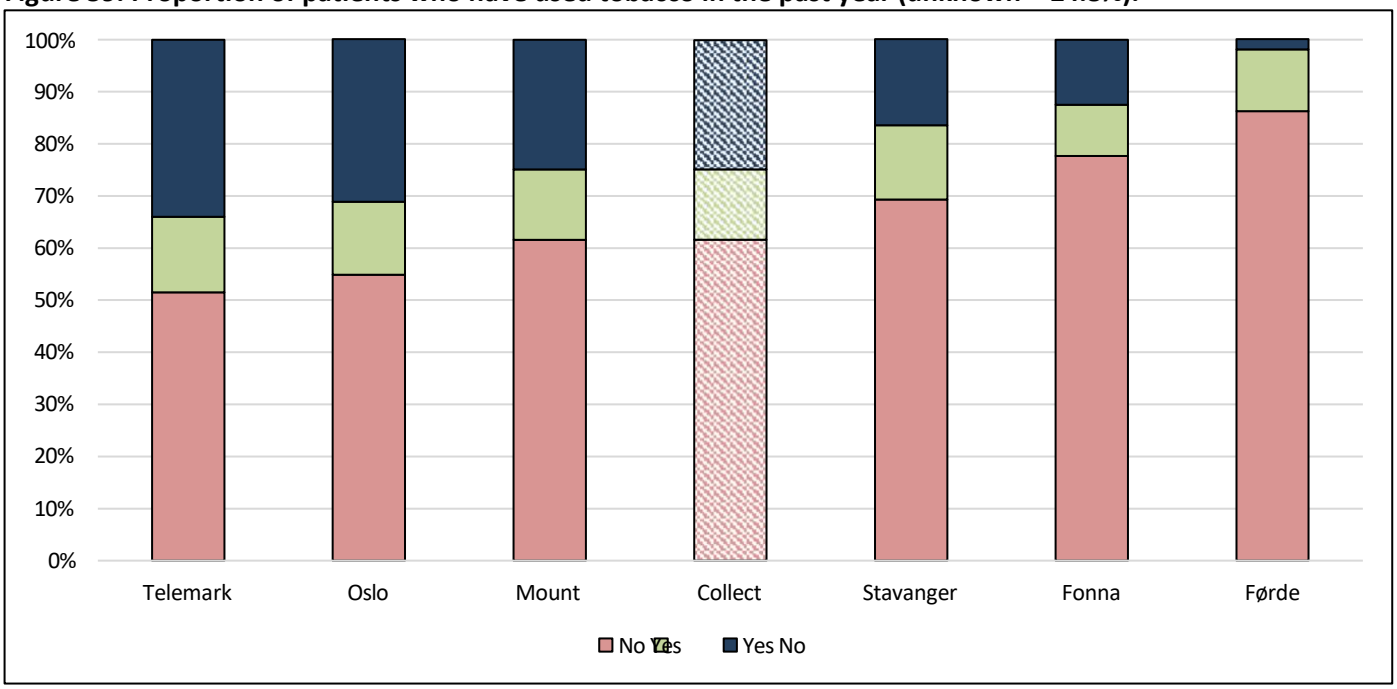
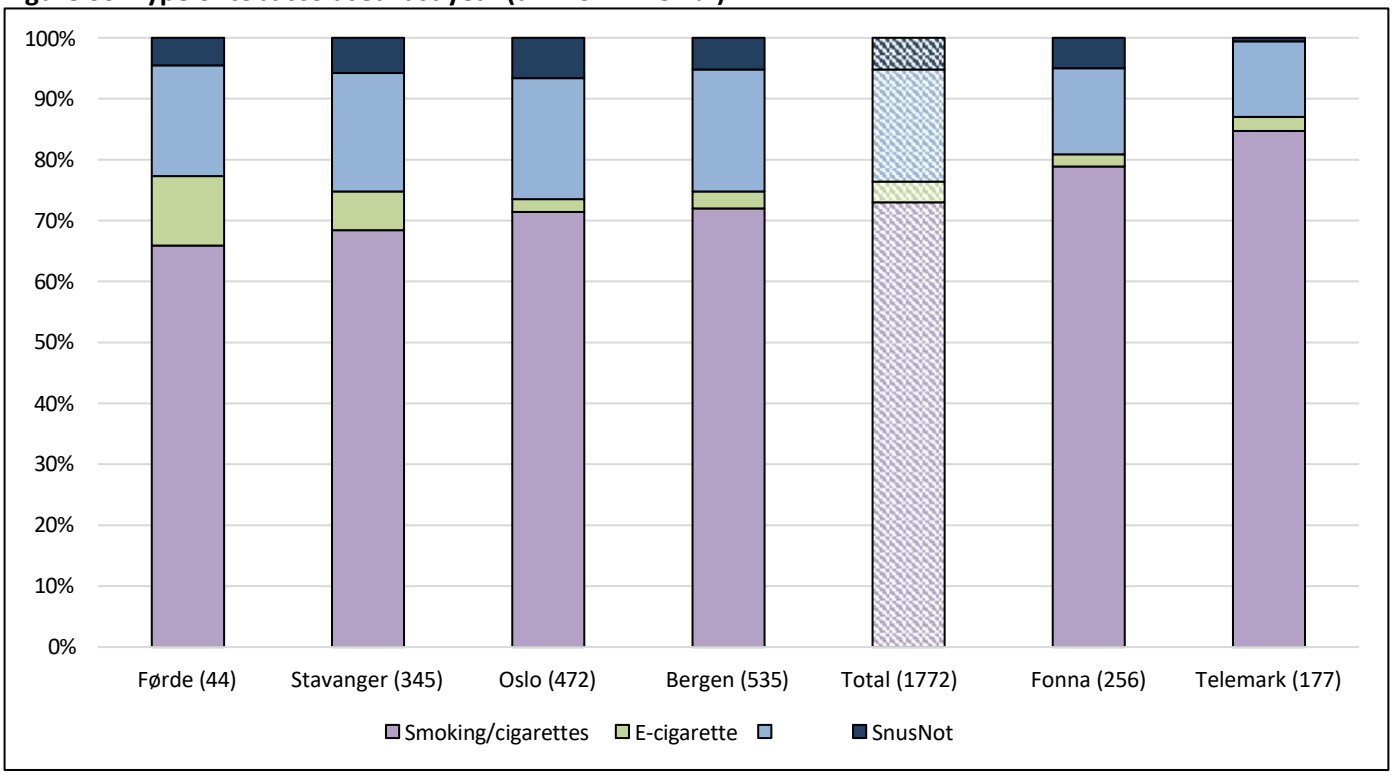


Figure 60. Type of tobacco used last year (unknown = 5.2%).

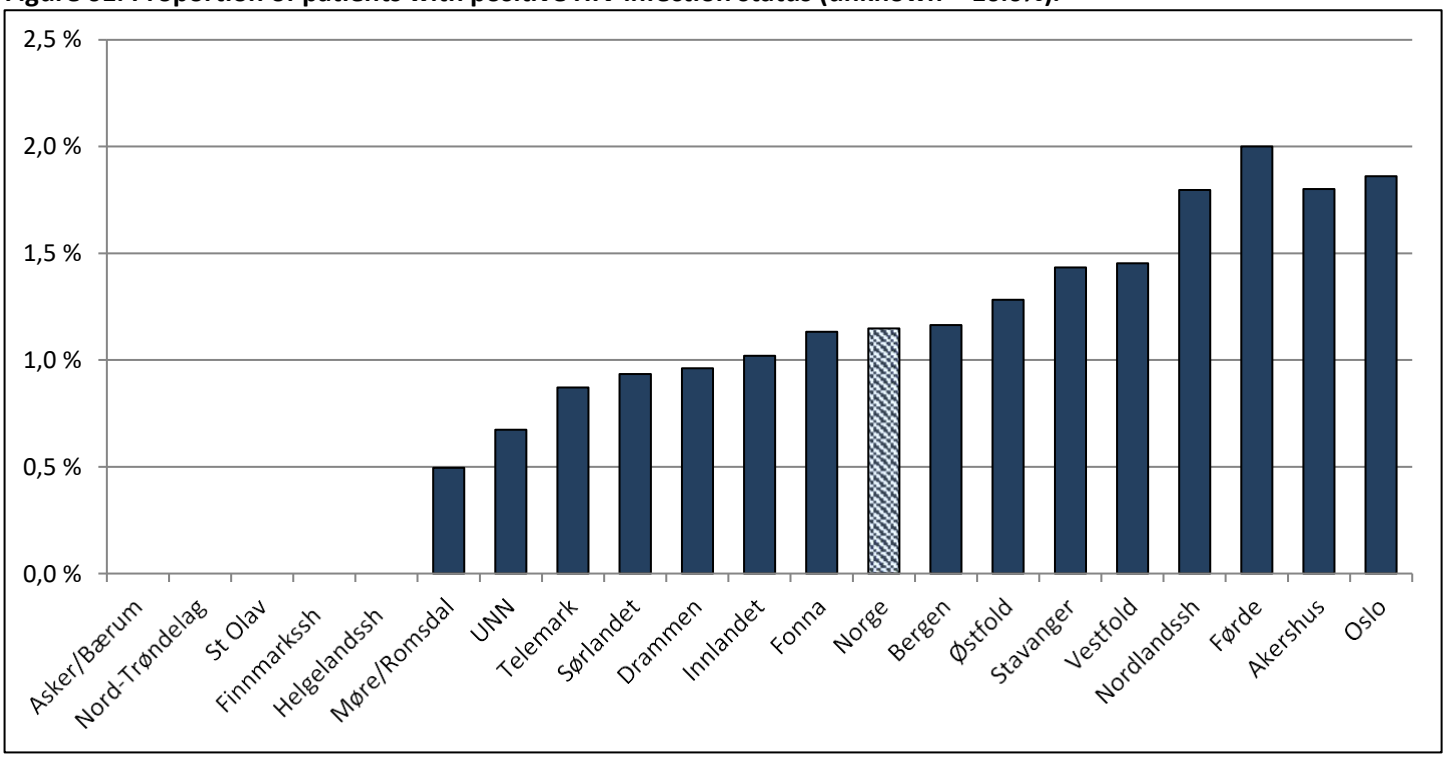


Human immunodeficiency virus (HIV)

In the general population in Norway, between 200 and 250 new cases of HIV are registered each year[11] . Tablet therapy (antiretroviral drugs) has been available since 1997 and has proved highly effective in reducing both the risk of infection and serious sequelae. Provided the patient can adhere to daily medication for life, modern HIV treatment prevents immunodeficiency and subsequent AIDS-related deaths to a very large extent.

Among OMT patients, the proportion of those infected with HIV has been stably low for several years. In 2023, the proportion with HIV-positive status was 1.1% (Figure 61), compared with 1.3% in 2022 and 1.0% in 2021. The proportion with known negative status was 88.9%, while the unknown proportion was 10.0%, which is undesirably high. No HIV infection was detected among patients in Asker and Bærum, Nord-Trøndelag, St. Olav's Hospital, Finnmark Hospital or Helgeland Hospital. The proportion with positive HIV status was highest in Oslo (1.9%) and Akershus, Førde (2.0%) and Nordland Hospital (all 1.8%). The proportion of unknown status was highest in Møre og Romsdal (17.8%), Bergen (17.7%) and at Helgelandssykehuset (17.6%), which suggests marked variation in the degree of overview of infection status between OMT units. Nationally, the proportion with unknown status remained undesirably high (8.0%). Since OMT patients are at risk of HIV infection and receive specialist treatment over time, it should be a goal to offer regular testing and treatment to all patients who want it, regardless of where they receive OMT treatment. Overall, however, the status survey shows that there is a low degree of prevalence of known HIV infection in the OMT population, with an average level that is very low in an international context.

Figure 61. Proportion of patients with positive HIV infection status (unknown = 10.0%).



[11] Norwegian Institute of Public Health (2023). Annual report 2022. Surveillance of sexually transmitted infections. Rapport 2022. Oslo: Norwegian Institute of Public Health. https://www.fhi.no/contentassets/3e70076e6e704b27843e26cc33c4214e/soi_arsrapport_2022_endelig.pdf

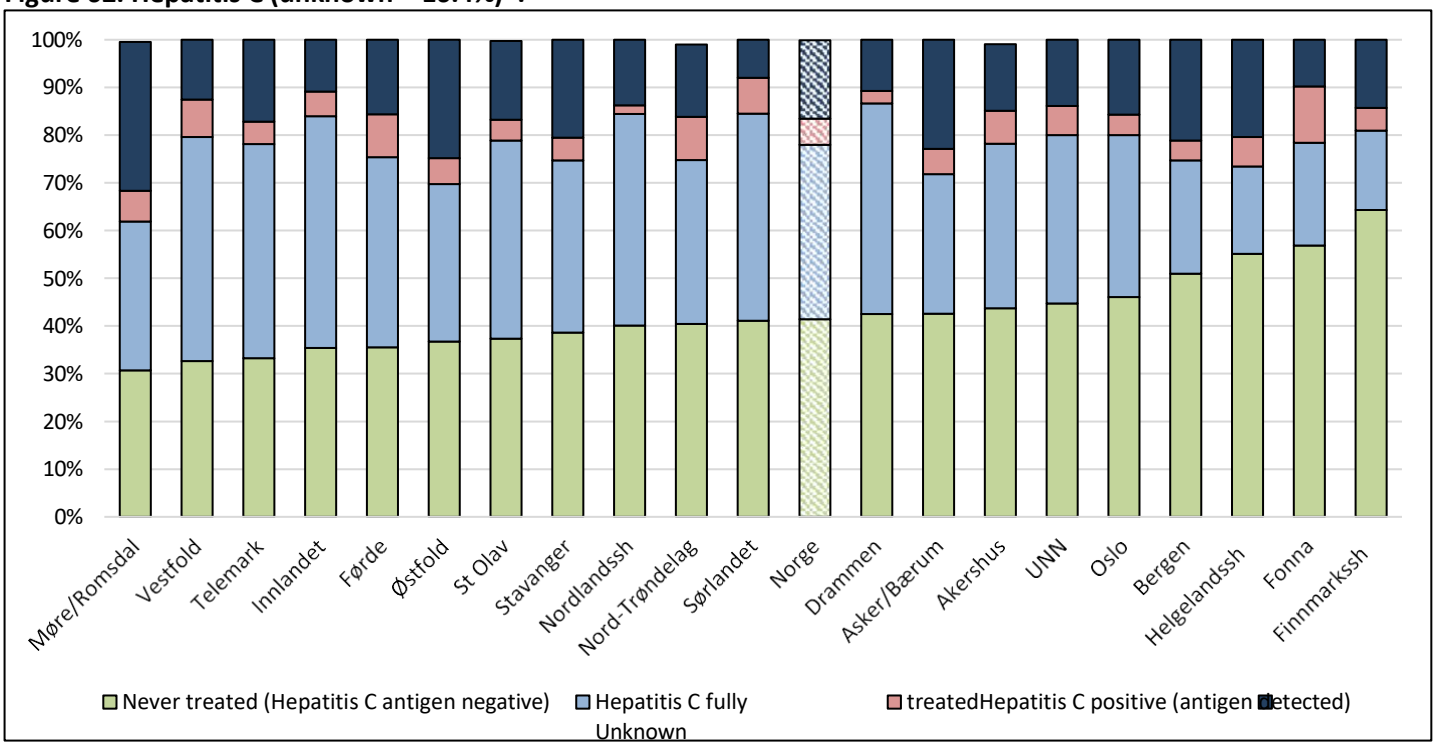
Hepatitis C

Hepatitis C has historically been highly prevalent among people who inject drugs[12] . In the general population, the prevalence of hepatitis C is estimated at approximately 0.1%. From 2018, drug treatment based solely on tablets has been available. The national strategy to eradicate hepatitis C by 2023[13] has furthermore been an important part of a renewed treatment optimism in recent years, and has contributed to a significant reduction in the prevalence of hepatitis C. The treatment prognosis for hepatitis C is good if follow-up is interdisciplinary within the specialist health service. In principle, everyone in OMT is eligible for assessment and possibly treatment for hepatitis C, and patients should therefore be offered regular antigen tests. Since there is no HCV vaccine, there is a risk of reinfection, which suggests need-based screening examinations in special risk groups, such as people who actively inject drugs.

Hepatitis C reporting in the status survey has been imprecise in that it could not distinguish between previous and new infections. Nor could it be used to estimate the actual infection status, as this requires updated information on the detected viral antigen. The challenges are partly due to the fact that the mapping of hepatitis C is extensive and requires specialist knowledge, and partly due to the fact that the opportunities for mapping are limited because the survey is only carried out once a year. In recent years, we have tried to conduct a more objective survey. At the same time, different versions of the status form have been used, with varying wording. Attempts have been made to integrate these. Today, antigen testing is primarily used, and antibody tests are rarely used.

Based on this year's figures for hepatitis C (Figure 62), 36.6% have completed treatment for hepatitis C (compared to 35.6% in 2022), in addition to 41.4% having hepatitis C confirmed based on antigen tests (compared to 38.1% in 2022). These figures give hope that we can reduce the incidence of hepatitis C among OMT patients in the years to come. Further work on assessment, diagnosis and treatment is important to achieve the long-term goal of eradicating hepatitis C in the OMT population. Access to clean user equipment is important for those who inject drugs and should therefore be prioritized.

Figure 62. Hepatitis C (unknown = 16.4%)*.



[12] Norwegian Institute of Public Health (2023). Status report on the elimination of hepatitis B and C as a public health problem in Norway. Oslo: Norwegian Institute of Public Health. https://www.fhi.no/contentassets/f35ea65ab2694b408f0957fc4a9d695b/statusrapport_fhi_hdir_eliminasjon-_hepatitis-b-and-c_norge_2023.pdf

[13] Ministry of Health and Care Services. National strategy against hepatitis 2018-2023. https://www.regjeringen.no/contentassets/0a7db35f049c46e8b368ad9751f0c870/nasjonal-strategi-mot-hepatitter.pdf

Physical health assessments and treatment

The findings on physical health and treatment over the past four weeks show that health problems that affected lifestyle and quality of life were widespread, in about 4 out of 10 patients, and that 1 in 3 had experienced chronic pain during the past year. In addition to chronic pain, the most common health problems were dental problems, chronic lung disease and high blood pressure, but a number of others also occurred. In terms of blood infection status, the figures show that the efforts aimed at hepatitis C mapping and treatment have been largely successful. The prevalence of HIV is also stably low among OMT patients.

Most patients, 7 out of 10, had been to a medical examination in the past year, and those who had specific illnesses or ailments had received follow-up or treatment for this. The figures thus show that some patients experience a number of different health problems that require follow-up, but the figures also show that many receive relevant follow-up and treatment for these problems. For example, dental treatment is free for patients in OMT. When a large proportion of patients in OMT experience dental problems, it is positive to see that many receive dental treatment. The figures also suggest that it is important to continue to offer free dental treatment. Of those who received treatment for chronic pain, a small proportion of around 6% received opioid-based treatment for this. We see that there are a number of other approaches used when patients have chronic pain, but also that many do not receive any follow-up for their chronic pain. Of the lifestyle-related factors, the use of tobacco was mapped. A large proportion of patients in OMT smoke and may be in need of smoking cessation interventions.

The prevalence of physical injuries and illnesses increases with increasing age in the OMT population, and the proportion in need of follow-up related to physical health is therefore likely to increase in the coming years. In addition, OMT patients live up to 15 years shorter and develop health problems earlier than the rest of the population.[14] Since physical health problems such as cancer, cardiovascular disease and chronic lung disease increase with age, OMT services should plan and coordinate regular examinations of health problems, including mapping the side effects of prescribed medication.

[14] Lewer et al (2020). Life expectancy of people who are dependent on opioids: a cohort study in New South Wales, Australia. *Journal of Psychiatric Research.* https://pubmed.ncbi.nlm.nih.gov/32905957/

INTOXICATION

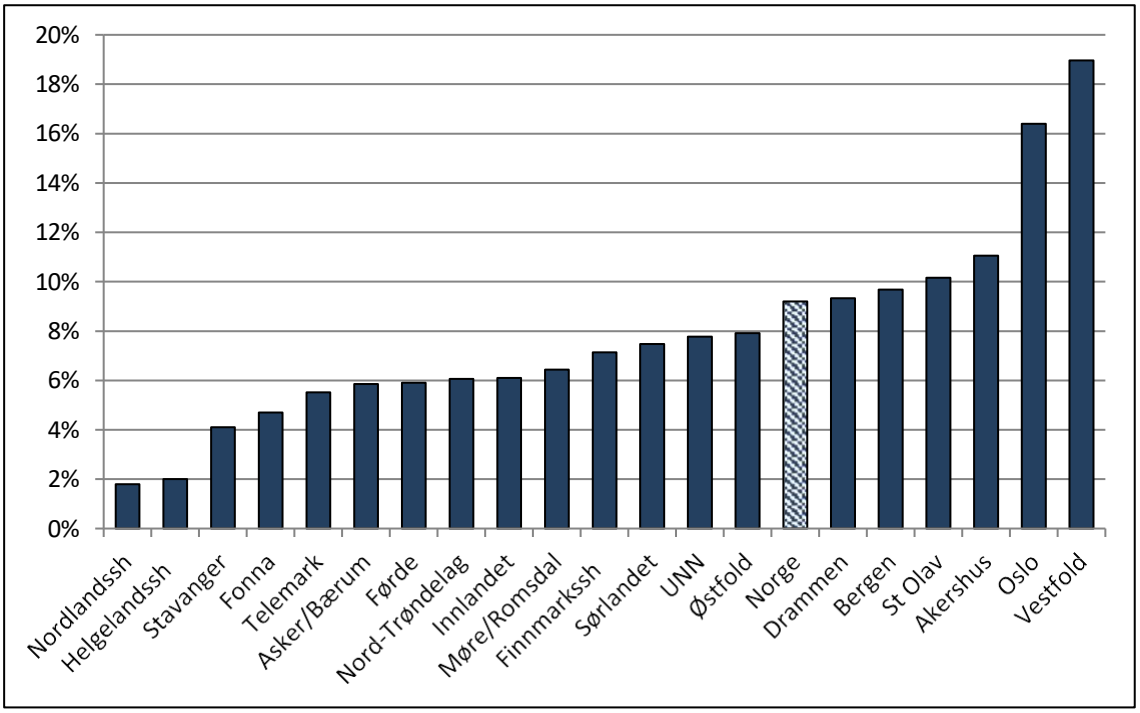
The status survey includes questions about substance use (alcohol, illicit drugs, and drugs, prescribed or non-prescribed) during the previous four weeks. The questions concern self-reported or proven use of opioids other than OMT, cannabis, benzodiazepines and stimulants, as well as an evaluation of the extent of ongoing substance use and current substance abuse. The questions do not provide information about frequency or degree of use. Some questions about substance abuse in the past year are also included. In particular, assessments of substance use in the past year require regular contact with patients, information about the patient's situation and professional judgment.

Opioids other than OAT medication

Figure 63 shows the use of opioids in the last four weeks. Opioid use was reported for 9.2% of patients (compared to 10.4% in 2022). Regionally, the lowest proportion of opioid use was in the north (5.4%) and the highest in the east (11.6%). Nordland Hospital (1.8%) and Helgeland Hospital (2.0%) had the lowest proportion of patients with opioid use, while Vestfold (19.0%) and Oslo (16.4%) had the highest. However, the proportion of unknown patients was high in the north (34.1% at Nordland Hospital and 28.0% at Helgeland Hospital). Overall, the figures indicated that around 1 in 10 had concurrent opioid use. This level has been stable over the past decade. However, the high proportion of patients with unknown opioid use status makes underreporting likely.

Figure 63. Proportion of patients with reported use of opioids in the last four weeks (unknown = 17.0%).

Nordlandssh1	.8 %
Helgelandssh2	.0 %
Stavanger4	,1 %
Fonna4	,7 %
Telemark5	.5 %
Asker/Bærum5	,9 %
Førde5	.9 %
Nord-Trøndelag6	,1 %
Inland Norway6	,1 %
Møre/Romsdal6	,4 %
Finnmarkssh7	.1 %
Southern Norway7	.5 %
UNN7	,8 %
Østfold7	,9 %
Norway9	**.2 %**
Drammen9	.3 %
Bergen9	,7 %
St Olav10	.2 %
Akershus11	,1 %
Oslo16	.4 %
Vestfold19	.0 %

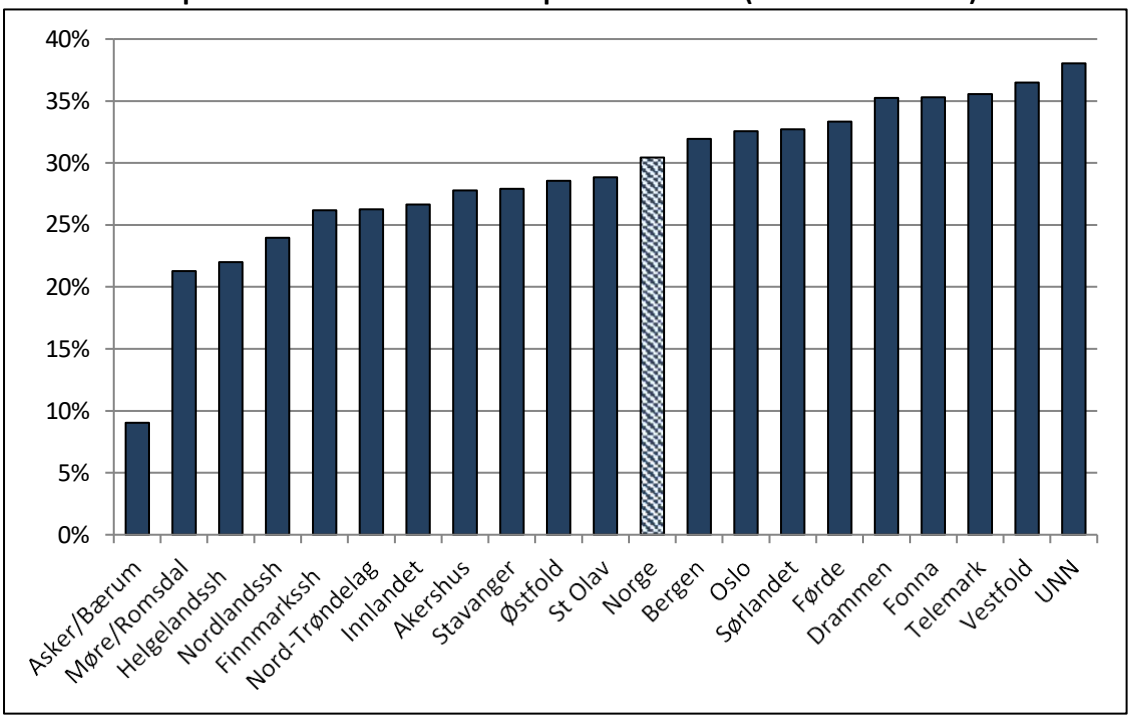


Cannabis

As shown in Figure 64, 30.4% reported using cannabis in recent weeks (compared to 32.0% in 2022). The prevalence was fairly similar across the regions (between 26.2 and 32.0%). Asker and Bærum stood out with the lowest proportion of patients with reported cannabis use in the past four weeks (9.0%), but also with a very high proportion with unknown status for cannabis use (40.4%). The proportion with unknown status was also high at Nordland Hospital (32.3%) and Helgeland Hospital (32.0%). Førde has the lowest proportion with unknown status (4.1%). The distribution at unit level is approximately the same as the previous year. It is not clear whether the differences are systematic or due to differences in reporting practices and coincidences.

Figure 64. Proportion of patients with reported use of cannabis in the past four weeks (unknown = 17.3%).

Asker/Bærum	9,0 %
Møre/Romsdal	21,3 %
Helgelandssh	22,0 %
Nordlandssh	24,0 %
Finnmarkssh	26,2 %
Nord-Trøndelag county	26,3 %
Inland	26,6 %
Akershus	27,8 %
Stavanger, Norway	27,9 %
Østfold	28,6 %
St Olav	28,8 %
Norway	**30,4 %**
Mountains	31,9 %
Oslo, Norway	32,6 %
Southern Norway	32,7 %
Førde	33,3 %
Drammen	35,3 %
Fonna	35,3 %
Telemark	35,6 %

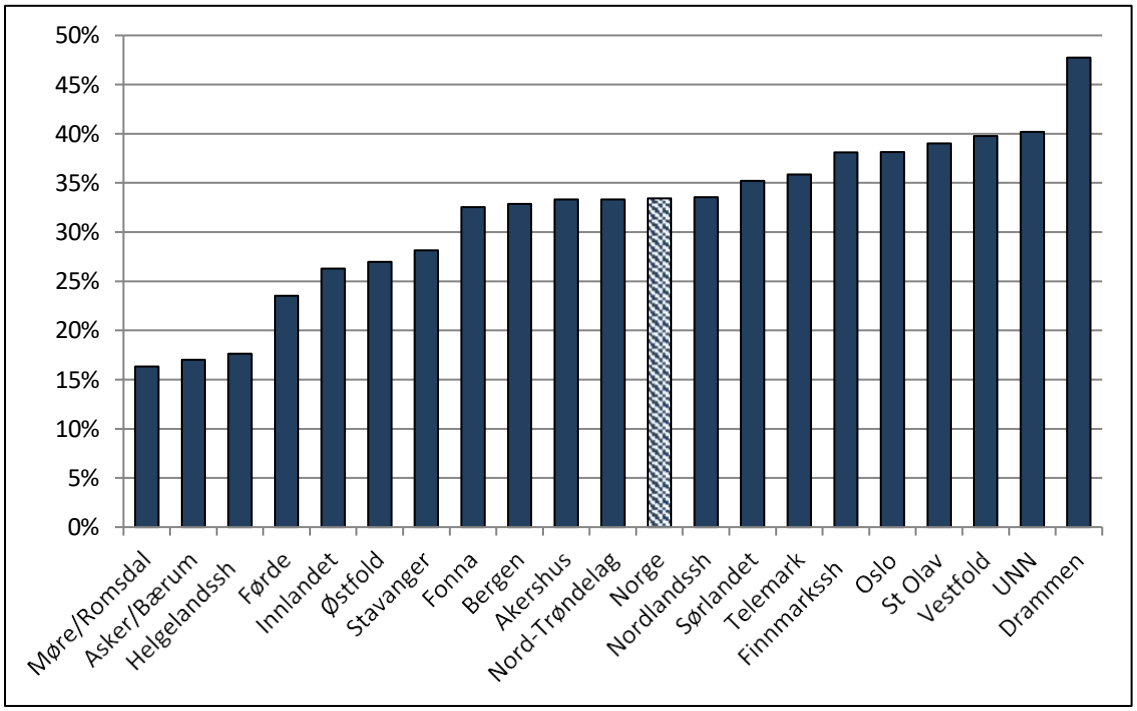


Benzodiazepines

As Figure 65 shows, 33.4% reported substance use of benzodiazepines in recent weeks, a clear decrease from 41.3% in 2022. This can probably be partly linked to increased prescribing and reduced need for drug-induced use. The proportion with substance use was somewhat higher in the south (36.5%) and north (36.0%). The proportion was lowest in Møre og Romsdal (16.3%), Asker and Bærum (17.0%) and Helgelandssykehuset (17.6%), and highest in Drammen (47.8%). There were large differences in the proportion with unknown status (1.8-36.7%).

Figure 65. Proportion of patients with reported use of benzodiazepines in the last four weeks (unknown = 13.5%).

Møre/Romsdal	16,3 %
Asker/Bærum	17,0 %
Helgelandssh	17,6 %
Førde	23,5 %
Inland	26,3 %
Østfold	27,0 %
Stavanger, Norway	28,1 %
Fonna	32,5 %
Mountains	32,9 %
Akershus	33,3 %
Nord-Trøndelag	33,3 %
Norway	**33,4 %**
Nordlandssh	33,5 %
Southern Norway	35,2 %
Telemark	35,9 %
Finnmarkssh	38,1 %
Oslo, Norway	38,1 %
St Olav	39,0 %
Vestfold	39,8 %
UNN	40,2 %

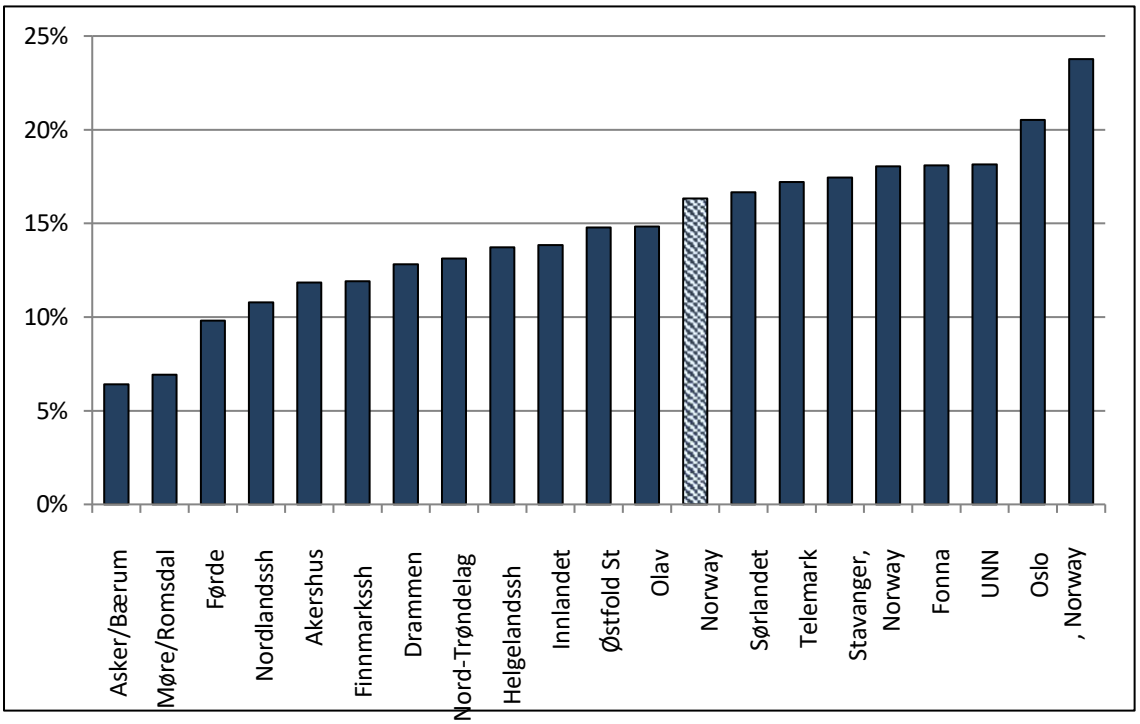


Central stimulants

As shown in Figure 66, 16.3% reported using stimulants in recent weeks, compared with 15.6% in 2022. The national average has been fairly stable over the past decade. The distribution was fairly similar at regional level, but with differences between SUD units. The proportion using stimulants was lowest in Asker and Bærum (6.4%) and Møre og Romsdal (6.9%), and highest in Bergen (23.8%).

Figure 66. Proportion of patients with reported use of stimulants in the last four weeks (unknown = 17.0%).

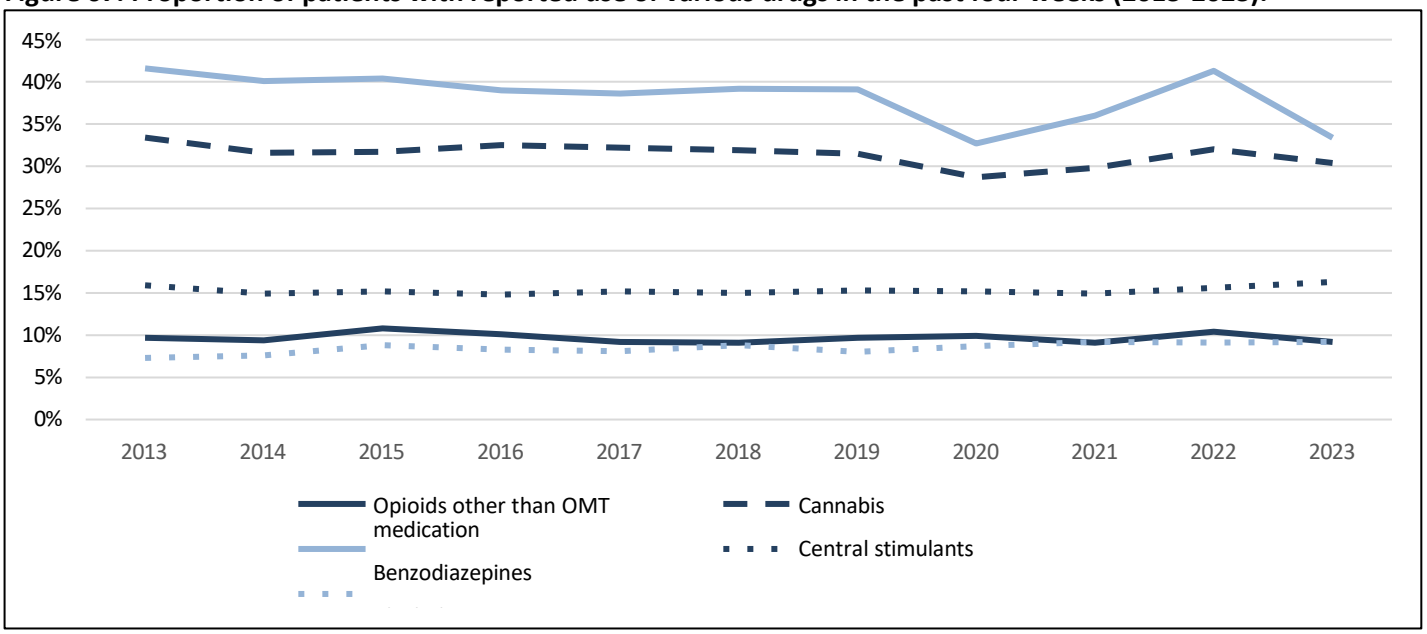
Asker/Bærum	6,4 %
Møre/Romsdal	6,9 %
Førde	9,8 %
Nordlandssh	10,8 %
Akershus	11,8 %
Finnmarkssh	11,9 %
Drammen	12,8 %
Nord-Trøndelag	13,1 %
Helgelandssh	13,7 %
Inland	13,8 %
Østfold	14,8 %
St Olav	14,8 %
Norway	**16,3 %**
Southern Norway	16,7 %
Telemark	17,2 %
Stavanger, Norway	17,5 %
Fonna	18,0 %
UNN	18,1 %
Oslo, Norway	18,1 %
Vestfold	20,5 %
Mountains	23,8 %



Current substance use over time

The distribution of trends in the use of various drugs over the past decade is shown in Figure 67. The use of opioids other than OMT has remained stable at around 10%. The same applies to problem alcohol use. The use of stimulants has remained stable at 15% over the last ten years, and cannabis at around 30%. However, there was a decrease in the use of benzodiazepines and cannabis from 2019 to 2020, probably due to reduced access during the pandemic. The use of benzodiazepines increased by about ten percentage points from 2020 to 2022, to just above the pre-pandemic level, before we see a clear reduction in 2023. The use of benzodiazepines appears to be most prevalent among patients in OMT, followed by cannabis. Some of the units that reported a lower prevalence of substance use also appear to be among those that reported the highest degree of unknown status. Frequent unknown status may be more prevalent in OMT units with less frequent patient contact and lower levels of patient participation in the status survey, without necessarily reflecting actual substance use.

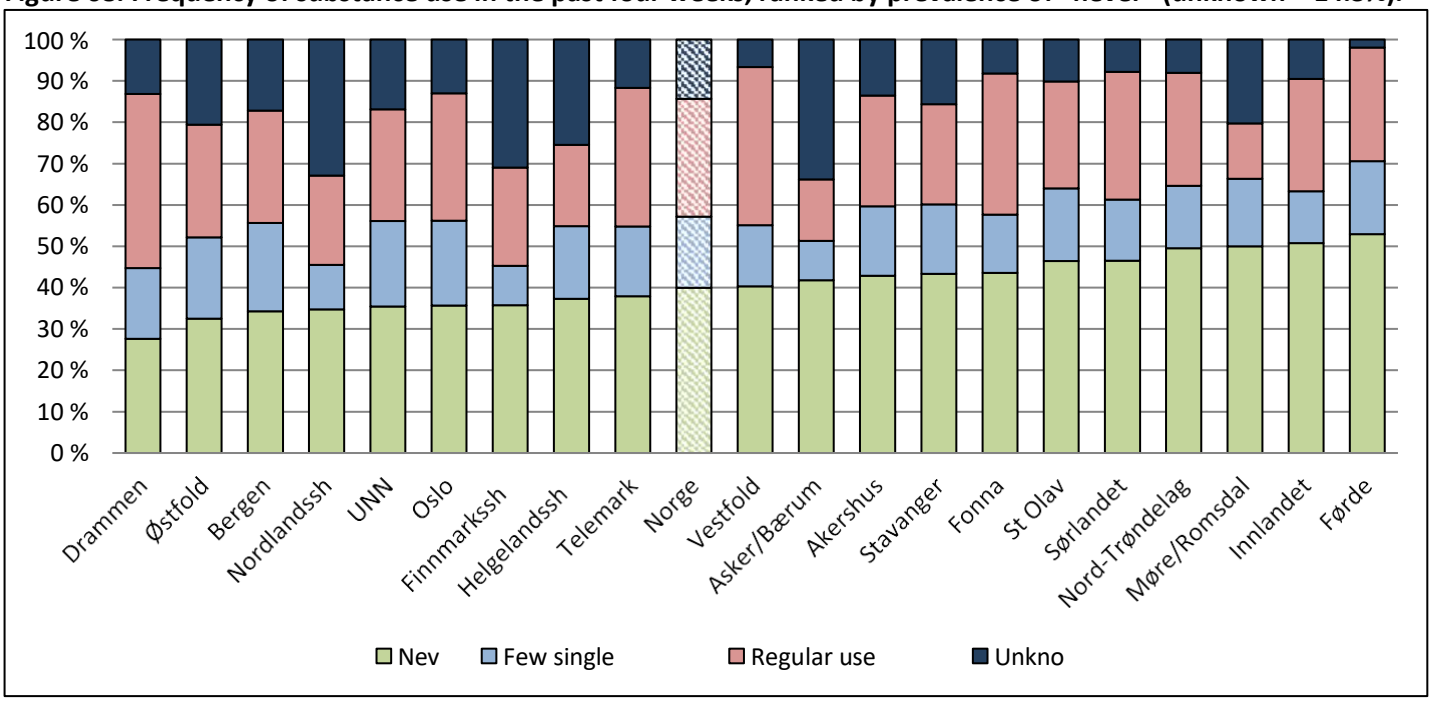
Figure 67. Proportion of patients with reported use of various drugs in the past four weeks (2013-2023).



Frequency of substance use

On a national basis, 40.0% reported no known substance use in recent weeks (Figure 68), compared with 38.4% in 2022. Furthermore, 17.2% had had single episodes, and 28.5% more regular use. Figure 45 shows the distribution of responses in the individual units. Møre og Romsdal had the lowest proportion with known regular use (13.4%) and Drammen the highest proportion with known regular use (42.1%), while OAT Asker and Bærum had the fewest with known regular use (14.8%).

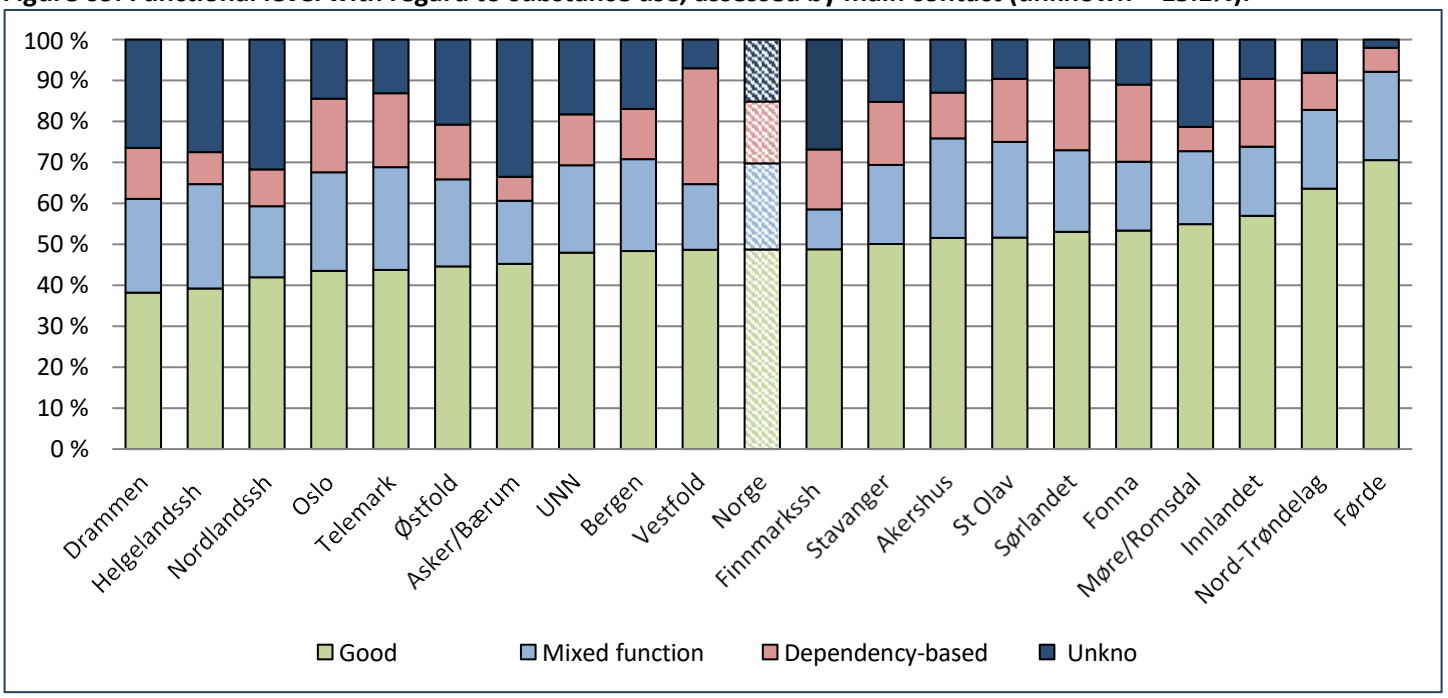
Figure 68. Frequency of substance use in the past four weeks, ranked by prevalence of "never" (unknown = 14.3%).



Intoxication control

When conducting the status survey, the patient's primary contact has assessed the patient's coping with substance abuse in the past year, according to good function, mixed function and addictive substance use. Good functioning means that there is no substance use that has a negative impact on social functioning or quality of life. Mixed function refers to some degree of negative impact. Addictive use means use that dominates everyday life. In 2023, 48.7% were considered to have good function in everyday life (Figure 69), roughly the same as in 2022 and previous years. Furthermore, 21.0% were assessed as having mixed functioning, and 15.1% with addictive use, and in an intermediate category with more variable functioning. There were generally small differences between the SUD units.

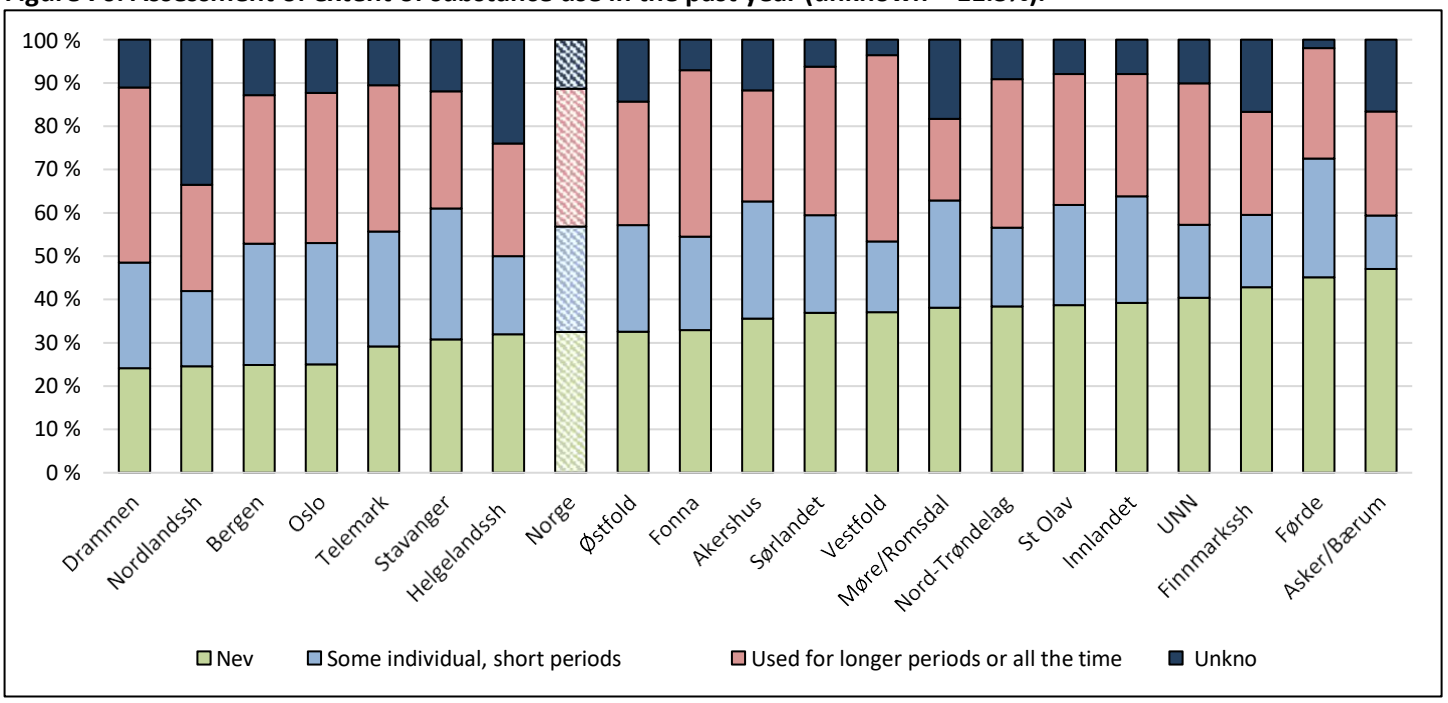
Figure 69. Functional level with regard to substance use, assessed by main contact (unknown = 15.1%).



Extent of substance use

As shown in Figure 70, 32.5% reported that they had not used intoxicants in the past year (32.3% in 2022). Furthermore, 24.3% had only used intoxicants occasionally, and 31.8% for longer periods or throughout the year. There were some minor regional differences in substance use. The OAT unit with the highest proportion that had not used drugs in the past year was Asker and Bærum (47.0%), while Drammen, Nordlandssykehuset, Bergen and Oslo all had around 25% that had not used drugs in the past year. Figure 73 shows the annual proportion of those assessed as not having used intoxicants in the past year since 2005. The proportion fell in the first few years but has varied between 30 and 35% since 2007. After 2013, there has been a slight increase in the proportion who do not use intoxicants.

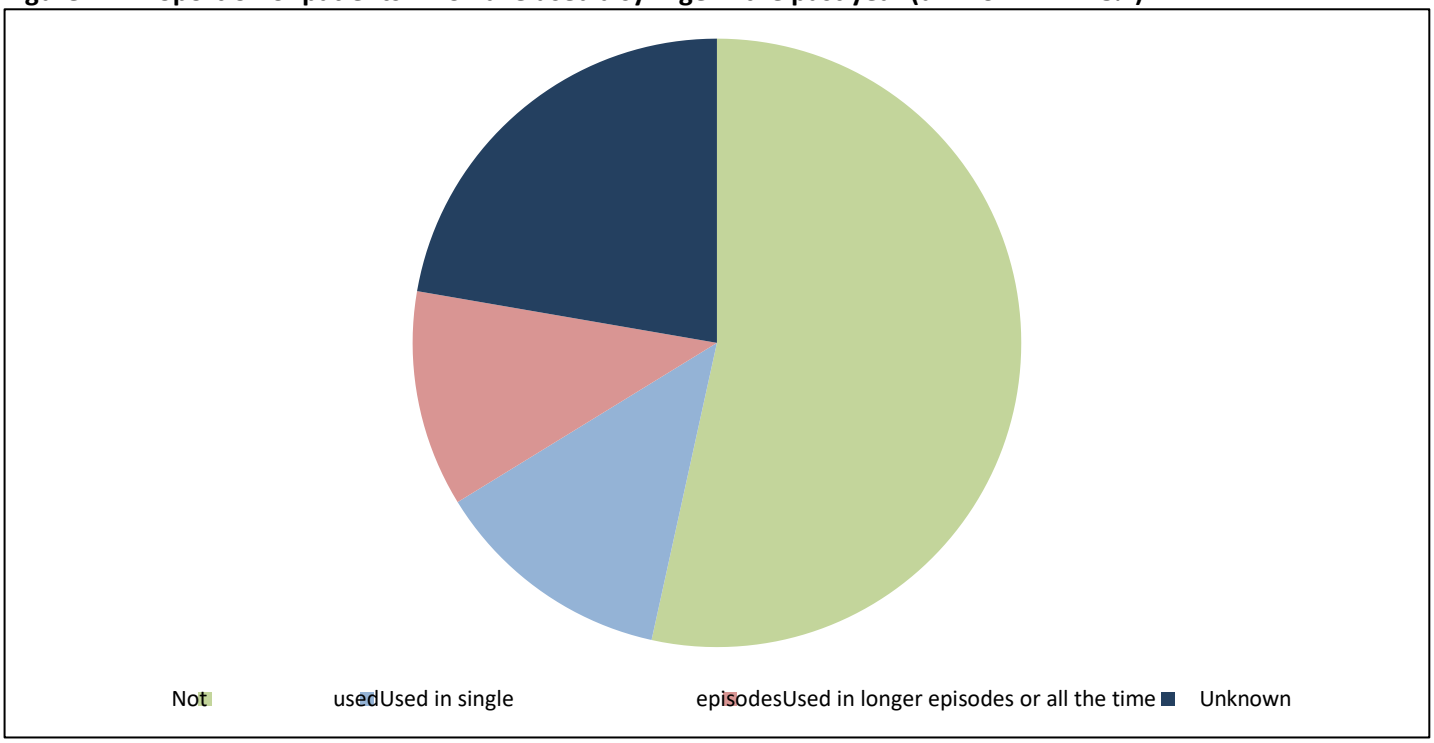
Figure 70. Assessment of extent of substance use in the past year (unknown = 11.3%).



Injecting drug use

For those of the health trusts that use the DIPS Arena medical record system, the status survey for 2023 included a question about the use of syringes in the past year. As shown in Figure 71, 53.5% of patients had not used drugs with a syringe in the past year (49.9% in 2022). A smaller proportion of 11.5% had used syringes for longer periods or throughout the year, while 12.8% had only used syringes in limited episodes.

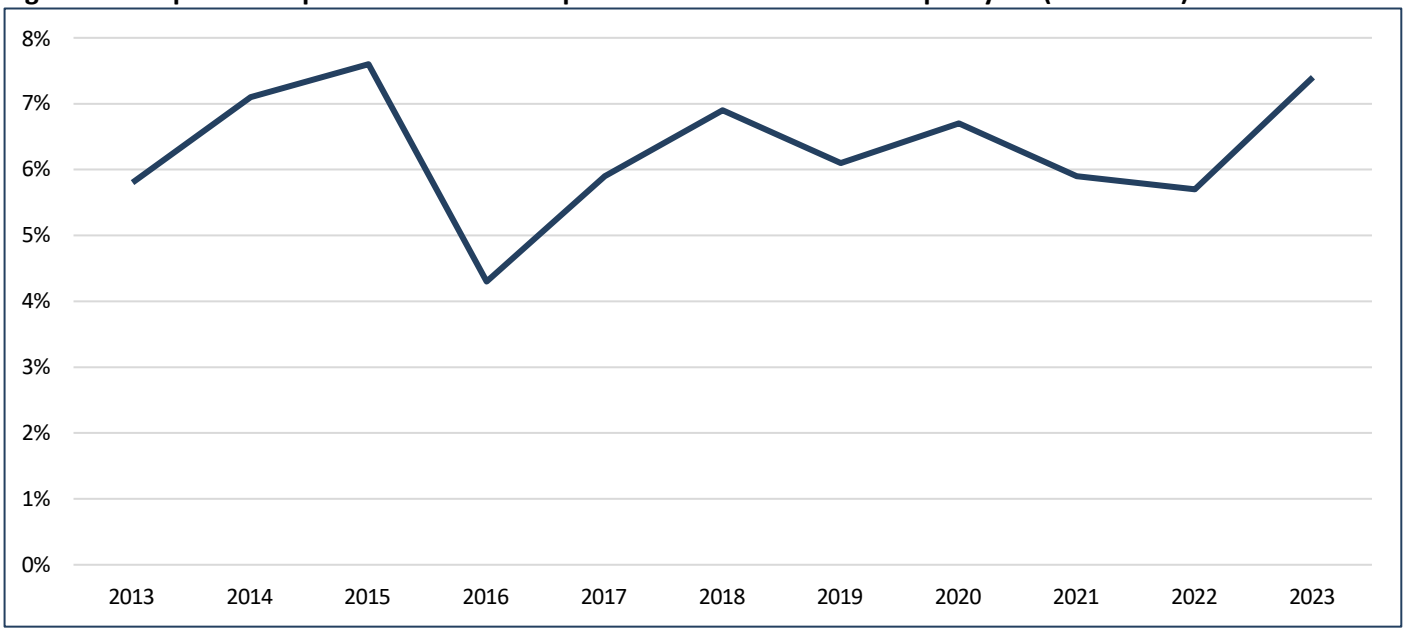
Figure 71. Proportion of patients who have used a syringe in the past year (unknown = 21.8%).



Overdose

The majority had not experienced an overdose (life-threatening poisoning) in the past year (80.9%, compared with 83.0% in 2022). A proportion of 7.4% reported having had an overdose in the past year, slightly higher than in 2022 (5.7%). The proportion of unknown has not changed significantly from 2022 (11.3%) to 2023 (11.7%). Figure 72 shows the trend in annual overdoses among patients in OMT. This applies to overdoses that have not resulted in death. For overdoses that have resulted in death, see separate chapter on mortality in OMT.

Figure 72. Proportion of patients who have experienced an overdose in the past year (2013-2023).



Assessments of substance use in the past year

In the status survey, recent use of various substances is measured individually, in addition to frequency of substance use and coping with substance abuse. Far from all substance use causes problems or is problematic, but the type and degree of substance use during treatment in OMT can provide indications of the benefits of the treatment. This applies in particular to concomitant use of opioids other than OMT medication, but the use of other drugs can also have an impact on treatment outcomes. In particular, complex use may have implications for treatment and the individual's outcome of treatment. However, ongoing substance use during treatment can also be an indication that adjustments should be made to the treatment.

Overall, the use of the various substances has been stable for a number of years. A large proportion had an unknown status when it came to the use of various substances, and it is therefore expected that the actual proportion with ongoing substance use is somewhat higher. In smaller units, it is probably easier to have an overview of the current substance use of individual patients. Overall, about half of the patients had good functioning in terms of substance abuse management, and four out of 10 had no ongoing substance abuse. We see that there is a small group of patients who use intoxicants regularly and uncontrollably, and who may therefore be in need of treatment changes or customized follow-up. Through OMT, these patients will be able to maintain contact with the services and will be offered health care and psychosocial follow-up when needed. The choice of medication, dispensing arrangements and drug testing can be important topics to address in treatment.

In conclusion, the figures for substance use last year are comparable with last year. More than half of the patients can be considered to be in a good situation when it comes to substance use in the past year, and a third are persistently drug-free. At the same time, we see that a third can be considered to have sustained serious substance use, and a slight increase in experienced overdoses last year. Overall, we see that the majority of OMT patients thus have good substance abuse control both in the past four weeks and in the past year, and in proportional terms in line with the proportion who have freedom from substance abuse as their treatment goal. At the same time, it should be emphasized that the majority of patients with persistent

substance use have stable psychosocial conditions, and that OMT also seems to work well from a harm reduction perspective.

BREACH OF LAW

The status survey includes individual questions about offenses in the past year (arrest, custody, prosecution and/or conviction). No questions are asked about the type of offense. The majority, 75.1%, had not committed an offense. The proportion who have been arrested, remanded in custody, prosecuted or convicted during the previous year is shown in figure 73. During the previous year, 7.9% were reported to have committed an offence, compared to 8.4% in 2022, 9.6% in 2021 and 10.3% in 2020. There was a fairly high proportion with unknown status (17.0%). In recent years, we have seen a slight downward trend in terms of known offenses (Figure 74).

Figure 73. Percentage who have been arrested in the past year (unknown = 17.0%).

Asker/Bærum	4,7 %
Finnmarkssh	4,8 %
Østfold	4,9 %
Førde	5,9 %
Helgelandssh	6,0 %
UNN	6,0 %
Oslo, Norway	6,4 %
Nord-Trøndelag	7,1 %
Drammen	7,4 %
Mountains	7,5 %
Fonna	7,5 %
Stavanger, Norway	7,8 %
Vestfold	7,8 %
Norway	**7,9 %**
Møre/Romsdal	7,9 %
Nordlandssh	8,4 %
Inland	9,2 %
Akershus	9,4 %
Southern Norway	9,8 %
Telemark	10,2 %
St Olav	11,3 %

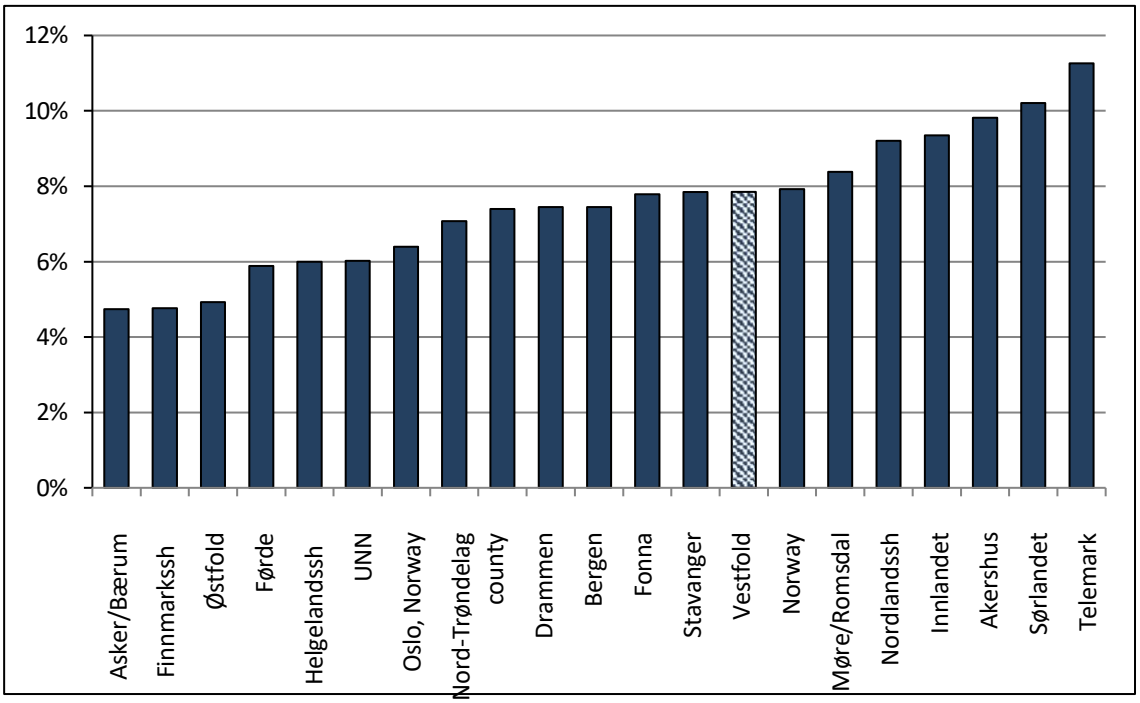
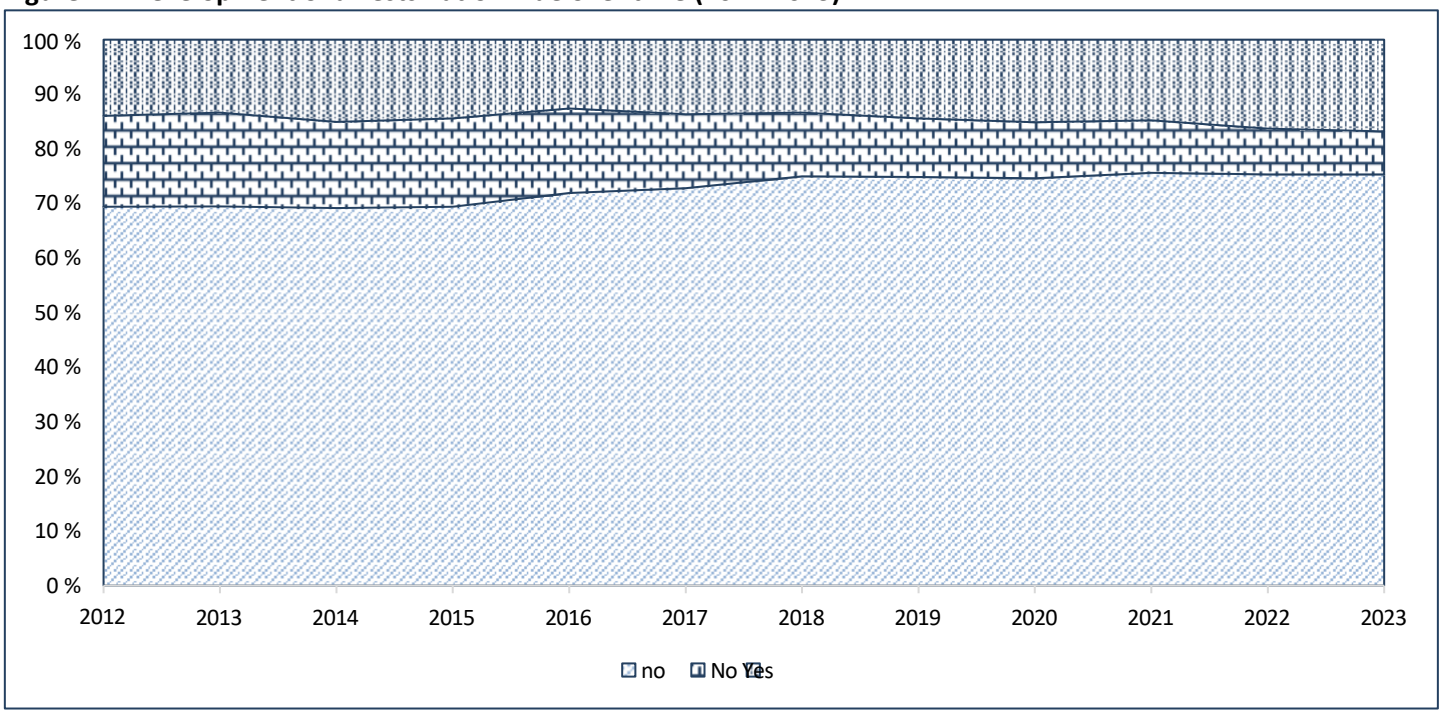


Figure 74. Development of arrests nationwide over time (2012-2023).



PATIENTS IN HEROIN-ASSISTED TREATMENT

Heroin-assisted treatment (HAT) is a five-year trial project covering Oslo and Bergen, with start-up in 2021 and patient inclusion from 2022. The purpose is, as elsewhere in OMT, to provide life-saving and stabilizing treatment that leads to improved quality of life, while at the same time HAT will be able to reach out to people who have tried ordinary OMT, but where ordinary OMT has not provided sufficient treatment effect[15]. Below is a brief description of the patients' situation and treatment, compared with patients in ordinary OMT.

Patients in HAT are prescribed diacetylmorphine (medical heroin) as their primary OMT medication. The treatment usually involves attending the HAT clinic twice a day to take the drug, either intravenously, intramuscularly or in tablet form, as well as other drug treatment and psychosocial follow-up as needed. In Oslo, the maximum simultaneous patient capacity is currently around 50, and in Bergen 40.

Participants

A total of 55 patients in HAT participated in the status survey (20.0% women, 80.0% men). The gender distribution differs somewhat from ordinary OMT, where 30.2% are women. Of the 55 patients, 58.2% were in treatment in Oslo and 41.8% in Bergen. The average age in HAT was 46.3 years, compared with 48.1 years in ordinary OMT. A smaller proportion of HAT patients had their own rented or owned home (67.3%) than in ordinary OMT (80.1%).

Drug treatment and medical safety

Unlike ordinary OMT, all HAT treatment was anchored in TSB, with the HAT doctor as the prescribing doctor. The treatment goal for patients in HAT was mainly stabilization without necessarily aiming for freedom from substance abuse (94.5%), compared with 26.6% in ordinary OMT. Regarding the additional prescription of benzodiazepines, 38.2% of patients in HAT had this, comparable to ordinary OMT (39.6%).

In terms of medical appropriateness, 69.1% had no drug testing agreement beyond daily observation and clinical assessments in the clinic in connection with drug dispensing. In addition to this, 21.8% had regular sampling, and 9.1% random sampling. Here, HAT differs from ordinary OMT, where the proportion without drug testing was 44.5%. However, it is important to emphasize that patients in HAT have a completely different follow-up and that observation and clinical assessments in practice replace the use of drug tests.

Psychosocial follow-up and treatment satisfaction

As many as 52.7% of patients in HAT had an individual plan, in contrast to ordinary OMT (11.0%). However, the proportion who had had a responsibility group meeting in the last three months was comparable (27.3% in HAT, 27.6% in OMT). The proportion with an active treatment plan was higher in HAT (83.6%) than in OAT (28.6%). The proportion receiving treatment for mental health problems was also somewhat higher in HAT (20.0%) than in OMT (14.0%). Some of these differences may be due to a more recent start of treatment for patients in HAT, as well as the need for more closely coordinated treatment. Closer follow-up in HAT may, among other things, be linked to treatment satisfaction.[16]

Treatment satisfaction among patients was somewhat higher in HAT (70.9% satisfied, 18.2% mixed satisfaction, 5.5% dissatisfied), compared with ordinary OMT (58.8% satisfied). This also implies an increase from 58.5% satisfaction in HAT in 2022. Treatment satisfaction among therapists was roughly comparable in HAT (67.3% satisfied) with ordinary OMT (67.0%).

[15] Eide et al (2019). Treatment of opioid-dominated substance use disorder: a pilot project with heroin-assisted treatment. A review of the evidence base for heroin-assisted treatment and recommendations for a pilot project commissioned by the Norwegian Directorate of Health. Oslo: UiO.

[16] Ellefsen et al (2022). Patients' satisfaction with heroin-assisted treatment: a qualitative study. *Harm Reduction Journal, 20.* https://link.springer.com/article/10.1186/s12954-023-00808-8

Mental and physical health

The distribution of mental health problems was a few percentage points lower than in ordinary OMT: 12.7% of patients in HAT reported severe depressive symptoms (16.0% in ordinary OMT) and 23.6% severe anxiety symptoms (25.9% in OMT). On the other hand, the proportion with delusions was somewhat lower in HAT (3.6%) than in OMT (7.1%). The distribution of physical illnesses or injuries in the past year was somewhat higher in HAT (47.3%) than in OMT (43.3%). The proportion with chronic pain was significantly higher in HAT (43.6%) than in OAT (34.0%). The proportion who had been to a medical examination in the past year was slightly higher in HAT (74.5%) than in OMT (68.6%).

Substance abuse

When it came to substance use in the past four weeks, the patients in HAT and in OMT were in quite different situations: 43.6% of patients in HAT used regularly (compared to 28.5% in ordinary OMT), 34.5% had few single episodes (17.2% in OMT), and 16.4% had no known substance use (40.0% in OMT).

Assessments of the patients' situation

This year's status report is the second after the start of HAT as a pilot project in Oslo and Bergen. Patients in HAT differ somewhat from patients in ordinary OMT both in terms of psychosocial situation, organization of treatment and type of follow-up, as well as in treatment satisfaction.

The proportion of women in HAT is smaller than in other SUDs, and the average age is two years younger. Furthermore, patients in HAT appear to have a somewhat less stable social situation than patients in other OMT, with proportionally more having temporary housing and temporary sources of income, and more not in employment or education. Patients in HAT are in close contact with the treatment system on a regular basis, with the opportunities this provides to follow up the patients. All treatment for patients in HAT is anchored in TSB, and the medical treatment and follow-up of medication safety takes place in TSB. The follow-up provided is therefore slightly different and not directly comparable.

Despite the fact that HAT means that patients have to spend more time following up on treatment requirements and routines, we see a slight increase in treatment satisfaction from 2022 to 2023, as well as a slightly higher proportion of satisfied patients than in ordinary OMT. Perhaps this method of organization also leads to higher satisfaction, not in spite of the time and effort invested in following the treatment, but also because of it. Overall, the figures indicate that the majority of patients find HAT useful. It is also worth noting that the number of patients per therapist FTE is very low in HAT compared to ordinary OMT. This means that in HAT there are opportunities to provide a qualitatively different and closer follow-up per patient than the resources would normally allow in OMT.

There is a clear difference in the treatment goals for patients in HAT, who almost exclusively have stabilization without drug-free requirements as their treatment goal. This shows that HAT, which is intended to reach patients who have found ordinary OMT insufficiently useful, is particularly important as harm reduction for a relatively small group of patients in a more difficult social situation. However, it is conceivable that the treatment goals of HAT will also change over time, and that the picture will look different in the long term.

When it comes to mental health problems, the differences are small, and the prevalence of depression and anxiety symptoms is roughly equally distributed in HAT and other OMT. When it comes to substance abuse, we see that substance abuse is significantly more prevalent among patients in HAT. There may appear to be different needs in the work on substance abuse and harm reduction in HAT compared with other OMT.

FATALITY

OAT in the health authorities has registered the number of deaths every year since 2000. The proportion of patients in treatment who died each year (the mortality rate) has been published in the status reports and, since 2013, in an expanded mortality survey. This year's report largely presents results on the same variables as in previous reports.

A total of 160 deaths were reported by the health trusts (HF) for 2023, and forms with information about the death (hereinafter referred to as "death registration form") were available for all of them. We lack information from three health trusts (Finnmark, Helgeland and OAT Asker) which are therefore not included in the overview. Figures for Helse Nord and, to some extent, Vestre Viken HF in table 7 below are therefore not comparable with previous years. The national mortality rate has been corrected for missing data from these health trusts (we have assumed that the mortality rate in these trusts is the same as the national average) and the national rate is therefore comparable with previous years. When calculating the national mortality rate, we have used 160 deaths (all reported deaths) and the average number of patients in treatment at the beginning and end of 2023 in the health trusts that have reported the number of deaths. This gives a mortality rate in 2023 of 1.94/100 patient years (1.94%).

Table 7: Annual incidence of deaths in OMT reported by the OMT units.

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
East	27	42	45	54	55	42	53	47	37	65	41	58	61
South	17	22	13	21	30	22	25	31	36	30	23	25	29
Vest	5	17	24	30	27	32	36	30	29	29	29	46	54
Middle	0	1	10	9	7	5	4	8	5	9	2	3	7
North	5	2	6	6	8	7	4	11	5	13	7	15	9
Norway	54	84	98	121	127	108	122	127	112	146	102	147	160
% of all in treatment/year	0,8	1,2	1,3	1,6	1,7*	1,3*	1,6*	1,7*	1,4*	1,8*	1,3*	1,8*	1,9*

Prevalence (deaths/100 patient years calculated from the mean number in treatment).

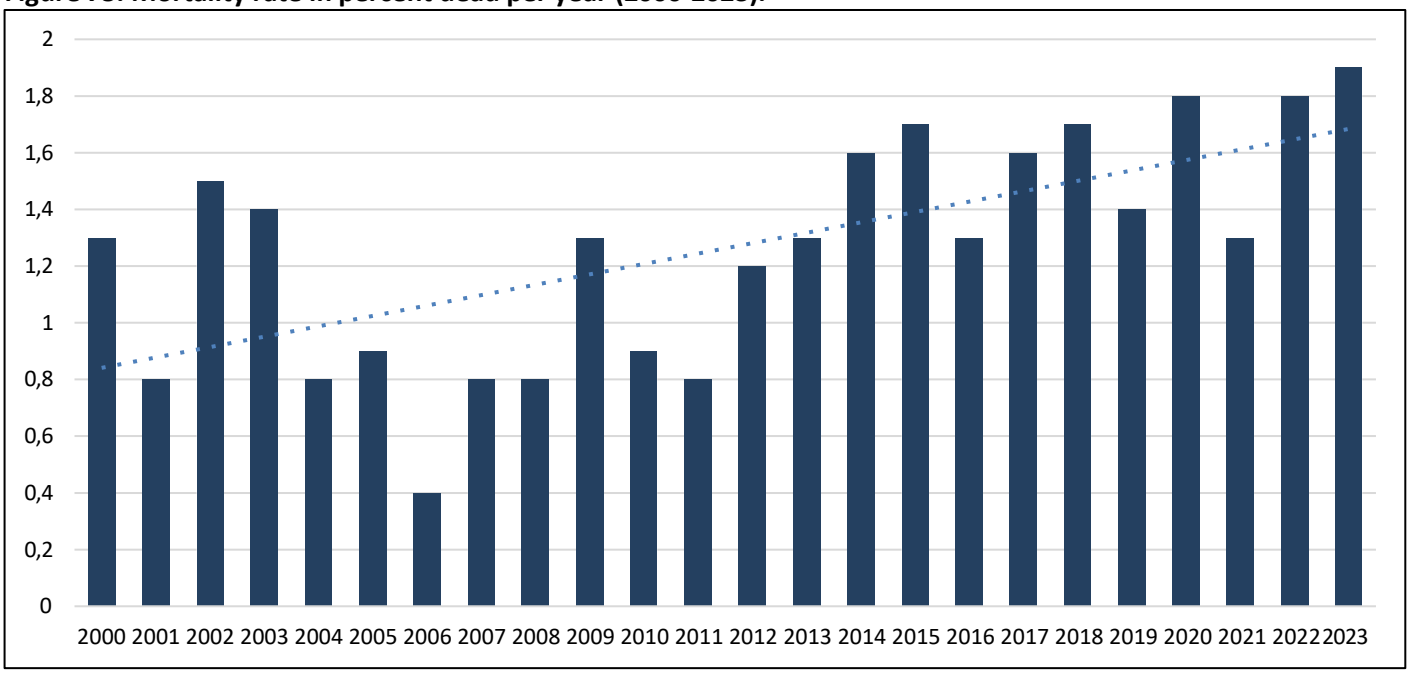
* After correction for deaths that occur more than five days without medication, the rate is 1.4 per 100 patient years in both 2014 and 2015, 1.2 in 2016, 1.4 in 2017 and in 2018, 1.3 in 2019, and 1.7 in 2020, 1.2 in 2021, and 1.7 in 2022 and 2023.

Of the 160 deaths, 136 were in active OMT treatment (medication) at the time of death, two had not taken OMT medication in the last 1-5 days, four had not taken it in the last 6-30 days and eight had not taken it for more than 30 days, four were without OMT medication of unknown duration, one was included but had not started treatment and for five the OMT status was unknown.

Due to the rapid loss of opioid tolerance after discontinuation of opioids, we consider, as in previous years, those who were under ongoing medication and those who had been without OMT medication for a maximum of five days to be "under OMT treatment" (138 people), while those who had been unmedicated for more than five days were considered "after/without OMT" (17 people). In addition, as mentioned above, the OMT status was unknown for five people. If we include these, we get a maximum of 143 deaths during treatment, which gives a death rate of 1.7%.

In the following description of the deaths, unless otherwise specified, we take as our starting point the 138 deaths that we know with certainty have occurred "during OMT treatment". The death rate during OMT in 2023 (Figure 75) is 1.7%. This is significantly higher than in 2021 (1.2%), but at the same level as in 2020 and 2022 (1.7%). The rate for 2023 is in line with the long-term trend of slightly increasing mortality that we have seen throughout the history of OMT in Norway (see other assessments).

Figure 75. Mortality rate in percent dead per year (2000-2023).



Causes of death and age profile

The death registration form provides information about gender, age, health trust, presumed cause of death (based on the knowledge that the OMT therapists in the health trust have about the cause of death, not the official cause of death from the Cause of Death Registry), place of death, OMT drug and dose, whether the patient was in active OMT treatment at the time of death, how long, if any, it had been since the OMT medication was discontinued and substance abuse in the last month before death.

In 2023, the average age of those who died was 53.5 years, with the youngest being 26 and the oldest 78 years. In 2021, the average age was 53.2 years and 53.6 years in 2022. In 2023, the average age for everyone in OMT was 48.1, compared with 47.0 in 2021 and 47.8 in 2022.

Table 8 shows the presumed cause of death reported by OMT in the health authorities for the 138 deaths "under OMT treatment". In 37 of the 138 deaths (27%), the cause of death is unknown to OMT in the health trusts. As previously, we have not had access to data from the Cause of Death Registry. Among all the 160 reported deaths, the sources of information on the presumed cause of death were distributed as follows: 7% autopsy reports, 35% hospital discharge summaries, 11% treating physicians and 37% other sources such as other parts of the treatment system or family and friends. For 9% it is stated that there is no information about the cause of death. All in all, an assumed cause of death is stated for 116 of the 160 reported cases (73%), while for (28%) the cause of death is stated as unknown. Compared to 2022, OAT in the HFs has a better overview of causes of death, but this varies significantly between the HFs. The distribution of reported causes of death has changed little from previous years.

When we only look at those who were in active OMT treatment with a stated cause of death, 80% died of somatic disease in 2023, compared to 79 in 2022, 76% in 2021, 73% in 2020, 72% in 2019, 71% in 2018, 66% in 2017, 59% in 2016, 68% in 2015,
63% in 2014 and 56% in 2013. So we see that most people die of somatic causes and there is a slow increase over time in the proportion with natural causes of death.

Among those who died of somatic disease, the average age was 56.4 years, for violent deaths 48.1 years and for overdose deaths also 45.6 years. Among the 138 undergoing OMT (including those with unknown cause of death), 42% of those under the age of 51 died of somatic disease. For those aged 51 and above, 69% died of somatic causes. If we disregard those with unknown causes, the figures are 63% and 89% respectively. This shows the increasing mortality rate of somatic diseases, acute and chronic, with increasing age. In the entire OMT population, 70% were men and 30% women in 2022, while among those who died during OMT treatment, 69% were men and 31% women. The mortality rate was thus 1.6% for men and 1.7% for women.

Men accounted for 70% of those who died of somatic causes, 7 out of 12 who died of overdose and 5 out of 8 with a violent cause of death in 2022.Table 8. Deaths during OMT treatment* in 2023 by cause of death, gender and age.

Cause of death	Number (percent of all with assumed known cause of death)	Men (percent of women + men)	women	Age average (lowest and highest)
Liver disease incl. liver cancer	5	4	1	63,4 (53-69)
Bacterial infection, incl. "multi-organ failure"	8	5	3	52,9 (33-78)
Cancer (except liver cancer)	19	14	5	56,5 (44-67)
Heart/vessels	18	13	5	57,4 (34-73)
Kidney	9	6	3	51,0 (36-62)
Other somatic**	11	8	3	62,3 (53-74)
Unspecified somatic***	11	7	4	53,1 (42-679
Somatic total	**81 (80)**	**57 (70)**	**24**	**56,4 (33-78]**
Overdose	**12 (12)**	**7 (58)**	**5**	**45,6 (26-63)**
Homicide****	1***		1	
Suicide****	3***	3	0	
Accident****	4***	2	2	
Unspecified, violent death	0	0	0	
Violent death, total	**8(8)**	**5(63)**	**3**	**48,1 (35-60)**
Unknown	**37**	**26 (70)**	**11**	**51,0 (31-73)**
Total	**138**	**95 (69)**	**43**	**53,5 (26-78)**

Included in the calculations are 138 deaths, 101 with an assumed known cause of death and 37 without.

*During ongoing OMT medication or a maximum of 5 days after the last intake of OMT medication.

** Deaths with a *specified* somatic cause of death (not covered by the categories above).

*** Deaths reported as somatic, but without a *specific* somatic cause of death.

**** Age not stated as there are few people involved.

Overdose deaths

17 (11%) of all reported deaths in 2023 were overdoses. 12 occurred during ongoing OMT medication, while one occurred between six and 30 days after discontinuation of medication, three more than 30 days after discontinuation and one was without OMT medication of uncertain duration. The mortality rate for known overdoses is 0.14% during OMT. This is about the same as in previous years; there are minor fluctuations that are considered random. There were 37 deaths of unknown cause and it is reasonable to assume that a larger proportion of these are due to overdose than among deaths of known cause. However, there is reason to believe that overdose mortality in OMT in Norway is significantly reduced compared to the corresponding population outside OMT. The issues surrounding overdose deaths in OMT and OMT drugs as a cause of deaths outside OMT are discussed in more detail in the Status report for 2019 (link Status report 2019).

Place of death

Of the 81 who died of somatic causes, 51 (63%) died in hospitals/nursing homes and 19 (23%) at home. Although the proportion dying in hospitals/nursing homes is somewhat lower than in 2021 and 2022, there is reason to assume that many of those who die of *chronic* somatic disease receive adequate medical treatment at the end of life. However, when 24% of those with a somatic cause of death die at home (17% in 2021 and 21% in 2022), this may also indicate that a significant proportion of those who die of *acute* somatic illness do not receive medical treatment. Here there is an opportunity for improvement through better routines for the follow-up of patients who become ill. 5 of the 12 who died of an overdose died at home, while 26 of the 37 with an unknown cause of death also died at home, which may indicate a higher proportion of overdoses among those with an unknown cause of death compared to the rest.

OAT medications and dosage levels

In 2023, 30% of all OMT patients used methadone, while 61% used buprenorphine (37% bupr. molten tablet, 5% buprenorphine/naloxone molten tablet and 19% buprenorphine depot injection) and 8% other opioids as OMT medication. Table 9 shows which OMT drugs the deceased used in 2022. 50% used methadone compared to 56% in 2021, 52% in 2022 and an average of 54% in 2014-2020. 35% used buprenorphine compared to 40% in 2021 and 37% in 2022and on average 42% 2014-2020. Of the 21 who used other opioids as OMT, seven used levomethadone (five somatic deaths), five used oral morphine with 12 or 24 hours duration of action, one used heroin (HAT) and six used other opioids/palliative medication. These findings differ little from previous years. The overall mortality rate for those on methadone in 2023 was 2.79% and 0.95% on buprenorphine. The generally higher mortality rates for patients on methadone compared to buprenorphine are in line with previous years.

Age difference alone cannot explain the difference in mortality between patients on methadone and buprenorphine, and the findings of our studies are consistent with international meta-analyses. The reason for the difference in mortality is not clear, but it is reasonable to assume that there may be systematic differences between the patient groups using methadone versus buprenorphine.

Table 9: OMT medication at death and cause of death for all patients undergoing OMT treatment with a death registration form in 2023*.

Cause of death	methadone	Buprenorphine	Other	Total
Somatic	40	24	17	81
Overdose	4	6	2	9
Violent death	2	6	0	8
Unknown	23	12	2	37
Total	69	48	21	138

* Included in the calculations are 138 deaths.

The average dose among the dead was 86.3 mg for methadone (range 25 mg - 250 mg), for buprenorphine 15.8 mg (6 mg - 28 mg), for buprenorphine/naloxone and 12.0 mg (8 mg-16 mg). The average doses are similar to previous years.

Use of intoxicants last month before death

Among the deceased, 42% were stably drug-free, 13% had less severe, 21% severe and 24% unknown use. In other words, 55% were stably drug-free or had less serious drug use. This differs little from 2022.

Assessments of deaths in OMT

Mortality in OMT in 2023 differs little from last year in terms of the distribution of causes of death, mortality rate and age distribution. It is most reasonable to view the annual changes in mortality in OMT as mainly random fluctuations within the long-term trend in mortality development (Figure 78) and the distribution of causes of death (Table 7). This is largely driven by the slowly increasing average age with increased somatic morbidity and mortality. Somatic causes of death dominate with a marked increase from between the ages of 40 and 50.

Overdose mortality is largely reduced in OMT compared to people with opioid dependence who are not in OMT. They therefore live longer, but are also affected by acute and chronic somatic diseases with increasing age and natural causes of death dominate, with a particular increase between the ages of 40 and 50. This mainly applies to diseases that affect the entire population, such as cardiovascular diseases, lung diseases and cancer. While this is an expected development, it is important to emphasize that efforts to detect, treat and follow up chronic diseases and routines for identifying and treating acute illness are very important. Here, different parts of the healthcare and support system must work together: OAT in the health trusts, GPs, municipal health and social services and the specialist health service. Responsibility must not be pushed between the services, but those who are in a position must act. There is considerable potential for improvement here.

Health promotion and prevention are also important and should have a natural place in a comprehensive

rehabilitation process. It is also important to be aware that there is an interaction between substance use and somatic impairment and that this can increase the risk of both overdoses and acute and chronic somatic illness and death. A focus on coping with substance abuse in OMT is therefore also important in this perspective, not least as patients get older.

IMPLICATIONS

The findings from the status survey for 2023 provide a basis for identifying some relevant priority areas. An important priority area in practice should be to strengthen patients' access to resources and conditions for good living habits and quality of life. Support and facilitation for participation in social activities that are not part of ordinary work efforts should be strengthened in the future. This type of holistic follow-up can advantageously be included as part of an individual plan, responsibility group meetings or an active treatment plan, based on the individual's needs and goals.

Furthermore, mental health and mental health problems are a focus area for the future. Many patients in OMT experience various symptoms of mental health problems that can reduce their quality of life, while too few receive treatment for any mental health conditions. In addition, the prioritization of mental health may become more important with increasing age. It will therefore be necessary to have a systematic focus on making assessment and treatment for mental disorders available to those who need and want it.

Based on our findings, it appears that most patients in OMT have fairly good substance abuse control. Continued substance use in OMT may partly reflect treatment needs that have not been adequately addressed, but it may also reflect what the initial phase of OMT looks like. When it comes to treatment satisfaction, dialog and user participation will continue to be important. As part of ensuring dialogue and user involvement, it may be relevant to continue to discuss the choice of medication, dosage and perceived side effects of OMT medications in order to best adapt the treatment.

Finally, it will be important to facilitate the implementation of regular medical examinations, as well as the mapping and treatment of somatic injuries and diseases. In an ageing patient population in OMT, with a significant disease burden and stressful lifestyle factors, an increasing focus on the detection and treatment of somatic conditions is more important than ever. Implementing relevant interventions, for example related to tobacco use, nutrition or physical activity, could have positive ripple effects on patients' health and quality of life.

OAT-RELEVANT PUBLICATIONS FROM SERAF

Drug treatment and psychosocial support:

- Clausen, T. & Waal, H. (2024). *OMT - Treatment model in change. Reflections on alternatives and choices*. University of i Oslo. https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2024/seraf-notat-1-2024-lar.pdf
- Welle-Strand, G., Pierron, M., Olsen, R., & McDonald, R. (2024). 'Life feels better with the right medication'. Results from a service user organization-led survey of opioid maintenance treatment patients in Norway. *Heroin Addiction and Related Clinical Problems*, *26*(19). https://www.heroinaddictionrelatedclinicalproblems.org/article.php?id=4877
- McDonald, R., Bech, A. B., & Clausen, T. (2023). Flexible delivery of opioid agonist treatment during COVID-19 in Norway: qualitative and quantitative findings from an online survey of provider experiences. *BMC Health Services Research*, *23*(1), 965. https://doi.org/10.1186/s12913-023-09959-7
- Todd-Kvam, J., & Clausen, T. (2024). Practitioner perspectives on working with older patients in opioid agonist treatment (OAT) in Norway: opportunities and challenges. *Addiction Science & Clinical Practice*, *19*(1), 1-14. https://doi.org/10.1186/s13722-024-00473-7

Mental health, physical health and substance abuse:

- Bukten, A., Skjærvø, I., & Stavseth, M. R. (2023). Exploring mental health comorbidities and opioid agonist treatment coverage among people in prison: a national cohort study 2010-2019. *Drug and Alcohol Dependence*, *250,* 1-7. https://doi.org/10.1016/j.drugalcdep.2023.110896
- Rolová, G., Skurtveit, S., Gabrhelík, R., Mravčík, V., & Odsbu, I. (2024). Exploring dual diagnosis in opioid agonist treatment patients: a registry-linkage study in Czechia and Norway. *Addiction Science & Clinical Practice*, *37*(19), 1-10. https://doi.org/10.1186/s13722-024-00467-5
- Bjørnestad, E. D., Vederhus, J. K., & Clausen, T. (2024). Change in self-reported somatic symptoms among patients in opioid maintenance treatment from baseline to one-year follow up. *BMC Psychiatry, 24*, 1-9. https://doi.org/10.1186/s12888-024-05590-w
- Bjørnestad, E. D., Vederhus, J. K., & Clausen, T. (2024). Change in substance use among patients in opioid maintenance treatment: baseline to one-year follow-up. *Harm Reduction Journal*, *21*, 1-9. https://doi.org/10.1186/s12954-024-01005-x
- Malme, K. B., Ulstein, K., Finbråten, A. K., Wüsthoff, L. E. C., Kielland, K. B., Hauge, J., Dalgard, O., & Midgard, H. (2023). Hepatitis C treatment uptake among people who inject drugs in Oslo, Norway: A registry-basedstudy . *InternationalJournal of DrugP olicy,* 116,1-*11*. https://doi.org/10.1016/j.drugpo.2023.104044
- Kostovski, E., Hamina, A., Hjellvik, V., Clausen, T., & Skurtveit, S. (2024). Increased cancer incidence and mortality among people with opioid use-related disorders: A nation-wide cohort study. *Addiction*, 1-10. https://doi.org/10.1111/add.16524

Heroin-assisted treatment:

- Ellefsen, R., Wüsthoff, L. E. C., & Arnevik, E. A. (2023). Patients' satisfaction with heroin-assisted treatment: a qualitative study. *Harm Reduction Journal*, *20*(1), 1-14. https://doi.org/10.1186/s12954-023- 00808-8
- Melis, F., Hesse, M., Eide, D., Thylstrup, B., Tjagvad, C., Brummer, J. E., & Clausen, T. (2024). Who receives heroin-assisted treatment? A comparison of patients receiving opioid maintenance treatment in Denmark. *Drug and Alcohol Dependence*, *254*, 1-8. https://doi.org/10.1016/j.drugalcdep.2023.111051
- Myklebust, L. H., Eide, D., Arnevik, E. A., Dadras, O., Pirro, S. D., Ellefsen, R., Fadnes, L. T., Hesse, M., Kvamme, T. L., Melis, F., Oldervoll, A., Thylstrup, B., Wusthoff, L. E. C., & Clausen, T. (2024). Evaluation of heroin-assisted treatment in Norway: protocol for a mixed methods study. *BMC Health Services Research, 24,* 1-8. https://doi.org/10.1186/s12913-024-10767-w

Mortality rate:

- Eide, D., Skurtveit, S., Clausen, T., Hesse, M., Mravčík, V., Nechanská, B., Rolova, G., Thylstrup, B., Tjagvad, C., Seid, A. K., Odsbu, I., & Gabrhelík, R. (2023). Cause-Specific Mortality among Patients in Treatment for Opioid Use Disorder in Multiple Settings: A Prospective Comparative Cohort Study. *European Addiction Research*, *29*(4), 272-284. https://doi.org/10.1159/000530822

- Ericson, Ø. B., Eide, D., Lobmaier, P., & Clausen, T. (2024). Mortality risk and causes of death among people who use opioids in a take-home naloxone cohort. *Drug and Alcohol Dependence*, *255*, 1-7. https://doi.org/10.1016/j.drugalcdep.2024.111087
- Gabrhelík, R., Hesse, M., Nechanská, B., Handal, M., Mravčík, V., Tjagvad, C., Thylstrup, B., Seid, A. K., Bukten, A., Clausen, T., & Skurtveit, S. (2023). Large variations in all-cause and overdose mortality among >13,000 patients in and out of opioid maintenance treatment in different settings: a comparative registry linkage study. *Frontiers in Public Health*, *11*, 1-8. https://doi.org/10.3389/fpubh.2023.1179763
- Rolová, G., Eide, D., Gabrhelík, R., Odsbu, I., Clausen, T., & Skurtveit, S. (2023). Gender differences in physical morbidity in opioid agonist treatment patients: population-based cohort studies from the Czech Republic and Norway. *Substance Abuse Treatment, Prevention, and Policy*, *18*(1), 1-9. https://doi.org/10.1186/s13011-023-00557-8

TABLES AND STATISTICS

NORWAY AND REGIONS

	Middle	North	South	Vest	East	Norway
Number of responses	665	564	1837	1673	2287	7026
Response rate	97 %	83 %	94 %	74 %	79 %	83 %
Gender						
Men	68,7 %	69,9 %	70,5 %	70,5 %	68,3 %	69,6 %
women	31,3 %	30,1 %	29,5 %	29,5 %	31,7 %	30,4 %
Age (average)	46,4	47,4	48,7	47,3	49,0	48,1
A. Current situation						
A0. Current situation						
0. Not discharged	95,6 %	95,7 %	95,1 %	98,7 %	97,6 %	97,0 %
1. Own desire for weaning	2,1 %	2,5 %	1,3 %	0,3 %	0,9 %	1,1 %
2. Dissatisfied with the treatment	1,4 %	0,5 %	0,9 %	0,2 %	0,4 %	0,6 %
3. Lack of effect, irresponsible	0,2 %	0,3 %	0,2 %	0,1 %	0,1 %	0,1 %
4. Treatment difficulties	0,0 %	0,0 %	0,1 %	0,1 %	0,0 %	0,0 %
10. Annet	0,8 %	1,0 %	2,5 %	0,6 %	0,9 %	1,2 %
A1. Employment						
a. Occupational status						
0. Without employment	75,6 %	78,1 %	84,7 %	84,2 %	83,0 %	82,6 %
1. Full-time job	12,8 %	11,2 %	8,7 %	9,8 %	7,5 %	9,2 %
2. Part-time job	7,2 %	7,1 %	4,8 %	4,1 %	5,8 %	5,4 %
3. During education	1,7 %	0,2 %	1,2 %	0,8 %	0,9 %	1,0 %
4. Part-time job and in education	0,5 %	0,2 %	0,3 %	0,4 %	0,2 %	0,3 %
9. Unknown	2,3 %	3,2 %	0,3 %	0,7 %	2,6 %	1,5 %
b. Work training/courses						
0. No	92,5 %	91,2 %	92,6 %	89,8 %	89,9 %	91,0 %
1. Yes	4,8 %	3,8 %	5,7 %	6,7 %	6,4 %	5,9 %
9. Unknown	2,7 %	5,0 %	1,7 %	3,5 %	3,6 %	3,1 %
c. Day care services						
0. No	86,9 %	89,5 %	89,1 %	79,6 %	84,6 %	85,2 %
1. Yes	10,1 %	4,9 %	9,1 %	15,8 %	11,2 %	11,1 %
9. Unknown	3,0 %	5,6 %	1,9 %	4,6 %	4,3 %	3,7 %
A2. Most important income						

	Middle	North	South	Vest	East	Norway
1. Employment income	15,2 %	11,6 %	9,7 %	10,3 %	8,5 %	10,1 %
2. Supported by others	0,2 %	0,2 %	0,3 %	0,1 %	0,1 %	0,2 %
3. Daily allowance	0,0 %	0,4 %	0,5 %	1,0 %	0,7 %	0,6 %
4. Sick pay	0,5 %	1,2 %	0,6 %	0,8 %	0,8 %	0,7 %
5. AAP	8,6 %	9,8 %	9,5 %	11,8 %	12,1 %	10,8 %
6. Disability/pension	69,2 %	68,0 %	75,2 %	67,7 %	69,2 %	70,3 %
7. Social security benefits	2,3 %	2,1 %	2,0 %	4,9 %	4,2 %	3,4 %
8. Student loans	0,0 %	0,0 %	0,1 %	0,0 %	0,0 %	0,0 %
9. Other/unknown	4,2 %	6,8 %	2,2 %	3,4 %	4,3 %	3,7 %
A3. Housing conditions						
0. No housing	2,7 %	1,3 %	2,1 %	3,5 %	1,7 %	2,3 %
1. Hospits/hybelhus/hotels	1,4 %	2,5 %	1,9 %	3,3 %	3,1 %	2,6 %
2. Institution	4,2 %	3,0 %	4,4 %	3,8 %	9,8 %	5,9 %
3. Prison	1,4 %	1,4 %	1,3 %	0,9 %	0,8 %	1,0 %
4. With parents	3,2 %	5,7 %	3,0 %	4,8 %	2,9 %	3,6 %
5. For others	2,1 %	5,0 %	2,9 %	1,9 %	3,0 %	2,8 %
6. Own home	82,9 %	76,7 %	83,1 %	81,0 %	75,5 %	79,6 %
10. Other / Unknown	2,3 %	4,3 %	1,4 %	0,8 %	3,2 %	2,2 %
A5. Blood infection status (HIV/hepatitis C)						
a. HIV						
0. Not infected	88,0 %	88,7 %	93,9 %	85,3 %	87,7 %	88,9 %
1. Infected	0,2 %	0,9 %	0,9 %	1,3 %	1,6 %	1,1 %
9. Unknown	11,9 %	10,4 %	5,2 %	13,4 %	10,7 %	10,0 %
b. Hepatitis C						
0. Never treated (Hepatitis C antigen negative)	36,0 %	45,8 %	38,4 %	45,1 %	41,8 %	41,5 %
1. Hepatitis C fully treated	37,5 %	35,1 %	43,0 %	29,8 %	36,5 %	36,6 %
2. Hepatitis C positive (antigen detected)	5,7 %	4,7 %	6,0 %	5,3 %	5,3 %	5,5 %
9. Unknown hepatitis C status	20,8 %	14,5 %	12,6 %	19,7 %	16,4 %	16,4 %
A6. OAT medication						
0. Methadone	23,9 %	28,2 %	31,0 %	23,7 %	36,7 %	30,0 %
1. Buprenorphine (Subutex)	33,5 %	39,3 %	34,8 %	53,6 %	26,0 %	36,9 %
1a. Buprenorphine depot	24,1 %	15,3 %	23,0 %	9,3 %	23,2 %	19,2 %
2. Buprenofin/naloxone (Suboxone)	9,8 %	8,3 %	6,3 %	1,5 %	4,1 %	5,0 %
3. SROM	0,0 %	0,0 %	0,0 %	0,2 %	0,2 %	0,1 %

	Middle	North	South	Vest	East	Norway
4. Heroin	0,0 %	0,0 %	0,0 %	1,4 %	1,6 %	0,8 %
5. Others	7,5 %	8,1 %	4,6 %	9,7 %	7,8 %	7,4 %
9. Unknown	1,2 %	0,9 %	0,3 %	0,5 %	0,4 %	0,5 %
A7. Daily dose in mg (average)						
0. Methadone	78,3	92,7	88,0	93,8	90,5	89,6
1. Buprenofin (Subutex)	15,1	15,7	15,2	14,2	14,3	14,7
2. Buprenofin/naloxone (Suboxone)	16,1	14,4	14,2	10,8	12,2	13,9
A8. Prescribing physician						
0. Doctor employed in OAT unit	57,3 %	55,6 %	66,4 %	96,0 %	56,3 %	68,5 %
1. GP	39,2 %	42,3 %	32,0 %	3,5 %	37,7 %	28,5 %
2. Other doctor	1,8 %	0,8 %	1,5 %	0,2 %	4,9 %	2,3 %
9. Unknown	1,7 %	1,3 %	0,1 %	0,2 %	1,1 %	0,7 %
A9. Special conditions						
a. Informed about the right to complain?						
0. No						
1. Yes						
2. Uncertain						
9. Unknown						
b. Are benzodiazepines prescribed?						
0. No	60,0 %	43,3 %	58,5 %	59,3 %	52,6 %	55,7 %
1. Yes	35,5 %	50,4 %	38,4 %	37,5 %	41,6 %	39,9 %
9. Unknown	4,5 %	6,4 %	3,1 %	3,1 %	5,8 %	4,4 %
c. Are other morphine substances prescribed?						
0. No	93,4 %	79,1 %	79,2 %	94,2 %	83,0 %	85,3 %
1. Yes	1,7 %	5,8 %	8,6 %	3,6 %	5,7 %	5,6 %
9. Unknown	5,0 %	15,1 %	12,2 %	2,2 %	11,3 %	9,1 %
A10. OAT medication dispensing						
a. Number of deliveries per week (average)	2,3	2,7	2,7	2,9	3,1	2,8
b. Of which the number of delivered monitored	2,3	2,8	2,6	2,8	3,4	2,9
c. Main place of delivery						
0. OAT unit	24,1 %	16,6 %	21,6 %	39,5 %	25,4 %	26,9 %
1. Pharmacy	39,1 %	44,3 %	38,0 %	26,3 %	45,4 %	38,2 %
2. Municipal services	25,9 %	28,6 %	33,8 %	22,0 %	18,3 %	24,8 %
3. Institution/residential center/prison	6,5 %	4,4 %	5,1 %	5,3 %	8,4 %	6,3 %

	Middle	North	South	Vest	East	Norway
4. Doctor's office	2,3 %	4,4 %	0,6 %	4,2 %	0,4 %	1,9 %
10. Annet	0,8 %	0,5 %	0,8 %	2,5 %	1,4 %	1,4 %
9. Unknown	1,5 %	1,3 %	0,1 %	0,2 %	0,6 %	0,5 %
A11. Urine sampling scheme						
a. Type of agreement						
0. No urine samples	44,1 %	51,4 %	46,3 %	42,4 %	45,1 %	45,2 %
1. Random samples	34,9 %	26,2 %	28,3 %	20,8 %	33,8 %	28,8 %
2. Regular sampling	17,1 %	14,1 %	24,6 %	34,2 %	15,5 %	22,4 %
9. Unknown	3,9 %	8,3 %	0,8 %	2,5 %	5,6 %	3,6 %
b. Number of urine samples per week (average)	0,2	0,7	0,2	0,4	0,2	0,3
B. LAST FOUR WEEKS BEFORE COMPLETION DATE						
B1. Treatment and advice last 4 weeks						
a. Objective of the treatment						
0. Rehab with freedom from addiction	69,8 %	62,2 %	67,2 %	68,1 %	71,5 %	68,7 %
1. Stabilization without drug-free requirements	26,5 %	25,6 %	29,9 %	27,2 %	23,6 %	26,5 %
9. Not agreed	3,8 %	12,3 %	2,9 %	4,6 %	4,9 %	4,8 %
b. Primary responsibility in the specialist health service						
0. Not transferred	41,5 %	64,5 %	79,3 %	96,0 %	78,1 %	78,1 %
1. Transferred	56,5 %	32,8 %	20,2 %	3,7 %	19,3 %	20,5 %
9. Other / Unknown	2,0 %	2,7 %	0,4 %	0,3 %	2,6 %	1,4 %
c. Completed rehab, maintenance follow-up						
0. No	35,3 %	46,3 %	54,3 %	49,2 %	49,7 %	49,2 %
1. Yes	57,7 %	42,1 %	41,0 %	44,5 %	44,1 %	44,5 %
9. Unknown	6,9 %	11,6 %	4,6 %	6,3 %	6,1 %	6,3 %
d. Is the patient in psychiatric/psychological treatment?						
0. No	83,8 %	80,7 %	88,9 %	76,8 %	78,1 %	81,4 %
1. Yes	10,5 %	11,3 %	9,4 %	17,8 %	16,7 %	14,0 %
9. Unknown	5,7 %	8,1 %	1,7 %	5,4 %	5,2 %	4,6 %

e. Has an individual plan been drawn up?						
	Middle	North	South	Vest	East	Norway
0. No	60,6 %	83,1 %	92,7 %	63,8 %	74,2 %	76,0 %
1. Yes	28,4 %	4,1 %	3,5 %	15,1 %	10,5 %	11,0 %
9. Unknown	11,0 %	12,8 %	3,8 %	21,1 %	15,3 %	13,0 %
f. Systematic psychotherapeutic treatment						
0. No						
1. Yes						
9. Unknown						
B2. Has it been held responsibility group meeting last 4 weeks?						
0. No	77,6 %	71,8 %	65,7 %	70,1 %	68,9 %	69,4 %
1. Yes	17,6 %	20,4 %	33,9 %	28,5 %	26,5 %	27,6 %
9. Unknown	4,8 %	7,9 %	0,4 %	1,4 %	4,6 %	3,0 %
B3. Mental health problems last 4 weeks						
a. Severe depression						
0. No	69,5 %	64,4 %	74,8 %	63,8 %	68,3 %	68,7 %
1. Yes	15,6 %	12,9 %	14,1 %	16,0 %	18,5 %	16,0 %
9. Unknown	14,9 %	22,7 %	11,1 %	20,2 %	13,2 %	15,2 %
b. Severe anxiety						
0. No	63,2 %	53,0 %	65,8 %	53,4 %	59,0 %	59,4 %
1. Yes	22,7 %	25,0 %	23,9 %	27,7 %	27,5 %	25,9 %
9. Unknown	14,1 %	22,1 %	10,3 %	19,0 %	13,4 %	14,7 %
c. Delusions/hallucinations						
0. no	78,5 %	70,3 %	83,4 %	75,5 %	78,1 %	78,3 %
1. Yes	7,1 %	6,5 %	6,8 %	6,1 %	8,3 %	7,1 %
9. Unknown	14,4 %	23,2 %	9,8 %	18,5 %	13,6 %	14,6 %
B4. Physical injuries/illnesses that affect the way of life or quality of life last 4 weeks						
0. no						
1. Yes						
9. Unknown						
B5. Drug and alcohol use last 4 weeks						
a. Opiods						

0. No	75,8 %	72,1 %	75,7 %	73,4 %	72,5 %	73,8 %
	Middle	North	South	Vest	East	Norway
1. Yes	8,4 %	5,4 %	9,4 %	7,1 %	11,6 %	9,2 %
9. Unknown	15,8 %	22,5 %	14,9 %	19,4 %	15,9 %	17,0 %
b. Cannabis						
0. No	57,3 %	47,5 %	53,0 %	50,3 %	52,9 %	52,3 %
1. Yes	26,2 %	31,5 %	32,0 %	31,3 %	29,6 %	30,4 %
9. Unknown	16,5 %	21,0 %	15,0 %	18,4 %	17,5 %	17,3 %
c. Benzodiazepines or similar						
0. No	54,0 %	45,0 %	51,8 %	55,7 %	53,9 %	53,1 %
1. Yes	31,3 %	36,0 %	36,5 %	31,1 %	32,7 %	33,4 %
9. Unknown	14,7 %	19,1 %	11,7 %	13,1 %	13,5 %	13,5 %
d. Central stimulants						
0. No	72,3 %	63,7 %	69,1 %	61,5 %	67,5 %	66,7 %
1. Yes	12,2 %	15,0 %	15,8 %	20,6 %	15,2 %	16,3 %
9. Unknown	15,5 %	21,3 %	15,1 %	17,9 %	17,3 %	17,0 %
e. Alcohol for intoxication						
0. no	75,6 %	69,0 %	72,7 %	70,5 %	70,8 %	71,5 %
1. Yes	6,9 %	6,9 %	10,8 %	7,9 %	10,7 %	9,4 %
9. Unknown	17,4 %	24,1 %	16,5 %	21,6 %	18,5 %	19,1 %
B6. Frequency of drug and alcohol use						
last 4 weeks						
0. Never	48,0 %	35,4 %	40,0 %	39,0 %	39,4 %	40,0 %
1. Few single episodes	16,8 %	16,5 %	15,0 %	18,8 %	18,1 %	17,2 %
2. Regular use	22,3 %	24,5 %	33,0 %	27,4 %	28,5 %	28,5 %
9. Unknown	12,9 %	23,6 %	11,9 %	14,8 %	14,1 %	14,3 %
B7. Severity of drug and alcohol use						
last 4 weeks						
0. Good function, works "like others"	54,4 %	45,4 %	47,2 %	50,3 %	48,0 %	48,7 %
1. Mixed function. Occasionally under the influence of alcohol.	21,1 %	19,7 %	20,2 %	20,6 %	22,3 %	21,0 %
2. Addictive, drug-dominated function	11,6 %	11,1 %	18,5 %	14,0 %	15,1 %	15,1 %
9. Unknown	12,9 %	23,9 %	14,1 %	15,0 %	14,5 %	15,1 %
C. LAST YEAR						

C1. Offenses last year						
Arrested, taken into custody, prosecuted; convicted						
	Middle	North	South	Vest	East	Norway
0. no	80,3 %	68,1 %	78,2 %	73,6 %	73,9 %	75,1 %
1. Yes	9,6 %	6,6 %	8,6 %	7,5 %	7,3 %	7,9 %
9. Unknown	10,1 %	25,3 %	13,2 %	18,9 %	18,8 %	17,0 %
C2. Overdose last year						
0. No	82,9 %	73,7 %	84,1 %	79,3 %	80,7 %	80,9 %
1. Yes	7,1 %	4,3 %	6,9 %	9,8 %	7,0 %	7,4 %
9. Unknown	10,1 %	22,0 %	9,1 %	10,9 %	12,2 %	11,7 %
C3. Suicide attempts last year						
0. No	77,6 %	84,7 %	88,4 %	81,6 %	85,4 %	84,4 %
1. Yes	4,1 %	2,7 %	2,4 %	2,4 %	2,1 %	2,3 %
9. Unknown	18,4 %	12,6 %	9,2 %	16,0 %	12,5 %	13,3 %
C4. Drug and alcohol use in the past year						
0. Never	38,5 %	35,1 %	34,4 %	28,5 %	31,6 %	32,5 %
1. Some single, short periods	22,9 %	17,1 %	21,4 %	27,6 %	26,5 %	24,3 %
2. Used for longer periods or all the time	27,4 %	29,0 %	35,8 %	32,5 %	30,1 %	31,8 %
9. Unknown	11,3 %	18,9 %	8,4 %	11,3 %	11,8 %	11,3 %
C5. Satisfaction						
a. The patient's assessment						
0. Satisfied successful	55,2 %	54,6 %	65,3 %	55,6 %	58,0 %	58,8 %
1. Both and	17,3 %	15,5 %	15,3 %	16,1 %	16,5 %	16,1 %
2. Dissatisfied/not successful	5,3 %	6,1 %	2,7 %	3,5 %	4,3 %	3,9 %
9. Unknown	22,3 %	23,8 %	16,7 %	24,8 %	21,2 %	21,1 %
b. Filler's assessment						
0. Satisfied successful	65,9 %	51,8 %	71,8 %	62,7 %	70,2 %	67,0 %
1. Both and	25,1 %	24,0 %	23,6 %	31,0 %	23,3 %	25,4 %
2. Dissatisfied/not successful	3,9 %	2,0 %	2,7 %	2,7 %	2,1 %	2,6 %
9. Unknown	5,1 %	22,2 %	1,9 %	3,7 %	4,4 %	5,1 %
C6. Are treatment changes recommended?						
0. No	78,9 %	83,0 %	85,1 %	73,3 %	79,6 %	79,7 %
1. Yes	13,5 %	9,3 %	12,1 %	18,4 %	13,9 %	14,1 %
9. Unknown	7,5 %	7,7 %	2,7 %	8,3 %	6,6 %	6,2 %
C7. Who has participated/asked when filling						

out the form?						
a. Pasient						
	Middle	North	South	Vest	East	Norway
0. no	25,4 %	28,4 %	24,3 %	30,2 %	26,1 %	26,7 %
1. Yes	74,4 %	70,7 %	75,6 %	69,4 %	73,8 %	73,0 %
9. Unknown	0,2 %	0,9 %	0,1 %	0,4 %	0,2 %	0,3 %
b. Employee						
0. No	79,5 %	83,4 %	72,4 %	87,0 %	68,5 %	76,3 %
1. Yes	20,5 %	15,8 %	27,4 %	11,3 %	31,1 %	23,0 %
9. Unknown	0,0 %	0,8 %	0,2 %	1,8 %	0,4 %	0,7 %
c. Responsibility group						
0. No	95,9 %	94,4 %	84,8 %	95,2 %	86,8 %	89,8 %
1. Yes	4,1 %	4,6 %	15,0 %	2,5 %	12,8 %	9,4 %
9. Unknown	0,0 %	1,0 %	0,2 %	2,3 %	0,4 %	0,8 %

South

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
Number of responses	348	312	191	344	642
Response rate	99,1 %	93,7 %	63,7 %	100,3 %	104,1 %
Gender					
Men	69,8 %	72,1 %	69,6 %	75,6 %	67,6 %
women	30,2 %	27,9 %	30,4 %	24,4 %	32,4 %
Age (average)	49,8	49,0	49,7	48,9	47,5
A. Current situation					
A0. Current situation					
0. Not discharged	89,2 %	94,0 %	98,9 %	98,5 %	94,7 %
1. Own desire for weaning	2,6 %	2,1 %	0,0 %	0,6 %	1,4 %
2. Dissatisfied with the treatment	0,0 %	0,9 %	0,0 %	0,6 %	1,6 %
3. Lack of effect, irresponsible	0,9 %	0,0 %	0,5 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,5 %	0,0 %	0,0 %
10. Annet	7,4 %	3,0 %	0,0 %	0,3 %	2,4 %
A1. Employment					
a. Occupational status					
0. Without employment	81,9 %	86,5 %	88,4 %	84,6 %	84,3 %
1. Full-time job	11,2 %	5,4 %	7,4 %	11,6 %	7,8 %
2. Part-time job	5,2 %	6,1 %	3,2 %	2,9 %	5,5 %
3. During education	1,4 %	1,0 %	0,5 %	0,6 %	1,7 %
4. Part-time job and in education	0,3 %	0,0 %	0,0 %	0,3 %	0,6 %
9. Unknown	0,0 %	1,0 %	0,5 %	0,0 %	0,2 %
b. Work training/courses					
0. no	95,1 %	96,5 %	96,3 %	91,0 %	89,3 %
1. Yes	3,8 %	2,9 %	3,7 %	2,9 %	10,1 %
9. Unknown	1,2 %	0,6 %	0,0 %	6,1 %	0,6 %
c. Day care services					
0. No	93,3 %	95,2 %	95,8 %	81,7 %	85,8 %
1. Yes	5,8 %	4,2 %	3,7 %	11,6 %	13,4 %
9. Unknown	0,9 %	0,6 %	0,5 %	6,7 %	0,8 %
A2. Most important income					
1. Employment income	12,1 %	6,7 %	8,4 %	12,8 %	8,7 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
2. Supported by others	0,6 %	0,0 %	0,5 %	0,3 %	0,2 %
3. Daily allowance	0,6 %	0,6 %	0,0 %	1,2 %	0,2 %
4. Sick pay	0,6 %	1,0 %	0,0 %	0,0 %	0,9 %
5. AAP	10,9 %	8,0 %	12,6 %	6,1 %	10,4 %
6. Disability/pension	70,1 %	76,9 %	74,7 %	73,3 %	78,2 %
7. Social security benefits	3,4 %	3,2 %	0,0 %	3,5 %	0,3 %
8. Student loans	0,0 %	0,3 %	0,0 %	0,0 %	0,0 %
9. Other/unknown	1,7 %	3,2 %	3,7 %	2,9 %	1,1 %
A3. Housing conditions					
0. No housing	1,8 %	0,6 %	0,0 %	3,2 %	3,0 %
1. Hospits/hybelhus/hotels	3,6 %	2,6 %	4,2 %	0,6 %	0,6 %
2. Institution	3,0 %	5,8 %	11,1 %	3,5 %	3,0 %
3. Prison	0,9 %	1,0 %	1,1 %	2,0 %	1,2 %
4. With parents	2,1 %	3,2 %	1,6 %	2,6 %	3,9 %
5. For others	2,4 %	2,3 %	2,1 %	5,5 %	2,2 %
6. Own home	84,9 %	83,2 %	80,0 %	81,4 %	84,1 %
10. Other / Unknown	1,2 %	1,3 %	0,0 %	1,2 %	2,0 %
A5. Blood infection status (HIV/hepatitis C)					
a. HIV					
0. Not infected	90,7 %	96,5 %	94,7 %	90,1 %	96,1 %
1. Infected	1,5 %	1,0 %	0,0 %	0,9 %	0,9 %
9. Unknown	7,8 %	2,6 %	5,3 %	9,0 %	3,0 %
b. Hepatitis C					
0. Never treated (Hepatitis C antigen negative)	32,7 %	42,5 %	42,6 %	33,2 %	41,1 %
1. Hepatitis C fully treated	46,9 %	44,2 %	29,3 %	44,9 %	43,4 %
2. Hepatitis C positive (antigen detected)	7,9 %	2,6 %	5,3 %	4,7 %	7,5 %
9. Unknown hepatitis C status	12,5 %	10,7 %	22,9 %	17,2 %	8,0 %
A6. OAT medication					
0. Methadone	19,4 %	46,0 %	51,3 %	25,6 %	26,8 %
1. Buprenorphine (Subutex)	31,0 %	24,1 %	31,2 %	38,4 %	41,1 %
1a. Buprenorphine depot	34,5 %	18,6 %	7,4 %	24,7 %	22,6 %
2. Buprenofin/naloxone (Suboxone)	10,7 %	5,5 %	6,9 %	7,3 %	3,6 %
3. SROM	0,0 %	0,0 %	0,0 %	0,0 %	0,0 %
4. Heroin	0,0 %	0,0 %	0,0 %	0,0 %	0,0 %
5. Others	4,1 %	5,5 %	3,2 %	3,8 %	5,5 %
9. Unknown	0,3 %	0,3 %	0,0 %	0,3 %	0,5 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
A7. Daily dose in mg (average)					
0. Methadone	80,2	89,9	91,9	81,4	90,7
1. Buprenofin (Subutex)	16,9	12,7	16,1	12,2	16,4
2. Buprenofin/naloxone (Suboxone)	14,0	11,1	14,8	15,8	15,0
A8. Prescribing physician					
0. Doctor employed in OAT unit	70,5 %	22,1 %	16,9 %	87,5 %	88,8 %
1. GP	27,1 %	76,0 %	79,4 %	11,6 %	10,3 %
2. Other doctor	2,4 %	1,9 %	3,7 %	0,6 %	0,8 %
9. Unknown	0,0 %	0,0 %	0,0 %	0,3 %	0,2 %
A9. Special conditions					
a. Informed about the right to complain?					
0. No					
1. Yes					
2. Uncertain					
9. Unknown					
b. Are benzodiazepines prescribed?					
0. no	65,4 %	49,5 %	63,7 %	57,6 %	58,1 %
1. Yes	29,1 %	48,2 %	35,8 %	39,8 %	38,6 %
9. Unknown	5,5 %	2,3 %	0,5 %	2,6 %	3,3 %
c. Are other morphine substances prescribed?					
0. No	73,3 %	75,9 %	56,4 %	95,9 %	81,6 %
1. Yes	19,0 %	9,3 %	5,9 %	1,2 %	7,5 %
9. Unknown	7,8 %	14,8 %	37,8 %	2,9 %	10,9 %
A10. OAT medication dispensing					
a. Number of deliveries per week (average)	2,9	3,2	3,1	2,5	2,3
b. Of which the number of delivered monitored	2,8	3,1	2,9	2,4	2,4
c. Main place of delivery					
0. OAT unit	64,6 %	2,6 %	4,8 %	13,7 %	17,6 %
1. Pharmacy	15,6 %	42,3 %	65,4 %	30,2 %	43,6 %
2. Municipal services	16,2 %	48,2 %	17,6 %	50,0 %	32,2 %
3. Institution/residential center/prison	3,3 %	5,2 %	11,7 %	4,7 %	4,4 %
4. Doctor's office	0,0 %	1,6 %	0,5 %	0,6 %	0,5 %
10. Annet	0,3 %	0,0 %	0,0 %	0,9 %	1,6 %
9. Unknown	0,0 %	0,0 %	0,0 %	0,0 %	0,2 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
A11. Urine sampling scheme					
a. Type of agreement					
0. No samples	59,5 %	19,6 %	60,8 %	35,8 %	53,6 %
1. Random samples	34,4 %	31,2 %	25,9 %	33,1 %	21,8 %
2. Regular sampling	5,5 %	48,9 %	11,6 %	29,7 %	24,1 %
9. Unknown	0,6 %	0,3 %	1,6 %	1,5 %	0,5 %
b. Number of urine samples per week (average)	0,1	0,4	0,1	0,5	0,1
B. LAST FOUR WEEKS BEFORE COMPLETION DATE					
B1. Treatment and advice last 4 weeks					
a. Objective of the treatment					
0. Rehab with freedom from addiction	58,2 %	71,1 %	80,0 %	61,6 %	69,5 %
1. Stabilization without drug-free requirements	38,9 %	25,1 %	19,5 %	34,3 %	28,0 %
9. Not agreed	2,9 %	3,9 %	0,5 %	4,1 %	2,5 %
b. Primary responsibility in the specialist health service					
0. Not transferred	95,7 %	96,5 %	17,5 %	92,2 %	73,5 %
1. Transferred	4,0 %	3,2 %	81,0 %	7,3 %	26,3 %
9. Other / Unknown	0,3 %	0,3 %	1,6 %	0,6 %	0,2 %
c. Completed rehab, maintenance follow-up					
0. No	61,3 %	70,1 %	38,8 %	52,3 %	48,6 %
1. Yes	35,8 %	19,3 %	54,8 %	42,7 %	49,4 %
9. Unknown	2,9 %	10,6 %	6,4 %	4,9 %	2,0 %
d. Is the patient in psychiatric/psychological treatment?					
0. No	86,1 %	90,0 %	84,2 %	86,0 %	92,7 %
1. Yes	11,3 %	9,0 %	14,7 %	10,5 %	6,4 %
9. Unknown	2,6 %	1,0 %	1,1 %	3,5 %	0,9 %
e. Has an individual plan been drawn up?					
0. No	91,0 %	96,8 %	94,2 %	89,0 %	93,1 %

1. Yes	3,2 %	0,3 %	3,7 %	5,8 %	3,9 %
	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
9. Unknown	5,8 %	2,9 %	2,1 %	5,2 %	3,0 %
f. Systematic psychotherapeutic treatment					
0. No					
1. Yes					
9. Unknown					
B2. Has it been held					
responsibility group meeting last 4 weeks?					
0. No	86,1 %	35,5 %	73,3 %	75,3 %	62,1 %
1. Yes	13,3 %	64,5 %	25,7 %	23,5 %	37,9 %
9. Unknown	0,6 %	0,0 %	1,1 %	1,2 %	0,0 %
B3. Mental health problems last 4 weeks					
a. Severe depression					
0. no	73,0 %	67,9 %	91,0 %	72,4 %	75,7 %
1. Yes	16,4 %	13,5 %	6,4 %	13,4 %	15,8 %
9. Unknown	10,6 %	18,6 %	2,7 %	14,2 %	8,6 %
b. Severe anxiety					
0. no	63,0 %	53,2 %	80,9 %	66,3 %	68,8 %
1. Yes	26,3 %	31,7 %	16,5 %	20,3 %	22,8 %
9. Unknown	10,7 %	15,1 %	2,7 %	13,4 %	8,4 %
c. Delusions/hallucinations					
0. No	82,9 %	81,1 %	88,9 %	79,1 %	85,5 %
1. Yes	6,4 %	3,2 %	8,5 %	9,0 %	7,0 %
9. Unknown	10,7 %	15,7 %	2,6 %	11,9 %	7,5 %
B4. Physical injuries/illnesses					
that affect the way of life or quality of life					
last 4 weeks					
B5. Drug and alcohol use last 4 weeks					
a. Opiods					
0. No	73,3 %	75,9 %	56,4 %	77,3 %	81,6 %
1. Yes	19,0 %	9,3 %	5,9 %	5,5 %	7,5 %

9. Unknown	7,8 %	14,8 %	37,8 %	17,2 %	10,9 %
	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
b. Cannabis					
0. no	55,2 %	48,7 %	50,5 %	48,7 %	57,0 %
1. Yes	36,5 %	35,3 %	9,0 %	35,6 %	32,7 %
9. Unknown	8,3 %	16,0 %	40,4 %	15,7 %	10,3 %
c. Benzodiazepines or similar					
0. No	53,0 %	39,1 %	46,3 %	58,0 %	55,6 %
1. Yes	39,8 %	47,8 %	17,0 %	35,9 %	35,2 %
9. Unknown	7,2 %	13,1 %	36,7 %	6,1 %	9,2 %
d. Central stimulants					
0. No	69,1 %	71,2 %	55,1 %	67,9 %	72,9 %
1. Yes	20,5 %	12,8 %	6,4 %	17,2 %	16,7 %
9. Unknown	10,4 %	16,0 %	38,5 %	14,9 %	10,4 %
e. Alcohol for intoxication					
0. no	73,2 %	72,0 %	51,6 %	70,0 %	80,2 %
1. Yes	14,5 %	11,6 %	5,9 %	12,8 %	8,9 %
9. Unknown	12,4 %	16,4 %	42,5 %	17,2 %	10,9 %
B6. Frequency of drug and alcohol use last 4 weeks					
0. Never	40,3 %	27,7 %	41,8 %	37,9 %	46,5 %
1. Few single episodes	14,8 %	17,0 %	9,5 %	16,9 %	14,8 %
2. Regular use	38,3 %	42,1 %	14,8 %	33,5 %	30,9 %
9. Unknown	6,7 %	13,2 %	33,9 %	11,7 %	7,8 %
B7. Severity of drug and alcohol use last 4 weeks					
0. Good function, works "like others"	48,7 %	38,2 %	45,2 %	43,7 %	53,0 %
1. Mixed function. Occasionally under the influence of alcohol.	16,0 %	22,9 %	15,4 %	25,1 %	20,0 %
2. Addictive, drug-dominated function	28,3 %	12,4 %	5,9 %	18,1 %	20,1 %
9. Unknown	7,0 %	26,5 %	33,5 %	13,1 %	6,9 %
C. LAST YEAR					
C1. Offenses last year					

Arrested, taken into custody, prosecuted; convicted					
	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
0. no	81,7 %	72,7 %	70,5 %	79,9 %	80,4 %
1. Yes	7,8 %	7,4 %	4,7 %	10,2 %	9,8 %
9. Unknown	10,5 %	19,9 %	24,7 %	9,9 %	9,8 %
C2. Overdose last year					
0. no	82,9 %	77,2 %	86,2 %	85,1 %	86,8 %
1. Yes	11,0 %	7,1 %	4,8 %	7,3 %	5,0 %
9. Unknown	6,1 %	15,7 %	9,0 %	7,6 %	8,3 %
C3. Suicide attempts last year					
0. No	88,5 %	79,7 %	91,0 %	90,4 %	90,8 %
1. Yes	3,8 %	2,6 %	1,1 %	2,6 %	1,9 %
9. Unknown	7,7 %	17,7 %	7,9 %	7,0 %	7,3 %
C4. Drug and alcohol use in the past year					
0. Never	37,1 %	24,1 %	47,1 %	29,2 %	36,9 %
1. Some individual, short periods	16,3 %	24,4 %	12,3 %	26,5 %	22,6 %
2. Used for longer periods or all the time	43,0 %	40,4 %	24,1 %	33,8 %	34,3 %
9. Unknown	3,6 %	11,1 %	16,6 %	10,5 %	6,2 %
C5. Satisfaction					
a. The patient's assessment					
0. Satisfied successful	72,6 %	62,7 %	52,4 %	66,5 %	65,7 %
1. Both and	16,6 %	7,1 %	14,3 %	19,8 %	16,5 %
2. Dissatisfied/not successful	2,9 %	1,3 %	1,6 %	2,0 %	4,0 %
9. Unknown	7,9 %	28,9 %	31,7 %	11,7 %	13,7 %
b. Filler's assessment					
0. Satisfied successful	75,8 %	78,8 %	67,7 %	60,1 %	73,7 %
1. Both and	18,4 %	15,7 %	25,9 %	36,1 %	22,9 %
2. Dissatisfied/not successful	4,7 %	1,3 %	2,1 %	2,1 %	3,0 %
9. Unknown	1,2 %	4,2 %	4,2 %	1,8 %	0,5 %
C6. Are treatment changes recommended?					
0. No	81,3 %	87,5 %	80,6 %	82,8 %	88,6 %
1. Yes	17,3 %	6,8 %	16,7 %	14,3 %	9,5 %
9. Unknown	1,4 %	5,8 %	2,7 %	2,9 %	1,9 %
C7. Who has participated/asked when filling out the form?					

a. Pasient					
0. No	16,8 %	29,5 %	62,6 %	21,3 %	16,0 %
	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
1. Yes	83,2 %	70,5 %	36,3 %	78,7 %	84,0 %
9. Unknown	0,0 %	0,0 %	1,1 %	0,0 %	0,0 %
b. Employee					
0. No	85,1 %	49,4 %	41,6 %	83,1 %	80,3 %
1. Yes	14,9 %	50,6 %	56,8 %	16,9 %	19,7 %
9. Unknown	0,0 %	0,0 %	1,6 %	0,0 %	0,0 %
c. Responsibility group					
0. no	97,0 %	58,3 %	80,6 %	93,9 %	87,9 %
1. Yes	3,0 %	41,7 %	18,3 %	5,8 %	12,1 %
9. Unknown	0,0 %	0,0 %	1,1 %	0,3 %	0,0 %

Vest

	Mountains	Stavanger, Norway	Fonna	Førde
Number of responses	868	498	256	51
Response rate	72,9 %	78,2 %	73,1 %	52,0 %
Gender				
Men	70,7 %	68,9 %	72,3 %	74,5 %
women	29,3 %	31,1 %	27,7 %	25,5 %
Age (average)	47,1	47,0	48,9	46,0
			e	
A. Current situation				
A0. Current situation				
0. Not discharged	99,3 %	98,4 %	97,3 %	100,0 %
1. Own desire for weaning	0,2 %	0,0 %	1,2 %	0,0 %
2. Dissatisfied with the treatment	0,1 %	0,2 %	0,8 %	0,0 %
3. Lack of effect, irresponsible	0,1 %	0,0 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,4 %	0,0 %
10. Annet	0,2 %	1,4 %	0,4 %	0,0 %
A1. Employment				
a. Occupational status				
0. Without employment	88,1 %	79,7 %	81,6 %	74,5 %
1. Full-time job	7,2 %	13,3 %	12,1 %	9,8 %
2. Part-time job	3,1 %	5,5 %	2,3 %	15,7 %
3. During education	0,6 %	0,6 %	2,3 %	0,0 %
4. Part-time job and in education	0,2 %	0,4 %	0,8 %	0,0 %
9. Unknown	0,8 %	0,4 %	0,8 %	0,0 %
b. Work training/courses				
0. No	89,5 %	90,8 %	91,0 %	80,4 %
1. Yes	6,3 %	6,4 %	6,3 %	19,6 %
9. Unknown	4,3 %	2,9 %	2,7 %	0,0 %
c. Day care services				
0. No	78,5 %	81,1 %	82,0 %	70,6 %
1. Yes	15,3 %	15,4 %	15,6 %	29,4 %
9. Unknown	6,3 %	3,5 %	2,3 %	0,0 %
A2. Most important income				
1. Employment income	8,0 %	13,3 %	11,7 %	11,8 %

2. Supported by others	0,0 %	0,2 %	0,0 %	0,0 %
	Mountains	Stavanger, Norway	Fonna	Førde
3. Daily allowance	0,7 %	1,6 %	0,8 %	0,0 %
4. Sick pay	0,7 %	1,0 %	0,8 %	0,0 %
5. AAP	12,3 %	10,2 %	11,3 %	21,6 %
6. Disability/pension	66,2 %	67,6 %	74,2 %	62,7 %
7. Social security benefits	6,8 %	3,9 %	0,8 %	3,9 %
8. Student loans	0,0 %	0,0 %	0,0 %	0,0 %
9. Other/unknown	5,3 %	2,0 %	0,4 %	0,0 %
A3. Housing conditions				
0. No housing	4,5 %	3,3 %	1,2 %	0,0 %
1. Hospits/hybelhus/hotels	3,9 %	3,7 %	0,8 %	0,0 %
2. Institution	3,8 %	4,7 %	2,0 %	3,9 %
3. Prison	0,9 %	1,4 %	0,0 %	0,0 %
4. With parents	5,9 %	3,7 %	3,1 %	3,9 %
5. For others	2,7 %	1,2 %	0,8 %	2,0 %
6. Own home	77,3 %	81,1 %	91,8 %	88,2 %
10. Other / Unknown	0,9 %	0,8 %	0,4 %	2,0 %
A5. Blood infection status (HIV/hepatitis C)				
a. HIV				
0. Not infected	81,1 %	88,5 %	91,4 %	94,1 %
1. Infected	1,2 %	1,4 %	1,2 %	2,0 %
9. Unknown	17,7 %	10,0 %	7,4 %	3,9 %
b. Hepatitis C				
0. Never treated (Hepatitis C antigen negative)	50,9 %	38,6 %	56,9 %	35,5 %
1. Hepatitis C fully treated	23,8 %	36,1 %	21,6 %	39,8 %
2. Hepatitis C positive (antigen detected)	4,2 %	4,7 %	11,8 %	9,0 %
9. Unknown hepatitis C status	21,1 %	20,5 %	9,8 %	15,6 %
A6. OAT medication				
0. Methadone	30,1 %	19,5 %	13,7 %	5,9 %
1. Buprenorphine (Subutex)	44,4 %	61,4 %	67,6 %	66,7 %
1a. Buprenorphine depot	7,4 %	10,0 %	12,5 %	17,6 %
2. Buprenofin/naloxone (Suboxone)	0,6 %	3,0 %	1,6 %	3,9 %
3. SROM	0,3 %	0,0 %	0,0 %	0,0 %
4. Heroin	2,7 %	0,0 %	0,0 %	0,0 %
5. Others	13,8 %	5,9 %	3,9 %	5,9 %
9. Unknown	0,7 %	0,2 %	0,8 %	0,0 %

A7. Daily dose in mg (average)				
	Mountains	Stavanger, Norway	Fonna	Førde
0. Methadone	96,4	89,9	85,9	93,3
1. Buprenofin (Subutex)	15,0	13,3	13,9	13,9
2. Buprenofin/naloxone (Suboxone)	13,5	10,0	0,0	12,0
A8. Prescribing physician				
0. Doctor employed in OAT unit	99,5 %	97,5 %	82,8 %	88,2 %
1. GP	0,0 %	2,0 %	16,4 %	11,8 %
2. Other doctor	0,3 %	0,2 %	0,0 %	0,0 %
9. Unknown	0,1 %	0,2 %	0,8 %	0,0 %
A9. Special conditions				
a. Informed about the right to complain?				
0. No				
1. Yes				
2. Uncertain				
9. Unknown				
b. Are benzodiazepines prescribed?				
0. No	56,3 %	63,0 %	62,1 %	60,8 %
1. Yes	39,7 %	34,7 %	35,2 %	39,2 %
9. Unknown	3,9 %	2,3 %	2,7 %	0,0 %
c. Are other morphine substances prescribed?				
0. No	94,1 %	93,4 %	94,9 %	100,0 %
1. Yes	3,1 %	5,1 %	2,7 %	0,0 %
9. Unknown	2,8 %	1,4 %	2,3 %	0,0 %
A10. OAT medication dispensing				
a. Number of deliveries per week (average)	2,8	3,1	3,0	1,9
b. Of which the number of delivered monitored	2,8	2,8	3,1	1,9
c. Main place of delivery				
0. OAT unit	55,7 %	22,1 %	23,0 %	15,7 %
1. Pharmacy	23,2 %	24,7 %	39,1 %	29,4 %
2. Municipal services	11,0 %	32,9 %	32,0 %	52,9 %
3. Institution/residential center/prison	5,0 %	8,0 %	2,3 %	0,0 %
4. Doctor's office	2,8 %	7,8 %	2,3 %	2,0 %
10. Annet	2,2 %	4,5 %	0,4 %	0,0 %
9. Unknown	0,1 %	0,0 %	0,8 %	0,0 %

A11. Urine sampling scheme				
	Mountains	Stavanger, Norway	Fonna	Førde
a. Type of agreement				
0. No samples	48,4 %	38,9 %	28,1 %	47,1 %
1. Random samples	21,2 %	15,8 %	26,2 %	35,3 %
2. Regular sampling	28,1 %	42,8 %	41,8 %	17,6 %
9. Unknown	2,3 %	2,5 %	3,9 %	0,0 %
b. Number of urine samples per week (average)	0,4	0,4	0,4	0,3
B. LAST FOUR WEEKS BEFORE COMPLETION DATE				
B1. Treatment and advice last 4 weeks				
a. Objective of the treatment				
0. Rehab with freedom from addiction	61,9 %	77,0 %	70,7 %	74,5 %
1. Stabilization without drug-free requirements	30,8 %	21,5 %	27,0 %	23,5 %
9. Not agreed	7,3 %	1,4 %	2,3 %	2,0 %
b. Primary responsibility in the specialist health service				
0. Not transferred	99,4 %	97,5 %	82,4 %	92,2 %
1. Transferred	0,5 %	2,2 %	16,4 %	7,8 %
9. Other / Unknown	0,1 %	0,2 %	1,2 %	0,0 %
c. Completed rehab, maintenance follow-up				
0. No	51,7 %	46,5 %	51,6 %	21,6 %
1. Yes	41,7 %	45,7 %	44,9 %	76,5 %
9. Unknown	6,5 %	7,8 %	3,5 %	2,0 %
d. Is the patient in psychiatric/psychological treatment?				
0. no	76,5 %	76,8 %	79,3 %	68,6 %
1. Yes	18,2 %	17,6 %	13,7 %	31,4 %
9. Unknown	5,2 %	5,5 %	7,0 %	0,0 %
e. Has an individual plan been drawn up?				
0. No	63,1 %	60,2 %	74,2 %	58,8 %
1. Yes	10,7 %	23,0 %	10,2 %	39,2 %

9. Unknown	26,2 %	16,8 %	15,6 %	2,0 %
f. Systematic psychotherapeutic treatment				
	Mountains	Stavanger, Norway	Fonna	Førde
0. No				
1. Yes				
9. Unknown				
B2. Has it been held				
responsibility group meeting last 4 weeks?				
0. No	77,6 %	68,0 %	53,9 %	45,1 %
1. Yes	21,0 %	31,6 %	42,6 %	54,9 %
9. Unknown	1,4 %	0,4 %	3,5 %	0,0 %
B3. Mental health problems last 4 weeks				
a. Severe depression				
0. no	57,9 %	65,8 %	73,4 %	94,1 %
1. Yes	17,5 %	16,4 %	12,1 %	5,9 %
9. Unknown	24,5 %	17,8 %	14,5 %	0,0 %
b. Severe anxiety				
0. no	48,9 %	53,7 %	61,7 %	82,4 %
1. Yes	28,6 %	28,9 %	24,2 %	17,6 %
9. Unknown	22,4 %	17,4 %	14,1 %	0,0 %
c. Delusions/hallucinations				
0. No	71,2 %	78,9 %	79,2 %	96,1 %
1. Yes	7,5 %	4,7 %	4,3 %	3,9 %
9. Unknown	21,4 %	16,4 %	16,5 %	0,0 %
B4. Physical injuries/illnesses				
that affect the way of life or quality of life				
last 4 weeks				
B5. Drug and alcohol use last 4 weeks				
a. Opiods				
0. No	68,5 %	77,4 %	78,8 %	90,2 %
1. Yes	9,7 %	4,1 %	4,7 %	5,9 %
9. Unknown	21,8 %	18,5 %	16,5 %	3,9 %

b. Cannabis				
0. no	46,3 %	55,4 %	51,4 %	64,7 %
1. Yes	31,9 %	27,9 %	35,3 %	33,3 %
	Mountains	Stavanger, Norway	Fonna	Førde
9. Unknown	21,8 %	16,6 %	13,3 %	2,0 %
c. Benzodiazepines or similar				
0. no	52,6 %	61,0 %	52,5 %	74,5 %
1. Yes	32,9 %	28,1 %	32,5 %	23,5 %
9. Unknown	14,6 %	10,9 %	14,9 %	2,0 %
d. Central stimulants				
0. No	57,2 %	64,1 %	65,1 %	90,2 %
1. Yes	23,8 %	17,5 %	18,0 %	9,8 %
9. Unknown	19,0 %	18,5 %	16,9 %	0,0 %
e. Alcohol for intoxication				
0. No	66,5 %	73,7 %	72,9 %	96,1 %
1. Yes	8,5 %	7,6 %	7,1 %	3,9 %
9. Unknown	25,0 %	18,7 %	20,0 %	0,0 %
B6. Frequency of drug and alcohol use				
last 4 weeks				
0. Never	34,3 %	43,3 %	43,5 %	52,9 %
1. Few single episodes	21,4 %	16,8 %	14,1 %	17,6 %
2. Regular use	27,2 %	24,2 %	34,1 %	27,5 %
9. Unknown	17,2 %	15,6 %	8,2 %	2,0 %
B7. Severity of drug and alcohol use				
last 4 weeks				
0. Good function, works "like others"	48,4 %	50,1 %	53,3 %	70,6 %
1. Mixed function. Occasionally under the influence of alcohol.	22,4 %	19,3 %	16,9 %	21,6 %
2. Addictive, drug-dominated function	12,3 %	15,4 %	18,8 %	5,9 %
9. Unknown	16,9 %	15,2 %	11,0 %	2,0 %
C. LAST YEAR				
C1. Offenses last year				
Arrested, taken into custody, prosecuted; convicted				
0. No	68,8 %	76,8 %	79,6 %	94,1 %

1. Yes	7,5 %	7,8 %	7,5 %	5,9 %
9. Unknown	23,7 %	15,4 %	12,9 %	0,0 %
C2. Overdose last year				
	Mountains	Stavanger, Norway	Fonna	Førde
0. No	76,3 %	81,6 %	81,6 %	98,0 %
1. Yes	12,0 %	7,8 %	7,8 %	2,0 %
9. Unknown	11,8 %	10,7 %	10,6 %	0,0 %
C3. Suicide attempts last year				
0. no	78,2 %	83,8 %	85,5 %	98,0 %
1. Yes	2,0 %	3,3 %	2,0 %	2,0 %
9. Unknown	19,8 %	12,9 %	12,5 %	0,0 %
C4. Drug and alcohol use in the past year				
0. Never	24,9 %	30,8 %	32,9 %	45,1 %
1. Some individual, short periods	28,0 %	30,2 %	21,6 %	27,5 %
2. Used for longer periods or all the time	34,3 %	27,1 %	38,4 %	25,5 %
9. Unknown	12,8 %	11,9 %	7,1 %	2,0 %
C5. Satisfaction				
a. The patient's assessment				
0. Satisfied successful	49,9 %	59,7 %	61,9 %	80,4 %
1. Both and	15,9 %	16,9 %	15,1 %	15,7 %
2. Dissatisfied/not successful	2,2 %	4,3 %	6,3 %	3,9 %
9. Unknown	32,0 %	19,1 %	16,7 %	0,0 %
b. Filler's assessment				
0. Satisfied successful	61,8 %	59,8 %	66,3 %	87,5 %
1. Both and	32,5 %	35,3 %	22,1 %	10,4 %
2. Dissatisfied/not successful	3,0 %	2,2 %	2,8 %	0,0 %
9. Unknown	2,7 %	2,8 %	8,8 %	2,1 %
C6. Are treatment changes recommended?				
0. no	72,9 %	70,0 %	77,6 %	88,2 %
1. Yes	19,9 %	21,6 %	9,8 %	7,8 %
9. Unknown	7,2 %	8,4 %	12,5 %	3,9 %
C7. Who has participated/asked when filling out the form?				
a. Pasient				
0. no	38,2 %	23,3 %	22,4 %	2,0 %
1. Yes	61,4 %	76,7 %	76,1 %	98,0 %

9. Unknown	0,4 %	0,0 %	1,6 %	0,0 %
b. Employee				
0. No	94,6 %	86,7 %	63,5 %	78,4 %
1. Yes	4,9 %	13,3 %	26,7 %	21,6 %
	Mountains	Stavanger, Norway	Fonna	Førde
9. Unknown	0,5 %	0,0 %	9,8 %	0,0 %
c. Responsibility group				
0. No	97,7 %	97,3 %	85,1 %	82,4 %
1. Yes	1,9 %	2,7 %	1,6 %	17,6 %
9. Unknown	0,5 %	0,0 %	13,3 %	0,0 %

East

	Akershus	Oslo, Norway	Østfold	Inland
Number of responses	559	860	474	394
Response rate	63,7 %	84,3 %	85,1 %	91,0 %
Gender				
Men	64,4 %	71,0 %	68,1 %	67,8 %
women	35,6 %	29,0 %	31,9 %	32,2 %
Age (average)	47,1	50,3	47,6	50,3
A. Current situation				
A0. Current situation				
0. Not discharged	98,2 %	98,7 %	96,2 %	95,3 %
1. Own desire for weaning	1,4 %	0,1 %	1,1 %	2,3 %
2. Dissatisfied with the treatment	0,4 %	0,0 %	1,1 %	0,4 %
3. Lack of effect, irresponsible	0,0 %	0,2 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,2 %	0,0 %
10. Annet	0,0 %	0,9 %	1,5 %	1,9 %
A1. Employment				
a. Occupational status				
0. Without employment	78,3 %	84,5 %	86,6 %	82,0 %
1. Full-time job	9,4 %	7,3 %	6,4 %	6,6 %
2. Part-time job	3,6 %	5,2 %	5,3 %	10,4 %
3. During education	0,9 %	1,4 %	0,4 %	0,5 %
4. Part-time job and in education	0,4 %	0,2 %	0,2 %	0,0 %
9. Unknown	7,4 %	1,3 %	1,1 %	0,5 %
b. Work training/courses				
0. no	84,7 %	89,3 %	94,4 %	93,4 %
1. Yes	7,2 %	7,3 %	4,1 %	6,1 %
9. Unknown	8,1 %	3,4 %	1,5 %	0,5 %
c. Day care services				
0. No	78,7 %	82,7 %	91,8 %	88,3 %
1. Yes	12,1 %	12,9 %	6,7 %	11,4 %
9. Unknown	9,2 %	4,4 %	1,5 %	0,3 %
A2. Most important income				

1. Employment income	8,8 %	8,6 %	7,4 %	9,2 %
2. Supported by others	0,2 %	0,1 %	0,2 %	0,0 %
	Akershus	Oslo, Norway	Østfold	Inland
3. Daily allowance	0,5 %	1,4 %	0,2 %	0,3 %
4. Sick pay	1,1 %	0,9 %	0,7 %	0,3 %
5. AAP	13,8 %	14,1 %	10,6 %	7,1 %
6. Disability/pension	63,0 %	67,0 %	72,7 %	78,6 %
7. Social security benefits	4,1 %	5,0 %	3,3 %	3,8 %
8. Student loans	0,2 %	0,0 %	0,0 %	0,0 %
9. Other/unknown	8,3 %	2,9 %	5,0 %	0,8 %
A3. Housing conditions				
0. No housing	1,1 %	2,2 %	1,7 %	1,3 %
1. Hospits/hybelhus/hotels	1,6 %	5,2 %	3,1 %	0,8 %
2. Institution	3,8 %	18,8 %	5,2 %	3,9 %
3. Prison	1,1 %	0,8 %	0,4 %	0,8 %
4. With parents	4,7 %	1,9 %	3,9 %	1,3 %
5. For others	2,5 %	2,6 %	3,7 %	3,6 %
6. Own home	78,3 %	67,3 %	78,2 %	86,7 %
10. Other / Unknown	7,0 %	1,2 %	3,7 %	1,6 %
A5. Blood infection status (HIV/hepatitis C)				
a. HIV				
0. Not infected	84,1 %	87,6 %	87,4 %	93,4 %
1. Infected	1,8 %	1,9 %	1,3 %	1,0 %
9. Unknown	14,1 %	10,6 %	11,3 %	5,6 %
b. Hepatitis C				
0. Never treated (Hepatitis C antigen negative)	44,1 %	46,0 %	36,7 %	35,4 %
1. Hepatitis C fully treated	34,8 %	34,0 %	33,0 %	48,6 %
2. Hepatitis C positive (antigen detected)	7,0 %	4,3 %	5,4 %	5,2 %
9. Unknown hepatitis C status	14,1 %	15,7 %	24,8 %	10,9 %
A6. OAT medication				
0. Methadone	39,0 %	40,4 %	29,9 %	35,8 %
1. Buprenorphine (Subutex)	25,5 %	21,6 %	24,8 %	35,0 %
1a. Buprenorphine depot	25,2 %	20,8 %	34,4 %	10,7 %
2. Buprenorphine/naloxone (Suboxone)	5,9 %	2,4 %	3,4 %	5,1 %
3. SROM	0,0 %	0,6 %	0,0 %	0,0 %
4. Heroin	0,0 %	5,0 %	0,0 %	0,0 %
5. Others	4,1 %	8,4 %	6,8 %	13,3 %

9. Unknown	0,2 %	0,8 %	0,6 %	0,0 %
A7. Daily dose in mg (average)				
	Akershus	Oslo, Norway	Østfold	Inland
0. Methadone	97,3	87,5	79,4	96,2
1. Buprenorphine (Subutex)	14,4	15,6	13,6	13,4
2. Buprenorphine/naloxone (Suboxone)	12,0	11,1	13,9	12,0
A8. Prescribing physician				
0. Doctor employed in OAT unit	43,7 %	57,1 %	90,8 %	32,0 %
1. GP	52,3 %	32,3 %	8,5 %	62,9 %
2. Other doctor	0,7 %	9,8 %	0,7 %	4,9 %
9. Unknown	3,2 %	0,8 %	0,0 %	0,3 %
A9. Special conditions				
a. Informed about the right to complain?				
0. No				
1. Yes				
2. Uncertain				
9. Unknown				
b. Are benzodiazepines prescribed?				
0. No	49,5 %	51,4 %	57,9 %	53,2 %
1. Yes	40,8 %	42,7 %	38,2 %	44,5 %
9. Unknown	9,7 %	5,9 %	3,9 %	2,3 %
c. Are other morphine substances prescribed?				
0. No	87,4 %	87,7 %	67,9 %	84,0 %
1. Yes	3,1 %	6,0 %	7,9 %	6,1 %
9. Unknown	9,5 %	6,3 %	24,2 %	9,9 %
A10. OAT medication dispensing				
a. Number of deliveries per week (average)	2,1	4,0	3,5	2,8
b. Of which the number of delivered monitored	2,6	4,0	3,6	2,7
c. Main place of delivery				
0. OAT unit	25,0 %	27,9 %	40,2 %	3,1 %
1. Pharmacy	53,6 %	43,5 %	35,8 %	49,1 %
2. Municipal services	13,8 %	12,9 %	17,7 %	37,3 %
3. Institution/residential center/prison	5,0 %	12,9 %	6,3 %	5,9 %
4. Doctor's office	0,0 %	0,1 %	0,0 %	2,3 %

10. Annet	0,7 %	2,4 %	0,0 %	1,8 %
9. Unknown	1,8 %	0,2 %	0,0 %	0,5 %
A11. Urine sampling scheme				
	Akershus	Oslo, Norway	Østfold	Inland
a. Type of agreement				
0. No samples	61,4 %	46,3 %	33,1 %	33,6 %
1. Random samples	14,6 %	34,7 %	46,5 %	44,3 %
2. Regular sampling	13,3 %	13,3 %	18,0 %	20,6 %
9. Unknown	10,6 %	5,8 %	2,4 %	1,5 %
b. Number of urine samples per week (average)	0,1	0,4	0,2	0,2
B. LAST FOUR WEEKS BEFORE COMPLETION DATE				
B1. Treatment and advice last 4 weeks				
a. Objective of the treatment				
0. Rehab with freedom from addiction	72,1 %	70,2 %	69,6 %	75,6 %
1. Stabilization without drug-free requirements	20,0 %	26,2 %	25,4 %	20,8 %
9. Not agreed	7,9 %	3,6 %	5,0 %	3,6 %
b. Primary responsibility in the specialist health service				
0. Not transferred	79,7 %	66,5 %	95,9 %	80,2 %
1. Transferred	14,4 %	32,0 %	3,9 %	16,8 %
9. Other / Unknown	5,9 %	1,5 %	0,2 %	3,1 %
c. Completed rehab, maintenance follow-up				
0. no	35,1 %	48,5 %	65,9 %	54,3 %
1. Yes	55,9 %	45,9 %	27,5 %	42,9 %
9. Unknown	9,0 %	5,6 %	6,6 %	2,8 %
d. Is the patient in psychiatric/psychological treatment?				
0. no	78,1 %	70,7 %	91,3 %	79,1 %
1. Yes	12,8 %	23,1 %	7,0 %	19,6 %
9. Unknown	9,2 %	6,2 %	1,7 %	1,3 %

e. Has an individual plan been drawn up?				
0. no	70,8 %	66,2 %	80,1 %	89,8 %
1. Yes	12,6 %	8,7 %	13,6 %	7,9 %
9. Unknown	16,6 %	25,1 %	6,3 %	2,3 %
f. Systematic psychotherapeutic treatment				
	Akershus	Oslo, Norway	Østfold	Inland
0. No				
1. Yes				
9. Unknown				
B2. Has it been held				
responsibility group meeting last 4 weeks?				
0. no	65,5 %	70,1 %	80,7 %	57,4 %
1. Yes	30,4 %	22,0 %	17,2 %	42,1 %
9. Unknown	4,2 %	7,9 %	2,1 %	0,5 %
B3. Mental health problems last 4 weeks				
a. Severe depression				
0. no	56,5 %	65,9 %	82,6 %	72,9 %
1. Yes	29,6 %	18,4 %	6,0 %	18,2 %
9. Unknown	13,9 %	15,7 %	11,4 %	9,0 %
b. Severe anxiety				
0. No	49,8 %	54,5 %	72,2 %	66,4 %
1. Yes	35,9 %	30,3 %	14,8 %	24,8 %
9. Unknown	14,3 %	15,1 %	13,1 %	8,8 %
c. Delusions/hallucinations				
0. No	78,8 %	72,9 %	83,0 %	83,1 %
1. Yes	7,3 %	10,5 %	6,0 %	7,7 %
9. Unknown	14,0 %	16,6 %	11,0 %	9,2 %
B4. Physical injuries/illnesses				
that affect the way of life or quality of life				
last 4 weeks				
B5. Drug and alcohol use last 4 weeks				

a. Opiods				
0. No	75,5 %	67,7 %	67,9 %	84,0 %
1. Yes	11,1 %	16,4 %	7,9 %	6,1 %
9. Unknown	13,4 %	15,9 %	24,2 %	9,9 %
b. Cannabis				
0. No	58,3 %	47,8 %	46,2 %	64,2 %
1. Yes	27,8 %	32,6 %	28,6 %	26,6 %
	Akershus	Oslo, Norway	Østfold	Inland
9. Unknown	13,9 %	19,7 %	25,3 %	9,1 %
c. Benzodiazepines or similar				
0. No	53,9 %	52,0 %	48,2 %	64,5 %
1. Yes	33,3 %	38,1 %	27,0 %	26,3 %
9. Unknown	12,8 %	9,9 %	24,8 %	9,2 %
d. Central stimulants				
0. No	74,5 %	63,6 %	59,2 %	75,9 %
1. Yes	11,8 %	18,1 %	14,8 %	13,8 %
9. Unknown	13,7 %	18,3 %	26,0 %	10,3 %
e. Alcohol for intoxication				
0. No	75,7 %	71,2 %	61,3 %	74,2 %
1. Yes	9,7 %	8,7 %	11,5 %	15,5 %
9. Unknown	14,5 %	20,1 %	27,2 %	10,3 %
B6. Frequency of drug and alcohol use				
last 4 weeks				
0. Never	42,9 %	35,7 %	32,5 %	50,8 %
1. Few single episodes	16,8 %	20,5 %	19,7 %	12,6 %
2. Regular use	26,8 %	30,8 %	27,2 %	27,2 %
9. Unknown	13,6 %	13,0 %	20,6 %	9,5 %
B7. Severity of drug and alcohol use				
last 4 weeks				
0. Good function, works "like others"	51,5 %	43,5 %	44,6 %	57,0 %
1. Mixed function. Occasionally under the influence of alcohol.	24,3 %	24,1 %	21,2 %	16,8 %
2. Addictive, drug-dominated function	11,2 %	18,0 %	13,3 %	16,6 %
9. Unknown	13,0 %	14,4 %	20,8 %	9,6 %
C. LAST YEAR				

C1. Offenses last year				
Arrested, taken into custody, prosecuted; convicted				
0. no	76,4 %	69,0 %	73,2 %	81,8 %
1. Yes	9,4 %	6,4 %	4,9 %	9,2 %
9. Unknown	14,2 %	24,7 %	21,8 %	9,0 %
C2. Overdose last year				
	Akershus	Oslo, Norway	Østfold	Inland
0. No	79,5 %	76,9 %	83,9 %	87,2 %
1. Yes	7,0 %	8,0 %	5,1 %	7,2 %
9. Unknown	13,5 %	15,1 %	10,9 %	5,6 %
C3. Suicide attempts last year				
0. No	83,6 %	82,0 %	88,3 %	92,1 %
1. Yes	2,7 %	2,4 %	0,9 %	1,8 %
9. Unknown	13,7 %	15,6 %	10,8 %	6,2 %
C4. Drug and alcohol use in the past year				
0. Never	35,6 %	25,0 %	32,6 %	39,2 %
1. Some single, short periods	27,1 %	28,0 %	24,6 %	24,6 %
2. Used for longer periods or all the time	25,6 %	34,7 %	28,6 %	28,2 %
9. Unknown	11,7 %	12,3 %	14,3 %	7,9 %
C5. Satisfaction				
a. The patient's assessment				
0. Satisfied successful	61,0 %	50,9 %	59,7 %	66,6 %
1. Both and	20,4 %	17,1 %	11,2 %	16,2 %
2. Dissatisfied/not successful	4,9 %	3,7 %	4,5 %	4,4 %
9. Unknown	13,7 %	28,3 %	24,6 %	12,8 %
b. Filler's assessment				
0. Satisfied successful	71,3 %	67,8 %	63,4 %	81,7 %
1. Both and	18,7 %	25,1 %	31,6 %	16,2 %
2. Dissatisfied/not successful	1,9 %	2,0 %	3,3 %	1,0 %
9. Unknown	8,1 %	5,1 %	1,8 %	1,0 %
C6. Are treatment changes recommended?				
0. No	75,1 %	74,5 %	86,0 %	89,3 %
1. Yes	10,9 %	19,3 %	11,4 %	8,9 %
9. Unknown	14,0 %	6,2 %	2,6 %	1,8 %

C7. Who has participated/asked when filling out the form?				
a. Pasient				
0. No	16,3 %	31,9 %	34,1 %	17,4 %
1. Yes	83,7 %	67,9 %	65,5 %	82,6 %
9. Unknown	0,0 %	0,2 %	0,4 %	0,0 %
b. Employee				
0. no	61,6 %	67,7 %	77,1 %	67,8 %
1. Yes	38,4 %	32,2 %	22,3 %	31,1 %
	Akershus	Oslo, Norway	Østfold	Inland
9. Unknown	0,0 %	0,1 %	0,7 %	1,1 %
c. Responsibility group				
0. No	85,0 %	94,9 %	87,3 %	69,1 %
1. Yes	15,0 %	4,9 %	12,1 %	30,1 %
9. Unknown	0,0 %	0,2 %	0,7 %	0,8 %

Middle

	Nord-Trøndelag county	Møre/Romsdal	St Olav
Number of responses	99	202	364
Response rate	89,2 %	96,7 %	100,0 %
Gender			
Men	59,6 %	75,7 %	67,3 %
women	40,4 %	24,3 %	32,7 %
Age (average)	47,1	46,0	46,4
A. Current situation			
A0. Current situation			
0. Not discharged	96,0 %	97,5 %	94,5 %
1. Own desire for weaning	2,0 %	1,5 %	2,5 %
2. Dissatisfied with the treatment	1,0 %	0,5 %	1,9 %
3. Lack of effect, irresponsible	0,0 %	0,5 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,0 %
10. Annet	1,0 %	0,0 %	1,1 %
A1. Employment			
a. Occupational status			
0. Without employment	71,7 %	72,3 %	78,6 %
1. Full-time job	12,1 %	16,3 %	11,0 %
2. Part-time job	11,1 %	5,0 %	7,4 %
3. During education	3,0 %	1,0 %	1,6 %
4. Part-time job and in education	0,0 %	0,5 %	0,5 %
9. Unknown	2,0 %	5,0 %	0,8 %
b. Work training/courses			
0. No	91,9 %	91,1 %	93,4 %
1. Yes	6,1 %	3,0 %	5,5 %
9. Unknown	2,0 %	5,9 %	1,1 %
c. Day care services			
0. No	87,9 %	80,7 %	90,1 %
1. Yes	10,1 %	12,9 %	8,5 %
9. Unknown	2,0 %	6,4 %	1,4 %
A2. Most important income			
1. Employment income	13,1 %	19,8 %	13,2 %

2. Supported by others	0,0 %	0,5 %	0,0 %
	Nord-Trøndelag county	Møre/Romsdal	St Olav
3. Daily allowance	0,0 %	0,0 %	0,0 %
4. Sick pay	0,0 %	0,5 %	0,5 %
5. AAP	9,1 %	11,9 %	6,6 %
6. Disability/pension	72,7 %	59,9 %	73,4 %
7. Social security benefits	1,0 %	0,5 %	3,6 %
8. Student loans	0,0 %	0,0 %	0,0 %
9. Other/unknown	4,0 %	6,9 %	2,7 %
A3. Housing conditions			
0. No housing	0,0 %	3,5 %	3,0 %
1. Hospits/hybelhus/hotels	0,0 %	0,0 %	2,5 %
2. Institution	2,0 %	5,0 %	4,4 %
3. Prison	0,0 %	1,5 %	1,6 %
4. With parents	1,0 %	5,9 %	2,2 %
5. For others	0,0 %	3,0 %	2,2 %
6. Own home	96,0 %	76,2 %	83,0 %
10. Other / Unknown	1,0 %	5,0 %	1,1 %
A5. Blood infection status (HIV/hepatitis C)			
a. HIV			
0. Not infected	92,9 %	81,7 %	90,1 %
1. Infected	0,0 %	0,5 %	0,0 %
9. Unknown	7,1 %	17,8 %	9,9 %
b. Hepatitis C			
0. Never treated (Hepatitis C antigen negative)	40,8 %	30,8 %	37,5 %
1. Hepatitis C fully treated	34,7 %	31,3 %	41,6 %
2. Hepatitis C positive (antigen detected)	9,2 %	6,5 %	4,4 %
9. Unknown hepatitis C status	15,3 %	31,3 %	16,5 %
A6. OAT medication			
0. Methadone	26,3 %	27,7 %	21,2 %
1. Buprenorphine (Subutex)	31,3 %	28,2 %	37,1 %
1a. Buprenorphine depot	20,2 %	25,2 %	24,5 %
2. Buprenofin/naloxone (Suboxone)	15,2 %	13,9 %	6,0 %
3. SROM	0,0 %	0,0 %	0,0 %
4. Heroin	0,0 %	0,0 %	0,0 %
5. Others	6,1 %	2,0 %	11,0 %
9. Unknown	1,0 %	3,0 %	0,3 %

A7. Daily dose in mg (average)			
	Nord-Trøndelag county	Møre/Romsdal	St Olav
0. Methadone	82,5	88,6	69,4
1. Buprenofin (Subutex)	15,2	15,2	15,0
2. Buprenofin/naloxone (Suboxone)	15,7	17,1	14,9
A8. Prescribing physician			
0. Doctor employed in OAT unit	35,4 %	34,7 %	75,8 %
1. GP	64,6 %	57,9 %	22,0 %
2. Other doctor	0,0 %	3,0 %	1,6 %
9. Unknown	0,0 %	4,5 %	0,5 %
A9. Special conditions			
a. Informed about the right to complain?			
0. No			
1. Yes			
2. Uncertain			
9. Unknown			
b. Are benzodiazepines prescribed?			
0. No	55,6 %	69,3 %	56,0 %
1. Yes	44,4 %	18,3 %	42,6 %
9. Unknown	0,0 %	12,4 %	1,4 %
c. Are other morphine substances prescribed?			
0. no	97,0 %	86,6 %	96,2 %
1. Yes	3,0 %	0,5 %	1,9 %
9. Unknown	0,0 %	12,9 %	1,9 %
A10. OAT medication dispensing			
a. Number of deliveries per week (average)	2,8	1,9	2,4
b. Of which the number of delivered monitored	2,9	1,8	2,4
c. Main place of delivery			
0. OAT unit	5,1 %	23,8 %	29,4 %
1. Pharmacy	39,4 %	39,1 %	39,0 %
2. Municipal services	49,5 %	21,8 %	21,7 %
3. Institution/residential center/prison	4,0 %	7,4 %	6,6 %
4. Doctor's office	2,0 %	2,5 %	2,2 %
10. Annet	0,0 %	1,0 %	0,8 %
9. Unknown	0,0 %	4,5 %	0,3 %

A11. Urine sampling scheme			
	Nord-Trøndelag county	Møre/Romsdal	St Olav
a. Type of agreement			
0. No samples	42,4 %	26,2 %	54,4 %
1. Random samples	32,3 %	45,5 %	29,7 %
2. Regular sampling	23,2 %	19,3 %	14,3 %
9. Unknown	2,0 %	8,9 %	1,6 %
b. Number of urine samples per week (average)	0,3	0,3	0,2
B. LAST FOUR WEEKS BEFORE COMPLETION DATE			
B1. Treatment and advice last 4 weeks			
a. Objective of the treatment			
0. Rehab with freedom from addiction	68,7 %	75,2 %	67,0 %
1. Stabilization without drug-free requirements	31,3 %	15,3 %	31,3 %
9. Not agreed	0,0 %	9,4 %	1,6 %
b. Primary responsibility in the specialist health service			
0. Not transferred	26,3 %	18,8 %	58,2 %
1. Transferred	72,7 %	77,2 %	40,7 %
9. Other / Unknown	1,0 %	4,0 %	1,1 %
c. Completed rehab, maintenance follow-up			
0. No	41,4 %	26,2 %	38,7 %
1. Yes	56,6 %	59,9 %	56,9 %
9. Unknown	2,0 %	13,9 %	4,4 %
d. Is the patient in psychiatric/psychological treatment?			
0. No	80,8 %	78,7 %	87,4 %
1. Yes	18,2 %	8,4 %	9,6 %
9. Unknown	1,0 %	12,9 %	3,0 %
e. Has an individual plan been drawn up?			
0. No	60,6 %	48,5 %	67,3 %
1. Yes	35,4 %	35,1 %	22,8 %

9. Unknown	4,0 %	16,3 %	9,9 %
f. Systematic psychotherapeutic treatment			
	Nord-Trøndelag county	Møre/Romsdal	St Olav
0. no			
1. Yes			
9. Unknown			
B2. Has it been held			
responsibility group meeting last 4 weeks?			
0. no	67,7 %	72,8 %	83,0 %
1. Yes	32,3 %	16,8 %	14,0 %
9. Unknown	0,0 %	10,4 %	3,0 %
B3. Mental health problems last 4 weeks			
a. Severe depression			
0. No	78,8 %	57,9 %	73,4 %
1. Yes	15,2 %	15,3 %	15,9 %
9. Unknown	6,1 %	26,7 %	10,7 %
b. Severe anxiety			
0. No	66,7 %	51,5 %	68,7 %
1. Yes	27,3 %	24,3 %	20,6 %
9. Unknown	6,1 %	24,3 %	10,7 %
c. Delusions/hallucinations			
0. No	83,8 %	69,3 %	82,1 %
1. Yes	10,1 %	4,0 %	8,0 %
9. Unknown	6,1 %	26,7 %	9,9 %
B4. Physical injuries/illnesses			
that affect the way of life or quality of life			
last 4 weeks			
B5. Drug and alcohol use last 4 weeks			
a. Opiods			
0. No	84,8 %	70,3 %	76,4 %
1. Yes	6,1 %	6,4 %	10,2 %
9. Unknown	9,1 %	23,3 %	13,5 %

b. Cannabis			
0. No	62,6 %	56,4 %	56,3 %
1. Yes	26,3 %	21,3 %	28,8 %
	Nord-Trøndelag county	Møre/Romsdal	St Olav
9. Unknown	11,1 %	22,3 %	14,8 %
c. Benzodiazepines or similar			
0. No	57,6 %	60,4 %	49,5 %
1. Yes	33,3 %	16,3 %	39,0 %
9. Unknown	9,1 %	23,3 %	11,5 %
d. Central stimulants			
0. no	76,8 %	69,3 %	72,8 %
1. Yes	13,1 %	6,9 %	14,8 %
9. Unknown	10,1 %	23,8 %	12,4 %
e. Alcohol for intoxication			
0. No	80,8 %	66,8 %	79,1 %
1. Yes	11,1 %	7,4 %	5,5 %
9. Unknown	8,1 %	25,7 %	15,4 %
B6. Frequency of drug and alcohol use			
last 4 weeks			
0. Never	49,5 %	50,0 %	46,4 %
1. Few single episodes	15,2 %	16,3 %	17,6 %
2. Regular use	27,3 %	13,4 %	25,8 %
9. Unknown	8,1 %	20,3 %	10,2 %
B7. Severity of drug and alcohol use			
last 4 weeks			
0. Good function, works "like others"	63,6 %	55,0 %	51,6 %
1. Mixed function. Occasionally under the influence of alcohol.	19,2 %	17,8 %	23,4 %
2. Addictive, drug-dominated function	9,1 %	5,9 %	15,4 %
9. Unknown	8,1 %	21,3 %	9,6 %
# C. LAST YEAR			
C1. Offenses last year			
Arrested, taken into custody, prosecuted; convicted			
0. No	87,9 %	75,7 %	80,8 %

1. Yes	7,1 %	7,9 %	11,3 %
9. Unknown	5,1 %	16,3 %	8,0 %
C2. Overdose last year			
	Nord-Trøndelag county	Møre/Romsdal	St Olav
0. No	91,9 %	79,2 %	82,4 %
1. Yes	5,1 %	5,0 %	8,8 %
9. Unknown	3,0 %	15,8 %	8,8 %
C3. Suicide attempts last year			
0. No	60,5 %	83,3 %	76,2 %
1. Yes	2,4 %	2,3 %	2,4 %
9. Unknown	37,1 %	14,3 %	21,4 %
C4. Drug and alcohol use in the past year			
0. Never	38,4 %	38,1 %	38,7 %
1. Some single, short periods	18,2 %	24,8 %	23,1 %
2. Used for longer periods or all the time	34,3 %	18,8 %	30,2 %
9. Unknown	9,1 %	18,3 %	8,0 %
C5. Satisfaction			
a. The patient's assessment			
0. Satisfied successful	59,6 %	49,0 %	57,4 %
1. Both and	13,1 %	18,8 %	17,6 %
2. Dissatisfied/not successful	9,1 %	6,9 %	3,3 %
9. Unknown	18,2 %	25,2 %	21,7 %
b. Filler's assessment			
0. Satisfied successful	75,8 %	62,4 %	65,1 %
1. Both and	23,2 %	27,2 %	24,5 %
2. Dissatisfied/not successful	0,0 %	4,5 %	4,7 %
9. Unknown	1,0 %	5,9 %	5,8 %
C6. Are treatment changes recommended?			
0. No	86,9 %	71,8 %	80,8 %
1. Yes	12,1 %	13,4 %	14,0 %
9. Unknown	1,0 %	14,9 %	5,2 %
C7. Who has participated/asked when filling out the form?			
a. Pasient			
0. no	23,2 %	28,2 %	24,5 %
1. Yes	76,8 %	71,8 %	75,3 %

9. Unknown	0,0 %	0,0 %	0,3 %
b. Employee			
0. No	69,7 %	82,7 %	80,5 %
1. Yes	30,3 %	17,3 %	19,5 %
	Nord-Trøndelag county	Møre/Romsdal	St Olav
9. Unknown	0,0 %	0,0 %	0,0 %
c. Responsibility group			
0. no	93,9 %	98,0 %	95,3 %
1. Yes	6,1 %	2,0 %	4,7 %
9. Unknown	0,0 %	0,0 %	0,0 %

North

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
Number of responses	167	304	42	51
Response rate	78,0 %	99,7 %	71,2 %	52,0 %
Gender				
Men	74,9 %	68,8 %	66,7 %	62,7 %
women	25,1 %	31,3 %	33,3 %	37,3 %
Age (average)	47,5	48,3	44,5	44,7
A. Current situation				
A0. Current situation				
0. Not discharged	97,6 %	94,6 %	86,1 %	100,0 %
1. Own desire for weaning	1,2 %	3,4 %	8,3 %	0,0 %
2. Dissatisfied with the treatment	0,0 %	0,0 %	5,6 %	0,0 %
3. Lack of effect, irresponsible	0,6 %	0,0 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,0 %	0,0 %
10. Annet	0,6 %	2,0 %	0,0 %	0,0 %
A1. Employment				
a. Occupational status				
0. Without employment	80,8 %	76,2 %	78,6 %	80,4 %
1. Full-time job	12,0 %	9,9 %	14,3 %	13,7 %
2. Part-time job	6,0 %	7,9 %	7,1 %	5,9 %
3. During education	0,0 %	0,3 %	0,0 %	0,0 %
4. Part-time job and in education	0,0 %	0,3 %	0,0 %	0,0 %
9. Unknown	1,2 %	5,3 %	0,0 %	0,0 %
b. Work training/courses				
0. No	91,6 %	89,6 %	89,7 %	100,0 %
1. Yes	4,2 %	4,3 %	2,6 %	0,0 %
9. Unknown	4,2 %	6,0 %	7,7 %	0,0 %
c. Day care services				
0. no	88,0 %	89,3 %	92,3 %	94,1 %
1. Yes	6,6 %	4,4 %	0,0 %	5,9 %
9. Unknown	5,4 %	6,4 %	7,7 %	0,0 %
A2. Most important income				
1. Employment income	12,0 %	9,9 %	16,7 %	15,7 %
2. Supported by others	0,0 %	0,3 %	0,0 %	0,0 %

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
3. Daily allowance	0,0 %	0,3 %	2,4 %	0,0 %
4. Sick pay	1,8 %	1,0 %	0,0 %	2,0 %
5. AAP	7,8 %	10,6 %	7,1 %	13,7 %
6. Disability/pension	70,1 %	67,9 %	64,3 %	64,7 %
7. Social security benefits	4,2 %	1,7 %	0,0 %	0,0 %
8. Student loans	0,0 %	0,0 %	0,0 %	0,0 %
9. Other/unknown	4,2 %	8,3 %	9,5 %	3,9 %
A3. Housing conditions				
0. No housing	1,8 %	1,0 %	0,0 %	2,0 %
1. Hospits/hybelhus/hotels	1,8 %	3,7 %	0,0 %	0,0 %
2. Institution	3,0 %	2,7 %	4,9 %	3,9 %
3. Prison	1,8 %	1,7 %	0,0 %	0,0 %
4. With parents	3,6 %	8,0 %	0,0 %	3,9 %
5. For others	5,4 %	3,0 %	7,3 %	13,7 %
6. Own home	79,0 %	75,7 %	82,9 %	70,6 %
10. Other / Unknown	3,6 %	4,3 %	4,9 %	5,9 %
A5. Blood infection status (HIV/hepatitis C)				
a. HIV				
0. Not infected	91,0 %	88,9 %	85,7 %	82,4 %
1. Infected	1,8 %	0,7 %	0,0 %	0,0 %
9. Unknown	7,2 %	10,4 %	14,3 %	17,6 %
b. Hepatitis C				
0. Never treated (Hepatitis C antigen negative)	40,1 %	44,7 %	64,3 %	55,1 %
1. Hepatitis C fully treated	44,3 %	35,3 %	16,7 %	18,4 %
2. Hepatitis C positive (antigen detected)	1,8 %	6,1 %	4,8 %	6,1 %
9. Unknown hepatitis C status	13,8 %	13,9 %	14,3 %	20,4 %
A6. OAT medication				
0. Methadone	31,7 %	28,8 %	17,1 %	22,0 %
1. Buprenorphine (Subutex)	36,5 %	39,5 %	43,9 %	44,0 %
1a. Buprenorphine depot	19,8 %	12,0 %	12,2 %	22,0 %
2. Buprenofin/naloxone (Suboxone)	7,8 %	7,0 %	22,0 %	6,0 %
3. SROM	0,0 %	0,0 %	0,0 %	0,0 %
4. Heroin	0,0 %	0,0 %	0,0 %	0,0 %
5. Others	3,6 %	11,4 %	4,9 %	6,0 %
9. Unknown	0,6 %	1,3 %	0,0 %	0,0 %
A7. Daily dose in mg (average)				

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
0. Methadone	104,3	85,1	122,9	77,5
1. Buprenofin (Subutex)	18,9	14,5	14,8	14,6
2. Buprenofin/naloxone (Suboxone)	13,5	15,5	13,3	13,3
A8. Prescribing physician				
0. Doctor employed in OAT unit	43,7 %	53,5 %	85,4 %	82,0 %
1. GP	53,3 %	45,0 %	12,2 %	16,0 %
2. Other doctor	1,8 %	0,4 %	0,0 %	0,0 %
9. Unknown	1,2 %	1,1 %	2,4 %	2,0 %
A9. Special conditions				
a. Informed about the right to complain?				
0. No				
1. Yes				
2. Uncertain				
9. Unknown				
b. Are benzodiazepines prescribed?				
0. No	47,3 %	43,2 %	41,5 %	30,4 %
1. Yes	46,1 %	51,0 %	48,8 %	63,0 %
9. Unknown	6,6 %	5,7 %	9,8 %	6,5 %
c. Are other morphine substances prescribed?				
0. no	87,4 %	77,7 %	66,7 %	70,0 %
1. Yes	3,0 %	7,8 %	7,1 %	2,0 %
9. Unknown	9,6 %	14,5 %	26,2 %	28,0 %
A10. OAT medication dispensing				
a. Number of deliveries per week (average)	2,9	2,6	2,9	2,0
b. Of which the number of delivered monitored	3,2	2,8	2,8	1,7
c. Main place of delivery				
0. OAT unit	16,2 %	18,6 %	0,0 %	20,0 %
1. Pharmacy	43,1 %	45,0 %	34,1 %	52,0 %
2. Municipal services	27,5 %	26,1 %	56,1 %	24,0 %
3. Institution/residential center/prison	5,4 %	3,8 %	7,3 %	2,0 %
4. Doctor's office	7,2 %	3,4 %	2,4 %	2,0 %
10. Annet	0,0 %	1,0 %	0,0 %	0,0 %
9. Unknown	0,6 %	2,1 %	0,0 %	0,0 %
A11. Urine sampling scheme				

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
a. Type of agreement				
0. No samples	43,1 %	67,0 %	23,8 %	15,7 %
1. Random samples	29,3 %	16,1 %	45,2 %	54,9 %
2. Regular sampling	21,6 %	5,7 %	28,6 %	23,5 %
9. Unknown	6,0 %	11,1 %	2,4 %	5,9 %
b. Number of urine samples per week (average)	1,4	0,1	0,2	0,2
B. LAST FOUR WEEKS BEFORE COMPLETION DATE				
B1. Treatment and advice last 4 weeks				
a. Objective of the treatment				
0. Drug-free rehab	64,1 %	59,1 %	83,3 %	56,0 %
1. Stabilization without drug-free requirements	15,6 %	31,8 %	9,5 %	36,0 %
9. Not agreed	20,4 %	9,1 %	7,1 %	8,0 %
b. Primary responsibility in the specialist health service				
0. Not transferred	73,7 %	52,0 %	83,3 %	92,2 %
1. Transferred	25,1 %	44,6 %	11,9 %	5,9 %
9. Other / Unknown	1,2 %	3,4 %	4,8 %	2,0 %
c. Completed rehab, maintenance follow-up				
0. No	52,1 %	38,6 %	73,8 %	49,0 %
1. Yes	35,3 %	49,8 %	14,3 %	43,1 %
9. Unknown	12,6 %	11,6 %	11,9 %	7,8 %
d. Is the patient in psychiatric/psychological treatment?				
0. No	79,0 %	81,3 %	83,3 %	80,4 %
1. Yes	13,2 %	9,7 %	9,5 %	15,7 %
9. Unknown	7,8 %	9,0 %	7,1 %	3,9 %
e. Has an individual plan been drawn up?				
0. No	82,6 %	85,5 %	64,3 %	86,3 %
1. Yes	3,6 %	3,0 %	19,0 %	0,0 %
9. Unknown	13,8 %	11,5 %	16,7 %	13,7 %
f. Systematic psychotherapeutic treatment				

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
0. No				
1. Yes				
9. Unknown				
B2. Has it been held				
responsibility group meeting last 4 weeks?				
0. No	70,7 %	73,7 %	62,5 %	72,0 %
1. Yes	23,4 %	16,5 %	32,5 %	22,0 %
9. Unknown	6,0 %	9,7 %	5,0 %	6,0 %
B3. Mental health problems last 4 weeks				
a. Severe depression				
0. No	52,7 %	72,0 %	50,0 %	71,7 %
1. Yes	15,0 %	12,2 %	11,9 %	10,9 %
9. Unknown	32,3 %	15,9 %	38,1 %	17,4 %
b. Severe anxiety				
0. No	39,5 %	60,5 %	42,9 %	62,5 %
1. Yes	27,5 %	24,0 %	26,2 %	20,8 %
9. Unknown	32,9 %	15,5 %	31,0 %	16,7 %
c. Delusions/hallucinations				
0. No	61,1 %	76,9 %	54,8 %	75,0 %
1. Yes	6,6 %	6,8 %	7,1 %	4,2 %
9. Unknown	32,3 %	16,3 %	38,1 %	20,8 %
B4. Physical injuries/illnesses				
that affect the way of life or quality of life				
last 4 weeks				
B5. Drug and alcohol use last 4 weeks				
a. Opiods				
0. No	64,1 %	77,7 %	66,7 %	70,0 %
1. Yes	1,8 %	7,8 %	7,1 %	2,0 %
9. Unknown	34,1 %	14,5 %	26,2 %	28,0 %
b. Cannabis				
0. No	43,7 %	49,8 %	45,2 %	48,0 %

1. Yes	24,0 %	38,0 %	26,2 %	22,0 %
	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
9. Unknown	32,3 %	12,1 %	28,6 %	30,0 %
c. Benzodiazepines or similar				
0. No	37,7 %	47,6 %	40,5 %	56,9 %
1. Yes	33,5 %	40,2 %	38,1 %	17,6 %
9. Unknown	28,7 %	12,2 %	21,4 %	25,5 %
d. Central stimulants				
0. No	56,3 %	68,3 %	59,5 %	64,7 %
1. Yes	10,8 %	18,1 %	11,9 %	13,7 %
9. Unknown	32,9 %	13,7 %	28,6 %	21,6 %
e. Alcohol for intoxication				
0. no	62,9 %	74,4 %	59,5 %	65,3 %
1. Yes	3,6 %	7,8 %	7,1 %	12,2 %
9. Unknown	33,5 %	17,7 %	33,3 %	22,4 %
B6. Frequency of drug and alcohol use				
last 4 weeks				
0. Never	34,7 %	35,5 %	35,7 %	37,3 %
1. Few single episodes	10,8 %	20,6 %	9,5 %	17,6 %
2. Regular use	21,6 %	27,0 %	23,8 %	19,6 %
9. Unknown	32,9 %	16,9 %	31,0 %	25,5 %
B7. Severity of drug and alcohol use				
last 4 weeks				
0. Good function, works "like others"	41,9 %	47,9 %	48,8 %	39,2 %
1. Mixed function. Occasionally under the influence of alcohol.	17,4 %	21,4 %	9,8 %	25,5 %
2. Addictive, drug-dominated function	9,0 %	12,4 %	14,6 %	7,8 %
9. Unknown	31,7 %	18,3 %	26,8 %	27,5 %
C. LAST YEAR				
C1. Offenses last year				
Arrested, taken into custody, prosecuted; convicted				
0. No	55,7 %	73,2 %	73,8 %	74,0 %
1. Yes	8,4 %	6,0 %	4,8 %	6,0 %
9. Unknown	35,9 %	20,7 %	21,4 %	20,0 %
C2. Overdose last year				

	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
0. No	58,7 %	80,1 %	80,5 %	80,0 %
1. Yes	4,8 %	4,4 %	2,4 %	4,0 %
9. Unknown	36,5 %	15,5 %	17,1 %	16,0 %
C3. Suicide attempts last year				
0. No	75,4 %	96,0 %	75,2 %	86,8 %
1. Yes	2,5 %	0,0 %	4,0 %	2,7 %
9. Unknown	22,0 %	4,0 %	20,8 %	10,4 %
C4. Drug and alcohol use in the past year				
0. Never	24,6 %	40,4 %	42,9 %	32,0 %
1. Some individual, short periods	17,4 %	16,8 %	16,7 %	18,0 %
2. Used for longer periods or all the time	24,6 %	32,7 %	23,8 %	26,0 %
9. Unknown	33,5 %	10,1 %	16,7 %	24,0 %
C5. Satisfaction				
a. The patient's assessment				
0. Satisfied successful	47,9 %	59,4 %	47,6 %	54,2 %
1. Both and	13,2 %	15,4 %	14,3 %	25,0 %
2. Dissatisfied/not successful	6,0 %	6,7 %	7,1 %	2,1 %
9. Unknown	32,9 %	18,5 %	31,0 %	18,8 %
b. Filler's assessment				
0. Satisfied successful	60,5 %	45,5 %	47,6 %	62,7 %
1. Both and	27,5 %	16,2 %	47,6 %	37,3 %
2. Dissatisfied/not successful	1,8 %	2,1 %	4,8 %	0,0 %
9. Unknown	10,2 %	36,2 %	0,0 %	0,0 %
C6. Are treatment changes recommended?				
0. no	83,2 %	81,8 %	88,1 %	85,1 %
1. Yes	8,4 %	9,2 %	7,1 %	14,9 %
9. Unknown	8,4 %	8,9 %	4,8 %	0,0 %
C7. Who has participated/asked when filling out the form?				
a. Pasient				
0. No	34,1 %	21,6 %	35,7 %	43,1 %
1. Yes	64,7 %	77,4 %	64,3 %	56,9 %
9. Unknown	1,2 %	1,0 %	0,0 %	0,0 %
b. Employee				

0. No	85,6 %	79,9 %	88,1 %	91,5 %
1. Yes	13,8 %	19,0 %	11,9 %	8,5 %
	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
9. Unknown	0,6 %	1,1 %	0,0 %	0,0 %
c. Responsibility group				
0. No	93,4 %	95,8 %	97,6 %	87,2 %
1. Yes	6,0 %	2,7 %	2,4 %	12,8 %
9. Unknown	0,6 %	1,5 %	0,0 %	0,0 %