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SERAF REPORT 1/2023

Status report 2022

First year with new LAR guidelines

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Foreword

SERAF prepares an annual national status report on drug-assisted rehabilitation (DAR) on behalf of the Norwegian Directorate of Health. The status report is based on a survey that all OMT initiatives carry out once a year. The purpose is to map the patients' situation, treatment and treatment outcomes in DAR. This survey has been conducted over the past 23 years and has shown that over time, OMT has developed into a well-established, standardized treatment for most people with opioid-dominated addiction.

The status report summarizes key findings on 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 problems and substance use in the last four weeks, and substance use and health-related conditions in the last year, and satisfaction with treatment. In addition, findings on deaths among patients in OMT in the last year are presented. Ivar Skeie has analyzed mortality data and has followed the DAR measures closely in order to include complete figures on overdoses, suicides and natural deaths.

This year's status report is based on responses from 18 different DAR initiatives in five regions. The introduction of the electronic medical record system Helseplattformen at St. Olavs Hospital and in Nord-Trøndelag has led to challenges that have meant that these DAR initiatives have not been able to complete the status survey. This means that the figures presented for the Central region cannot be compared with last year's figures for the same region, and that national averages do not include St. Olavs Hospital and Nord-Trøndelag.

In 2022, new LAR guidelines were introduced, and this is the first status report that has been carried out since then. In addition, this year's status report contains several new elements. DAR measures that use the electronic medical record system DIPS Arena have responded to a slightly refined version of the status survey that includes new additional information. The measures in question are Oslo, Bergen, Fonna and Førde. The new questions concern, among other things, perceived side effects of OMT medication, and various questions about physical health, illnesses and treatment in the past year. The questions are answered by approximately 1 in 4 patients in OMT, and help to further develop knowledge about the treatment and the patients' situation. This is also the first time that patients undergoing heroin-assisted treatment (HAB) have participated in the national survey. One of the chapters summarizes the main findings for patients in HAB.

We see that the increase in the average age in OMT continues this year. We would like to remind you that an ageing OMT population is a success in itself. OMT has meant that many people with opioid dependence can age with the disease. At the same time, in the future we want to strengthen the conditions for good lifestyle habits, accessible assessment and treatment for mental disorders, assessment and treatment for somatic diseases such as hepatitis C, and regular medical check-ups. It is important that OMT continues to be a treatment model that is perceived as accessible, easy to live with over time, with high professional quality and soundness. At the same time, it is important to support the majority of patients in maintaining a reasonably good level of substance abuse. This balancing act is part of everyday life for patients and therapists in OMT.

This report is the result of considerable efforts in each DAR initiative. We would like to thank the patients in DAR who have responded to the status survey, DAR staff across the country for their efforts in collecting responses, and for the good collaboration with the DAR initiatives and the Norwegian Directorate of Health.

Oslo, 2023

Linda Nesse, Philipp Lobmaier, Ivar Skeie, Pål H. Lillevold, and Thomas Clausen

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LAR IN 2022 - CAPACITY AND PATIENT FLOW

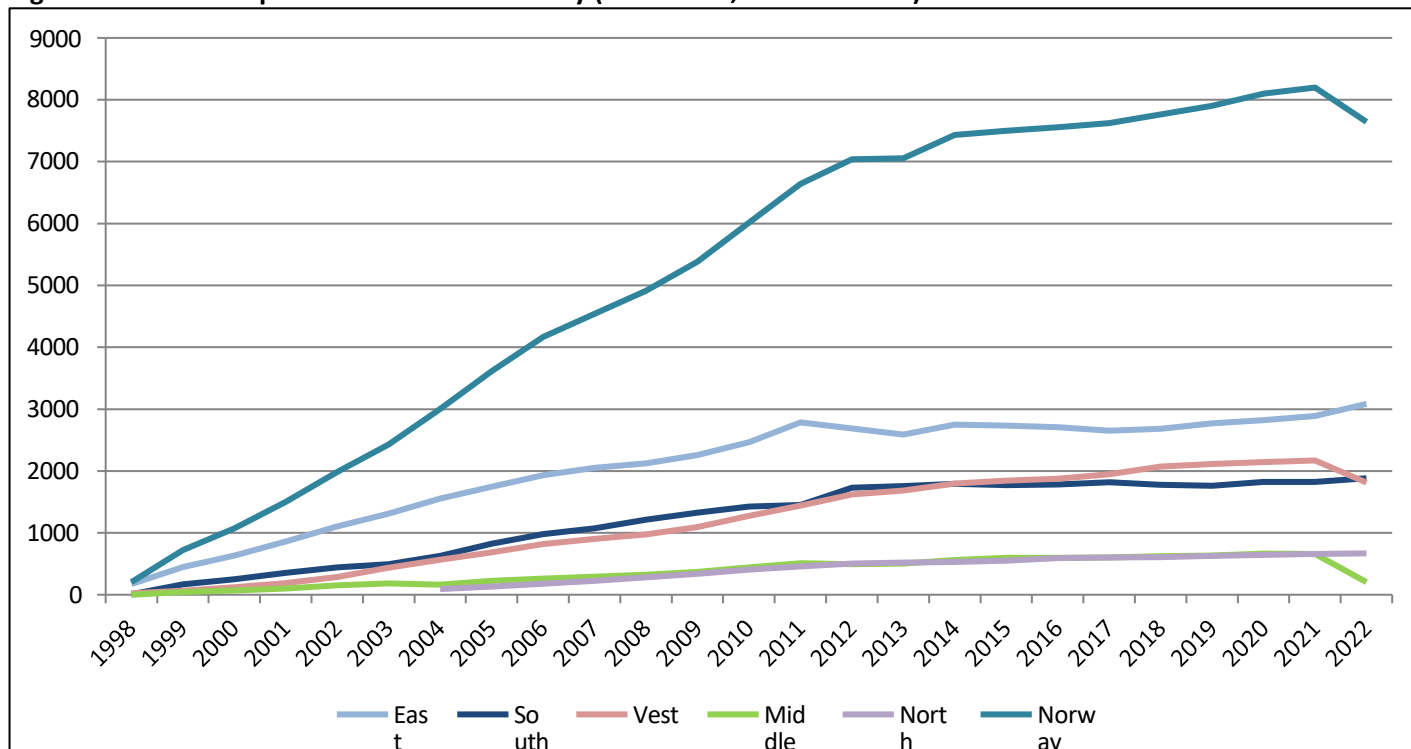
Each DAR facility completes reports on the number of patients and patient flow on December 31 each year. This annual report describes the number of patients in treatment, the number entering and the number leaving, and forms the basis for our estimates of need, capacity and circulation throughout the country and in the individual DAR facilities.

Number of patients in treatment

As of 31.12.2022, there were 7643 people in DAR. However, St. Olavs Hospital and Nord-Trøndelag are not included this year, due to the introduction of the electronic medical record system Helseplattformen and the challenges this has entailed. At the same time, comprehensive figures from Fonna are not available due to technical challenges. The total number of patients at the end of the year is therefore not directly comparable with the total number of patients at the end of 2021 (8198). However, as a point of reference, there were 401 patients in Fonna, 342 at St. Olav's Hospital in Oslo and 342 at St. Olav's Hospital in Oslo. Olavs hospital and 115 in Nord-Trøndelag as of 31.12.2021. Based on this year's number of patients, and taking last year's figures for Fonna, St. Olav and Nord-Trøndelag, the total number of patients for the year can be estimated to be approximately 8,315. This represents a slight increase from the previous year, and thus a continuation of the trend. However, this estimate must be interpreted with caution.

65.0% of patients were in Helse Sør-Øst, 23.7% in Helse Vest, 2.6% in Helse Midt (only Møre og Romsdal) and 8.8% 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 was reported that 52 patients nationwide had not started treatment at the end of the year, but could thus be described as being on a waiting list, an increase from 15 in 2021.

Figure 1. Number of patients in OMT in Norway (1998-2022, as of 31.12.22).

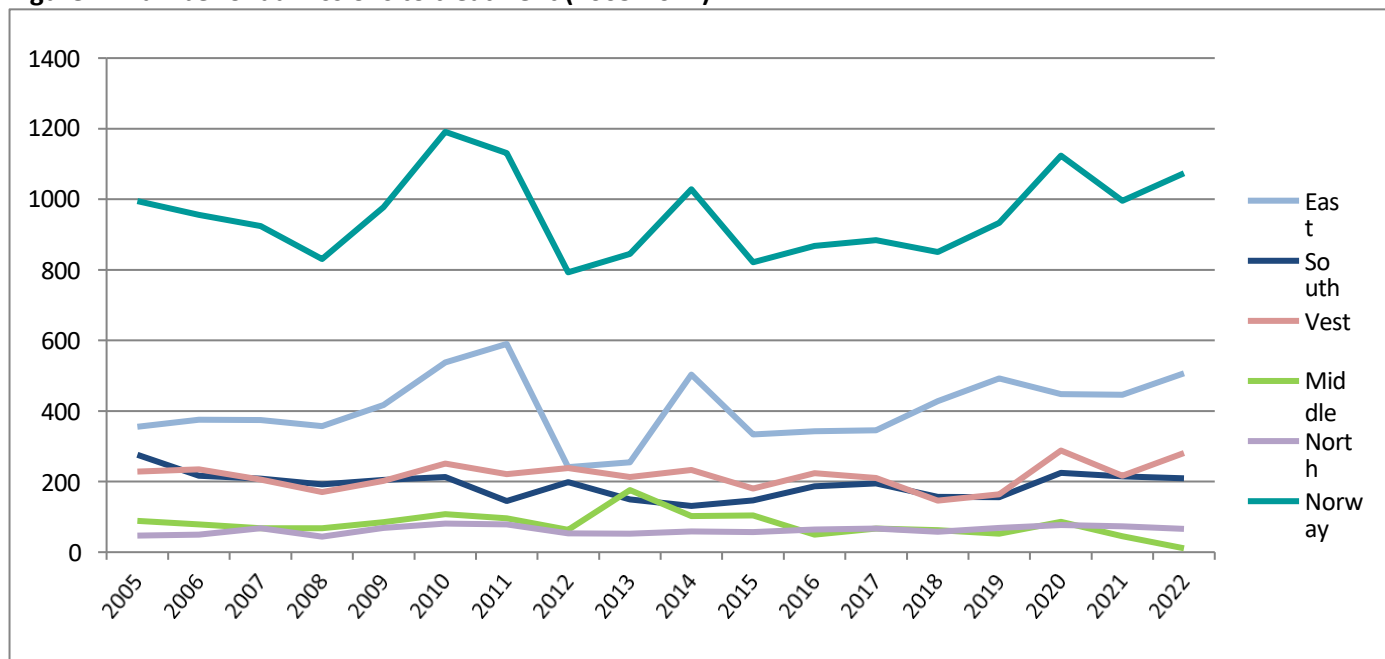


Admissions and discharges

In 2022, 1,074 patients (including transfers) started OMT, 78 more than the previous year (Figure 2). The

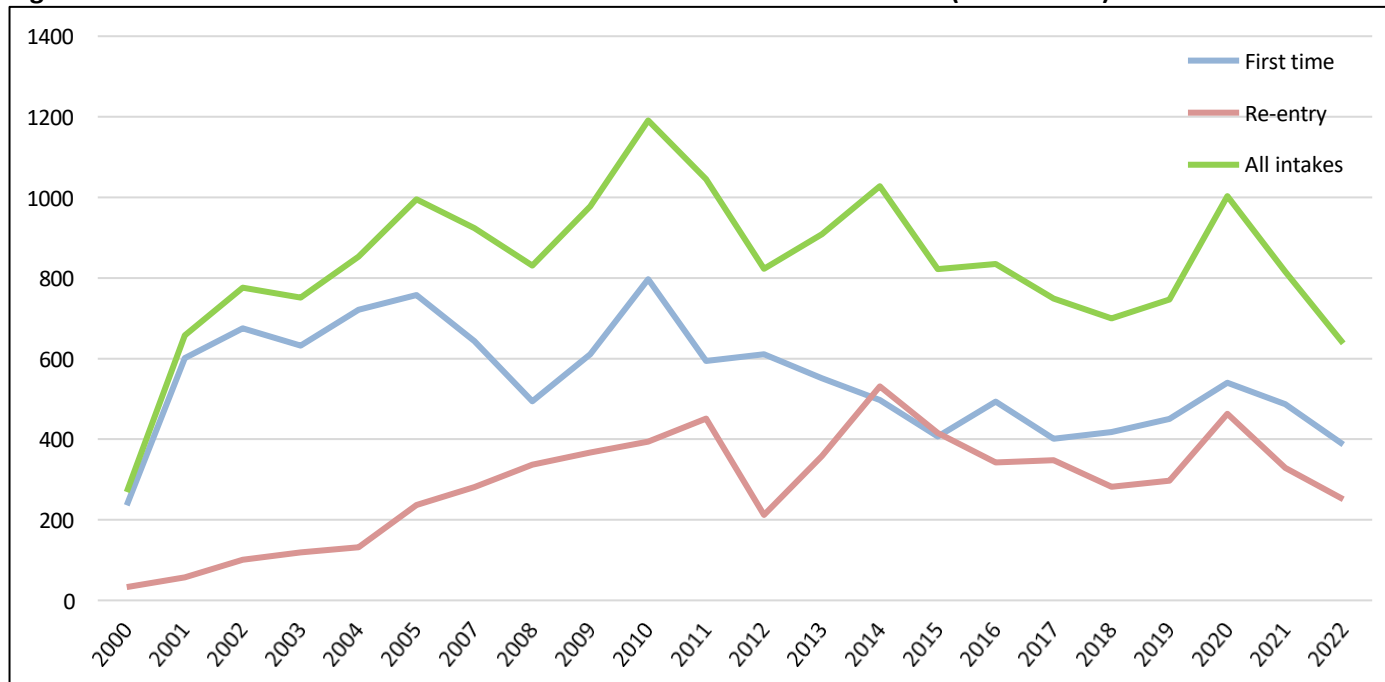
figure shows the sum of first-time and re-admissions, including transfers, from 2005, the year when Region North was added. South-Eastern Norway Regional Health Authority is divided into South and East regions for a better overview.

Figure 2. Number of admissions to treatment (2005-2022).



In 2022, there were 387 first-time admissions and 251 readmissions. The remaining admissions were transfers between OMT interventions. Figure 3 shows a fairly stable number of first-time admissions in recent years, with just over 400 annually, while a few fewer return after previous discharges. Since 2016, the number of annual admissions has been fairly stable.

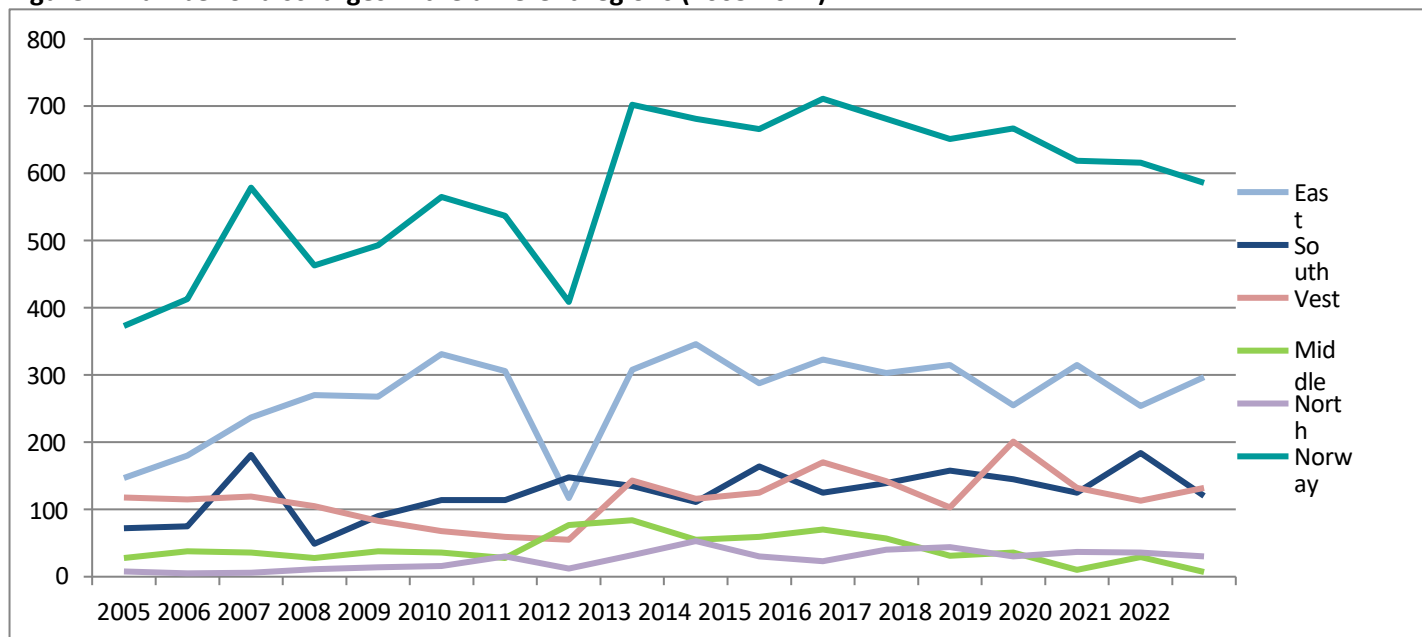
Figure 3. Intake in OMT in total and divided into first-time intake and re-take (2000-2022*).



*Missing data for 2006.

Figure 4 shows the development in discharges from DAR. There were a total of 586 discharges, compared with 616 in 2021. Transfers to other OMT measures are not included. The proportion of discharges has been fairly stable at around 700 annually (approximately 8%) since 2013. The proportion remaining in OMT over time continues to be high from one year to the next, with approximately 9 out of 10 patients.

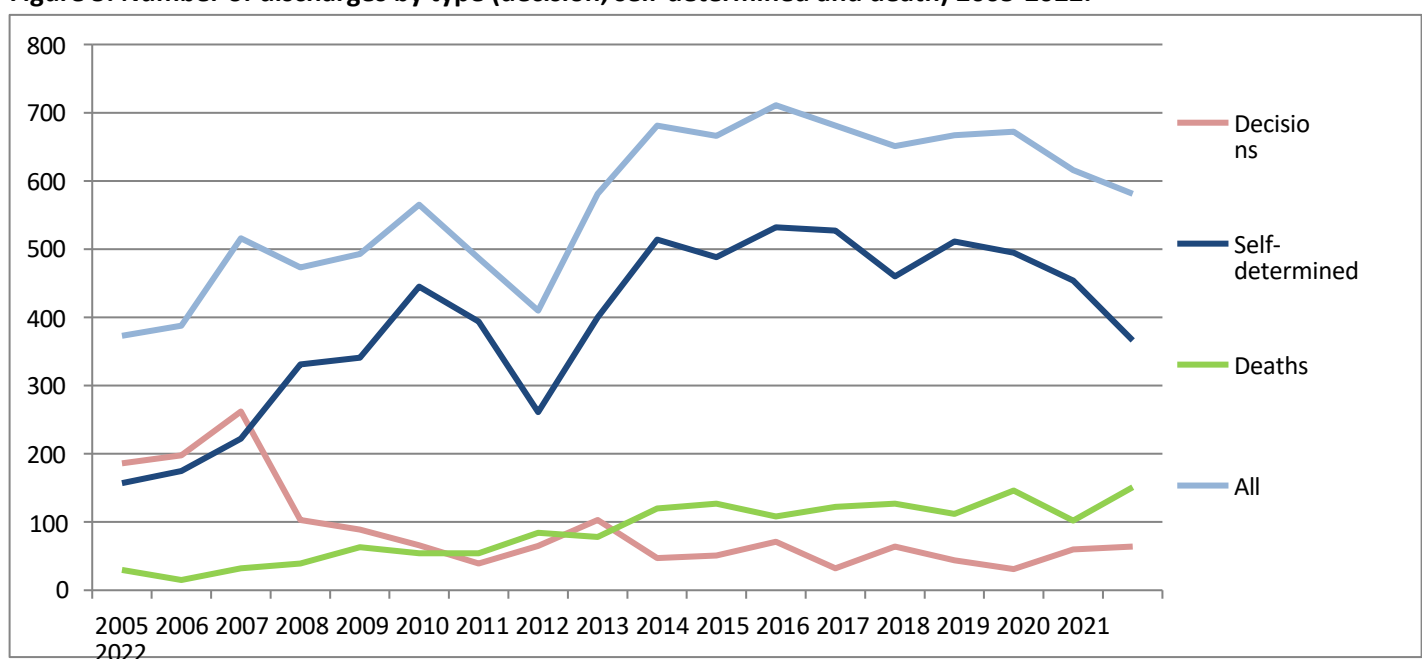
Figure 4. Number of discharges in the different regions (2005-2022).



Initially, OMT is recommended as a long-term and indefinite, possibly lifelong, treatment, but both planned tapering and unplanned breaks 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 assessment (decision of unjustifiability), 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, this is considered to be a self-determined treatment interruption (dark blue 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. In 2022, 64 patients (11.0%) were discharged following a decision on medical recklessness, slightly higher than in 2021 (60 patients, 9.7%). In 2022, 147 patients (26.0%) were reported terminated due to death, compared with 102 patients (corresponding to 16.6%) in 2021.

Figure 5. Number of discharges by type (decision, self-determined and death) 2005-2022.



The number of discharges has increased in line with the increased number of patients in treatment. Very few patients have been discharged against their will since 2008, and the number of discharge decisions has been stably low since 2014 (an average of 60 per year), despite the increase in the number of patients receiving treatment. The main reason for treatment termination is self-determined termination. The number of deaths is higher this year than last year (for details, see the chapter on deaths in LAR).

Assessments of developments in admission and discharge practices

Overall, the number of patients in OMT is still rising, but significantly less than before 2014. Admissions have been somewhat reduced in recent years, while the trend relating to new patients coming in instead of re-admission appears to be stable. This confirms that there is still a need to reach new groups that may benefit from OMT. Patients who apply for OMT are assessed for eligibility in accordance with the prioritization guide and start treatment quickly. As in previous years, there are few patients who are not granted the right to OMT, which indicates well-established application routines for this part of TSB as well. Discharge practice has changed significantly in recent years in a direction where maintenance is facilitated to the greatest possible extent, regardless of substance abuse or rehabilitation goals.

THE ORGANIZATION OF THE

DAR is part of TSB (interdisciplinary specialized substance abuse treatment) in the specialist health service, organized in the individual health trusts. The DAR service is organized as a collaboration between the health trust's unit for substance abuse treatment, the health and social services in the municipality where the patient lives, and the GP. LAR adheres to the model of responsibility group collaboration, preferably with a municipally anchored individual plan, which ensures the organization of complex and long-term services.

OMT is organized in outpatient units, some of which are co-located with psychiatric outpatient clinics, DPS. Previous reports have described different organizational models for OMT, but the boundaries between the individual models can be fluid (e.g. outpatient drug and alcohol clinic and OMT team model). Already established conditions often determine how OMT is organized locally. If the number of patients is large, it is natural to allocate responsibility between different OMT measures, and it will then be perfectly possible to establish different organizational models in the same health trust.

Assessments of structure and resources

The organization as a collaboration between the specialist health service and municipal services has made it possible for the treatment to be available in all of Norway's municipalities. The structure is designed to ensure clear responsibilities and management, even though OMT is not always a separate management area. It provides opportunities for collaboration, but responsibilities are still often perceived as unclear. Practice in terms of collaboration and integration varies considerably. Developments will depend on knowledge and interest in DAR in general TSB.

The overall treatment will in many ways depend on municipal priorities and municipal resources. This may lead to differences in the services offered, but also that the services can be designed according to the pressure of problems in the individual municipalities. OMT is organized in several, sometimes very different ways with different advantages and disadvantages. Close collaboration with municipal services facilitates continuity and active municipal rehabilitation work. Proximity to psychiatric services, as in a DPS model, can be expected to increase services and continuity in the treatment of mental disorders. The various models for specialized OMT can more easily be developed with differentiated substance abuse treatment and treatment of concurrent substance abuse disorders. There is a need for systematic evaluation in this area.

Today, OMT includes a clear harm reduction perspective in addition to the rehabilitation objective. This has led to several important changes in the treatment approach and working methods. The changes have been incorporated to somewhat different degrees in the health trusts, and this is one of the explanations for the differences in treatment plans and results. But all in all, it is a strength of OMT in Norway that it includes both treatment with high rehabilitation goals and results and treatment with a stabilizing and harm reduction focus.

NEW LAR GUIDELINES

Last year marks a transitional phase in OMT. In May 2022, the Norwegian Directorate of Health introduced updated DAR guidelines (Norwegian Directorate of Health, 2022). These replaced the previous guidelines from 2010 (Norwegian Directorate of Health, 2010), following a revision process that has been ongoing since 2015. The introduction of updated guidelines marks a step forward in the history of Norwegian DAR.

The guidelines consist of ten key recommendations that are academically justified, research-based and include a number of recommendations for practical implementation. The overall recommendations are summarized below (see Table 1). Together with the OMT regulations, these will guide treatment in OMT.

Compared with the old guidelines, the new guidelines place greater emphasis on patients' user participation and involvement in their own treatment. Whereas the previous guidelines primarily emphasized the information aspect of user participation, the involvement of patients in decision-making processes is now more explicitly emphasized. In general, the new guidelines allow therapists to make more individual assessments, for example in the choice of medication, dosage, drug testing and dispensing arrangements. On this point, the new guidelines are less instructional than before. Dialogue is also emphasized as an important tool in the way forward for OMT. While the new guidelines continue the central principles of OMT, they also entail a clear further development of these and an ambition for the future of OMT treatment.

The status report for 2022 is based on data collected shortly after the introduction of the new DAR guidelines, and the results therefore give us an insight into the current status at a time of transition. Translating guidelines into practice is a process, and clinical practice is affected by structural conditions, priorities and resources, as well as political guidelines. Interventions and practitioners who have followed previous guidelines for a number of years must now relate to new recommendations. The introduction depends, among other things, on different interventions and therapists' knowledge and interpretations of the recommendations. It is therefore reasonable to assume that the translation of the recommendations into practice will take time. Prior to the introduction of the new guidelines, there were also a number of different practices in the OMT programs, and for some, the adaptation to the new guidelines is probably more of a minor adjustment, while for other programs an incentive for a more significant change in practice. The assumption is that any changes will probably gradually be reflected in future status surveys.

On behalf of the Norwegian Directorate of Health, SERAF is currently conducting an evaluation of the introduction of the revised DAR guidelines. The purpose of the evaluation is to gain insight into how patients, therapists and managers experience, assess and relate to the new guidelines. In the coming years, findings from the annual status survey will supplement the evaluation of the guidelines by providing knowledge about the patients' situation and treatment after the introduction, as well as indirectly about whether and how the patients' situation and various treatment outcomes are affected by the new guidelines.

Table 1: Overview of the recommendations in the revised OMT guidelines.

Recommendation 1	Patients with opioid dependence should be considered for OMT, and should be offered OMT when, after a holistic assessment is the treatment method that provides the best benefit for the patient.
Recommendation 2	Patients in OMT should be given comprehensive and coordinated rehabilitation throughout the entire course and with high degree of user involvement.
Recommendation 3	Buprenorphine and methadone are recommended as substitution drugs in OMT. In case of insufficient treatment effect or significant side effects of buprenorphine and methadone, levomethadone or long-acting morphine is considered.

Recommendation 4	Stepping up buprenorphine or methadone in OMT can be done on an outpatient or inpatient basis. Outpatient escalation of methadone requires the establishment of and compliance with special procedures to reduce the risk of overdose.
Recommendation 5	The maintenance dose of a substitution drug in OMT should be set individually and adjusted when need.
Recommendation 6	Switching substitution drugs in OMT should be done during a stay in an inpatient unit, with a gradual transition in the dose of the substitution drugs, to reduce the risk of overdose and abstinence.
Recommendation 7	Patients in OMT who, after assessment with a doctor, wish to taper their substitution drug should be offered gradual and long-term tapering, with adapted psychosocial support. follow-up and rapid dose increase if needed.
Recommendation 8	Mapping of the patient's use of drugs in OMT should be done by observation and dialog with the patient. Whether urine tests are required in addition is assessed individually.
Recommendation 9	Individual dispensing arrangements for substitution drugs in OMT should be decided based on an assessment of the patient's use of drugs, the patient's needs in treatment and rehabilitation, and the risk of the medicinal product becomes available to third parties.
Recommendation 10	In cases of benzodiazepine dependence in patients in OMT, psychosocial treatment and tapering of benzodiazepines.

STATUS SURVEY 2022

Response rate

Nationally, status forms were reported from 7643 patients, while 8198 were receiving OMT at the turn of the year 2021/2022. The response rate was 83.8%, fairly similar to 2021 (80.5%). We have calculated the response rate among those who responded, i.e. not including St. Olavs Hospital, Nord-Trøndelag and parts of Fonna. It is the patient's coordinator or main responsible therapist who must complete the forms.

The response option "unknown" is rarely used for most questions about the patients' situation and ongoing treatment, but the degree of uncertainty is somewhat higher when it comes to COVID-19 and hepatitis C (27.7% and 11.9% respectively).

"unknown") and specific mental health problems (13.2-14.1% "unknown") in the last four weeks.

The questions about whether the patient has an individual plan showed the same degree of uncertainty as in previous years (11.1% in 2022, 9.5% in 2021). The status of physical health in the last four weeks was unknown for 10.6% of patients, while the questions on substance use in the last four weeks showed somewhat higher uncertainty of between 14.1-17.0% with "unknown" as the answer. This applied to a lesser extent to the assessment questions on frequency (13.5% unknown) and coping (13.7% unknown) of substance use.

As in the previous year, the questions concerning the entire past year showed a somewhat higher degree of uncertainty than questions concerning the past four weeks. The proportion with unknown status for the past year was between 10.8% (substance abuse in the past year) and 16.3% (offenses in the past year). The patient's degree of satisfaction with treatment was unknown for 21.2%, similar to the previous year. This appears to be consistent with the fact that in a total of 26.8% of cases, patients did not participate in the status survey, which excludes self-assessment of satisfaction.

Despite generally good data quality, there are still many missing answers about the patient's current treatment situation (the response rate here is 75.1% compared with 83.8% overall). At the same time, some measures answer this question as well as the remaining questions in the status survey. The difference in response rate between the treatment situation and the remaining questions was also pointed out in last year's report. We will adjust this question in the next revision of the status questionnaire.

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. Otherwise, the completers generally appear to have good knowledge of the patient's condition. However, the high proportion who do not know whether the patient is satisfied should be reduced by involving the patient in completing the status survey, where this is not standard practice.

Assessments of the survey

The response rate in this year's status survey is at about the same level as last year. The response rate is considered relatively good for most of the single questions in the survey, and most questions are answered with a reasonable degree of certainty (few use the response category "unknown"). In some areas, there is less knowledge of the individual patient's condition, and this applies in particular to assessment questions about mental health and substance use in the last four weeks prior to completion. Even in the most difficult areas, respondents felt that they knew the condition well enough for assessment in about 85% of cases.

LAR ACTION

Table 2 below shows an overview of the OMT interventions that participated in the status survey. All interventions reported individually and are grouped as shown in the table. This grouping is repeated in the following presentation. "OMT interventions" refers to drug-assisted rehabilitation as organized in the health trusts' TSB (interdisciplinary specialized substance abuse treatment). The DAR regulations apply to all treatment of opioid-dominated addiction. After 2004, DAR measures have gradually been integrated into the specialist health service. There is room for considerable local variation in terms of the organization of tripartite cooperation between DAR, GPs and municipal services.

Challenges related to the introduction of the new medical record system Helseplattformen at St. Olavs Hospital and Nord-Trøndelag have meant that they have not been able to participate in the status survey for 2022. Results from the LAR

The measures at St. Olavs Hospital and Nord-Trøndelag are therefore not available this year, and are not included in estimates of national averages. This means that the Central region this year only includes Møre og Romsdal.

Table 2: Overview of participating LAR initiatives and the degree of patient involvement in the status survey for 2022.

<i>Region (number of participants)</i>	<i>LAR measures*</i>	<i>Patients reported (number)</i>	<i>"Has the patient participated in the filling?" (%)</i>	<i>Trend** compared with the previous year</i>
North (644)	Nordland Hospital	211	66,4	↓
	UNN	279	74,3	↑
	Finnmark Hospital	52	69,2	↓↓
	Helgeland Hospital	102	48,0	↓↓
Middle (207)	Møre and Romsdal	207	76,1	≈
West (1519)	Bergen	778	60,4	↑
	Stavanger	482	79,7	↓
	Fonna	186	78,5	≈
	Førde	73	87,7	↑↑
South (1855)	Vestfold	345	87,5	≈
	Telemark	361	82,2	↓
	Drammen	317	66,9	↓
	Asker and Bærum	194	43,0	↓
East (2177)	Southern Norway	638	83,1	≈
	Akershus	516	80,4	↑
	Oslo	809	66,9	↓
	Inland	403	78,4	≈
	Østfold	449	70,8	↑

* The DAR interventions are here distributed across five regions (from four different health trusts) and are presented in the report as these 18 DAR interventions. Sometimes the DAR measures follow county boundaries, sometimes hospital catchment areas. For example, Akershus University Hospital reports for DAR patients in Kongsvinger and for those south and east of Oslo, as well as three districts in Oslo. Oppland consists of Gjøvik and Lillehammer, which together with LAR in Hedmark are part of Innlandet Hospital Trust. LAR in Vestre Viken Helseforetak is represented by Drammen, and Asker and Bærum.

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

PARTICIPANTS

Gender and age

The average age of patients in OMT in 2022 was 47.8 years. Table 3 illustrates the gradual ageing of the population in DAR, and shows that this trend has continued this year. The oldest patients on average in 2022 came from Innlandet (50.1 years) and Oslo (49.5 years), while the youngest came from Finnmark Hospital (43.2 years) and Førde (43.8 years). As before, there was little difference in average age between the DAR interventions. The gender distribution among OMT patients has remained stable over time, with a female share of around 30%. However, there is some variation across trusts. Akershus had the highest proportion of women in 2022 (37.2%), while Møre og Romsdal had the lowest proportion of women (23.2%).

Table 3: Gender and average age among patients in OMT.

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Average age (years)	41,7	41,9	42,7	43,4	43,7	44,3	44,9	45,6	46,1	46,5	47,0	47,8
Share of women (%)	29,6	29,8	30,2	29,3	30,1	30,0	30,4	29,3	30,5	30,4	30,1	29,7

As shown in Table 4, patients in OMT are getting older. The proportion of patients over the age of 50 in 2022 was 42.1%, compared with 23.7% in 2015. The proportion over the age of 60 has more than quadrupled since 2015. Increased age often leads to somatic co-morbidity, and ageing has implications for the adaptation of OMT services and treatment outcomes.

Table 4. Age distribution among patients in OMT.

Age group (%)	2015	2016	2017	2018	2019	2020	2021	2022
Under 21	0,1	0,1	0,0	0,0	0,0	0,1	0,0	0,0
21-25	1,8	1,6	1,5	1,1	1,0	1,1	1,0	1,3
26-30	6,4	6,5	6,3	5,7	5,5	5,1	4,2	4,0
31-40	29,5	27,6	26,3	25,4	24,9	23,6	23,5	21,1
41-50	37,0	36,3	35,0	34,7	33,7	33,4	32,4	31,6
51-60	22,4	24,1	25,7	26,7	27,4	27,8	28,7	29,5
Over 60	2,8	3,9	5,3	6,3	7,5	8,9	10,2	12,6

The status report for 2017¹ contains a detailed review of how gender and age correlate with choice of treatment and various treatment outcomes ([can be downloaded here](#)).

Housing situation

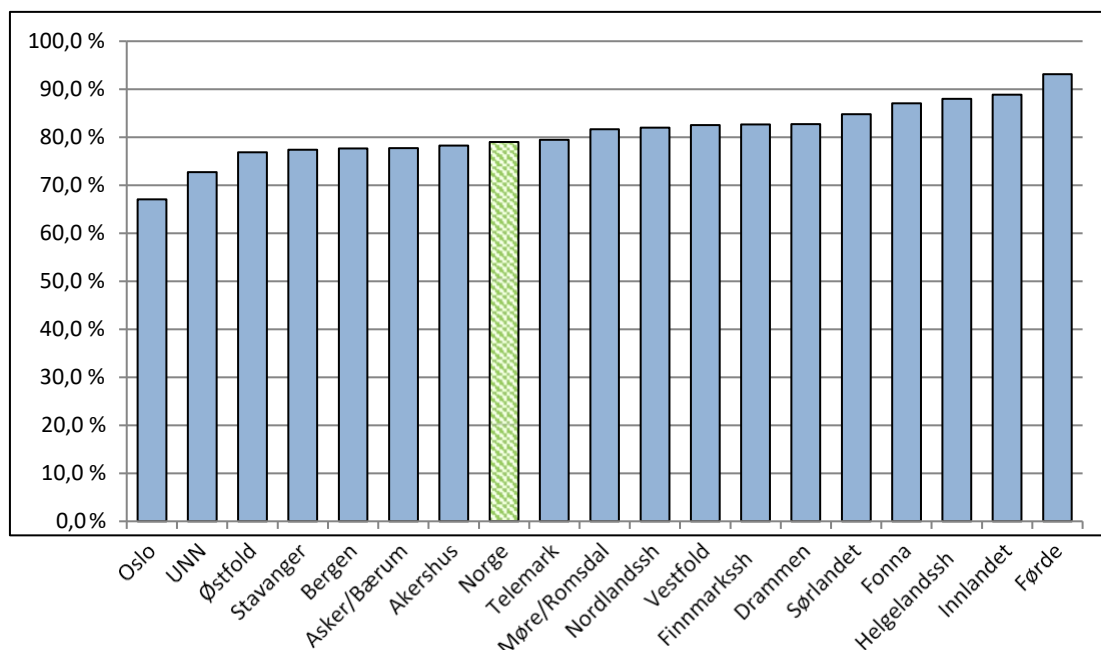
At national level, 1.8% of patients in OMT were homeless, 3.0% lived in hospices/hospices/hotels, 5.7% were in institutions, 1.2% were in prison, 3.6% lived with parents, 2.8% lived with others, 79.0% had their own home. 2.8% had an unknown housing situation. The majority of patients in DAR have their own home, with a similar percentage as in previous years (Figure 6). The proportion with their own home in Oslo was lower (67.1%) and clearly below average. The proportion of patients with their own home was highest in Førde (93.2%).

¹ Waal, H., Bussesund, K., Clausen, T., Lillevold, P.H. (2017). SERAF report 1/2018, Gender and age in OMT. Oslo: UiO and OUS_

<https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2018/seraf-rapport-nr-1-2018-alder-og-kjonn-i-lar.pdf>

Figure 6. Proportion who rent or own a home (unknown = 2.8%).

Oslo	67,1 %
UNN	72,7 %
Østfold	76,8 %
Stavanger	77,4 %
Bergen	77,6 %
Asker/Bærum	77,7 %
Akershus	78,3 %
Norway	79,0 %
Telemark	79,5 %
Møre/Romsdal	81,6 %
Nordlandssh	82,0 %
Vestfold	82,5 %
Finnmarkssh	82,7 %
Drammen	82,7 %
Southern Norway	84,8 %
Fonna	87,1 %
Helgelandssh	88,0 %
Inland	88,9 %
Førde	93,2 %



Main activity

Nationally, 82.4% of patients in DAR were unemployed, 9.0% were in full-time employment, 5.6% were in part-time employment, 1.3% were in education, and 0.4% were in part-time employment and education (Table 5). Nationally, 1.3% had unknown status in terms of main activity. As the figures show, there was some variation between measures and regions in main activity. Møre og Romsdal, followed by Førde, had the lowest proportion of patients without employment, and at the same time the highest proportion of patients in full-time employment. As before, a larger proportion of patients were unemployed in the areas around the larger cities. The proportion without gainful employment has been fairly stable over the past decade.

Table 5. Main activity (unknown = 1.3%).

LAR measures	Without employment	Full-time job	Part-time job	In education	Part-time job and in education
Møre/Romsdal	69,6%	18,8%	4,3%	1,0%	0,0%
Førde	69,9%	13,7%	15,1%	1,4%	0,0%
UNN	70,8%	10,8%	8,7%	0,7%	0,0%
Nordlandssh	75,4%	11,8%	10,9%	0,0%	0,0%
Stavanger	79,3%	12,0%	4,8%	3,1%	0,8%
Vestfold	79,9%	12,2%	5,5%	1,5%	0,3%
Inland	80,6%	8,2%	8,7%	1,0%	0,7%
Finnmarkssh	80,8%	7,7%	11,5%	0,0%	0,0%
Akershus	81,3%	8,6%	4,9%	1,4%	0,2%
Norway	82,4%	9,0%	5,7%	1,3%	0,4%
Southern Norway	83,4%	8,8%	5,2%	1,7%	0,6%
Helgelandssh	84,0%	10,0%	6,0%	0,0%	0,0%
Fonna	84,9%	7,5%	3,8%	3,8%	0,0%
Østfold	85,3%	7,6%	5,6%	0,4%	0,4%
Telemark	85,3%	9,1%	4,4%	0,6%	0,6%

Drammen	85,5%	6,9%	5,7%	0,6%	0,0%
Oslo	86,0%	6,3%	5,1%	1,5%	0,6%
Bergen	87,0%	6,7%	4,1%	1,2%	0,5%
Asker/Bærum	88,1%	7,8%	3,1%	1,0%	0,0%

Main income

Figure 7 shows main income in 2022, and Figure 8 shows the development in main income over time. At the time of the status survey, 70.2% had disability or retirement pension, 10.8% had work assessment allowance and 4.2% social assistance as their main income, while 9.9% had earned income. The proportion with a disability or retirement pension was relatively similar to last year (68.7% in 2021), but over the past five years there has been a gradual, cautious increase in disability or retirement pensions (Figure 8). Given that the LAR population is ageing, it is not unexpected that a high proportion are either incapacitated for work or receiving an old-age pension. The rules for work assessment allowance were tightened with effect from January 1, 2018, when the maximum period was reduced from four to three years. For the LAR population, this change does not appear to have had much impact on the type of main income. For several years, disability and retirement pensions have proved to be more relevant as the main source of income in the LAR population. The proportion on social assistance remains low. It is positive that this temporary benefit scheme is rarely used in the DAR population, as other schemes provide greater predictability. Bergen and Oslo appear to have the highest proportion receiving social assistance (8.1% and 6.9%).

Figure 7. Main income (unknown = 3.3%).

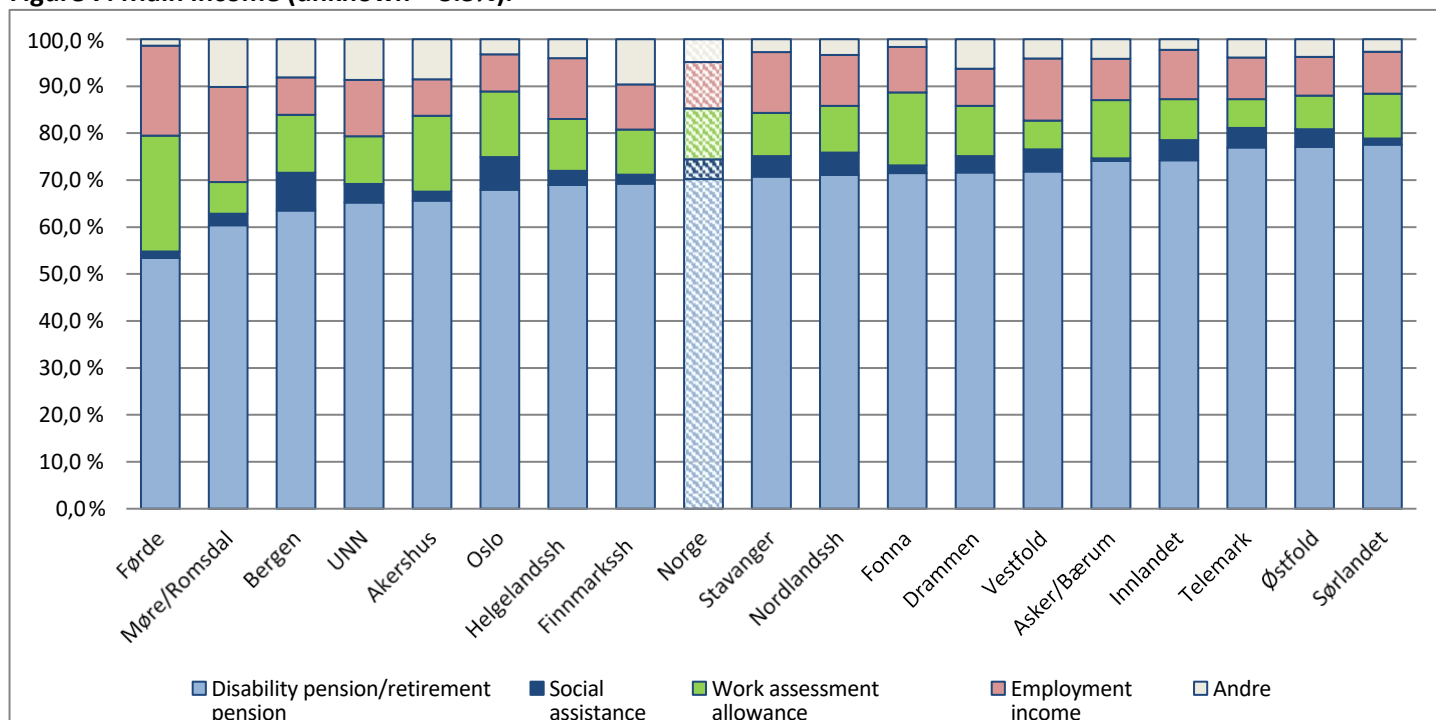
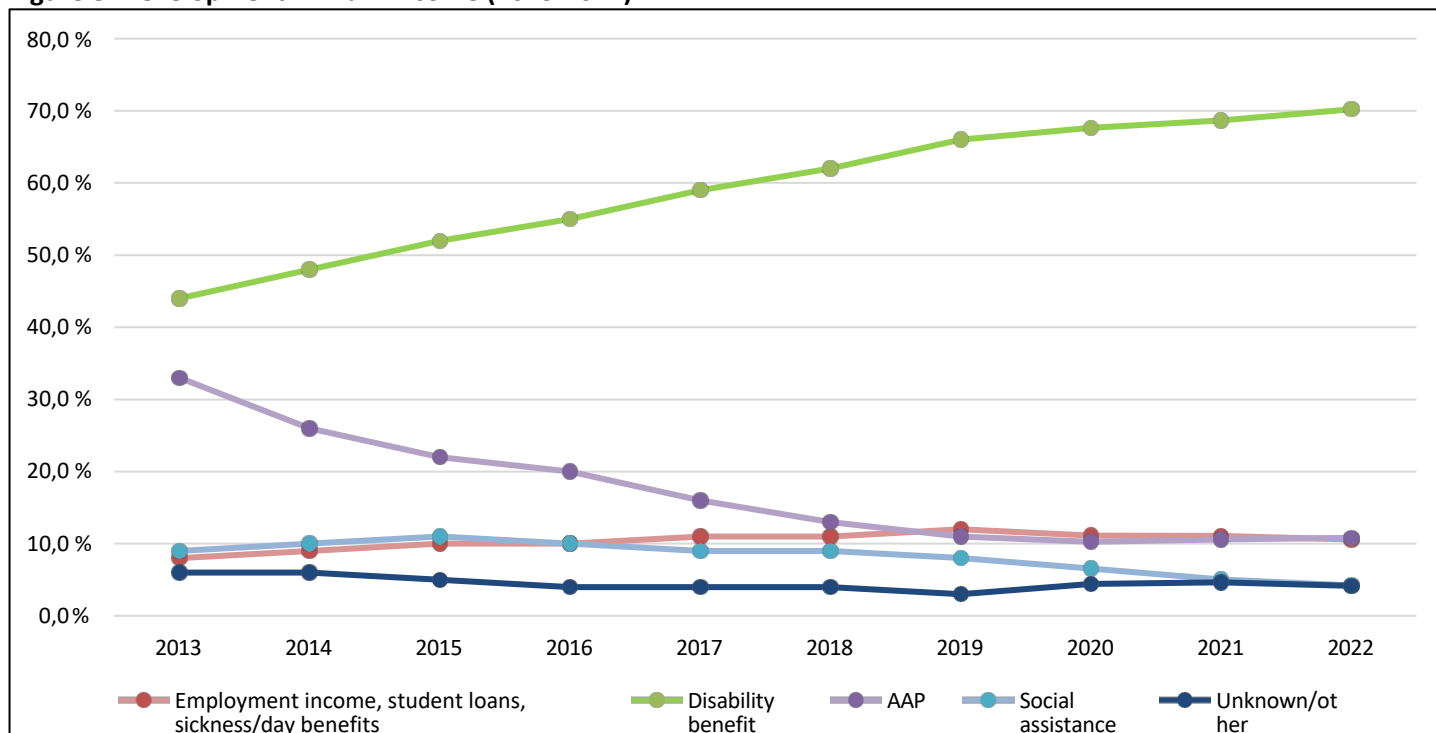


Figure 8. Development in main income (2013-2022).



Assessments of the patients' situation

In the DAR population, the proportion of patients aged 30 years and younger continues to be very low, while the proportion over 50 years is increasing. Over 40% of the OMT population is now older than 50 years. The increasing age of patients is a marker of the benefits 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 about the same as among people with substance abuse problems nationally.

Among patients in OMT, most 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. In the larger cities, the proportion of patients with their own homes is somewhat lower.

As before, the status survey shows that the vast majority of the population has an orderly social situation in several respects. At the same time, few are engaged in work or study-related activities, and by far the most important income is disability and retirement pensions. Few have earned income and the proportion on work assessment allowance and social assistance is relatively low. In some smaller measures, there is a lower proportion of patients without employment, and more people with full-time or part-time jobs.

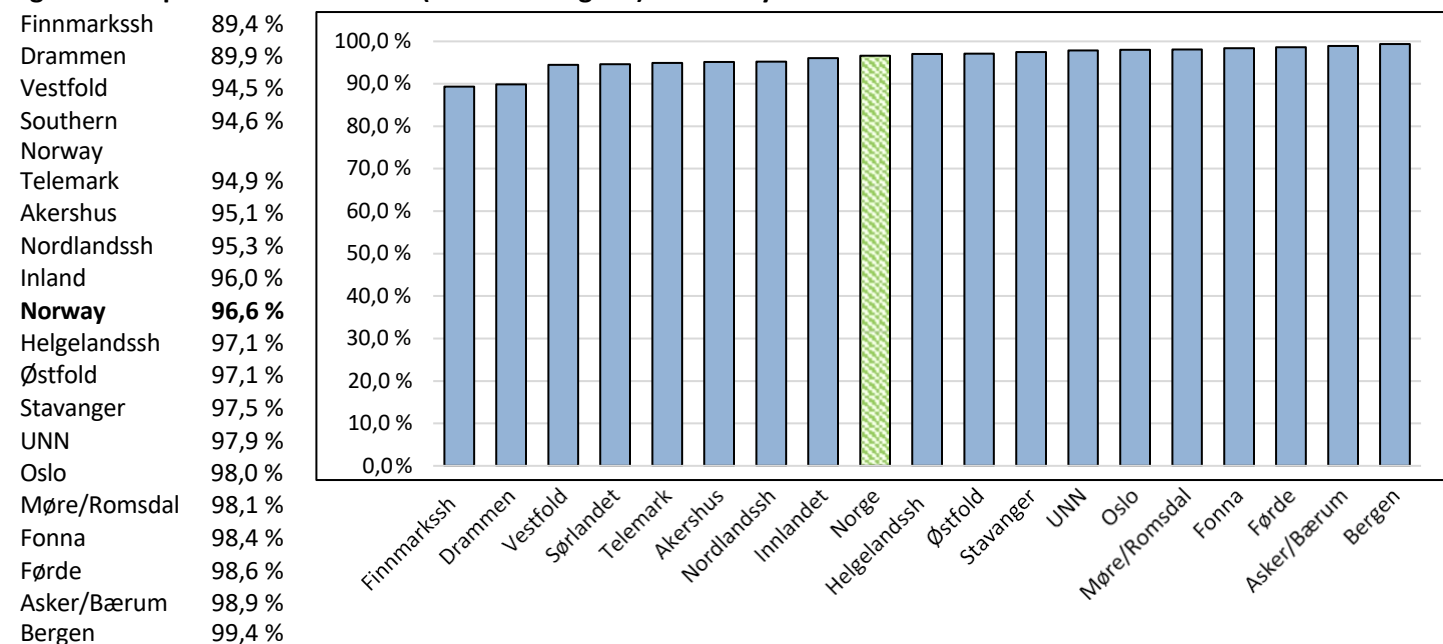
Participation in daily meaningful activity and social contexts is an important issue for DAR, and meaningful activity can be understood broadly. The challenges in practice will be to create and utilize opportunities for participation in various forms of activity to counteract social isolation and promote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

TREATMENT STATUS

Current treatment status

Among those who responded to the survey (7643 in total), information on treatment status is available for 89.6% of these (Figure 9). Among those for whom we have information, almost all (96.6%) were in treatment, i.e. not discharged, at the time of the status survey.

Figure 9. Proportion in treatment ("not discharged") nationally and in the various measures.

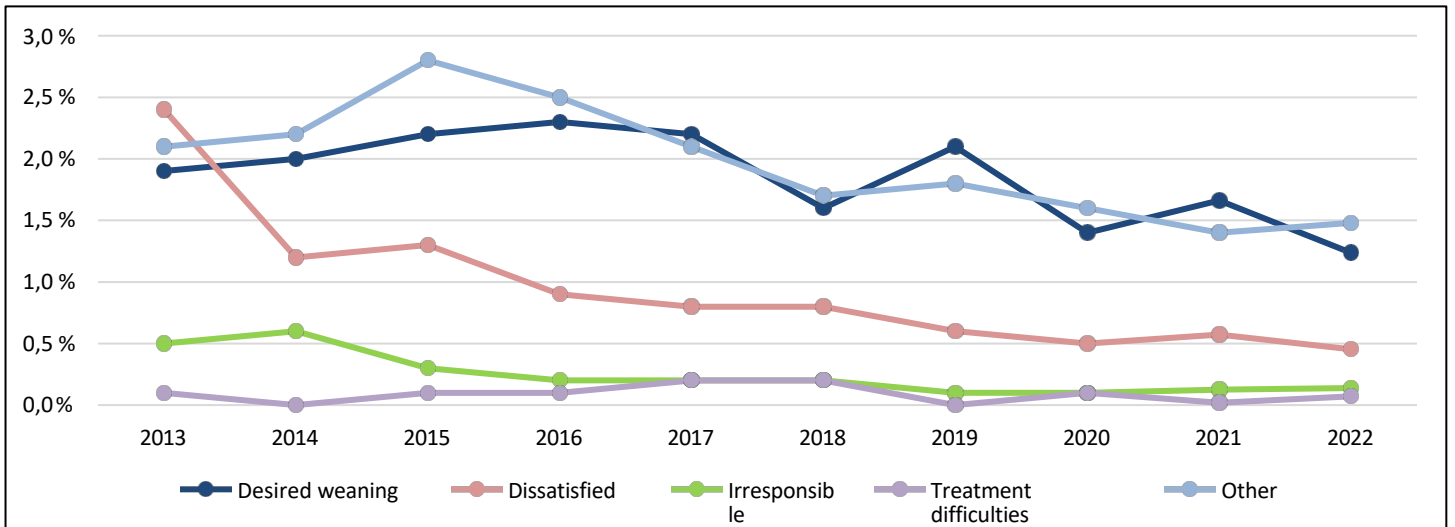


Discharge and assessment of discharge practices

Figure 10 provides an overview of the reasons for termination of treatment over time. The proportion of discharges in the period 2013-2022 was consistently lower than 5%. The group "other" also includes those discharged due to death*. The proportion discharged against their own will has decreased. Among the rest, the most common reason for discharge appears to be a desire to taper off/end OMT, as well as being actively dissatisfied with the treatment. Very few patients are discharged due to difficulties in the treatment or because the treatment is considered unjustifiable by the therapist.

This may indicate quality improvements over time.

Figure 10. Reasons for discharge (2013 - 2022).



*147 deaths were registered in DAR in 2022 (see separate chapter).

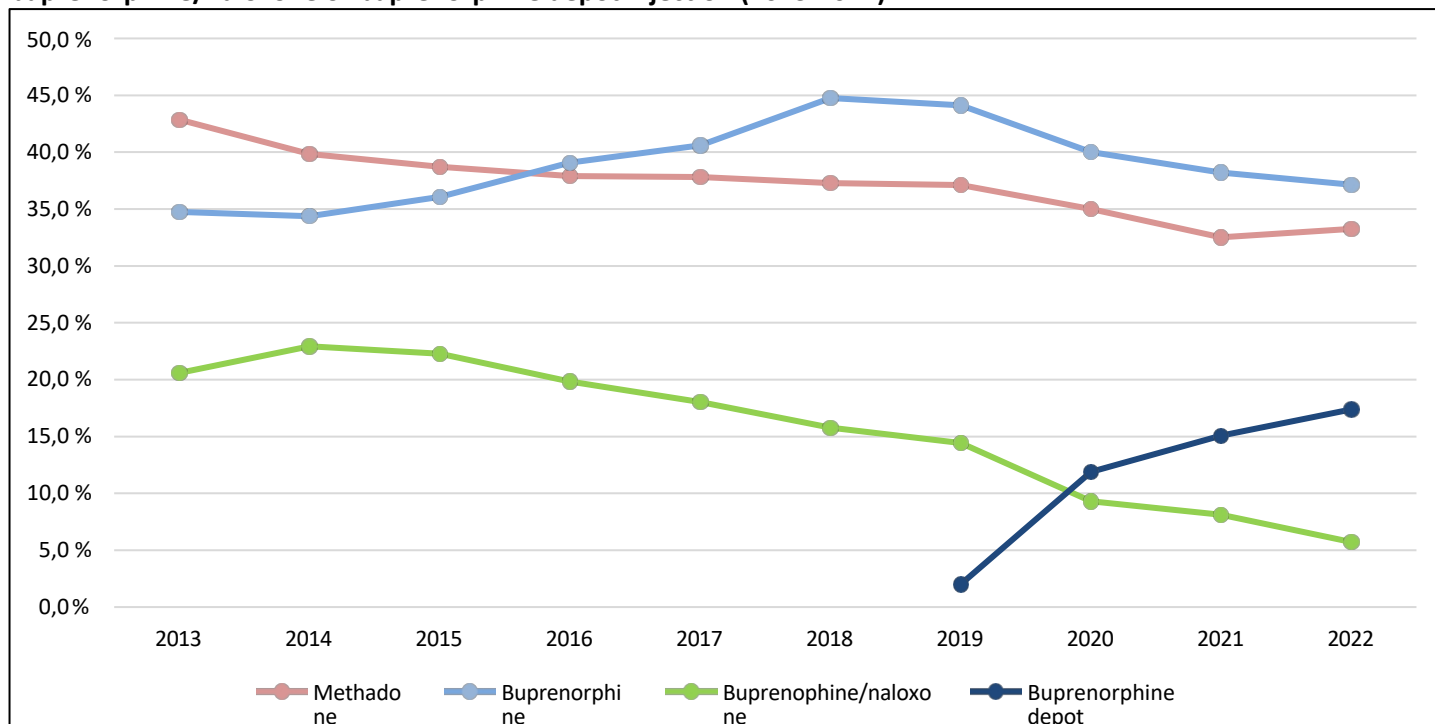
DRUG TREATMENT

Choice of medication

Nationwide, 33.3% of patients were treated with methadone in 2022, a slight increase from the previous year, despite the declining trend over time (Figure 11). The proportion using buprenorphine monopreparation was slightly lower than previously (37.1% compared with 38.2% in 2021 and 40.0% in 2020). The same applied to combination preparations

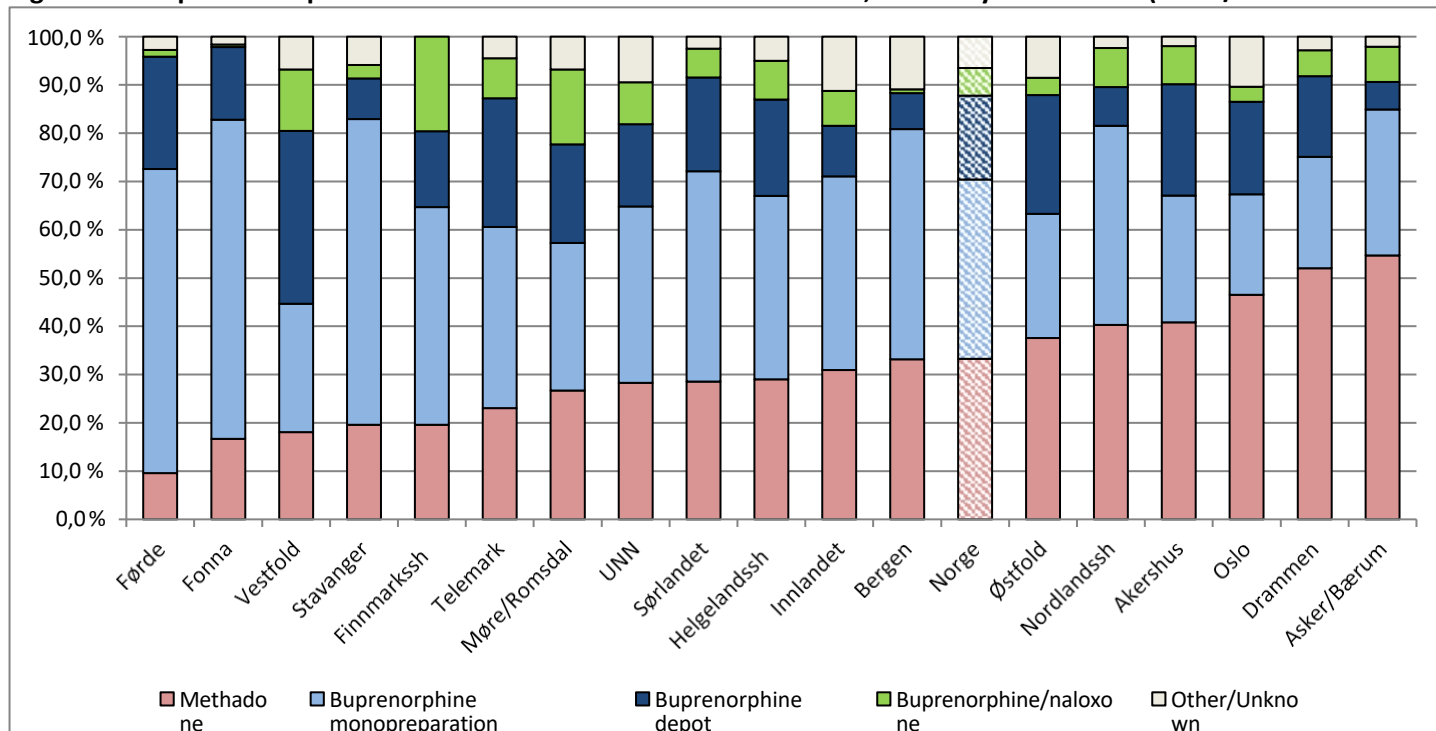
buprenorphine/naloxone (5.7% compared with 8.1% in 2021 and 9.3% in 2020). After buprenorphine depot was introduced as an OMT medication in 2019, questions about buprenorphine depot injection were also included in the status survey. The proportion of patients receiving buprenorphine depot was 11.9% in 2020 and 15.1% in 2021, and increased further to 17.4% in 2022. The new OMT guidelines have allowed for a greater degree of individual assessment in the choice of OMT medication. At national level in 2022, 5.9% used other opioid-based preparations. This proportion has been increasing over time, and includes, for example, levomethadone and dolcontin.

Figure 11. Proportion of patients who were prescribed methadone, buprenorphine monopreparation, buprenorphine/naloxone or buprenorphine depot injection (2013-2022).



There are local variations in which OMT medications are used (Figure 12). Some DAR interventions stand out with a higher proportion using the combination buprenorphine-naloxone. In this year's status survey, this was particularly true of Finnmark Hospital (19.6%) and Møre og Romsdal (15.5%), in contrast to Bergen (0.8%) and Fonna (0.5%), where only a small number used buprenorphine-naloxone as a DAR medication. As before, some interventions had particularly high use of buprenorphine monotherapy. This was particularly true in the West, with the highest percentage in Fonna (66.1%), Stavanger (63.4%) and Førde (63.0%). In some enterprises, buprenorphine depot was widely used, such as in Vestfold (35.8%). In other places, buprenorphine depot had not been introduced as an OMT medication. This is likely to change in the coming years. The Eastern Norway area had the highest use of methadone, with the highest proportion in Asker and Bærum (54.7%) and Drammen (52.1%). In the 1990s, all patients in OMT were treated with methadone, and buprenorphine only became available as a drug for OMT in 2002. The interventions that have a significant proportion of their patient population that started treatment in this first period will therefore tend to have more people using methadone as an OMT medication than interventions that have been added more recently.

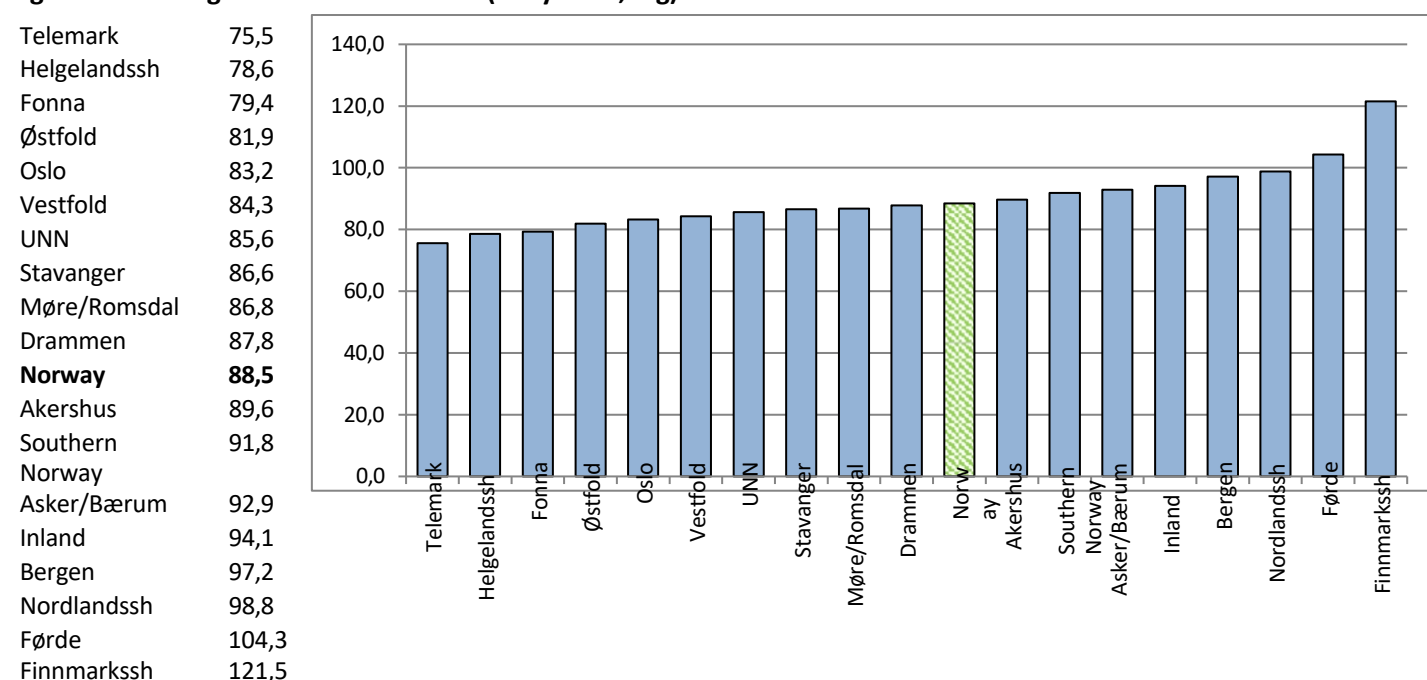
Figure 12. Proportion of patients treated with the various medications, sorted by methadone (other/unknown = 6.7%).



Dosage of LAR medication

For methadone, the average dose was 88.5 mg in 2022 (Figure 13). The average dose has been relatively stable in recent years (89.7 mg in 2021, 89.5 mg in 2020 and 90.1 mg in 2019). However, the last decade shows a steady reduction in the dosage level of methadone since 2011 (102.8 mg). Figure 13 shows the dosage level of methadone in the various interventions and nationally. The variation was small, and primarily within the recommended limits of 80-110 mg per day. The highest doses were reported from Finnmark Hospital (121.5 mg). This may be due to individual patients requiring high doses, which would make the average in a small group artificially high.

Figure 13. Average dose of methadone (daily dose, mg).



Figures 14a and 14b show the dosage level for buprenorphine monopreparation and combination preparation (naloxone and buprenorphine mixed in a 1:4 ratio). The recommended daily dosage is 12-24 mg buprenorphine for both.

The national dose level was 14.8 mg for the monopreparation and 13.1 mg for the combination product in 2022, compared with 14.5 mg for the monopreparation and 13.7 mg for the combination product in 2021. There was little difference between the OMT interventions in dosage levels, but Drammen (9.9 mg) and Oslo (10.2 mg) were slightly below the recommended daily dose for the combination product. Based on the available data, it is difficult to find a good explanation for why the dosage of the combination product is somewhat lower than that of the monopreparation. The combination product is preferred when harm reduction is the main goal, i.e. when OMT is primarily used as a stabilizing treatment, despite the fact that the risk of non-medical use should be somewhat lower for the combination product.

Figure 14a. Average dose of buprenorphine monopreparation (daily dose, mg).

Telemark	12,4
Innlandet	12,8
Drammen	12,9
Førde	13,1
Stavanger	13,4
Østfold	13,5
Fonna	13,7
Finnmarkssh	13,9
Helgelandssh	14,3
Norway	14,8
UNN	15,0
Oslo	15,3
Bergen	15,8
Møre/Romsdal	15,8
Southern	16,2
Norway	16,2
Vestfold	16,4
Asker/Bærum	16,4
Akershus	16,5
Nordlandssh	16,8

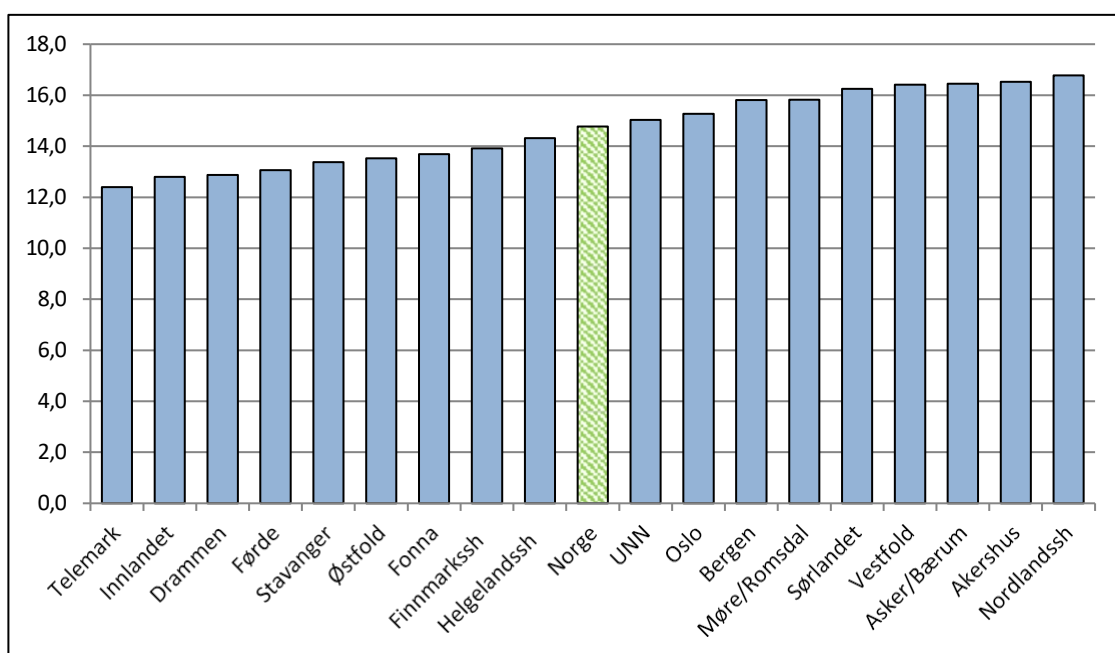
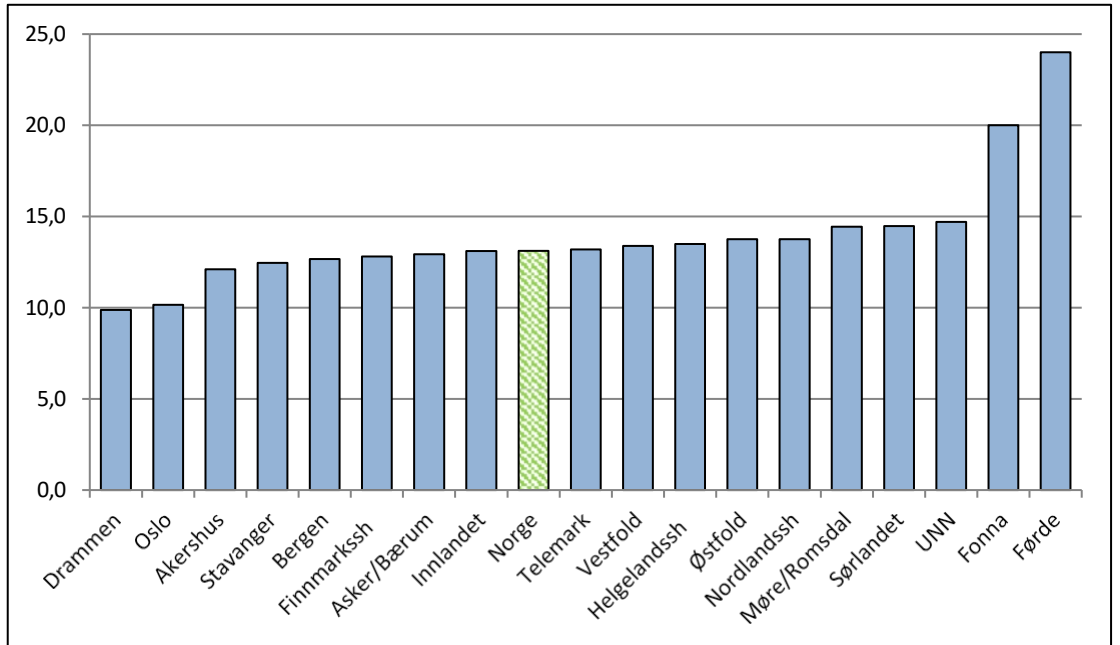


Figure 14b. Average dose of buprenorphine/naloxone combination product (daily dose, mg).

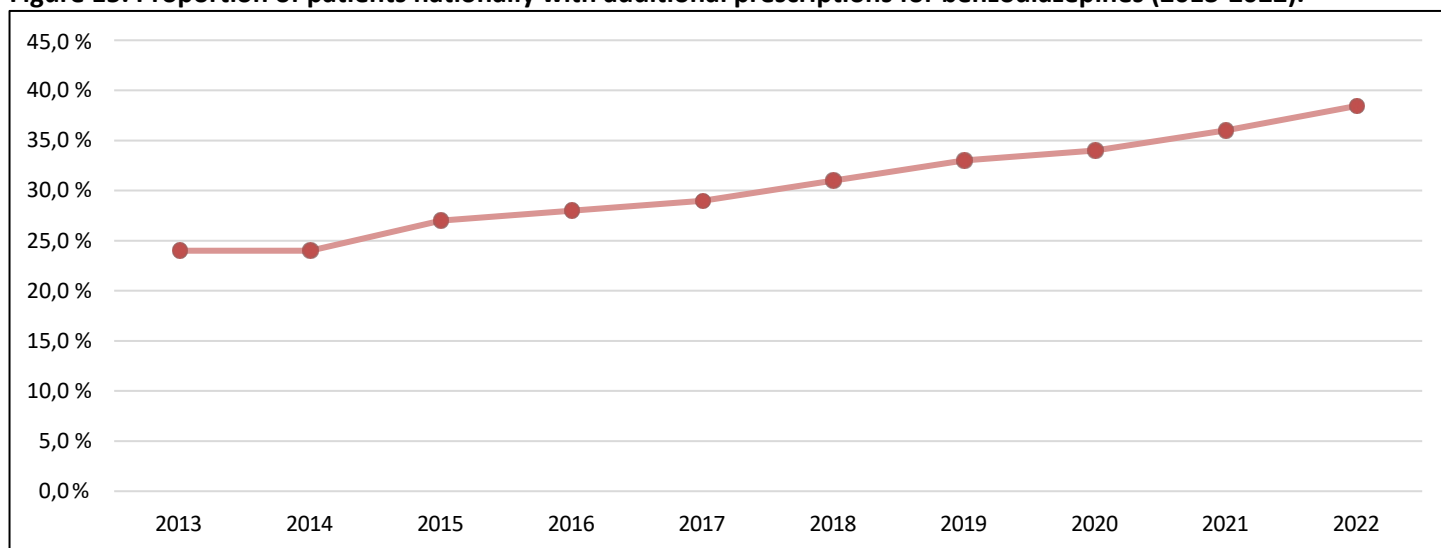
Drammen	9,9
Oslo	10,2
Akershus	12,1
Stavanger	12,5
Bergen	12,7
Finnmarkssh	12,8
Asker/Bærum	12,9
Inland	13,1
Norway	13,1
Telemark	13,2
Vestfold	13,4
Helgelandssh	13,5
Østfold	13,8
Nordlandssh	13,8
Møre/Romsdal	14,4
Southern Norway	14,5
UNN	14,7
Fonna	20,0
Førde	24,0



Additional prescription of benzodiazepines

The status survey reports whether doctors prescribe medication that can affect the effect of the OMT medication, which is particularly true in the case of additional prescriptions of benzodiazepine preparations. As a general rule, benzodiazepine preparations are not recommended in OMT unless there is a clear indication for this. However, the new OMT guidelines allow for greater individual assessment of additional benzodiazepine prescriptions. Figure 15 below shows a steady increase in the prescription of benzodiazepines over time, from 29.3% in 2017, 36.4% in 2021, to 38.4% in 2022.

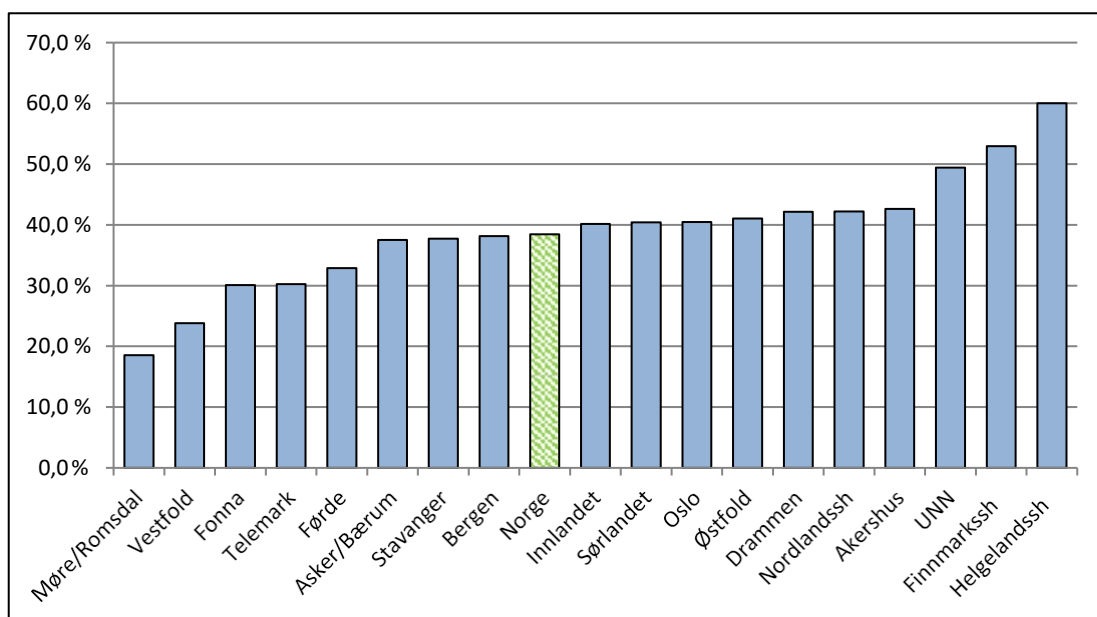
Figure 15. Proportion of patients nationally with additional prescriptions for benzodiazepines (2013-2022).



There was considerable variation in the prescribing of benzodiazepine preparations to patients across DAR interventions in 2022 (Figure 16). The lowest prescription figures were found in Møre og Romsdal (18.5%), followed by Vestfold (23.8%), while Helgeland Hospital prescribed benzodiazepines to the largest proportion of patients (60.0%), followed by Finnmark Hospital (52.9%) and the University Hospital of North Norway (52.9%). As last year, the prescription of benzodiazepines at regional level was highest in Nord (49.0%).

Figure 16. Proportion of patients with additional prescriptions for benzodiazepines (unknown = 4.0%).

Møre/Romsdal	18,5 %
Vestfold	23,8 %
Fonna	30,1 %
Telemark	30,3 %
Førde	32,9 %
Asker/Bærum	37,5 %
Stavanger	37,7 %
Bergen	38,2 %
Norway	38,4 %
Inland	40,1 %
Southern Norway	40,4 %
Oslo	40,5 %
Østfold	41,0 %
Drammen	42,2 %
Nordlandssh	42,2 %
Akershus	42,6 %
UNN	49,5 %
Finnmarkssh	52,9 %
Helgelandssh	60,0%

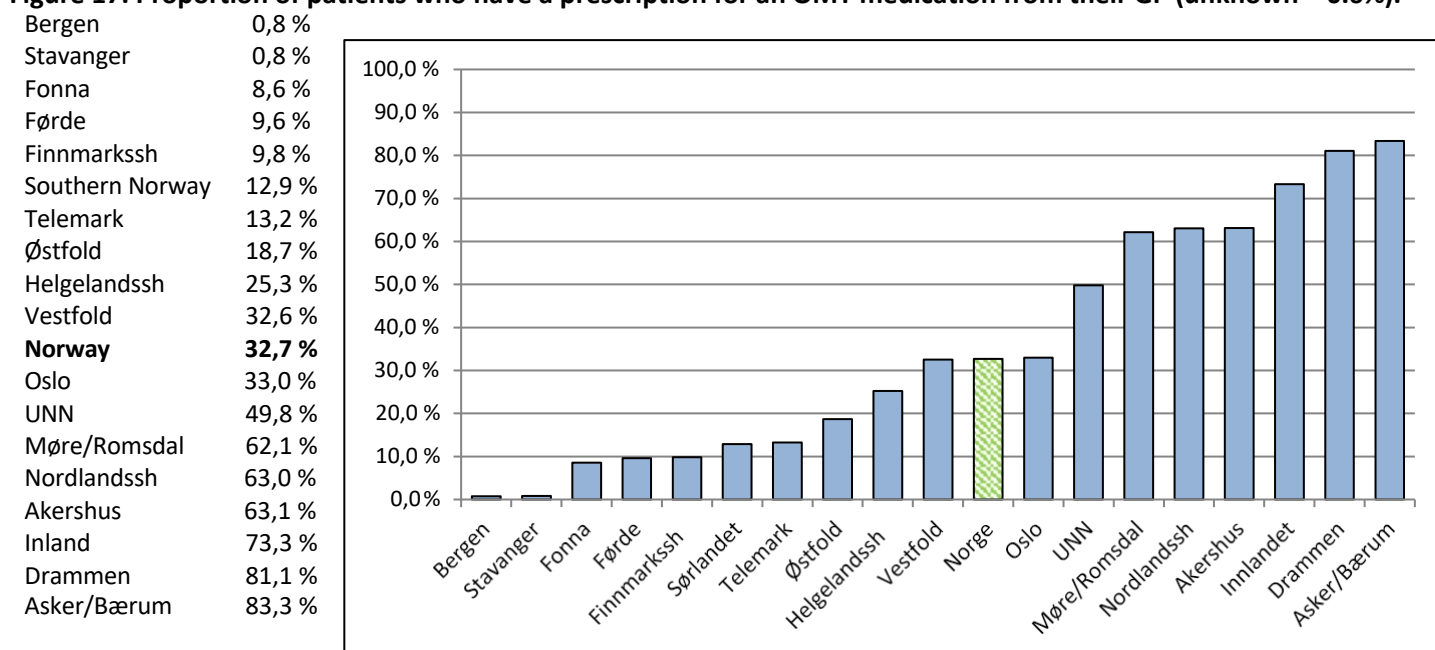


Attending physician

Nationwide, there has been a significant reduction over time in the proportion of people who are prescribed the drug by their GP (Figure 17). In 2022, 32.7% had their GP as their prescribing doctor. In 2021, the proportion was 34.7%. In 2022, 64.3% of patients were prescribed OMT medication by a doctor in OMT, compared with 62.7% in 2021. Only a small number were prescribed OMT medication by another doctor (2.4% in 2022 versus 2.2% in 2021), or an unknown prescribing doctor (0.6% in 2022, 0.4% in 2021).

GPs play a central role in OMT, but the proportion of prescribing OMT medication is clearly declining. There is a systematic difference between the interventions (Figure 17), which has also been reported previously. In six enterprises, the GP was the treating doctor for more than half of the patients, in contrast to Bergen and Stavanger, which hardly used GPs as treating OMT doctors. Eight enterprises only exceptionally used GPs as prescribing doctors. This clear difference in organizational practice has been stable for several years. The gradual increase in the use of buprenorphine depot, which is prescribed by the specialist health service, is a potential explanation for the reduced use of GPs as prescribing doctors. It has been the case that pharmacies charge for dispensing DAR medication, which is a cost that the health trust must cover. Some larger health trusts have therefore prioritized a greater degree of dispensing in the specialist health service, rather than prescribing from a GP with dispensing in a pharmacy at high dispensing rates. It may appear that the tariff schemes and funding schemes in DAR therefore affect the organizational form of some of the DAR measures.

Figure 17. Proportion of patients who have a prescription for an OMT medication from their GP (unknown = 0.6%).



Side effects of OMT medication

In the status survey for 2022, some measures had an updated status questionnaire with additional information. This applied to interventions that use the electronic record-keeping system DIPS Arena, and thus applies to Oslo (809 participants), Bergen (778 participants), Førde (73 participants), and Fonna (186 participants). Of relevance to the drug treatment was a new question on perceived side effects of OMT medication. Below we present the proportion of patients with experienced adverse reactions by intervention and overall, i.e. the total of the four interventions that have reported using DIPS Arena (Figure 18), and by type of medication (Figure 19).

When it came to experienced side effects (1,844), 8.4% answered in the affirmative, 38.4% in the negative, 35.9% that it was not relevant, and 17.2% had unknown status regarding side effects. In Oslo (5.1%) and Fonna (6.5%), fewer people reported experiencing side effects than in Bergen (12.0%) and Førde (11.0%). Førde had the

lowest

proportion with unknown status when it comes to side effects (5.0%), compared with Oslo (22.7%), Bergen (14.3%) and Fonna (10.2%). This applied regardless of the type of medication.

The largest proportion of patients who experienced side effects from the OMT drug were patients who used other OMT drugs (12.0%), followed by buprenorphine depot injection 1 week (9.7%). In comparison, 4.9% reported side effects for buprenorphine depot injection 4 weeks. There were no reports of side effects for buprenorphine combination product. It is worth noting that there is a large difference in group size, with particularly small groups for buprenorphine depot injection 1 week, buprenorphine combination product, and unknown OMT medications, and the responses should therefore be interpreted with caution.

Patients who responded affirmatively to experienced side effects had the option to add a description of the type of side effect, which 125 out of 155 participants did (80.6%). Experienced side effects 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 at the same time as being an OMT patient. It is impossible to distinguish this with the data material available. In total, more than 70% reported that they had no side effects or felt that the question was irrelevant.

Figure 18. Proportion of patients with experienced adverse effects of OMT medication in the past year (unknown = 17.2%).

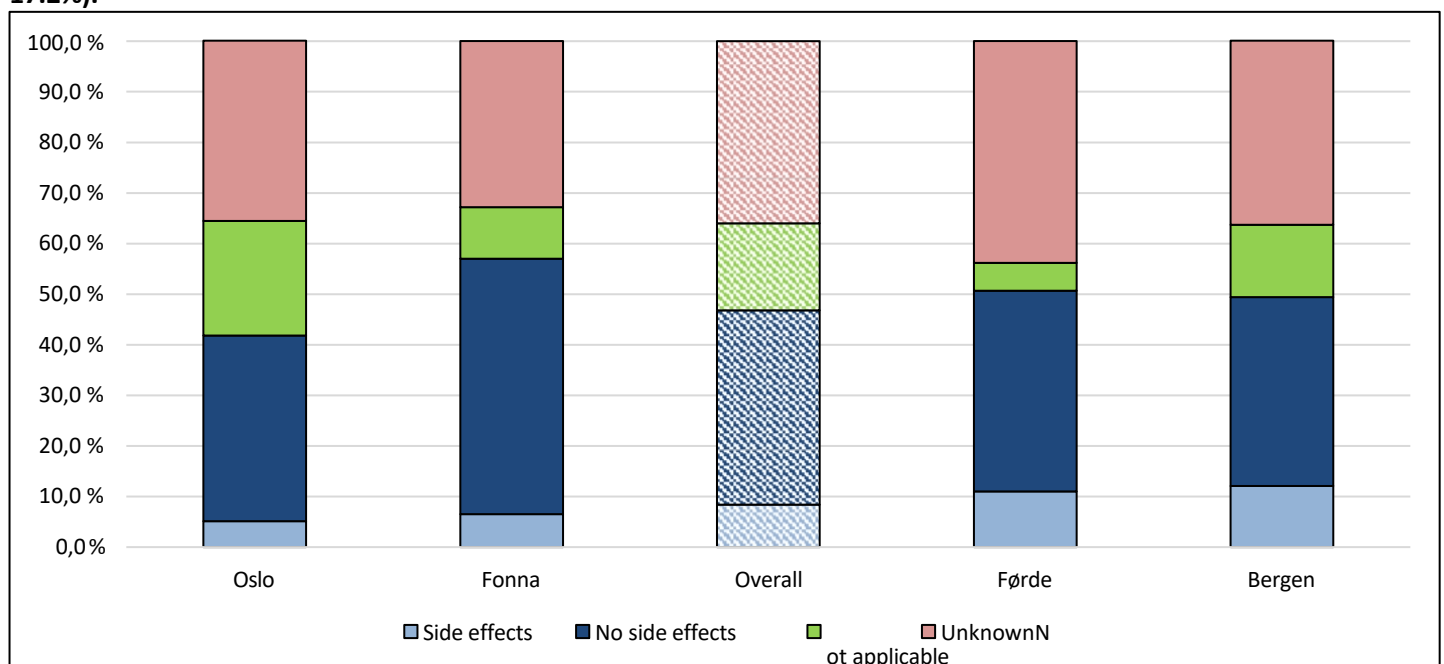
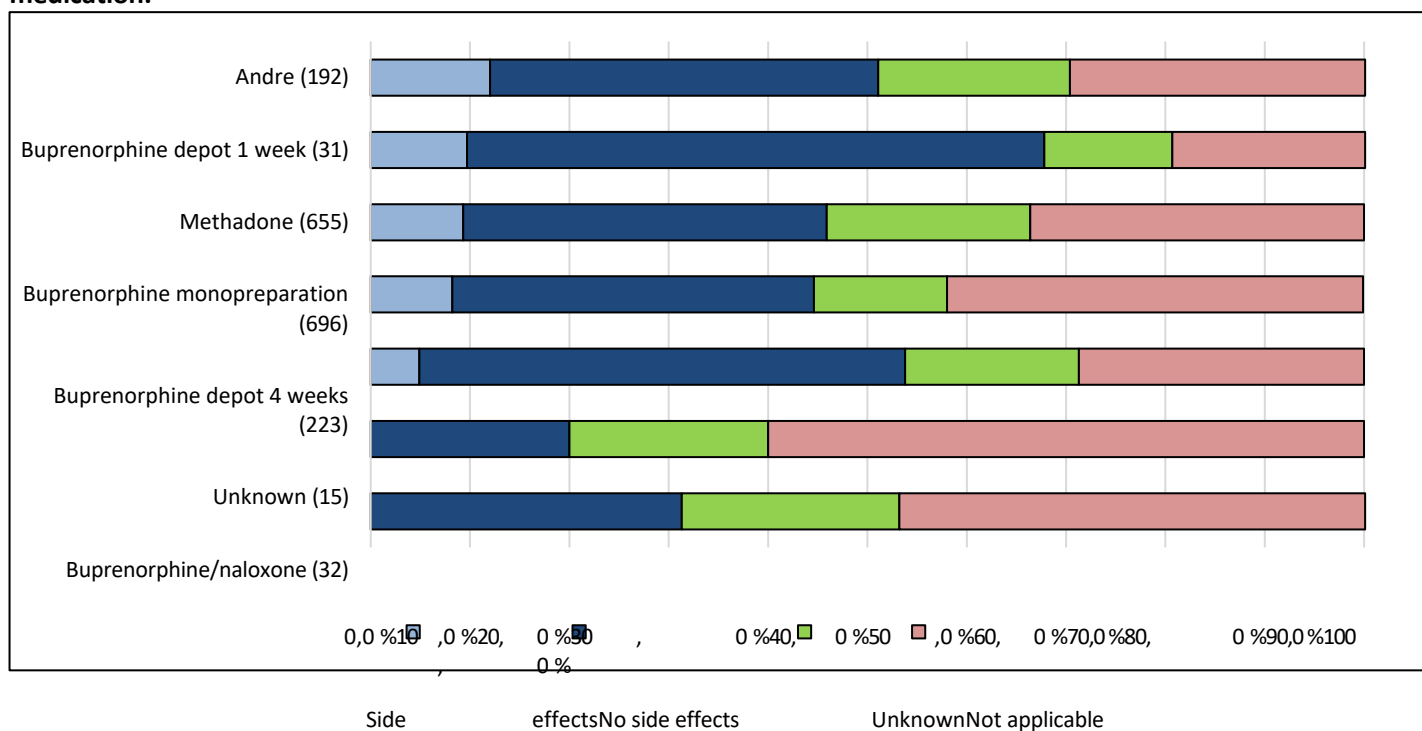


Figure 19. Proportion of patients with experienced adverse reactions to OMT medication in the past year, by type of medication.



Assessments of the drug treatment

The drug treatment in OMT was evaluated in the 20th anniversary report² ([download here](#)).

In line with the recommendations in the 2010 guidelines on buprenorphine as the first choice, there is a high degree of use of buprenorphine. The OMT programs that use methadone to the greatest extent are also the programs that started OMT before buprenorphine became available in 2002. Clinical experience of key professionals in the programs and patient preferences also play a role. The revised OMT guidelines have allowed for a greater degree of individual assessment by professionals and increased user participation, and further developments in the choice of medication may be affected by this.

The data material for 2022 shows that an increasing proportion of patients are using buprenorphine depot injection as an OMT medication, and also shows an increase in the proportion of patients who are prescribed OMT medications other than methadone, buprenorphine monopreparation and buprenorphine combination preparation. Buprenorphine depot has a stabilizing effect over seven to 28 days for those patients who want it, while injections can allow for a more normalized everyday life, without pick-up arrangements. This can also entail new challenges, such as maintaining sufficient contact with patients in the periods between injections if psychosocial treatment is not taking place in parallel, as well as the breakdown of the routines that more frequent drug treatment may have provided for the individual.

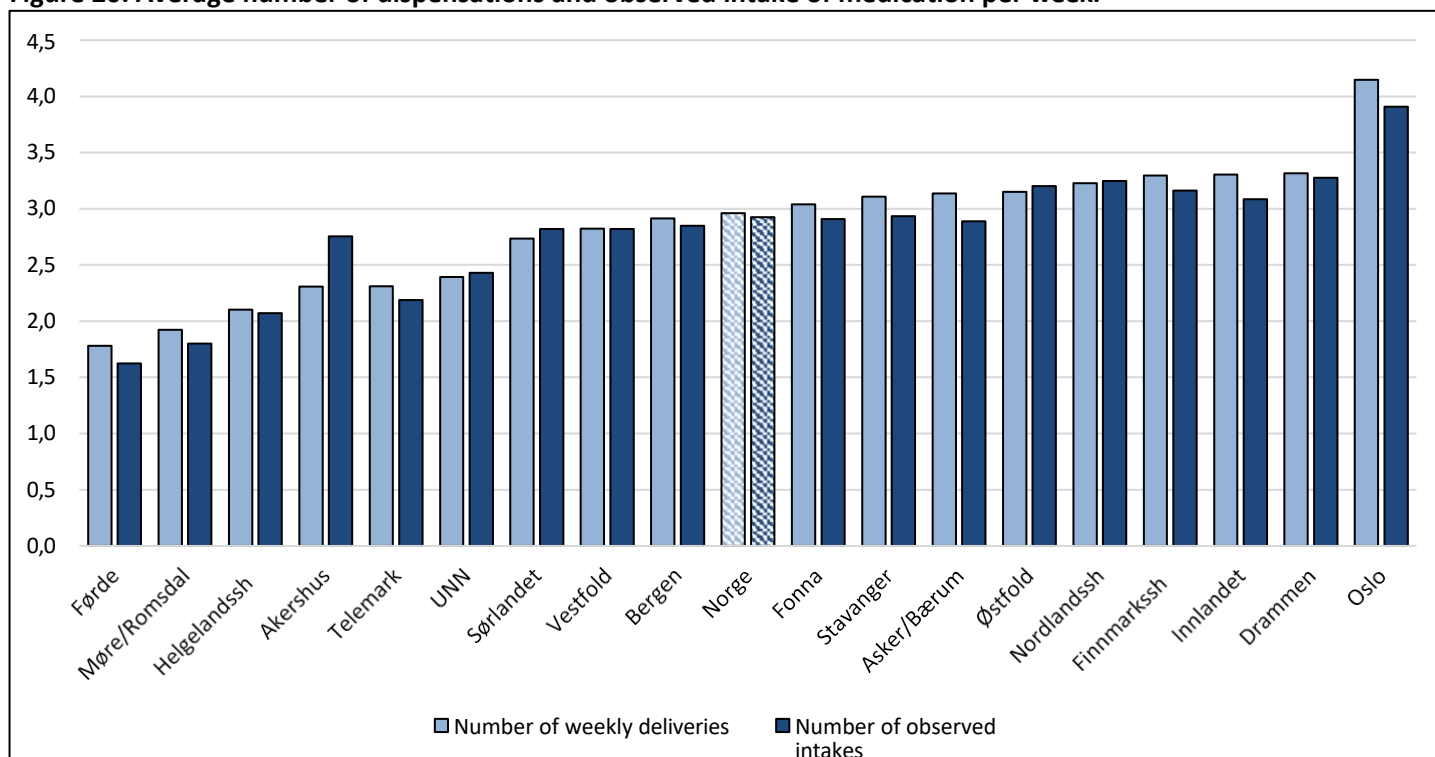
The status survey for 2022 includes information on side effects of OMT medication for a sample of patients, and shows that less than 1 in 10 of these actively report experienced side effects. The material also provides us with some descriptions of various side effects. Over time, the questions about side effects can be used to obtain a more systematized overview of the degree of side effects experienced in the larger OMT population.

² Waal, H., Bussesund, K., Clausen, T., Lillevold, P.H., Skeie, I. (2018). SERAF report 3/2018. Status report 2017. LAR 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 SOUNDNESS AND SAFETY IN THE *Dispensing of medication*

The dispensing of OMT medication must be adapted to the patient's level of intoxication and situation. Most patients in Norway must attend several times a week to collect their medication. This usually means observed intake on the day of collection. The number of dispensations usually varies from one to seven times a week. Figure 20 shows the number of weekly dispensations, as well as the number of observed intakes. In 2022, the patient attended on average 3.0 times a week for dispensing medication, of which 2.9 were under observation. The number of dispensations per week has gradually decreased in recent years (from 4.1 times per week in 2017 to 3.0 in 2021).

Figure 20. Average number of dispensations and observed intake of medication per week.

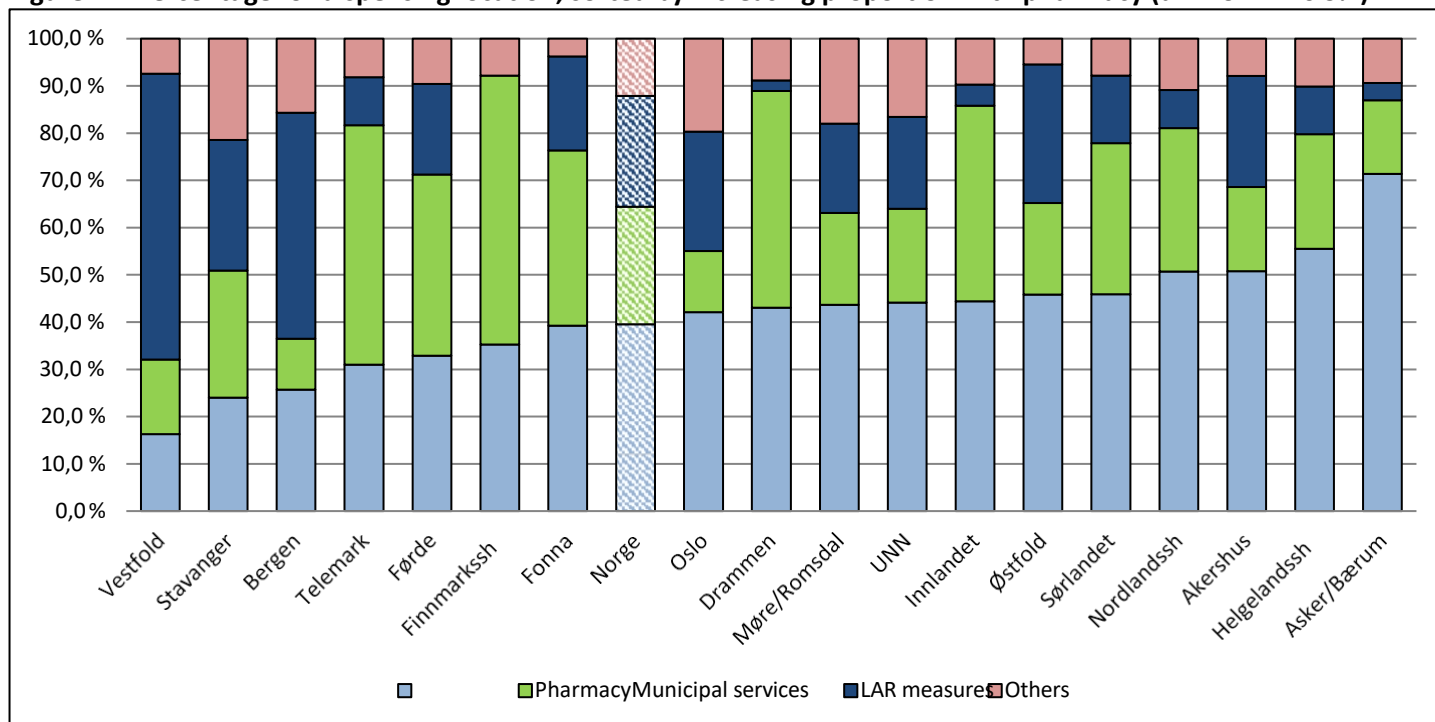


Delivery point

The proportion using different dispensing sites is shown in Figure 21. Less than half (39.6%) had their medication dispensed through pharmacies, roughly the same as in 2021 (41.4%). The proportion dispensed at pharmacies has decreased slightly in recent years (49.4% in 2017). Buprenorphine depot injection is most often prescribed by the specialist health service, and may therefore in the long term lead to a further reduction in the use of pharmacies as a dispensing point.

There were clear differences between the interventions in the use of dispensing points (Figure 21). In some areas, the pharmacy was the primary point of dispensing, such as in Asker and Bærum (71.4%). In comparison, fewer people used pharmacies as a dispensing point in Vestfold (16.3%), Stavanger (24.0%) and Bergen (25.7%). Outpatient clinics were used to a greater extent for dispensing medication. Dispensing through municipal services (including home nursing) occurred to some extent across regions, but was most widespread at Finnmark Hospital (56.9%) and in Telemark (50.7%). The distribution was fairly similar to the previous year.

Figure 21. Percentage for dispensing location, sorted by increasing proportion with pharmacy (unknown = 0.9%).



Drug tests

On average, patients provided 0.2 urine samples per week in 2022, and the number of weekly urine samples is roughly unchanged in recent years. In 2022, only 24.8% provided urine samples regularly, compared with 30.7% in 2021, 35.6% in 2020, and 43.2% in 2019. Around 29.3% provided random samples, about the same as in 2021 (32.7%).

Over the past five years, the proportion with random samples has varied from 28.8% in 2017 to 37.0% in 2019. At the same time, the proportion not providing urine samples has gradually increased, from 22.8% in 2020 and 33.0% in 2021, to 42.4% in 2022. Regular sampling was most common in the West (35.6%), in contrast to the North (14.4%), where regular sampling was less common. Figure 22 shows a significant reduction in the use of urine samples over time, suggesting that urine samples are only used systematically as a safety measure to a limited extent today.

Figure 22. Use of urine samples (unknown = 4.0%).

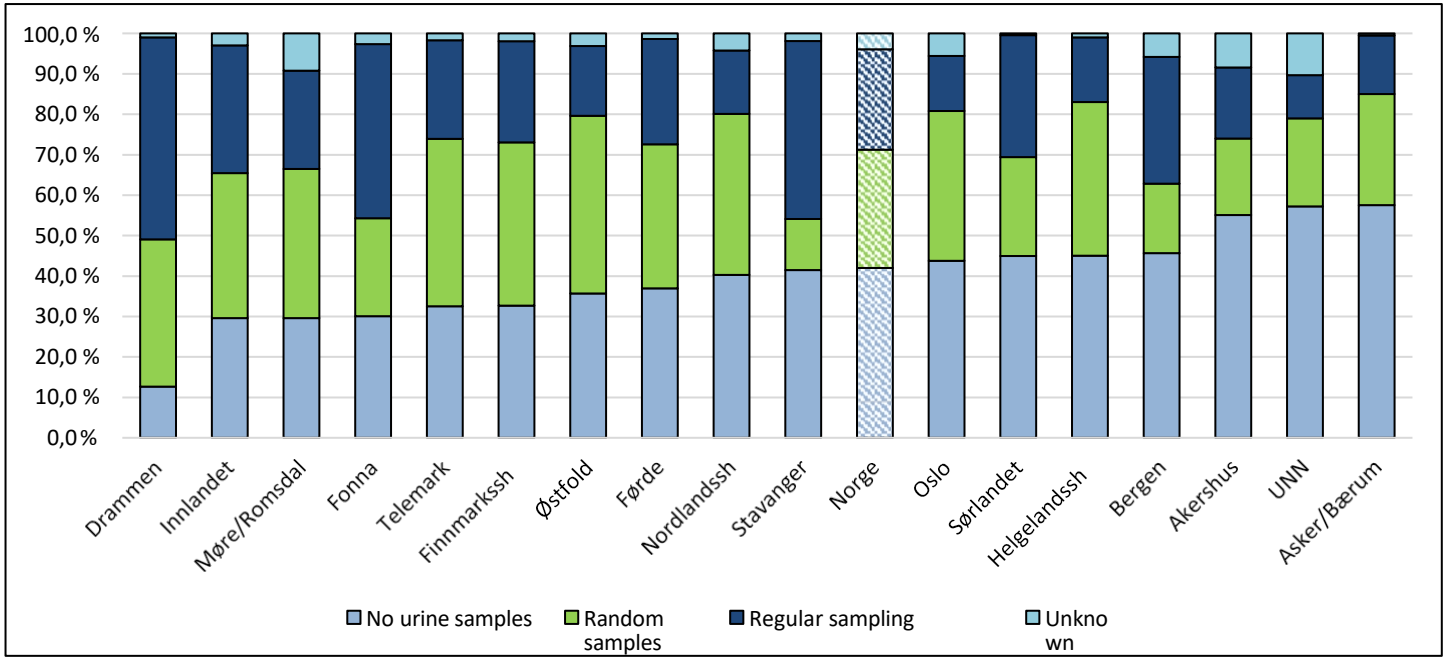
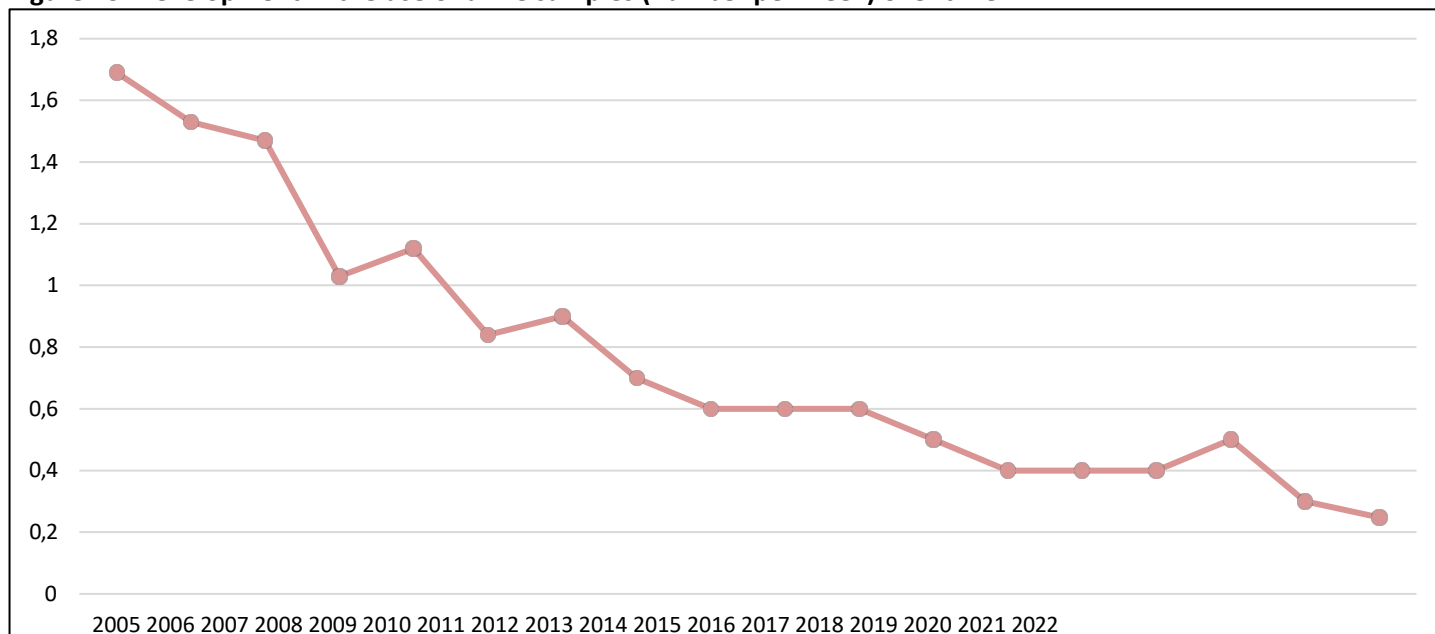


Figure 23. Development in the use of urine samples (number per week) over time.



Assessments of medical justifiability

On average, patients in OMT attended three times a week for supervised medication intake in 2022. There has been a reduction in the number of weekly dispensing and urine samples in recent years, and the reduction appears to be continuing after the restrictions related to the COVID-19 pandemic have been lifted. The dispensing scheme and the use of urine samples were assessed in detail in the 2017 report³ ([download the report here](#)).

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 measures, and the soundness of the treatment. The new DAR guidelines emphasize dialogue and observation rather than drug tests, and the figures from the status survey this year and previous years show that drug tests are rarely used today compared with previously. Since highly addictive drugs are used in DAR, special regulation according to the DAR regulations is necessary to counteract misuse of the drugs and prevent harm to both patients and third parties. Urine and saliva samples can be used to obtain an overview of drug intake and substance use, but should only be used to the extent necessary to ensure professionally sound treatment. The goal should therefore be a balanced use of objective tests 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. The prescriber of OMT medication must balance user participation and accessibility against the risk of the medication being taken by someone other than the patient. Finding this balance can be challenging in practice⁴.

If substance use is detected in a patient who has previously been drug-free, you should discuss the function of the substance use with the patient and whether you should adapt the further treatment strategy together. It may be that the patient needs a higher dose of OMT medication or a change of medication. Urine or saliva samples should be used to some extent as a supplement to dialog and observation in order to monitor the treatment effect and the need to adapt treatment in collaboration with the patient.

³ Waal H, Bussesund K, Clausen T, Lillevold PH, Skeie I (2018). SERAF report 3/2018. Status report 2017. LAR 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>.

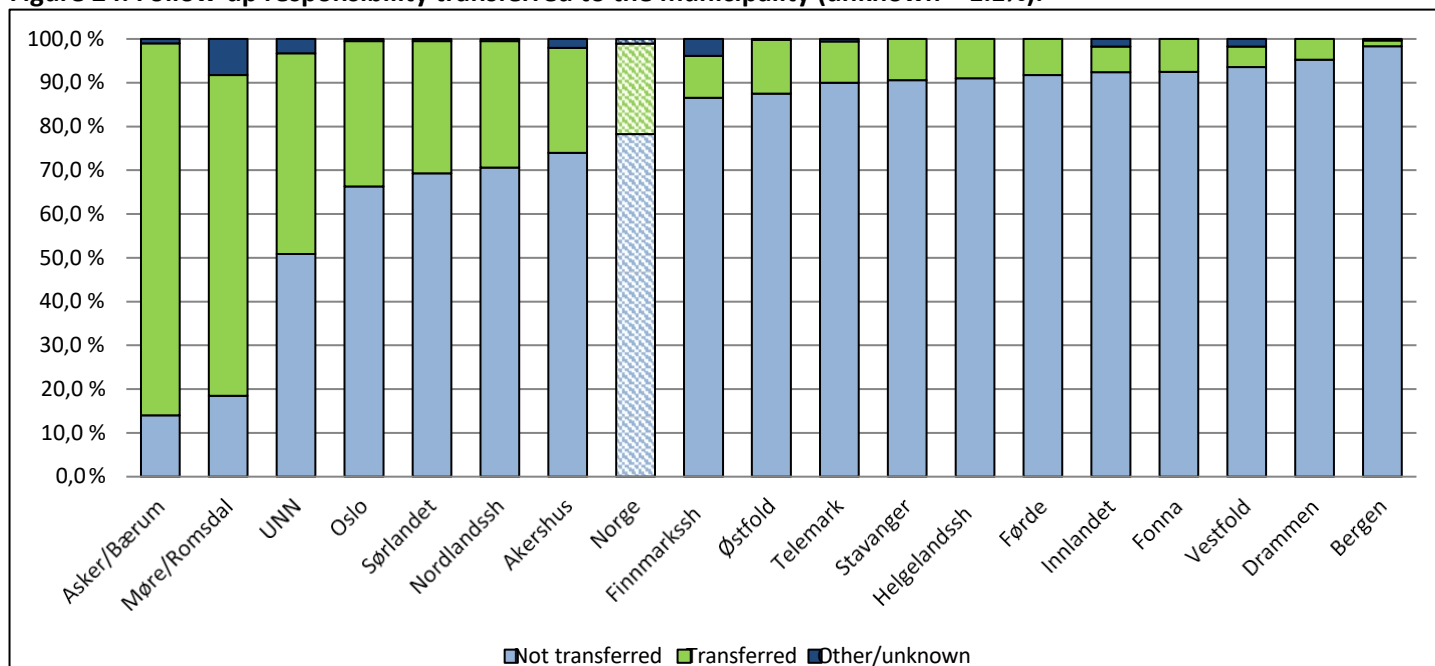
⁴ European Monitoring Center for Drugs and Drug Addiction (2021). Balancing access to opioid substitution treatment with preventing the diversion of opioid substitution medications in Europe: Challenges and implications. https://www.emcdda.europa.eu/publications/technical-reports/opioid-substitution-treatment-ost-in-europe-availability-and-diversion_en

PSYCHOSOCIAL TREATMENT

Anchoring the treatment

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

Figure 24. Follow-up responsibility transferred to the municipality (unknown = 1.1%).



As shown in Figure 24, DAR treatment in 2022 was mainly anchored in TSB for 78.3% of patients (blue bars), where last year's figure was somewhat lower (72.9%). Local authorities had the main responsibility for follow-up for 20.7% of patients (green bars), a slightly smaller proportion than the previous year (26.1%). Only 1.1% had other or unknown anchoring, which is comparable to last year's figures.

As the figure shows, there are significant differences in organization between the various initiatives. OMT in Bergen is almost exclusively anchored in TSB (98.3%), and the same applies to most of the other interventions. However, OMT in Asker and Bærum, which belongs to Vestre Viken, is organized as almost purely first-line treatment, while OMT in Drammen, which belongs to the same health trust, has as a starting point that treatment responsibility for OMT will be anchored in TSB, despite the GPs prescribing the drugs. Like DAR in Asker and Bærum, DAR in Møre og Romsdal is also primarily municipally based.

The differences in how follow-up responsibilities are organized have been stable for many years. It is not a given that OMT should be organized in the same way in all health trusts. Room for local organizational adaptations within a common national framework based on tripartite collaboration, user participation and a common national guideline has probably contributed significantly to the stability and good results achieved by DAR over time.

Treatment goals

In the status survey, the individual is asked about the overall treatment goal for OMT, where the alternatives are rehabilitation with drug-free treatment, stabilization without drug-free requirements, and not agreed. The interpretation of what drug-free and stabilization means will vary between patients and between therapists.

In 2022, 68.5% stated rehabilitation with drug-free status as their overall treatment goal, while 27.1% stated stabilization without drug-free status as their overall goal (Figure 25). The proportion without a specific agreement was low across interventions, but in Møre og Romsdal, the University Hospital of North Norway and Nordland Hospital, approximately 1 in 10 did not have a clear treatment goal. There are some regional differences in the goal of being drug-free, but these are less clear than previously. In most enterprises, 7 out of 10 patients have freedom from substance abuse as a goal. Figure 26 shows the distribution of treatment goals over time, and shows that this distribution has been stable over the past decade.

Figure 25. Overall treatment goal (not agreed = 4.3%).

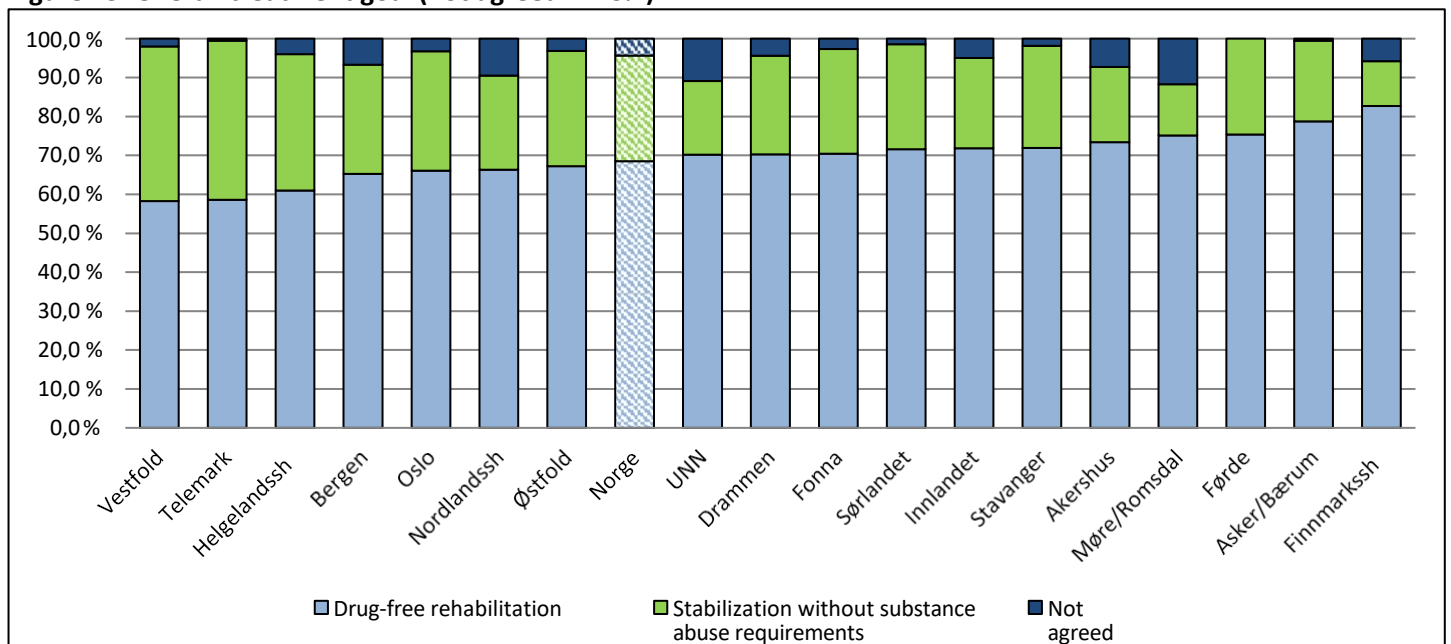
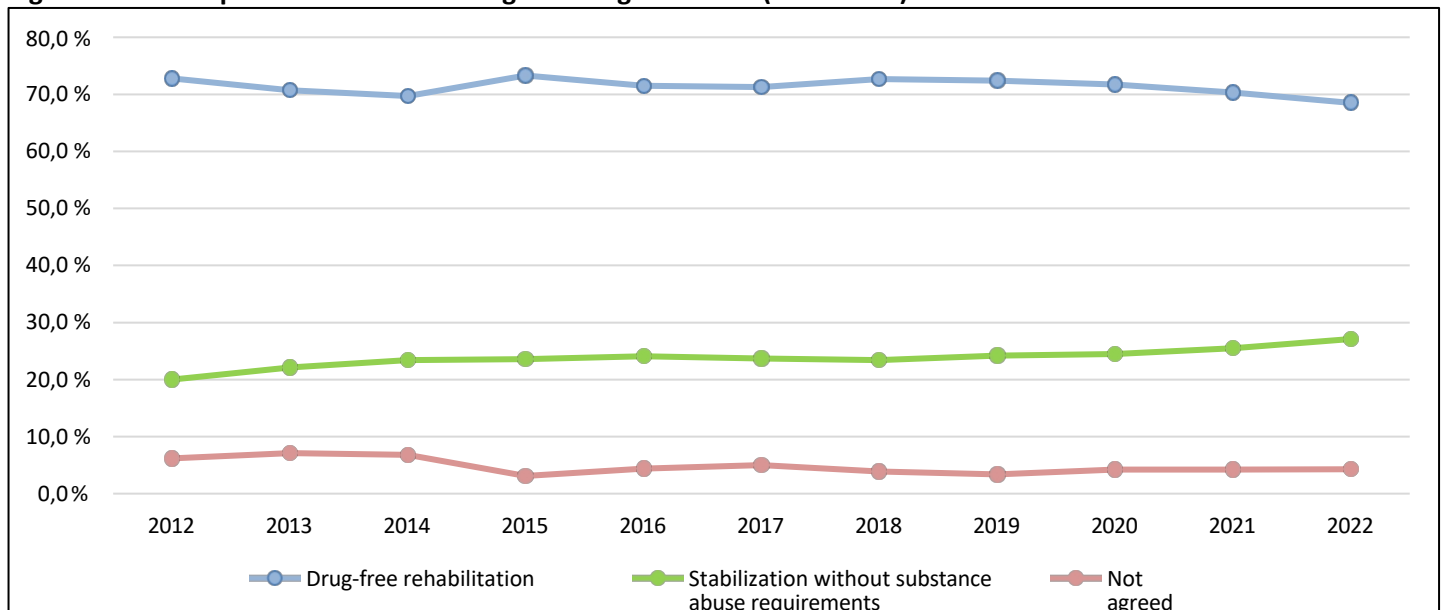


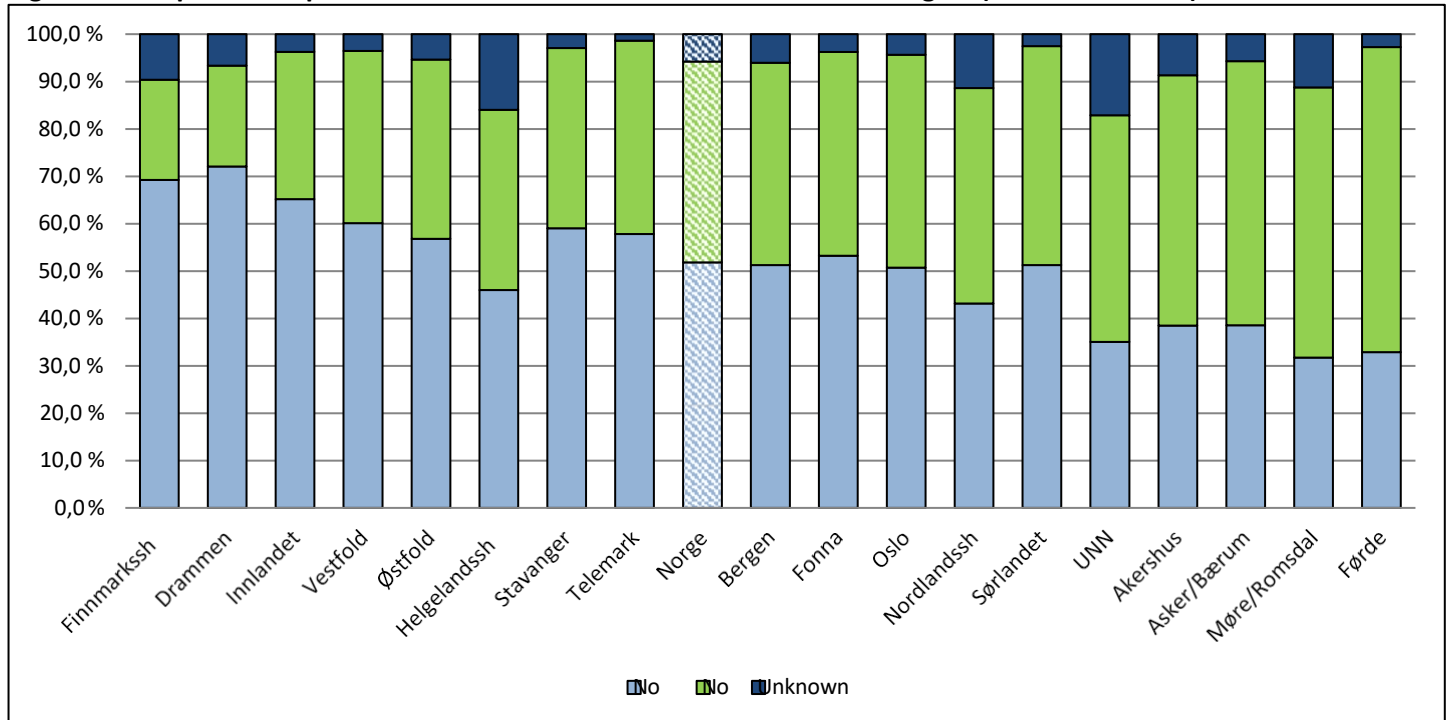
Figure 26. Development in treatment target setting over time (2012-2022).



Treatment goals achieved

The survey shows that 42.4% were considered to have achieved their overall treatment goal, while 51.8% were in the process or in sustained stabilization and harm reduction. This distribution is similar to the previous year. The highest proportion of patients who had not yet reached their treatment goal was in Drammen (72.1%) and at Finnmark Hospital (69.2%). More than half had reached their treatment goal in Førde (64.4%), Møre og Romsdal (57.1%) Asker og Bærum (55.7%) and Akershus (52.9%). Figure 27 shows that the vast majority of OMT interventions reported a proportion with achieved treatment goals that was comparable to the national average.

Figure 27. Proportion of patients who have achieved the overall treatment goal (unknown = 5.8%).



Individual plan

All persons in need of long-term and coordinated services are entitled to have an individual plan (IP) drawn up. According to the OMT regulations, the specialist health service has a special responsibility for preparing an IP when a patient starts OMT, and the preparation of the IP must take place in collaboration with the GP, municipal services and other relevant agencies. However, only 11.1% had an IP in 2022 (Figure 28), down from 13.0% in 2021. The reasons why many are missing may be complex, and may be due to a lack of initiative from the intervention system or that the patient does not want IP. With an increasing proportion of disabled people, there may also be a reduced need for IP.

As before, there is some variation in the proportion of patients across enterprises that have IP. In Førde (35.6%), Stavanger (28.0%) and Møre og Romsdal (25.7%), IP is used to the greatest extent, in line with last year's figures. At Helgeland Hospital, only 2.0% of patients have IP. Figure 29 below shows a gradual and clear reduction in the use of IP over time, from 36.4% in 2012. Given the right to IP, the measures are recommended to increasingly map the patient's wishes and needs for this.

Figure 28. Proportion of patients who have an individual plan (unknown = 11.1%).

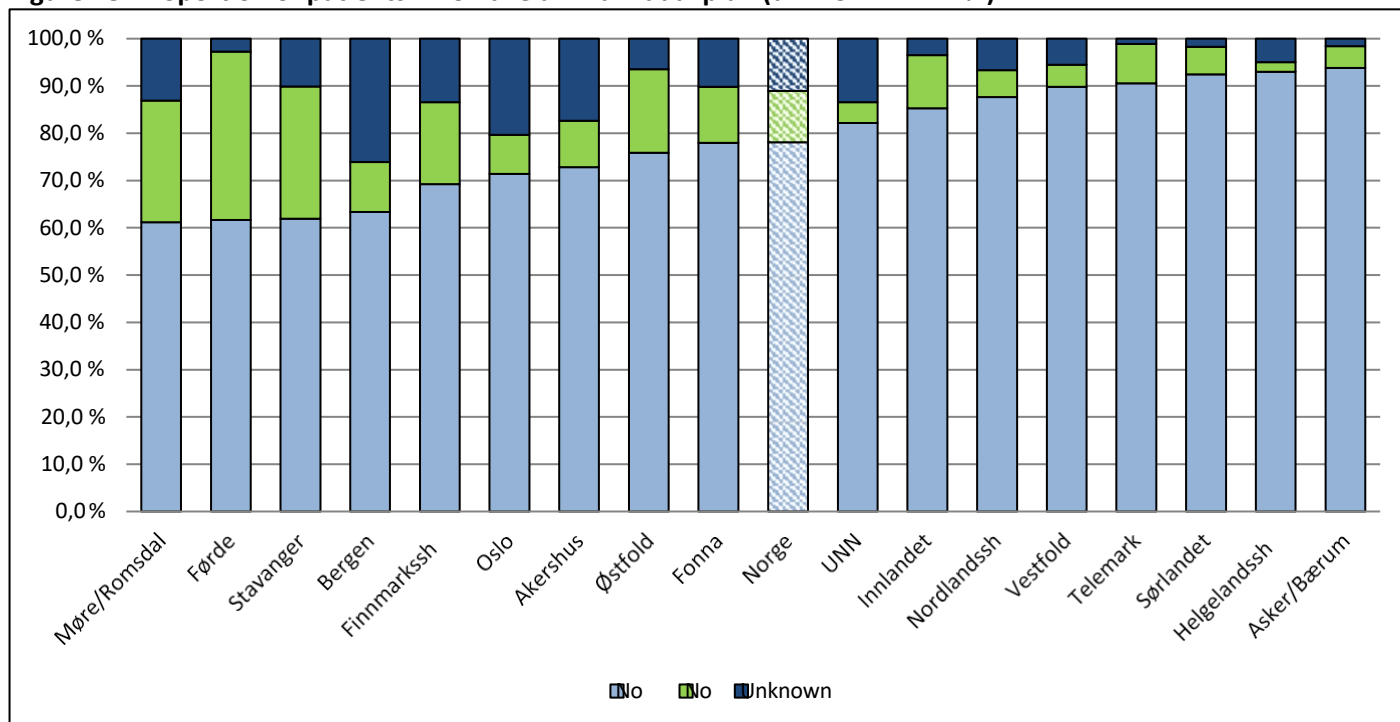
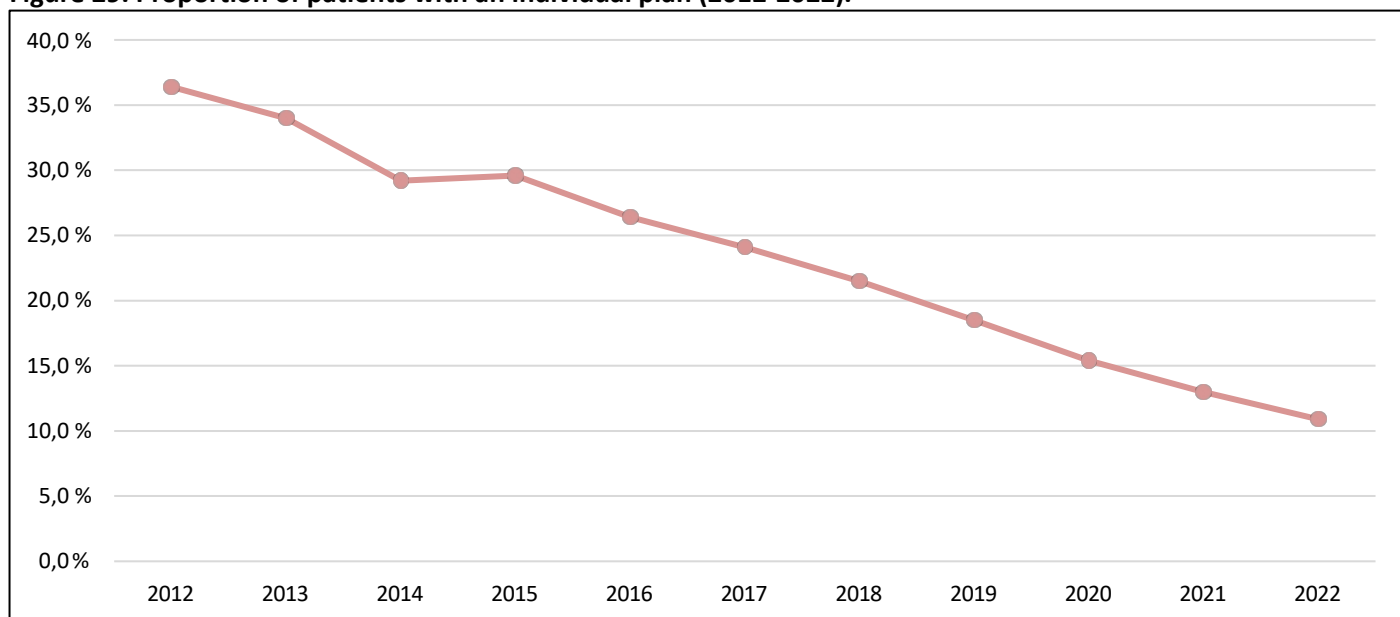


Figure 29. Proportion of patients with an individual plan (2012-2022).



Responsibility group meetings

According to the DAR regulations, drug treatment with methadone or buprenorphine should be a sub-measure in a comprehensive rehabilitation process. Responsibility groups consisting of all relevant agencies that collaborate with and around the patient are an important tool for coordinating the various services, with the aim of achieving comprehensive treatment. Responsibility groups should be based on the premise that the patient should have active participation.

Figure 30 shows the proportion of patients who had a responsibility group meeting in the last three months before participating in the status survey. In 2022, 32.2% of patients had had a responsibility group meeting in the last three months, compared with 29.6% in 2021. Prior to the pandemic, a larger proportion of patients had an accountability group meeting (42.0% in 2019). There were large differences between DAR measures, with the lowest proportion of patients with completed responsibility group meetings at the University Hospital of North Norway (11.9%), and the highest in Drammen (61.4%) and Fonna (61.3%). As with IP, the trend for responsibility group meetings has been downward over time (Figure 31).

Figure 30. Percentage with a responsibility group meeting in the last month (unknown = 0.6%).

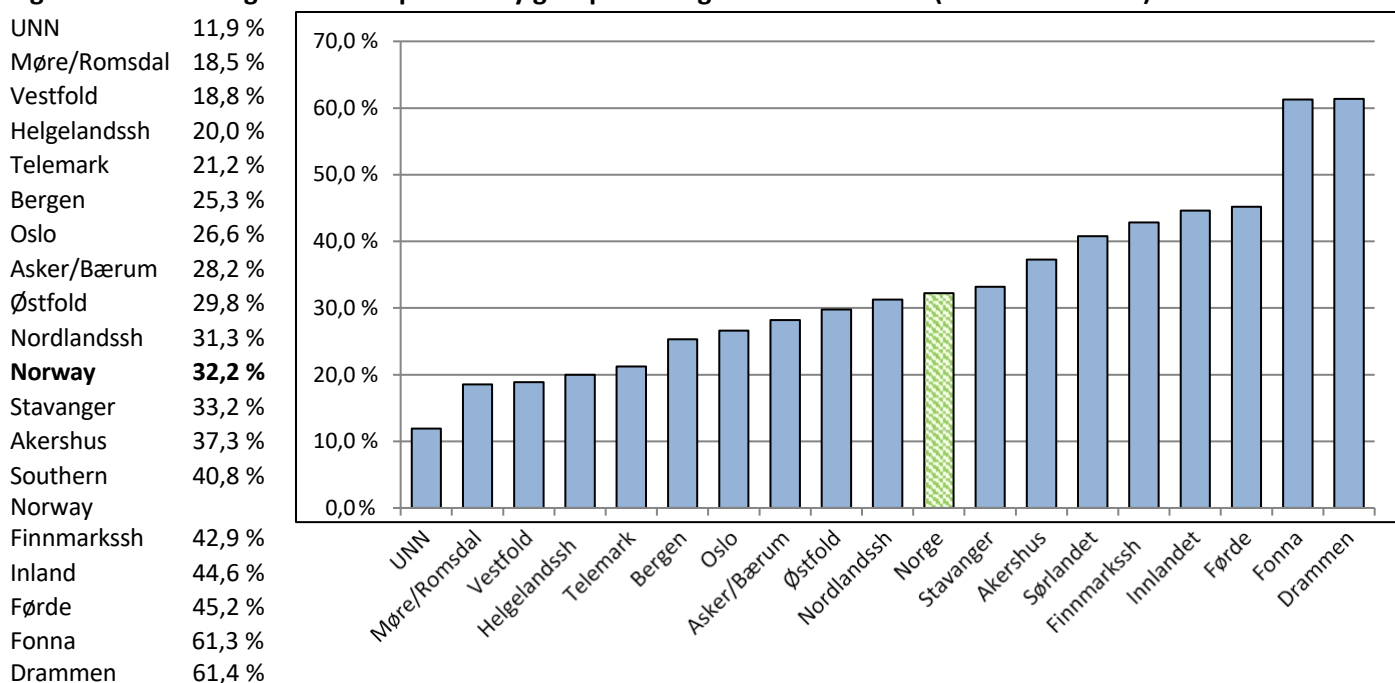
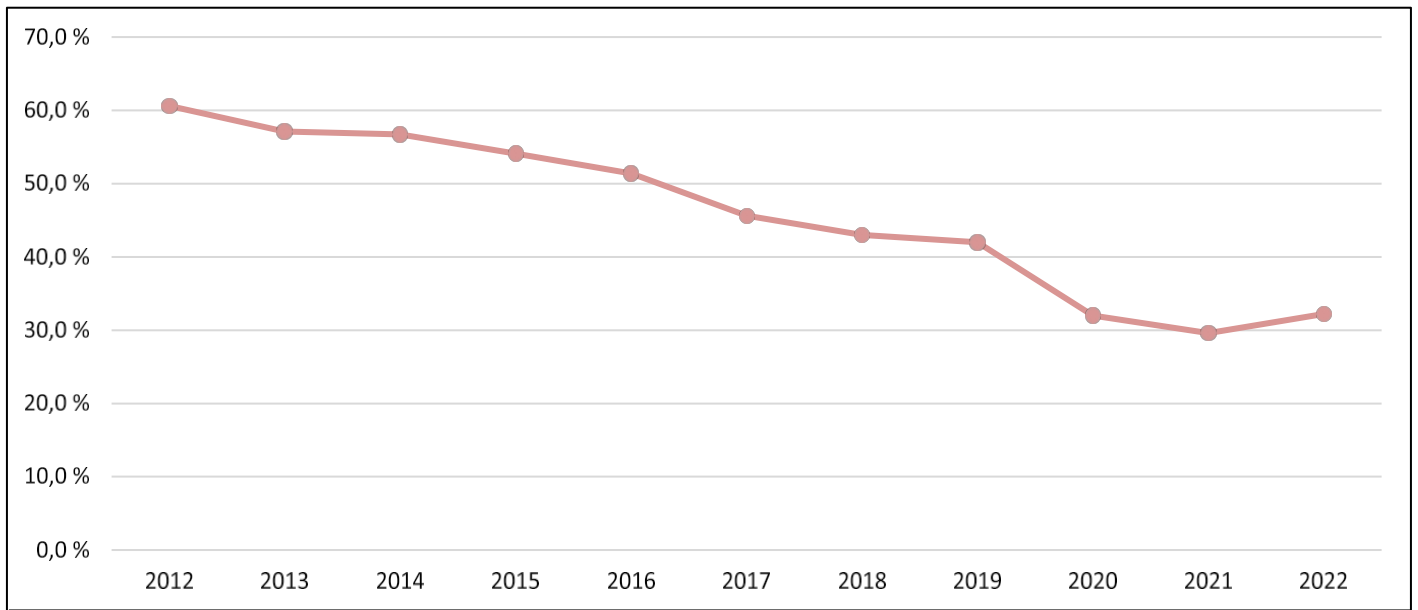


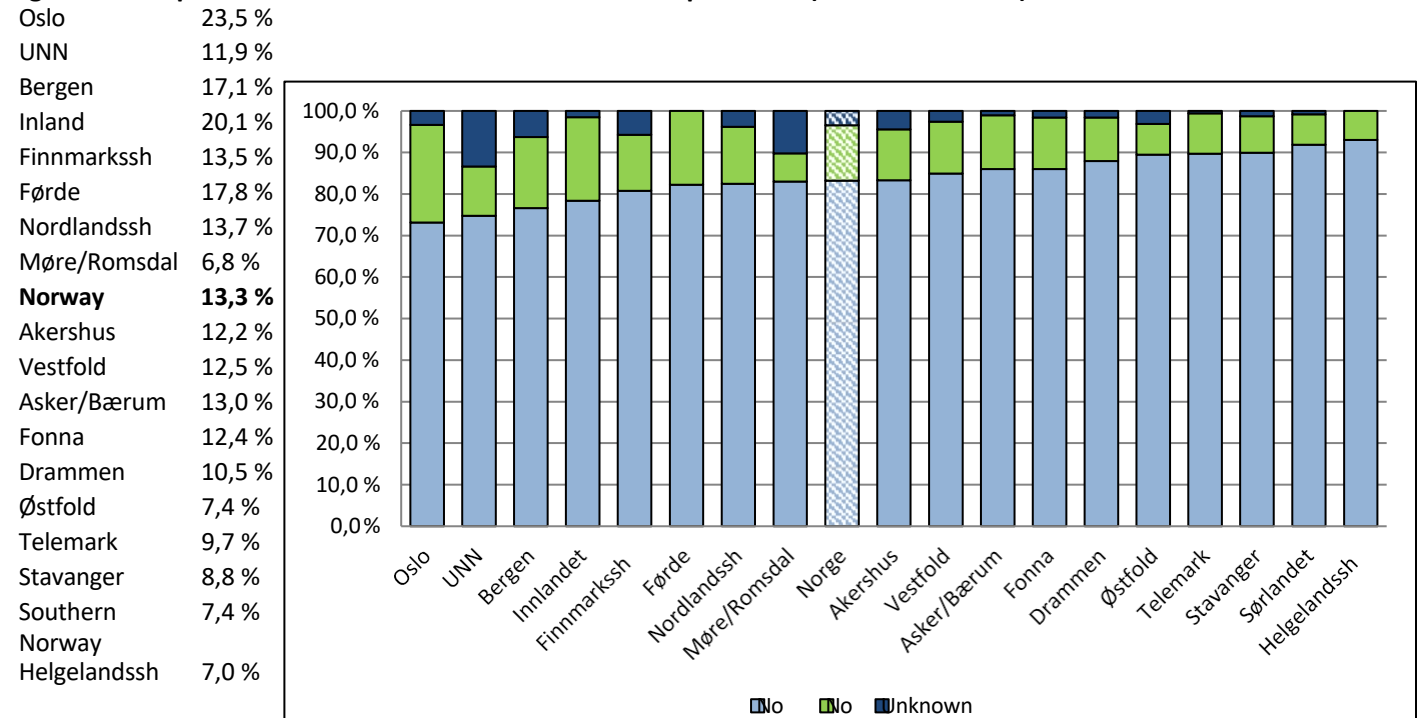
Figure 31. Percentage with a responsibility group meeting in the last three months (2012-2022).



Treatment for mental health problems

Patients in OMT should be able to receive assessment and treatment for mental health problems in the specialist health service when needed. Only a small proportion of OMT patients received treatment for mental health problems in 2022 (Figure 32). Nationally, 13.3% were receiving treatment for mental health problems when the status survey was conducted. This proportion has been stable over the past decade. There is generally little difference between most of the measures. Oslo and Innlandet had 2 out of 10 patients in treatment for mental health problems. In the other measures, just over or under 1 in 10 received treatment.

Figure 32. Proportion with treatment for mental health problems (unknown = 3.4%).



Assessments of the psychosocial treatment

As in previous years, the treatment in DAR is primarily anchored in TSB, but with great variation between health trusts. The differences in whether DAR treatment is anchored in municipal agencies or in the specialist health service have been stable at the measure level over time. The reasons for these differences have not been systematically investigated, but the impression is that traditions in the individual health trust and resources at municipal level are more decisive for the solutions locally than assessments of appropriateness.

Over the past decade, there has been a clear reduction in the use of IP and responsibility group meetings in the last four weeks. In 2022, only 1 in 10 had an IP and 1 in 3 had had a responsibility group meeting during the last month before completion. This means reduced opportunities for coordinated follow-up. Patients who have a stabilized situation may over time have less need for coordinated follow-up, which may be a partial explanation for the reduction in the use of IP and responsibility group meetings. At the same time, increasing age and associated somatic challenges may result in an increased need for coordinated follow-up in the long term.

In addition to coordinated follow-up, patients in OMT may need treatment for mental health problems, including assessment and counseling. The figures for treatment received for mental health problems should be seen in the context of the figures showing experienced mental health problems recently.

Most patients in OMT, around 7 out of 10, have rehabilitation with freedom from substance abuse as their overall treatment goal, and just under 3 out of 10 have stabilization without the requirement of freedom from substance abuse as their treatment goal. These figures show that for many, OMT is an important part of rehabilitation, and for many it is important as harm reduction.

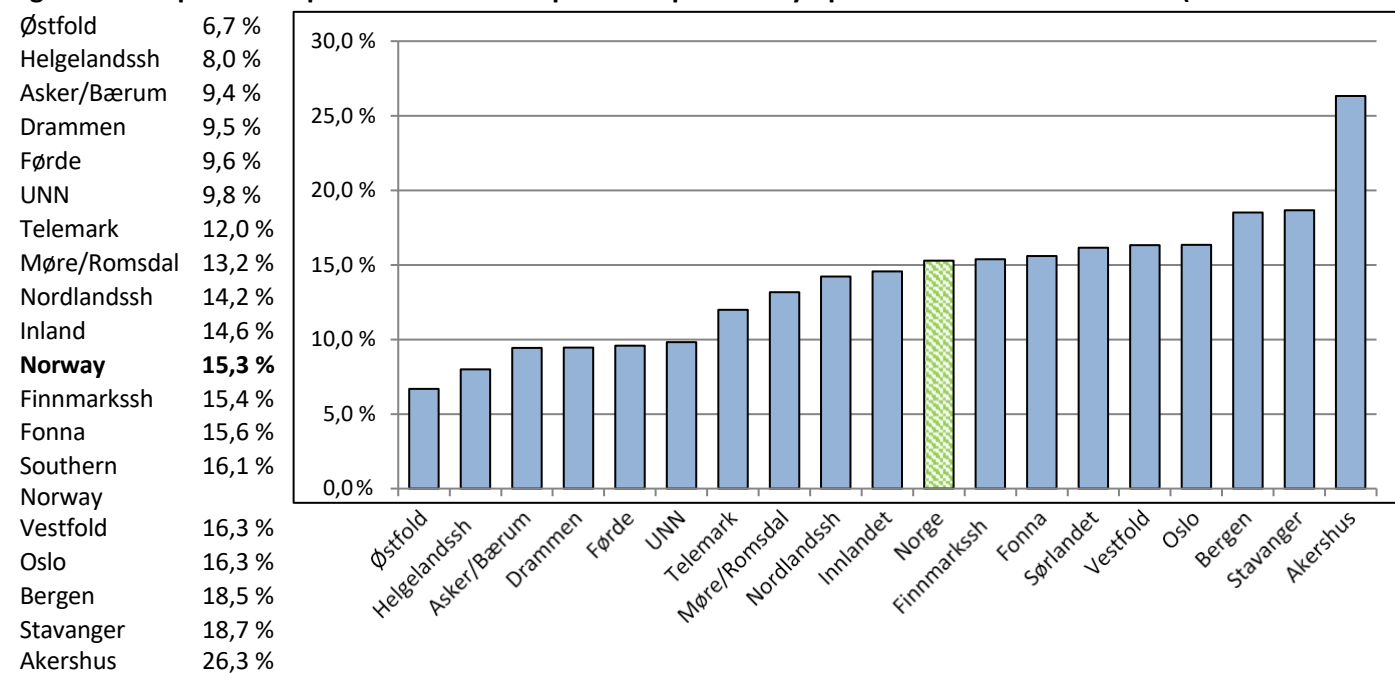
CURRENT HEALTH STATUS

The status survey includes questions about mental and physical health status over the past four weeks. The questions on mental health status relate to whether patients have experienced severe depressive symptoms, anxiety symptoms and delusions. The questions on physical health status relate to whether patients have suffered from physical injuries or illnesses in the past four weeks. Overall, the questions provide an indication of the current state of health among patients in DAR.

Depressive symptoms

Nationally, 15.3% of patients reported having experienced severe depressive symptoms in the past month, while 70.6% had not experienced depressive symptoms recently (Figure 33). This distribution is roughly the same as in 2021. The distribution is fairly similar across the regions, with the North region having the lowest proportion of patients with depressive symptoms (11.4%) and the West region the highest (17.8%). However, there are clear differences between the health trusts in the degree of depressive symptoms experienced, including the proportion with unknown status. The proportion of patients with depressive symptoms is lowest at LAR in Østfold (6.7%), followed by Helgelandssykehuset (8.0%). In contrast, 1 in 4 patients in DAR in Akershus (26.3%) reported depressive symptoms.

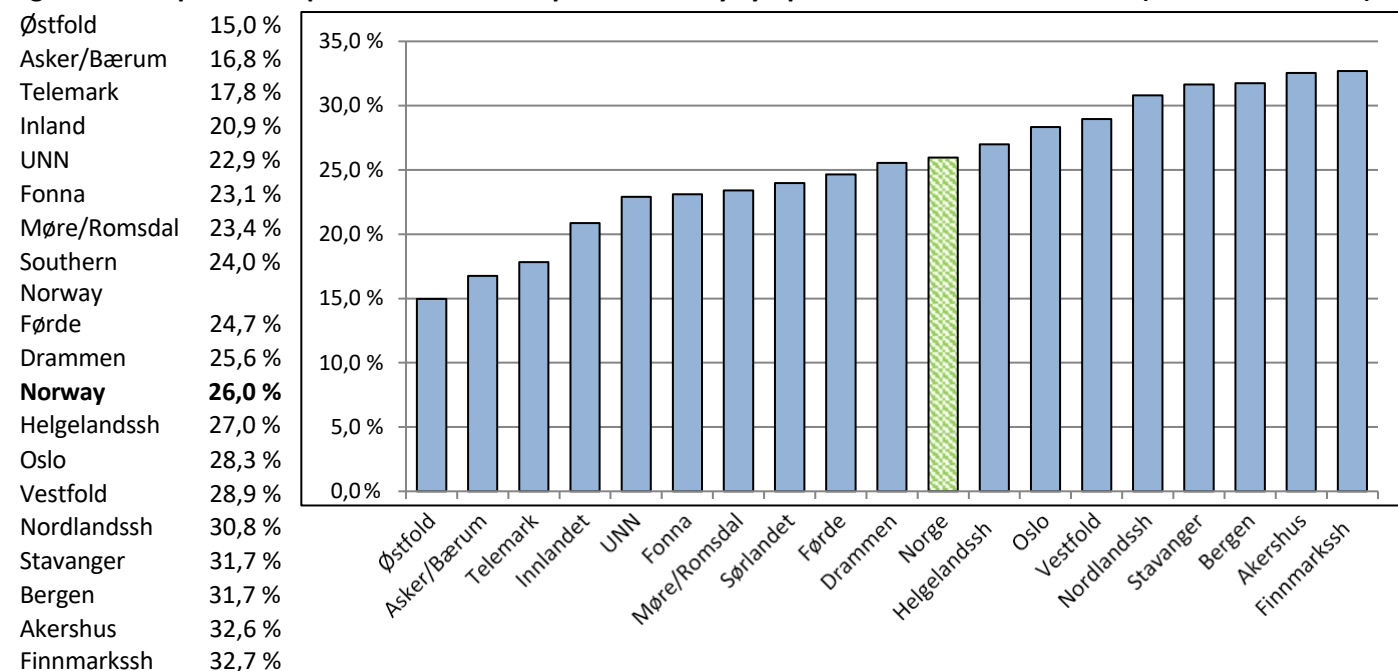
Figure 33. Proportion of patients with self-reported depressive symptoms in the last four weeks (unknown = 14.1%).



Symptoms of anxiety

Nationally, 26.0% of patients reported having had severe anxiety symptoms in the past month (Figure 34). This means that as many as 1 in 4 patients have had anxiety symptoms. The majority, 60.8%, had not experienced severe anxiety symptoms in the past month. The distribution is similar to that in 2021. The proportion with anxiety symptoms is fairly similar across regions, with the lowest proportion in Region South (23.2%) and the highest in Region West (30.3%). There is some variation between health trusts, with the lowest prevalence of recent anxiety symptoms among patients in LAR Østfold (15.0%), Asker and Bærum (16.8%) and Telemark (17.8%). The prevalence is highest among patients in DAR at Finnmark Hospital, Akershus, Bergen, Stavanger and Nordland Hospital, where around 1 in 3 have reported anxiety symptoms.

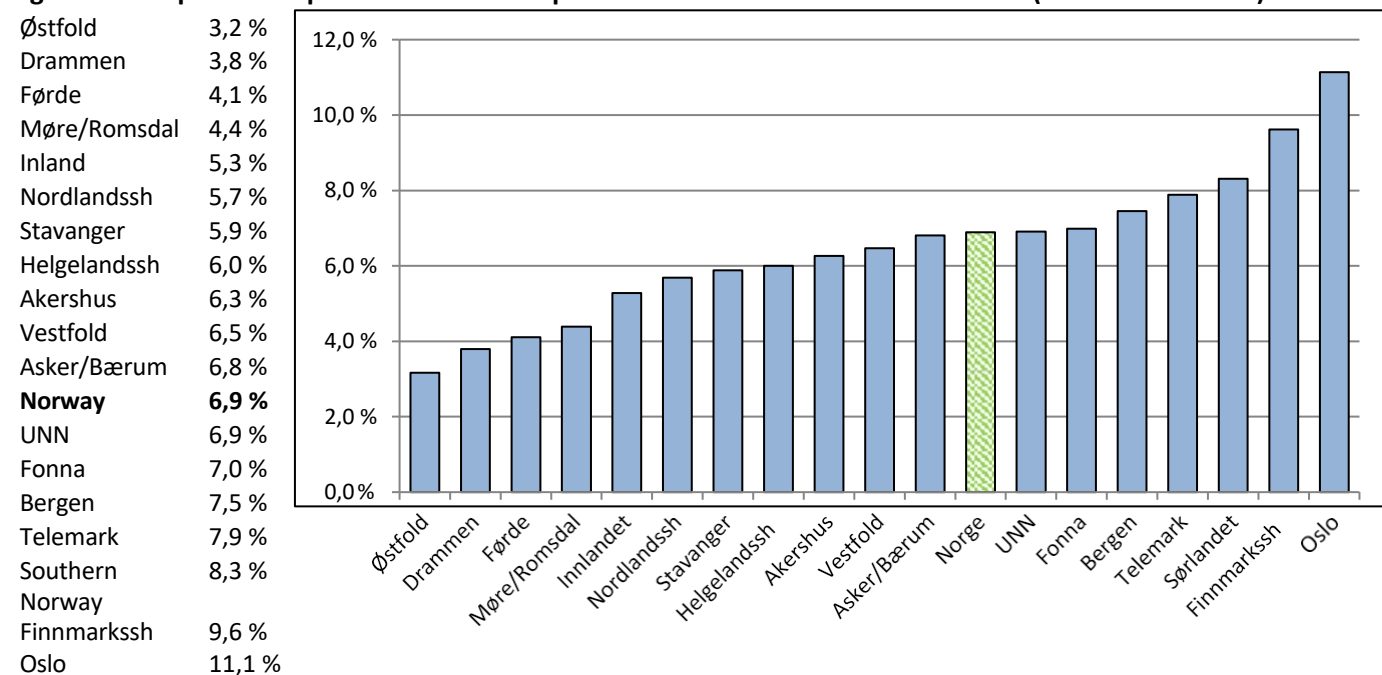
Figure 34. Proportion of patients with self-reported anxiety symptoms in the last four weeks (unknown = 13.2%).



Delusional thinking

Overall, 6.9% of patients reported experiencing delusions in the last four weeks, compared with 7.1% last year (Figure 35). 79.7% reported that they had not experienced delusions in the past month, similar to 2021 (80.9%). There are minor differences between regions, with the lowest prevalence in the Central region (4.4%) and the highest in the East (7.3%). At the measure level, the incidence is lowest in Østfold (3.2%), and highest in Oslo (11.1%).

Figure 35. Proportion of patients with self-reported delusions in the last four weeks (unknown = 13.4%).

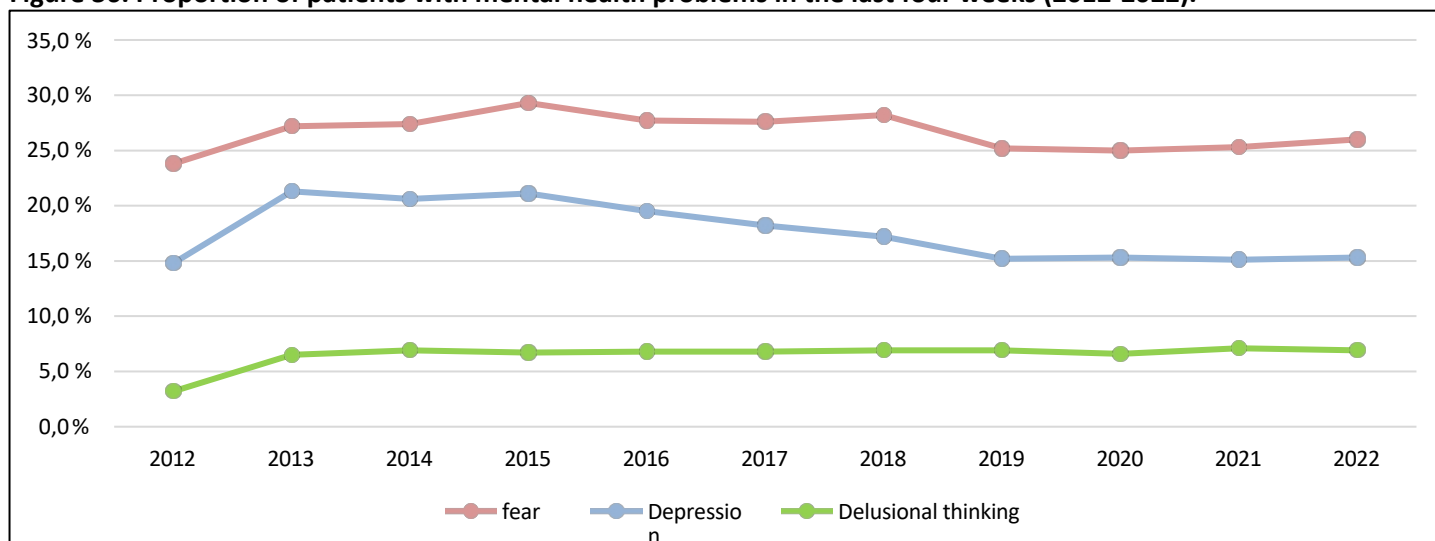


Mental health issues

Figure 36 provides an overview of the development of mental health problems in the DAR population over time. The highest prevalence is self-reported anxiety. Depression is somewhat less prevalent. Prevalence of self-reported anxiety,

depression and delusions appear to be fairly stable in the patient group over time. 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 36. Proportion of patients with mental health problems in the last four weeks (2012-2022).



Physical health

The proportion with physical health problems of a degree that affects lifestyle or quality of life was 38.8% in 2022 (Figure 37), and has increased slightly over the past decade (Figure 38). This should be understood in the context of the fact that the average age of patients in OMT has increased over time. At the same time, the level is higher among OMT patients than in the general population with a similar age distribution. Note that the national average for this question does not include Oslo, Bergen, Fonna and Førde. This is because these measures have been asked about physical injuries/illnesses in the past year (see separate chapter). The distribution was fairly similar across regions, but somewhat lower in Central (35.1%) than in West (42.4%). In terms of individual health trusts, the prevalence was clearly lower in DAR in Drammen (19.6%), and highest in Akershus (47.0%). There is some variation in the degree of physical health problems, but we cannot explain whether this is due to reporting or random variation.

Figure 37. Proportion of patients with physical injuries/illnesses in the last four weeks (unknown = 10.6%).

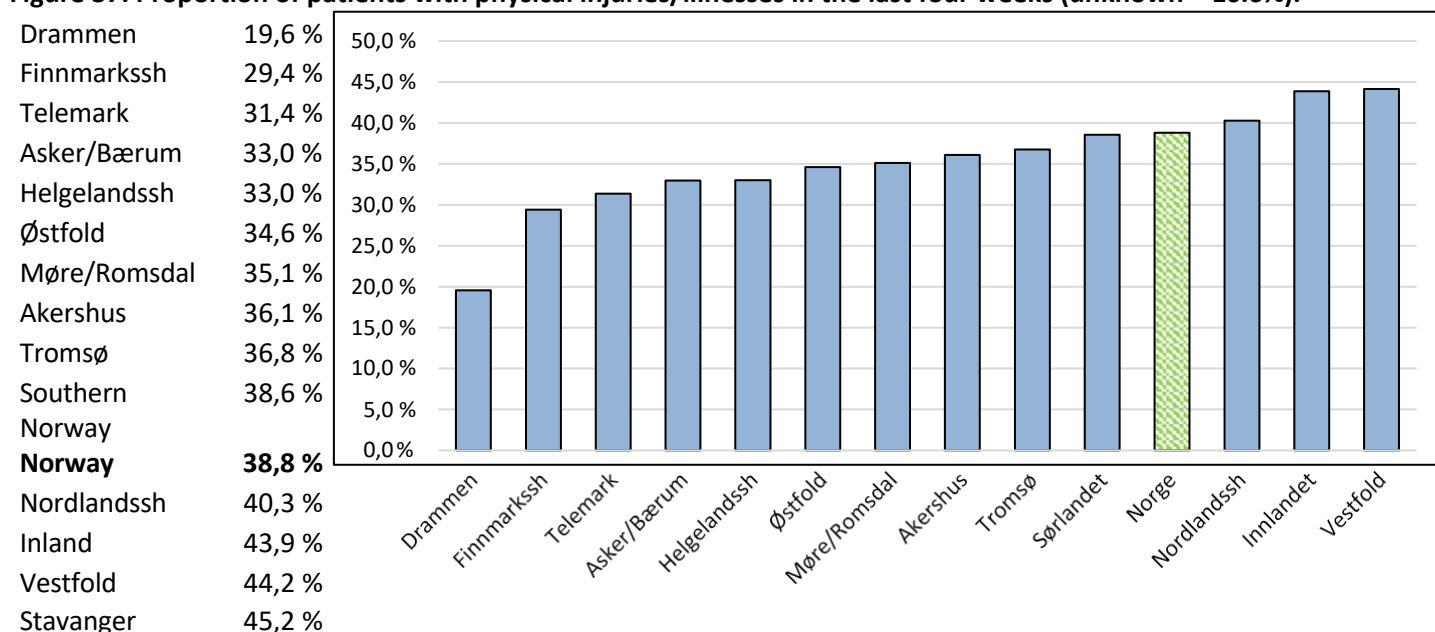
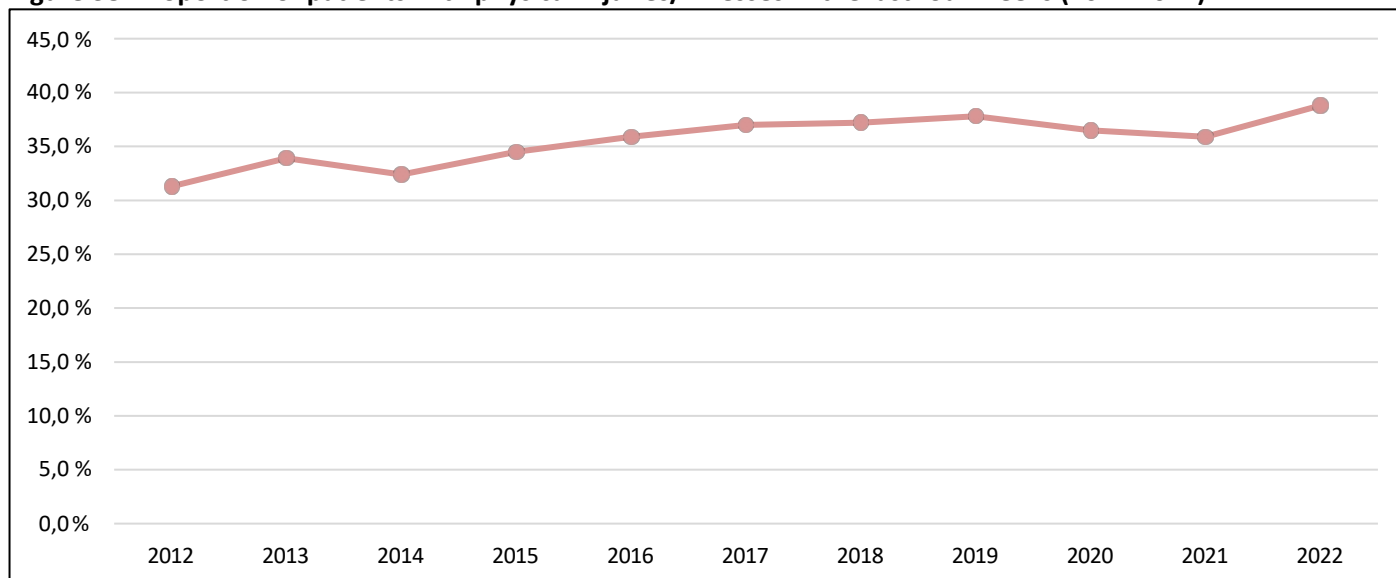


Figure 38. Proportion of patients with physical injuries/illnesses in the last four weeks (2012-2022).



Assessments of current health status

The findings regarding mental health problems and physical injuries or illnesses in the past month are based on simple questions that shed light on prevalence. The questions do not shed light on the degree of perceived symptom burden or different types of symptoms. Thus, the questions about mental health problems and physical injuries or illnesses can provide a picture of the patients' current health situation, without drawing conclusions about the actual prevalence of diagnosable mental disorders or the degree of need for treatment. The findings should therefore be interpreted as a simple description of the perceived level of problems, rather than as disease prevalence.

The status survey shows that anxiety symptoms are fairly common among patients in DAR, followed by depressive symptoms and, for a minority, delusions. It is not known whether the various symptoms typically occur separately or together among those who experience symptoms. Overall, we see that many patients in OMT experience mental health problems. If we draw on the findings regarding current psychosocial treatment, we see that few are receiving treatment for mental health problems. Some are therefore probably not receiving adequate health care for their mental health problems, while most are receiving other psychosocial follow-up.

There are some differences between the measures in terms of the burden of disease for mental health symptoms, but also some differences in the proportion receiving treatment for this. The explanation for the latter may lie in different regional problem burdens, but also different clinical practices. Differences in clinical practice, where some investigate and refer a lot, while others do so to a lesser extent, may be an area where those with the lowest treatment rate review their own practice and assess whether they can and should investigate/refer more people. All units within TSB must be able to carry out mapping and assessment of mental disorders and cognitive functioning⁵. In some health trusts and municipalities, measures have also been established for patients with concurrent substance abuse and mental disorders who need closer follow-up than what is normally provided in DAR and municipal rest services. This includes outreach activities in the form of teams that work according to the principles of Flexible Assertive Community Treatment (FACT).

The prevalence of physical injuries and illnesses increases with age in the DAR population, and the proportion in need of follow-up related to physical health is therefore likely to increase in the coming years. Within TSB, TSB units must be able to assess and treat somatic illness. The patient pathway "Somatic health and living habits in mental disorders and/or substance abuse problems" identifies important areas for mapping somatic health.

⁵ Norwegian Directorate of Health (2018). Nasjonalt pasientforløp for tverrfaglig spesialisert rusbehandling (TSB). Oslo: Norwegian Directorate of Health. <https://www.helsedirektoratet.no/nasjonale-forlop/rusbehandling-tsb>

CURRENT SUBSTANCE USE

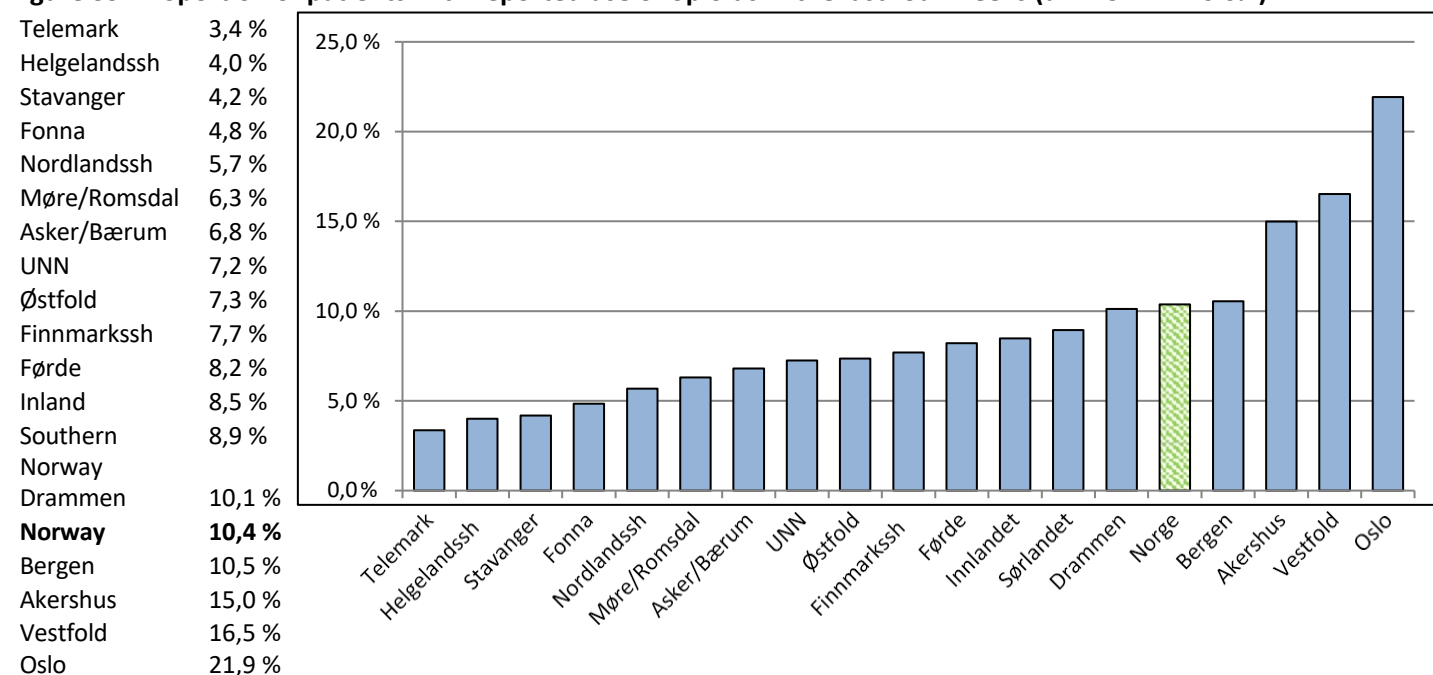
The status survey includes questions about substance use (alcohol, illicit drugs, and drugs, prescribed or non-prescribed) in the previous four weeks. The questions concern self-reported or proven use of opioids other than OMT medication, cannabis, benzodiazepines, stimulants and alcohol, as well as an evaluation of the extent of ongoing substance use and current substance use management. The specific questions about the use of the various substances do not provide information about frequency or degree of use.

Opioids outside LAR medication

As shown in Figure 39, 10.4% reported having used opioids in the past four weeks, compared to 9.1% in 2021. The national level has been stable over the past decade. In the Central and Northern regions, opioid use was reported for 6.3% of patients. In comparison, the level in the East was 14.8%. There were variations between measures, with the highest level in Oslo, followed by Vestfold and Akershus. In Telemark, at Helgeland Hospital, in Stavanger and Fonna, opioid use was reported for just under 5%. The proportion with unknown status was particularly high in Asker and Bærum (31.5%) and at Helgeland Hospital (35.0%), and lowest in Førde (5.5%).

Overall, the figures indicated that around 1 in 10 patients had concurrent opioid use. However, the high proportion of patients with unknown opioid use status makes underreporting likely.

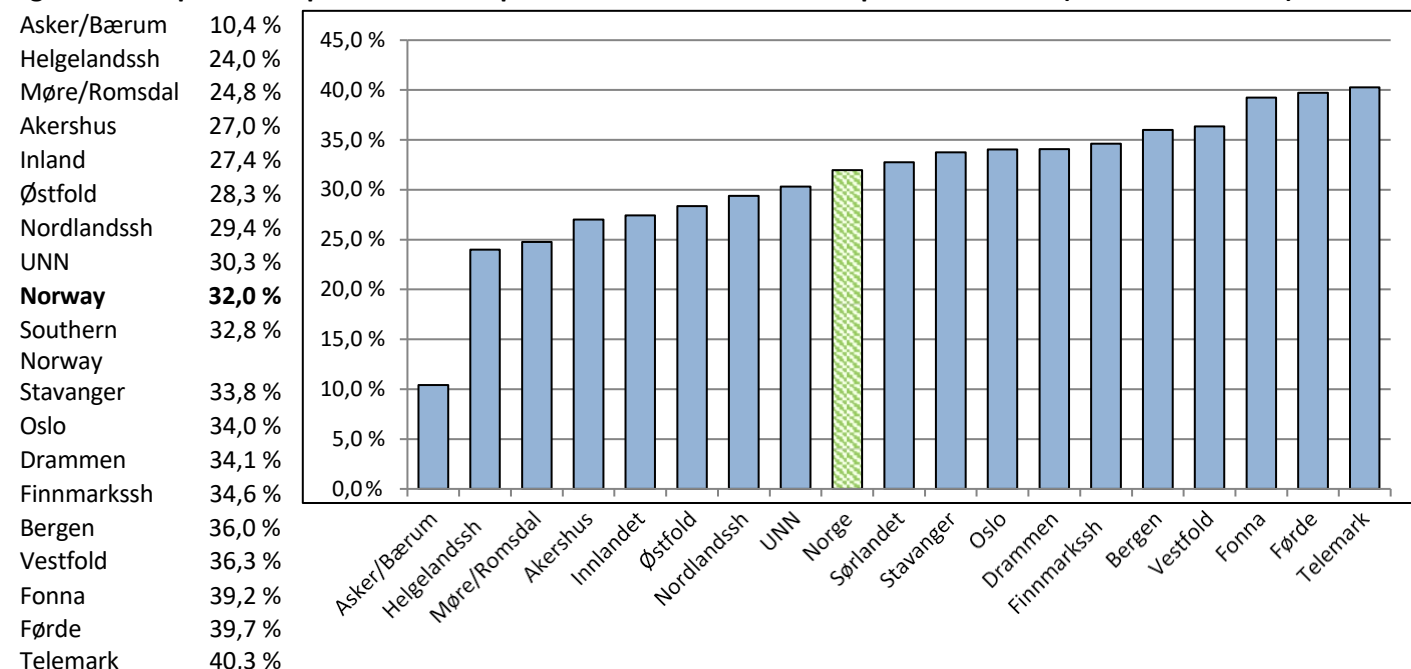
Figure 39. Proportion of patients with reported use of opioids in the last four weeks (unknown = 16.0%).



Cannabis

As shown in Figure 40, 32.0% reported that they had used cannabis in the last four weeks prior to the status survey, compared with 29.8% in 2021. This is similar to previous years. In the Central region, cannabis use was reported by 24.8% of patients, and in the West region by 35.9%. LAR in Asker and Bærum stands out with the lowest proportion of patients with reported cannabis use in the last four weeks (10.4%), but also with a very high proportion with unknown status for recent cannabis use (37.0%). The proportion with unknown status is also high at Nordland Hospital (32.2%) and Helgeland Hospital (32.0%). Førde has the lowest proportion with unknown status (4.1%). The distribution by measure level is roughly the same as in previous years. It is not clear whether the differences are systematic or due to different reporting and coincidence.

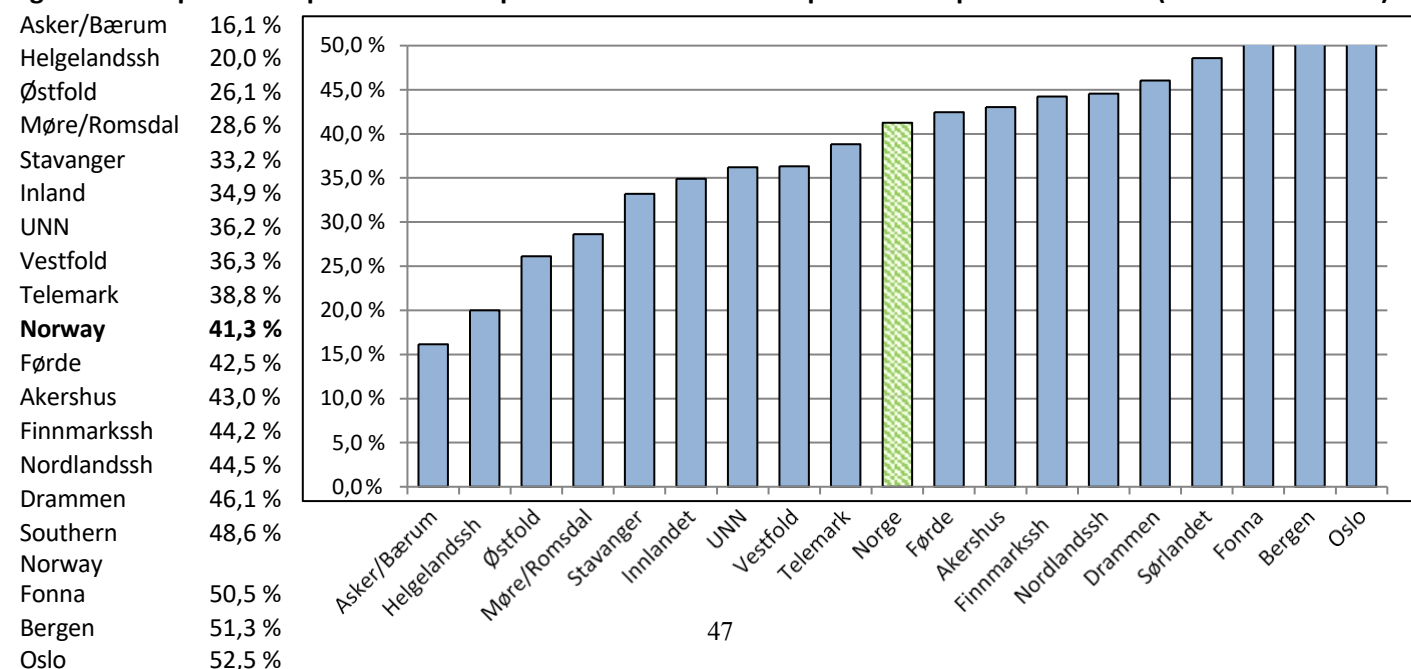
Figure 40. Proportion of patients with reported use of cannabis in the past four weeks (unknown = 17.0%).



Benzodiazepines

As Figure 41 shows, 41.3% reported benzodiazepine use in the four weeks prior to the status survey. It is important to note that the question on benzodiazepine use does not distinguish between doctor-prescribed and self-administered use. At regional level, the proportion of patients with benzodiazepine use in the last month was highest in West (45.1%) and lowest in Central (28.6%). There were differences between different interventions in the proportion with benzodiazepine use, with the lowest proportion in Asker and Bærum (16.1%) and the highest in Oslo (52.5%) and Bergen (51.3%). There were also differences in the proportion with unknown status for benzodiazepine use, with the extremes being Helgelandssykehuset (30.0%) and Førde (4.1%). The varying degree of unknown status makes it difficult to interpret differences at the measure level. After a gradual reduction in benzodiazepine use from 2012 (41.9%) to 2021 (36.0%), the figures for 2022 show an increase.

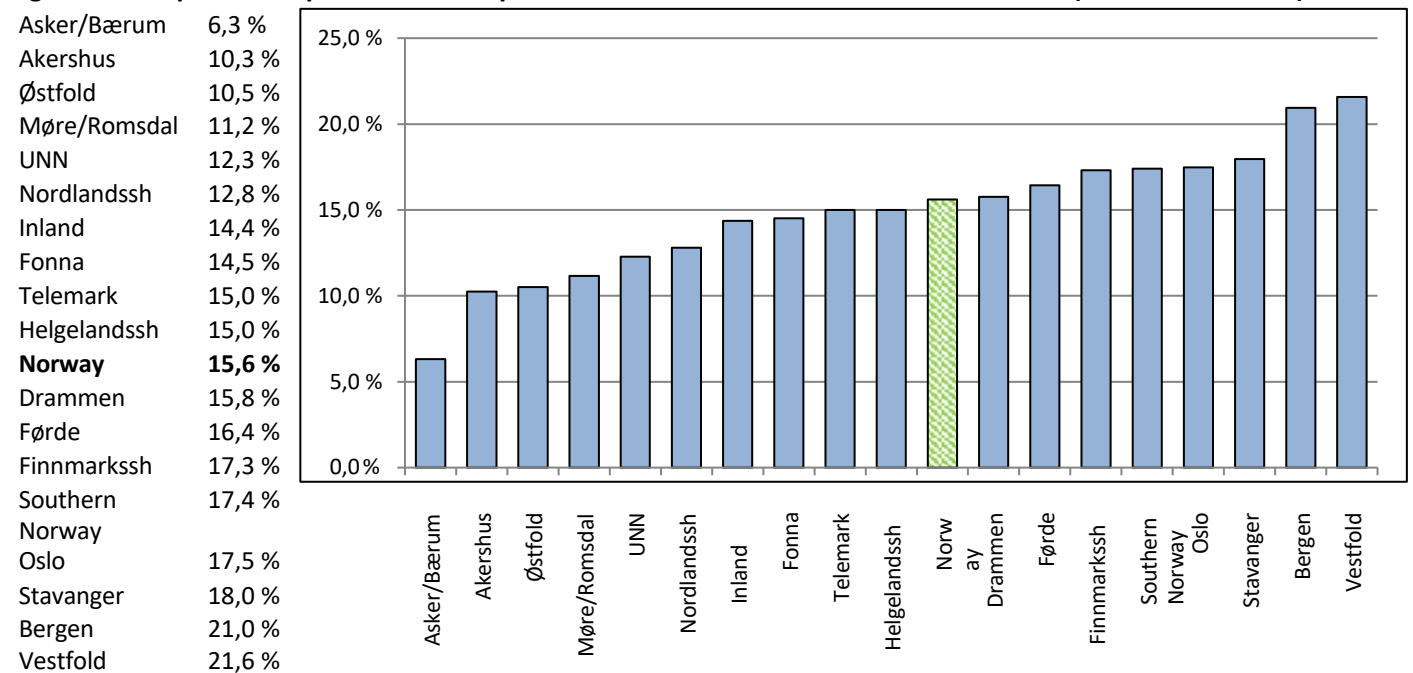
Figure 41. Proportion of patients with reported use of benzodiazepines in the past four weeks (unknown = 14.1%).



Central stimulants

As shown in Figure 42, 15.6% stated that they had used stimulants in the four weeks prior to the status survey. The findings apply to both self-reported use and proven use of amphetamine derivatives and cocaine, but there may be places that have not had cocaine as a standard in the urine samples. The national average has been fairly stable since 2014. The distribution between regions and measures varies somewhat from year to year. In 2022, the use of stimulants was lowest in the Central region (11.2%) and highest in the West region (19.0%). Asker and Bærum had by far the lowest proportion of patients with reported use of stimulants (6.3%). Eight DAR interventions were above average, with Vestfold (21.6%) and Bergen (21.0%) at the top. The proportion with unknown status of stimulant use was between 13.9 and 25.3% at regional level. The extremes at the measure level were Førde (5.5%), and Helgeland Hospital (31.0%) and Nordland Hospital (29.4%).

Figure 42. Proportion of patients with reported use of stimulants in the last four weeks (unknown = 16.7%).

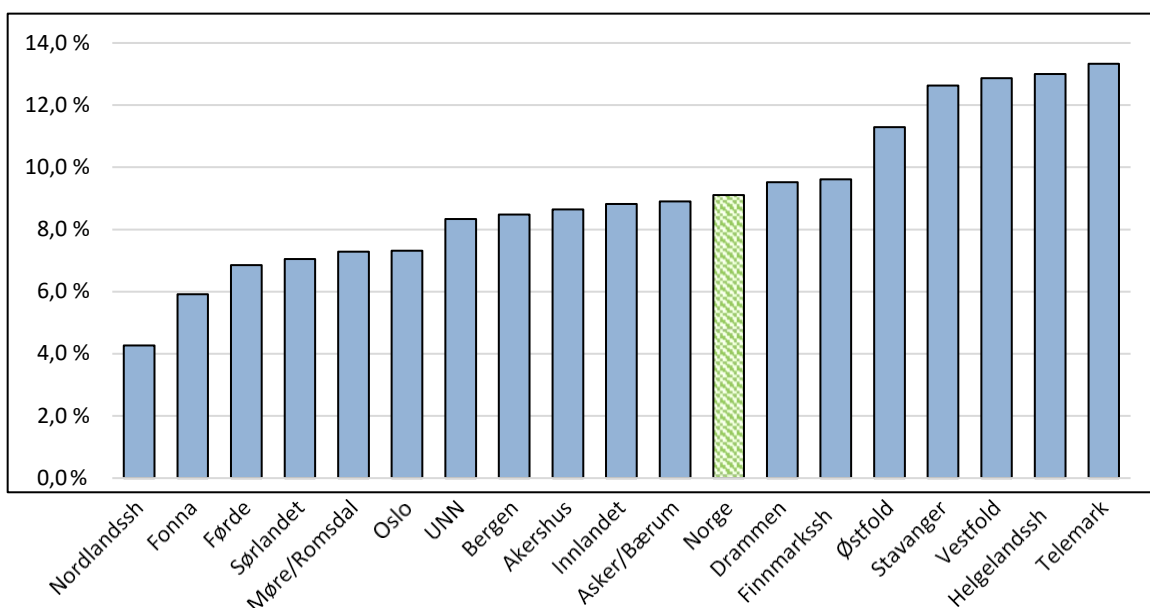


alcohol

Alcohol use in the four weeks prior to the status survey is summarized in Figure 43. In the status survey, the question is formulated as "alcohol for intoxication". 9.1% reported using alcohol in the past month. This level has been fairly stable between 7.8% in 2012 and 9.2% in 2021. At regional level, there are small differences in the proportion with alcohol use (7.3-10.0%). The proportion with unknown status was lowest in the South (13.9%) and highest in the North (26.9%). There were some differences between DAR interventions, with the highest proportion with alcohol use for intoxication in the last month in Telemark (13.3%) and Vestfold (12.9%), and the lowest at Nordland Hospital (4.3%).

Figure 43. Proportion of patients with reported use of alcohol for intoxication in the past four weeks (unknown = 17.8%).

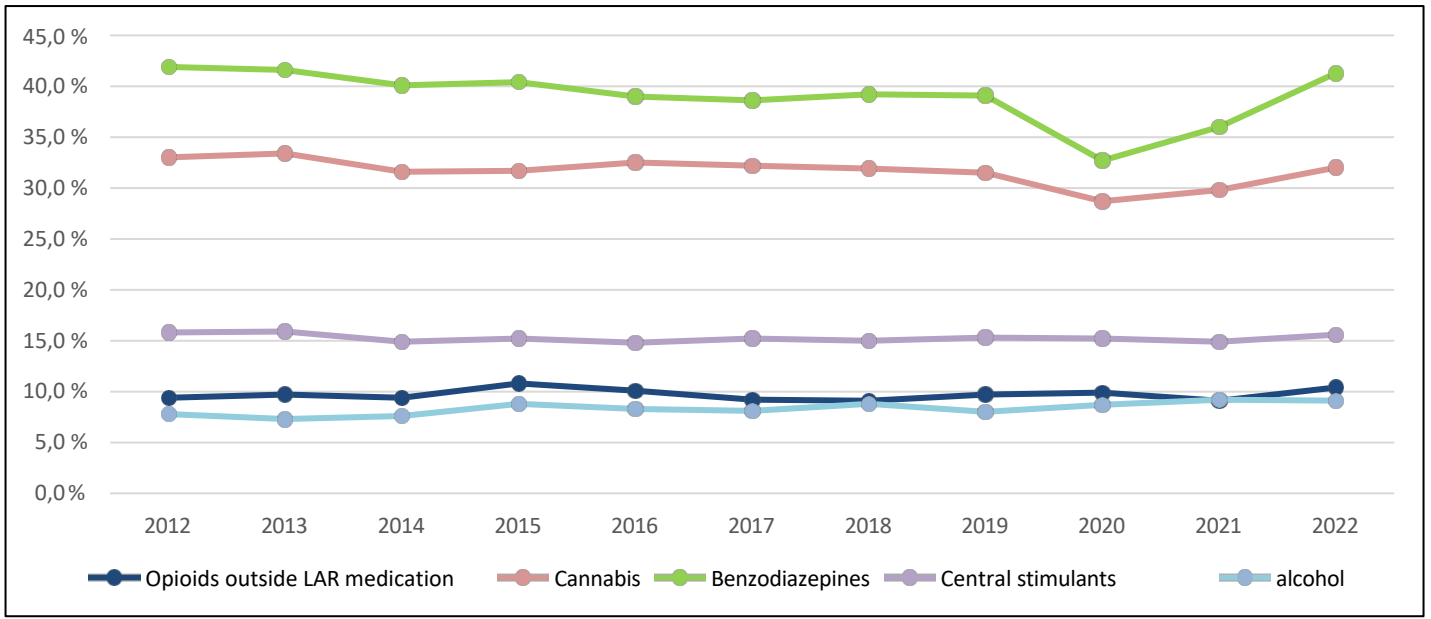
Nordlandssh	4,3 %
Fonna	5,9 %
Førde	6,8 %
Southern Norway	7,1 %
Møre/Romsdal	7,3 %
Oslo	7,3 %
UNN	8,3 %
Bergen	8,5 %
Akershus	8,6 %
Inland	8,8 %
Asker/Bærum	8,9 %
Norway	9,1 %
Drammen	9,5 %
Finnmarkssh	9,6 %
Østfold	11,3 %
Stavanger	12,6 %
Vestfold	12,9 %
Helgelandssh	13,0 %
Telemark	13,3 %



Current substance use over time

The distribution of the development in the use of various drugs over the past decade is shown in Figure 44. The use of opioids other than OMT medication has remained stable at around 10%. The same applies to the use of alcohol for intoxication. The use of stimulants has been stable at 15% over the last ten years, and cannabis at around 30%. However, there was a reduction in the use of benzodiazepines and cannabis from 2019 to 2020, probably due to reduced access during the pandemic. The use of benzodiazepines has increased by about ten percentage points from 2020 to 2022, to just above pre-pandemic levels. Benzodiazepine use appears to be most prevalent among patients in OMT, followed by cannabis. Some of the measures that reported lower prevalence of substance use also appear to be among those that reported the highest degree of unknown status. Frequent use of "unknown" may be more prevalent in organizational models with less frequent patient contact and lower levels of participation during the completion of the status survey, without necessarily reflecting the actual substance use in the population.

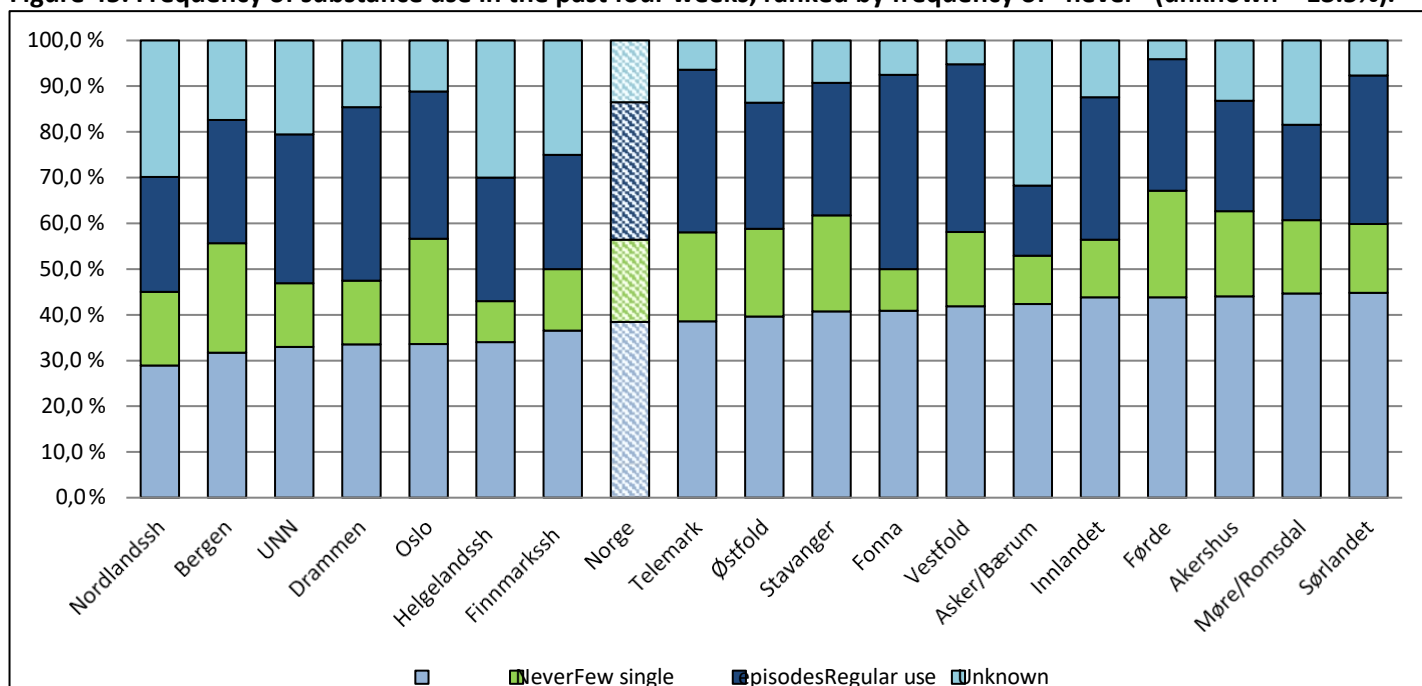
Figure 44. Proportion of patients with reported use of various substances in the last four weeks (2012-2022).



Frequency of substance use

Nationally, 38.4% reported that they had not used alcohol or other drugs in the four weeks prior to the status survey (Figure 45), compared with 41.7% in 2021. A proportion of 18.0% had had single episodes of substance use in the last four weeks, and 30.1% had more regular use. The figures are consistent with last year's, where 17.2% had single episodes and 28.7% regular use. Figure 45 shows the distribution of responses in the individual DAR interventions. There are small differences between the DAR initiatives. LAR Asker and Bærum had the fewest regular users (15.3%). Fonna had the most regular users (42.5%).

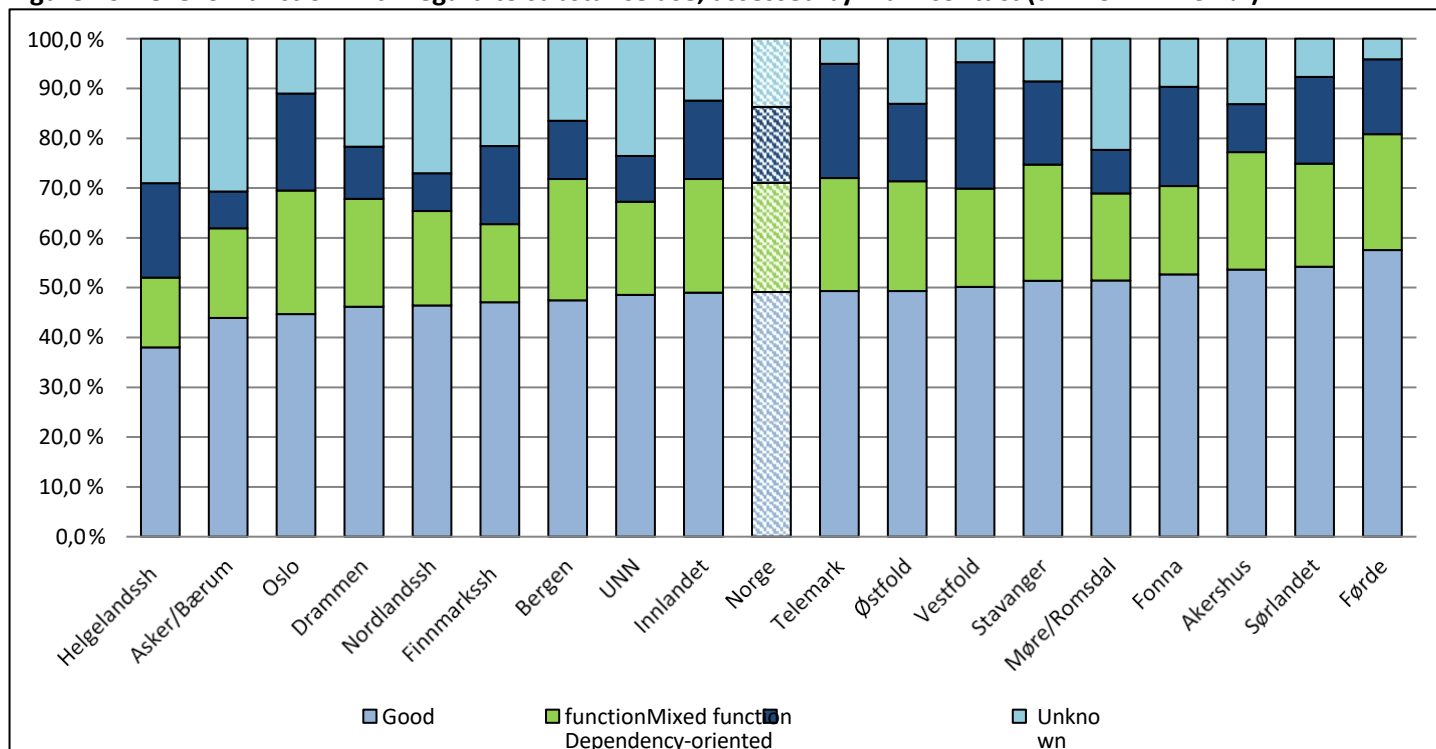
Figure 45. Frequency of substance use in the past four weeks, ranked by frequency of "never" (unknown = 13.5%).



Substance abuse

In conducting the status survey, the patient's primary contact has assessed the patient's ability to cope with substance abuse, according to good function, mixed function and dependent substance use. Good functioning means that there is no substance use that has a negative impact on social functioning or quality of life. Mixed functioning refers to some degree of negative impact. Dependent use implies use that dominates everyday life. In 2022, 49.1% were assessed as having good function in everyday life (Figure 46), roughly the same as in 2021 (51.3%) and the previous year. We also see consistently comparable levels from previous years for the other categories. 15.3% were assessed with an addictive use, and 21.9% in an intermediate category with more variable functioning. The proportion of patients with good functioning was lowest at Helgeland Hospital (38.0%) and highest in Førde (57.5%). There were generally small differences between the health trusts.

Figure 46. Level of function with regard to substance use, assessed by main contact (unknown = 13.7%).



Assessments of current substance use

The status survey measures recent use of various substances individually, as well as frequency of substance use and coping with substance use. The type and degree of substance use in OMT are key measures that provide indications of the benefit of the treatment. This is especially true for concomitant use of opioids outside of OMT, but use of other substances may also have an impact on treatment outcomes. Compound use in particular may have implications for treatment.

The responses showed concurrent use of opioids in about 1 in 10 patients in OMT. The use of benzodiazepines and cannabis was most common, in 4 and 3 out of 10 patients respectively. A weakness in the data material is that no distinction is made between patients who receive benzodiazepines on prescription or use them in some other way and are still controlled, and patients with problematic use. A large proportion had unknown status with regard to current substance use, and it is therefore expected that the actual proportion with ongoing substance use is somewhat higher. A previous control study showed satisfactory agreement between patients' and therapists' responses on the use of the various substances in the last four weeks (over 70%)⁶. In smaller OMT interventions, it is probably easier to keep track of current substance use among individual patients. The choice of medication, dispensing scheme and drug testing scheme also have an impact. Overall, the use of the various drugs has been stable over a number of years.

Far from all substance use causes problems, but the target group in OMT is at higher risk of problematic use. Nationwide, around 60% had not used drugs recently, or had only had occasional episodes. About half were considered to have good functioning, and in addition, 1 in 5 had mixed functioning. Taken together, the figures indicate that more than half have good coping with low substance use. The findings are not entirely surprising, given that 70% have rehabilitation with drug-free treatment as their treatment goal and 30% harm reduction. At the same time, there is a subgroup that uses drugs regularly and uncontrollably. Through OMT, these people will still be able to maintain contact with the intervention system and will be offered health care when needed.

⁶ Waal, H., Bussesund, K., Clausen, T., Haaseth, A., Lillevold, P.H., Skeie, I. (2019). SERAF report 1/2018. Status report 2018. DAR in the time of the drug reforms. Oslo: UIO and OUS. <https://www.med.uio.no/klinmed/forskning/sentre/seraf/publikasjoner/rapporter/2019/seraf->

[rapport-nr-1-2019-statusrapport-2018.pdf](#)

SUBSTANCE USE IN THE PAST YEAR

In the previous chapter, substance use in the last four weeks was summarized and assessed. This chapter concerns the extent of substance use throughout the past year. Assessments of substance use in the past year require regular contact with patients, information about the patient's situation and professional judgment.

Extent of substance use

As shown in Figure 47, 32.3% of patients nationwide reported that they had not used drugs in the past year, up from 34.5% in 2021. 25.1% had only used drugs for short, isolated periods during the past year, and 31.8% had used drugs for longer periods or throughout the past year. In comparison, the figures for 2021 were 25.4% and 30.3% respectively. The proportion with unknown status was 10.8% in 2022 and 9.9% in 2021.

There were some nuanced differences in substance use in the last year between the regions. The DAR facility with the highest proportion of patients who had not used drugs in the past year was Asker and Bærum (45.0%), and the facility with the lowest proportion was Nordland Hospital (22.3%), while they also had the highest proportion with unknown status (31.3%). Fonna and Drammen had the highest proportion with long-term use in the past year (40.9% and 40.8% respectively).

Figure 47. Assessment of substance use in the past year (unknown = 10.8%).

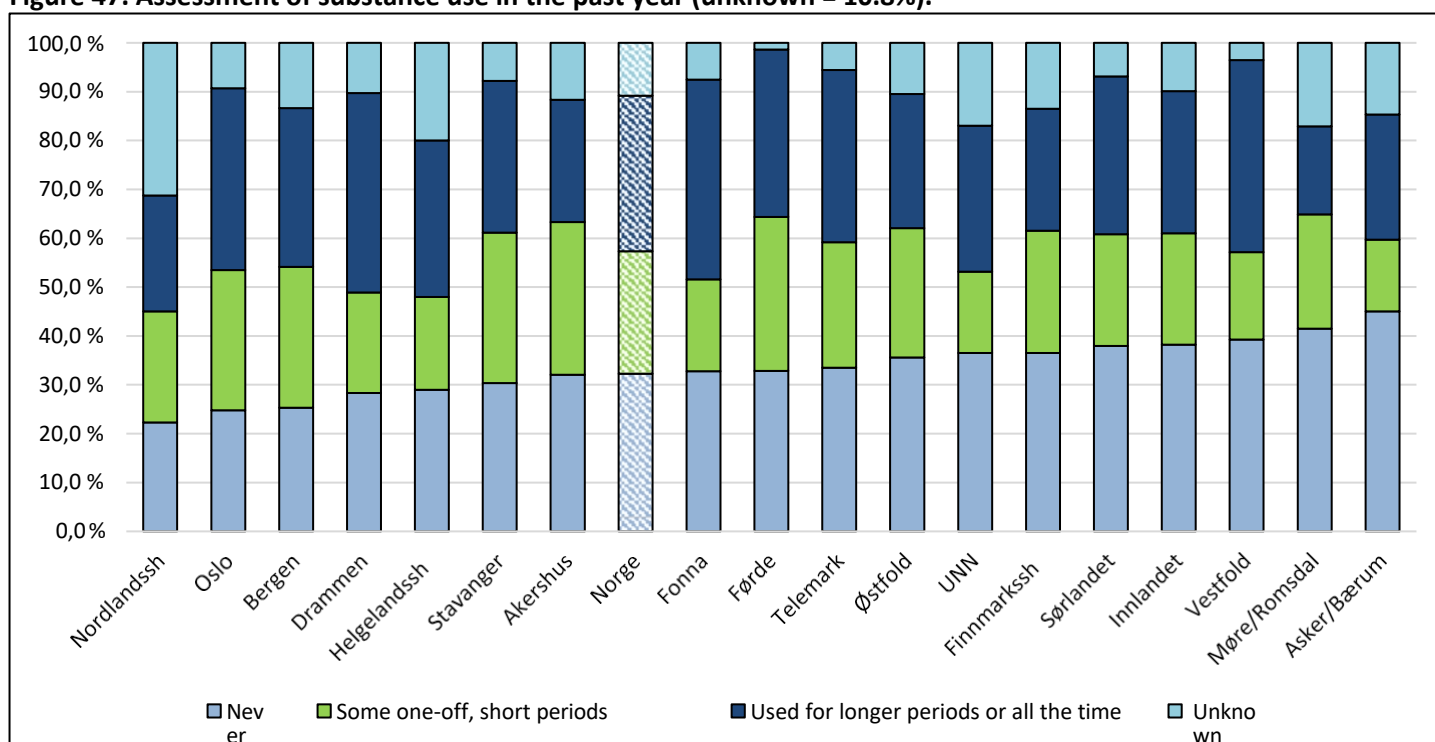
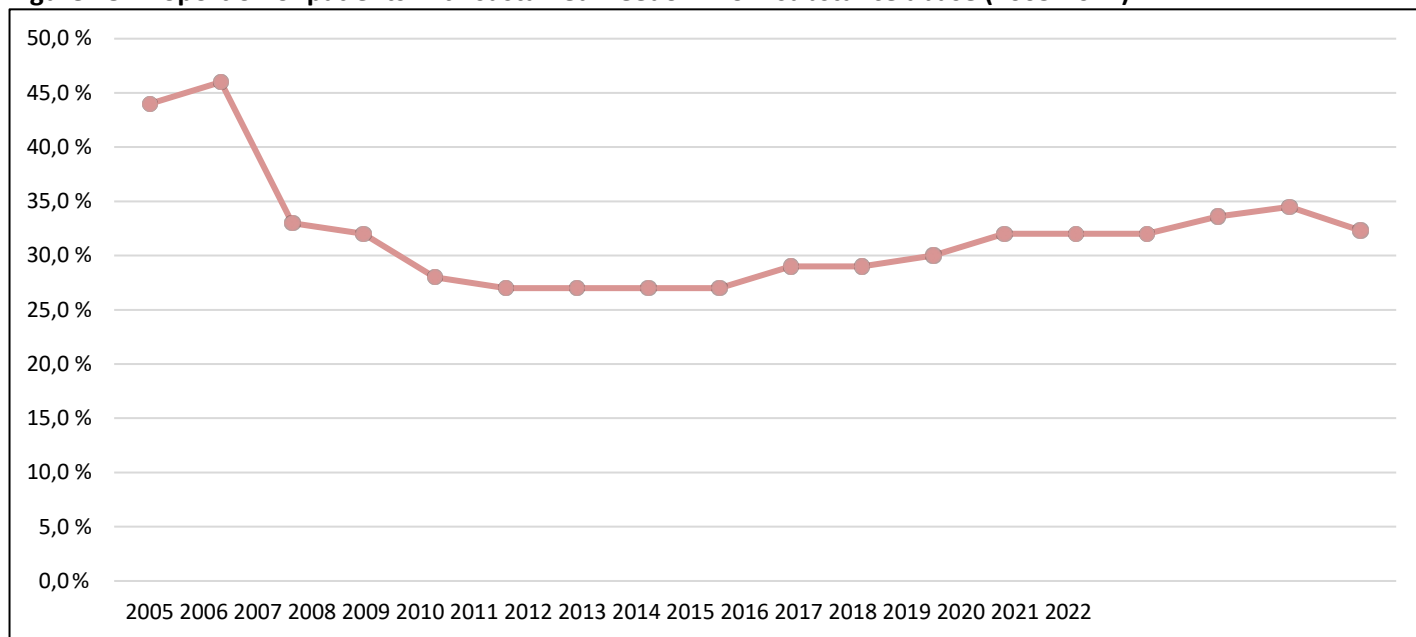


Figure 48 below shows the annual percentage who are considered not to have used drugs or had a harmful use of alcohol in the last year since 2005. The proportion fell in the early years, but has varied between 30-35% since 2007. After 2013, a slight increase can be traced, i.e. a few more people who have been fully rehabilitated with regard to substance use. This year's level marks a slight decrease from last year.

Figure 48. Proportion of patients with sustained freedom from substance abuse (2005-2022).

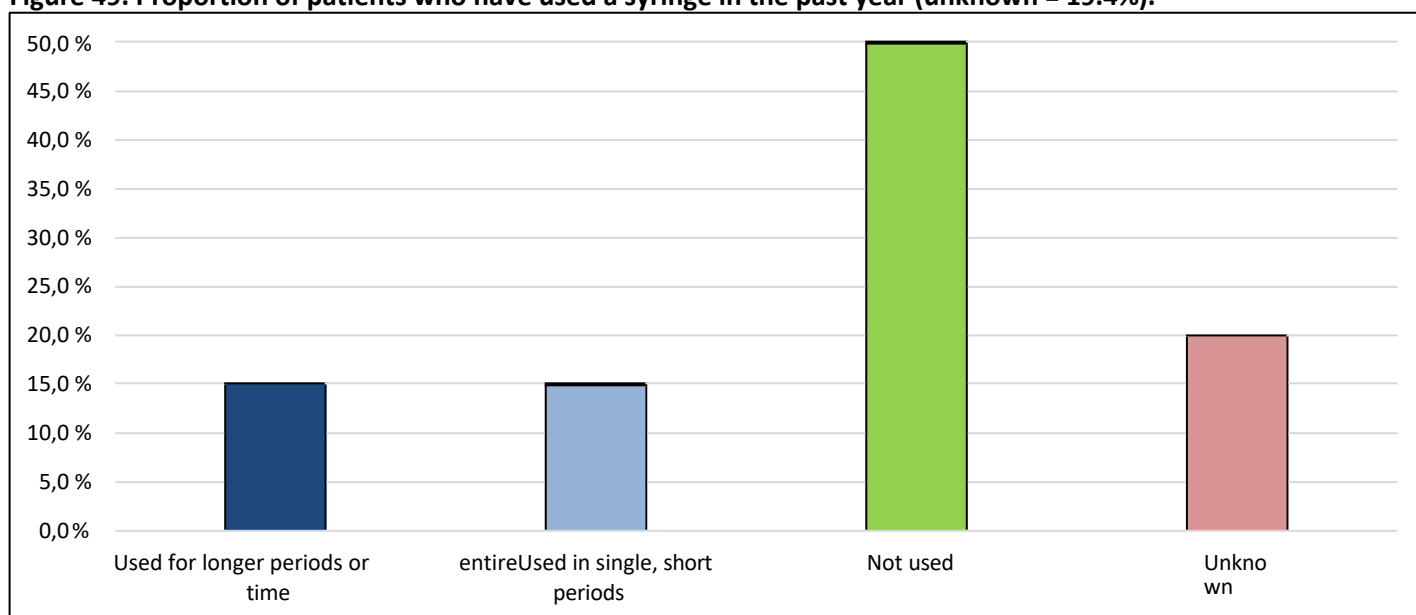


Use of syringe

For those health trusts that use the DIPS Arena medical record system, the status survey for 2022 included some new questions that have not previously been included in the DAR population. This applied to a total of 1,846 participants from Oslo, Bergen, Fonna and Førde. Of relevance to substance use, questions were asked about syringe use in the past year.

As shown in Figure 49, 30.5% of the patients in the OMT programs in Oslo, Bergen, Fonna and Førde had used a syringe in the past year, about half of these for longer periods or all the time (15.7%), and the remaining half (14.8%) for isolated periods. Half (49.9%) had not used a syringe. The proportion who had not used a syringe was highest in Førde (61.6%), followed by Fonna (58.6%), and Oslo (50.3%), and Bergen (46.4%) had the lowest proportion without use. The proportion who had used a syringe for longer periods was highest in Oslo (17.9%), followed by Bergen (14.8%), Fonna (13.4%), and lowest in Førde (5.5%).

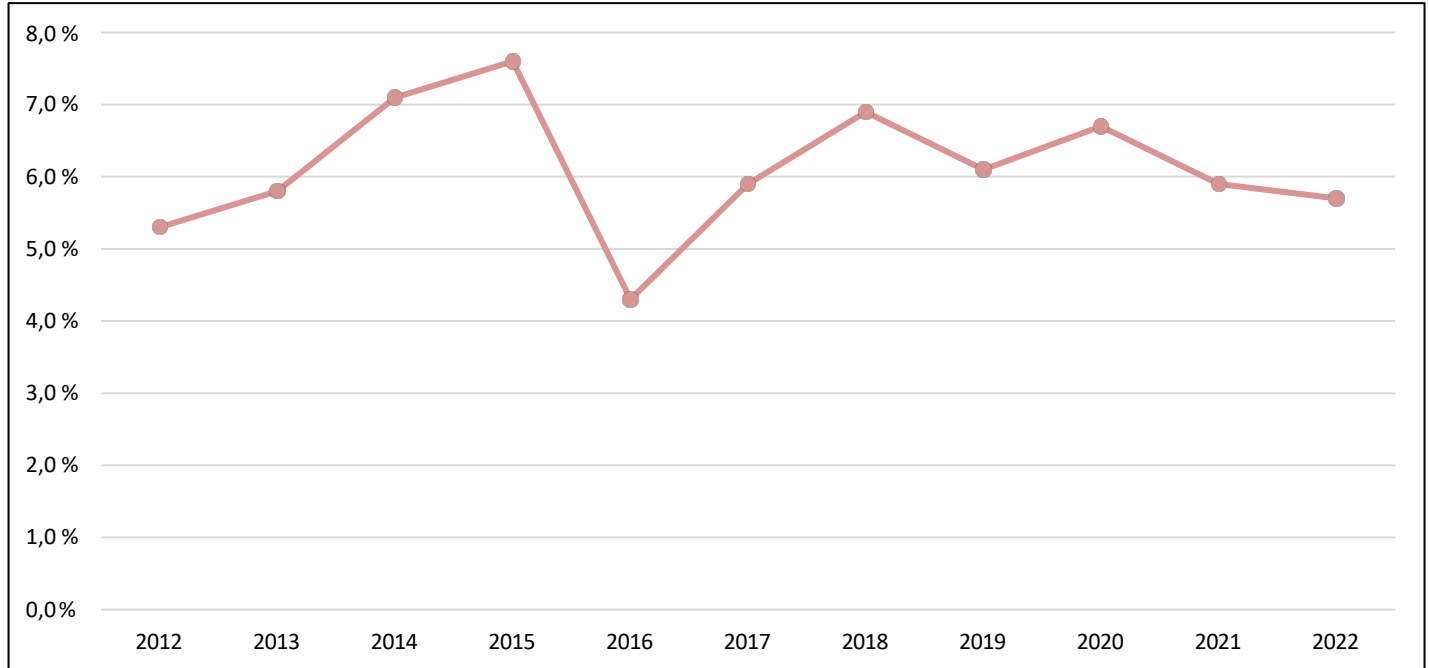
Figure 49. Proportion of patients who have used a syringe in the past year (unknown = 19.4%).



Overdose

The majority of patients in OMT had not experienced an overdose (life-threatening poisoning) in the past year (83.0%). A proportion of 5.7% reported having experienced an overdose in the past year. The status was unknown for 11.3%. Figure 50 shows the trend in annual overdoses among patients in DAR. This applies to overdoses that have not resulted in death. For overdoses that have resulted in death, see the separate chapter on mortality in DAR.

Figure 50. Proportion of patients who have experienced an overdose in the past year (2012-2022).



Assessments of substance use in the past year

Overall, the figures for substance use in the past year are comparable with last year. More than half of the patients can be considered to be in a good or very good situation in terms of substance use in the past year, and one third are permanently drug-free. At the same time, we see that one third can be considered to have persistently serious substance use. For the sub-sample where additional information on substance use is available, we see that one third have used needles in the past year, and half of these have persistent needle use. Overall, we see that the majority of OMT patients thus have good substance abuse control in both the last four weeks and the last year, and proportionally 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 appears to work well from a harm reduction perspective.

OFFENSES LAST YEAR

The status survey includes individual questions about offenses in the past year. No questions are asked about the type of offense. The proportion who have been arrested, remanded in custody, charged or convicted during the previous year is shown in figure

45. During 2022, 8.4% of patients in OMT had been arrested, compared with 9.6% in 2021 and 10.3% in 2020. 75.3% had not been arrested, compared with 75.6% in 2021 and 74.6% in 2020. The proportion with unknown status was 16.3%. The level of crime in recent years has been fairly stable nationwide over time, with a slight downward trend in recent years (Figure 51).

At regional level, there were small differences in the proportion who had been arrested in the last year (from 7.8% in the North to 9.4% in the West). The proportion with unknown status was lowest in the South (11.5%), and highest in the North (24.7%). LAR in Asker and Bærum had the lowest proportion with known arrest last year (3.1%), and Førde the highest (15.1%), where Helgelandssykehuset had the lowest proportion last year (4.9%), and Finnmarkssykehuset the highest. The proportion with unknown status was highest at Nordland Hospital (31.8%), followed by Helgeland Hospital (27.0%).

Figure 51. Proportion who have been arrested, remanded in custody, prosecuted or convicted in the past year (unknown = 16.3%).

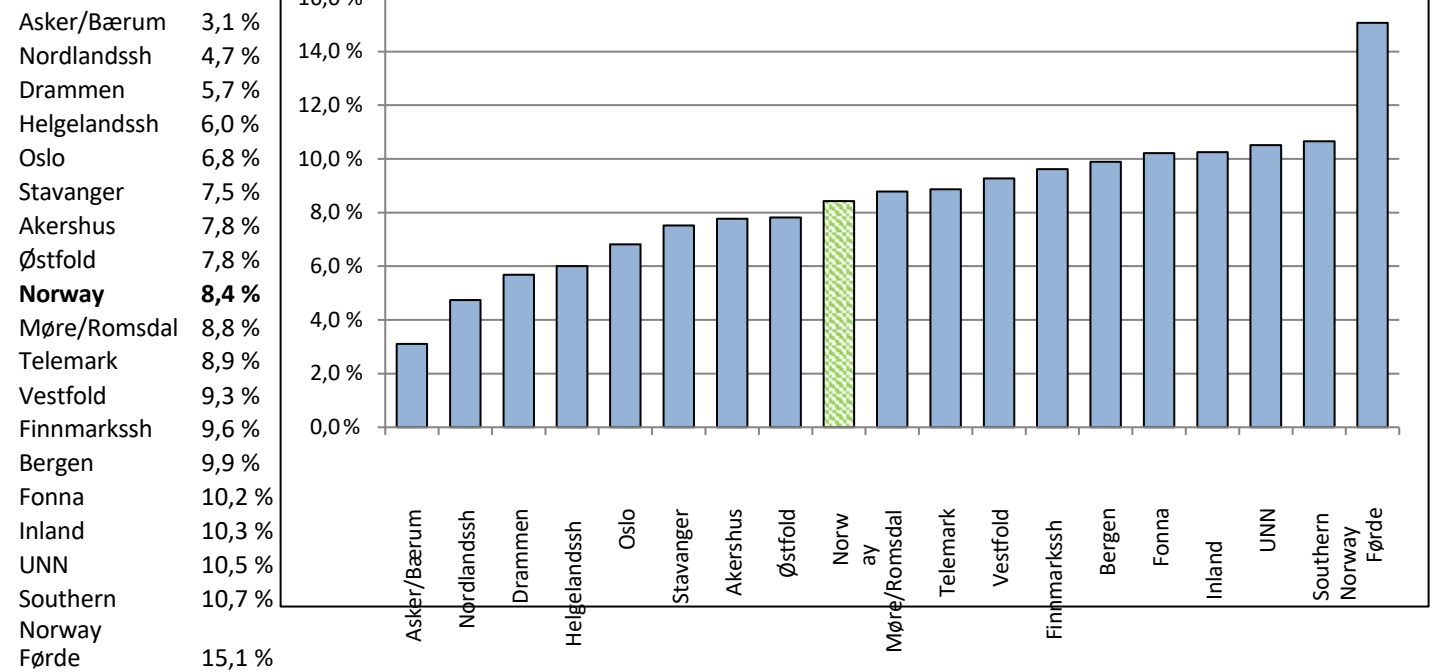
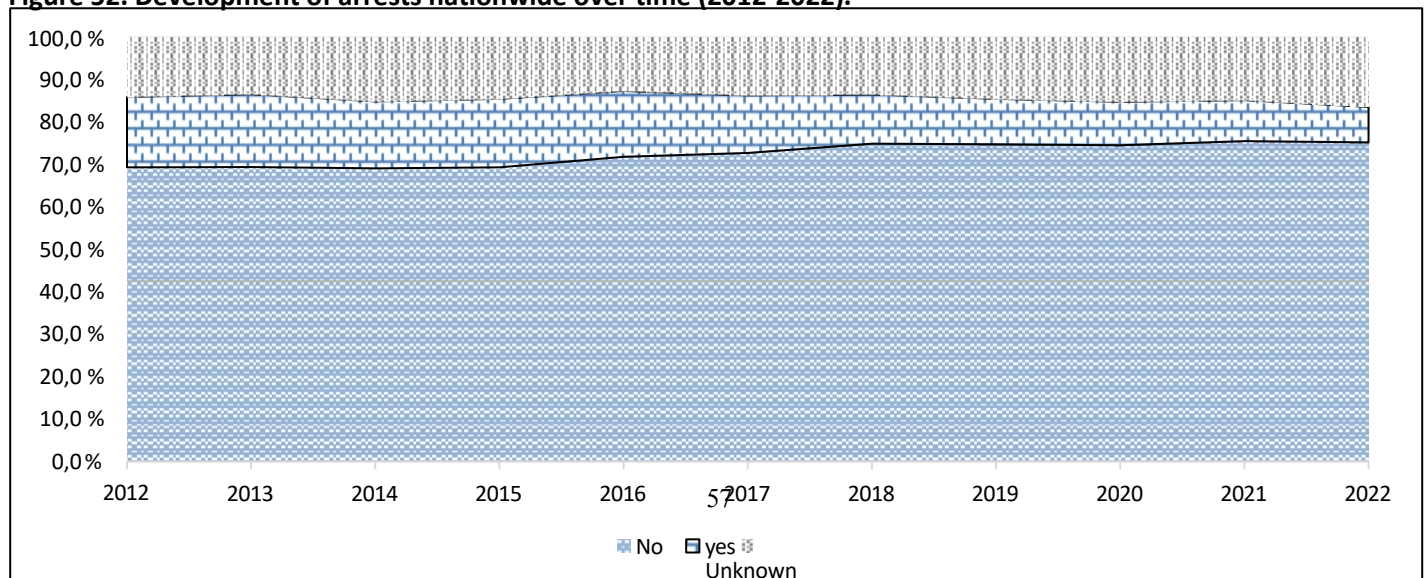


Figure 52. Development of arrests nationwide over time (2012-2022).



INFECTION STATUS

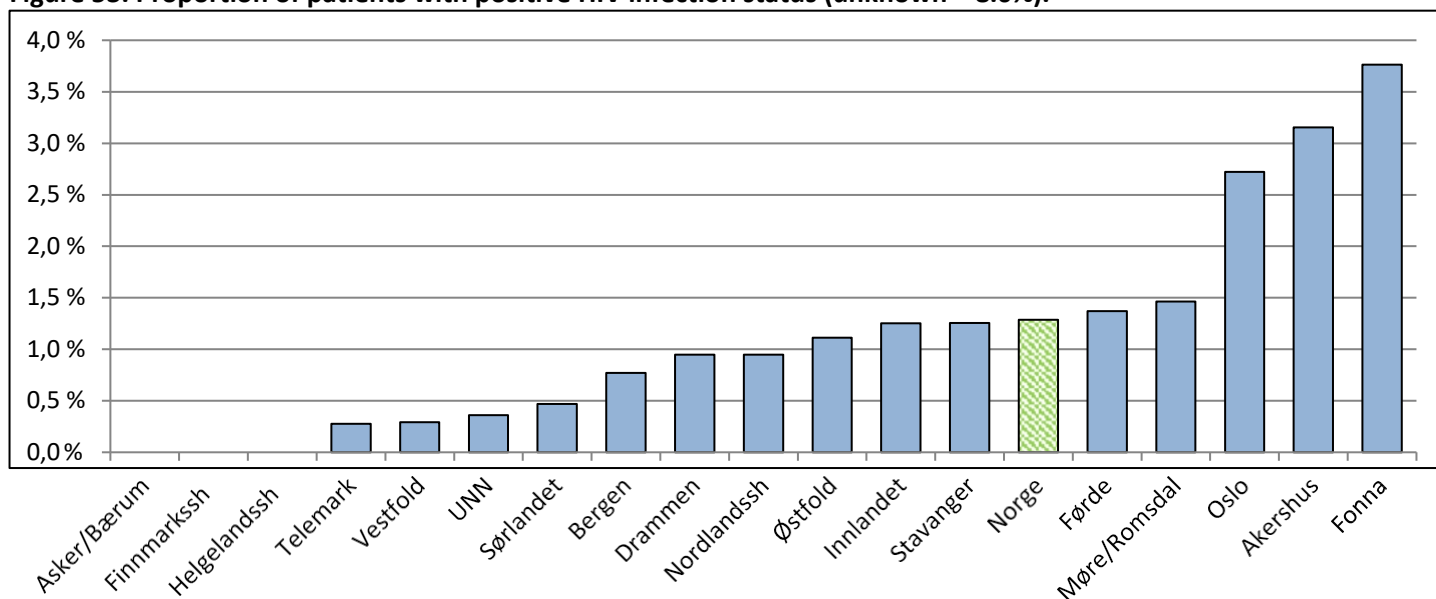
The status survey includes questions about infection status for HIV, hepatitis C and COVID-19 over the past year. Opioid addiction is often accompanied by needle use and, for some, sharing of injection equipment and therefore also exposure to HIV and hepatitis C infection. Questions about COVID-19 have been included in recent years to map how patients in OMT have been affected by the pandemic.

Human immunodeficiency virus (HIV)

In the general population in Norway, between 200 and 250 new cases of HIV are registered each year⁷. Tablet treatment (antiretroviral therapy) has been available since 1997 and has proved highly effective in significantly reducing both the risk of infection and serious sequelae. Provided that the patient can comply with daily medication for life, modern HIV treatment prevents immunodeficiency and subsequent AIDS-related death to a very large extent.

Among OMT patients, the proportion of HIV infections in 2022 is about as low as in previous years (Figure 53), at 1.3%, compared with 1.0% in 2021. The proportion with known negative HIV status was 90.8%. Most DAR patients with HIV-positive status were located in Fonna (3.8%), Akershus (3.2%) and Oslo (2.7%). There were no reports of HIV infection among DAR patients in Asker and Bærum, at Finnmark Hospital or Helgeland Hospital. The proportion of patients with unknown HIV status was highest at Helgeland Hospital (17.0%) and in Møre og Romsdal (16.1%). Nationally, the proportion with unknown status continued to be 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.

Figure 53. Proportion of patients with positive HIV infection status (unknown = 8.0%).



⁷ Norwegian Institute of Public Health (2023). Annual report 2022. Surveillance of sexually transmitted infections. Report 2022. Oslo: Norwegian Institute of Public Health. https://www.fhi.no/contentassets/3e70076e6e704b27843e26cc33c4214e/soi_arsrapport_2022_endelig.pdf

Hepatitis C

Over time, hepatitis C has been highly prevalent among people who inject drugs⁸. In the general population, the prevalence of hepatitis C is estimated at 0.1%. According to FHI⁹, the most frequent subtypes are HCV genotype 3 (which accounts for about 50%) and the globally dominant HCV genotype 1 (accounts for about 40% in Norway). At the same time, good treatment has been established for a number of genetic subtypes. From 2018, treatment based solely on tablets has been available. The national strategy for eradication of hepatitis C by 2023¹⁰ has also been an important part of a renewed treatment optimism in recent years, and has contributed to a significant reduction in the incidence of hepatitis C.

Investigation and treatment for hepatitis C is a priority for both people who inject drugs and for OMT patients. The treatment prognosis is good if interdisciplinary follow-up takes place within the specialist health service. In principle, everyone in OMT is eligible for assessment and 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 means that screening examinations should be carried out as needed in special risk groups (e.g. active syringe use).

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

As shown in Figure 54, 6.4% nationally had hepatitis C detected by antigen testing in the past year, and 38.1% had hepatitis C confirmed by antigen testing. The proportion with a positive test was highest in Møre og Romsdal (21.0%). Nordland Hospital had the lowest proportion with a positive test (2.4%). There were large variations in the proportion with unknown hepatitis C status, with the highest proportion unknown in Møre og Romsdal (31.2%), in Fonna (25.3%) and at Helgeland Hospital (24.0%). The lowest number of patients with unknown status was in Sørlandet (6.6%). The figures are similar to last year.

⁸ Norwegian Institute of Public Health. Statusrapport om eliminasjon av hepatitt B og C som folkehelseproblem i Norge [Status report on the elimination of hepatitis B and C as a public health threat in Norway]. Oslo: Norwegian Institute of Public Health, 2023.

https://www.fhi.no/contentassets/f35ea65ab2694b408f0957fc4a9d695b/statusrapport_fhi_hdir_eliminasjon-hepatitt-b-og-c_norge_2023.pdf

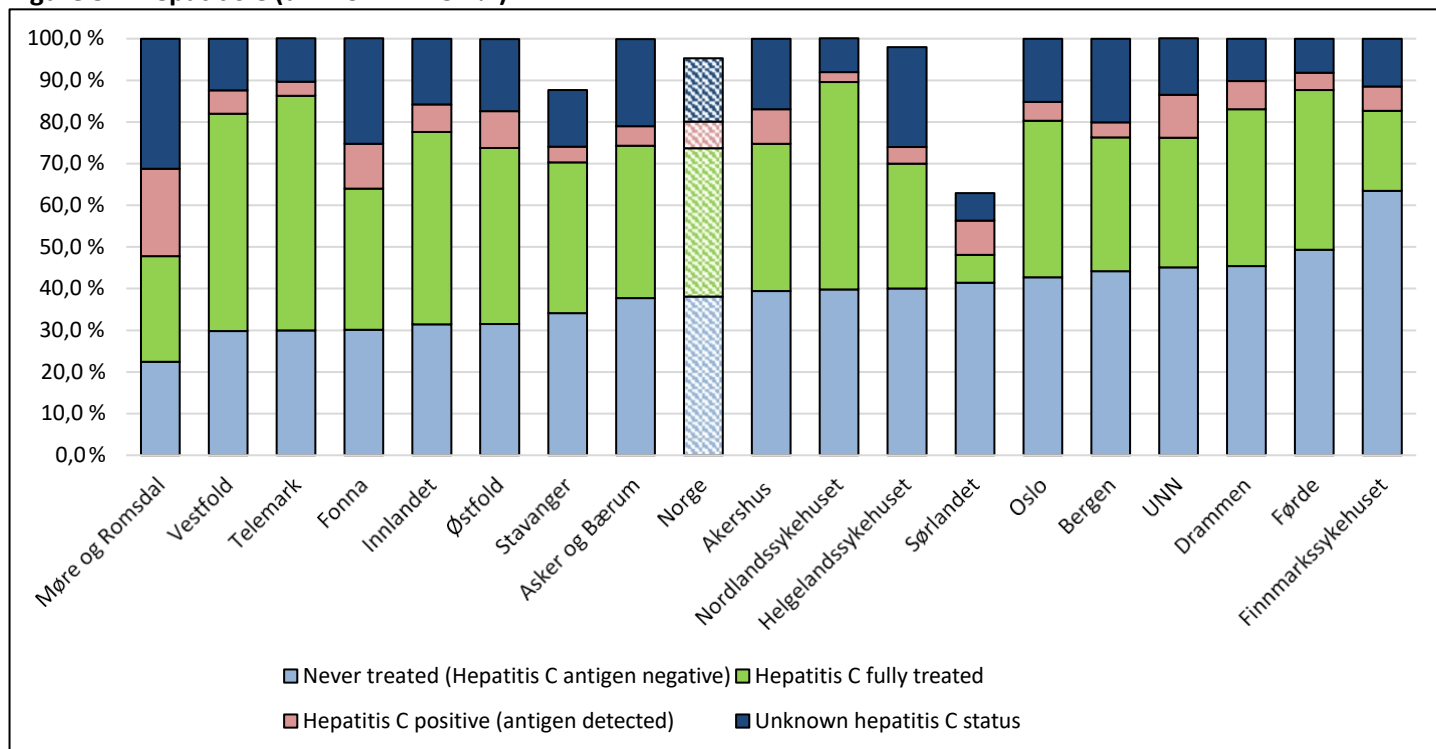
⁹ Norwegian Institute of Public Health. Hepatitis C - Veileder for helsepersonell.

<https://www.fhi.no/nettpub/smittevernveilederen/sykdommer-a-a/hepatitt-c---veileder-for-helsepers>

¹⁰ Ministry of Health and Care Services. National strategy against hepatitis 2018-2023.

<https://www.regjeringen.no/contentassets/0a7db35f049c46e8b368ad9751f0c870/nasjonal-strategi-mot-hepatitter.pdf>

Figure 54. Hepatitis C (unknown = 15.2%)*.

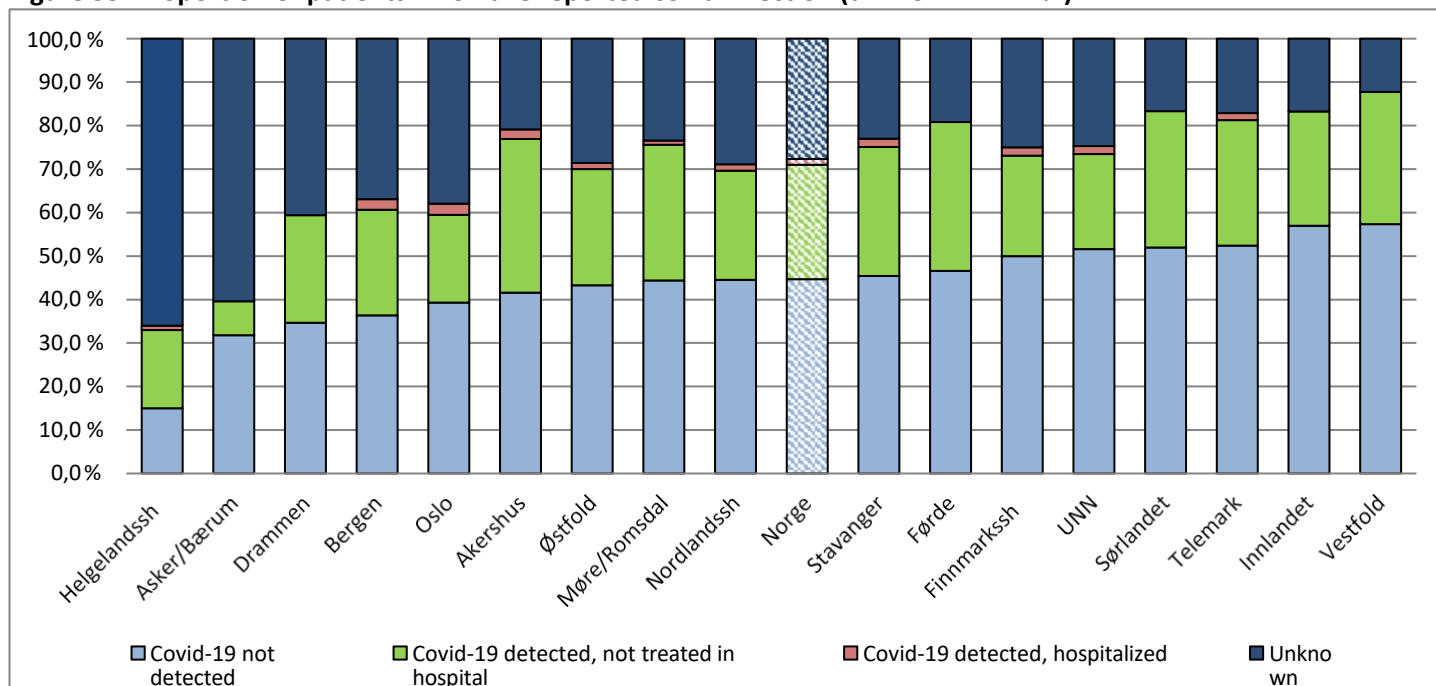


* The different DAR initiatives have used different versions of the status form. Stavanger and Sørlandet have used an older version that also includes the response option "previously infected, antibody detected". This response option is not included in the figure, and the total share for Stavanger, Sørlandet, Helgelandsykehuset and Norway is therefore less than 100%.

Covid-19

In light of the COVID-19 pandemic, questions about COVID-19 and its treatment were added. The purpose was to obtain an overview of infection, the severity of the disease and knowledge of the patients' COVID-19 status in various DAR measures. The figures for 2022 show that 26.3% were diagnosed with the virus without needing hospital treatment (Figure 55). A small proportion of 1.3% were diagnosed with the virus and received treatment in hospital. Just under half, 44.7%, had not been diagnosed with COVID-19 infection. These figures differ from last year's figures, where 3.4% were diagnosed with covid and did not require hospital treatment, while 0.5% received hospital treatment and 77.0% were not diagnosed with covid. The proportion with unknown status for 2022 was 27.7%, an increase from 2021 (19.1%).

Figure 55. Proportion of patients who have reported covid infection (unknown = 27.7%).



Assessments of infection status

The survey confirms a low prevalence of known HIV infection in the LAR population, with an average level that is very low in an international context. However, it is worrying that the proportion with unknown HIV infection status remains high nationally (8.0%) and is markedly higher in some regions.

Based on this year's figures for hepatitis C, 35.6% have completed treatment for hepatitis C, and 38.1% have had the disease confirmed based on antigen tests. 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 the group that continues to inject drugs, and should therefore be prioritized.

The figures on COVID-19 infection show that very few patients in DAR have needed hospital treatment after infection with COVID-19. Compared with last year, a larger proportion of patients have undergone COVID-19 treatment. Nationally, many patients had unknown COVID-19 status, which should be understood in light of the reduced focus on testing in the general population after the restrictions were lifted in the first part of 2022.

PHYSICAL HEALTH AND TREATMENT IN THE PAST YEAR

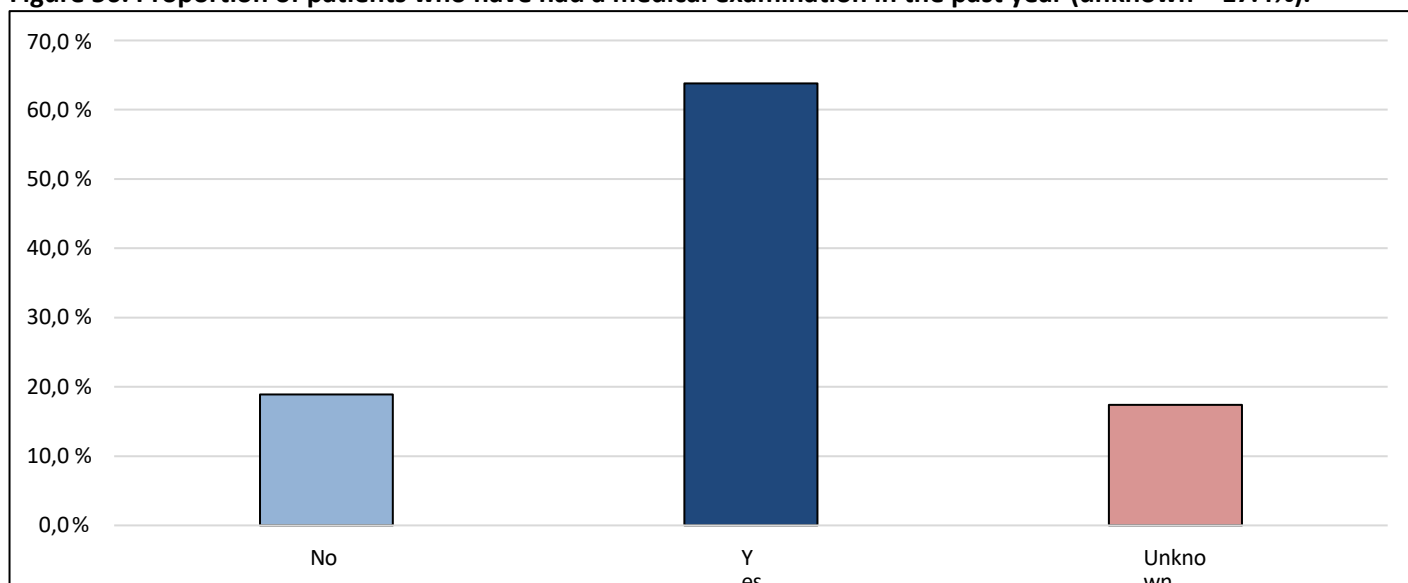
For those organizations that use the DIPS Arena medical record system, the status survey included some new questions that have not previously been addressed in the DAR population. This applied to a total of 1846 participants from Oslo (809 participants), Bergen (778 participants), Fonna (186 participants), and Førde (73 participants). The questions concerned medical examination in the past year, physical health problems/illnesses, prevalence of chronic pain and treatment for this, as well as the prevalence of various diseases and treatment received for these in the past year. This means that this year we have new and important information about health conditions for about a quarter of the LAR population.

Medical examination

Among the 1,846 patients who answered the question about a medical examination, 63.8% had been to a medical examination in the past year (Figure 56). 18.9% had not had a medical examination, and 17.4% had unknown status.

The proportion with a completed medical examination was highest in Fonna (73.1%), followed by Førde (69.9%), then Oslo (62.5%) and Bergen (62.1%). The proportion with unknown status was unevenly distributed across the DAR initiatives; highest in Oslo (22.3%) and somewhat lower in Bergen (14.7%) and Fonna (10.8%). Førde had the lowest proportion with unknown status (8.2%). Oslo (15.0%) and Fonna (16.1%) had the lowest proportion of patients who had not been to a medical examination, compared with Bergen (23.0%) and Førde (21.9%).

Figure 56. Proportion of patients who have had a medical examination in the past year (unknown = 17.4%).



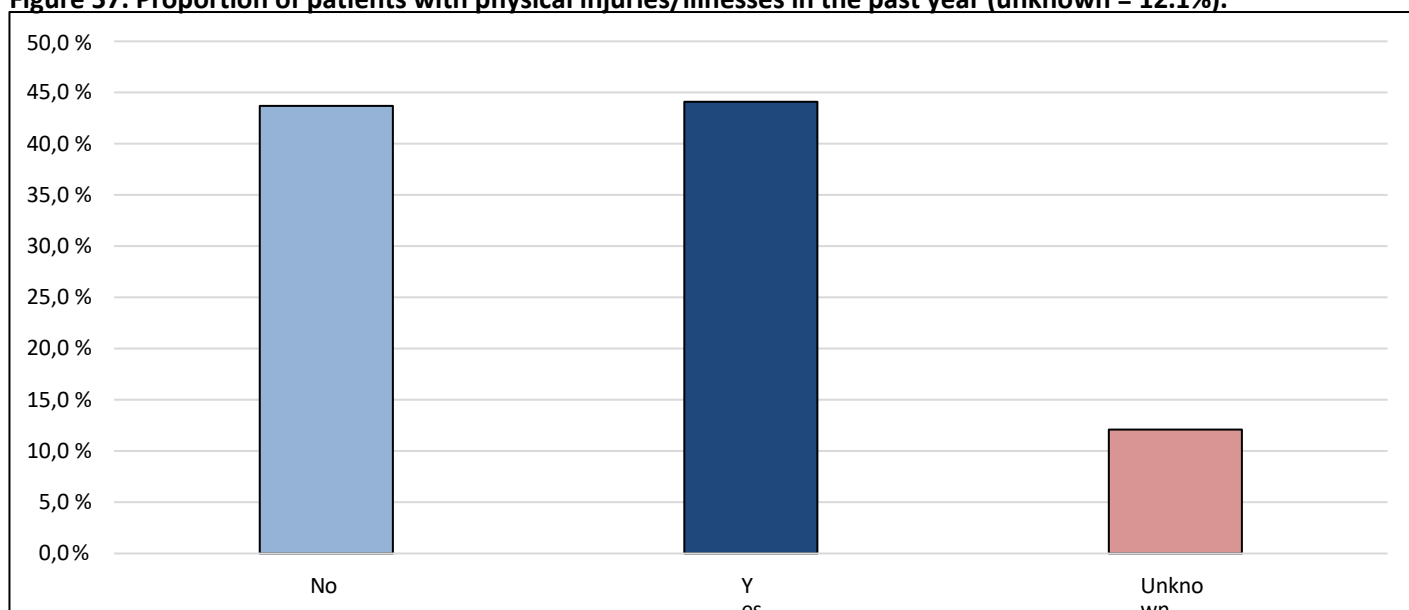
Physical injuries/illnesses

Regarding the occurrence of physical injuries or illnesses that have affected life or quality of life in the past year, 43.7% responded that they had not had this in the past year (Figure 57). 44.1% had had physical injuries or illnesses that affected their way of life or quality of life, and 12.1% had unknown status regarding physical injuries or illnesses. For comparison, we have shown earlier in the report that among the measures that report by

In the "original format", 38.8% reported a physical condition that inhibited life or quality of life in the last four weeks. There were some differences in the prevalence of injuries and illnesses across DAR interventions, where Førde stood out with the lowest proportion with reported injuries or illnesses (32.9%), but fairly similar distribution in Oslo (47.0%), Fonna (46.8%), and Bergen (41.6%). The proportion with no injuries or illnesses in the last year was highest in Førde (65.8%), and otherwise fairly evenly distributed in Oslo (44.9%), Fonna

(41.9%) and Bergen (40.9%). The proportion with unknown status was lowest in Førde (1.4%) and highest in Bergen (17.5%).

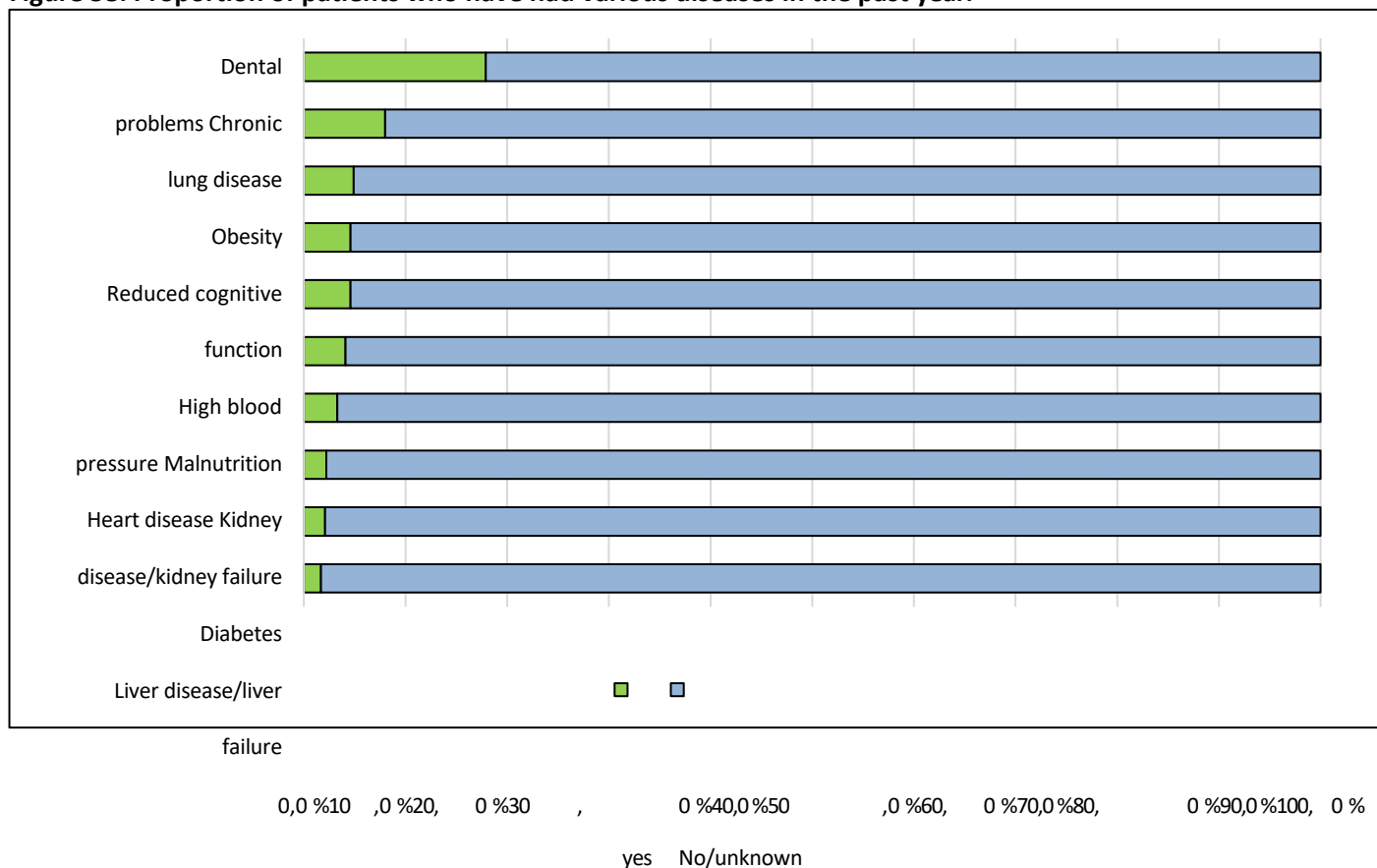
Figure 57. Proportion of patients with physical injuries/illnesses in the past year (unknown = 12.1%).



Incidence of various diseases

Figure 58 shows an overview of the prevalence of various diseases during the previous year. Of the various diseases identified, the highest prevalence was clearly dental problems (17.9%), followed by chronic lung disease (8.0%). For the remaining diseases represented in the patient group, the prevalence was between 2-5%.

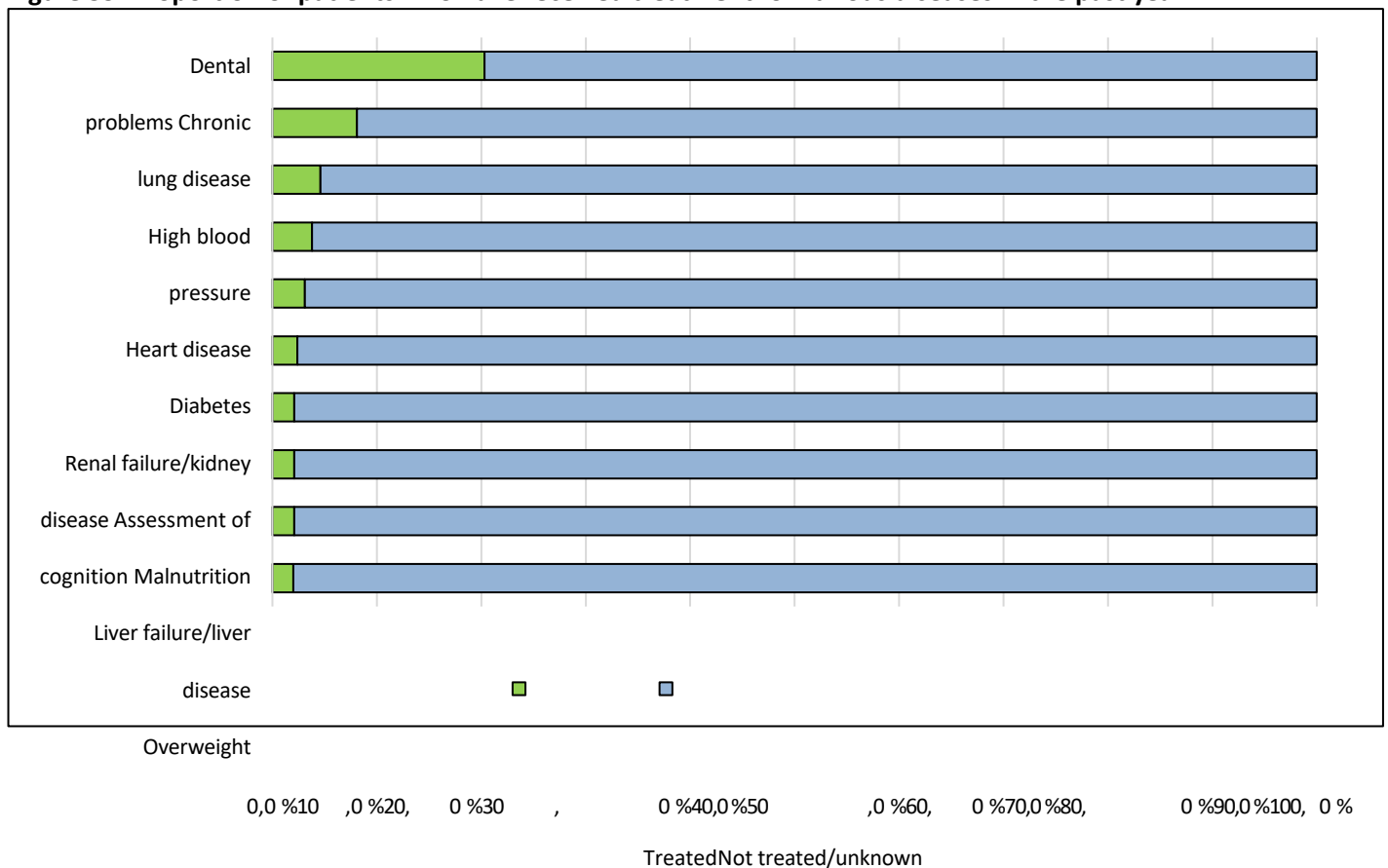
Figure 58. Proportion of patients who have had various diseases in the past year.



Treatment for various diseases

Figure 59 summarizes the treatment received for various diseases in the past year. The proportion that had received treatment for dental problems was the largest (20.3%), followed by chronic lung disease (8.1%). There were some differences in the distribution of completed treatment across DAR interventions. The proportion receiving treatment for dental problems was highest in Førde (38.4%) and Fonna (34.9%), and lower in Oslo (17.8%) and Bergen (17.7%). A higher proportion had received treatment for chronic lung disease in Fonna (21.0%) than in Oslo (5.7%), Bergen (7.6%) and Førde (8.2%). The largest proportion had received treatment for high blood pressure in Fonna (11.3%), compared with Oslo (4.1%), Førde (4.1%) and Bergen (3.6%). Furthermore, the largest proportion had received treatment for lung disease in Fonna (21.0%), compared with 8.2% in Førde, 7.6% in Bergen and 5.7% in Oslo. For the remaining diseases, the distribution of treatment received was fairly similar across measures. Overall, there was a high degree of correspondence between the various diseases identified and the treatment provided for these.

Figure 59. 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 60). Chronic pain was defined here as persistent pain lasting more than three months. Overall, 33.4% responded that they had had chronic pain in the past year (39.8% in Fonna, 34.6% in Oslo, 31.0% in Bergen and 30.1% in Førde). 20.2% had unknown status regarding chronic pain in the past year (23.7% in Bergen, 5.5% in Førde, 12.4% in Fonna, 20.0% in Oslo). 46.4% denied having had chronic pain in the past year (64.4% in Førde, 47.8% in Fonna, 45.5% in Oslo, and 45.4% in Bergen). In comparison, it is often reported that about one third of the general population report having chronic pain.

Of the 33.4% who responded affirmatively to chronic pain (616 people), 89.3% answered the question of whether they had received treatment for this (550 people). Of this proportion, 45.3% had not received treatment and 3.7% had unknown status. 21.4% had received treatment with non-opioid painkillers, 13.6% had received

treatment that was non-pharmacological, and 5.2% had received treatment with opioids in addition to their OMT medication. In total, 40.2% had received treatment for chronic pain. Figure 61 shows the distribution of chronic pain treatment overall and by OMT intervention.

Figure 60. Proportion of patients who have had chronic pain in the past year (unknown = 20.2%).

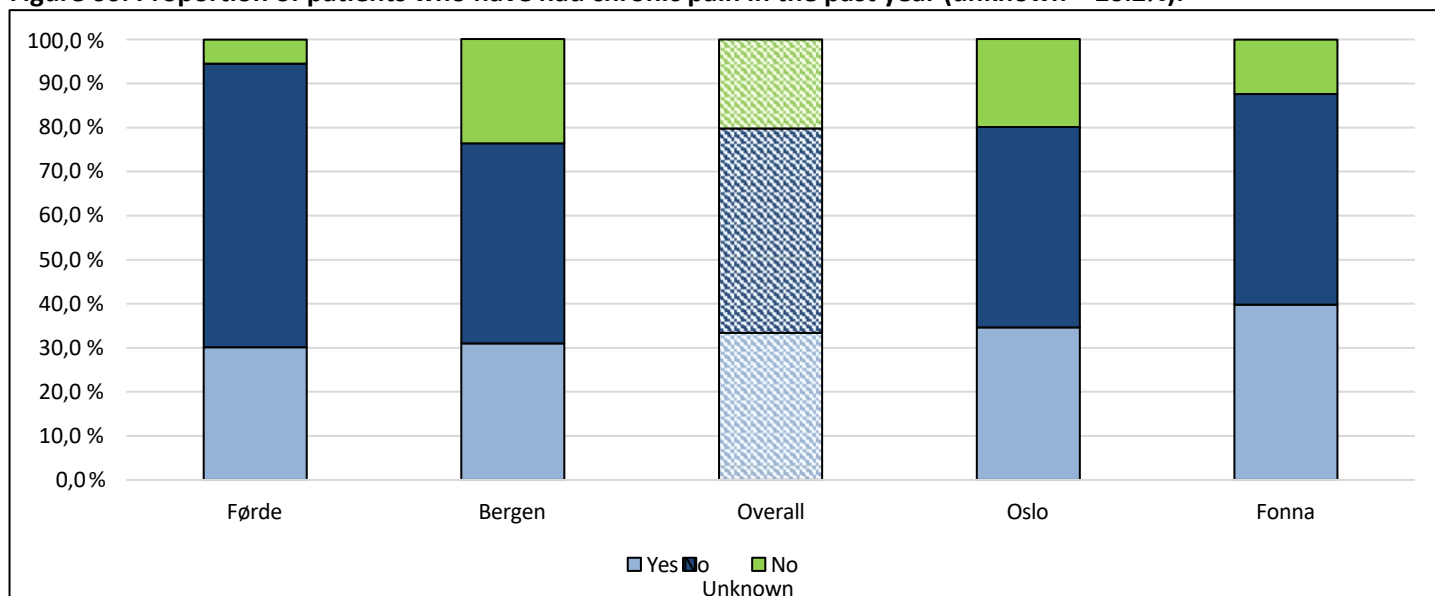
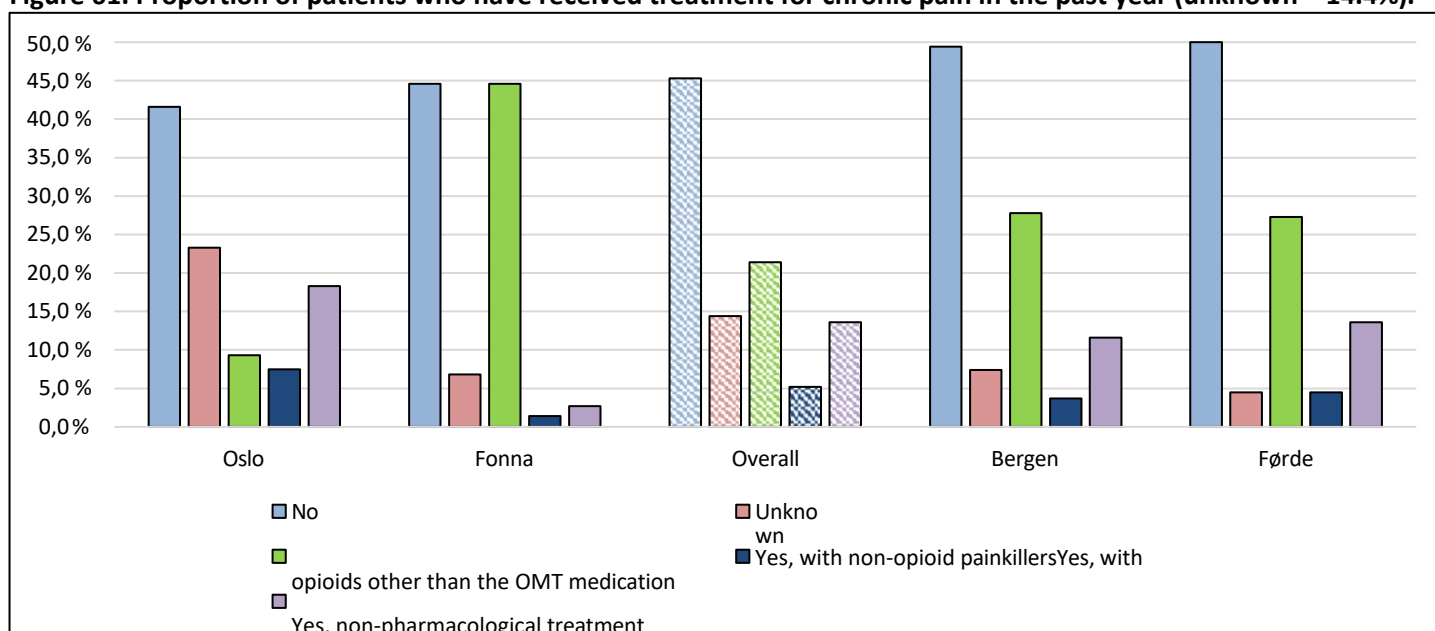


Figure 61. Proportion of patients who have received treatment for chronic pain in the past year (unknown = 14.4%).



Use of tobacco

Regarding tobacco use in the past year (Figure 62), 59.1% answered in the affirmative and 13.2% in the negative. Information was missing for a quarter of the participants, and the proportion who had used tobacco in the past year was probably higher. Among those who had used tobacco (Figure 63), 41.8% reported using cigarettes and 10.5% reported using snus. A small proportion had used e-cigarettes (1.6%).

Figure 62. Proportion of patients who have used tobacco in the past year (unknown = 27.7%).

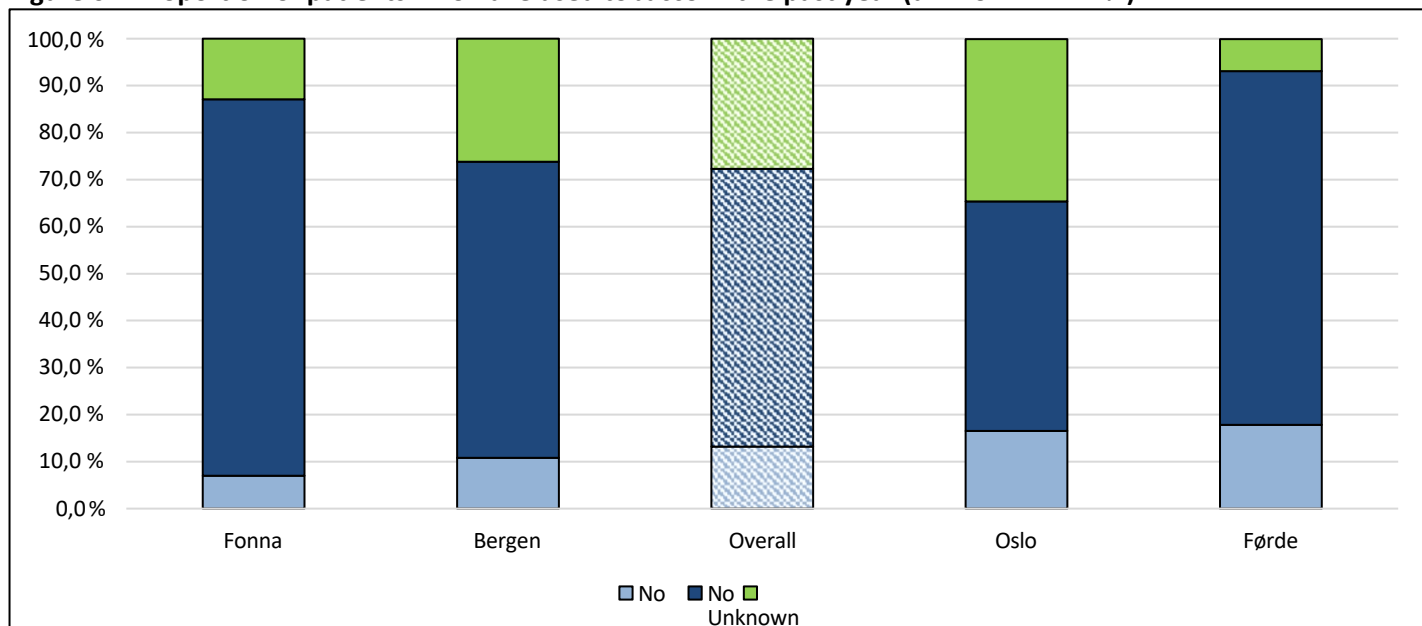
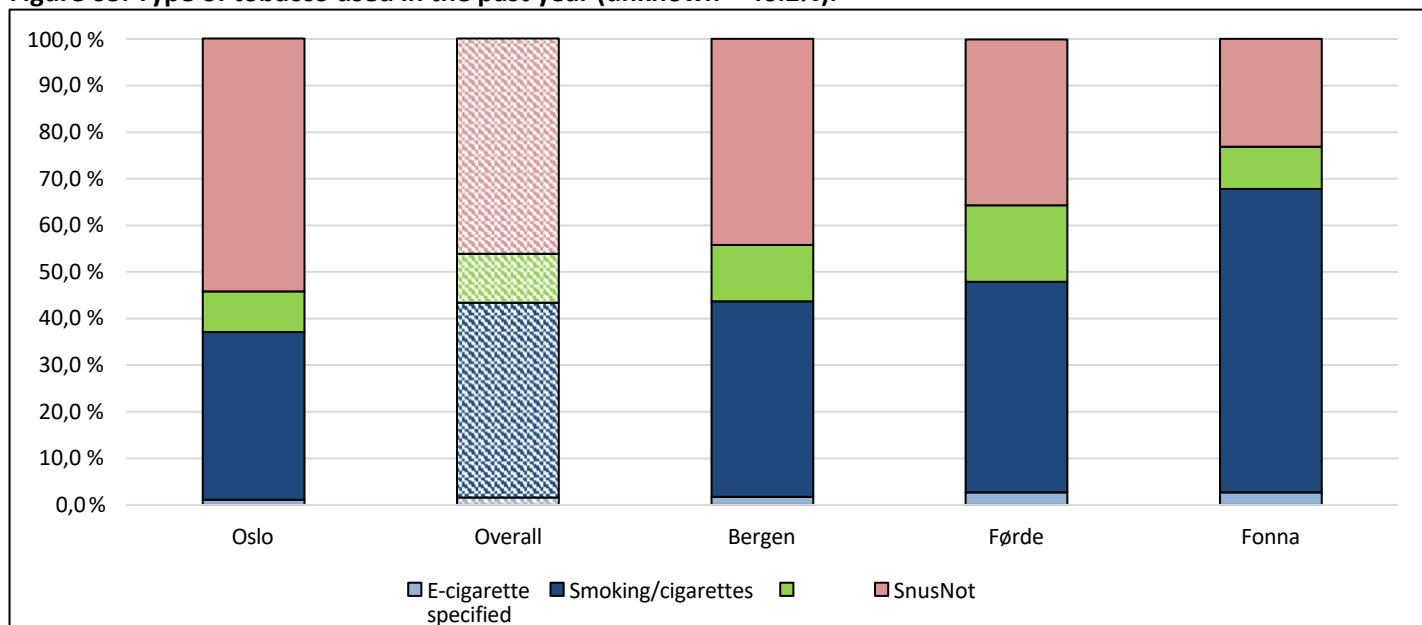


Figure 63. Type of tobacco used in the past year (unknown = 46.2%).



Assessments of physical health and treatment in the past year

The status survey shows that just under half of the patients in this sub-sample had experienced health problems that affected their lifestyle and quality of life, and a third had suffered from chronic pain. The most common health problems, in addition to chronic pain, were dental problems and chronic lung disease, but a number of others also occurred.

Dental treatment is free of charge for patients in DAR, unlike patients in other parts of TSB. When a large proportion of patients in DAR experience dental problems, it is positive to see that many receive dental treatment. The figures give reason to believe that it is important to continue to offer free dental treatment.

Among lifestyle-related factors, tobacco use was surveyed. Fewer people reported tobacco use than has been described in studies of patients in DAR¹¹, but this must be understood in the context of the fact that the status is unknown for a large proportion of the DAR patients who participated in the status survey. Tobacco use increases the risk of chronic lung disease and should be an important priority area.

Most patients had been to a medical examination in the past year, and have thus received some follow-up for somatic health. In addition, the treatment received largely corresponded with the various diagnosed diseases. Of those who received treatment for chronic pain, a small proportion of around 5% received opioid-based treatment for this. The figures thus show that some patients experience a number of different health-related stresses, but also follow up and receive relevant treatment for these.

The findings show that patients in OMT have a number of different physical health problems that require follow-up. DAR patients live up to 15 years shorter¹² and develop health problems earlier than the rest of the population. Since physical health problems such as cancer, cardiovascular disease and chronic lung disease increase with age, OMT services should plan and coordinate regular check-ups of health problems, including monitoring side effects of prescribed medication. GPs play a key role in the tripartite collaboration in OMT, and have a particularly important role in identifying and treating somatic illness. Especially in the health trusts where the OMT doctor prescribes OMT medication, it is important that the GP is actively involved in the treatment, or that the OMT initiative itself facilitates such systematic medical examinations and relevant follow-up.

¹¹ Bjørnstad, E., Vederhus, J. K., & Clausen, T. (2022). High smoking and low cessation rates among patients in treatment for opioid and other substance use disorders. *BMC Psychiatry*. <https://link.springer.com/article/10.1186/s12888-022-04283-6>

¹² Lewer, D., Jones, N. R., Hickman, M., Nielsen, S., & Degenhardt, L. (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/>

SATISFACTION SURVEYS

Patients' assessments of the treatment they receive are a key measure of whether the individual subjectively experiences benefit from and satisfaction with the treatment. It is also relevant to look at the degree of satisfaction among patients together with the therapists' assessment and any identified need for change. Patients are asked about satisfaction with the treatment as a whole, and may therefore have different aspects of the treatment in mind when answering the question. The question can thus cover both the drug treatment and the psychosocial follow-up.

Patients' assessment of the treatment

Below is an overview of average patient satisfaction with treatment for the previous year (Figure 64). Despite the emphasis on asking the patient, the proportion of patients with an unknown perception of the treatment was high (21.2%) compared to most other questions in the status survey. On average, more than half (56.9%) of DAR patients stated that they were satisfied with the treatment they received, similar to the satisfaction figures for 2021 (56.1%). A proportion of patients reported mixed treatment satisfaction (17.7%). A minority were dissatisfied or perceived their treatment as unsuccessful (4.2%), marking a slight increase from last year (3.1%).

Patients' satisfaction with the treatment was fairly evenly distributed between the different regions. However, there was some variation between the health trusts. The highest proportion of satisfied patients was in Vestfold (69.9%) and Førde (67.1%), and the lowest proportion of satisfied patients was at Helgelandssykehuset (45.0%) and Finnmarkssykehuset (46.2%). Fonna Hospital had the highest proportion of patients who were dissatisfied (9.7%), and Nordland Hospital had the lowest proportion of patients who were dissatisfied with their treatment (1.4%). The proportion with unknown treatment satisfaction was generally quite high, but lowest in Førde (6.8%) and Vestfold (8.1%).

Figure 64. Proportion of patients assessed as satisfied with the treatment program (unknown = 21.2%).

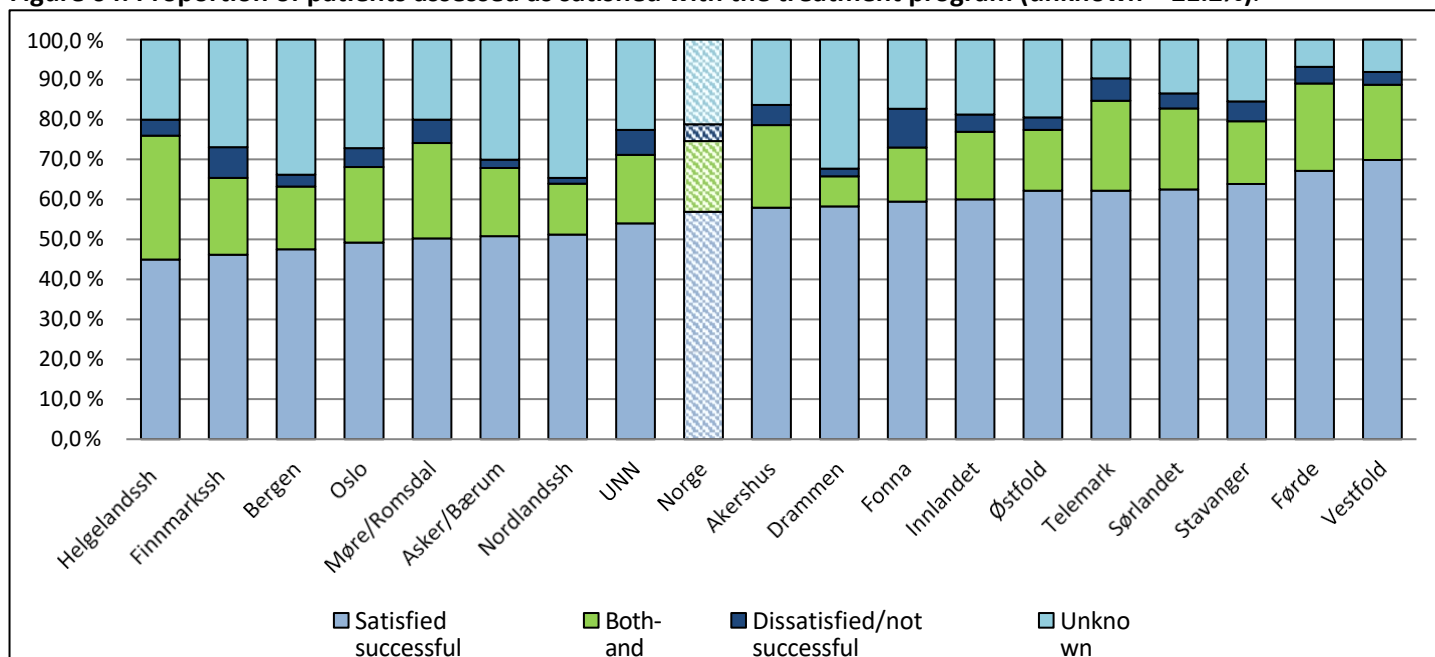
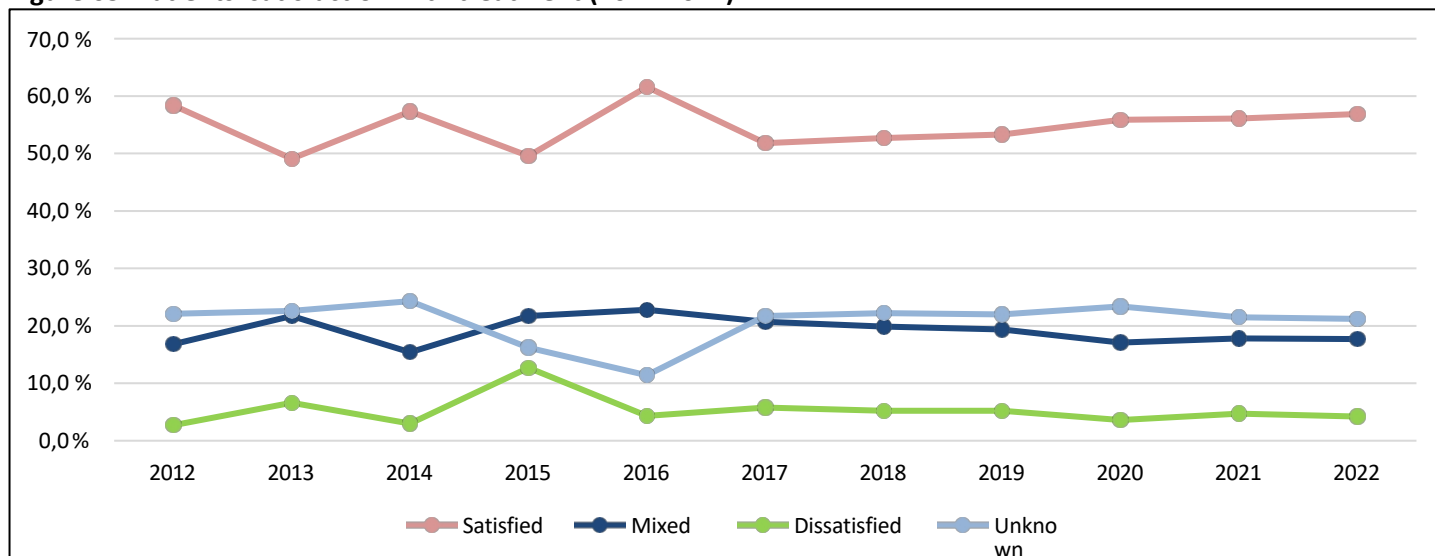


Figure 65 shows the development in patients' satisfaction with treatment over time. Between 2012 and 2017, there were clear fluctuations from year to year, while the proportion of satisfied patients has been stable, but slightly increasing in recent years.

Figure 65. Patients' satisfaction with treatment (2012-2022).



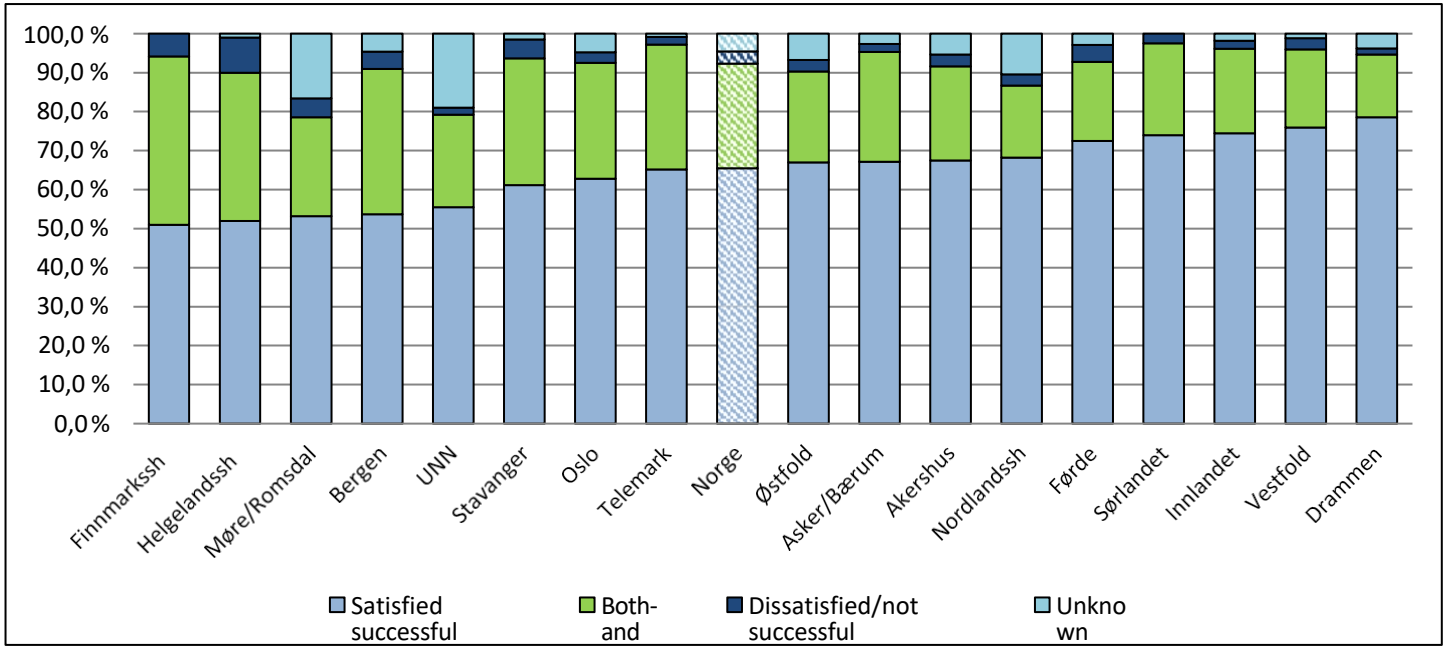
Practitioners' assessment of the treatment

Figure 66 shows the extent to which the person who completed the status survey with the patient is satisfied with the treatment. On average, practitioners were satisfied with the treatment for 65.4% of patients, and partially satisfied for 27.0%. In only 3.1% of cases did the practitioner declare themselves dissatisfied with the treatment.

There was clear variation between regions in practitioners' satisfaction with treatment. In the South, practitioners reported satisfaction with treatment for as many as 72.7% of patients. The distribution of dissatisfaction with treatment was generally low. At the intervention level, satisfaction with treatment was highest among therapists in Drammen (78.5%), Vestfold (75.9%) and Innlandet (74.4%). Most practitioners were partially satisfied with the treatment for individual patients at Finnmark Hospital (43.1%), Helgeland Hospital (38.0%) and Bergen (37.3%). The proportion of practitioners who felt that the treatment was not sufficiently satisfactory was lowest in Fonna (1.1%) and Drammen (1.6%). In some locations, the proportion with unknown treatment satisfaction was elevated.

This was particularly true in DAR at the University Hospital of North Norway (19.0%) and Møre og Romsdal (16.6%).

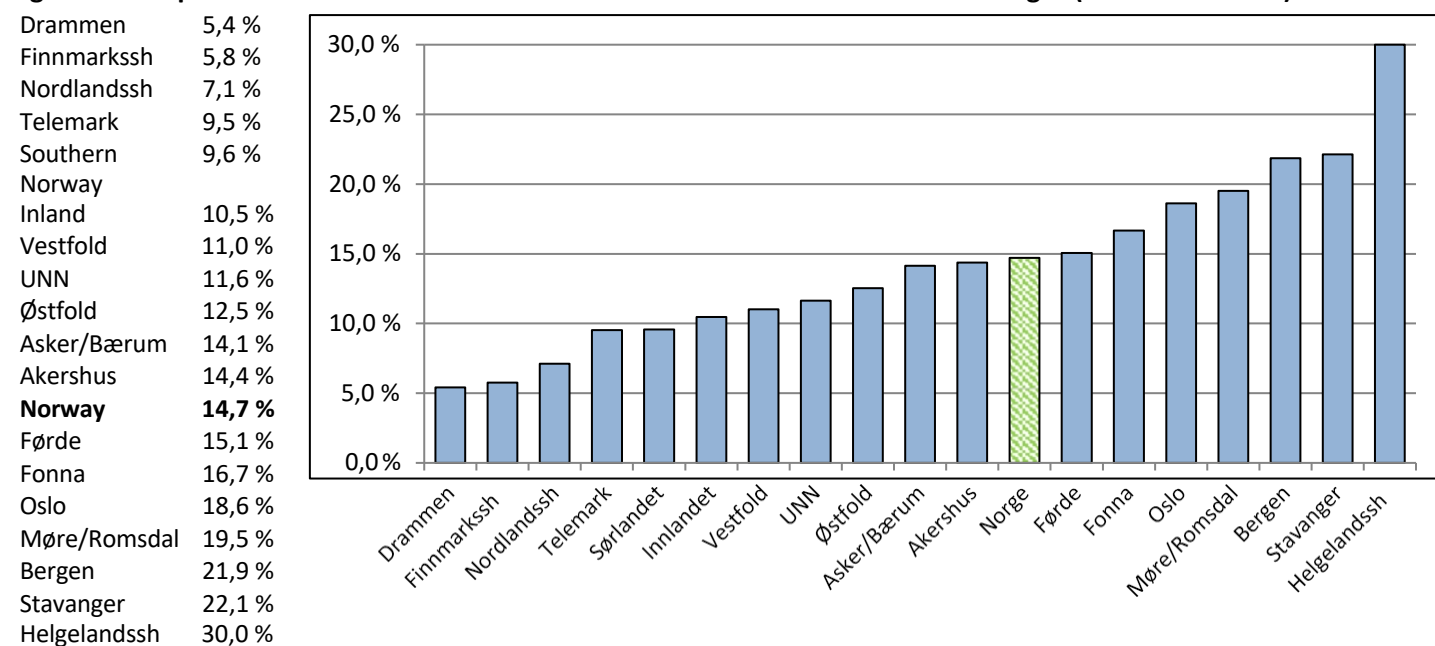
Figure 66. Proportion of fillers who are satisfied with the treatment (unknown = 4.6%).



Need for change in treatment

Figure 67 shows an overview of therapists' assessments of whether the treatment plan or treatment goals should be revised. Nationally, 14.7% of therapists identified a need for treatment changes for their respective patients, roughly the same as in the previous year. The fewest identified the need for treatment changes were in Drammen (5.4%) and at Finnmark Hospital (5.8%). At Helgelandssykehuset, the need for treatment changes was reported for up to 30.0% of patients, roughly the same as in the previous year.

Figure 67. Proportion of fillers who consider that there is a need for treatment changes (unknown = 6.5%).



Patient and provider satisfaction ratings

This part of the survey is mainly intended as information for each DAR initiative. The questions are primarily intended as quality assurance, and there is no objective assessment of the quality 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 is little difference between the DAR measures. The differences that do exist stem primarily from the weighting between satisfied and partially satisfied, and from the proportion reporting an unknown degree of satisfaction. The responses for 2022 are very similar to the responses from 2021.

One important finding is that therapists want a change of treatment for 1-2 out of 10 patients. This order of magnitude is comparable with previous years. 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 pick-up arrangement, or other elements related to the medication or psychosocial follow-up. There are also fairly large differences between the measures in these assessments. Differences in terms of problem pressure and clinical ambitions therefore make it difficult to emphasize the pattern. Perhaps the most important thing is that the survey should lead to a conscious status for each individual patient at least once a year, and that this can be followed up with an assessment of further efforts. This should then be followed up with an assessment in each individual case.

PATIENTS IN HEROIN-ASSISTED TREATMENT

Based on the choice of medication, it was possible to identify patients who participated in the status survey and who were receiving heroin-assisted treatment within OMT. Heroin-assisted treatment (HAB) is a five-year trial project covering Oslo and Bergen, starting in 2021. The purpose is, as in other forms of OMT, to provide life-saving and stabilizing treatment that leads to improved quality of life, while at the same time enabling HAB to reach people who have tried ordinary OMT but have not experienced sufficient benefit from this treatment¹³.

Patients in HAB are prescribed diacetylmorphine, or heroin, as their OMT medication. The treatment involves attendance at the HAB clinic twice a day for drug intake (ingested, intramuscular or in tablet form), as well as other drug treatment and psychosocial follow-up as needed. In Oslo, the maximum concurrent patient capacity is currently 50, and in Bergen 40. A total of 41 patients who participated in the status survey reported diacetylmorphine/heroin as their OMT medication, 27 in Oslo and 14 in Bergen.

The lowest dosage of diacetylmorphine was 240 mg/24 hours, and the highest dosage was 920 mg/24 hours. Below is a brief description of the patients' situation and treatment, compared with patients in other OMT.

Figure 68. Comparison of situation and treatment factors among patients in HAB with patients in other OMT.

	Patients in HAB	Patients in LAR
Gender	19.5% women 80.5% men	29.7% women 70.3% men
Age	46.7 years	47.8 years
Housing situation	65.9% own home 17.1% hospices/hospices/hotels 4.9% with others 9.8% in an institution 2.4% without permanent housing	79.0% own home 3.0% hospices/hospitals/hotels 3.6% with parents 2.8% with others 1.2% in prison 5.7% in an institution 1.8% without permanent housing 2.8% unknown living situation
Main activity	95.1% without employment 4.9% in part-time jobs	82.4% without employment 9.0% in full-time employment 5.6% in part-time jobs 1.3% in education 0.4% in part-time work and education 1.3% unknown
Main income	58.5% disability pension 22.0% AAP 14.6% social assistance 2.4% sickness or rehabilitation benefit 2.4% other/unknown	70.2% disability pension 10.8% AAP 4.2% social assistance 9.9% earned income 4.9% other
Anchoring the treatment	100% anchoring in TSB	78.3% anchoring in TSB
Additional prescription of benzodiazepines	19.5% additional prescription 75.6% no additional prescription 4.9% unknown status	38.4% additional prescription 57.5% no additional prescription 4.0% unknown status
Side effects of OMT medication*	9.8% side effects 53.7% no side effects 34.1% not applicable 2.4% unknown status	8.4% side effects 38.4% no side effects 36.0% not applicable 17.0% unknown

¹³ Eide, D., Muller, A., Bukten, A., & Clausen, T. (2019). Treatment of opioid-dominated substance use disorder: a pilot project with heroin-assisted treatment. A review of the knowledge base for heroin-assisted treatment and recommendations for a pilot project commissioned by the Norwegian Directorate of Health. Oslo: UiO.

Drug tests	97.6% not regular drug tests 2.4% unknown status	42.0% non-regular drug tests 29.3% random tests 24.8% regular drug tests 3.9% unknown status
Treatment goal setting	97.6% stabilization without drug-free requirements 2.4% rehabilitation with drug-free status	27.1% stabilization without drug-free requirements 68.5% rehabilitation with drug-free status 4.3% not clarified
Individual plan	41.5% IP 51.2% not IP 7.3% unknown status	10.9% IP 78.1% not IP 11.1% unknown status
Responsibility group meeting last three months	22.0% responsibility group meeting 70.7% no responsibility group meeting 7.3% unknown status	32.2% Responsibility group meeting 65.6% no responsibility group meeting 2.2% unknown
Treatment for mental health problems in the last four weeks	2.4% received treatment 90.2% did not receive treatment 7.3% unknown status	13.3% received treatment 83.2% did not receive treatment 3.4% unknown status
Mental health problems in the last four weeks	12.2% depressive symptoms 29.3% anxiety symptoms 2.4% delusions	15.3% depressive symptoms 26.0% anxiety symptoms 6.9% delusions
Substance use in the last four weeks	14.6% no substance use in the last four weeks 19.5% few individual episodes 63.4% regular use 2.4% unknown status	38.4% no substance use in the last four weeks 18.0% few individual episodes 30.1% regular use 13.5% unknown status
Overdose last year	14.6% overdose	5.7% overdose
Patient satisfaction with treatment	58.5% satisfied 26.8% mixed 2.4% dissatisfied 12.2% unknown	56.9% satisfied 17.7% mixed 4.2% dissatisfied 21.2% unknown
Practitioner satisfaction with treatment	53.7% satisfied 31.7% mixed 2.4% dissatisfied 12.2% unknown status	65.4% satisfied 27.0% mixed 3.1% dissatisfied 4.5% unknown
Need for change	80.5% no need for change 17.1% need for change 2.4% unknown status	78.8% no need for change 14.7% need for change 6.5% unknown status

* Includes only DAR initiatives that have DIPS Arena, i.e. Oslo, Bergen, Førde and Fonna.

Assessments of the patients' situation

Patients in HAB have participated in the annual status survey for the first time, and differ in several respects from patients in other forms of OMT. The proportion of women in HAB is lower than in other OMT, and the average age is one year younger. Furthermore, patients in HAB appear to have a somewhat less stable social situation than patients in other OMT, with a higher proportion having temporary housing and temporary sources of income, and a higher proportion being unemployed. At the same time, a larger proportion of HAB patients are undergoing work assessment.

In line with the intentions of HAB, patients 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 the patients in HAB is anchored in TSB, whereas this is the case for three out of four in other OMTs. Furthermore, we see that more patients in HAB have an IP than in other OMTs, while the proportion with a responsibility group meeting was somewhat lower in HAB. This indicates that the follow-up provided is slightly different.

There is a clear difference in the treatment goals for patients in HAB, who almost exclusively have

stabilization without drug-free requirements as their treatment goal. This shows that HAB, which is intended to reach patients who have found ordinary OMT insufficiently useful, is particularly important as harm reduction for a fairly small group

heavily burdened patients. However, it is conceivable that treatment goals will change over time, and that the picture will look different after more time with HAB.

When it comes to mental health, the differences are small, and the prevalence of depression and anxiety symptoms is roughly equally distributed in HAB and other OMT. When it comes to substance abuse, we see that having some substance abuse is significantly more prevalent among patients in HAB, while 6 out of 10 can be considered to have good substance abuse control. The proportion who have experienced an overdose is also higher among patients in HAB. There may appear to be different needs in the work on substance abuse management and harm reduction in HAB compared with other OMT.

It is interesting to see that the degree of treatment satisfaction is largely comparable between patients in HAB and patients in other OMT. At the same time, there is a large degree of overlap between the patients' satisfaction and the therapists' assessments of whether the treatment is satisfactory, and for most patients there is no reported need for changes in treatment. This indicates that HAB is perceived as useful for the majority of patients.

FATALITIES IN LAR

The OMT initiatives have reported the number of deaths through the initiatives' annual reporting since 2000. Compared with the average number of patients in treatment, the annual mortality rate can therefore be calculated as the number of deaths/100 patient years, which is the same as the percentage that died of the number of patients in treatment (mortality rate). This year's status report largely presents results for the same variables as in previous reports.

A total of 147 deaths were reported by the health trusts for 2022 and there were 146 forms with information about the death (hereafter referred to as "death registration forms"). The health trusts in Trøndelag have not reported deaths for 2022 due to registration problems in connection with the introduction of the healthcare platform and have therefore been removed from the overview. The figures for Central Norway Regional Health Authority in the table below are therefore not comparable with previous years. The national mortality rate has been corrected for missing data from Trøndelag and is therefore comparable with previous years. When calculating annual mortality, we have assumed 147 deaths. This corresponds to a mortality rate in 2022 of 1.82/100 patient years (1.82%). Table 6 shows the number of deaths, nationally and regionally.

Table 6. Annual incidence of deaths in OMT reported by the OMT interventions.

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

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

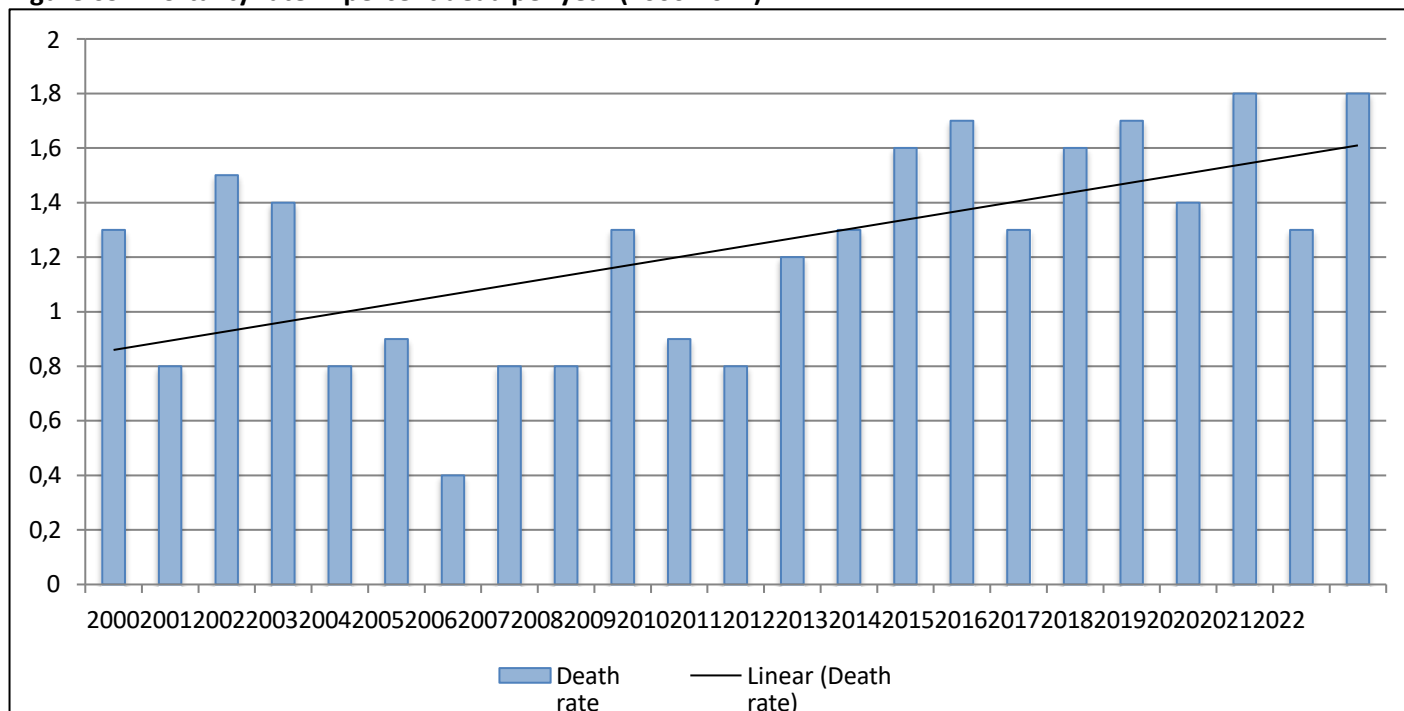
* After correction for deaths that occur more than 5 days without medication, the rate is 1.4 per 100 patient-years in both 2014 and 2015, 1.2 in 2016, 1.4 in 2017 and 2018, 1.3 in 2019, 1.7 in 2020, 1.2 in 2021 and 1.7 in 2022.

Of the 147 deaths, 133 were in active OMT (medication) at the time of death, one had not taken OMT medication in the last 1-5 days, five had not taken it in the last 6-30 days, three had not taken it in more than 30 days and for five, the OMT status was unknown.

Due to the rapid loss of opioid tolerance after discontinuation of opioids, as in previous years, we consider 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" (134 people), while those who had been unmedicated for more than five days were considered "after OMT" (8 people). In addition, as mentioned above, the OMT status was unknown for five people. If we include these, we get a maximum of 139 deaths during treatment, which gives a death rate of 1.7%. Unless otherwise specified, the following description of the deaths is based on the 134 deaths that we know with certainty occurred "during DAR treatment".

The death rate during OMT (Figure 69) is 1.7%. This is significantly higher than in 2021 (1.2%), but at the same level as 2020 (1.7%). It is most natural to consider the rates for 2021 (low) and 2022 (high) as random fluctuations within the long-term trend of slightly increasing mortality in OMT that we have seen throughout the history of OMT in Norway (see other reviews).

Figure 69. Mortality rate in percent dead per year (2000-2022).



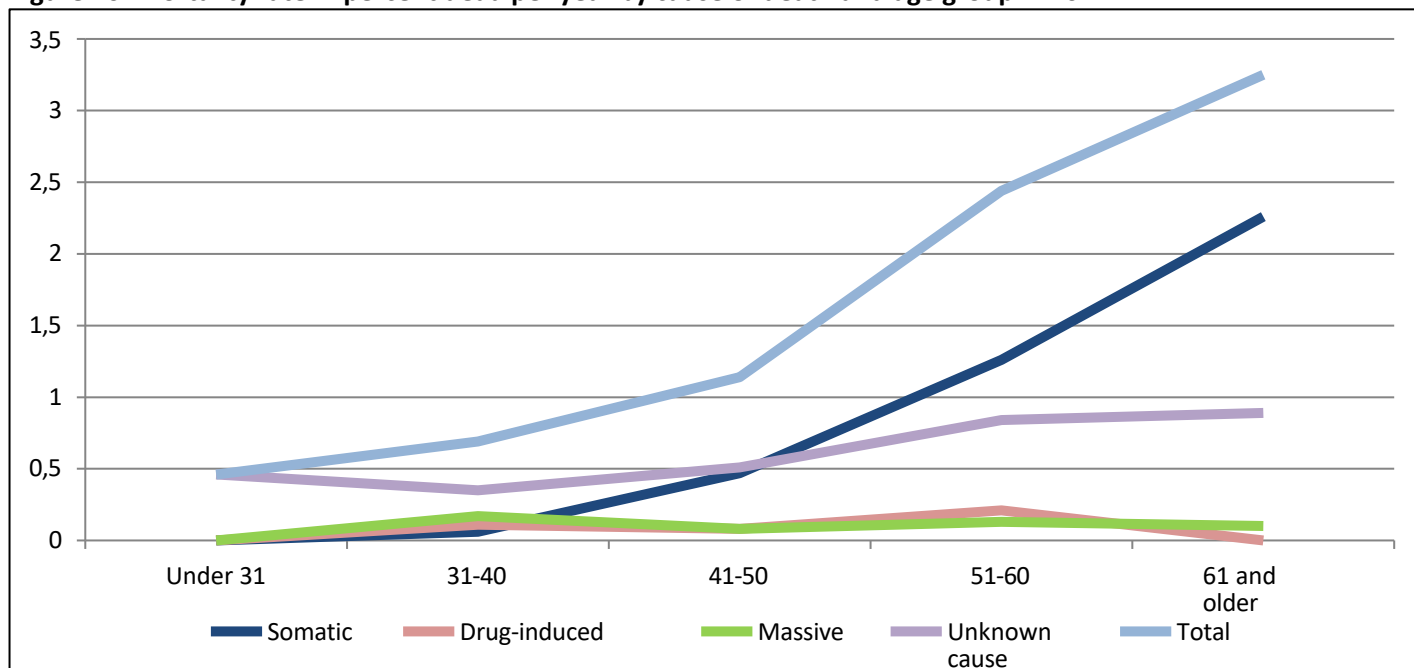
Causes of death and age profile

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

In 2022, the average age of those who died was 53.6 years, the youngest was 24 and the oldest 70. In 2021, the average age was 53.2 years. The average age for everyone in DAR in 2022 was 47.8 compared to 47.0 in 2021.

The mortality rates for the different main groups of deaths in the different age groups are shown in Figure 70. The rates show essentially the same pattern as in previous years. The rates for overdose deaths and violent deaths are relatively stable across age groups, while deaths from somatic causes rise from around the age of 40. Deaths where the cause of death is not known in DAR also rise from around the age of 50. The increase in somatic deaths after the age of 40 is the main reason for the age profile of total mortality.

Figure 70. Mortality rate in percent dead per year by cause of death and age group in 2022*.



* Causes of death after assessment of DAR in the health trusts, not the Cause of Death Registry.

Table 7 shows the presumed cause of death reported by DAR in the health trusts in the 134 deaths "under DAR treatment". In 50 of the 134 deaths (37%), the cause of death is unknown to DAR in the health trusts. As before, we have not had access to data from the Cause of Death Registry. Among all the 147 reported deaths, the sources of information on the presumed cause of death were distributed as follows: 4% autopsy reports, 48% hospital discharge summaries, 6% attending physician and 21% other sources, such as other parts of the treatment system or family and acquaintances. For 20%, no source was stated. All in all, the presumed cause of death was stated for 91 of the 147 reported cases, while for 56 (38%) the cause of death was stated as unknown. The overview of causes of death is thus limited and uneven in DAR in the HFs, and there is potential for improvement here. The distribution of reported causes of death is little changed from previous years.

When we only include those in active OMT with stated cause of death, 79% died from somatic disease in 2022, compared to 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. Most, and an increasing proportion, die from somatic causes. Cancer, cardiovascular disease, lung disease and bacterial infections dominate.

Among those who died from somatic diseases, the average age was 58.6 years, 47.2 years for violent deaths and 47.2 years for overdose deaths. The age of those who die from somatic disease is rising as expected. For the 134 people undergoing OMT (including those with unknown cause of death), 30% of those under the age of 51 died of somatic disease. For those aged 51 and over, 58% died from somatic causes. If we exclude those with unknown causes, the figures are 59% and 86% respectively. This shows the increasing mortality from somatic diseases, acute and chronic, with increasing age.

In the entire DAR population, 70% were men and 30% women in 2022, while among those who died during DAR treatment, 76% were men and 24% women. The mortality rate was 1.8% for men and 1.3% for women (one person whose gender was not stated is not included in the calculation). Men accounted for 77% of those who died from somatic causes, 5 out of 9 who died from overdose, and 9 out of 9 with violent causes of death in 2022.

Table 7. Deaths during OMT* in 2022: cause of death, gender and age.

Included in the calculations are 134 deaths, 82 with a known cause of death and 52 without.

Cause of death	Number (percent of all with presumed known cause of death)	Men (percent of women + men)	Women	Average age (lowest and highest)
Liver disease incl. liver cancer	5	3	2	58,6 (54-68)
Bacterial infection, incl. "multi-organ failure"	12	9	3	56,9 (43-68)
Cancer (except liver cancer)	20	15	5	56,7 (46-70)
Heart/vessels	5	3	2	55,8 (46-64)
Kidney	5	3	2	56,0 (45-65)
Other somatic**	19	18	1	57,5 (39-69)
Somatic total	66 (79)	50 (77)	15	57,0 (39-70)
Overdose	9 (11)	5 (63)	3	47,2 (33-54)
Homicide***	1***	1	0	
Suicide***	2***	2	0	
Accident	4	4	0	49,0 (33-56)]
Non-special, violent death***	2***	2	0	
Violent death, total	9 (11)	9(100)	0	47,2 (33-64)
Unknown	50	38 (75)	13	51,4 (24-66]
Total	134	102 (76)	22	53,6 (24-70)

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

** Includes both those who have not stated a *specific* somatic cause of death (only somatic death) and those with a specific cause of death that is not covered by the above categories.

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

Overdose deaths

11 (7%) of all reported deaths in 2022 were overdoses. 9 occurred during ongoing OMT medication, while one occurred between six and 30 days and one more than 30 days after completion of medication. The mortality rate for known overdoses is 0.11% during OMT. This is similar to previous years, with minor fluctuations that are considered random. There were as many as 50 deaths with unknown causes, and it is reasonable to assume that a larger proportion of these were due to overdose than among deaths with known causes. Nevertheless, there is reason to assume that the overdose mortality rate in DAR in Norway is significantly reduced compared with the corresponding population outside DAR. The issue of overdose deaths in OMT and OMT drugs as a cause of deaths outside OMT is discussed in more detail in the 2019 Status Report ([download here](#)).

Place of death

Of the 66 who died from somatic causes, 44 (67%) died in hospitals/nursing homes and 14 (21%) at home. Although the proportion of deaths in hospitals/nursing homes is somewhat lower than in 2021, there is reason to assume that many of those who die from *chronic* somatic disease receive adequate medical treatment at the end of life. However, when more than 20% of those with somatic causes of death die at home (17% in 2021), this may also indicate that a significant proportion of those who die from *acute somatic illness* do not receive medical treatment. There is an opportunity for improvement here through better routines for following up patients who become ill. 5 of the 9 who died of an overdose died at home, while 28 of the 50 with unknown cause of death also died at home, which may indicate a higher proportion of overdoses among those with unknown cause of death compared with the rest.

LAR drugs used by those who died

In 2022, 33% of all OMT patients used methadone, while 60% used buprenorphine (37% buprenorphine molten tablet, 6% buprenorphine/naloxone molten tablet, and 17% buprenorphine depot injection) and 6% other opioids as OMT medication. Table 8 shows which OMT medication the deceased used in 2022. 52% used

methadone, compared with 56% in 2021, and an average of 54% 2014-2020 and 37% buprenorphine, compared with 40% in 2021, and an average of 42% 2014-2020. Four of the buprenorphine patients used depot injection. In 2022, six people used "other" and seven "unknown/not stated" OMT drugs. Of the six with "other", four used 12-hour morphine tablets (Dolcontin /Malfin[®]), one used oxycodone and one was reported to be using "palliative treatment". These findings are in line with previous years.

The overall mortality rate for those on methadone in 2022 was 2.6% and 1.0% on buprenorphine. For somatic causes of death, the rate for methadone was 1.2% versus 0.4% for buprenorphine, for overdose deaths 0.1% for both methadone and buprenorphine, for violent causes of death 0.1% for both methadone and buprenorphine and for deaths from unknown causes 1.1% for methadone and 0.4% for buprenorphine. The generally higher mortality rates for patients on methadone compared to buprenorphine are in line with findings from previous years. The average age of methadone patients who died was 54.0 years compared to 52.7 years for those on buprenorphine and this is almost identical to 2021.

Age difference alone cannot explain the difference in mortality between patients on methadone and buprenorphine, and the findings in 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. The risk of overdose death is probably also greater for full agonists, such as methadone, compared with buprenorphine.

Table 8. OMT medication at death and cause of death for all patients undergoing OMT with a death registration form in 2022*.

Cause of death	Methadone	Buprenorphine	Other	Total
Somatic	33	22	11	66
Overdose	4	4	1	9
Violent death	4	5	0	9
Unknown	30	19	1	50
Total	71	50	13	134

* Included in the calculations are 133 deaths.

Dosage level of LAR medication

The average dose of methadone was 88.5 mg for the entire population and 91.7 mg among the deceased (range 30 mg-180 mg), for buprenorphine monopreparation 14.8 mg for everyone and 14.4 mg for the deceased (2 mg-24 mg), for buprenorphine/naloxone 13.1 mg for everyone and 16.3 mg for the deceased. The average dose for methadone is somewhat lower and for buprenorphine monopreparation is somewhat higher than last year. This is perceived as random fluctuations and the assessment is that there are minor changes from previous years.

Deaths after interruption and planned termination of OMT

We do not have an overview of mortality after termination of OMT. We assume that all deaths that occur 1-5 days after the last intake of OMT have been reported, but we do not have a systematic overview of subsequent deaths.

A total of eight deaths have been reported that occurred more than five days after discontinuation of medication, five of these are without agreed tapering (drop-out) and one after planned tapering. Two of the eight deaths (both drop-outs) were overdoses, two were due to somatic illness (one drop-out and one planned discontinuation) and for four the cause was unknown. These four deaths occurred 7-10 days after the last intake of OMT medication, and the likelihood that they were overdose deaths is therefore high. The two known overdoses occurred 10 and 13 days after the last drug intake.

Substance use in the last month before death

Among all OMT patients, 38% were stably drug-free in the last 4 weeks, 18% had sporadic/less serious drug use, 30% extensive/serious use and 14% unknown use. Among the deceased, the corresponding figures were 49% stably drug-free, 9% less severe, 15% severe and 28% unknown use. If we add up the drug-free and those with less serious substance use, the figure is 56% among all those in OMT compared with 58% among the deceased. The level of substance abuse thus appears to be fairly similar when we consider the overall mortality rate.

Among the 66 with somatic cause of death, 68% were stably drug-free, 3% had sporadic and 8% extensive drug use, while for 21% the status was unknown. Among the nine who died from overdose, one was stably drug-free, four had sporadic less serious drug use and only one had extensive serious drug use, while the status was unknown for three. Among the nine with violent cause of death, three were stably drug-free, one had less severe drug use, while three had severe drug use and for two the drug use was unknown. Among the 50 with unknown cause of death, 32% were stably drug-free, 10% had sporadic and 22% extensive substance use, while the status was unknown for 36%. This shows that among those with registered substance use and who die from overdose or violent causes, only four out of 13 (31%) are considered stably drug-free, compared with 45 out of 53 (87%) of those with somatic causes of death. As in previous years, this indicates an association between substance use and an increased risk of fatal overdose and violent death.

Assessments of deaths in LAR

Significantly more deaths were registered in total (147 vs. 102) and during active OMT (134 vs. 92) in 2022 compared with 2021. In 2022, Trøndelag is not included due to registration problems, and with the same mortality rate as the rest of the country, the expected number of deaths there would be around eight. However, in 2020, a total of 146 deaths were reported and 137 under OMT, which is very similar to 2022.

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 67) and the distribution of causes of death (Table 8). 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 40 and 50 years of age.

This year's figures are in line with previous years. The reduced mortality rate in OMT compared with opioid addicts who are not in OMT treatment is largely due to the fact that far fewer die of overdose early in life in OMT than outside OMT, even though mortality is also reduced for other reasons in OMT compared with outside OMT. This means that opioid addicts in OMT as a group live longer than before OMT was available, but also that they are increasingly affected by chronic and acute somatic diseases as they get older. This applies partly to diseases specifically related to substance use, but also to the somatic diseases that are most common in the population, such as cardiovascular diseases, cancer and lung diseases, which are also common causes of death in DAR. As a group, they are affected by these diseases earlier than the average in the population, which is partly related to previous long-term, and for some ongoing, substance use and a very high prevalence of smoking.

Although the increase in somatic mortality is expected, it can be reduced. As in previous years, we would therefore like to emphasize that the treatment system must focus on the detection, treatment and follow-up of chronic diseases and good routines for identifying and treating acute somatic illness. There is considerable potential for improvement here. Health promotion measures are also important, not least measures for smoking cessation or reduction. This should be a natural part of 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 overdoses and acute and chronic somatic illness and death. Focusing on substance abuse management in OMT is therefore also important from this perspective, not least as patients get older.

SUMMARY

The status report for 2022 is the first after the new guidelines were introduced in May 2022. The main trend in the findings is that much is fairly similar to what has been reported in previous years. In some areas, there is geographical variation between the OMT initiatives, which to some extent can be explained by different characteristics among the patients, while some must probably be attributed to differences in organization or differences in the treatment provided.

There were 7643 patients in OMT in 2022, but the actual number is higher and probably in line with the steady increase in the number of patients. Participation in the status survey was high, with an 83% response rate among DAR patients from the previous year. This year, Nord-Trøndelag and St. Olavs hospital are not included in the data basis of the report, as the transition to the medical record system Helseplattformen did not allow for reporting to the status survey for 2022.

In this year's report, some new variables have been reported for four DAR initiatives that use DIPS Arena, with more nuances in somatic health and lifestyle. We hope and believe that more interventions will be able to report in the new format in the future, where the registration of data is also more integrated as part of the medical record system.

Overall, the assessment is that OMT in Norway is a treatment that is increasing in scope over time, and today includes several options when it comes to OMT medication. It is a treatment that the majority remain in over time, and that both patients and therapists are reasonably satisfied with. As before, most patients in OMT have rehabilitation with drug-free treatment as their treatment goal, but OMT is also important as harm reduction treatment for many.

Most patients use one of the buprenorphine-based OMT medications, with 1 in 5 using buprenorphine depot this year. Over time, there has been a reduction in the use of drug tests and observed intake of OMT medication, and as many as 1 in 3 do not have urine tests/drug tests as part of the regular follow-up in OMT. Approximately 8% of OMT patients (in a sub-sample of the reporting material) report side effects from the OMT medication. Side effects are reported most frequently among those taking other OMT drugs (such as levomethadone, dolcontin or similar, 12%), while few side effects are reported among those receiving long-term buprenorphine depot (four weeks).

Many patients in OMT report mental or somatic complaints. Anxiety symptoms are most prevalent, followed by depressive symptoms. Few receive treatment for mental health problems. A new development this year is that we have documented that about one third of DAR patients (in a sub-sample of the reporting material) experience chronic pain, about the same proportion as in the general population, but that a fairly large proportion do not receive treatment for this pain. Among other somatic complaints, dental problems and chronic lung disease are the most common, and among these, treatment for the condition in question is fairly widespread.

The use of regular drug tests continues to decline. Around 1 in 10 report having used opioids other than OMT medication in the past month in the status survey. The use of stimulants and benzodiazepines is most prevalent. Around 60% of patients do not use drugs or have only had isolated episodes of drug use recently, and 50% are considered to have good substance abuse control. As a supplement to this information, this year we have new data on syringe use among a sub-sample of OMT patients, which shows that in the past year about 30% have used syringes, half of these on a regular basis.

In terms of infectious diseases, the prevalence of HIV is low in DAR in Norway, and the proportion with active hepatitis C is fairly low, at around 6%. At the same time, there is potential for improvement in that nationally around 15% have unknown hepatitis C status. With effective treatment, testing and treatment of infectious

diseases should be fairly complete and carried out regularly, also to detect reinfection. Many OMT patients experienced COVID-19 during 2022, but only a small number required hospital treatment.

Mortality in OMT is relatively low overall, but is dominated by somatic causes of drowsiness, which rises fairly steeply after the age of 40. Mortality from overdose is low in OMT, as the purpose of the treatment suggests, if

you manage to adequately balance the requirements for soundness and accessibility as well as quality of treatment.

In this year's status report, patients in heroin-assisted treatment are included for the first time. Patients in HAB 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. Patients in HAB and patients in OMT are about equally satisfied with the treatment they receive. In the coming years, the HAB population and the experiences from the pilot projects in Oslo and Bergen will be evaluated through follow-up research led by SERAF, in collaboration with partners.

In the next couple of years, we will gain more knowledge about whether and how the new guidelines for OMT contribute to changes in treatment and treatment-related outcomes, and whether this will lead to changes in the geographical differences we have seen previously. SERAF is conducting an evaluation of the introduction of the new guidelines for OMT.

In an ageing OMT patient population, with a not insignificant disease burden and stressful lifestyle factors, such as a long history of tobacco use, an increasing focus on detection and treatment of somatic conditions is more important than ever. Even though OMT interventions are organized differently, it is important to find ways of working that allow for regular health check-ups and adequate follow-up of somatic illness. In light of this, discussion and exploration of perceived side effects is also important to integrate. Mental health problems are also common and, where appropriate, OMT patients must also be assessed and referred to the right level of treatment. Many patients in OMT experience loneliness and social marginalization, and assistance and facilitation for participation in social activities that are not part of ordinary work efforts should be strengthened in the future. This type of planned work can advantageously be included as part of an IP or systematic treatment plan, and cooperation as part of the tripartite collaboration.

TABLES AND STATISTICS

Norway and regions

	Middle	North	South	Vest	East	Norway
Number of responses	207	644	1855	1519	2177	6402
Response rate	102 %	96,3 %	98,5 %	84,2 %	70,6 %	83,8 %
Gender						
Men	76,8 %	71,6 %	70,8 %	70,5 %	68,8 %	70,3 %
Women	23,2 %	28,4 %	29,2 %	29,5 %	31,2 %	29,7 %
Age (average)	45,5	47,2	48,2	46,7	48,7	47,8

A. Current situation

A0. Current situation

0. Not discharged	98,1 %	96,0 %	94,5 %	98,7 %	96,8 %	96,6 %
1. Own desire for weaning	1,0 %	1,5 %	1,9 %	0,3 %	1,3 %	1,2 %
2. Dissatisfied with the treatment	0,0 %	0,4 %	0,9 %	0,2 %	0,3 %	0,5 %
3. Lack of effect, unjustifiable	0,0 %	0,0 %	0,4 %	0,0 %	0,1 %	0,1 %
4. Treatment difficulties	0,0 %	0,0 %	0,1 %	0,0 %	0,1 %	0,1 %
10. Other	1,0 %	2,2 %	2,1 %	0,7 %	1,4 %	1,5 %

A1. Employment

a. Professional status

0. Without employment	69,6 %	75,2 %	84,0 %	83,5 %	83,8 %	82,4 %
1. Full-time job	18,8 %	10,8 %	9,1 %	8,8 %	7,5 %	9,0 %
2. Part-time job	4,3 %	9,2 %	5,0 %	4,8 %	5,8 %	5,6 %
3. During education	1,0 %	0,3 %	1,2 %	2,1 %	1,2 %	1,3 %
4. Part-time job and in education	0,0 %	0,0 %	0,4 %	0,5 %	0,5 %	0,4 %
9. Unknown	6,3 %	4,5 %	0,4 %	0,3 %	1,3 %	1,3 %

b. Work training/courses

0. No	87,4 %	89,4 %	94,0 %	89,8 %	91,0 %	91,3 %
1. Yes	5,8 %	3,6 %	5,5 %	6,7 %	6,8 %	6,0 %
9. Unknown	6,8 %	6,9 %	0,5 %	3,5 %	2,2 %	2,6 %

c. Day care

0. No	80,2 %	87,4 %	91,4 %	81,4 %	85,5 %	86,3 %
1. Yes	13,0 %	5,2 %	8,1 %	14,3 %	11,9 %	10,8 %
9. Unknown	6,8 %	7,4 %	0,5 %	4,3 %	2,5 %	3,0 %

A2. Main income

	Middle	North	South	Vest	East	Norway
0. Supported by others	0,5 %	0,3 %	0,2 %	0,1 %	0,2 %	0,2 %
1. Employment income	20,3 %	11,6 %	9,5 %	10,3 %	8,4 %	9,9 %
2. Student loans/scholarships	0,0 %	0,0 %	0,1 %	0,1 %	0,0 %	0,1 %
3. Unemployment benefit (unemployed)	1,4 %	0,2 %	0,5 %	1,3 %	0,4 %	0,7 %
4. Sickness benefit/partial sickness benefit	0,5 %	0,3 %	0,8 %	0,7 %	0,6 %	0,6 %
5. Work assessment allowance	6,8 %	10,2 %	8,8 %	12,3 %	12,1 %	10,8 %
6. Disability pension/retirement pension	60,4 %	68,1 %	75,0 %	66,3 %	70,4 %	70,2 %
8. Social assistance	2,4 %	3,9 %	2,8 %	5,8 %	4,6 %	4,2 %
10. Other / Unknown	7,7 %	5,5 %	2,4 %	3,1 %	3,1 %	3,3 %

A3. Housing conditions

0. No housing	1,9 %	1,3 %	1,4 %	3,0 %	1,4 %	1,8 %
1. Hospice/hospital/hotel	0,0 %	0,6 %	2,5 %	3,8 %	4,0 %	3,0 %
2. Institution	2,4 %	2,4 %	4,9 %	4,0 %	8,8 %	5,7 %
3. Prison	1,0 %	1,1 %	1,4 %	1,1 %	1,1 %	1,2 %
4. With parents	3,4 %	5,2 %	3,5 %	4,6 %	2,6 %	3,6 %
5. In others	2,9 %	4,1 %	2,7 %	2,3 %	2,9 %	2,8 %
6. Own home	81,6 %	79,0 %	82,3 %	79,5 %	75,7 %	79,0 %
10. Other / Unknown	6,8 %	6,4 %	1,4 %	1,7 %	3,4 %	2,8 %

A5. Blood infection status (HIV/hepatitis C)

a. HIV

0. Not infected	82,4 %	89,7 %	94,4 %	89,2 %	89,9 %	90,8 %
1. Infected	1,5 %	0,5 %	0,4 %	1,3 %	2,2 %	1,3 %
9. Unknown	16,1 %	9,8 %	5,2 %	9,5 %	7,9 %	8,0 %

b. Hepatitis C

0. Never treated (Hepatitis C antigen negative)	22,4 %	44,0 %	37,3 %	39,6 %	37,5 %	38,1 %
1. Hepatitis C fully treated	25,4 %	36,2 %	33,1 %	33,9 %	39,6 %	35,6 %
2. Hepatitis C positive (antigen detected)	21,0 %	6,3 %	6,1 %	4,6 %	6,6 %	6,4 %
9. Unknown hepatitis C status	31,2 %	13,2 %	10,5 %	18,1 %	16,2 %	15,2 %

A6. LAR drug

0. Methadone	26,7 %	31,7 %	32,3 %	25,7 %	40,5 %	33,3 %
1. Buprenorphine (Subutex)	30,6 %	39,0 %	34,4 %	55,6 %	26,7 %	37,1 %
1a. Buprenorphine depot	20,4 %	14,4 %	22,0 %	9,5 %	19,6 %	17,4 %
2. Buprenofine/naloxone (Suboxone)	15,5 %	9,2 %	7,7 %	1,4 %	5,1 %	5,7 %
3. Others	1,0 %	3,6 %	3,4 %	7,5 %	7,6 %	5,7 %
9. Unknown	5,8 %	2,0 %	0,3 %	0,3 %	0,6 %	0,8 %

A7. Daily dose in mg (average)

0. Methadone	86,8	92,0	87,9	93,3	86,1	88,5
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	Middle	North	South	Vest	East	Norway
1. Buprenofine (Subutex)	15,8	15,4	15,1	14,4	14,5	14,8
2. Buprenofine/naloxone (Suboxone)	14,4	13,9	13,2	13,4	12,2	13,1
A8. Prescribing doctor						
0. Doctor employed in LAR initiatives	27,7 %	51,6 %	63,3 %	97,4 %	49,2 %	64,3 %
1. GP	62,1 %	47,2 %	35,6 %	2,2 %	44,5 %	32,7 %
2. Other doctor	1,9 %	0,3 %	1,0 %	0,3 %	5,7 %	2,4 %
9. Unknown	8,3 %	0,9 %	0,2 %	0,2 %	0,6 %	0,6 %
A9. Covid-19						
a. Has the patient been exposed to COVID-19?						
0. No evidence of COVID-19 (nose/blood test)	44,4 %	43,4 %	48,1 %	42,3 %	43,9 %	44,7 %
1. Virus was detected, not hospitalized.	31,2 %	22,4 %	27,1 %	26,4 %	26,3 %	26,3 %
2. Virus was detected, patient hospitalized.	1,0 %	1,6 %	0,3 %	1,9 %	1,8 %	1,3 %
9. Unknown	23,4 %	32,6 %	24,5 %	29,5 %	28,1 %	27,7 %
b. Are benzodiazepines prescribed?						
0. No	68,3 %	44,9 %	62,5 %	60,1 %	54,2 %	57,5 %
1. Yes	18,5 %	49,0 %	35,4 %	36,8 %	41,0 %	38,4 %
9. Unknown	13,2 %	6,1 %	2,2 %	3,1 %	4,7 %	4,0 %
c. Are other morphine substances prescribed?						
0. No	87,3 %	81,7 %	78,4 %	90,4 %	84,2 %	83,8 %
1. Yes	1,0 %	5,6 %	9,3 %	3,0 %	6,7 %	6,3 %
9. Unknown	11,7 %	12,7 %	12,4 %	6,6 %	9,1 %	9,9 %
A10. LAR drug dispensing						
a. Number of deliveries per week (average)						
	1,9	2,7	2,8	2,9	3,3	3,0
b. Of which the number of monitored						
	1,8	2,7	2,8	2,8	3,4	2,9
c. Main point of delivery						
0. LAR measures	18,9 %	12,6 %	18,8 %	36,6 %	21,8 %	23,5 %
1. Pharmacy	43,7 %	47,4 %	39,8 %	27,2 %	45,3 %	39,5 %
2. Municipal services	19,4 %	27,0 %	33,3 %	20,4 %	20,7 %	24,9 %
3. Institution/residential center/prison	4,9 %	4,3 %	6,7 %	6,0 %	9,6 %	7,2 %
4. Doctor's office	3,9 %	5,4 %	0,6 %	5,3 %	0,3 %	2,2 %
10. Other	1,9 %	0,6 %	0,7 %	4,1 %	1,4 %	1,8 %
9. Unknown	7,3 %	2,7 %	0,2 %	0,3 %	0,8 %	0,9 %
A11. Urine testing scheme						
a. Type of agreement						
0. No urine samples	29,6 %	47,6 %	41,3 %	42,0 %	42,1 %	42,0 %

	Middle	North	South	Vest	East	Norway
1. Random samples	36,9 %	31,9 %	31,6 %	17,5 %	34,0 %	29,3 %
2. Regular sampling	24,3 %	14,4 %	26,2 %	36,5 %	18,6 %	24,8 %
9. Unknown	9,2 %	6,2 %	1,0 %	4,0 %	5,3 %	3,9 %
b. Number of urine samples per week (average)	0,2	0,3	0,2	0,4	0,2	0,2

B. LAST FOUR WEEKS BEFORE FILLING DATE

B1. Treatment and counseling last 4 weeks

a. Objective of the treatment

0. Drug-free rehab	75,1 %	68,5 %	67,1 %	68,5 %	69,1 %	68,5 %
1. Stabilization without substance abuse requirements	13,2 %	22,6 %	31,1 %	27,1 %	26,4 %	27,1 %
9. Not agreed	11,7 %	8,9 %	1,8 %	4,3 %	4,5 %	4,3 %

b. Primary responsibility in the specialist health service

0. Not transferred	18,4 %	66,6 %	76,5 %	94,9 %	77,3 %	78,3 %
1. Transferred	73,3 %	31,6 %	22,8 %	5,0 %	21,7 %	20,7 %
9. Other / Unknown	8,3 %	1,9 %	0,7 %	0,2 %	1,0 %	1,1 %

c. Completed rehab, maintenance follow-up

0. No	31,7 %	42,2 %	56,4 %	53,1 %	51,8 %	51,8 %
1. Yes	57,1 %	43,3 %	40,1 %	42,3 %	42,8 %	42,4 %
9. Unknown	11,2 %	14,4 %	3,5 %	4,6 %	5,5 %	5,8 %

d. Is the patient undergoing psychiatric treatment?

0. No	83,0 %	80,6 %	88,9 %	82,2 %	79,9 %	83,2 %
1. Yes	6,8 %	11,9 %	9,9 %	13,9 %	16,9 %	13,3 %
9. Unknown	10,2 %	7,5 %	1,2 %	3,8 %	3,2 %	3,4 %

e. Has an individual plan been prepared?

0. No	61,2 %	84,6 %	92,1 %	64,6 %	75,2 %	78,1 %
1. Yes	25,7 %	5,5 %	5,4 %	17,4 %	11,1 %	10,9 %
9. Unknown	13,1 %	9,9 %	2,5 %	18,0 %	13,7 %	11,1 %

f. Systematic psychotherapeutic treatment

0. No	87,4 %	84,2 %	91,1 %	51,1 %	58,4 %	69,6 %
1. Yes	1,9 %	7,5 %	6,8 %	41,3 %	38,4 %	25,7 %
9. Unknown	10,7 %	8,3 %	2,1 %	7,6 %	3,2 %	4,7 %

B2. Have there been held

	Middle	North	South	Vest	East	Norway
responsibility group meeting in the last 4 weeks?						
0. No	69,8 %	71,9 %	64,1 %	65,5 %	64,7 %	65,6 %
1. Yes	18,5 %	22,3 %	35,4 %	33,2 %	33,1 %	32,2 %
9. Unknown	11,7 %	5,8 %	0,5 %	1,3 %	2,2 %	2,2 %

B3. Mental health problems in the last 4 weeks

a. Severe depression

0. No	66,3 %	64,9 %	78,3 %	64,7 %	70,2 %	70,6 %
1. Yes	13,2 %	11,4 %	13,5 %	17,8 %	16,4 %	15,3 %
9. Unknown	20,5 %	23,7 %	8,2 %	17,6 %	13,4 %	14,1 %

b. Severe anxiety

0. No	57,6 %	50,0 %	69,2 %	54,2 %	61,8 %	60,8 %
1. Yes	23,4 %	27,0 %	23,2 %	30,3 %	25,2 %	26,0 %
9. Unknown	19,0 %	23,0 %	7,5 %	15,5 %	13,0 %	13,2 %

c. Delusions/hallucinations

0. No	75,1 %	70,8 %	85,4 %	77,3 %	79,7 %	79,7 %
1. Yes	4,4 %	6,6 %	7,0 %	6,7 %	7,3 %	6,9 %
9. Unknown	20,5 %	22,6 %	7,7 %	16,0 %	13,1 %	13,4 %

B4. Physical injuries/illnesses

that affect lifestyle or quality of life
last 4 weeks

0. No	47,3 %	43,7 %	58,9 %	45,1 %	48,9 %	50,3 %
1. Yes	35,1 %	36,8 %	34,4 %	43,0 %	41,3 %	39,0 %
9. Unknown	17,6 %	19,6 %	6,7 %	11,9 %	9,8 %	10,6 %

B5. Drug and alcohol use in the last 4 weeks

a. Opioids

0. No	75,7 %	67,0 %	78,4 %	74,6 %	70,7 %	73,6 %
1. Yes	6,3 %	6,3 %	9,3 %	7,7 %	14,8 %	10,4 %
9. Unknown	18,0 %	26,8 %	12,4 %	17,7 %	14,5 %	16,0 %

b. Cannabis

0. No	57,3 %	43,8 %	54,3 %	46,3 %	53,2 %	51,1 %
1. Yes	24,8 %	29,4 %	32,8 %	35,9 %	30,0 %	32,0 %
9. Unknown	18,0 %	26,9 %	12,9 %	17,9 %	16,8 %	17,0 %

c. Benzodiazepines or similar

0. No	53,4 %	40,4 %	47,8 %	40,7 %	45,0 %	44,6 %
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1. Yes	28,6 %	37,1 %	40,6 %	45,1 %	41,6 %	41,3 %
	Middle	North	South	Vest	East	Norway
9. Unknown	18,0 %	22,5 %	11,6 %	14,2 %	13,4 %	14,1 %

d. Stimulants

0. No	69,9 %	61,4 %	70,8 %	63,5 %	69,6 %	67,7 %
1. Yes	11,2 %	13,3 %	16,3 %	19,0 %	13,8 %	15,6 %
9. Unknown	18,9 %	25,3 %	12,9 %	17,5 %	16,6 %	16,7 %

e. Alcohol for intoxication

0. No	73,3 %	65,3 %	76,1 %	72,0 %	73,5 %	73,1 %
1. Yes	7,3 %	7,8 %	10,0 %	9,4 %	8,7 %	9,1 %
9. Unknown	19,4 %	26,9 %	13,9 %	18,7 %	17,8 %	17,8 %

B6. Frequency of drug and alcohol use last 4 weeks

0. Never	44,7 %	32,1 %	40,9 %	36,3 %	39,2 %	38,4 %
1. Few single episodes	16,0 %	13,8 %	15,5 %	21,2 %	19,3 %	18,0 %
2. Regular use	20,9 %	28,6 %	33,0 %	29,6 %	29,2 %	30,1 %
9. Unknown	18,4 %	25,5 %	10,6 %	13,0 %	12,4 %	13,5 %

B7. Severity of drug and alcohol use last 4 weeks

0. Good function, works "like others"	51,5 %	46,1 %	50,1 %	49,8 %	48,5 %	49,1 %
1. Mixed function. Occasionally intoxicated	17,5 %	17,8 %	20,8 %	23,2 %	23,6 %	21,9 %
2. Addictive, substance-dominated function	8,7 %	10,7 %	17,7 %	14,4 %	15,7 %	15,3 %
9. Unknown	22,3 %	25,4 %	11,4 %	12,6 %	12,2 %	13,7 %

C. LAST YEAR

C1. Offenses last year

Arrested, detained, prosecuted; convicted

0. No	74,6 %	67,4 %	80,1 %	73,3 %	74,8 %	75,3 %
1. Yes	8,8 %	7,8 %	8,4 %	9,4 %	7,9 %	8,4 %
9. Unknown	16,6 %	24,7 %	11,5 %	17,3 %	17,3 %	16,3 %

C2. Overdose last year

0. No	81,0 %	75,0 %	87,3 %	82,0 %	82,6 %	83,0 %
1. Yes	4,4 %	3,4 %	5,9 %	7,6 %	5,1 %	5,7 %
9. Unknown	14,6 %	21,6 %	6,8 %	10,4 %	12,4 %	11,3 %

C3. Suicide attempts last year

0. No	81,0 %	76,7 %	90,5 %	83,8 %	85,6 %	85,6 %
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1. Yes	2,4 %	1,6 %	1,7 %	3,1 %	2,2 %	2,2 %
	Middle	North	South	Vest	East	Norway
9. Unknown	16,6 %	21,8 %	7,8 %	13,1 %	12,2 %	12,2 %

C4. Drug and alcohol use in the past year

0. Never	41,5 %	30,6 %	36,4 %	28,2 %	31,2 %	32,3 %
1. Some single, short periods of time	23,4 %	19,7 %	21,3 %	28,3 %	27,8 %	25,1 %
2. Used for extended periods or all the time	18,0 %	27,8 %	34,9 %	33,2 %	30,8 %	31,8 %
9. Unknown	17,1 %	21,9 %	7,4 %	10,3 %	10,2 %	10,8 %

C5. Satisfaction

a. Patient assessment

0. Satisfied successful	50,2 %	51,0 %	61,9 %	55,2 %	56,2 %	56,9 %
1. Both-and	23,9 %	18,1 %	17,9 %	15,7 %	18,2 %	17,7 %
2. Dissatisfied/not successful	5,9 %	4,4 %	3,5 %	4,5 %	4,4 %	4,2 %
9. Unknown	20,0 %	26,5 %	16,7 %	24,5 %	21,3 %	21,2 %

b. Filler assessment

0. Satisfied successful	53,2 %	58,8 %	72,7 %	58,4 %	67,0 %	65,4 %
1. Both-and	25,4 %	25,8 %	23,7 %	34,2 %	25,5 %	27,0 %
2. Dissatisfied/not successful	4,9 %	3,6 %	2,3 %	4,2 %	2,7 %	3,1 %
9. Unknown	16,6 %	11,8 %	1,3 %	3,3 %	4,8 %	4,5 %

C6. Are treatment changes recommended?

0. No	65,4 %	75,2 %	88,0 %	70,7 %	78,9 %	78,8 %
1. Yes	19,5 %	12,5 %	9,6 %	21,0 %	14,9 %	14,7 %
9. Unknown	15,1 %	12,2 %	2,4 %	8,3 %	6,2 %	6,5 %

C7. Who has participated/asked in the completion?

a. Pasient

0. No	22,4 %	32,4 %	23,2 %	29,3 %	26,8 %	26,8 %
1. Yes	76,1 %	67,1 %	76,8 %	70,0 %	73,0 %	72,9 %
9. Unknown	1,5 %	0,5 %	0,1 %	0,7 %	0,2 %	0,3 %

b. Employee

0. No	75,6 %	73,7 %	73,0 %	82,0 %	72,0 %	75,0 %
1. Yes	22,4 %	25,8 %	26,8 %	16,3 %	27,8 %	24,4 %
9. Unknown	2,0 %	0,5 %	0,2 %	1,6 %	0,2 %	0,6 %

c. Responsibility group

0. No	92,7 %	94,9 %	86,8 %	94,3 %	87,1 %	89,7 %
1. Yes	5,9 %	4,6 %	13,1 %	4,1 %	12,6 %	9,7 %
9. Unknown	1,5 %	0,5 %	0,1 %	1,7 %	0,2 %	0,6 %

South

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
Number of responses	345	317	194	361	638
Response rate	104,2 %	101,9 %	65,1 %	104,6 %	106,7 %
Gender					
Men	68,1 %	71,6 %	73,2 %	77,0 %	67,6 %
Women	31,9 %	28,4 %	26,8 %	23,0 %	32,4 %
Age (average)	49,7	48,3	48,9	49,0	46,7

A. Current situation

A0. Current situation

0. Not discharged	94,5 %	89,9 %	98,9 %	94,9 %	94,6 %
1. Own desire for weaning	2,8 %	2,8 %	0,0 %	1,9 %	1,9 %
2. Dissatisfied with the treatment	0,0 %	2,3 %	0,0 %	0,9 %	1,1 %
3. Lack of effect, unjustifiable	0,0 %	0,0 %	0,5 %	0,5 %	0,6 %
4. Treatment difficulties	0,0 %	0,0 %	0,5 %	0,5 %	0,0 %
10. Other	2,8 %	5,1 %	0,0 %	1,4 %	1,7 %

A1. Employment

a. Professional status

0. Without employment	79,9 %	85,5 %	88,1 %	85,3 %	83,4 %
1. Full-time job	12,2 %	6,9 %	7,8 %	9,1 %	8,8 %
2. Part-time job	5,5 %	5,7 %	3,1 %	4,4 %	5,2 %
3. During education	1,5 %	0,6 %	1,0 %	0,6 %	1,7 %
4. Part-time job and in education	0,3 %	0,0 %	0,0 %	0,6 %	0,6 %
9. Unknown	0,6 %	1,3 %	0,0 %	0,0 %	0,3 %

b. Work training/courses

0. No	95,0 %	95,3 %	97,9 %	95,8 %	90,6 %
1. Yes	4,4 %	3,8 %	2,1 %	3,9 %	8,8 %
9. Unknown	0,6 %	0,9 %	0,0 %	0,3 %	0,6 %

c. Day care

0. No	93,0 %	90,2 %	96,4 %	93,9 %	88,2 %
1. Yes	6,4 %	8,9 %	3,6 %	5,8 %	11,3 %
9. Unknown	0,6 %	0,9 %	0,0 %	0,3 %	0,5 %

A2. Main income

0. Supported by others	0,0 %	0,3 %	0,5 %	0,3 %	0,2 %
1. Employment income	13,2 %	7,9 %	8,8 %	8,9 %	8,9 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
2. Student loans/scholarships	0,3 %	0,3 %	0,0%	0,0%	0,0%
3. Unemployment benefit (unemployed)	0,9 %	0,3 %	0,0%	0,6 %	0,5 %
4. Sickness benefit/partial sickness benefit	0,6 %	1,3 %	0,0%	0,6 %	0,9 %
5. Work assessment allowance	6,2 %	10,7 %	12,4 %	6,1 %	9,6 %
6. Disability pension/retirement pension	71,8 %	71,6 %	74,1 %	76,9 %	77,6 %
8. Social assistance	4,7 %	3,5 %	0,5 %	4,2 %	1,3 %
10. Other / Unknown	2,3 %	4,1 %	3,6 %	2,5 %	1,1 %

A3. Housing conditions

0. No housing	3,3 %	0,6 %	0,0%	2,5 %	0,6 %
1. Hospice/hospital/hotel	2,7 %	2,2 %	8,3 %	1,7 %	1,1 %
2. Institution	4,8 %	6,1 %	9,3 %	3,1 %	3,9 %
3. Prison	1,5 %	0,0%	0,5 %	1,4 %	2,4 %
4. With parents	2,4 %	4,2 %	1,6 %	3,9 %	4,1 %
5. In others	0,9 %	2,2 %	2,6 %	7,0 %	1,6 %
6. Own home	82,5 %	82,7 %	77,7 %	79,5 %	84,8 %
10. Other / Unknown	1,8 %	1,9 %	0,0%	0,8 %	1,6 %

A5. Blood infection status (HIV/hepatitis C)

a. HIV

0. Not infected	91,6 %	96,5 %	95,3 %	90,6 %	96,7 %
1. Infected	0,3 %	0,9 %	0,0%	0,3 %	0,5 %
9. Unknown	8,1 %	2,5 %	4,7 %	9,2 %	2,8 %

b. Hepatitis C

0. Never treated (Hepatitis C antigen negative)	29,8 %	45,4 %	37,7 %	30,0 %	41,4 %
1. Hepatitis C fully treated	52,2 %	37,7 %	36,6 %	56,3 %	6,7 %
2. Hepatitis C positive (antigen detected)	5,6 %	6,7 %	4,7 %	3,4 %	8,2 %
9. Unknown hepatitis C status	12,4 %	10,2 %	20,9 %	10,4 %	6,6 %

A6. LAR drug

0. Methadone	18,0 %	52,1 %	54,7 %	23,1 %	28,5 %
1. Buprenorphine (Subutex)	26,6 %	23,0 %	30,2 %	37,5 %	43,6 %
1a. Buprenorphine depot	35,8 %	16,7 %	5,7 %	26,7 %	19,4 %
2. Buprenofine/naloxone (Suboxone)	12,7 %	5,4 %	7,3 %	8,3 %	6,0 %
3. Others	5,3 %	2,8 %	2,1 %	4,4 %	2,5 %
9. Unknown	1,5 %	0,0%	0,0%	0,0%	0,0%

A7. Daily dose in mg (average)

0. Methadone	84,3	87,8	92,9	75,5	91,8
1. Buprenofine (Subutex)	16,4	12,9	16,4	12,4	16,2
2. Buprenofine/naloxone (Suboxone)	13,4	9,9	12,9	13,2	14,5

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
9. Unknown	1,5 %	0,9 %	0,5 %	1,7 %	0,5 %
b. Number of urine samples per week (average)	0,1	0,4	0,1	0,2	0,1

B. LAST FOUR WEEKS BEFORE FILLING DATE

B1. Treatment and counseling last 4 weeks

a. Objective of the treatment

0. Drug-free rehab	58,3 %	70,3 %	78,8 %	58,6 %	71,6 %
1. Stabilization without substance abuse requirements	39,7 %	25,3 %	20,7 %	40,8 %	27,0 %
9. Not agreed	2,0 %	4,4 %	0,5 %	0,6 %	1,4 %

b. Primary responsibility in the specialist health service

0. Not transferred	93,6 %	95,3 %	14,0 %	90,0 %	69,3 %
1. Transferred	4,7 %	4,7 %	85,0 %	9,5 %	30,3 %
9. Other / Unknown	1,7 %	0,0 %	1,0 %	0,6 %	0,5 %

c. Completed rehab, maintenance follow-up

0. No	60,1 %	72,1 %	38,5 %	57,8 %	51,3 %
1. Yes	36,4 %	21,3 %	55,7 %	40,8 %	46,2 %
9. Unknown	3,5 %	6,7 %	5,7 %	1,4 %	2,5 %

d. Is the patient undergoing psychiatric treatment?

0. No	84,9 %	87,9 %	86,0 %	89,7 %	91,8 %
1. Yes	12,5 %	10,5 %	13,0 %	9,7 %	7,4 %
9. Unknown	2,6 %	1,6 %	1,0 %	0,6 %	0,8 %

e. Has an individual plan been prepared?

0. No	89,8 %	94,9 %	93,8 %	90,6 %	92,5 %
1. Yes	4,7 %	2,3 %	4,7 %	8,3 %	5,8 %
9. Unknown	5,5 %	2,9 %	1,6 %	1,1 %	1,7 %

f. Systematic psychotherapeutic treatment

0. No	89,2 %	91,0 %	76,7 %	93,9 %	94,8 %
1. Yes	7,9 %	3,5 %	22,3 %	4,7 %	4,4 %
9. Unknown	2,9 %	5,5 %	1,0 %	1,4 %	0,8 %

B2. Have there been held

responsibility group meeting in the last 4 weeks?

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
0. No	79,2 %	38,6 %	71,3 %	78,8 %	58,9 %
1. Yes	18,8 %	61,4 %	28,2 %	21,2 %	40,8 %
9. Unknown	1,9 %	0,0 %	0,5 %	0,0 %	0,3 %

B3. Mental health problems in the last 4 weeks

a. Severe depression

0. No	75,8 %	74,1 %	89,0 %	82,7 %	76,0 %
1. Yes	16,3 %	9,5 %	9,4 %	12,0 %	16,1 %
9. Unknown	7,9 %	16,4 %	1,6 %	5,3 %	7,8 %

b. Severe anxiety

0. No	64,9 %	60,6 %	81,7 %	76,0 %	68,3 %
1. Yes	28,9 %	25,6 %	16,8 %	17,8 %	24,0 %
9. Unknown	6,1 %	13,9 %	1,6 %	6,1 %	7,7 %

c. Delusions/hallucinations

0. No	85,6 %	83,9 %	91,1 %	85,9 %	84,0 %
1. Yes	6,5 %	3,8 %	6,8 %	7,9 %	8,3 %
9. Unknown	7,9 %	12,3 %	2,1 %	6,2 %	7,7 %

B4. Physical injuries/illnesses

that affect lifestyle or quality of life
last 4 weeks

0. No	48,5 %	66,0 %	66,5 %	64,1 %	55,8 %
1. Yes	44,2 %	19,6 %	33,0 %	31,4 %	38,6 %
9. Unknown	7,3 %	14,4 %	0,5 %	4,5 %	5,6 %

B5. Drug and alcohol use in the last 4 weeks

a. Opioids

0. No	76,2 %	76,6 %	58,1 %	90,5 %	79,6 %
1. Yes	16,5 %	10,1 %	6,8 %	3,4 %	8,9 %
9. Unknown	7,2 %	13,3 %	35,1 %	6,1 %	11,4 %

b. Cannabis

0. No	56,1 %	52,1 %	52,6 %	52,5 %	56,1 %
1. Yes	36,3 %	34,1 %	10,4 %	40,3 %	32,8 %
9. Unknown	7,6 %	13,9 %	37,0 %	7,2 %	11,1 %

c. Benzodiazepines or similar

0. No	56,4 %	41,6 %	49,5 %	53,9 %	42,3 %
1. Yes	36,3 %	46,1 %	16,1 %	38,8 %	48,6 %
9. Unknown	7,3 %	12,3 %	34,4 %	7,3 %	9,1 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
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d. Stimulants

0. No	69,7 %	71,0 %	58,4 %	77,2 %	71,5 %
1. Yes	21,6 %	15,8 %	6,3 %	15,0 %	17,4 %
9. Unknown	8,7 %	13,2 %	35,3 %	7,8 %	11,1 %

e. Alcohol for intoxication

0. No	75,1 %	74,9 %	53,4 %	79,4 %	82,1 %
1. Yes	12,9 %	9,5 %	8,9 %	13,3 %	7,1 %
9. Unknown	12,0 %	15,6 %	37,7 %	7,2 %	10,8 %

B6. Frequency of drug and alcohol use last 4 weeks

0. Never	41,9 %	33,5 %	42,3 %	38,6 %	44,8 %
1. Few single episodes	16,3 %	13,9 %	10,6 %	19,4 %	15,0 %
2. Regular use	36,6 %	38,0 %	15,3 %	35,6 %	32,4 %
9. Unknown	5,2 %	14,6 %	31,7 %	6,4 %	7,7 %

B7. Severity of drug and alcohol use last 4 weeks

0. Good function, works "like others"	50,1 %	46,2 %	43,9 %	49,3 %	54,2 %
1. Mixed function. Occasionally intoxicated	19,8 %	21,7 %	18,0 %	22,7 %	20,7 %
2. Addictive, substance-dominated function	25,4 %	10,5 %	7,4 %	23,0 %	17,4 %
9. Unknown	4,7 %	21,7 %	30,7 %	5,0 %	7,7 %

C. LAST YEAR

C1. Offenses last year

Arrested, detained, prosecuted; convicted

0. No	81,4 %	76,7 %	75,1 %	85,9 %	79,3 %
1. Yes	9,3 %	5,7 %	3,1 %	8,9 %	10,7 %
9. Unknown	9,3 %	17,7 %	21,8 %	5,3 %	10,0 %

C2. Overdose last year

0. No	84,9 %	81,1 %	88,1 %	91,1 %	89,3 %
1. Yes	9,0 %	5,7 %	4,7 %	5,6 %	4,9 %
9. Unknown	6,1 %	13,2 %	7,3 %	3,3 %	5,8 %

C3. Suicide attempts last year

0. No	89,8 %	82,6 %	93,8 %	94,4 %	91,7 %
1. Yes	2,6 %	0,9 %	1,0 %	1,9 %	1,6 %
9. Unknown	7,6 %	16,4 %	5,2 %	3,6 %	6,7 %

	Vestfold	Drammen	Asker/ Bærum	Telemark	Southern Norway
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C4. Drug and alcohol use in the past year

0. Never	39,3 %	28,3 %	45,0 %	33,5 %	37,9 %
1. Some single, short periods of time	17,9 %	20,6 %	14,7 %	25,7 %	22,9 %
2. Used for extended periods or all the time	39,3 %	40,8 %	25,7 %	35,2 %	32,3 %
9. Unknown	3,5 %	10,3 %	14,7 %	5,6 %	6,9 %

C5. Satisfaction

a. Patient assessment

0. Satisfied successful	69,9 %	58,2 %	50,8 %	62,2 %	62,5 %
1. Both-and	18,8 %	7,6 %	17,1 %	22,5 %	20,2 %
2. Dissatisfied/not successful	3,2 %	1,9 %	2,1 %	5,6 %	3,8 %
9. Unknown	8,1 %	32,3 %	30,1 %	9,7 %	13,5 %

b. Filler assessment

0. Satisfied successful	75,9 %	78,5 %	67,2 %	65,2 %	74,0 %
1. Both-and	20,0 %	16,1 %	28,1 %	32,0 %	23,5 %
2. Dissatisfied/not successful	2,9 %	1,6 %	2,1 %	1,9 %	2,5 %
9. Unknown	1,2 %	3,8 %	2,6 %	0,8 %	0,0 %

C6. Are treatment changes recommended?

0. No	86,7 %	88,9 %	82,7 %	88,8 %	89,5 %
1. Yes	11,0 %	5,4 %	14,1 %	9,5 %	9,6 %
9. Unknown	2,3 %	5,7 %	3,1 %	1,7 %	0,9 %

C7. Who has participated/asked in the completion?

a. Pasient

0. No	12,5 %	33,1 %	56,5 %	17,8 %	16,9 %
1. Yes	87,5 %	66,9 %	43,0 %	82,2 %	83,1 %
9. Unknown	0,0 %	0,0 %	0,5 %	0,0 %	0,0 %

b. Employee

0. No	85,3 %	58,0 %	42,7 %	76,2 %	81,2 %
1. Yes	14,7 %	42,0 %	56,3 %	23,5 %	18,8 %
9. Unknown	0,0 %	0,0 %	1,0 %	0,3 %	0,0 %

c. Responsibility group

0. No	97,9 %	68,5 %	78,5 %	97,2 %	86,8 %
1. Yes	2,1 %	31,5 %	20,9 %	2,5 %	13,2 %
9. Unknown	0,0 %	0,0 %	0,5 %	0,3 %	0,0 %

Vest

	Bergen	Stavanger	Fonna	Førde
Number of responses	778	482	186	73
Response rate	69,7 %	81,3 %		77,7 %
Gender				
Men	72,0 %	66,4 %	72,0 %	78,1 %
Women	28,0 %	33,6 %	28,0 %	21,9 %
Age (average)	46,3	47,0	48,6	43,8

A. Current situation

A0. Current situation

0. Not discharged	99,4 %	97,5 %	98,4 %	98,6 %
1. Own desire for weaning	0,1 %	0,9 %	0,0 %	0,0 %
2. Dissatisfied with the treatment	0,1 %	0,0 %	0,5 %	1,4 %
3. Lack of effect, unjustifiable	0,0 %	0,0 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,0 %	0,0 %
10. Other	0,4 %	1,6 %	1,1 %	0,0 %

A1. Employment

a. Professional status

0. Without employment	87,0 %	79,3 %	84,9 %	69,9 %
1. Full-time job	6,7 %	12,0 %	7,5 %	13,7 %
2. Part-time job	4,1 %	4,8 %	3,8 %	15,1 %
3. During education	1,2 %	3,1 %	3,8 %	1,4 %
4. Part-time job and in education	0,5 %	0,8 %	0,0 %	0,0 %
9. Unknown	0,5 %	0,0 %	0,0 %	0,0 %

b. Work training/courses

0. No	87,1 %	93,9 %	94,1 %	79,5 %
1. Yes	6,7 %	5,6 %	4,3 %	20,5 %
9. Unknown	6,2 %	0,4 %	1,6 %	0,0 %

c. Day care

0. No	76,9 %	88,9 %	82,3 %	78,1 %
1. Yes	15,9 %	10,1 %	16,1 %	20,5 %
9. Unknown	7,2 %	1,0 %	1,6 %	1,4 %

A2. Main income

0. Supported by others	0,1 %	0,2 %	0,0 %	0,0 %
1. Employment income	8,0 %	13,0 %	9,7 %	19,2 %

	Bergen	Stavanger	Fonna	Førde
2. Student loans/scholarships	0,0%	0,2 %	0,0%	0,0%
3. Unemployment benefit (unemployed)	2,2 %	0,0%	1,1 %	1,4 %
4. Sickness benefit/partial sickness benefit	1,2 %	0,0%	0,5 %	0,0%
5. Work assessment allowance	12,3 %	9,2 %	15,6 %	24,7 %
6. Disability pension/retirement pension	63,5 %	70,7 %	71,5 %	53,4 %
8. Social assistance	8,1 %	4,4 %	1,6 %	1,4 %
10. Other / Unknown	4,6 %	2,3 %	0,0%	0,0%

A3. Housing conditions

0. No housing	4,1 %	1,7 %	3,2 %	0,0%
1. Hospice/hospital/hotel	4,2 %	4,7 %	1,6 %	0,0%
2. Institution	3,2 %	6,3 %	1,6 %	2,7 %
3. Prison	1,2 %	1,5 %	0,5 %	0,0%
4. With parents	5,0 %	4,9 %	3,2 %	2,7 %
5. In others	2,7 %	1,9 %	2,2 %	0,0%
6. Own home	77,6 %	77,4 %	87,1 %	93,2 %
10. Other / Unknown	1,9 %	1,7 %	0,5 %	1,4 %

A5. Blood infection status (HIV/hepatitis C)

a. HIV

0. Not infected	87,7 %	93,1 %	84,4 %	91,8 %
1. Infected	0,8 %	1,3 %	3,8 %	1,4 %
9. Unknown	11,6 %	5,6 %	11,8 %	6,8 %

b. Hepatitis C

0. Never treated (Hepatitis C antigen negative)	44,2 %	34,1 %	30,1 %	49,3 %
1. Hepatitis C fully treated	32,1 %	36,2 %	33,9 %	38,4 %
2. Hepatitis C positive (antigen detected)	3,6 %	3,8 %	10,8 %	4,1 %
9. Unknown hepatitis C status	20,1 %	13,6 %	25,3 %	8,2 %

A6. LAR drug

0. Methadone	33,2 %	19,6 %	16,7 %	9,6 %
1. Buprenorphine (Subutex)	47,7 %	63,4 %	66,1 %	63,0 %
1a. Buprenorphine depot	7,5 %	8,4 %	15,1 %	23,3 %
2. Buprenofine/naloxone (Suboxone)	0,8 %	2,7 %	0,5 %	1,4 %
3. Others	10,5 %	5,5 %	1,6 %	2,7 %
9. Unknown	0,4 %	0,4 %	0,0%	0,0%

A7. Daily dose in mg (average)

0. Methadone	97,2	86,6	79,4	104,3
1. Buprenofine (Subutex)	15,8	13,4	13,7	13,1
2. Buprenofine/naloxone (Suboxone)	12,7	12,5	20,0	24,0

	Bergen	Stavanger	Fonna	Førde
A8. Prescribing doctor				
0. Doctor employed in LAR initiatives	98,7 %	98,5 %	91,4 %	90,4 %
1. GP	0,8 %	0,8 %	8,6 %	9,6 %
2. Other doctor	0,3 %	0,4 %	0,0 %	0,0 %
9. Unknown	0,3 %	0,2 %	0,0 %	0,0 %
A9. Special conditions				
a. Has the patient been exposed to COVID-19?				
0. No evidence of COVID-19	36,4 %	45,4 %	57,5 %	46,6 %
1. Virus was detected, not hospitalized.	24,3 %	29,6 %	23,7 %	34,2 %
2. Virus was detected, patient hospitalized.	2,4 %	1,9 %	0,0 %	0,0 %
9. Unknown	36,9 %	23,0 %	18,8 %	19,2 %
b. Are benzodiazepines prescribed?				
0. No	58,4 %	59,9 %	65,1 %	67,1 %
1. Yes	38,2 %	37,7 %	30,1 %	32,9 %
9. Unknown	3,5 %	2,3 %	4,8 %	0,0 %
c. Are other morphine substances prescribed?				
0. No	93,8 %	82,8 %	91,9 %	98,6 %
1. Yes	2,6 %	4,2 %	2,7 %	1,4 %
9. Unknown	3,6 %	13,0 %	5,4 %	0,0 %
A10. LAR drug dispensing				
a. Number of deliveries per week (average)	2,9	3,1	3,0	1,8
b. Of which the number of monitored	2,8	2,9	2,9	1,6
c. Main point of delivery				
0. LAR measures	47,8 %	27,6 %	19,9 %	19,2 %
1. Pharmacy	25,7 %	24,0 %	39,2 %	32,9 %
2. Municipal services	10,8 %	26,9 %	37,1 %	38,4 %
3. Institution/residential center/prison	5,7 %	8,6 %	2,2 %	2,7 %
4. Doctor's office	4,1 %	8,8 %	1,1 %	5,5 %
10. Other	5,9 %	3,2 %	0,0 %	1,4 %
9. Unknown	0,0 %	0,8 %	0,5 %	0,0 %
A11. Urine testing scheme				
a. Type of agreement				
0. No samples	45,6 %	41,5 %	30,1 %	37,0 %
1. Random samples	17,2 %	12,6 %	24,2 %	35,6 %
2. Regular sampling	31,4 %	44,0 %	43,0 %	26,0 %
9. Unknown	5,8 %	1,9 %	2,7 %	1,4 %

	Bergen	Stavanger	Fonna	Førde
b. Number of urine samples per week (average)	#DIV/0!	0,4	0,3	#DIV/0!

B. LAST FOUR WEEKS BEFORE FILLING DATE

B1. Treatment and counseling last 4 weeks

a. Objective of the treatment

0. Drug-free rehab	65,3 %	71,9 %	70,4 %	75,3 %
1. Stabilization without substance abuse requirements	28,0 %	26,2 %	26,9 %	24,7 %
9. Not agreed	6,7 %	1,9 %	2,7 %	0,0%

b. Primary responsibility in the specialist health service

0. Not transferred	98,3 %	90,6 %	92,5 %	91,8 %
1. Transferred	1,3 %	9,4 %	7,5 %	8,2 %
9. Other / Unknown	0,4 %	0,0%	0,0%	0,0%

c. Completed rehab, maintenance follow-up

0. No	51,3 %	59,0 %	53,2 %	32,9 %
1. Yes	42,7 %	38,0 %	43,0 %	64,4 %
9. Unknown	6,0 %	2,9 %	3,8 %	2,7 %

d. Is the patient undergoing psychiatric treatment?

0. No	76,6 %	89,9 %	86,0 %	82,2 %
1. Yes	17,1 %	8,8 %	12,4 %	17,8 %
9. Unknown	6,3 %	1,3 %	1,6 %	0,0%

e. Has an individual plan been prepared?

0. No	63,4 %	61,9 %	78,0 %	61,6 %
1. Yes	10,5 %	28,0 %	11,8 %	35,6 %
9. Unknown	26,1 %	10,1 %	10,2 %	2,7 %

f. Systematic psychotherapeutic treatment

0. No	26,5 %	87,7 %	60,8 %	50,7 %
1. Yes	63,6 %	9,1 %	28,5 %	45,2 %
9. Unknown	9,9 %	3,2 %	10,8 %	4,1 %

B2. Have there been held responsibility group meeting in the last 4 weeks?

0. No	73,0 %	65,7 %	37,6 %	54,8 %
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1. Yes	25,3 %	33,2 %	61,3 %	45,2 %
	Bergen	Stavanger	Fonna	Førde
9. Unknown	1,7 %	1,1 %	1,1 %	0,0 %

B3. Mental health problems in the last 4 weeks

a. Severe depression

0. No	56,6 %	71,5 %	72,6 %	86,3 %
1. Yes	18,5 %	18,7 %	15,6 %	9,6 %
9. Unknown	24,9 %	9,9 %	11,8 %	4,1 %

b. Severe anxiety

0. No	46,4 %	59,7 %	65,1 %	72,6 %
1. Yes	31,7 %	31,7 %	23,1 %	24,7 %
9. Unknown	21,9 %	8,6 %	11,8 %	2,7 %

c. Delusions/hallucinations

0. No	70,8 %	84,2 %	80,6 %	91,8 %
1. Yes	7,5 %	5,9 %	7,0 %	4,1 %
9. Unknown	21,7 %	9,9 %	12,4 %	4,1 %

B4. Physical injuries/illnesses

that affect lifestyle or quality of life

last 4 weeks

0. No		50,1 %		
1. Yes		45,2 %		
9. Unknown		4,7 %		

B5. Drug and alcohol use in the last 4 weeks

a. Opioids

0. No	67,5 %	82,8 %	78,5 %	86,3 %
1. Yes	10,5 %	4,2 %	4,8 %	8,2 %
9. Unknown	22,0 %	13,0 %	16,7 %	5,5 %

b. Cannabis

0. No	41,0 %	53,1 %	46,8 %	56,2 %
1. Yes	36,0 %	33,8 %	39,2 %	39,7 %
9. Unknown	23,0 %	13,1 %	14,0 %	4,1 %

c. Benzodiazepines or similar

0. No	32,3 %	53,7 %	37,6 %	53,4 %
1. Yes	51,3 %	33,2 %	50,5 %	42,5 %
9. Unknown	16,5 %	13,2 %	11,8 %	4,1 %

d. Stimulants

0. No	58,0 %	68,1 %	69,4 %	78,1 %
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	Bergen	Stavanger	Fonna	Førde
1. Yes	21,0 %	18,0 %	14,5 %	16,4 %
9. Unknown	21,1 %	14,0 %	16,1 %	5,5 %

e. Alcohol for intoxication

0. No	66,8 %	75,4 %	78,5 %	87,7 %
1. Yes	8,5 %	12,6 %	5,9 %	6,8 %
9. Unknown	24,7 %	12,0 %	15,6 %	5,5 %

**B6. Frequency of drug and alcohol use
last 4 weeks**

0. Never	31,7 %	40,8 %	40,9 %	43,8 %
1. Few single episodes	23,9 %	21,0 %	9,1 %	23,3 %
2. Regular use	27,0 %	29,0 %	42,5 %	28,8 %
9. Unknown	17,4 %	9,2 %	7,5 %	4,1 %

**B7. Severity of drug and alcohol use
last 4 weeks**

0. Good function, works "like others"	47,4 %	51,4 %	52,7 %	57,5 %
1. Mixed function. Occasionally intoxicated	24,4 %	23,3 %	17,7 %	23,3 %
2. Addictive, substance-dominated function	11,7 %	16,7 %	19,9 %	15,1 %
9. Unknown	16,5 %	8,6 %	9,7 %	4,1 %

C. LAST YEAR

C1. Offenses last year

Arrested, detained, prosecuted; convicted

0. No	67,6 %	80,4 %	77,4 %	76,7 %
1. Yes	9,9 %	7,5 %	10,2 %	15,1 %
9. Unknown	22,5 %	12,1 %	12,4 %	8,2 %

C2. Overdose last year

0. No	78,7 %	85,0 %	85,5 %	89,0 %
1. Yes	7,5 %	9,0 %	4,3 %	8,2 %
9. Unknown	13,9 %	6,0 %	10,2 %	2,7 %

C3. Suicide attempts last year

0. No	78,8 %	89,6 %	87,6 %	90,4 %
1. Yes	3,0 %	3,3 %	2,2 %	5,5 %
9. Unknown	18,3 %	7,1 %	10,2 %	4,1 %

C4. Drug and alcohol use in the past year

0. Never	25,3 %	30,4 %	32,8 %	32,9 %
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	Bergen	Stavanger	Fonna	Førde
1. Some single, short periods of time	28,8 %	30,8 %	18,8 %	31,5 %
2. Used for extended periods or all the time	32,5 %	31,0 %	40,9 %	34,2 %
9. Unknown	13,4 %	7,8 %	7,5 %	1,4 %

C5. Satisfaction

a. Patient assessment

0. Satisfied successful	47,5 %	63,9 %	59,5 %	67,1 %
1. Both-and	15,7 %	15,7 %	13,5 %	21,9 %
2. Dissatisfied/not successful	2,9 %	5,0 %	9,7 %	4,1 %
9. Unknown	33,8 %	15,4 %	17,3 %	6,8 %

b. Filler assessment

0. Satisfied successful	53,7 %	61,1 %	63,8 %	72,5 %
1. Both-and	37,3 %	32,6 %	31,6 %	20,3 %
2. Dissatisfied/not successful	4,5 %	4,8 %	1,1 %	4,3 %
9. Unknown	4,6 %	1,5 %	3,4 %	2,9 %

C6. Are treatment changes recommended?

0. No	66,5 %	73,7 %	75,3 %	84,9 %
1. Yes	21,9 %	22,1 %	16,7 %	15,1 %
9. Unknown	11,7 %	4,2 %	8,1 %	0,0 %

C7. Who has participated/asked in the completion?

a. Pasient

0. No	39,1 %	20,1 %	18,3 %	12,3 %
1. Yes	60,4 %	79,7 %	78,5 %	87,7 %
9. Unknown	0,5 %	0,2 %	3,2 %	0,0 %

b. Employee

0. No	87,3 %	85,6 %	52,7 %	79,5 %
1. Yes	12,0 %	14,1 %	38,2 %	20,5 %
9. Unknown	0,8 %	0,2 %	9,1 %	0,0 %

c. Responsibility group

0. No	97,0 %	93,9 %	86,0 %	87,7 %
1. Yes	2,3 %	6,1 %	3,8 %	12,3 %
9. Unknown	0,6 %	0,0 %	10,2 %	0,0 %

East

	Akershus	Oslo	Østfold	Inland
Number of responses	516	809	449	403
Response rate	59,9 %	64,0 %	83,3 %	96,0 %
Gender				
Men	62,8 %	72,3 %	69,0 %	69,0 %
Women	37,2 %	27,7 %	31,0 %	31,0 %
Age (average)	46,6	49,5	48,3	50,1

A. Current situation

A0. Current situation

0. Not discharged	95,1 %	98,0 %	97,1 %	96,0 %
1. Own desire for weaning	2,3 %	0,4 %	1,1 %	2,3 %
2. Dissatisfied with the treatment	0,4 %	0,4 %	0,0 %	0,6 %
3. Lack of effect, unjustifiable	0,0 %	0,1 %	0,2 %	0,0 %
4. Treatment difficulties	0,2 %	0,0 %	0,2 %	0,0 %
10. Other	2,0 %	1,1 %	1,3 %	1,1 %

A1. Employment

a. Professional status

0. Without employment	81,3 %	86,0 %	85,3 %	80,6 %
1. Full-time job	8,6 %	6,3 %	7,6 %	8,2 %
2. Part-time job	4,9 %	5,1 %	5,6 %	8,7 %
3. During education	1,4 %	1,5 %	0,4 %	1,0 %
4. Part-time job and in education	0,2 %	0,6 %	0,4 %	0,7 %
9. Unknown	3,5 %	0,5 %	0,7 %	0,7 %

b. Work training/courses

0. No	87,1 %	90,6 %	95,7 %	91,8 %
1. Yes	7,6 %	8,2 %	2,9 %	7,3 %
9. Unknown	5,3 %	1,2 %	1,3 %	1,0 %

c. Day care

0. No	79,7 %	84,9 %	91,8 %	87,3 %
1. Yes	14,6 %	14,0 %	6,5 %	10,5 %
9. Unknown	5,7 %	1,1 %	1,8 %	2,3 %

A2. Main income

0. Supported by others	0,4 %	0,0 %	0,4 %	0,3 %
1. Employment income	7,8 %	7,9 %	8,2 %	10,5 %
2. Student loans/scholarships	0,2 %	0,0 %	0,0 %	0,0 %

	Akershus	Oslo	Østfold	Inland
3. Unemployment benefit (unemployed)	0,2 %	0,7 %	0,4 %	0,0 %
4. Sickness benefit/partial sickness benefit	1,2 %	0,4 %	0,7 %	0,5 %
5. Work assessment allowance	16,1 %	14,0 %	7,1 %	8,8 %
6. Disability pension/retirement pension	65,6 %	67,9 %	77,1 %	74,3 %
8. Social assistance	1,9 %	6,9 %	3,8 %	4,3 %
10. Other / Unknown	6,6 %	2,1 %	2,2 %	1,5 %

A3. Housing conditions

0. No housing	0,8 %	2,0 %	0,9 %	1,8 %
1. Hospice/hospital/hotel	1,6 %	7,9 %	2,4 %	0,8 %
2. Institution	4,7 %	16,3 %	4,5 %	3,6 %
3. Prison	1,9 %	1,1 %	0,4 %	0,8 %
4. With parents	4,1 %	1,5 %	4,7 %	0,8 %
5. In others	3,5 %	2,5 %	4,2 %	1,6 %
6. Own home	78,3 %	67,1 %	76,8 %	88,9 %
10. Other / Unknown	5,2 %	1,6 %	6,0 %	1,8 %

A5. Blood infection status (HIV/hepatitis C)

a. HIV

0. Not infected	85,8 %	89,2 %	94,2 %	91,5 %
1. Infected	3,2 %	2,7 %	1,1 %	1,3 %
9. Unknown	11,0 %	8,0 %	4,7 %	7,3 %

b. Hepatitis C

0. Never treated (Hepatitis C antigen negative)	39,4 %	42,7 %	31,5 %	31,4 %
1. Hepatitis C fully treated	35,4 %	37,6 %	42,3 %	46,2 %
2. Hepatitis C positive (antigen detected)	8,3 %	4,5 %	8,8 %	6,6 %
9. Unknown hepatitis C status	16,9 %	15,2 %	17,3 %	15,8 %

A6. LAR drug

0. Methadone	40,8 %	46,5 %	37,6 %	30,9 %
1. Buprenorphine (Subutex)	26,2 %	20,8 %	25,7 %	40,1 %
1a. Buprenorphine depot	23,1 %	19,2 %	24,6 %	10,5 %
2. Buprenofine/naloxone (Suboxone)	7,9 %	3,1 %	3,6 %	7,2 %
3. Others	2,0 %	8,9 %	8,3 %	11,2 %
9. Unknown	0,0 %	1,5 %	0,2 %	0,0 %

A7. Daily dose in mg (average)

0. Methadone	89,6	83,2	81,9	94,1
1. Buprenofine (Subutex)	16,5	15,3	13,5	12,8
2. Buprenofine/naloxone (Suboxone)	12,1	10,2	13,8	13,1

A8. Prescribing doctor

	Akershus	Oslo	Østfold	Inland
0. Doctor employed in LAR initiatives	33,1 %	55,3 %	80,4 %	22,4 %
1. GP	63,1 %	33,0 %	18,7 %	73,3 %
2. Other doctor	3,2 %	11,0 %	0,2 %	4,2 %
9. Unknown	0,6 %	0,7 %	0,7 %	0,0 %
A9. Special conditions				
a. Has the patient been exposed to COVID-19?				
0. No evidence of COVID-19	41,6 %	39,3 %	43,2 %	57,0 %
1. Virus was detected, not hospitalized.	35,4 %	20,2 %	26,8 %	26,3 %
2. Virus was detected, patient hospitalized.	2,1 %	2,6 %	1,4 %	0,0 %
9. Unknown	20,9 %	37,9 %	28,6 %	16,7 %
b. Are benzodiazepines prescribed?				
0. No	49,4 %	55,2 %	54,0 %	58,6 %
1. Yes	42,6 %	40,5 %	41,0 %	40,1 %
9. Unknown	8,0 %	4,3 %	4,9 %	1,2 %
c. Are other morphine substances prescribed?				
0. No	86,3 %	90,5 %	77,3 %	76,6 %
1. Yes	5,9 %	5,9 %	7,3 %	8,5 %
9. Unknown	7,8 %	3,6 %	15,4 %	15,0 %
A10. LAR drug dispensing				
a. Number of deliveries per week (average)	2,3	4,1	3,2	3,3
b. Of which the number of monitored	2,8	3,9	3,2	3,1
c. Main point of delivery				
0. LAR measures	23,5 %	25,2 %	29,3 %	4,5 %
1. Pharmacy	50,8 %	42,1 %	45,8 %	44,4 %
2. Municipal services	17,8 %	13,0 %	19,4 %	41,4 %
3. Institution/residential center/prison	7,1 %	15,5 %	4,3 %	6,7 %
4. Doctor's office	0,0 %	0,0 %	0,2 %	1,5 %
10. Other	0,6 %	2,7 %	0,0 %	1,5 %
9. Unknown	0,2 %	1,5 %	0,9 %	0,0 %
A11. Urine testing scheme				
a. Type of agreement				
0. No samples	55,1 %	43,7 %	35,7 %	29,6 %
1. Random samples	18,9 %	37,1 %	43,9 %	35,8 %
2. Regular sampling	17,6 %	13,6 %	17,3 %	31,6 %
9. Unknown	8,4 %	5,6 %	3,1 %	3,0 %
b. Number of urine samples per week (average)	0,2	0,7	0,1	0,3

B. LAST FOUR WEEKS BEFORE FILLING DATE

B1. Treatment and counseling last 4 weeks

a. Objective of the treatment

0. Drug-free rehab	73,4 %	66,0 %	67,3 %	71,8 %
1. Stabilization without substance abuse requirements	19,4 %	30,7 %	29,6 %	23,2 %
9. Not agreed	7,2 %	3,2 %	3,1 %	5,0 %

b. Primary responsibility in the specialist health service

0. Not transferred	73,9 %	66,3 %	87,5 %	92,4 %
1. Transferred	24,0 %	33,2 %	12,2 %	5,8 %
9. Other / Unknown	2,0 %	0,5 %	0,2 %	1,8 %

c. Completed rehab, maintenance follow-up

0. No	38,5 %	50,7 %	56,8 %	65,2 %
1. Yes	52,9 %	44,9 %	37,9 %	31,1 %
9. Unknown	8,7 %	4,3 %	5,3 %	3,8 %

d. Is the patient undergoing psychiatric treatment?

0. No	83,3 %	73,1 %	89,5 %	78,4 %
1. Yes	12,2 %	23,5 %	7,4 %	20,1 %
9. Unknown	4,5 %	3,3 %	3,1 %	1,5 %

e. Has an individual plan been prepared?

0. No	72,9 %	71,4 %	75,9 %	85,3 %
1. Yes	9,8 %	8,3 %	17,6 %	11,3 %
9. Unknown	17,4 %	20,3 %	6,5 %	3,5 %

f. Systematic psychotherapeutic treatment

0. No	81,1 %	9,3 %	91,6 %	91,5 %
1. Yes	13,6 %	89,0 %	4,3 %	6,0 %
9. Unknown	5,3 %	1,7 %	4,1 %	2,5 %

B2. Have there been held responsibility group meeting in the last 4 weeks?

0. No	61,3 %	70,2 %	67,7 %	54,4 %
1. Yes	37,3 %	26,6 %	29,8 %	44,6 %

9. Unknown	1,4 %	3,2 %	2,6 %	1,0 %
	Akershus	Oslo	Østfold	Inland

B3. Mental health problems in the last 4 weeks

a. Severe depression

0. No	58,9 %	70,0 %	84,6 %	69,1 %
1. Yes	26,3 %	16,3 %	6,7 %	14,6 %
9. Unknown	14,8 %	13,6 %	8,7 %	16,3 %

b. Severe anxiety

0. No	53,2 %	58,8 %	76,1 %	63,1 %
1. Yes	32,6 %	28,3 %	15,0 %	20,9 %
9. Unknown	14,2 %	12,9 %	8,9 %	16,1 %

c. Delusions/hallucinations

0. No	78,9 %	75,6 %	88,5 %	79,1 %
1. Yes	6,3 %	11,1 %	3,2 %	5,3 %
9. Unknown	14,9 %	13,2 %	8,4 %	15,6 %

B4. Physical injuries/illnesses

that affect lifestyle or quality of life

last 4 weeks

0. No	50,7 %		57,8 %	45,1 %
1. Yes	36,1 %		34,6 %	43,9 %
9. Unknown	13,2 %		7,6 %	11,0 %

B5. Drug and alcohol use in the last 4 weeks

a. Opioids

0. No	70,8 %	64,1 %	77,3 %	76,6 %
1. Yes	15,0 %	21,9 %	7,3 %	8,5 %
9. Unknown	14,2 %	14,0 %	15,4 %	15,0 %

b. Cannabis

0. No	58,2 %	46,5 %	55,8 %	57,4 %
1. Yes	27,0 %	34,0 %	28,3 %	27,4 %
9. Unknown	14,8 %	19,4 %	15,8 %	15,2 %

c. Benzodiazepines or similar

0. No	43,8 %	34,5 %	58,9 %	52,4 %
1. Yes	43,0 %	52,5 %	26,1 %	34,9 %
9. Unknown	13,2 %	13,0 %	15,0 %	12,7 %

d. Stimulants

0. No	75,1 %	65,2 %	71,6 %	69,3 %
1. Yes	10,3 %	17,5 %	10,5 %	14,4 %

	Akershus	Oslo	Østfold	Inland
9. Unknown	14,6 %	17,3 %	17,9 %	16,4 %
e. Alcohol for intoxication				
0. No	75,4 %	73,1 %	69,8 %	76,1 %
1. Yes	8,6 %	7,3 %	11,3 %	8,8 %
9. Unknown	15,9 %	19,6 %	19,0 %	15,1 %
B6. Frequency of drug and alcohol use				
last 4 weeks				
0. Never	44,0 %	33,6 %	39,6 %	43,8 %
1. Few single episodes	18,7 %	23,0 %	19,2 %	12,7 %
2. Regular use	24,2 %	32,2 %	27,6 %	31,1 %
9. Unknown	13,2 %	11,2 %	13,6 %	12,4 %
B7. Severity of drug and alcohol use				
last 4 weeks				
0. Good function, works "like others"	53,6 %	44,7 %	49,3 %	49,0 %
1. Mixed function. Occasionally intoxicated	23,6 %	24,8 %	22,1 %	22,8 %
2. Addictive, substance-dominated function	9,6 %	19,5 %	15,5 %	15,7 %
9. Unknown	13,2 %	11,0 %	13,1 %	12,4 %

C. LAST YEAR

C1. Offenses last year

Arrested, detained, prosecuted; convicted

0. No	77,9 %	71,5 %	76,8 %	75,5 %
1. Yes	7,8 %	6,8 %	7,8 %	10,3 %
9. Unknown	14,4 %	21,7 %	15,4 %	14,3 %

C2. Overdose last year

0. No	82,5 %	80,0 %	87,4 %	82,2 %
1. Yes	5,6 %	4,7 %	4,0 %	6,3 %
9. Unknown	11,8 %	15,2 %	8,5 %	11,5 %

C3. Suicide attempts last year

0. No	84,7 %	83,4 %	90,8 %	85,4 %
1. Yes	2,7 %	2,4 %	1,8 %	1,5 %
9. Unknown	12,6 %	14,3 %	7,4 %	13,1 %

C4. Drug and alcohol use in the past year

0. Never	32,0 %	24,8 %	35,6 %	38,2 %
1. Some single, short periods of time	31,3 %	28,7 %	26,5 %	22,8 %

	Akershus	Oslo	Østfold	Inland
2. Used for extended periods or all the time	25,0 %	37,2 %	27,4 %	29,1 %
9. Unknown	11,7 %	9,3 %	10,5 %	9,9 %

C5. Satisfaction

a. Patient assessment

0. Satisfied successful	58,0 %	49,2 %	62,2 %	60,0 %
1. Both-and	20,6 %	18,9 %	15,2 %	17,0 %
2. Dissatisfied/not successful	5,1 %	4,7 %	3,1 %	4,3 %
9. Unknown	16,3 %	27,2 %	19,5 %	18,7 %

b. Filler assessment

0. Satisfied successful	67,5 %	62,8 %	67,0 %	74,4 %
1. Both-and	24,2 %	29,8 %	23,4 %	21,7 %
2. Dissatisfied/not successful	3,0 %	2,7 %	2,9 %	2,1 %
9. Unknown	5,4 %	4,8 %	6,7 %	1,8 %

C6. Are treatment changes recommended?

0. No	76,6 %	75,1 %	81,0 %	87,2 %
1. Yes	14,4 %	18,6 %	12,5 %	10,5 %
9. Unknown	9,0 %	6,3 %	6,5 %	2,3 %

C7. Who has participated/asked in the completion?

a. Pasient

0. No	19,2 %	33,1 %	29,2 %	21,1 %
1. Yes	80,4 %	66,9 %	70,8 %	78,4 %
9. Unknown	0,4 %	0,0%	0,0%	0,5 %

b. Employee

0. No	72,8 %	68,4 %	75,8 %	74,2 %
1. Yes	27,0 %	31,5 %	24,2 %	25,3 %
9. Unknown	0,2 %	0,1 %	0,0 %	0,5 %

c. Responsibility group

0. No	83,9 %	94,5 %	88,5 %	73,4 %
1. Yes	15,6 %	5,3 %	11,5 %	26,1 %
9. Unknown	0,5 %	0,1 %	0,0 %	0,5 %

Central and North

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
Number of responses	207	211	279	52	102
Response rate	102,0 %	102,9 %	86,9 %	115,6 %	104,1 %
Gender					
Men	76,8 %	76,3 %	68,8 %	71,2 %	69,6 %
Women	23,2 %	23,7 %	31,2 %	28,8 %	30,4 %
Age (average)	45,5	47,3	48,1	43,2	46,5

A. Current situation

A0. Current situation

0. Not discharged	98,1 %	95,3 %	97,9 %	89,4 %	97,1 %
1. Own desire for weaning	1,0 %	0,9 %	1,1 %	6,4 %	1,0 %
2. Dissatisfied with the treatment	0,0 %	0,0 %	0,0 %	4,3 %	0,0 %
3. Lack of effect, unjustifiable	0,0 %	0,0 %	0,0 %	0,0 %	0,0 %
4. Treatment difficulties	0,0 %	0,0 %	0,0 %	0,0 %	0,0 %
10. Other	1,0 %	3,8 %	1,1 %	0,0 %	2,0 %

A1. Employment

a. Professional status

0. Without employment	69,6 %	75,4 %	70,8 %	80,8 %	84,0 %
1. Full-time job	18,8 %	11,8 %	10,8 %	7,7 %	10,0 %
2. Part-time job	4,3 %	10,9 %	8,7 %	11,5 %	6,0 %
3. During education	1,0 %	0,0 %	0,7 %	0,0 %	0,0 %
4. Part-time job and in education	0,0 %	0,0 %	0,0 %	0,0 %	0,0 %
9. Unknown	6,3 %	1,9 %	9,0 %	0,0 %	0,0 %

b. Work training/courses

0. No	87,4 %	91,9 %	85,9 %	91,7 %	93,0 %
1. Yes	5,8 %	3,3 %	3,6 %	2,1 %	5,0 %
9. Unknown	6,8 %	4,7 %	10,5 %	6,3 %	2,0 %

c. Day care

0. No	80,2 %	84,4 %	87,0 %	93,9 %	92,0 %
1. Yes	13,0 %	9,0 %	2,9 %	0,0 %	6,0 %
9. Unknown	6,8 %	6,6 %	10,1 %	6,1 %	2,0 %

A2. Main income

0. Supported by others	0,5 %	0,5 %	0,4 %	0,0 %	0,0 %
1. Employment income	20,3 %	10,9 %	12,0 %	9,6 %	13,0 %

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
2. Student loans/scholarships	0,0%	0,0%	0,0%	0,0%	0,0%
3. Unemployment benefit (unemployed)	1,4 %	0,0%	0,0%	1,9 %	0,0%
4. Sickness benefit/partial sickness benefit	0,5 %	0,5 %	0,4 %	0,0%	0,0%
5. Work assessment allowance	6,8 %	10,0 %	10,1 %	9,6 %	11,0 %
6. Disability pension/retirement pension	60,4 %	71,1 %	65,2 %	69,2 %	69,0 %
8. Social assistance	2,4 %	4,7 %	4,0 %	1,9 %	3,0 %
10. Other / Unknown	7,7 %	2,4 %	8,0 %	7,7 %	4,0 %

A3. Housing conditions

0. No housing	1,9 %	0,9 %	2,2 %	0,0%	0,0%
1. Hospice/hospital/hotel	0,0%	0,5 %	1,1 %	0,0%	0,0%
2. Institution	2,4 %	1,9 %	3,3 %	3,8 %	0,0%
3. Prison	1,0 %	0,0%	2,5 %	0,0%	0,0%
4. With parents	3,4 %	6,2 %	5,8 %	1,9 %	3,0 %
5. In others	2,9 %	3,8 %	2,9 %	7,7 %	6,0 %
6. Own home	81,6 %	82,0 %	72,7 %	82,7 %	88,0 %
10. Other / Unknown	6,8 %	4,7 %	9,5 %	3,8 %	3,0 %

A5. Blood infection status (HIV/hepatitis C)

a. HIV

0. Not infected	82,4 %	95,3 %	88,4 %	86,5 %	83,0 %
1. Infected	1,5 %	0,9 %	0,4 %	0,0%	0,0%
9. Unknown	16,1 %	3,8 %	11,2 %	13,5 %	17,0 %

b. Hepatitis C

0. Never treated (Hepatitis C antigen negative)	22,4 %	45,1 %	5,1 %	63,5 %	40,0 %
1. Hepatitis C fully treated	25,4 %	31,1 %	3,8 %	19,2 %	30,0 %
2. Hepatitis C positive (antigen detected)	21,0 %	10,3 %	6,9 %	5,8 %	4,0 %
9. Unknown hepatitis C status	31,2 %	13,6 %	3,8 %	11,5 %	24,0 %

A6. LAR drug

0. Methadone	26,7 %	40,3 %	28,3 %	19,6 %	29,0 %
1. Buprenorphine (Subutex)	30,6 %	41,2 %	36,6 %	45,1 %	38,0 %
1a. Buprenorphine depot	20,4 %	8,1 %	17,0 %	15,7 %	20,0 %
2. Buprenofine/naloxone (Suboxone)	15,5 %	8,1 %	8,7 %	19,6 %	8,0 %
3. Others	1,0 %	1,9 %	5,1 %	0,0%	5,0 %
9. Unknown	5,8 %	0,5 %	4,3 %	0,0%	0,0%

A7. Daily dose in mg (average)

0. Methadone	86,8	98,8	85,6	121,5	78,6
1. Buprenofine (Subutex)	15,8	16,8	15,0	13,9	14,3
2. Buprenofine/naloxone (Suboxone)	14,4	13,8	14,7	12,8	13,5

Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
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A8. Prescribing doctor

0. Doctor employed in LAR initiatives	27,7 %	34,6 %	49,5 %	88,2 %	74,7 %
1. GP	62,1 %	63,0 %	49,8 %	9,8 %	25,3 %
2. Other doctor	1,9 %	0,0 %	0,7 %	0,0 %	0,0 %
9. Unknown	8,3 %	2,4 %	0,0 %	2,0 %	0,0 %

A9. Special conditions

a. Has the patient been exposed to COVID-19?

0. No evidence of COVID-19	44,4 %	44,5 %	51,6 %	50,0 %	15,0 %
1. Virus was detected, not hospitalized.	31,2 %	25,1 %	21,8 %	23,1 %	18,0 %
2. Virus was detected, patient hospitalized.	1,0 %	1,4 %	1,8 %	1,9 %	1,0 %
9. Unknown	23,4 %	28,9 %	24,7 %	25,0 %	66,0 %

b. Are benzodiazepines prescribed?

0. No	68,3 %	53,6 %	41,0 %	39,2 %	40,0 %
1. Yes	18,5 %	42,2 %	49,5 %	52,9 %	60,0 %
9. Unknown	13,2 %	4,3 %	9,5 %	7,8 %	0,0 %

c. Are other morphine substances prescribed?

0. No	87,3 %	93,8 %	70,7 %	69,2 %	93,0 %
1. Yes	1,0 %	2,4 %	7,2 %	7,7 %	7,0 %
9. Unknown	11,7 %	3,8 %	22,1 %	23,1 %	0,0 %

A10. LAR drug dispensing

a. Number of deliveries per week (average)	1,9	3,2	2,4	3,3	2,1
b. Of which the number of monitored	1,8	3,2	2,4	3,2	2,1
c. Main point of delivery					
0. LAR measures	18,9 %	8,1 %	19,5 %	0,0 %	10,1 %
1. Pharmacy	43,7 %	50,7 %	44,1 %	35,3 %	55,6 %
2. Municipal services	19,4 %	30,3 %	19,9 %	56,9 %	24,2 %
3. Institution/residential center/prison	4,9 %	3,8 %	5,9 %	5,9 %	0,0 %
4. Doctor's office	3,9 %	6,2 %	3,7 %	2,0 %	10,1 %
10. Other	1,9 %	0,0 %	1,5 %	0,0 %	0,0 %
9. Unknown	7,3 %	0,9 %	5,5 %	0,0 %	0,0 %

A11. Urine testing scheme

a. Type of agreement

0. No samples	29,6 %	40,3 %	57,2 %	32,7 %	45,0 %
1. Random samples	36,9 %	39,8 %	21,8 %	40,4 %	38,0 %
2. Regular sampling	24,3 %	15,6 %	10,7 %	25,0 %	16,0 %

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
9. Unknown	9,2 %	4,3 %	10,3 %	1,9 %	1,0 %
b. Number of urine samples per week (average)	0,2	0,6	0,1	0,2	0,1

B. LAST FOUR WEEKS BEFORE FILLING DATE

B1. Treatment and counseling last 4 weeks

a. Objective of the treatment

0. Drug-free rehab	75,1 %	66,4 %	70,2 %	82,7 %	61,0 %
1. Stabilization without substance abuse requirements	13,2 %	24,2 %	18,9 %	11,5 %	35,0 %
9. Not agreed	11,7 %	9,5 %	10,9 %	5,8 %	4,0 %

b. Primary responsibility in the specialist health service

0. Not transferred	18,4 %	70,6 %	50,9 %	86,5 %	91,0 %
1. Transferred	73,3 %	28,9 %	45,8 %	9,6 %	9,0 %
9. Other / Unknown	8,3 %	0,5 %	3,2 %	3,8 %	0,0 %

c. Completed rehab, maintenance follow-up

0. No	31,7 %	43,1 %	35,0 %	69,2 %	46,0 %
1. Yes	57,1 %	45,5 %	47,8 %	21,2 %	38,0 %
9. Unknown	11,2 %	11,4 %	17,2 %	9,6 %	16,0 %

d. Is the patient undergoing psychiatric treatment?

0. No	83,0 %	82,5 %	74,7 %	80,8 %	93,0 %
1. Yes	6,8 %	13,7 %	11,9 %	13,5 %	7,0 %
9. Unknown	10,2 %	3,8 %	13,4 %	5,8 %	0,0 %

e. Has an individual plan been prepared?

0. No	61,2 %	87,7 %	82,2 %	69,2 %	93,0 %
1. Yes	25,7 %	5,7 %	4,4 %	17,3 %	2,0 %
9. Unknown	13,1 %	6,6 %	13,5 %	13,5 %	5,0 %

f. Systematic psychotherapeutic treatment

0. No	87,4 %	89,6 %	76,5 %	86,0 %	93,0 %
1. Yes	1,9 %	6,2 %	9,7 %	4,0 %	6,0 %
9. Unknown	10,7 %	4,3 %	13,7 %	10,0 %	1,0 %

B2. Have there been held responsibility group meeting in the last 4 weeks?

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
0. No	69,8 %	67,3 %	76,2 %	53,1 %	80,0 %
1. Yes	18,5 %	31,3 %	11,9 %	42,9 %	20,0 %
9. Unknown	11,7 %	1,4 %	11,9 %	4,1 %	0,0 %
B3. Mental health problems in the last 4 weeks					
a. Severe depression					
0. No	66,3 %	56,9 %	71,3 %	51,9 %	71,0 %
1. Yes	13,2 %	14,2 %	9,8 %	15,4 %	8,0 %
9. Unknown	20,5 %	28,9 %	18,9 %	32,7 %	21,0 %
b. Severe anxiety					
0. No	57,6 %	39,8 %	58,2 %	42,3 %	53,0 %
1. Yes	23,4 %	30,8 %	22,9 %	32,7 %	27,0 %
9. Unknown	19,0 %	29,4 %	18,9 %	25,0 %	20,0 %
c. Delusions/hallucinations					
0. No	75,1 %	65,9 %	75,6 %	59,6 %	74,0 %
1. Yes	4,4 %	5,7 %	6,9 %	9,6 %	6,0 %
9. Unknown	20,5 %	28,4 %	17,5 %	30,8 %	20,0 %
B4. Physical injuries/illnesses that affect lifestyle or quality of life last 4 weeks					
0. No	47,3 %	37,0 %	46,7 %	45,1 %	49,0 %
1. Yes	35,1 %	40,3 %	36,8 %	29,4 %	33,0 %
9. Unknown	17,6 %	22,7 %	16,5 %	25,5 %	18,0 %
B5. Drug and alcohol use in the last 4 weeks					
a. Opiods					
0. No	75,7 %	64,5 %	70,7 %	69,2 %	61,0 %
1. Yes	6,3 %	5,7 %	7,2 %	7,7 %	4,0 %
9. Unknown	18,0 %	29,9 %	22,1 %	23,1 %	35,0 %
b. Cannabis					
0. No	57,3 %	38,4 %	48,0 %	42,3 %	44,0 %
1. Yes	24,8 %	29,4 %	30,3 %	34,6 %	24,0 %
9. Unknown	18,0 %	32,2 %	21,7 %	23,1 %	32,0 %
c. Benzodiazepines or similar					
0. No	53,4 %	33,2 %	42,8 %	38,5 %	50,0 %
1. Yes	28,6 %	44,5 %	36,2 %	44,2 %	20,0 %
9. Unknown	18,0 %	22,3 %	21,0 %	17,3 %	30,0 %

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
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d. Stimulants

0. No	69,9 %	57,8 %	67,1 %	59,6 %	54,0 %
1. Yes	11,2 %	12,8 %	12,3 %	17,3 %	15,0 %
9. Unknown	18,9 %	29,4 %	20,6 %	23,1 %	31,0 %

e. Alcohol for intoxication

0. No	73,3 %	63,5 %	69,2 %	63,5 %	59,0 %
1. Yes	7,3 %	4,3 %	8,3 %	9,6 %	13,0 %
9. Unknown	19,4 %	32,2 %	22,5 %	26,9 %	28,0 %

**B6. Frequency of drug and alcohol use
last 4 weeks**

0. Never	44,7 %	28,9 %	33,0 %	36,5 %	34,0 %
1. Few single episodes	16,0 %	16,1 %	13,9 %	13,5 %	9,0 %
2. Regular use	20,9 %	25,1 %	32,6 %	25,0 %	27,0 %
9. Unknown	18,4 %	29,9 %	20,5 %	25,0 %	30,0 %

**B7. Severity of drug and alcohol use
last 4 weeks**

0. Good function, works "like others"	51,5 %	46,4 %	48,5 %	47,1 %	38,0 %
1. Mixed function. Occasionally intoxicated	17,5 %	19,0 %	18,8 %	15,7 %	14,0 %
2. Addictive, substance-dominated function	8,7 %	7,6 %	9,2 %	15,7 %	19,0 %
9. Unknown	22,3 %	27,0 %	23,5 %	21,6 %	29,0 %

C. LAST YEAR

C1. Offenses last year

Arrested, detained, prosecuted; convicted

0. No	74,6 %	63,5 %	69,6 %	73,1 %	67,0 %
1. Yes	8,8 %	4,7 %	10,5 %	9,6 %	6,0 %
9. Unknown	16,6 %	31,8 %	19,9 %	17,3 %	27,0 %

C2. Overdose last year

0. No	81,0 %	65,9 %	78,7 %	82,4 %	80,0 %
1. Yes	4,4 %	2,4 %	4,0 %	2,0 %	5,0 %
9. Unknown	14,6 %	31,8 %	17,3 %	15,7 %	15,0 %

C3. Suicide attempts last year

0. No	65,4 %	78,8 %	85,0 %	76,7 %	81,0 %
1. Yes	1,4 %	1,9 %	0,0 %	1,6 %	2,4 %

	Møre/ Romsdal	Nordlandssh	UNN	Finnmarkssh	Helgelandssh
9. Unknown	33,2 %	19,2 %	15,0 %	21,8 %	16,6 %
C4. Drug and alcohol use in the past year					
0. Never	41,5 %	22,3 %	36,5 %	36,5 %	29,0 %
1. Some single, short periods of time	23,4 %	22,7 %	16,6 %	25,0 %	19,0 %
2. Used for extended periods or all the time	18,0 %	23,7 %	29,9 %	25,0 %	32,0 %
9. Unknown	17,1 %	31,3 %	17,0 %	13,5 %	20,0 %
C5. Satisfaction					
a. Patient assessment					
0. Satisfied successful	50,2 %	51,2 %	54,0 %	46,2 %	45,0 %
1. Both-and	23,9 %	12,8 %	17,2 %	19,2 %	31,0 %
2. Dissatisfied/not successful	5,9 %	1,4 %	6,2 %	7,7 %	4,0 %
9. Unknown	20,0 %	34,6 %	22,6 %	26,9 %	20,0 %
b. Filler assessment					
0. Satisfied successful	53,2 %	68,2 %	55,5 %	51,0 %	52,0 %
1. Both-and	25,4 %	18,5 %	23,7 %	43,1 %	38,0 %
2. Dissatisfied/not successful	4,9 %	2,8 %	1,8 %	5,9 %	9,0 %
9. Unknown	16,6 %	10,4 %	19,0 %	0,0 %	1,0 %
C6. Are treatment changes recommended?					
0. No	65,4 %	80,6 %	72,0 %	90,4 %	65,0 %
1. Yes	19,5 %	7,1 %	11,6 %	5,8 %	30,0 %
9. Unknown	15,1 %	12,3 %	16,4 %	3,8 %	5,0 %
C7. Who has participated/asked in the completion?					
a. Pasient					
0. No	22,4 %	33,2 %	25,0 %	30,8 %	52,0 %
1. Yes	76,1 %	66,4 %	74,3 %	69,2 %	48,0 %
9. Unknown	1,5 %	0,5 %	0,7 %	0,0 %	0,0 %
b. Employee					
0. No	75,6 %	70,1 %	86,2 %	90,2 %	41,0 %
1. Yes	22,4 %	29,4 %	13,0 %	9,8 %	59,0 %
9. Unknown	2,0 %	0,5 %	0,8 %	0,0 %	0,0 %
c. Responsibility group					
0. No	92,7 %	91,0 %	96,4 %	100,0 %	97,0 %
1. Yes	5,9 %	8,5 %	2,8 %	0,0 %	3,0 %
9. Unknown	1,5 %	0,5 %	0,8 %	0,0 %	0,0 %