Summary in English



Ukom



NÅR RUSEN DEFINERER HELSEHJELPEN

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This investigation explores patient safety risks in how health and care services respond to people with severe substance dependence, often alongside co existing mental health conditions and physical illness. It was initiated in response to repeated notifications to the Norwegian Healthcare Investigation Board (Ukom) concerning serious adverse events involving this patient group. The purpose of the investigation is to support learning by examining how service design, organization and practice influence care, continuity and outcomes.

The investigation draws on three patient histories from different parts of Norway. The cases involve a woman who entered opioid agonist treatment (OAT) later in life and died in her sixties, likely from a respiratory infection; a young man who was repeatedly refused OAT and died at a young age; and a man in his thirties whose functioning deteriorated following transfer between two regional specialist care providers. Considered together, these cases show how patients with complex and long term needs can encounter care pathways that are difficult to access, difficult to navigate and difficult to sustain.

A central finding is that care for this patient group is often delivered through services that operate separately rather than as part of a coherent pathway. Responsibilities between OAT services, general practitioners, municipal health and social care services, and specialist health services are often unclear. Where substance use treatment, mental health care and physical health care are organized separately, patients may not receive effective help in any of these areas. This fragmentation creates risk at transition points, increases the potential for delay or discontinuity, and can leave patients without coordinated follow up when their needs span multiple services.

The investigation also finds that services are often organized around assumptions that patients can coordinate their own care. This includes managing appointments, conveying information between providers and using digital systems to maintain contact. For people with severe substance dependence, unstable living circumstances, cognitive difficulties or reduced

functioning, these assumptions may not reflect the realities of daily life. In practice, this can mean that access to care depends not only on clinical need, but also on a patient's capacity to navigate complex systems.

Variation in practice is another significant finding. This includes variation in access to OAT, medication choices and dosing, and the use of monitoring and control measures. Differences are particularly visible when patients move between geographical areas or between provider organizations. Patients describe such variation as difficult to understand and difficult to predict. The investigation finds that this can affect trust, reduce opportunities for meaningful involvement in care decisions, and contribute to conflict between patients and services.

The cases also show how capacity constraints and organizational conditions shape the care that is delivered. Waiting time, limited flexibility and short treatment episodes can make it harder for services to respond when patients are ready or motivated to engage. Services with low barriers of access and voluntary organizations often provide important continuity, especially for people with low levels of functioning, but access to these services varies. The investigation also identifies experiences of stigma and low expectations in encounters with services. Measures experienced as intrusive or punitive may reduce openness and delay help seeking, with implications for both safety and continuity.

These findings are consistent with concerns previously identified in Norway by oversight, audit and human rights bodies, which have described fragmented services, limited coordination and substantial variation in practice. They also sit alongside long standing policy ambitions for more integrated, flexible and user involved care. The persistence of these issues suggests that improvement is unlikely to come from individual effort alone. It requires attention to how services are organized, how responsibilities are defined, and how care pathways are designed for patients whose needs do not fit neatly within one part of the system.

The investigation points to several areas for improvement. These include more practical decision support for health professionals working with complex OAT cases; more clearly coordinated and parallel care across substance use, mental health and physical health services; and clearer accountability during transitions between providers and levels of care. The findings also support service models that are better adapted to patients with low functioning, instability and repeated non attendance, that make more systematic use of information from relatives and significant others, and that do not rely solely on digital access.

Taken together, the findings suggest that risks to patient safety in this area arise less from isolated decisions and more from the cumulative effects of fragmentation, variability and limited continuity. Reducing these risks will depend on designing services that are able to work around the needs of the patient, rather than expecting the patient to work around the needs of the system.

Statens undersøkelseskommisjon
for helse-og omsorgstjenesten

Postboks 225 Skøyen
0213 Oslo
E-post: post@ukom.no
Org nr: 921018924