



Facilitators and Challenges in Oral Health Care for Iranian Patients Undergoing Opioid Maintenance Treatment: A Qualitative Study

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Abstract

Introduction: This qualitative study aimed to explore the challenges and enablers of oral health care for patients receiving opioid maintenance treatment.

Method: Forty-nine patients under opioid maintenance treatment were included in the study. All interviews were audio recorded and transcribed verbatim. The interview proceeded until data saturation, after which the collected data were analyzed using content analysis methods.

Findings: The most common reasons for problems preventing access to dental services include lack of financial resources, long travel distances (e.g., living in mountainous areas), prioritizing drug seeking, limited availability of dentists, addiction-related indifference, difficulty tolerating waiting times, fear of arrest, lack of time off from work, and prioritizing substance use over dental treatment. Two participants reported that the clinic staff were kind and behaved appropriately. Additionally, seven participants stated that the staff did not discriminate between them and other patients. Regarding dental services, the participants requested that costs be covered, services be insured or free, and that they be informed about suitable service locations.

Conclusion: Patients undergoing maintenance treatment with opioids need more oral and dental health care than the general population. For better access of patients undergoing opioid maintenance treatment to these services, it is better to provide special centers for these people with trained personnel to treat them with insurance coverage.

Keywords: Barriers, Facilitators, Health care, Patients, Addiction

Citation: Zeinali M, Dehestanee MR, Hashemipour MA. Facilitators and challenges in oral health care for Iranian patients undergoing opioid maintenance treatment: a qualitative study. *Addict Health* 2026;18:1662. doi:10.34172/ahj.1662

Received: January 28, 2025, **Revised:** August 13, 2025, **Accepted:** February 3, 2026, **ePublished:** March 2, 2026

Introduction

Globally, it is estimated that 230 million adults (approximately 1 in 20) use illegal drugs at least once per year, while only 1.7 treatment beds per 100,000 population are available for managing substance use.¹

According to official statistics, an estimated 1.35 million individuals in Iran use drugs. Based on the national average household size (3.6 persons), approximately 5 million people are directly affected by substance use disorders (SUDs). The Iranian Legal Medicine Organization reported that 13 deaths per day were attributable to substance abuse.²

Data from the Prisons and Security and Corrective Measures Organization indicate that nearly half of criminal convictions in Iran are related to illicit drugs.² Although the widespread use of methamphetamines in

recent years has altered substance-use patterns, drugs such as crack and heroin remain the most commonly used and are major contributors to the growing population of individuals with substance dependence. Although oral and dental conditions are recognized as significant adverse consequences of substance use, they receive limited attention in drug-use databases.^{3,4,5,6} Furthermore, studies specifically examining oral health among individuals receiving opioid maintenance therapy (OMT) remain insufficient.^{3,4,5,6,7}

Individuals with SUD and those receiving opioids have poorer oral and dental health compared with age-matched individuals in the general population.^{7,8,9} While adequate dental function is defined as having at least 20 functional natural teeth^{10,11,12}, the mean number of functional teeth in patients with SUD is typically below this threshold.^{13,14}



Studies have shown that more than half of patients undergoing opioid maintenance therapy (OMT) are dissatisfied with the appearance of their teeth and mouth and frequently experience oral health problems.^{15,16} A 33-year follow-up study of men with long-term SUD in the United States reported a mean of 16 remaining teeth.¹⁷

Evidence indicates that limited financial resources are a major contributor to the low prioritization of oral and dental care among individuals with SUD.¹⁸ Overall, patients with SUD demonstrate poorer oral health than the general population or comparable groups.^{4,19,20} For example, prosthesis use is markedly more common among individuals with SUD than in the general population (34% vs. 8%).²¹

Oral problems are reported most frequently among individuals with opioid dependence²¹ and are commonly associated with personal neglect, poverty, malnutrition, and high consumption of sugary foods.¹⁷

Individuals with SUD report high levels of dental caries, periodontal disease, and xerostomia.^{4,5,22,23,24} Many individuals who have recovered from SUD attribute their decayed teeth, tooth pain, and tooth loss to methadone used in OMT.¹⁶ In addition, patients receiving OMT have been shown to increase their consumption of sugary foods four years after initiating treatment.²⁵

Accordingly, evidence suggests that, in addition to illicit drug use, several prescribed medications, including methadone and buprenorphine, may contribute to oral and dental problems such as dental caries and xerostomia.^{16,26}

Several individual and organizational barriers may prevent patients undergoing OMT from seeking dental care.⁵ Individual barriers—such as low self-esteem, ongoing substance use, dental phobia, low pain tolerance, anxiety, and prior traumatic dental experiences.²⁶

Despite the high prevalence of oral problems and the substantial need for oral healthcare²⁰, patients with SUD frequently neglect their dental needs.^{14,22} Such neglect often results in missed opportunities for early diagnosis and timely treatment.^{22,27} Evidence indicates that individuals with SUD commonly seek dental care only when experiencing pain or discomfort.^{28,4,17} Furthermore, limited access to care often results in fewer restored teeth within this population group.²⁹

Avoiding and neglecting oral and dental healthcare services can lead to poor oral health, which, in turn, can deteriorate an individual's health, social relations, and quality of life.¹⁶ Poor oral health care can cause feelings of isolation and have profound psychological consequences for individuals with SUDs.^{30,31,32,33,34}

Barriers to seeking oral health care among individuals with SUDs include personal factors such as low self-esteem, persistent substance use, and dental phobia, as well as structural factors like poor access to services and social stigma. These barriers often result in neglect

of oral health problems and missed opportunities for early intervention and treatment.^{35,36} Conversely, addressing dental issues has been shown to contribute to the development of a renewed identity among patients undergoing OMT. Research suggests that dental treatment can positively impact self-confidence, self-esteem, and social integration among OMT participants. Despite these challenges, recognizing the essential role of oral health in overall well-being is crucial. Understanding and mitigating the barriers that prevent individuals with SUD from accessing dental care has significant potential to improve their health outcomes. Addressing these barriers can foster better health habits and improve the quality of life for those receiving treatment.^{37,38} Therefore, the present study aimed to assess facilitators and barriers to oral and dental healthcare among patients undergoing opioid maintenance therapy.

Method

Sample Size

In this research, which was a comprehensive functional study, group and individual interviews were conducted with a number of patients admitted to addiction treatment centers in Kerman in the form of eight focus groups.

Sampling ended when theoretical saturation was reached, i.e., when additional data no longer helped to complete and specify new theoretical categories, and the samples appeared similar thereafter. In other words, by continuing the process, the researchers concluded that adding more cases and continuing the study would not yield any new information. As a result, no points would be added to the previous analysis.

Inclusion/Exclusion Criteria

Adults aged 18 or older who were receiving treatment at addiction centers in Kerman were selected as focus group participants.^{39,40}

Study Design

A semi-structured focus group interview guide with open-ended questions was employed to examine the strengths and challenges faced by patients in addiction treatment centers in Kerman. The discussion in each focus group was centered around topics such as individual barriers (e.g., patient anxiety about undergoing treatment and concerns about anesthetics not working effectively), structural barriers (dental health workers' lack of knowledge and lack of knowledge about OMT), and facilitators (impact on quality of life, free oral health care, and assistance for patients to attend their appointments).

Before the interview, verbal consent was obtained from the patients undergoing opioid maintenance treatment in Kerman. They were assured that their information would stay confidential and be presented solely in the form of a report. Researchers visited [addiction treatment centers](#)

and, after explaining the study's method and purpose, interviewed those willing to participate.

To ensure broad representation, a maximally diverse purposive sample was selected, encompassing variations in occupation, gender, age, and educational level. The participants were informed of their right to withdraw from the study at any time without explanation until its publication.

An interview guide was developed prior to the project's initiation, drawing on findings from relevant scientific literature and the clinical expertise of the interview team. Semi-structured individual interviews were conducted at locations chosen by patients undergoing opioid maintenance treatment.^{35,36,37,38}

The interviews were conducted by two people (a professor of oral medicine and a senior student). The senior student received one month of training in interview technique.

The interview began with predetermined questions that were prepared by two oral disease specialists and a statistician. To verify its validity and reliability, four faculty experts reviewed it for scientific relevance, clarity of content, and comprehension. Adjustments were made based on the experts' feedback and relevant literature.

All interviews were audio-recorded and transcribed verbatim. Following each interview, review notes and reminders were documented. These field notes captured the contextual details of the topic, the manner in which patients undergoing opioid maintenance treatment conveyed their experiences, the overall atmosphere during the interviews, and notable reactions observed throughout. The transcripts were cross-checked and refined against the audio recordings to ensure accuracy.

The interviews were recorded, and the participants' opinions were analyzed and coded independently by two researchers immediately following the initial interview. This process continued until the data reached saturation. To enhance the study's scientific accuracy, the codes derived from each interview were shared with the participants to confirm the researchers' understanding of their perspectives. Additionally, participants were encouraged to freely express their thoughts, which allowed their experiences and attitudes in this area to be thoroughly assessed. All conversations were audio-recorded without taking notes during the sessions, enabling a more focused, uninterrupted dialogue. The timing and approach for each participant varied since they displayed different characteristics and behavioral traits. For instance, some participants answered without further prompting, while others needed additional questions from the interviewer. The interview was conducted entirely in a colloquial manner, so that the participants could express more detailed views and engage in more detailed conversations.

Ethical Considerations

The confidentiality of all subject-related information was

strictly maintained. This project received approval from the university's Ethics Committee under the code IR.KMU.REC.1401.414. All experiments adhered to relevant guidelines and regulations, including the Declaration of Helsinki. Additionally, participants communicated in a manner that prompted the interviewer to seek further clarification through additional questions.

Data analysis

Focus group sessions were recorded and processed using NVivo 8 qualitative analysis software. The data underwent thematic analysis, a technique designed to identify, examine, and interpret patterns or themes within the dataset. This method is versatile, accommodating various theoretical frameworks, and includes both inductive and deductive approaches. Coding the focus group discussions revealed no significant new themes, suggesting that data saturation had been achieved. Preliminary analysis and findings were shared during meetings with MAS and MRD as part of the member-checking process. The categorized data were further organized, and the corresponding number of respondents for each category was identified.

Results

A total of 49 individuals participated in the study. The focus group interview included all participants, comprising 2 women (4.1%) and 47 men (95.9%), with an average age of 39.4 ± 3.2 years (males: 38.3 ± 3.2 years; females: 40.1 ± 1.0 years). In terms of marital status, the breakdown was as follows: 6 participants were divorced (13%), 18 were single (39%), 7 had deceased spouses (15.3%), and 15 were married (32.7%). The addiction period among the participants ranged from 4 to 14 years. Regarding living arrangements, 15 individuals lived with their parents (32.6%), seven were homeless (15.3%), 19 lived with their children (41%), and 5 had private residences (10.8%). Regarding education, 29 participants (63%) had not completed high school, and 33 individuals (71.7%) were unemployed. [Table 1](#) provides an overview of the demographic characteristics of the study participants.

All interviews were conducted in a confidential environment during clinic hours, typically in the clinic's lunch or break room, and lasted 20-30 minutes (24.2 ± 1.3).

[Table 2](#) presents the main themes and sub-themes identified in the study. The research organized key themes based on participants' responses, highlighting the number of respondents for each topic.

Individuals with addiction

Reasons for missing appointments: 12 participants (26.1%)

The impact of oral health on daily life: 14 participants (30.4%)

Knowledge of available oral and dental services: 17 participants (37%)

Table 1. Demographic characteristics of the people participating in the study

No.	Gender	Age	Marital status	Addiction period (years)	Living status	Literacy level	Employment status
1	Man	40	Divorced	7	With Parents	≥ diploma	Employed
2	Woman	42	Single	9	Homeless	≥ diploma	Unemployed
3	Woman	39	Spouse deceased	4	With child	≥ diploma	Unemployed
4	Man	38	Married	5	Private house	≥ diploma	Unemployed
5	Man	36	Married	8	Private house	≥ diploma	Unemployed
6	Man	42	Spouse deceased	10	Private house	≥ diploma	Unemployed
7	Man	45	Married	12	Private house	≥ diploma	Unemployed
8	Man	41	Married	5	Private house	≥ diploma	Unemployed
9	Man	43	Single	6	Homeless	≥ diploma	Unemployed
10	Man	37	Single	8	with Parents	≥ diploma	Unemployed
11	Man	38	Single	9	with Parents	< diploma	Employed
12	Man	36	Married	11	Homeless	< diploma	Unemployed
13	Man	41	Married	6	With child	< diploma	Unemployed
14	Man	42	Married	5	With child	< diploma	Unemployed
15	Man	52	Single	8	with Parents	< diploma	Unemployed
16	Man	51	Single	7	with Parents	< diploma	Unemployed
17	Man	42	Divorced	6	Homeless	≥ diploma	Unemployed
18	Man	41	Divorced	5	With child	≥ diploma	Employed
19	Man	41	Spouse deceased	11	With child	≥ diploma	Employed
20	Man	36	Single	12	With Parents	< diploma	Unemployed
21	Man	39	Married	6	With child	< diploma	Unemployed
22	Man	38	Married	6	Homeless	< diploma	Unemployed
23	Man	40	Spouse deceased	8	With child	< diploma	Unemployed
24	Man	41	Spouse deceased	7	With child	< diploma	Employed
25	Man	25	Single	9	With child	< diploma	Unemployed
26	Man	26	Spouse deceased	13	With child	< diploma	Unemployed
27	Man	29	Spouse deceased	5	With child	< diploma	Unemployed
28	Man	40	Divorced	6	Homeless	< diploma	Employed
29	Man	39	Single	8	With Parents	< diploma	Unemployed
30	Man	38	Divorced	7	With child	< diploma	Employed
31	Man	40	Single	9	With Parents	< diploma	Unemployed
32	Man	41	Single	6	With Parents	< diploma	Unemployed
33	Man	43	Single	7	With Parents	< diploma	Employed
34	Man	41	Single	5	With Parents	< diploma	Unemployed
34	Man	42	Divorced	11	With child	< diploma	Unemployed
36	Man	41	Single	13	Homeless	< diploma	Unemployed
37	Man	39	Married	14	With child	< diploma	Unemployed
38	Man	38	Married	13	With child	< diploma	Employed
39	Man	40	Married	5	With child	< diploma	Employed
40	Man	41	Single	6	With Parents	≥ diploma	Employed
41	Man	42	Single	10	With Parents	≥ diploma	Unemployed
42	Man	42	Single	11	With Parents	≥ diploma	Unemployed
43	Man	41	Single	5	With Parents	≥ diploma	Unemployed
44	Man	43	Married	6	With child	< diploma	Unemployed
45	Man	45	Married	8	With child	< diploma	Employed
46	Man	40	Married	9	With child	< diploma	Unemployed

Table 2. The facilitators and barriers in oral health of the people participating in the study

Theme	Sub-theme	No.	%
Individual barriers	Patient anxiety about undergoing treatment	21	45.6
	Concerns about anesthetics not working effectively	22	47.8
	The challenges posed by socio-economic deprivation	31	67.4
	Odontophobia	36	78.3
	Discrepancies between patients, expectations, and offered service	19	41.3
	Perceived stigma	22	47.8
	Teeth mean more than other disfigurements	25	54.3
Structural barriers	Dental health workers' lack of knowledge	24	52.2
	Lack of knowledge about opioid maintenance therapy	26	56.5
	Stigma	21	45.6
	Negative perceptions from healthcare providers	19	41.3
Facilitators	Difficulties making an appointment with a dentist, limited availability of services	23	50
	Influence on quality of life	34	73.9
	Oral healthcare free of charge	31	67.4
	The patient can get help to show up to the appointments	21	45.6
	Being accompanied to the appointments	19	41.3
	Adapted anesthesia	25	54.3
	Clinician–patient relationship	26	56.5
	Being acknowledged and taken care of	24	52.2
Experiential communication	25	54.3	

Past dental treatment experiences: 21 participants (45.6%)

Expectations and opinions regarding oral healthcare services: 23 participants (50%)

Table 1 shows the subcategories and categories.

Difficulties and Problems of Receiving Dental Services

The most frequently reported barriers included lack of financial resources, long travel distances (e.g., living in mountainous areas), prioritizing drug seeking, limited availability of dentists, addiction-related indifference, difficulty tolerating waiting times, fear of arrest, lack of time off from work, and prioritizing substance use over dental treatment.

Statements of the individuals with addiction

“We can’t afford to see a dentist, so some people burn the nerve with a needle and a lighter and try to relieve the pain using unsanitary methods, like burning a piece of fabric and inhaling the smoke. If they manage to find any money, they spend it on drugs instead.”

Four of my front teeth were damaged. I could not afford a private dentist, so I went to Shafa Hospital at six. They told me they had to open a file for me, and even that minimum cost was more than I could pay.”

Statement from a rehabilitation center expert (camp expert’s statement)

“A budget is allocated for dental services, and we

repeatedly call patients and encourage them to seek treatment—we even cover the cost. Some go, but others do not. In my opinion, it would be ideal if a dentist could come to the center to provide dental care. Many patients have difficulty commuting because most live on the outskirts of the city, and reaching medical facilities may cost around 60,000 tomans. They say they would rather spend that money on drugs to calm themselves and feel they have nothing to lose.”

In response to the question, “If dental services were free, would you have any problem seeking treatment?” Nearly all participants said they would have no problem.

Clinic staff behavior

Two participants reported that the clinic staff were kind and behaved appropriately. Additionally, seven participants stated that the staff did not discriminate between them and other patients.

Statements from individuals with addiction

“There are places that provide public medical services, such as Abolfazl Clinic, where you are not welcome. When they see that you do not have a proper appearance, they ignore you, give you the last appointment, then say the clinic is closed or just stop the pain with a quick spray.”

“Some see that you are an addict and do nothing for you, or they do not even admit you.”

“If we have money, they do not treat us differently, but if we don’t, they do not even allow us to enter.”

“I once went to Abolfazl Clinic, and the dentist treated me very badly and did not respect me at all. The receptionist pleaded to me to wait, but I said no, he is very rude. I know we are pitiful, but this does not justify such treatment.”

“A person with addiction feels inferior; they do not necessarily treat us badly. I myself feel inferior, and it is not just with dental services. I do not go to weddings because I am ashamed of my situation.”

“I wear a mask all the time because I am ashamed to speak due to the appearance of my teeth. I can see that they notice and say that I am an addict.”

Fear of dental services

Most participants stated that they did not fear receiving dental treatment. Only two individuals reported experiencing stress, specifically when they feared that local anesthesia would be ineffective.

Access to dental services among patients under OMT

Nearly all participants stated that they would seek dental care if treatment costs were covered, services were insured or free, and they were informed about suitable service locations. Participants also expressed willingness to pursue care if they were assured of effective treatment, the use of appropriate dental materials, or referral to clinics offering low-cost or free services.

Statement from an individual with addiction

“There should be a clinic that provides services specifically for people with addiction—somewhere the staff understand us. Even if there were only one such center in the entire province, that would be fine. We would get there at any cost, but the staff must understand us.”

Statements from a rehabilitation center expert

“If someone could come here once a week voluntarily and provide services from morning until evening, it would be ideal. I will give them reference letters, but you have to help us. I sent a letter to the department; one day, they said their professor must be present, and another day, there were other excuses. We have been trying to have a dental impression made for about two months. One patient with SUD went to the clinic several times, spent 200,000 Tomans on transportation, and eventually gave up. These things need to be scheduled properly.”

“The patients with SUD also make another mistake: sometimes one of them has enough money, but goes to a dentist’s office or medical center dressed like a homeless person...”

Expectations from medical staff

Medical staff are expected to exhibit professional behavior and demand lower costs.

Statements from an individual with addiction

“I had been in prison for 16 years. I do not have any

insurance. I expect to be treated like a normal person.”

“They notice the disheveled appearance, decayed teeth, and bad breath, and then they behave badly. They should treat patients professionally.”

“We expect medical staff to understand our circumstances. For example, a person with an addiction is not like others in society; they may have been thrown out of their home. I went to a center and had a tooth extracted, but the way they treated me has stayed in my mind. I know a homeless person who had enough money, but they refused to admit him because of his appearance.”

Postponing the appointment

Five participants reported postponing their dental appointments or not attending any. The reasons they mentioned included lack of money, spending available funds on drugs, and feeling embarrassed about their appearance or the condition of their teeth.

Discussion

A total of 49 participants were interviewed in the present study. The coded categories included reasons for missing appointments ($n = 12$), the impact of oral hygiene on daily life ($n = 14$), knowledge of available oral and dental healthcare services ($n = 17$), previous experiences with dental treatment ($n = 21$), and expectations and opinions about oral healthcare services ($n = 23$).

The most frequently reported barriers included lack of financial resources, long travel distances (e.g., living in mountainous areas), prioritizing drug seeking, limited availability of dentists, addiction-related indifference, difficulty tolerating waiting times, fear of arrest, lack of time off from work, and prioritizing substance use over dental treatment. Five participants reported postponing or not attending their dental appointments. The reasons they mentioned included lack of money, spending available funds on drugs, and feeling embarrassed about their appearance or the condition of their teeth.

Carlsen et al. (2021)⁴¹ reported several reasons for missing dental appointments, including not having a bus ticket or sufficient money to attend the appointment, as well as sudden drug cravings. Patients also cited a lack of daily structure and difficulties with time management as additional reasons for missing appointments.

Evidence indicates that only a small proportion of individuals with addiction use the free dental and oral healthcare services available to them, except when they experience acute pain or discomfort.^{37,42,43,44}

Carlsen et al. (2022)⁴¹ reported that individuals with addiction consider oral health important. This finding aligns with a Norwegian study in which 92% of 29 participants with addiction regarded free oral and dental healthcare services as valuable.⁴⁵

Dental professionals also support the importance of

providing free dental care for individuals with addiction; in a Norwegian survey of 141 dentists and dental hygienists, 84% endorsed the principle of offering free dental services to this population.⁴⁶

Barriers such as difficulties with making dental appointments, lack of access to treatment, stigmatization, negative attitudes of healthcare professionals toward individuals who use drugs, fear of dental procedures, low priority of personal appearance, and compromised financial and social circumstances may influence treatment-seeking for oral healthcare among substance users.⁴²

Evidence suggests that barriers to accessing and using oral and dental healthcare services include 1) anxiety and fear or phobia related to dental procedures, 2) discrepancies between patient expectations and available services, 3) limited knowledge among individuals with addiction and dental practitioners, and 4) shame and stigmatization. In the present study, one of the reported reasons for avoiding dental visits was fear of arrest. All participants stated that they were not afraid of dental procedures; only two expressed concerns that local anesthesia might be ineffective.

Two studies by Carlsen et al.^{37,41} reported that dental phobia, fear, and anxiety regarding dental procedures were among the reasons for missing scheduled appointments, failing to make new appointments, or repeatedly rescheduling. Patients with addiction experienced greater stress than other groups. They stated that they sought dental care only when their condition became severe, expecting the dentist to resolve the “problem” quickly in one or a few visits.

Interestingly, some drug users who inject substances daily avoid seeking dental care due to a fear of needles. In a small study of methadone users in Scotland, anxiety related to dental procedures was assessed, and approximately half of the participants had scores indicating severe dentophobia. Thus, regardless of pre-existing phobias, many drug users struggle to assume the responsibilities and commitments required for dental treatment. Additional drug-related barriers to dental care included homelessness, long-term substance use, long waiting lists in rehabilitation or treatment centers, and disrupted services.³⁶

In the present study, two participants stated that the staff's behavior and attitude in the rehabilitation and medical center were appropriate, and seven participants reported that the staff did not discriminate against individuals with SUD. However, participants indicated that experiences varied across different facilities. They reported that some public clinics were unwelcoming toward drug users; when the staff perceived a patient had an unkempt appearance, they would often ignore the patient, give them the last appointment of the day, tell them the clinic was closing, or treat them with minimal

or inadequate attention. Some centers reportedly refused to accept patients because of treatment costs or due to their history of substance use. Participants noted that when individuals with addiction had sufficient financial resources, they were treated similarly to other patients. Several participants stated that they routinely wore masks to hide the appearance of their teeth and to avoid the stigma associated with being identified as a person with addiction.

Carlsen et al.^{37,41} reported that individuals with addiction frequently experienced discrimination and rejection related to their oral health status. Stigmatization had a direct negative impact on their self-esteem, contributing to feelings of shame and self-hatred.

According to one participant, visiting the dentist can be particularly distressing due to judgmental and insensitive treatment. People with addictions feel unfairly labeled and criticized, particularly about substance use, making them hesitant to seek necessary dental care for fear of further judgment or reprimands.

Despite improvements in overall quality of life among individuals with addiction, they continue to experience stigma related to poor oral and dental health, and report reduced oral health-related quality of life.^{43,44,46,47}

In the present study, individuals with addiction expressed willingness to use dental services if the services were insured, costs were covered, dedicated treatment locations were available, high-quality materials were used during procedures, and treatment centers were either free or low-cost. Almost all individuals were willing to have their teeth treated, consistent with other studies.^{16,37,41,42}

Evidence suggests that residence in a rehabilitation center is itself a facilitating factor, as it can help establish an organized and stable daily routine, increase patients' availability, and provide them with the opportunity to focus on themselves and their personal needs, including healthcare services, such as oral and dental care.^{16,47,48}

In the present study, the rehabilitation center expert noted that providing dental services for these patients would be feasible in collaboration with a dentistry department or medical center. The expert also suggested volunteer initiatives (Jihadi) or the establishment of an on-site dental unit within the rehabilitation center.

Evidence indicates that although collaboration between public dental services and medical centers is encouraged in some European countries, the level of cooperation remains insufficient.^{41,42,43,48,49}

In the present study, five participants reported that they had postponed their scheduled dental appointments or had never attended them. Reported reasons included lack of financial resources, spending available funds on drugs rather than dental care, and embarrassment about their personal appearance and the condition of their teeth.

Cognitive impairments, including dyschronia⁵⁰ and deficits in decision-making and working memory⁵¹, are

common among individuals with SUD and may contribute to forgetting or missing appointments. The conventional appointment system for single dental procedures is often unsuitable for patients with SUD. Dentists may be reluctant to schedule appointments for this population due to concerns about missed visits and the consequent loss of time and income. Moreover, when resources are allocated specifically to dental care for individuals with SUD, dentists may still prefer to provide simpler, time-saving procedures for similar reasons. Emergency-based dental care is also inadequate for this group, as many patients are homeless and therefore have limited ability to access local emergency services.

The lifestyle of individuals with substance use disorder (SUD) often differs substantially from that of the general population, and oral and dental hygiene are frequently neglected. Evidence indicates that individuals who use substances require targeted dental care. In addition to the high prevalence of oral diseases in this population, they experience significant barriers to accessing dental services. Dental professionals play an important role in preventing the escalation of substance use-related oral problems; therefore, this population requires greater access to dental care than the general population. This does not imply that they must necessarily be managed by specialists. Most oral health needs in patients with SUD can be addressed by general dental practitioners, as dental conditions in this group typically do not require specialist care.^{37,41}

Substance users may not possess complete control of their life and health until they enter a safe place of residence, which in most cases is a drug rehabilitation center. Addressing their need to use drugs helps them focus more on their health. Available resources, attention, and staff and other user support promote self-esteem and foster a willingness to care for themselves. Therefore, this population's access to dental healthcare is vital. In fact, if dental treatment directly affects the reconstruction of their personal identity, it can support their rehabilitation.^{37,41}

Conclusion

This study showed that barriers to accessing care include difficulties making appointments with a dentist, limited availability of services, stigma associated with being a drug user, negative perceptions from healthcare providers, patient anxiety about undergoing treatment, concerns about anesthetics not working effectively, and the challenges posed by socio-economic deprivation. Shame over physical appearance or previous neglect of oral health further compounds these obstacles. Facilitators included improvements in quality of life, access to free oral health care, support with attending and being accompanied to appointments, the use of adapted anesthesia, positive clinician-patient relationships, feeling acknowledged and cared for, and effective experiential communication.

Recommendations

- Planning in the dental education system and retraining programs for the treatment of patients with addiction.
- Emphasizing the importance of empathy with patients with addiction, treating them with respect, and using different approaches depending on their needs.
- Learning about oral manifestations and health problems in patients with addiction.
- Emphasizing the importance of dental care in people under drug withdrawal care.

It is recommended that another study be designed with a larger sample, more questions, and a questionnaire.

Limitations

The limitations of the study included the lack of cooperation from some participants and certain camp officials. To overcome these challenges, participants were assured that any information provided during interviews would be kept strictly confidential. Names and personal identifiers were omitted during data processing to ensure anonymity.

Authors' Contribution

Conceptualization: Maryam Alsadat Hashemipour
Data collection: Mohammad Reza Dehestanee
Investigation: Mohammad Reza Dehestanee
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Writing-review & editing: Mahdie Zeinali

Ethical Approval

This project received approval from the university's Ethics Committee under the code IR.KMU. REC.1401.414.

Funding

None.

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