MASTEROPPGAVE

‘Drug addict’s experiences on oral health care’

– An interview study

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ABSTRACT

Objective: To understand the dental health challenges of recovered drug addicts, and how the system of oral health rehabilitation works and functions as seen from the perspective of recovered addicts. **Basic Design:** Semi-structured interviews with seven recovered drug addicts from the city of Tromsø, Norway. The audio from the interviews was transcribed and analysed using NVIVO software. **Results:** All informants had experienced or were experiencing oral health problems related to their history of drug abuse. These problems adversely affect their quality of life. The care-seeking process was perceived as challenging by some informants; both in the case of obtaining emergency treatment when they were active addicts, and in relation to full oral health rehabilitation when enrolled in drug rehabilitation programs. Also, some groups of addicts were found to be left out of the legislative framework of the system. **Conclusion:** The system of oral health rehabilitation for recovered drug addicts has undergone legislative changes over the later years. This seems to have made the system somewhat more effective and including, but there are still groups left outside the system that, it could be argued, should be included. Also, challenges exist in conveying to drug addicts the possibilities for financial aid for emergency treatment.

INTRODUCTION

In Norway there is at present some on-going research in to the matter of dental rehabilitation for drug addicts. It was not until 2005 that clear guidelines were given by the Ministry of Health, where the county councils[1] were given responsibility for the provision of dental healthcare for drug-users living in institutions for periods of more than three months. This responsibility was widened in 2006 to include drug users in receipt of social welfare provisions. In 2008, this was expanded to also include patients enrolled in drug substitution therapy (LAR). This provided some much needed clarification about groups of drug users who were entitled to oral rehabilitation funded by the public sector. In 2010, SIRUS[2] compiled a report (1) where interviews were made with the Chief dental officers in each county. This report indicates that despite these clarifications, there seems to be some remaining confusion, and also a sense that some groups of previous drug addicts have been overlooked in the process.

The aim of our study is to investigate how the system of oral rehabilitation is perceived to function from the point of view of the drug users themselves. The SIRUS report indicates that there are regional differences. For practical reasons our study must focus on the situation in the county of Troms, and specifically in the city of Tromsø.

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An analysis consisting of semi-structured interviews with recovered drug-addicts was carried out to get an insight into the informants' own perception of how the system had seen to their needs in relation to oral rehabilitation. During these interviews, other information about the interviewee's specific drug history and its oral health consequences was so deeply entwined with the narrative concerning their care seeking process that it would have been very difficult not to touch upon this subject. The study therefore contains accounts and information about the oral health consequences of drug abuse, and also how the interaction with dental health staff is experienced from the point of view of the informants.

METHODS

To get the questions of our study answered to a satisfactory degree, we needed to get an insight in how the law and practice of dental rehabilitation for drug addicts are perceived by the addicts themselves. The natural choice of base method was therefore a given one, namely qualitative interviews. Prior to the study we made a protocol, indicating to our supervisor, our door-openers and ourselves what we wanted to do, and the methods we intended to use. As the researchers had no prior experiences with qualitative research, we also conducted a fair bit of studying on the subject to familiarise ourselves with the concept and methodology (8,14,15).

Fieldwork

We contacted «Kafé X» in Tromsø. This cafe is by design a drug-free social arena for recovered drug addicts, a meeting place to meet people in the same situation. In addition, the second floor houses the office of the local branch of the «Drug addicts' interest organisation[3]», and the local office of MARBORG, the organisation for addicts who have recovered through drug substitution programs. The cafe also provides essential work training for recovered addicts, as they can sign up for shifts to run the cafe.

The staff at Kafé X filled the function of «door-openers» for the study. Questions regarding one's previous drug habits and the effects of one's addiction are very sensitive, and one might imagine not easily shared to young students like the researchers, who might easily be perceived by the

[3] RIO – Rusavhengiges Interesseorganisasjon

informants to be of a completely different social class and background. To counter this possible, inherent suspiciousness, the staff at the cafe first informed about the study at a user meeting, talked about what we were doing and stated the day we would be there to conduct interviews. This, one can imagine, gave the study a «stamp of validity», basically having the study, and our intentions for conducting it, pre-validated by figures of authority within the social network of recovered addicts.

We also decided to conduct the interviews at the cafe. In conjunction with the offices of the second floor, there is a meeting room. We were graciously offered the use of this room as the setting for the interviews. This had the advantage of being very close to the group of informants (literally «right up stairs»), and also the advantage of being on their «home pitch»; a sense of us coming to them rather than calling them up and arranging to meet at some other place alien to them, where they might not normally go on their own accord.

The interviews were conducted over the course of two afternoons in December. The cafe was well visited at the time, due to Christmas preparations and surrounding activities. The recruiting of informants was informal, basically involving the staff member on duty introducing us when we arrived, and asking the assembled group whether someone would like to talk to us. We quickly had a few volunteers, and after these first initial interviews had been conducted, we had no problem in finding informants. This informal and relatively random selection process meant that we had little control over which informants we had available. An advantage of this approach, however, was that the interviews were spontaneous, with the informants not being able to talk too much with each other before the interviews were conducted.

Data processing and analysis

We decided on semi-structured interviews, as it allows the informants to freely speak their minds, while at the same time ensuring that the interviewers have a «tool kit» of questions to get the conversation back on track should it digress excessively. The questions are also intended to make sure that the informant is made to speak about their experiences on the topics deemed relevant in the specific case. We opted to use Malterud's systematic text condensation as the methodic framework for our analysis (8).

The interviews were taped on a digital recorder. This was, of course, accepted by the informants beforehand. The audio from the interviews was then transcribed, and then inserted into an analysis software for qualitative data, NVivo (16). Using this software, the transcripts were analysed to

identify quotations that held information about some particular subject, in the program called «nodes». We had pre-decided on the nodes we were to use, but were open throughout the process and continually analysed the need for adding nodes or changing existing ones. The nodes we ended up using were:

1. Accessibility of dental treatment
    1. When active addicts
    2. When enrolled in a programme
2. Economy
3. Interaction with dental staff
4. Treatment satisfaction

The software then collects all the quotations linked to each node, making it very easy to get a full view of the information available on each topic. The different topics were then analysed thoroughly, and results were put in writing. Quotations that were especially poignant or deemed to contain vital information were included in the results. This naturally called for a translation of these quotes to English. Malterud (8) emphasises the importance of not having a mechanical understanding of reliability, meaning that meaning and intention can be lost if an extreme effort is made to keep the wording and syntax absolutely in tune with the original quote at all times. In addition, the Norwegian spoken by our informants is in some instances influenced by their previous life-style, both in accentuation and choice of words. A direct translation of this would at times be hard to comprehend in English, or make little sense to someone who is not intimately familiar with the street slang of Tromsø.

RESULTS

Seven interviews were conducted, with two female and five male informants. All of the informants had been addicted to illicit drugs for extended periods, the timespan of their addiction-period ranging from around seven to twenty-five years. The nature of their addiction varied somewhat, with four informants giving amphetamine as the chief substance of their addiction, and three stating heroin or other injected opioids. Additional use of alcohol, assorted pills and marihuana was common. All but two of the informants had overcome their drug addiction through an approved rehabilitation program; two had overcome their addiction through «LAR» (Drug substitution therapy), and the other three through various non-medical rehabilitation models.

Drug abuse's impact on dental health

The informants had experienced a wide range of dental problems, the problems varying in their manifestation according to which substance had been the main focus of their addiction, E.g. classic cases of «meth mouth», rampant caries activity, and tooth loss from advanced periodontitis.
All of the informants described forms of negative impact on their oral health from drug abuse; *"…'Cause I've had big problems with my teeth since a few years after I started doing drugs".* Some described a direct correlation between the drugs and their decaying oral health. Expressions used to describe their own oral health included *"destroyed", "crumble" , "worn down"* and *"big problems".* Amphetamine was pointed out by several as being especially "hard on the teeth" ; *"...you grind your teeth day and night, so I grinded my teeth all the way down".* Dry mouth was also mentioned as a factor imposed by drug use.
Others conceded that the problems they had experienced were at least partly a result of them not being able to maintain a pertinent level of oral hygiene, due to the all-consuming nature of their addiction.

Some reported severe problems which had led to the loss of the majority of teeth; *"I believe eight or nine of my teeth had to be extracted in 2007".* A vivid description depicting the severity of oral health problems was given by a female subject; *"I remember eating a slice of white bread; Suddenly a tooth came loose and stuck to the bread".* Others took a more laconic approach to describe the decay; *"...and a couple of years went by, I think, before the first of the molars started crumbling. I've lost, I believe I've got four or five roots left now".*

Feelings associated with impaired oral health status.

The uttered effects of deteriorated oral health on the individual can be divided into two main groups; The direct functional effects, and the social effects. As per functional effects, some had experienced toothache; *"Lots of toothache and stuff. Lots of pain", "I had a real bad toothache".* Others described some diffiulties chewing and eating properly; *"Nah, It's alright, even though I'm chewing on my gums", "I miss being able to eat potato chips without it hurting"*. The degree of functional loss varied between the informants.

The social effects were by far the area given the most attention by the interviewees. One of the subjects, a young woman who had lost all of her maxilarry teeth, summed the importance of oral health as a marker for drug abuse as follows:

"I've got a family, I've got a job, I'm due for my drivers licence, a nice apartment and so on. If it wasn't for my teeth, I don't think anybody'd be able to see that I used to be a junkie."

Some told tales of their own and other's isolation. One of the informants even used the word "hermit" when he described the steps an acquaintance of his took to avoid human contact, because of the state of his teeth. Another informant described the panic-like feeling of attending a social gettogether; *"I panic. When I'm talking to people. The only thing I can think of is, "can they see my teeth? Can they see my teeth? Can they see them?!""*

The informants differentiated between lacking anterior teeth and only lacking more posterior teeth. The social stigma of missing anterior teeth was conveyed as closely connected to self esteem, while only missing molars was not regarded as a major social problem. One informant regarded himself lucky to have kept his anterior teeth for this reason; *"I have trouble eating, not socially. Cause I've kept all my anterior teeth, so I've experienced no [social] difficulties"*.

Interaction with dentists

Most of the informants described their relationship with their dentist as a good one. In general they felt well taken care of, and that they had been duly informed of their options when it comes to treatment. Also at an interpersonal level most subjects felt as though they had been treated respectfully, despite their potentially stigmatizing status as drug addicts/former drug addicts; *"I think they've been very kind at the dentist's. Took time out to talk, we, like, hit it off"*.

However, being carriers of blood transmittable diseases, some patients had encountered scepticism. A male interviewee described his encounter with the dentist as follows; *"During the period in which I was a carrier of Hepatitis C, I could sense a hidden aversion towards my kind of people at the dental office. But it was never spoken, you know what I'm saying, it was more like this feeling you got".* He then went on to explain possible causes to these feelings, and that they to a certain degree were due to the extensive hygiene measures taken by the dental personnel.

Even though most of the informants seemed pleased with the way in which they have been met by dental health personnel, one of the informants in particular expressed dismay with the dentist. This informants was young, and had lost all maxillary teeth; *"I don't trust him, 'cause he's changed his opinion thrice in three consultations […] Then he says; "To be honest with you, we don't know if you'll go back to using, so we don't want to spend too much on you""*. This informant clearly did not trust the dentist performing the treatment, and was in no way convinced that the dentist was providing the treatment the informant was entitled to.

Most subjects had, according to themselves, been compliant to their dentists both when it came to appointments and the personal follow-up of treatment schemes. However one informant, a young man, points out that his abusive ways had been a hindrance at times; *"I couldn't sit still in the chair, so the dentist was unable to do what he was supposed to […] I don't think there are any dentists who like patients coming in all sped-up, you know what I'm saying, 'cause it's risky to have that in the chair".*

Fear of Dentists

Odontophobia was not mentioned as much as we would have thought. Though mentioned, it was not emphasized a great deal by any of the subjects. One subject went as far as saying that he is *"not looking forward to it [his dental appointments]",* but odontophobia was not pointed out as the main reason for not attending appointments by any of the subjects.

Cost of care as a hindrance

All of the informants mentioned the cost of seeking dental care as a main factor that had kept them from attending a dentist on a general basis during the time they were active addicts. They were also forthcoming about the seeking of dental care being rather a bit towards the end of their lists of priorities in these periods, as they had *«better things to spend their money on [i.e. drugs]».*

The informants were also clearly no strangers to the concept of acute dental pain, all of them stating that they had experienced this at some point. Many also stated that economy was a factor that had kept them from seeking care for these conditions *(«...you just get a lot higher until the pain goes away»).*

The informants also universally stated that they would have been more likely to take measures to improve their oral health status if they had had the economic means to do so, but that the price level made this unachievable on their own, leaving them dependant on eventual dental rehabilitation funding through a programme; *(«it's crazy expensive», «I should have gotten it fixed, but i can't afford it, so I just have to use what [teeth] I've got, hehe»).*

Seeking dental care abroad

One of our informants had, after his rehabilitation program ended gone abroad to have his teeth

fixed, covering the expenses with money borrowed from friends and family. He had done this to evade waiting time and also thought that *«I don't think I would have gotten the same [dental treatment] as I've got here. I think it's an economical aspect for the dentists»*. Other informants told us that they had thought about doing the same, but had not been able to do it financially *«Right now I couldn't even afford the ticket»*.

Access to dental care

Our informants were resoundingly unanimous in that as an «active» drug addict, you only go to the dentist when you are forced to by painful symptoms that are not easily managed by self-medication. *« ...you only really think about it when it hurts»; «I only went twice when I was using. But that was because I just had to. I had this boil they had to cut open. Otherwise I never went, no matter how much it hurt»*. None of the informants indicated that getting an appointment had been problematic, but some of them expressed that the idea of seeing a dentist had been a remote concept at this stage in their lives. One informant addressed the inherent issues arising when trying to conduct any form of medical aid on a drug addict; *"Well, I remember he [the dentist] just did some temporary things*[4] *to take away the pain, because I couldn't lie still in the chair. Then he'd ask me to come back in a week and not take any drugs. But that's not so easy, when you're using"*.

Information about rights when in rehabilitation programme

All of our informants stated that they found the rules and regulations regarding dental rehabilitation assistance confusing. Some of the informants also stated that they had received little help in navigating the murky waters of public health regulations *«Nothing! I've been told that I have some rights, but not what they are, or why, or how to go about it»*. Sometimes this confusion seems to have persisted even after clinical measures had been started *«...the dentist said what I had to do, right, was to find out who was paying for me. If it was municipal or governmental. And I didn't know those were different things»*. Even informants who had received dental rehabilitation assistance were at times confused as to who had actually provided the financial support *«well, somebody has paid for it, clearly, but I can't really say I know who it is »*.

The informants who had been or were enlisted in a approved rehabilitation programme, generally had received some information about their rights in these matters by staff members and councillors

[4] In all probability treatment along the lines of cavum trepanation. I e. treatment designed to quickly remove painful symptoms.

at the relevant clinic. These rights, and hence the information, can be divided in two different stages; A) Acute dental problems arising in the initial phase at the rehabilitation clinic (before sufficient time has passed to make them eligible for dental rehabilitation assistance), and B) Dental rehabilitation assistance proper.

As regards to A, they were generally advised that they would get financial coverage for what was deemed emergency («acute») treatment. This, for all intents and purposes, is treatment with the aim being pain-relief. The nature of this treatment indicates that it is generally provided when a problem of some sort arises, i.e. it is requested; *«when I've asked. When I've had, like, acute emergencies. Then I've applied to the «social office» for help for acute stuff».*

The second stage (B) comes into play in a late stage of their rehabilitation, as there are rules as to how many months you have had to be in the program before dental rehabilitation is considered to be of any value (i.e. the chance of relapses into drug addiction are lowered).[5] Our informants, who had been part of rehabilitation programmes, had received varied amounts of information from staff and councillors involved in their programme about their rights to dental rehabilitation. Some had not received any information; *"I got some acute treatment covered. Other than that, I didn't get much information about how things worked with the dentist. Everything I know about that, I've had to figure out on my own".* Others had received information, and been helped along the way by staff and councillors; *"…[she] told me it's my right. That it would probably be covered through the programme I'm in. So she's been great at informing. Pushed me."* It seems that the staff and councillors employed at the rehabilitation programs are instrumental in facilitating and motivating the rehabilitees to apply for dental rehabilitation. It would seem that the level of information given by staff varies somewhat with where their rehabilitation took place.

The two informants who had overcome heir addiction on their own stated that they had not received any offers to have their teeth rehabilitated. One of them, however, stated that he *«...just applied to the «welfare office»[6]. I wrote an application to have my teeth fixed while I was in jail (...)*
I didn't write that the reason was drug abuse. I wrote that it was because of psychiatric problems and stuff like that». This informant had received dental rehabilitation on par with those who had been qualified through their rehabilitation programme, but presumably this was financed from another source, as drug abuse was pointedly left out of the application. The other informant who

5 Generally this period is three months.
6 Original wording: Trygdekontoret. Meaning NAV.

had overcome his addiction autonomously had not received any aid whatsoever.

Treatment requested and satisfaction with care

When asked what they had wanted to be the end results of their dental rehabilitation, the informants responses centred on functional and aesthetic considerations; *"I just want my mouth do be done with, for it to be OK. To be able to eat proper food". "I want to be able to smile without thinking about it."*

The informants were in varying stages of their dental rehabilitation. Some had received extensive prosthetic constructions, while others had solutions in the form of partial or full dentures. Generally, the informants were happy enough with the treatment they had received. The informants who had received prosthetic restorations were happy with the results, and also adamant that removable dentures of any kind would not have been a solution they could have lived with: *"(...) I don't want that loose stuff. Not yet. I'm too young for that.* Especially the younger informants held this view. Another informant stated that the dentist landed on making a removable plate after economic considerations: *"(...) Yeah, I think I'll be happy [with the removable plate]. She talked about putting them on posts, but it was really expensive. So she didn't want to apply for it. We risked getting a "no" on the whole thing. As long as I get some teeth, I think It'll be fine".*

DISCUSSION

All of our informants have experienced oral health difficulties during and after their time as drug addicts, and gave vivid accounts of the functional and social impact of decaying oral health. It is a well established fact that drug abuse in many cases leads to impairment of oral health (5,6,7), and drug users often present demanding and complex dental treatment needs. This impact, along with the social consequences thereof, was the subject most often voluntarily focused upon by the informants. The oral health complications of drug abuse are multi-factorial, and failure to seek appropriate care upon symptoms, complicates initial problems further. Those of the informants who had lost anterior teeth described the social impact of their tooth loss as detrimental. Worsened self esteem and shame, leading to isolation and loss of social skills, is the result. It is safe to say that the loss and decay of anterior teeth in young individuals is at times regarded as somewhat of a personal tragedy, and has effects on the individual spanning far beyond the mere increase in DMFT. This was during the interview process further illustrated by the sense of pride and satisfaction in those of the subjects who in some way had undergone complete oral rehabilitation. Their perfect teeth had

become means to further distance themselves from their past abusive ways and pursue full inclusion in society.

In Norway it is, on application, possible for the municipal "social service" to cover expenses towards acute dental treatment. There are provisions attached, such as the private economy of the applier/patient and that no expensive treatment is undertaken. This is generally treatment to relieve pain, e.g. excavation and temporary filling of carious lesions, cavum trepanation/chemo mechanical treatment of irreversible pulpitis or pulpal necrosis, or extractions. The aim of the treatment is, clearly, to alleviate the painful condition, with no obligation on the dentist's behalf to perform a treatment that can be deemed permanent, as no permanent fillings or canal obturations are covered. It seems to have been the case that our informants were not aware of this possibility to have the financial costs of acute treatment covered while they were active drug addicts. Some stated that they can not remember how their acute treatment was paid for, possibly indicating that the dentists in these specific cases have applied on their behalf retrospectively. Others had clear memories of having had to pay for acute treatment themselves, and presented this as barrier that kept them from seeking acute care on other occasions.

In addition to this possibility to obtain financial aid for emergency treatment, the project «LAV»[7](9) has funds over the national budget specifically set aside for emergency treatment of drug abusers, primarily active drug addicts. These funds are accessible on application (since 2009), and are generally obtained through municipal social health centres[8]. These centres are low-threshold initiatives, providing counselling and health care on the street level. These funds were first implemented in the 2009 national budget, and our inquiries to the staff at SMS reveal that these funds are used for emergency treatments and surveying the treatment need of individuals.

Our informants were seemingly not aware of these options for financial support. While it may be argued that the municipal (NAV) option has been available for quite some time, it is a rather bureaucratic process and system that is not very well suited to the needs of active drug addicts. The low threshold option is fairly new (2009) and most of our informants had been rehabilitated of their drug habits for longer than that. However, it seems that this possibility could be advocated more adamantly, as it seems reasonable to think that our informants would have known about it had it by now been a well known possibility in the drug scene of Tromsø.

7 «Lavterskel helsetiltak for rusmiddelmisbrukere»
8 In Tromsø: Sosialmedisinsk Senter (SMS)

In addition to the perceived financial costs, the primary reason given by the informants for having neglected to seek oral health care during their time as active drug addicts was apathy. They describe their apathy at the time as a combination of a lack of ability and motivation to take action on anything in their lives not directly related to the acquisition or usage of drugs, and a progressing feeling of isolation and separation from the «ordinary world», leading to less and less involvement and interaction with society. This isolation can make it difficult to identify people in this situation, and often they are not identified and integrated in the public support system until they are hospitalised or incarcerated.

Odontophobia was not given as the main reason for not seeking appropriate care by any of the informants. As some of the informants gave the impression that they were not looking forward to their dental appointments, the fear of dentist did not seem to be a bigger problem amongst our informants, than in the general population at large. This was also pointed out in the SIRUS-report, where statistics regarding failure to show up for dental appointments within this group of patients, revealed that a low number of patients were responsible for the majority of "no-shows".

The system of municipal (NAV) financial coverage of acute treatment clearly works when it comes to alleviating pain, thus being clearly in line with «absence of pain and discomfort» being one of the primary definitions of acceptable oral health according to the Norwegian Directorate of Health (10). However, even with the researchers' limited clinical experience, we have seen examples of patients who can not pay for dental treatment[9] being trapped in an acute treatment spiral where a long succession of intermediate measures, often on single teeth, have been made instead of a definite and permanent solution, which might in some cases even have been less costly in the long run. It could be argued that teeth in this situation should be extracted, but it would seem that many dentists are reluctant to extract teeth that do in fact have a favourable prognosis if a permanent solution is made in the relatively near future. This may lead to cycles of intermediate treatment measures to keep the options open should the patient suddenly have access to funds for the permanent treatment. This is in contrast to the clinical guidelines from the Norwegian Directorate of Health, where it is stated that people without financial means to pay for treatment must be prepared to accept a lower standard of treatment (i. e. extractions)

To qualify for oral health rehabilitation in Norway at present, one needs to be an «officially rehabilitated» drug addict. This entails that you need to have successfully completed a rehabilitation programme at an officially recognised clinic, or through drug substitution programmes (LAR).

[9] Not neccesarily drug users.

Five of our informants had been officially rehabilitated through such programmes and had received, or were currently receiving, some form of oral health rehabilitation. Most of them were happy with the process and the end result of the treatment, with the notable exception of one informant who was very much displeased with the ongoing process of dental rehabilitation. It seems to us that in this particular case, this may have had more to do with a lack of communication from the dentist as to what the time frame of the process was, and that some degree of discomfort would be hard to avoid in the intermediate steps. This indicates that former drug addicts may have a heightened need for information about the treatment process, as they are understandably impatient to have their treatment completed, and may at times be susceptible to interpret delays, ill-fitting temporary dentures and other complications as a result of bias from the dentist because of their drug history.

Some groups of recovered drug addicts are not included by the framework of rules and regulations set to help. These include those who have quit their habit on their own, without help from different rehabilitation institutions, and those who have finished their rehabilitation, and therefore no longer have any law bound rights to free dental treatment even though they still have severe dental problems. This is confirmed by the informants, and some point out that the window in which institutionalized addicts are entitled to coverage of expenses is too short relative to the extent of their treatment need. Policlinical, non-medical treatment is not included in the regulations as to which treatments entitle coverage. The problem arises because of the three month rule which states that the patient must be drug free for three months in the institution, before they can receive treatment. That the regulations at the moment fail to integrate all groups of drug addicts is also known to the Chief Dental Officers in the counties interviewed in the SIRUS-report.

Also, it is a paradox that those who actually manage to break their habit on their own, without enrolment in publically funded programmes (i.e. LAR (drug substitution treatment) or around-the-clock rehabilitation institutions like Færingen, Tromsø) are "punished", in that they are not entitled to free dental treatment, despite their treatment need in most cases being as comprehensive the other drug addicts'. A good example of the latter is one informant who quit his drug abuse on his own more than ten years ago, after decades of addiction. His oral health status was significantly impaired, mostly due to negligence and wear during his years of abuse, but no system had been able to pick him up right after he quit, and he has neither right to coverage of expenses today, nor sufficient funds to pay for the necessary treatment himself.

As the rehabilitation measures directed towards drug addicts in the Norwegian society continue to improve, it becomes more important that the dental health sector evolves along with it in order to

accommodate the increase in rehabilitees coming through the system. The sheer number of dentists in Norwegian cities should be sufficient to meet these needs, and, although complex treatment needs, most cases can be handled by the general practitioner given time, resources and willingness. Our interviews with prior drug addicts show that the system has in the later years become more accessible, and according to the SIRUS-report it has also become more manageable for the administrative authorities since legislative changes were made in 2005, 2006 and 2008. However, given the complexity of this matter the authors feel that research into how the system is perceived to be functioning from the perspective of the end-user, the drug addict, is important to assess the impact and real world application of abstract legislation.

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