Revista Portuguesa de Estomatologia, Medicina Dentária e Cirurgia Maxilofacial
Portuguese Journal of Stomatology, Dental Medicine and Maxillofacial Surgery
REV PORT ESTOMATOL MED DENT CIR MAXILOFAC. 2026;67(x):1-7

Original Research

Oral health behaviors and perceptions in a Portuguese therapeutic community: a cross-sectional study

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ARTICLE INFO

Article history:
Received 3 November 2025
Accepted 5 October 2026
Available online 12 November 2026

Keywords:
Cross-sectional studies
Health behavior
Oral health
Portugal
Substance-related disorders

ABSTRACT

Objectives: Oral health needs are frequent among people with substance dependence but are often insufficiently addressed in residential treatment. This study aimed to describe self-reported oral health behaviors and perceptions in a Portuguese therapeutic community and compare newly admitted with long-term residents.
Methods: A questionnaire-based cross-sectional study was conducted in one Portuguese therapeutic community using non-probabilistic convenience sampling. Participants were categorized as newly admitted (six months or less) or long-term residents (more than six months). The questionnaire assessed sociodemographic and substance-related characteristics, oral hygiene behaviors, self-perceived oral health, self-reported oral problems, dental service use, and the community's oral health approach. Categorical variables were summarized using absolute and relative frequencies and compared using Pearson's chi-square test or Fisher's exact test.
Results: The sample included 84 men: 41 newly admitted residents and 43 long-term residents. Alcohol and use of multiple substances were frequently reported. Daily toothbrushing was reported by 43.9% and 55.8%, respectively, while poor or very poor self-perceived oral health was reported by 48.7% and 46.5%. Dental attendance after admission was reported by 26.8% and 58.1%. Significant group differences concerned dental service use before admission, after admission, and attendance within the previous year; no significant differences were found for the selected oral hygiene outcomes.
Conclusions: Long-term residents reported more favorable oral hygiene behaviors and greater dental service use, although negative self-perceived oral health remained common. Given the convenience sample and cross-sectional design, the findings should be interpreted as exploratory and not as evidence of causality. (Rev Port Estomatol Med Dent Cir Maxilofac. 2026;67(x):1-7)

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http://doi.org/10.24873/j.rpemd.2026.12.1593
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Introduction

Substance dependence is a major public health problem with biological, psychological, social, and economic consequences for individuals, families, and communities.[1] In Portugal, the substances most frequently reported include alcohol, cannabis, cocaine, heroin, other opioids, and ecstasy, and the demand for treatment for addictive behaviors continues to represent an important healthcare need.[2] According to the report by Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD), the prevalence of use for most drugs in Portugal shows general stability or decline, with alcohol, cannabis, cocaine, heroin, opioids, and ecstasy being the most consumed substances. In 2021, demand for addictive-behavior treatment increased, primarily among individuals residing in the districts of Lisboa, Porto, Setúbal, Faro, Aveiro, and Braga.[2]

Oral health is frequently compromised in people with substance dependence. Reported conditions include dental caries, periodontal disease, tooth loss, xerostomia, oral mucosal lesions, candidiasis, dental erosion, bruxism, tooth wear, and temporomandibular disorders.[3-5] These complications may result directly from the pharmacological and local effects of psychoactive substances on the oral cavity, or indirectly from factors associated with substance use, including poor oral hygiene, inadequate nutrition, increased carbohydrate intake, a chaotic lifestyle, and traumatic orofacial injuries.[6,7] This dual impact imposes a comprehensive approach to oral healthcare for individuals with substance dependence.[8-11]

Studies of residential treatment services have shown that individuals with substance dependence frequently present with multiple co-occurring physical health problems, reinforcing the need to integrate oral health into a broader healthcare framework.[12] Evidence from other contexts supports this concern. A study in 2002 evaluated 102 male residents of a Brazilian therapeutic community and found a high mean decayed, missing, and filled teeth (DMFT) index of 14.88, poor oral hygiene habits (69.6% did not use dental floss), and significant correlations between poor oral health indicators and low perceived importance of oral health. Importantly, their preventive-educational program led to lower plaque indices, demonstrating that structured interventions in therapeutic communities can improve oral health outcomes among individuals with substance dependence.[13]

Therapeutic communities are residential, non-hospital settings that provide structured treatment and social support for people with substance dependence.[13] These centers aim to help individuals break from harmful environments, relearn how to live without drugs, and rebuild self-esteem and life skills. This long process, focused on rebuilding health, self-image, and self-esteem, is essential for a successful reintegration.[9]

Nevertheless, evidence remains limited regarding oral health behaviors, self-perceived oral health, dental service use, and oral health support within therapeutic communities. This study aimed to describe these outcomes in one Portuguese therapeutic community and compare participants who had been living in the community for six months or less with those living there for more than six months. It hypothesized that long-term residents would report more favorable oral health behaviors, greater dental service use, and better self-perceived oral health than newly admitted residents.

Material and Methods

A questionnaire-based observational, cross-sectional study was conducted at Comunidade Vida e Paz, a residential therapeutic community in Portugal. The study protocol was approved by the Ethics Committee of the Faculty of Dental Medicine of the University of Lisbon on 27 March 2023 (CE-FMDUL202317). Participation was voluntary and anonymous, and all participants provided written informed consent. All procedures were conducted in accordance with the Declaration of Helsinki. The study did not include a control group or a clinical oral examination.

Adult male residents receiving treatment for alcohol or drug dependence were invited to participate through non-probabilistic convenience sampling. No a priori sample size calculation was performed, and all eligible residents available during the data-collection period were invited to participate.

Inclusion in the study required individuals to be over 18 years old, have a diagnosed substance dependence, be enrolled in the community's treatment program, and voluntarily agree to participate by signing the informed consent form. Exclusion criteria included mental incapacity or refusal to respond to the survey and refusal or inability to provide informed consent.

The questionnaire comprised 30 numbered entries divided into four sections, including 28 items requiring a response and two conditional instructions (4.2 and 5.1 in Section 3) that did not require a response. The researchers administered the questionnaire in paper format, usually in groups of up to five participants. Participants with literacy or language difficulties were interviewed individually to facilitate their understanding of the questions. No clinical diagnosis was made, and all information concerning oral health status was self-reported. An English translation of the complete questionnaire is provided as Supplementary Appendix 1.

The main grouping variable was length of stay in the therapeutic community. Participants were classified as newly admitted residents if they had been living in the community for six months or less and as long-term residents if they had been living there for more than six months.

Sociodemographic variables included age group (18–24, 25–34, 35–64, or >64 years), educational level, employment status, and living arrangements. Substance-related variables included the main substance or combination of substances associated with treatment, age at onset of dependence (<18, 18–24, 25–34, or 35–64 years), and duration of substance use (<1, 1–5, 6–10, or >10 years).

Oral health variables included toothbrushing frequency, dental floss use, fluoridated toothpaste use, self-perceived oral health, and self-reported oral problems. Variables related to dental care included dental attendance before and after admission to the community, time since the last dental appointment, and the main reason for attendance. Variables concerning the community's approach to oral health included the provision of oral hygiene materials, oral health promotion, oral health counseling, and referral for dental care.

Data were analyzed using IBM SPSS Statistics for Windows, version 27.0 (IBM Corp., Armonk, NY, USA). Categorical variables were summarized using absolute and relative frequen-

cies. Comparisons between the two groups were performed using Pearson's chi-square test or Fisher's exact test when the chi-square assumptions were not met. The statistical significance level was set at $p < .05$. Exact p values were reported, except when $p < .001$. The analyses were exploratory and were not interpreted as evidence of causal effects.

Results

Eighty-four adult male residents participated in the study, while 29 eligible residents declined to participate. Of the 84 participants, 41 were newly admitted to the community, and 43 were long-term residents.

Table 1 summarizes selected sociodemographic and substance-use characteristics. Most participants in both groups were unemployed, and educational levels were generally low. None of the selected sociodemographic characteristics differed significantly between the groups. The majority developed dependence before the age of 18 (53.7% of newly admitted and 53.5% of long-term residents). In 78% of newly admitted and 83.7% of long-term residents, consumption lasted more than 10 years. In addition to alcohol, participants reported dependence involving cocaine, heroin/opioids, cannabis, and several combinations of substances. These characteristics did not differ significantly between the groups.

Table 2 presents oral health behaviors and dental service use. Long-term residents reported toothbrushing daily and consistently using fluoridated toothpaste more frequently than newly admitted residents, whereas dental floss use was uncommon in both groups. These differences were not statistically significant. Self-reported oral problems were common in both groups, and tooth loss was the most frequently reported individual response category. There was no statistically significant difference between groups in the proportion of respondents reporting at least one oral problem. Figure 1 shows the distribution of self-perceived oral health. Poor or very poor self-perceived oral health was common in both groups, and the dichotomized comparison showed no statistically significant difference ($p = .835$).

Table 1. Selected sociodemographic and substance-use characteristics according to length of stay in the therapeutic community

Characteristic	Newly admitted, n/N (%)	Long-term residents, n/N (%)	*p* value
Aged 35-64 years	30/41 (73.2)	35/43 (81.4)	.368
Completed secondary education	14/41 (34.1)	10/43 (23.3)	.269
Attended higher education	3/41 (7.3)	2/43 (4.7)	.672*
Unemployed	25/41 (61.0)	30/43 (69.8)	.397
Living alone	20/41 (48.8)	16/43 (37.2)	.284
Dependence onset before 18 years old	22/41 (53.7)	23/43 (53.5)	.988
Substance use for more than 10 years	32/41 (78.0)	36/43 (83.7)	.508
Alcohol** as the single reported substance	12/41 (29.3)	15/43 (34.9)	.582

Values are n/N (%). P values were calculated using Pearson's chi-square test; *Fisher's exact test. Analyses were exploratory.
Alcohol was reported by participants under the free-text 'Other' option and was subsequently coded as alcohol for analysis.

Table 2. Self-reported oral health problems, behaviors, and dental service use according to length of stay

Characteristic	Newly admitted, n/N (%)	Long-term residents, n/N (%)	*p* value
At least one self-reported oral problem	32/41 (78.0)	38/43 (88.4)	.204
Tooth loss as an individual response category	8/41 (19.5)	10/43 (23.3)	.676
Daily toothbrushing	18/41 (43.9)	24/43 (55.8)	.275
Never uses dental floss	33/40 (82.5)	36/43 (83.7)	.882
Always uses fluoridated toothpaste	8/41 (19.5)	12/43 (27.9)	.367
Dental attendance before admission	22/41 (53.7)	34/43 (79.1)	**.014**
Dental attendance after admission	11/41 (26.8)	25/43 (58.1)	**.004**
Last dental appointment within the previous year	11/28 (39.3)	24/37 (64.9)	**.041**
Routine dental attendance	9/27 (33.3)	16/37 (43.2)	.422
Dental attendance for treatment of an oral problem	13/27 (48.1)	14/37 (37.8)	.409

Values are n/N (%). Denominators vary because of missing responses and skip patterns. P values were calculated using Pearson's chi-square test and are exploratory. Statistically significant p values are shown in bold.

Long-term residents reported dental attendance before admission, dental attendance after admission, and attending a dental appointment within the previous year more frequently than newly admitted residents, with statistically significant differences (p = .014, p = .004, and p = .041, respectively). The reported reasons for dental attendance did not differ significantly between the groups.

Overall, the statistically significant differences concerned dental service use rather than oral hygiene behaviors or self-perceived oral health. No statistically significant association was identified between length-of-stay group and the selected oral hygiene outcomes (Table 2).

Figure 2 shows the oral health-related measures reported by participants. Provision of oral hygiene materials was the most frequently reported measure, followed by referral for dental care. Structured oral health promotion and counseling were less frequently reported. Multiple responses were allowed for this question.

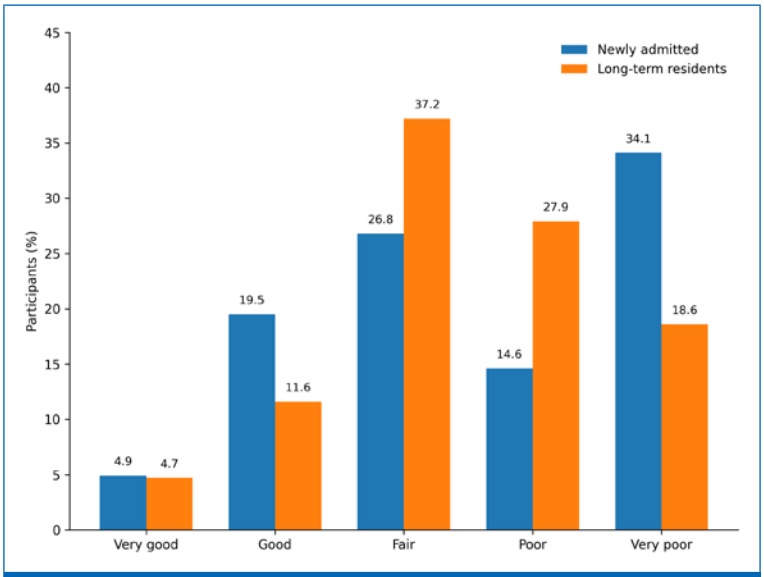


Figure 1. Distribution of self-perceived oral health according to length of stay in the therapeutic community. Values represent percentages within each group (newly admitted residents, n=41; long-term residents, n=43).

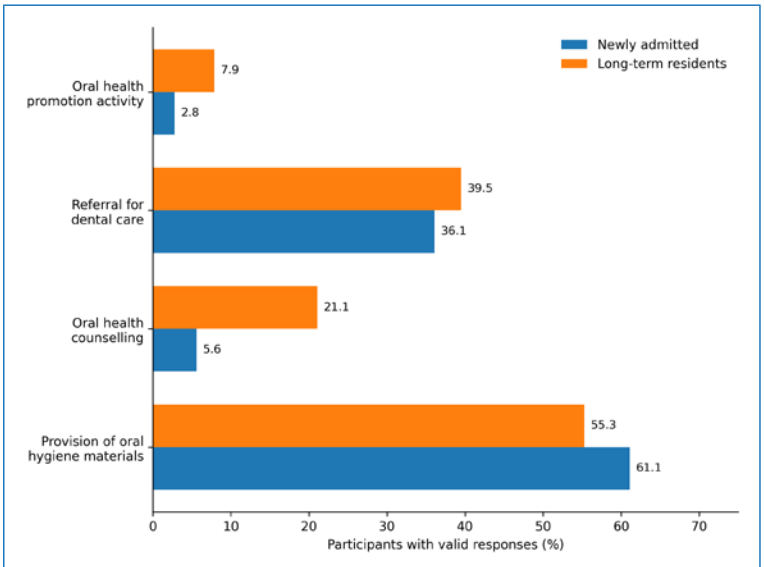


Figure 2. Oral health-related measures provided by the therapeutic community, as reported by newly admitted and long-term residents. Multiple responses were allowed. Percentages are based on participants with valid responses (newly admitted residents, n=36; long-term residents, n=38).

Discussion

The present study found that both newly admitted and long-term residents had a predominantly negative perception of their oral health. Long-term residents generally reported more favorable oral health behaviors and greater use of dental services. However, self-perceived oral health was similar in the two groups.

The demographic and substance-use characteristics of the study population underline the severity and complexity of substance dependence issues faced by the participants. The frequent use of multiple substances, particularly involving alcohol, cannabis, and opioids, is consistent with patterns described in addiction research. Evidence from studies on methamphetamine users reinforces these findings, showing that chronic consumption is often linked with unstable socioeconomic conditions, extensive co-use of other substances, and a marked lack of professional dental care. Rommel et al. reported oral health problems such as rampant caries, gingival inflammation, tooth fractures, and dry mouth among methamphetamine users, findings consistent with the so-called "Meth Mouth" phenomenon.[14] These results underline how multiple risk factors converge to exacerbate oral health deterioration in individuals with substance dependence. These observations illustrate how substance-related, behavioral, and socioeconomic risk factors may jointly contribute to oral health deterioration.[8]

The study highlighted that both newly admitted and long-term residents reported a poor perception of their oral health, emphasizing the need to integrate oral health into substance dependence recovery strategies. Previous research has identified a high prevalence of tooth loss, dental caries, and periodontal diseases among people with substance dependence.[8] Similar results were found in 2002 in a Brazilian therapeutic community, where drug-dependent individuals presented high DMFT values and poor oral hygiene, emphasizing the systemic neglect of oral health in this population.[13] In the present study, inadequate oral hygiene behaviors were also reported, and long-term residents reported brushing daily and using dental floss and fluoridated toothpaste more frequently than newly admitted residents. However, because no clinical oral examination was performed, the prevalence or severity of dental and periodontal disease could not be determined.

Large-scale evidence comparing methamphetamine users with a matched national cohort has shown substantial oral health deficits and a disproportionate burden of dental disease. Methamphetamine users were significantly more likely to suffer recurrent toothache, difficulties in eating, and self-consciousness due to dental appearance, with intravenous users presenting the most severe outcomes.[15] Despite these high levels of need, only a small proportion accessed regular dental care, although HIV-positive substance users demonstrated accessing it more than their HIV-negative counterparts.[15] These findings highlight both the magnitude of the problem and the persistent barriers to adequate oral health care among substance-dependent populations.

Among long-term residents, a higher percentage (around 58.1%) used oral health services compared to newly admitted residents (around 26.8%). This finding is noteworthy and may reflect greater opportunities to access healthcare during a longer stay in the community. The 2002 study also demonstrated that structured educational-preventive programs in therapeutic communities can reduce plaque indices and improve oral health behaviors, showing the potential of these settings to actively foster change.[13] This is in line with research emphasizing the importance of healthcare accessibility in recovery settings.[16] On the other hand, the results may derive from newly admitted residents not having had enough time yet to organize and prioritize their needs, or still not perceiving the need for dental consultation. The somewhat more favorable oral health practices reported by long-term residents are consistent with previous research describing facilitators of healthcare use among people with substance-use disorders.[17]

According to the community's management, the community supports residents seeking dental care in choosing the most suitable clinics. However, this study did not directly assess financial barriers, treatment costs, or the participants' ability to pay. Therefore, it is not possible to determine whether financial factors influence dental service use. Some non-financial barriers could explain the lack of adherence, including anxiety, fear of dentists, difficulties in attending appointments, discrepancies in expectations, lack of information, and poor interprofessional communication.[18]

Reasons for dental service utilization also differed between the groups. Long-term residents favored routine attendance, whereas newly admitted residents more frequently reported seeking care because of an oral problem. This may indicate that preventive attendance becomes more feasible after residents spend more time in a structured treatment setting, although this interpretation requires confirmation in longitudinal studies.

In terms of oral health education, the approach offered by the community most frequently reported was providing oral hygiene materials, with little or no training offered. Recent evidence shows that innovative mobile-based oral health promotion strategies can effectively improve knowledge, attitudes, and practices. A study using WhatsApp as a delivery tool, with pictures, videos, and interactive messages, reported a significant reduction in oral hygiene and gingival index scores, together with marked improvements in oral health knowledge and practices among young adults. Such digital interventions could be adapted for therapeutic communities, offering an accessible and engaging way to address current gaps in oral health education.[19]

These findings suggest that the therapeutic community may offer opportunities to support oral health behaviors, while also revealing gaps in the oral health approach reported by participants. Both groups rated their oral health as poor, which may reflect the accumulated burden of oral problems or the reported limited guidance on using the provided oral hygiene materials. This observation aligns with findings from residential treatment settings in other countries, where individuals with substance dependence were found to suffer from a wide range of co-occurring physical health problems, highlighting the importance of integrating dental professionals into multidisciplinary care to address the full spectrum of health needs.[12]

A more structured and targeted oral health approach should therefore be evaluated in therapeutic communities. This may include regular oral health education, practical guidance on using hygiene materials, referral pathways, and the possible involvement of oral health professionals in multidisciplinary teams. Ribeiro et al. support this perspective by showing that oral health education and preventive strategies implemented in a rehabilitation setting may improve clinical indices and reinforce the perceived importance of oral health.[13]

These findings suggest that therapeutic communities may provide opportunities to reinforce oral health behaviors and facilitate dental service use. However, the cross-sectional design does not allow attributing the observed differences to length of stay or the community's intervention.

This study has several limitations. It was based on a non-probabilistic convenience sample recruited from a single therapeutic community, which limits the external validity of the findings. All participants were men, and the results cannot be generalized to women or to residents of other therapeutic communities. The use of self-reported data may have introduced recall and social-desirability bias, and no clinical oral examination was performed. In addition, the questionnaire was developed for this study and was not formally assessed for validity and reliability. The cross-sectional design does not allow evaluating changes within the same participants over time and prevents causal conclusions regarding the effect of length of stay. Future studies should include multicenter samples, clinical oral examinations, validated instruments, longitudinal follow-up, and, when appropriate, comparison groups.

Conclusions

This study revealed that oral health perception among substance users of a therapeutic community is generally negative, regardless of the duration of their stay. Although long-term residents demonstrated slightly better oral hygiene behaviors, these differences were not accompanied by a significant difference in self-perceived oral health.

The limited reporting of structured oral health promotion and counseling, together with the predominance of oral hygiene materials provision, highlights a gap in the current approach to oral health. This underscores the need for a more comprehensive strategy that includes structured educational programs and the integration of oral health professionals into multidisciplinary teams in therapeutic communities. Given the convenience sample, the inclusion of a single therapeutic community, and the cross-sectional design, these findings should be interpreted as exploratory and cannot demonstrate that the duration of residence caused the observed differences.

Acknowledgments

The authors gratefully acknowledge the valuable collaboration and support of *Comunidade Vida e Paz*, whose contribution was essential to the successful conduct of this study.

Conflict of interest

The authors have no conflicts of interest to declare.

Ethical disclosures

Protection of human and animal subjects. The authors declare that the procedures followed were in accordance with the regulations of the relevant clinical research ethics committee and with those of the Code of Ethics of the World Medical Association (Declaration of Helsinki).

Confidentiality of data. The authors declare that no patient data appear in this article.

Right to privacy and informed consent. The authors have obtained the written informed consent of the patients or subjects mentioned in the article. The corresponding author is in possession of this document.

CRediT authorship contribution statement

Andreia Fonseca: Data curation; Investigation; Writing – original draft. **Bruno Russo:** Data curation; Formal analysis; Investigation; Writing – original draft. **Victor Assunção:** Methodology; Supervision; Writing – review & editing. **Fátima Bizarra:** Writing – review & editing. **Inês Santos:** Writing – review & editing. **Henrique Luis:** Conceptualization; Project administration; Supervision; Writing – review & editing.

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Comportamentos e perceções de saúde oral numa comunidade terapêutica portuguesa: estudo transversal

RESUMO

Objetivos: As necessidades de saúde oral são frequentes nas pessoas com dependência de substâncias, mas estão pouco integradas no tratamento residencial. Este estudo pretendeu descrever comportamentos e perceções de saúde oral numa comunidade terapêutica e comparar recém-admitidos com residentes de longa duração.

Métodos: Foi realizado um estudo transversal numa comunidade terapêutica portuguesa, com amostragem de conveniência. Os participantes foram classificados como recém-admitidos (até seis meses) ou residentes de longa duração (mais de seis meses). Avaliaram-se características sociodemográficas e da dependência, comportamentos de higiene oral, perceção da saúde oral, problemas orais autorreportados, utilização de serviços de medicina dentária e abordagem à saúde oral. As variáveis categóricas foram descritas por frequências e comparadas pelo qui-quadrado de Pearson ou teste exato de Fisher.

Resultados: A amostra incluiu 84 homens: 41 recém-admitidos e 43 residentes de longa duração. A escovagem diária foi referida por 43,9% e 55,8%, respetivamente, e a perceção da saúde oral como má ou muito má por 48,7% e 46,5%. A utilização de serviços de medicina dentária após a admissão foi referida por 26,8% e 58,1%. As diferenças significativas respeitaram à utilização de serviços de medicina dentária; não se observaram diferenças nos comportamentos de higiene oral.

Conclusões: Os residentes de longa duração referiram comportamentos de higiene oral mais favoráveis e maior utilização de serviços de medicina dentária, embora a perceção negativa continuasse frequente. Devido à amostra de conveniência e ao desenho transversal, os resultados são exploratórios e não demonstram causalidade. (Rev Port Estomatol Med Dent Cir Maxilofac. 2026;67(x):xxx-xxx)

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Palavras-chave:
Estudos Transversais
Comportamento de Saúde
Saúde Oral
Portugal
Perturbações Relacionadas com Substâncias