The Comparative Evaluation of the Effectiveness of the Actions Taken by Clinics, Camps, and NA Groups and Development of an Effective Model for Addiction Prevention and Reduction

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Abstract

Objective: The current study was an attempt to conduct a comparative evaluation of the success of the actions and measures taken by clinics, camps, and NA groups, and also to develop an efficient model for the prevention and reduction of drug addiction. Method: For this purpose, 150 addicted people (40 men and 10 women) from clinics, camps, and NA groups were qualitatively studied using in-depth interviews. Results: The findings of the present study showed that all the activities of clinics, camps, and NA groups have some strengths and weaknesses. Conclusion: As a result, both dry and methadone treatments should be considered in addiction treatment. In both treatment methods, the continuous relations of addicts with their family requires their participation in activities of the rehabilitation center, and the creation of a sense of security, and employment.

Keywords: addiction, clinic, camp, NA, model

Research on Addiction Quarterly Journal of Drug Abuse

Presidency of the I. R. of Iran
Drug Control Headquarters
Department for Research and Education

Vol. 11, No. 42, Summer 2017
http://www.etiadpajohi.ir/

Introduction

Today, three places and methods of drug quitting are used in the country: Clinics, camps and NA groups. In most cases, referral to the clinic eventually results in methadone prescription. Methadone was made in Germany during the Second World War and was first used to relieve pain. Its greatest application is in the treatment of dependence on other opioids such as heroin, codeine and morphine (Rahmani, 2007). Methadone is a synthetic drug that is taken orally and can be replaced by heroin, and instead of the drug used by addicts, it is used to quench the withdrawal symptoms (Bhadani, Habrani and Arshadi, 2007). Maintenance therapy prevents opium withdrawal symptoms. It also reduces or eliminates its demand. The use of methadone maintenance dose does not result in the patient treatment, but it has a therapeutic effect. Methadone treatment is able to compensate the injured brain of drug user, so that the addict has no sedation and euphoria and has the ability to return to work and career. S/he could has a good appetite and it has great effects on his/her mood and emotional affairs (Rahmani, 2007). Although methadone maintenance therapy is evaluated a type of physical addiction to this drug, it is not considered to be an addiction, because the person is taking a steady course of the drug and is get rid of the monotonous sequence (consumption, sedation, euphoria, looking for the next round of drugs, consumption) (Rastashari, 2001). The goals of methadone treatment include: normalizing the patient's life; helping him/her re-engage in the community; keeping him in treatment as long as he or she benefits from it (Vaziryani and Mostashari, 2003). According to the experts, in general, opium and heroin replacement with methadone has at least two benefits: reducing the prevalence of drug injection and reducing the incidence of dangerous illnesses, such as AIDS, the disconnection with drug suppliers and delinquency possibility in society is reduced (Farhadinasab and Mani Kashani, 2008).

Narcotic anonymous (NA) is a nonprofit association of women and men whose addiction to drugs is a major problem in their lives and believes that twelve steps are positive ones that make their recovery possible. Any addicted person who desires to quit can be a member of this association. Being addicted in the past is a condition of attending the association. The members of the association all have a common feature called addiction, and members of the association can be any male and female addict; regardless of religion, race or language (NA groups, 2004). Anonymity is the basis of all the traditions of the association; anonymity creates trust and motivation (Moazami and Parsa, 2009). Spirituality is central to treatment in NA (Smith, 1993). In NA, members enjoy each other's emotional and information support. Old members provide for new entrants the necessary support so that they can avoid drugs and be encouraged for frequent attendance at sessions (Groh, Jason & Keys, 2008). Addiction is a disturbance with frequent relapses (Miller, 2009). Addicts have rehabilitated their physical health, often after experiencing different quitting methods, but after a short time they return to drug abuse (Moazzemi and Parsa, 2009). Physical

withdrawal of drugs is not so difficult. The main problem is to return and to start again this bad habit (Laleh, 2006). The common treatment methods of addiction are efficient enough, and even in the best therapeutic methods, the one- year success rate is reported to be 30-50% (Brien & McLellan, 1996). Unfortunately, the main problem in the addicts' treatment, even in the long quitting period, is the high rate of relapse. Currently, there are no detailed statistics on how many percent of the patients have returned to drug abuse (Ghorbani, Mohammadkhani, and Sarrami, 2012). However, the increase in statistics on drug abuse can indicate that methods the treatment methods have not been effective or comprehensive (Samarasing, 2001).

The results of the research are also contradictory regarding the quitting methods. Findings of the study of Hubbard et al. (1989) showed that methadone maintenance therapy is the most successful way to reduce heroin use. Findings of the research by Meterge, & Woody (1993) confirm this issue. Findings of Marques, & Formigoni (2001) showed that although drug therapies, such as methadone are effective in regulating one's excitement , cognitive and behavioral therapies have more effective therapeutic effect and generally cognitive and behavioral therapy is more beneficial for relapse prevention in drug users. Seifert's (2002) findings in the study of detoxification methods revealed that patients are not satisfied with methadone. The findings of Rajabi and Moqadas Tabrizi (2011), Scherbauma et al. (2005) and Levin et al (2006) showed that in methadone maintenance therapy and Bupronorphine maintenance therapy that are used as common methods in addiction treatment clinics in our country, high rate of relapse is also observed. The results of the research of Alirevadinia (2009), Moos & Moos (2005), McGraw (2012), Masi, Chen, Hawkley, and Cacioppo (2011) showed that volunteered addicts in NA reduced the addiction relapse. Therefore, in order to increase the ability of individuals to cope with relapse, it is necessary to present a comprehensive research that evaluates all the strengths and weaknesses of clinics, camps and NA groups from the perspective of addicts, and ultimately to present an additional model based on these strengths and weaknesses.

Method

Population, sample and sampling method

This research is a causal-comparative design and is applied in terms of purpose. The statistical population of this study was addicts in camps, clinics NA groups in Yazd in 2014. In NA groups, sampling was done by convenient sampling method and multi-stage cluster method was used in a sampling of camps and clinics. At first, 4 camps (3 male camps and 1 female's camp) and 8 clinics (7 male clinics and 1 female clinic) were selected randomly. In this research, a sample of 150 addicts was selected from the clinic, camp and NA groups in Yazd province (Iran). A total of 50 people in camps and 50 people in NA groups were selected. Each group included 10 women and 40 men.

Instrument

The interview was used in this research. The questions were designed as open-ended and were raised in the interview. Content validity was used in this research. To do this, the items that measure the research variables were selected from previous research items. The views of other scholars and professors were applied to select the best items for new variables. Finally, the developed questionnaire was submitted to the faculty and experts and their comments were used to correct the interview questions. Data analysis was performed using content analysis. As a result, at first, with some reviews of the interview text, a full introduction to the content was achieved. Then the codes were extracted in the text of each interview. The codes were grouped in order to extract the content

Findings

The average age of the respondents was 34.6, the lowest was 14 and the highest 60 years. The mean age for first use was 18.42 years. The average number of attempts to quit was 28.9 times. There were 22.7% single, 66.7 % married and 10.7 % divorced. 2% of the samples were illiterate, 19.3% elementary school, 38% third grade of high school, 30.7% diplomas, 2.7% associate, 6% BA and 1.3% had MA. 69.3% had an addict family and 57.3% had addict friends.

Table 1: Frequency Distribution of the Strengths and Weaknesses of Clinics by Respondents in Terms of Samples

Points	*Cases*	*Total*		*Clinic sample*		*Camp sample*		*NA groups sample*	
		F	*%*	*F*	*%*	*F*	*%*	*F*	*%*
Strength	Medicine existence	25	16/7	25	50	0	0	0	0
	Doctor presence	38	25/3	29	58	4	8	5	10
	Not being far from the family	4	2/7	4	8	0	0	0	0
	Not being farm from job	3	2	3	6	0	0	0	0
	Good behavior	9	6	9	18	0	0	0	0
	Having honor	2	1/3	1	2	1	2	0	0
	Psychologist presence	2	1/3	2	4	0	0	0	0
	Being free	1	0/0/7	1	2	0	0	0	0
	Legal	1	0/0/7	1	2	0	0	0	0
Weakness	Addiction nature of the medicine	102	68	15	30	45	90	42	84
	Increasing the medicine dose based on one's request	7	4/7	4	8	2	4	1	2
	The importance of money for the doctor	9	6	3	6	0	0	3	6
	Lack of price difference between consumption of people	2	1/3	2	4	0	0	0	0
	Lack of spiritual relationship between the doctor and addict	13	8/7	2	4	0	0	11	22

The medicine and doctor presence are the most important strengths and medicine addition nature and the importance of money for the doctor are the most important weaknesses.

Table 2- The Frequency Distribution of the Strengths and Weaknesses of Camp from the View of Respondents in Terms of Samples

Points	***Cases***	***Total***		***Clinic sample***		***Camp sample***		***NA groups sample***	
		F	***%***	***F***	***%***	***F***	***%***	***F***	***%***
Strength	Empathy existence	37	24/7	7	14	28	56	2	4
	Quitting without medicine	64	42/7	6	12	19	38	39	78
	No access to drugs	5	3/3	0	0	5	10	0	0
Weakness	Obligation existence	47	31/3	30	60	3	6	14	28
	Bad behavior	48	32	22	44	4	8	22	44
	No service providing	31	20/7	14	28	9	18	8	16
	Painful	11	7/3	8	16	3	6	0	0
	Far from family	11	7/3	6	12	1	2	4	8
	Far from job	5	3/3	4	8	1	2	0	0
	Being familiar with much delinquency	5	3/3	3	6	1	2	1	2
	Money importance	7	4/7	0	0	1	2	6	12

Quitting without medicine and the empathy existence are the most important strengths; bad behavior and force are the most important weaknesses.

Table 3- The Frequency Distribution of the Strengths and Weaknesses of NA Groups from the View of Respondents in Terms of Samples

Points	***Cases***	***Total***		***Clinic sample***		***Camp sample***		***NA groups sample***	
		F	***%***	***F***	***%***	***F***	***%***	***F***	***%***
Strength	People's participation	52	34/7	13	26	20	40	19	38
	Empathy	57	38	11	22	21	42	25	50
	Awareness increase	52	34/7	14	28	29	58	9	18
	Suitable behavior and one's attraction	26	17/3	6	12	7	14	13	26
	Encouragement and increase hope	19	12/7	6	12	5	10	8	16
	Increase faith and spirituality	11	7/3	4	8	4	8	3	6
	Anonymity and keeping honor	7	4/7	0	0	0	0	7	14
	Not giving importance to money	5	3/3	0	0	0	0	5	10
Weakness	Transgressing the privacy	7	4/7	6	12	0	0	1	2
	Lack of full acceptance by the authorities	4	2/7	0	0	0	0	4	8

Empathy, participation and awareness increase are the most important strengths and transgressing privacy is the most important weakness.

Table 4- Frequency Distribution of Neighbors Behavior and Family after the First Clean Time

Behavior	*Neighbors*		*Family*	
	F	*%*	*F*	*%*
Disconnection, lack of support and attraction	72	48	78	52
Encouragement and hope	37	24/7	66	44
No one knows	41	27/3	6	4
Sum	150	100	150	100

Often the behavior of others with the addict is disconnected and lack of support after quitting.

Table 5- Frequency Distribution of Problems Regarding the Job after the First Clean Time

Problems	*F*	*%*
I didn't seek any job	11	7/3
My job was private (no problem)	41	27/3
They didn't let me work	49	32/7
They gave me a job	17	11/3
Housewife	21	14
Knowing nothing	11	7/3

Mostly, due to the pessimistic view of those who were addicts already, the addict can not find any job.

Discussion and Conclusion

There is a significant difference between the opinions of the individuals present in the clinic on the one hand and the individuals in the camp and NA groups, on the other hand. People in the clinic consider the presence of physicians and drugs as the most important strength of the clinic, while the people in the camp and NA groups are not considered. A strong point in the clinic, apart from physicians' existence and keeping honor (ignorable). From the view of the 50% of the respondents in the clinic, the existence of medication was the strength of the clinic, while 68% of all respondents considered this to be a weakness point. The most important weakness of the clinic was the medication's addiction nature, and even a significant proportion of those present in the clinic found it a weak point. Another weakness of the clinic was the lack of spiritual relationship between the doctor and the patient, and the importance of money to the doctor from the point of view of respondents. According to individuals, there is no deep relationship between a doctor and an addict, and the doctor only intends to prescribe medication and make money. Since there is no difference between the amount of medicine used by individuals and the amount of money paid, the addict for some reasons such as taking more medicine and using more; taking much medicine and selling some or all of it in the community and making money from it or even providing money to buy drugs, asks for much medicine and if he intends to use it, he can be an addict and if he intends to sell it, sometimes, the income of selling medicine is dedicated to provide drugs and in both cases, the

clinic will be far from the ultimate goal. . One of the main challenges of methadone maintenance therapy is slip and durability of therapy (Ghorbani, Mohammadkhani and Sarrami, 2012). Karimi Talabari (2012) indicated that methadone therapy has a single-dimensional nature and does not address the psychological and social dimensions of therapy. The focus of treatment is the use of methadone, and due to the doctor-orientation of the center and the lack of attention to the quality of treatment, applicants are not adequately consulted or counselor is not skillful in counseling. The result of methadone maintenance therapy is more successful when it is used with counseling, social support, and career and educational situations (Waldron, Slesnick, Brody, Turner, & Peterson, 2001).

Since addicts in the camp are related to each other, there is a lot of empathy and sympathy in them. They have no access to any drugs in the camp. It is noteworthy that only 4% of respondents of NA groups do not know that empathy is the strength of the camp. Bad behavior, disrespect, beatings, coercion, lack of freedom and zeal, lack of health and nutrition, distress and pain, being far from the family and the workplace, familiarity with the other offenses and the importance of money to the camp authorities are the weakness points of the camp. The findings of Karimi Talabari (2012) indicated that hostile and humiliating behavior and the uncontrollable relationship between therapists was an important factor in treatment discontinuation, which were referred by most of the addicts. The only weaknesses of the individuals in NA groups is the transgression of privacy and the opening up of private life issues, which people believe the NA groups exaggerate in this area, and some people abuse it. On the other hand, the problem is carrying out some of the conferences and administrative procedures available to this association as non-acceptance by the authorities is considered as one of the weaknesses of the NA groups. It should be noted that the full rejection by the authorities, apart from its true or false nature is not the weakness that is referred to the executive structure of NA groups regarding the treatment. Participation in association meetings increases social contact opportunities in patients and provides them with high social support. Participation in the sessions besides promoting self-esteem, increases their communication and social interactions and provides the opportunity to improve and enhance the personality traits of patients. Participation in continuous meetings of NA groups leads to being away from introversion and loneliness, re-establishing constructive social relationships and using the useful experiences of other patients (Sotoudeh asl et al., 2013).

In most cases, after the first clean time, neighbors and the family with are not connected with addict and have pessimistic views toward him, no one attempts to have any affair with the addict and if the addict tries to be in touch with others, he is failed with the bad behavior by the others. In the concept of actualized prediction, White (2004) states that each person is identified by two elements: those who define his reality; and how the definition is created. According to this

view, people who are labeled as addicts display responses that fit the label. A person changes identity after being labeled. Not only he can find a job, but is defined as a perverted person, treated as an offender and a criminal, and loses his social acceptability as a normal citizen. As a result, it is highly likely that he will commit addiction or other deviations again (Ahmadi, 2005). Researched in Iran show that public opinion and the view of rulers on addiction is a personal and individual problem and the addict is considered as a culprit and is always blamed and hated (Mozaffar et al.,, 2009). This finding is consistent with the findings of Anne (2008). This encounter exists also in finding work for people. This distrust and lack of absorption in society and their acceptance can be one of the important reasons for their return to addiction. Kajbaf and Rahimi (2011) consider returning to the labor market and gaining social status and income as additional maintenance of addiction non-dependency.

As the clinic has a doctor and an individual is not far from house and workplace, it is attractive for people. But the narcotic nature of methadone and the inability of many people in its quitting are the weak points for the addicts. The presence of a doctor is for the assurance of addicts and the lack of strong mental and spiritual relationship between the doctor and addict is one of the motivation weakening factors for treatment continuance. The excessive increase of medicine based on the request of the addict in some clinics makes the clinic far from its ultimate goal. Thus, we need high commitment of some of the physicians and more supervision of authority systems. Empathy is higher in camp compared to clinic. The individuals are more connected and have similar experiences. However, bad behavior, lack of entertainment in the camp, the presence of some offenders and being connected to them, assault and beating, lack of suitable service provision and lack of connection with family are the points making an individual desperate in the camp environment and the addiction treatment is problematic in this case. NA groups by increasing awareness in people, participation in affairs and improving religious morale, faith, encouragement and increase of hope by keeping them anonymous are helpful in drugs quitting. Sometimes, by transgressing the privacy and abusing some individuals, some problems are made for the members.

By sum up[1] the weaknesses and strengths and the cause of relapse, the following Table is achieved:

1 In some cases, we could sum up the strengths and weaknesses and they were gathered for summarization. For example, in the strength section, not being far from family, 4 cases were mentioned and in the weaknesses section, being far from family, 11 cases were mentioned. Generally, the importance of not being far from family, 15 cases was mentioned.

Table 6- The general stated points

General stated points	*F*	*General stated points*	*F*
Being free	1	Anonymity and not entering one's privacy	16
Lack of price difference between methadone use amount	2	Increasing faith and spirituality	17
Being legal and accepted by the authorities	5	Not giving importance to money	21
Not increasing medicine on one's request	7	Medicine existence and quitting without pain	36
No access to drugs and being familiar with more offences	37	Unemployment	47
The presence of physician and psychiatrist	40	Forcing	47
Suitable service providing and increase entertainment facilities	43	Increase hope and create spiritual relationship of addicts and authorities of quitting center	50
Good behavior	83	Empathy existence	94
Participation existence	104	Awareness increase	108
Lack of good behavior with the family and being far from them	126	Addicted acquaintances	125
It is not addictive and quitting is performed without medicine.	166		

The main members of the health center are: psychologist, psychiatrist, social worker, physician, sociologist; the supervisory authorities of the treatment center are: the welfare organization, the counter narcotics coordination council, the social security department of the police; the center's collaborating institutions treatment: Governor's office, municipality, governorate, relief committee, sports and youth department, women's affairs, etc. To quit in this model, individuals are divided into two groups of non-maintenance and maintenance quitting, which the diagnosis belongs to the treatment team. Individuals who need to quit without maintenance are kept at the center during the quitting process. Other health services are common for two groups. Having a good and friendly relationship with the family has a significant role in drug quitting. In most of the addiction treatment methods, the role of the family is very little or it has no role at all. In this model, one of the essential elements for the addiction treatment and treatment stability is the presence of the family throughout the course of treatment and afterwards. The treatment team trains the families regarding the communication method and even the type of addict's control by multiple meetings, and during these treatment sessions, counseling continues with the family. This has two advantages. 1) The addict sees himself beside the family and is assured. 2) The family is trained about how to deal with an addict. On the other hand, during the day, meeting and face-to-face visits of family members can be very helpful for one to two hours. Therefore, the family can meet with the addict in coordination with the authorities at the time specified for the visit. It's possible to quit drugs, but if the people around you are addicted, the

likelihood of a person returning to addiction treatment failure is tremendous. The addiction quitting failure can change the attitude of the individual to quitting and one person is vulnerable to addiction. Therefore, when a person intends to quit, they must disconnect with the addicts, and if they are forced to communicate, this connection will be made in the presence of other family members

The role of the treatment team is very important in awareness raising stage. When a person goes to addiction center for quitting, the treatment team can play a significant role in the drug quitting by increasing awareness, knowledge and insight in drug addicts in relation to addiction. This rise in awareness and insight can lead people to health and well-being and, on the other hand, can persuade a person to disconnect with other addicts. Creating a sense of partnership and empathy can be done together. For example, you can ask quitters to encourage their friends and relatives to attend a health center[1].

An addict who refers to quitting center is with a lot of psychological, physical, emotional, family and other problems. Therefore, he should be respected, and be treated in such a way as to attract more people, rather than having to behave badly and make them escape. Encouragement and proper relationship can lead to an increase of hope in the individual. If the addict is encouraged by the center's authorities, he feel that he is a great person and hope is increased in him, and this hope encourages him to continue the treatment. On the other hand, these encouragements and increased hopes by the authorities create an emotional and spiritual relationship between addicts and authorities. Eliminating unemployment is a point that directly and indirectly helps to continue as quitters. This is related mostly to the authorities of center. It is recommended that the center's authorities collect information about the job skills of the people and with the approval of the treatment center authorities, they employ these people in some jobs or the job is provided by purchasing the required device for individuals and taking it back in installments and long-term. Or, some of the people who were at the center are now quitters and they can be employed for service affairs. This has several advantages: the unemployment problem of some of these people will be solved and they will be encouraged and persuaded to be present and continue their relationship with the center; the sense of coercion will be reduced in the center; and It also helps to complete some of the previous steps (encouraging and increasing hope, and reducing the sense of coercion), and preventing the relapse of some people into addiction due to unemployment.

Improving nutrition, health, hobby in the health center, etc. for the individuals can play a significant role in reducing the sense of coercion and increasing the urge to attend the center. The presence of a doctor and a psychiatrist at the center can be assurance for the addicts. In this model, the role of psychologist and

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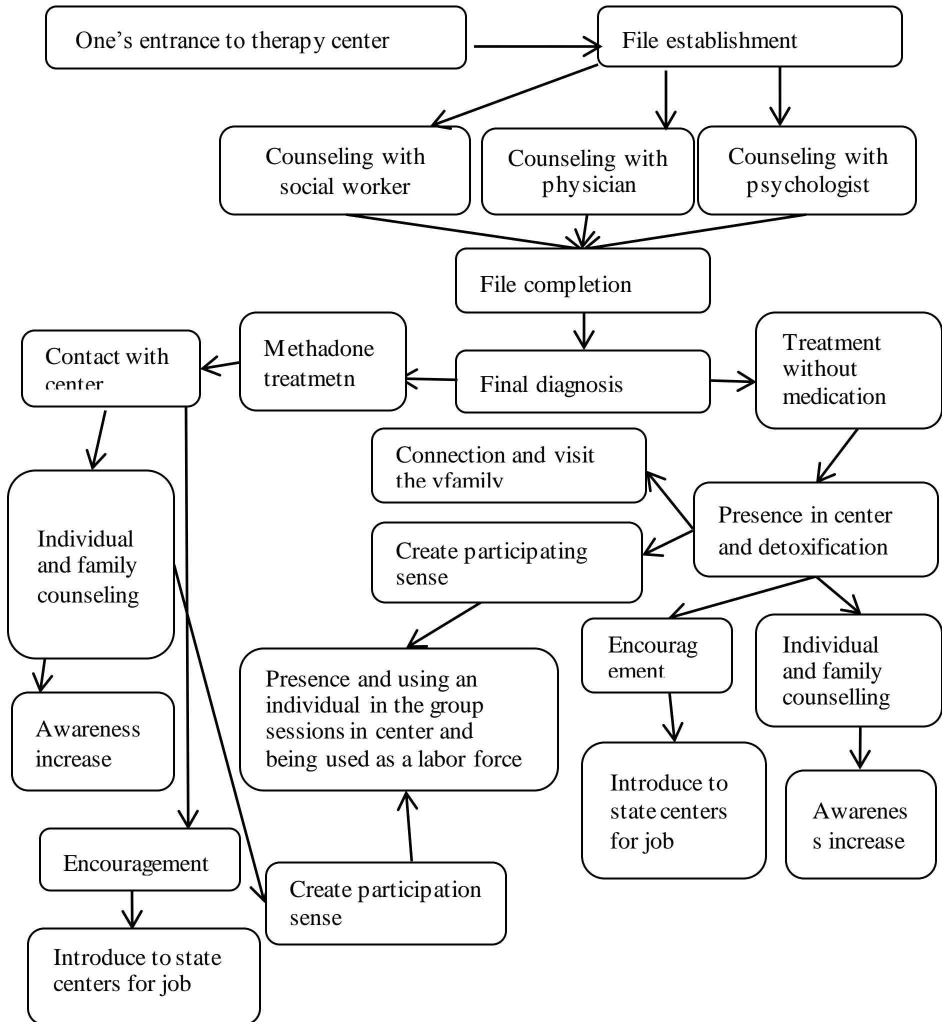
1 It is worth noting that if the treatment process is done correctly, individuals advertise this method for other addicts.

psychiatrist is very high, and in addition to advice given to the addict individually, counseling should be provided to the addicts' family, and in some meetings, family counseling should be performed (with the presence of addict and his family). The addict should not feel that the center's authorities are more likely to think and earn money than help and heal. Increasing faith is one of the points being considered. One can come to the conclusion that one can overcome obstacles by appealing to God and asking for help from Him. According to the members of the treatment team, keeping the secrets and characteristics of the private life of the addicts as a patient, is at the top of their scientific, social, and religious knowledge. It is suggested that the relationship between the family and those who have been able to quit continues with the center, in order to reduce replace possibility in these individuals or once or twice per week, those with high clean time can be invited to center and hold a meeting with them or even the meeting management can be given to these individuals to talk about their experiences for those newly quitting to encourage those with high clean time to continue and increase improvement hope among the individuals under treatment. Much absorption of quitters' in family and having much relationship with the quitters by the family and friends is necessary. Absorbing more quitters in society by job creation for them plays an important role in continuing quitting. High supervision on the clinics regarding the medication presentation process, much supervision on the facilities of addiction quitting camps and the process of behaving with the addicts present in the camps are necessary.

The therapy chart of the proposed model



References

Ahmadi, H. (2005). Sociology of deviations. Tehran: SAMT publication.

Ali Verdinnia, A. (2009). The Effectiveness of Anonymous Addicts' Programs in the Attitude of Drug Addicts. *Journal of Social Studies of Iran*, 3 (3), 41-46.

Association of Anonymous Addicts (2004). *Anonymous Addicts Program.* Translation Committee, Taraghi publication.

Behdani, F., Hebrani, P., Arshadi, H. (2007). Epidemiological characteristics of patients in methadone maintenance treatment, admitted in Hejazi Hospital, Mashad (2005-2006). *Journal of Fundamentals of Mental Health*, 9 (33-34), 53-59.

DeLeon, G. (2000). *The therapeutic community: Theory model and method*. New York: Springer Publishing Company.

Farhadi Nesab, A., Mani Kashani, Kh. (2008). The effect of methadone replacement therapy on depression after quitting in the treatment of addicts in Hamedan. *Scientific Journal of Ilam University of Medical Sciences,* 16 (2), 44-50.

Groh, D. R., Jason, L. A., Keys, C. B. (2008). Social network variable in a literature review. *Clinical Psychology Review*, 28, 430-450.

Hubbard, R. L., Marsden, M. E., Rachal, J. V., Harwood, H. J., Cavanaugh, E. R., Ginzburg, H. M.(1989). *Drug abuse treatment: A national study of effectiveness*. New York: University of North California Press.

Kajbaf, M. B., & Rahimi, F. (2011). Comparison of Individual and Social Motivations and Social Capital of Addicts in Isfahan Therapeutic Groups. *Journal of Educational Approaches,* 6 (1), 148-125.

Karimi Talabari, Z. (2012). Reasons for discontinuation of methadone maintenance therapy in patients referred to the National Center for Addiction Studies. *Iranian Journal of Psychiatry and Clinical Psychology*, 18 (4), 309-299.

Laleh, M. (2000). *Addiction, Individual Disease, Social Disaster*. Tehran: Teimourzadeh Publications.

Levin, F. R., Evans, S. M., Brooks, D. J., Kalbag, A. S., Edward, F. G., Nunes, N. (2006). Treatment of methadone-maintained patients with adult ADHD: Double-blind comparison of methylphenidate, bupropion and placebo. *Drug and Alcohol Dependence*, 81, 137–148.

Marques, A. C. P. R., Formigoni, M. L. O. S. (2001). Comparison of individual and group cognitive-behavioral therapy for alcohol and/or drug-dependent patients. *Addictions*, 96, 835-846.

Masi, C. M., Chen, H. Y., Hawkley, L. C., Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review*, 15, 219-266.

McGraw, J.G. (1993). *Personality disorders and states of aloneness, intimacy and aloneness: A multi-volume study in philosophical psychology*. New York: Rodopi.

Metzger, D. S., Woody, G. E., McLellan, A.T., O'Brien, C. P., Druley, P., Navaline, H. …, Abrutyn, E. (1993). HIV seroconversion among intravenous drug user in and out of treatment prospective follow up. *AIDS Journal of Acquired Immune Deficiency Syndromes*, 6(9), 1049-1056.

Miller, P. M. (2009). *Evidence- Based addiction treatment*. USA: Academic press.

Moazami, Sh., & Parsa, M. (2009). Association of Anonymous Addicts in terms of restorative justice. *Law Jurisprudence Magazine*, 68, 136-121.

Moos, R. H., Moos, B. S. (2005). Paths of entry into alcoholic anonymous: Consequences for participation and remission. *Alcoholic Clinical Experimental Research*, 29(10), 1858-1868.

Mostashari, G. (2001). *Preliminary evaluation of methadone maintenance therapy. Welfare Organization of the country*. Tehran: Publishing Department of Cultural Affairs and Prevention.

Mozaffar, H., Zakaraie, M., & Sabeti, M. (2009). Cultural anomy and drug addiction among young people aged 13 to 28 in Tehran. *Social Sciences Research*, 3 (4), 54-33.

O'Brien, C.P., McLellan, A.T. (1996). Myths about the treatment of addiction. *Lancet*, 347(8996), 237-240.

Qorbani, T., Mohammad Khani, Sh., &Sarami, Gh. R. (2012). Comparison of the effectiveness of cognitive-behavioral group therapy and methadone maintenance therapy in changing substance beliefs and relapse prevention. *Journal of Addiction Studies,* 6 (22), 38-23

Rajabi, R., & Moghadas Tabrizi, Y. (2011). The Effect of Sport Exercises on Prevention of Morphine Relapse in Methadone treatment patients. *Quarterly Journal of Physiology and Management Research in Sport,* 5, 35-41.

Sacks, S., Banks, S. (2008). Modified therabeutic community for co-occurring disorders: A summary of four studies. *Journal Of substance abuse treatment*, 34, 112-122.

Samarasing D. (2001). Combat with substance abuse. *World Health*, 11(1), 1-3.

Scherbauma, N., Kluwiga, J., Speckaa, M., Krauseb, D., Mergeta, B., Finkbeinera, T., Gastparb, M. (2005). Group Psychotherapy for Opiate Addicts in Methadone Maintenance Treatment – A Controlled Trial. *European Addiction Research*, 11, 163– 171.

Seifert, J. (2002). Detoxificationof opiate addicts with multiple drugs abuse: comparison of buprenorphine vs.methadone. *Pharmacopsychiatry*, 35(5), 159-164.

Shahmohammadi, A., Kheirabadi, Gh. R. (2011). The efficacy of the therapeutic community on increasing the level of hope in the referrals to this center. *Quarterly Journal of Addiction Research*, 5 (19), 85-71.

Smith, D.E., Buxton, M.E., Bilal, R., Seymour, R.B. (1993). Cultural points of resistance to the12-step recovery process. *Journal of Psychoactive Drugs*, 25, 97-108.

Sotoudehasl, N., Behnam, B., & Qorbani, R. (2012). The Effects of Anonymous Addicts' Meetings on Personality Traits of Substance-Dependent Patients. *Koomesh Journal,* 14 (3), 320-316.

Vazirian, M. (2006). *Handbook of Substance Abuse Users Treatment. Second Edition*. Tehran, Porshokuh publications.

Waldron, H. R., Slesnick, N., Brody, J. L., Turner, C. W., Peterson, T. R. (2002). Treatment outcomes for adolescent substance abuse at 4-7- month assessments. *Journal of Consulting and Clinical Psychology*, 69, 802-813.

Ward, E. A. (2008). *Effects of Length of Time in Treatment and Criminal Classification Level on Recidivism Following Residential Treatment Programs for Drug Offenders* (Master of Science dissertation). Virginia Polytechnic Institute and State University.

White, R. (2004). *Crime and Criminology*. Translation by A. Salimi, M. Karkhaneh, F. Ghomee's Addressee. Qom: Publications of the Institute of Constituency and University.