Original Article
http://mjiri.iums.ac.ir

Medical Journal of the Islamic Republic of Iran (MJIRI)
Iran University of Medical Sciences

Challenges of recovery in medium-term residential centers (camps)

Abbas Shamsalinia[1], Kian Nourozi[2], Masoud Fallahi Khoshknab[3], Ali Farhoudian[4]

Received: 6 May 2014 Accepted: 20 June 2014 Published: 30 September 2014

Abstract

Background: Addiction is a global problem for which effective treatment is crucial. Stopping the consumption of abused substances in a camp is a strong predictor of the success for the recovery process. The present study employed a qualitative approach to explore the camp recovery experiences in individuals with substance addictions.

Methods: The research conducted in Iran's northern cities with participants that included 17 men with a history of substance abuse, who were all engaged in the recovery process at the time of the study. They were invited to participate in the research based on a purposive and snowball sampling method. The data were collected by individual face-to-face and phone interviews using semi-structured questions. Data were then analyzed using conventional content analysis

Results: three main categories were identified: selecting a camp: an appeal for rescue, substance deprivation crisis, and out of the frying pan into the frying pan or into the fire.

Conclusion: Results showed that participants can be helped in the recovery process by the provision of public facilities and financial support for camps, by monitoring the performance of these centers and by attempting to address existing deficiencies. We concluded with three recommendations for improving services and preventing physical, psychological, and emotional damage to addicted individuals: remove unauthorized camps, establish camps with treatment designated to the needs of addicted individuals.

Keywords: Addiction, Substance Abuse, Medium-term Residential Centers (Camps), Qualitative Study, Recovery.

Cite this article as: Shamsalinia A, Nourozi K, Fallahi Khoshknab M, Farhoudian A. Challenges of recovery in medium-term residential centers (camps). *Med J Islam Repub Iran* 2014 (30 September). Vol. 28:106.

Introduction

Addiction is one of today's global problems and the World Health Organization has estimated its prevalence at 230 million people worldwide (1). Iran, due to its proximity to Afghanistan, is a target country for substance dealers and studies have indicated increasing prevalence of substance consumption (2,3). This issue has moved officials in Iran to seek solutions for controlling addiction in the community. One is the establishment of substance abuse treatment centers managed publicly and privately. They include methadone maintenance therapy centers (4), narcotics anonymous (5), and medium-term residential centers (camps) which they all play a crucial role in treating and rehabilitating people with these problems (2).

Dinparast, the deputy head of Iran's Drug Control Headquarters, recently announced that at the end of 2013 more than 5233 authorized and operational camps have been dedicated to addiction treatment and harm reduction (6).

Camps are important centers for the treatment of addicted individuals and tend to operate in both residential areas and the

1. PhD student, Nursing Department, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran. abbasshamsalinia@yahoo.com
2. (**Corresponding author**) PhD, Assistant Professor, Nursing Department, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran. drkian_nourozi@yahoo.com
3. PhD, Associate Professor, Nursing Department, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran. msflir@yahoo.com
4. MD, Assistant Professor, Researcher of Substance Abuse and Dependence Research Center, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran. farhoudian@yahoo.com

medium-term (30–90 days). Its main approach is to focus on participation of peer and self-help (facilitated by recovered addicts) groups and their services offered mainly by recovered addicts (7).

Other treatment programs mimick a model for camps treatment. For example, a residential treatment program for developing coping mechanisms (without substance problems) prepares individuals for real life by helping them to gain successful life experiences in a small community. This method seems appropriate for improving psychological health and self-esteem providing hope and enhancing life skills such as problem solving, communicational skills (8), self-awareness, emotion management, and self-care. Together these improvements should lead to overall improvement in quality of life.

The general director of the drug addiction prevention and treatment of Iran's Welfare Organization has stated that little attention has been paid to the quality of services provided at substance abuse treatment centers and their role in assisting recovery of people who abuse substances. Although camp officials claim to implement abstinence-based treatments, but it appears to have adopted an idiosyncratic style, putting into question the rationale for establishing this type of center (9). Because camp centers are essential aspects of addiction treatment in Iran, exploring and evaluating their performance could play a crucial role in improving treatment quality. We could find no qualitative study of the camp recovery experiences of people who abuse substances; indeed, there is a lack of scientific study in this area. Exploring personal experiences of addicted individuals may identify: hidden dimensions of the process of addiction withdrawal, individual needs of people during their camp stay, and regulatory policies and programs for improving services to individuals with substance abuse problems. Accordingly, the present qualitative research studied the camp recovery experiences of addicted individuals.

Methods

Design

The current study employed a qualitative design based on a conventional content analysis approach. Content analysis is a method in qualitative studies, by which data are summarized, described and interpreted (10)

Data Collection

Participants were 17 men with a history of substance abuse and who were staying in camps; with at at least a 6-month of recovery history. The present study took place during a 10-month period in 2013 and the general research areas consisted of was Iran's northern cities. Participants were recruited through licensed and unlicensed addiction treatment clinics and camps ("unlicensed" refers to camps without an establishment license from Iran's Welfare Organization) and peer groups. Participant selection was by a purposive snowball sampling method, with a wide variety of age, education level, type of substance consumed, and consumption and recovery periods. Data were collected from individual by in-depth and face-to-face interviews according to the interview guidelines. Phone interviews were also used to complement face-to-face interviews and to better categorize the data. The face-to-face interviews were conducted in a relaxing environment, with questions moving from general to more specific. Participants refuse to answer questions and were free to withdraw from the interview at any time. The first interview question asked participants about their comprehension and experiences of residing in treatment camps. In total, we conducted 17, 40- to 70-minute, face-to-face interviews and 4, 15- to 20-minute phone interviews. Interview length varied according to environmental factors, participant tolerance for questions, level of information, and willingness to share information. All interviews were recorded using a digital voice recorder.

Data Analysis

Data were analyzed using a conventional content analysis based on the Graneheim and Lundman (11) method. The contents of each interview were transcribed verbatim immediately after the conversation. The contents were then reviewed several times to achieve a general understanding of the issues raised by the participants and in line with the objectives of the research. The meaning units or the initial codes were extracted and integrated based on similarities and differences and thea four Guba and Lincoln criteria used to test the validity of the data (10). This study gained rigor from the first author's extensive contact and involvement with the participants. Early in the study the first author worked to show his interest in the participants and insured his availability to them. This gave the participants confidence interested toward them. Also some of the participants participated in two interviews. This extended involvement helped to build trust between the interviewer and the participants and to enhance the researcher's understanding of the research context. Accuracy and rigor were further enhanced as two faculty members analyzed the interview scripts and the extracted codes. Additionally, the themes extracted were subsequently discussed with selected participants who previously indicated a willingness to be involved in further inquiry. These discussions enabled the researchers to refine the themes in light of the participant feedback.

Ethical Considerations

The present study was approved by the ethics committee of the University of Social Welfare and Rehabilitation**.** The participants were informed of the research objectives and provided written consent. They were assured that their private information and interviews would remain confidential and that data would be collected and stored anonymously. Interested participants were presented with the study results. We observed all ethical considerations regarding the use and publication of participant texts.

Results

Participant characteristics are shown in Table 1. content analysis of the interviews resulted in three categories(described below): selecting entering a camp (an appeal for rescue) with sub-categories self-selection and forced entry, misty atmosphere with sub-categories limbo of substance consumption joys and servilities and camp environment: from service to punishment, and out of frying pan into the frying pan or into the fire with sub-categories defects in the rebuilding the infrastructures, narrow outlook on the patient, expecting an escape: an unfinished attempt, and risk of falling.

Entering a Camp (An Appeal for Rescue)

Most participants believed that the way they entered a camp was the most important predictive factor of substance treatment consequences while staying in the camp. This camp entry consists of two sub-categories, such as self-selected entry and forced entry.

Self-selected entry**:** the two factors contributing to camp attendance and staying in the recovery process are: voluntarily seeking help and believing in the possibility of having an opportunity to improve life. Changing the life path by entering a treatment camp requires knowledge, confidence, love, and trust in the treatment. Future camp participants must also have sufficient motive for reconstructing their lives. In our study, participants acquired limited information (from relatives, friends or prison stays) about abstinence in the camps, camp acceptance of addicted individuals, and availability of camp services. Based on this knowledge, participants felt that the camps were less expensive when compared to other substance addiction treatment centers. Other important motivations for entering camps were opportunities to attend group therapy, become acquainted with people like themselves and with those who had successfully recovered, hear about suc-

Table 1. Demographic characteristics of participants

Participant	Age (years)	Marital Status	Education	Substance of Abuse	Duration of Use (years)	Duration of Recovery (months)
1	34	Single	Bachelor's Degree	Desomorphine Opium	3	13
2	45	Married	Bachelor's Degree	Methamphetamine Opium	13	20
3	30	Single	High School	Methamphetamine	4	13
4	28	Single	Diploma	Methamphetamine Opium residue	6	10
5	23	Single	Diploma	Desomorphine Methamphetamine	2	8
6	42	Married	Diploma	Desomorphine Methamphetamine Opium	22	19
7	43	Married	Bachelor's Degree	Methamphetamine Opium Opium residue	8	9
8	35	Married	Diploma	Desomorphine Opium	5	17
9	3	Single	Diploma	Desomorphine Methamphetamine	3	18
10	55	Married	High School	Opium	16	11
11	29	Single	High School	Heroin Metham-phetamine Opium	4	16
12	48	Married	Diploma	Methamphetamine Opium	20	60
13	58	Married	High School	Opium Opium residue	18	23
14	40	Married	Bachelor's Degree	Opium	4	11
15	39	Single	Diploma	Methamphetamine Opium	7	15
16	31	Single	Diploma	Methamphetamine	2	13
17	26	Single	Diploma	Desomorphine Heroin	4	16

cessful abstinence experiences of their peers, and participate in NA sessions (Participant 16: "My recovery started with my submission, I mean, I felt feeble against substances; I tried to love staying in the camp with all honesty, an d pursue my recovery"). Other motivators for voluntary (self-selected) entry were: the desire to return to family, witnessing the miserable situations of others with substances abuse, indebt feeling to family and friends, and observing the death of a close relative or friend (Participant 11: "Before going to the camps, I had a friend and we used to do substances together. One day, I called him and said that I want to die. but when I met him, it was like quenching the fire with water. When nobody wanted to approach me, he hugged and kissed me, cooling me down and playing a big role in keeping me clean and in the recovery process; after 6 months, he slipped and committed suicide. I feel indebted to him").

Forced entry**:** The most important barriers to voluntary treatment (in the camps) were fear of withdrawal symptoms and failure in treatment. These fears were particularly obvious in participants with a history of several relapses. Friends' and family's forces to quit are also effective. Participants were sometimes forced into camps by families who were tired of consequences of substance use, such as altered goals and priorities for the family, spending financial and psychological resources to protect the family and addiction, and being fearful of an ambiguous future for themselves. Such mandatory entries into camps were associ-

ated with several important factors influencing treatment failure: lack of preparedness and willingness to quit, a sense of exclusion, anger toward family members, and stubbornness caused by the force full entry (Participant 7: "They arrested me and took me to the camp by an ambulance ... I wished to go out and piss them off. They should understand that they cannot treat me as an animal, tie my hands and legs, and take me to the camp").

Misty Atmosphere

Physical and psychological side effects of substance deprivation can lead to acute and critical situations for the participants. Success or failure to manage this critical state (with the assistance of families, the community, and camp officials) paved the way for corresponding success or failure of the recovery process. This category describes the early stage of the recovery process and consists of two sub-categories, like enjoyment in and slavery to the substance and camp environment: from service to punishment.

Enjoyment in and slavery to the substance**:** The first step of treatment in the camps was physical withdrawal, which took place in isolation rooms. Before entering the isolation room, participants who came to the camp voluntarily were given the opportunity to become familiar with the camp's environment. In most cases of mandatory entry to the camp, this initial introduction did not take place. At this stage, participant's feelings varied from a sense of security to that of fear and threat, and from anxiety to psychological comfort. Our data shows that the sense of fear, threat, and anxiety often pertain to the situation of forced entry into the camp. At this early stage of the recovery process, the negative psychological and emotional reactions of those who acquired some prior information about camp services were fewer but they had longer recovery period. From the participant perspective, acceptance of the place (12) and its residents aided the recovery process. Further, early words and behavior of camp officials and peers, and especially their real understanding of the participants' situations eased the pain of withdrawal symptoms, the hardship of being separated from family, and hidden pain resulting from miserable life situations (Participant 6: "When I entered the camp, its official came to me immediately, shook hands and welcomed me. He embraced me and said, "Do not afraid, we will be with you." This very sentence calmed me down").

According to the participants, the most difficult stage and that which exerted the highest level of psychological and physical pressure was the detoxification stage; this stage was recalled with great grief. One of the most important issues identified in our study was the isolation of the participants in early stage of their treatment. This isolation was associated with feelings of confinement and exclusion. At the peak of psychological problems associated with withdrawal, severe and often unendurable grief resulted from a sense of loneliness. This led to reactions such as crying, restlessness, and urge to exit the isolation room. The common symptoms of physical withdrawal experienced in the isolation room included severe vomiting, chills, and sweating. In addition to the problems associated with physical withdrawal, there were others factors that made enduring time in the isolation room extremely difficult such as: struggling with temptation and thoughts of relapsing into substance abuse, agonies of conscience, fear of failure and losing the trust of family and friends, regretting past behaviors and deeds, self-questioning, and in general, contemplating the consequences of substance addiction (Participant 13: "The physical withdrawal occurred in the isolation room, the humiliation and miseries of substance use came to my mind, that what on earth I was doing, to myself what am I doing? I ruined my life, troubled my wife and child, and dishonored my father and mother").

The length of stay in the isolation room

depended on the type of substance abused and the consumption method. Those who abused industrial-type substances stayed in the isolation room for longer periods, and underwent more hardship than participants who abused natural narcotics. The lack of alternative treatments such as methadone therapy and other prohibition prolonged stays in the isolation room. For those withdrawing from industrial-type substances many negative responses found such as restlessness, aggressiveness, increase in suicidal thoughts, and poor behavior toward others, especially camp officials (Participant 6: "I wanted to kill myself several times to save me from this situation, but an official was observing us constantly. I was ready to give up all my belonging in return for a little substance").

The camp environment: From service to punishment: The participants stated that, after the physical withdrawal, they entered a stage of psychological withdrawal. At this stage, the substance deprivation crisis was somewhat mitigated, and participants entered the camp environment; this entry was probably a decisive factor in the recovery process. According to most participants, this stage was the most vital to continued residence in the camp, and included a range of measures from care services to corporal, psychological, and emotional punishments. These measures were designed to help participants develop a sense of responsibility, abide by camp regulations, engage in teamwork, experience growth of a sense of humanity, and to help fellow human beings. Some participants considered the camp atmosphere to be friendly and helpful and accepted punishments as natural consequences of violating rules or crossing "red lines" (Participant 11; "The camp does not involve a negative experience; it looks like a naughty student who is punished by the teacher. A student with bad grade would be punished by the teacher").

However, some participants who stayed in unlicensed camps reported more negative experiences. These participants reported that, when they violated camp rules, they were beaten by camp authorities or by their peers. Violations included breaking glass, escaping, and bothering themselves and others (Participant 3: "You should not talk; in overall, I stayed in the center for 27 days; they tied my hands and legs from the behind, beated me with a baseball bat; they themselves said that they would beat to break the addict's pride"). The consequences of these "official" behaviors were despair, frustration, fear, delay in entering future treatment and immediate substance use after discharge from the camp. For some participants, bad memories from the camp experience also caused distrust towards other addiction treatment centers (Participant 1: "These bad behaviors and punishments made me sicker of the camp's environment. The first day I came out of the camp, I felt free, and consumed substances immediately").

Out of a Frying Pan into a Frying Pan or into the Fire

Other consequences of staying in the camp were the tendency to "walk in previous footsteps" and even the deterioration of physical, psychological, and social situations of participants. Factors possibly affecting these consequences were defects in construction of infrastructures and a narrow outlook on the patient/participant. These factors caused participants to feel that they were "falling out of a frying pan into a frying pan," as described in the subcategory expecting an escape: an unfinished attempt and the risk of falling.

Defects in construction of infrastructures: The lack of construction contexts is one of the main factors contributing to relapsing into substance abuse after discharging from the camp. The defective infrastructures of the camps include the lack of: (1) appropriate speech and behavior patterns, (2) comprehensive attempts to direct addicted individuals onto the "right" human path, and (3) educational sessions about reconstructing life. Further, issues such as the remote locations of treatment centers, difficulty in getting access to them, and the financial burden of a long-term stay deprived most

participants from the required comprehensive family support (Participant 17: "They attacked me in the camp, and crashed my personality; my family abandoned me, and they would not take my calls. The result was that after leaving the center, the abstinence did not last even for one day").

Participant excuses for escaping the camp were associated with regrets about their abstinence and with blaming the inability of social workers or camp officials to attract and motivate them to stop abusing substances. These individuals sought ways to escape the camp, such as expressing their regret, seeking commiseration of the family, malingering, and claiming that their addiction was not addressed in the camp. They also perceived threat as a result of the distribution of substances and the risk of temptation (Participant 1: "I told my mother that I had a heart attack, but no one was helping me here. She feared and got me discharged"). Further, participant and family trust in the camps was reduced after listening to the negative withdrawal experiences of participant peers, and observing hygienically unfavorable conditions. The structure and the kind of relationships of officials with the addicted individuals also reduced participant and family trust in the camps (Participant 5: "Everywhere was dirty and messy. I was scared. As I went there, I realized that it was worse than a prison").

A narrow outlook on the participant: An excessive focus on physical withdrawal causes neglect of other needs. Maintaining the recovery path requires constant attention to psychological, spiritual, and social recovery. This important issue appears to be overlooked by the family, the community and by camp officials, thus interrupting the recovery process. Important factors in treatment failure are likely neglect of patient needs during the withdrawal process and an excessive focus on the results of the addiction test (as the criterion for successful addiction withdrawal) (Participant 3: "When the substance did not reach me for a few days, I injured myself; they just took me to the hospital, and then tied my hands to prevent me not to repeat this again").

Expecting an escape: An unfinished attempt: The main factors explaining participants' excessive desire to escape were: staying in hygienically unfavorable conditions, neglect of individual needs, lack of opportunity to reconstruct life, and being deprivation of family and community support (Participant 5: "I was roommated with a mentally ill person; sleepiness had rendered me restless. The camp's officials did not listen to my complaints. I was just counting the hours to run away from there"). Another group of participants stated escape motives such as aspiring to take revenge on people who had offended them and hoping that a temporary stay in the camp would help them tolerate future hardships (Participant 15: "I was counting the days to go out and grapple with my father who had taken me to the camp forcefully. After discharge, I went immediately to his workplace and fought with him. I wanted to dishonor him to get relieved"). Treatment in the camps is abstinence-based but some participants referred to the accessibility of substances as a reason for remaining in the camp and tolerating its conditions.

The risk of falling**:** A few participants who had the experience of staying in unlicensed camps stated that in addition to substance abuse relapse the camp experience introduced other issues. Specifically, participants learned from their peers: new methods of acquiring and consuming substances, new ways to escape legal barriers and to face the policeman and judicial systems, and immoral ways of abusing others. Such learnings contributed to the worsening situations for participant. They also noted that staying in the camp led them to learn different methods for violating behavioral and social norms for generating income (Participant 2: "When I was quitting the camp, I learned from other patients that some substances were odorless and could be used very easily. When I got out, I started consuming that sort of substance").

Discussion

Four conceptual categories were drawn in this study as follows: "selecting a camp: an appeal for rescue," "substance deprivation crisis," "an opportunity for change," and "out of frying pan into frying pan or into the fire." "Selecting a camp: an appeal for rescue" was one of the most important categories extracted during the present study. Essentially, voluntary or forced entry to the camp was a strong determinant of the results in the treatment. This was consistent with the finding that only 5% of addicts who withdrew after forced entry into treatment did not relapse (13,14).

Our study showed that addicted participants often felt imprisoned within the camp environment because their individual needs were overlooked, relationships with friends and the family severed, and they had fear of being deprived of the substance. An important point is that termination of treatment is not a fixed process dependent only on patient traits; rather, it is a complex and dynamic procedure reflecting the interactions between the patient and treatment environment (15). Medical checkups for diagnosing severe physical and psychological effects of substance deprivation can help the addicted individual tolerate treatment conditions and improve health at this stage. Also, feelings of fear and threat may be reduced at the time of camp entry by introducing peer groups, camp officials and other service providers, by visiting available facilities and explaining the treatment method.

Most participants viewed punishment by the camp officials or by peers as an important cause of their failure to achieve recovery. This is consistent with the findings of Karimi (2013) who also showed that hostile and offensive behavior of therapists and their non-therapeutic and unprofessional relationships with addicts were among the most important causes of termination of the treatment process. Other contributing factors are: ineffective monitoring of the camp performance, exceeding capacity of the treatment centers, lack of welfare and cultural facilities, lack of screening, not observing limitations regarding acceptance of individuals with mental and psychological disorders (16) and, not employing qualified persons and professional treatment teams (e.g., social workers and psychologists). According to most experts in the field, the first and most urgent step for securing addicted individuals against serious and irreversible damage is to prevent the operation of unlicensed centers and hence without exception, to close all illegal centers (17).

Although the camps were the first choice of many participants for initiating recovery, these centers presented many challenges, including lack of necessary infrastructure, insufficient support from family and community during the staying, and the one-dimensional nature of treatment. For example, issues such as remote location of treatment centers, difficulty in gaining access, and financial burden deprived most participants of comprehensive family support. Families were disappointed in participants because of constant engagement in problems associated with substance abuse (e.g., imprisonment, legal problems such as paying fines, temporary imprisonment, and recurring treatment failures). Consequently, families considered successive withdrawal attempts to be failures. A lack of spousal support was also influenced by factors such as the collapse of marital relationship, infidelity, spending family income on substances, unemployment of the addicted individual, and spousal abuse (physical, emotional and/or sexual).

The suitability of the family context for supporting and accepting the individual in the recovery stage is a main barrier to substance abuse and relapse (18).This finding is consistent with a study Karimi Talabari, et al (2013). Identifying three factors in the recovery failure of addicted individuals: the family not being aware of the treatment, the family's lack of cooperation with treatment, and lack of knowledge about addiction symptoms on the part of people surrounding the addicted individual (16). Some participants thought that the family needed to

increase awareness of and trust in the addicted individual during their camp stay. From the participant perspective, daily visits and psychological and emotional supports were the most important motives in aspiring to recovery (16,19). The family can support lifestyle changes in the addicted individual, such as rebuilding identity, rebuilding marital life, and finding a suitable job. All the changes take time and considerable psychological strength. Further, family members should try to understand the condition of the addicted individual and to avoid prejudicing (20).

Conclusion

The principled selection of the camps' officials based on their physical, psychological, and financial abilities when issuing the establishment licenses and holding educational sessions about behaving with the relief seekers and managing withdrawal effects help them adapt to the critical withdrawal symptoms. The results of the present study show that equipping substance abuse treatment camps with state facilities and providing financial support would improve the efficiency of addiction treatment and maintain addicted individuals on the recovery path after discharge. Our results indicate that to prevent physical, psychological, and emotional damage of addicted individuals, camp performance should be monitored, existing defects removed, unlicensed centers eliminated, and specific camps/therapies established according to patient need. Camp officials could contribute to the efficiency of treatment by providing access to social work services, behavioral and psychological consultations, consultation with family members, and encouraging families to participate in family therapy.

Limitations

One limitation was that it was not possible to study females seeking relief from addiction; social stigma of addiction for women and a lack of female-oriented camps prevented research with this group. In addition, because of the diversity of substances consumed and abused in Iran, we inevitably studied only individuals with a history of drug use. Thus, we were unable to address camp recovery experiences of individuals addicted to other industrial substances. It is possible that these individuals could show different experiences of recovery in the treatment camps.

References

1. UNODC, World Drug Report 2012 (United Nations publication, Sales No. E.12.XI.1). New York: United Nation Office On Drugs And Crime; [cited 2014 2.3]. Available from: http://www.unodc.org/documents/data-and-analysis/WDR2012/WDR_2012_web_small.pdf.

2. Tayebani T, Sohrabi A, Samouei R. The Job Burnout of Therapists in the Licensed Addiction Centers in Isfahan, Iran and its Relationship with Individual and Professional Factors. Director General. 2013;9(7):1015-23.

3. Khastoo G. Commmonity-Based drug abuse prevention. Social welfare. 2003; 2(6):223-34.

4. Rouhani S, Kheirkhah F, Salarieh I, Abedi S. Quality of life, its early change and retention in MMT program in Iran: Evidence for policymakers and service providers. Life Science Journal. 2012;9(3):2633-8.

5. What is recovery? A working definition from the Betty Ford Institute. 2007 20070924 DCOM-20080110(0740-5472 (Print)). eng.

6. Dinparast B. the private management of the 89% of licensed addiction treatment and harm reduction centers. The Public Relations, Iran's substance control headquarters 2013 [cited 2014 5.3]. Available from: http://www.dchq.ir/index.php?option=com_content&view=article&id=4207:89&catid=90&Itemid=5266.

7. Maleki. The guidelines for establishing medium-term recovering centers 2013 [cited 2014 12.3]. Available from: http://blog.behzistitehran.org.ir.

8. Sadrol Sadat J RKZ, Koldi, Arfken CL. The effect of daily therapeutic community program on social relationship in Golestan province. J Rehab. 2005;6(3):10-3.

9. Barati Sedeh F. addicts in compulsory centers are not interested in quitting. Eetemad Newspaper; 2013. p. 9.

10. Polit DF. Essentials of nursing research: Appraising evidence for nursing practice: Lippincott Williams & Wilkins; 2013.

11. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts,

procedures and measures to achieve trustworthiness. Nurse education today. 2004;24(2):105-12.

12. Tempier A, Dell CA, Papequash EC, Duncan R, Tempier R. Awakening: 'Spontaneous recovery'from substance abuse among Aboriginal peoples in Canada. The International Indigenous Policy Journal. 2011;2(1):7.

13. Barati Sedeh F. Addicts in the forced centers are not interested in quitting. Etemaad Newspaper 2013.

14. Zafarqandi MBS. Addiction withdrawal: voluntarily or forcefully/ voluntary Withdrawing: Falling into a more severe Addiction 2013 [cited 2014 13.3]. Available from: http://www.mehrnews.com/detail/News/1608510.

15. McKellar J, Kelly J, Harris A, Moos R. Pretreatment and during treatment risk factors for dropout among patients with substance use disorders. Addictive Behaviors. 2006;31(3):450-60.

16. Karimi Talabari Z, Noori Khajavi M, Rafiei H. Reasons of methadone maintenance therapy drop out in clients of Iranian National Center for Addiction Studies (INCAS): A Qualitative Study. Iranian journal of psychiatry and clinical psychology. 2013; 18(4): 299-309.

17. Saberi Zafarqandi MB. Death and misbehaviour in uncertified addiction withdrawal: fars news agency; 2012 [cited 2014 15.2]. Available from: http://khabarfarsi.com/ext/2207257.

18. Livingston JD, Milne T, Fang ML, Amari E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. Addiction. 2012;107(1):39-50.

19. McDonnell A, Van Hout MC. A grounded theory of detoxification-seeking among heroin users in south east Ireland. 2010.

20. Sherman C. Multidimensional family therapy for adolescent drug abuse offers broad, lasting benefits. NIDA Notes. 2011;23(3):13.