



The impact of Drop in center services on homeless drug users' quality of life, reduction of dangerous behaviours, and improvement of emotional regulation

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Abstract

The purpose of the current study was to examine the impact of Drop in center services on reducing risky behaviors, improving quality of life, and emotional regulation of homeless drug users. The statistical population consists of all homeless addicts in Shiraz who were chosen at random sampling. Samples in 2 groups were 100 service recipients from Drop in centers, and 100 people of homeless addicts who do not have access to these facilities. Additionally, they were subjected to tests by Gross and John emotion regulation tests, Rajaei and Shafiei high-risk behavior tests, and Mayer and Sherborn quality of life tests. The questionnaires' validity and reliability have been rated favorably. After collecting the questionnaires with SPSS 26, they were analyzed at two descriptive and inferential statistics. The results of the multivariate variance analysis showed that services of Drop centers were effective in reducing high-risk behaviors and improving the quality of life for homeless drug users, but it did not have a significant effect on their emotional regulation.

Key words: Drop in center, reducing addiction harm, quality of life, high-risk behaviors, emotion regulation, homeless drug users

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people worldwide are addicted to using illegal addictive substances like opioids, cannabis, and tainted stimulants, according to statistics from the UN Office of Drugs and Crime.[4] Statistics show that 2,800,000 people use drugs in Iran in a narcotic manner, and sadly, this problem worsens the social harm. Although the number of addicts may be higher, there are thought to be 1,400,000 undiagnosed drug users.[5] On the other hand, risky behaviours cover a wide range of actions, including those that endanger others and endanger people's health. It is possible to

1. Introduction

Today, drug use has emerged as one of the most significant overall issues, with numerous biological, psychological, and societal repercussions [1]. Addiction means continuous and continuous use of a drug or chemical substance, with or without physical dependence, which affects the areas of a person's actions and causes many disabilities.[2] With the aid of compulsion in the release of gratifying impulses despite the disastrous effects, addiction is regarded a brain-intellectual problem [3]. 20 million



Reducing Addiction damages, a non-governmental organisation, was founded in Shiraz.

Positive outcomes were attained after three and a half years of nonstop work, and the association's office was relocated to Tehran in Mehr 2011 [19] because it began undertaking harm reduction initiatives at the national level. Counselling centres for behavioural illnesses, centres that offer services to those who are socially vulnerable, or centres for harm reduction (DIC) are among the significant locations where injecting drug users congregate [18]. Harm reduction refers to policies and programmes whose main objective is to lessen the negative health effects of drug use. It is one of the most fundamental public health methods that have been adopted to replace high-risk behaviours of people in society.

A harm reduction strategy acknowledges that drug use has always been a part of society. This should lead us to decide to work to lessen its detrimental effects [20].

(DIC) is the first center for the reduction of complications and addiction, especially for intravenous drug users, homeless addicts, providing methadone, health services, support and education [19]. These centers use free facilities such as needles, syringes and safe and low-damage injection devices and educational programs to control the harm caused by addiction and high-risk addicts who are at risk of contracting infectious diseases such as AIDS and hepatitis by visiting these centers. The services provided by these institutions are mostly based on education and awareness. The purpose of educating drug users is to inform them of the risks associated with drug use and persuade them to alter dangerous usage patterns and adopt safer practices. (DIC) offers methadone, health care, support, and education. It is the first center for reducing issues and addiction, especially for homeless drug users and intravenous drug users [19]. The harm caused by addiction and high-risk addicts who run the risk of catching infectious diseases like AIDS and hepatitis by attending these centres are controlled by these centres using free resources including needles, syringes, safe and low-damage injection devices, and instructional programmes. The services provided by these centres are mostly based on education and awareness. The purpose of educating drug users is to inform them of the risks associated with drug use and persuade them to alter dangerous usage patterns and adopt safer behaviours. Clients are asked about current or past use of heroin, cocaine, hashish, sedatives and other drugs and alcohol use. The difficulties such as giving up injections, using disposable injectable devices, cleaning injection

bring up drug and alcohol misuse, smoking and drinking, addiction, skipping class, physical altercations, unsafe sex, gambling, unrestrained and illegal activities, reckless driving, and risky sports

[6]. On the other side, the Infectious Diseases Society of America conducted a research that found a conclusion that the risk of infection and engaging in risky behaviours is higher in homeless people than it is in other groups, including drug users who inject drugs and engage in unsafe sex, both of which are significant contributors to the spread of infectious diseases like hepatitis B, hepatitis C, and AIDS. [7]

The domain of emotion regulation is one that has an impact on addicts; recent studies have shown that brain malfunction and emotional dysregulation are highly common in addicts. [8]

Therefore, the process by which individuals modify their responses to emotionally charged situations can be described as emotion regulation

[9]. Lower emotion control makes people more likely to turn to substance usage to numb their negative emotions. [10] Additionally, emotion control can aid individuals in having a better understanding of negative and risky events. [11] Some of the primary symptoms, like inattention, can be linked to dysregulation. [12] A person's level of physical, psychological, and social well-being, as well as their level of pleasure with life's blessings, are considered to be indicators of their quality of life. [13]

It might be argued that one of the indicators used to gauge health and a full condition of physical, mental, and social well-being is quality of life. It also refers to a person's comprehension of their level of social, economic, psychological, emotional, and spiritual well-being, which encompasses their family's health and ability to function. [14] Since health is a multifaceted concept that depends on quality of life, the psychological and social dimensions are equally as significant as the physical one. In reality, there are two subjective and objective dimensions that can be used to analyse the effects of quality of life. [15] Therefore, a person's perspective on the gap between what is and what should be is referred to as their quality of life. [16] The quality of life can be impacted by a number of variables, including stress, poor diet, natural and man-made disasters, and others. Addiction worsens life quality than anything else in this regard. [17] It appears vital to develop centres where addicts may easily access these centres and give them the chance of educational, preventive, and therapeutic interventions in order to improve the quality of life of addicts [18]. Due to the significance of addiction damages in Iran, the Association for



the Shiraz Medical University's temporary injury reduction centres and hangouts, which are overseen by the vice chancellor for health;

In this manner, 50 patients are chosen at random from each of Shiraz's two damage reduction centres. For the second group, five sleeping bag addicts are randomly chosen from each hangout located in Shiraz's remote and outlying locations (20 hangouts). Being at least 18 years old and having an active file at the Transient Centre for Harm Reduction for at least one month prior to the research's start date are requirements for participation in the study. Acquiring an introduction letter and going through the proper legal channels by acquiring the appropriate permits from the relevant authorities are requirements for people's agreement to participate in the study. Non-cooperation in the study and removal of the sample for any reason throughout the investigation are two exclusion criteria.

In order to evaluate the research variables in this study, high-risk behaviours, emotion regulation (ERQ), and quality of life (SF-36) questionnaires were employed.

1-2 The services provided in temporary damage reduction centers

Recognising and interacting with drug users, and offering sterile needles, syringes, and injecting supplies. Recognising and interacting with drug users, and offering sterile needles, syringes, and injecting supplies. Providing bedding, filters, etc., low-threshold methadone maintenance treatment, sexual health education, promoting condom usage, posting condoms in public places and providing condoms, counselling, and rapid HIV testing. Information, education, and communication regarding risky behaviours, risk reduction techniques, and services that are available. Basic medical services, such as wound dressing, and basic hygiene supplies, such as soap, shampoo, pants, etc.

The provision of basic support services, such as a hot meal, the distribution of warm clothing for cold seasons, the provision of educational and counselling materials, and the referral to health facilities and hospitals in situations requiring medical treatments [20].

2-2 Tools used

The Quality of Life Questionnaire (SF-36) is a 36-item survey that was created by Mayer and Sherburne in 1992. It includes general health (GH) as one of its eight health subscales. Physical Functioning (PF) (Questions 1 through 3), Role Disruption Due to Physical Health (RP) (Questions 13 through 16), Role

equipment, etc., are those where behavioural adjustments are most sought. Use of a condom, education on how to handle substance misuse in others, substitution of high-risk substances with less-risky ones, and adoption of a healthy lifestyle are all recommended as safer injection techniques [20]. All new clients are checked before being accepted. An interview where demographic data, including history of drug use and age, gender, marital status, occupation, geographic race, are collected. Clients are questioned regarding their use of alcohol and other drugs, including sedatives, heroin, cocaine, hashish, and other narcotics.

The mode of usage (injection, inhalation, smoking, etc.) is noted if the reference mentions using heroin or cocaine [21]. Drug users have worse mental health than non-users, according to numerous studies [22–24]. According to studies by Shams, Esfandabad, and Nejad Naderi [25], those who are addicted have a lesser quality of life than those who are not. Sadrolsadat, Nejadnabri, Shams, Esfandabadi, and Emamipour [26] AIDS-related mental illnesses and quality of life among four groups of male users. Contrasted healthy people, non-addicts with AIDS, and non-addicts with AIDS. According to the research, non-addicts with AIDS who are not addicts,

AIDS addicts, AIDS non-addicts got higher scores in the SCL90 questionnaire and lower scores in the quality of life questionnaire (SF_36). Also, Hepwood et al. [27] showed in their research that the cognitive regulation of emotion has a significant effect on reducing cravings and suppressing the urge to smoke. Therefore, according to the research conducted regarding high-risk behaviors, quality of life, emotional regulation in homeless drug users, there is a research gap and the current research answers the basic question of whether centering addiction harm reduction has a significant effect on reducing risky behaviors, improving the quality of life and emotional regulation of homeless drug users?

2- Research method

This section includes descriptions of the study's design, sample, measuring tools, research implementation strategy, and data analysis technique. The current study is a post-event causal-comparative kind. The homeless and users of sleeping cartons in Shiraz City are both included in the statistical population. The statistical sample consists of two groups: 100 clients of temporary harm reduction facilities who get treatments, and 100 residents of the city who are addicted to sleeping medications but do not have access to these facilities. Given that the samples for this study were chosen at random from



14, 16, 19, 21, 28, 29, 31, 33, 36, 42, 45, 47, 49, 54, 56, and 58), drug addiction and abuse (25, 27, 35, 37, 39, 57, and 60), AIDS (2, 24, 26, 32, 40 and 41), tobacco (5, 7, 10, 12, 15), AIDS, and unhealthy eating patterns (30, 38, 43, 44, 48, 50, 52, 53, 59, and 61).

The scores for each question range from 0 (never) to 4 (always). This questionnaire has a minimum and maximum score range of 0 and 244. Low-risk behaviours are those that score between 61 and 81, moderate-risk behaviours are those that score between 81 and 162, and high-risk behaviours are those that score over 162. According to Ghasemi's study, the reliability of the high-risk behaviour questionnaire created by the researcher was 0.81, which is the ideal level. In their research, Sadri Demirchi, Artan Qoje Baglo, Basir Amir and Qolizadeh have reported the self-reliability of this questionnaire using the Cronbach's alpha method of 0.93 [29].

Emotion Regulation Questionnaire (ERQ): This questionnaire was prepared by Gross and John to measure emotion regulation; which consists of two subscales of reappraisal with 6 items and repression with 4 items. Participants respond on a 7-point Likert scale from strongly disagree (with a score of 1) to strongly agree (with a score of 7).

Reappraisal has been correlated with the scale of happy feelings (0.24) and negative emotions (-0.14) in the criterion validity of this questionnaire, while suppression has been correlated with the scale of positive emotions (0.15) and negative emotions (0.04) (Balzorty, John, and Gross, 2010). After three months, the scale as a whole had a Cronbach's alpha coefficient of 0.69, 0.73 for suppression, and 0.79 for reappraisal (John & Gross, 2003). According to Hosseini and Khair (2013), the questionnaire's Cronbach's alpha was 0.70 and the validity of the entire scale was 0.68. The reliability of this scale was obtained in the research of Barzegari Dehaj, Mohammadpour, Adhafi, Karimi Barzin and Jahandari (1400) using Cronbach's alpha of 0.76 [30].

3. Findings

With the use of the statistical programme SPSS 26 and the multivariate analysis of variance test, the data from the current study were analysed. The study's participants had an average age of 41.771 11.536. 56.8% of the participants were single, compared to 85.6% of the individuals who were married.

Most people, equivalent to 82.7%, had a diploma or lower education, and 59%, that is, most of the participants in the research lived alone.

Disruption Due to Emotional Health (RE) (Questions 17 through 19), Energy or Fatigue (EF) (Questions 23, 27, 29 and 31), and Emotional Well-Being (EW) (Questions 24, 25, 26, 28 and 30), are some of the topics covered in the questionnaires. Pain (P) (questions 21 and 22) and social function (SF) (questions 20 and 32). No subscale uses Question 2, which asks the respondent to rate his health during the previous month. The scoring of the questions is based on the Likert scoring system and the score is from 0 to 100, and the score of each subscale is from the total scores obtained from the questions of that subscale. The sum of the subscales for physical function (PF), role disturbance due to physical health (RP), pain (P), and general health (GH) is obtained from the integration of the subscales, and the sum of the subscales for mental health (RE), energy/fatigue (EF), emotional well-being (EW), and social functioning (SF) is obtained from the integration of the subscales. The Likert scale is used to rate the questions, and the results range from 0 to 100. Each subscale's score is derived from the sum of the scores for all of the questions in that subscale. The more points earned, multiplied by the number of questions, the higher the quality of life. Only one scale's score is computed for each question. Scores are recoded for some questions. As a result, the scores on all scales are in unison. Each scale's scores range from 0 to 100, with 0 representing the worst case scenario and 100 the best case scenario for that particular scale. Montazeri et al. conducted a psychometric evaluation of this questionnaire in Iran. With the exception of the energy and vitality dimension ($\alpha = 0.65$), which has a minimum standard reliability coefficient of 0.77 to 0.90, the reliability of the tool was assessed using ((Analysis of Internal Consistency)). Convergent validity and group comparison have both been used to assess the questionnaire's validity. This tool can distinguish between demographic subgroups according to gender and age, according to the statistical test ((comparison of known groups)), and according to the convergence validity test, all correlation coefficients were greater than 0.4. The overall score can vary from 0 to 100, with 100 representing the highest possible level of quality of life [28]. High-risk behaviour questionnaire: Rajaei and Shafiei developed the high-risk behaviour questionnaire in accordance with the psychological and social circumstances of Iranian society, referencing Ghasemi. The current questionnaire comprises 61 items and six variables. The six factors of this questionnaire are violence (1, 3, 4, 6, 8, 11, 13,



Table 1: Demographic variables

Variable		Abundance	Frequency	Valid percentage	Cumulative frequency percentage
Age	Under 30 years	27	13.5	17.2	17.2
	31 to 40 years	51	25.5	32.5	49.7
	41 to 50 years	42	21	26.8	76.4
	Over 50 years old	37	18.5	23.6	100
	Total	157	78.5	100	
Missing data (no response)		43	21.5		
	Total	200	100		
gender	Man	125	62.5	85.6	85.6
	Female	21	10.5	14.4	100
	Total	146	73	100	
	Missing data (no response)	54	27		
Total		200	100		
marital status	married	63	31.5	43.2	43.2
	Single	83	41.5	56.8	100
	Total	146	73	100	
	Missing data (no response)	54	27		
Total		200	100		
education	illiterate	19	9.5	12.2	12.2
	Undergraduate and Diploma	129	64.5	82.7	94.9
	Bachelor's degree	4	2	2.6	97.4
	Master's degree	4	2	2.6	100
	Total	156	78	100	
	Missing data (no response)	44	22		
Total		200	100		
Living condition	Living with family	31	15.5	39.7	39.7
	living alone	46	23	59	100
	Total	78	39	100	
	Missing data (no response)	122	61		
Total		200	100		

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In table number 2, the descriptive statistics of the research variables are given.

Table 2: Descriptive statistics of the variables

Variable	group	Average	Standard Deviation	Skewness	The standard error	tension	The standard error
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Quality of Life	Service recipient	51.494	8.006	0.153	0.241	0.275	0.478	
	No service received	48.215	11.143	-0.490	0.241	1.787	0.478	
physical health	Service recipient	53.327	10.639	0.486	0.241	0.847	0.478	
	No service received	50.219	14.570	-0.319	0.241	1.842	0.478	
mental health	Service recipient	47.565	7.638	-1.279	0.241	1.542	0.478	
	No service received	44.206	11.096	-0.678	0.241	-0.205	0.478	
Risky behaviors	Service recipient	125.399	11.641	-0.492	0.241	0.067	0.478	
	No service received	130.017	15.861	0.270	0.241	0.266	0.478	
Excitement regulation	Suppression	Service recipient	16.491	2.184	0.171	0.241	0.100	0.478
		No service received	16.790	2.532	0.003	0.241	-0.391	0.478
	re-evaluation	Service recipient	25.936	3.646	0.146	0.241	-0.189	0.478
		No service received	25.150	4.779	0.105	0.241	-0.508	0.478

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account the values of skewness and kurtosis for all study variables, which fall between 1.96 and -1.96.

In tables No. 2 and 3, the assumptions of the multivariate analysis of variance test have been examined.

The research variables' means, standard deviations, skewness, and kurtosis indices are displayed in Table .2.

The assumption of normal distribution for the variables has not been broken while taking into

Table 3: Box's M test

M box	F statistic	Degree of freedom 1	Degree of freedom 2	Significant level
33/588	3/286	10	187429/482	0/0003

The significance level of this test is less than 0.001, so this assumption has been violated.

Table 4: Lone test

Variable	F statistic	Degree of freedom 1	Degree of freedom 2	Significant level
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Quality of Life	4.325	1	198	0.039
Risky behaviors	6.041	1	198	0.015
Suppression	4.052	1	198	0.045
re-evaluation	7.074	1	198	0.008

After the equality of variances assumption, this test's significance level for variables with less than a 0.05 threshold indicates that it has been broken. Therefore, the stricter alpha of 0.025 will be used instead of 0.05 for the multivariate analysis of variance test due to the violation of the two assumptions of the M-box and Lone test.

Table 5: Multivariate tests

	The amount	F statistic	Significant level	Effect size
Pillai effect	0.063	3.259	0.013	0.063
Wilks Lambda	0.937	3.259	0.013	0.063
Hotelling's work	0.067	3.259	0.013	0.063
The largest zinc root	0.067	3.259	0.013	0.063

The groups getting services and those not receiving them differ significantly, as indicated by the significance level of both statistics, which is less than 0.05.

Table 6: The results of analysis of variance to compare research variables between the groups receiving services and those not receiving services

References	Variables	Total roots	degrees of freedom	mean square	F statistic	The significance level	Effect size (eta squared)
group	Quality of Life	537.695	1	537.695	5.712	0.018	0.028
	Risky behaviors	1066.079	1	1066.079	5.508	0.020	0.027
	Suppression	4.458	1	4.458	0.797	0.373	0.004
	re-evaluation	30.851	1	30.851	1.707	0.193	0.009

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group not receiving services, which is 48.215. Additionally, the group receiving services has a mean variable of high-risk behaviours that is 125.399 lower than that of the group not receiving services, which is 130.017.

As a result, the services provided by addiction treatment centres have been successful in lowering dangerous behaviours and enhancing the quality of life for homeless drug users, but they have not significantly improved their ability to regulate their emotions.

Table 6 shows that there is a significant difference in quality of life (F=5.712 and (P0.025)) and high-risk behaviours (F=5.508 and (P0.025)) between two groups getting services and not receiving services. Additionally, 2.8% of quality of life and 2.7% of risky behaviours are explained by the group variable. The significance level (P>0.025) indicates that there is no difference in emotion regulation (suppression and reappraisal) between the two groups getting services and those not receiving services. If you look closely at table number 2, you can see that the group receiving services has an average quality of life that is 51.494 higher than the

4. Conclusion



better lives. Additionally, DIC centers offer basic support services, such as serving a hot meal, and basic hygiene products like soap and shampoo. The provision of basic healthcare services, like as wound care [20], as well as the distribution of warm clothing during cold months improves addicts' physical health, which eventually improves their quality of life. According to Table 6, there is a significant difference in the variable of high-risk behaviours between the two groups receiving services and not receiving services ($F=5.508$ and $P=0.025$), such that the average of the variable of high-risk behaviours in the group receiving services (125.399) from the group not receiving services (130.017) is less. This conclusion is in line with those of Baltazer et al. [21], Alilou et al. [18], and Sadeghi et al. [19] in their respective studies. Studies have showed that addicts have unhealthy sexual relationships and poor personal cleanliness, and they frequently use dangerous, frequent, and many injections. Due to their behaviours, drug users are most likely to get infectious diseases and spread those ailments to others. The findings of a behavioural study that was carried out to learn more about the risky behaviours of injection drug users in relation to HIV/AIDS infection, including several daily injections, a history of high-risk injection behaviours, such as the usage of syringes, vials, cotton, filters, and everyday items, as well as the filling of syringes with other people's used syringes' contents.

Among the high-risk behaviours are same-sex and opposite-sex relationships, as well as drug users who engage in sexual activity without the use of a condom. Studies have demonstrated that following the supply of a number of basic services in package format (DIC), health promotion, and educational intervention, Provision of health advice and necessary health and medical arrangements. In addition to schooling, dangerous behaviours are considerably decreased by psychology and family influences. Following the intervention, addicts are more motivated to cut back on injections or switch from injection to another method of consumption. Also significantly decreased are high-risk sexual behaviours. [18] According to Karimi and Ghafari's study findings, educational intervention is successful in altering drug users' AIDS prevention behaviours. This means that between the level of awareness, The attitudes and health behaviours of the AIDS-prevention addicts assessed before and after the implementation of the educational programme showed a statistically significant difference. [34] Psychological therapies can help addicts become

The purpose of the current study is to examine how the services of temporary addiction reduction centers affect homeless drug users' risky behaviours, quality of life, and emotional regulation. 200 people from the statistical population were randomly selected for this purpose, and then evaluated using suitable tools. We analyzed the raw data at two descriptive and inferential levels in the prior section. In this section, we will first review the research's findings before talking about its limitations and recommendations. According to Table 6, there is a significant difference in the quality of life between the two groups receiving services and not receiving services, with the average quality of life in the group receiving services being higher (51.494) than the group not receiving services. (48.215)

The findings of Tawakkol, Naseri Rad, Avansian, and Anis [31], Metin Ara, Shebarang Moridani, and Mohammadzadeh [32], Perzor, Alizadeh Gouradel, Yaqouti Zargar, and Bashirpour [33], as well as other studies, are in agreement with this one. Being a complicated, all-encompassing, and multifaceted concept, quality of life is influenced by a person's mental perception as well as their physical and social circumstances. Therefore, in order to improve it, it is essential to have a long-term, all-encompassing intervention that pays attention to the patient's physical, social, and environmental aspects as well as their psychological one. According to cognitive-behavioral theory, drug addiction is a collection of acquired behaviours that are utilised by copying patterns as a result of realising the effects of drugs. This is similar to how other behaviours are understood to work. It can be learned to do things like lessen anxiety and sadness, ease pain, and improve socialisation. The most crucial objective of therapy is to recognize key moments and teach clients and the addict how to control them in order to abstain from drug use. Additionally, employing positive psychotherapies can have a reciprocal impact on an addict's negative symptoms and serve as a deterrent to their relapse rather than just producing more positive resources. Along with working on documents, they are also taught how to offer solutions and guidelines to improve happiness and problem-solving by offering psychological services in centers (DIC). Additionally, negative thinking can be replaced with positive thinking by utilizing positive psychology and its tenets. [33] Considering the facts above and claiming that mental health is also a key component of quality of life and that cognitions, happiness, and both positive and negative emotions are related to it. It makes sense that by offering counselling and psychological therapy, DIC centers help addicts live



intervention and increase health, they needed to win the trust of addicts and draw them to the centers (DIC). Given the inexperience of such facilities, it was particularly challenging to win their trust; but, with persistence and a clear statement of the study team's objectives, this problem was eventually resolved. Additionally, it is very challenging to train them due to the fact that their residence is not fixed, and the physical state of injection drug addicts makes it very challenging to provide training in the first sessions. Of course, this issue can be resolved by cutting training duration, employing effective training techniques, and keeping these individuals active. In order to promote health, particularly to regulate people's emotions because they lessen unhealthy behaviours and change them to healthy behaviours, it seems necessary for health professionals to pay special attention to the important role of action and interactive behaviour and to carry out basic interventions and training. The use of fundamental knowledge and the appropriate method of interpersonal interaction is very important for researchers who are attempting to alter the behaviour of addicts and in the field of addiction, particularly injectable addiction, which has negative side effects and undesirable outcomes [18]. To give addicts the drive and power to change, it is therefore vital to apply newer, more effective psychological therapies in treatment centres (DIC) that focus on teaching emotion management skills. Dialectical behaviour therapy and therapy focused on acceptance and commitment are two examples of effective therapies for emotion control [38]. Undoubtedly, there are restrictions to every research project that are nearly impossible to overcome. We can list the small sample size, the use of just questionnaires to gather data, participant self-reporting, and other characteristics and variables—social, economic, etc.—that the researcher was not able to use as limitations of the current study. It is advised that this research also be looked into in other cities in light of the research's limitations. Additionally, in future studies, newer psychological techniques like dialectical behaviour therapy should be used in temporary harm reduction facilities, along with other data collection methods like interviews.

5-Gratitude

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Reference

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more conscious, change their attitudes or cultivate good ones, and exhibit acceptable behaviours.[18]

The findings of Ebrahim Pour's study, which involved 70 disadvantaged and at-risk women who were referred to facilities to lessen infectious and benign social effects, indicated that the use of condoms rose in the intervention group following the educational intervention compared to the control group.[35] According to Sadeghi et al.'s study, addicts receiving treatments (DIC) experienced a significant decrease in crimes and other high-risk behaviours. The implementation of a harm reduction programme considerably reduced crime rate among drug users, according to research done at the opioid prevention centre in Zagreb.[19] DIC services thereby lessen the prevalence of high-risk behaviours. Additionally, it was discovered that there is no statistically significant difference in emotion regulation (suppression and reappraisal) between the two groups receiving services and those not receiving services ($P > 0.025$).

The role of emotional inactivity and inadequate emotion regulation has caught the attention of researchers as one of the variables contributing to the tendency of substance abuse. According to studies, emotional dysfunction—which is brought on by an inability to effectively deal with and manage emotions—plays a part in the decision to start using drugs. This dysfunction includes the addicted person's low level of positive emotional regulation, high sensation seeking, and low level of distress tolerance. Addicts must find a quick way to release their excitement due to their low tolerance for it. Addiction to drugs and alcohol appears to be a coping mechanism based on emotions.

Emotional dysfunction is one of the major factors that contributes to addiction because emotion-oriented coping techniques, unlike problem-oriented coping strategies, cause fast emotional change without the need of cognitive or progressive coping mechanisms.[36] Addicts frequently struggle with regulation, which makes it difficult for them to control their emotional states.[37] If people's unhealthy behaviours are changeable through educational interventions and the provision of suitable platforms and necessary facilities, provided that the interventions are carried out in a scientific and ethical manner, interactive behaviour with people, especially in vulnerable groups with special conditions like addicts, needs to be given a lot of attention. Because changing behaviour cannot be accomplished just through teaching without taking into account people's circumstances and without encouraging cooperation and contact. For instance, in their study, Alilou et al. found that in order to conduct an educational

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