Unravelling the "Black Box": Treatment-Staff Perceptions of Hermon Prison's Drug-Rehabilitation Program

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Abstract: This current qualitative study analyzed treatment-staff perceptions of the advantages and weaknesses of Israeli's primary prison-based drug rehabilitation program, as implemented in Hermon Prison in Israel. Semi-structured interviews were conducted with 12 social workers and recovery mentors who worked as therapists in Hermon Prison during the research period. The analysis showed that the main advantages described were that the program was varied (included psychotherapy, education, vocational training, and work) and required a 1-year stay in a therapeutic community setting, with intensive exposure to eclectic psychotherapy methods and was delivered in a prison that is organizationally and architecturally designed to serve treatment goals. The primary weaknesses that the therapists perceived were shortages of treatment staff (staff turnover was high), individual psychological therapy and of follow-up treatment in the community. The research suggests that reducing these deficiencies may improve the program's effectiveness, and it offers an initial theoretical model for creating an effective drug rehabilitation program.

Keywords: Prisoners, drug users, offenders, treatment staff, substance abuse disorder, drug addiction, Israel, Hermon Prison, substance-abuse treatment program.

INTRODUCTION

Substance Use Disorder (SUD) is defined as "a cluster of cognitive, behavioural, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (American Psychiatric Association, 2013, pp. 481). In 2017, approximately 19.7 million Americans aged 12 or older had suffered from a SUD related to their use of alcohol or illicit drugs in the past year (SAMHSA, 2018). In the same year, the prevalence of SUDs in European countries for adults (15–64) ranged between 2.2% in Cyprus (the lowest rate) to 11.8 in France (the highest rate) (European Monitoring Centre of Drugs and Drugs Addiction, 2017).

SUD is associated not only with other mental or physical health disorders but also with criminality and criminal recidivism (Hughes, Payne, Macgregor, & Pockley, 2014; Wong-Link & Hamilton, 2017), which intensifies society's need to create an effective treatment for drug-using offenders (Leukefeld & Tims, 1993; Prendergast & Wexler, 2004). Thus, from the mid-1980s, many incarceration facilities in the United States and Europe adopted rehabilitation-based methods and therapies for their substance-abusing populations (Kolind, Frank, & Dahl, 2010; Turley, Thornton, Johnson, & Azzolino, 2004). The most common treatments in prisons for drug-using offenders are therapeutic community (TC) programs (De Leon, 2000; Dye, Ducharme, Johnson, Knudsen, & Roman, 2009; Halstead & Poynton, 2016; Mitchell *et al*., 2012; Welsh, Zajac, & Bucklen, 2014), cognitive-behavioral treatment (CBT) (Gates, Sabioni, Copeland, Le Foll, & Gowing, 2017; Rotgers & Nguyen, 2006), methadone-maintenance treatment (MMT) (Gordon *et al*., 2008; Mitchell *et al*., 2012; National Institute on Drug Abuse, 2019), 12-step programs (Donovan, Ingalsbe, Benbow, & Daley, 2013), and eclectic counseling programs (Mitchell *et al*., 2012; Welsh *et al*., 2014).

Although many prisons today offer substance-abuse treatments, evaluation studies of these programs have produced conflicting findings of the programs' effectiveness in decreasing recidivism or drug abuse (Amato *et al*., 2005; Carroll & Onken, 2013; Chandler, Fletcher, & Volkow, 2009; Friedmann, Taxman, & Henderson, 2007; Gordon, Kinlock, Schwartz, & O'Grady, 2008; Inciardi, Martin, & Butzin, 2004; Mattick, Breen, Kimber, & Davoli, 2014; Miller, 2008; Mitchell *et al*., 2007; Mitchell *et al*., 2012; Pearson & Lipton, 1999; Turley *et al*., 2004; Welsh *et al*., 2014). For instance, Mitchell and colleagues (2012) systematically reviewed 74 quasi-experimental and experimental evaluations of the effectiveness of incarceration-based drug-treatment programs in reducing post-release recidivism and drug relapse.

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They found that TC was the only treatment program that had relatively consistent (though modest) reductions in recidivism and drug relapse. Counseling programs, on average, reduced recidivism but not drug relapse; MMT had sizeable reductions in drug relapse but not recidivism; and boot camps had negligible effects on both recidivism and drug relapse.

It is important to note that while most studies tested prison-based drug-rehabilitation programs using primarily quantitative methods, only a few researchers conducted qualitative studies to examine programs from the viewpoints either of patients-inmates participating in them (Frank, Dahl, Holm, & Torsten, 2015; Melnick, Hawke, & Wexler, 2004) or of staff (Kolind, Frank, & Dahl, 2010). For instance, Kolind *et al*. (2010) interviewed 21 treatment personnel in 4 cannabis treatment programs and 4 psychosocial drug-treatment programs in 4 Danish prisons. The study focused on the staff's perceptions of their relationships with the prisoners or the prison officers; it revealed that the treatment staff perceived a gap between the program's official goals (to rehabilitate inmates from drugs and crime) and its actual goals—namely, to alleviate the pain of imprisonment.

As mentioned above, there is a shortage of qualitative studies on prison-based drug-rehabilitation programs, and, further, none of the previous qualitative studies have focused on the therapists' opinions of which specific components of drug-rehabilitation programs are crucial for the programs' success. Such an inquiry would have obvious benefits. For example, in such interviews, staff may provide examples of organizational or managerial factors that are not taken into account in quantitative testing (especially when most evaluation studies are not experiments) although they might influence the results of the evaluation research. Therefore, the goal of the current qualitative study is to understand those factors and offer an exploratory theoretical model of the necessary conditions for creating an effective rehabilitation program.

The current qualitative study is part of a mixed-methods evaluation study examining the effectiveness of various drug-treatment programs in reducing recidivism rates in the Israeli Prison Service (IPS) (Hasisi *et al*., 2016). The quantitative analysis in the study was conducted on drug-using prisoners who were released from prison between 2004 and 2012 (N = 1,087). The study used a Propensity Score Matching method and examined repeat arrests and incarcerations as recidivism indices, five years after their initial release. The only significant results found was that participants who completed the entire treatment in one program (out of four programs in the IPS) in Hermon Prison (N=393) had lower recidivism rates compared to the control group.

Once we found an effective program, it became necessary to understand what factors affected its usefulness and how the program might be improved. Therefore, we analysed the interviews with the Hermon prison rehabilitation staff who served in those years (2004–2012) regarding their insights into the rehabilitation program.

METHOD

Setting

Hermon Prison was established in 1998 in the north of Israel (Lower Galilee). This is the first and heretofore the only prison in Israel designed specifically as a therapeutic facility in a campus setting. Hermon Prison is located in a natural environment with a Mediterranean, mountainous landscape, near rural villages. It is a medium-security prison meant to accommodate only male prisoners. A fence, rather than a wall, surround it, to allow a view of the scenery; guard dogs supplement the security arrangements.

The prison has four departments for psychoactive addiction rehabilitation. Other departments also exist for the diagnosis and classification of addictions (AD&C); one for the graduates of the therapeutic department; and others designated for sex offenders, domestic violence (DV) prisoners, and drug-free inmates.

The prison has a 1-year psychosocial program for drug rehabilitation. To be accepted into the program, the inmate must agree to participate and must meet such other requirements as a minimum remaining incarceration period of 9–12 months, absence of active mental illness (comorbidity), and giving up narcotic maintenance, with Methadone or Buprenorphine.

All the drug-rehabilitation departments in Hermon were managed as TCs. In the mornings, the inmates must participate in programs for higher education (completing an equivalent of 8–12 years of study), in vocational-training programs, or employment programs in one of the prison's workshops. In the afternoon, the inmates take part in various psychotherapies such as hierarchical TC treatment, structured CBT group

therapy, psycho-educational groups such as anger management and communication skills, unstructured psychodynamic groups, NA (Narcotics Anonymous) 12-step meetings, and/or TC groups.

All departments are built on two floors, with separate rooms for each inmate (conditions that exist in no other prison in Israel). Each department has a generous lobby, a large "secure space" within the structure used for group meetings, and a smaller meeting room. The department has outsized windows that bring in natural light and a view of nature, and high ceilings that give a feeling of space.

Table **1**, below, presents the characteristics of the program participants that were examined in the quantitative part of this study.

Table 1: Characteristics of Addicted Inmates Studied in the Quantitative Analysis (n=1087)

	Socio-demographic variables
25.8%	Married
64.6%	Religion (Jewish)
35.02	Average age
9.40	Average years of schooling
24.7%	New immigrant
	Criminal background
4.01	Number of previous incarcerations
	Characteristics of incarceration
23.90	Age first entered prison
22.64	Duration of incarceration (months)
1.1%	Sex offence
35.8%	Violence offence
59.6%	Property offence
45.5%	Drug offence
13.0%	Drug trafficking

Participants

For the qualitative analysis of IPS's rehabilitation program, we conducted semi-structured interviews with 9 social workers who worked as therapists and managed rehabilitation frameworks in Hermon Prison in the research period (2012–2004), as well as with 3 recovery mentors-i.e., former inmates and drug users who underwent training for this function. Since the research followed the 2004-2012 cohorts for 5 years, we selected only staff members for the study who worked during those years, which made it difficult to find qualified participants. The average therapeutic experience of the therapists in this study was 9.38 years (SD=5.500), and all the participants had worked in at least one other prison besides Hermon. To protect the privacy of the research participants who are still working for the IPS we will refer to them only by the role they played and not by either their first names or their initials.

Tools

The interview guide included the following questions concerning the interview: name, education, job description at Hermon Prison, experience in dealing with people with a SUD, opinion of the therapy program's advantages and disadvantages. However, since the interviews were semi-structured, they allowed the interviewees and the interviewers the freedom to discuss other subjects as well.

Procedure

Before the research, the IPS Research Department approved the study and coordinated between the team and the national IPS coordinator of SUD therapy. The researchers themselves conducted the interviews (mainly inside the prison), which lasted about three hours each—altogether, around 36 hours. The participants were informed that everything they said might be written and published, and they expressed their full consent. It should be noted that the interviewees and the researchers had no prior acquaintance with each other, and had no continued working relationship after the study was completed.

The data was analyzed using thematic analysis (Braun & Clarke, 2006). Two research team members who were proficient in qualitative studies did the coding and created the meta-themes and subthemes.

Findings

The qualitative findings are presented according to two meta-themes and subthemes extracted from the research.

1. The Strengths of the Hermon Prison Program: Diversity and Rehabilitation Orientation

During our conversations with them, the therapists were unaware of the results of the quantitative part of the study. What stood out was that—even though everyone talked about the limitations and difficulties of treating inmates with SUD (in the interviewees' language: "patients") as well as a number of weaknesses of the program (see below)—all were

confident that the treatment in Hermon Prison would show positive results. This was because the program impressed the interviewees as varied and having a true orientation towards prisoner rehabilitation, reflected in the following strengths of the program:

Varied Rehabilitation Programs

All the therapists stated that drug users are one of the most difficult inmate populations to treat and have the widest range of needs. From the therapists' perceptions, this population has a high habitual criminality rate (various property, drug, and violence crimes); usually comes from low socioeconomic status and dysfunctional, neglected, or abusive families; and exhibits poor social, educational, and vocational skills and various pathological personality traits (self-centered, high impulsivity, paranoid tendencies, low self-esteem, emotional dysregulation, and sensation-seeking). They also suffer from feelings of inferiority and a fatalistic view of their capacity to change.

Given the above, all the therapists pointed to the benefits of the *multisystemic and diverse* psychological, educational, vocational training, and employment-rehabilitation programs that Hermon offers to drug-using inmates, as one of the therapists explained:

> Addiction is a general problem that stems from biological, psychological, familial, social, and spiritual components, and it affects all aspects in their life, which is why this population also has the widest range of needs that should be fulfilled by the therapeutic program (psychological treatment, life skills, hygiene habits, employment habits, education, etc.). Drugs are not the real problem of the drug users. In fact, for a moment they are believed to be doing the drug user some good. However, treatment must reach life problems that create the need for drugs.

Psychotherapy in a TC setting

Despite the importance of multisystemic psychosocial treatment, all the therapists emphasized on the significance of *psychotherapy* as a basis for inmates' success in employment and education. As one of them said:

> Psychotherapy affects one's mental, cognitive, and behavioral state. An addict prisoner is a troublemaker everywhere! Thus, only when the therapeutic platform promotes self-control, self-awareness, and mental balance. The other functions based on it, such as functioning in an educational or occupational setting can be restored.

Another therapist added, "Psychotherapy changes the atmosphere in prisons. These places have a lot less violence in the air, they are calmer and with less scams, they are cleaner and more organized."

According to all the therapists, since SUD is a multidimensional phenomenon, the group therapies in the program *have to be eclectic* (as described in the Methods section) and *gradual*. Most therapists preferred the use of CBT, psycho-educational groups, and NA meetings in the preliminary phases of the program, and the dynamic groups and 12-steps programs for advanced stages:

> Most of the patients begin at a low cognitive level and with more concrete thinking; for those patients, one must work using mostly the behavioral-cognitive method and the TC tools. On the other hand, patients at more advanced stages of therapy are at a higher level of consciousness and better cognitive function, and so they respond better to dynamic therapy and the more spiritual "Steps program".

All the therapists claimed that the benefits of psychotherapy are enhanced during the prisoner's stay in a *hierarchical TC,* which actually creates a 24/7 treatment setting:

> The TC consists of people working together on the pattern of their addiction and pain and trying to adopt a healthy lifestyle without drugs. The objectives are achieved through clear principles and through participation in close and constantly reflective social relations. The TC has clear expectations for behavioral, moral, and personal development. It uses positive reinforcement, reactions, and modeling learning to motivate change. The goal is to acquire a new self.

All the interviewees also thought that *group therapy,* which is a major component in TCs, has important therapeutic benefits: "In group therapy, the very self-centered patient, learns to see himself through another's eyes. This generates an accelerated process

of self-consciousness because the group does not cut you any slack."

Another therapist added one more benefit: "The group reinforces the sense of belonging that the drug users lack so much. The prisoner suddenly feels like he exists, he feels that someone cares about him, and he feels that he is finally being understood. "

Program Length

All therapists specified the duration of the program (one year) as one of its strongest advantages. They said that only a lengthy program can produce a significant therapeutic process and long-term results for patients.

> Most people drop out in the first three months ... It's very hard for them to cope up with discipline, with togetherness, with exposure, and as with everything in their life – they give up ... So, for the program to be effective, it must be longer than three months. The patient will most probably pass the initial crisis and then begin the more effective learning process.

Another therapist asserted, "The treatment focuses on cognitive distortions, attitudes, values, and problems in self-image that are very difficult to change in three months ... Therapy must be much longer than three months."

Although all the therapists thought that a treatment program should take about a year, they felt that a longer program might be regressive:

> There is this curve, a kind of peak, after which there is only regression. From that point, therapy should be the only individual, not in the community. At a certain stage of living in a community, there is certain mental fatigue. The more veteran members of the community don't have the mental energy for the members who are taking their beginning steps, to have more of the same.

Prison's Therapeutic Orientation

The therapists thought that in-prison therapy would be most efficient in Hermon Prison compared to other prisons in Israel because of its organizational characteristics as one of them explained:

> Hermon is preferable since it was established *organizationally* as a *therapeutically* oriented prison aimed not only at security and custody but also at treatment and rehabilitation. Such an orientation gives the rehab staff influence in decision-making and not only the intelligence and security personnel, as in other prisons.

The staff also emphasized Hermon's *architectural design*, which reflects its rehabilitative orientation and affects on the mood of everyone in Hermon, staff as well as inmates: "It is spacious, with plenty of green spaces that soothes you and opens a person up.... The prisoners are allowed to walk around freely, and there is a more pleasant atmosphere for both staff and prisoners."

The therapists also attached importance to the *internal architectural design* of the departments as a component that contributes to therapy:

> At Hermon, the architectural structure serves the therapeutic purpose—the person has his privacy in a private room, which allows him to think quietly about his life, and to relax alone. There is a lobby quite similar to a living room at home that gives a feeling of hominess, it gives a chance to come together, to talk at the end of the day, in a pleasant way… Hermon is a great contrast to other prisons I know; where there are rooms where the inmates sleep, eat, and also undergo therapy... This is an invasion of privacy, of intimate space that cannot create a healthy separation between a therapeutic setting and the routine of everyday life.

The description of the strong points of the program operating in Hermon, as reported by the therapists interviewed, led us to wonder even more why, despite all of this, the quantitative study showed differences in rates of recidivism only among addicted prisoners who graduated from the program but not among those who only participated in the program but did not complete it.

2. The Weaknesses of the Hermon Prison Program: The TC is more Important than the Individual

The most serious problem revealed in the quantitative study revolved around the issue of high

dropout rates among participants (about 64%). The therapists' initial explanation for the high dropout rates was that, given the characteristics of hardcore drug users (as described earlier), it is more difficult for them than for other prisoners to meet the requirements of the program and to handle its intensity. Notwithstanding the foregoing, the therapists also mentioned several weak elements of the program that could increase dropout rates, as follows:

Shortage of Therapists

Despite the advantages of the existing program, the therapists felt frustrated because they had many clerical tasks in the prison—e.g., shifts at detention facilities or working on administrative issues—that stole time from doing therapy.

Another problem the interviewees raised was the instability or lack of continuity among the therapy staff (social workers) in the rehab departments. They claimed that if a therapist leaves for study, maternity or any other purpose (and many do), stability is affected because he/she cannot be replaced, and, as a result, the entire therapeutic process suffers. However, when there is a replacement, the TC continues to exist and the groups carry on with new therapists, so it *seems* that things are satisfactory. According to the interviewees, the therapeutic process is nonetheless hurt since the therapeutic relationship or alliance between therapist and patient is vital for success;

> A lot of patients are insecure oral types lacking basic security in the world. Finally, they begin to open up to the world and believe in therapists, then the therapist leaves the process in the middle ... In my opinion, this is destructive to the treatment and therefore therapists must be required to stay *at least a year* in the program. The directors must understand that.

Conversations with the staff revealed that they believed that the shortage of paid positions for recovery mentors was more serious than the shortage of therapists who are social workers. All the therapists mentioned the importance of recovery mentors as role models and as the most experienced in maintaining TC life, as one of the therapists explained:

> The recovery of mentors must be former drug users and ex-convicts. These people contribute greatly to the rehab sections because they know all the ploys of the prisoners and they contribute to the therapists, especially with the Twelve-Step program. These are people who are living the life of a "clean addict," with all this implies. These are people who seem to "radiate recovery"—setting a personal example is the basis for this entire process.

They said they believe that there aren't enough mentors in the program and that they are not valued or rewarded enough in the prison. They recommended that the IPS always fill all the job slots allotted for recovery mentors, increase their working hours, and even improve their conditions of employment.

Lack of Individual Psychotherapy

The therapists admitted that, due to the heavy workload, the rehabilitation programs do not hold individual sessions regularly, as part of the therapy routine but consist mostly of group therapy. The interviews revealed that most of the therapists thought to hold regular individual meetings with the patients, especially during the first few months of therapy, which are more prone to active dropout, could indeed reinforce the relationship between the patient and the staff members, improve support, and prevent inmates from dropping out of the program. As one therapist explained:

> If there were more recovery mentors and more social workers, there would be more time to give to each inmate personally. This population is like a small child who is just beginning to walk. In the first three months, you need more people for individual attention.

The participants also thought that individual therapy is crucial, especially in TCs since being in a community creates a burden for the prisoner, which is not simple:

> The patient in the community is faced with handling challenges and requirements that are not familiar to him from the past. He has to take responsibility; obey laws; handle confrontations; expose his feelings, criminality, and lies in front of changing groups; to function every day… to shave, be sensitive and caring to the environment; to manage his free time positively;

> to deal with the emptiness he feels in a process without drugs… It is very intensive and sometimes very stressful.

The following subtheme reflects a factor that may harm the long-term results of the Hermon program, although it does not belong directly to the rehabilitation program at the prison.

Lack of Follow-Up Treatment

All the therapists noted that even if there is a change for the better in prison, in the absence of continuous community therapy for drug rehab, the chances to rehabilitate are still low:

> Every year in Israel, 2,000 addicted prisoners are released and what awaits them? Four hostels, at best. If there is no continuity of treatment and no hostel, no half-way house, everything we did goes down the drain. There is a saying: "A person cannot be a prophet in his own city, and a drug addict cannot be rehabilitated in his own city." In other words, the most important thing in the early stages of his rehabilitation is to keep the released prisoner away from the environment he knows as a user. The situation in Israel today just doesn't make this possible.

According to therapists, if community hostels would give preference to prisoners who graduate from IPS rehab programs, it would increase the motivation of prisoners to participate in these programs and complete them, and thus largely preserve the treatment results.

Lack of Medicinal Treatment

The study revealed that most of the therapists thought that the person in the program must give up the use of any kind of chemicals, as a way of dealing with life problems. Consequently, the patients were not allowed to use any kind of psychiatric medication or MMT in the program.

Only one interviewee, who at the time of the study was the administrator of the sex offenders' department, said:

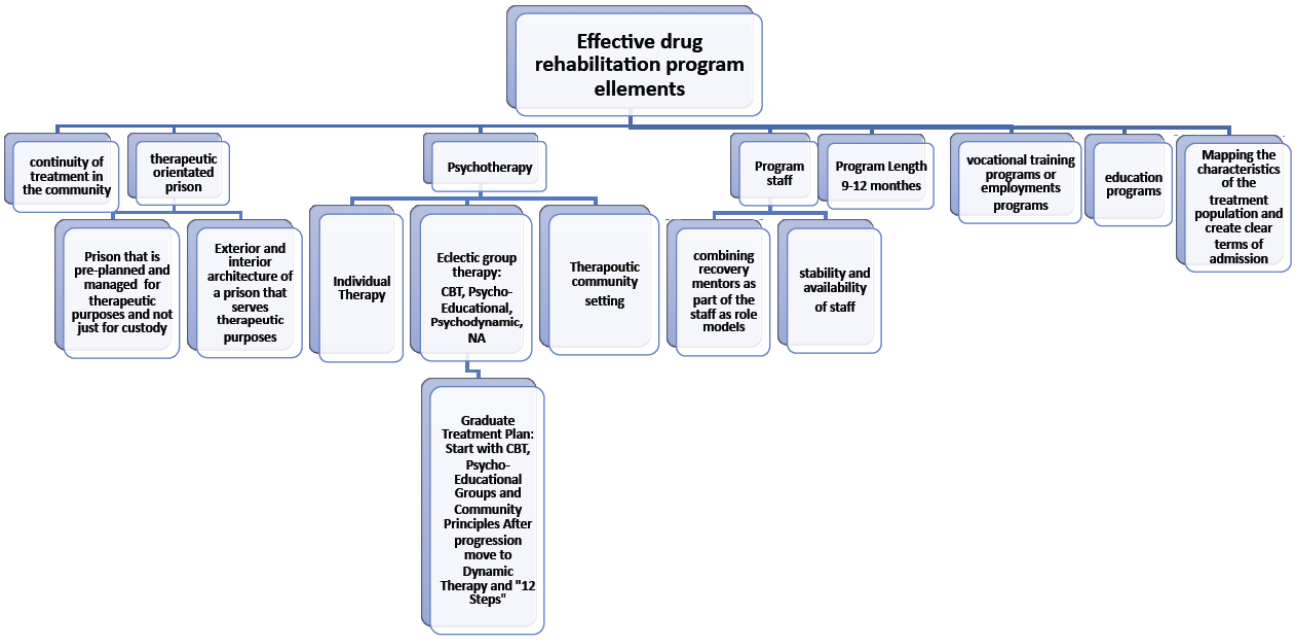
> We are exposed today in literature and lectures to the way that psychiatric medicines can add to psychotherapy. There is no reason why one should not sleep at night because he is not allowed to receive a sleeping pill, or a person suffering from ADHD does not receive appropriate medical care. In my opinion, to deny a vast domain of expertise just because there is an ideological resistance to chemicals is a mistake.

DISCUSSION

For years, the prison drug-treatment program at Hermon Prison was considered by IPS the "flagship" of rehabilitation programs in the Israeli prison system. Nevertheless, the findings of the mixed-methods study conducted among drug-using prisoners who participated in the Hermon Prison program shows that participation in the programs leads to a significant decrease in recidivism only among prisoners who actually completed its rehab program (Hasisi *et al*., 2016). The current qualitative part of the research shows, indeed, that according to treatment staff the Hermon rehabilitation program has several advantages but has also some major weaknesses. Based on the advantages and disadvantages found in the study, an exploratory model was created of an effective drug rehabilitation program:

The first advantage described by therapists was that it is a varied and multisystemic program that fits drug-using offenders' vast criminogenic needs (mental health problems; lack of social, educational, and occupational skills; difficult family backgrounds; etc.). (See also Appel, Ellison, Jansky, & Oldak, 2004; Rapp *et al*., 2006.) This multifaceted approach to the treatment of drug users is also mentioned in the literature as a prerequisite for successful rehabilitation (Friedmann *et al*., 2007; National Institute on Drug Abuse, 2018).

The second benefit mentioned by the therapists is the large component of psychotherapy in the drug-rehabilitation program, which includes a variety of psychological group treatments as well as residence in a TC. Comparing this to the literature, one sees that many researchers mention residence in a TC as one element essential for the effective treatment of addiction (e.g., Goethals, Soyez, Melnick, De Leon, & Broekaert, 2011; Friedmann, *et al*., 2007; Mitchell *et al*., 2012) and CBT (Friedmann *et al*., 2007; National Institute on Drug Abuse, 2018; Walther, Gantner, Heinz, & Majić, 2016). On the other hand, the current



literature does not emphasize other therapies that the therapists in this study considered to be indispensable in advanced stages of treatment, like psychodynamic therapy or participation in NA 12-step meetings. The therapists also recommended the use of different therapies in different treatment stages: using CBT, NA, and psycho-educational groups at the beginning of treatment but psychodynamic groups and "Twelve-step" for advanced patients.

The third advantage of the program mentioned by all therapists was the program duration, which is about 1 year. It seems that therapy at Hermon is much longer than the 90 days recommended in the literature (Friedmann *et al*., 2007; Kolind *et al*., 2010; National Institute on Drug Abuse, 2018). It is also notable that the study participants thought that a longer program might be regressive.

The fourth advantage of the program that was noted was its location at Hermon Prison, due to the prison's therapeutic values and architectural design. While the organizational structure is recognized as a contributing element to the success of treatment program (Friedmann *et al*., 2007), the participants also pointed out the important influence of the architectural design of the prison and the departments on the therapeutic process (on the impact of design on the prison climate, see Wener, 2000, 2012).

Alongside the benefits of Hermon's rehabilitation program, the therapists addressed weak points that might explain the program's main problem: high dropout rate. This problem is critical to us since the evidence showed that *only the inmates who completed the program* had lower recidivism rates (Hasisi *et al*., 2016). The therapists' initial explanation for the high dropout rates referred to drug users' characteristics—including high impulsivity, a tendency toward paranoia, emotional dysregulation—and the literature, indeed, mentions that this population is characterized by high dropout rates (Evans, Li, & Hser, 2009; National Institute on Drug Abuse, 2018). However, the therapists also pointed to several weaknesses of the program that, if corrected, would increase inmates' chances of completing the program.

The first flaws mentioned by all the therapists were the lack of recovery mentors (see also Horigan *et al*., 2016) and the high turnover among therapists. The literature recommends maintaining treatment stability but does not consider the maintaining of treatment-staff stability and the therapeutic alliance (Friedmann *et al*., 2007; Kolind *et al*., 2010; National Institute on Drug Abuse, 2019). The importance of therapist stability was found in studies that examined the efficacy of psychotherapy, not necessarily in the field of drug rehabilitation (e.g., Greeson, Guo, Barth, Hurley, & Sisson, 2009; Johnson, Ketring, Rohacs, & Brewer, 2006; Karver, Handelsman, Fields, & Bickman, 2006). All therapists also stated that there is a shortage of a specific treatment-staff type: recovery mentors. They believed that recovery mentors have a crucial role in managing the TCs and being role models for the inmates.

The second flaw mentioned by the therapists was the lack of individual psychotherapy in the program. All the participants claimed that introducing individual therapy would decrease the program's high dropout rate, especially in TCs, which are intensive and confrontational by nature (see also Prangley, Pit, Rees, & Nealon, 2018). Again, while the literature emphasizes the importance of providing psychological treatment for drug users (Jhanjee, 2014, National Institute on Drug Abuse, 2018), there is almost no special emphasis on the necessity of individual therapy in these programs.

The third shortcoming, mentioned by only one therapist, was the absence of medical treatment of addiction; such treatment is not allowed in most TCs. This is a very interesting finding since many researchers nowadays perceive SUD as a brain disease (Amato *et al*., 2005; Mattick *et al*., 2014; McLellan, Lewis, O'Brien, & Kleber, 2000; National Institute on Drug Abuse, 2019) and highlight the importance of medication-combined therapy as one of the key elements in treating drug users.

In light of all the above, we have chosen to summarize the main theme that describes the program's disadvantages as, "TC is more important than the individual." This is because we find that the very existence of a TC framework causes managers and even some therapists to see the specific needs of the individual in the TC (therapist or patient) as less important than the continuation of the TC framework.

The last flaw mentioned by all the therapists was the lack of community treatment for the inmate after his release from prison. Studies have shown this element to be crucial to sustaining a program's results (Farabee *et al*., 1999; Friedmann *et al*., 2007; Kolind *et al*., 2010; Visher, LaVigne, & Travis, 2004). However, in Israel today, most of the hostels for rehabilitation of drug users released prisoners are closed, and the public health system finds it hard to assist released prisoners who suffer from various health problems (Shoham, 2012).

CONCLUSION

Interviews with the treatment staff offered a glimpse into the inner workings of the program at Hermon Prison, down to the level of content, allowing policymakers in Israel and around the world to understand which are the positive and the problematic elements in the Hermon drug-rehabilitation programs. These findings call for program changes based on the suggestions made by the professional staff.

We must emphasize that we conducted the present qualitative study on a relatively small sample. Due to high staff turnover we had difficulties locating the staff that worked in the program during 2004-2012. It should be noted that we also based the research conclusions on the professional perspective of the therapists alone. Future work should present the views and attitudes of the inmates. It is important to mention that the qualitative study cannot quantify the relative importance of each component in the proposed model.

Recommendations for further study include increasing the sample and testing the importance of the critical components proposed in the model. An experimental or semi-experimental study might assist in differentially investigating and quantifying and validating the various components of the theoretical model.

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REFERENCES

Amato, L., Davoli, M., Perucci, C. A., Ferri, M., Faggiano, F., & Mattick, R. P. (2005). An overview of systematic reviews of the effectiveness of opiate maintenance therapies: Available evidence to inform clinical practice and research. *Journal of Substance Abuse Treatment*, 28, 321–329. https://doi.org/10.1016/j.jsat.2005.02.007

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author. https://doi.org/10.1176/appi.books.9780890425596

Appel, P. W., Ellison, A. A., Jansky, H. K., & Oldak, R. (2004). Barriers to enrollment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *The American Journal of Drug and Alcohol Abuse*, *30*, 129–153. https://doi.org/10.1081/ADA-120029870

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Carroll, K. M., & Onken, L. S. (2013). Behavioral therapies for drug abuse. *American Journal of Psychiatry, 162*, 1452–1460. https://doi.org/10.1176/appi.ajp.162.8.1452

Chandler, R. K., Fletcher, B. W., & Volkow, N. D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *JAMA*, *301*, 183–190. https://doi.org/10.1001/jama.2008.976

De Leon, G. (2000). *The therapeutic Community: Theory, model, and method*. New York: Springer Publishing. https://doi.org/10.1891/9780826116673

Donovan, D. M., Ingalsbe, M.H., Benbow, J., & Daley, D. C. (2013). 12-step interventions and mutual support programs for

substance use disorders: An overview. *Social Work Public Health*, *28*, 313–332. https://doi.org/10.1080/19371918.2013.774663

Dye, M. H., Ducharme, L. J., Johnson, J. A., Knudsen, H. K., & Roman, P. M. (2009). Modified therapeutic communities and adherence to traditional elements. *Journal of Psychoactive Drugs, 4*, 275–283. https://doi.org/10.1080/02791072.2009.10400538

Evans, E., Li, L., & Hser, Y. I. (2009). Client and program factors associated with dropout from court mandated drug treatment. *Evaluation and Program Planning*, *32*, 204–212. https://doi.org/10.1016/j.evalprogplan.2008.12.003

Farabee, D., Prendergast, M., Cartier, J., Wexler, H., Knight, K., & Anglin, M. D. (1999). Barriers to implementing effective correctional drug treatment programs. *The Prison Journal, 79*, 150–162. https://doi.org/10.1177/0032885599079002002

Frank, V. A., Dahl, H. V., Holm, K. E., & Torsten, K. (2015). Inmates' perspectives on prison drug treatment: A qualitative study from three prisons in Denmark. *Probation Journal, 62*, 156–171. https://doi.org/10.1177/0264550515571394

Friedmann, P. D., Taxman, F. S., & Henderson, C. E. (2007). Evidence-based treatment practices for drug-involved adults in the criminal justice system. *Journal of Substance Abuse Treatment*, *32*, 267–277. https://doi.org/10.1016/j.jsat.2006.12.020

Gates P. J., Sabioni, P., Copeland, J., Le Foll, B., & Gowing, L. (2017). Psychosocial interventions for cannabis use disorder. *Cochrane Database of Systematic Reviews 2016, no. 5.* Art. No.: CD005336. https://doi.org/10.1002/14651858.CD005336.pub4

Goethals, I., Soyez, V., Melnick, G., Leon, G. D., & Broekaert, E. (2011). Essential elements of treatment: A comparative study between European and American therapeutic communities for addiction. *Substance Use & Misuse, 46*, 1023–1031. https://doi.org/10.3109/10826084.2010.544358

Gordon, M. S., Kinlock, T. W., Schwartz, R. P., & O'Grady, K. E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post release. *Addiction, 103*, 1333–1342. https://doi.org/10.3109/10826084.2010.544358

Greeson, J. K. P., Guo, S., Barth, R. P., Hurley, S., & Sisson J. (2009). Contributions of therapist characteristics and stability to intensive in-home therapy youth outcomes. *Research on Social Work Practice, 2*, 239–250. https://doi.org/10.1177/1049731508329422

Hasisi, B., Weisburd, D., Shoham, E., Haviv, N., & Zelig, A. (2016). *Assessment of drug and alcohol rehabilitation programs*. Ramla, Israel: The Israeli Prison Services.

Halstead, I., & Poynton, S. (2016). The NSW Intensive Drug and Alcohol Treatment Program (IDATP) and recidivism: An early look at outcomes for referrals. *Crime & Justice Bulletin, 192*, 1–20.

Horigian, V. E., Espinal, P. S., Alonso, E., Verdeja, R. E., Duan, R., Usaga, I. M., … & Feaster, D. J. (2016). Readiness and barriers to adopt evidence-based practices for substance abuse treatment in Mexico. *Salud Mental, 39*, 77–84. https://doi.org/10.17711/SM.0185-3325.2016.004

Hughes, C., Payne, J., Macgregor, S., & Pockley, K. (2014). A beginner's guide to drugs and crime: Does one always lead to the other? *The National Magazine on Alcohol, Tobacco and Other Drugs, 12*, 26–29.

Inciardi, J. A., Martin, S. S., & Butzin, C. A. (2004). Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison. *Crime and Delinquency, 50*, 88–107. https://doi.org/10.1177/0011128703258874

Jhanjee, S. (2014). Evidence based psychosocial interventions in substance use. *Indian Journal of Psychological Medicine, 36*, 112-118. https://doi.org/10.4103/0253-7176.130960

Johnson, L. N., Ketring, S. A., Rohacs, J., & Brewer, A. L. (2006). Attachment and the therapeutic alliance in family therapy. *American Journal of Family Therapy, 34*, 205–218. https://doi.org/10.1080/01926180500358022

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: The evidence for different relationship variables in the child and adolescent treatment literature. *Clinical Psychology Review*, 26, 50–65. https://doi.org/10.1016/j.cpr.2005.09.001

Kolind, T., Frank, V.A., & Dahl, H. V. (2010). Drug treatment or alleviating the negative consequences of imprisonment? A critical view of prison-based drug treatment in Denmark. *International Journal of Drug Policy, 21*, 43–48. https://doi.org/10.1016/j.drugpo.2009.03.002

Kolind, T., Frank, V. A., Lindberg, O., & Tourunen, J. (2015). Officers and drug counsellors: New occupational identities in Nordic Prisons. *British Journal of Criminology, 55*, 303–320. https://doi.org/10.1093/bjc/azu088

Leukefeld, C. G., & Tims, F. M. (1993). Drug abuse treatment in prisons and jails. *Journal of substance abuse treatment, 10*, 77–84. https://doi.org/10.1016/0740-5472(93)90103-9

McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*, 1689–1695. https://doi.org/10.1001/jama.284.13.1689

Martin, S. S., Butzin, C. A., Saum, C. A., & Inciardi, J. A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *The Prison Journal, 79*, 294–320. https://doi.org/10.1177/0032885599079003002

Mattick, R. P., Breen, C., Kimber, J., & Davoli, M. (2014). Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Version of Record online: 6 FEB 2014. https://doi.org/10.1002/14651858.CD002207.pub4

Melnick, G., Hawke, J., & Wexler, H. K. (2004). Client perceptions of prison-based therapeutic community drug treatment programs. *The Prison Journal, 84*, 121–138. https://doi.org/10.1177/0032885503262459

Miller, J. C. (2008). 12-Step treatment for alcohol and substance abuse revisited: Best available evidence suggests lack of effectiveness or harm. *International Journal of Mental Health and Addiction 6,* 568–576. https://doi.org/10.1007/s11469-008-9146-4

Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology, 3*, 353–375. https://doi.org/10.1007/s11292-007-9040-2

Mitchell, O., Wilson, D. B., & MacKenzie, D. L. (2012). The effectiveness of incarceration-based drug treatment on criminal behavior: A systematic review. Campbell Systematic Reviews 2012:18. https://doi.org/10.4073/csr.2012.18

Najavits, L. M., Kivlahan, D., Kosten, T. (2011). A national survey of clinicians' views of evidence-based therapies for PTSD and substance abuse. *Addiction Research and Therapy,19,* 138–147. https://doi.org/10.3109/16066350903560176

National Institute on Drug Abuse (2018). *Principles of drug addiction treatment: A research-based guide*. 3rd ed. Retrieved [*January 2018*] from https://www.drugabuse.gov/publications/

principles-drug-addiction-treatment-research-based-guide-third-edition/acknowledgments.

National Institute on Drug abuse (2019). *Treatment approaches for drug addiction*. Retrieved [January 2019] from https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction

Pearson, F. S., & Lipton, D. S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *The Prison Journal, 79*, 384–410. https://doi.org/10.1177/0032885599079004003

Polcin, D. L. (2001). Drug and alcohol offenders coerced into treatment: A review of modalities and suggestions for research on social model programs. *Substance Use & Misuse, 36*, 589–608. https://doi.org/10.1081/JA-100103562

Prendergast, M. L., & Wexler, H. K. (2004). Correctional substance abuse treatment programs in California: A historical perspective. *The Prison Journal*, *84*, 8–35. https://doi.org/10.1177/0032885503262453

Prangley, T., Pit, S. W., Rees, T., & Nealon, J. (2018). Factors influencing early withdrawal from a drug and alcohol treatment program and client perceptions of successful recovery and employment: A qualitative study. *BMC Psychiatry, 18*, 301. https://doi.org/10.1186/s12888-018-1864-y

Rapp, R. C., Xu, J., Carr, C. A., Lane, D. T., Wang, J., & Carlson, R. (2006). Treatment barriers identified by substance abusers assessed at a centralized intake unit. *Journal of substance abuse treatment*, *30*, 227–235. https://doi.org/10.1016/j.jsat.2006.01.002

Rotgers, F., & Nguyen, T. A. (2006). Substance abuse. In P. J. Bieling, U. McMaster, O.T. Hamilton, R. E. McCabe, & M. M. Antony (eds.), *Cognitive-behavioural therapy in groups*. New York: Guilford.

SAMHSA [Substance Abuse and Mental Health Services Administration] (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health. Retrieved [September 2018] from https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report

Shoham, E. (2012). Gazing beyond the walls: Violence towards domestic partners in closed communities**.** Be'er-Sheva, Israel: Ben-Gurion University in the Negev.

Tai, B., Straus, M. M., Liu, D., Sparenborg, S., Jackson, R., & McCarty, D. (2010). The first decade of the national drug abuse treatment clinical trials network: Bridging the gap between research and practice to improve drug abuse treatment. *Journal of Substance Abuse Treatment*, 38, 4–13. https://doi.org/10.1016/j.jsat.2010.01.011

Taxman, F. S., & Bouffard, J. A. (2000). The importance of systems in improving offender outcomes: New frontiers in treatment integrity. *Justice Research and Policy, 2,* 37–58. https://doi.org/10.3818/JRP.2.2.2000.37

Taxman, F. S., Perdoni, M. L., & Harrison, L. D. (2007). Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment*, *32*, 239–254. https://doi.org/10.1016/j.jsat.2006.12.019

Turley, A., Thornton, T., Johnson, C., & Azzolino, S. (2004). Jail drug and alcohol treatment program reduces recidivism in nonviolent offenders: A longitudinal study of Monroe County, New York's jail treatment drug and alcohol program. *International Journal of Offender Therapy and Comparative Criminology, 48*, 721–728. https://doi.org/10.1177/0306624X04265088

Visher, C., LaVigne, N. & Travis, J. (2004). Returning home: Understanding the challenges of prisoner reentry. *Maryland pilot study: Findings from Baltimore.* Washington, DC: Urban Institute. https://doi.org/10.1037/e720382011-001

Walther, L., Gantner, A., Heinz, A., & Majić, T. (2016). Evidence-based treatment options in cannabis dependency. *Deutsches Aerzteblatt International*, *113*, 653–659. https://doi.org/10.3238/arztebl.2016.0653

Welsh, W. N., Zajac, G., & Bucklen, K. B. (2014). For whom does prison-based drug treatment work? Results from a randomized experiment. *Journal of Experimental Criminology, 10*, 151–177. https://doi.org/10.1007/s11292-013-9194-z

Wener, R. E. (2000). Design and the likelihood of prison assaults. In L. Fairweather & S. McConville (Eds.), Prison architecture: Policy, design, and experience (pp. 49–54). Boston: Architectural Press.

Wener, R. E. (2012). The environmental psychology of prisons and jails: Creating humane spaces in secure settings (environment and behavior). Cambridge: Cambridge University Press. https://doi.org/10.1017/CBO9780511979682

Wexler, H. K., Melnick, G. L., Lowe, L., & Peters, L. (1999). Three year re-incarceration outcomes for Amity in prison therapeutic community and aftercare in California. *Prison Journal, 79*, 321–336. https://doi.org/10.1177/0032885599079003003

Wong-Link, N., & Hamilton, L. K. (2017). The reciprocal lagged effects of substance use and recidivism in a prisoner reentry context. *Health & Justice, 5*, 1–14. https://doi.org/10.1186/s40352-017-0053-2

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