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; Friedman, 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.
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.

| Socio-demographic variables                  |
|---------------------------------------------|
| 25.8% Married                                |
| 64.6% Religion (Jewish)                     |
| 35.02 Average age                           |
| 9.40 Average years of schooling             |
| 24.7% New immigrant                         |

| Characteristics of incarceration            |
|--------------------------------------------|
| 4.01 Number of previous incarcerations     |
| 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 (Farabees 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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