# CLIENTS ADMITTED TO "THE BUTTERY",

# A THERAPEUTIC COMMUNITY, 1980-1992

**Wayne Hall and Rosemarie Chen**

**National Drug and Alcohol Research Centre,**

**University of New South Wales,**

**and**

**Barry Evans,**

**The Buttery,**

**Lismore, NSW**

## Introduction

Therapeutic communities had their origins in the late 1940s when Maxwell Jones, a psychiatrist working in London, established a residential community as an alternative to medical treatment for young people with behavioural problems. In 1958, the first drug-free therapeutic community, Synanon, was established in California to rehabilitate drug users.

According to the Therapeutic Communities of America, a therapeutic community, is a non-medical, residential setting that encourages personal growth by changing the lifestyle of individuals with social deficits, including criminal behaviour. People in a therapeutic community are members, not patients, and they play a part in the management of the community. The main emphasis is on the resocialisation of an individual within this community prior to moving back into society.

Some of the common features of therapeutic communities for drug users include a drug free environment, clear rules to govern the behaviour of all members, the development of problem solving skills, encounter groups, and behaviour modification through a hierarchical social system with the goal of re-entry into society (Luger, 1979; Gerstein and Harwood, 1990).

Therapeutic communities have provided drug-free treatment in Australia for approximately twenty years. In 1991, the Australian Therapeutic Communities Association has a membership of 24 organisations, 10 of which are located in New South Wales. According to the much more liberal definition of a "therapeutic community" used in the Australian Directory of Alcohol and Other Drug Services (Mills, 1992), there were a total of 83 therapeutic communities in Australia, 32 of which were in N.S.W.. Since it is doubtful, however, that many of the organisations so classified would meet the narrower definition used by the American Association we prefer the lower estimate of the ATCA.

Currently, therapeutic communities comprise approximately 21% of Australian drug and alcohol treatment agencies that offer a service to individuals who use opioid drugs (Baillie, Webster & Mattick, 1992). A national census of drug and alcohol treatment service agencies undertaken in 1992 (Chen, Mattick, and Baillie, 1993) found that 700 people were residents of therapeutic communities throughout Australia on census day, 317 of whom were in N.S.W..

Surprisingly little is known about the clientele of therapeutic communities. We have only rudimentary information on: the number of persons they assist, their demographic characteristics, drug use, and treatment history, and their length of stay (see Didcott, Flaherty and Muir, 1988 for an exception). This report aims to partly remedy this lack of knowledge by describing the characteristics of clients, and their length of stay, at one such therapeutic community, the Buttery, over the period from 1980 to 1992.

## The Buttery.

The Buttery is a residential therapeutic community for the treatment of chemical dependence. It is situated at Binna Burra on the Far North Coast of NSW, in a the former Binna Burra butter factory (hence the "Buttery"). It caters for a maximum of twenty four single adults living in three

separate households. The Buttery endeavours to maintain as "normal" a non institutional setting as possible. The extended household concept maximises the opportunities for interaction and acquiring living skills through the shared responsibility of managing a house. A strong emphasis is placed on individuals being active participants in the recovery process by accepting responsibility for the personal application of insights gained.

**History**

In 1972 John McKnight who was working as a Church Army Officer in the Anglican Parish of Ballina started a ministry for youth in response to an influx of young people into the North Coast following the Aquarius Festival. Captain McKnight wanted to establish a base for an outreach service to the surrounding areas of Nimbin, Mullumbimby and Lismore at the Buttery to assist itinerant youth and to provide a statewide service for troubled youth. He moved into the old butter factory when it was offered to him in 1973.

Since its establishment in 1973 the Buttery has evolved from an outreach ministry into a therapeutic community for drug dependent persons (see Appendix 1 for a more detailed history). In its early days it provided a "dropin" refuge on the Far North Coast. In 1976, for example, 3,728 people stayed at Buttery for varying periods of time, and 4,000 visitors came to see the work that was being done.

An increasing interaction with drug affected people shifted the goal of the Buttery from developing an alternative Christian Community with an outreach mission to becoming a therapeutic community with the specific task of treating drug dependence. In 1978 a grant was received from the NSW Drug and Alcohol Authority and work was begun on expanding the accommodation facilities. In 1979 a Constitution was drawn up which became effective in August 1979, a second accommodation unit was completed, and with increased Government funding staff were employed to provide administrative and counselling support that required specific drug counselling skills. The first Annual General Meeting was held in August 1980 when the first "graduate" received their graduation medal.

In 1980 Captain John Mcknight departed and was replaced by Andrew Biven who introduced changes in direction and structure. Group therapy was introduced, and a program was documented with rules and guidelines governing acceptable behaviours as a condition of staying, and art and craft were also included in this embryonic program. Early in 1981 a 17 hectare farm was purchased nearby with the intention of expanding the program by providing independent accommodation to "graduates", or those in the later stages of the program.

By 1981 the structure of the program clearly conformed to the classic definition of a therapeutic community with a staged program consisting of eight levels, behavioural, moral and ethical boundaries were becoming more clearly defined, and the concept of shared responsibility in all areas of an individuals progress and the general welfare of the community was consolidated. The Buttery had become a community of addicts, volunteers and trained staff where decision making was shared and where each member was expected to actively participate in all aspects of the program.

The employment of two new staff in 1981 and 1982 introduced the "12 step philosophy" which gradually became incorporated into the program as an adjunct to the holistic living skills education. By 1983 residents were being encouraged to consider the philosophy and the Fellowship as a means of providing practical, emotional and spiritual support immediately after leaving the Buttery and in the longer term.

In October 1983 a half way house was established at Artarmon to ease the difficult transition from an isolated long term residential program by providing residents with an opportunity to move gradually back into society through a supportive network in the house and the support of the Narcotics Anonymous Fellowship. A flow-on from the development of this aftercare support was the shortening of the residential program, knowing that people who left before completing the program could continue their recovery in Sydney. The next two years provided a period of stability which allowed consolidation of the program.

In late 1985 Andrew Biven accepted a position with the S.A. Drug and Alcohol Services Council to establish a therapeutic community in Adelaide. There were two short term Directors over the next two and a half years, Carolyn Stoney and Steve Kinney. In 1986 another half way house was secured in Surry Hills and The Buttery joined the newly formed Australian Therapeutic Communities Association. In mid 1988 Steve Kinney left The Buttery and was replaced by Barry Evans, the current director.

Three Directors in a relatively short period of time, the retirement of some long serving Board Members, and the inevitable staff changes had contributed to a period of dislocation in the management of the program. A period of relative stability returned in 1989 with the appointment of a new Director and a new Board of Management.

Between 1989 and the present day The Buttery program has continued to evolve. The traditional emphasis on the value of the therapeutic milieu remained but an effort was made to broaden the skills of the counselling staff, many of whom enrolled in the TAFE Drug and Alcohol Advanced Certificate course. The content of group therapy became more structured, and daily individual case management was provided to help in addressing the attitude and behaviour change.

**Treatment Philosophy**

Today residents at The Buttery embark on a standard program involving group therapy and education, living skills instruction and stress management training, and art therapy, as well as orientation to the 12 Step philosophy and self help groups. Following a six week assessment phase they can elect to move into a second phase of five months during which as well as continuing to work in the personal areas already mentioned they can begin to address personal issues which have affected their lives and reduced their potential to cope without using drugs or alcohol.

Currently The Buttery's philosophy of treatment is very eclectic, with the emphasis on addressing a persons living problems and not the drugs which have facilitated their decline. The 12 Step influence remains strong, but a bio-psycho-social definition of addiction successfully coexists in the program. This partnership works because the bio-psycho-social interpretation influences treatment direction and intervention by staff, while the 12 Step perspective and

language provide a metaphorical interpretation of the issues that the residents find comfortable and generally easy to relate to (see Appendix 1 for a detailed statement of treatment goals and objectives).

# Methods

*Procedure*

An admission form was filled out for each client and the data collected included: the client's age, gender, and postcode of residence at the time of admission; their drug/s of choice, the source of referral, and participation in detoxification and methadone maintenance treatment programs prior to the index admission to the Buttery; and the date of admission, and the date on which the client left the program, from which the client's length of stay could be calculated.

*Data analysis*

These data were tabulated by year of admission for the study period. Because there were so few admissions (37 persons) in 1978 and 1979 statistical analyses were performed only on data for the period 1980 to 1992 inclusive. Descriptive statistical analyses were used to summarise the characteristics of clients by gender, age, drug use, treatment experience and year of admission. A simple index of polydrug use was calculated by summing the number of different drug types for which a client sought help. Drug problems and polydrug use have only been reported for the period 1980 to 1991 because of changes in the way in which this data were collected in 1992.

Multivariate statistical analyses were undertaken to examine changes in age, length of stay, prior exposure to methadone maintenance, and drugs of choice over the period of study. When the outcome variables were continuous (e.g. age, polydrug index) linear multiple regression analyses were performed. When the outcome variables were categorical (e.g. an alcohol problem or not) logistic multiple regression analyses were conducted. All analyses were performed using the SYSTAT package (Wilkinson, 1987), or its additional module for logistic regression.

# Results

## *1. **Client characteristics***

There were 1219 admissions to the Buttery in the years from 1978 to 1992. Excluding 89 readmissions, these represented 1130 persons of whom 783 (69.7%) were male and 341 (30.3%) were female (with gender not recorded for 6 clients). The average age of the sample was 28.1 years (standard deviation = 5.6 years), with males being older (28.8 years) than females (26.5 years) ($t$ [737 df] = 6.84, $p < 0.001$).

Information on place of residence was available on 64% of admissions in the form of the postcode of their address prior to admission to the Buttery. The remainder either did not have a fixed address or did not provide one. The majority of these clients (82%) came from New South Wales, with 13% coming from Victoria, and 5% from Queensland. In New South Wales, 14% came from the inner city suburbs such as Darlinghurst, Surry Hills, and Newtown which are well known centres for illicit drug use.

### *Sources of referral and prior treatment experience*

Among the 15 listed referral agencies the largest source of referrals were the Langton Clinic (16%) and Wisteria House in Sydney (3%), the Richmond Clinic in Lismore, New South Wales (3%), and the Pleasant View Centre in Victoria (3%). Unspecified sources of referral numbered 663 (62%) while there were 11 (1%) self-referred clients. These proportions have changed over time in the ways that are difficult to describe in detail. Moreover, the significance of the source of referral has changed as waiting lists for entry to the Buttery have increased. More often that not the referring agency has become less a source of referral than a centre for obtaining detoxification which is required of all clients prior to their entry to the Buttery program.

The majority of clients had some previous exposure to treatment services. As already mentioned, *all* clients had been detoxified prior to the index admission to the Buttery. In addition, a total of 851 clients had undergone detoxification (75%) on at least one occasion prior to the treatment episode that preceded their admission to the Buttery. A third of clients (30%) had also been exposed to methadone treatment prior to seeking help at the Buttery.

### *Drugs of choice*

The most frequently nominated drug of choice was an opioid drug (85%). Heroin was the most commonly used opioid (78%) with a smaller group using synthetic opioids (such as cough mixtures, physeptone, mersyndol, pethidine, codeine) instead of or as well as heroin. Other drug problems in addition to opioids were common. Over a third of the clients (37%) had a problem with alcohol, 20% had a problem with stimulants, 11% had problems with benzodiazepines, and 52% had problems with a variety of other drugs. The proportion of clients who reported problems with three or more drug types was a third (33%).

## ***2. Length of stay***

The distribution of length of stay over the period of study was positively skewed, i.e. the length of stays for most clients were bunched around 40 to 60 days with a small proportion who spent longer periods in residence at the Buttery. The median length of stay was 42 days (41 for males and 47 days for females). Because of the skewed distribution the median provides a better indication of typical length of stay than does a mean. The majority of clients (59%) spent 60 or less days, while 21% spent between 61 and 120 days in rehabilitation.

***3. Gender differences***

The major differences between male and females clients at the Buttery was in age, with men being 3.2 years older on average than women. As can be seen in the following table of drugs of choice, with the exception of benzodiazepines, males outnumbered females by more than 2:1 for each category of drug, the ratio in which they were over-represented among the Buttery's clients. There was a similar gender ratio among polydrug users, 71% (n = 264) of whom were males.

| TYPE OF DRUG | MALES | FEMALES |
|---|---|---|
| ALCOHOL | 71% | 30% |
| STIMULANTS | 73% | 27% |
| NARCOTICS | 71% | 29% |
| OTHER DRUGS | 69% | 31% |
| BENZODIAZEPINES | 58% | 42% |

*Prior detoxification and treatment experience.*

There was a similar pattern of gender differences in prior exposure to detoxification and methadone maintenance treatment. Males comprised 72% of the 851 persons who had been detoxified prior to their current admission, and 73% of the 344 clients who had been enrolled in methadone maintenance treatment.

*3.* ***Changes over time***

*Age and Gender*.

The most striking change in client characteristics over the period of study was a steady increase in the average age of clients, from 24.6 years in 1980 to 32.1 years in 1992 (see figure 1). An analysis of variance indicated that there was a significant linear trend in average age across these years ($F [1, 1066] = 176.63$, $p < 0.001$). This indicates that the average age of the persons seeking treatment at the Buttery increased by approximately 7 months per year over the period of study. Although there was some variation in the proportion of males over time (from a low of 64% to a high of 79%) this variation was not statistically significant when examined by a logistic regression analysis.

*Drugs of choice.*

There have been a number of changes in the drugs of choice among the Buttery's clients between 1980 and 1991 (see figure 2). The proportion with opioid problems has shown a slight decrease over time (OR = 0.91 per year [95% CI: 0.86, 0.95]) while there have been corresponding increases in the proportions reporting problems with alcohol (OR = 1.14 per year [95% CI: 1.09, 1.18]) and stimulant drugs such as cocaine and amphetamines (OR = 1.16 per year [95% CI: 1.10, 1.21]). There has been no consistent change in the proportion reporting problems with benzodiazepines (OR = 1.01 per year [95% CI: 0.95, 1.07]).

There has also been an increase in the prevalence of polydrug use among clients over time. There was a statistically significant increase in the average score on the polydrug index which was calculated by adding the number of different drug types nominated as a problem (see figure 3). This index has consistently increased between 1980 and 1991, a result confirmed by a test of linear trend over time ($F [1, 922] = 164.50$, $p < 0.001$).

*Prior treatment experience.*

The proportion of clients who had prior experience with methadone maintenance treatment on one or more occasions prior to the index admission also increased over the period from 1980 to 1992 (OR = 1.08 per year [95% CI: 1.04, 1.13]). The major change in the proportion with previous methadone exposure was before and after 1985, the year in which the provision of methadone treatment was expanded under the National Campaign Against Drug Abuse (OR = 1.58 [95% CI: 1.19, 2.08]).

*Length of stay.*

The median length of stay changed in a complex way over the period of study (see figure 4). For the period 1980 to 1987 the median length of stay decreased before increasing again between 1988 and 1992. This recent change in pattern was statistically significant when examined by an appropriate form of statistical analysis. (This involved a test of quadratic trend by an analysis of variance performed on the logarithm of length of stay over the study period $F [1, 1151 df] = 44.45$, $p < 0.001$).

*Predictors of length of stay*

Apart from year of admission, none of the client variables measured in the study predicted length of stay at the Buttery. Neither a survival analysis nor the simple calculation of Spearman rank correlation coefficients between client characteristics and length of stay revealed any statistically significant relationships between age, gender, drug of choice, and length of stay. That is, there was no difference between males and females in median length of stay, no relationship between age and length of stay, and no relationships between drugs of choice and length of stay.

# Discussion

The main findings of this analysis of the data collected on all clients admitted to the Buttery between 1980 and 1992 can be briefly summarised as follows:

1. The typical Buttery client during the period of study was a 28 year old male with a primary opioid drug problem complicated by polydrug use, particularly of alcohol and stimulants.

2. Prior treatment experience was common with three out of four of clients having been detoxified (other than as a condition of entry to the Buttery), and one in three having been enrolled in methadone maintenance treatment.

3. The average age of clients increased steadily (by about seven months per year) over the period of study.

4. There was an increase in the prevalence of alcohol and stimulant problems, and of polydrug problems among the Buttery's clients over the period of study.

5. Over the period of study there was an increase in the exposure of clients to methadone maintenance treatment prior to admission to the Buttery.

6. There was a steady decrease in median length of stay until 1987, whereafter it increased.

The characteristics of the Buttery's clientele were similar to those seen in methadone maintenance treatment during the same period (e.g. Caplehorn, 1992). The most obvious similarities were in the preponderance of opioid problems and polydrug use, the predominance of males, the average age in the late 20s, and the extensive prior exposure to detoxification.

The time trends in average patient age and increasing polydrug use probably reflect changes in the population of persons who are dependent on heroin and other illicit drugs. Similar increases in age and the prevalence of polydrug use have been observed in methadone maintenance patients (Hall, Bell and Hay, 1993), and among clients admitted to WHOS therapeutic community between 1985 and 1991 (Swift, Darke, Hall, and Popple, 1993). The consistency in these trends across treatment types (methadone and drug-free and different agencies) suggests that heroin users seeking treatment over the past decade in Australia have constituted an aging cohort. A similar phenomenon has been observed among American methadone maintenance patients (Ward, Mattick, and Hall, 1992). The reasons for these changes remain unexplored although one likely possibility is that there have relatively few new recruits to opioid drug use over the period.

The increased prevalence of polydrug use including stimulants among illicit drug users has also been an international phenomenon, particularly in the United States (Gerstein and Harwood, 1990). The shift towards greater stimulant use in the Buttery's clients has been much less dramatic than the much larger shift to cocaine use among injecting drug users in the United States (Gerstein and Harwood, 1990). This reflects differences between Australian and the United States in the availability of cocaine, and hence in the prevalence of problematic stimulant use (Hall, Carless, Flaherty, Homel and Reilly, 1992; Hall and Hando, 1993).

The increased exposure to methadone maintenance treatment reflects changes in treatment provision in Australia. Methadone places in Australia have steadily increased from less than 3,000 places in 1985 to over 10,000 in 1992 (Ward, Mattick and Hall, 1992). Given the preponderance of clients with an opioid drug problem at the Buttery it is not surprising that there has been an increase in the proportion of clients who have been enrolled in methadone treatment.

The changes in length of stay are less likely to reflect changes in the population seeking help at the Buttery and more likely to reflect changes in policy, program philosophy and treatment goals and content over the period of study. The decline in length of stay in the early 1980s reflects staff concerns about creating dependency upon the program which resulted in the establishment of an aftercare support system and an increased emphasis upon the use of the Narcotics Anonymous fellowship after discharge. Once such a support system was in place shorter client stays were possible and were encouraged. The increase in length of stay after 1987 reflected the concern of program staff that the decline in length of stay had gone too far and longer lengths of stay were required.

Although there are reassuring similarities between the trends in patient characteristics at the Buttery and WHOS it would be premature to conclude that the Buttery's clients are representative of drug users in therapeutic communities throughout Australia. It is hoped that the results obtained from this analysis of patient records may encourage other therapeutic communities, and drug-free treatment centres, to undertake similar studies, the results of which will provide a more accurate description of their clientele. Such analyses may turn up information that has been missed when treatment providers have their noses pressed to the treatment grindstone, such as occurred in the present case with the increase in average age which had largely gone unnoticed by Buttery staff. By undertaking such analyses, a national picture of patient characteristics, treatment content and program duration may be obtained that will enable drug treatment and education to be better tailored to client needs.

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**Appendix 1: A history and description of The Buttery.**

The Buttery is a residential therapeutic community for the treatment of chemical dependence. It is situated at Binna Burra on the Far North Coast of NSW, and located in a building that once was the Binna Burra butter factory (hence the "Buttery"). It caters for a maximum of twenty four single adults living in three separate households. The Buttery endeavours to maintain as "normal" a non institutional setting as possible. The extended household concept maximises the opportunities for interaction and acquiring living skills through the shared responsibility of managing a house. A strong emphasis is placed on individuals being active participants in the recovery process by accepting responsibility for the personal application of insights gained.

**History**

In 1972 John McKnight who was working as a Church Army Officer in the Anglican Parish of Ballina started a ministry for youth in response to an influx of young people into the North Coast following the Aquarius Festival. Capt McKnight wanted to establish a base for an outreach service to the surrounding areas of Nimbin, Mullumbimby and Lismore at the Buttery to assist itinerant youth and to provide a statewide service for troubled youth seeking help with living problems generally. His vision was to develop a Christian Community where people needing assistance could come, contribute to the community in whatever way they could and at the same time benefit from their stay here. He moved into the old butter factory (which had been sold to private ownership in 1947) when it was offered to him in 1973.

To quote from a promotional pamphlet of the time:

"Since then (1973) a community of committed Christians has evolved (and is evolving) having four clear aims.

Firstly: To communicate the Gospel of Christ.
Secondly: To care for fellow Christians.
Thirdly: To be involved in Social Action.
Fourthly: To develop Christian Community."

Like all community based organisations the Buttery was strongly indebted to the commitment of large numbers of volunteers who participated in facilitating the vision through contributions to management, construction, counselling and fundraising. The galvanising of energies through McKnight's evangelism drew support from both the local Christian community and from Christian groups statewide.

Since its establishment in 1973 the Buttery has evolved into a therapeutic community. In its early days it provided a "dropin" refuge on the Far North Coast. In 1976, for example, 3,728 people stayed at Buttery for varying periods of time and 4,000 visitors came to see the work that was being done. Reports from the time indicate that the large numbers of people passing through provided a constant drain on the energies of McKnight and his followers.

As early as 1977 there was questioning of the overall direction in which The Buttery was heading. An increasing interaction with drug affected people caused the focus to shift from the heady ideals of developing an alternate Christian Community with an outreach mission to becoming a therapeutic community with the specific task of treating drug dependence.

In 1978 a grant was received from the NSW Drug and Alcohol Authority and work was begun on expanding the accommodation facilities. A Constitution was drawn up which became effective in August 1979, a second accommodation unit was completed and with increased Government funding staff were employed to provide administrative and counselling support that required specific drug counselling skills. The first Annual General Meeting was held in August 1980 and the first "graduate" passed through the program and received their graduation medal.

In 1980 Capt John Mcknight took up a position as coordinator of NADA (Network of Drug and Alcohol Agencies). McKnight took twelve months leave of absence and Andrew Biven took up the position of Acting Director. Andrew Biven introduced changes in the program's direction and structure. Group therapy was introduced, and a program was documented with rules and guidelines governing acceptable behaviours as a condition of staying, art and craft were also included in this embryonic program.

None of these changes were greeted with enthusiasm by the incumbent residents as they meant a move away from the previously leisurely nature of the program. The question of abstinence arose early in the restructured program. Attempts to teach social drinking were not working and so the idea of teaching people to modify or control their drinking was abandoned. This change precipitated another mass exodus of residents from the program.

Early in 1981 a 17 hectare farm was purchased nearby with the intention of expanding the program by providing independent accommodation to "graduates" or those in the later stages of the program. During this year the structure of the program clearly conformed to the classic definition of a therapeutic community with a staged program consisting of eight levels, behavioural, moral and ethical boundaries were becoming more clearly defined and the concept of shared responsibility in all areas of an individuals progress and the general welfare of the community was consolidated.

By 1982 The Buttery was offering in its description of its program:

"support and understanding.
a drug free environment.
space and time to learn and experience new ways of living.
creative alternatives.

"The Buttery is a community of addicts,volunteers and trained staff where decision making is shared and where each member is expected to actively participate in all aspects of the program."

The employment of two new staff in 1981 and 1982 introduced the "12 step philosophy" to the program and its influence grew from that time. After some initial resistance, the 12 step philosophy gradually became incorporated into the program as an adjunct to the holistic living skills education. By 1983 residents were being encouraged to consider the philosophy and the Fellowship as a means of providing practical,emotional and spiritual support in both the immediate and the long term aftercare situation.

Aftercare was a consideration in securing a half way house at Artarmon in October of that year; the transition from a long term residential program isolated from the mainstream had been a difficult time for many residents and the opportunity to move gradually back into society through a supportive network in the house and the Narcotics Anonymous Fellowship was a welcome addition to the program. A flow-on from the development of this aftercare support was the shortening of the residential program which could be done knowing that people who left before completing the program would not be without support or a means of continuing their recovery in Sydney. The next two years provided a period of stability which allowed consolidation of the program.

In late 1985 Andrew Biven accepted a position with the S.A. Drug and Alcohol Services Council to establish a therapeutic community in Adelaide. Prophetically Andrew Biven anticipated some disruption after his departure: "The change and the challenge for me and The Buttery may be a little traumatic in the short run,but I'm sure that a new infusion of ideas and energy can only be for the good."

Two short term Directors replaced Biven over the next two and a half years: Carolyn Stoney and Steve Kinney. In 1986 another half way house was secured in Surry Hills and The Buttery joined the newly formed Australian Therapeutic Communities Association. In mid 1988 Steve Kinney left The Buttery and was replaced by Barry Evans, the current director.

Three Directors in a relatively short period of time, the retirement of some long serving Board Members and the inevitable staff changes had contributed to a period of dislocation in the management of the program. A period of relative stability returned with the appointment of a new Director and a new Board of Management in 1989.

Since then The Buttery program has continued to evolve. The traditional strong emphasis on the value of the therapeutic milieu remained but was built upon by broadening the skills of the counselling staff, many of whom enrolled in the TAFE Drug and Alcohol Advanced Certificate course. The content of group therapy became more structured, and daily individual case management was provided to help in addressing the attitude and behaviour change.

Today residents at The Buttery embark on a standard program involving group therapy and education, living skills instruction and stress management training, and art therapy, as well as orientation to the 12 Step philosophy and self help groups. Following a six week assessment phase they can elect to move into a second phase of five months during which as well as continuing to work in the personal areas already mentioned they can begin to address personal issues which have affected their lives and reduced their potential to cope without using drugs or alcohol.

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**The Buttery treatment goals and objectives.**

1) **Abstinence**

1.1 Acceptance of the need for abstinence as a precursor to the process of personal/behavioural change.

1.2 Examination of reservations/barriers to the need to adopt abstinence.

1.3 Increased understanding of harm minimisation/at risk behaviour issues

1.4 Introduction to the self-help model as a mode for recovery.

2) **Increased understanding of addiction & its effects on self & others.**

2.1 Understanding of the nature of the addictive process.

2.2 Increased awareness of effects of addiction on self.

2.3 Increased awareness of effects on significant others.

3) **Improved self-esteem**

3.1 Increased use of cognitive restructuring techniques to undo negative thoughts, negative emotional states and dysfunctional behaviour.

3.2 Increased use of problem solving skills, self assessment, decision making.

3.3 Increased use of planning and problem solving techniques.

4). **Improved Relationships**

4.1 Increased understanding of effective relationships, active use of support systems.

4.2 Increased use of assertive communication and behavioural skills in relationships.

4.3 Increased understanding of the needs of family/partners etc.

5). **Improved Social Functioning**

5.1 Introduction to leisure time activities which do not include drugs/alcohol

5.2 Learning to live with other people, accept individual differences.

5.3 Involvement in community activities such as sport, "dining out", local Fellowships, etc

6). **Relapse Prevention**

6.1 Increased understanding of the relapse process and increased use of relapse prevention techniques.

6.2 Introduction and use of meditation and relaxation techniques.

6.3 Increased use of self assessment and decision making skills.