Submission to Issues Paper 10 Topic E on behalf of Heal For Life Foundation (previously called Mayumarri)

Background
Heal For Life Foundation (Mayumarri) was the healing arm of ASCA (Adults Surviving Child Abuse). ASCA was founded in 1995 by Liz Mullinar AM, who is the CEO of Heal For Life Foundation, to advocate for better resources and appropriate healing therapies for survivors of child abuse. This was because, as a survivor of church and family sexual abuse, she was unable in the early nineties to find services to meet her needs.

The original concept of ASCA was to bring survivors together, and 55 groups throughout Australia were formed to provide validation and mutual support. Liz Mullinar AM was commissioned to write 2 books on the subject by Hodder Headline, both of which were to support survivors and encourage them to heal from their abuse.

However, survivors found that meeting in groups was not sufficient as people tended to stay victims finding that repeating their story again and again only confirmed the victimhood. Everyone wanted to heal, not just to be validated, and healing was not possible in the time or the environment of group meetings.

Weekend healing seminars were also trialled but they just scratched the surface and had the danger of possibly leaving people not only feeling unsafe but actually being worse than before they came as they started to unpack painful hidden childhood memories. It was agreed by the management of Mayumarri /ASCA that what we needed desperately was a residential healing program. This was confirmed by an enormous correspondence with survivors from all parts of Australia during the nineties. We all decided we needed our own place, run by survivors, a safe place, where survivors would set the guidelines and we would decide on the treatment instead of often well-intentioned, but sometimes ill-informed health professionals. Almost all of whom had not studied trauma* and did not understand about the importance of safety when working with trauma. We knew a prime necessity to healing was to have a residential service run by survivors of child abuse, well trained in how to help survivors heal from trauma. We knew that - for safety - we needed to stay for several days or weeks if we were to successfully unlock trauma. We knew that attending even the best psychologist for one hour meant the healing process was very long and almost impossible to get to the heart of our fear.

As Heal For Life we determined we would help people heal by providing a safe residential centre. Hopefully a side benefit might be that the people we healed might chose to become the health professionals of the future, so more appropriate empathetic understanding services would be offered in the future. This has proved to be the case; we now have our own list of fully qualified therapists who have healed and trained and now support survivors to heal throughout Australia.

In 1999 Mayumarri, our first centre for survivors of child abuse, was opened by the then Governor-General Sir William Deane. Since then a centre for children was opened by Mike Munro and Bryce Courtney in 2003 and a centre for young women, Hennessy House, was opened by the then Minister for Health, Tony Abbott MHR in 2006. Phillip House was opened by the State Minister for Mental Health, Kevin Humphries, in 2010.

The three centres (now called Heal For Life Foundation) have supported over 6,500 survivors and their families to heal.
Training became a priority, to ensure best possible practices. Initially we employed psychologists and psychiatrists who were survivors of child abuse but found they had difficulties with a truly Trauma Informed approach so in 2003 we determined it was necessary to run training for all our staff in-house. This to be in addition to any external qualifications. We decided that knowledge about trauma and being able to be non-judgmental, empathetic and congruent were critical to enable our guests to feel safe. This training is now extended and runs all over Australia to anyone working with trauma survivors and for therapists who wish to understand how to heal people from trauma.

We pride ourselves on our training for Aboriginal people and this has been run throughout Australia including in the far North for remote Aboriginal Communities. Organizations we have trained are many and varied and include: Bloomfield hospital nurses; Wesley Mission Youth workers; Headspace team Southern Victoria; West Australian sexual crime squad; Salvation Army Oases shelter and smaller organizations such as Jenny’s Place – a women’s refuge in Newcastle.

Our healing programs currently receive no Government funding. We are self-sustaining through running our training, by running commercial services such as private retreats on our property, and a “coffee van” which we use at markets to raise awareness as well as funds. Most of us are volunteers because we believe passionately in the rights for survivors to have somewhere where they can heal.

Specific questions

Topic A. We need:

1. A. Services genuinely run by trained survivors of child abuse or trauma.
   B. Services which empower, recognizing the deep impact of the powerlessness felt during abuse.
   C. Services which recognize we are the experts and innately know what we need to do in order to heal.
   D. Services which use inclusive non-blaming language.
   E. Services where everyone is genuinely Trauma-Informed.
   F. Services which look to us as the experts.
   G. Services where the therapists have had extensive training in Trauma.
   H. Services which are not too time-limited - such as ten sessions only - as it needs to be recognized that healing from child abuse is not quick.
   I. Non-authoritarian.
   J. Non-judgmental.
   K. Services which recognize we are more than the mental health diagnosis we have been given and which expect us to heal.
   L. Services informed by the latest neuroscientific evidence.

2. We do not want:
   A. Services which discourage the concept that current problems might be caused by childhood issues.
   B. Run by non-experts, newly qualified counselors with little experience.
   C. Run by people who trained more than five years ago, unless they have undergone extensive re-training.
   D. Non-specialist services particularly from large organisations.
E. Services which think a few sessions will “fix” us.
F. Services which do not recognize addictions, mental illness, homelessness, violence, domestic violence as symptoms of childhood abuse or trauma and attempt to address the symptoms separately from the core problem: the abuse.
G. Services which offer sympathy and let us tell our story over and over again.
H. Services which engage the left brain such as Cognitive Behaviour Therapy, Dialectic Behaviour therapy or narrative therapy (that is, until we have resolved our core trauma).

3. A) Finance is the major barrier, plus the very very limited services available.
B) Personal shame and belief that it is our fault, and we are not worthy of support or help.

Our service is available to all regardless of income. The barrier to appropriate services would be addressed with more funding and more listening to survivors, as we do know best what we need.

4. Trauma is intergenerational; people who received dysfunctional parenting parent in the same way. At Heal For Life we encourage parents - once they have healed - to send their children to our kids camps so that the whole family has healed. Our research showed that most parenting services only work for people with some concept of parenting. They do not attract those in real need because they are too ashamed to go. (Research attached).

Topic B – Diverse Victims and Survivors

1. Heal For Life Foundation provides residential healing programs for all without discrimination by age, sex, spiritual beliefs or cultural background.
Our model has been proven to work with people from all cultural backgrounds. Our programs run in the Philippines very successfully and in Aboriginal communities. However, due to societal abuse, we always have the people of non-dominant cultures helped by people from the same culture. This, we believe, is essential. Our Aboriginal programs are run by trained Aboriginal people and in the Philippines by Filipinos who, of course, are also trained counselors and trained by us in trauma informed practise.
Any service needs to be not only non-discriminatory but also empowering. This is particularly important for those from non-dominant cultures, who have been disempowered not only by their abuse but also because of their skin colour or race.

2. Each culture needs people who are survivors and are of that culture to run the services and to advocate. If the dominant culture runs the service then it cannot be an empowering service. We have found this to be essential for success. Training with understanding of the educational limitation of many of our Aboriginal people, as well as for people for whom English is second language, means provision has to be made for learning through non-conventional methods. For all our training programs students can submit their assignments verbally to prevent shaming because of lack of writing skills. We have found training in Trauma Informed Care by services an essential ingredient to ensure the best possible services are offered. Trauma Informed Care taught by survivors of the same culture is, for us, an imperative.
In the first instance we had to use white people to run training, assisted by people from the same culture, however now we can work together always ensuring the main voice is that of the person of the same culture.
3. Having a pre-release program housed separately from the normal prison environment so inmates can address their abuse issues prior to leaving prison. People need to allow themselves to feel vulnerable and this is not safe while still with other prisoners. If all prisoners were offered a one-week residential program prior to or upon release the rates of recidivism would surely lower. We have supported many prisoners on their release with great success.

4. We were funded by the juvenile Justice system in West Australia to run a week long program for Aboriginal young girls (12-16 years old) in Kununurra who were constantly offending and in risk of a lifetime of incarceration. Not one of the girls had re-offended a year after completion of the one week program. This sort of success could be repeated and would be very cost effective. Testimonial attached.

5. The extraordinarily successful SafeCare in West Australia was a perpetrator program which supported the entire family. We need services like SafeCare re-introduced. Healing perpetrators is very important for a safe society. At Heal For Life we believe that all perpetrators are victims of abuse themselves and if they can heal from their abuse and accept their actions there is hope for the future. The demonizing of abusers is not helping survivors of child abuse. Just the general public to feel better. However these services need to be separate from victim services.

Further comment: We do not believe in lump sum compensation unless support is offered. We witnessed one of our volunteers drinking himself to death when he received a large compensation from the Tasmanian Government. Survivors need support and compensation linked to healing so they can overcome the life-long impacts of abuse as well as cash compensation.

**Topic C Geographic considerations**

1. We are situated in the Hunter Valley and in West Australia. Soon an Indigenous program hopes to open in Albury/Wodonga if they can secure funding. The problem of where our clients come from is not a major issue. The issue is cost of the travel. In fact many people want to travel away from their own area to ensure confidentiality and to feel safe, as for some the abuse is ongoing. Aboriginal people are often happy to heal out of country. However, for remote indigenous communities such as Halls Creek or Kununurra it would be far better if they could heal as a whole community in their country. This is their wish but again no funds! In November 2015 Liz Mullinar lectured to half of the schools in the Kimberleys covering half a million square kilometres on Trauma Informed Care in their schools, this is information they were so thrilled to receive and the technology used was very basic but effective, communicating with remote regions need not be expensive but is very important. The Trauma Informed training was followed up with a manual to give ongoing support.

2. Although our main centres are in the Hunter Valley only 20% of our guests come from the local area. People travel from all over Australia to our healing programs as they are not available elsewhere. Distance is only a problem for children as the parents have to accompany them and then stay close by for the whole week which is difficult for them. We have great success with Skyping and we currently have a very good psychologist who has attended our program and who lives in San Francisco. She supports our guests after they leave from the USA!
3. So with modern technology, as long as it is face to face (the optical neurons are the strongest) distance is not a barrier. Finances are the barrier, not distance.

Topic D Service system issues
1. No comment.
2. A central place where all safe services are listed. The system would need to clearly say which organisations have been trauma-trained and which ones are genuinely run by survivors. The current Royal Commission list is very imperfect as you will only allow organizations funded by Government, once again determining for us who we can see. Heal For Life Foundation is not listed even though we are the most researched evidence based successful program running in Australia. It would be far better to use an independent source to ensure anywhere listed is safe. The accreditation system established by the NSW State Government is a starting point. All services should have independent accreditation free from Government opinion. Best of all, let us choose who is best, not the Government or one service deciding about others. Survivors can quickly tell if a service is appropriate. List all services offered. Once again we are being told who is OK to go to. This is very disempowering.

4. Trauma should be a compulsory part of all training for doctors, psychiatrists, psychologists, social workers and all other health professionals. Until this happens we will continue to be ill-served.

As there was no appropriate training for helping people through trauma when we started in 2004 we had to start our own training, even for our most qualified facilitators. We train all our staff and volunteers ourselves, as training courses are woefully inadequate. When we started we did employ survivors of abuse who were psychologists or psychiatrists - however they did not have the knowledge required to really effectively help. Apart from the trauma course run by Judy Atkinson we know of no other training, other than our own which really trains people in how to heal survivors. A course which teaches therapists how to help their clients access their trauma and to help them to feel re-empowered. We now train health professionals and are stunned on a weekly basis of the lack of basic knowledge even many psychologists have.

This does mean it takes a considerable amount of additional study to become a facilitator at Heal For Life and it should be the same for all therapists wanting to work in this area; it should take extra specific training before being allowed to work in this field.

Our curriculum is attached.

Topic E. Evidence and promising practices
1. I would like to submit that the program that Heal For Life runs as being promising, innovative, well researched and entirely devised by survivors of child abuse to meet our very specific needs.

Heal For Life Foundation has been operating a highly successful, trauma-informed recovery model for over 16 years across Australia. The consumer-orientated model has been independently researched and proven to be highly successful. Research attached.

Heal For Life provides a proven innovative evidence based practice developed here in Australia and copied and admired by the rest of the World. In our annual training in January 2016 we will be welcoming psychologists from China, the USA as well as our therapists who
run the program in the Philippines and the UK. All of these people are survivors of child abuse. The peer support element is a critical reason for our successful outcomes. The Heal For Life program has been extensively researched (see attachments) showing that changes are discernible and measurable across a broad range of physical and mental issues. The measures used were those most commonly used by Government and medical professionals, being the SF36 and the K10. Just one example from our research, using the K10; six months after a healing week there was a 43% reduction in people who would be considered by doctors to have a serious mental health illness. All improvements from a healing week are long-lasting. A four year longitudinal study shows that the mental health of our clients continues to improve, as does the reduction in addictions. Four years after a healing program there is a 40% reduction in people who would consider themselves to be addicted to illicit drugs or alcohol. This is double the success rate claimed by AA. It is very unusual for there to be a longitudinal study in this cohort, however we now intend when funds are available to do a ten-year follow up showing the changes in the mental health is permanent. The program has continually be improved and updated from feedback from guests, as well as being informed by the latest neurological research.

The chart shown above shows how far below the Australian norm our guests are and this would be typical of many survivors of child abuse. Middle line shows the improvements in our guests six months after a one week program.

**Components we have found that are critical for successful healing from abuse.**

“Only the hurt physician can heal”

Jung

Safety
Unconditional love  
Equality  
Peer support  
Non judgment

“These components primarily refer to the therapeutic relationship between facilitator-guest and peer support volunteer-guest and are based on humanistic therapeutic paradigms. Specifically, HFL draws largely from Rogers’ work on the necessary and sufficient conditions for a successful therapeutic relationship. Non-judgment and unconditional love are essentially *unconditional positive regard*, and safety assumes PSVs and facilitator are more congruent than guests, thus allowing them the capacity to guide and support. As in person-centred approaches, the guest is assumed to be *vulnerable* while the PSV is not. Though more congruent, the fact that PSVs and facilitators are trained survivors of abuse and previous HFL guests helps ensure the equality of the therapeutic relationship. Peer support and equality here are then reciprocal, and both can be likened to the Rogerian concept of *genuineness*. Non-judgment can be likened to the person-centred process of *accurate empathy*, which is again strengthened by the equality of a peer-support therapeutic relationship. As in Rogers’ original work, all these consistent components should work to foster guest *perceptions of genuineness*.

Though these constant and consistent components do primarily refer to the therapeutic relationship, relationships between facilitator-PSV and PSV-PSV are also characterised by the same qualities. The HFL program therefore indirectly utilises Bandura’s social learning theory, specifically role modelling processes. Through this, the guest-guest relationship becomes characterised by these same components, though obviously without the provision of therapy between guests.

**Plus: we have a very important educational component.**

**EDUCATION COMPONENT**

All sub-components here are based on current evidence-based theories of psychopathology, child development and personality, with the exception of Transactional Analysis, which admittedly has a poor evidence base. However, there is no provision of traditional TA therapy (see below). Given research into the efficacy of psycho-education in facilitating self-awareness and behaviour change, the provision of informative workshops is well justified. The educational sub-components (plus the constants described above and additional theoretical concepts) help to form the theoretical basis of the program’s experiential subcomponents.” Quoted from Megan Perry as part of PH.D research

Our services are available to anyone who wishes to attend regardless of ability to pay. Uniquely 95% of our work force are passionate volunteers from all walks of life. Only our facilitators are paid.

2. We have had independent research, longitudinal studies. A research project funded by FARE (Foundation for Alcohol and Research Education) and currently 2 PhD students are comparing our model with other trauma models.

We need more funded research which has the funds to do random control trials comparing the effectiveness of the various treatments offered.
We firmly believe - and our own independent research consistently shows - the only way to really heal from the actual trauma is by providing residential programs. It is not possible in an hour in a therapist’s office to allow oneself to go into the pain and shame and fear from the abuse, safely.

Through a gradual refinement of experiential successes with complex clients as well as integrating recent research into the program, the Foundation has developed proven methods to assist clients with extreme responses to childhood trauma, such as DID, Complex PTSD and BPD, to take responsibility for their own recovery, learn tools to manage themselves and to take positive action towards a full recovery.

*We prefer the word trauma as it is less blaming and it is trauma that impacts on brain development whereas not all abuse does.
Heal For Life Qualitative Research Report

Introduction

Heal For Life (Mayumarri) is undertaking a series of research projects to evaluate the parenting programme and parenting elements of the Healing week. As part of the broader research, this report concerns a qualitative study conducted by Judi White Research Pty Ltd. The research objectives were to understand and assess the value parents feel they have gotten from Healing Week in terms of their parenting and to evaluate the perceived effects of the Parenting Week and how it might build on the Healing week experience.

Specifically the research aimed to find out:

- What participants feel they have gained from Healing Week
- Whether they feel they have benefited as parents and in what ways
- What specific areas of the Healing Week are seen to achieve most for them as parents
- Whether they have considered going to Parenting Week and reasons why or why not, including expectations of Parenting Week
- Among those who have been to Parenting Week, what were their expectations and how would they describe the experience and the effect on their parenting.
- If they have experienced other Parenting programmes how does Mayumarri compare
In order to fulfil these objectives two focus groups were conducted at Mayumarri.
The groups were structured as follows….

Group One: Males and Females who were parents and had experienced Healing Week but had not experienced the Mayumarri Parenting Week.

Group Two: Males and Females who were parents and had experienced Healing Week and Parenting Week and some of whom had also been to Training Week.

**Conclusions**

1. Parents participating in the focus groups believed that the process of healing themselves was a major key to being able to successfully parent their children. They positioned healing as providing an emotional framework of self acceptance, responsibility and ownership of feelings within which parenting skills could be developed and utilised, and they regarded the inner child technique and the environment of safety and non judgement as the major components of the healing process.

2. Healing was seen as a gradual unfolding and realisation requiring reinforcement over time. Though participants described an apparent flow over of benefits in their attitudes and relationships with their children the most difficult part was returning from a Healing Week to daily life where triggers and pressures took their toll on the healing process.
3. Those who had not been to a Parenting Week were often too focused on their own pressing need to heal to consider other options. Many believed there was no point in going until they were further down the healing path when the parenting issues would either be largely resolved or solutions and strategies more easily taken on board.

4. Though some were keen to learn parenting techniques and skills that they might use in the process of healing, a major barrier to attending a Parenting Week was the involvement of other family members. There was fear and uncertainty surrounding how, when and what to tell their children and how their children might react (or what they might reveal) within the Mayumarrri environment.

5. Some who had attended Parenting Week did so out of interest after being to several Healing Weeks and some of these had subsequently gone back to both. Despite uncertainty about the involvement of their children, some had gone with the hope of moving their families forward while they healed or to gain some support and understanding at home. Whatever the case, most expected to get strategies they could use for more effective parenting, even if these were of a practical short-term nature to be used as their healing progressed.

6. Having been to several Healing and Parenting Weeks, respondents found it somewhat difficult to clearly differentiate the specific benefits of each. However they believed that without Healing, Parenting Week did not offer long lasting or real benefits.

7. The primary differences were that Healing Week was about the emotional self and parenting the inner child, while Parenting week was about parenting others and external consequences. There is no doubt that participants had found value in Parenting Week in the reinforcement of Healing Week and in
skills regarding conflict resolution and the recognition of how their behaviour effected those around them, but nonetheless that without healing the benefits were probably transient.

8. Those who had attended other parenting courses/days or programmes felt that these too were more valuable the more their healing progressed, and though providing helpful hints and strategies for parenting were more stop gap strategies on a surface level. It was the healing that allowed the real parenting benefits to emerge.

9. There were some suggestions about the content of parenting week

- Follow up day sessions to reinforce parenting week
- A parenting manual to refer to at home to help in specific situations or simply to give confidence
- Age related parenting strategies
- Importantly, advice on how when and what to tell children

10. To sum up, the research indicates that healing weeks provide the basis for long term parenting benefits which develop as the healing progresses. The benefits are primarily in providing a framework to allow parenting strategies to develop and grow. The Parenting Week helps to reinforce this and can provide short term rational strategy while healing continues.
Findings

1. The Group Participants

The group participants had come to Mayumarri out of varying levels of need, some with excessively high levels of emotional overload, feeling unable to cope and/or suffering extreme depressive bouts /long term depression. A number had undergone treatment/therapy for much of their lives and some continue to have ongoing therapy.

The people in the groups had been to Healing Week between once and up to 6+ times and a few had been for the first time as recently as two weeks prior to the focus groups.

Given this mix and the other variables of personality and situation, the group participants represented varying stages of healing, some regarding themselves as only just aware that healing might be a possibility, others describing themselves as well down the track to being healed. As intended, one group had been to Healing Week only, the other group had also been to Parenting Week and some also Training. In discussing the perceived benefits and outcomes of each it was sometimes a complex task for them to clearly separate the Healing and Parenting Week experiences as these were seen as closely interwoven.
2. The Healing Week Experience

a) Safe Environment

In discussing the Healing Week experience participants tended to emphasise the Mayumarri environment as a major factor of differentiation contrasting with other therapeutic environments they had experienced. The major differential was the fact that all at Mayumarri were survivors of child abuse where other environments involved the presence of psychologists/councillors or medical/welfare/church professionals. While several still attended other therapy and some inferred they trusted and valued their therapist, the one clear characteristic emerging as an overwhelming positive in contributing to their healing at Mayumarri was a feeling of safety and encouragement that emerged without fear of being judged or misinterpreted.

“Just to come to Mayumarri on the first day, I sat on the chair and I looked at everyone ..I’d never met another person who’d been abused before... I looked at the faces and it was like ‘oh my goodness, you know, you know!’ and people understood” .... “When you are with people who’ve been through the same thing you’re on the same journey, you know you won’t get that kind of acceptance elsewhere, you risk being vulnerable to others who don’t know and that’s terrifying to an abused person” .... ”You’re in a group of people all from the same boat, a safe place to start because no-one wants to rock the boat for anyone else” .... ”It’s not till you come here you feel safe enough to let it all out” ... “I started in therapy, I trusted him, but I didn’t feel safe enough to deal with it till I came here- I felt hugely safe, now I can take it back to therapy and back there it hasn’t changed but the healing week gave me the security” ...”It’s safe to look at your stuff here”

In such an environment, several described feeling free to release their emotions/feelings/pain/anger more readily, some for the first time in their lives.
“You’re holding back all your life, you come here and you’re allowed to feel”...
“I think for me it was having space to be allowed to feel, to cry and let stuff out
that in normal life you just put away, space, love and acceptance”...
“I sat near a statue in the garden, I interpreted it as a child cowering down and that just
triggered all this emotion and I sat there blubbering and felt like an idiot and Liz
happened to walk past and she said ‘its OK to cry dear, let it out’ and it was like
ooh.. unbelievable”

b) The Healing Process

The process of healing was described by group members as a journey which some
were just beginning, some in the middle and others feeling closer to completing.
The heart of the process was portrayed as tapping into inner feelings through the
technique of the inner child which was seen as a valuable and meaningful tool.
A few, particularly some males in the groups, described how they had taken some
time to get in touch with their inner feelings because they had spent so much
energy suppressing them. The healing week experience had given them the ability
to unleash feelings some were unaware they had.
“it’s the release by allowing yourself to feel – the inner child does that”...
“It was great unleashing this kid I didn’t know”....
“I thought it was a bunch of bananas at first, then I started to feel and learned how to be a child, that was a key”
The healing process was viewed as a continuing one which needed to be built on
and reinforced. While respondents used descriptors such as “overwhelming” and
“life changing” and “empowering” or “an absolute revelation” when talking
about their experiences, they nonetheless recognised the need to reinforce the
process by repeating it. Some had found the experience of returning to their
families and daily lives somewhat difficult in the sense that they had been through
a “huge” experience while their families had not.
“They know you as one person then you come back different in some ways and it's hard to explain however understanding they are... it's enormous”

c) Healing Week Outcomes
The outcomes of the Healing Week experience were depicted primarily in terms of the self – self awareness, self confidence, self esteem, self validation and the concept of accepting responsibility and ownership of decisions, actions and feelings. Group members described a realisation and a sense of ‘falling into place’ leading to spiritual and emotional release.

“You realise you are worth something apart from a reflection of what other people think”... “It changed me in knowing I'm a worthwhile person, not just because I'm a mother or a wife”.. “Validation of yourself as an individual, feeling good about yourself”... “The most important thing about healing week was to accept myself for who I am rather than hate myself for what I've been to other people”... “I was running, running from me and not relating to other people”.. “Validation, it’s not my fault but I'll take a long time to work through, its been a long time in the building”.. “I learned we are all important and adequate, its about myself”.. “I've got more self worth and that, I've been depressed all my life, its all about getting a feeling for myself”

For those who had come to Mayumarri in a distressed state, the experience of the healing week had been highly impactful, building a framework within which they felt they could continue to heal

“There’s that protection you live so long with pain inside and you just obliterate it. I attempted suicide and it was a relief to find others felt that bad, you think you
should know better, you can outwardly function and you’re inwardly a mess. Here you let out all the stuff you put away, ..you claim back your life and get a tool to work through” .. “Mayumarri gave me purpose to keep living, I was prepared to do myself in if this didn’t work, it was the last straw, it gave me purpose and direction, a purpose to my life, ... you can’t be free if you don’t have a person inside, I’ve got to get ..love from me” .. ”the whole thing has turned my life around, I was sick and I had to get into what was happening emotionally and spiritually, let it out then my physical body started to get better”

d) The Effect of Healing Week on Parenting
All participants in these discussions were parents and most had seen their own problems and inability to cope as the major reason to go to Mayumarri, and the main benefits of the week in terms of their ‘self’. However some implied that being parents had magnified their inability to cope and had been an incentive to heal. Many recognised that in order for them to become good/better parents and, specifically, not to repeat their own parents’ mistakes, it was essential for them to face their own problems and heal as individuals The healing week was seen as providing a valuable framework for all relationships and as having a strong flow over effect on parenting, the premise being that the start point was themselves. Some had experienced difficulty in parenting or relating to their children while others feared that they may repeat their own abuse on their children, recognising the potential for this to happen and seeing the healing week as a step towards preventing this.

“I was aware that I didn’t want to parent my child the way I was so I went on the healing journey’ ... “It’s always part of you an you’re aware that what is inside here effects your children, that was one of my reasons, I didn’t want my child to go through the same trauma” ... “Before I came here I wasn’t coping with life let alone being a parent, if you’re not coping with life then you’re not coping with being a parent” ... “Their security will come from having a more secure
"Mum"... "I was committed to healing for the benefit of my family, for the people I love"

Participants described their parenting problems and issues in various terms. In some cases it was demonstrated in their general frustration with their children and tendency to shout or lash out, and in their unwillingness to allow their children to let their own feelings out, in other cases they described a distancing from their children, either deliberate withdrawal or simply lack of ability to relate well.

“I was this horrible angry yelling mother to my kids all the time and not coping, couldn’t go anywhere even shopping” ... “I was getting flashbacks, the kids would whinge or cry and that’s like what’s in your head, you’re just not saying it out loud’ .. “I used to lapse into the authoritarian role” .. “Didn’t know what to do with my emotions, I’d regress and yell if she got upset” ... “I’d snap then they couldn’t talk to me” .... “I couldn’t relate to them so I backed off and left it all to their mother”... “When you’re thrown in there as a parent the tape’s already wired, it’s like in the heat of the moment you will yell and scream and call them whatever, just like you were called.. it’s like trying to re programme them tapes”... “ I realise how much of my personality they see and pick up how much I’m putting stuff onto them hadn’t realised how far it had gone, I need to address that first”

Going to healing week had resulted in resolving or at least addressing and being aware of the causes of some of these issues. As such it had formed a strong platform from which their parenting skills could develop. The parents in these groups recognised their own healing and its relationship to their attitudes to parenting. They described the experience of getting in touch with their inner child, of taking responsibility for their feelings and of self validation as freeing them from much of the frustration, anger and pain that threatened their relationships with their children. In identifying their own changes they described how their parenting approach had begun to change or in some cases had changed
considerably, how they recognised and reacted to triggers and how their inner understanding had led to benefits for those closest to them.

“Once I came here I was transformed—not so angry— they’re not afraid to approach me now” ... “Mayumarrri allowed me to value me, to fix that little girl, so I could parent my own children” ... “Now I’m easier I have more patience, I let them let out their anger and I know it’s not against me”... “I’ve been hospitalised, I’ve been on a long journey of counselling yet you soldier on trying to key into the parenting more; when you come here it’s the self worth thing, you learn to talk” ... “Mayumarrri taught me self respect and that made me respect others including my kids” ... “It’s hard because spread over my kids ages is when my abuse occurred and its hard to get in touch with normal feelings of that age group - things I felt at those ages weren’t validated for me, they were wrong, now I speak to them better not at them”... “when I first came back home the kids said we’ve never seen you so calm”... “You have the power to stop before you react, and think”

2. Parenting Week

a) Reasons for Not Attending Parenting Week

Reasons for not having been to a Parenting Week were varied, though clearly some had not made up their minds while others were fairly definitive.

- Personal healing was viewed as a necessary pre-requisite to, and a major element of parenting. For those who had only recently attended Healing Week or who saw themselves on a fairly long and difficult road to healing, there was a clear feeling that they needed to attend to their own healing before being able to even consider a parenting course. For these people the process of healing and the emphasis on the self was still paramount.
“I’ve got to look after me first, I’m not ready yet – I don’t want to overwhelm myself, I need to do as much as I can to work on myself... for her” ... “I’m just starting on my own and I want to get a bit further down the track before I go on to a parenting course”

- Further to the above some were convinced that there was no point in their learning about parenting before they were healed and that the process of healing would largely take care of the parenting issues as was evidenced by their own experience up to now.

“It’s no point me going to a parent course until I’m healed myself” .. “I’ve already become a better more balanced parent by going to the healing weeks you realise so much about yourself as a parent”

- Some felt they had done all they could to become good parents in the past from reading all the literature to attending classes and courses. They had all the information, the rules and ‘do’s and don’ts’ in their heads and indeed some stated how they had religiously stuck to these even to the point of overdoing it. They argued that this did not help them become any more than robotic carers while they were not healed themselves. They felt that healing would allow them to relate to and know how to love their children so that the parenting strategies could be carried out in that context.

“I’ve done parenting stuff and read books and been this conscientious mother, you know, baby can’t be fed on it’s own, I’ve got to nurse it and all this stuff, I was doing it all but I was emotionally detached because I hadn’t dealt with my own pain, we need to deal with us to make (the parenting) work” ... “If you reclaim your sense of being able to direct your own life then you get to claim it back and have a tool to work through it because you’re unaware you’re dumping it on your children, if you work through it you’re kids won’t cop it” ... “Did all the right things that the parenting people tell you... but it was very plastic and
One group participant had been to a parenting course after Healing Week (but before Mayumarri had begun a specific parenting programme) and felt she had gained a few useful strategies. She did not want to confuse herself or her husband/children by attending another parenting programme and had made the decision not to go to the Mayumarri Parenting Week. She felt that the Healing Week had laid a good foundation for carrying out the parenting strategies from the (ST John of God) parenting programme and was satisfied that these were useful and workable as long as her healing continued.

One of the major issues in the decision about attending a parenting week and a barrier to some considering it, was related to the understanding of what it involved and the implications of this. Several made the assumption that a parenting week would involve their children and this in itself caused some consternation (and indeed fear). Some had not told their children about their own abuse or the reasons they had been to Healing Week, or had only conveyed a very diluted version of their situation. In part this was to save their children from suffering and in part it was simply seen as inappropriate (or sometimes dependant on the ages of the children). They had yet to decide whether telling their children was the right path to take or not, were unsure how to go about it and were weighing up the pros and cons. Among those who had told their children on some level, there was a concern that the children themselves may talk or taunt each other or give misinformation and they were not yet ready to handle this. In their efforts to save/protect their children from sharing their own pain and in their desire to protect themselves, they chose to keep them at a distance from Mayumarri.
Related to the above was the feeling that if they had not abused their own children they should not expose them to the whole experience nor to send them to a programme for abused children because it introduced an inappropriate stress on their lives. Clearly some had been abusive to their own children, or were aware their children had been abused (though the nature/extent of abuse was not discussed at length in the groups) and had some feelings of shame about it and did not want this to be revealed until they were ready, if at all.

“ My kids feel badly done by if they miss a video, I don’t want to burden them with all this”  … “They don’t know why I’m here, I wouldn’t like them involved, some would know and some wouldn’t, for me it’s a bit of a cauldron, kids who are innocent and kids like to pick on others – it’s an unknown quantity.”  … “My kids have a vague idea of what mum’s been through I guess if I came to Parenting Week I’d like them to be there and deal with it, I just have to judge when we’re all ready”  … “I want in a way, I want to keep it nice and I want to keep my parents nice, their (the children’s) wellbeing is being able to be feeling normal growing into adults”  … “ Talking to kids is a hard issue, I feel scared of them being abused through exposure to stuff they don’t need to be it’s not right for me”  … “I think I’m a better parent now and we’ve talked about it at home and we have a healthier, well directed, less forceful relationship, so I don’t see the need to open it up”  … “ My kids haven’t been through any abuse, it’s me and the kids kamp is for abused kids or they might be there, so I don’t know”  … “I feel more balanced in my parenting now”

When participants were asked what they would like from a Parenting week responses were fairly varied and often a function of their stage of healing, the ages of their children and how they felt they were coping as parents. Most believed that their own healing and their ability to parent were so closely linked that continuing going to Healing Week would provide them with
the ability to parent successfully, or the ability to take on board and put into practice parenting strategies and ideas. However with regard to the content and purpose of parenting week some expected it might be an extension of nurturing their inner child and as such an extension of Healing Week, while others were more inclined to see it as a chance to get some practical advice on parenting strategies, or on strategies to deal with telling different child age groups about their healing. A few felt it was a chance to get their partner/family involved in their journey at least in terms of their parenting skills and for some it would be to get reassurance that they were “doing a good job”

“To get the whole family moving forward not just me”… “I’d expect skills on how to parent that I missed out on in childhood, how can I, what is it I have to do to be a parent, instead of fumbling in the dark.” … “After dealing with my stuff then I could cope with a parenting course and utilize the tools they give me”.. “Ideas on how to reverse what we’ve done”

There is some indication that some parents may view the involvement of family in the parenting week as a chance to get some understanding (sympathy?) for themselves from family members.

b) Reasons For Attending A Parenting Week

Within the group who had all been to at least one Parenting Week some were specific about their reasons for attending while others appeared to simply have thought it would be of interest after having been to several healing weeks. The most difficult part of the healing process was often the return to normal routine at home away from the safety and acceptance
of the Mayumarri environment, where all the triggers and pressures resume and where the other family members have not experienced the same journey. A few had seen Parenting Week with the involvement of other family members as a chance to allow the family to move forward while they continued their personal healing or to get their family members to understand more about their situation.

In some instances the Healing Week experience(s) had changed their attitude and approach to parenting and attending the Parenting Week was to get some reinforcement and support that they were doing the right thing.

Whatever the reason for deciding to attend most had gone with an expectation of getting some strategies for more effective parenting.

c) Responses to The Parenting Week

Those participants in the groups who had been to both Healing Week and Parenting Week were in a position to evaluate what they gained from each. Because the benefits were so closely linked, and because some had alternated between the two, it was often difficult for participants to separate and define the benefits specific to each. However what did emerge clearly was….

- That the benefits derived from Healing Week fed directly into Parenting Week and that Parenting Week did not necessarily stand alone in producing change or long term outcomes.

- This is not to suggest that there were no positive outcomes or benefits from Parenting Week, but indications are that healing was viewed as a necessary preliminary platform for Parenting Week or any parenting programme if they were to derive any real benefits.
Moreover, it emerged that the Healing Week was of the highest priority and value in their being able to function as individuals and as parents, and the Parenting Week was in some sense a reinforcement/redirection of Healing Week.

That the fundamental distinction between the two ‘weeks’ was that the Healing Week focused on the self, dealt with the internal, the emotional and less tangible, while the Parenting Week dealt with external application, the more tangible/practical and the idea of consequence.

Thus where Healing Week allowed them to identify their feelings, Parenting Week showed them how they could express them to others without just getting angry; where Healing Week was about self acceptance, being responsible for feelings and coming to terms with the self, Parenting Week looked at acceptance of children, and responsibility for and consequences of behaviour; while Healing Week was about how to recognise and parent the inner child, Parenting Week was about how to parent others, and while Healing Week was about ‘me’, Parenting Week was about ‘me in the context of home and family’.

“By the time I did the healing I had an understanding of nurturing myself and the Parenting Week showed me how not to let anger get in the way of parenting” … “Healing Week helped me identify my feelings, to accept yourself a bit more and by doing that you learn to accept others you can see how things are effecting them, and Parenting Week adds to this” … “The further I go into healing the more I realise I have to be responsible for me and this has assisted me in being more responsible as a parent instead of shutting down, and understanding how to resolve conflict from Parenting Week” … “The Healing Week showed me how absent I’d been as a parent and that you have a choice of behaviours through your inner child and the Parenting Week makes you more aware of how you are parenting externally through your own children” … “Healing Week was about me, that I hadn’t been a parent to my inner child or my children, in Parenting Week I saw that my children were the mirror image of myself” … “If you didn’t do Healing Week to parent your
inner child, we couldn’t do Parenting Week to parent on the outside. I thought I was loving them before but I wasn’t, now they know I’m there”

Some of these participants had attended several healing and parenting weeks describing the healing process as an ongoing one, an unfolding of their self awareness and acceptance of responsibility. Return visits to Parenting Week were sometimes explained in terms of helping them to further ‘ingest’ parenting strategies in the hope they would become part of their intrinsic parenting patterns.

“The information became an unconscious confidence instead of having to consciously search for it, it becomes second nature” … “Its not learning by rote it’s putting it in there in the subconscious mind”... “The further I go the more I can own where I’m coming from and to own it is to put strategies in place and hopefully I can eventually integrate a reality instead of an enforced behaviour”…” coming back (to healing and parenting) you get more each time, its like opening up and I can let people love me and I can love back”

In addition to this participants found that in Parenting Week where attendees would bounce off each other, they would gain something different from the varied issues and dynamics arising within each different group.

Participants also described how Parenting Week on top of Healing Week, had in some cases brought about changes in their relationship with their own parents often the perpetuators of their abuse. They described a changing of their cycle of behaviour and response that in turn allowed them to achieve a different outcome. They also described less anger and hatred, which was a releasing process.

“I showed my mother a miniscule amount of compassion and it came back tenfold and she is actually trying to nurture me, to be my mother for the first time in my bloody life and without the skills I learned in Parenting Week and Healing Week we’d be going round in circles”... “Spoke to my real mother
for the third time in my life….wonderful to be able to acknowledge to her that I had now taken this journey of recovery ...and say I forgive her ....to have (daughter) speak to her grandmother for the first time.. She was dancing with joy and straight away I saw the generational abuse stop”.

The issue of including the family/children in the Parenting Week was as potent for some of this group as among those who had not been to a Parenting Week. While some had simply decided against it, others had included their children with some mixed feelings. A few described being worried about their children’s involvement and about what to tell them, when, and how to go about it and their concern that it was an indication or admission that their children had suffered abuse.

“I had concern, I hoped it wouldn’t be a heavy week, I told them mainly they might learn skills on anger management, talk about mummy being angry and how they might learn ways of dealing with it and with their own anger also. I might have mentioned you know, some children might talk a little bit about how they’ve had it even worse at home than you’ve got it, I didn’t mention sexual things” … “My boys, they’ve known about my abuse but not specific things, they still see their grandmother under supervision, the oldest had huge problems with the thought of coming here, didn’t want to...said he’d be bored, we got into a hugely emotional discussion...he finally broke down and said ‘look at this (Mayumarri Brochure) its for abused kids ..we’ve talked about that, there’s no problem’, finally they went and said it was the best holiday they’ve had”... “Did Parenting twice because it was an opportunity for the kids to learn how to deal with me as well”

In explaining the outcomes in terms of their daily lives and parenting, participants spoke about boundaries, realistic expectations, listening, communication and conflict resolution. They also referred to techniques as ‘the magic one, two three’, and the recognition of triggers and how to deal with them. As with all the
discussion surrounding the Parenting Weeks, the capacity to utilise these was
drawn from the healing process.

“ I use the idea of boundaries to allow them to be boys and not have the
expectation that they’re going to be perfect.. let them be kids”... “I listen
to them more”.. “ I can cuddle them and feel relaxed about it” ... We
work on consistency, like using the one, two, three magic and it works”...
“I have a better understanding of the way I interact with my children and
the need for continuity”

The need to continue healing was a major factor for these participants and the
need to continue to work their healing into their lives and families was a major
element of this that they believed they might achieve through parenting week.
Some suggested that they could benefit from a parenting programme that operated
on different levels because each time you take a voyage and learn something new
and different angles and perspectives emerge. One who had been to an outside
parenting course indicated that there had been a follow up to the programme in
which participants regrouped to go over their learnings and check on their
progress. A few felt it would be helpful to have a manual to refer to at home with
help regarding specific problems, and others felt they would benefit from strategic
direction regarding age related issues..
Curriculum and Study Guide
2015

1. PSV Certificate in Trauma Healing (Supporting Adults to Heal from Child Trauma with heal For life model) Peer support.
2. Advanced Certificate in Facilitating Healing Groups at HFLF.
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Part 1 - Overview : Heal For Life Foundation, Quorrobolong

Introduction

Background

Mayumarri Trust was formed in 1998 after Liz Mullinar discovered there was no place for survivors of abuse to go to heal from their childhood abuse or trauma. Land is its principal asset, land gifted in perpetuity to provide a healing sanctuary for survivors of childhood trauma and abuse. Since then the land area owned by the Trust has expanded to 220 acres, and a total of 17 buildings and other structures have been added. The land is also buffered by a further 120 acres owned personally by Liz Mullinar and her husband Rod Phillips.

The adult centre was opened in October 1999 by former Governor-General, Sir William Deane. Since then, over 5,000 guests have come for healing.

In October 2003 the Kids Kamp was opened by Bryce Courtenay, and in March 2006 Hennessy House, a residence for young women with traumatic childhoods was opened by Hon Tony Abbott MHR. Phillip House was then opened in October 2010 by Mike Munro, for kids, young men and private guests.

On 1 July 2010 Mayumarri changed its name to Heal For Life Foundation, to more adequately reflect the nature of the services provided.

Who we are

Heal For Life is a not-for-profit organisation based at Quorrobolong in the Hunter Valley NSW.

The trust is managed day-to-day by residents of the Heal For Life Community and a Management Committee of volunteers and staff, with oversight and governance the responsibility of the Trustee’s Board of Directors.

The Heal for Life Healing Program is headed by facilitators who have access to Heal For Life’s Professional Supervisor and also by trained HFLF Peer Support Volunteers who are trained in the healing model, supported by a dedicated band of volunteers and staff.

All facilitators and HFLF Peer Support Volunteers are themselves survivors of childhood trauma or abuse. The Board of Directors – all volunteers – have backgrounds in different disciplines including law, accountancy, health profession etc. The founder and CEO is Liz Mullinar AM, BTh, MCouns.

What we do

The scope of Heal For Life Foundation is providing healing programs for survivors of childhood trauma and abuse run by survivors of childhood trauma utilising a unique peer support model.

Heal For Life provides safe, affordable places for survivors of adverse childhood experiences to come to heal from their long-held trauma. The unique Heal For Life model of healing with a one to three week long program, dependent on age, uses a proven holistic approach embracing the emotional, physical, psychological and spiritual. Its remarkable success, now being extended nationally and internationally. The healing principle is:

Our Vision

‘by survivors, for survivors’
Heal for Life Foundation’s Vision

Everyone, regardless of income, has the opportunity to heal from childhood abuse and trauma which is impacting their daily life.

Be a ‘Centre of Excellence’ for healing from childhood trauma, leading the field in adopting new ways to help survivors heal, effectively and affordably.

Be a valuable resource for survivors and their families, available through all media forms.

Assist survivors, without discrimination by age, gender, spiritual beliefs or cultural background.

Show through our program that peer-supported programs are unequalled.

Have survivor-counsellors of the highest professional standards, supporting our guests.

Have a nationally-accredited training course for Trauma-Informed Care, so Heal For Life philosophies can influence the way trauma victims are healed in all social welfare areas.

Change the way parenting, child-rearing and even perpetrators – are treated in this country, showing a more compassionate view than that currently encouraged.

Operate an effective outreach program to promote a better understanding of the effects of childhood trauma, and to encourage survivors to heal, rather than suffer the debilitating consequences of trauma throughout their lives.

Train health professionals in Trauma-Informed Care so they can be more effective in their support.

Use our knowledge to train workers in all areas of social welfare in Trauma-Informed Care.

Our Mission

To provide affordable effective healing for survivors of all forms of childhood trauma.

Our Values

- Unconditional love
- Empowerment
- Non-judgmental Safety
- Equality
- Empathy
- Integrity
The principles that guide all we do:
Heal For Life is based on unconditional love of self and others, equality, being non-judgmental and is guided by the teachings of Jesus.
Heal For Life provides a safe place for survivors to heal from childhood abuse and trauma.
Heal For Life is run by survivors for survivors.
Heal For Life operates in a non-authoritarian way.
The Heal For Life program offers survivors the opportunity to empower themselves and recognise their own self-worth and potential. Education is an important part of empowerment.
HFLF Peer Support Volunteers / facilitators and staff are actively pursuing their own journey of healing and growth and are endeavouring to follow the Heal For Life Aspirations in their daily lives.
The Heal For Life program offers in-residence healing within a loving and supportive community.
Heal For Life Foundation’s approach is holistic, placing equal importance on spiritual, physical, emotional and intellectual healing.

Services and Programs offered by Heal For Life Foundation

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1.1 Philosophy of Healing
Heal For Life Foundation was created as a healing retreat for survivors of child abuse. The core principles of the loving teachings of Jesus Christ are incorporated into the model. Heal For Life Foundation believes that every person has the innate ability to heal from childhood trauma. We see healing as holistic; i.e. involving body, mind and spirit. Living within a community with clear and agreed boundaries, it is designed to be physically, emotionally and culturally safe to promote healing.

Each person need to be in control of their own healing journey. Healing, we believe, occurs when the person is able to create better integration between their right and left brain. Healing begins with the creation of a holistically safe space. Therapeutic strategies are used to assist the guest connect with the right side of their brain. This leads to emotional release associated with past trauma. The
final stage of healing involves re-empowerment of the inner child and the adult guest. Knowledge, derived from contemporary theories and research, is foundational to understanding and personal responsibility for ongoing healing.

Feeling loved and accepted is essential for a person to heal from within; thus love is our therapeutic ally. Peer Support Volunteers and facilitators, who are themselves survivors of childhood abuse, are best able to support, love, understand and help others. Each guest is supported to create their own meaning and interpretations. Peer Support Volunteers and facilitators avoid directing, giving advice or placing their own interpretation on the guest’s process or meanings. Issues of power and control should be dealt with openly, transparently and in ways that promote equality. All people, regardless of race, religion, gender, culture or sexual preferences have the right to access self-healing with the loving acceptance and support of Heal For Life Foundation Peer Support Volunteers.

1.2 Philosophy of Teaching and Learning

The Heal For Life Foundation teaching model is situated learning. The situated learning perspective is based on the belief that skill development and knowledge is contextually situated and is fundamentally influenced by the culture in which it is used. Learning and skill development are advanced through interaction with facilitators, qualified Peer Support Volunteers and our guests.

Our teaching philosophy means that we use simple language. We aim to help students be active in learning by presenting in a non-authoritarian manner and encouraging interaction between teacher and students and students as a group. We recognise that for many of our students this will be the first time they are able to engage in the learning experience effectively, as previously, their trauma may have created cognitive developmental delays. We organise teaching, learning and assessment in a way that ‘scaffolds’ the student so that their success in learning is made easier. This involves creating learning situations within which students feel safe to learn and to make mistakes without fear of humiliation. We organise learning and assessment tasks to move from simple to complex, progressively over the duration of the programme.

Heal For Life Foundation Community

As knowledge is situated within the Heal For Life Foundation Community, some information regarding this community is relevant. The leader of the week is called a Facilitator. It is their responsibility to run the workshops and oversee the smooth running of the Healing Week. Assisting the Facilitator are Peer Support Volunteers. Peer Support Volunteers specifically walk alongside guests, assist with de-triggering and ensure comprehension of the workshops. At the Adult Centre, we have a week-long healing program. At Hennessy House we hold a two-week, residential program for young women aged 16-25. As with the Adult Centre, each week at Hennessy House is led by a Facilitator who is assisted by a team of Peer Support Volunteers. At Hennessy House, this is on a rotating roster for the duration of the program.
1.3 Library
Heal For Life Foundation has a comprehensive library of over 400 books and journals, which we encourage our students to utilise. All books, journals and articles are available to be borrowed by our students. We can also photocopy pages (within copyright legislation) and print online information for students without access to a printer. Most of the books on our reading lists are available from the library. We are happy to help our students access computers to support their study.

1.4 Student support services
Each new student is offered a more senior student as a mentor. The education coordinator has a role that encompasses pastoral care for current students of the program. Students are encouraged to address any problem or issues they have and to continue to attend regular healing weeks. Facilitators are available to assist students during their practical weeks at Heal For Life Foundation. Peer Support Volunteers meetings are held every six weeks to allow students to discuss any common issues. The general manager provides regular peer supervision and is available face-to-face, and by email or phone to address any serious concerns related to the program or their own healing journey.

1.5 Indigenous Students
Heal For Life Foundation welcomes and supports indigenous students. We offer mentoring from previous indigenous Peer Support Volunteers. In the past we have had Indigenous students and guests so we have a proven record of walking alongside Indigenous guests. One of the competencies of the module is that all graduates will be culturally safe: we recognise the Indigenous culture as a key element in society and embrace knowledge and understanding towards this culture.
Part 2 Curriculum Overview

2.1 Programme rationale
There has been increasing awareness of the impact of childhood trauma and abuse on the victim. However, despite increasing research into the reasons behind behavioural changes and recognition that healing is possible, there has been little specifically focussed trauma healing for survivors of child abuse offered in Australia. This programme teaches a successful way of helping survivors of all forms of childhood trauma: abandonment; neglect; loss of parents, as well as emotional, physical, sexual and satanic ritual abuse. The Heal For Life Foundation Model follows all the latest research and trends in trauma therapy. It is based on up-to-the-minute research and continually supported by the research that is carried out across the globe. It is replicable and affordable. The training programme will be of value for all practitioners in the social welfare arena wishing to work more effectively with survivors of childhood trauma and abuse who, in most instances, will comprise the majority of their clients.

Heal For Life Foundation is increasing its services and availability for survivors. It is critical that the service offered should be consistent, professional and of the highest quality.

In order to achieve this high standard, consistent and clear training needs to be provided by Heal For Life Foundation.

Heal For Life Foundation recognises that survivors of abuse are the most able to help other survivors to heal, so the secondary purpose of this educational programme is to empower ex-guests who are struggling to overcome their intellectual abuse/trauma to recognise, through study, their innate and unique abilities.

The curriculum is experiential and learning utilised together. The training focuses on empowerment of the individual, as both guest and student. The word guest is used throughout, rather than client, to recognise the importance of the non-hierarchical/ non-authoritarian approach which is an essential characteristic of this model. A serving-with-joy approach is an essential component of the Heal For Life Foundation way of helping survivors of child abuse.

2.2 Profile of the Graduate

The graduates of the certificate in adult healing from childhood trauma will be qualified to support the healing of adults, both at Heal For Life Foundation and in other areas of psychology, social and mental health work.

Graduates of the advanced certificate will be able to facilitate healing for individuals and groups including those with complex needs. In addition they will be able to plan, implement and evaluate healing weeks. They will be able to supervise and teach Peer Support Volunteers and trainees. They will know how to ensure that the healing environment is safe for both Peer Support Volunteers and guests.
2.3 Program Aim
Within a supervised and supported environment, the primary aim is to enable Peer Support Volunteers and facilitators to facilitate the healing of other survivors of childhood trauma. A secondary aim is to promote the ongoing healing and educational development of each trainee Peer Support Volunteer and facilitator.

2.4 Program Competencies
1. Demonstrates a continuing commitment to own healing and spiritual development.
2. Accepts accountability and responsibility for own actions.
3. Communicates sensitively and effectively with guests.
4. Promotes safe and effective work practices.
5. Provides and evaluates effective caring interactions.
6. Provides and evaluates own caring interactions for guests with complex needs.
7. Works collaboratively with other members of the Heal For Life Foundation team.
8. Ensures own practises are culturally safe.
9. Ensures own behaviour is consistent with Heal For Life Foundation ethics and philosophy.
10. Identifies own values and beliefs in ways that enhance caring practice.
11. Acts to enhance own learning and development.
12. Practises in accordance with the law.
13. For guests with complex needs, plan, provide, supervise and evaluate the care provided by self and Peer Support Volunteers under supervision (facilitators).
14. Assess, plan and effectively work with groups to promote learning and healing (facilitators).
15. Acts to enhance the professional development of others (facilitators).
16. Use theory and research to inform practice as a facilitator (facilitators).
17. Demonstrate skills in leadership, administration and management in the provision of healing weeks (facilitators).

2.5 Program Structure

2.5.1. Certificate in Trauma Healing (Supporting Adults to Heal from Child Trauma) Peer Support

The certificate is awarded to students who complete all components of the prescribed modules, each of which includes a week’s practice as a Peer Support Volunteer at Heal For Life Foundation. Each module involves 160 hours of student effort.

Each module is offered once a year. Students may take up to four years to complete the certificate.

Table 2 Certificate Program Structure

<table>
<thead>
<tr>
<th>Module</th>
<th>Introduction to Peer Support Volunteer Practice at Heal For Life Foundation</th>
<th>Professional Practice Issues - Boundaries and Visualisations</th>
<th>Applied Transactional Analysis and Conflict Resolution</th>
<th>How to Utilise Faith to Assist In Trauma Healing</th>
<th>Advanced Skills for HFLF Peer Support Volunteers.</th>
<th>WHS &amp; First Aid</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAR 1</td>
<td>10 hours</td>
<td>80 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>8 hours</td>
<td></td>
</tr>
<tr>
<td>CAR 2</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>32 hours</td>
<td></td>
</tr>
<tr>
<td>CAR 3</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>32 hours</td>
<td></td>
</tr>
<tr>
<td>CAR 4</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>32 hours</td>
<td></td>
</tr>
<tr>
<td>CAR 5</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>32 hours</td>
<td></td>
</tr>
</tbody>
</table>

2.5.1.1 Program Hours

Each module totals 160 hours of student effort divided into various components as described below.

<table>
<thead>
<tr>
<th>Module</th>
<th>Self directed learning</th>
<th>Face to face or Equivalent Online Learning</th>
<th>Clinical experience supervision</th>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAR 1</td>
<td>10 hours</td>
<td>80 hours</td>
<td>60 hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>CAR 2</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>CAR 3</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>CAR 4</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>CAR 5</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
</tr>
</tbody>
</table>
NB: During CAR 8 students will be required to attend 1 hour of clinical Professional Supervision to achieve competency.

2.5.2 Advanced Certificate in Facilitating Healing Groups at HFLF

The advanced certificate is awarded to students who complete all components of the prescribed 16 modules; inclusive of the 8 modules in the Peer Support Volunteer's certificate. Thus, for the facilitator’s advanced certificate there are 8 additional modules each of which includes a week’s practice as a facilitator at Heal For Life Foundation. Each module involves 160 hours of student effort.

Each module is offered once a year. Students may take up to four years to complete the advanced certificate.

Table 3 Advanced Certificate Program Structure

<table>
<thead>
<tr>
<th>Semester One</th>
<th>Semester 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAC 9 Introduction to facilitating adults healing in groups at Heal For Life Foundation</td>
<td>FAC 13 Advanced Group Dynamics and Group Facilitation</td>
</tr>
<tr>
<td>FAC 10 Advanced Theory and Research of the Brain, Trauma and Healing</td>
<td>Fac 13 B Issues specific to teenagers, co-morbidity, self harming and addiction issues</td>
</tr>
<tr>
<td>FAC 11 Healing Developmental Delays in Adults</td>
<td>FAC 14 Supporting Survivors with Complex Needs</td>
</tr>
<tr>
<td>FAC 12 Education, training, supervision and development of Peer Support Volunteers</td>
<td>FAC 15 Introduction to theory and practice of facilitating healing for adolescents and children</td>
</tr>
<tr>
<td>FAC 12 B Facilitating young people. How to engage with young people with a Trauma Informed Approach Differences between working with adults and children.</td>
<td>FAC 16 Leadership, administration and competency to Practise as a Heal For Life Foundation Facilitator</td>
</tr>
</tbody>
</table>

2.5.2.1 Program Hours
Each module totals 148 hours of student effort divided into various components as described below.

<table>
<thead>
<tr>
<th>Module</th>
<th>Self directed learning</th>
<th>Face to face or Equivalent Online Learning</th>
<th>Clinical experience</th>
<th>Clinical supervision</th>
<th>Assignments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAC 9</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 10</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 11</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 12</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 13</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 14</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 15</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
<tr>
<td>FAC 16</td>
<td>50 hours</td>
<td>16 hours</td>
<td>60 hours</td>
<td>2 hours</td>
<td>20 hours</td>
</tr>
</tbody>
</table>

2.6 Admission requirements
The admission requirements for both programs should be read in conjunction with our policies on recognition of prior learning and accelerated progression.

2.6.1. Certificate in Trauma Healing (Supporting Adults to Heal from Child Trauma)
In order to be admitted to the Peer Support Volunteer certificate module an applicant shall have:

Essential Criteria:
- Have completed at least one HFLF healing week
- Be open and able to recognise their own vulnerabilities
- Working with Children Check*
- Prohibited Employment declaration (Criminal Record)
- Signed a HFLF ethics (including confidentiality) agreement.
- Evidence of well developed interpersonal skills
- Evidence of teamwork skills

Desirable criteria
- Ideally have access to a mobile phone and internet.
- External qualification in social work, mental health or counselling.

2.6.1.1 Acceptance and Provisional Enrolment in Program
Potential students for the Peer Support Volunteer Certificate are usually recommended by the facilitator of the healing week. This is based on the facilitator’s opinion that the potential student is a sensitive and effective communicator. The student may be provisionally accepted into CAR1 Introduction to Practice at Heal For Life Foundation and complete a one week induction. If, on the rare occasion, the student is deemed unsuitable at the end of the first week of training then they will be interviewed, given reasons and sometimes invited to re-apply at a later date.

A selection interview process may be undertaken dependent on number of applicants in any given year. Priority may be given to some students dependent on the location of the applicant.

Students may also be accepted via interview with general manager and one other HFLF person. Overseas and interstate applicants can be interviewed via Skype or video, not through telephone only.

2.6.2 Advanced Certificate in Facilitating Groups

Student selection is a joint responsibility of the facilitators and CEO. In order to be admitted to the facilitator’s module an applicant shall have or receive prior to completion of training.: 

Essential criteria

- a HFLF healing program as a guest
- Certificate in Trauma Healing (Supporting Adults to Heal from Child Trauma) Peer Support
- A Criminal Record Clearance
- A current Senior First Aid certificate
- Diploma, degree in social or health services or equivalent in relevant experience (including higher order cognitive skills)
- Personal reference to suitability from professional supervisor or counsellor.
- Access to computer with internet facilities
- Access to mobile phone
- A strong commitment to their own healing journey

2.6.2.1 Acceptance and Provisional Enrolment in Program

As well as the criteria listed above, potential students for the Advanced Certificate must be recommended by the Coordinator or facilitator of the Heal For Life Foundation centre where they are hoping to work. This is based on the facilitator’s opinion that the potential student is a sensitive and effective communicator, group leader and educator.

A selection interview process may be undertaken dependent on number of applicants in any given year. Priority may be given to some students dependent on the location of the applicant.
2.7 Modes of delivery
The program will be offered exclusively face to face at Heal For Life Foundation.
We have other modules available as distance education for those people who do
not want to work at Heal For Life centres.

2.7.1 Computer Resources Required by Students
Students who wish to complete any component of the program via online
learning would need access on a weekly basis to:
- A computer with internet connection
- The Software to download and listen to sound.

2.7.2 Modules that are Suitable for Online Delivery
All students need to spend some to at a Heal For Life Foundation site in order to
complete the clinical components of the program under supervision. In addition,
some of the modules require students to be face to face in order to:
- Meet and develop relationships with teachers
- Meet and develop relationships with other students
- Role playing and practice skill learning

2.8 Teaching and Learning

2.8.1 Program Staff
Australia
Program Convenor Liz Mullinar BTh,
M.Couns.GradDipPastoral Couns; Cert 4 Workplace
Training and Assessment.

Lecturer Gloria Cartmel

Professional supervisor Karen Morris

General Manager June Parkin

United Kingdom
Program Convenor Lucy Huntington M.Sc.; PostGrad. Dip;
Dip. Pastoral Couns;
2.8.2 Teaching Methods

A wide range of teaching methods are used including:

- Lecture/tutorial
- Role plays
- Reflection on experience
- Face to face supervision with facilitator to reflect on experiences during healing weeks
- Independent learning
- Guided skill performance
- Project based learning
- Experiential learning

The module is offered in eight parts with attendance at Heal For Life Foundation. It is also available as a distance education programme for those students who wish to apply the principles of Heal For Life Foundation to their own practice. The on-line module offers take-home sheets as well as the opportunity for online discussion with other students and questions to lecturer via written questions.

2.8.3 Assignments

Assignments may be submitted online or by post. All assignments must be submitted within two months of completion of module. All assignments will be returned within one month of submission.

2.8.4 Recognition of Prior Learning (RPL)

Students who can demonstrate that they have learned at least 70% of the objectives of a particular module may be considered for credit for that module. Students may have learned the content of particular modules via formal study or by a combination of experience and self-learning. All RPL requests are submitted to the general Manager and her/his decision reviewed by the accreditation committee. The full process is in appendix 1. Any cases of RPL will be documented and reasons for the decision to give credit will be recorded. Fairness to all students, and the safety of guests, will be a hallmark of the RPL process.

2.8.5 Accelerated Progression

Students who hold formal qualifications (Bachelors or equivalent) in a related discipline, may be eligible for accelerated progression. Some students may be allowed to complete the two programs in an accelerated way. The process for assessment for suitability of accelerated progress is that the student must first apply for RPL (above) to the general manager in writing. This application will be forwarded to the Training and Accreditation committee for verification. After the RPL process there may be some modules remaining. The student who is completing the programs in an accelerated way may, with the approval of the program convenor, enrol in a number of modules simultaneously. Students will have to complete all assessment from those modules and at least 3 weeks (120
hours) of supervised practice at Heal For Life Foundation. Any cases of accelerated progression will be documented and reasons for the decision will be recorded. Fairness to all students, and the safety of guests, will be a hallmark of the process for deciding accelerated progression for individual students.

2.8.6 Working with Students who have Learning Difficulties
Many survivors of child trauma have residual learning difficulties. We take account of this by allowing alternative assessment tasks when students have difficulty writing; these normally take the form of a one-to-one oral presentation of knowledge. We work with students to help them develop their cognitive skills by using worksheet assessment tasks that require small amounts of reading and writing for each question. We specifically teach analytical and decision-making strategies and then test these skills. Only students who are able to read and write and engage in analysis will be able to qualify as Facilitators. Our assessments are developed based upon the scaffolding technique: each module’s assessments build upon the skills developed in the preceding module. As the modules progress, we encourage excellence in fields such as presentation, evidence of time taken, and reflection. In this manner, we set our students up to enjoy ongoing success throughout the module.

2.9 Assessment
Assessment tasks include essays, multi-choice quizzes, self-paced learning packages, critical reflection on experience, presentation in class, participation in classroom discussion. The module includes integrated clinical experience therefore students must display satisfactory progress in clinical learning.

2.10 Academic Integrity
Heal For Life Foundation promotes high standards of academic honesty. We check for plagiarism and require re-submission if detected. Repeated plagiarism can lead to exclusion from the program. We ask for your assistance in this by not sharing your assessments with other students, present or future.

2.11 Clinical Education
Clinical experiences are an essential component of all modules for both facilitator and Peer Support Volunteer. The clinical learning framework has been developed to allow students to gain optimal learning from experience with guests. Peer Support Volunteers are required to complete a minimum of one clinical week with each module. Trainee facilitators are expected to complete a minimum of one caring week for each module*. The theoretical components of the programme are integrated into the clinical experience. Critical reflection is an important part of learning from clinical experience.
2.12 Formative Clinical Assessment

Formative clinical assessment involves three components.

2.12.1 Satisfactory attendance at and participation in the healing weeks

Satisfactory performance will be an evaluation that is made by the facilitator for each week that the student attends (see appendix 2 which uses the final competencies as a basis for considering student progress towards achieving final competency).

Towards the end of each healing week facilitators will meet with each student to provide feedback and encouragement. Well below expectation, slightly below expectation, meets expectations, exceeds expectation]. Where the student is deemed below expectations detailed learning goals are to be developed for that student and a time frame for successful completion is to be set. Once the learning goals have been achieved, the student has passed clinical competency for that module.

If any facilitator has any serious concerns about the student's performance they refer the matter to the General Manager as soon as possible. The student's involvement in the remainder of the week may be suspended pending a meeting with the General Manager. Suspension from the program may continue until a time when, in the opinion of the professional supervisor, the student is ready to resume.

2.12.2 Satisfactory Participation in Peer Supervision

Satisfactory performance will be judged based solely on statement from the lecturer /facilitator that the student has been attending and participating.

2.12.3 Peer Support Volunteer's Clinical Skills Test

Mastery of the following clinical skills is essential to be awarded a Heal For Life Certificate in Trauma Healing (Supporting Adults to Heal from Child Trauma)

Peer Support

1. Basic, safe and effective communication skills in one-to-one settings
2. Commitment to the whole group activities Reflections and Labour of Love, including the ability to organise and lead these activities
3. The ability to guide guests in sharing emotions and insights, and also in visualisations
4. The ability to support guests in accessing their 'inner child', to release emotions effectively and safely, and to re-empower themselves
2.12.4 Mastery of the following clinical skills is essential to be awarded a Heal For Life Foundation Facilitator Advanced Certificate

1. Advanced, confident, safe and effective communication skills, including group dynamics, leadership, administration, boundaries, conflict resolution and listening skills
2. Familiarity and confidence with the teachings of Heal For Life Foundation, including the Heal For Life Foundation Model Process and 'inner child' work
3. Confidence and familiarity with Heal For Life Foundation theory, including trauma and the effects on the brain, attachment theory, and the effects of extreme childhood trauma
4. An understanding of the Christian principles in line with the Heal For Life Foundation Model, coupled with the ability to provide a safe and professional environment for Peer Support Volunteers including feedback and guidance.

2.13 Summative Competency Assessment
Students, who are enrolled in their final module, will be assessed for competence. Competency is assessed by a qualified facilitator.

Competency will be assessed whilst the student is working at Heal For Life during a healing program. It will be assessed by the facilitator during one of the healing weeks that the student is attending for practice. The assessor uses a competency check list to determine if the student can demonstrate all the competencies. Assessment occurs whilst the student performs the role of a Peer Support Volunteer or facilitator with a survivor, or group of survivors of childhood trauma.

The evidence that shall be taken into account includes the facilitator’s direct observation, discussion between the student and facilitator, the student’s own stories and reflections on their practice and guests’ comments.

2.13.1 Outcomes of Competency Assessment
The competencies will be either met or not met. If any competency is not met then the student will be given specific feedback. If necessary a learning plan will be developed to make up any gap in knowledge or skill. The student can repeat competency assessment at a healing week three times. Three non-successful attempts

2.13.2 Competencies For Peer Support Volunteers
1. Demonstrates a continuing commitment to own healing and spiritual development.
2. Accepts accountability and responsibility for own actions.

3. Communicates sensitively and effectively with guests.

4. Promotes safe and effective work practices.

5. Provides and evaluates effective caring interactions.

6. Provides and evaluates own caring interactions for guests with complex needs.

7. Works collaboratively with other members of the Heal For Life Foundation team.

8. Ensures own practises are culturally safe.

9. Ensures own behaviour is consistent with Heal For Life Foundation ethics and philosophy.

10. Identifies own values and beliefs in ways that enhance caring practice.

11. Acts to enhance own learning and development.

12. Practises in accordance with the law

2.13. 3 Competencies For Facilitators

1. Demonstrates a continuing commitment to own healing and spiritual development.

2. Accepts accountability and responsibility for own actions.

3. Communicates sensitively and effectively with guests.

4. Promotes safe and effective work practices.

5. Provides and evaluates effective caring interactions.

6. Provides and evaluates own caring interactions for guests with complex needs.

7. Works collaboratively with other members of the Heal For Life Foundation team.

8. Ensures own practises are culturally safe.

9. Ensures own behaviour is consistent with Heal For Life Foundation ethics and philosophy.

10. Identifies own values and beliefs in ways that enhance caring practice.
11. Acts to enhance own learning and development.

12. Practises in accordance with the law

13. For guests with complex needs, plan, provide, supervise and evaluate the care provided by self and Peer Support Volunteers under supervision (facilitators).

14. Assess, plan and effectively work with groups to promote learning and healing (facilitators).

15. Acts to enhance the professional development of others (facilitators).

16. Use theory and research to inform practice as a facilitator (facilitators).

17. Demonstrate skills in leadership, administration and management in the provision of healing weeks (facilitators).

2.14 Monitoring of Program Quality and Program Review

The draft program was developed by Liz Mullinar, Founder and CEO of Heal For Life Foundation and Professor Kathleen Fahey, midwifery academic with expertise in education and curriculum.

The final program was approved by the external review panel and endorsed by the Board of Heal For Life Foundation Trust.

Confidential student feedback is sought about each module and at the end of each calendar year the program is evaluated. Program evaluation involves considering feedback from students, lecturers and guests. A report of program evaluation and planned changes is presented to the Board within 3 months of completing the evaluation. On the basis of considered feedback, minor changes to the modules or program may occur at the Program Convenor's discretion. Major changes to the program or modules require the Board's approval and may require a formal program review.

A formal program review is scheduled each three years. Program review will involve a process similar to the initial program development with the involvement of the external panel.
3. Module Outlines

CAR 1 Introduction to practice at Heal For Life Foundation Healing Centre.

Semester 1.
Unit weighting: 10
Teaching Methods:

Lectures
Interactive Tutorials
Role Play
Problem-based learning
Self Directed learning
Worksheet completion
Practicum
Supervision

Brief Course description
This is a pre-practice training course. Students will continue to work on their own healing journey. Learning is largely experiential. Students practise working within Heal For Life philosophies, policies and clinical protocols. The priority for this course is learning how to effectively help people heal from childhood using the Heal For Life Healing Process as the therapeutic base. How to be a ‘therapeutic friend’. Teamwork, ethics and keeping guests safe are all covered.

Contact Hours:
Five face-to-face onsite study days– 50 hours
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.

Course Objectives
Upon completion of the learning activities for this course, supported by appropriate use of the literature and self-directed study the student will be able to:

1. Demonstrate responsibility for own healing including the ability to accept and learn from feedback.
2. Apply a peer support philosophy of healing when practising, discussing or caring for people who are healing from childhood trauma.
3. Ensure own behaviour is consistent with the highest ethics and the Heal For Life philosophy.
4. Describe, and provide a rationale for each of the components of the healing week.
5. Explain the broad principles for each of the workshops presented at Heal For Life.
6. Explain how carers help survivors to heal by forming, developing and terminating ‘therapeutic friendships’ with guests.
7. Distinguish a 'therapeutic friendship' from a social friendship.
8. Demonstrate non-hierarchical behaviour both with the guests and fellow carers.
9. Demonstrate basic listening skills.
10. Apply basic conflict resolution skills when in conflict with another person.
11. Demonstrate how to help a guest de-trigger themselves effectively.
12. Encourage guests to analyse their own paintings by asking appropriate questions.
13. Describe to guests how to contact their inner child; how to affect an emotional release and re-empowerment.
14. Explain different interventions necessary to address emotional dysregulation.
15. Describe protocols for a carer in emergency situations.
16. Demonstrate the ability to create and maintain environments which have all the components of 'safety'.
17. Work within legal frameworks as a volunteer Peer Support Volunteer.

**Assessment**

1. Pre reading and Class participation 20%
2. Take home worksheet comprising 10 short answer questions requiring answers of two hundred words each. Direct references provided by Heal For Life to help ensure student success. 30%
3. Attendance and participation in peer supervision 10%
4. Satisfactory progress in caring practice. 40%
5. Complete list in 'required text.'

NB: All assessment must be passed at a satisfactory level in order to pass this course.

**Required Text**

Module reading material
HFLF Peer Support Volunteers Manual 2014/15
Heal For Life Integrated Systems Manual 004 (Policy and Procedures)
Counsellors & Psychotherapists' Association of New South Wales 'Code of Ethics & Good Practice', available at www.capa.asn.au

**Recommended reading materials/texts.**

Atkinson Sue *Breaking the Chains of Abuse* (2006 Lion Books Oxford)
Herman J.L. *Trauma and recovery* (Basic Books USE 1992)
Levine Peter A. *Waking the Tiger* (North Atlantic Books California 1997)
NB: All assessments must be passed at a satisfactory level in order to pass this module.

**Required Text**
HFLF Peer Support Volunteers Manual 2014/15
Heal For Life Integrated Systems Manual 004 (Policy and Procedures)

**Recommended reading materials/texts.**
Atkinson Sue *Breaking the Chains of Abuse* (2006 Lion Books Oxford)
Herman J.L. *Trauma and recovery* (Basic Books USE ’1992)
Levine Peter A. *Waking the Tiger* (North Atlantic Books California 1997)

**CAR 1B Caring at Hennessy House**

**Semester 1.**
**Unit weighting:** 10
**Teaching Methods:**
- Lectures
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Worksheet completion
- Practicum
- Supervision

**Brief Module description**
The teenage brain is different to the adult brain. Teenage behaviour, therefore, is different to adult behaviour. This is due to brain development, the process of the brain becoming adult. As teenagers, the young women at Hennessy House do not have fully developed brains, therefore there are behaviours, reasoning, and motivators that will be vastly different to those of an adult. An understanding of these differences will assist Peer Support Volunteers in their work at Hennessy House.

**Contact Hours:**
Two study days (or equivalent online learning) – 16 hours
80 hours of experiential super-numerary practice at 16-25 yrs healing program under supervision of facilitator.

**Module Objectives**
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self-directed study the student will be able to:

19. Demonstrate an understanding of the differences between caring at the adult centre versus caring at Hennessy House
20. Demonstrate an understanding of teenage brain development
21. Explain teenage behaviour in light of brain development
22. Demonstrate that own behaviour and language is suitable for interaction with the teenage brain
23. Describe the components of the Hennessy House healing program.
24. Explain the elements of group dynamics with teenage girls
25. Familiarity with and commitment to the Hennessy House “procedures and protocols”
26. Awareness of transference issues with teenage girls
27. Demonstrate non-hierarchical behaviour both with the young women and fellow Peer Support Volunteers.
28. Demonstrate basic listening skills.
29. Describe protocols for assisting young women in crisis.
30. Describe protocols for the young women’s departure, including assurance of safety.

Assessment

6. Class participation 20%
7. Take home worksheet comprising 10 short answer questions. Direct references provided by Heal For Life Foundation to help ensure student success 70% (to come when readings are finalised)
8. Hennessy House Peer Support Volunteer skills checklist satisfactorily completed 10%

NB: All assessment must be passed at a satisfactory level in order to pass this module.

Required Text
HFLF Peer Support Volunteers Manual 2014/15
Heal For Life Integrated Systems Manual 004 (Policy and Procedures)
Counsellors & Psychotherapists’ Association of New South Wales ‘Code of Ethics & Good Practice’, available at www.capa.asn.au

Recommended reading materials/texts.
Atkinson Sue Breaking the Chains of Abuse (2006 Lion Books Oxford)
Herman J.L. Trauma and recovery (Basic Books USE ’1992)
Levine Peter A. Waking the Tiger (North Atlantic Books California 1997)
CAR2 History and Theory of Trauma Healing

Semester 1.

Unit weighting: 10

Teaching Methods:
- Lectures
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self-Directed learning
- Worksheet completion
- Practicum
- Supervision

Brief Module description
The history of psychotherapy is reviewed with emphasis on those theories that are most relevant to the Heal For Life Foundation healing process. Peer Support Volunteers are taught the skills of creating holistically safe environments. Strategies for helping guests to contact their ‘inner child’ are presented. Peer Support Volunteers are taught beginning skills for working safely and effectively with guests who are processing past trauma.

Contact Hours:
Two study days (or equivalent online learning) – 16 hours
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.

Course Objectives
Upon completion of the learning activities for this course, supported by appropriate use of the literature and self-directed study the student will be able to:
1. Summarise the history of trauma therapy.
2. Articulate the key elements of Freud's psychoanalysis approach to trauma.
3. Describe the major modalities of therapy for survivors of childhood trauma.
4. Articulate the theory contributions of major practitioners as applied within the Heal For Life Foundation healing process.
5. Discuss the relationship of the Heal For Life Foundation healing approach to other therapeutic modalities.
6. Articulate what transference and counter transference is
7. Recognise how to avoid creating negative elements of transference and counter transference.
8. Identify all elements of the Drama Triangle.
9. Recognise the basic symptoms of diagnoses for personality disorders.
10. Identify differing ways to help clients/guests connect with their inner child.
11. Identify the various forms of child abuse and neglect.
Assessment
1. In class quiz on pre-reading. 20%
2. Take home worksheet comprising 3 short answer questions requiring answers of maximum of three hundred words each. Direct references provided by Heal for Life to help ensure student success. 70%
3. Attendance and participation in clinical supervision during healing week practical.
4. Satisfactory progress in caring practice. 10%
5. Listening skills check list satisfactorily completed

NB: All assessment must be passed at a satisfactory level in order to pass this course

Required Text
Capacchione, L. Recovery of The Inner Child
Peck, M Scott The Different Drum
CAR 3 The Brain, Trauma and healing

Semester 1.
Unit Weighing: 10
Teaching Methods:
Lectures

Interactive Tutorials
Problem-based learning
Self-Directed learning
Worksheet completion
Practicum
Supervision

Brief Module Description
The Heal For Life Foundation programme is based on education of our guests. This module teaches our Peer Support Volunteer the aspects of the brain which are affected by trauma so they are better able to understand the changes in their own brain as a result of trauma as well as explain it to our guests in a one to one situation. The module is designed to assist in developing students' understanding and application about the brain. Specifically, students will become familiar with the structure and function of the parts of the brain concerned with fear. The significance of trauma in changing brain structure and function is taught, as this underpins behavioural problems in life. The relationship between the brain and the Autonomic Nervous System are explored with emphasis on the effects that hormones have on behaviour. The functions and relationship between the left and right side of the brain are presented. The way the brain processes memory and the differences between implicit and explicit memory are discussed; the student learns ways to reduce the sympathetic system. The four parts of the Heal For Life Foundation trauma healing process in relation to brain development are discussed. This subject is key to understanding why what we do at Heal For Life actually works.

Contact Hours:
Two study days (or equivalent online learning) – 16 hours
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.

Course Objectives
Upon completion of the learning activities for this course, supported by appropriate use of the literature and self-directed study the student will be able to:
1. Describe the role of neurons in the brain.
2. Explain the structure and function of reptilian, mammalian and neo-mammalian parts of the brain.
3. Describe the functions of the two sides of the brain.
4. Explain how trauma affects brain development and list the various impacts on different brain structures.
5. Explain, in simple language, the various hormones and their effects.
6. Discuss with guests the basic structure of the fear network and how this affects behaviour.
7. Explain the difference between implicit and explicit memory.
8. Explain the role emotions play in thinking and behaviour.
9. Explain the role the ANS has in the fear system of the brain.
10. Identify body indicators of the parasympathetic state and the sympathetic state.
11. Reduce the activity of the sympathetic nervous system with guided meditation and other grounded techniques.
12. Identify the signs of hyper-arousal and hyper tension when presented with them.
13. Explain to guests the physiological reasons behind ‘triggering’ and support them in the use of cognitive and behavioural tools to correct triggering.
14. Enunciate the differences between teenagers’ brains and that of an adult with a fully developed brain.

Assessment Items
1. In class quiz on pre-reading. 20%
2. Worksheet Anatomy and Physiology of the Brain and Trauma Effects 70%
3. Attendance and participation in peer supervision.
5. Satisfactorily completed 10%

Required text
CAR 3 booklet
Dayton Tian *Trauma and Addiction* (Health Communications Florida 2000)

Recommended texts
Bremner J.D. *Does Stress Damage the Brain?*(Norton and Co. New York) 2002
Darwin Charles *The Expression of emotion in man and Animals* (Chicago University of Chicago press 1965)
Etherington Kim *Adult male survivors of childhood sexual abuse* (Pitman publishing 1995)
Freyd Jennifer J. *Betrayal Trauma* (Harvard University press 1996)
Herman J.L. *Trauma and recovery* (Basic Books USE `1992)
Ledoux Joseph *The Emotional brain* (Simon and Schuster 1996)
Levine Peter A. *Waking the Tiger* (North Atlantic Books California 1997)
Levine Peter. A. *Healing Trauma* (Sounds True Inc. Korea 2005)
Marcus Gary *The Birth of the Mind* (Basic Books USA 2004)
Siegel D. *Developing mind toward a neurobiology of interpersonal experience* (Guilford press 1999)
Stein Phyllis T. Kendall Joshua *Psychological trauma and the developing brain* (Haworth Maltreatment and Trauma Press New York 2004)
Van der Kolk Bessel. A. McFarlane Alexander C. Weisaeth Lars, editors
*Traumatic Stress – The Overwhelming experience on mind, body and society* (Guilford press London 1996)
Whitfield Charles L. *Memory and Abuse* (Health Communications Inc. Florida USA 1995)

**Journals**
Coccaroe.f. Siever L.J. Klar H.M. & Maurer G. *Serotonergic studies in patients with affective and personality disorders* Archives of general psychiatry 46
Williams L.M. *Recall of childhood trauma; a prospective study of women's memories of child sexual abuse* Journal of consulting and clinical psychology 62 (6)
**CAR 4 Childhood Abuse and Altered Development**

**Semester 1.**  
**Unit Weighing:** 10  
**Teaching Methods:**  
Lectures  
Interactive Tutorials  
Role Play  
Problem-based learning  
Self-Directed learning  
Practicum  
Supervision

**Brief Course Description**  
The effect of a traumatic experience, and to what extent it affects a person, is largely determined by parenting factors. Trauma cannot be dealt with in isolation. In order to fully understand ourselves and others, students need to understand child development. This course builds upon and integrates with the two previous courses. In this course students will discuss the psychological paradigms of childhood development. Students who do not already know the different theoretical models of childhood development are expected to study them as part of this module. These models will be applied during the sessions to understanding real life examples of developmental delays. Attachment style is introduced and applied. The impact of the early family and social environment on the developing child’s cognition and ethical behaviour are explored. Students will be supported to identify the developmental stage when major disruption occurred in their own childhood. The student will apply understanding of this course practically, as a peer support volunteer.

**Contact Hours:**  
Two study days (or equivalent online learning) – 16 hours  
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.
Course Objective:

Upon completion of the learning activities for this course, supported by appropriate use of the literature and self directed study the student will be able to:

1. Discuss the importance and impact of home environment on the development of a child.
2. Describe the five stages of child development as defined by Robin Grille and the effects on adult behaviour.
3. Use observation skills of a person's posture and behaviour to recognise possible signs of the developmental stage when major disruption may have occurred in childhood.
4. Discuss the impact of parenting on adult behaviour and relationships.
5. Articulate their own developmental disruption/s and the reasons they occurred, without going into inappropriate 'story'.
6. Help guests explore their possible developmental delays.
7. Discuss the four different attachment styles and recognise their own attachment style.

Assessment Items

1. Self-analysis and thoughtful sharing in class discussion.  20%
2. Pre – class activity sheet 70%
3. Reflections, labour of love and sharing skills satisfactorily completed 10%
4. Attendance and participation in clinical supervision (for active peer support volunteers)
5. Satisfactory progress in caring practice (for active peer support volunteers)

NB: All assessment must be passed at a satisfactory level in order to pass this course.

Required Text

Grille, Robin *Parenting For a Peaceful World*

Recommended Reading
Berk Laura E. *Child Development* Sixth Ed. (2001 Allyn and Bacon, Boston)


Holmes Jeremy *The Search For the Secure Base* (2001 Brunner and Routledge Sussex)


**CAR 5 Professional Practice Issues**

**Semester 1.**  
**Unit Weighing:** 10

**Teaching Methods:**

- Lectures
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Supervision

**Brief Course Description**

This course will help students learn about boundaries as a key element of the Heal For Life model. The different types of boundaries will be discussed. Students will learn how to recognise, set and maintain healthy boundaries in their own lives. They will also learn how to help guests recognise, set and maintain healthy boundaries in their lives. Students will learn to recognise the signs of broken boundaries. Effective team work and collaboration is discussed. Students will learn how to recognise and respond to bullying. Students will also be introduced to ethical decision-making in Peer Support Volunteer practice at HFLF.

**Contact Hours:**

Two study days (or equivalent online learning) – 16 hours  
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.
Course Objectives

Upon completion of the learning activities for this course, supported by appropriate use of the literature and self-directed study the student will be able to:

12. Describe the similarities and differences between spiritual, emotional, physical and time boundaries.

13. Demonstrate that the student can set appropriate boundaries with guests.

14. Explain to guests that lack of boundaries and inflexible boundaries cause suffering.

15. Apply and maintain appropriate boundaries personally and professionally with colleagues.

16. Apply boundaries to assist with collaboration and team work.

17. Describe broken boundaries, observe when boundaries have been broken and respond appropriately.

18. Use ethical values to make appropriate ethical decisions in practice.

19. Explain the reasons why visualisations are such an important part of programme.

20. Conduct group and one-on-one visualisations

Assessments

1. Self-analysis and thoughtful sharing in class discussion.  10%

2. Written assignment (see below and study sheet)  20%

3. Conduct group and one-on-one visualisations 50%

4. Attendance and participation in clinical supervision

5. Satisfactory progress in caring practice.

6. Boundaries skills check list satisfactorily completed 20%

NB: All assessment must be passed at a satisfactory level in order to pass this course.
Required Text

Recommended Reading
(Please note that readings with the symbol, ** beside their name can be read online at www.questia.com for a small charge.

Cloud H; Townsend J. Boundaries in Marriage (1999 Zondervan publishing Michigan)
Katherine, A., 2000, Where to draw the line: How to set healthy boundaries every day, Simon & Schuster, New York.
Handout tited 'The Winner Triangle', given out to students in Heal For Life


Any books about co-dependency usually include discussions on boundaries. Melody Beattie has several books that are worth reading – for example, ‘Codependent No More’ and ‘Beyond Codependency’. (Usually available in bookshops, libraries or www.amazon.com).

Any books about recovery from alcohol or drug addiction also tend to cover the issue of boundaries. John Bradshaw’s books may also be useful e.g. ‘Homecoming: Reclaiming and Championing Your Inner Child’, or ‘Healing the Shame That Binds You’. (Usually available in bookshops, libraries or www.amazon.com).

**CAR 6. Applied Interactional Analysis**

**Semester 2**

**Unit Weighing: 10**

**Teaching Methods:**

- Lectures
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Supervision

**Brief Course Description**

This course will help students develop reflective communication skills including noticing and responding to subtle cues of the healing impulse. The skills of facilitating inner focus will be taught. Students will learn how to respond to
emotional expression of past trauma, by guests. An introduction to transactional analysis will be given: the parent/adult/child model for analysing interactions. Application of interactional analysis within the Heal For Life model. Students will learn how to recognise the various interactional states state both aurally and visually. They will learn how to recognise and respond appropriately to a guests “interactional state”. “Stroking” as defined by Berne, negative and positive, will be practically demonstrated. Students will also learn how to recognise conflict, deal with conflict and where possible see conflict as an opportunity to further heal.

Contact Hours:

Two study days (or equivalent online learning) – 16 hours
40 hours of experiential super‐numerary practice at healing week under supervision of facilitator.

Course Objective:

Upon completion of the learning activities for this course, supported by appropriate use of the literature and self directed study the student will be able to:

1. Describe and differentiate the three interactional states: parent, adult, child.
2. Analyse transactions in terms of parent, adult, child interactions and discuss whether the interaction is mutually respectful and appropriate.
3. Describe the different physical clues to each of the three states.
4. Define the term ‘strokes’, and identify how to meet this need in their own lives.
5. Apply principles of TA to their work at Heal For Life Healing Centre.
6. Self recognise when they are modelling a child or parent state.
7. Explain the need for maintaining an adult state while a HFL Peer Support Volunteer.
8. Identify the appropriate way to help a guest dependent on the guests needs.

Assessment Items
1. Self-analysis and thoughtful sharing in class discussion. Weighting 10%
2. TA and safe work practises take home worksheet. Weighting 60%
3. Attendance and participation in peer supervision
4. Satisfactory progress in peer support practice
5. TA application in healing week: check list satisfactorily completed 10%
6. Understanding of HFLF Golden Guidelines for Conflict resolution 10%
7. Required reading completed 10%

NB: All assessment must be passed at a satisfactory level in order to pass this course.

**Required Text**

Stewart, I and Jones, V TA’Today (1993 Russell Press Nottingham)

**Recommended Reading**


James, M, 2002, *'It’s Never Too Late To Be Happy'*, Quill Driver Book/Word Dancer Press, Sanger.

James, M, 1981, *'Breaking Free: Self-Reparenting For A New Life'* , Addison Wesley Publishing, USA


[www.ta-tutor.com](http://www.ta-tutor.com) Comprehensive website with TA Tools

[www.itaa-net.org](http://www.itaa-net.org) International Transactional Analysis Association

CAR 7 How to Utilise Faith to Assist in Healing

Semester 2.

Unit Weighing: 10

Teaching Methods:

- Lectures
- Interactive Tutorials
- Problem-based learning
- Self Directed learning
- Practicum
- Group clinical supervision

Brief Course Description
This module is to help students explore where their own culture, religion, gender or world view may impact on their empathy understanding and compassion.

Heal For Life is based in a country which is predominantly Christian and so this module is to help students learn ways to help Christians who are struggling by using the Bible as a reference point. It is also intended to broaden each persons perception and respect of the different faiths. It is intended that during this module Students will explore their own spiritual journey and recognise their own biases towards religions and beliefs and how this may impact on their ability to help others.

During this course, students will learn how to apply the teachings of Jesus in their role at Heal For Life, as well as how to counteract seemingly negative Christian teachings. Students will learn the importance of being non judgemental; sharing; living in community; and servanthood. A non-authoritarian approach to working with survivors of childhood trauma is taught, as is the meaning of servanthood. How the use of power needs to be avoided.

The impact of their own gender, culture and world view will be discussed and people from different cultures particularly those most likely to be presenting as guests will explain in person their different approach to life and where their culture needs to be understood if we are to help them effectively. Students will learn what they need to do on their own journey of healing in order to really give unconditional love to our guests. Shame, guilt and forgiveness and their origins will be discussed and appropriate intervention strategies shared. Recognition of and discussion of the spiritual elements of healing will also be explored.
Extensive experiential opportunities to practice all elements of the Heal For Life programme.

**Contact Hours:**

Two study days (or equivalent online learning) – 16 hours
40 hours of experiential super-numerary practice at healing week under supervision of facilitator.

**Course Objectives:**

Upon completion of the learning activities for this course, supported by appropriate use of the literature and self directed study the student will be able to:

1. Explain the teachings of Jesus and how they relate to the Heal For Life model.
2. Discuss helpful ways of interpreting the Bible to help a guests who is struggling.
3. Articulate their own spiritual journey and feel empowered to share it regardless of the basis on their own faith.
4. Truly recognise and be prepared to genuinely be able to welcome all guests regardless of their sexual orientation, culture or religion.
5. Demonstrate an ability to work collaboratively with others.
6. Demonstrate a compassionate attitude to help guests overcome shame and guilt.
7. Have developed a deeper understanding of methods to help guests understand the different ways a survivor can forgive and have learnt a helpful approach to counteract negative Christian teachings.
8. Demonstrate by behaviour an understanding of what is meant by unconditional love.
9. Identify the spiritual element in SRA and protect and prepare themselves accordingly.
10. Apply the principles of servanthood in their attitude.
11. Know the core beliefs for each of the five major religions in Australia namely Christianity, Judaism, Islam, Hinduism and Buddhism Aboriginal spirituality?
12. Recognise the key elements of Original Australians, Maori, Chinese, and Vietnamese culture and be more effectively conscious of cultural needs and differences.

13. Recognise and identify their own culture, gender and world view and learn how this may impact on their ability to open their hearts to certain people or situations.

Assessment Items

1. Self-analysis and thoughtful sharing in class discussion. Weighting 20%

2. Understanding the meaning of healing the spirit. Take home worksheet. Weighting 70%

3. Attendance and participation in peer supervision

4. Satisfactory progress in caring practice

5. Acting in a way that follows the teachings of Jesus, displaying unconditional love, working collaboratively, working with guests on shame or guilt and utilising own faith skills. Check list satisfactorily completed 10% pass or not yet passed

NB: All assessments must be passed at a satisfactory level in order to pass this course.

Required Text

Vanier Jean: *Community and Growth*

Recommended Reading

Atkinson Sue Struggling to Forgive (Norton Publishing 2014)

Cloud Henry *Changes that heal. How to understand your past to ensure your future* (Zondervan Publishing Michigan ) 1992

Higginson Richard *Transforming Leadership* (SPCK London 1996)


Miller Dusty *Your Surviving Spirit* (New Harringer Publications)2003

Moore Thomas *Dark Nights of The Soul* (Piatkus Press) USA 2004

Painter John *The Quest For the Messiah* (T &T Clark Edinburgh 1991)
Sandford R.L. *Wounded warriors* (Victory House Inc Oklahoma) 1987
Urquhart Colin *Receive your Healing* (Hodder & Stoughton London) 1986
Wood Wendy Ann *Triumph over darkness* (Beyond words publishing) 1993
Any books by Phillip Yancey

The Bible

*Time For Action* – the report to Churches Together in Britain and Ireland of the Group established to examine issues of Sexual Abuse.

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**CAR 8 Advanced Skills for HFLF Peer Support Volunteers**

**Semester 2.**

**Unit Weighing:** 10

**Teaching Methods:**

Lectures

Interactive Tutorials

Role Play

Problem-based learning

Self Directed learning

Practicum

Supervision

**Brief Course Description**

In this course, students learn how to assist more complex cases. They will learn the more severe effects of trauma on development. Schizophrenia, DID and SRA are explained. The definitions for border personality disorder and complex post traumatic stress disorder are defined. There is a very basic explanation of some commonly used medications. Ways to effectively work with guests suffering from
any of these diagnoses are explored. Recognising own scope of practice and referring to supervisor as appropriate, and at all costs, avoiding diagnosis of guests.

**Contact Hours:**

Two study days (or equivalent online learning) – 16 hours
40 hours of experiential super-numeric practice at healing week under supervision of facilitator.
1 hour professional supervision

**Course Objective:**

Upon completion of the learning activities for this course, supported by appropriate use of the literature and self directed study the student will be able to:

1. Work with guests with complex traumas
2. Identify and apply appropriate interventions with guests who want to self-harm or have suicidal ideation.
3. Identify the signs of DID in a guest and offer appropriate information and support to the guest without diagnosing
4. Identify the signs of SRA in drawings and memories and offer appropriate validating support without diagnosing.
5. Describe the basis of diagnosis by health professionals of DID as defined by DSM-V.
6. Describe appropriate guidelines for working with people who have experienced extreme traumas.
7. Identify when they need to refer to facilitator or outside support.
8. Help guests with complex needs take responsibility and learn tools so as to more effectively manage self responsibility for healing.
9. Demonstrate a full understanding of ‘triggering/de-triggering’ and ‘the process’.

**Assessment Items:**

1. Self-analysis and thoughtful sharing in class discussion. 20%
2. Complex effects from trauma and self responsibility; take home worksheet Weighting 50%

3. Attendance and participation in clinical and peer supervision 10%


5. Working with persons with complex needs and self responsibility skills check list satisfactorily completed 10%

6. Required reading completed 10%

NB: All assessments must be passed at a satisfactory level in order to pass this course.

Required Text

Miles, Kel. "Looking In The Mirror" (available only from HFLF office)

Recommended Reading


Egan, G (2002) The Skilled Helper Wadsworth Group, USA

Miller, A (2011) Healing the Unimaginable: Treating Ritual Abuse and Mind Control

Sigelman C K & Rider E (2006), Life-Span Human Development, Thomson Wadsworth CA USA

Smith Margaret Ritual Abuse (HarperSanFrancisco 1993)

Steinberg, M & Schnall, M (2001) The Stranger in the Mirror, First Cliff Street Books, USA

Weiten, W (1998), Psychology Themes and Variations, Brooks Cole Publishing USA

Ruff matt Set This House In Order (2003 Harper Perennial New York) bad language may offend!
Introduction to Facilitator Training Modules

These modules are designed to give the background theory and practical skills to be able to confidently present each of the workshops during a healing week, to guide and support a team of HFLF Peer Support Volunteer and to effectively facilitate a HFLF healing week safely.

The first module, (FAC 9 Introduction to Facilitating Adults Healing in Groups at Heal For Life), is the initial intensive week of Facilitator training.

The other 7 modules in their order of completion are listed below:

1. **FAC 10** Advanced Theory and Research of the Brain, Trauma and Healing
2. **FAC 11** Healing Developmental Delays in Adults Caused by Trauma and Attachment Theory
3. **FAC 12** Understanding the Role of Transactional Analysis in Trauma Support.
   - Optional FAC 12B Facilitating young people. How to engage with young people with a Trauma Informed Approach
   - Recognising the differences between working with adults and children.
4. **FAC 13** Advanced Group Dynamics with Special Reference to Trauma Survivors and the Importance of Joy in Healing.
   - Optional Fac 13B Issues specific to teenagers, co-morbidity, self harming and addiction issues
5. **FAC 14** Supporting Survivors of Trauma with Complex Needs
7. **FAC 16** Leadership, Administration and Competency to Practise as a Heal For Life Facilitator

The order of modules allows students to gradually develop confidence in presenting the workshops with the first workshop to be delivered (associated with FAC9) the simplest one then the next easiest (FAC10) and so on building towards the more complex workshops in the later modules.

The theory part of the modules will mostly be delivered in distance education mode to allow people to complete them when they have the available time. The practical component involves a week of caring utilising the skills learnt after completion of the relevant assignment. There is a workshop to be delivered for each module and it is an important part of the assessment for that module.

The way to complete each module will be:

1. Read through the module information and associated readings and any PowerPoint presentations.
2. Complete the written assessment items prior to caring week and submit them to the office at least 1 week prior to caring week.
3. Prepare a lesson plan and submit it to the office at least 1 week prior to caring week for checking and feedback. This will ensure the trainee has the background theory required to deliver the associated workshop.
4. The trainee will deliver the workshop during a caring week. The facilitator of the week will assess workshop content, delivery and group skills as proficient or needing further work. They will give feedback to the trainee about achievements and improvements that could be made.
5. For some modules there is a self reflection exercise to complete after completion of delivery of the workshop which will also need to be submitted to the general manager 2 weeks after the caring week. (For details on how to complete a self-reflection exercise, see the “Completing Assignments” section below.)
6. Each week of caring that is done as a trainee facilitator, an assessment will be given on General Facilitator Skills by the facilitator of the week (see details in the section below).
7. The trainee will also need to attend a Professional Supervision session (in person or by phone) in between each caring week.

The modules and their associated workshops are listed below:

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<th>Module</th>
<th>Workshop/ Practical Component</th>
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<td>Introduction to Facilitating Adults Healing in Groups at Heal For Life</td>
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<tr>
<td>FAC 10</td>
<td>Advanced Theory and Research of the Brain, Trauma and Healing</td>
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<td>FAC 11</td>
<td>Healing Developmental Delays</td>
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<td>Monday afternoon workshop – answering guests questions, triggering and the process</td>
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<td>Tuesday afternoon workshop – The Effects of Trauma on the Brain</td>
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in Adults Caused by Trauma and Attachment Theory

**FAC 12** Understanding the Role of Transactional Analysis in Trauma Support.

**FAC 12B Optional** Facilitating young people. How to engage with young people with a Trauma Informed Approach. Recognising the differences between working with adults and children.

**FAC 13** Advanced Group Dynamics with Special Reference to Trauma Survivors and the Importance of Joy in Healing.

**FAC 13B** Issues specific to teenagers, co-morbidity, self-harming and addiction issues.

**FAC 14** Supporting survivors with complex needs.

**FAC 15** Education, Training, Supervision and Development of Support Workers.

**FAC 16** Leadership, Administration and Competency to Practise as a Heal For Life Facilitator.

**FAC 17 (Optional)** Introduction to Theory and Practice of Facilitating Healing for Adolescents and Children.

Theory, self nurture and support systems

Thursday workshop – Transactional Analysis and Self Nurturing.

Two workshops for kids camp.

Wednesday morning workshop – finding joy.

Two workshops at Hennessy House.

Monday morning workshop: Concept of inner child:safety.

Tuesday morning workshop. Run HFLF Peer Support Volunteer meetings during a healing week, supervising and empowering HFLF Peer Support Volunteers, HFLF Peer Support Volunteer sharing. Have competencies for running meetings and supporting HFLF Peer Support Volunteers checked off by another facilitator/program coordinator.

Sunday evening - Group Agreements. Run a healing week as a facilitator and have facilitator competencies checked off by another facilitator/program coordinator.

Deliver workshops at adolescent or children’s healing week.

This structure will hopefully allow all trainees to complete facilitator training at their own pace. It may only be possible to do 3 caring weeks in one year, so this would mean the completion of the first 3 facilitator modules and the presentation of the 3 workshops that go with each module, 1 on each caring week.

For those wishing to become a facilitator, there will be a review with the CEO or General manager half way through the training (after FAC12) to discuss any additional needs to be worked on to become a competent facilitator. There will
also be a final review with the CEO or General manager when all modules are completed to ensure the facilitator competencies have been met.
FAC 9 Introduction to Facilitating Adults Healing in Groups at Heal For Life

Semester 1.
Unit Weighing: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Group clinical supervision
- Lecture

Brief Module Description
In this module, trainee facilitators will learn how to present information to a group. Students learn how to form, orientate and work with a group. They will also learn about and apply the elements of how to keep the group safe. Students are committed to, and can ensure, that healing weeks run in well structured ways. The module also covers the introduction to the facilitator's responsibility for Occupational Health and Safety (OH&S), as well as the introduction to ethical and legal responsibilities of facilitators.

Contact Hours:
One clinical week under supervision of facilitator
1 hour Clinical Supervision
2 Compulsory study days (or equivalent online/distance)

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Facilitate the Monday afternoon workshop.
2. Model effective communication and group facilitation skills.
3. Explain the key risks to WH&S at Heal For Life.
4. Take responsibility for WH&S issues relating to HLF Peer Support Volunteers and guests during the healing weeks.
5. Demonstrate the skills of being able to manage emergencies in line with Heal For Life policies.
6. Demonstrate different ways to ground guests and HLF Peer Support Volunteers.
7. Explain the HFL healing process effectively
8. Explain practically as well as verbally the Heal For Life process at all stages.
9. Develop and improve general facilitator skills (see list in introduction section)

Assessment Items:
1. 500 words – Why is safety important for our healing and how do we create it at HFL? 20% Referencing required, due before you attend 1st caring week.
2. 1000 word assignment on the four stages of the HFL process & the theoretical background to each step. 40% Referencing required, due before you attend 1st caring week (trainee practical week)
3. Lesson plan for Facilitating Monday afternoon workshop. 10% Due before you attend 1st caring week (trainee practical week)
4. Attendance and participation in clinical supervision.
5. Run Monday afternoon workshop satisfactorily. 30%
6. Take responsibility for all WH&S for the healing week (which includes; completing WH&S safety checks on Sunday prior to healing week, explaining key risks to HFLF Peer Support Volunteers and also to guests during the Sunday tour, and identifying risks to safety during the week).
7. Develop and improve general facilitator skills.

NB: All assessment must be passed at a satisfactory level in order to pass this module.

**Required Texts**
Heal For Life Policies and Procedures
Facilitators Manual 2014/15
Taylor Kylea (1995) *The Ethics of Caring (Hanford Mead California)*
Lucia Capacchione (1991) *Recovery of Your Inner Child*
*The HFL TREE model*
Peter A. Levine and Ann Frederick (1997) *Waking the Tiger*

**Recommended Reading**
Anderson Terry D. *Transforming leadership* (St. Lucie Press USA 1997)
Coady, M., Block, S., 1996 *Codes of ethics and the professions*, Melbourne University Press, Carlton South
Cozolino Louis *The making Of a Therapist* (Norton London) 2004
**


FAC9 Assessment Cover Sheet

Name: ______________________

1. 500 words - What is safety and why is it important in healing? (Focus on safety in general not just HFL programs). 20%

   Assignment received at HFL Office: _______

   Assignment Marked: Satisfactory/ Not Yet

   Comments/ Suggestions for Improvement: __________________________

   Assignment Returned: _______

2. 1000 word assignment on the four stages of the HFL process & the theoretical background to each step. 40%

   Assignment received at HFL Office: _______

   Assignment Marked: Satisfactory/ Not Yet

   Comments/ Suggestions for Improvement: __________________________

   Assignment Returned: _______

3. Lesson plan for Facilitating Monday afternoon workshop. 10%

   Lesson Plan received at HFL Office: _______

   Lesson Plan checked: Satisfactory/ Not Yet

   Comments/ Suggestions for Improvement: __________________________

   Lesson Plan Returned: _______

4. Attendance and participation in clinical supervision.

   Date of Supervision: _______

   Supervisors Signature: __________________________
5. Run Monday afternoon workshop satisfactorily. 30%

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Remind facilitator to check off general skills sheet.

Facilitator Signature: ___________________ Date of Assessment: ___________
FAC 10 Advanced Theory and Research of the Brain, Trauma and Healing.

Semester 1.
Unit Weighing: 10

Teaching Methods:
Interactive Tutorials
Role Play
Problem-based learning
Self Directed learning
Practicum
Group clinical supervision
Lecture

Brief Module Description
Students learn how to present the material on the effect of trauma on the brain in a way that makes it easy for guests to understand. Students ensure they understand thoroughly, the complex structures of the brain including the effects of hormones, the importance of the cerebellum and functioning of the hippocampus. The significance of trauma in changing brain structure and function is taught, as this underpins behavioural problems in life. Recognition of symptoms in adult survivors that are indicative of healing states and autonomic nervous system dysfunction, the four stages of the Heal For Life trauma healing process, safety, accessing the right side of the brain, releasing emotions and re-empowerment are all revised at an advanced level.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of professional supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Explain to guests and HFLF Peer Support Volunteers the effects of trauma on brain development
2. Enunciate clearly in simple English the basic structures of the brain.
3. Explain clearly in simple English the fear mechanisms and the effect of this mechanism on adult behaviour.
4. Critically evaluate any indicators of dysfunction of the ANS including chronic dissociation and demonstrate appropriate action.
5. Explain the importance and role of the Autonomic Nervous System in the fear system.
6. Explain the reason for triggering and how to combat its effects.
7. Explain to a guest or HFLF Peer Support Volunteer the role hormones play in the fear system.
8. Explain the roles of left and right brain mechanisms and the importance of integration.
9. Develop and improve general facilitator skills

**Assessment Items:**
1. PowerPoint Presentation of the Brain for the delivery of a 30 minute lecture on the effects of trauma on the brain. (Referencing not required) 40%
2. 1000 words on the autonomic nervous system or any part of the brain you wish to research & write on. (Referencing required) 30%
3. Lesson plan for facilitating Tuesday afternoon workshop. 10%
4. Attendance and participation in clinical supervision.
5. Tuesday afternoon workshop satisfactorily completed 30%
6. Develop and improve general facilitator skills.

NB: All assessment must be passed at a satisfactory level in order to pass this module.

**Required Text**
Briere J. & Scott Catherine *Principles of Trauma Therapy* (2006 Sage Publications Inc California)
Ellenberger Henri F. *The Discovery Of the Unconscious*

**Recommended Reading**
Bremner J.D. *Does Stress damage the Brain?* (Norton and Co. New York) 2002
Darwin Charles *The Expression of emotion in man and Animals* (Chicago University of Chicago press 1965)
Dayton Tian *Trauma and Addiction* (Health Communications Florida 2000)
Freyd Jennifer J. *Betrayal Trauma* (Harvard University press 1996)
Ledoux Joseph *The Emotional brain* (Simon and Schuster 1996)
Marcus Gary *The Birth of the Mind* (Basic Books USA 2004)
Ross Colin A. *The trauma Model – A solution to the problem of comorbidity in psychiatry* (Manitou communications Inc. 2000)
Siegel D. *Developing mind toward a neurobiology of interpersonal experience* (Guilford press 1999)
Stein Phyllis T. Kendall Joshua *Psychological trauma and the developing brain* (Haworth Maltreatment and Trauma Press New York 2004)
Van der Kolk Bessel. A. McFarlane Alexander C. Weisaeth Lars, editors
*Traumatic Stress – The Overwhelming experience on mind, body and society* (Guilford press London 1996)
Whitfield Charles L. *Memory and Abuse* (Health Communications Inc. Florida USA 1995)

**Journals**
Coccaroe.f. Siever L.J. Klar H.M. & Maurer G. *Serotonergic studies in patients with affective and personality disorders* Archives of general psychiatry 46
Williams L.M. Recall of childhood trauma; a prospective study of women's memories of child sexual abuse Journal of consulting and clinical psychology 62 (6)
FAC10 Assessment Cover Sheet

Name:_________________________

1. PowerPoint Presentation of the Brain for delivery of a 30 minute lecture on the effects of trauma on the brain. 30%

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Lesson Plan checked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________________

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Assignment Returned: _______

2. 1000 words on the autonomic nervous system or any part of the brain you wish to research & write on. 30%

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________________

_____________________________________________________________________

Assignment Returned: _______

3. Lesson plan for facilitating Tuesday afternoon workshop. 10%

Lesson Plan received at HFL Office: _______

Lesson Plan checked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________________

_____________________________________________________________________

Lesson Plan Returned: _______

4. Attendance and participation in clinical supervision.
Date of Supervision: __________

Supervisors Signature: ________________

5. Tuesday afternoon workshop satisfactorily completed 30%

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Remind facilitator to check off general skills sheet.

Facilitator Signature: ________________ Date of Assessment: ________
FAC 11 Healing Developmental Delays in Adults Caused by Trauma and Attachment Theory

Semester 1.
 Unit Weighing: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

Brief Module Description
When abuse occurs in early developmental stages there are profound effects to the development of the brain. In this module trainee facilitators will build on the acquired knowledge from the previous module and learn how to recognise signs of developmental delays and how to help guests. The student will be able to explain the various developmental stages as expounded by Grille and others and how this will affect behaviour.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Communicate and be cognisant of, the importance and role the home environment has on child development.
2. Identify the stages of child development as recognised by various theorists and be able to recognise the effects of trauma on guests at each stage of development.
3. Use observation skills of a person's posture and behaviour to recognise possible signs of the developmental stage when major disruption may have occurred in childhood, therefore guiding and approaching the guest in an age-appropriate manner
4. Communicate and impart the impact of parenting on adult behaviour and relationships
5. Help guests explore their possible developmental delays with the view of empowering guests to continue their own healing.
6. Run an effective Friday workshop that explains comprehensively the four different attachment styles.
7. Describe to the group in simple English, attachment theory and how it affects relationships in adult life.

8. Develop and improve general facilitator skills

**Assessment Items**

1. 1000 word assignment on attachment theory or 1000 word assignment on the different stages of development (Grille) and how to recognise the impact of trauma on each of these stages. (Referencing required) Weighting 30%

2. Lesson plan for attachment theory workshop 10%

3. Attendance and participation in clinical supervision.

4. Successfully deliver Friday attachment theory workshop. 40%

5. After you have delivered the workshop - 500 word self reflection on how you went in delivering the workshop, with reference to how the required texts were useful in understanding the material and in preparing and delivering the workshop. (referencing not required) 20%

6. Develop and improve general facilitator skills.

**Required Text**

Bowlby John (1982) *Attachment*

Grille Robin (2005) *Parenting For A Peaceful World*


**Recommended Reading**


Berk Laura E. *Child Development* Sixth Ed. ( 2001 Allyn and Bacon ,Boston)

Holmes Jeremy *The Search For the Secure Base* (2001 Brunner and Routledge Sussex)


Robert Karen *Becoming Attached: First Relationships and How They Shape our Capacity for Love*, 1998

**FAC11 Assessment Cover Sheet**
Name: ______________________

1. **1000 word assignment on attachment theory or 1000 word assignment on the different stages of development (Grille) and how to recognise the impact of trauma on each of these stages. Weighting 30%**

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: ____________________________

_________________________________________________________________

Assignment Returned: _________

2. **Lesson plan for attachment theory workshop 10%**

Lesson Plan received at HFL Office: ______

Lesson Plan Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: ____________________________

_________________________________________________________________

Lesson Plan Returned: _________

3. **Attendance and participation in clinical supervision.**

Date of Supervision: _________

Supervisors Signature: _______________
4. Friday workshop satisfactorily completed 40%

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Remind facilitator to check off general skills sheet.

Facilitator Signature: _________________ Date of Assessment: __________

5. After you have delivered the workshop - 500 word self reflection on how you went in delivering the workshop, with reference to how the required texts were useful in understanding the material and in preparing and delivering the workshop. 20%

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________

______________________________________________________________

Assignment Returned: ________
FAC 12 Understanding of the Role of Transactional Analysis in Trauma Support

Semester 2.
Unit Weighing: 10

Teaching Methods:
Interactive Tutorials
Role Play
Problem-based learning
Self Directed learning
Practicum
Clinical supervision
Lecture

Brief Module Description
At completion of this module students will be able to teach some of the concepts of Transactional Analysis (TA) used in the HFL healing model using simple English. Students will be able to explain the difference between the original TA model and our Heal For Life development of Berne’s concept. They will be able to explain to both guests and HFLF Peer Support Volunteers how to recognise each state both aurally and visually; the importance of recognising and responding appropriately to a guest’s “state”; understanding how these “states” are created within us and how this effects our daily behaviour. Students will also be able to teach the effects different styles of parenting have on adult behaviour, and also how to counteract negative parental influences. Student facilitators will be able to analyse transactions and know how to apply the TA model to their work at Heal For Life.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Teach the six life positions of the HFL version of TA.
3. Teach and respond appropriately to the state a guest is in by analysing their body language and speech.
4. Ensure HFLF Peer Support Volunteers’ needs to be stroked are met.
5. Explain the different effects the style of mothering has on the adult.
6. To help guests or HFLF Peer Support Volunteers recognise when they are modelling a child or parent state.
7. Develop and improve general facilitator skills.

**Assessment Items**

1. 1000 words essay - *How HFL utilises the concepts of TA to work more effectively with guests.* (Referencing required) 30%
2. Lesson plan for the Thursday workshop submitted one week prior to taking group. 10%
3. Attendance and participation in clinical supervision.
4. Successfully deliver Thursday Transactional Analysis workshop. 40%
5. After you have delivered the workshop - 500 word reflection on how you went in delivering the workshop, with reference to how the required texts were useful in understanding the material and in preparing and delivering the workshop (see how to write a reflection document in introductory session). (Referencing not required) 20%
6. Develop and improve general facilitator skills.
7. Book in an appointment with the CEO for your review.

NB: All assessment must be passed at a satisfactory level in order to pass this module.

**Required Text**

**Recommended Reading**
James, M, 2002, *’It’s Never Too Late To Be Happy’*, Quill Driver Book/Word Dancer Press, Sanger.
James, M, 1981, *‘Breaking Free: Self-Reparenting For A New Life’,* Addison Wesley Publishing, USA
Generic Human Studies Publishing, Malibu

[www.ta-tutor.com](http://www.ta-tutor.com) Comprehensive website with TA Tools
[www.itaa-net.org](http://www.itaa-net.org) International Transactional Analysis Association


**FAC12 Assessment Cover Sheet**

**Name:** ____________________

1. **1000 words essay - How HFLF utilises the concepts of TA to work more effectively with guests - 30%**

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: ________________________________

______________________________________________________________

Assignment Returned: ________

2. **Lesson plan for Thursday workshop submitted one week prior to taking group 10%**

Lesson Plan received at HFL Office: ______

Lesson Plan Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: ________________________________

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Lesson Plan Returned: ________

3. **Attendance and participation in clinical supervision.**

Date of Supervision: ________

Supervisors Signature: ________________
4. Thursday workshop satisfactorily completed 40%

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Remind facilitator to check off general skills sheet.

Facilitator Signature: _______________ Date of Assessment: __________

5. After you have delivered the workshop - 500 word self reflection on how you went in delivering the workshop, with reference to how the required texts were useful in understanding the material and in preparing and delivering the workshop. 20%

Assignment received at HFL Office: ________

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: _______________________

_________________________________________________________________________

Assignment Returned: __________

6. Book an appointment with the general manager for your review.
FAC 12 B Facilitating young people. How to engage with young people with a Trauma Informed Approach Differences between working with adults and children.

Semester 2.
Unit Weighing: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

Brief Module Description
This is an optional module which replaces treating people with complex needs for trainee facilitators who wish to facilitate at the kids camps. This module allows the student to identify the approaches most effective when working with people up to the age of sixteen. The student will be able to explain the ways to work most effectively with children and ways to work with children without using authority, adult power or discipline. Learn how to do mandatory reporting sensitively and correctly.

Contact Hours:
- Two compulsory study days (or equivalent by distance mode)
- One clinical week under supervision of facilitator
- 1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Explain the most effective ways to work with children who have suffered from trauma.
2. Run the workshops for parents
3. Be able to mediate effectively between parent and child
4. Recognise and be able to work with PSV’s as well as volunteers and be able to articulate the difference between their roles
5. Know the requirements for mandatory reporting
6. Articulate the reasons why a PSV needs to sleep in the vicinity of the young guests.
7. Able to articulate the special requirements of being the prime care giver for the young people in their care.

Assesments for this module are under development.
FAC 13 Advanced Group Dynamics with Special Reference to Trauma Survivors and the Importance of Joy in Healing.

Semester 2.
Unit Weighting: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

Brief Module Description
Developing healthy boundaries are a vital part of healing and personal growth. A facilitator needs to be able to model and teach healthy boundaries to guests and to be able to identify when a boundary issue has occurred in the healing week and how to deal with it. Having a good understanding of boundaries also allows the facilitator to see when there is a problem in group dynamics and how to deal with this. The module also looks at various ways guests can connect with their inner child/ren particularly in finding joy in their lives. Joy, and the importance of allowing freedom to enjoy life, is often overlooked in healing. This module assists students to explore how to effectively help guests find joy.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Identify any boundary issues relating to ethical behaviour by guest or HFLF Peer Support Volunteers.
2. Assist the caring team to set and maintain appropriate boundaries.
3. Recognise the signs of broken boundaries in guests and offer constructive guidance in rectifying.
4. Describe through understanding group dynamics, any dysfunctional behaviour patterns in group.
5. Describe ways people can connect with the joyful inner child.
6. Know how to help guests overcome obstacles to feeling joy and how to facilitate a workshop to encourage a sense of fun in the group.
7. Develop and improve general facilitator skills
Assessment Items
1. 1000 words – *The importance of joy in healing.* (Referencing required) 20%
2. 500 words - Describe the differences in the application of boundaries from being a HFLF Peer Support Volunteer to being a facilitator. (referencing not required) 20%
3. 500 words – *What are the issues which impact on group cohesion during a healing week* (eg. Why we don’t have friends coming on the same week, why we make sure we spend equal time with each guest, etc). (Referencing not required) 20%
4. Lesson plan for Wednesday joy workshop submitted one week prior to taking group. 10%
5. Attendance and participation in clinical supervision
6. Successfully deliver Wednesday workshop. 30%
7. Develop and improve general facilitator skills.

Required Text


Stephanie Dowrick (2008) *Choosing Happiness: Life and Soul Essentials*

Recommended Reading
(Please note that readings with the symbol, ** beside their name can be read online at www.questia.com for a small charge.


Cloud H; Townsend J. *Boundaries in Marriage* (1999 Zondervan publishing Michigan)


professional relationships. Westport, CT: Praeger. **
*Any books about co-dependency usually include discussions on boundaries. Melody Beattie has several books that are worth reading – for example,
‘Codependent No More’ and ‘Beyond Codependency’. (Usually available in bookshops, libraries or www.amazon.com).

*Any books about recovery from alcohol or drug addiction also tend to cover the issue of boundaries. John Bradshaw’s books may also be useful e.g. ‘Homecoming: Reclaiming and Championing Your Inner Child’, or ‘Healing the Shame That Binds You’. (Usually available in bookshops, libraries or www.amazon.com)
FAC13 Assessment Cover Sheet

Name: _______________________

1. **1000 words – The importance of joy in healing. 20%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: _______________________

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Assignment Returned: _______

2. **500 words - Describe the differences in the application of boundaries from being a HFL Peer Support Volunteer to being a facilitator. 20%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: _______________________

_________________________________________________________________

Assignment Returned: _______

3. **500 words – What are the issues which impact on group cohesion during a healing week (eg. Why we don't have friends coming on the same week, why we make sure we spend equal time with each guest, etc). 20%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: _______________________

_________________________________________________________________

Assignment Returned: _______
4. **Lesson plan for Wednesday workshop including ways to encourage joy during entire workshop submitted one week prior to taking group 10%**

Lesson Plan received at HFL Office: ________

Lesson Plan Marked: Satisfactory / Not Yet

Comments / Suggestions for Improvement: __________________________

______________________________________________________________

Lesson Plan Returned: ________

5. **Attendance and participation in clinical supervision.**

Date of Supervision: ________

Supervisors Signature: ______________

6. **Wednesday workshop satisfactorily completed 30%**

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Remind facilitator to check off general skills sheet.

Facilitator Signature: ______________ Date of Assessment: ________
Fac 13 B  Issues specific to teenagers, co-morbidity, self harming and addiction issues

Semester 2.
Unit Weighing: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

Brief Module Description
This is an optional module for anyone who wishes to qualify to work with young people aged 16-25 years. Students will learn how to relate to young people and to help them effectively with their specific issues such as self harming, addictions, suicide ideation and other issues.

The most recent research on the different cebetweent he adult brian and the teenage brainm will be discussed and its importance to the program formation will be understood.

Students will learn how to work effectively with self harm and sexuality issues beign major issues for this cohort.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Work effectively with young people who are at risk of self harming.
2. Be able to articulate the differences between the adult and the teenage brain.
3. Be confident in matters relating to sexuality and sexual awareness
4. Present a workshop in a manner that makes it effective with this age group.
5. Enunciate how you would explain to a teenager the reasons for self harming and tools to prevent self harming.
6. Describe all aspects of the Hennessy House program.
7. Identify the stages of child development and recognise any developmental delays in children.
8. Explain what different workshops are relevant to children and why.

Assessment Items:
1. 2500 word - Effective ways of connecting with young people who have suffered from trauma. 40%
2. 750 words - *Describe five different behavioural issues which are more likely to be apparent in teenagers compared to adults.* 40%

3. Attendance and participation in clinical supervision

4. Successfully participating in program at Hennessy House with skills check list satisfactorily completed 20%

NB: All assessments must be passed at a satisfactory level in order to pass this module.

**Required Text**


Hennessy House Policy and Protocols

**Recommended Reading**

To be developed

**FAC 13B Assessment Cover Sheet**

**Name:** _______________________

1. 2500 word - *Effective ways of connecting with children who have suffered from trauma* 40%

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ______________

______________________________________________________________________________

Assignment Returned: ______

2. 750 words - *Describe five different behavioural issues which are more likely to be apparent in teenagers compared to adults.* 40%

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ______________

______________________________________________________________________________

Assignment Returned: ______

3. **Attendance and participation in clinical supervision.**
Date of Supervision: __________

Supervisors Signature: __________________

4. Successfully participating in week at Eva House with skills check list satisfactorily completed 20%

<table>
<thead>
<tr>
<th>Eva House/ Kids Kamp Skills Checklist</th>
<th>Satisfactory (√)</th>
<th>Not yet satisfactory (√)</th>
<th>Comments/suggestions for improvement</th>
</tr>
</thead>
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</tbody>
</table>

Facilitator Signature: ________________ Date of Assessment: _______
FAC 14 Supporting Survivors of Trauma with Complex Needs

Semester 2.
Unit Weighing: 10

Teaching Methods:
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

Brief Module Description
On this module students will learn how to recognise more complex cases. They will learn how to raise self awareness in guests suffering from Schizophrenia, DID and SRA and how guests can help themselves heal. They will also learn to recognise and support guests diagnosed with Borderline Personality Disorder and Complex Post Traumatic Stress Disorder. Students by the end of this module will be expected to know the effects and reason for prescribing the more common medications. The importance of not directly offering guests’ diagnoses will be discussed, as will appropriate ways to present information in this area. This module also examines cultural differences that may arise during a healing week. Students are asked to look at the 5 major cultural groups in Australia (Indigenous, Maori, Chinese, Vietnamese, Muslim) and explore what cultural differences do we need to be aware of when running a healing program at HFL. While not all cultural groups are represented here, we also need to be mindful of all cultures and to be inclusive and respectful of all. Students will also explore the need to have an openness that allows guests of other faiths, sexual orientation and cultures to feel included. Finally students will examine ways of assisting guests to establish safety and connect to the inner child.

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Explain complex needs relating to trauma and abuse to other HFLF Peer Support Volunteers.
2. Recognise the signs of DID in a guest and offer appropriate information and support to the guest without diagnosing or leading.
3. Recognise the signs of SRA in drawings and memories and offer appropriate validating support without diagnosing or leading.
4. Understand the effects and reasons for taking the major medications currently used by guests, and disclose to HFLF Peer Support Volunteers if appropriate.
5. Apply knowledge of available resources to offer effective support to guests on Friday, helping them make sense of how to integrate their experiences into their adult life.
6. Explain clearly to HFLF Peer Support Volunteers, culturally appropriate action prior to guests arrival.
7. Discuss with guest prior to healing week, ways of ensuring their cultural needs are met.
8. Explain clearly to guests cultural appropriate inclusions for the healing week to cater for guests of all cultures.
9. Recognise and take positive action to counteract any gender imbalances or biases.
10. Identify and address any lack of inclusivity for all attendees during Reflections.
11. Ensure guests and HFLF Peer Support Volunteers are taking responsibility for their own healing and preventing rescuing behaviour from other guests or HFLF Peer Support Volunteers.
12. Enunciate to guests with complex needs how to take responsibility and learn the tools so as to more effectively manage self responsibility for healing.
13. Identify the different symptoms for each of the major personality disorders.
14. Describe ways of assisting guests establish a sense of safety and connect to their inner child.
15. Develop and improve general facilitator skills

Assessment Items:
1. 1000 word assignment - *How to effectively work with guests with DID; SRA; BPD and complex PTSD.* (Referencing required) Weighting 30%
2. 500 words - *List five major medications prescribed for survivors of childhood trauma and the reasons for the prescription and possible effects on behaviour.* (Referencing not required)15%
3. 500 words - *What are the key points of each major cultural group in Australia (Indigenous, Maori, Chinese, Vietnamese, Muslim) that need to be addressed to ensure there is cultural inclusion for all guests.* (Referencing not required)15%
4. Lesson Plan for Monday morning workshop. 10%
5. Attendance and participation in clinical supervision
6. Successfully deliver the Monday morning workshop on establishing safety and connecting with the Inner Child. 30%
7. Develop and improve general facilitator skills.

NB: All assessments must be passed at a satisfactory level in order to pass this module.

**Required Text**
Colin A. Ross (1995) *Satanic Ritual Abuse: Principles of Treatment*
Creative Compassion (2012) *Satanic Ritual Abuse Information and Healing Guide* (booket)
Alison Miller (2011) *Healing the Unimaginable: Treating Ritual Abuse and Mind Control*
Atkinson, J (2002), *Trauma trails, recreating song lines: the transgenerational effects of trauma in Indigenous Australia*, Spinifex Press, North Melbourne
Herman, Judith (1997) *Trauma and Recovery*

**Recommended Reading**


Egan, G (2002) *The Skilled Helper* Wadsworth Group, USA

Gail Carr Feldman (1994) *Lessons In Evil, Lessons From the Light: True story of Satanic Abuse and Spiritual Healing*

Sigelman C K & Rider E (2006), *Life-Span Human Development*, Thomson Wadsworth CA USA

Smith Margaret *Ritual Abuse* (Harper San Francisco 1993)

Steinberg, M & Schnall, M (2001) *The Stranger in the Mirror*, First Cliff Street Books, USA


Ruff Matt *Set This House In Order* (2003 Harper Perennial New York) *(bad language may offend!)*

**Journals**

Holmes, E, Brewin, CR & Hennessy, RG (2004) *Trauma Films, Information Processing and Intrusive Memory Development* in *Journal of Experimental Psychology* Volume 133, Number 1, pp 3-22, American Psychological Association, USA


Internet

http://home.comcast.net/~riversrages/

http://www.sidran.org/didbr.html

http://www.needid.bizland.com/Home.shtml


**On-line references:**
PharmInfoNet allows you to access drug information resources for drugs by generic or trade names.

RxList—the Internet Drug Index, allows you to search for drugs and retrieve a wealth of information about usage and side-effects.
**FAC14 Assessment Cover Sheet**

Name: ________________________

1. **1000 word assignment - How to effectively work with guests with DID; SRA; BPD and complex PTSD. Weighting 30%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: __________________________

________________________________________________________________________

Assignment Returned: _______

2. **500 words - List five major medications prescribed for survivors of childhood trauma and the reasons for the prescription and possible effects on behaviour. 15%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: __________________________

________________________________________________________________________

Assignment Returned: _______

3. **500 words - What are the key points of each major cultural group in Australia (Indigenous, Maori, Chinese, Vietnamese, Muslim) that need to be addressed to ensure there is cultural inclusion for all guests. 15%**

Assignment received at HFL Office: _______

Assignment Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: __________________________

________________________________________________________________________

Assignment Returned: _______

4. **Lesson Plan for Monday workshop. 10%**
Lesson Plan received at HFL Office: _______

Lesson Plan Marked: Satisfactory/ Not Yet

Comments / Suggestions for Improvement: ____________________________

_________________________________________________________________

Lesson Plan Returned: ________

5. Attendance and participation in clinical supervision.

Date of Supervision: _________

Supervisors Signature: ________________

6. Successfully deliver the Monday morning workshop on establishing safety and connecting with the Inner Child. 30%

<table>
<thead>
<tr>
<th></th>
<th>Satisfactory (√)</th>
<th>Not yet satisfactory (√)</th>
<th>Comments/ suggestions for improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes Responsibility for OH&amp;S during healing week</td>
<td></td>
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<tr>
<td>Content of Workshop</td>
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<tr>
<td>Communication of Information</td>
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<td></td>
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<tr>
<td>Group Facilitation Skills</td>
<td></td>
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</tr>
</tbody>
</table>

Remind facilitator to check off general skills sheet.

Facilitator Signature: ________________ Date of Assessment: _________
**FAC 15 Education, Training, Supervision and Development of Support Workers**

**Semester 2.**
Unit Weighing: 10

**Teaching Methods:**
- Interactive Tutorials
- Role Play
- Problem-based learning
- Self Directed learning
- Practicum
- Clinical supervision
- Lecture

**Brief Module Description**
The aim of this module is to provide students with the knowledge and skills to guide and support a team of HFLF Peer Support Volunteers so that a healing week runs smoothly with all HFLF Peer Support Volunteers feeling valued and appreciated and being able to effective do their jobs. This module is largely practical based but will require some thoughtful preparation prior to the caring week so students can be prepared to fulfil the criteria listed on the checklist. If you haven't run a meeting before, you may like to read up on this, but the skills are largely based on good listening and effective communication. The module is designed so students can develop confidence in running HFLF Peer Support Volunteer meetings, delegating jobs, supporting and encouraging HFLF Peer Support Volunteers and being able to provide constructive feedback. Facilitator trainees will also develop skills to deliver the Tuesday morning workshop so guests can connect with their inner child to access and process childhood trauma.

**Contact Hours:**
- Two compulsory study days (or equivalent by distance mode)
- One clinical week under supervision of facilitator
- 1 hour of Supervision

**Module Objectives:**
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Effectively run HFLF Peer Support Volunteer meetings, delegate workloads and plan and negotiate time off for HFLF Peer Support Volunteers.
2. Support HFLF Peer Support Volunteers by leading meaningful HFLF Peer Support Volunteer sharing sessions.
3. Support HFLF Peer Support Volunteers during a healing week through deep listening, assisting with de-triggering or processing if necessary, encouraging them and giving positive affirmations, spending time with
them and discussing issues with them to help them understand complex situations.

4. Encourage HFLF Peer Support Volunteers to take on roles such as leader of the day and continue to develop their spirituality to provide moving reflections for guests.

5. Provide guidance and constructive feedback for HFLF Peer Support Volunteers so they can continue to improve.

6. Provide a sense of safety for HFLF Peer Support Volunteers and guests through safe work practices and modelling good boundaries.

7. Work collaboratively with HFLF Peer Support Volunteers and build an effective team.

8. Describe ways of assisting guests connect to the inner child to allow them to access and process childhood trauma.

9. Develop and improve general facilitator skills.

Assessment Items:

1. 500 words in point form on the different ways to help guests access the inner child. (Referencing not required) 20%

2. Lesson Plan for Tuesday morning workshop. 10%

3. Attendance and participation in clinical supervision

4. Agenda/ plan for initial Sunday meeting with HFLF Peer Support Volunteers prepared, provide support and pastoral care to HFLF Peer Support Volunteers during a healing week, successfully run HFLF Peer Support Volunteer meetings, delegate workloads, run HFLF Peer Support Volunteer sharing and feedback session (see checklist on Assessment Cover Sheet). 40%

5. Successfully deliver the Tuesday morning workshop on connecting with the Inner Child to access and process childhood trauma. 30%

6. Develop and improve general facilitator skills.

NB: All assessments must be passed at a satisfactory level in order to pass this module.

Required Text

Recommended Reading


Higginson Richard Transforming Leadership (SPCK London 1996)

Sandford R.L. Wounded warriors (Victory House Inc Oklahoma) 1987

Urquhart Colin Receive your Healing (Hodder & Stoughton London) 1986


Wood Wendy Ann Triumph over darkness (Beyond words publishing) 1993


FAC15 Assessment Cover Sheet

Name: _____________________

1. 500 words in point form on the different ways to help guests access the inner child. 20%

Assignment received at HFL Office: ______

Assignment Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________

______________________________________________________________

Assignment Returned: _______

2. Lesson Plan for Tuesday workshop. 10%

Lesson Plan received at HFL Office: ______

Lesson Plan Marked: Satisfactory/ Not Yet

Comments/ Suggestions for Improvement: ________________________

______________________________________________________________

Lesson Plan Returned: _______

3. Attendance and participation in clinical supervision.

Date of Supervision: _______

Supervisors Signature: _________________

4. Successfully guide and support a caring team demonstrating a satisfactory level of the following competencies. 40%

<table>
<thead>
<tr>
<th>Facilitator Competencies</th>
<th>Satisfactory (✓)</th>
<th>Not yet satisfactory (✓)</th>
<th>Comments/ suggestions for improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates sensitive and effective communication skills including deep listening</td>
<td></td>
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<tr>
<td>One-to-one (HFLF Peer Support Volunteers)</td>
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</tbody>
</table>
Small group (HFLF Peer Support Volunteer meetings)  

Promotes safe and effective work practices

<table>
<thead>
<tr>
<th>Facilitator Competencies (continued)</th>
<th>Satisfactory (√)</th>
<th>Not yet satisfactory (√)</th>
<th>Comments/suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Models good boundaries</td>
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<tr>
<td>Supports HFLF Peer Support Volunteers throughout the week by providing a safe and supportive workplace</td>
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<tr>
<td>Works collaboratively with HFLF Peer Support Volunteers to build an effective team</td>
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<tr>
<td>Develops loving and effective relationships with HFLF Peer Support Volunteers</td>
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<tr>
<td>Provide guidance, encouragement and constructive feedback for HFLF Peer Support Volunteers</td>
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<tr>
<td>Organises and delegates responsibilities throughout the week, plans and negotiates time off for all HFLF Peer Support Volunteers</td>
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<tr>
<td>Runs successful meetings with HFLF Peer Support Volunteers, check list satisfactorily completed</td>
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</tbody>
</table>

Facilitator Signature: ____________________ Date of Assessment: __________

5. Successfully deliver the Tuesday morning workshop on connecting with the Inner Child to access and process childhood trauma. 30%
<table>
<thead>
<tr>
<th></th>
<th>Satisfactory (√)</th>
<th>Not yet satisfactory (√)</th>
<th>Comments/ suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes Responsibility for OH&amp;S during healing week</td>
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<tr>
<td>Content of Workshop</td>
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<tr>
<td>Communication of Information</td>
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<tr>
<td>Group Facilitation Skills</td>
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</tbody>
</table>

Remind facilitator to check off general skills sheet.

Facilitator Signature: _________________ Date of Assessment: __________
FAC 16 Leadership, Administration and Competency to Practice as a Heal For Life Facilitator

Semester 2.
Unit Weighing: 10

Teaching Methods:
Interactive Tutorials
Role Play
Problem-based learning
Self Directed learning
Practicum
Clinical supervision
Lecture

Brief Module Description
This module aims to bring all the previous learning together and prepares students to lead a healing week as a facilitator. Trainee facilitators also prepare to deliver the most important workshop of the week, the Sunday night group agreements. Students are encouraged to look at the list of facilitator competencies and discuss with the program coordinator or a facilitator what competencies you may like to think about and work on prior to your first week of facilitating. It may also be useful to read through your facilitator's manual and revise your lesson plans for the workshops. Discuss any issues or questions with the Program Coordinator or a facilitator. Be confident that the modules and all your caring experience has prepared you for the role of facilitator and this will come through in your first week as a facilitator. Good luck!

Contact Hours:
Two compulsory study days (or equivalent by distance mode)
One clinical week under supervision of facilitator
1 hour of Supervision

Module Objectives:
Upon completion of the learning activities for this module, supported by appropriate use of the literature and self directed study the student will be able to:

1. Successfully lead a healing week demonstrating a satisfactory level of Facilitator competencies (see list in Assessment Items below).
2. Begin to take responsibility for group safety by monitoring individual behaviour and intervening as appropriate.
4. Successfully deliver the Sunday night group agreements workshop.
5. Develop and improve general facilitator skills

Assessment Items:
Assessable items in this unit are largely competency based. Therefore, you must be deemed as competent in each skill to complete this unit.

1. Facilitator Competencies check list (as listed on the assessment cover sheet below) satisfactorily completed 70%
2. Successfully deliver Sunday night group agreements to a group of guests on a healing week. 30%
3. Satisfactorily demonstrate general facilitator skills (the total score of the General Facilitator Skills checklist assessed in your 8 caring weeks as a trainee facilitator is deemed satisfactory).

Facilitator Competencies checklist must be completed in full in order to pass this module. It is worth 70% of the assessment. This checklist is able to be completed throughout one full week, acting as Facilitator. The checklist will be completed in conjunction with another facilitator or the Program Coordinator.

NB: All assessments must be passed at a satisfactory level in order to pass this module.

**Required Text**

**Recommended Reading**
Higginson Richard *Transforming Leadership* (SPCK London 1996)
Sandford R.L. *Wounded warriors* (Victory House Inc Oklahoma) 1987
Urquhart Colin *Receive your Healing* (Hodder & Stoughton London) 1986
Wood Wendy Ann *Triumph over darkness* (Beyond words publishing) 1993


### FAC16 Assessment Cover Sheet

**Name:** ______________

**Successfully lead a healing week demonstrating a satisfactory level of Facilitator competencies. 70%**

<table>
<thead>
<tr>
<th>Facilitator Competencies</th>
<th>Satisfactory (✓)</th>
<th>Not yet satisfactory (✓)</th>
<th>Comments/suggestions for improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated commitment to own ongoing healing and spiritual development</td>
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<tr>
<td>Demonstrates sensitive and effective communication skills</td>
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<tr>
<td>One-to-one</td>
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<td>Small group</td>
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<tr>
<td>Whole group</td>
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<tr>
<td>Administrative</td>
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<tr>
<td>Culturally sensitive and safe practices</td>
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<tr>
<td>Works collaboratively with entire Heal For Life team</td>
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<tr>
<td>Provide caring interactions for guests with complex needs and conduct a self-evaluation of interactions</td>
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<tr>
<td>Complete an incident report (either actual for fictional)</td>
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<tr>
<td>Behave in a manner consistent with Heal For Life ethics and philosophy</td>
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<tr>
<td>Organise guest’s arrival to Heal For Life including sleeping arrangements and kitchen duties</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Facilitator Competencies (continued) | Satisfactory (√) | Not yet satisfactory (√) | Comments/suggestions for improvement.
--- | --- | --- | ---
Organises and presents information effectively throughout the week |  |  | 
Operates within the Heal For Life teachings and code of conduct |  |  | 
Discuss and maintain responsibility for ethical and legal practices |  |  | 

Facilitator Signature: ________________ Date of Assessment: __________

1. Successfully deliver the Sunday evening workshop on group safety agreements. 30%

| Satisfactory (√) | Not yet satisfactory (√) | Comments/suggestions for improvement. |
--- | --- | ---
**Takes Responsibility for OH&S during healing week** |  |  |
**Content of Workshop** |  |  |
**Communication of Information** |  |  |
**Group Facilitation Skills** |  |  |

Remind facilitator to check off general skills sheet.

Facilitator Signature: ________________ Date of Assessment: __________

**Book in with the CEO for your final review.**
Appendix 1.
Employment and Accreditation of Facilitators

Heal for Life has an established set of accreditation requirements which are administered by the Accreditation Committee through the General Manager. These requirements ensure quality service delivery and safety for guests and staff.

Selection Criteria

A HFL Facilitator will:
• Hold a tertiary qualification commensurate with the role

• Completed HFL PSV Certificate in Trauma Healing

• Completed HFL Facilitator Certificate in Trauma Healing

• Attendance at a successful interview

or

• Prior learning and relevant experience will be considered in some circumstances

The Accreditation Committee

The Training and Accreditation Committee is a group consisting of external professionals and HFLF Managers who maintain HFLF standard of entry and ongoing accreditation for all Facilitators through a transparent set of criteria. The Committee is the gate-keeper for quality control within the Organisation through its role in approving course material, service handbooks and program development.
Committee Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Professional Role</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrew Walker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr John Toussaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen Morris</td>
<td></td>
<td></td>
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</tbody>
</table>

Terms of Reference

1. The Training and Accreditation Committee is a group of professional people (both external & internal) with suitable expertise endorsed by the HFLF Board of Directors, to provide advice on a range of training and accreditation matters. The Chief Executive Officer is an ex officio member of the committee. Its meetings are normally chaired by an external person.

2. The Committee considers training and accreditation matters based on recommendations from the Manager responsible for programs.

Process of recognition of prior learning

Prior learning and experience will be assessed by the Committee for those applicants who do not hold the relevant tertiary or other qualifications.
- applications for prior learning will be made in writing to the General Manager
- applicants will provide a portfolio of evidence which addresses the criteria listed above
- the General Manager will present the application to the Accreditation Committee for outcome
- applicants will be notified in writing of the Committee decision

The applicant needs to include;

- Certified copies of their tertiary qualification and academic record;
- A brief CV including details of relevant training/experience.

3. Manager informs the applicant of;
- The outcome of the interview;

4. Manager sends to Training and Accreditation Committee;
- CV of applicant;
- Copies of Tertiary qualifications;
- Interview questions;
- Australian Federal Police and Working with children checks;
- 100 points of identification.

5. Training and Accreditation Committee forward the application to Manager of programs to be reviewed by Manager of programs.

6. Manager of programs makes recommendation to Training and Accreditation Committee.

7. Training and Accreditation Committee determines outcome.

8. Manager of programs forwards the Training and Accreditation Committee decision to applicant.

**Committee Members at 2015**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Professional Role:</th>
<th>Qualifications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. John Toussaint</td>
<td>Academic and therapist</td>
<td>P.HD</td>
</tr>
<tr>
<td>Dr. Andrew Walker</td>
<td>Psychiatrist</td>
<td>BDS(Bristol) BMedSc MB,BS(U.Tas) M.Psychotherapy(UNSW) M.Criminology(Hons.II, U.Syd) LDSRCS(Eng) FRACDS FA.I.M MRCPsych FRANZCP FACHAM</td>
</tr>
</tbody>
</table>

**Appointment**

If successful, the applicant will be appointed as a facilitator.

**All applications in writing to:**

General Manger  
Heal For Life Foundation  
PO Box 361 Cessnock NSW 2325

Or
Annual Accreditation
All Facilitators will be reviewed annually in order to maintain accreditation. Re-accreditation will include:

- Facilitation of any 2 healing programs (minimum per year)
- Regular attendance at individual and group supervision
- Satisfactory supervision appraisal reports
- Meet HFLF accreditation requirements
- Undertaking the required level of 20 hours per year of Professional development.
- Satisfactory feedback from HFL Peer Support Volunteers and guests through feedback reports.

Note: Facilitators who do not meet the criteria listed above will have their re-accreditation withheld. The Committee will then review these facilitators, should the accreditation be declined 3 times, termination of employment will be recommended.

Facilitators who take leave from HFLF for more than 2 years will need to re-submit competencies to the Committee.

Any questions relating to accreditation should be taken up in the first instance with the Manager of programs.

Facilitators Skills and Competencies
Accreditation within Heal For Life Foundation is dependent upon the competence a facilitator is able to demonstrate at the appropriate accreditation level.

Application for recognition of Prior Learning
Please send this completed form and RPL assessment work to:

General Manager
PO Box 361
Cessnock NSW 2325
Or
programs@healforlife.com.au

RPL Applicant to complete
Applicant Name: ________________________________

Employer (if applicable): ________________________________

I declare that the information / evidence that I submit for this RPL application is
all my own work.

Applicants Signature_____________________________ Date:______________

Date of RPL Assessment work submitted:________________________________________

What is Recognition of Prior Learning?
Recognition of Prior Learning (RPL) is an assessment process that recognises competencies you currently have, regardless of how, when or where the learning occurred. This includes competencies attained through any combination of formal or informal training and education, work experience or general life experience.

In order to apply for recognition of prior learning in this module you must provide evidence that addresses and meets the requirements for this module. Your evidence may take a variety of forms and could include:
- Certificates and/or qualifications achieved
- References from past employers
- Testimonials from clients and previous work samples
- Substantiated *Curriculum Vitae*

To be able to grant RPL the assessor must be confident that the applicant is currently competent against all elements of competency within this module and must ensure that submitted evidence is authentic, valid, reliable, current and sufficient.

Who Can Apply
RPL is for full modules only. If partial RPL is awarded for elements within a module of competency, then the applicant must complete the other remaining elements to achieve the full module.

How does the RPL process work?
The entire process is explained at the initial interview. Evidence that is presented by the applicant is matched to the performance criteria contained within the elements for the module(s) applied for. The evidence is assessed using the following criteria:
- Is the prior learning relevant to the course and address the performance criteria specifically?
- Is the knowledge and skill current?
- Is it authentic and can be verified?
- Is the knowledge and skill appropriate to the level of the module?
How long will it take to be informed?
You will be notified of the outcome within four weeks of the RPL application / final interview.

What is Credit Transfer
Credit transfer recognises any formal qualifications you have achieved. You will need to provide a copy of the qualification and a list of the modules achieved. Their content needs to match the modules you are mapping against.

### Qualification Title (facilitator, psv, etc):

<table>
<thead>
<tr>
<th>HFLF Module e.g. car 3; fac 12:</th>
<th>List qualifications / evidence submitted to meet criteria</th>
<th>Detail work experience to meet criteria</th>
<th>Assessed C or NYC</th>
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</thead>
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</tr>
</tbody>
</table>

Assessors signature: __________________________  Date: __________
Evaluation Report of the Eva House Drug and Alcohol Program
April 2012

Dr Christine Edwards

This report represents the findings of the independent evaluation of the first 12 months of the Eva House Drug and Alcohol Program. The evaluation was funded by the Foundation for Alcohol Research and Education Ltd.
Acknowledgements

The author would like to thank all the young women who took part in this evaluation and acknowledge the contribution they have made to the Eva House Program in candidly answering my interview questions and completing the lengthy questionnaires with honesty and generosity. I would also like to thank the staff and management of Eva House and Heal for Life for their cooperation in this independent evaluation.
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Key findings

This report of the evaluation of the Eva House Drug and Alcohol Program is based on 20 program respondents who completed a series of questionnaires when they commenced the program and completed follow up questionnaires as well as a telephone interview six months after completing the program. Of the 27 individual guests who attended the three week program between September 2010 and September 2011, 26 agreed to be followed up and of these 20 were able to be reached by phone and returned completed questionnaires. This comprised a response rate of 77%.

The report describes the respondents’ health status, their use of licit and illicit drugs and the degree of risky behaviours associated with their drug and alcohol use pre and post attending the program. Where possible the results have been compared with females in the general population who completed the 2007 National Drug Strategy Household Survey to provide some context for the Eva House respondents' responses.

Health pre program

- 55% in the Eva House sample rated their health as fair or poor
- 100% of the sample were being treated for a diagnosed mental illness issue
- 75% reported very high levels of psychological distress

Health post program

- 35% in the Eva House sample rated their health as fair or poor
- 65% of the sample were being treated for a diagnosed mental illness issue
- 35% reported very high levels of psychological distress

Tobacco and alcohol use pre program

- 65% were daily smokers
- 85% drank at levels considered risky or high risk in the short term
- 45% reported drinking more than 20 standard drinks in one session during the previous 6 months
- Only 20% considered themselves to be binge drinkers or heavy drinkers
- 40% drank at levels considered risky or high risk for both short-term and long-term harm
- 50% had, in the last 6 months, experienced some form of abuse from someone affected by alcohol
Tobacco and alcohol use post program

- 50% were daily smokers
- 60% drank at levels considered risky or high risk in the short term
- 50% reported drinking more than 20 standard drinks in one session during the previous 6 months
- Only 20% considered themselves to be binge drinkers or heavy drinkers
- 25% drank at levels considered risky or high risk for both short-term and long-term harm
- 55% had, in the last 6 months, experienced some form of abuse from someone affected by alcohol

Illicit drug use pre program

- 90% of the sample had used illicit drugs in the last 6 months
- 60% had used in the previous month
- Marijuana was the most common type of illicit drug used with 50% of Eva House respondents having used marijuana in the last 6 months, followed by painkillers (40%) and tranquilisers (35%).
- One Eva House attendee had injected drugs in the previous 6 months
- 35% of the Eva House respondents had, in the last 6 months, experienced some form of abuse from someone affected by drugs
- 35% received physical injuries from someone affected by alcohol and/or drugs including bruises/abrasions, lacerations requiring stitches and a fracture

Illicit drug use post program

- 45% of the sample had used illicit drugs in the last 6 months
- 40% had used in the previous month
- Statistically significant decrease in the number of drugs used post program
- Marijuana was the most common type of illicit drug used with 40% of Eva House respondents having used marijuana in the last 6 months, followed by painkillers (15%) and tranquilisers (10%).
- No Eva House respondents had injected drugs in the previous 6 months
- 35% of the Eva House respondents had, in the last 6 months, experienced some form of abuse from someone affected by drugs
- 20% received physical injuries from someone affected by alcohol and/or drugs including bruises/abrasions, minor lacerations and a fracture

Guest Program Satisfaction

- 81% of respondents reporting the facilities and accommodation to be very good or excellent
- 88% found the workshops to be good to excellent with the Trauma on the Brain workshop deemed the most enjoyable and interesting
- 100% of Eva House respondents rated the carers as very helpful
• 100% of respondents rated the overall program positively with 53% rating the program as "life changing"

Satisfaction with the program at 6 Months follow up.

• All respondents felt that the program had a positive impact on their lives and offered examples such as gaining employment, improving their education or decreasing their drug and alcohol use since completing the program. One 3 week program was cut short by a week because the facilitator became ill and one respondent felt this had a negative effect on her coping abilities after she returned home.
• Almost every comment concerning carers described them as compassionate, professional and understanding. Respondents stressed the importance of the carers having been survivors of childhood trauma themselves.
• Respondents stressed the uniqueness of the program in that it attempts to deal with the trauma and resultant low self esteem that causes mental health problems and self destructive behaviours.

Staff Program Satisfaction

• All 8 staff members were either satisfied or very satisfied with the overall program, with the content of the program and with their role as carers or facilitator of the program.
• All 8 staff members were either confident or very confident in their own ability to implement the program and other staff members ability to implement the program.
• All 8 staff members were either satisfied or very satisfied with their access to training for the program.
• Seven of the 8 staff members said they were very satisfied with the level of respect for guests’ confidentiality and safety that the program provided and one staff member was dissatisfied but felt that staff were doing all they could do to ensure that guests were safe.

Recommendations

• Include a drug and alcohol workshop in the program to teach the young women practical skills to avoid binge drinking and drug and alcohol related risky and abusive situations.
• Include a cognitive behavioral component in the program to help the young women deal with stressful situations when they go home.
• Make certain there is someone to take over the program should the facilitator become ill. Cutting the program short caused distress to several participants.
1 Introduction

Goal of the Eva House Drug and Alcohol Program

To reduce the number of young women using alcohol and drugs to cope with the emotional pain caused by childhood trauma

Objectives of the Eva House Drug and Alcohol Program

1. To train Heal For Life carers and facilitators on how to more effectively work with young substance abusers
2. To run programs for 35 young women who have a history of childhood trauma and substance abuse
3. To decrease the frequency of substance abuse by participants. (How often they use)
4. To decrease the amount of substance abuse by participants. (How much they use)
5. To decrease the unsafe behaviours around substance use that put participants at risk
6. To improve the mental health of participants
7. To improve the general health of participants
8. To evaluate the efficacy of the program
9. To promote the program to the wider community
Heal For Life, Eva House Evaluation Plan

Target groups for the evaluation

1. 35 young women between the ages of 16 and 24 who are survivors of childhood trauma and have a history of drug and/or alcohol abuse
2. Staff and volunteers of Heal For Life
3. Wider community

Process Evaluation Strategy

1. The Heal For Life database will be analysed to provide data for the following indicators:
   - Demographic details of those taking part in the program including number of guests, age, gender, language spoken at home, aboriginality, education level, socio-economic status, home state
   - Number of guests who complete the program, and reasons for leaving of non-completers
   - Source of referrals
   - Types of child abuse experienced by guests
   - Number of facilitator and carer training programs conducted

2. A survey of staff, volunteers and facilitators of the program will be conducted to provide qualitative and quantitative data for the following performance indicators:
   - Level of overall satisfaction with the program
   - Level of satisfaction with their role in the program
   - Level of satisfaction with specific aspects of the program including access to relevant training for staff, program content, professionalism of staff, respect for guests’ confidentiality and safety
   - Perceived strengths of the program
   - Perceived weaknesses of the program
   - Suggestions for improvement of the program

3. Telephone interviews with guests who take part in the program will be conducted shortly after they complete the program to provide qualitative and quantitative data for the following indicators:
   - Level of overall satisfaction with the program
• Level of satisfaction with specific aspects of the program including program content, professionalism of staff, respect for guests’ confidentiality and safety
• Perceived strengths of the program
• Perceived weaknesses of the program
• Suggestions for improvement of the program

Short Term Outcome Evaluation Strategy

Pre-program and 6 month follow-up questionnaires will be administered to all consenting participants who attend the 3 week programs. Data will be collected for the following indicators:

• The number of guests suffering from psychological distress according to the Kessler Psychological Distress Scale - 10 (K10) (See Appendix 1)
• The number of guests suffering from ill health according to the Short Form (36) Health Survey (SF36) (See Appendix 2)
• The number of guests using alcohol and/or illicit drugs as identified by questions taken from the National Drug and Alcohol Strategy Household Survey 2007 (See Appendix 3)
• What types of drugs and/or alcohol are being used as identified by questions taken from the National Drug and Alcohol Strategy Household Survey 2007
• How often guests use as identified by questions taken from the National Drug and Alcohol Strategy Household Survey 2007
• How much guests use, as identified by questions taken from the National Drug and Alcohol Strategy Household Survey 2007
• The number of guests who, while under the influence of alcohol or illicit drugs, put themselves or others at risk of harm, as identified by questions taken from the National Drug and Alcohol Strategy Household Survey 2007

Research Methodology

• Pre program questionnaires will be distributed at Eva House to all consenting participants after they have been fully informed of the purpose and process of the evaluation and have had time to settle in and feel secure and safe in the Eva House Program. The opportunity to verbally complete the questionnaire in a confidential setting will be afforded to anyone with literacy problems and it will be made clear to the participants that whether they take part in the evaluation will have no bearing on their participation in the program.
• 6 month Post program Methodology- A preliminary phone call and/or email will be made to confirm that documented addresses are still current and
participants still wish to take part in the evaluation. During this phone call, with the participant’s permission, qualitative information will be obtained on how the participant has been coping since their visit to Eva House. Questionnaires will then be emailed using electronic software which allows automatic return of completed questionnaires at the press of a button, where possible. If no email address is available the questionnaires will be posted with stamped addressed envelopes supplied. If the participant has literacy problems the questionnaires will be administered by telephone. A $40 incentive will be offered to encourage participants to return the questionnaires. This incentive is imperative to the validity of the research. With a sample of 35 even a small non compliance rate will affect the validity of the results as it could be assumed that those who have not reduced their drug and alcohol use are the participants who have dropped out.
2 Detailed findings

The sample

The first 3 week program commenced in September 2010 with five respondents followed by 3 week programs every second month on an ongoing basis. For the purpose of the evaluation data were collected for guests who attended from September 2010 to September 2011 and completed the 3 week program.

Over this 12 month period 36 individual young people attended in total (some of these attended more than once) ranging between the ages of 15 to 24. The number of young people completing each program ranged from 2 to 7 with an average of 5 young people in each group. On average 1 to 2 guests withdrew after the first day or two in each 3 week program. The reasons given for voluntary withdrawal from the program in the first two days were primarily that the program was not what they expected and/or that they were not ready to deal with the issues that the program raised at this time. Many of these guests returned at a later date to complete the program. A few guests were asked to leave because of possession of illicit drugs or disruptive behaviour that caused distress or compromised the safety of other guests.

Response Rate

Of the 27 first-time guests who completed the three week program between September 2010 and September 2011, 25 agreed to be followed up in 6 months and of these 20 were able to be reached by phone and returned completed questionnaires, providing a response rate of 74%.

Where possible, demographics of the 20 responding guests were compared with those of the entire sample. Comparisons were made of age, state of origin, type of childhood abuse and source of referral. No significant differences were found. The Eva House database did not collect information on the ethnic background, aboriginality or education level of their guests and employment status was incomplete so no comparison on these variables could be undertaken. Where guests had completed baseline data but could not be contacted for follow-up, comparisons were made between their baseline health status, drug and alcohol use and type of childhood trauma. Those who were unable to be followed up were not found to be significantly different at baseline to the 20 respondents who completed the follow up interviews and questionnaires.
Table 1 shows the number of first time guests who completed the program over the 12 months duration of the evaluation and the number of guests who responded to both the pre and post questionnaires and interviews.

Table 1: Eva House Programs by date, number of first time guests and number of respondents.

<table>
<thead>
<tr>
<th>Date</th>
<th>No. of first time guests</th>
<th>No. of pre &amp; post evaluation respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 2010</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Nov 2010</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Jan 2011</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mar 2011</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>May 2011</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Jul 2011</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Sep 2011</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>27</td>
<td>20</td>
</tr>
</tbody>
</table>

All 20 guests had suffered some type of childhood trauma. Seventy percent of guests had suffered sexual abuse. Table 2 describes the type of childhood trauma guests reported having suffered.

Table 2: Type of childhood trauma guests had suffered previous to attending Eva House. (Guests could record more than one type of abuse).

<table>
<thead>
<tr>
<th>Trauma type</th>
<th>No. of guests</th>
<th>% of guests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional abuse</td>
<td>17</td>
<td>85%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>14</td>
<td>70%</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>9</td>
<td>45%</td>
</tr>
<tr>
<td>Neglect/Abandonment</td>
<td>10</td>
<td>50%</td>
</tr>
</tbody>
</table>

Table 3 describes who referred the respondents to Eva House. Guests’ referral sources varied, with about a third hearing about Eva House from family and/or friends, a third being referred by their counsellor or other health professional and a further third seeing or hearing about the service from a media source.
Table 3: Referral Source

<table>
<thead>
<tr>
<th>Referral source</th>
<th>No. of guests</th>
<th>% of guests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/friends</td>
<td>7</td>
<td>36.84%</td>
</tr>
<tr>
<td>Counsellor</td>
<td>3</td>
<td>15.79%</td>
</tr>
<tr>
<td>Other Health professional</td>
<td>3</td>
<td>15.79%</td>
</tr>
<tr>
<td>Brochure</td>
<td>3</td>
<td>15.79%</td>
</tr>
<tr>
<td>Radio</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td>TV</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td>Web</td>
<td>1</td>
<td>5.26%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>19</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Tables 4 shows the state of origin of the 20 respondents. Guests came from all over Australia to attend the program.

Table 4: State of origin

<table>
<thead>
<tr>
<th>State</th>
<th>No. of guests</th>
<th>% of guests</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>12</td>
<td>60.0%</td>
</tr>
<tr>
<td>QLD</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>VIC</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>WA</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>SA</td>
<td>1</td>
<td>5.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

The remainder of this report describes the evaluation samples health status, their use of licit and illicit drugs and the degree of risky behaviours associated with their drug and alcohol use pre and post attending the program. Where possible the results have been compared with females in the general population that completed the 2007 National Drug Strategy Household Survey to provide some context for the Eva House guests responses.
General Health

The 2007 National Drug Strategy Household Survey (from which these questions were sourced) found that around one in eight people (12.2%) who were over 14 years of age rated their health as fair or poor. The Household Survey also found that higher rates of drug use were related to poorer health status. Although you might expect that most young women in the 15 to 24 year age group would have excellent health, 11 of the 20 young people (55%) in the Eva House sample rated their health as fair or poor before they completed the program and 9 considered their health good. After completing the program 13 considered their health either good, very good or excellent (65%) with 7 (45%) still rating their health as fair or poor. Of the 20 respondents 9 reported improvements in their general health since completing the program, 8 reported their general health had remained the same and 3 reported some deterioration in their health.

Table 5: Respondents rating of their general health pre and post program in response to the question ‘In general, would you say your health is…?’

<table>
<thead>
<tr>
<th>Pre program</th>
<th>General health</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>2</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>9</td>
<td>45.0%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>9</td>
<td>45.0%</td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post program</th>
<th>General health</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>1</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td>6</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>11</td>
<td>55.0%</td>
<td></td>
</tr>
<tr>
<td>Very Good</td>
<td>1</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>1</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
Mental Health

The Drug Strategy Household survey reported 10.8% of the Australian population with a diagnosed mental illness. All of the 20 respondents at Eva House during this period had been diagnosed with a mental illness, which means 100% of the sample had a diagnosed mental illness before attending Eva House. Seven respondents reporting that they were no longer receiving treatment for chronic mental health problems 6 months post program because of improvement in their conditions.

Chart 1: Respondents self-reported health conditions.

Respondents could select more than one condition from a comprehensive list of conditions, or insert a different condition in response to the question ‘In the last 6 months have you been diagnosed or treated for…?’. Other than low iron, which is a common condition in adolescent females*, depression and anxiety disorder were the most common conditions reported. The number of respondents reporting being treated for low iron, anxiety disorder, eating disorders, asthma, sexually transmitted diseases, borderline personality disorder, hypertension and migraine decreased 6 months post program.

Chart 1: Respondents self-reported health conditions pre and post program

Respondents self reported health conditions pre and post program
n=20

![Chart showing self-reported health conditions pre and post program]
Psychological Distress

Among Australians aged 18 years or older in the 2007 Household Survey, one in ten (9.9%) reported high or very high levels of psychological distress in the preceding four-week period.

Among the Eva House sample 15 of the 20 respondents (75%) reported very high levels of psychological distress. The average pre-program K10 psychological distress score was 35 of a possible 50. There was a statistically significant reduction in post program scores with the average post program score being 26 ($t=5.29, df=19, p<.0001$). Of the 20 respondents 18 showed reductions in their psychological distress scores since completing the program, one respondent's score remained the same and 1 respondent's distress score increased.

Table 6: Respondents psychological distress (K10) scores pre and post program.

<table>
<thead>
<tr>
<th>Pre program K10</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (10-15)</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Moderate (16-21)</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>High (22-29)</td>
<td>5</td>
<td>25.0%</td>
</tr>
<tr>
<td>Very High (30-50)</td>
<td>15</td>
<td>75.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post program K10</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low (10-15)</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>Moderate (16-21)</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>High (22-29)</td>
<td>8</td>
<td>40.0%</td>
</tr>
<tr>
<td>Very High (30-50)</td>
<td>7</td>
<td>35.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
**Tobacco Use**

Of 17.2 million Australians aged 14 years or older in the 2007 Household Survey, one in six (16.6%) smoked daily and females started smoking daily at 18.1 years on average.

Thirteen of the 20 young women who attended the Eva House Program (65%) were daily smokers and started smoking daily at 16 years on average. Of the thirteen who were smokers 3 gave up smoking after attending the program. None had taken it up since attending the program so 50% of respondents were smoking 6 months post program. Of these, one smoker was planning to give it up within the next 30 days, 5 were planning to give it up within the next 3 months, 2 intended to give up but not in the near future and two smoking respondents had no plans to give up smoking.

**Alcohol Use**

In 2007, 10.1% of Australians aged 14 years or older had never consumed a full serve of alcohol; a further 7.0% had not consumed alcohol in the previous 12 months. The average age at which females first consumed a full glass of alcohol was 17.1 years.

In the Eva House sample one respondent had never had an alcoholic drink and another respondent had not consumed alcohol in the 6 months before attending the program. (10% of the sample were non drinkers). The average age the respondents had first consumed a full glass of alcohol was 14.1 years.

**Alcohol consumption risk status**

Central to much of the analysis of alcohol consumption in this report is the concept of risk. For comparison purposes with the 2007 National Drug Strategy Household Survey the model used is that outlined in the Australian Alcohol Guidelines (NHMRC 2001), for short-term and long-term risk of alcohol-related harm. In summary:

- **Short-term risk of harm** (particularly injury or death) is associated with given levels of drinking on any drinking occasion. For adult females the consumption of up to 4 standard drinks on a single occasion is considered ‘Low risk’, 5 to 6 per occasion ‘Risky’, and 7 or more per occasion ‘High risk’.

- **Long-term risk of harm** is associated with regular daily patterns of drinking. For adult females the consumption of up to 14 standard drinks per week is considered ‘Low risk’, 15 to 28 per week ‘Risky’, and 29 or more per week ‘High risk’.
Readers should note that these alcohol risk guidelines were reviewed by the National Health and Medical Research Council in 2009\(^1\). According to the new guidelines, for healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury and drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion. For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible. It should be noted that 6 of the young women in the Eva House sample are not yet 18 years of age.

In 2007, approximately one in ten (8.6%) Australians aged 14 years or over, drank at levels considered risky or high risk for both short-term and long-term harm according to the 2001 NHMRC Guidelines.

Among Eva House respondents 17 of the 20 respondents (85%) drank at levels considered risky or high risk in the short term (binge drinking) prior to attending Eva House, one was drinking at safe levels and 2 were non drinkers. Six months later 12 (60%) were still drinking at risky or high risk levels in the short term though not as often and 3 were non drinkers with five drinking at safe levels. (Two of these were consuming so little alcohol that they labeled themselves non-drinkers but for the purpose of this report I have included them as drinkers as they were still consuming alcohol occasionally).

Eight of the Eva House respondents (40%) drank at levels considered risky or high risk for both short-term and long-term harm prior to attending the Eva House program. At the 6 month follow up five of the Eva House respondents (25%) were drinking at levels considered risky or high risk for both short-term and long-term harm. One respondent who belonged to both the long and short term high risk drinking groups prior to attending the program reported that she had stopped drinking altogether since attending the program. (This was confirmed by her very proud mother whom the respondent insisted on putting on the phone during her qualitative interview in order to validate how well she was doing).

Although 12 of the respondents were still binge drinking after they completed the program only 4 labelled themselves as binge drinkers. One of these had previously labeled herself a social drinker and one of the respondents who had labelled herself a binge drinker before attending the program was now in the ex-drinker category.

There was no significant difference in how often the respondents drank pre and post program (\(t=.71, \text{df}=19, \text{p}=.48\))

---

\(^1\) National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol 2009.
Table 7: Number of days per week respondents drank alcohol pre and post attending the program

<table>
<thead>
<tr>
<th>How often drink</th>
<th>Pre program</th>
<th>No. of Respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 to 4 days a wk</td>
<td>4</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>1 to 2 days a wk</td>
<td>6</td>
<td>30.0%</td>
<td></td>
</tr>
<tr>
<td>2 to 3 days a mth</td>
<td>5</td>
<td>25.0%</td>
<td></td>
</tr>
<tr>
<td>about 1 day a mth</td>
<td>2</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>less often</td>
<td>1</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>never</td>
<td>2</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How often drink</th>
<th>Post program</th>
<th>No. of Respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 to 4 days a wk</td>
<td>4</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>1 to 2 days a wk</td>
<td>4</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>2 to 3 days a mth</td>
<td>5</td>
<td>25.0%</td>
<td></td>
</tr>
<tr>
<td>about 1 day a mth</td>
<td>2</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>less often</td>
<td>2</td>
<td>10.0%</td>
<td></td>
</tr>
<tr>
<td>never</td>
<td>3</td>
<td>15.0%</td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>20</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Chart 2: Maximum amount of drinks Eva House respondents reported drinking in at least one session during the previous 6 months pre and post attending the Eva House Program

**Maximum number of drinks respondents reported drinking in a session during the past 6 months**

n=20
Table 8: Respondents self-rating of their drinking status in response to the question ‘At the present time do you consider yourself …?’

<table>
<thead>
<tr>
<th>Type of drinker</th>
<th>Number of Respondents Pre program</th>
<th>%</th>
<th>Number of Respondents Post program</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Drinker</td>
<td>2</td>
<td>10.0%</td>
<td>2</td>
<td>10.0%</td>
</tr>
<tr>
<td>An Ex-drinker</td>
<td>2</td>
<td>10.0%</td>
<td>3</td>
<td>15.0%</td>
</tr>
<tr>
<td>An occasional drinker</td>
<td>5</td>
<td>25.0%</td>
<td>5</td>
<td>25.0%</td>
</tr>
<tr>
<td>A Light drinker</td>
<td>1</td>
<td>5.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>A Social drinker</td>
<td>6</td>
<td>30.0%</td>
<td>6</td>
<td>30.0%</td>
</tr>
<tr>
<td>A Heavy drinker</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>A Binge drinker</td>
<td>4</td>
<td>20.0%</td>
<td>4</td>
<td>25.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0%</strong></td>
<td><strong>20</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Moderating behaviour

In the 2007 National survey, approximately 0.9% of drinkers had not undertaken any of the blood alcohol limiting measures surveyed. The most common blood alcohol limiting measure undertaken by the drinkers aged 14 years or older in the 2007 Australian survey was to ‘limit the number of drinks’ they consumed (77.7%).

Among the Eva House respondents, all had at some time undertaken a blood alcohol limiting measure although four of the 18 respondents who drank pre program reported rarely moderating their drinking behaviour. Three of the 17 respondents that were still drinking alcohol post program reported rarely moderating their drinking behaviour. Chart 3 shows the number of respondents who reported undertaking moderating behaviours "always" or "most of the time" pre and post Eva House program. Respondents could nominate more than one behaviour.
Chart 3: Number of respondents who reported moderating drinking behaviours "always" or "most of the time" pre and post Eva House program.

Behaviours drinking respondents reported undertaking to modify their alcohol consumption

- Limit the number of drinks you have in an evening
- Quench your thirst by having a non-alcoholic drink before having alcohol
- Make a point of eating while consuming alcohol
- Refuse an alcoholic drink you are offered because you really don't want it
- Deliberately alternate between alcoholic and non-alcoholic drinks
- Count the number of drinks you have
- Only drink low alcohol drinks

No. of respondents

0 1 2 3 4 5 6

Limit the number of drinks you have in an evening
Quench your thirst by having a non-alcoholic drink before having alcohol
Make a point of eating while consuming alcohol
Refuse an alcoholic drink you are offered because you really don't want it
Deliberately alternate between alcoholic and non-alcoholic drinks
Count the number of drinks you have
Only drink low alcohol drinks

pre
post
Alcohol related harm

Only two of the 20 Eva House respondents did not report any alcohol related harmful or potentially harmful experiences in the 6 months previous to attending the program. Six months post program six of the 20 respondent did not report any alcohol related harmful or potential harmful experiences. Chart 4 shows the distribution of experiences respondents reported. Respondents could choose more than one. Pre program responses came from 18 respondents and post program responses came from 14 respondents. There were reductions in 3 of the 7 alternatives.

Chart 4: Number of respondents who reported potentially harmful alcohol related experiences in the previous six months pre and post attending the Eva House program.

Alcohol related potentially harmful experiences in the last 6 months

<table>
<thead>
<tr>
<th>Experience</th>
<th>Pre Program</th>
<th>Post Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed to do what was normally expected of you because of drinking</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Unable to stop drinking once you had started</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>You or someone else injured because of your drinking</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Unable to remember what happened while you were drinking</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Had a feeling of guilt or remorse after drinking</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Needed a first drink in the morning after a heavy drinking session</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>A relative, friend or doctor been concerned about your drinking</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

Alcohol related abuse

Before attending the program 10 of the 20 Eva House respondents (50%) had in the previous 6 months, experienced some form of abuse from someone affected by alcohol. At follow up 11 of the 20 respondent had experienced some form of abuse from someone affected by alcohol.
Illicit Drug Use

This section presents data on the use of any illicit drug. Illicit drugs include illegal drugs (such as marijuana/cannabis), pharmaceutical drugs (such as pain-killers, tranquillisers) when used for non-medical purposes (strictly an illicit behaviour), and other substances used inappropriately (such as inhalants).

The survey questions were taken verbatim from the 2007 National Drug Strategy with the exception that The Household Survey defines recent drug use as use in the last 12 months, whereas the Eva House Survey defines recent use as having used in the last 6 months. This discrepancy corresponds with the 6 months duration of the Eva House study and should be kept in mind when comparing the data in the following tables.

The age range for the Household Survey tables is 14 years to 29 years, whereas the Eva house age range is 15 to 24 years. (There was one 15 year old in the...
Eva House sample who was 16 years old in time for the 6 months follow up survey and had parental permission to be included in the study). Eva House respondents were not asked if they had used in the last week because it was a condition of their program attendance that if they used illicit drugs while taking part in the program they would be sent home.

The comparison of the two surveys is used to give some context to the drug and alcohol and health problems the young women at Eva House face compared to the general population and is not designed to serve as an exact comparison.

**Illicit Drug Use**

Table 9: Use of any illicit drug- 2007 Household Survey data, compared with Eva House Sample.

<table>
<thead>
<tr>
<th>Period</th>
<th>Household Survey All females %</th>
<th>Household Survey 14-19 yrs %</th>
<th>Household Survey 20-29 yrs %</th>
<th>Eva House Pre program 15 to 24 yrs %</th>
<th>Eva House Post program 15 to 24 yrs %</th>
</tr>
</thead>
<tbody>
<tr>
<td>In lifetime</td>
<td>34.8</td>
<td>23.6</td>
<td>54.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td>In last 12 mths (Household)/ In last 6 mths (Eva House)</td>
<td>11.0</td>
<td>16.6</td>
<td>27.7</td>
<td>90.0</td>
<td>45%</td>
</tr>
<tr>
<td>In the last month</td>
<td>6.0</td>
<td>9.8</td>
<td>15.5</td>
<td>60.0</td>
<td>40%</td>
</tr>
</tbody>
</table>

Of the 20 Eva House respondents, all but one had used illicit drugs at some time in their life, 18 had used in the previous 6 months (90%) and twelve had used in the previous month (60%) before attending the program. The number of different types of illicit drugs used ranged from 0 to 9 with a mean of 3. At follow up 9 had used illicit drugs in the previous 6 months (45%) and 8 (40%) had used in the previous month. The number of different types of illicit drugs used ranged from 4 with a mean of one. This was a statistically significant reduction (t=2.65, df=38,p=.013). Although 45% of the sample still used illicit drugs after the program and this is much higher than the general population, for half this cohort of troubled young people to cease their illicit drug use after a 3 week intervention is a very positive outcome.

The types of drugs used by Eva House respondents did not differ markedly from the general population. Marijuana was the most common type of illicit drug used with 50% of Eva House respondents having used marijuana in the 6 months, before attending the program. This reduced to 40% at follow up. Painkillers were the next most commonly used illicit drug reducing from 40% to 15% at follow up. Before attending the program 35% of respondents used tranquilisers illicitly. This reduced to 10% of respondents at follow-up. There were reductions in the
number of respondents using every illicit drug that was reported at baseline. At baseline one respondent was using six types of illicit drugs including injecting heroin. At follow up this respondent reported having given up all drug use and had not used or injected for over 6 months. The respondents self report was corroborated by her grandmother who was her primary carer and spoke briefly to the interviewer as part of the respondent’s qualitative interview (with the respondent’s knowledge and permission).

Chart 4 shows the types of illicit drugs Eva House respondents had used in the previous 6 months pre and post program.

### Types of illicit drugs used in the previous 6 months pre and post program

<table>
<thead>
<tr>
<th>Types of Illicit Drugs</th>
<th>n=18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>12</td>
</tr>
<tr>
<td>Painkillers</td>
<td>10</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>8</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>6</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>4</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>2</td>
</tr>
<tr>
<td>Methadone</td>
<td>1</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>1</td>
</tr>
<tr>
<td>Heroin</td>
<td>1</td>
</tr>
<tr>
<td>Zanabazol</td>
<td>1</td>
</tr>
<tr>
<td>Ketamine</td>
<td>1</td>
</tr>
</tbody>
</table>

**Injecting drugs**

In the 2007 Household Survey of Australian females aged 14 years or older, 1.3% had ever injected illicit drugs and 0.3% had injected illicit drugs in the previous 12 months. The average age at which users first injected illicit drugs was 21.3 years. In the Eva House Survey one attendee had injected drugs and had injected in the previous 6 months. She represents 5.0% of the Eva House sample. She began injecting at age 15 and injected 2 to 3 times a day and had used a needle after someone else had used it in the last 6 months. As reported earlier this respondent has given up all drug use since completing the program and has not used in over 6 months.
Drug related incidents

Seven of the 20 Eva House respondents (35%) had, in the 6 months before attending the program, experienced some form of abuse from someone affected by drugs. All seven young women had received physical injuries from someone affected by alcohol and/or drugs including bruises/abrasions, lacerations requiring stitches and a fracture. At follow up 7 respondents again reported experiencing some form of abuse from someone affected by drugs. Four of these resulted in the physical injuries of bruising/abrasions, minor lacerations and 1 fracture.

Summary of respondents outcomes pre and post

Of the 20 respondents who attended the program, all 20 reported at least one form of general health, mental health or drug and alcohol related improvement six month after attending the program. Respondent C would have to be considered to have the most successful post program outcomes. In the 6 months since finishing the Eva House program respondent C managed to improve her general health, reduce her psychological distress scores, quit smoking, reduce her alcohol consumption to less than one day a month, stop binge drinking and stop injecting or using any of the six different types of drugs that she was injecting before she visited Eva House. Other respondents’ outcomes varied considerably, as did the problems with which they came to the program. Ten respondents reported an increase in their general health rating and 17 respondents reduced their psychological distress score, with 10 of these moving into a safer K10 category. Seven respondents reported drinking less often, with one of these becoming a non-drinker. Four respondents stopped binge drinking and fourteen respondents reduced their illicit drug use with eight of these stopping altogether. Three respondents quit smoking. Two respondents decreased the amount of drugs they were using but these respondents reported increases in how often they were drinking.
<table>
<thead>
<tr>
<th>Respondent ID</th>
<th>Age</th>
<th>General health pre</th>
<th>General health post</th>
<th>Psychological distress pre</th>
<th>Psychological distress post</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>19</td>
<td>good</td>
<td>fair</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>B</td>
<td>24</td>
<td>fair</td>
<td>good</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>C</td>
<td>19</td>
<td>fair</td>
<td>good</td>
<td>Very High</td>
<td>High</td>
</tr>
<tr>
<td>D</td>
<td>21</td>
<td>good</td>
<td>good</td>
<td>Very High</td>
<td>Moderate</td>
</tr>
<tr>
<td>E</td>
<td>15</td>
<td>good</td>
<td>Excellent</td>
<td>Very High</td>
<td>High</td>
</tr>
<tr>
<td>F</td>
<td>17</td>
<td>fair</td>
<td>good</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>G</td>
<td>22</td>
<td>poor</td>
<td>fair</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>H</td>
<td>20</td>
<td>good</td>
<td>good</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>I</td>
<td>19</td>
<td>fair</td>
<td>fair</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>J</td>
<td>16</td>
<td>good</td>
<td>good</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>K</td>
<td>20</td>
<td>fair</td>
<td>fair</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>L</td>
<td>23</td>
<td>fair</td>
<td>good</td>
<td>Very High</td>
<td>Moderate</td>
</tr>
<tr>
<td>M</td>
<td>20</td>
<td>poor</td>
<td>good</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>N</td>
<td>17</td>
<td>fair</td>
<td>fair</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>O</td>
<td>20</td>
<td>good</td>
<td>good</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>P</td>
<td>17</td>
<td>good</td>
<td>Very good</td>
<td>Very High</td>
<td>High</td>
</tr>
<tr>
<td>Q</td>
<td>18</td>
<td>fair</td>
<td>good</td>
<td>Very High</td>
<td>Low</td>
</tr>
<tr>
<td>R</td>
<td>16</td>
<td>good</td>
<td>good</td>
<td>Very High</td>
<td>High</td>
</tr>
<tr>
<td>S</td>
<td>20</td>
<td>good</td>
<td>fair</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>T</td>
<td>21</td>
<td>fair</td>
<td>poor</td>
<td>Very High</td>
<td>High</td>
</tr>
</tbody>
</table>
Table 11: Tobacco and Alcohol Outcomes of individual respondents

<table>
<thead>
<tr>
<th>Respondent ID</th>
<th>Age</th>
<th>Smoked daily pre</th>
<th>Smoke daily post</th>
<th>how often drink pre</th>
<th>how often drink post</th>
<th>Binging pre</th>
<th>Binging post</th>
<th>No. of illicit drugs pre</th>
<th>No. of illicit drugs post</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>19</td>
<td>smoker</td>
<td>smoker</td>
<td>2 to 3 days a mth</td>
<td>3 or 4 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>B</td>
<td>24</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>2 to 3 days a mth</td>
<td>2 to 3 days a mth</td>
<td>risky</td>
<td>Low risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>19</td>
<td>smoker</td>
<td>Recently quit</td>
<td>2 to 3 days a mth</td>
<td>rarely</td>
<td>risky</td>
<td>Low risk</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>D</td>
<td>21</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>rarely</td>
<td>Don't drink</td>
<td>Low risk</td>
<td>Don't drink</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>E</td>
<td>15</td>
<td>smoker</td>
<td>smoker</td>
<td>3 or 4 days a wk</td>
<td>1 or 2 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>17</td>
<td>smoker</td>
<td>smoker</td>
<td>1 or 2 days a wk</td>
<td>1 or 2 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>G</td>
<td>22</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>2 to 3 days a mth</td>
<td>rarely</td>
<td>High risk</td>
<td>High risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>H</td>
<td>20</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>1 or 2 days a wk</td>
<td>3 or 4 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>I</td>
<td>19</td>
<td>smoker</td>
<td>smoker</td>
<td>1 or 2 days a wk</td>
<td>2 to 3 days a mth</td>
<td>High risk</td>
<td>High risk</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>J</td>
<td>16</td>
<td>smoker</td>
<td>smoker</td>
<td>1 or 2 days a wk</td>
<td>2 to 3 days a mth</td>
<td>High risk</td>
<td>High risk</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>K</td>
<td>20</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>1 day a mth</td>
<td>1 day a mth</td>
<td>risky</td>
<td>Low risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>L</td>
<td>23</td>
<td>smoker</td>
<td>smoker</td>
<td>3 or 4 days a wk</td>
<td>3 or 4 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>M</td>
<td>20</td>
<td>smoker</td>
<td>smoker</td>
<td>2 to 3 days a mth</td>
<td>2 to 3 days a mth</td>
<td>High risk</td>
<td>High risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>17</td>
<td>smoker</td>
<td>Non-smoker</td>
<td>3 or 4 days a wk</td>
<td>3 or 4 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>O</td>
<td>20</td>
<td>smoker</td>
<td>smoker</td>
<td>1 or 2 days a wk</td>
<td>1 or 2 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>P</td>
<td>17</td>
<td>smoker</td>
<td>smoker</td>
<td>1 day a mth</td>
<td>2 to 3 days a mth</td>
<td>High risk</td>
<td>High risk</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Q</td>
<td>18</td>
<td>smoker</td>
<td>smoker</td>
<td>3 or 4 days a wk</td>
<td>1 or 2 days a wk</td>
<td>High risk</td>
<td>High risk</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>R</td>
<td>16</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>1 day a mth</td>
<td>1 day a mth</td>
<td>High risk</td>
<td>Low risk</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>S</td>
<td>20</td>
<td>smoker</td>
<td>Recently quit</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>T</td>
<td>21</td>
<td>Non-smoker</td>
<td>Non-smoker</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>Don't drink</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Satisfaction with the Program Immediately Post Program

Seventeen of the 20 young women who completed pre and post drug and alcohol surveys also completed a written satisfaction survey on the last day of the program. The satisfaction survey includes questions concerning the Eva House facilities, carers and program components. For details about what the Eva House program offers see Appendix 4.

Satisfaction with Accommodation and facilities

All but one respondent found the accommodation and facilities to be good, with 81% of respondents reporting the facilities to be very good or excellent. Several respondents felt that the accommodation could benefit from some air conditioning and one person was dissatisfied because she found a dead mouse in her room.

Table 12: Respondents’ satisfaction with accommodation and facilities

<table>
<thead>
<tr>
<th>Accommodation &amp; Facilities</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>8</td>
<td>47.1%</td>
</tr>
<tr>
<td>very good</td>
<td>5</td>
<td>29.4%</td>
</tr>
<tr>
<td>good</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>adequate</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>poor</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>very poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Satisfaction with Components of the program

**Morning Reflections**- A time for spiritual reflection and exploring our needs for the day.

Most respondents (88.2%) found the morning reflections component of the program to be inspiring or enjoyable. Several people commented that they really enjoyed the way the mornings began and one person said they would love to get a list of the music and readings used for morning reflections. A couple of people found it hard to focus that early in the morning and would have preferred to have it later in the day. (*Morning reflections* begins at 10am).
**Table 13: Respondents satisfaction with morning reflections**

<table>
<thead>
<tr>
<th>Morning Reflections</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>inspiring</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>enjoyable</td>
<td>9</td>
<td>52.9%</td>
</tr>
<tr>
<td>ok</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>boring</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>hated it</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Labour of Love** - This is time to give back to the community through helping out around the house.

Most respondents were happy to volunteer their labour although one of the respondents felt it was "a drag". Comments concerning this component of the program were generally positive e.g. "It's great to help out as part of the community".

**Table 14: Respondents satisfaction with labour of love**

<table>
<thead>
<tr>
<th>Labour of Love</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very good idea</td>
<td>8</td>
<td>47.1%</td>
</tr>
<tr>
<td>good</td>
<td>5</td>
<td>29.4%</td>
</tr>
<tr>
<td>ok</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>a drag</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>hated it</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Sharing at 6pm** - A time to practice acknowledging your feelings within the group in a safe environment.

All respondents found the sharing part of the program beneficial to some degree e.g. "Makes me feel more comfortable about my abuses and makes me feel good to say it out loud", although some respondents found it quite a difficult part of the program. e.g. "Hardest part of the day but it is very empowering." and from another respondent "difficult but worth it".
Table 15: Respondents' satisfaction with sharing

<table>
<thead>
<tr>
<th>Sharing at 6 PM</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>really beneficial</td>
<td>11</td>
<td>64.7%</td>
</tr>
<tr>
<td>beneficial</td>
<td>5</td>
<td>29.4%</td>
</tr>
<tr>
<td>slightly beneficial</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>not beneficial at all</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Evening Workshops

The majority of respondents (88.2%) found the evening workshops to be good to excellent with the Trauma on the Brain workshop deemed the most enjoyable followed by the visualisation workshop e.g. "Trauma on the brain workshop gave me massive insight, really good information on the scientific basis of trauma" and "Workshops involving visualisations really changed my perspective on having an inner child and made me understand a lot more about myself". One respondent found the anger workshop "scary".

Table 16: Respondents' satisfaction with evening workshops

<table>
<thead>
<tr>
<th>Evening Workshop</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>4</td>
<td>23.5%</td>
</tr>
<tr>
<td>very good</td>
<td>9</td>
<td>52.9%</td>
</tr>
<tr>
<td>good</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>adequate</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>very poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Evening Reflections- Inspirational readings and music to help you relax before bed.

Over half respondents (58.9%) found the evening reflections component of the program to be inspiring or enjoyable e.g. "Loved listening to the music before bed. It calmed me." This part of the program was not compulsory and some people chose to spend this time on their own eg. "Liked them but glad we are not forced to go". 
Table 17: Respondents' satisfaction with evening reflections

<table>
<thead>
<tr>
<th>Evening Reflections</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>inspiring</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>enjoyable</td>
<td>8</td>
<td>47.1%</td>
</tr>
<tr>
<td>ok</td>
<td>7</td>
<td>41.2%</td>
</tr>
<tr>
<td>boring</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>hated it</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Weekends**- free time to chill, read, walk, chat, play some games, be creative, or watch some DVD's

All but one attendee felt the weekends' activities were good to excellent. One attendee felt there were not enough carers around during the weekend. Suggestions for improvements included a swimming pool and a list of activities to do when going to town.

Table 18: Respondents' satisfaction with weekends

<table>
<thead>
<tr>
<th>Weekends</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>excellent</td>
<td>6</td>
<td>35.3%</td>
</tr>
<tr>
<td>very good</td>
<td>8</td>
<td>47.1%</td>
</tr>
<tr>
<td>good</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td>adequate</td>
<td>1</td>
<td>5.9%</td>
</tr>
<tr>
<td>poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>very poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Satisfaction with Carers**

Respondents were asked to rate their satisfaction with the carers from "very helpful" to "very unhelpful". All 17 respondents rated the carers as "very helpful". Comments about carers were all positive and included:

- The carers at Eva House have been inspiring in their own individual ways. All the carers have brought something to help in the healing process of the client
- Carers are amazing and have truly changed my life
- I love all the carers. They help me believe in myself and I'm so grateful to have met them and can't wait till my next program.
- Beautiful carers. Very helpful and caring
- It was so good to have someone who actually cared about me
- The carers were amazing
Overall rating of the program

All respondents rated the program positively with over half rating it as "life changing". All respondents' comments were positive e.g. "Thank you so much. The healing program is amazing and I will definitely spread the word." and " Best thing I have ever decided to do."

Suggestions on ways to improve the program were mainly met with comments saying that the program did not need improving but a few respondents suggested the following:

- A list of ways to express / release feelings to take home
- More work on the "rebel child"
- Maybe a workshop on physical health
- Drug and alcohol information
- A little bit of information on eating disorders
- Have back up in case facilitator gets sick

Table 19: Respondents overall satisfaction with the program

<table>
<thead>
<tr>
<th>Overall Rating</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>life changing</td>
<td>9</td>
<td>52.9%</td>
</tr>
<tr>
<td>very positive</td>
<td>5</td>
<td>29.4%</td>
</tr>
<tr>
<td>positive</td>
<td>3</td>
<td>17.6%</td>
</tr>
<tr>
<td>poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>very poor</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>17</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Respondents' Comments regarding their satisfaction with the program

Four respondents provided comments regarding their overall satisfaction with the program.

I appreciate everything Eva House has not only given me but also the genuinely caring survivors that have helped me realise what healing really is. Their understanding has been amazing. I have never felt accepted let alone understood but here I have realised not only what I am capable of but I've started to appreciate myself and started to really heal. I didn't realise how much I needed this. No-one in my life so far would even open my eyes to that idea let alone help me want to appreciate me and to believe I can heal. I wish I had more words to show my gratitude but thank you, thank you. (Respondent A)

Thank you so much. Be back soon ..... The healing program is amazing and I will definitely spread the word (Respondent B)
Eva House is awesome. Words can’t express how grateful I am (Respondent C)

Best thing I have ever decided to do (Respondent D)

Satisfaction with the program at 6 Months follow up.

Seventeen of the 20 young women who completed pre and post drug and alcohol surveys were able to be reached by telephone 6 months after completing the program and agreed to be interviewed regarding their experience of the Eva House Program. These interviews provided a longer term perspective of guests satisfaction with the program and enabled these guests to assess the impact the program had on their lives. The three guests who had not completed written satisfaction surveys on the last day of the program were able to be reached at 6 months follow up and are included in this section of the evaluation. Their inclusion in this section ensured that all 20 respondents had an opportunity to comment on their satisfaction with the Eva House Program.

The interview was semi structured and included questions on how they were faring since completing the program and their perceptions of how it had impacted on their lives, what they perceived the strengths and weakness of the program to be and any suggestions they had for improvements.

Respondents’ comments regarding the impact of the program on their lives

All seventeen respondents felt that the program had a positive impact on their lives including one respondent who was asked to leave before the program finished. One program was cut short by a week because the facilitator became ill and one respondent felt this had a negative effect on her coping abilities, and others in this group were disappointed that it finished early.

A life changing experience (Respondent A)

Gave me hope that things could change. My third time at Eva House (Respondent B)

I’ve definitely improved. I’m job hunting and have a boyfriend who treats me right and I’m happy I went there (Respondent C)

I’m doing really well. Have a job as an apprentice hairdresser and have a new boyfriend. Made good friends and off medication three months ago. Have not self harmed once since Eva House. I cut myself six times in twelve months before that. No drugs since Eva House but still drinking a bit. (Respondent D)

A brilliant program. Am doing a lot better and working as a volunteer there now (Respondent E)
I'm extremely satisfied with the program. I've been to six programs and finished four. It was hard at first but I get stronger every time I go (Respondent F)

The program majorly helped me (Respondent G)

The program helped while I was there. Pity it was cut short. Haven’t been doing the program at home but intend to go back at the end of the year (Respondent H)

The support is good. The program goes deeper to the core issues than anything else I’ve done. I’ve been to two healing programs but I’ve struggled (Respondent I)

Really good. A life changing experience. I’m doing another program in July and another in November. (Respondent J)

Great program, new environment but cut short because I got sick (Respondent K)

Amazing. Unique and very helpful. I've done three programs (Respondent L)

I’m doing well.. I’m a corporal in the Army now and doing kick boxing. I was disappointed the program was cut short a week because the facilitator got sick. The program was confronting and worked for a little while but distressing because it was shortened. It was too quick a time frame to go back into society. Too much emotion to let go of. (Respondent M)

Really good. Content was comprehensive and everybody's needs got met (Respondent N)

My self esteem is better and my drug and alcohol problems are better. I’d like to go back but can’t afford it. I got asked to leave three days before the end of the program because I was mucking up but I didn’t have any problems with them because they told me I can go back. It was a good experience (Respondent O)

Generally very good and the content very informative (Respondent P)

Amazing and has definitely helped. I’m doing volunteering now (Respondent Q)

Previous hospital admissions had not helped. Psychiatrists and psychologists agree it has been very helpful for me. I'm still using the things I learnt at Eva House (Respondent R)

Respondents’ comments regarding the professionalism of the carers

Respondents were asked about the professionalism of Eva House carers in terms of their empathy and respect for the confidentiality and safety of guests during the program.

Almost every comment concerning carers described them as compassionate, professional and understanding. Respondents stressed the importance of the carers having been survivors of childhood trauma themselves.
They are professional staff who care, have empathy and respect guests confidentiality and safety. They are survivors (Respondent A)

Carers are professionals who respect privacy and have been through trauma themselves (Respondent B)

Carers, the retreat and the program were very good. (Respondent C)
They were professional and kept confidentiality. They've been through it too (Respondent D)

Staff were very professional (Respondent E)

Carers all very good and have gone through similar situations (Respondent F)

Carers were lovely. Very caring (Respondent G)

Carers were friendly and welcoming (Respondent H)

Very professional however one made derogatory comments about a guest to one of the parents (Respondent I)

They were great (Respondent J)

They were very caring and the program all good with compassion and understanding from people who have been there (Respondent K)

Respondents' comments regarding strengths of the program

Respondents stressed the uniqueness of the program in that it attempts to deal with the trauma and resultant low self esteem that causes mental health problems and self destructive behaviours.

A good support system (Respondent A)

Builds self esteem (Respondent B)

Better than any other I've been to especially mental health programs. Treated what was behind eating disorder, depression and drug abuse (Respondent C)

There is nothing like it anywhere else. It is unique but is too far to go. Lots of support and no judgment. Lets us be who we want to be, not who we should be (Respondent D)

Gave me a clear perspective on things (Respondent E)

I feel validated. Compared to the Mental Health System where you are just a number, just another person, haven’t talked to a single person that didn’t benefit (Respondent F)
Respondents suggestions on how it could be improved

Most respondents said that the program did not need improving but a few respondents suggested the following:

- Organise weekends into town better’
- Too much leisure time. Need to be kept busier
- Promote it more and fund it better
- A jumping castle
- Beautify the place and build more gardens
Carers’/Facilitators’ satisfaction survey

The Sample

An anonymous evaluation survey was emailed to 9 volunteer carers and 1 paid facilitator responsible for the program during the 12 month period of the evaluation. Eight surveys were returned, from 1 facilitator and 7 carers providing a response rate of 80%. The number of programs the staff members had been involved in ranged from 4 to 23 with a mean of 13.5.

All 8 staff members were either satisfied or very satisfied with the overall program.

Table 20: Staff overall satisfaction with the program

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>6</td>
<td>75.0%</td>
</tr>
<tr>
<td>satisfied</td>
<td>2</td>
<td>25.0%</td>
</tr>
<tr>
<td>dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>very dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

All 8 staff members were either satisfied or very satisfied with their role as carers or facilitator of the program.

Table 21: Staff satisfaction with their role in the program

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>satisfied</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

All 8 staff members were either satisfied or very satisfied with the content of the program.

Table 22: Staff satisfaction with the program content

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>6</td>
<td>75.0%</td>
</tr>
<tr>
<td>satisfied</td>
<td>2</td>
<td>25.0%</td>
</tr>
<tr>
<td>dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
All 8 staff members were either confident or very confident in their ability to implement the program.

Table 23: Staff level of confidence in their ability to implement the program

<table>
<thead>
<tr>
<th>Level of confidence</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very confident</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>confident</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>unconfident</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very unconfident</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

All 8 staff members were either confident or very confident in other staff members ability to implement the program.

Table 24: Staff level of confidence in other staff members’ ability to implement the program

<table>
<thead>
<tr>
<th>Level of confidence</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very confident</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>confident</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>unconfident</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very unconfident</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

All 8 staff members were either satisfied or very satisfied with their access to training for the program.

Table 25: Staff satisfaction with their access to training

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>5</td>
<td>62.5%</td>
</tr>
<tr>
<td>satisfied</td>
<td>3</td>
<td>37.5%</td>
</tr>
<tr>
<td>dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Seven of the 8 staff members said they were very satisfied. with the level of respect for guests’ confidentiality and safety that the program provided and one staff member was dissatisfied. That particular staff member qualified her response with the following comment:
Though I said I was dissatisfied with confidentiality and safety issues, I don't know what more can be done. The problems with safety we experience usually result from guests not informing carers when something within the group is compromising their safety. Somehow we need to make the guests feel safe enough to approach us when it first occurs, but I don't know what else we can do to achieve this.

Table 26: Staff satisfaction with the level of respect for guests’ confidentiality and safety that the program provides

<table>
<thead>
<tr>
<th>Level of satisfaction</th>
<th>No. of respondents</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>very satisfied</td>
<td>7</td>
<td>87.5%</td>
</tr>
<tr>
<td>satisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>dissatisfied</td>
<td>1</td>
<td>12.5%</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

**Staff members' view of the strengths of the program**
(Each dot point represents the view of one staff member)

- The empathy, acceptance, compassion, love and care the guests tell us they experience, and the tools they learn to overcome their trauma. The amazingly supportive and competent team I have the privilege of working with. Never before have I experienced such an unconditionally loving work environment, with such mutual respect, between carers, and carers and facilitator. Everyone feels equally valued, and I think this kind of role modelling is one of the things that helps allow the guests to feel safe enough to heal.
- That we can walk along side our guests with them knowing that we really understand their pain and what they have been through and the effects their trauma and/or abuse has and is having on them now. Also that we DO NOT tell the guests that “we” can heal them, that they ultimately know what they need to heal and we are there to listen and offer support in their healing and provide them with the framework to do so.
- The fact that it gets through to adolescence, upon completion of the program the girls have an understanding of what is taking place in their minds and why they are reacting to what has happened to them in their childhood.
- The compassion and leadership of the careers, the amount of time available to work through issues, the vast range of workshop material that we cover.
- the guests are supported in learning day-to-day living skills that they may otherwise not learn in their lives due to the trauma
- It is the combination of information, creative workshops, free time and one on one attention that are the programs strength.
- Length of program, which allows for flexibility in meeting guests needs. Diversity of workshops, non judgment, unconditional love, understanding. Sense of community.
- Some of the greatest strengths of the program are the girls are encouraged to take charge of their own healing and not told by anybody else that they can heal them. The message is consistently that they hold the power within themselves to make a better
future for themselves, and only they can be in charge of their own healing. This is incredibly empowering for the girls, while at the same time ensuring they do not hold anyone else responsible for the outcome. It’s all them. One of the other greatest strengths of the program is that because the girls are given 3 weeks, they have time to do what they need to do. Time is so important in healing.

Carers’/facilitators’ Final Comments

Carers were asked whether there were any other comments they would like to make about the program. 7 responded:

- I think the program is great and has saved my life.
- I would recommend the program to everyone who has experienced any form of trauma or abuse, especially those with serious mental health issues.
- It was the last resort for me because no-one I knew was aware that the program existed.
- After spending years in the public mental health system, I wish Heal For Life would have been the first option given to me, instead of spending years in the mental health system where I was given false hope of recovery and then was eventually told there was nothing else they could do to help me.
- Heal For life does not promise they can make you better or heal you but what you put into the program you do get out and with everybody being a survivor themselves I believe makes a massive positive impact on the program.
- The team I am privileged to work with at Eva are amazing.
- I’ve seen a fair few girls come through the Eva House Program now, and I feel so privileged to be part of their healing journey. Eva House and Heal For Life is saving lives. It is not a belief it is a fact!
Staff suggestions for improving the program
(Each dot point represents the view of one staff member)

- **I would like to see a little more cognitive-style therapy, not a lot because the emotional work we do is more important. However, in order for guests to overcome critical and rescuing parent messages, I believe it requires first recognising and empowering against the core issue, then a conscious cognitive effort to restructure the negative thought patterns trauma survivors are left with. These self-beliefs take more than a single process to work through.**
- **There is nothing I would do to change the program but to help the program and staff I wish there could be more carers to help share the load of a 3 week program.**
- **Cannot think of any changes to the program, it works as it is for now anyways.**
- **To add some cognitive approaches into the program. While it is of most importance that the trauma is worked through using our current method, workshops in which the girls are taught how to "digest" what has come up for them with cognitive methods would provide extra success and help with coping once leaving the program. Also, a workshop on music therapy may be very good as many of the girls find music to be a major aspect in their lives and healing.**
- **there are too few mature age carers willing to work at Eva House so I would want to find a way to encourage more of them to work there as I feel it unfair to ask young carers to be able to cope with the pressures of 3 straight weeks of caring. also, there are not enough carers in general at Eva House**
- **More carers to provide the one on one support we try to have.**
- **Ideally month long program. More adult carers.**
- **The only changes I would personally make to the program would be to include more on things like mindfulness mediation, and other closely related subjects, to teach the girls how to get through the moments in their lives when in the real world they don't have time to immediately deal with an issue, due to whatever circumstance is preventing them from doing so. So many times girls have asked how they can get through those certain types of moments, and I believe it would be great to provide them with more skills to do that.**
3 Conclusions & Discussion

The Goal of the Eva House Drug and Alcohol Program

This evaluation was designed to assess how well the Eva House Program had met its goal to reduce the number of young women using alcohol and drugs to cope with the emotional pain caused by childhood trauma.

There is no question that of the 20 young women who were assessed as part of this evaluation there has been a significant reduction in the number using drugs and alcohol. Seven respondents reported drinking less often, with one of these becoming a non-drinker. Four respondents stopped binge drinking and fourteen respondents reduced their illicit drug use with eight of these stopping altogether. Three respondents quit smoking. Unfortunately two respondents reported increases in how often they were drinking after decreasing the amount of drugs they were using. This is not an unusual initial reaction and hopefully with further visits to Eva House these respondents’ alcohol consumption may further reduce. This negative outcome does however attest to the honesty of the self-report responses of the young women who filled out the surveys and took part in the interviews.

Of the 20 respondents who attended the program all 20 reported at least one form of general health, mental health or drug and alcohol related improvement six months after attending the program. Respondent C would have to be considered to have the most successful post program outcomes. In the 6 months since finishing the Eva House program respondent C managed to improve her general health, reduce her psychological distress scores, quit smoking, reduce her alcohol consumption to less than one day a month, stop binge drinking and stop injecting or using any of the six different types of drugs that she was injecting before she visited Eva House. Other respondents’ outcomes varied considerably, as did the problems with which they came to the program. Ten respondents reported an increase in their general health rating, and 17 respondents reduced their psychological distress score, with 10 of these moving into a safer psychological distress category. Seven respondents reported drinking less often, with one of these becoming a non-drinker. Four respondents stopped binge drinking and fourteen respondents reduced their illicit drug use with eight of these stopping altogether. Three respondents quit smoking. Two respondents decreased the amount of drugs they were using but also reported increases in how often they were drinking.
Objectives of the Eva House Drug and Alcohol Program

The first objective of the program was To train Heal for Life carers and facilitators on how to more effectively work with young substance abusers. The satisfaction surveys of both the young people and the carers and facilitators as well as the interviews with the young people indicate quite clearly that the carers and facilitators are empathic, professional and capable and that they themselves are satisfied with their training and with their role in the program. This objective has been met.

The second objective To run programs for 35 young women who have a history of childhood trauma and substance abuse has been met. Over the 12 month period of the evaluation 36 individual young people attended in total and 20 were able to be surveyed and interviewed pre and post program to make up the sample for this evaluation. All respondents in the Eva House sample reported experiencing some form of childhood abuse with most respondents suffering more than one form of abuse and 70% experiencing sexual abuse. These young people have been so traumatised that almost without exception they all suffer from mental health problems ranging from depression and anxiety disorders to post traumatic stress disorder, borderline personality disorder and schizophrenia.

Objectives three and four To decrease the frequency and amount of substance abuse of participants. Respondents were at different stages in this process as mentioned earlier, but to have eight respondents stop using illicit drugs altogether and a further six reduce their consumption is quite an achievement for a three week program. There was also a statistically significant reduction in the number of different drugs the young people were using. The results for alcohol consumption were not quite as positive but seven respondents drinking less often and one quitting altogether is certainly a strong indication that the program can reduce respondent's alcohol consumption. The program has met this objective.

Objective five was To decrease the unsafe behaviours around substance use that put participants at risk. There was some reduction in potentially harmful alcohol related behaviours and experiences that the young people reported after attending Eva House but no overall reduction in alcohol or other substance related abuse. Verbal abuse did appear to increase and physical abuse decrease but it is difficult to come to any conclusions over such a short time frame. It may be that it takes longer than six months for a reduction in consumption to result in environmental and context changes in the young peoples' lives. Another words,
even if they are drinking and using less they may not yet be changing the places they go and the people they associate with. This objective has not yet been met.

To improve the mental health of participants was the sixth objective and this one was met with a statistically significant decrease in respondents psychological distress scores according to the K10.

The final objective that is within the scope of this evaluation is improving the general health of the participants and this objective was partially met with 9 of the 20 participants improving their health. This is a very difficult outcome to change in 6 months particularly for those respondents with chronic illnesses and probably requires a longer time span to see how the young peoples' health progress after they stop binge drinking and abusing illicit drugs.

The evaluation shows clearly that the guests that take part in the Eva House Program are at the extreme end of the spectrum in terms of physical, emotional and social problems. It also shows clearly that three weeks at Eva House can make a difference. Many of the respondents have gone so far as to score it as “life changing” for them in terms of their satisfaction with the program.

Although simple pre- and post- test analyses are considered to be at the lowest level of evidence in the outcome evaluation hierarchy and the resultant data is usually insufficient to accurately determine causation or program impact, these findings provide compelling evidence that this program is effective in assisting people to recover from the effects of child abuse and reduce their drug and alcohol use. Although 45% of the sample still used illicit drugs after the program and this is much higher than the general population, for half this cohort of troubled young people to cease their illicit drug use after a 3 week intervention is a very positive outcome. Respondents also felt that the program had a positive effect on their lives and improved their mental health. It is highly unlikely that respondents could have recalled how they scored the tests 6 months previously, so the improvements would appear to be valid even though, without a control group, we can’t be certain that they are entirely due to the Eva House Program. Sourcing a control group for this type of study is almost impossible and probably unethical as Heal for Life has a policy of not turning any survivors of child abuse away from the program and they do not keep waiting lists. The program itself is quite unique so trying to source a comparison program is also quite difficult especially given the large battery of tests that the participants were asked to complete.
One of the major strengths of the evaluation is that 74% of those people who agreed to take part in the evaluation actually returned completed follow up evaluations by email. This is an unusually high response rate for any follow up evaluation. The fact that each participant was asked to complete such a large survey and a telephone interview six months after they completed the program attests to the commitment of the participants to the program. No selection bias was evident in who chose to complete the evaluation. There were no demographic differences between respondents and non respondents and no differences in how well they liked the program.

Recommendations:

These recommendations are taken directly from the quantitative results and from the comments made by staff and respondents.

- Include a specific component in the program to teach the young women practical skills to avoid binge drinking and drug and alcohol related risky and abusive situations.
- Include a cognitive behavioral component in the program to help the young women deal with stressful situations when they go home.
- Make certain there is someone to take over the program should the facilitator become ill. Cutting the program short caused distress and disappointment to several participants.
4 Appendices

Appendix 1: Kessler Psychological Distress Scale - 10

Usage of the K10 in Australia

The focus of the K10 is to measure psychological distress and it does not include any questions to identify psychosis, as this is difficult using a brief questionnaire. The K10 instrument may be appropriate to estimate the needs of the population for community mental health services, as people with psychosis generally do get depressed (Andrews & Slade, 2001). For these reasons, the K10 scale has been chosen for ABS health surveys, routine public health telephone surveys in a number of Australian states, and for use on patients in contact with mental health services in NSW.

The usage of the K10 in Australia stemmed from its selection for use in the ABS 1997 National Survey of Mental Health and Wellbeing (SMHWB). The survey results enabled comparison of the K10 with other measures, including medical diagnosis (CIDI). A strong association was found between K10 scores and the diagnosis of anxiety and depression based on the CIDI.

The K10 has also been included in a number of State surveys including the New South Wales (NSW) Continuous Health Survey, the 2000 Health and Wellbeing Survey (conducted by the Health Department of Western Australia in collaboration with the South Australian and Northern Territory Health Departments and the then Commonwealth Department of Health and Aged Care), South Australian Health & Wellbeing Survey 2000 and the 2001 Victorian Population Health Survey. It was included in the 2001 National Health Survey (NHS) conducted by the ABS and administered to adults aged 18 years and over. The K10 was included in the 2001 NHS because it was found to be a better predictor of mental health and psychological distress compared with the other short general modules used in the 1997 SMHWB.

The scale consists of ten questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms a person may have experienced in the four weeks prior to interview. Other time periods can be used as a substitute for the last four weeks. For example, in the US the last month time period is used.

The K10 questionnaire yields a measure of psychological distress based on questions about negative emotional states experienced by respondents in the four weeks prior to interview. It
contains low through to high threshold items. For each item there is a five-level response scale based on the amount of time the respondent reports experiencing the particular problem. The response options are:
- none of the time;
- a little of the time;
- some of the time;
- most of the time; and
- all of the time.

Generally, each item is scored from 1 for 'none of the time' to 5 for 'all of the time'. Scores for the ten items are then summed, yielding a minimum possible score of 10 and a maximum possible score of 50, with low scores indicating low levels of psychological distress and high scores indicating high levels of psychological distress.
Appendix 2: Short Form 36 Health Survey (SF-36)

The SF-36V1\(^2\), released in 1988, is the world’s ubiquitous health status measure; a simple search of PubMed (May 2005) identified 4,029 references. Of these, 115 were Australian studies, far more than for any other health status measure used in Australia. The implication is that the SF36 is also the ubiquitous health status measure used by Australian researchers. Further evidence regarding its popularity is that there have been several Australian validation studies including the publication of Australian population norms for the SF36\(^3\).

The SF-36™ is a short form measure of generic health status in the general population. The SF-36™ is designed for self-administration. Alternatively, a trained interviewer can use a standardized script for face to face and telephone interview. The SF™-36 takes 5 –10 minutes for respondent to complete. Can be administered to anyone over the age of 14. From the 36 items, eight health profiles are derived from summarised scores. All dimensions are independent of each other. A comprehensive manual and interpretation guide is available from the author (Ware, 1993).

**Designed to be used in**

- Clinical Practice – screening individual patients
- Research – differentiating health benefits produced by different treatments
- Health Policy Evaluations – comparing the burden of different diseases
- Monitoring specific and general populations

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Australian Institute of Health and Welfare’s National Drug Strategy Household Survey has been conducted every 2 to 3 years since 1985. The ninth survey in this program was conducted in 2007, with previous surveys in 1985, 1988, 1991, 1993, 1995, 2001 and 2004. The data collected from these surveys have contributed to the development of policies for Australia’s response to drug-related issues. The 2007 NDSHS was built on the design of the 2001 and 2004 surveys, which both had larger sample sizes and covered more extensive aspects of drug use than earlier surveys. In the 2007 survey, more than 23,000 people aged 12 years or older provided information on their drug use, knowledge, attitudes and behaviours.

The use of this survey for the Eva house evaluation has two main advantages:

- it contains comprehensive, validated, reliable questions that cover most aspects of drug and alcohol use
- it allows the evaluator the opportunity to compare the drug and alcohol use of the young women who attend the Eva House program with young women in the general population

Appendix 4: Information on the Eva House Program for respondents

You will take part in a full daily program whilst living in a supportive community who deeply honour and respect who you are and where you're at. What we ask of you is to be committed to and to take responsibility for your own healing journey. You will be supported by carers, who are survivors themselves, living in a quiet, safe and loving environment.

You'll learn things about:

- Personal safety
- Effects of trauma on the brain
- Inner Child
- Boundaries
- Self nurturing
- Wounded and rebel self
- Re-parenting ourselves
- Self concept and self acceptance/love
- Attachment theory
- Conflict resolution
- Life Skills
- Triggering and de-triggering
- Empowerment
- Feelings
- Creative activities
- Understanding our needs
- + more ...

1. A bit about Eva House

Here, you will be living in a community with other young women who you will find have survived similar experiences to you and who have also decided that it is time to begin their healing journey. Eva House is a place where you will find support and understanding, and the opportunity to care for yourself and learn to live again – and maybe learn the life skills you have missed out on so far. It's helpful to remind yourself that it's not your fault that you've missed out on these things. You had no choice.

Our aim is to help you better understand yourself and the way your past has affected you today, so you can be the person you were born to be, not the person you were forced to be. Many people feel like they are walking around with a mask on to protect themselves or others. They feel they need to be brave, show no emotions, keep it inside. They try to use coping mechanisms to deal with their pain...drugs, alcohol, eating disorders, sex, self-harm, whatever seems to work. But that doesn't fix it. It just causes you more problems. Your trauma has caused you to turn to these coping mechanisms to help you survive the pain you are trying to hide from. But you don't need to go on abusing yourself. You have been through enough! We can help, and we want to help. Everyone here knows what a battle it is trying to survive the life you are living. We have been down that road but with Heal for Life Foundation's help we have survived it and are living the life we want now.
It is possible to heal. But the hard fact is that you have to work towards it. You can't just try to push it away and forget. It doesn't work like that. Until you face the past it will continue to control you.

At Eva House we don't just listen to your story; and if you feel you don't want to share that part either we won't make you. But we allow you to emotionally go back to the point of trauma and feel the feelings that were unsafe for you to feel at the time. You will get to know that hurt child that's still a part of you, waiting for you to listen and acknowledge the truth about what has happened. This may sound scary but it is necessary.

During your stay the first week will be aimed at grasping a basic understanding of the Heal for Life Model as well as beginning to look at your issues and developing skills by participating in workshops about things such as understanding trauma and its effects, self-esteem, coping mechanisms, overcoming fear and anxiety, healthy relationships and boundaries. Don't worry, there will be some fun and nurturing stuff like creativity workshops and pampering as well. By the second week you will have gotten to know how everything works, settled in and be feeling safe with everyone involved in the program. This week will be more intense as you will be spending more time working through the trauma you have experienced. And the last week will be helping you to prepare for your return home. Overall, the program is pretty flexible, depending on the needs you and the other guests have.

2. What is Eva House like?

Eva House is designed to be the safe, welcoming home every child deserves. With large spacious buildings with open verandas. In the guests' living space, there is a common sitting room, shared kitchen, dining area, lounge room and laundry; 4 double bedrooms and 3 bathrooms. There is also a small Carers' side where the Carers will be living for the duration of the program. The cooking and cleaning is shared, and other tasks are performed as a part of Labour of Love (helping out in and around the home for an hour or so each day). We want you to feel comfortable and safe enough here to care for Eva / Phillip House as you would your own home.

Eva House/ Phillip house is a place where you can feel confident that you are safe to work on your healing and look at other issues that have made it hard for you to live right at this minute. Young people who come here often have problems with drugs, alcohol, self-harm, relationships, school, the law, family and peers. The list is never ending as trauma causes so much dysfunction in people's lives; and we all have our own way of trying to deal with it.

There will be Carers on site for the entire time you are here. The Carers are of all different ages who are survivors themselves, and have been through either the Adult Healing Program or the Eva House Program, benefited, been trained as well as having external qualifications giving them a wealth of experience and knowledge that helps them give you the very best they have to offer. They each volunteer their time because they want to help others through the pain of their past the way they were helped; with love, respect, understanding, validation and encouragement.
3. What's expected of me?

It’s really important that you are **committed to your healing** and are here for yourself. Your time here will be more beneficial if you come with the ability to focus on yourself, and are in good physical health. If you are experiencing any of the following, we recommend you postpone your time with us and access medical help:

1. Major problematic side effects from medication.

2. Major alcohol or drug dependency, or severe withdrawals.

3. A very recent trauma (i.e. in the last 3 months) which has not yet been addressed.

4. Severe symptoms of mental illness or intellectual impairment that mean you are unable to function within a group or take care of yourself.

We are not a medical or mental health facility, and can’t be responsible for administering medication or other medical care. If there’s an emergency, the facilitator and some of our carers are trained in first aid and if necessary ambulance services can be called. If you have an injury, have just been in hospital or need medical/dental surgery, we ask that you postpone your time here with us until you are well enough. At Eva House you will be valued for who you are, in a place where you can honour yourself and find the strength to heal. There is no judgment here. We don’t expect you to pretend to be someone you’re not. We want you to feel like you can be exactly who you are. All your feelings are valid and you should never be told not to feel them. Here we will encourage you to express those feelings safely, and we will be there to validate you in doing so. You won’t be alone in this. You will be surrounded by heaps of support. We know what it’s like to let down that wall that’s been protecting you for so long. It’s hard, but worth it!

4. An outline of what happens each day

On Sunday you will meet the other guests and Carers and be shown around so you can become familiar with your surroundings. The group will share dinner together, get to know each other, discuss what to expect from your time here and go through some safety agreements. You may also be invited to participate in a voluntary survey that helps us to research the success of our Healing programs. The following is a general format for the day, though we are not rigid or authoritarian. As survivors, we know that we do not like being told what to do! We start our program fairly late in the morning in recognition of research which shows it's hard for the adolescent brain to function well first thing in the morning.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00am</td>
<td>Reflections</td>
<td>A time for spiritual reflection and exploring our needs for the day.</td>
</tr>
<tr>
<td>10:45am</td>
<td>Labour of Love</td>
<td></td>
</tr>
</tbody>
</table>
This is time to give back to the community through helping out around the house. You will be encouraged to do what fits your feelings, not what you think you should do!

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00am</td>
<td>Workshop</td>
<td>A chance to connect with your inner-self and your emotions.</td>
</tr>
<tr>
<td>1:30pm</td>
<td>Lunch</td>
<td>Prepared by Guests &amp; Carers.</td>
</tr>
<tr>
<td>3:00pm</td>
<td>Creative or Information Workshop</td>
<td>Time for you to learn and or connect with / develop your creative side or learn more about the ways in which trauma has effected you.</td>
</tr>
<tr>
<td>4:00pm</td>
<td>Free Time</td>
<td></td>
</tr>
<tr>
<td>6.00pm</td>
<td>Sharing</td>
<td>A time to practice acknowledging your feelings within the group in a safe environment.</td>
</tr>
<tr>
<td>7.00pm</td>
<td>Dinner</td>
<td>Prepared by one or two guests and carers.</td>
</tr>
<tr>
<td>8.00pm</td>
<td>Group discussion/Guest Speaker/Craft/Free Time</td>
<td></td>
</tr>
<tr>
<td>9.30 pm</td>
<td>Reflections</td>
<td>Inspirational readings and music to help you relax before bed.</td>
</tr>
</tbody>
</table>

**Weekends**
The weekend is usually free time to chill, read, walk, chat, play some games, be creative, or watch some DVD's. The week can be pretty full on so this is time to relax and prepare for the new week ahead.
Appendix 5: Evaluator’s Biography

Dr Christine Edwards (BA Psych Hons, PhD) was the Research and Evaluation Coordinator for Health Promotion on the Central Coast of New South Wales for 19 years and chaired the NSW Health Research and Evaluation Network in 2003. She has an honours degree in psychology, and a PhD in Health Promotion Evaluation. Dr Edwards has published and presented in many areas of Health Promotion practice and evaluation at a National and International level but has a special interest in drug and alcohol issues and has completed several comprehensive evaluations in this area. Six years ago she established Central Coast Research and Evaluation – a consultancy service that conducts program evaluations for Non-Government Organisations. As Chief Consultant for Central Coast Research and Evaluation she has completed program evaluations for the Central Coast Division of General Practice, The Central Coast Domestic Violence Intervention Team, Heal for Life Healing Centre and the Commonwealth Government Intergovernmental Committee on Drugs to name just a few. In 2007 Dr Edwards completed a PHD at the University of Newcastle on the marketing of tobacco to young women through product placement in movies.

* Rosemary Stanton. Adolescents, nutrition and eating disorders. New South Wales Public Health Bulletin, Vol. 10 No. 4 Pages 33 - 34, Published 1 April 1999