Evaluation of the Eva House Drug and Alcohol Program

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Evaluation Report of the Eva House Drug and Alcohol Program

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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 & Education

Central Coast Research & Evaluation

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 per cent.

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 (NDSHS) to provide some context for the Eva House respondents' responses.

TABLE 1: EVA HOUSE RESPONDENTS PRE- AND POST- PROGRAM SELF-REPORTED HEALTH, ALCOHOL AND DRUG USE.

	Pre Program	Post Program
HEALTH		
	55 per cent in the Eva House sample rated their health as fair or poor	**35 per cent in the Eva House sample rated their health as fair or poor**
	100 per cent of the sample were being treated for a diagnosed mental illness issue	**65 per cent of the sample were being treated for a diagnosed mental illness issue**
	75 per cent reported very high levels of psychological distress.	**35 per cent reported very high levels of psychological distress**
TOBACCO AND ALCOHOL USE		
	65 per cent were daily smokers	**50 per cent were daily smokers**
	85 per cent drank at levels considered risky or high risk in the short term	**60 per cent drank at levels considered risky or high risk in the short term**
	45 per cent reported drinking more than 20 standard drinks in one session during the previous 6 months	50 per cent reported drinking more than 20 standard drinks in one session during the previous six months
	Only 20 per cent considered themselves to be binge drinkers or heavy drinkers	Only 20 per cent considered themselves to be binge drinkers or heavy drinkers

	Pre Program	Post Program
	40 per cent drank at levels considered risky or high risk for both short-term and long-term harm	**25 per cent drank at levels considered risky or high risk for both short-term and long-term harm**
	50 per cent had, in the last 6 months, experienced some form of abuse from someone affected by alcohol.	55 per cent had, in the last six months, experienced some form of abuse from someone affected by alcohol.
ILLICIT DRUG USE		
	90 per cent of the sample had used illicit drugs in the last six months	**45 per cent of the sample had used illicit drugs in the last six months**
	60 per cent had used in the previous month	**40 per cent had used illicit drugs in the previous month** **There was a statistically significant decrease in the number of drugs used post program.**
	Marijuana was the most common type of illicit drug used with 50 per cent of Eva House respondents having used marijuana in the last six months, followed by painkillers (40 per cent) and tranquilisers (35 per cent).	**Marijuana was the most common type of illicit drug used with 40 per cent of Eva House respondents having used marijuana in the last six months, followed by painkillers (15 per cent) and tranquilizers (10 per cent).**
	One Eva House attendee had injected drugs in the previous six months	**No Eva House respondents had injected drugs in the previous six months**
	35 per cent of the Eva House respondents had, in the last six months, experienced some form of abuse from someone affected by drugs	35 per cent of the Eva House respondents had, in the last 6 months, experienced some form of abuse from someone affected by drugs
	35 per cent received physical injuries from someone affected by alcohol and/or drugs including bruises/abrasions, lacerations requiring stitches and a fracture.	**20 per cent received physical injuries from someone affected by alcohol and/or drugs including bruises/abrasions, minor lacerations and a fracture.**

Guest program satisfaction

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

Satisfaction with the program at six 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 three-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 eight 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 eight staff members were either confident or very confident in their own ability to implement the program and other staff members' abilities to implement the program.
- All eight staff members were either satisfied or very satisfied with their access to training for the program.
- Seven of the eight 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 behavioural 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

The Eva House Program

The Eva House Program is a three-week residential program for young women aged 16 to 25 years who have been impacted by child abuse and/or trauma. Guests take part in a healing program whilst living in a supportive and respectful community. Guests are asked to be committed for the duration of the program and to take responsibility for their own healing journey. They are supported by carers, who are survivors themselves. The aim of the idyllic bush land setting is to provide a quiet, safe and loving environment in which to heal from past trauma.

The program was developed in 1998. The program endeavours to incorporate the experiential knowledge of survivors of child abuse with neuro-scientific information on the effects of trauma on the brain and its impact on human development, behaviour and life patterns (Siegel, 1999; Cozolino, 2002; Schore et al 2003). It seeks to utilise effective therapeutic interventions that redirect neural pathways by releasing the emotions suppressed at the time of the trauma. The program is based on a belief in the neuroplasticity of the brain and its ability to change as a result of therapy (van der Kolk, 1987; Doidge, 2007; Ross et al, 2009). The healing principle is by survivors, for survivors.

The Program addresses:

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

Goals of the Program

- For guests to better understand themselves
- For guests to understand the way their past has affected their brain and therefore their behaviour
- For guests to understand their own coping mechanisms to deal with their pain ... drugs, alcohol, eating disorders, sex, self-harm, etc.
- For guests to feel and release the emotional pain of their childhood trauma

For more details about the program see Appendix 4.

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. (i.e. how often they use)
4. To decrease the amount of substance abuse by participants. (i.e. 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 non-completers' reasons for leaving
   - 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 six month follow-up questionnaires will be administered to all consenting participants who attend the three 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 NDSHS (See Appendix 3)
- What types of drugs and/or alcohol are being used as identified by questions taken from the NDSHS
- How often guests use as identified by questions taken from the NDSHS
- How much guests use, as identified by questions taken from the NDSHS
- 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 NDSHS.

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.

Six 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 three week program commenced in September 2010 with five respondents followed by three 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 three 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 years. The number of young people completing each program ranged from two to seven with an average of five young people in each group. On average one to two guests withdrew after the first day or two in each three 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 six months and of these 20 were able to be reached by phone and returned completed questionnaires, providing a response rate of 74 per cent.

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, Aboriginal or Torres Strait Islander status 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 2 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 2: EVA HOUSE PROGRAMS BY DATE, NUMBER OF FIRST TIME GUESTS AND NUMBER OF RESPONDENTS.

Date of program	First time guests (n)	Pre-and Post- evaluation respondents (n)
Sept 2010	7	5
Nov 2010	5	4
Jan 2011	4	4
Mar 2011	3	0
May 2011	0	0
Jul 2011	3	2
Sep 2011	5	3
TOTAL	**27**	**20**

All 20 guests had suffered some type of childhood trauma. Seventy per cent of guests had suffered sexual abuse. Table 3 describes the type of childhood trauma guests reported having suffered.

TABLE 3: TYPE OF CHILDHOOD TRAUMA GUESTS HAD SUFFERED PREVIOUS TO ATTENDING EVA HOUSE. (GUESTS COULD RECORD MORE THAN ONE TYPE OF ABUSE).

Trauma type	Guests (n)	Guests (%)
Emotional abuse	17	85
Sexual abuse	14	70
Physical abuse	9	45
Neglect/Abandonment	10	50

Table 4 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 4: Referral Source

Referral source	Guests (n)	Guests (%)
Family/friends	7	36.84
Counsellor	3	15.79
Other Health professional	3	15.79
Brochure	3	15.79
Radio	1	5.26
TV	1	5.26
Web	1	5.26
TOTAL	**19**	**100.00**

Table 5 shows the state of origin of the 20 respondents. Guests came from all over Australia to attend the program.

Table 5: State of origin

State	Guests (n)	Guests (%)
NSW	12	60.0
QLD	3	15.0
VIC	2	10.0
WA	2	10.0
SA	1	5.0
TOTAL	**20**	**100.0**

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 who completed the NDSHS (2007) to provide some context for the Eva House guests' responses.

General Health

The NDSHS (from which these questions were sourced) found that around one in eight people (12.2 per cent) over 14 years of age rated their health as 'fair' or 'poor'. The 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 per cent) in the Eva House sample rated their health as 'fair' or 'poor' before they completed the program and nine considered their health 'good'. After completing the program, 13 considered their health 'good', 'very good' or 'excellent' (65 per cent) with seven (45 per cent) still rating their health as 'fair' or 'poor'. Of the 20 respondents, nine reported improvements in their general health since completing the program, eight reported their general health had remained the same and three reported some deterioration in their health.

Table 6: Respondents rating of their general health pre and post program in response to the question 'In general, would you say your health is…?'

General health	Pre Program		Post Program	
	No. of respondents	**%**	**No. of respondents**	**%**
Poor	2	10	1	5
Fair	9	45	6	30
Good	9	45	11	55
Very good	0	0	1	5
Excellent	0	0	1	5
TOTAL	20	100	20	100

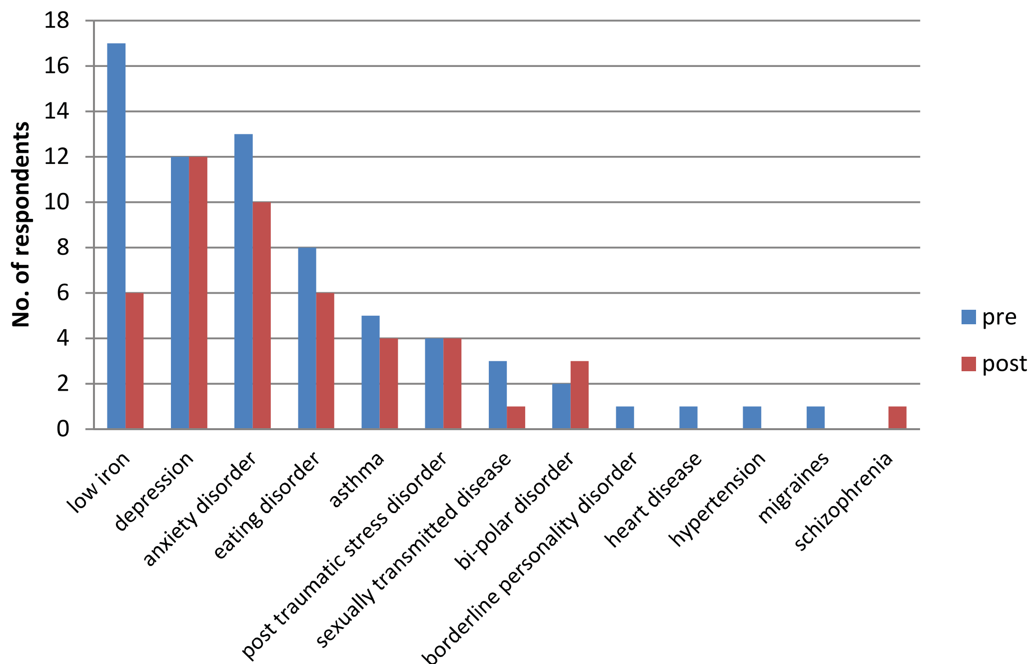
Mental Health

The Drug Strategy Household survey reported 10.8 per cent 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 per cent 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.

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,[1] 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 six months post program.

CHART 1: RESPONDENTS' SELF-REPORTED HEALTH CONDITIONS PRE AND POST PROGRAM



[1] Stanton, R. *Adolescents, nutrition and eating disorders.* NSW Public Health Bulletin, Vol.10 No. 4, pp. 33 – 34. Published 1 April 1999.

Psychological Distress

Among Australians aged 18 years or older in the NDSHS, one in ten (9.9 per cent) 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 per cent) 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 one respondent's distress score increased.

TABLE 7: RESPONDENTS PSYCHOLOGICAL DISTRESS (K10) SCORES PRE AND POST PROGRAM

K10	Pre Program		Post Program	
	No. of respondents	**%**	**No. of respondents**	**%**
Low (10 – 15)	0	0	3	15
Moderate (16 – 21)	0	0	2	10
High (22 – 29)	5	25	8	40
Very High (30 – 50)	15	75	7	35
TOTAL	20	100	20	100

Tobacco Use

Of 17.2 million Australians aged 14 years or older in the NDSHS, one in six (16.6 per cent) 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 per cent) were daily smokers and started smoking daily at 16 years on average. Of the thirteen who were smokers, three gave up smoking after attending the program. None had taken it up since attending the program so 50per cent of respondents were smoking six months post program. Of these, one smoker was planning to give it up within the next 30 days, five were planning to give it up within the next three months, two 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 per cent of Australians aged 14 years or older had never consumed a full serve of alcohol; a further 7.0 per cent 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 six months before attending the program. (10 per cent of the sample comprised of 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 NDSHS 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 four standard drinks on a single occasion is considered 'Low risk', five to six per occasion 'Risky', and seven 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.[2] 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 per cent) 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.

[2] National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol 2009.

Among Eva House respondents 17 of the 20 respondents (85 per cent) 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 two were non-drinkers. Six months later 12 (60 per cent) were still drinking at risky or high risk levels in the short term though not as often and three were non-drinkers with five drinking at safe levels. (Two of these were consuming so little alcohol that they labelled 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 per cent) 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 per cent) 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 four labelled themselves as binge drinkers. One of these had previously labelled 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, df = 19, p=.48).

TABLE 8: NUMBER OF DAYS PER WEEK RESPONDENTS DRANK ALCOHOL PRE AND POST ATTENDING THE PROGRAM

How often drink alcohol	Pre Program		Post Program	
	No. of respondents	**%**	**No. of respondents**	**%**
3 to 4 days a week	4	20	4	20
1 to 2 days a week	6	30	4	20
2 to 3 days a month	5	25	5	25
About 1 day a month	2	10	2	10
Less often	1	5	2	10
Never	2	10	3	15
TOTAL	20	100	20	100

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

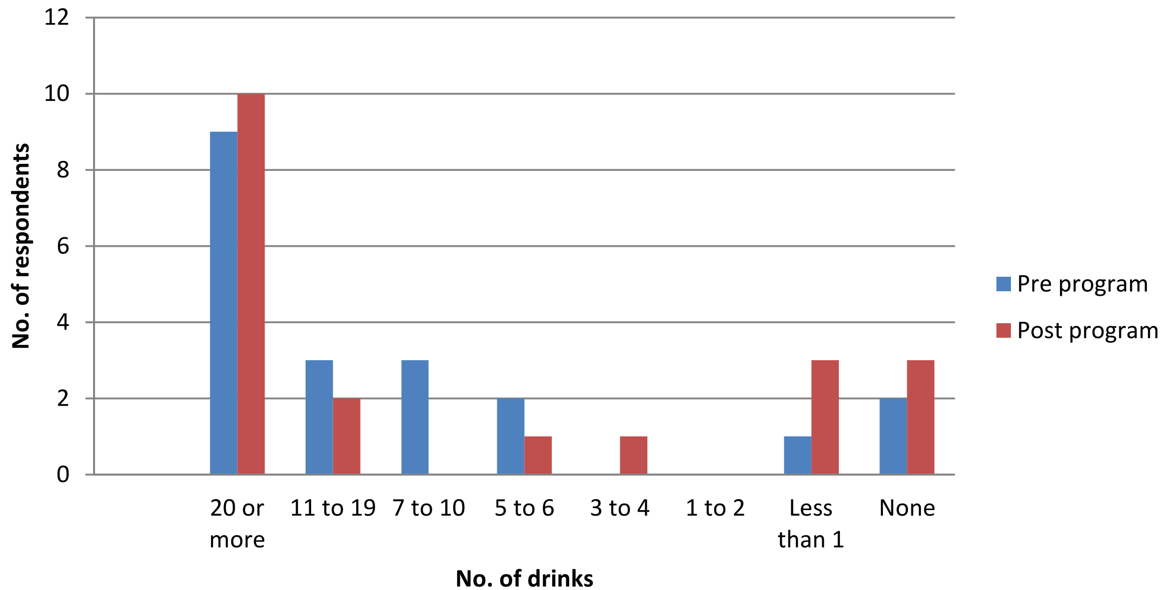


TABLE 9: RESPONDENTS SELF-RATING OF THEIR DRINKING STATUS IN RESPONSE TO THE QUESTION 'AT THE PRESENT TIME DO YOU CONSIDER YOURSELF …?'

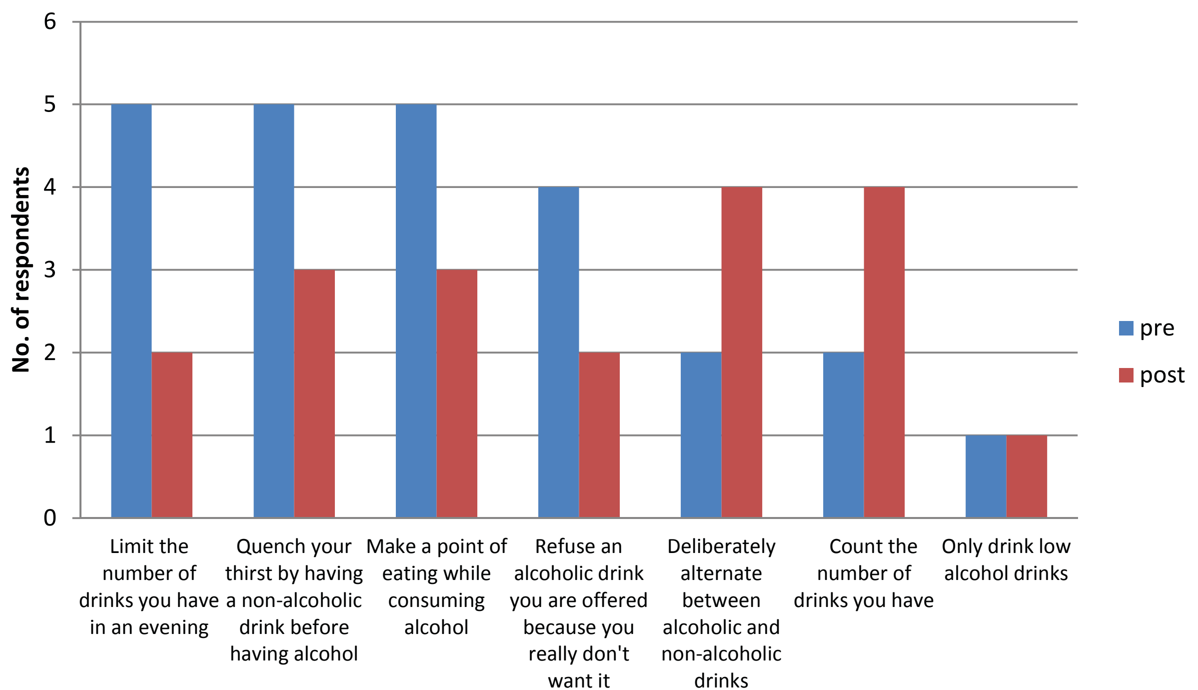
Type of drinker	Pre Program		Post Program	
	No. of respondents	**%**	**No. of respondents**	**%**
Non-drinker	2	10	2	10
An ex-drinker	2	10	3	15
An occasional drinker	5	25	5	25
A light drinker	1	5	0	0
A social drinker	6	30	6	30
A heavy drinker	0	0	0	0
A binge drinker	4	20	4	20
TOTAL	20	100	20	100

Moderating behaviour

In the 2007 NDSHS, approximately 0.9 per cent 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 Survey was to 'limit the number of drinks' they consumed (77.7 per cent).

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 drinking behaviour.

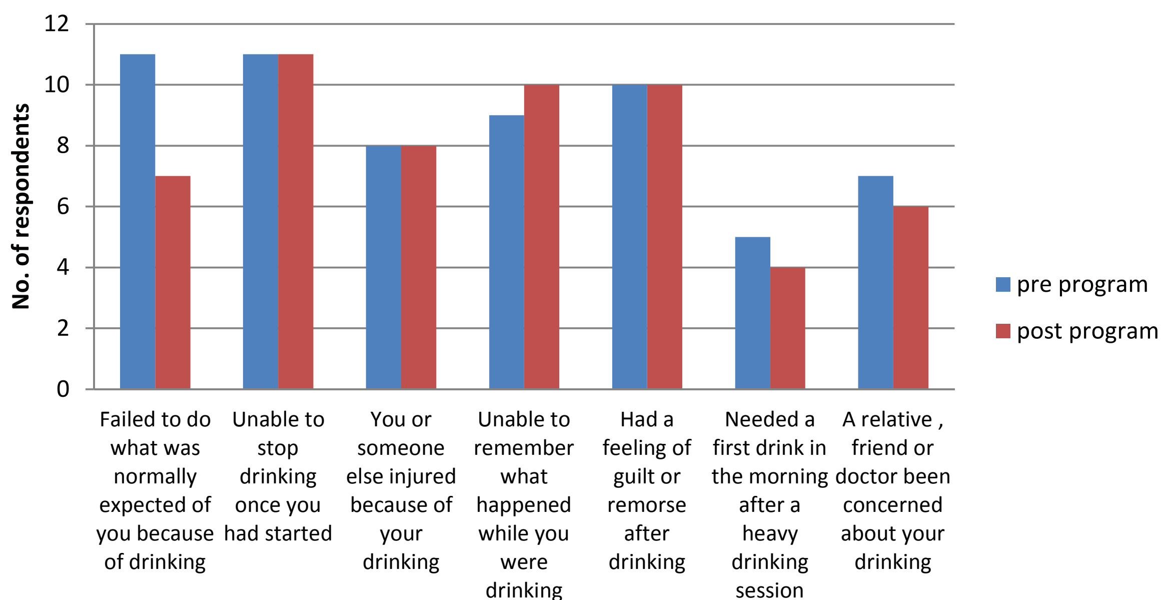
CHART 3: NUMBER OF RESPONDENTS WHO REPORTED MODERATING DRINKING BEHAVIOURS "ALWAYS" OR "MOST OF THE TIME" PRE AND POST EVA HOUSE PROGRAM.



Alcohol related harm

Only two of the 20 Eva House respondents did not report any alcohol related harmful or potentially harmful experiences in the six months prior 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 three of the seven alternatives.

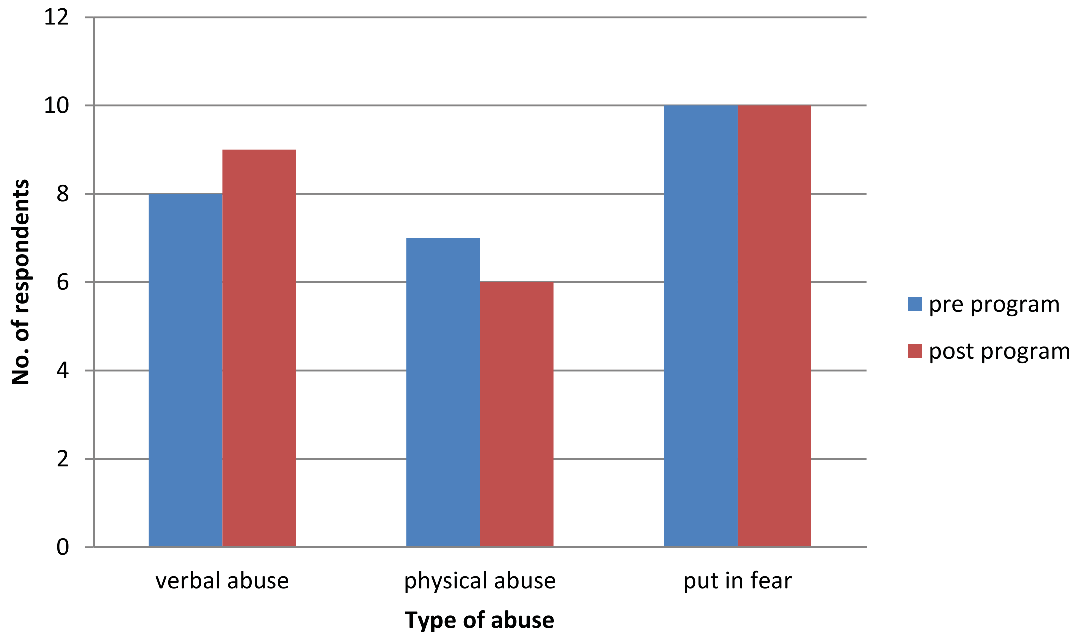
Chart 4: Number of respondents who reported potentially harmful alcohol related experiences in the previous six months pre and post attending the Eva House program.



Alcohol related abuse

Before attending the program 10 of the 20 Eva House respondents (50 per cent) had in the previous six 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.

Chart 5: Number of respondents who reported alcohol related abuse in the previous six months pre and post attending the Eva House program.



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 six months. This discrepancy corresponds with the six 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 six 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 10: USE OF ANY ILLICIT DRUG- 2007 NDSHS DATA, COMPARED WITH EVA HOUSE SAMPLE.

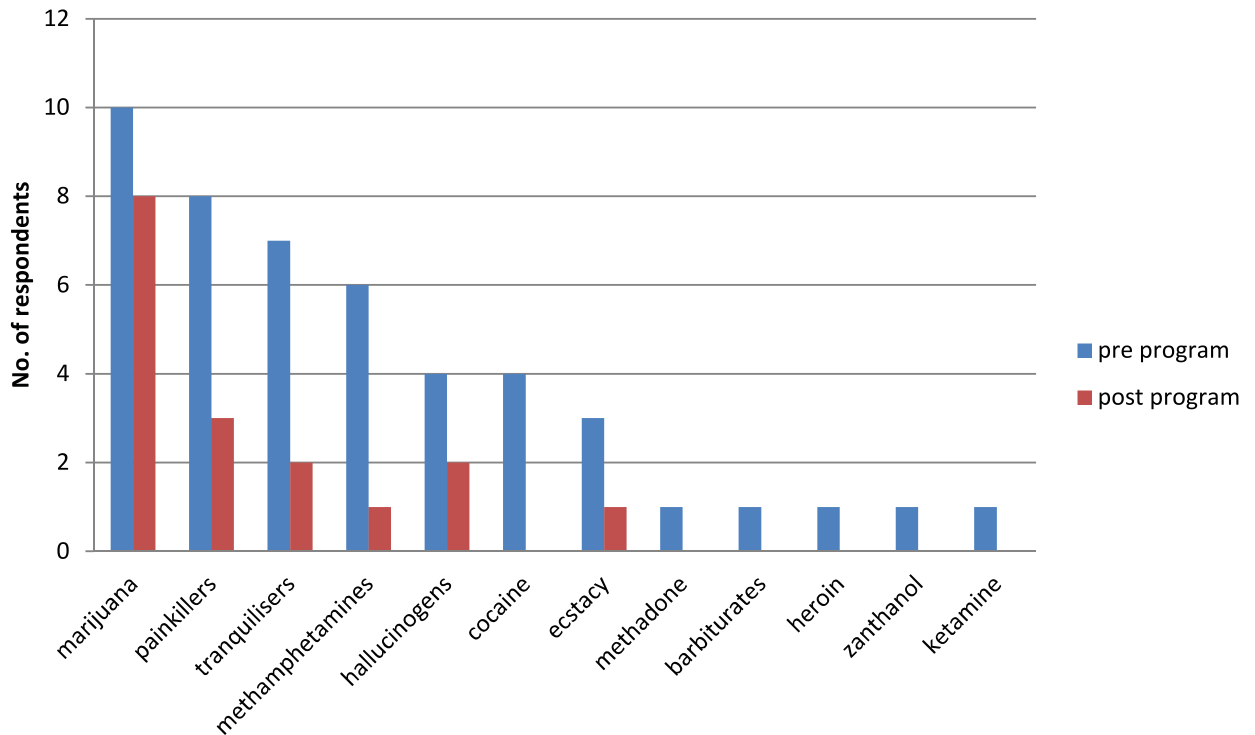
	NDSHS			Eva House (15 – 24 year olds)	
	14-19 year olds (%)	**20-29 year olds (%)**	**All females (%)**	**Pre- program (%)**	**Post- program (%)**
In lifetime	23.6	54.0	34.8	95.0	95
In last 12 months (Household)/ In last 6 months (Eva House)	16.6	27.7	11.0	90.0	45
In the last month	9.8	15.5	6.0	60.0	40

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 six months (90 per cent) and twelve had used in the previous month (60 per cent) before attending the program. The number of different types of illicit drugs used ranged from 0 to nine with a mean of three. At follow up nine had used illicit drugs in the previous six months (45 per cent) and eight (40 per cent) had used in the previous month. The number of different types of illicit drugs used ranged from four with a mean of one. This was a statistically significant reduction (t=2.65, df=38, p=.013). Although 45 per cent 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 three 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 per cent of Eva House respondents having used marijuana in the 6 months, before attending the program. This reduced to 40 per cent at follow up. Painkillers were the next most commonly used illicit drug reducing from 40 per cent to 15 per cent at follow up. Before attending the program 35 per cent of respondents used tranquilisers illicitly. This reduced to 10 per cent 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 six months. The respondent's 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 6: THE TYPES OF ILLICIT DRUGS EVA HOUSE RESPONDENTS USED IN THE PREVIOUS 6 MONTHS PRE AND POST PROGRAM.



Injecting drugs

In the 2007 Household Survey of Australian females aged 14 years or older, 1.3 per cent had ever injected illicit drugs and 0.3 per cent 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 six months. She represents 5.0 per cent of the Eva House sample. She began injecting at age 15 and injected two to three times a day and had used a needle after someone else had used it in the last six months. As reported earlier this respondent has given up all drug use since completing the program and has not used in over six months.

Drug related incidents

Seven of the 20 Eva House respondents (35 per cent) had, in the six 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, seven 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 one 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 six 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 11: HEALTH OUTCOMES OF INDIVIDUAL RESPONDENTS

Respondent ID	Age	General health* pre	General health* post	Psychological distress** pre	Psychological distress** post
A	19	Good	Fair	Very high	Very high
B	24	Fair	**Good**	High	High
C	19	Fair	**Good**	Very high	**High**
D	21	Good	Good	Very high	**Moderate**
E	15	Good	**Excellent**	Very high	**High**
F	17	Fair	**Good**	High	High
G	22	Poor	**Fair**	Very high	Very high
H	20	Good	Good	High	**Low**
I	19	Fair	Fair	Very high	Very high
J	16	Good	Good	High	High
K	20	Fair	Fair	High	**Low**
L	23	Fair	**Good**	Very high	**Moderate**
M	20	Poor	**Good**	Very high	Very high
N	17	Fair	Fair	Very high	Very high
O	20	Good	Good	Very high	Very high
P	17	Good	**Very good**	Very high	**High**
Q	18	Fair	**Good**	Very high	**Low**
R	16	Good	Good	Very high	High
S	20	Good	Fair	Very high	Very high
T	21	Fair	Poor	Very high	**High**

* General Health Scale: Poor, Fair, Good, Very Good, Excellent
** Psychological Distress Scale: Very High, High, Moderate, Low

Table 12: Tobacco and Alcohol Outcomes of individual respondents

Respondent ID	Age	Smoker status		How often drink alcohol		Binging status		No. of illicit drugs	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
A	19	Smoker	Smoker	2-3 days/month	3-4 days/week	High risk	High risk	5	**3**
B	24	Non-smoker	Non-smoker	2-3 days/month	2-3 days/month	Risky	**Low risk**	1	**0**
C	19	Smoker	**Recently quit**	2-3 days/month	**Rarely**	Risky	**Low risk**	6	**0**
D	21	Non-smoker	Non-smoker	Rarely	**Don't drink**	Low risk	**Don't drink**	1	1
E	15	Smoker	Smoker	3-4 days/week	**1-2 days/week**	High risk	High risk	6	**1**
F	17	Smoker	Smoker	1-2 days/week	1-2 days/week	High risk	High risk	4	**2**
G	22	Non-smoker	Non-smoker	2-3 days/month	**Rarely**	High risk	High risk	1	**0**
H	20	Non-smoker	Non-smoker	1-2 days/week	3-4 days/week	High risk	High risk	1	1
I	19	Smoker	Smoker	1-2 days/week	**2-3 days/month**	High risk	High risk	3	**0**
J	16	Smoker	Smoker	1-2 days/week	**2-3 days/month**	High risk	High risk	2	2
K	20	Non-smoker	Non-smoker	1 day/month	1 day/month	Risky	**Low risk**	1	**0**
L	23	Smoker	Smoker	3-4 days/week	3-4 days/week	High risk	High risk	3	**1**
M	20	Smoker	Smoker	2-3 days/month	2-3 days/month	High risk	High risk	1	**0**
N	17	Smoker	**Non-smoker**	3-4 days/week	3-4 days/week	High risk	High risk	3	4

Respondent ID	Age	Smoker status		How often drink alcohol		Binging status		No. of illicit drugs	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
O	20	Smoker	Smoker	1-2 days/week	1-2 days/week	High risk	High risk	1	**0**
P	17	Smoker	Smoker	1 day/month	2-3 days/month	High risk	High risk	3	**1**
Q	18	Smoker	Smoker	3-4 days/week	1-2 days/week	High risk	High risk	9	**4**
R	16	Non-smoker	Non-smoker	1 day/month	1 day/month	High risk	**Low risk**	1	**0**
S	20	Smoker	**Recently quit**	Don't drink	Don't drink	Don't drink	Don't drink	0	0
T	21	Non-smoker	Non-smoker	Don't drink	Don't drink	Don't drink	Don't drink	0	0

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 per cent 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 13: RESPONDENTS' SATISFACTION WITH ACCOMMODATION AND FACILITIES

Accommodation & Facilities	No. of respondents	%
Excellent	8	47.1
Very good	5	29.4
Good	3	17.6
Adequate	0	0.0
Poor	1	5.9
Very poor	0	0.0
TOTAL	17	100.0

Satisfaction with Components of the program

Morning Reflections: time for spiritual reflection and exploring our needs for the day.

Most respondents (88.2 per cent) 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 14: RESPONDENTS SATISFACTION WITH MORNING REFLECTIONS

Morning Reflections	No. of respondents	%
Inspiring	6	35.3
Enjoyable	9	52.9
Ok	2	11.8
Boring	0	0.0
Hated it	0	0.0
TOTAL	17	100.0

Labour of Love: 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 15: RESPONDENTS SATISFACTION WITH LABOUR OF LOVE

Labour of Love	No. of respondents	%
Very good idea	8	47.1
Good	5	29.4
Ok	3	17.6
A drag	1	5.9
Hated it	0	0.0
TOTAL	17	100.0

Sharing at 6.00pm: 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”; “difficult but worth it”.

TABLE 16: RESPONDENTS SATISFACTION WITH SHARING

Sharing at 6.00 pm	No. of respondents	%
Really beneficial	11	64.7
Beneficial	5	29.4
Slightly beneficial	1	5.9
Not beneficial at all	0	0.0
TOTAL	17	100.0

Evening Workshops

The majority of respondents (88.2 per cent) 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 17: RESPONDENTS SATISFACTION WITH EVENING WORKSHOPS

Evening Workshop	No. of respondents	%
Excellent	4	23.5
Very good	9	52.9
Good	2	11.8
Adequate	2	11.8
Poor	0	0.0
Very poor	0	0.0
TOTAL	17	100.0

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

Over half respondents (58.9 per cent) 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 e.g. "Liked them but glad we are not forced to go".

TABLE 18: RESPONDENTS SATISFACTION WITH EVENING REFLECTIONS

Evening Reflections	No. of respondents	%
Inspiring	2	11.8
Enjoyable	8	47.1
Ok	7	41.2
Boring	0	0.0
Hated it	0	0.0

TOTAL	17	100.0

Weekends: free time to chill, read, walk, chat, play some games, be creative, or watch some DVDs.

All but one attendee felt the weekend 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 19: RESPONDENTS SATISFACTION WITH WEEKENDS

Weekends	No. of respondents	%
Excellent	6	35.3
Very good	8	47.1
Good	2	11.8
Adequate	1	5.9
Poor	0	0.0
Very poor	0	0.0
TOTAL	17	100.0

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 20: RESPONDENTS OVERALL SATISFACTION WITH THE PROGRAM

Overall Rating of Program	No. of respondents	%
Life changing	9	52.9
Very positive	5	29.4
Positive	3	17.6
Poor	0	0.0
Very poor	0	0.0
TOTAL	17	100.0

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 six month follow up.

Seventeen of the 20 young women who completed pre and post drug and alcohol surveys were able to be reached by telephone six 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 six 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 interviews were 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. Respondents' specific comments included:

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 (sic) 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 nine volunteer carers and one paid facilitator responsible for the program during the 12 month period of the evaluation. Eight surveys were returned, from one facilitator and seven carers providing a response rate of 89 per cent. The number of programs the staff members had been involved in ranged from four to 23 with a mean of 13.5.

Overall satisfaction with program

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

TABLE 21: STAFF OVERALL SATISFACTION WITH THE PROGRAM

Level of satisfaction	No. of respondents	%
Very satisfied	6	75.0
Satisfied	2	25.0
Dissatisfied	0	0.0
Very dissatisfied	0	0.0
TOTAL	8	100.0

Satisfaction with role in the program

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

TABLE 22: STAFF SATISFACTION WITH THEIR ROLE IN THE PROGRAM

Level of satisfaction	No. of respondents	%
Very satisfied	5	62.5
Satisfied	3	37.5
Dissatisfied	0	0.0
Very dissatisfied	0	0.0
TOTAL	8	100.0

Satisfaction with the content of the program

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

TABLE 23: STAFF SATISFACTION WITH THE PROGRAM CONTENT

Level of satisfaction	No. of respondents	%
Very satisfied	6	75.0
Satisfied	2	25.0
Dissatisfied	0	0.0
Very dissatisfied	0	0.0
TOTAL	8	100.0

Confidence in ability to implement the program

All eight staff members were either confident or very confident in their ability to implement the program the program.

TABLE 24: STAFF LEVEL OF CONFIDENCE IN THEIR ABILITY TO IMPLEMENT THE PROGRAM

Level of confidence	No. of respondents	%
Very confident	5	62.5
Confident	3	37.5
Unconfident	0	0.0
Very unconfident	0	0.0
TOTAL	8	100.0

All eight staff members were either confident or very confident in other staff members' abilities to implement the program.

Table 25: Staff level of confidence in other staff members' ability to implement the program

Level of confidence	No. of respondents	%
Very confident	5	62.5
Confident	3	37.5
Unconfident	0	0.0
Very unconfident	0	0.0
TOTAL	8	100.0

Satisfaction regarding staff access to program training

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

Table 26: Staff satisfaction with their access to training

Level of satisfaction	No. of respondents	%
Very satisfied	5	62.5
Satisfied	3	37.5
Dissatisfied	0	0.0
Very dissatisfied	0	0.0
TOTAL	8	100.0

Satisfaction with the level of respect for guests' confidentiality and safety offered by the program

Seven of the eight 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 27: STAFF SATISFACTION WITH THE LEVEL OF RESPECT FOR GUESTS' CONFIDENTIALITY AND SAFETY THAT THE PROGRAM PROVIDES

Level of satisfaction	No. of respondents	%
Very satisfied	7	87.5
Satisfied	0	0.0
Dissatisfied	1	12.5
Very dissatisfied	0	0.0
TOTAL	8	100.0

Staff members' views of the strengths of the program[3]

- *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*

[3] Each dot point represents the view of one staff member

- *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.*

Staff suggestions for improving the program[4]

- *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*

[4] Each dot point represents the view of one staff member

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.

Carers'/facilitators' final comments

Carers were asked whether there were any other comments they would like to make about the program. Seven 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!*

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 14 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 six 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.

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 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 has been met:

To run programs for 35 young women who have a history of childhood trauma and substance abuse.

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 per cent 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 were:

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. In other 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.

The sixth objective:

To improve the mental health of participants

was met with a statistically significant decrease in respondents psychological distress scores according to the K10.

The seventh and final objective that is within the scope of this evaluation is:

Improving the general health of the participants.

This objective was partially met with nine of the 20 participants improving their health. This is a very difficult outcome to change in six 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 per cent of the sample still used illicit drugs after the program and this is much higher than the general population, for half of this cohort of young women with histories of trauma and abuse to cease their illicit drug use after a three 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 six months previously, so the improvements would appear to be valid even though, without a control group, we cannot 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 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 per cent 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 to improve the program

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

- 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 behavioural 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 Australian Bureau of Statistics (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 New South Wales (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 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

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 one for 'none of the time' to five for 'all of the time'. Scores for the 10 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[5], 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[6] .

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 five to 10 minutes for respondent to complete and it 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).

The SF-36™ is 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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[5] Ware JE, Snow KK, Kosinski M, Gandek B. SF-36 Health Survey: Manual and Interpretation Guide. Boston: The Health Institute, New England Medical Centre; 1993.

[6] ABS. National Health Survey: SF-36 Population Norms, Australia. Canberra: Australia Bureau of Statistics; 1997.

Appendix 3: National Drug and Alcohol Strategy Household Survey 2007

Australian Institute of Health and Welfare's (AIHW) National Drug Strategy Household Survey (NDSHS) has been conducted every two to three 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.

A copy of the Australian Institute of Health and Welfare's NDSHS can be found at http://www.aihw.gov.au/drugs/documents/questionnaire.pdf

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 ...

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.

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.

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!

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.

10:00am	**Reflections** A time for spiritual reflection and exploring our needs for the day.
10:45am	**Labour of Love** 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!
12:00am	**Workshop** A chance to connect with your inner-self and your emotions.
1:30pm	**Lunch** Prepared by Guests & Carers.
3:00pm	**Creative or Information Workshop** Time for you to learn and or connect with / develop your creative side or learn more about the ways in which trauma has affected you.
4:00pm	**Free Time**
6.00pm	**Sharing** A time to practice acknowledging your feelings within the group in a safe environment.
7.00pm	**Dinner** Prepared by one or two guests and carers.
8.00 pm	**Group discussion/Guest Speaker/Craft/Free Time**
9.30 pm	**Reflections** Inspirational readings and music to help you relax before bed.

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.

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