Speak Out Evaluation Report FINAL

Prepared by Hecate Consulting

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1. Acknowledgements

We acknowledge and pay our respects to the traditional custodians of the lands on which we each work, the Wangal people of the Eora Nation, and the Boonwurrung people of the Kulin Nation. We also pay our respects to the traditional custodians of the land on which Weave is located, the Gadigal and Bidjigal people of the Eora Nation. We acknowledge the ongoing impacts of colonisation, and the resilience and wisdom of Aboriginal and Torres Strait Islander people across Australia.

This Evaluation has benefited enormously from the generosity of the sixteen Speak Out clients, two of their significant others, and the two Youth Advocates who shared their stories and insights with us. We deeply appreciate your contribution to this process.

We would also like to thank the following people:

- Dylan Clay, Program Manager, Speak Out
- Mardi Diles, Manager, Brand and Strategy, Weave
- Siobhan Bryson, CEO, Weave
- Melanie Schwartz, Programs Lead, Weave
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- Dr Joanne Ross and Dr Fadil Pedic, NSW Ministry of Health
- Professor Katherine Mills and Dr Christina Marel, MATILDA Centre (Technical Advisory Group)
- Members of the Community Advisory Group
- The Speak Out staff team

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A list of all contributors to the Evaluation, including participants in the Speak Out Evaluation Summit, are included in Appendix 8.1

Glossary and Acronyms

AH&MRC HREC	Aboriginal Health and Medical Research Council Human Research Ethics Committee, who reviewed and approved the Speak Out Evaluation Protocol (approval 1637/20)
AOD	Alcohol and other drugs
CESPHN	Central and Eastern Sydney Primary Health Network. CESPHN manages the recurrent funding for the Speak Out program
COMS	Client Outcomes Management System developed by NADA, collecting standardised outcomes information from AOD services in NSW regarding AOD use, severity of dependence, psychological health, health and social functioning and blood borne virus risk
CRM	Client relationship management system; Weave is currently in the process of procuring a new CRM system that will replace the current CRM system (DEREK) used by Speak Out
EIIF	Early Intervention and Innovation Fund from the NSW Ministry of Health, that funded this Evaluation of the Speak Out program
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
MEL	Monitoring, Evaluation and Learning
NADA	Network of Alcohol and other Drugs Agencies, the peak body for AOD services in NSW. Weave is a member of NADA
Narrative Therapy	Narrative approaches are focused on seeing people as the experts in their own lives and viewing problems as separate from people; and in doing so enabling individuals to examine and rewrite the 'narrative' of how their life has been and will be in the future
Weave	Weave Youth and Community Services, the organisation operating the Speak Out program

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2. Executive Summary

The Speak Out program is one of the flagship programs run by Weave Youth and Community Services. Established some 24 years ago, Speak Out is a community-based program working with young people with co-occurring mental health and alcohol and drug-related challenges in the inner city of Sydney.

The Speak Out program is funded via the Alcohol and Other Drugs stream of the Central and Eastern Sydney Primary Health Network (CESPHN). The program's primary goals are to improve the mental health and social and emotional wellbeing of young people; and to reduce the use and impact of alcohol and other drugs. Speak Out's secondary goals are to improve physical health; to increase connection to others and to community; to increase cultural connection; and to reduce stigma in the community regarding mental health and alcohol and drug challenges.

Speak Out uses a holistic model of care that responds to the issues that young people identify as their priorities. Support for achieving outcomes relating to mental health and wellbeing, and alcohol and other drug use, is woven into the overall program of support. That program of support is highly tailored to the individual and frequently includes support around housing, justice system engagement, employment and education, and family relationships.

The program is multimodal, providing young people with the opportunity to access individualised support (casework and counselling), social connectedness and peer learning (group programs), creativity and self-expression (art therapy) and leadership development, skill development and growth (projects, Youth Advocacy). Speak Out is currently staffed by 5.7 staff members, including a program manager, five part-time case worker/counsellors and two part-time project workers.

i. Evaluation Purpose

Weave is committed to external evaluation of its programs, and identified this Evaluation as an opportunity to assess the implementation and impact of the Speak Out program, in particular to:

1. **Document the Speak Out model,** including points of uniqueness such as:
    - Providing service to young people and in particular vulnerable youth (primarily Aboriginal young people)
    - The design principles that underpin the Speak Out program
    - The unique approaches to treating young people experiencing both mental health and alcohol and drug use challenges, which may serve as a foundation for future evaluation directions.
2. Assess the **alignment of the program with available evidence** regarding effective services and models for young people experiencing both mental health and alcohol and drug use challenges
3. Gather **pilot qualitative and quantitative data to assess the achievements** of Speak Out relative to its intended short, medium term and long-term outcomes (where available)
4. Identify the **resources** used by the program to achieve those outcomes

5. Make recommendations for the **future development** of the program, including ongoing monitoring and evaluation
6. **Build the capacity of Weave staff** to evaluate programs and to utilise data generated for future program development and delivery.

In commissioning the Evaluation, Speak Out (and Weave more generally) identified that the historical descriptions of the purpose and objectives of the program no longer fully reflected the range of outcomes being achieved by the program. In addition, they recognised that the Program Logic previously used to describe the link between program activity, impact and outcomes was in need of a refresh.

The evaluation was funded by the NSW Ministry of Health Early Intervention and Innovation Fund, as part of the NSW Government commitment to building the evidence-base for early intervention models.

ii. Evaluation Questions

The Evaluation was designed to answer the following evaluation questions:

1. **What is the Speak Out Model?**
    - How is it being implemented?
    - How does this model align (or not) with the latest evidence on effective approaches for supporting young people experiencing both mental health and alcohol and drug use challenges?
2. **What outcomes do clients, their families and communities and Speak Out staff want from the Speak Out program?**
3. **How and in what ways have participants' lives changed since their first engagement with Speak Out?**
4. **How could the Speak Out program's monitoring, evaluation and learning processes be strengthened to better inform the program design and delivery?**

iii. Evaluation Design, Implementation and Governance

The Evaluation was conducted by an independent Evaluation team comprising Lisa Ryan and Dr Judy Gold, with support from Dylan Clay, Mardi Diles, Siobhan Bryson and Associate Professor Melanie Schwartz of Weave. It was overseen by a Technical Advisory Group (to advise on and support the quality and rigour of the evaluation method) and a Community Advisory Group (to advise on and support the cultural safety and appropriateness of the Evaluation). The Evaluation Plan was reviewed and unconditionally approved by the Aboriginal Health and Medical Research Council Human Research Ethics Committee before data collection commenced.

iv. Evaluation Methods

The Evaluation covers Speak Out activity from 1 January 2015 - 31 December 2020, and was based on collection and analysis of four main data sources:

- **Existing Speak Out data and documents**, including:

a. The previous evaluation of the Speak Out program
b. Program design documents and associated resourcing (including the current Service Agreement with CESPHN)
c. Existing program data, including de-identified aggregate client data on: demographics, client circumstances, use of alcohol and other drugs, mental health, and identified issues/needs at entry to and exit from the program, and outcomes; and program activity data, including data on: number of clients participating in different types of groups, and number of counselling and case work sessions

- A **Targeted Literature Review** of Australian and international literature covering a range of topics, including: treatment and management of co-existing mental health and drug and alcohol issues in the general population, among young people, and among Aboriginal and Torres Strait Islander young people. Publications reviewed included journal articles, existing good practice guidelines, and evaluations of existing equivalent programs nationally/internationally.
- Collection of **primary data** in September to December 2020, including:
    a. Data from 16 Speak Out clients, collected via individual interviews conducted either face-to-face (in line with COVID protocols) or via telephone
    b. Data from two significant others, that is, family members of previous/current Speak Out clients
    c. Data from focus groups with Speak Out staff members and individual interviews with Weave leaders (including senior managers and a board member)
    d. Data from individual interviews with external stakeholders
- An **Evaluation Summit,** the purpose of which was to workshop, quality-test and refine emerging findings and recommendations. Some 32 participants representing nine organisations were invited to attend the Summit which was held via two Zoom sessions in February 2021.

v. Key findings

Evaluation Question 1: The Speak Out Model and implementation

Evaluation Question 1: What is the Speak Out Model? How is it being implemented? How does this model align (or not) with the latest evidence on effective approaches for supporting young people experiencing both mental health and alcohol and drug use challenges?

This Evaluation found that:

- Speak Out is a **multimodal program** that includes provision of case work, counselling, group work, community development and Youth Advocacy. In addition, young people accessing Speak Out are also linked to other Weave programs that may be of benefit to them (e.g. driving program, tutoring, mentoring). Section 5.1.5.1 provides a detailed description of the Speak Out model.
- In the period 1 January 2015 – 31 December 2020, the Speak Out program saw **316 clients**. At any one time Speak Out will be providing care to around 65-90 clients. The majority of those clients were male, born in Australia, spoke English as their first language and were aged 18-28 years. Two thirds identified as Aboriginal and/or Torres Strait Islanders.
- Assessment conducted at the commencement of an episode of care found:

a. **High levels of social disadvantage**, with 65% of clients unemployed, 40% homeless or in need of assistance in relation to accommodation and 25% in contact with the criminal justice system.
b. **Mental health and quality of life were generally poor**, with a median score on the Kessler Psychological Distress Scale of 24, indicating a high level of psychological distress at intake, and over 40% of clients either dissatisfied or very dissatisfied with their quality of life.

In relation to **population need**, the Evaluation found that:

- The program is working with a sizeable and under-served population in Sydney.
- Waiting list data, and interviews with Weave staff and external stakeholders, indicates that there is a significant gap between population need and the funded capacity of the Speak Out program. There is greater demand for the program than there are places available for clients.
- Current clients would welcome Speak Out expanding its offerings.
- The model allows Speak Out to continue to support young people into **early adulthood (ie to age 28),** unlike other services which cease supporting young people at age 21 or 25. This is widely recognised by all stakeholder groups as filling a key gap in working with young people with complex needs.

In relation to **the strengths of the model**, the Evaluation found that:

- The model is **client-centred and holistic**, including an integrated response to mental health and drug and alcohol (evidence-base: as recommended in Australian literature and the National Co-Morbidity Guidelines; qualitative data: client interviews, interviews with Speak Out and Weave staff).
- The model **brings together individual case work, counselling, group work and community-development and creative expression project work,** and thus can concurrently offer young people the opportunity to work on a diverse range of internal outcomes, life stability, interpersonal relationships/social wellbeing, resilience, creative expression and leadership (source: qualitative data: client interviews, interviews with Speak Out and Weave staff, interviews with external informants).
- The **long-term nature of the work** allows clients to work at their own pace, to perhaps work on a pressing issue (often related to life stability) and then move onto deeper work on internal outcomes (often related to long-term trauma, including intergenerational trauma). This is in contrast to alternate models available to young people in the area, which offer a limited number of sessions in total or a limited number of sessions per year (source: qualitative data: client interviews, interviews with Speak Out and Weave staff, interviews with external informants).
- The **Youth Advocates** program provides a range of specific benefits to participants, including: fostering hope and a bigger vision about their own life and potential; developing advocacy and leadership skills; creating opportunities for paid employment; developing new networks within the community and community organisations; and being recognised as a role model within their own communities (source: qualitative data: client interviews, interviews with Speak Out and Weave staff).

Key **challenges in relation to the model** include:

- There is widespread concern among current and former clients, Weave staff and external informants that the current requirement to **exit all clients at 28 years of age** is detrimental to some young people, and missing an opportunity to support young adults to consolidate the changes they have made as a result of their engagement with the program (source: qualitative data: client interviews, interviews with Speak Out and Weave staff, interviews with external informants).
- The need for a higher level of **mental health support** to be available for many of the young people accessing Speak Out, in particular a need for increased capacity for counselling (including long-term trauma-informed counselling). (Source: qualitative data: client interviews, interviews with Speak Out and Weave staff). At present, Speak Out has re-allocated some staffing capacity from case work to counselling, which addresses the specific need for counselling but does not increase overall capacity and access for young people.
- There may be a need to further tailor client work to the developmental needs and cognitive capabilities of clients. That tailoring is recommended by the current Australian Co-Morbidity Guidelines.

The Evaluation identified the following as the **strengths of program implementation**:

- The depth and breadth of the **skills of the Speak Out staff team.** Over the five years, the case work and counselling staff have been highly successful in engaging clients, creating a sense of safety, supporting clients to 'do the work' at their own pace, expand their self-knowledge and self-efficacy, and support them to identify options and priorities for the future; and the project staff have been highly successful in co-designing and co-delivering engaging, relevant and impactful group learning, social connection and community development initiatives (source: qualitative data: client interviews, interviews with Speak Out and Weave staff, interviews with external informants).
- Speak Out has a strong emphasis on and track record in **engaging clients**. Engagement is flexible and consistent and achieved via a variety of means that are tailored to the individual preferences of the client (source: qualitative data: client interviews, significant others, interviews with Speak Out and Weave staff, interviews with external informants).
- The model has been highly effective in engaging and retaining **Aboriginal and Torres Strait Islander** young people in case work/counselling, group work and community development. Aboriginal and Torres Strait Islander clients reported feeling safe, welcome and included, and that their culture was respected and valued within Speak Out and Weave (source: client registration data; qualitative data: client interviews, significant others, interviews with Speak Out and Weave staff).

The Evaluation identified the following as **program implementation challenges**:

- The holistic nature of the work – in particular, the capacity to also work with family members, where appropriate – and the interconnections between Speak Out clients, can raise **privacy** concerns for some young people (source: qualitative data: client interviews).

- The client-centred nature of the support can create **variation in the level of support provided** to clients. This can create challenges in consistency and role/organisational boundaries (source: qualitative data: client interviews, interviews with Speak Out and Weave staff).
- **Rapport with case workers.** As can occur in all case management programs, several Speak Out clients reported times when they did not have a rapport with the case worker allocated to them. This was identified as a risk in engaging and retaining young people (source: qualitative data: client interviews, interviews with Speak Out and Weave staff).
- **Continuity of care**. Transition from one case worker to another is a key risk in maintaining engagement with young people and needs to be well-supported by practice and protocols (source: qualitative data: client interviews, interviews with Speak Out and Weave staff).
- **Aboriginal and Torres Strait Islander staff** play a critical role in providing culturally safe support for young people and can be important cultural brokers and advisors for the non-Indigenous staff. At the time of writing, Speak Out does not have any Aboriginal or Torres Strait Islander staff, though it should be noted that Weave is currently heavily investing in strengthening the Aboriginal workforce within the organisation overall (source: qualitative data: interviews with Speak Out and Weave staff).
- **Aboriginal cultural governance**. Weave has strong and long-standing relationships with the local Aboriginal community and with local Aboriginal organisations. There is the potential to further strengthen this through more formal mechanisms for embedding decision making by Aboriginal and Torres Strait Islander people into the organisation (source: qualitative data: interviews with Speak Out and Weave staff).
- Other services report positive collaborations with Speak Out on a client-by-client basis, and identified the potential to **strengthen broader collaborations** (source: qualitative data: external informants)..

Evaluation Questions 2 & 3: Outcomes and Impact

Speak Out is working on short, medium and long-term goals and outcomes with and for clients. These outcomes are generally being worked on concurrently, depending on the needs and preferences of the individual client.

This Evaluation has identified that Speak Out is working toward the following outcomes:

Overall Goal	
Speak Out clients have increased resilience, and more control over and satisfaction with their lives	
Short and Medium Term Outcomes	**Long Term Outcomes**
S1. **Improved access** to health and social welfare services, including clinical mental health services	**L1. Relational Outcomes:** Strengthened connections with others, including family, friends, community and culture
S2. **Reduced problematic use** of alcohol and/or other drugs	**L2. Internal Outcomes:** Improved confidence and sense of agency; improved awareness and self

	regulation of feelings, thoughts and behaviour
S3. Improved self-management of **mental health and wellbeing**	**L3. Life Stability Outcomes:** Increased safety and security in living and financial situation; reduced risk of incarceration
S4. Improved engagement with the **justice system** (subset)	**L4. Enabling Environment:** Creating a community environment that enables young people to thrive
S5. Improved engagement with **education and/or employment** (subset)	

See Appendix 8.2 for the draft theory of change visual, including the pathways/linkages between them

Achievement of Short and Medium Term Outcomes

Qualitative data indicated that Speak Out is achieving the following outcomes:

- **Improved access to health and social welfare services**. Those services included support to access housing services (mentioned by 9 of the 16 clients interviewed); access to clinical mental health services (mentioned by 6 of the 16 clients); access to drug and alcohol services (mentioned by 4 of the 16 clients); access to Federal Government agencies including Centrelink and Medicare care; and access to dental health services.
- **Reduced problematic use of alcohol and/or other drugs**. Five of the clients interviewed (and one of their significant others) indicated that Speak Out had helped them to **reduce or control their use of alcohol and other drugs**, including avoiding harms associated with excessive use. Another five clients indicated that they had now stopped using alcohol and other drugs.
- **Improved self-management of mental health and wellbeing.** Seven clients - all females - described different ways in which their involvement in Speak Out had helped them to self-manage their mental health and wellbeing. Most commonly these were **tips and strategies**, such as mindfulness tools, how to set boundaries and breathing awareness.
- **Improved engagement with the justice systems.** For the subset of clients engaged with the justice system, Speak Out works to improve their engagement in the system, such as attendance at court dates. Three clients, and a significant other of another client, described in the interviews how **Speak Out had provided practical support** to engage with the criminal justice system.
- Many of the clients interviewed indicated that Speak Out had helped strengthen their involvement in education and/or employment. Five clients talked about **education engagement**, including enrolling or enrolling in school or post-school education and staying enrolled; and a further seven of the clients interviewed indicated that Speak Out had helped them with **employment**, most commonly obtaining or staying in a job (five clients) but also opportunities to build experiences they could include on their CVs and becoming more prepared to work.

Achievement of Longer-Term Outcomes

Key longer term outcomes that Speak Out contributes to are:

- **Relational outcomes** – that is, strengthened connections with others, including family, friends, community and culture. Most of the clients interviewed for this Evaluation reported that Speak Out had helped them strengthen these relationships.
- Improved **confidence** and **sense of agency**; improved **awareness and self-regulation of feelings**, thoughts and behaviour; increased emotional maturity. Multiple clients and Youth Advocates described how their involvement with Speak Out had increased their self-confidence, self-worth and sense of agency.
- That increase in confidence and self-worth was seen as also **enabling positive behavioural outcomes**, such as reducing the harms associated with alcohol and drug use, leaving a toxic relationship, or more intentionally responding to major life challenges.
- **Improvements in life stability**, including: increased safety and security in living and financial situations, reduced risk of incarceration, and development of practical life skills (such as a drivers licence and budgeting).

As expected, there is currently only limited available quantitative data routinely collected from clients on achievement of these outcomes; see evaluation question four below and the main findings section for more information.

Achievement of Enabling Outcomes

In addition to working directly with individuals on short, medium and long term outcomes, this Evaluation also found that Speak Out also contributes to creating a community environment that enables young people to thrive, including reducing stigma around mental health and drug and alcohol use.

Evaluation Question 4: Strengthening Monitoring, Evaluation and Learning (MEL)

Evaluation Question 4:
How could the Speak Out program's monitoring, evaluation and learning processes be strengthened to better inform the program design and delivery?

At present, there is a range of existing MEL processes within Speak Out, including:

- **Tracking of client engagement and progress via electronic client management system (DEREK); including client outcome measures.** These client measures are aligned to the Client Outcomes Management System (COMS) developed by the Network of Alcohol and other Drugs Agencies (NADA), the peak body for AOD services in NSW
- **Speak Out team discussions to reflect and learn from client interactions and progress**, such as regular Speak Out team and individual supervision meetings incorporating reflective practice and periodic team planning days

Speak Out has also been independently evaluated in the past.

Some of the **challenges** with the existing MEL processes include:

- Challenges in consistently implementing MEL processes, particularly when there are staff vacancies and/or increased client need.

- The need for MEL tools and approaches that better align with the Speak Out model, including better access to culturally appropriate tools for working with Aboriginal and Torres Strait Islander clients and a more trauma-informed approach to MEL.
- The limitations of the type of data currently collected, including the incompleteness of the quantitative data and the mismatch between what data is currently being collected and what are intended and meaningful outcomes for Speak Out clients.
- The lack of routine mechanisms for collection of data from Speak Out group programs and community development initiatives.
- The limitations of the current client electronic management system (DEREK), which is difficult to use and poorly aligned to Speak Out practice. This has created a situation in which individual staff work around the limitations of DEREK, which is time-consuming and may limit consistency.
- The absence of an overarching MEL framework for how Speak Out program activities are linked to intended Speak Out (and indeed, broader Weave) outcomes.

There is significant activity underway within Weave to strengthen the whole of organisation approach to MEL and data management, including:

- The development of a new CRM to replace DEREK
- The appointment of a Speak Out manager with strong skills in project and data management
- The implementation of the recently finalised Weave Healing Framework

The recommendations from the current evaluation identify priority areas for further development of MEL to enable tracking of program impact and outcomes into the future. This includes further developing the draft Theory of Change developed through this Evaluation.

vi. Discussion

This Evaluation was conducted in order to describe the current Speak Out model, comment on the extent to which the model and its implementation is addressing client need and is aligned with current domestic and international literature; investigate the outcomes being achieved by the program; and make recommendations for the future development of the program, including the future development of monitoring, evaluation and learning.

The Evaluation has found that the Speak Out model:

- Provides a mixture of individualised support (casework and counselling), social connectedness and peer learning (group programs), creativity and self-expression (art therapy) and leadership development, skill development and growth (projects, Youth Advocacy).
- Is a highly integrated, holistic response to the needs of young people affected by co-existing mental health and drug and alcohol challenges.
- Strongly aligns with Australian and international literature and guidelines on working with people with co-occurring mental health and drug and alcohol challenges.

The qualitative data collected and the available program data, indicates that the Speak Out model is highly successful in supporting clients to make progress towards a range of **short and medium term outcomes**, including:

- **Improved access** to health and social welfare services, including clinical mental health services; **reduced problematic use** of alcohol and/or other drugs
- Improved access to **housing**
- Improved self-management of **mental health and wellbeing**
- Improved engagement with the **justice system**
- Improved engagement with **education and/or employment**

Analysis of data collected for this Evaluation suggests that Speak Out also assists young people to achieve a range of **long-term outcomes**, including:

- **Strengthened connections** with others, including family, friends, community and culture
- Improved **confidence and sense of agency**
- Improved **awareness and self-regulation** of feelings, thoughts and behaviour
- Increased **safety and security** in living and financial situation
- Reduced risk of **incarceration**
- Fostering a **community environment** that enables young people to thrive

Speak Out is addressing a **critical need in the local community,** and is especially important given the **paucity of other services providing integrated, holistic support** for young people aged up to 28 years with co-existing mental health and drug and alcohol challenges. Speak Out is particularly remarkable for its **ability to engage Aboriginal and Torres Strait Islander young people**, and to provide them with **culturally safe and effective support.** This is evidenced by the fact that 65% of clients identify as Aboriginal, and is supported by the data provided by Aboriginal and Torres Strait Islander clients and their family members via the qualitative data.

Overall, this Evaluation has endorsed the strengths of the model and the practice of Speak Out. The approach taken by Speak Out is consistent with research and guidelines on good practice when working with people with co-existing mental health and drug and alcohol challenges. Given all the above, one of the key findings is that there is a need for increased capacity within Speak Out (see recommendations). Such an increased capacity would allow it to address some of the current access issues created by the extremely limited budget.

This Evaluation has also identified several areas where the Speak Out model may benefit from further development, including consideration of:

- Raising the upper age limit for participants
- Further tailoring the model to the needs of subsets of Speak Out clients (e.g. those aged under 15 years and those with severe, persistent mental illness).

The Evaluation has also identified other areas for action (including in relation to Aboriginal governance, Aboriginal workforce and MEL) that are already being addressed through whole-of-Weave processes.

The Evaluation has been able to draw on a rich pool of data, including data from interviews with Speak Out clients and their significant others, Youth Advocates, Speak Out staff, Weave staff and Board members and external stakeholders. The richness of that data notwithstanding, participation numbers were small and it may not be appropriate to generalise to all Weave clients nor other populations based on these findings. Nonetheless, this Evaluation found indicative of the value and effectiveness of the Speak Out program, as well as identifying opportunities for further strengthening.

vii. Evaluation Recommendations

<table>
<tr><th colspan="2"><u>Recommendation 1:</u>
<u>Maintain the existing model and existing approach to implementation</u></th></tr>
<tr><th>Recommendations</th><th>Rationale</th></tr>
<tr><td>1a. That Speak Out maintain the existing core elements of the Program. This includes their core approach to working with young people (integrated and holistic support, client-centred care, non-judgemental approach, flexibility in timing and location of care; and collaborating with family members and carers where appropriate) and the core elements of the program (case work, counselling, group work, events, community development and Youth Advocates program).</td><td>● The current Speak Out model showing promising evidence for achieving short, medium and long-term outcomes for clients; is strongly supported by Speak Out clients; is consistent with best practice as outlined in published National Guidelines and domestic and international literature; and is strongly endorsed by Speak Out staff, Weave senior leaders, local Aboriginal community leaders and external stakeholders.</td></tr>
<tr><td>1b. That Speak Out maintain the strengths of current practice.</td><td>● The Speak Out model is well implemented: practice is consistent with the overriding philosophy of the model; and there is a high degree of fidelity across the various domains of the model. The current strengths of Speak Out practice should be maintained, with a focus on continuing to recruit highly skilled staff members and provide policies, protocols and tools that enable them to work effectively.</td></tr>
<tr><td>1c. That Speak Out maintain and continue to strengthen collaboration with other providers, and collaboration with the community, including the local Aboriginal community.</td><td>● Speak Out clients often present with multiple, intersecting needs. As such, strong collaborative relationships with other services working in the area, including legal, health and Aboriginal community-controlled services, are vital for joined-up approaches to working with individual clients.
● At the same time, there would be benefits in strengthening collaboration on a range of other fronts - including collaborative project work and advocacy - with other partner organisations.
● Speak Out has a strong relationship with local Aboriginal community leaders. This</td></tr>
</table>

	is critical in its ability to provide culturally safe care, and to respond to emerging community needs and concerns. Continuing to deepen these connections is an integral component of Weave's Healing Framework.
Recommendation 2: ***Identify opportunities to increase the capacity of the Speak Out program***	
Recommendations	**Rationale**
2a. That the capacity of Speak Out be **increased** through the addition of **2 additional full-time case worker/counsellor positions and one case worker specialising in working with young people under the age of 15** (see also Recommendation 5b)**.**	● Young people affected by co-existing mental health and drug and alcohol challenges are significantly underserviced, with demand for Speak Out significantly exceeding capacity. At the time of data collection, the program had 12 people on the waiting list. We recommend that Weave work with potential funders across government (State, Federal, local, and Local Health Districts) and philanthropy to secure increased investment in the program, with the aim being to secure a minimum of 2 additional full-time positions. Depending on need, these could be structured as casework/counselling roles or dedicated counselling roles (or a combination of both).
Recommendation 3: ***Increase access to counselling and clinical mental health support***	
Recommendations	**Rationale**
3a. That Speak Out increase access to counselling and clinical mental health support through **increased counselling capacity within the Speak Out team**.	● There is significant unmet need in the local community for counselling around mental health and AOD issues, as evidenced by waiting lists and feedback from Weave staff, significant others and external informants. Speak Out will require additional capacity to meet this need. ● Findings from this Evaluation suggest that even a modest increase in full-time staff such as two additional casework/counsellor

	positions would better align Speak Out's capacity with existing population need.
3b. That Speak Out increase access to counselling and clinical mental health support through **partnerships with other providers.**	• Speak Out and Weave are considered a safe place for young people to access mental health support, as shown by the interviews with young people and significant others. Partnerships with other providers for services delivered within Weave may increase access to counselling and mental health support. • The current Speak Out model does not include some modalities of clinical support (e.g. psychiatric care). Partnerships would potentially increase access to a broader range of clinical care. These partnerships would need to be formalised to ensure that those partnerships align with core elements of Weave's model of care (integrated care, holistic care, cultural safety).
Recommendation 4: ***Advocate for an increased emphasis on holistic responses to young people affected by mental health and drug and alcohol across NSW***	
Recommendations	**Rationale**
4a. Advocate for the expansion of access to holistic, integrated support for young people affected by mental health and drug and alcohol challenges	• This Evaluation suggests that Speak-Out's holistic, integrated, community-based response to the needs of young people affected by co-occurring mental health and drug and alcohol challenges shows great promise and has the potential to be used to advocate for the provision of similar holistic integrated support for young people affected by mental health and drug and alcohol challenges across NSW. • We recommend that Speak Out and Weave consider how to take up a strategic advocacy role to promote this way of working with young people.

Recommendation 5: ***Continue to refine and develop the Speak Out model, including specific tailoring for age groups and needs of clients***	
Recommendations	**Rationale**
5a. That Speak Out **review the upper age limit for clients**	• Clients and staff both identified the upper age limit as a source of concern; specifically, that the age limit may, at times, cause clients to be exited at a key time of their stabilisation or development. We recommend that Speak Out investigate this further and support any change with protocols covering criteria and a phased approach to transitioning to other services.
5b. That Speak Out **review whether there is a need to modify the approach based on developmental stage and other population characteristics.** (See also Recommendation 2a regarding dedicated staffing capacity to work with young people under the age of 15.)	• At present, the Speak Out offering is both universal and highly individualised. There may, however, be an opportunity to provide a more tailored approach to the needs of specific sub-groups of young people, in particular, young people aged 15 and under, young people with severe mental illness, and young people with cognitive impairment. This more tailored approach is supported by the National Guidelines.
Recommendation 6: ***Continue to refine and develop the Speak Out practice and protocols, particularly around confidentiality, boundaries and consistency and transition processes***	
Recommendations	**Rationale**
6a. That Speak Out **review confidentiality protocols** and how young people are informed about confidentiality protocols	• Speak Out works in a holistic way with young people. This includes working with others in their family system (where appropriate) and with other service providers. This can occasionally create perceptions that privacy is not strictly protected.
6b. That the Speak Out team **undertake a reflective practice process** to address boundaries and consistency	• The very nature of client-centred support is to provide levels and types of support specific to individual client needs. There may be greater variation than intended and it would be useful for the team to clarify boundaries.
6c. That Speak Out **review key points of transition** and identify areas that could be strengthened	• Key points of transition (such as allocation to a case worker, transition to a new case worker)

	may disrupt the relationship between Weave/Speak Out and the client. Targeted attention to these key points will strengthen client engagement and outcomes.
Recommendation 7: **Working with young Aboriginal and Torres Strait Islander people, communities and organisations**	
Recommendations	**Rationale**
7a. That Speak Out, and Weave, continue to maintain a **welcoming environment**	● Speak Out, and Weave, are recognised by clients and their family members as a welcoming and culturally safe environment for young Aboriginal and Torres Strait Islander people. This safe environment is critical to engaging clients and retaining them in care.
7b. That Speak Out establish access to an **Aboriginal or Torres Strait Islander cultural mentor or consultant for staff**	● The Speak Out program is highly successful in engaging and working with Aboriginal and Torres Strait Islander young people, as demonstrated by the high proportion of clients who identify as Aboriginal and the feedback from interviews with clients and significant others. Part of this success is predicated on the skills and knowledge of the Speak Out staff. We recommend that Speak Out enhance this with more formal arrangements for staff to receive support and advice from external Aboriginal or Torres Strait Islander cultural mentors or consultants, to both ensure that the program remains proactive in providing culturally safe and responsive support, and to provide an opportunity for staff to address any emerging challenges.
7c. That Speak Out increase their **Aboriginal and Torres Strait Islander workforce**	● Aboriginal and Torres Strait Islander staff can play a critical role in informing culturally appropriate care; and providing young people with the option of being supported by an Indigenous person. We recommend that Speak Out consider allocating one of the positions within the Speak Out team as a designated position for an Aboriginal or Torres Strait Islander person.

7d. That Speak Out continue to strengthen **community engagement and partnerships**	• Weave has long-standing and deep relationships with the local Aboriginal community and many local Aboriginal community organisations. At present, Aboriginal and Torres Strait Islander communities and organisations are actively consulted on new directions and strategic priorities. We recommend that Weave explore options to strengthen the role of Aboriginal community and organisations in making decisions and further shaping program and service development.
Recommendation 8: **Further develop and refine the draft Speak Out Theory of Change to ensure an explicit and shared understanding of program activities, outcomes, and the connection between them**	
Recommendations	**Rationale**
8a. That Speak Out develop and refine the draft Speak Out Theory of Change	• Further development of the draft Theory of Change will provide Speak Out with a contemporary framework for mapping the relationship between activities and outcomes and will support planning, monitoring, evaluation and learning.
Recommendation 9: **Consider how best to balance encouraging Speak Out clients to be role models and take up leadership and mentoring roles, without creating undue expectation on them**	
9a. That Speak Out ensure that young people who take up opportunities to be role models, leaders and mentors are well supported	• Some stakeholders flagged a concern that young people who take on these visible roles may feel burdened by expectation. This is clearly not the intention for Speak Out. We recommend that Speak Out review its approach to supporting young people who take on these roles to ensure that roles are shared; that young people are prepared and supported in these roles; and that the 'highs and lows' of young people's journeys are celebrated and supported.

Recommendation 10: Apply the findings and learnings from this Evaluation	
10a. That Speak Out ensure that the new Weave CRM system addresses the needs of Speak Out and addresses some of the challenges identified during this Evaluation.	• Weave has recently commissioned an external provider to develop a new whole-organisation CRM system. Speak Out and Weave should ensure that the system is designed for both supporting individual clients as well as tracking progress and outcomes across the whole client cohort.
10b. That the Speak Out team develop an internal Speak Out Evaluation action plan.	• An evaluation action plan, and associated periodic review, will support strategic implementation of the recommendations of this Evaluation.
Recommendation 11: **Co-design an appropriate, feasible and robust MEL framework for Speak Out**	
Recommendations	**Rationale**
11a. That the Speak Out team co-design a MEL framework for Speak Out that includes a finalised Speak Out Theory of Change, MEL principles, Key Monitoring and Evaluation Questions, Data Sources (existing and new), Updated Data Collection Tools, Data Analysis, Dissemination and Use of findings and MEL Resourcing, Roles and Responsibilities.	• This will enable MEL to be embedded within Speak Out and will support continuous learning and improvement.
11b. That the Speak Out team develop systematic approaches for collecting client feedback.	• This will provide ongoing insight into how Speak Out clients are experiencing the programs, and enable adjustments to programs and services in response, without having to 'wait' for external evaluation.

Recommendation 12: Strengthen MEL culture, capacity and resources within Weave	
Recommendations	**Rationale**
12a. That Speak Out strengthen and maintain MEL culture	● This will enable MEL to be embedded within Speak Out and will support continuous learning and improvement.
12b. That MEL capacity and capability be strengthened through staff training and mentoring in MEL, and recruitment of a MEL coordinator role (whole-of-Weave position).	● This will enable MEL to be embedded within Speak Out and will support continuous learning and improvement.

3 Introduction

The Speak Out Program is a multifaceted program working with young people with co-existing challenges relating to mental health and drug and alcohol. This section provides a brief overview of the Speak Out program, including its history and intended outcomes; summarises the findings of the targeted literature review on the needs of young people affected by mental health and drug and alcohol; outlines the objectives of this Evaluation; and describes core elements of the Evaluation design and implementation, including governance, timeline and the makeup of the Evaluation team.

3.1 Brief overview of the Speak Out Program

3.1.1 Program History

The Speak Out Program has been operating since 1997, and was the **first program** established for young people in NSW with coexisting challenges related to mental health and alcohol and other drug use. The program was established because young people experiencing these conditions were falling through the gaps of service delivery in the broader community. These gaps had arisen due to the singular focus of existing programs - that is, mental health services were reluctant to accept and/or work therapeutically with people who were using drugs and alcohol, and drug and alcohol services were reluctant to work with clients who were experiencing co-occurring challenges with mental health.

3.1.2 Program Description

The Speak Out Program works with young people **aged 12-28 years** who are experiencing challenges with both **mental health and use of alcohol and other drugs.**

Historically, the **primary intended outcomes** of the Speak Out program have been described in funding applications and other Weave documents as:

- Reduced usage and impact on health and quality of life of alcohol or other drugs
- Improved mental health/social and emotional wellbeing

Historically, the **secondary intended outcomes** for the Speak Out program have been described as:

- Improved physical health
- Increased connection to others and community
- Increased cultural connection
- Reduced stigma associated with mental health issues and alcohol and other drug use among community members.

The Speak Out program operates across **multiple modalities**, including:

- Individual client support work - that is, case work and counselling
- Group work, including art groups, therapeutic groups (e.g. SMART Recovery), social groups, exercise activities and life skills groups (e.g. cooking and nutrition)

- The Youth Advocates program, which develops leadership and advocacy skills amongst young people
- Community development and community events.

A detailed description of the Speak Out model, including the core elements of the program and the underpinning theoretical and practice framework is provided in the findings section focused on The Speak Out Model and Implementation.

3.1.3 Previous Evaluations

Independent evaluations of the Speak Out program were conducted in 2002 and 2010. The 2010 Evaluation focused mainly on documenting program design and delivery and potential gaps, based on a staff survey, some client interviews and review of program data[1]. That Evaluation concluded that "from the perspective of clients, staff, managers and other organisations surveyed, Speak Out is progressing very well in meeting its funded objectives, and in many cases is exceeding expectations"[2]. It found that Speak Out was:

- Highly successful in providing individualised therapeutic support and reducing client harms and death
- Increasing access to specialised and mainstream services (with the note that this was constrained by the capacity of those services)
- Increasing client knowledge about alcohol and drugs, and mental health
- Increasing knowledge of client needs among the broader service system.

Key recommendations included:

- Closely monitoring staff workload, to ensure that caseloads are manageable
- Increasing access to 'talking therapies'
- Addressing key gaps relating to: transport, IT, brokerage funding and physical environment
- Strengthening consistency in relation to client assessment and documentation
- Working with the program funder to streamline reporting and thus make reporting less onerous.

3.2 Needs of young people affected by mental health and drug and alcohol

Incidence and prevalence of co-existing mental health and drug and alcohol challenges

In recent years there has been increasing attention on the **intersection between mental health and alcohol and other drug use**. Australian research and policy recognises that there is a **significant prevalence** of co-existing mental health and drug and alcohol challenges, with estimates ranging between 25-50% co-morbidity.[3]

[1] *Hughes, K. (2010), Independent Evaluation of the Speak Out Dual Diagnosis Program, unpublished, Sydney, Australia.*

[2] *Hughes, K. (2010), Independent Evaluation of the Speak Out Dual Diagnosis Program, unpublished, Sydney, Australia.*

[3] *Teeson, M (2014), Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment*

Young people are at **high risk** of challenges with both mental health and use of alcohol or other drugs. Adolescence and young adulthood is a **time of change**, creating vulnerabilities for mental health and problematic use of alcohol or other drugs, and is often the first time symptoms of mental health conditions present.[4]

Data is incomplete and reflects the fragmented nature of the service system (where data tends to be collected on incidence and prevalence of mental health conditions among young people with alcohol and drug use challenges or on the incidence and prevalence of problematic drug and alcohol use among young people with diagnosable mental health disorders). Recognising the limitations of the data then, it is important to note that:

- One in four Australian young people will experience a diagnosable mental health disorder in any given year[5].
- Mental health concerns are the predominant cause of the burden of disease for young people[6]. Young people at higher risk of poor mental health include homeless young people, Aboriginal young people, LGBTI young people and young people living in rural areas.
- Suicide is the leading cause of death among young people, with rates of hospitalisation for self-harm highest for young Aboriginal people[7].
- More than one third of 13-17 year olds with a major depressive disorder reported alcohol consumption in the previous thirty days, which was more than double the proportion of young people with no diagnosed disorder. Of those, around 13% reported risky alcohol use at least weekly. Among 13-17 year olds with a major depressive disorder, the rate of cannabis use was more than three times higher than among young people with no diagnosed disorder; and almost one quarter of 13-17 year olds with a major depressive disorder had used another illicit drug in the month prior to being surveyed.
- Almost a quarter of 18-25 year olds with a mental illness reported the use of at least one type of substance in the previous month[8].
- In relation to the population overall (i.e. not youth specific), the 2011 Evaluation of the Victorian Dual Diagnosis Initiative reported that it is estimated that dual diagnosis disorders were found between one third to one half of the client population of mental health and drug and alcohol services[9].
- Higher rates of mental health and drug and alcohol challenges have been reported among lesbian, gay, bisexual, transgender and intersex young people.

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[4] *Described further in the section on Young People in Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016*

[5] *Baker, D and Kay-Lambkin F. Two at a time: alcohol and other drug use by young people with a mental illness. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.*

[6] *NSW Ministry of Health. Substance Use and Young People Framework, 2014*

[7] *NSW Ministry of Health. Substance Use and Young People Framework, 2014*

[8] *Baker, D and Kay-Lambkin F. Two at a time: alcohol and other drug use by young people with a mental illness. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.*

[9] *Australian Health Care Associates. Evaluation of the Victorian Dual Diagnosis Initiative, 2011*

- The health impact of co-existing mental health and drug and alcohol challenges is high and potentially life-long, with co-morbid mental health and substance use conditions a major cause of disability among young people and, in the longer-term, a key cause of poor quality of life and preventable mortality[10].

Social and emotional wellbeing, Aboriginal and Torres Strait Islander young people

The **social and emotional wellbeing** of Aboriginal and Torres Strait Islander peoples is understood to be shaped by **connections**: to body, to mind and emotions, to family and kinship, to community, to culture, to land and spirituality.[11] Aboriginal and Torre Strait Islander peoples face **intersecting risks** to their health and social and emotional wellbeing due to the history of colonisation and the associated intergenerational legacies including grief and loss, trauma, abuse, removal from family, land and culture, racism and discrimination, and social disadvantage and exclusion.[12]

This history has resulted in Aboriginal and Torres Strait Islander peoples experiencing a **burden of disease that is 2.3 times greater** than the rate of non-Indigenous Australians.[13] Although Aboriginal and Torres Strait Islanders are more likely to abstain from drinking alcohol than non-indigenous Australians, **rates of risky alcohol consumption and use of illicit drugs are higher**.[14] Furthermore, adult Aboriginal and Torres Strait Islander peoples are 2.6 times more likely than non-Indigenous adults to **experience high or very high levels of psychological distress**; 68% report experiencing one or more life stressors in the past 12 months, and suicide rates are twice that of non-Indigenous Australians.[15]

Despite experiencing many challenges with health and wellbeing due to the legacy of colonisation and other intersecting risk factors, Aboriginal and Torres Strait Islander peoples have proven to be remarkably **resilient**.[16] Several studies have identified the association of stable family life, social and community support and physical health with resilience among Aboriginal peoples, including among young people.[17]

Impact of co-occurring mental health conditions and substance use issues

Having a mental health condition may make some people more likely to use alcohol or other drugs to relieve their symptoms; for others, the use of alcohol or other drugs may trigger symptoms of mental

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[10] *Teesson, M (2014), Mental Health and Substance Use: Opportunities for Innovative Prevention and Treatment*

[11] *Gee et al. Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Government Department of the Prime Minister and Cabinet, 2014*

[12] *Zubrick et al. Social Determinants of Social and Emotional Wellbeing in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Government Department of the Prime Minister and Cabinet, 2014*

[13] *Australian Institute of Health and Welfare. (AIHW) Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2011. Australian Government, 2016*

[14] *AIHW. Alcohol, tobacco & other drugs in Australia, Australian Government, 2019*

[15] *AIHW. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) report 2017, Australian Government, 2018*

[16] *Gee et al. Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Government Department of the Prime Minister and Cabinet, 2014*

[17] *McLennen. Family and community resilience in an Australian Indigenous community. Australian Indigenous Health Bulletin 2015: 15(3); Young et al. Stressful life events and resilience among carers of Aboriginal children in urban settings: cross sectional findings from the Study of Environment on Aboriginal Resilience and Child Health (SEARCH). BMJ Open 8 (2018) e021687-1-e021687-12; Young et al. The prevalence and protective factors for resilience in adolescent Aboriginal Australians living in urban areas: a cross-sectional study. ANZJPH 2018: 43;1, 8-14*

illness.[18] Experiencing both conditions has been associated with **multiple negative consequences** beyond experiencing each condition individually. These include increased severity of symptoms, more frequent relapse, increased use of multiple drugs, and increased suicidal ideation and attempts. Once developed, each condition can also act to exacerbate and maintain other disorders.[19] In relation to social vulnerability, co-existing mental health and drug and alcohol challenges are associated with increased risk of violence and exploitation, unemployment and work instability, poverty, housing difficulties and homelessness, and increased risk of forensic involvement. In relation to health care costs, co-existing mental health and drug and alcohol challenges are associated with increased treatment costs, partly due to the risk of more frequent hospitalisations.

Access to services

It is widely recognised that there are **significant variations in access** to mental health and drug and alcohol services for young people. The most recent *Young Minds Matter Survey (2016)* found that just over 50% of children and young people with a mental health challenge had accessed a service for mental health support, but that a significant minority had not accessed any service. Of those who had accessed a service, the majority had accessed either a primary care provider or a staff member working in an educational setting (e.g. school counsellor). Only 3.3% of mental health care for children and young people was provided by specialist mental health services[20]. The *Young Minds Matter Survey* also found that there were significant gaps in access to counselling services: of those who had accessed counselling, only one third reported that their needs had been fully met in the previous year, with one third reporting that their needs had been partially met and one-third reporting that their needs had been completely unmet.

Available clinical research evidence suggests that **integrated treatments** offer the best method of both engaging and retaining the client in care AND improving outcomes (due to increased understanding of the links between their conditions and the potential to make improvements across multiple domains)[21]. Conversely, receiving treatment for one issue but not the other reduces the likelihood of sustained treatment benefits.[22] Despite this

> ***"There continues to be limited evidence of integrated service delivery."*** [23]

In their 2019 submission to the Victorian Royal Commission on Mental Health, the Victorian Dual Diagnosis Institute noted that

> ***"These [people with co-occurring mental health and drug and alcohol challenges] are the people who tend to have poorer outcomes and higher costs of care. However, instead of***

[18] *Loxely et al. The prevention of substance use, risk and harm in Australia: a review of the evidence. NDRI and CAH, 2004*

[19] *Leung et al. Co-morbid mental and substance use disorders – a meta-review of treatment effectiveness. NDARC, 2016*

[20] *Australian Institute of Family Studies, Young Mind Matters Survey, 2016. https://aifs.gov.au/cfca/2016/08/22/young-minds-matter-use-services-young-people-mental-disorders*

[21] *Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016*

[22] *Baker, D and Kay-Lambkin F. Two at a time: alcohol and other drug use by young people with a mental illness. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.*

[23] *Baker, D and Kay-Lambkin F. Two at a time: alcohol and other drug use by young people with a mental illness. Melbourne: Orygen, The National Centre of Excellence in Youth Mental Health, 2016.*

systems being designed to clearly welcome and prioritise [them], individuals and families with complexity have historically been experienced as misfits at every level."[24]

3.3 Evaluation Objectives

The objectives of this evaluation of Speak Out are to:

- **Document the Speak Out model,** including points of uniqueness such as:
    - Providing service to young people and in particular vulnerable youth (primarily Aboriginal young people)
    - The design principles that underpin the Speak Out program
    - The unique approaches to treating young people experiencing both mental health and alcohol and drug use challenges, which may serve as a foundation for future evaluation directions.
- Assess the **alignment of the program with available evidence** regarding effective services and models for young people experiencing both mental health and alcohol and drug use challenges
- Gather **pilot qualitative and quantitative data to assess the achievements** of Speak Out relative to its intended short, medium and long-term outcomes (where that data is available)
- Identify the **resources** used by the program to achieve those outcomes
- Make recommendations for the **future development** of the program, including ongoing monitoring and evaluation
- **Build the capacity of Weave staff** to evaluate programs and to utilise data generated for future program development and delivery

3.4 Evaluation Planning

3.4.1 Evaluation Governance

Design and implementation of the evaluation was overseen by:

- Senior leaders within Weave
- A Technical Advisory Group, the role of which was to:
    - Provide expert feedback on the proposed evaluation method, both via meetings and out of session
    - Assist the Evaluation team to address any challenges as they arise
    - Review and provide advice on the draft Evaluation report and final Evaluation report
    - Provide ongoing support and advice for the Evaluation
- A Community Advisory Group, the role of which was to ensure that:
    - The Evaluation was culturally sensitive
    - The processes for the Evaluation were appropriate and safe for clients and community members

[24] *Cline and Minkoff cited in Croton,G. Better Outcomes: Towards a Victorian Complexity-Capable Service System.Submission to the Royal Commission into Victoria's Mental Health System. Victorian Dual Diagnosis Initiative, 2019*

- The client experience of Speak Out is represented accurately in the Evaluation
- The Evaluation team talks to the community and to other services about the Evaluation in an appropriate way

The members of the Technical Advisory Group and Community Advisory Group are listed in Appendix 8.1 Evaluation Participants.

3.4.2 Evaluation Timeline

Weave secured funding for this Evaluation in 2018 and initially contracted Primitive, a consulting organisation, to develop the evaluation plan. In early 2019, Weave contracted the Hecate Consulting team to further develop, operationalise and implement the Evaluation.

Key evaluation milestones included:

- September 2019: the NSW Ministry of Health approved the Evaluation Plan prepared by Hecate Consulting in conjunction with Weave
- January 2020: the full Evaluation Protocol was submitted to the Aboriginal Health and Medical Research Council (AH&MRC) Human Research Ethics Committee (HREC) for review
- June 2020: the AH&MRC conditionally approved the protocol, and requested that the Evaluation team provide details as to COVID-safe adaptations before commencing field work
- September 2020: the COVID-safe adaptations were approved by the AH&MRC, and data collection with Speak Out clients commenced. Data collection with Speak Out clients, Speak Out staff, Weave staff and external stakeholders occurred during September 2020 to January 2021
- February 2021: An Evaluation Summit was held to present emerging findings, undertake joint sense-making and generate preliminary recommendations
- February - April 2021: The Evaluation report (this document) was drafted and finalised.

3.4.3 Aboriginal Health and Medical Research Council Human Research Ethics Committee

The Evaluation Protocol was submitted to the Aboriginal Health and Medical Research Council (AH&MRC) Human Research Ethics Committee (HREC). This was a priority given that the majority (65%) of Speak Out clients are Aboriginal and/or Torres Strait Islander. In addition to an overall review of the quality and safety of the proposed approach, the AH&MRC also specifically reviewed the Evaluation protocol against the five key principles of:

1. Does the proposed research provide a net benefit for Aboriginal people and communities?
2. Is there Aboriginal Community Control over the research?
3. Is the research culturally sensitive?
4. Will Aboriginal people be reimbursed for costs associated with participating in the research?
5. Will the research enhance Aboriginal people's skills and knowledge? (AH&MRC, 2020).

The Evaluation protocol, and the subsequent COVID-Safe Strategy, received unconditional approval from the AH&MRC HREC.

3.4.4 Evaluation Team

This Evaluation was designed and completed by a team from Hecate Consulting, consisting of Ms Lisa Ryan (Project Manager) and Dr Judy Gold (Technical Evaluation Lead).

Lisa is a systems change practitioner with over 25 years' experience in direct service delivery, health promotion, policy development and leadership development.

Judy is an evaluator and researcher with over 15 years' experience in research, public health and international development.

The external Evaluation team was supported by key staff in Weave, in particular Ms Mardi Diles, Mr Dylan Clay and Ms Siobhan Bryson.

3.5 Evaluation Questions and Theory of Change

To achieve the evaluation objectives, this Evaluation was structured around answering the following four evaluation questions:

- **What is the Speak Out Model?**
  - How is it being implemented?
  - How does this model align (or not) with the latest evidence on effective approaches for supporting young people experiencing both mental health and alcohol and drug use challenges?
- **What outcomes do clients, their families and communities and Speak Out staff want from the Speak Out program?**
- **How and in what ways have participants' lives changed since their first engagement with Speak Out?**
- **How could the Speak Out program's monitoring, evaluation and learning processes be strengthened to better inform the Program design and delivery?**

In developing the Evaluation Plan, we revised and updated the existing Program Logic for Speak Out (Appendix X). Through the evaluation process, the program logic has been redeveloped into a draft Theory of Change (Appendix 8.2) that articulates the current activities, and short-term and long-term outcomes of the program. See section 5.2.1.1 Draft Theory of Change for more detail of how this theory of change was developed.

4 Methodology

This Evaluation is a mixed method retrospective pilot study to answer the four evaluation questions.

The main data sources for the Evaluation were:

1. Review of existing Speak Out Data and Documents
2. Targeted Literature Review
3. Primary Data Collection via interviews and focus groups
4. Evaluation Summit

Findings from these data sources were analysed and compiled into this Evaluation report.

4.1 Review of Existing Speak Out Data and Documents

4.1.1 Existing Program Documents

The Evaluation team reviewed and analysed key existing program documentation from the Speak Out program, including:

- **Previous evaluations** of the Speak Out program[25]
- **Program design documents and associated resourcing** e.g. project plans, program budget, and acquittals dating back to 2015, and the current Service Agreement with CESPHN

We also received extensive briefings from Speak Out and Weave leadership on the evolution of the Speak Out program in recent years, including management responses to previous evaluations.

4.1.2 Existing Program Data

The Evaluation team also reviewed and analysed all data held on Speak Out clients in the Weave client management system (DEREK) for the period 1 January 2015 - 31 December 2020. Data provided to the Evaluation team was in aggregated format and included:

- Client demographic data, such as gender, age, country of birth and if a client identifies as Aboriginal
- Data on life situation of clients, such as if studying/in formal education, living situation, and type of benefits being received
- Data on alcohol and other drug use and mental health, such as primary drug of concern and if ever have attempted suicide
- Identified client issues at entry and exit
- Source of referral to Speak

[25] *Hughes, K (2010) Independent Evaluation of the Speak Out Dual Diagnosis Program, unpublished, Sydney, Australia; Synnott, E and Laurie, G (2002), Review of South Sydney Youth Services and the Richmond Fellowship of NSW Dual Diagnosis Project, Final Report. Unpublished, Sydney, Australia.*

Weave staff actively participated in cleaning and interpreting that data.

DEREK also includes aggregate data on participation in different Speak Out activities e.g. how many clients participated in different types of groups, number of counselling sessions delivered each year.

The data stored in DEREK is collected and entered by Speak Out program staff during the client's engagement with the Speak Out program, in accordance with the Privacy and Confidentiality Statement signed by clients when they first engage as a client.

Existing data on client outcomes was also extracted from the Network of Alcohol and other Drugs Agencies (NADA) client outcome measures (COMS) system. COMS includes assessment at intake, each six month point and exit about drug and alcohol use (consumption and severity of dependence), psychological health (K10 scale of psychological distress),[26] health and social functioning,[27] and blood borne virus risk (not captured by Weave). The COMS data is entered by Speak Out case workers into the DEREK client management system, and exported monthly to the central NADA database.

4.2 Targeted Literature Review

The Evaluation team conducted a targeted literature review of Australian and international literature covering a range of topics including: treatment and management of co-existing mental health and drug and alcohol issues, including treatment of those issues for young people and the specific needs of Aboriginal and Torres Strait Islander young people (see reference list). Publications included journal articles as well as existing good practice guidelines, and evaluations of existing equivalent programs nationally/internationally, to provide an evidence base for recommendations to improve the program and its ongoing monitoring and evaluation.

4.3 Primary Data Collection

We collected and analysed primary data generated from interviews and focus groups with clients and significant others, Speak Out staff and Weave senior leaders, and external stakeholders. Further details of each aspect of the methodology are described in brief below; full details can be found in the final Speak Out Evaluation Protocol approved by the AH&MRC. Informed consent was obtained from all evaluation participants prior to the commencement of interviews/focus group discussions.

The question guides approved by the AH&MRC for primary data collection are available in Appendix 8.6.

[26] *The K10 is a widely used 10 question scale to identify self-reported psychological distress, and identify who may need further assessment for anxiety and/or depression. Each question is scored on a 1-5 scale (from 'none of the time' to 'all of the time', resulting in a total scale score of between 10 and 50. A score of 10-15 is considered a low level of psychological distress; scores of 16-21 considered a moderate level, 22-29 a high level and 30-50 a very high level of psychological distress. More information about the K10 scale can be found in the NADA COMS guide or at https://comorbidityguidelines.org.au/pdf/K10-and-Scoring-Guide.pdf*

[27] *The World Health Organisation Quality of Life 8 questions (WHO QoL-8) is used to measure quality of life across six domains using a five point scale from 'very poor' to 'very good' but is not numerically scored or aggregated. More information about the WHO QoL-8 can be found in the in the NADA COMS guide or at https://www.sciencedirect.com/science/article/pii/S1098301511036655*

4.3.1 Interviews with Clients

Speak Out clients were a key source of information for the Evaluation. Clients are uniquely placed to reflect on their experiences with the Speak Out program, including:

- What they wanted to get out of the program at the outset
- What changes[28] have emerged in their lives since their engagement with Speak Out, and
- What role (if any) participation in Speak Out played in those changes.

Clients were considered eligible to participate in the Evaluation if they:

- Had had substantive engagement with Speak Out in the period 1 January 2015 - 31 December 2020 - that is, that they had engaged with Speak Out for at least three months at the time of interview; and had at some point engaged in counselling or casework
- Were aged 16 years or older at the time of the Evaluation.

Clients were initially recruited via random sampling; the random sampling was then later augmented with purposive sampling to address key gaps in representation across the Speak Out client cohort.

For the random sampling element, Weave attempted to contact 150 young people to seek their consent to provide their contact details to the Evaluation team. The majority of those young people could not be contacted (e.g. due to change of telephone number since their time as an active client). Of those 26 young people that Weave were able to contact, 22 consented to have their contact details provided to the Evaluation team. The Evaluation team then contacted those clients, provided more information and arranged a time for interview if consent to participate was given.

Clients then participated in a confidential semi-structured interview with one member of the Evaluation team. These interviews were conducted either face to face or via telephone (depending on client preference) at a private location off-site from Weave.

A total of 16 clients were interviewed, of whom 14 were recruited via random sampling and two of whom were recruited via purposive sampling.

The client interviews covered the following areas:

- The nature of the participant's involvement in the Speak Out program(s)
- What each participant wanted to get out of the Speak Out program(s)
- Stories of Most Significant Change since their engagement with Speak Out
- Other changes experienced through and after their engagement with Speak Out
- Suggestions for improvement of the Speak Out program(s)

4.3.2 Interviews with Significant Others

We also collected primary data from 'significant others' of clients. The purpose of inclusion of significant others was to bring the **insights of wider family units and kinship units** into the Evaluation. This was seen as important given that Speak Out has a large focus on connection, and that extended family and kinship

[28] *This could include changes perceived by participants to be positive, negative or neutral changes to their lives*

relationships are particularly important for Aboriginal people, who make up the majority of Speak Out clients. Insights from 'significant others' may **complement and extend the insights provided by clients** themselves.

Significant others had not been formally included in previous evaluations of the Speak Out program. This Evaluation was a **pilot** to test:

- Whether significant others can feasibly be recruited for a program evaluation
- Whether significant others can provide useful information on client experiences and outcomes, and
- How similar or different their responses are to client responses.

At the end of the client interview, they were invited to nominate someone they considered a significant other. The only criteria applied by the Evaluation team was that the significant other needed to have known the client at the time they were engaged with Speak Out, and for at least one year at the time of the Evaluation.

We had initially aimed to recruit 5-8 significant others for interviews but were only successful in recruiting two significant others. Both of these interviews were conducted via telephone. Expected and unexpected factors that affected recruitment of significant others included: the additional burdens on family members associated with COVID-19; the reluctance of some young people to nominate a significant other for interview; the absence of long-term, trusted significant others in some young people's lives; and the practical challenges associated with securing both a young person and a significant other's consent before contact information of the significant other was passed onto the Evaluation team.

The interviews with significant others covered the following areas:

- How the person they know was engaged with Speak Out
- Their expectations of the Speak Out program(s) for the person
- Stories of Most Significant Change they saw in the person since their engagement with Speak Out
- Other changes experienced by the person they know during and after their engagement with Speak Out
- Suggestions for improvement of the Speak Out programs

4.3.3 Focus group with Youth Advocates

The Youth Advocates are an **existing group of young people** convened by Weave. Advocates have a combination of lived experience of mental health and/or use of alcohol or other drugs. The group includes a combination of current Speak Out clients, clients of other Weave programs and clients of other organisations.

All current Youth Advocates were invited to take part in a focus group for the evaluation. Their inclusion was intended to provide a **complementary perspective** to that provided through the Speak Out client interviews, particularly around the needs of young people experiencing challenges with mental health and/or use of alcohol or other drugs.

The focus group was attended by 2 Youth Advocates and covered the following topics:

- What the Youth Advocates see as the **key needs** of young people with mental health and challenges with alcohol or other drugs
- What **value** they think the Youth Advocates program brings
- Why the Youth Advocates think young people **may come** to Speak Out and Weave
- What the Youth Advocates see as **different** about Speak Out compared to other casework and support programs they are aware of
- **Recommendations for improvement** to services and programs for young people with co-existing mental health challenges and challenges with alcohol or other drugs

4.3.4 Interviews and Focus Groups with Speak Out Staff and Weave Senior Leaders

Weave staff, particularly current and former staff working on the Speak Out program, have a valuable and different perspective on the intended and actual outcomes of the Speak Out program compared to clients and significant others.

Data was collected from Weave staff and the Weave Board via:

- Two interviews with the current **Speak Out Program Manager** (one participant, via zoom)
- Two group interviews with all available **Speak Out staff,** including counsellor/caseworkers and project staff (eight participants across the two interviews, face to face)
- One group interview with the **Speak Out project staff**, to identify opportunities and challenges unique to project work (two participants, via zoom)
- One group interview with Weave senior managers (two participants, via a face to face interview)
- One interview with a Weave Board member (one participant, via zoom)

The interviews and focus groups covered:

- Description and understanding of the **Speak Out model**
- How the **model is being implemented** in practice
- **Desired outcome**s of Speak Out for participants and their families
- Staff perception of whether these **outcomes are being achieved**, and why or why not
- Any **unexpected (positive or negative) outcomes** emerging as a result of participation in Speak Out
- **Suggestions for improvement** of the Speak Out program(s) and other programs and services for young people experiencing challenges with their mental health and use of alcohol or other drugs.

4.3.5 Interviews with External Stakeholders

Other services that Speak Out works closely with, for instance those that cross-refer clients, have a unique perspective on how the Speak Out program works in practice, including how the program may differ from other services available to young people in the area. This perspective complemented other perspectives included in the Evaluation, such as Speak Out clients and staff.

Eligible services included health, social and other support services that Speak Out is similar to and/or works closely with, defined as services that:

- Refer clients to Speak Out; and/or

- Receive client referrals from Speak Out; and/or
- Co-case manage Speak Out clients; and/or
- Work with young people experiencing challenges with both mental health and alcohol and other drug use
- Work with young Aboriginal people.

We had intended to conduct a focus group with several services, and representatives of five services were approached to participate. Although all were enthusiastic to participate in the focus group, scheduling difficulties resulted in only two services participating via individual interviews.

The interviews covered the following topics:

- Services' perception and understanding of the **Speak Out model**
- The **alignment** of the Speak Out model with their own approaches
- The **alignment** of the Speak Out model with the evidence base for this client population
- The **outcomes** they have observed (positive and negative) among participants in Speak Out, and the extent to which they attribute these changes to the Speak Out program(s)
- Suggestions for **improvement** of the Speak Out program(s) and other programs and services for young people experiencing challenges with their mental health and use of alcohol or other drugs.

4.3.6 Evaluation Summit

An evaluation summit is an opportunity to bring together different evaluation stakeholders to:

- **Present emerging findings** from the Evaluation
- Identify if any areas require **further exploration,** and
- **Co-create the recommendations** to include in the Evaluation report.

Evaluation summits help to maximise the value of evaluations by:

- Strengthening stakeholders' **understanding of and engagement** with evaluation data and the evaluation process
- Creating opportunities for the affected populations, in this case particularly **Aboriginal people** to participate in and shape interpretation of the data
- Identify **areas that may have been overlooked** by the Evaluation team, and require further investigation (if feasible) or deeper/different analysis of data
- Maximise the likelihood the resulting **report and recommendations are culturally appropriate** and **useful** to stakeholders, including that recommendations can be feasibly implemented.

Originally envisaged as a face-to-face workshop, due to COVID restrictions the Speak Out Evaluation Summit was conducted as two two-hour sessions via Zoom in February 2021. Invitees included:

- Key Weave staff, including those from the Speak Out program and representatives from the Weave Aboriginal staff group (as appropriate)
- Members of the Community and Technical Advisory Groups for the Evaluation
- Representatives from the Youth Advocates - to represent the voice of young people
- Any other key external or internal stakeholders identified during the evaluation process

Appendix 8.7 includes the program for each session.

4.3.7 Theory of Change

Prior to the evaluation summit we used the data gathered to evolve our initial program logic for Speak Out (included in the evaluation plan) into a much more comprehensive and holistic draft theory of change for the Speak Out program. The draft was further updated based on discussion at the evaluation summit, and subsequent comments received during the report review phase. Given this theory of change was developed by us for the purpose of the Evaluation, further development and stakeholder engagement is needed before this is suitable for use by the Speak Out program - see recommendation 8a for more detail.

4.3.8 Evaluation Report

We used the information from the review of existing Speak Out data and documents, the targeted literature review, the primary data collection and the discussions at the evaluation summit to compile the draft version of this report.

To ensure participant anonymity, names of clients and significant others have been replaced with pseudonyms. Quotes from interviews with Weave senior management staff and board members are cited as 'interview with senior leaders at Weave' and interviews with external agencies (referring services and funder) are cited as 'interview with external agency'. The full list of participants in the Evaluation can be found in Appendix 8.1.

The draft report was reviewed by the Speak Out program manager, Weave senior managers, a Child, Youth and Family Case Worker, members of the Technical Advisory Group and representatives of the Community Advisory Group and then finalised and provided to the evaluation funder and AH&MRC for final approval.

The evaluation findings are organised to align with the evaluation questions, with each section including accompanying recommendations. While most recommendations are specifically for the Speak Out program, some recommendations (or parts of recommendations) are directed more broadly to Weave and external stakeholders recognising their role in enabling Speak Out to continually evolve and improve. We have noted clearly where recommendations are made that fall outside of the Speak Out program.

4.4 Evaluation Limitations

As with all evaluations, this Evaluation has some limitations. This includes the limited number of interviews conducted with clients (n=16) and significant others (n=2).

We used two different modes of sampling of clients (see above) to maximise the likelihood that clients recruited represented a range of experiences with Speak Out. [The first 14 clients were recruited via random sampling, and then an additional 2 were recruited via purposive sampling.] Despite this, it is **likely that the client sample was biased in some ways**. The clients that were able to be contacted, consented and take part in the interview may reflect those for whom the model was a good fit, had good experiences or outcomes with the program and/or may reflect those who are currently doing fairly well in life and comfortable to look back over their engagement in previous years. However, multiple clients did identify some areas of potential improvement for Speak Out, including some experiences that were

less positive with the program, suggesting that we were at least somewhat successful in collecting data from at least some clients with a less positive experience. Although we offered flexibility in interview times and mode (in person or via phone) the sample may also reflect those who have more time available to participate e.g. have fewer caring responsibilities or do not have full time education or employment commitments.

In addition, our interview sample did over-represent females (56% compared to 35% in overall client cohort); and a significant number of those sampled reported first engaging with Speak Out in their early to mid-teens, compared to an average age of first engagement of 21.5 years in the overall client cohort. This may have affected how generalisable the interview findings are to the overall client cohort.

The target sample size was 20 clients, however the Speak Out team found it difficult to contact many of those selected in the random sample (only 20-30% were able to be contacted) and as expected, not all of those contacted agreed for their contact details to be passed on to the Evaluation team. Although the number of clients interviewed may appear small, for many findings there was a clear pattern of responses suggesting we were nearing saturation on some themes. When findings are based on findings from five or fewer clients, we have clearly noted that in the reporting of the results; and where possible have triangulated the findings with other sources (data collected from other stakeholders or existing program data and documentation). Given the limitations in the routinely collected program and outcomes data, and absence of a systematic client feedback mechanism (see MEL findings), this set of interviews provides important insights into client experience, client outcomes and client feedback. Interviews with clients and significant others focused primarily on individual client journey's, and thus less information was collected on the influence of the wider environment (enabling or otherwise).

As described in more detail in the findings section, there are **limitations with the existing client management system** including how data is entered, how data is summarised in existing reports, and if and how data can be exported into spreadsheet format for further analysis. This limited the extent to which existing data was able to be analysed. Some variables, for instance, were unable to be exported. Furthermore, the reliability of the data in some instances was questionable. Variables where there was a lot of missing data, or the results appeared widely inaccurate based on the existing knowledge of the Evaluation team and Weave staff of the Speak Out client cohort have not been reported. We worked closely with Weave staff, particularly the Speak Out Team Leader, to ensure that the data we have analysed and reported is as accurate as possible within the limitations of the client management system.

Our Evaluation team did not include an Aboriginal or Torres Strait Islander person and we are very cognisant of our limitations as non-Indigenous people. Although Speak Out is not a specific program for Aboriginal and Torres Strait Islander people, the majority of the client cohort identifies as part of these populations. We maximised Aboriginal ownership and control of the Evaluation through several means including:

- Seeking approval for the Evaluation from a HREC focused on Aboriginal people
- Establishing a community advisory group made up of senior Aboriginal leaders from health, community and government services and periodically seeking their input at the evaluation design (evaluation plan and detailed evaluation protocol for AH&MRC), data collection and sense-making stages of the Evaluation

- Actively seeking out Aboriginal staff and senior leaders at Weave to contribute to the design, implementation and sense-making stages of the Evaluation
- Ensuring that Aboriginal staff members at Weave would benefit from the capacity building element of the Evaluation (still underway).

Finally, the **Speak Out program is embedded within a wider range of youth and family programs and services** offered by Weave, and clients and others may often not be aware of which support they received from the Speak Out program specifically, and which related to other programs and services funded separately. We attempted to clarify at the outset of interviews that the focus of the Evaluation was on the Speak Out program specifically, but it is possible that some comments made by some stakeholders relate to other Weave programs or services (or Weave overall), rather than the Speak Out program specifically. In addition, some of the issues raised within the Evaluation may have been attributed (by participants) to Speak Out whereas they were in fact a result of broader Weave processes and systems.

5 Findings

5.1 Speak Out Program Model and Implementation

Evaluation Question 1:

What is the Speak Out Model? How is it being implemented?

How does this model align (or not) with the latest evidence on effective approaches for supporting young people experiencing both mental health and alcohol and drug use challenges?

5.1.1 Program Staffing and Resources

The Speak Out Program is funded by the **Australian Government Department of Health** via the Central and Eastern Sydney Primary Health Network (CESPHN). For the financial year 2019/2020, Weave received $600,000 from CESPHN for the Speak Out program. This **core funding** allows the Speak Out team to provide intensive casework and counselling support, and allows many of Speak Out's projects to be delivered. Funding for other Speak Out projects and events (i.e. non-casework/counselling activities) is sourced through grant and tender applications such as Youth Opportunities (NSW Department of Family and Community Services), NGO Evaluation Grant Scheme (NSW Health), WayAhead and City of Sydney grants.

The core staffing for the program consists of:

- One Program Manager (0.9 FTE), whose primary role is in leadership and management of the program. In addition, the Program Manager provides back-up case management support to the team as required
- Five part-time counsellor/case workers (3.6 FTE)
- Two part-time project workers, including one 0.8 Groups/Project Worker and one 0.4 FTE Art Project Worker

In addition, Speak Out benefits from:

- Active engagement and leadership from senior leaders within Weave
- The in-kind contribution of Youth Advocates
- Access to other Weave programs, such as Driving Change and Tutoring.

5.1.2 Program Eligibility and Entry Pathways

Speak Out works with young people **aged 12-28 years** who are experiencing challenges with both **mental health and use of alcohol and other drugs**

Young people are **not required to have a formal diagnosis** in relation to either their mental health or their drug and alcohol usage. Rather, eligibility is based on self-identified need (that is, a young person

identifying that they have challenges in relation to both mental health and use of alcohol and/or other drugs).

Unlike many other programs offered to young people (which typically end at age 24 or 25), Speak Out sees clients up to the age of 28. This extended age range was instigated following the observation that many clients who exited to adult systems did not receive adequate support, and were not able to consolidate gains made while engaged in the Speak Out Program.

Since its inception, the program has offered **multiple modalities**: individual client support work through case management and counselling; group work; and community development. These modalities continue to be the mainstay of the Speak Out program.

The client pathway into and through Speak Out is **fluid and tailored to individual need and context**. These entry pathways are believed to minimise the barriers to entry, as obtaining formal diagnoses can be logistically challenging, and disempowering and/or triggering to clients. Entry into the program is via self-referral, referral by family member or significant other, or by service providers (including other NGOs, health services, welfare services, the justice system, or justice services). Most Speak Out clients (72%) are **self-referred (57%**), or referred by a **family member/friend (15%).** The remainder are referred by a variety of other services.

5.1.3 Program Intended Outcomes

Historically, the **primary intended outcomes** of the Speak Out program have been described in funding applications and other Weave documents as:

- Reduced usage and impact on health and quality of life of alcohol or other drugs
- Improved mental health/social and emotional wellbeing

Historically, the **secondary intended outcomes** for the Speak Out program have been described as:

- Improved physical health
- Increased connection to others and community
- Increased cultural connection
- Reduced stigma associated with mental health issues and alcohol and other drug use among community members.

These historical outcomes were defined between Weave and funders; as such, the framing may reflect the priorities of funders. Regardless, it is clear that Speak Out is working on a broader range of both primary and secondary outcomes and that these historical descriptions do not capture the breadth of the work being done. As a result, a key output of this evaluation process has been evolving these outcomes into a draft theory of change for the Speak Out program, to better articulate the intended outcomes of the program, and the connections between them.

5.1.4 Core Elements of the Program Model and Practice

Over its 20+ years of existence, Speak Out has drawn on available evidence, practice wisdom, ongoing needs analyses and client and community input to drive its model and evolution. **Core elements of the program model** include:

- Delivered early and in a community setting
- Accessed as-needed (often long term or periodically)
- Trauma informed and healing-centred (see definition below and more detail in Appendix 8.3.1)
- Strengths based
- Being culturally safe
- Holistic (concurrently focussing on multiple factors in the lives of clients)
- Community and client-centred.

These core elements are informed by **multiple underlying theories and approaches to practice**, in particular:

- **Narrative therapy** - which sees people as the experts in their own lives, orients to individual's strengths and capabilities to reduce the influence of problems in their lives; and that the process of telling and 're-authoring' their story can shift meaning making (e.g. from blaming self or family for difficulties to recognising the impact of broader dynamics such as intergenerational trauma), identify internal and external resources and reauthor their story about both themselves and their options.
- The **PERMA theory of wellbeing** - which states that wellbeing consists of five measurable elements: positive emotion, engagement, relationships, meaning, and accomplishment.
- **Aboriginal cultural healing** - which recognises that Aboriginal and Torres Strait Islander people's health is built on the social, emotional, cultural, spiritual and physical wellbeing of the whole community and that healing from the current and long-term impacts of colonisation and ongoing oppression requires a holistic response, including increasing social and cultural identity and self-esteem, cultural knowledge and skills and cultural connectedness[29].

These theories and frameworks are described in more detail in Appendix 8.3.1.

The program is also informed by a diverse evidence base and overall aligns well with that evidence base. In particular, the program model and delivery align well with the current Australian guidelines[30] on working with clients experiencing both mental health and drug and alcohol challenges, including in relation to:

- Focusing on **engaging the client** in treatment

[29] *McKendrick, J. et al (2017) Aboriginal and Torres Strait Islander Healing Programs: A Literature Review*

[30] *Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016.*

- Adopting a **holistic approach**; including consideration of clients' other medical, family and social needs
- Adopting a **client-centred approach**; approaching treatment considering clients wants and expectations, including a range of treatment goals (which may not be abstinence from substance use)
- Having a **non-judgemental attitude**
- **Involving clients and carers in treatment** (where consent is given, and possible and appropriate) and;
- **Collaboration** with other healthcare providers and ensuring **continuity of care**

Alignment of Speak Out with the evidence base is described in more detail in Appendix 8.3.3.

5.1.5 Program Implementation

5.1.5.1 Speak Out Activities

During the period 2015-2020, the core activities of the Speak Out program continued to be:

- Provision of case work
- Provision of counselling
- Co-design and co-delivery of projects, groups and events with Speak Out clients.

Core support, received by all Speak Out clients, consists of individualised therapeutic casework (that is, support to address individual practical, social or emotional needs) and/or counselling support.

Project work and group work is a critical component of Speak Out. The work is **diverse** and covers a large proportion of the service continuum including early intervention work, crisis work, long-term and short-term support. The focus of this work is co-designed and co-delivered with young people, and informed by ongoing community consultation and dialogue.

In recent years, Speak Out has offered a **wide range of groups**, including:

- **Physical activity** groups, such as the Park Warrior Men and Boy's Fitness Program
- **Social and educational groups**, including cooking and nutrition
- **Therapeutic groups**, including art therapy and SMART recovery
- **Population-specific groups**, including men's group and women's group.

The **Youth Advocates Leadership Program** is supported by the Projects staff and is a unique offering. The Youth Advocates Leadership Program brings together young people to participate in the design and implementation of youth-led projects, have a voice regarding issues they feel passionate about, and give them the opportunity to lead change in their communities.

Speak Out also hosts several **events** each year. These events aim to both develop the skills and confidence of the young people co-designing and co-delivering them, and to increase community awareness of the issues that matter to young people. As such, the events have frequently focused on increasing awareness of mental health, including both the negative impact of poor mental health on young people and

celebrating the creativity and resilience of young people experiencing mental health concerns (e.g. MAD Pride).

These groups, projects and events are designed to **complement** counselling and casework. They create a space for young people to choose the nature of their engagement and work on whatever aspects of their life they are ready to. Clients can work intensively on the mental health and alcohol and/or other drug challenges they face whilst also building new friendships and/or skills; they can focus on stabilising key practical aspects of life (such as housing and income) while they build trust and readiness to work on 'internal outcomes' (such as self-identity and healing from trauma).

The Speak Out program model has **evolved over time** in consultation with stakeholders, clients and community, with the Park Warrior Health and Wellbeing Group and the Youth Advocate Leadership Program the most recent additions.

Speak Out is also **embedded within the wider Weave 'ecosystem'** of complementary programs and services, enabling provision of 'wrap around' services in a supportive and non-stigmatising environment.

Based on the data available in the DEREK client management system, during the period 1 January 2015 - 31 December 2020, the Speak Out program's counselling and case work staff:

- Saw 316 unique clients; with 65-90 clients participating in the program each year[31].
- Provided 674 episodes (blocks) of care[32], with a median number of 43 new episodes of care commencing each year.

Of those clients seeing casework and counselling staff:

- 70% of clients accessed support and case management only, and
- 27% of clients accessed counselling[33] *(likely to be an underestimate; see footnote)*.

In the same period, project staff:

- Designed and facilitated 1206 group sessions for over 20 different types of groups (including: cooking and nutrition; art therapy; SMART recovery; men's group, women's group)
- Co-designed and co-delivered 35 events with young people, with an average of 6-7 events held each year.

[31] *Some of the variation in annual numbers of clients supported by the program reflects capacity - in particular, the reduction in capacity that occurs in the period between a caseworker resigning and a new caseworker being appointed.*

[32] *An episode of care includes all the services a client received from the time of intake to the time of exit (i.e. multiple occasions of service are included within one episode of care). The same client may have multiple episodes of care if they re-enter the program e.g. if an individual was a Speak Out client in 2016 (first episode of care) and then returned in 2018 (which would be considered their second episode of care). Clients may also have multiple open episodes of care at the one time if they are enrolled in different programs at Weave.*

[33] *Speak Out staff strongly believe that the percentage of clients recorded as having accessed counselling is an underestimate and reflects historical variations in how counselling data has been captured.*

5.1.6 Client Demographics and Life Circumstances

The majority of the 316 Speak Out clients seen in the period 1 January 2015 - 31 December 2020 were male, born in Australia, spoke English as their first language and were aged 18-28 years. Two thirds identified as Aboriginal and/or Torres Strait Islanders.

Table 1: Speak Out Client Demographics (sourced from DEREK client management system)

Variable	
Male	61%
Born in Australia	97%
English as preferred language	98%
Identify as Aboriginal and/or Torres Strait Islander	65%
Average age of first engagement	21.5 years

From the available data, at the outset of an episode of care most Speak Out clients are unemployed and receiving government benefits; 19% are engaged in study (Table 2). One quarter are engaged with the criminal justice system. Just 9% reported definitely having enough money to meet daily needs.

Table 2: Speak Out Client Life Circumstances (sourced from DEREK client management system)

At commencement of an episode of care*	
Unemployed	65%
Receiving government benefits[34]	61%
Engaged in study	19%
Involved with the criminal justice system	25%

**Note only 52% of the 674 episodes of care had this information completed*

Assessment conducted at the commencement of an episode of care found that **mental health and quality of life** were generally poor. From the available data from intake assessments (see Appendix 8.4.2 for more detail on this data):

- The median score on the Kessler Psychological Distress Scale (more commonly referred to as the K10) was 24, indicating a high level of psychological distress

[34] *One of the important roles performed by the Speak Out team is getting people onto benefits that they are eligible for. As a result, around 90% of established Speak Out clients are estimated by the Speak Out team to be receiving benefits, representing a significant increase during their engagement with Speak Out.*

- In relation to quality of life, over 40% were either dissatisfied or very dissatisfied with their quality of life and 33% were neither satisfied or dissatisfied.

In relation to use of alcohol and other drugs:

- The primary drugs of concern were cannabis (reported by 30% of Speak Out clients) and alcohol (27% of clients). Other key drugs of concern identified by clients were amphetamines (9% of clients) and heroin (3% of clients)
- The median score on the severity of dependence scale at intake was over four for each of those substances, indicating dependence

Other presenting needs included:

- Homelessness, or being in need of assistance in relation to housing or accommodation (40%)
- Employment (31%).

5.1.7 Strengths of and challenges for the Speak Out program

Addressing population need: Strengths

Population need. Young people, Weave staff (including Speak Out staff) and external stakeholders are in agreement that Speak Out works with a sizeable and underserved population in Sydney.

"Speak Out services a client group that doesn't always get serviced elsewhere. Dual diagnosis is not often dealt with very well. It's a challenge if you are a mental health clinician and you are trying to treat or diagnose mental health, it's challenging for AOD services. Those services tend to treat young people as being in the too hard basket, they ask people to detox or get off the gear, there is too much passing people off between one or the other."

External partner agency

Addressing population need: Challenges

There is a significant **gap between population need and the funded capacity** of the Speak Out program. The Speak Out program has an extremely modest budget in comparison to the number of clients it aims to serve, their needs and the holistic nature of the service model.

There is greater **demand** for the program than there are places available for clients. At present, Speak Out has the capacity to see a maximum of 90 clients per year, based on current funding and staffing levels. There is currently a waiting list of 12 young people (equivalent to at least one full-time caseworker's caseload) seeking to access the program. Anecdotal reports indicate that there is far greater demand than the waiting list reflects.

"Weave won't turn it's back on people...Like if there's a waiting list, like, you'll be told there's a waiting list, this is how long it's going to be, we'll keep you updated, like, and if you need any help in the meantime, then obviously come in and we will find someone to talk to you on that day. Like, it's not like you can't hang out, you can't come before we can find you a proper case worker or counsellor."

Larissa, Youth Advocate*

"We get mixed messages about caseload - only take on as many as you can, look after yourself AND there are so many on the waitlist...there's a tension between long-term care, quality care and the urgency of the needs of young people on the waiting list. Sometimes it means we are stretched beyond capacity….That means that things get missed, like casenotes and recording in files, preparation. I worry it will affect the quality of our work."

Speak Out staff focus group

In addition, current clients would welcome Speak Out **expanding its offerings**. Many of the ideas for improvement - particularly as identified by Speak Out clients - related to expanding group programs and activities. Suggestions included: ongoing men's and women's groups; strengthening cultural activities, including hosting the back to country camp that was postponed due to COVID.

At the same time, the budget is under pressure from factors such as Award-mandated increases to salaries and wages. Providing annual increases is an important consideration in staff retention and staff feeling like their efforts are recognised and valued, but can be challenging in the context of limited funding.

The Speak Out Model: key strengths

The model **brings together individual case work, counselling, group work and community-development and creative expression project work**. This means that Speak Out can concurrently offer young people the opportunity to work on a diverse range of internal outcomes, life stability, interpersonal relationships/social wellbeing, resilience, creative expression and leadership. This holistic approach is welcomed by the young people and is supported by the literature.

"Weave offered variety, it was not just about mental health shit, it was WELCOMING."

Steven*, Speak Out client

Case management, counselling and group work are **holistic and include an integrated response** to mental health and drug and alcohol. Several interviewees reflected on how different and valuable this model is, compared to other services available to this population.

"Not a lot of places will treat you if, you know, you're a drug user with mental health problems. They are like, lost cause one like that, you know."

Larissa*, Youth Advocate

"Speak Out responds to what I see the needs of young people to be, they need someone to understand them in all their potential complexity, and not only focus on drug and alcohol use, or mental health."

External partner agency

Service delivery is **client-centred and holistic**. It responds to whichever issues the young person identifies as the presenting need, whether they relate 'directly' to mental health or alcohol and other drug use. Speak Out works with young people to set goals that matter to them personally, including goals that relate to life stability, as well as their relationships with family, friends and community. This means that young people are able to work on their own goals in relation to alcohol and other drugs, regardless of whether that goal is harm reduction or abstinence.

"There's a lot of programs out there that just play the game, they tick the box but a program like Speak Out, there's no judgment, they work with you holistically, it goes beyond the initial pain points."

Senior Weave leader

Flexibility, including 'drop-in' capacity and follow up for missed appointments. Support is delivered flexible and tailored to both individual preferences (e.g. meeting on-site at Weave vs meeting off-site) and individual circumstances (e.g. recognising that young people may be less consistent in attendance for appointments during periods of high stress). While there is not necessarily a focus on 'drop-in' appointments for case work and counselling, young people are actively encouraged to drop into the Weave building and do so frequently. There is capacity across the team to support each other's clients with incidental support needs if their worker is unavailable; the Program Manager also plays a role in opportunistic support and casework if required.

"Trauma heals in the context of stable, safe relationships. We need to be consistent with contact every week. We notice when they aren't showing up. There's lots of nurturing, touching base."

Speak Out staff

Access to hospital and support post discharge. Because of the high level of trust between caseworker/counsellors and clients, Speak Out is often well-placed to support young people to access mainstream health services in moments of crisis (especially related to mental health and/or self harming) and to then also provide support immediately following discharge from hospital.

"...the level of support that this program provides to young people who are suicidal, at risk of suicide, or just been discharged from that hospitalisations because of suicide. ...we're really doing a lot of that work. And I often [worry], a lot of people don't have [the kind of] support and follow up and care [that we provide our clients]....this program is really unique, because I think we do really good advocacy to get people into hospital when they need it the most. But we also do follow up care, which the hospital doesn't do, the system doesn't do."

Senior Weave leader

Group work and project work (events, community development, Youth Advocacy) are innately beneficial for young people in that they can work (directly or indirectly) on relationship building and networking, self-knowledge, creativity, and self-expression; skills development; growth and leadership; and can provide additional AOD and mental health support.

At the same time, they can also provide a soft entry point into counselling and case work.

"The art group was a huge source of enjoyment, the creative outlet was very valuable to me personally, and it was interesting to see the diversity in how other people were managing their mental health."

Mahlee*, Speak Out client

"It really helped to be in a group, we would influence each other, there would be less shame,

we'd have less shame to speak more. When we were younger and being spoken to one on one there was sort of a bit more pressure and we'd be a bit more closed in expressing our answers just alone. But in the group, we had a group of us around, we all relate to each other. It's less pressure, it's a more comfortable environment, we were just being peers amongst ourselves."

Adam*, Speak Out client

The Youth Advocates report that they have experienced many benefits from participating in this initiative. Youth Advocates who participated in this Evaluation identified several benefits that they had experienced from their involvement, including fostering hope and a bigger vision about their own life and potential; developing advocacy and leadership skills; creating opportunities for paid employment, including as speakers and trainers for other services and sector events; developing new networks within the community and community organisations; and being recognised as a role model within their own communities.

"I've never, I've never felt more comfortable, welcomed, listened to than being in this program. They value our voice and they value our opinion. They let us plan this whole thing, basically by ourselves with their guidance and connections, but we made this happen. We came up with the idea….Through the Youth Advocacy program, I've been able to do a forum for the Mental Health Association….and we do the podcast! People come into Weave and they say "I heard you speak at the Youth Action meetings".

Megan*, Youth Advocate

"Yeah. So I've been doing Youth Advocates for three years now. I have been suffering with mental health problems since I was 14, I was diagnosed with depression, anxiety at 13, and a mood disorder halfway through last year. I've been here for three years, I ended up getting sober because I was like, I love what I'm doing. I love this. Amazing, like I feel useful. And that feeling useful helped me get sober. I want to be able to help people….And now...our resumes are just stacked full because of the amazing opportunities that they created for us through being a Youth Advocate."

Larissa*, Youth Advocate

"... we [young people] want to be heard, we want to be respected, we want to have a platform to actually be listened to. And that's kind of what the Youth Advocate [role] gives us, it gives us a place, a time and the respect to give our point of view and our stance on things. I think it's really, really important. Because, yeah, young people are kind of outraged with how the world's functioning."

Larissa*, Youth Advocate

The model has been highly effective in engaging and retaining **Aboriginal and Torres Strait Islander** young people in case work/counselling, group work and community development. Aboriginal and Torres Strait Islander clients reported feeling safe, welcome and included, and that their culture was respected and valued within Speak Out and Weave.

"I think for me, being Indigenous and seeing a lot of Indigenous people coming in and out of the service group, one thing was that cultural safety that people talk about. All those sorts of little things around Weave means you just naturally feel comfortable there."

Alinta*, Speak Out client

"It doesn't make a difference to me that Weave isn't Aboriginal...I feel more comfortable at Weave than I do at AES and AMS, I guess it's because I'm not from here, from this country."

Kirra*, Speak Out client

The **long-term nature of the work** allows clients to work at their own pace, to perhaps work on a pressing issue (often related to life stability) and then move onto deeper work on internal outcomes (often related to long-term trauma, including intergenerational trauma). This is in contrast to alternate models, which offer a limited number of sessions in total or a limited number of sessions per year.

"I was connected to another temporary [time-limited] counselling service... and that helped a bit, but I still needed more help."

Mahlee*, Speak Out client

The model allows Speak Out to continue to support young people into **early adulthood (i.e. to age 28)**. This is widely recognised as filling a key gap in working with young people with complex needs and was raised by clients, significant others, Speak Out staff and Weave senior leaders.

"Those three years are so significant - it is an opportunity for integration, it's a time when they might be brave enough to look at their issues, to look at their trauma, it allows the space to approach trauma."

Speak Out staff focus group

The Speak Out Model: key challenges

Eligibility to age 28 years. There was widespread concern about the upper limit of eligibility for the program being 28 years of age. Several Speak Out clients and staff commented on the adverse impact of 'ageing out' of the program, and suggested that it would be beneficial to have a more flexible age limit for exiting the program.

The rationale for a more flexible age limit included the potential to further consolidate life stability and internal outcomes, the limitations of the 'adult' system (that is, more reliant on self-navigation, more singular as opposed to holistic, and less tailored to the needs of young people, in contrast to the youth or paediatric systems) and the risk of traumatising young people through loss of their support system (particularly for those young people who have accessed a broad range of both professional and social supports via Weave). Some clients also commented that they felt that Speak Out could improve its approach to transitioning clients out when they reach the upper age limit.

" I didn't like how they moved me on when I turned 28, I was really shattered."

Elizabeth*, former client

Mental health support. Speak Out staff and senior Weave leaders queried whether the current model provides the level of mental health support required by young people. This issue was on their minds owing to the often limited or sub-optimal engagement that Speak Out clients have with the mainstream mental health system. One of the complexities for Speak Out is that the current staffing mix consists of

people employed in a dual case management/counselling function. It would appear that for some clients and for some staff this is the ideal combination, allowing them to move between practical life support and therapeutic work in the moment and as client needs evolve. For other clients, however, there is a gap in access to long term counselling that is trauma informed.

"With my case worker - she was really nice, she wanted to help me out with my life and my depression. We just used to sit down and talk about my depression and my childhood, I used to get bashed when I was younger, that was like the worst times in my life, I used to sit and just cry with her….I never got around to doing like a therapist or anything…"

Sean*, Speak Out client

"We have nowhere to refer them on to [for deep counselling], that is my worry, we train ourselves in the deep stuff."

Speak Out staff focus group

"One of the things we would want is...access to a psychiatrist. See, even if we had access once a fortnight to a psychiatrist through Medicare or headspace, that would be a game changer."

Weave senior leader

At present, the Speak Out team is piloting one new approach to this issue, which is to substantially reduce one counsellor/case worker's caseload so that they can be more available to do deeper therapeutic work with several Speak Out clients. Speak Out will monitor the impact of this initiative.

Tailoring for **cognitive capabilities and developmental differences**. The Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition) recommend that interventions be tailored to address different cognitive capabilities and developmental differences. Each client is worked with in a manner that is highly specific to that client. There does not appear to be a tailored approach to working with young people based on cognitive capabilities and/or developmental differences. It may be that there are sub-groups of young people with more distinct needs - such as those aged 15 and under and those with severe persistent mental illness - who may require a more targeted approach.

Speak Out Implementation and Practice: key strengths

The **depth and breadth of the skills of the Speak Out team** was often cited as one of the key strengths of the Speak Out program. This is consistent with research that suggests that the therapeutic relationship is responsible for some 30% of the overall impact (compared to 15% attributed to the specific therapeutic approach).

Speak Out clients spoke at length about staff skills in engaging them, in creating a sense of safety, in supporting them to 'do the work' at their own pace, and in expanding both their self-knowledge and their thoughts about options for the future. Likewise, the project staff were highly regarded for their ability to co-design and co-deliver with young people.

"they hire people that they know will be a good fit, people who really understand it, you know, really care for young people, care for the community... just make everyone feel really welcome"

Larissa*, Youth Advocate

One particularly important aspect of that was the ability of the Speak Out staff to create a **trusting relationship** in which the young person felt safe to be open and to address both life stability and inner outcomes. This includes creating relationships which are safe and non-judgemental. The importance of a non-judgemental attitude is one of the key elements highlighted in the Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition).

"Weave is better [than the service that I saw] because they engage a bit more and they are more trusting, I trust them more. They have lived the way that we live, they have been involved in the community for a while."

David*, Speak Out client

"It took me two years to even open up to [Speak Out worker], I would just tell her stuff that I thought she wanted to hear. She would say "I know that there's other stuff, you don't have to [hold back]."

Kirra*, Speak Out client

"I think the most important thing of all was that when they walk into Weave there are no questions asked, you don't feel guilty for what you are doing when you walk into Weave, they don't make you feel guilty, it's non-judgemental, that's how [worker] always made it, even if you had criminal issues, mental health issues, you were a domestic violence situation there was always someone there to help, with expertise to help, with housing, with mental health, with physical health."

Jedda*, Significant Other

"...I think the model of SpeakOut, of being able to have that case management sit alongside and counselling, you build trust quite quickly in getting wins on the board through casework – like getting someone their birth certificate, getting them on Centrelink. Like they can actually see stuff getting done for them, which might be the first time in a long time that they have felt someone has helped them get stuff done for them, and not had to have jumped through so many hoops. And then I think that creates an opportunity to connect them with counselling, drug and alcohol counselling, getting a psychiatric assessment, working out, you know, is rehab or detox something that they need to do."

Senior Weave leader

"There are other models of funding out there that are about fee for service...which doesn't allow you to give someone an individual staff member. Grant funding means that we can give someone a proper, reliable salary [and in return] we get the right people, our people are the tools of the trade, without our staff we are nothing."

Senior Weave leader

Likewise, Speak Out has a strong emphasis on engaging the client in treatment. This is consistent with the recommendations of the Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). Engagement is flexible and consistent, and achieved via a variety of means including weekly check-ins via phone calls, SMSs, scheduled appointments and chatting to young people when they visit Weave.

"The counsellors checking in is something valuable. I worry about wasting their time, but I don't believe I could have done that with the previous counsellor (at another organisation), I wouldn't have felt comfortable checking in."

Mahlee*, Speak Out client

"I thought counselling was a heap of shit but I thought I'd give it a go. I realised it was true, some of the stuff I was told. They gave me tips and strategies, ….I had counselling every week, it kept me on track, they persisted without putting me under any pressure...I got a lot out of it, the stuff I told them."

Elizabeth*, former client

Speak Out Implementation and Practice: key challenges

Confidentiality. The holistic nature of the Speak Out model can result in situations where Speak Out is either providing support to multiple members of a single family; working with both people in an intimate relationship; or working directly with a young person and at the same time engaging with their parents, carers or other family members. Some Speak Out clients interviewed expressed concern that the Speak Out staff may develop a conflict of interest around these multiple relationships, and/or a reservation that their confidentiality might be compromised.

"I've had a few issues with my caseworker, my caseworker has talked with my parents a lot and taken on my parents' opinion of me so I've been more distant from my case worker" .

Charlotte*, Speak Out client

"The worst thing about [my caseworker] was he was actually a caseworker for my ex's boyfriend, I had a feeling that there was information leaked….it felt like everything [I] said to [my caseworker] was somehow getting to [my ex-partner]. I don't know if [my caseworker] was talking to her caseworker but it felt like that."

Sean*, Speak Out client

Inconsistency with the level of support provided to clients. Some staff commented that long-standing former clients receive a higher level of support, including ongoing support after exiting the service, and that this can undermine role and organisational boundaries.

"If you have known us for longer, you tend to get more from the organisation….The legacy clients have a long-term relationship with Weave. It's not a hard boundary, but boundaries are important to clients, workers and organisations."

Speak Out staff focus group

"When managers step in because of past relationships with clients, you can feel scrutinised...there's pressure 'you must make everything happen for that client because of our past history'."

Speak Out staff focus group

Balancing consistency and equity with responsiveness. As is common with all programs providing intensive support to clients with complex needs, Speak Out staff reported actively grappling with finding the balance between responsiveness - that is, responding to the unique needs of the young person - with consistency and role boundaries.

"Boundaries are really important - what is available when, when it is not available, what you will do and what you won't do. It's sometimes difficult to enforce. There are exceptions to the rule because of history. It raises some hard questions around equity of access….If a young person asks for something and you can't do it, but another young person has had it from another worker, their friend has had it, it's hard but it used to be a lot worse."

Speak Out staff focus group

Rapport with case workers. As occurs in all case management programs, several Speak Out clients had had times when they did not have a rapport with the case worker allocated to them. Sometimes this had occurred when a client was first allocated a case worker, and at other times it had occurred when a case worker moved on and the client was allocated a new case worker. Most of the clients had found a way to communicate this to Speak Out or to Weave and were then allocated another case worker who was a better fit for them. However, this was identified as a key risk factor in engaging and retaining young people.

"I did have another case worker before [current case worker] but she didn't really get me like [she] does, it was only for a week or two, I only met her twice. I asked that case worker could I change, could I get another case worker, I just don't feel like I can talk to her and she changed me to [current case worker]. She was good about it."

Kirra*, Speak Out client

Continuity of care. As indicated above, transition from one case worker to another is a key risk in maintaining engagement with young people. This can be a particular challenge if the change is as a result of staff turnover. Some young people commented that they had struggled in the transition from a previous case worker to a new case worker. This was also noted as a key point of vulnerability by Weave senior leaders, who commented that there are multiple dynamics at play: that sometimes the client and new case worker do not have a rapport; sometimes the handover is poorly managed; sometimes the client has unrealistic expectations about the new case worker based on the working style of the previous case worker; and sometimes the very relational nature of the way of working poses an innate challenge to transitioning that relationship to a new case worker. Some of the challenges associated with incomplete handover (of client information) may also relate to existing limitations in the existing systems to capture client data (see later section on strengthening MEL)

Aboriginal workforce

Employment of Aboriginal and Torres Strait Islander staff within Speak Out has fluctuated over the 5 year period covered by this Evaluation: at present, Speak Out does not have any Aboriginal or Torres Strait Islander staff member; however, there have been Aboriginal or Torres Strait Islander staff members in recent years, and Speak Out will shortly have an Aboriginal student on placement in the team. Around two-thirds of Speak Out clients are Aboriginal and/or Torres Strait Islander, and so it is important to continue to prioritise employment of Aboriginal staff in the team. Weave is currently investing heavily in this area, through the development of the Aboriginal Healing Framework, and substantial investment in a whole of organisation approach to implementation of that Framework. The Speak Out program will benefit significantly from this program of work.

"We need Aboriginal staff in those programs to navigate the interface with Aboriginal communities. Aboriginal staff bring cultural intelligence, they act as cultural brokers, they sit between Weave as a service provider and the community. We need to recruit Aboriginal staff into Speak Out."

Weave Senior Leader

Aboriginal cultural governance. Speak Out is highly successful in engaging Aboriginal young people and has long-standing and deep connections with Aboriginal families and Aboriginal community organisations in the local area. The Evaluation has also highlighted areas where this work could be strengthened, in particular in relation to Aboriginal staff and Aboriginal community decision making. At present, Aboriginal and Torres Strait Islander communities and organisations are actively consulted on new directions and strategic priorities. However, formal mechanisms for embedding decision making by Aboriginal and Torres Strait Islander people into the organisation need to be further strengthened. At present, almost half the Weave Board of Directors are Aboriginal, and there is one Aboriginal staff member in the Weave Senior Leadership Team (with 'dotted line' oversight of Speak Out). At the same time, many of the relationships appear reliant on a small number of long-standing Weave leaders, creating vulnerability should those leaders move on.

This is an area that Weave has been actively working on during the period that this Evaluation has been conducted. Activities underway include: the development of the *Aboriginal Healing Framework,* which identifies the elements that need to be in place to enable healing-centred practice; funding for implementation of that Framework, including two dedicated staff positions; and embedding new HR and governance practices through the Framework, such as the inclusion of an Aboriginal staff member on all recruitment panels.

Collaboration with other services.

Similarly, Speak Out has long standing relationships with many local service providers. Reports from young people suggest that Speak Out staff are highly effective in utilising and creating referral pathways, and in advocating for their clients' access to services and supports (such as housing). This is often built on.

Those strengths notwithstanding, some participants commented that collaboration is often built on individual relationships between staff members in each organisation and there are areas where Speak out could strengthen its more formal partnerships.

"They do work collaboratively, recognising that these clients have quite complex needs….Recently [their approach to collaboration has been] not so much - when people move on - so many of the relationships are very much individual, personal relationships. Does take time and effort to make sure that they know you are around etc."

External service provider

"Since he has been connected with Weave, other agencies in the area have worked in with it."

Jedda*, Significant other

5.1.8 Recommendations for Speak Out Model and practice

Recommendation 1:

Maintain the existing model and existing approach to implementation

This Evaluation has identified the strengths of the Speak Out model and has also identified aspects of the model and its implementation that would benefit from further refinement and/or development. Specific elements emerging from this Evaluation that should be actioned include:

a. Maintain the existing core elements of the Program

The current Speak Out model is strongly supported by Speak Out clients and is consistent with Australian and international literature, and with National Guidelines for the management of co-existing mental health and drug and alcohol challenges. The model is also strongly endorsed by Speak Out staff, Weave senior leaders and external stakeholders.

We recommend that Speak Out continue to maintain core elements of the Program, including:

- Integrated (across mental health and drug and alcohol) care
- Holistic support (responding to the young person as whole, and their full range of needs, rather than only addressing those issues considered 'directly related' to mental health or drug and alcohol)
- The focus on engaging young people
- Client-centred approach
- Non-judgemental approach
- Flexibility in timing and location of care
- Involving clients and, where appropriate, family and carers

We further recommend that Speak Out continue to strengthen the following core elements of the program:

- Working collaboratively with other providers
- Working collaboratively with the community, including the local Aboriginal community

b. Maintain the strengths of current practice

At present, the Speak Out model is well implemented, with practice consistent with the overriding philosophy of the model and fidelity across the various domains of the model. We recommend that the current strengths of Speak Out practice should be maintained, with a focus on continuing to recruit highly skilled staff members and provide policies, protocols and tools that enable them to work effectively with young people with mental health and drug and alcohol challenges.

c. Strengthening collaboration with other services

We recommend that the Speak Out team identify their critical local collaborators (including health, welfare, Aboriginal community-controlled, housing, legal and other services) and develop a strategy to strengthen those relationships over the course of the coming year.

Recommendation 2:
Identify opportunities to increase the capacity of the Speak Out program

a. Expand Speak Out through securing increased resources

It was widely agreed that young people affected by co-existing mental health and drug and alcohol challenges are significantly underserviced and that demand for Speak Out significantly exceeds capacity. We recommend that Weave continue to work with potential funders across government (State, Federal, local, and Local Health Districts) and philanthropy to secure increased investment in the program, with the aim being to secure 2 additional full-time full-time generalist case worker/counsellor positions and one case worker specialising in working with young people under the age of 15. (See also Recommendation 5b regarding the specific needs of young people aged 12-15.)

Recommendation 3:
Increase access to counselling and clinical mental health support

a. Increase access to counselling and clinical mental health support through increased counselling capacity within the Speak Out team

We recommend that Speak Out identify opportunities to increase counselling and access to mental health support for young people.

A priority is securing additional resources specifically for the purposes of increasing counselling capacity. Findings from this Evaluation suggest that even a modest increase in full-time staff such as two additional casework/counsellor positions would better align Speak Out's capacity with existing population need.

An alternative to securing additional resources would be for Speak Out to reorganise existing resources and convert one of the existing casework/counselling roles to perform a dedicated counselling function. This is currently being trialled by Speak Out now in light of the gap between demand and capacity. We are, however, reluctant to recommend this as an ongoing solution as reallocation of casework resources to counselling would simply solve the resourcing gap in counselling by widening the existing gap in resources in casework. This would obviously be a poor outcome.

b. Increase access to counselling and clinical mental health support through partnerships with other providers

We also recommend that Speak Out explore a partnership agreement with other organisations (in particular South Eastern Sydney Local Health District and Sydney Local Health District) and/or private clinicians operating in the area to provide mental health services that complement the services provided by Speak Out. This could include but not be limited to psychiatric outreach, as Weave is obviously considered a safe place for young people to access mental health support; and existing public and private options are not entirely accessible (due to a combination of models of care, financial barriers and perception and/or reality around not being culturally safe). Such an arrangement could operate in a model akin to the existing Drug and Alcohol counselling currently offered as an outreach service from Sydney Local Health District .

In making this recommendation we note that Weave has had varying success with this model in the past. The provision of Drug and Alcohol counselling via a Sydney Local Health District Clinical Nurse Consultant working out of Weave offices has been a great success. However, Weave has had less successful experiences of mental health outreach in the past in partnering with some services, owing to differences in purpose and approach.

As such, any future arrangement should include negotiation at the outset and throughout the formal relationship to ensure alignment with values and ways of working, including a commitment to integrated care, a commitment to a strengths-based approach and a deep commitment to and knowledge of culturally safe practice with Aboriginal and Torres Strait Islander young people.

Recommendation 4:

Advocate for an increased emphasis on holistic responses to young people affected by mental health and drug and alcohol across NSW

a. Expand access to holistic, integrated support for young people affected by mental health and drug and alcohol challenges

In addition to scaling up Speak Out itself, there is also a need to disseminate the learnings from this Evaluation about the effectiveness of the Speak Out model, and to advocate for the provision of holistic integrated support for young people affected by mental health and drug and alcohol challenges across NSW. We recommend that Speak Out and Weave consider how to take up a strategic advocacy role to promote this way of working with young people. Options to consider could include: convening a Policy and Programs Roundtable to launch this report; collaboration with Just Reinvest (given the contribution Speak Out makes to supporting young people in the court system and the promising signs that support from a Speak Out case worker may reduce the risk of incarceration); and consideration of commissioning an economic analysis of the cost savings associated with the Speak Out model.

Recommendation 5:

Continue to refine and develop the Speak Out model, including specific tailoring for age groups and needs of clients

a. Review the upper age limit

We recommend that Speak Out review its current approach to eligibility being limited to those aged 28 and under. There are distinct advantages to raising this upper limit, though this would also impact Speak Out's capacity to accept new referrals. In light of that, it is recommended that Speak Out have a more flexible approach to when a client exits. This should be underpinned by a protocol that spells out the Speak Out position on: the criteria for extending a client's time in the program; whether some clients would continue to get individual casework and/or counselling, while others might retain access to group programs; and how transition to other community-based services might occur in the future. This would then need to be negotiated with the CESPHN (as current funder) and potential future funders.

b. Review whether there is a need to modify the approach based on developmental stage and other population characteristics

At present, the offering to Speak Out clients is both universal and highly individualised. This may represent a missed opportunity for a more tailored approach to the needs of specific sub-groups of young people, in particular people aged 15 and under, young people with severe mental illness, and young people with cognitive impairment. Such a tailored approach is currently supported in the Australian National Guidelines, which highlight the evidence-base for and benefits of tailoring models to specifically address the developmental and cognitive needs of the client population. We recommend that the Speak Out staff examine the risks and benefits of such a tailored approach, and if supported, identify how the approach might need to be modified. (See also Recommendation 2a regarding increased staff capacity for working with young people aged 12-15.)

Recommendation 6:

Continue to refine and develop the Speak Out practice and protocols, particularly around confidentiality, boundaries and consistency and transition processes

a. Review confidentiality protocols and how young people are informed about confidentiality protocols

We recommend that the Speak Out team review their existing protocols for managing and communicating about confidentiality, particularly as it relates to: having two or more members of a family as clients concurrently; working with both partners in a couple; and communicating with parents, carers and family members about a client's situation and needs. Interviews suggested that a small number of young people had concerns about whether Speak Out had sufficient privacy protections in place, although it may be that they were alert to the risk of privacy being compromised and unaware of the privacy protections that were in place. Regardless, this finding highlights the need to actively manage and regularly communicate with clients around confidentiality processes in place.

b. Undertake a reflective practice process to address boundaries and consistency

This Evaluation has identified some potential issues with variations in the level and nature of support provided to clients (particularly long-standing clients), and some potential challenges in relation to maintaining boundaries around what is offered to clients. We recommend that the Speak Out team convene a staff workshop to further map out where there may be inconsistencies and agree on an approach moving forward.

c. Review key points of transition and identify areas that could be strengthened

Some moments mark a key point of transition - such as the first time a young person is allocated to a case worker after being assessed, and when a young person is allocated a new caseworker (either due to staff turn over or their own request). These are times when the young person may struggle to remain engaged and active if they do not have a good rapport with the case worker. We recommend that Speak Out ensure that there is a protocol for both the new case worker and another person checking in with the client to ensure that the allocated worker is a good fit for them. Developing systematic client feedback

mechanisms (see recommendation 11b) may also provide another means of monitoring transition success or otherwise at periodic time points across the Speak Out client cohort.

Recommendation 7:
Working with young Aboriginal and Torres Strait Islander people, communities and organisations

a. Continue to maintain a welcoming environment

There are several factors that make Speak Out a welcoming and culturally safe environment for Aboriginal and Torres Strait Islander young people. This includes the values, skills and knowledge of the staff, the welcoming and inclusive environment that is created within the Weave office, the deep value and respect Weave has for Indigenous ways of knowing, doing and being, and the long history of collaboration and trust between Weave and the local Aboriginal community. Together, these factors have enabled Speak Out to be highly successful in engaging young Aboriginal and Torres Strait Islander people, and should continue to be strengthened and valued. We recommend that Speak Out maintain and continue to strengthen this approach.

b. Access to an Aboriginal or Torres Strait Islander cultural mentor or consultant

The Speak Out program is highly successful in engaging and working with Aboriginal and Torres Strait Islander young people. Part of this success is predicated on the skills and knowledge of the Speak Out staff. We recommend that Speak Out enhance this with more formal arrangements for staff to receive support and advice from external Aboriginal or Torres Strait Islander cultural mentors or consultants, to both ensure that the program remains proactive in providing culturally safe and responsive support, and to provide an opportunity for staff to address any emerging challenges. We note that this will be progressed via implementation of the *Aboriginal Cultural Healing Framework*.

c. Aboriginal and Torres Strait Islander workforce

Aboriginal and Torres Strait Islander staff can play a critical role in informing culturally appropriate care; and providing young people with the option of being supported by an Indigenous person. At the time of writing, Speak Out did not have any Aboriginal or Torres Strait Islander staff. We recommend that Speak Out consider allocating one of the positions within the Speak Out team as a designated position for an Aboriginal or Torres Strait Islander person. The advantage of having a dedicated position would be that an Aboriginal or Torres Strait Islander case worker/counsellor is available for those Indigenous clients who strongly prefer an Indigenous staff member. However if a dedicated position is created, care must be taken to ensure that there is not over reliance on the one staff member to be responsible for all issues related to Aboriginal and Torres Strait peoples (clients, cultural insight, wider organisational processes etc). A dedicated position should be seen as one part of a larger response to involve Aboriginal and Torres Strait Islander knowledge and values within the Speak Out program.

d. Community engagement and partnerships

Weave has long standing and deep relationships with the local Aboriginal community and many local Aboriginal community organisations. At present, Aboriginal and Torres Strait Islander communities and organisations are actively consulted on new directions and strategic priorities. We recommend that Weave explore options to strengthen the role of Aboriginal community and organisations in making decisions and further shaping program and service development.

5.2 Speak Out Outcomes

Evaluation Questions 2 & 3:

What outcomes do clients, their families and communities and Speak Out staff want from the Speak Out program?

How and in what ways have participants' lives changed since their first engagement with Speak Out?

5.2.1 Intended Outcomes

This section of the Evaluation findings focuses on the intended and actual outcomes of the Speak Out program. By outcomes, we are **referring to changes in client's lives linked in some way to their involvement in Speak Out**; these changes could be positive or negative, and intended or unintended.

The findings from these two evaluation questions are reported together in this section as they are interlinked, but also as **limited information was available for analysis against the first question of intended outcomes** at the outset of clients' involvement in Speak Out. Although Speak Out clients do go through a process of goal setting and iterative review with their case worker and/or counsellor, this data on client goals is not available in the routine program data extractions from the DEREK client management system. We did include a question in client interview guides regarding their recollections of what they wanted to get out of the Speak Out program when they first joined, but due to limited time for interview this question was not asked of all clients, nor directly asked of all stakeholders interviewed.

Among the eight clients asked about **what they recall wanting out of the Speak Out program** when they first joined, there were **a variety of responses.** Two clients referred to wanting assistance with housing; one client referred to support for their mental health and two clients referred to internal outcomes around better awareness and regulation of their feelings and behaviours. One client couldn't remember what they wanted out of the program, and two clients said they had no expectations at the start

"Well, in the beginning it was kind of an agreement with court [to get counselling] so I didn't have much of a choice. ..it was more so for me to kind of identify what the issue was and how I came to that point in my life. ... It was also just kind of evaluating my own behaviors and having someone who was professional, I guess, to help me through that."

Colin*, Speak Out client

"I was a lost kid, I didn't want anything, I was trying to tread water to stay alive."

Patricia*, Speak Out client

Speak Out staff reflected that **clients coming into Speak Out had diverse needs,** and that the program was designed to help clients identify and address their own needs in a holistic and flexible manner rather than requiring them to 'fit' into a predetermined service or pathway.

"I think often our service models are predicated on young people walking up and saying, I really want to join a young men's group for young men like men who go through bla bla bla bla bla, rather than holding the space for that to kind of come to the surface."

Interview with Senior Weave Leader

5.2.1.1 Draft Theory of Change

We used the information gathered during the evaluation process to compile a **draft theory of change for the Speak Out program** (see Appendix 8.2) to articulate the intended outcomes of the Speak Out program, and the connections between them.

The theory of change is intentionally organised into two parts; the lower half focuses on **short and medium term outcomes** and the upper half focuses on the **longer term outcome and overall goal** for the Speak Out program.

Draft Goal for Speak Out Program:
Speak Out clients have increased resilience, and more control over and satisfaction with their own lives

The goal and outcome statements, and the connections between them drew largely on the information gathered from Speak Out staff and Weave leaders, as well as what clients and their significant others described in their interviews as the most significant changes they had experienced in their lives since being part of Speak Out.

"A lot of things helped me break the cycle and its kind of bigger things and those practical little things that make up everything. It was housing, it was getting out of domestic violence with counselling. Not staying in that trauma or even around people that were doing drugs…
Yeah and having that positive sort of place to go to."

Patricia*, Speak Out client

"Surface level outcomes are around mental health and drug and alcohol, access to services and support to address their needs. But underlying that - opportunities [for clients] to engage with themselves, be honest with themselves, it's a reflective space, an opportunity to think differently about how they can be creative to address the issues in their lives."

Interview with Senior Weave Leader

Note that although the draft theory of change is organised into separate sections for short and medium term outcomes, and longer term outcomes, it can be seen from the mapping of Speak Out activities to the outcomes (see Appendix 8.2) that action towards both of these outcome sets may occur at the same time. For example, engagement with counselling may lead towards progress towards the longer term internal outcomes as well as shorter term outcome of improved self-management of mental health and wellbeing. However while the short and medium term outcomes can often be achieved during the time a client is involved in Speak Out, achievement of the longer term outcomes rely more heavily on other inputs apart from Speak Out, and are often not fully achieved until months or years after clients exit the program.

It is expected that **this draft theory of change will be further refined and extended** by Speak Out after this Evaluation is complete (see recommendation 8a).

The remainder of this section of the findings related to outcomes achieved by Speak Out is organised to align with the draft theory of change, and covers the following outcomes:

Short and medium term outcomes	Long term outcomes
S1. **Improved access** to health and social welfare services, including clinical mental health services	**L1. Relational Outcomes:** Strengthened connections with others, including family, friends, community and culture
S2. **Reduced problematic use** of alcohol and/or other drugs	**L2. Internal Outcomes:** Improved confidence and sense of agency; improved awareness and self regulation of feelings, thoughts and behaviour
S3. Improved self-management of **mental health and wellbeing**	**L3. Life Stability Outcomes:** Increased safety and security in living and financial situation; reduced risk of incarceration
S4. Improved engagement with the **justice system** (subset)	**L4. Enabling Environment:** Creating a community environment that enables young people to thrive
S5. Improved engagement with **education and/or employment** (subset)	

See Appendix 8.2 for the draft theory of change visual, including the pathways/linkages between them

The majority of the findings regarding outcomes achieved is drawn from the interviews with clients; where available and appropriate the available quantitative information from the NADA COMS measures have been included in the relevant section. More detail on the NADA COMS data is provided in Appendix 8.4.2.

5.2.2 Achievement of Short and Medium Term Outcomes

5.2.2.1 Improved access to health and social welfare services, including clinical mental health services (Outcome S1)

Many of the clients interviewed for this Evaluation described how Speak Out had helped them access various health and social welfare services. **Support to access housing services** was the service most commonly described, mentioned by nine of the 16 clients interviewed.

"They [Speak Out] helped me out with housing, I was homeless for a bit around 3 years ago and I went in there and they got me into the Housing Commission, they signed all the forms and got me to sign it, they made stuff real easy. I wouldn't be able to do all that by myself, it's like ten forms or something."

Jack*, Speak Out client

One client interviewed felt that Speak Out hadn't really helped her with housing; she was homeless at one point and felt her case worker didn't help her enough and she attributed that lack of assistance to the case worker having "sided with her parents" who strongly desired her to return to living at home.

After housing, the next most commonly mentioned service type was **access to mental health services** (six of the clients interviewed). This included counselling services offered at Weave, as well as access to external clinical mental health services.

"It was more housing at the time [that I wanted] but then they asked if I wanted counselling...I didn't agree to it, and I ended up going through a lot of stuff with family, with a lot of my relatives passing away and it's helped me heaps."

Kirra*, Speak Out client

"... through Weave I have access to a psychologist who helps me unpack my trauma. My mental health and addiction were really helped with."

Amira*, Speak Out client

Four of the clients interviewed described being able to access **alcohol and other drug services** through their involvement in Speak Out; two referred to the drug and alcohol counselling available through the program, and two described how they had been supported to access and attend (external) rehabilitation services.

"Been doing drug and alcohol counselling since I got out...seeing [nurse] for drug and alcohol - I go to Weave weekly and talk to her. It's opened up my perspective, there's more to life than drugs."

David*, Speak Out client

"They [Speak Out] also helped me access a rehab, which was really amazing...Weave did the referral to rehab, they drove me there and were there to pick me up when I finished. They were always researching to find the best referral for me."

Amira*, Speak Out client

Two clients also referred to **support to access other types of services**; one client described help with paperwork for government agencies such as Centrelink and Medicare, and the other described support to access dental health services.

5.2.2.2 Reduced problematic use of alcohol and/or other drugs (Outcome S2)

Five of the clients interviewed (and one of their significant others) described how Speak Out had helped them to **reduce or control their use of alcohol and other drugs**, including avoiding harms associated with excessive use.

"I still do drugs recreationally, I have my 5pm wine on Friday because I deserve it! It's a lot more control, and responsible and enjoyable. Because I'm not getting myself into any trouble."

Colin*, Speak Out client

"Since he has been connected with Weave ... he's off the drugs, he's on like methadone, they've not only helped him, they have helped his partner, that's had good results for their relationships, they are both clean, he's become clearer and more focused."

Jedda*, grandmother of a Speak Out client

An **additional five clients described how they had now stopped using alcohol and other drugs**, but they didn't necessarily make an explicit link between ceasing using and their involvement in Speak Out.

"I used to have a bit of a drug and alcohol problem but now I don't do none of that. I just stopped doing it, it was fun while it lasted."

Steven*, Speak Out client

"...like I dropped out of high school, I was an addict at the time ...then I got connected to like a youth service where they do like tertiary courses and stuff. And I got into my diploma, like my community service and stuff ... after that I got connected to Weave. And I've been here for three years, I ended up getting sober because I was like, I love what I'm doing. .. I feel useful. ...
And that like feeling useful, helped me get sober."

Larissa*, Youth Advocate

One client interviewed described how he had 'a bit of problem smoking weed', and eventually stopped, but he felt his case worker didn't help him address his marijuana use.

From the available NADA COMS data it appears between intake and progress one (six months in) there *may* be some decrease in frequency of use of most drugs, but not a change in quantity of consumption (see table in Appendix 8.4.2). However this data must be interpreted with a high degree of caution given the apparent decrease may not be statistically significant and potential biases in who completes the progress one survey (see Appendix 8.4.2 for more details of these biases).

5.2.2.3 Improved self-management of mental health and wellbeing (Outcome S3)

Seven clients - all females - described different ways in which their involvement in Speak Out had helped them to self-manage their mental health and wellbeing. Most commonly these were **tips and strategies**, such as mindfulness tools, how to set boundaries and breathing awareness.

"And [counselling] gave me the tools to use in life. Just like mindfulness tools, flipping things around in my brain if that makes sense."

Ngala*, Speak Out client

She [worker] would give me these little things to work on throughout the week, not like your average "tell me how you feel", working through underlying issues... honestly I wasn't doing it at first, she started breaking it down in different ways, like daily affirmations."

Mele*, Speak Out client

One client described how Speak Out had helped her access a Buddhist temple which helped her manage her anxiety; another described how becoming involved in yoga through Speak Out had brought her peace and serenity.

"I remember even like when I was going through a lot of anxiety. They ended, they connected me to a Buddhist Buddhist temple down at Newtown, and the worker actually came with me to place, and sat with me and just to make them feel more calm, you know, and you don't get that a lot...They have someone there to feel like they're every step of the way."

Alinta*, Speak Out client

5.2.2.4 Improved engagement with the justice system (Outcome S4)

For the subset of clients engaged with the justice system, Speak Out works to improve their engagement in the system, such as attendance at court dates. Three clients, and a significant other of another client, described in the interviews how **Speak Out had provided practical support** to engage with the criminal justice system.

"They have helped me out with court matters, there was someone who was there with all the kids court matters; and they would let us know when court is and that, sometimes give us a lift; they tried to help us out as much as they can with court."

Jack*, Speak Out client

"Although Speak Out isn't a justice program, they are working with a lot of young people, you know, navigating the justice system...So much court support court letters, So giving context, you know, to their circumstances. Every program could be a justice program at Weave…"

Interview with Senior Weave Leader

5.2.2.5 Improved engagement with education and/or employment (Outcome S5)

Many of the clients interviewed described how Speak Out had helped strengthen their involvement in education and/or employment. Five clients talked about **education engagement**, including enrolling or enrolling in school or post-school education and staying enrolled.

"[Involvement in Speak Out] helped me with achieving a lot of the things I have, I've done courses, that's a lot to do with my case worker and counsellor. My counsellor helped me with staying with my course and completing it. Encouraged me to keep going."

Ngala*, Speak Out client

Seven of the clients interviewed described how Speak Out had helped them with **employment**, most commonly obtaining or staying in a job (five clients) but also opportunities to build experiences they could include on their CVs and becoming more prepared to work.

"They [Speak Out] have helped me a lot with my job. I have got my jobs on my own but ...I have never stayed in a job for a long time, it's hard, just talking about it, going there [to Weave] and venting about it, helped me think about it, I've stayed in a job longer because of that."

Kirra*, Speak Out client

"It [Youth Advocates program] was really good, gave me a foot into the door into the kind of work that I'm doing now."

Patricia*, Speak Out client

5.2.3 Achievement of Longer Term Outcomes

5.2.3.1 Relational Outcomes (Outcome L1)

Strengthened connections with others, including family, friends, community and culture

"I think in every relationship, that [Speak Out] sort of helped me just learn to listen, understand, appreciate and respect."

Adam*, Speak Out client

Most of the clients interviewed for this Evaluation reported how Speak Out had helped them strengthen relationships with others. **Relationships with family members** were the most commonly mentioned, with eight clients and two significant others reporting how their relationships with family had changed in a positive way due to their involvement in Speak Out. Most commonly clients referred to reconnecting with family members they had loosened connections with previously and/or improving communication with their family members.

"They helped me to connect to my family, to my sisters so I have my sisters back in my life... I don't feel so isolated and so alone."

Amira*, Speak Out client

"[Case worker] helped me understand how to set boundaries, talking to mum instead of just shouting, communicating with mum and with family. I've been setting boundaries with all of them,...it's helped us come closer too, knowing that instead of just having a big fight, just row, that's how we express how we feel."

Kirra*, Speak Out client

"Counselling helped him open up...Now, we could talk about anything...we got a lot closer, I think it's because of him going to counselling, he can express his feelings...one night he called me crying after he and [worker] had an argument, I was so happy because it showed that he could call me."

Tahnee*, sister of a Speak Out client

Five clients described how through Speak Out they had **connected with other young people and made new friends**.

"But being part of the groups, really helped me as well and being connected and finding friends, because I didn't really know many people in Sydney …yeah, got a few friendships out of Weave."

Alinta*, Speak Out client

"So a lot of the young people that we support through Speak Out are quite isolated... they don't have that many friends or friendship groups or health, healthy relationships, yeah, around them. So it's [projects and groups] a way to kind of start to connect them up in a non threatening way with other young people with similar lived experience, but who are focused on really constructive positive endeavours…"

Interview with Senior Weave Leader

Six clients, and two significant others of other clients, described how Speak Out had helped them strengthen their **connection with the community and culture**, including several who referred specifically to connection to their Aboriginal heritage.

"We just came back from a culture camp and it was very deeply spiritual, and they [Weave] arranged for that to happen. ... we just got back from a five day camp to connect us back with our culture, because a lot of us boys in this group are Aboriginal boys. And sorta it was like yeah a very cultural experience and something that we needed, to open our minds sort of thing."

Adam*, Speak Out client

"They [Weave] gave us opportunities to work at one of their stores like the Weave stores, and a garden festival, just being in and a part of the community, feeling like you're part of something."

Alinta*, Speak Out client

One Aboriginal client interviewed did describe how for her, Weave was not the place she would go for connection to her culture.

"There are better avenues for doing that [connecting to culture]. I don't think Weave could provide connection to culture, I would go to an elder or an Aboriginal organisation for that."

Mahlee*, Speak Out client

Some of the ways in which the Speak Out program helps clients to achieve these relational outcomes include opportunities to participate in community activities and take up leadership roles, counselling and role modelling to develop strengthened relationship skills and through the connection with Weave (individual staff and organisation overall) including creating the sense of 'being held'.

"They [Speak Out] have helped me be a leader, a mentor, a support to others in my community. They say "we have been here for you and you can be there for other people too."

Elizabeth*, Speak Out client

However, while there were multiple examples described by clients and other stakeholders of the positive effect of the leadership and role modelling opportunities encouraged through Speak Out, a potential negative unintended consequence was also raised. Separately, a client, a Weave senior leader and the Speak Out staff raised the issue that **sometimes clients perceived to be doing well become a 'poster child'** and have an unreasonable amount of pressure to succeed (unintentionally) placed on them, which may be setting them up to fail.

"If you fit the typical Aboriginal kid doing well then they will poster the crap out of you. You kinda get a bit annoyed especially if they haven't always been here for you. I want credit for myself too, you didn't do all of it."

Elizabeth*, Speak Out client

"The pressure we put on young people is immense. We need to make sure that we, Weave, don't overload them by creating an image that a young person is a 'poster child'. ..Their issues aren't going to be a one-time issue, we don't want to put that burden on them. We don't ever want them to feel about Weave "that is another group I have let down if I relapse". People are going to need 4th, 5th, 6th chances...Young people who want to step forward, who want to give back can do that, who want a platform, but it's important that Weave is not pushing that."

Interview with Senior Leader at Weave

5.2.3.2 Internal Outcomes (Outcome L2)

Improved confidence and sense of agency; Improved awareness and self regulation of feelings, thoughts and behaviour; Increased emotional maturity

Multiple clients and Youth Advocates described how their involvement with Speak Out had increased their **self confidence, self worth and sense of agency**.

"[Involvement in Speak Out] definitely boosted my confidence, made me realise my worth."

Ngala*, Speak Out client

"...it just makes me feel so proud of myself and other people and like I just it's just amazing how the opportunities that we get [in Youth Advocates] and how important makes me feel my sense of self confidence. I can give young people a voice and some proof that there is another world behind the drugs and alcohol."

Larissa*, Youth Advocate

I think the number one thing [change] is having an ability or that ability to have sort of ownership over your own life. When you haven't been shown from other people how to function in society or just, you know, it's just not having role models….I felt like I got a lot of my power back as well and my independence."

Alinta*, Speak Out client

"They have helped me be a leader, a mentor, a support to others in my community. They say "we have been here for you and you can be there for other people too."

Elizabeth*, Speak Out client

Speak Out staff and staff from external agencies reflected how the increase in confidence and self worth experienced could then lead to positive behavioural outcomes.

"More confidence would be a really big one [outcome] - whether it be confidence to leave a toxic relationship, confidence to say "this is not my fault" or confidence to take responsibility for their own behaviours and adjust them. Having the confidence to know that mental health and alcohol and drug use don't have to limit what they are able to do in life."

Interview with external agency

Several clients interviewed described how their involvement in Speak Out had led to them becoming **more aware and better able to self-regulate their feelings, thoughts and behaviours**. This included being more aware of how their use of alcohol and other drugs was affecting them, being aware of and shifting their 'mindset' and to better manage their responses to challenges.

"And now a lot of the time I do still go through my own personal things but I found a way to actually sort of regulate my emotions, go through them and go through the motions instead of blocking it out or I'll just get off my head or drink. You know what I mean. Instead of running away from the problem I just face it head on, now."

Alinta*, Speak Out client

"I didn't imagine to be 26, to live to this age, it's like I have brand new glasses, there are hard days and good days, even when there are hard days I know that it's just life and I will get through it."

Amira*, Speak Out client

Four clients and a significant other of another client also reflected on how they had become more **emotionally mature** through their involvement in Speak Out.

"I was a tough nut and they made me into a big softie, I used to be a tough nut to crack, just a little shit, now I'm more mature."

Isaac*, Speak Out client

"I think I've just grown up [since being involved with Speak Out], it's taken me from being an absolute idiot to a grown up."

Charlotte*, Speak Out client

Some of the ways in which these internal outcomes are achieved through Speak Out include re-framing/re-authoring of life story, processing of trauma and associated healing, and enabling young people see alternates and options in their lives (see Appendix 8.3) for more detail on these aspects of the Speak Out program)

"The more time you spend with Weave, the more positive things go up. And we couldn't change the things when we went back into the community. But we learned how to deal with them. And not let it affect us. As much, it still does, but not as much."

Adam*, Speak Out client

"Weave helped me understand situations that I'm in but they can't force me to act. They influenced certain changes. It was a steady flow, they introduced me to (certain) options." (Tylah)

Mahlee*, Speak Out client

5.2.3.3 Life Stability Outcomes (Outcome L3)

Increased safety and security in living and financial situation; reduced risk of incarceration

Although Speak Out is not a housing or employment focused program, many of the clients interviewed described how access to housing services and support to gain or sustain employment were aspects of the Speak Out program that were most useful to them. Several clients reflected during interviews on their increased life stability now due to improvements in their living and financial situations.

"Now, I am just so stable, financially, and in so many ways. Housing is really stable now, I am ahead with all my bills."

Mele*, Speak Out client

"My life has flipped alright since then [since I started Speak Out]. I have secured full time employment, I've bought a house, I have been working in the field for 8 years now, had a kid."

Patricia*, Speak Out client

Four clients also referred to **practical life skills** they had gained through their engagement in Speak Out, particularly driving lessons and getting a drivers licence, and also ability to budget.

"I have been doing the driving lessons with Weave, they got me into that. That is another big achievement that they helped me with."

Mele*, Speak Out client

More broadly, some of those interviewed reflected on how involvement in Speak Out has **helped to keep young people safe,** and likely reduced risk of young people (re)entering institutions including jail.

"I am glad that I have been supported, it has meant that my mental health challenges have been consequence free. I consider myself quite lucky that I have decided to follow through on being active on my mental health."

Mahlee*, Speak Out client

"I think we've really kept people alive. And I don't mean that lightly like ...I think the program has actually saved a lot of young people's lives, and we've kept lots out of jail... And probably out of other institutions potentially."

Interview with senior leader at Weave

5.2.3.4 Enabling Environment (Outcome L4)

Creating a community environment that enables young people to thrive

While Speak Out focuses on working with individual clients, including their significant others and community as appropriate, the program also seeks to influence the wider community by reducing the stigma and discrimination around mental health and alcohol and drug use among young people. This is particularly through young people's own organisation and participation in community activities.

"[Weave] really destigmatise mental health - e.g. MAD Pride, destigmatise help seeking"

Interview with external agency

"we... know, particularly from working for so long with Aboriginal people, it's very difficult for an Aboriginal young person who really does have ambition, and wants to make things better for themselves. But if the rest of their family is struggling, it's hard for them to be one out going forward and leaving everyone behind. Because that's just not culturally how it is comfortable. And so it's, it allows that young person to go forward if you can bring everyone as well. And not just the families and youth. But we try to do that with communities. Yeah. Because those communities need to be strong to support the progress of those young people and those families….so it's at all levels. That's why that community development work, the events ... all of that plays a role in each young person's success."

Interview with senior leader at Weave

Although creating an enabling environment did not feature as strongly as the other longer term outcomes in the interviews (potentially due to who was or wasn't interviewed, and the focus of the interviews on changes in clients lives), it is strongly supported by literature and came through in interviews with Weave staff and external stakeholders, as such it is considered an essential element in achieving the overall Speak Out program goal.

5.2.4 Recommendations for Speak Out Outcomes

Recommendation 8:

Further develop and refine the draft Speak Out Theory of Change to ensure an explicit and shared understanding of program outcomes, activities and the connections between them

a. Development of a Theory of Change

While this Evaluation found clear evidence of many short and longer term outcomes being achieved by the Speak Out program, there was no pre-existing clear framework (i.e. an existing program logic or theory of change) to assess what was reported being achieved against what was intended from the program design and implementation. Part of the work of this Evaluation has been to develop a draft theory of change for Speak Out (included as Appendix 8.2) to articulate the intended outcomes of the Speak Out program, and the connections between them.

We recommend that Speak Out and Weave continue to further develop and refine this theory of change as a priority action coming out of this Evaluation. This should include:

- **Ensuring that the theory of change accurately captures** the intended outcomes of the Speak Out program, the linkages between these outcomes, and how the current activities of Speak Out contribute to the outcomes. Particular attention should be paid to ensuring the intended outcomes of the community development work are adequately included, as there are less funder and sector requirements for measuring outcomes related to this work.
- **Seeking further input and feedback from stakeholders;** although the draft theory of change has had some feedback (from those who reviewed the draft version of this Evaluation report), further consultation and input with stakeholders is required, particularly with all Speak Out staff and with the cohort that Speak Out exists to serve (i.e. clients, or other young people experiencing challenges with their mental health and AOD use). Given the majority of Speak Out clients are Aboriginal, further consultations with Aboriginal leaders and organisations are recommended, along with ensuring sufficient Aboriginal staff and clients are included in consultations.
- **Articulation of the assumptions**[35] that underlie the theory of change, so that an appropriate risk management and review plan can be established.

Once there is an agreed, working version of the theory of change for Speak Out (or the overall Weave programs), then this can be used to **ensure a shared and explicit understanding** of what the program is trying to achieve among current staff, new joiners, external services referring in/out and current and potential program funders. We recommend that the **theory of change is reviewed periodically** (e.g. every 12 months) to ensure ongoing relevance, including updating as new evidence emerges or the suite of activities offered by Speak Out evolves.

The theory of change can also be used:

- **As a tool to assess ideas for new activities under Speak Out** (e.g. as suggested by young people or staff or as funding opportunities emerge), to ensure that any new activities fit within the intended outcomes and change pathways of the theory of change.[36]
- **To help establish what a monitoring, evaluation and learning framework for Speak Out should focus on** (see later recommendation 11a under strengthening MEL)

[35] *Including assumptions about the pathways between the outcomes, the underlying 'worldview(s)' that underpins how it's' believed change happens, and beliefs held about the cohort and operational context of Speak Out*

[36] *Or alternatively, identify when the Theory of Change needs to evolve in order to accurately portray the current intentions and directions of the Speak Out program*

- **As a way to explain the Speak Out program model and intended outcomes** to current and potential funders, and advocate for more funding to support the holistic nature and intentions of the program (i.e. move beyond funding and associated reporting requirements tied solely to alcohol and drug use and/or mental health) (see earlier recommendations 2, 3 and 5 under Speak Out Program Model Recommendations)

Given the overlap between Speak Out outcomes and outcomes that other Weave programs are working towards, we also recommend that Weave management consider **if/how the Speak Out Theory of Change fits in with a wider organisational Theory of Change**. For example the draft theory of change could evolve into a wider organisational theory of change that includes but is not specific to Speak Out, or development of a nested theory of change or program logic for Speak Out that sits within a wider organisational theory of change. This would enable articulation of how the holistic nature of programs and services provided by Weave are working to meet clients needs and expectations, rather than somewhat artificially separating Speak Out into its own program 'silo'.

Recommendation 9:

Consider how best to balance encouraging Speak Out clients to be role models and take up leadership and mentoring roles, without creating undue burden or expectation on them

a. Ensure that young people who take up opportunities to be role models, leaders and mentors are well supported

It appeared from the data collected for this Evaluation that there was concern from several stakeholders that Speak Out (or Weave more generally) may be unwittingly putting too much pressure on some young people, by creating a feeling that they are 'poster children' for the program and have (unreasonable) expectations to live up to.

While it is our strong impression from our discussion with the Weave and Speak Out staff that this is *not* the intention, we recommend that the Speak Out team and Weave senior management **hold an open discussion** about how best they can balance the desire to encourage clients to become role models and take up leadership and mentoring roles without creating undue burden or expectation on the young people. This may include consideration of how to:

- **Avoid excessive burden on a small number of clients,** e.g. how to continually seek out and rotate which clients are used in public events and promotions
- **Best to prepare and support young people** choosing to take up these roles, e.g. additional support that may be required, particularly if the young people are no longer active clients of Speak Out or other Weave programs and thus may have less access to counsellors etc. Weave may also consider the process by which young people initially agree to take part in public events and promotions and/or share their stories with others, and how this consent process is periodically revisited to ensure participation is still something that is safe and positive for the young person participating.
- **Expect, actively include and celebrate** both the 'highs' and 'lows' of young people's journeys, i.e. remain honest to the reality of young people's lives (don't just share the good news stories) while ensuring safety and 'do no harm' of young people participating in public events and promotions.

Note that issues identified related to the collection of client outcome data (what is collected, how, when, and systems for data entry, analysis and reporting) are addressed in the next section on strengthening monitoring, evaluation and learning, under recommendations.

5.3 Strengthening Monitoring, Evaluation and Learning (MEL)

Evaluation Question 4:

How could the Speak Out program's monitoring, evaluation and learning processes be strengthened to better inform the Program design and delivery?

5.3.1 Current MEL Situation

The Evaluation of the Speak Out program involved collation and review of the existing data and documents held by the Speak Out team (see methods section for more detail), and interviews with Speak Out staff. It was apparent that **there was already a variety of monitoring, evaluation and learning (MEL) processes** within the Speak Out program.

These existing MEL processes within Speak Out include:

- **Tracking of client engagement and progress via electronic client management system (DEREK); including client outcome measures.** These client measures are aligned to the Client Outcomes Management System (COMS) developed by the Network of Alcohol and other Drugs Agencies (NADA), the peak body for AOD services in NSW
- **Speak Out team discussions to reflect and learn from client interactions and progress**, such as regular Speak Out team and individual supervision meetings incorporating reflective practice and periodic team planning days
- **Previous evaluations of the Speak Out program** (see earlier section 3.1.3)

However, the Evaluation also **identified some challenges with the existing MEL processes**, and potential opportunities for improvement. Speak Out and Weave management staff, along with the program funder, commented that monitoring and evaluation of Speak Out was often not consistently conducted, and often pushed down the priority list of (busy) staff (see earlier). In addition, current MEL tools and approaches did not match the Speak Out program model (how it operates and what it aims to achieve), and there was a need to better demonstrate the impact of Speak Out.

"We don't have a [monitoring and evaluation] system that fits the client services model."

Focus Group with Speak Out Staff

"I think the things that get in the way of [consistent documentation] ….people are just flat out. Yeah, you know, supporting multiple, lots of clients with complex issues... it's easy to push something like that down the bottom of the list."

Interview with Senior Weave Leader

"They [Speak Out] do need to better demonstrate their effectiveness in terms of the data stuff, in terms of the reports and where they need to improve...Definitely better data - more defensible evidence base is great for communicating for a variety of audiences."

Interview with External Agency

Several specific challenges with current data collection were described. These included the **limitations with the type of data collected**, including the incompleteness of the quantitative data collected (see below) and the mismatch between what data is being collected and what are intended and meaningful outcomes for Speak Out clients.

There is very limited data collected from Speak Out group activities, and client feedback is only anecdotal - there are no systematic mechanisms in place to seek client feedback either during engagement with Speak Out, or at or after exit.

"Some of that has dropped [client experience surveys and random check ins]. [We] need to ask more routinely "how are you finding this?" Want to catch it contemporaneously, not too late...It's a common issue in NGOs, the casenotes, care plans and check ins are the first thing to go….It would be good to make it more systematic, a bit more considered."

Interview with Speak Out Staff

"Data collection for group work is super limited currently - mainly just date [of group], and how many people attend."

Deep dive discussion group at Evaluation Summit on strengthening MEL

Another **key current limitation is the current client electronic management system (DEREK)**; this system was customised over 7 years ago from an older system originally designed for another NGO and even requires a log in to a virtual Windows 95 desktop environment to operate. Staff reported finding DEREK very difficult to use, not capturing the information they thought was important to effectively support clients and track their progress, and not presenting the information stored in DEREK in a format that was easily able to be analysed, exported or shared with others.

"Because of how DEREK is structured it is not useful for monitoring the work. DEREK is not helpful for project work either. How are we supposed to prove the impact of the work we are doing?"

Focus Group with Speak Out Staff

For this Evaluation, we trialled several methods of exporting data stored in DEREK, including manual export by a third party (the developer who designed the original software), the existing in-built reports within the system, and the exports provided to NADA for import in the COMS system. We found challenges with each approach, including inconsistencies in which data fields were included and differences in numbers of clients and episodes of care in each export.

Weave management staff and the Speak Out funders are **well aware of the challenges with DEREK,** and Weave is currently in the process of procuring a new client relationship management (CRM) system that responds to many of the challenges experienced currently with DEREK. The new CRM is intended to be in place across Weave by mid 2021.

As a result of the challenges with DEREK, **staff use various workarounds** to store the information they require, using their own electronic or paper systems. This means information is stored in different places

in different ways by different people and is not consistent nor easily available for analysis across the Speak Out client cohort. It is anticipated that implementation of the new CRM will resolve this issue, and will support mental health symptoms being consistently monitored in an ongoing manner (as recommended in the national guidelines) by all Speak Out staff.

"I have it all in a spreadsheet - last contact, future contact, a note about what [the client is] working on, what [the client is] wanting to work on, when next do COMMS. DEREK is a problem, you can't pull up your own caseload. It's essential to have your own system. It would be good to have consistency."

Focus Group with Speak Out Staff

"I have post-it notes for each client. I contact each one each week. I don't have a system to prompt me, it's a manual system"

Focus Group with Speak Out Staff

Several staff members also commented on challenges with the **new case plan template** developed for use across Weave (which sits outside DEREK). While staff recognised the need to improve record keeping, they felt it did not meet their needs. However, the Speak Out team leader reports they have now developed a case plan template specific for Speak Out to better meet the programs' needs.

"Our case plans are not very good. It's record keeping, but does not add value. [There are] unique needs of case workers and project workers…The new case work form - caseworkers were not involved in developing it!"

Focus Group with Speak Out Staff

The current MEL challenges are compounded by the **absence of a clear statement or visualisation of how Speak Out program activities link to intended program outcomes** (i.e. prior to this Evaluation, there was no Speak Out program logic or theory of change). This means that there is no explicit statement or potentially shared understanding among Speak Out staff and other stakeholders (e.g. Weave management, funders) around what outcomes Speak Out is working to achieve, which makes it very difficult to develop appropriate MEL mechanisms. Furthermore, **many of the outcomes Speak Out is working to achieve overlap with outcomes of other programs at Weave**, and achievement of these outcomes depend not only on the work done by the Speak Out team. This suggests that any work to improve MEL within Speak Out should also consider the wider MEL system within Weave.

5.3.2 Moving Forward

Despite the MEL challenges outlined in the section above, there are some clear opportunities for strengthening MEL within Speak Out. These include:

- **Data systems and skills:** New CRM is currently being procured to replace DEREK; the current Speak Out team leader who joined in 2020 has strong project and data management skills, and the motivation to improve MEL.
- **This Evaluation:** The Evaluation is an opportunity to build interest in MEL (e.g. through the evaluation summit), and to review current strengths and weaknesses and make recommendations. The draft theory of change developed as part of this Evaluation provides a starting point for Speak Out and Weave to define and agree on their shared outcomes and pathways to these outcomes for the Speak Out program, and refine MEL processes accordingly.

- **Healing framework being developed at Weave**: This framework defines Weave's intentions around healing, and considers culturally appropriate measurement tools and approaches. Any future MEL framework should be heavily informed by this framework.
- **Continued flexibility in program models** e.g. co-case management across Weave teams. This demonstrates the interest and ability of the Speak Out and Weave staff to continually learn and improve their services, an important element of developing stronger MEL processes and culture.

Staff interviewed for this Evaluation **described an interest and ideas for strengthening MEL** within Speak Out. These included improved measurement of the true impact of the program on wider health and wellbeing (including use of culturally appropriate assessment tools), better collection and use of routine program data and better reporting of program impact.

"The measurement of the work, that's something that I would love to see developed. How do we measure the social impact?"

Focus Group with Speak Out Staff

"How do we quantify social and emotional wellbeing, Aboriginal cultural safety, cultural pride and resilience? ...We need core measures that can be inserted across programs - measures that are meaningful to us…We know our work has results, we need to package it up so that it is easily digestible."

Interview with Senior Weave Leader

5.3.3 Recommendations for Strengthening MEL

Recommendation 10:
Apply the findings and learnings from this Evaluation

This Evaluation provides an opportunity and initial 'blueprint' for how MEL can be strengthened within Speak Out. Specific elements emerging from this Evaluation that should be actioned (as well as further refinement of the draft theory of change, see recommendation 8) include:

a. **Ensure that the new CRM system will address Speak Out program needs and address some of the challenges identified during this Evaluation**.

Weave has recently commissioned an external provider to develop a new whole-organisation CRM system. Speak Out and Weave should ensure that the system is designed for both supporting individual clients as well as tracking progress and outcomes across the whole client cohort. Ideally this system will be user-friendly, intuitive to use, flexible and allow for a variety of reports, data exports and/or data visualisation to enable more real-time analysis of client progress and outcomes to inform ongoing learning and improvement of services for clients. The CRM should enable collection of client outcome and client feedback data as these are developed and refined (see recommendations 10a and 11b), as well as ease of export of the data required for upload into the NADA COMS system.

The Speak Out team leader has already been able to use the emerging learnings from the Evaluation (particularly the challenges with the DEREK data exports) in the CRM system development. This translation of learnings from the Evaluation into the new CRM system should continue, including capturing

of relevant information that is not included within the current DEREK system (e.g. client goals, if clients are parents or not etc.).

b. Develop an internal Speak Out Evaluation action plan.

This process would provide the Speak Out team and Weave management with a structured approach to reviewing and prioritising the recommendations from this Evaluation, and identifying actions, timelines and responsibilities. Ideally progress against this action plan would be reviewed periodically e.g. every six or 12 months, to ensure progress is made against the priority agreed actions.

An evaluation action plan, and associated periodic review, may provide a more focused support for implementation, and thus reduce the risk of repeating the situation following the previous Speak Out Evaluation in 2010, whereby many of the recommendations made in that report remain partially actioned and relevant to the program in 2020-2021. This action plan (or MEL framework, see recommendation below) may also indicate when the next evaluation of Speak Out would ideally be conducted i.e. this should be planned for prospectively, including seeking any required funding or internal expertise (see recommendation 12b on MEL resourcing)

Recommendation 11:
Co-design an appropriate, feasible and robust MEL framework for Speak Out

a. Develop a MEL framework for Speak Out

It was clear from this Evaluation that there is a need, but also interest and motivation from within and outside Speak Out, to improve the monitoring, evaluation and learning from Speak Out. Once the Speak Out Theory of Change is further refined (see recommendation above), **an associated MEL framework should be developed to** articulate how progress towards the agreed program outputs and outcomes will be measured and used (by Speak Out and others) to improve programs for young people experiencing challenges with their mental health and AOD use.

Elements that could be included within the MEL framework include the Speak Out Theory of Change, MEL principles, Key Monitoring and Evaluation Questions, Data Sources (existing and new), Data Analysis, Dissemination and Use of findings and MEL Resourcing, Roles and Responsibilities.

Associated with the MEL framework should be **updated data collection tools** that enable the collection of agreed output and outcome measures from Speak Out clients and staff in a culturally appropriate and feasible manner that do not overly impede the building of client relationships and can be completed in a reasonable time (i.e. don't overly take away from time available for therapeutic work). Specific data collection tools should be developed for the project and group work, as well as the individual support provided through casework and counselling.

To ensure the MEL framework is feasible and owned by the Speak Out team, the **framework should be co-designed with the Speak Out team** which may require increasing MEL understanding and skills within Weave (see recommendation below). **Input on the MEL framework should also be sought from other stakeholders** including the population Speak Out aims to reach, other Weave staff and management, Speak Out funders, Aboriginal community members and services, and external people with technical expertise in addressing the outcomes Speak Out is aiming for (e.g. other services, academics).

It may be helpful as part of developing the Speak Out MEL framework to conduct an **assessment of organisational MEL capacity**[37] in order to understand capacity and readiness to implement a new MEL framework. This assessment could help identify the order in which parts of the Speak Out MEL framework are implemented (to keep it manageable), and also prioritise which areas of MEL capacity and resources most require strengthening (see recommendation below).

b. Develop systematic approaches for collecting client feedback

Currently Speak Out **only receives anecdotal feedback** from clients; this may be more likely to be negative (e.g. clients complaining about a particular situation or incident) and means that Speak Out staff and management have no way of systematically assessing how clients feel about the program. The client interviews conducted for this Evaluation revealed many positive stories of engagement and outcomes from Speak Out, but also uncovered some challenges and suggestions for improvement (described earlier). Embedding some systematic means of collecting client feedback would ensure that the Speak Out team have a better understanding of how Speak Out clients overall are experiencing the programs, and enable adjustments to programs and services in response, without having to 'wait' until the next program evaluation which may not be for several years.

To ensure feasible and useful client feedback, some of the following mechanisms could be useful to consider:

- **Inclusion of one or two questions on client experience and satisfaction** in existing data collection processes (e.g. at each six month point) and at time of referral in/out (i.e. asking about satisfaction with services referred in by or referred out to)
- **Periodic assessment of client experience** e.g. for two weeks each year asking every client visiting the Weave offices to complete a short survey or discussion on their experiences (with appropriate incentives e.g. provision of food, entry into a prize draw, small gift)
- **Periodic follow up with a sample of clients after they exit Speak Out** e.g. calling a random selection of clients one month after they have been provided a 'warm referral' out of the program; selecting a random subset of clients (e.g. 10 each year) to follow up periodically every six or 12 months to find out where they are at and if/how Speak Out has contributed to their journey.

Not all of these mechanisms would require a substantial investment of time or money; and could greatly improve the contemporaneous understanding of the Speak Out team of how clients are experiencing the program. Even longitudinal follow up of a subset of clients could be fairly small in scale (e.g. small number of randomly selected clients) but provide very valuable information to inform further improvements to the program.

Recommendation 12:
Strengthen MEL culture, capacity and resources within Weave

[37] *For example, a tool like the HealthWest Evaluation Capacity Health Check, which was designed to be used by a range of social purpose organisations including health and welfare services*

a. MEL culture

As with many busy programs and services, it is often easy for MEL to get de-prioritised given competing demands on Speak Out staff time. For MEL to be strengthened within Speak Out (and Weave more broadly as an organisation), **it is critical that a strong MEL culture is developed and maintained**. This may include: i. ensuring data collection, analysis and use are routinely included in staff meetings (and used to inform decision-making), ii. Weave management incorporating review of data collection as part of staff check-ins and performance review processes, and iii. recognition and valuing of MEL good practices (e.g. fiscal or other recognition for strengthening MEL processes or embedding learnings). A stronger MEL culture would likely help address some of the challenges identified in the Evaluation including inconsistency in if and how data collection tools are completed and data collection being perceived as (and being) a burden rather than a help to staff.

b. MEL capacity and capability

Strengthening MEL culture, and actioning the recommendations above on applying the learnings from this Evaluation and developing a MEL framework, will likely require additional resourcing for MEL within Weave. This could include things such as **staff training and mentoring in MEL**, and **recruitment of a MEL coordinator role** to support staff to develop and implement their own MEL processes. The intention of this role would not be to 'do' all the MEL related work, but support staff to ensure all programs have appropriate MEL frameworks, data is being collected in the ways agreed, coordinating the provision of data summaries to teams and management to inform decision making, hosting reflection meetings and overseeing any external commissioning of consultants or research partners to Weave. Funding would be needed to support this role, which would ideally be funded in an ongoing capacity, such as ensuring a certain percentage of all incoming program and service funding to Weave were reserved to support this position.

6 Discussion

This Evaluation was conducted in order to describe the current Speak Out model, comment on the extent to which the model and its implementation is addressing client need and is aligned with current domestic and international literature; investigate the outcomes being achieved by the program; and make recommendations for the future development of the program, including the future development of monitoring, evaluation and learning.

The Evaluation has found that the Speak Out model is a highly integrated, holistic response to the needs of young people affected by co-existing mental health and drug and alcohol challenges. Across the program, Speak Out provides a mixture of individualised support (casework and counselling), social connectedness and peer learning (group programs), creativity and self-expression (art therapy) and leadership development, skill development and growth (projects, Youth Advocacy).

Based on the qualitative data collected, and the analysis of available program data, this Evaluation has also found that Speak Out is highly successful in supporting clients to make progress towards a range of **short and medium term outcomes**, including **improved access** to health and social welfare services, including clinical mental health services; **reduced problematic use** of alcohol and/or other drugs; improved self-management of **mental health and wellbeing;** improved engagement with the justice system; and improved engagement with **education and/or employment.**

In addition, our analysis of the data collected for this Evaluation suggests that Speak Out assists young people to achieve a range of **long term outcomes**, including **strengthened connections** with others, including family, friends, community and culture, improved **confidence and sense of agency**; improved **awareness and self-regulation** of feelings, thoughts and behaviour, increased **safety and security** in living and financial situation, and reduced risk of **incarceration**, and creating a **community environment** that enables young people to thrive.

This work is addressing a **critical need in the local community,** as indicated by feedback from young people, significant others and external stakeholders and is especially important given the **paucity of other services providing integrated, holistic support** for young people with co-existing mental health and drug and alcohol challenges. Speak Out is particularly remarkable for its ability to engage Aboriginal and Torres Strait Islander young people, and to provide them with culturally safe and effective support.

Overall, this Evaluation has endorsed the strengths of the model and the practice of Speak Out. The approach taken by Speak Out is largely consistent with research and guidelines on good practice when working with people with co-existing mental health and drug and alcohol challenges.

Given all the above, one of the key findings is that there is a need for increased capacity within Speak Out. This includes increased **human resource capacity** to better meet needs (e.g. to support additional workers and extended programs to serve existing clients better and address access issues for new clients) as well as maintain and strengthen external relationships and engage in targeted strategic advocacy. It also includes increased **internal organisational capacity** for systems, structures and processes to support program implementation and monitoring, evaluation and learning. While a clear program and/or organisational theory of change and streamlined internal processes (e.g. improved systems) may

eventually free up some capacity within existing human resources, it is not realistic that the recommended improvements to Speak Out can all be achieved without a substantial increase in program funding. Such an increased capacity would allow it to address some of the current access issues created by the extremely limited budget.

This Evaluation has also identified several areas where Speak Out staff may benefit from further reflective practice on either current practice or protocols. These areas include: raising the upper age limit for participants, and considering whether it would be useful to further tailor the model to address the needs of subsets of the Speak Out client (e.g. those aged 15 and under and those with severe, persistent mental illness). It has also identified a number of areas that are currently under development in Weave (including in relation to Aboriginal governance and Aboriginal workforce) that will make an enormous contribution to Speak Out overall.

In terms of monitoring, evaluation and learning (MEL) the Evaluation identified several existing MEL processes within Speak Out, as well as challenges and opportunities for improvement. Of particular note is the need to further refine the theory of change drafted by the consultants for this Evaluation to reach an agreed understanding of the intended outcomes and pathways to change, and develop an overarching MEL framework with improved data collection to more accurately and usefully capture the achievements of the Speak Out program. A clear theory of change and application of an appropriate MEL framework would also better support the Speak Out staff, and allies and funders of Speak Out, to continually improve the program and ultimately better meet client needs.

The Evaluation has been able to draw on a rich pool of data, including data from interviews with Speak Out clients and their significant others, Youth Advocates, Speak Out staff, Weave staff and Board members and external stakeholders.

The richness of that data notwithstanding, participation numbers were small and it may not be appropriate to generalise based on these findings.

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8 Appendices

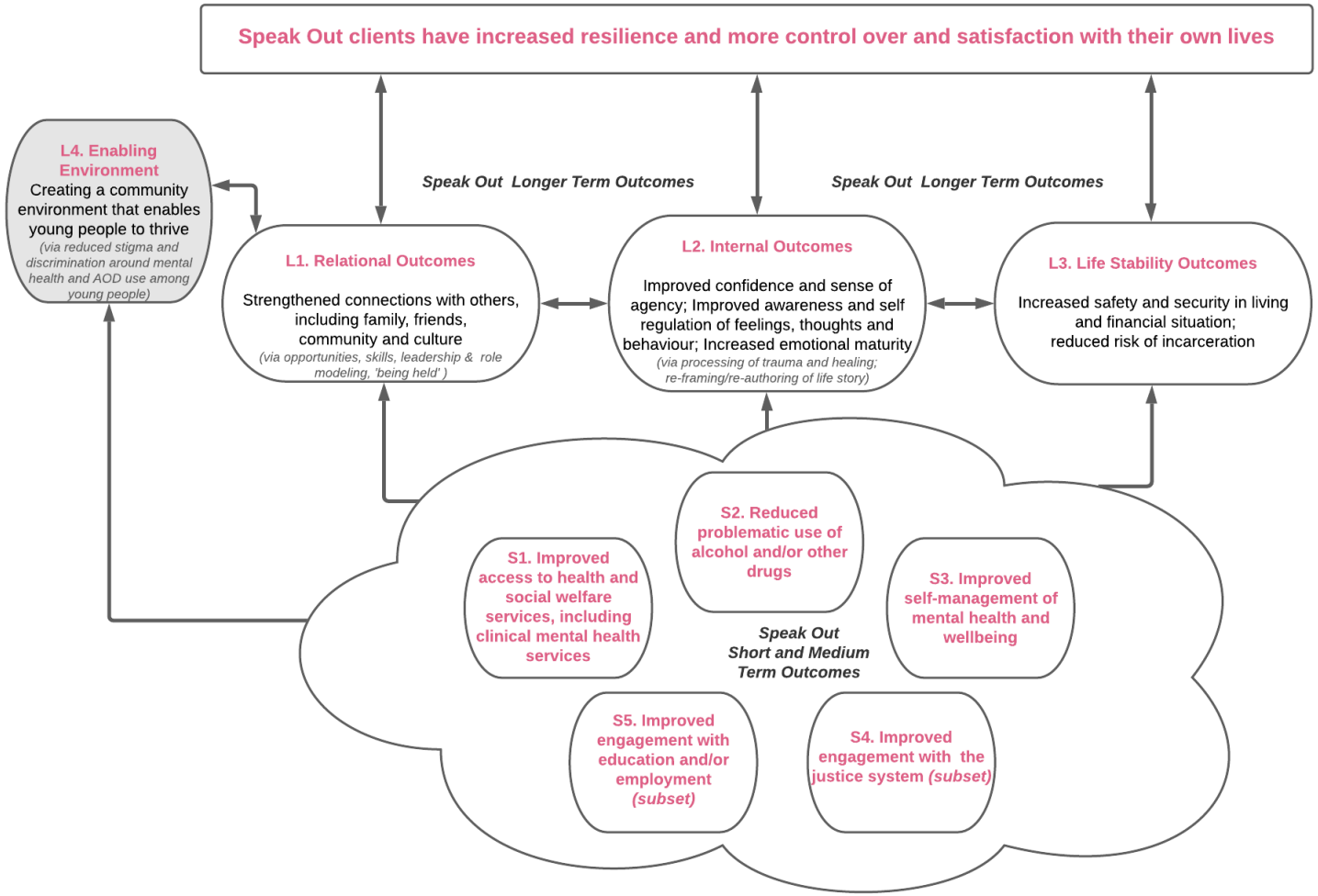
8.1 Evaluation Participants

The Evaluation benefited enormously from the participation of a range of individuals and we thank them for their time, generosity and thoughtful contributions:

Name	Role/organisation
Young people and their families	
16 young people	Current or former Speak Out clients
2 young people	Youth Advocates
2 significant others	Family members of current or former Speak Out clients
Speak Out Team	
Annabel	Previous Speak Out counsellor/caseworker
Carlyn Chen	Speak Out counsellor/caseworker
Claire Coleman	Speak Out counsellor/caseworker
Faith Agugu	Speak Out counsellor/caseworker
Paul (PJ) Graham	Speak Out counsellor/caseworker
Laura Mangen	Speak Out Project/group worker
Guilia Frangiacomo	Speak Out Art project worker
Dylan Clay	Speak Out Program Manager
Kylie Fegan	Previous Speak Out Program Manager
Weave Youth and Community Services	
Karlie Stewart	Child, Youth and Family Case Worker, Weave
Mardi Diles	Director, Brand and Strategy, Weave
Siobhan Bryson	Chief Executive Officer

Melanie Schwartz	Programs Lead
Kylie Fitzmaurice	Previous Weave Director, Programs
Jonathon Captain-Taylor	Weave Board Member
NSW Ministry of Health (EIIF Funder)	
Dr Joanne Ross	NSW Ministry of Health
Dr Fadil Pedic	NSW Ministry of Health
Technical Advisory Group	
Professor Katherine Mills	MATILDA Centre
Dr Christina Marel	MATILDA Centre
Community Advisory Group	
Ricky Lyons	Deputy Director, Aboriginal Health Unit, Sydney Local Health District
Mark Trewalha	Aboriginal Liaison Officer, NSW Police
Sharlene McKenzie	Aboriginal Programs Manager, 3 Bridges
Deirdre Trewalha	Drug Health, Sydney Local Health District
Warren Roberts	Local Aboriginal community leader
Kuyan Mitchell	Youth Justice, Department of Communities and Justice
Regan Mitchell	Program Manager, Weave Women and Children's Centre
External stakeholders, including Evaluation Summit attendees	
Jane Sanders	Shopfront Youth Legal Service
Chris Keyes	CESPHN
Esther Toomey	CESPHN
Morgan Bennett	WAGEC
Rosemaree Miller	NADA

8.2 Draft Speak Out Theory of Change



8.3 Summary of evidence base for Speak Out

8.3.1 Main Theories

Narrative Therapy

A **narrative approach**[38] underpins all of the work conducted through the Speak Out Program. Narrative approaches are focused on **seeing people as the experts in their own lives and viewing problems as separate from people**; people have many skills, competencies, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. Narrative approaches have been found to contribute to wellbeing and reduce depressive symptoms.[39] The narrative approach involves staff being genuinely curious about clients' experiences, and providing an opportunity for clients to **tell and 're-author' their stories** through a process of identifying strengths, resources, competencies, skills, expertise, knowledge and abilities. Other tools that can be useful in the narrative approach include therapeutic documentation, remembering conversations, outsider witness (retelling of the story by a third party) and definitional ceremonies.

PERMA Theory of Wellbeing

The Speak Out model is informed by the **PERMA theory of wellbeing** developed by Martin Seligman.[40] This theory states that wellbeing consists of five measurable elements - **p**ositive emotion (feeling good), **e**ngagement (finding flow), **r**elationships (authentic connections), **m**eaning (purposeful existence) and **a**ccomplishment (a sense of achievement). No single element defines wellbeing on its own but each contributes to it, and each will impact the amount of 'flourishing' a person experiences in their life. Speak Out's program diversity provides many opportunities for young people to connect and experience these five elements of wellbeing. The Speak Out team assists young people to identify their strengths and use these to overcome the challenges they face in their lives. This in turn contributes to positive social change for the broader community.

Cultural Healing

Aboriginal and Torres Strait Islander people define health as encompassing the social, emotional, cultural, spiritual and physical wellbeing of the individual and of the whole community. Indigenous healing-centred approaches recognise that optimal health for Aboriginal and Torres Strait Islander people requires healing from the historic, intergenerational and current traumas arising from colonisation and ongoing oppression. They draw on elements of Indigenous culture including "the underpinning values and concepts, traditional Indigenous healing practices and the essence of what it means to live a good life". Common aims of healing programs include "increasing social and cultural identity and self-esteem, cultural knowledge and skills and cultural connectedness".[41]

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[38] *As conceptualised by White, M. & Epston, D. (1990). Narrative means to therapeutic ends. New York: W. W. Norton.*

[39] *Vromans, L.D. & Schweitzer, R.D. (2010) Narrative therapy for adults with major depressive disorder: Improved symptom and interpersonal outcomes. Psychotherapy Research, 21 (1), pp.4-15.*

[40] *Seligman, M.E.P. (2012). Flourish: A visionary new understanding of happiness and well-being. London: Hodder and Staughton General Division.*

[41] *McKendrick, J. et al (2017) Aboriginal and Torres Strait Islander Healing Programs: A Literature Review*

8.3.2 Evidence and Guidelines

8.3.2.1 Treatment for Mental Health and Alcohol and Other Drug Use

Treatment models for people experiencing challenges with both mental health and alcohol and other drug use may be considered to be either:

- **Integrated**, whereby treatment is provided for both conditions at the same service at the same time; or
- **Non-integrated**, whereby treatments for each condition in parallel or sequentially at separate services, or treatment intensity is matched to case severity ('stepped care')

A 2016 meta-review found that the strongest evidence of effect in improving both mental health and substance use outcomes were from **integrated services,** and **non-integrated psychosocial treatment.**[42] The meta-review found insufficient evidence to make conclusions on the effectiveness of other approaches such as pharmacological treatment (use of medication) and case management on outcomes related to mental health and substance use. However multiple **studies of case management** included in the meta-review found positive social outcomes such as community engagement, improved quality of life and increased use of services associated with this approach.[43]

A 2019 Cochrane review of outcomes of psychosocial interventions among people with a severe mental illness (such as schizophrenia, bipolar disorder and major depression) found **no real difference between intervention types** (including integrated and non-integrated care) on retention in treatment, death, use of alcohol or other drugs, global functioning or quality of life.[44] However the authors also noted the absence of high quality evidence for the different interventions trialled.

Current Australian guidelines on working with clients experiencing both conditions in alcohol and other drug treatment settings recommend multiple principles of care including:[45]

- Focus on **engaging the client** in treatment
- **Ongoing monitoring** of mental health symptoms and assessment of outcomes
- Adopting a **holistic approach**; including consideration of clients other medical, family and social needs
- Adopting a **client-centred approach**; approaching treatment considering clients wants and expectations, including a range of treatment goals (which may not be abstinence from substance use)
- Having a **non-judgemental attitude**
- **Involving clients and carers in treatment** (where consent is given, and possible and appropriate)

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[42] *Leung et al. Co-morbid mental and substance use disorders – a meta-review of treatment effectiveness. NDARC, 2016*

[43] *Drake et al. A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. J Subst Abuse Treat. 2008 Jan;34(1):123-38*

[44] *Hunt et al. Psychosocial interventions for people with both severe mental illness and substance misuse. Cochrane Database Syst Rev. 2019 Dec 12;12:CD001088*

[45] *Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016.*

- **Collaboration** with other healthcare providers and ensuring **continuity of care**

Specifically, for depression, both cognitive behavioural therapy and behavioural activation have been found to be successful integrated psychological treatments for those with co-occurring challenges with alcohol and other drug use. Other approaches with evidence of effective outcomes for this group include antidepressant medication and some digital health (e-health) interventions.[46]

8.3.2.2 Specific needs of young people

Treatment for mental health and alcohol and other drug use for young people needs to match their **developmental and engagement needs,** and is recommended in the Australian guidelines[47] to be 'youth friendly', including features such as:

- **Prompt** screening and assessment
- **Flexibility**, including 'drop-in' capacity and follow up for missed appointments
- **Strong links** with other services, and provision of coordinated care
- Ensuring treatments offered reflect **different cognitive capabilities and developmental differences**

Many young people may have experienced **trauma** in their lives; trauma experienced during childhood is known to be particularly damaging,[48] and exposure to trauma is almost universal among clients of alcohol and other drug services.[49] **Trauma-informed services** recognise the widespread occurrence and impact of trauma and respond by fully integrating knowledge about trauma into policies, procedures and practices and actively resisting re-traumatisation.[50]

8.3.2.3 Specific needs of Aboriginal and Torres Strait Islander people

Good practices for programs and services looking to strengthen the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples include the need to[51]:

- Collaborate and build relationships within **community;**
- **Coordinate** work with other service agencies;
- Know or establish appropriate **referral pathways;**
- Have access to a **cultural mentor or consultant;** and
- Carefully **consider the meaning** of the signs and symptoms of distress experienced by clients.

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[46] *As above*

[47] *Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016.*

[48] *Wall et al. Trauma-informed care in child/family welfare services. Australian Institute of Family Studies (AIFS), 2016*

[49] *Mills et al. Trauma-informed care in the context of alcohol and other drug use disorders. In Humanising Mental Health Care In Australia: A Guide to Trauma Informed Approaches. Routledge, 2019*

[50] *Wall et al. Trauma-informed care in child/family welfare services. Australian Institute of Family Studies (AIFS), 2016*

[51] *Gee et al. Aboriginal and Torres Strait Islander Social and Emotional Wellbeing in Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Australian Government Department of the Prime Minister and Cabinet, 2014*

Many of these practices are included within the section of the current Australian guidelines on working with clients experiencing both conditions in alcohol and other drug treatment settings focused on the needs of Aboriginal and Torres Strait Islander populations.[52] Among other issues, the guidelines refer to the **high levels of shame** some Aboriginal and Torres Strait Islander clients may experience, **appropriate forms of communication** and highlight that mainstream models of treatment for use of alcohol or other drugs have generally been developed using **western**, rather than Indigenous, systems of knowledge.

Given the intergenerational trauma experienced by Aboriginal and Torres Strait Islander peoples, a **trauma-informed approach** to services (described earlier under young people) may enhance the effectiveness of care.[53]

Weave is currently developing its own ***Aboriginal Healing Framework*.** That (draft) *Framework* recognises that "Aboriginal and Torres Strait Islander people have been and continue to experience oppression, systemic racism and historic, intergenerational and current trauma" and states Weave's commitment to contributing to healing for Aboriginal and Torres Strait Islander clients and communities. It also recognises that a healing-centred approach requires dedicated focus and action across a range of organisational domains - i.e. that it is not just about direct practice but rather is embedded in:

- **Welcoming** Aboriginal and Torres Strait Islander clients into Weave's spaces, including: attention to the physical environment and initial staff interactions
- **Organisational structure and Human Resources**, including: training and development on healing-centred, trauma-informed and strengths based practice, recognition of the unique cultural personal responsibilities held by Aboriginal and Torres Strait Islander staff, students and volunteers, and actively seeking to increase Aboriginal and Torres Strait Islander representation across the organisation's Board and all paid management and leadership positions
- Promotion and development of a **strong Aboriginal and Torres Strait Islander workforce**, including recruitment, retention, and cultural supervision and mentoring.
- In relation to programs, community development and social change: collaborating with existing Aboriginal and Torres Strait Islander consultancy groups, consulting and co-designing programs and services with Aboriginal and Torres Strait Islander clients, and further developing the leadership of Aboriginal and Torres Strait Islander young people
- **Community engagement and partnerships**: strengthening and formalising collaboration with Aboriginal community groups, developing formal agreements with service agencies, and advocating for culturally responsive and healing-centred service delivery
- **Direct practice:** ensuring that each worker at Weave (Program Managers, case workers, activity workers, students and volunteers) performs their role in a way that is healing-centred, trauma-informed and strengths-based[54].

[52] *Marel et al. Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition). NDARC 2016*

[53] *Wall et al. Trauma-informed care in child/family welfare services. Australian Institute of Family Studies (AIFS), 2016*

[54] *Weave Youth and Community Services. Weave Aboriginal Healing Framework (DRAFT), 2020*

8.3.3 Applying Theories, Evidence and Guidelines within Speak Out

The following table describes the key approaches supported by evidence and guidelines for supporting young people experiencing challenges with mental health and alcohol or other drug use. Colour coding is used to indicate the degree to which Speak Out matches the recommended approaches. As can be seen from the Table, generally Speak Out approaches align well with the recommended approaches.

Table 3: Alignment of Speak Out approaches with Evidence and Guidelines

Key approaches supported by evidence and Guidelines	Application of these approaches within Speak Out
Have a non-judgemental attitude Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• Speak Out prides itself on a non-judgemental attitude. This non-judgemental attitude was referred to in multiple interviews with clients and other stakeholders. ***"I think the most important thing of all was that when they walk into Weave there are no questions asked, you don't feel guilty for what you are doing when you walk into Weave, they don't make you feel guilty, it's non-judgemental, that's how [worker] always made it, even if you had criminal issues, mental health issues, you were a domestic violence situation there was always someone there to help, with expertise to help, with housing, with mental health, with physical health"*** Jedda*, Significant Other
Prompt screening and assessment Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• Young people who self-refer to, or are referred to, Speak Out, are promptly assessed via the Weave Intake process. • Once allocated to the Speak Out team, clients are communicated with promptly. • There may be a period of time between the initial assessment completed by Intake and the more detailed assessment of need by a Speak Out case worker, as Speak Out's capacity to provide assessment of need is constrained by capacity. • Speak Out frequently has a waiting list of future clients. At the time of writing, there were 12 young people on the waiting list, which is equivalent to one full-time worker's case load. • In those circumstances where a young person is placed on a waiting list and indicates that they would prefer to wait than be referred to another agency, Speak Out endeavours to assist the young person to address any urgent needs (e.g. homelessness).

Focus on engaging the client in treatment Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• The program has a strong focus on engaging and retaining the client in support such as weekly check-ins via phone calls, SMSs, scheduled appointments and chatting to young people when they visit Weave. ***"The counsellors checking in is something valuable. I worry about wasting their time, but I don't believe I could have done that with the previous counsellor (at another organisation), I wouldn't have felt comfortable checking in."*** Mahlee*, Speak Out client ***"I thought counselling was a heap of shit but I thought I'd give it a go. I realised it was true, some of the stuff I was told. They gave me tips and strategies, ….I had counselling every week, it kept me on track, they persisted without putting me under any pressure...I got a lot out of it, the stuff I told them."*** Elizabeth*, former client • Service is offered in a flexible, client-centred way, with a focus on addressing the needs and goals that matter to the client (see row above).
Direct practice Source: *Weave Aboriginal Cultural Healing Framework*	• Speak Out's direct practice is deeply informed by the ongoing impact of colonisation on young Aboriginal and Torres Strait Islander young people and deeply values Aboriginal and Torres Strait Islander ways of knowing, doing and being.
Adopt a model of care that is integrated and holistic (including consideration of client's other medical, family and social needs) Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• The Speak Out program is based on a holistic approach to working with young people. Case management and counselling provides young people with an opportunity to work on whichever issues are of most pressing concern to them (whether they relate to internal outcomes, life stability or a mixture of both). • Assessment and support considers and responds to the individual in context of their broader social and cultural position, including family and community relationships. • Support is organised around client goals, which again are oriented to holistic rather than narrow definition of needs and evolve over time based on client priorities and readiness. • The approach includes an integrated response to mental health and drug and alcohol, reflecting the intertwined nature of both mental health and drug and alcohol challenges, and the intertwined impact of those challenges in a young person's life.
Adopting a client-centred approach; approaching treatment considering clients	• The approach to support is shaped by the young person's own goals, wants and expectations (see more detail in first row of this table). • Speak Out operates on a harm reduction model, in which the primary emphasis is on reducing harm.

wants and expectations, including a range of treatment goals (which may not be abstinence from substance use) Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	Young people are supported to achieve abstinence if that is their goal. ● Reducing harm associated with problematic alcohol and other drug use is integrated into an overall emphasis on social and emotional wellbeing, and healing (see draft theory of change).
Involving clients and carers in treatment (where consent is given, and possible and appropriate) Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	● Where appropriate, and desired by the young person, Speak Out can engage with family members including parents and siblings. This work can help the parents and siblings better support the young person. ● At times, Speak Out has clients from the same family (siblings, cousins) or may be providing support to two people in an intimate relationship. ● There are complexities around this aspect of the work (see below, confidentiality and boundaries)
Flexibility, including 'drop-in' capacity and follow up for missed appointments Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	● The approach to engagement is highly flexible and tailored to both individual preferences (e.g. meeting on-site at Weave vs meeting off-site) and individual circumstances (e.g. recognising that young people may be less consistent in attendance for appointments during periods of high stress). ● The model places a high value on follow-up and retaining young people in care. This includes regular follow up both on missed appointments and 'checking in' between appointments. ● While there is not necessarily a focus on 'drop-in' appointments for case work and counselling, young people are actively encouraged to drop into the Weave building and do so frequently. ● There is capacity across the team to support each other's clients with incidental support needs if their worker is unavailable; the Program Manager also plays a role in opportunistic support and case work if required. ***"Trauma heals in the context of stable, safe relationships. We need to be consistent with contact every week. We notice when they aren't showing up. There's lots of nurturing, touching base."*** Speak Out staff

Ongoing **monitoring** of mental health symptoms and assessment of outcomes Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• Each case manager and counsellor is actively engaged in both monitoring the client's presenting needs, including symptoms, and supporting the young person to self-assess and self-monitor. • Speak Out would benefit from a strengthened focus on documenting assessment of symptoms and outcomes (see MEL findings). It is anticipated that the implementation of the new CRM will support this process.
Carefully **consider the meaning** of the signs and symptoms of distress experienced by clients. Source: *Weave Aboriginal Cultural Healing Framework*	• The narrative therapy underpinnings of Weave ensure that staff both consider the meaning of signs and symptoms, and staff support young people to also interpret and reauthor the narrative regarding signs and symptoms.
Ensuring treatments offered reflect **different cognitive capabilities and developmental differences** Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2nd edition)*	• The work with young people is client-centred and responsive to both the specific needs and preferences of that young person. • There does not appear to be a tailored approach to working with young people based on cognitive capabilities and/or developmental differences.
Working effectively with other providers, including having strong links with other services, providing coordinated care, having continuity of care, and appropriate referral pathways Source: *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol*	• There are strong pathways into and via Speak Out from other programs offered by Weave (e.g. the Kool Kids Klub). • Speak Out works closely with a range of other health and social service providers, including other youth services, legal services and health services to facilitate access to other specialist services (legal advice and representation, housing, employment services). • At present, Sydney Local Health District provides in-reach specialist Alcohol and Other Drug counselling to Speak Out and other Weave clients. ***"Since he has been connected with Weave, other agencies in the area have worked in with it."***

and other drug treatment settings (2nd edition)	Jedda*, Significant other • Speak Out has strong referral and advocacy relationships with government (housing, justice, health) and Non-Government agencies. • Participants in the Evaluation commented that relationships are often based on interpersonal relationships between individuals. This can be a great asset for supporting client-centred care but can create vulnerability when those individuals move on. In addition, it can result in missed opportunities for organisations to collaborate on shared strategic challenges. • There is a perception among some stakeholders that Speak Out's collaborations with other organisations are not as strong as they have been at some times in the past.
Collaborate and build relationships and partnerships with the community Source: *Weave Aboriginal Cultural Healing Framework*	• Speak Out is well known within local communities, and this profile drives the high levels of self-referral. • Weave overall has very strong relationships with the local community, in particular with local Aboriginal communities. ***"I know Weave has helped 2 generations, 3 generations in my family, that is what I like about it. Weave has been a solid agency in our community, in our community it becomes you can trust it, if something just pops open and might stay for ten years but when they are there for a long time you trust them."*** Jedda*, Significant other • The relationship between Speak Out and the local Aboriginal Medical Service (AMS) appears to function well at the client level, but there appears to be limited collaboration between Speak Out and the AMS overall.
Welcoming environment for Aboriginal and Torres Strait Islander communities Source: *Weave Aboriginal Cultural Healing Framework*	• Speak Out - and Weave as an organisation - was reported by clients interviewed to provide a very welcoming environment for all clients, and particularly Aboriginal and Torres Strait Islander young people, families and communities. ***"It doesn't make a difference to me that Weave isn't Aboriginal...I feel more comfortable at Weave than I do at AES and AMS, I guess it's because I'm not from here, from this country."*** Kirra*, Speak Out client
Organisational structure and HR that supports healing-centred	• Weave is currently investing heavily in this area, through the development of the Aboriginal Healing Framework, and substantial investment in a whole of organisation approach to implementation of that Framework. The Speak Out program will benefit significantly from this program of work.

work with Aboriginal clients, and enables Aboriginal staff Source: *Weave Aboriginal Cultural Healing Framework*	
Strong Aboriginal and Torres Strait Islander workforce Source: *Weave Aboriginal Cultural Healing Framework*	• Weave is currently investing heavily in this area, through the development of the Aboriginal Healing Framework, and substantial investment in a whole of organisation approach to implementation of that Framework. The Speak Out program will benefit significantly from this program of work. • The Aboriginal and Torres Strait Islander workforce within Speak Out has fluctuated over the period covered by the Evaluation (2015-2020). • There are not currently any Aboriginal or Torres Strait Islander staff working within Speak Out. An Aboriginal student will shortly join Speak Out on placement.
Programs, community development and social change Source: *Weave Aboriginal Cultural Healing Framework*	• Project work, including community development, is actively co-designed and co-delivered with young people, including Aboriginal and Torres Strait Islander young people. • The Youth Advocacy stream provides opportunities for young people to further develop and express their leadership capability.
Have access to a **cultural mentor or consultant** Source: *Weave Aboriginal Cultural Healing Framework*	• Weave is currently investing heavily in this area, through the development of the Aboriginal Healing Framework, and substantial investment in a whole of organisation approach to implementation of that Framework. The Speak Out program will benefit significantly from this program of work. • Speak Out does not currently access an external cultural mentor or consultant, although staff do have access to Aboriginal staff within the organisation (including a senior leader).

Green is strong evidence of application of recommended approaches; yellow is some evidence of application of recommended approaches; orange is limited evidence of application of recommended approaches. It should be noted that these ratings may relate to the limitations of the evaluation methodology or gaps in available data rather than key gaps in the Speak Out program.

8.4 Additional Program Data

8.4.1 Client AOD and Mental Health Data (DEREK data)

Table 4: Primary drug of concern among Speak Out clients, 2015-2020

	n	%
Total episodes of care in DEREK	674	100
Episodes of care in DEREK with data entered on primary drug of concern	315	46.7
Primary Drug of Concern		
Alcohol	86	27.3
Amphetamines	29	9.2
Benzodiazepines	3	1.0
Cannabis	93	29.5
Ecstasy	2	0.6
Heroin	8	2.5
Inadequately Described	8	2.5
Methadone	2	0.6
Nicotine	31	9.8
TOTAL	**315**	

8.4.2 Client Outcomes Data (NADA COMS data)

The data below is derived from the data export from the DEREK client management system that is exported and sent to NADA for the centralised COMS reporting. For the period of focus for this Evaluation (1st January 2015 and 31st December 2020) the extraction included 225 clients with 256 episodes of care recorded;[55] 62 of these episodes were open (i.e. represent clients indicated as current clients of Speak Out at the end of 2020). Although DEREK includes some data on outcomes that do not form part of the NADA COMS reporting (e.g. improvements at exit compared to entry), as these were only completed for a minority of episodes of care these were not used for the analysis.

Among the 256 episodes of care in the NADA COMS data export analysed, 249 had a completed survey at intake, with a far smaller number of surveys completed at each six month mark. It is possible to compare results on the intake survey (n=249 completed surveys) and the survey at progress one (n=50 completed

[55] *Note this is somewhat fewer clients and episodes of care then are recorded in the DEREK client management system for the same time period; unfortunately as it was not possible to extract a full and complete individual line-listed data of all clients and episodes of care from DEREK it was not possible to fully investigate the reasons for this discrepancy. NB: data from DEREK reported earlier on program activities and client demographics and needs were based on the aggregate reports available in DEREK*

surveys); this data is summarised in the table on the next page. As there are only six episodes of care that contain both an intake and an exit survey, data on exit is not reported on below.

From the table, it can be seen that there ***may*** **be some decrease in frequency of use of most drugs (but not quantity of consumption)** between intake and progress one, but this data must be interpreted with a high degree of caution given:

- The apparent decrease may not be statistically significant; and
- It is not known why some people have completed progress one surveys and others haven't i.e. if these reflect more recent clients, clients of worker(s) more dedicated to survey completion, which clients are more willing to complete progress surveys, and/or clients more likely to have remained engaged in the program.

The **median K10 score** was 24 at both intake and progress one, which corresponds to a high level of psychological distress at both time points.

The proportion of clients who **report feeling dissatisfied or very dissatisfied with their overall quality of life and ability to perform daily living activities increases** between intake and progress one. This could reflect any of the following potential reasons:

- As clients engage more with Speak Out, their ability to recognise and discuss their dissatisfaction increases; and/or
- Speak Out causing increased dissatisfaction with quality of life (less likely, but possible); and/or
- Clients who are more dissatisfied with their lives are retained in Speak Out to the progress one time point (as they require a longer time period of support, or are more likely to continue coming); and/or
- Biases in which clients complete data collection at progress one time point (e.g. by who worker is, or that worker is more likely to enter complete progress one assessments for clients that still require support).

Table 5: Quality of Life - Comparison of results at intake and progress one, NADA COMS data

	Intake	Progress One (six months in)
Number of completed surveys	249	50
Satisfaction with quality of life		
Very poor	74	25
Poor	25	2
Neither poor nor good	83	13
Good	57	9
Very good	10	1

Table 6: AOD and Psychological Health - Comparison of results at intake and progress one, NADA COMS data

	Intake	Progress One (six months in)
Number of completed surveys	249	50
Alcohol and Other Drugs - Frequency of Consumption		
How many days in the last four weeks did you use:		
Alcohol	6.6	5.1
Amphetamines	7.6	8.3
Cannabis	15.4	13.1
Cigarettes	24.2	20.3
Heroin	19.4	17.0
Alcohol and Other Drugs - Consumption Quantity		
On average, how many standard drinks did you have on those days when you were drinking?	7.6	8.0
Number of drinks when drinking more heavily than usual	10.0	10.3
How many cigarettes did you have on a typical day when you used tobacco?	10.2	9.0
Psychological Health		
Median score on K10	24.0	24.0
% dissatisfied or very dissatisfied with overall quality of life	40%	54%
% dissatisfied or very dissatisfied with ability to perform daily living activities	40%	58%

As the Speak Out team works to more routinely collect and enter data at progress time points and client exit, the reliability and utility of the client outcome measures will increase.

8.6 Evaluation Methods by Evaluation Question

Table 7: Evaluation Methods by Evaluation Question

Topics covered	Methods	Information that will be provided
Evaluation Question 1: What is the Speak Out Model? ● How is it being implemented? ● How does this model align (or not) with the latest evidence on effective approaches for supporting young people experiencing both mental health and alcohol and drug use challenges?		
Documentation of activities undertaken Resources Population reached and retention Fidelity	Review of existing program data and documentation Targeted literature review Descriptive analyses of existing data on program participants Consultations with Weave Staff Focus group with other services	Program Logic planned and actual; and fidelity Process data on program reach and duration of engagement Recommendations on how to improve program implementation, reach and suggestions of evidence-based ways to improve implementation (test these with the technical and community advisory groups and staff workshop)

Evaluation Question 2: What outcomes do clients, their families and communities and Speak Out staff want from the Speak Out program?		
Needs and anticipated outcomes from the Speak Out program	Consultations with Weave Staff Interviews with clients Interviews with significant others	Qualitative assessment of desired outcomes Recommendations on how to embed these desired outcomes within the design of the Speak Out program and suggestions of evidence-based approaches/programs to achieve them (to be tested with the technical and community advisory groups and staff)
Evaluation Question 3: How and in what ways have participants' lives changed since their first engagement with Speak Out?		
To what extent are these changes due to their participation in Speak Out? Are these changes positive, negative or neutral? Are these changes expected by the Program or are these unexpected changes?	Review of existing program documentation Descriptive analysis of existing program quantitative data (if there is any outcome data available) Consultations with Weave Staff Interviews with clients - stories of most significant change Interviews with significant others - stories of most significant change	Pilot outcome data Recommendations on how to strengthen the program's ability to contribute to desired outcomes Recommendations to address any unintended consequences or outcomes occurring (to be tested with the technical and community advisory groups and staff)

Evaluation Question 4: How could the Speak Out program's monitoring, evaluation and learning processes be strengthened to better inform Program design and delivery?		
How is monitoring, evaluation and learning approached currently? How could monitoring, evaluation and learning processes be feasibly strengthened?	Review of existing program data and documentation Staff consultations to gather suggestions on indicators and what is feasible to implement into Weave systems	Recommendations to improve monitoring and evaluation processes including designing specific indicators to embed into the Speak Out program on an ongoing basis. These indicators could be developed on best available evidence (to be tested with the technical and community advisory groups and staff)

8.7 Methodology: Evaluation Summit

Speak Out Evaluation Summit

Session 1

Participant Agenda

Session 1 Purpose

The purpose of this session is to discuss the key themes emerging from the interviews & data and documentation review. We will co-develop recommendations based on the emerging themes during session 2 (18th February)

Session 1 Details

Tuesday 16 February 10am - 12pm https://us02web.zoom.us/j/83258697718

Facilitators

Lisa Ryan	0419 228 180	lisa@hecateconsulting.net.au
Dr Judy Gold	0408 529 856	judy.gold@gmail.com

Participants

Stakeholders in the Speak Out program, including staff from Speak Out and staff from Weave, funders, members of the Evaluation Community Advisory Group and Technical Advisory Group and key partner organisations; 32 participants from nine organisations invited to attend.

Session 1 Preparation

Please bring along three coloured objects to the session - one green, one yellow (or orange) and one red

If you would like to refresh yourself on the evaluation plan you could review the Approved Evaluation Protocol, or this slide deck summary (in particular slides 2-4).

Session 1 Agenda

#	Item
10:00	**Start** - please click on the link a few minutes before 10am so we can start promptly
1	**Welcome** including acknowledgement of country and introductions
2	**Orientation** to the Evaluation and evaluation summit
3	**Emerging findings**, presented under the four evaluation questions of 1) Service model design and evolution, 2) Outcomes sought by young people, families and staff 3) Outcomes achieved, 4) Monitoring, Evaluation and Learning Question & Answer following each focus area
11:15	***Five minute stretch/tea/toilet break***

4	Deep dive discussions in small groups
5	Summary and next steps, including reflection questions to answer before Session 2
12:00	Close

Speak Out Evaluation Summit

Session 2

Participant Agenda

Session 2 Purpose

To co-develop Speak Out Evaluation recommendations based on the emerging findings of the Evaluation *(focus of this session; previous session was focusing on sharing the emerging findings)*

Session 2 Details

Thursday 18th February 2021 10am - 12pm https://us02web.zoom.us/j/83258697718#success

Facilitators

Lisa Ryan	0419 228 180	lisa@hecateconsulting.net.au
Dr Judy Gold	0408 529 856	judy.gold@gmail.com
Beck Ronkson	[Guest facilitator]	

Participants

Stakeholders in the Speak Out program, including staff from Speak Out and staff from Weave, funders, members of the Evaluation Community Advisory Group and Technical Advisory Group and key partner organisations; 32 participants from nine organisations were invited to attend.

Session 2 Preparation

All participants to:

- Add to the session 2 learning reflections jamboard (virtual sticky notes) - link in email
- Bring along three coloured objects to the session - one green, one yellow (or orange) and one red
- If didn't attend session 1: Review the emerging findings presentation - slides in email

Session 2 Agenda

#	Item
10:00	**Start** - please click on the link a few minutes before 10am so we can start promptly
1	**Welcome** including acknowledgement of country and introductions
2	**Format for today's discussions -** rotation in groups to three of six topics
3	**First round deep dive topics. Options:** ● Strengthening mental health support ● Strategic Advocacy: expanding Speak Out ● Strengthening Monitoring, Evaluation and Learning
11:05	***Five minute stretch/tea/toilet break***
4	**Second round deep dive topics:** ● Working with Aboriginal young people ● Eligibility - age limit ● Strategic Advocacy 2 - expanding access to holistic service delivery
5	**Next steps**, including key takeaways for Speak Out, and preparation of the Evaluation report
12.00	***Close and thanks!***

8.8 Methodology: Question Guides for interviews and focus groups

8.8.1 Clients

Informed Consent

- Thanks for coming in today to talk about Speak Out. My name is XX and I'm one of the Evaluation team

- You were sent a **participant information statement** on your phone and you might have seen hard copies in the waiting area. Have you had a chance to read the sheet?
    - If yes: Do you have any questions about what was in there?
    - If no: Walk participants through main sections of the information sheet, focusing on voluntary nature of participation, risks and benefits and how can access results

- So before we get started I'll just **remind you** that:
    - Our conversation today will take up to an hour. You can choose not to answer any of my questions, or stop at any time
    - I don't work at Weave, and nothing you say today will affect your relationship with the staff at Weave
    - We won't be using your name when we report the results - your identity will be anonymous when we talk about the findings and when we publish them.
    - Your information will not be shared with anyone else, including Weave staff, without your permission except when required by law and/or duty of care
    - We are really interested in your honest responses to the questions. Your feedback will help Weave to improve its programs in the future so negative as well as positive feedback is really useful
    - You will be given a summary of the results of the Evaluation and invited to the launch of the report.

- Do you have any further questions? Answer any questions

- Are you happy to participate in the Evaluation today? *If no, thank participant for their time and end*

- Great, I'll just ask you to **sign this consent statement,** that says you have understood the information in the participant information statement and are willing to participate

- Are you happy for our chat to be **audio recorded**? It is only for my own record-keeping purposes and I'll also be taking notes. I won't share the recording or notes with anyone other than XX, the other person on the Evaluation team. Record if consent given for recording; start recording if consent given

Interview Questions

Involvement in Speak Out

1. To start off with, can you tell me how you **first got involved** in Weave or the Speak Out program? *[probe to find out how became aware of Weave/Speak - referral by service, friend etc and when first became involved. Also ask around how old they were when first engaged and how old now if they are willing to disclose age]*

2. So you said you first became involved around XX. What **kinds of activities and supports** have you received from Weave since then? *[probe to gain clarity on which ones are Speak Out related or not]*

So today we are particularly interested in one of the programs Weave provides which is called **Speak Out**. The Speak Out program involves multiple activities and support for young people experiencing challenges with mental health and alcohol or other drugs *[point to visual of Weave Programs and where Speak Out fits]*

3. From what you've told me it sounds like the Speak Out programs you've been involved in are XX, XXand XX. The other activities you've been involved in are part of other programs of Weave. So for today we'll focus just on the Speak Out programs i.e. XX, XXand XX. Is that ok? *[answer any questions they have around this]*

4. Which of these programs did **you enjoy** the most? Why?

Outcomes

5. Let's think back now to when you first joined Speak Out, so first did XX. Do you remember **what you wanted to get out** of the program? What was that? *[probe if to find out underlying reasons]*

6. What have been **some of the main changes in your life** since you became involved in Speak Out? These can be positive or negative changes. *After participant describes changes, ask if there are any other changes they want to report.*

7. Of these changes, which one of these do you think is the **most important** to you?
    - CAPTURE STORY. Clarify:
        - What the focus of the story is - what happened? To who?
        - Why did it happen? What happened before this? *[to get beginning of story; probe as needed for connections with other Weave programs and staff]*
        - What difference did it make? Why is this important? *[to get end of the story]*
        - What role if any did Speak Out or Weave play in these changes? *[to get contribution of Speak Out or Weave more generally to the change]*

8. *If timing permits and not already raised in earlier responses on changes experienced:* Do you think that your involvement in Speak Out has helped i**ncrease your connections** with your family, culture or community?
    - If yes: How has Speak Out helped you with these connections? *[if needed probe to clarify which type(s) of connections participant referring to]*
    - If no: Is there anything else Speak Out could have done to help you, or others like you, to increase connection with family, culture and community?

9. We've spoken today about different activities and support you've received through Speak Out like XX and XX.
    - Which of these was the **most useful** to you? Why?
    - How is Speak Out and Weave **similar** to/like other programs you've been involved in to support you with mental health or use of alcohol or other drugs? How is it **different**? *Probe to ensure understand whether the difference/s perceived are positive or negative one/s.*

Speak Out Feedback

Thank you for all your responses so far, we are almost done.

10. The final question is about how Speak Out and Weave could make their programs better in the future, to better support young people experiencing challenges with their mental health and alcohol or other drugs. What do **you suggest can be done to improve** the Speak Out program? *[probe as needed for clarification of suggestions, and at the end ask 'Any other suggestions you have for improvement?']*

11. That is the end of the interview questions. Is there anything else you want to say?

Interview Close
Turn off audio recorder

Do you have any **final questions** for me about the Evaluation?

How are you feeling after sharing those thoughts/stories with me? If you feel like it's brought up any big feelings for you, you can contact Weave for a bit of extra support (provide name of relevant staff member and contact details). You don't have to tell them anything about what we have talked about today, just let them know that you want a bit of extra support.

Thank you again for your time today. *Provide thank you card with reimbursement voucher.* We have just got a few final things to cover.

It would be really helpful for us if you could complete this **quick demographic survey.** That will help us keep track of the characteristics of who we've talked to, like how many men compared to women, and help us identify any gaps in the evaluation group. You can complete it yourself using this pen or I can ask you the questions out aloud *[complete client profile in way preferred by the client]*

A few more things. I want to remind you that **you can say no** to any or all of these requests and it won't affect your relationship with Weave.

- **Can we share your story about XX at the Evaluation Summit?** We would remove any details that are specific to you. The summit will be held later this year. It's for Youth Advocates, Weave staff, local community and others to hear about the findings of the Evaluation and help us make sense of what we've heard.

- **Can we share a version of your story with Weave once the Evaluation is complete?** Again, Weave would use the story to talk about the difference they are making in young people's lives and how they are going to use the Evaluation to make the program better.
- *(ONLY IF APPROPRIATE FOR THE YOUNG PERSON)* Do you have a **significant person in your life** who has seen some of your journey during Speak Out who you would like to be interviewed? We would not tell them anything about what you have told us. We think that significant people - like a kinship carer, brother, sister, cousin, girlfriend or boyfriend - will give us some new insights about the Speak Out program. If you are interested, could you give this referral card to the person and ask them to contact us. We will also be giving them a voucher for their time. *If they take the card, let them know that the person must have known them for at least a year to be eligible.*

As we said in the information sheet, we will be working on the Evaluation for the next few months and then we will **write a report and have a launch**. You will be invited to the launch, and we will provide a link to the report - including a more user-friendly summary! - for everyone who has been part of it.

Final thing - if you want to follow up with me, **you can contact me here** (provide contact details/card). If you have any questions, remember something really important that you want to add, or if you change your mind about us using any part of your story please get in touch with me.

Thank you so much for your time today. We really appreciate it, and it's been great to talk with you.

8.8.2 Significant others

Informed Consent

- Thanks for coming in today to talk about Speak Out. My name is XX and I'm one of the Evaluation team

- You were sent a **participant information statement** on your phone and you might have seen hard copies in the waiting area. Have you had a chance to read the sheet?
    - If yes: Do you have any questions about what was in there?
    - If no: Walk participants through main sections of the information sheet, focusing on voluntary nature of participation, risks and benefits and how can access results

- So before we get started I'll just **remind you** that:
    - Our conversation today will probably take around 45 minutes. You can choose not to answer any of my questions, or stop at any time
    - I don't work at Weave, and nothing you say today will affect your relationship with the staff at Weave
    - We won't be using your name when we report the results - your identity will be anonymous when we talk about the findings and when we publish them
    - Your information will not be shared with anyone else, including Weave staff, without your permission except when required by law and/or duty of care
    - We are really interested in your honest responses to the questions. Your feedback will help Weave to improve its programs in the future so negative as well as positive feedback is really useful

    - You will be given a summary of the results of the Evaluation and invited to the launch of the report.

- Do you have any further questions? Answer any questions
- Are you happy to participate in the Evaluation today? *If no, thank participant for their time and end*
- Great, I'll just ask you to **sign this consent statement,** that says you have understood the information in the participant information statement and are willing to participate
- Are you happy for our chat to be **audio recorded**? It is only for my own record-keeping purposes and I'll also be taking notes. I won't share the recording or notes with anyone other than XX, the other person on the Evaluation team. *Record if consent given for recording; start recording if consent given*

Interview Questions

Family Member Involvement in Speak Out

1. I believe that you have been referred by <Name> to participate, who is your <relationship>. Is that right?
2. Do you know what **type of activities and support** <Name> has received from Weave? *Reassure participant if they don't know that this is OK*
    - If yes: What are they? *[probe to gain clarity on which ones are Speak Out related or not]*

So today we are particularly interested in one of the programs Weave provides which is called **Speak Out**. The Speak Out program involves multiple activities and support for young people experiencing challenges with mental health and alcohol or other drugs. *[point to visual of Weave Programs and where Speak Out fits]*

3. From what you've told me it sounds like the Speak Out programs <Name> was involved in are XX, XXand XX. The other activities you've talked about are part of other programs of Weave.
4. So for today we'll focus just on the Speak Out programs i.e. XX, XXand XX. Is that ok? *[answer any questions they have around this]*
5. Are you able to tell me about **when and how** <Name> became involved with Speak Out? *Reassure participant if they don't know that this is OK and skip to Question 6*
    - Around how old was <Name> when they first became involved? How old are they now?

Outcomes

6. Let's think back now to when <Name> first joined Speak Out, so first did XX. Do you remember **what you wanted** <Name> **to get out** of the program? What was that? *[probe if to find out underlying reasons]*

7. What have been **some of the main changes in your life** since <Name> involved in Speak Out? These can be positive or negative changes. *After family member describes changes, ask if there are any other changes they want to report.*

8. Of these changes, which one of these do you think is the **most important** to you?
    - CAPTURE STORY. Clarify:
        - What the focus of the story is - what happened? To who?
        - Why did it happen? What happened before this? *[to get beginning of story]*
        - What difference did it make? Why is this important? *[to get end of the story]*
        - What role if any did Speak Out or Weave play in these changes? *[to get contribution of Speak Out or Weave more generally to the change]*

9. *If timing permits and not already raised in earlier responses on changes experienced:* One of the things that Speak Out aims to do is to **increase connection** with family, culture and community. Do you think that <Name's> involvement in Speak Out has helped them to increase connection with family, culture and community?
    - If yes: How has Speak Out helped <Name> with these connections? *[if needed probe to clarify which type(s) of connections participant referring to]*
    - If no: What else could have Speak Out done to help <Name>, or other young people like them, to increase connection with family, culture and community?

10. *If participant is appropriate age (22 years+), timing permits, and not already raised in earlier responses on changes experienced:* Speak Out often works with young people as they move from being teenagers to being adults. Do you think that Speak Out has helped <Name> with **becoming an adult?**
    - If yes: How has Speak Out helped <Name>become an adult?
    - If no: What else could have Speak Out done to help <Name>, or others like them, become an adult?

Speak Out Feedback

Thank you for all your responses so far, we are almost done.

11. The final question is about how Speak Out and Weave could improve their programs for the future, to better support young people experiencing challenges with their mental health and alcohol or other drugs. From what you know, what do you think would **improve** the Speak Out program? *[probe as needed for clarification of suggestions, and at the end ask 'Any other suggestions you have for improvement?']*

12. Thank you again for your time today. Is there anything else you want to say before we end our conversation?

Interview Close
Turn off audio recorder

Do you have any **final questions** for me about the evaluation?

How are you feeling after sharing those thoughts/stories with me? If you feel like it's brought up any big feelings for you, you can contact Weave for a bit of extra support (provide name of relevant staff member and contact details). You don't have to tell them anything about what we have talked about today, just let them know that you want a bit of extra support.

Thank you again for your time today. *Provide thank you card with reimbursement voucher.* We have just got a few final things to cover.

- As we said in the information sheet, we will be working on the Evaluation for the next few months and then we will **write a report and have a launch**. You will be invited to the launch, and we will provide a link to the report - including a more user-friendly summary! - for everyone who has been part of it.
- If you want to follow up with me, **you can contact me here** (provide contact details/card). If you have any questions or remember something really important that you want to add please get in touch with me.

Thank you so much for your time today. We really appreciate it, and it's been great to talk with you.

8.8.3 Youth Advocates Focus Group

Informed Consent

- Thank you all for coming in today for this chat about Speak Out. My name is XX and I'll be leading the discussion today, and this is XX who will be taking notes. We are part of the external team who is conducting this Evaluation of the Speak Out program for Weave.

- You were each sent a copy of **this participant information statement** on your phone and <name> also shared with you some hard copies before this meeting. Has everyone had a chance to read it?
    - If yes: Do you have any questions about what was in there?
    - If no: Walk participants through main sections of the information sheet, focusing on voluntary nature of participation, risks and benefits and how can access results

- So before we get started I'll just **remind you** that:
    - Our discussion today will take up to 1.5 hours and focus on the Speak Out program, which supports young people experiencing challenges with mental health and alcohol or other drugs
    - You have been asked to be part of this discussion because of your lived experience with mental health and/or alcohol or other drugs, and your knowledge about services that support young people experiencing these challenges. However you **are not expected** to tell us about your own personal challenges with mental health or alcohol or other drugs or with the Speak Out program today, but rather reflect on the experience of young people more generally
    - You can choose **not to answer** any of my questions, or stop at any time
    - We don't work for Weave, and **nothing you say today will affect your relationship** with the staff at Weave or your involvement in the Youth Advocate group
    - We are really interested in your **honest responses** to the questions. Your feedback will help Weave to improve its programs in the future so negative as well as positive feedback is really useful
    - We won't be using your name when we report the results - your **identity will be anonymous** when we talk about the findings and when we publish them. We'll also ask that you protect each others confidentiality and don't share the information discussed today with others
    - You will be provided with a **summary of the results** of the Evaluation. Do you have any further questions? *Answer any questions*
- Is everyone happy to participate in the Evaluation today? *If no, thank those who don't want to participate for their time and invite them to leave the room*

- Great, I'll just ask everyone to first **sign a consent statement,** that says you have understood the information in the participant information statement and are willing to participate

- Is everyone happy for our chat to be **audio recorded**? It is only for my own record-keeping purposes and we'll also be taking notes. *Record if consent given for recording; start recording if consent given*

Discussion Questions

1. We'll start off with a general question. What are some of the **main needs** of young people in Sydney who are experiencing challenges with their mental health and alcohol and drugs? *Record up responses on whiteboard/flip chart if available. If needed probe for needs around the two issues, other individual needs (e.g. housing, employment, sense of purpose and connection), needs of those around them (family/friends) and needs of institutions that support this population (e.g. schools, hospitals, police). Probe regarding suicide if not raised by group)*

2. Which of these needs are **currently being met** by existing services and programs? Which needs aren't being met? *(run through needs listed on board and identify those that are and aren't being met)*

3. Now we'll switch and think specifically about the **Youth Advocates program** that you are part of. **What value** do you think this type of program has? *Probe for benefits for the Youth Advocates themselves, young people more generally, Weave as an organisation and the wider sector*

4. Why do you think **young people might want to come** to the Youth Advocates program, or other programs that Weave runs such as Speak Out?

5. Speak Out is a program offering a mix of individual casework and counselling, and group activities such as Park Warriors, Art Group and MAD Pride to young people aged 12-28 years. **Is this similar or different** to other programs you are aware of that work with young people experiencing challenges with their mental health and alcohol and drugs?
    a. If different: What is different about Speak Out to other programs? Why are these differences important? *Probe to find out if the differences are seen as positive or negative*

6. We are now at the last question. What **recommendations** do you have for improving services and programs for young people experiencing challenges with their mental health and alcohol or other drugs? *Can be specific to Speak Out or Weave, or more generally*

7. Thank you all for your time today. Is there **anything else** anyone else wants to say before we end our discussion?

Focus Group Close
Turn off audio recorder

How are you feeling after sharing those thoughts/stories with me? If you feel like it's brought up any big feelings for you, you can contact Weave for a bit of extra support (provide name of relevant staff member and contact details). You don't have to tell them anything about what we have talked about today, just let them know that you want a bit of extra support.

Thank you again for your time today.

As we said in the information sheet, we will be working on the Evaluation for the next few months and then we will write a report and have a launch. You will be invited to the launch, and we will provide a link to the report - including a more user-friendly summary! - for everyone who has been part of it.

Just a reminder to please respect each other's confidentiality and don't discuss the details of what we talked about today with others.

Final thing - if you want to follow up with me, you can contact me here (provide contact details/card). If you remember something really important that you want to add, or if you change your mind about us using any of the information you have provided.

Thank you so much for your time today. *Provide thank you card with reimbursement voucher.* We really appreciate it, and it's been great to talk with you.

8.8.4 Speak Out staff and Weave senior leaders

Informed Consent

- Thank you all for making time today for this chat about Speak Out. My name is XX and I'll be leading the discussion today, and this is XX who will be taking notes. We are part of the external team who is conducting this Evaluation of the Speak Out program for Weave.

- As we begin, I'd like to acknowledge the traditional owners of the land we meet on, the Gadigal people of the Eora Nation, and pay my respect to Elders past and present.

- You were each sent a copy of **this participant information statement** by email. Has everyone had a chance to read it?
    - If yes: Do you have any questions about what was in there?
    - If no: Walk participants through main sections of the information sheet, focusing on voluntary nature of participation, risks and benefits and how can access results

- So before we get started I'll just **remind you** that:
    - Our discussion today will take up to 1.5 hours and will focus on the Speak Out program, which supports young people experiencing challenges with mental health and alcohol or other drugs
    - We are particularly focusing this Evaluation on Speak Out from 2015 onwards. We will capture specific information on Speak Out during the coronavirus pandemic, but would like you to reflect today on Speak Out over the past few years, not only the past five months
    - You have been asked to be part of this discussion because of your role [as a staff member in SpeakOut/leadership role in Weave].
    - You can choose **not to answer** any of my questions, or stop at any time
    - We don't work for Weave, and **nothing you say today will affect your role at Weave** or your relationship with staff and Board members at Weave
    - We are really interested in your **honest responses t**o the questions. Your feedback will help Weave to improve its programs in the future so negative as well as positive feedback is really useful
    - We won't be using your name when we report the results - your responses will be **combined with those from others and won't be attributable to you directly** when we talk about the findings and when we publish them. We'll also ask that you protect each others confidentiality and don't share the information discussed today with others
    - You will be provided with a **summary of the results** of the Evaluation. Do you have any further questions? *Answer any question*
- Are you happy to participate in the Evaluation today? *If no, thank those who don't want to participate for their time and invite them to leave the room*

- Great, I'll just ask you to each **sign a consent statement** that says you have understood the information in the participant information statement and are willing to participate
    - If conducted virtually: If you haven't already, I need you to send me a text or email now confirming that you agree to participate. *Wait for all texts/emails to be received before continuing*
- Are you happy for our chat to be **recorded**? It is only for my own record-keeping purposes and we'll also be taking notes. *Record if consent given for recording; start recording if consent given*

Discussion Questions

1. Can I ask you to start by introducing yourself, by name, your role [in SpeakOut/at Weave] and how long you've been in that role.

2. We'll start off with a general question. What are some of the **main needs** of young people in Sydney who are experiencing challenges with their mental health and alcohol and drugs - in general, not specifically around COVID-19? *Record up responses on whiteboard/flip chart if available. If needed probe for needs around the two issues, other social determinants of health (e.g. housing and living arrangements, employment, sense of purpose and connection, support from family), needs of those around them (family/friends) and needs of institutions that support this population (e.g. schools, hospitals, police). Probe regarding suicide if not raised by group)*

Let's talk more specifically about the Speak Out Program. As you know, Speak Out focuses on young people aged 12-28 who are experiencing challenges with both mental health and alcohol and other drugs. Speak Out offers a mix of individual casework and counselling, group activities such as Park Warriors, Art Group and MAD Pride and involvement in advocacy.

3. Tell me about the **Speak Out model**. What do you see as the main principles, frameworks and therapeutic models that underpin the design of the Speak Out program?

4. In your opinion, has the Speak Out model changed over the last five years? If so, what changes have you observed?

5. **What do you see as the unique characteristics** of the Speak Out program compared to other programs for this population? Potential follow-up questions:

    a. How is Speak Out **similar or different** to other programs you are aware of that work with young people experiencing challenges with their mental health and alcohol and drugs? *Probe in relation to the unique approach to treating young people experiencing both mental health and AOD use; working with young Aboriginal people; working with families where appropriate; providing services to 25-28 year olds; providing leadership and advocacy opportunities.*

    b. Why are these differences important? *Probe to find out if the differences are seen as positive or negative*

6. Now let's talk about the day to day implementation of the program. How does the program run on a day to day basis? *Prompt re screening and assessment, allocation, goal setting, how appointments are made.*

7. How is the day to day **implementation similar or different** to the program 'on paper'? *(Probe for fidelity/adaptation, barriers to consistency)*

8. Now thinking about the clients of the Speak Out program, why do you think Speak Out has been successful in reaching such a high proportion of young Aboriginal people? *(Probe around adaptations to the program to make it more culturally safe for young Aboriginal people.)* What other patterns have you observed in who engages with Speak Out? *(Probe: e.g. young people with different cognitive capabilities and developmental differences)*

We've been talking about the Speak Out client population and activities. Now let's think about the changes in young people's lives that Speak Out is working towards - we call these changes outcomes.

9. What do you think are the main **outcomes** that Speak Out is working towards for young people?

10. What are the main types of **changes have you personally seen in the lives of Speak Out clients** since they've been engaged with Speak Out?
    a. To what extent do you believe are those changes due to their participation in Speak Out vs due to other things?
    b. Are these changes positive, negative or neutral?
    c. Do you think the current design of Speak Out supports achieving those outcomes? Why or why not?
    d. Are these changes expected by the Program or are these unexpected changes?

11. Do you think that clients, their families, communities and Speak Out staff want similar or different outcomes for young people? If different: how do they differ?

12. What is your opinion on the **impact of COVID-19** on the needs of young people?

13. How has COVID-19 affected Speak Out program delivery? Are these changes positive or negative?

14. How do you think the Speak Out program should change to adapt to the needs and realities of young people in a COVID and post COVID world?

15. Please tell us about the relationship between SpeakOut and other Weave programs and services. Do Speak Out clients also access other Weave programs and services? Which ones in particular?

16. Please tell us about the relationships between SpeakOut and other services working in this area. How do you support clients who are accessing multiple services? How do you facilitate continuity of care?

17. Thinking about individual clients, how do you monitor their wellbeing and their progress towards their goals?

18. Are you aware of how the operations and outcomes of Speak Out are currently monitored or evaluated? If yes - how is this done? *Prompt re assessment, data collection, case reviews.*

19. All the following questions are about **how the Speak Out program could be improved.** *(if not mentioned previously)*
    a. How could Speak Out improve its reach to, and retention of, young people (where appropriate)?
    b. How could the implementation of the Speak Out Program be improved?
    c. How could the outcomes of the Speak Out program be improved?
    d. How could monitoring and evaluation of the program be improved?

20. We are now at the last group of questions. A previous evaluation of Speak Out in 2010 identified some challenges related to high caseload of clients for Speak Out staff, gaps in the skills and experiences of staff and some limitations in processes and systems to deliver Speak Out. Is that something you have experienced? If yes - how do you think that has affected the achievement of the intended outcomes of Speak Out?

21. Thank you all for your time today. Are you comfortable with us listing you in the Report as a participant in the Evaluation?

22. Is there **anything else** anyone else wants to say before we end our discussion?

Interview/Focus Group Close
Turn off recorder

How are you feeling after sharing those thoughts/stories with me? Is there anything we can do to support you?

Thank you again for your time today.

As we said in the information sheet, we will be working on the Evaluation for the next few months and then we will write a report and have a launch. You will be invited to the launch, and we will provide a link to the report for everyone who has been part of it.

Just a reminder [to those participating in focus groups] to please respect each other's confidentiality and don't discuss the details of what we talked about today with others.

Final thing - if you want to follow up with me, you can contact me here (provide contact details/card - in chat box if conducting virtually). If you remember something really important that you want to add, or if you change your mind about us using any of the information you have provided.

Thank you so much for your time today.

We really appreciate it, and it's been great to talk with you.

8.8.5 External stakeholders interviews

Informed Consent

- Thank you all for making time today for this chat about Speak Out. My name is XX and I'll be leading the discussion today, and this is XX who will be taking notes. We are part of the external team who is conducting this Evaluation of the Speak Out program for Weave.

- As we begin, I'd like to acknowledge the traditional owners of the land we meet on, the Gadigal people of the Eora Nation, and pay my respect to Elders past and present.

- You were each sent a copy of **this participant information statement** by email. Have you had a chance to read it?
    - If yes: Do you have any questions about what was in there?
    - If no: Walk participants through main sections of the information sheet, focusing on voluntary nature of participation, risks and benefits and how can access results

- So before we get started I'll just **remind you** that:
    - Our discussion today will take up to 1.5 hours and focus on the Speak Out program, which supports young people experiencing challenges with mental health and alcohol or other drugs
    - We are particularly focusing this Evaluation on Speak Out from 2015 onwards. We will capture specific information on Speak Out during the coronavirus pandemic but would like you to reflect today on Speak Out over the past few years, not only the past five months
    - You have been asked to be part of this discussion because you are an important external stakeholder for Weave.
    - You can choose **not to answer** any of my questions, or stop at any time
    - We don't work for Weave, and **nothing you say today will affect** your relationship with staff and Board members at Weave
    - We are really interested in your **honest responses** to the questions. Your feedback will help Weave to improve its programs in the future so negative as well as positive feedback is really useful
    - We won't be using your name when we report the results - your responses will be **combined with those from others and won't be attributable to you directly** and when we publish them. We'll also ask that you protect each others confidentiality and don't share the information discussed today with others
    - You will be provided with a **summary of the results** of the Evaluation. Do you have any further questions? *Answer any questions*

- Are you happy to participate in the Evaluation today? *If no, thank those who don't want to participate for their time and invite them to leave the room*

- Great, I'll just ask you each to **sign a consent statement** that says you have understood the information in the participant information statement and are willing to participate
    - If conducted virtually: If you haven't already, I need you to send me a text or email now confirming that you agree to participate. *Wait for all texts/emails to be received before continuing*
- Is everyone happy for our chat to be **recorded**? It is only for my own record-keeping purposes and we'll also be taking notes *Record if consent given for recording; start recording if consent given*

Discussion Questions

1. I'll first ask everyone to identify themselves with their name, organisation and why they are here today, including a little bit about your relationship with the Speak Out program.
2. We'll start off with a general question. What are some of the **main needs** of young people in Sydney who are experiencing challenges with their mental health and alcohol and drugs - in general, not specifically around COVID-19? *Record up responses on whiteboard/flip chart if available. If needed probe for needs around the two issues, other social determinants of health (e.g. housing and living arrangements, employment, sense of purpose and connection, support from family), needs of those around them (family/friends) and needs of institutions that support this population (e.g. schools, hospitals, police). Probe regarding suicide if not raised by group)*

Let's talk more specifically about the Speak Out Program. As you know, Speak Out focuses on young people aged 12-28 who are experiencing challenges with both mental health and alcohol and other drugs. Speak Out offers a mix of individual casework and counselling, group activities such as Park Warriors, Art Group and MAD Pride, and involvement in advocacy.

3. **What do you see as the strengths** of the Speak Out program? *Potential follow-up questions:*
    a. How is Speak Out **similar or different** to other programs you are aware of that work with young people experiencing challenges with their mental health and alcohol and drugs? *Probe in relation to the unique approach to treating young people experiencing both mental health and AOD use; working with young Aboriginal people; providing services to 25-28 year olds.*
    b. Why are these differences important? *Probe to find out if the differences are seen as positive or negative*
4. How would you describe the collaboration between Speak Out and other services working in this area?
    a. What kinds of collaboration occur (*probe - shared clients, shared projects, joint advocacy).*
    b. How effective is that collaboration?
    c. What are your observations about continuity of care between your service and Speak Out?

We've been talking about the Speak Out client population and activities. Now let's think about the changes in young people's lives that Speak Out is working towards - we call these changes outcomes.

5. What do you think are the main **outcomes** that Speak Out is working towards for young people?

6. For those of you who have joint clients with Speak Out, what are the main types of **changes you have seen in the lives of Speak Out clients** since they've been engaged with Speak Out?
    a. To what extent do you believe are those changes due to their participation in Speak Out vs due to other things?
    b. Are these changes positive, negative or neutral?
    c. Do you think the current design of Speak Out supports achieving those outcomes? Why or why not?

7. How, in your opinion, has **COVID-19 affected the needs** of young people? Do you have any observations about how COVID-19 has affected Speak Out program delivery?

8. How do you think programs like Speak Out for young people should change to adapt to the needs and realities of young people in a COVID and post COVID world?

9. We are now at the last group of questions. How do you think the Speak Out program could be improved? (probe if not raised: How could the relationship between Speak Out and other services be improved?)

10. Thank you all for your time today. Are you comfortable with us listing you in the Report as a participant in the Evaluation?

11. Is there **anything else** anyone else wants to say before we end our discussion?

Focus Group Close
Turn off recorder

How are you feeling after sharing those thoughts/stories with me? Is there anything we can do to support you?

Thank you again for your time today.

As we said in the information sheet, we will be working on the Evaluation for the next few months and then we will write a report and have a launch. You will be invited to the launch, and we will provide a link to the report for everyone who has been part of it.

Just a reminder to please respect each other's confidentiality and don't discuss the details of what we talked about today with others.

Final thing - if you want to follow up with me, you can contact me here (provide contact details/card - in chat box if conducting virtually). If you remember something really important that you want to add, or if you change your mind about us using any of the information you have provided.

Thank you so much for your time today.

We really appreciate it, and it's been great to talk with you.

8.9 Project Governance

8.9.1 Community Advisory Group

Speak Out Dual Diagnosis Program Evaluation

Community Advisory Group

Terms of Reference

What are we doing?

Weave Youth and Community Services has received funding to evaluate its Speak Out Dual Diagnosis Program. The Speak Out Program assists and supports young people aged 12 – 28 years who are experiencing mental health and alcohol and/or other drug challenges. About 68% of the young people we work with are Aboriginal young people.

The Speak Out Evaluation is an opportunity for us to determine the impact Speak Out is having on the lives of the young people we support. We want to find out what is working well and what needs changing or strengthening. The Evaluation has just begun and will run for the next 18 months.

The Evaluation will be led by independent consultant, Lisa Ryan and Judy Gold. The Weave Programs and Operations Manager and Speak Out Team Leader will work closely with Lisa and Judy on this project.

What we would like from you?

Weave is committed to working alongside our clients and community to inform the work we do. We are also committed to making sure that we do the best possible evaluation of our work.

For this reason, we are setting up a Community Advisory Group for the Speak Out Evaluation. The role of the Community Advisory Group is to advise Weave on the Evaluation. Weave will ultimately be responsible for making decisions about the Evaluation.

About the Community Advisory Group

The Community Advisory Group will meet regularly to discuss the Evaluation, share thoughts and ideas. The group will help to ensure:

- The Evaluation is *culturally sensitive*
- Our *processes for the Evaluation are appropriate and safe for* our clients and community members (research design)

- *The client experience of Speak Out is represented accurately in the Evaluation* (data interpretation)
- We talk to the *community and to other services* about the Evaluation in an appropriate way (publication/dissemination)

Membership

The Community Advisory Group will be made up of 5-6 members, including young people, people who used to be supported by the Speak Out Team and local community members and leaders.

Reimbursement

We really value your time and your contribution and we are grateful for your participation in this important project. All Community Advisory Group members will be reimbursed for their time.

Other Committees

The Speak Out Evaluation also includes a Technical Advisory Group, made up of experts in evaluations. Both committees will come together at times to help with the Evaluation.

8.9.2 Technical Advisory Group

Speak Out Program Evaluation

Speak Out Dual Diagnosis Program Evaluation

Technical Advisory Group

Terms of Reference

Background

Weave Youth and Community Services has secured funding to contract an independent Evaluation of the Speak Out Dual Diagnosis Program. The Speak Out Program assists and supports young people aged 12 – 28 years who are experiencing mental health and alcohol and/or other drug challenges. Approximately 68% of the young people we work with are Aboriginal young people.

The Speak Out Evaluation project creates a unique opportunity for Weave to determine the impact and outcomes achieved by Speak Out; identify areas for learning and strengthening of the program; and contribute to the evidence-base for working effectively with young people experiencing dual diagnosis. The Evaluation will be completed in 2020.

The Evaluation will be led by our independent consultant, Lisa Ryan. The Weave Programs and Operations Manager, and Speak Out Team Leader, will work closely with Lisa on this project.

Purpose

The purpose of the **Technical Advisory Group** (TAG) is to provide advice to Weave on the Evaluation. Specifically, the TAG will:

- Provide expert feedback on the proposed methodology, both via meetings and out of session
- Assist the Evaluation team and Weave to address any challenges as they arise
- Review and provide advice on the technical reports, draft Evaluation report and final Evaluation report
- Provide ongoing support and advice for the Evaluation, including to assist the project to meet key milestones.

Weave will retain responsibility for making decisions about the Evaluation.

Working arrangements

The Technical Advisory Group will meet once every two months from April, 2019 to July, 2020. Meetings will be co-chaired by the Weave Programs and Operations Manager and the Speak Out Team Leader.

Principles

Key principles that inform the relationship between the TAG and Weave are:

- A shared commitment to evaluation and research being conducted to the highest standard and
- A shared commitment to evaluation and research being informed by both technical expertise and community experience/wisdom.

Membership

Lisa Ryan	Independent Consultant, Hecate Consulting
Judy Gold	Independent Consultant, sub-contracting to Hecate Consulting
(Currently vacant)	Team Leader, Speak Out Dual Diagnosis Program, Weave
(Currently vacant)	Programs and Operations Manager, Weave
Christina Marel	MATILDA Centre for Research in Mental Health and Substance Use
Katherine Mills	MATILDA Centre for Research in Mental Health and Substance Use
Andrea Stone	Sydney Local Health District

Community Advisory Group

The project will also be overseen by a Community Advisory Group. Where appropriate, the Technical Advisory Group and Community Advisory Group will hold joint meetings to provide feedback and advice to the Evaluation team.