Mental Health and Psychosocial Support (MHPSS) Linked to the COVID-19 Crisis in the United States

Evaluation of the Project Component Implemented by Arthur Ashe Institute for Urban Health (AAIUH), Brooklyn

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Summary

From September 2020 to October 2021, a mental health and psychosocial support (MHPSS) project was implemented by the Arthur Ashe Institute for Urban Health (AAIUH), with the support of UNICEF USA (UUSA), in response to the COVID-19 pandemic in multi-ethnic, multi-racial urban communities in Brooklyn, New York. AAIUH built on their long standing engagement with communities, families and youth to mount a local and contextualized response to the mental health challenges faced by young people in the context of the pandemic.

Using a theory of change (ToC) and a logical framework (logframe) for results and interventions, the partnership conducted a needs assessment and developed training resources and mental health and psychosocial support strategies and tools for essential workers. The overall goal was to enable and empower girls and boys, youth and their families and communities to better cope with COVID-19-related MHPSS risks and vulnerabilities through the delivery of a culturally tailored curriculum to train community members in knowledge and skills and enable the delivery of key messages and support for community-based mental and emotional health and wellbeing. The targeted beneficiaries included community-based organizations (CBOs) with outreach with outreach to individuals in the community; faith-based leaders; barbers and hair stylists; and high school students. Planned outputs and outcomes were all surpassed, reaching larger numbers of beneficiaries than originally targeted.

The multiple strategies and interventions used by the project proved relevant to addressing the MHPSS issues in the target groups. The project was clearly adapted to the context of the COVID-19 pandemic, and to the simultaneous, historic racial reckoning that surged in the wake of George Floyd's killing and the Black Lives Matter movement. The assumptions of the ToC hold generally true and with the implementation of the project's logframe, AAIUH and UUSA achieved considerable success toward their overall objective to enable vulnerable children and youth, and their families and communities, to better cope with the mental health and psychosocial risks and vulnerabilities due to COVID-19.

The principal contribution of the project is in delivering a tailored mental health intervention to young people and their families in communities where there is considerable stigma associated with mental health services, and most people have had little or no prior access to mental health services. This included capacity building of frontline workers and service providers, professionals, educators, and community and faith-based leaders and elders, together with parents and young people. Youth participants consistently reported that they had never been exposed to discussions around mental health, and that they wanted more

knowledge and skills to address mental health for themselves and their peers. Factors contributing to project success included the dedication and high capacity of AAIUH staff; the high caliber of the Advisory Group; the emphasis on a participatory needs assessment; a robust monitoring and evaluation (M&E) framework and tools; and the strength of existing and new partnerships established.

A summary of outputs achieved is as follows:

- 173 youth and students participated in the needs assessment research.
- 21 MHPSS workshops were held, engaging 697 youth and adults, above the target of 585. AAIUH estimates that these people may have counselled or made referrals to another 2,788 community members.
- An estimated 5,000+ community members were reached with information, education and communication (IEC) materials.[1]
- 14 new institutional partnerships were established with local community-based and faith-based organizations.

In a 3-month post-project follow up survey, The vast majority of participants reported satisfaction with the MHPSS TOT course and improved MHPSS knowledge and awareness, including self-care, active listening, positive coping and support skills.

Resources available for the project appear to have been adequate to achieve the expected outputs, and none of the planned outputs were constrained due to resource limitations. Project benchmarks and achievements were thoroughly monitored for quality assurance and participant feedback during implementation. The project has also strengthened the institutional capacity of the implementing partners with respect to MHPSS programming. Coordination appears to have been more than adequate and responsive. Some of the strategies and interventions used by the project clearly lend themselves to wider scalability and program expansion. The program appears to be sustainable in terms of Leadership; Community Engagement; Relevance; Adaptability & Agility; Efficiency and Effectiveness; and Infrastructure, though many respondents are concerned about a lack of funding for continued MHPSS work.

Recommendations call upon AAIUH to: expand the reach of the MHPSS curriculum as an ongoing initiative; consult young people to find ways to keep the curriculum relevant over time; consider approaches based in the arts and creative expression; commit to the

[1] According to program managers, this Includes people who viewed articles, attended conference presentations, received followup emails, newsletters, etc.

consistent collection of demographic data on participants; better ensure gender parity of participation and bring in more marginalized groups in the community; further invest in human resources on mental health and wellbeing; and conduct refresher trainings and additional sessions on related issues.

Based on the findings, AAIUH should also find ways to integrate mental health into local school curricula; foster local and national networks on urban mental health, for example by convening a local working group on (youth) MHPSS; maintain links with academia as a means of contributing to the evidence base; advocate in coalition for city government funding for MHPSS programming; and identify pathways to future careers for young people in mental health.

Acronyms

AAIUH	Arthur Ashe Institute for Urban Health
CBO	Community-based organization
FGD	Focus group discussion
HDPI	Humanitarian and Development Partnerships International
KII	Key informant interview
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, +
M&E	Monitoring and evaluation
MHPSS	Mental health and psychosocial support
ToC	Theory of change
UUSA	UNICEF USA

Background

From September 2020 to October 2021, a project on mental health and wellbeing was implemented by AAIUH, supported by UUSA, in response to the COVID-19 pandemic. AAIUH built the project on their long-standing engagement with communities, families and youth to build a local and contextualized response to the mental health challenges faced by young people in the context of the pandemic.

The COVID-19 pandemic has caused devastating impacts on children and their families. While children have been less affected by the direct impacts of the pandemic on physical health, they have suffered the loss of their parents or family members, and millions of children around the world have fallen into extreme poverty. Widespread school closures due to COVID-19 have proved a setback to children's learning and the development of their social and life skills. Children have also been exposed to increased domestic violence and multiple forms of exploitation due to lockdowns, isolation and poverty. The impacts of the COVID-19 have been most severe for children already disadvantaged due to social and economic disparities, and among indigenous, marginalized and racially diverse communities.

In April 2020, recognizing the impacts of the COVID-19 pandemic on children's mental health and wellbeing among vulnerable communities, UUSA undertook a rapid gap analysis which surveyed more than 40 partners, including state and city government offices and community-based organizations, on children's vulnerability, access to services and schooling. Informed by the analysis, UUSA focused on strengthening resilience and building capacity for mental health and wellbeing in most vulnerable communities affected by COVID-19, to reach the children in greatest need.

The UUSA/AAIUH response served multi-ethnic urban communities in Brooklyn, New York. Using a theory of change (ToC) and a logframe for results and interventions, the partnership conducted a needs assessment and developed training resources and mental health and psychosocial support strategies and tools for frontline and essential workers in multi-racial urban communities. Children and families in these contexts are disproportionately affected by the pandemic. In addition, structural racism leads to disproportionately poor outcomes in health, including mental health, in access to education, in financial security and income, and exposure to violence. Specific disparities include racial profiling in encounters with the police and law enforcement, and obstacles in accessing the criminal justice system. The grant period and project implementation coincided with the police killing of George Floyd and the national and international uprising that followed. In this way, a program originally focused on

mental health and psychosocial (MHPSS) response to the pandemic necessarily broadened and became an MHPSS response to wide ranging issues, in particular, structural racism and police violence.

The program tools and resources developed during the program implementation include a curriculum on mental and emotional health and wellbeing adapted to the needs of multi-racial urban communities, addressing the stigma in those communities associated with accessing mental health services. The program also includes communication and social mobilization tools and activities to raise awareness, strengthen resilience and address the short and long-term impacts of COVID-19 on the mental and emotional health and wellbeing of children, their families and communities.

The project included an evaluation component to be conducted at project end, which would identify key achievements, successes and lessons, and also provide recommendations for the future.

This evaluation was conducted from October 2021 to January 2022.

UUSA program Objectives and Strategies

The overall objective of the UUSA program on domestic response to the COVID-19 crisis in the United States is to enable vulnerable children and youth, and their families and communities, to better cope with the mental health and psychosocial risks and vulnerabilities due to COVID-19.

The specific objectives were to:

- Strengthen resilience and mitigate the harmful effects of COVID-19 in designated sites in the United States;
- Engage affected communities and civil society in building capacity to better cope with the mental health and psychosocial risks and vulnerabilities due to COVID-19;
- Develop a results-based monitoring and evaluation framework for the program implementation;
- Expand the donor base dedicated to national causes.

The program response was intended to raise awareness and increase knowledge on mental health, and to improve the positive behavior and coping skills of children and young people, together with their parents and caregivers, and to engage faith-based leaders, educators and frontline and essential workers in the provision of mental health support and services. The

activities to be undertaken in building the capacity of vulnerable children, youth, families and communities include trainings on psychological first aid and self-care for frontline and essential workers, and trainings on mental health and psychosocial support, as well as community-based communication and social mobilization initiatives.

The MHPSS project was implemented by identifying two main partners, Arthur Ashe Institute for Urban Health (AAIUH), working with multi-ethnic and multi-racial communities in Brooklyn, New York, and Johns Hopkins Center for American Indian Health (JHCAIH), working with Native American tribal communities. This evaluation focuses only on the project component implemented by AAIUH, a CBO which utilises a model of community health to enable individuals to become advocates for their own health, as well as for the health of others within their communities. The Institute works in Brooklyn, New York, empowering youth and building capacity for youth leadership by providing young people with the skills needed to be successful in pursuing careers in the health professions. The communities served by AAIUH – Bedford-Stuyvesant, Brownsville, Crown Heights, East Flatbush and Prospect Heights – are predominantly Black and Latino with a high number of immigrants, and face the compounding factors of intergenerational poverty, structural racism and a lack of resources, exacerbating the devastating impact of the COVID-19 pandemic. AAIUH has a long track record of collaboration with youth, faith-based leaders and professional groups, such as barbers and hair stylists, who have an intimate relationship with parents, caregivers and young people. Through close ties with the community, AAIUH has been able to design, implement and evaluate neighborhood-based interventions that address health conditions disproportionately affecting people of color, including the impacts of COVID-19 in those communities.

The AAIUH project proposal originally had the following objectives:

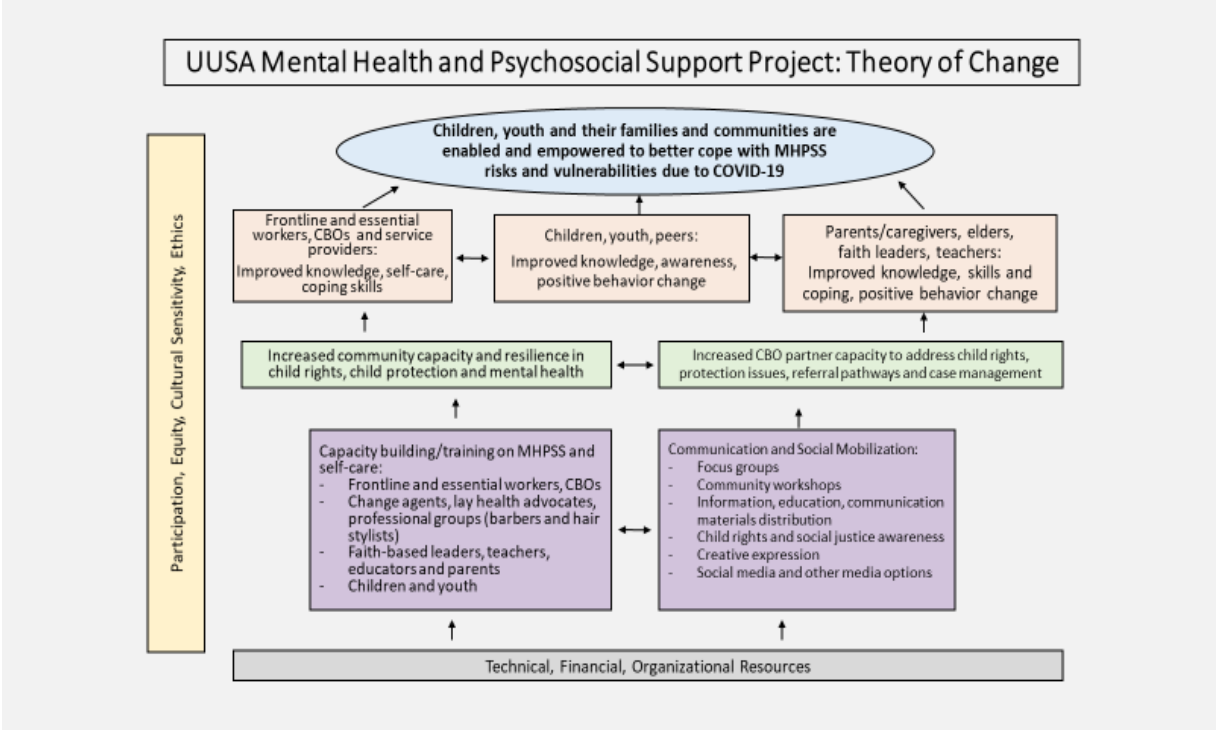
i) Increase the capacity of targeted beneficiaries through key informant interviews and focus groups exploring cultural norms, attitudes and beliefs related to mental health and psychosocial support, self-care and resilience; and through the delivery of a culturally tailored curriculum to train community members in knowledge and skills to enable the delivery of key messages and support for community-based mental and emotional health and wellbeing. The targeted beneficiaries include six community-based organizations (CBOs), with outreach to an estimated 360 individuals in the community; five faith-based leaders, with outreach to an estimated 300 individuals in the community; barbers and hair stylists from 20 barbershops and salons, with outreach to an estimated 1,200 individuals in the community; and twenty high school students, with outreach to an estimated 800 peer students in the community.

ii) Evaluate the impact of the mental health training on changing behaviors, including reducing stigma around mental health and mental health services.

An Advisory Group for the project was assembled by Humanitarian and Development Partnerships International (HDPI), an international consulting network with experienced practitioners working on critical issues in humanitarian response and long-term development. Throughout the implementation, HDPI provided technical support to UUSA and to AAIUH to ensure that interventions were in line with international child rights and child protection standards, and to build a model that could be adapted in response to participant feedback, establishing a participatory approach. HDPI helped to integrate monitoring and evaluation throughout the program such that the process and lessons learned can be used to expand UUSA program engagement, and to set useful precedent for UNICEF National Committees in providing technical support for a range of program interventions for the prot loop ection and wellbeing of children.

The initial desk review and discussion with the AAIUH team confirmed the importance of a needs assessment in the targeted communities where the AAIUH project was to be implemented. The needs assessment generated data and analysis on the nature and extent of the mental health risks and vulnerabilities linked to COVID-19, and assessed contextual factors, such as the availability of existing services and the gaps in services, related to coping and behavioral approaches.

Theory of Change



The broad objectives articulated in the UUSA program rationale, and the objectives and activities outlined in the JHCAIH and AAIUH project proposals, served as a starting point for formulating a theory of change (ToC). The ToC for the UUSA program (see below) identifies, at the impact level, the empowering and enabling of vulnerable children, youth, families and communities to better cope with mental health risks and vulnerabilities due to COVID-19. At the level of program outcomes, it calls for improved knowledge and coping skills of frontline and essential workers, individual children and youth, and parents and caregivers. The output level results relate to increased capacity and resilience of vulnerable communities, and the increased capacity of CBO partners to address child protection needs and to deliver services.

The key interventions outlined in the theory of change are i) capacity building and training of target groups and beneficiaries, notably frontline or essential workers, CBOs and service providers, professional groups, faith-based leaders, children and youth, and other relevant actors, and ii) communication and social mobilization, to promote a community-based approach to mental health and wellbeing and to address the impacts of the COVID-19 pandemic on children, young people, and their families.

The UUSA program ToC was shared with the implementing partners and both partners adapted it to their specific project objectives.

Program Logframe and Monitoring & Evaluation Framework

The ToC provided the basis for the development of the project results framework / logframe through a consultative process.The logframe includes the project impacts, outcomes and outputs, including indicators and means of verification to measure progress. Institutional capacity building was a key strategy of the project, focusing in particular on the AAIUH component to establish a foundation for designing and implementing MHPSS projects.

Institutional Capacity Building

In view of the pioneering nature of the UUSA program, capacity building of partner organisations was envisaged as a crucial component for the long-term sustainability of the program objectives. The HDPI Advisory Group of consultants supported the institutional capacity building of local partner organizations on program planning and design, as well as training and communication activities.

Evaluation Objectives and Use

The MHPSS project implemented by AAIUH has been a unique and path-breaking initiative, introducing innovative approaches to community-based mental health and wellbeing. A well designed evaluation is regarded as a logical conclusion to the project as it will have direct relevance for the ongoing work of AAIUH and other CBOs, UN agencies, donors and other stakeholders, and will also serve as a useful addition to the MHPSS literature. The evaluation will generate important findings, lessons and recommendations for use by a variety of child protection and child rights actors. The primary users of the evaluation include UNICEF/USA and AAIUH, the two institutions which collaborated closely in making the project happen. The lessons and findings will also be of relevance to a wider audience including other UN/UNICEF organisations, government bodies, donors and institutions involved in addressing/expanding MHPSS services in the context of the pandemic response and more broadly.

The main objectives of the evaluation are, as follows:

- Examine the relevance and appropriateness of the project with respect to the design (context and needs assessment), and delivery aspects including overall

conceptualization, coherence of interventions and implementation modalities used in the particular context of the pandemic and community level realities.

- Assess the effectiveness of the project in terms of the results (outputs and outcomes achieved) and the factors contributing to results. Also assess potential impact of the project at the level of the community and project participants.

- Examine the strategies used in the institutional capacity building (resilience, community engagement, partnerships) with respect to their adequacy and contribution to the project's success.

- Identify lessons and recommendations, including for the sustainability of the processes and results, and for the possible expansion of the project.

Evaluation Scope

The theory of change and logframe formulated for the project served as key reference documents for the evaluation. The evaluation assessed the achievements of the project with respect to outcomes, outputs and processes and, to the extent possible, identified the impact of the project at the level of the target communities and participants. It is understood that a rigorous assessment of the project's impact is outside the scope of the evaluation. The evaluation focused on key strategies, including institutional capacity building, community engagement, partnerships and participation, which were important features of the AAIUH project.

Evaluation Questions

Relevance and appropriateness

1. How appropriate are the multiple strategies and intervention used by the project with respect to addressing the MHPSS issues in the target groups?
2. To what extent have the strategies and interventions been adapted to the particular context, e.g., COVID-19 pandemic, racial injustice/BLM, through local-level consultation and needs consideration and assessments?
3. How adequately were overall principles/issues related to inclusion and gender equality and cultural sensitivity considered in the design and implementation of the project?

Effectiveness and potential impact

4. To what extent have the project interventions led to the achievement of planned outputs and outcomes as per the logframe?
5. What were the main achievements of the project with respect to the investments made by the project and what conclusions, if any, could be drawn regarding the potential impact of the project?
6. What were the key factors that contributed to the success/achievements of the projects and those that inhibited the project outcomes?
7. Are there any unanticipated positive or negative outcomes of the project that were noticed during or after project implementation?

Efficiency (resource use, value for money and quality issues)

8. To what extent were the resources available for the project adequate to achieve the expected outputs? Were there any specific interventions/ outputs that were constrained due to resource limitations?
9. What conclusions can be drawn with respect to the level of return from investments made through AAIUH by assessing capacity development and results (outputs and outcomes) achieved?
10. To what extent have project benchmarks and achievements been monitored for quality assurance and participant feedback during the course of project implementation and what lessons can be drawn for going forward?

Institutional capacity building, sustainability and potential scale up/expansion

11. To what extent has the project strengthened the institutional capacity of the implementing partners with respect to MHPSS programming? How adequate and responsive was coordination and technical support provided for the project including development of tools, capacity building of staff and follow up support?
12. How well do the strategies and interventions used by the project lend themselves to wider scalability and program expansion, overall and in specific contexts?
13. How systematically has institutional capacity development been pursued at all levels for long term sustainability of the program? What more needs to be done?
14. What good practices and/or lessons can be drawn for the future for UNICEF/USA and others with respect to convening power and institutional capacity building of implementing partners?
15. Based on the assessment, what can be recommended for the sustainability of the achievements made, and potential expansion / next phase of the project including what resources/tools/support may be needed?

16. To what extent has the project built upon and benefited from the past engagement of AAIUH with various community groups and CBO partners?
17. How have new partnerships been established and what has been the process to identify appropriate partners? How was their capacity and appropriateness/fit to serve as partners for this initiative determined? What best practices and lessons learned can be identified for the future?
18. How systematically have partnerships at the local levels (government bodies, civil society organizations, religious leaders, the media) been established to foster sustainability?
19. Are there any noteworthy good practices and lessons regarding overall program implementation, and the effectiveness of specific strategies or processes used, including partnerships, communication(media)/social mobilisation, and community engagement?

Evaluation approach and methodology

The evaluation took consideration of the context of the project including the challenges and realities posed by the COVID-19 pandemic, also the fact that it was a first such project initiated by UUSA and the particular strength and challenges experienced by AAIUH. The evaluation examined the expected outcomes and outputs outlined in the logical framework (logframe) and reviewed, *inter alia*, the overall coherence of the set of interventions implemented. The evaluation followed a participatory approach and used a mix of qualitative and quantitative data.

Data collection and analysis tools

Desk review of documents and secondary data: Electronic copies of key documents were shared with the evaluation team at the outset of the evaluation: project planning and design documents, needs assessment tools and findings; audio and video recordings of interviews s and focus group discussions; training and orientation materials; findings of training participant feedback; media produced by the project for public consumption; and progress reports. The information was reviewed and analysed during the inception phase to determine the need for additional information and finalisation of the detailed evaluation methodology and tools. Given the relative newness of the program and shortage of literature with value to the evaluation, the evaluation relied more heavily on KIIs and survey data than the desk review.

Key informant interviews: A total of 11 KIIs and two group interviews of three persons each were conducted at several levels and in phases by the evaluation team. A few key staff from UNICEF/USA and the Arthur Ashe team were interviewed together in the initial phase in

order to understand expectations for the evaluation itself. Additional staff from both institutions, as well as from among other stakeholders, were interviewed during the implementation phase, in individual interviews. Project managers from AAIUH and HDPI made introductions for key informant interviews and focus group discussions. When organising interviews, attention was given to ensure gender balance, racial representation, age distribution, cultural sensitivity, and representation of various population groups, as relevant. Respondents' names have been withheld when quoted, instead identified by their role in the project (peer leader, AAIUH staff, etc.). The KII questionnaires are included as an annex.

Surveys: Approximately three months post-project (in mid-January 2022), the evaluation employed an internet-based survey of 67 participants (53 female, 12 male, 2 nonbinary) to assess outcomes and potential impacts from various MHPSS training and orientation interventions. The brief questionnaire was developed in consultation between AAIUH, the evaluation consultant and the Advisory Group, and is included as an annex. The sample was obtained by emailing all participants in the program an invitation to participate in the survey in exchange for a gift card. Survey respondents were thus self-selected and the survey may have oversampled respondents who had a positive experience with the workshops. The sample was also more than 4-to-1 female vs. male.

The evaluation also relied on survey data from two online questionnaires that AAIUH had administered immediately following the workshops, during project implementation: one from the peer-to-peer youth workshops, and another from workshops of adult community leaders. Findings from these two surveys are not unlike the findings from the youth survey at three months post-project.

Analytical framework and methods

The overarching conceptual framework for this evaluation was a theory-based approach, focused on examining design effectiveness and sustainability. This approach is useful in analysing the range of factors that may have contributed to observed effects. Theory-based evaluations are used to examine design adequacy and the quality of the process of implementation to assess whether or not (to what extent) the interventions and processes employed made contributions towards the expected results. The analysis included factors that contributed to the achievements of expected results. In the event that results are not achieved, or partially achieved, this approach can explore whether this is because of theory/design gaps or because implementation did not proceed as expected (implementation failure).

Triangulation and Analytical Approaches

Example of Triangulation

In mixed-methods evaluations, some specific issues or areas of interest may require only one data source. However, most analysis is based on the use of multiple data sources which are guided by the evaluation evidence matrix. Overall analysis involved compiling, comparing and cross-checking the findings from the different lines of inquiry (e.g., document review, key informant interviews, focus group discussions) to address the evaluation questions. Findings regarded as verified, substantive and important to the evaluation were analysed within the cause and effect chains contained in different levels of the theory of change, enabling the team to arrive at conclusions and recommendations about the concept, design and implementation of the project and how these might be improved. In sum, for each evaluation question or groups of questions, a mix of the following analysis methods were utilized:

- Content analysis of existing documents and reports;
- Content analysis of interview findings;
- Analysis of secondary data supplied;
- Analysis of primary data from a survey at 3 months post-project;
- Analysis of actual versus intended results and contributing factors;
- Strengths and gap analysis.

The evaluation questions indicate that several questions should be addressed through multiple sources of evidence. This provides the opportunity for a strong triangulation process covering the full body of evidence gathered, using various methods and tools to generate credible and useful findings and conclusions.

Findings

This section responds to each of the individual evaluation questions in turn.

Relevance and appropriateness

The multiple strategies and interventions used by the project were found to have been relevant in addressing the MHPSS issues in the target groups. Respondents were unanimous on this point, noting that the project "filled a gap", was "extremely relevant", and provided an opportunity for discussion that was "unique to NYC" and "rare". Asked if there was some other combination of interventions that would have been more appropriate to the moment, all KII respondents said no.

> "It made it easy for my students to support each other, and it was also just, relevant. The content was engaging ... and my teachers can really resonate with mental health challenges that they experience. It was very appropriate..." --Education partner

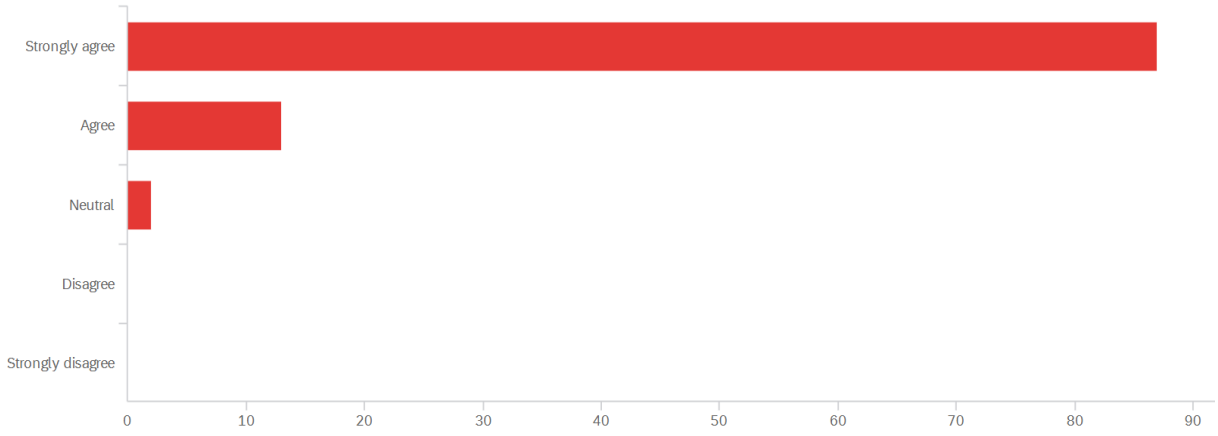
> "To be the organization that is leading the conversation around stigma and mental health in this community, that is the perfect thing to do. They gave young people information and tools that the schools do not provide, that their parents do not provide. I don't think that there is a better thing they could do." --CBO partner

> "Mental health is super stigmatized, and it's easy to write someone off or ignore them if they're angry all the time. I can help direct people, if they ask. I can make suggestions, tell people about Arthur Ashe…and their resources. I see myself as a mediator between professionals and a community that trusts me. You trust me because you've known me for years, I trust them because they bring accurate information, helpful information, information that is tailored to our community's needs."[2] --Participating barber

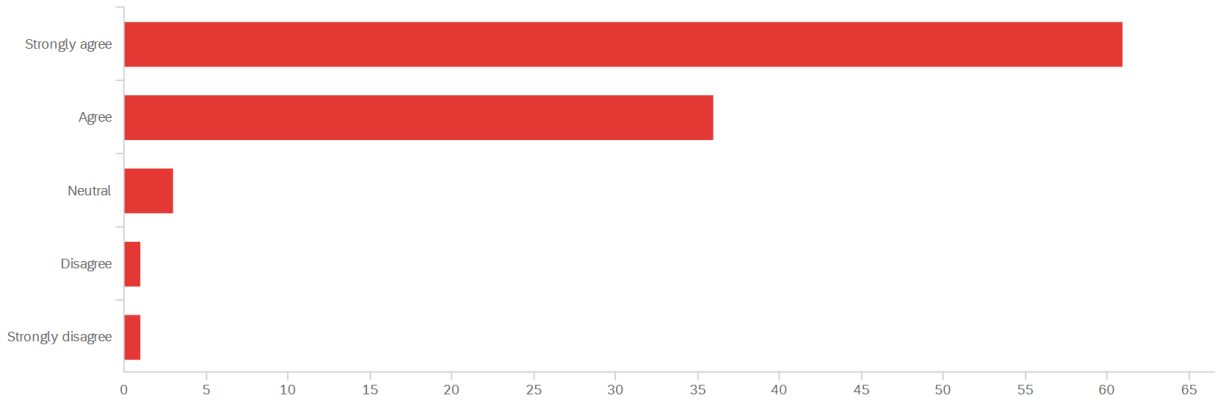
These sentiments are also seen in the survey feedback from young people who participated, many of whom asked for more time for discussion and more opportunities to engage on mental health issues, as well as to expand the scope of the discussions. Overall their reviews were glowing, with only minor complaints about use of time or getting bored during certain workshop sessions. Similarly, the barbers and stylists, CBOs, faith-based institutions and the one school engaged in workshops were nearly unanimous in their positive reviews.

[2] Quoted in Buechner, Maryanne. *UNICEF USA Initiatives: Peer Leaders Making a Difference in Mental Health*. October 22, 2021

Q2 - The information I received is useful.

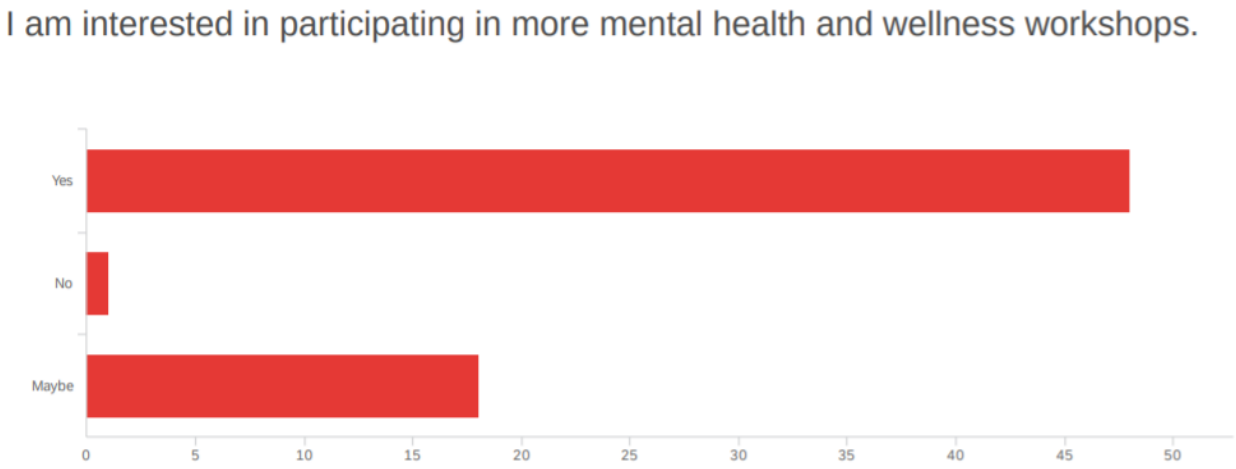


Q5 - This workshop gave me practical skills to provide mental health related support.



Source: AAIUH. *Default Report: Beyond the Stigma: MHPSS Post-Workshop Evaluation 2021. October 28, 2021*

As another indicator of the relevance of the program, in the end-line survey only one respondent indicated that they would not want to participate in further MMHPSS workshops.



Adaptations to context

Key to achieving this relevance is that the strategies and interventions were also clearly adapted to the particular context of the COVID-19 pandemic, and the simultaneous, historic racial reckoning that surged in the wake of George Floyd's killing and the Black Lives Matter movement. These adaptations were achieved through local-level consultation with various audiences, a process of continuous feedback from participants and partners, and adjusting the model in response. Respondents provided many concrete examples.

> "I think gender and cultural sensitivity were very well considered. [During planning], when [AAIUH] would discuss addressing the needs of a specific audience, we all discussed who needed to be in the room, how to get that balance of the different groups."

> "I agree. There was a lot of intentionality in the way they did that, to get that equal representation from all parties."

> "There was open and clear discussion of racial and ethnic groups, other demographics, and thinking about ways to engage them in the curriculum in ways that would work." --Two different respondents in FGD with partner organizations

> "Adaptations also included tailored facilitation to connect with workshop participants. For example, a workshop was held in partnership with CBOs who served pregnant, postpartum mothers, therefore we had to adapt our content to connect with their experiences. We did this for all our workshops, and it was instrumental to our success in getting folks to open up and engage in dialogue. This required intentional planning and prep. Understanding our partners and the community they serve, and then

identifying a facilitator (via MA Therapy's network of mental health experts) who had experiences within those communities was key."--AAIUH staff member via email

"…a one-size-fits-all model needed to be adapted for specific populations, and feedback from participants showed that this approach was valid. This gives the methodology more power and reliability." --Advisory Group member via email

Another one of the specific ways that the model was adapted to context was the significant time alloted in workshops for discussing the mental health impacts of frequent negative encounters with NYPD. One case example in the youth workshop curriculum features a hypothetical male youth's interaction with law enforcement personnel.[3] This gave participants a space to share their thoughts and concerns with the role of police in their communities. As captured in the audio recordings of discussions, adult participants also spent considerable time sharing their experiences with law enforcement and its negative effects on their mental wellbeing.[4]

The program also adapted additional MHPSS-related activities in response to feedback from participant youth to diversify the MPHSS outlets. These included a racial trauma workshop, one art therapy session, and a mental health career panel that were not originally included in the logframe.

Gender, identity and culture

Principles and issues related to inclusion, gender equality and cultural sensitivity were considered from the design phase, during implementation, and in monitoring and evaluation. This spirit is reflected in responses from all stakeholders, and could also be observed during the evaluation period itself.

In many of the AAIUH MHPSS adult workshops the participants were predominantly women, indicating the challenges in engaging men in mental health discussions due to stigma and other social stereotypes that misrepresent mental health needs and services as a "weakness."[5] However, the Focus Group with men/fathers was successful and indicated opportunities to dialogue with men on issues that do not generally fall into the comfort zone of

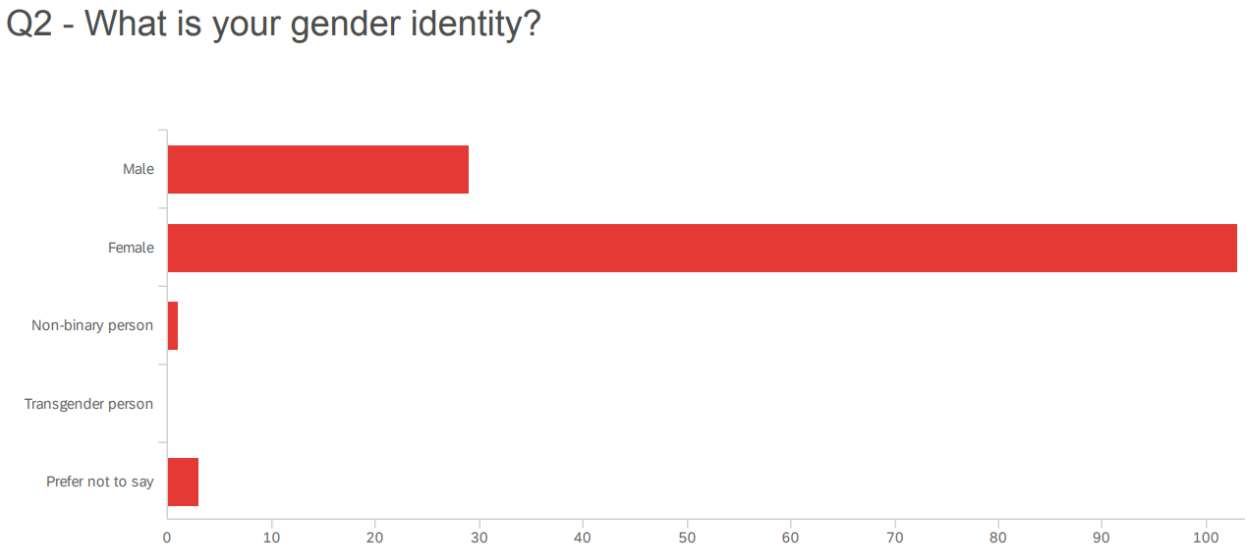
[3]AAIUH. Beyond the Stigma: A Collective Conversation on Mental Health and Wellness and Youth (Powerpoint presentation).

[4] Audio recordings supplied to the evaluation by AAIUH

[5] HDPI. *Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021*

masculinity. The lesson learned is that men may need an extra push to engage in dialogue on mental health.

There was more male representation in the youth workshops, but this is largely observational, as the partners did not collect demographic data on workshop participants. Basic demographic data was not consistently collected during implementation or monitoring. AAIUH does not know exactly how many women, girls, boys, men, participated in the different events, and information related to race, ethnicity, sexual orientation, etc., was not collected except at the assessment phase. We do know that the assessment phase was informed mostly by women and girls; the youth rapid response survey was filled out mostly by young women (110 females vs 30 males and a handful of 'nonbinary' or 'prefer not to say').



The peer-to-peer workshops had something approaching gender parity male/female, but the workshops for community leaders were, again, mostly female, in unknown numbers.

AAIUH staff remain humble about how well gender and identity issues were handled within the confines of a time-limited project. Specific gender and identity issues, including sexual orientation, are not found in the curriculum materials. However, these issues did reportedly surface in some discussions.

> "...if there was anything we could do better, it would be that. ...our workshops were predominantly attended by women, and we did talk about gender identities; that issue came up organically in our workshops and FGDs, but we didn't have the time to

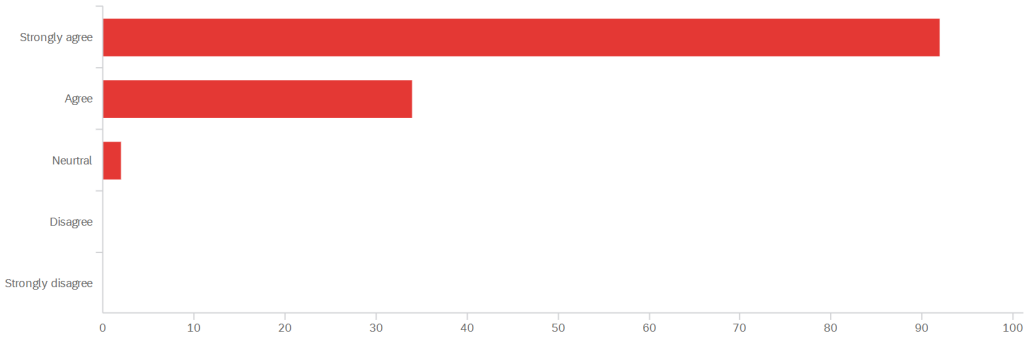
unpack that. And because of who our audience was, the conversations were usually informed by predominantly women and girls. When we think about how we want to expand, we want to talk more about masculinity and identity." --AAIUH staff member

"[AAIUH] is like, the ombudsperson for every group in society, every ethnic group, every identity, whatever. There was no way [they] would do anything that wasn't 100% inclusive of everybody in the community."--Advisory Group member

"People keep talking about the social determinants of mental health, but they are not always fully understanding the intersectionality of being an immigrant, being poor, being LGBT [in this community]. These are kids who are like, 'English is not my first language, and the school is not prepared to deal with me, with all [these identities] that I bring.'" --AAIUH staff member

A crucial further aspect of inclusion that was not directly addressed in the Theory of Change is that of age. Adjusting the curriculum and other interventions to be appropriate to specific age categories of young people would strengthen the youth-friendly model. Several sources of data confirm that a high degree of youth-friendliness has been achieved. Peer-to-peer workshop activities and trainings were adjusted for specific age groups, i.e., the 11-14 workshop was condensed in order for them to more easily digest the material. Trainings for the older cohort included virtual activities and plug-ins such as Kahoots and Jamboard. These strategies seem to have been effective; a full 125 of the 128 youth participants in the post-workshop survey indicated that they strongly agreed or agreed that the facilitator created a supportive atmosphere.

Q8 - The facilitator/peer leaders created a supportive atmosphere during the workshop.



In response to the open-ended post-workshop questions, youth participant feedback was, again, overwhelmingly positive, indicating that the approach was appropriate to the age group and culture.

> "... they broke down a lot of the information and it flowed really well, and everyone was involved."--Youth participant

Several anecdotes from KIIs and the literature further suggest the AAIUH approach is reaching young people where they are. According to the HDPI final report on the project, young people did express a need for more guidance regarding "active listening" and "referral skills".[6] Youth participants also indicated directly to AAIUH and partner CBO staff that they would like to have a greater role in the design of the program from the beginning. AAIUH acknowledges this feedback and plans to act upon it in future iterations.

Effectiveness and potential impact

Analysis of the Theory of Change

The evaluation reviewed the steps in the ToC to determine whether the program delivered, as theorized, and to verify how the organizers' fundamental assumptions played out in reality. As shown below, the assumptions of the ToC hold generally true and with the implementation of the project logframe, demonstrating that the initiative achieved its overall goals. Gaps in the ToC are noted in the Observations column.

Steps in the Theory of Change	Observations
Technical, financial and organizational resources allotted	Adequate resources were allocated to the project to cover the targeted numbers of participants; budget issues were not cited as a challenge, except when respondents noted that the program's reach, depth and breadth could have been greater with more funds. Technical capacity and commitment to the project were exceptionally high on all sides (donor, Advisory Group, AAIUH,

[6] HDPI. *Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021*

	CBOs, etc.). AAIUH organizational capacity was often lauded by respondents. Working relationships (“mutual respect”; “love”) between the different stakeholders were unusually strong.
Capacity building/training and communication and social mobilization activities implemented	As documented in the logframe and in reports to the donor, the capacity building/training, communication and social mobilization activities met or exceeded their target numbers of participants and events. The quality and relevance of these activities were obviously high, as the participant feedback is almost unanimously positive, with respondents asking for more workshops on a wider variety of mental health topics.
Increase in both 1). community capacity and resilience in child rights, child protection and mental health, and 2). CBO capacity to address child rights, protection issues, referral pathways and case management	Community capacity and resilience in child protection and child rights were addressed in several ways: 1. The program worked to help safeguard the mental health and psychosocial wellbeing of children, adolescents, parents and caregivers using inclusive and participatory approaches. 2. A Child Rights training/capacity building session was held for all AAIUH staff, which included issues of generational trauma and poverty, and these concepts informed the workshop curricula that were then developed. On the issue of capacity for making referrals, CBOs mentioned that the initiative led them to add MHPSS to their curricula/programs. Some mentions were made of improved referral pathways or improved case management. AAIUH reports that it is working to establish a protocol for referrals as a result of the program.

Improved knowledge, awareness, behavior, skills and self-care among participants and partnering organizations	Many anecdotal examples of improvement in knowledge and awareness were captured. Post-workshop surveys find nearly all participants reporting that their knowledge, confidence and skills in dealing with mental health issues have improved. While it is beyond the scope of the evaluation to measure changes in behavior, some respondents observed, or heard about, young people putting their new-found knowledge or skills into practice with their peers.
Participation, equity, cultural sensitivity, ethics	These principles were clearly embedded in the approach from beginning to end, as respondents were able to conjure many concrete examples, and the evaluation consultant could also observe these principles in action during the evaluation process. AAIUH acknowledges gaps in participation and inclusion of adult men and LGBTQIA+.
Families and communities enabled and empowered to better cope with MHPSS in the context of COVID-19	According to KIIs, FGDs and participant surveys, the initiative realized its outcomes and outputs, with the chief complaint being that the footprint and breadth of topics covered could have been greater given greater resources. Respondents generally consider this now to be a proven model that works.

The following findings expand on the above, and are grouped around the categories of evaluation questions supplied in the evaluation Terms of Reference created together by AAIUH, UUSA and HDPI.

Outputs and outcomes

Targets and achievements are tracked in the logframe (included as an Annex). According to the logframe, planned outputs were all surpassed, reaching larger numbers of participants than originally targeted, in all categories (CBOs, clergy, youth, etc.) with the exception of barbershops/salons, "because they [barber shops/salons] were saturated with other [AAIUH] programs because of the pandemic," according to a AAIUH staff member. "We had also wanted them to do outreach and recruitment for this." Fortunately the new partner faith-based

organizations were able to fill the gap in outreach. “We weren't anticipating our churches to recruit so many more people than we asked them to. They really stepped up,” according to AAIUH.

A summary of outputs achieved is, as follows. In total,

- 173 youth and students participated in the needs assessment research.
- 21 MHPSS workshops were held.
- 697 youth and adults were engaged in the workshops, over and above the target of 585.
- From this, AAIUH estimates its potential indirect reach at 2,788 (= 697 * 4 persons they might have counselled or connected with MHPSS resources).
- An estimated 5,000+ community members were reached with information, education and communication (IEC) materials.[7]
- 357 youth/students/peers participants subsequently convened peer-to-peer sessions, and active listening groups, as well as outreach to other MHPSS services and activities.
- 340 barbers and stylists, CBO staff, faith-based leaders, educators/staff and parents/caregivers and their constituents/clients subsequently convened support sessions and/or safe spaces for dialogue and active listening groups, as well as outreach to other MHPSS services and activities.
- The vast majority of participants indicated satisfaction with the MHPSS TOT course and improved MHPSS knowledge and awareness, including self-care, active listening, positive coping and support skills.
- 14 new institutional partnerships were established with local CBOs, FBOs, etc. (See *Partnerships and Community Engagement*, below.)

Major achievements

The principal achievement of the project is in delivering a tailored mental health intervention in communities where there is considerable stigma associated with mental health services and most people have had little or no prior access to MHPSS. This included capacity building of frontline workers and service providers, professionals, educators, and community and faith-based leaders and elders, together with parents and young people in recognizing signs of mental health issues in adolescents, referral networks, suicide prevention, and positive

[7] According to program managers, this Includes people who viewed articles, attended conference presentations, received followup emails, newsletters, etc.

mental health strategies. The development of training tools and resources was carried out in a participatory manner, working in close collaboration with the affected community.[8]

> "...for us, the big achievement was being able to reach out to different sectors that we didn't always engage before, bringing in the community voices, basically using a community engagement strategy to do a mental health response."
> --AAIUH staff member

> "I think it achieved its objectives to develop a mental health-based curriculum for adolescents and pilot the approach, and then have the adolescent peer-to-peer work. Arthur Ashe [Institue of Urban Health] was able to leverage its relationships, and as a public health organization that wasn't a mental health organization, they learned how mental health fits in with public health, because depression and anxiety affect people's health as well. And they added the social justice side of it too." --Advisory Group member

Youth participants consistently reported that they had never been exposed to discussions around mental health or mental health stigma before, or safe spaces to have a collective discussion, and that they wanted more exposure covering a greater range of issues. Many such responses were recorded:

> "To be very honest it was my first time talking about mental health issues so I found everything useful. I learned a lot of stuff."--Youth participant

As noted below, the project also gave CBOs a new and in-demand menu item to offer their clients. CBOs say that they had long seen the need for MHPSS in their communities, but they largely lacked the capacity or partnerships to offer it. AAIUH filled that gap, to some extent.

In another major achievement for AAIUH and the communities served, COVID-19 turned out to be a viable entry point for addressing not only mental health more broadly, but also specific issues, including structural racism, historical or generational trauma, police bias and aggression, harmful gender norms and expectations, the stresses of the youth experience, and the immigrant experience. AAIUH partnered with a local licensed clinical social worker (LCSW) to conduct a workshop on issues of racial trauma for the youth peer leaders.

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[8] HDPI. *Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021*

> “We felt that we needed to acknowledge the historical context, the Black Lives Matter thing that was happening all around us, to acknowledge the historical moment in present day, and have the youth be able to talk about it in a safe space.” --AAIUH staff member

All stakeholders are hopeful that this opening can be used to facilitate future, sustained efforts to address these issues.

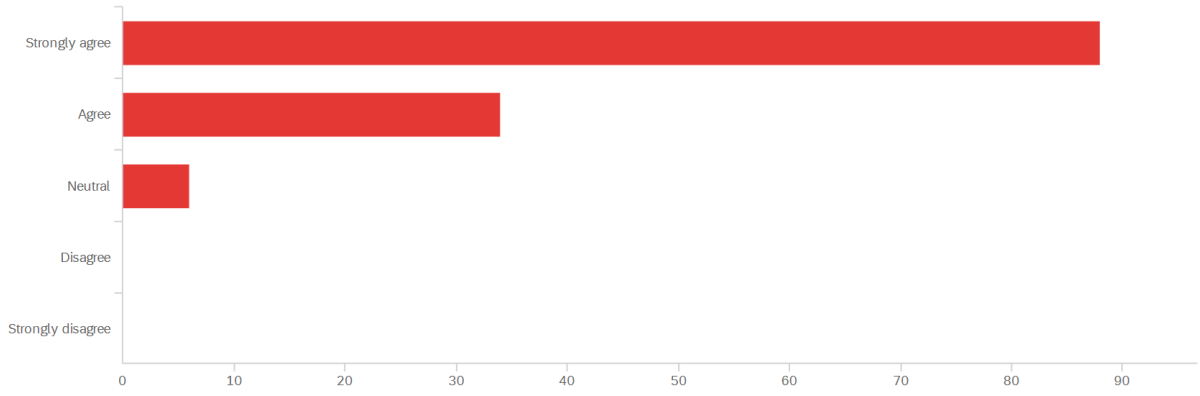
For several respondents, developing the curriculum was another important contribution, one that has value and applicability beyond the present initiative.

> “The big achievement is the curriculum. They have a good product that can be used in schools of public health [and] in colleges, to develop course work, certificate programs, on and on.”--UUSA staff member

Potential impacts

A rigorous assessment of the project’s impact is outside the scope of this evaluation. In fact, the project purposely did not implement activities that would require impact-level changes on MHPSS. However, several *potential* impacts were identified. Starting with the survey responses of participant youth, many specific mentions were made with respect to respondents' impact on the self, offering statements such as, “It gave me practical skills on mental health.”

Q3 - This workshop increased my confidence to provide mental health related support.



> "I was the type of person who, if someone's going through something, I wouldn't really know what to do...But the other day, two of my friends came to school crying. I used the stuff I learned [from the program] to try to comfort them, and it actually worked. Helping someone feel better, that's very satisfying."[9] --Male participant youth, Brooklyn

At the time of the 3-month post-project survey these effects were clearly still visible. Since participating in the Institute's Mental Health & Wellness Workshops, the majority of respondents indicated that they were now more aware of mental health and wellness issues, and that they feel more confident talking to others about them. Some respondents indicated that they still need more information about MHPSS resources that might be available.

#	Field	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Total
1	I am more aware of own mental health and wellness.	43.28% 29	50.75% 34	4.48% 3	1.49% 1	0.00% 0	67
2	I feel more confident having conversations about mental health and wellness.	40.30% 27	43.28% 29	16.42% 11	0.00% 0	0.00% 0	67
3	I am more familiar with local resources/services for support.	37.31% 25	37.31% 25	19.40% 13	5.97% 4	0.00% 0	67

Source: Default Report 2022: Mental Health & Wellness Workshop Post-Evaluation Survey, January 18, 2022

Asked directly about impacts that the workshops might have had, peer leaders cited concrete examples involving positive effects on their family and friends, and on themselves.[10]

> “For me, what's changed is that I'm really more so out there with my parents. I never used to tell them how I feel or bother them about how they feel about certain things, but now I feel like after doing the peer leading stuff, I could see that what they're feeling is something that I could be feeling too, and we're just not communicating that.

[9] Quoted in Buechner, Maryanne. *UNICEF USA Initiatives: Peer Leaders Making a Difference in Mental Health*. October 22, 2021

[10] Notes from interviews with participants and AAIUH staff conducted by consultant Maryanne Beuchner in preparation for the web article *UNICEF USA Initiatives: Peer Leaders Making a Difference in Mental Health*. October 22, 2021

So, I feel my communication has gotten stronger and it motivated me to push forward with that."

"After the workshop, I started to feel I can actually share more, especially to my parents too…[After] the workshop, my mom was texting me saying, "Hey, I'm there if you ever want to communicate." …Another thing ... Now, I can start calling people and… get to know … how they're doing, because I want to be a person that someone could rely on if they're ever not feeling okay,.... So, this workshop actually gave me a lot of pointers to use to actually start to be that ray of sunshine that people need sometimes."

"…before, …I knew that [referral] resources were there, but I didn't know how to utilize them or give them to someone who might actually need it. Now sometimes I would store phone numbers on my phone, just in case anyone needs it. …So, it actually allowed me to be able to distribute those resources to someone else…"
--Two different peer leaders

These responses echo sentiments expressed in the 3-month post-project survey as well, where young people attributed positive changes in their coping ability to the workshops, with such statements as:

"I handle my mental health differently and learn to make more time for myself and not overburden myself
"I've been able to promote self care in workplace."
"I am able to control my emotions more better."
"It has gotten stronger through meditation and balance."
"It's okay to reach out for help from friend or family"[11]

Similarly, in the key informant interviews, one of the CBO partners who is in direct daily contact with at-risk young people offered several anecdotes that she saw as evidence of impact.

"There was one young man, very quiet ... He said he really wanted to [attend the session] because he wanted to learn how to have these conversations about mental health. After he came back he said, 'Why didn't you pick everybody [to attend]?' But we could only send six kids. That 'Peer Leader' title that they give the kids, it may seem small, but a title alone gives them that confidence that they need. ...Instantly

[11] Source: Default Report 2022: Mental Health & Wellness Workshop Post-Evaluation Survey, January 18, 2022

following the session, it gave him a boost in confidence. ...about 3 weeks later [he came to one of our events] and it was a surprise for him to show up like that, and I want to attribute it to the workshop. ...He asked, 'Do you need me to do anything?' He was never the person to do that before.

There's another young woman ...very difficult home life, she had been … running away from home, so that's why I asked her to become a [AAIUH] peer leader. … After she participated, she texted me one night: 'What am I supposed to do again, when I can't take it anymore?' I asked, 'Do you have the information from Arthur Ashe? … I saw that she was now conscious that there was a tool or a mechanism in place to support her mental health. At least she acknowledged that she's in a place that if she's not ok [mentally, she knows what to do] instead of just turning to her normal vices. We don't have that type of programming [in our CBO], so I feel like it's [as a result of] the workshop."--CBO partner

Staff from the donor also expressed high confidence in potential impacts on mental health and psychosocial indicators.

"We know that it is changing opinions about mental health, working on stigma, and arming children with information they need, which is potentially reducing suicide. It's creating allyship between children, among adults, and between children and adults. That model is sustainable".--UUSA staff member

Keys to success

According to the donor, the Advisory Group members and CBO partners, the primary factor contributing to project success was the high capacity of AAIUH staff: their dedication, organizational skills, principled and inclusive approach, deep community connections, etc. Others pointed, as well, to the high caliber of the Advisory Group, mostly former UNICEF staff, who between them have many decades of experience in running programs for children and youth around the world.

The working relationship between the various stakeholders was also cited as exceptionally strong, due to mutual respect, mutual admiration. Several respondents used the word 'love' in reference to the program, e.g., "There was a lot of love." Any differences of understanding between AAIUH and the Advisory Group were worked out efficiently. In particular, the comprehensive note-taking and reporting of carefully crafted meeting minutes was praised as a valuable tool.

"One of the positive things was that we would feed back the notes every week …for people to take in. … identify trends and changes, and issues that can be really

> powerful as reflections. …it was about conversation and dialog. It wasn't an expert-centered model, which I thought was really good."--Advisory Group member

Another key to success was the emphasis on a participatory needs assessment, as well as flexibility around program design, to ensure a relevant response.

> "This is a really important point for the Institute, and what we consider to be a key to success for our program, and for those who want to replicate our program. In order to effectively design an intervention for the community, they must be active stakeholders in the process. This is how we were able to effectively elevate and integrate the on-the-ground experiences in real time."--AAIUH staff member

Even between the time the proposal was accepted and program design began, the goals shifted somewhat in response to community input, away from service provision and more toward addressing stigma around mental health issues.

> "We understood our community, and we found in the assessment, it's not just about providing linkages to services. You have to address trust, stigma, and those *barriers* to services. To say that services don't exist, or people don't know about them, is not the whole truth. There is a lot of mistrust, historically, and you have to recognize those things before you just say, 'Here are some services for you.'"
> --Another AAIUH staff member

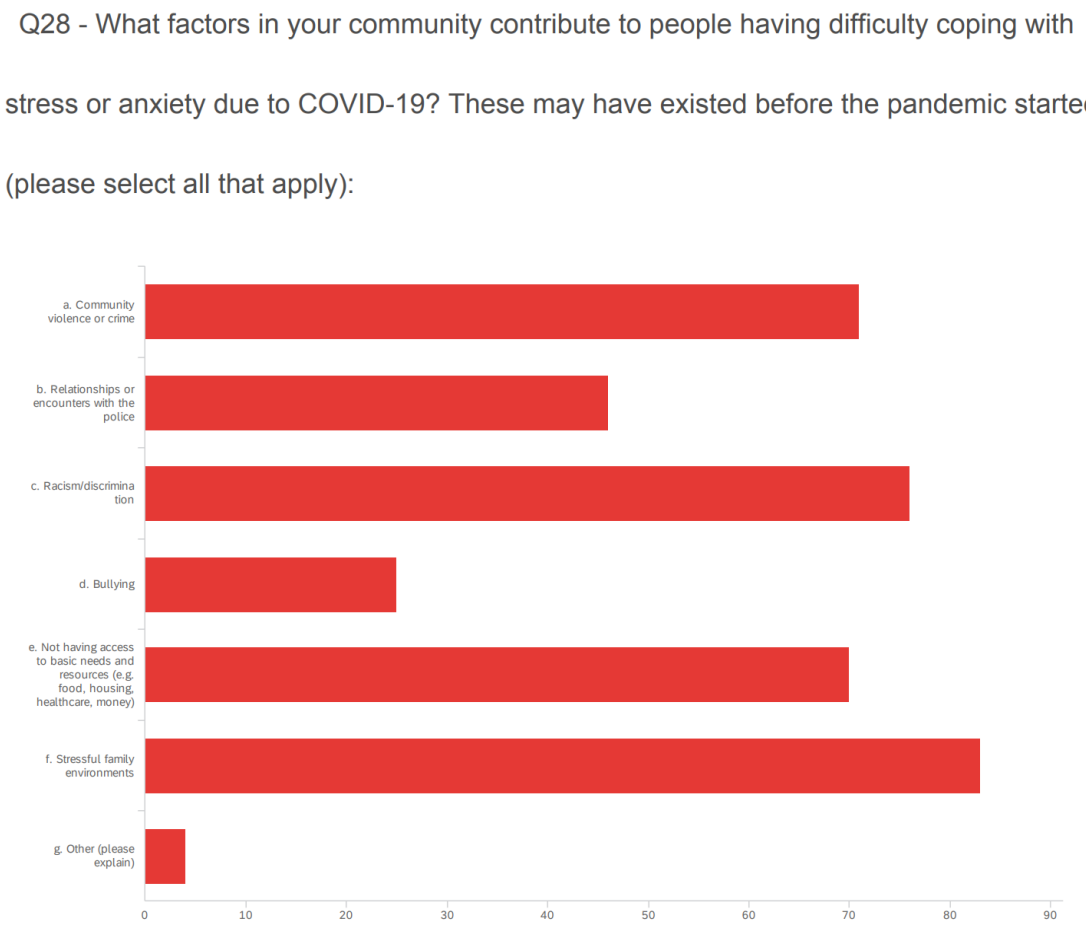
A final important key to success, often mentioned, is the many preexisting relationships and deep community connections that AAIUH maintains, as part of a long-term radical vision for community empowerment and liberation. In the words of one Advisory Group member, "They were adamant that this is not a 'project' on mental health; their objective is community transformation, and they told us they would not stop short of this." This sense of purpose and zeal may be unusual for a UNICEF USA grantee, and the other stakeholders clearly found it motivating.

Challenges

Challenges to effective program implementation were minor overall, with some respondents even straining to think of challenges to discuss. Looking at outputs and outcomes against the logframe, any challenges encountered by AAIUH were not enough to inhibit project objectives.

The primary limiting factor (and the very reason for the program) was COVID-19, which forced most activities into the remote/online realm, and restricted staff and participants' movement in general. "We would have preferred to hold more in-person workshops," said one AAIUH staff member, "but were constrained due to COVID safety protocols. In-person peer-to-peer trainings were critical for the younger group of peer leaders."

Another bigger-picture challenge for service provision in these communities is the ever-present phenomena of structural racism, inequality, and intergenerational trauma, and all the ways those factors manifest and affect mental health. A poll of pre-covid stresses for young people paints a clear picture:



Source: AAIUH. *Default Report: Youth Mental Health and Wellness During the COVID-19 Pandemic. March 29, 2021*

The response is clearly overwhelming. Any MHPSS initiative will be a drop in the ocean of mental health needs in such a context, and a small nonprofit organization cannot hope to address these underlying structural problems.

> "COVID did not invent poverty, stress, inequality--it's only just exacerbated it. People are like, 'I was already living in bad housing. I didn't have an appropriate school. I didn't have adequate income before.' So when we go in there, people call us out, like, 'We were screwed before COVID, and now you come around? It's important to validate their grievances or else they don't trust you." --AAIUH staff member

While the grant was known from the beginning to be a time-limited short-term response to the pandemic, the lack of follow-up funding was often mentioned as a challenge by all stakeholders, including staff of the donor. Most people interviewed have concerns that the work may not continue, even as so much time, funding and effort went into developing and testing it.

> "...it turned out how I envisioned it. I just wished we had more. To sunset a program in the middle of a pandemic… I don't like to just leave…." --UUSA staff member

AAIUH and its partners noted that the lack of sustainability is a potential threat to their hard-won partnerships and relationships in the community.

> "That's where my anxiety lies. Our community is so starved of real intervention, that how you invest your time matters. So we really need something that lasts. We do all this work and then the next step doesn't always happen. We get hard questions from the community, and we have to convince them that we are committed to doing this work and it's important that they participate."--AAIUH staff member

Efficiency (resource use, value for money and quality issues)

Adequacy of funding

According to the donor and AAIUH itself, the allotted funding was adequate for the task, as the program was designed around the available budget. The program was never meant to receive followup funding from UUSA; it was a one-off grant specifically in response to COVID-19. The resources available for the project appear to have been adequate to achieve the planned outputs. According to the logframe and interviews with all stakeholders, none of the planned outputs were constrained due to resource limitations.

That said, in interviews the main issue raised around the budget was that the project footprint could have been larger, and the duration longer, with greater funding. AAIUH and its partners lamented that the program should have included more participants, more sessions, and an expanded list of mental health discussion topics. Several respondents also mentioned the need to recruit a dedicated staff member with mental health expertise. The lack of followup funding was also on the minds of all respondents, who were keen to see the work continue even as the grant was known to be limited to a single year. While the grant has ended, UUSA staff say they are committed to helping the work continue with support from other funders, and have begun to make introductions and set up meetings for AAIUH.

Return on investment (ROI)

The overall budget envelope for the MHPSS project was US$250,000. With 697 direct and an estimated 2,788 indirect beneficiaries (=3485), this equates to US$71.73 per beneficiary. A quantitative assessment of ROI was not intended by the evaluation, however, and this section relies instead on the perception of the stakeholders.

In general, respondents said that the program had high value for the money spent. Pressed for detail, no one expressed concerns about wasted resources or cost overruns. In fact it was mentioned several times that the program was ‘a bargain,’ where a tight team of high-quality staff and advisors were working in a targeted manner for reasonable rates.

> “The ROI made sense for us. ... we say in this case that we set out to ameliorate the impact of COVID in particular communities, and we did it.” --UUSA staff member
> “On the issue of value for money, if you add up the number of beneficiaries to dollars, it’s not so big. Now the question is, how do they keep that going? How can they cascade that to other kids and other communities?”--Advisory Group member

> “They got a lot of return on investment. That has a lot to do with the motivation and the lifetime commitment of this particular NGO.” --Another Advisory Group member

Respondents also point to further potential returns from the training, capacity development, program setup, and building of partnership infrastructure. While these are difficult to assign a dollar value, they represent investments that can be used toward future MHPSS programming.

Monitoring and evaluation

To an unusual extent, in comparison to other programs with such a modest footprint, project benchmarks and achievements were thoroughly monitored for quality assurance and participant feedback during implementation. Processes and lessons learned were designed to be used to expand UUSA program engagement, and to set precedent for UNICEF National Committees in providing technical support for program interventions for the protection and wellbeing of children.

The Advisory Group brought a high level of capacity and expertise in M&E, and the donor was particularly interested in creating and testing a Theory of Change based on community input, and making course corrections based on participant feedback.

> “The fact that we started with the TOC, you had all the activities lined up, and we took the same trail for the M&E. I think one part that was very strong was the way we facilitated the whole needs assessment. The whole ongoing program monitoring, planning, finding out what is going on [before we started], those were very strong aspects of the project if you ask me, because we did what we planned.”
> --Advisory Group member

> “We knew that it would be hard to measure changes in mental health that are not clinical. So we measured community-based measures of success that can be validated by external partnership, funders; we want to understand how this can be strengthened. How can the report be used to sustain this type of work?”
> --AAIUH staff member

Rather than being seen as onerous or labor-intensive, stakeholders reported that the M&E processes were useful and built their capacity. HDPI conducted two results-based management (RBM) trainings during the grant period, which can be seen as a capacity transfer.

While several respondents mentioned that the process to develop a theory of change was time consuming, it was seen as a worthwhile exercise.

> "The Theory of Change thing--our colleagues at UNICEF were keen on that as a tool to kick off the program. How can we consider this from end to end? What are the inputs; what are the expected outcomes; the thesis; resources needed? And we took the framework to heart. [The Advisory Group] was integral to walking us through [developing] this tool. Does it provide an initial road map? Is it flexible enough that you can tweak and change it without harming the integrity of the program? At the outset, having that tool was a good lesson learned. We have been using our logframes forever, but the format of the ToC was great." --UUSA staff member

The project's logframe is seen as well by AAIUH and HDPI as having been adequately fit for purpose, with reasonable indicators that were neither too heavy nor too light.

It helped that AAIUH entered the project with a willingness to keep the model on track by repeatedly asking participants to reflect on their experience each time they engaged, and deliberately making spaces for reflection. Even in an agency that prides itself on its participatory approach to public health work, this project was unusually participatory from the early stages.

> "You don't normally engage community members from start to finish the way we did in this work. From the beginning we engaged the barbershops, etc., and they have come along with us through all stages, and got to bring in their lived experience, and that goes for the youth as well, through the focus groups, the survey, the workshops, and they tell us they also want to help develop the curriculum, etc."--AAIUH staff member

Institutional capacity building, sustainability and potential scale up/expansion

This section discusses the institutional capacity development of AAIUH, and then considers changes in the capacity of implementing partners.

AAIUH capacity

Capacity development efforts on behalf of AAIUH came mostly in the form of the Advisory Group being available for regular consultation on technical matters including MHPSS, M&E, program management and day-to-day implementation. AAIUH staff themselves expressed that they valued the assistance rendered by the Advisory Group.

> "UNICEF USA helped us establish a process for doing a community needs assessment, then developing the content. It was collaborative, and that's the way we always do our work."[12] --AAIUH staff member

> "On capacity, it's the first time we did mental health, so now we have experience with mental health that wouldn't have happened without this initiative. One of the other things that's been unique is that having UNICEF support the M&E, which really validated a model that's community-engaged and still has a rigorous M&E framework. Now we're able to implement that kind of work more effectively." --Another AAIHU staff member

Other stakeholders pointed to the value of bringing in such a seasoned team as HDPI to serve as the Advisory Group, with its high capacity for leadership and program management, as well as technical expertise. For example, HDPI staff sat in on the workshops via Zoom, or in some cases attended in person, and were able to give real-time feedback.

[12] Quoted in Buechner, Maryanne. *UNICEF USA Initiatives: Peer Leaders Making a Difference in Mental Health*. October 22, 2021

> "…think about the value … of bringing someone of this caliber into a small nonprofit, and there was a willingness to collaborate and learn. And both sides were completely open to learning. They can apply this experience to other projects." --UUSA staff member

As another example of increased capacity, AAIUH points to the eleven new partnerships established through the *Beyond the Stigma* work, expanding their footprint in the communities, as well as the depth and breadth of services they can offer.

> "...the partnerships were huge. We had more than 25 in all; that expands our reach, our relationships, our capacity to be able to provide for our community a little more diversely." --AAIHU staff member

In particular these partnerships have given AAIUH increased capacity for making linkages to care for mental health cases that arise in the course of their work. The agency reports that they can now more easily call upon local MHPSS service providers for referrals to care.

As a specific instance of capacity development, a few respondents mentioned the AAIUH participation in the American Public Health Association (APHA) annual meeting 2021, presenting the project to a prominent national audience of academics, which required proactive engagement with APHA and ample preparation. This participation is seen by all to have potential to lead to valuable future opportunities.

AAIUH has suggested further developing their own capacity through recruiting a mental health clinician, through expanded community-based partnerships, and through more outreach, including to secure resources in support of mental health and wellbeing.[13] These issues are all discussed below.

Partner CBO capacity

The project has strengthened the institutional capacity of the implementing partners with respect to MHPSS programming, though not always in the ways envisioned in the Theory of Change. The ToC envisaged an increase in "CBO capacity to address child rights, protection issues, referral pathways and case management". Some of this did result, as two CBOs reported that they have now added an MHPSS component to their curriculum or programming on a permanent basis, based on what they learned from AAIUH. Other CBOs

[13] Email from HDPI, "Notes to Zoom call 19 November". 20 Nov 2021

said AAIUH was more playing a role that relieved them of having to address mental health issues themselves, thus “taking this aspect off our plate,” in the words of one partner.

Another example of building partner capacity is CBO acknowledgment regarding changes in their own mindset and behavior around mental health. CBOs noted that they are now more aware of and apt to refer to MHPSS materials, tools and concepts if a mental health issue should arise. They say that they are now more likely to take youth mental health into consideration in their daily work, being less intimidated by mental health topics.

> “We are normally fearful of starting the conversation around mental health with young people because we don’t have the proper tools, and if that conversation goes in a direction that we are not prepared for, I am often on ‘pins and needles’ in anticipation of their response. Can I provide the right answers? Do I know where to refer them [if they are in crisis]? [AAIUH] gave [people working with youth] that information and knowledge ..., and reminded us to be a lot more intentional about it, like, ‘Let me look at this young person a little differently. The way that I honor and cherish my own mental health--let me give that same space to this young person.’” --CBO partner

Coordination and management

Coordination appears to have been fully adequate and responsive, as the AAIUH team was repeatedly complimented on its organisational ability, its transparency, and its responsiveness during implementation. As noted, KIIs referred to the high capacity of AAIUH staff: their dedication, organizational skills, principled and inclusive approach, deep community connections, etc.

The working relationship between the AAIUH and HDPI was often cited as exceptionally strong, due to candid reflections and mutual respect. Both the AAIUH and HDPI teams spoke well of the donor UUSA, who is seen to have been highly engaged in the work and supportive throughout the process. In particular it was noted that some UUSA staff on the grant have deep experience and connections in Central Brooklyn neighborhoods where the MHPSS work was taking place, a factor that was seen as valuable to the process.

According to both parties, weekly Zoom meetings between the HDPI Advisory Group and the UUSA team were useful in providing updates and sharing feedback to ensure smooth

progress in implementing the project. Some of these meetings were attended by UNICEF headquarters[14] staff who provided valuable inputs. This approach has relevance for designing and implementing similar projects in the future.

Coordination between AAIUH and its CBO partners seems to have been strong as well, as discussed under *Partnerships* below. Partners cited examples of connecting AAIUH with valuable contacts and potential program participants, and AAIUH returning these favors in meaningful ways, the two sides providing each other technical support as needed. For example, the connection to the CBO 67 Clergy Council greatly expanded the Institute's reach into a highly relevant population of faith leaders and church congregants, and in turn provided the Council with a highly relevant MHPSS service for the at-risk youth it serves.

Scalability and expansion

Some of the strategies and interventions used by the project clearly lend themselves to wider scalability and program expansion. In particular, several KII respondents spoke of the relative ease with which a wider variety of creative arts approaches could be brought in. Several art therapy workshops were held during the grant period, but some of the participants also mentioned the need for more outlets for creative expression as part of the program.

> "The kids wanted more music, they wanted dance, art. [Staff at all levels] can be trained to bring more of a creative process into all aspects of the program: [as a form of therapy], in program management, in meeting facilitation, etc. And it doesn't cost very much." --Advisory Group member

This finding is particularly relevant in a context where traditional approaches to MHPSS are unlikely to be feasible at scale.

Another opportunity for scaling or replication is seen in the aforementioned workshop curriculum, which was often cited as "the most important output," or the "crown jewel" of the project.

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[14] Founded as the United Nations International Children's Emergency Fund in 1946 to meet the emergency needs of children in post-WWII Europe and China, UNICEF's mandate was broadened in 1950 to address the long-term needs of children and women in developing countries. UNICEF became a permanent part of the UN system in 1953. UNICEF USA is one of 34 organizations, called national committees, around the world that secures crucial financial support and government funding for UNICEF. Source: *UNICEF vs. UNICEF USA: What's the Difference?*

"The value of the curriculum is limitless. [AAIUH] are located on the grounds of SUNY Downstate; wouldn't it be cool to build a course that everyone in that Social Work program needs to take, to make it be part of the SUNY [State University of New York] curriculum? Because the whole area of mental health is so broad they have been able to bring a level of focus. --UUSA staff member

"We have already been engaged to do something similar! It's in Far Rockaway, Queens, with barber shops and salons and conversations with adults. The great thing about the curriculum is that it can be transferred to communities that look and feel like ours. The model of facilitation is something that can be taken almost anywhere . So how can we leverage to get other orgs to do this too? If you're [a CBO] in Montgomery, Alabama, we can say to you, ''This is our model; here's how you consult the community, here's how you get feedback and input. If you lean too much on literature and reports, that approach can be out of touch. Doing something that's culturally tailored can have more of an effect.'" --AAIUH staff member

"The curriculum is a really good skeletal base to build on, that could use a lot more fleshing out. Really you need an accompanying guide or manual, apart from the slides they used. The bones are there. If they are excited about using it, the AA team should be the ones to develop it."--Advisory Group member

Also useful in efforts to scale and expand may be the P.A.U.S.E method[15], a tool adapted by AAIUH from the California-based organization Black Emotional and Mental Health (BEAM).[16] When asked about the most useful aspects of the material covered in workshops, there were many specific mentions of P.A.U.S.E. among youth participants.

- "I found the P.A.U.S.E method was most useful as it shows how you can help yourself and others to deal with mental health issues."
- "I found the acronym PAUSE very helpful because it was made into steps you can follow to help a friend out."
- "Most useful in this workshop was the discussion and information on "PAUSE"."

[15] PAUSE: **P**ractice active listening; **A**ssess distress or harm; **U**nderstand and affirm experiences; **S**upport and navigate to needed services; **E**ncourage self-help and other supportive strategies.
[16] According to its website, "BEAM is a national training, movement-building and grant making organization dedicated to the healing, wellness and liberation of Black and marginalized communities."

Sustainability

This section is organized around a recognized set of elements of sustainability for social services programs. Different agencies define sustainability in different ways, but most coalesce around a set of factors that typically includes Leadership; Community Engagement; Relevance; Adaptability & Agility; Efficiency and Effectiveness; Infrastructure; and Financial Health. Most of these issues are addressed in other sections, and will only be touched upon briefly here. Overall the program appears sustainable in most categories, with most concerns noted in the area of financing for continued MHPSS work.

Leadership: According to all respondents in KIIs, AAIUH is seen as a leader in the communities it serves, forging relevant partnerships, taking the initiative to identify, advocate for, and address community needs. The Institute is also seen by some respondents as a leader in the field of urban public health nationally, as its inclusion at the American Association of Public Health annual meeting will attest. The MHPSS initiative was itself mentioned as an example of the agency showing leadership. Solid and visionary leadership was evident at all levels of the program (management, staff and community).

Community Engagement: As shown, awareness and buy-in from the community are clearly present, as evidenced by the roster of partners, who are mostly grassroots community leaders themselves with their own robust community networks. The project was built upon and benefited from engagement with various community groups and CBO partners, a key factor in its success. The participatory, inclusive manner of design and implementation engages a broad cross-section of the community, though there is room for improvement in terms of deliberately bringing in greater diversity of community members. Among the community participants and key informants, the organization and its partnerships are perceived as robust and credible.

Relevance: The program clearly responds to community needs, though as mentioned above, AAIUH cannot hope to meet the potential demand for MHPSS in these communities within the parameters of the grant budget and timeline. The Institute sees this program as a first foray into mental health work, starting by addressing mental health stigma to lay the groundwork for more and different types of responses and for greater numbers of affected community members.

Adaptability & Agility: The MHPSS program was able to anticipate and respond productively to the changing external environment. Many specific examples are included above in

Adaptation to Context.

Efficiency and Effectiveness: As elaborated in *Efficiency* above, the program demonstrated its ability to make an impact and achieve positive outcomes in a cost-effective way.

Infrastructure: There are established internal practices and an effective business model that guided the program implementation. Staff capacity was noted to be especially high. However, when asked about what further resources, tools and support would be needed to continue the MHPSS work, several people called for hiring dedicated staff.

> "...they [AAIUH] need to develop their mental health capacity, like hiring a mental health specialist to lead the work. That would be the next step. [CBO partner] organizations have a lot more beneficiaries and [they need] training to get them to pull in the [MHPSS] work into their models. You need to get the mental health person to do that. That is a way to enlarge the footprint. How do we get the police involved, for example? The juvenile justice system?"--Advisory Group member

It may also be prudent to hire staff that can attract and manage a relationship(s) with larger institutions with the funds to continue *Beyond the Stigma* and other MHPSS initiatives, such as universities and national or international nonprofits. The key there, in the words of more than one KII, is for AIUHH to maintain its integrity, community connections and trust, as it grows.

> "The barriers that small organizations working in underserved communities face is that they don't have that public presence, and they can't be there in the face of a foundation or the government to pull in funding, in comparison to the way other orgs that are less competent can pull in money. They need allies to help them partner with, before [*Beyond the Stigma*] becomes too old. This is what is needed now. Mental Health is right now a global priority. [Funders] are putting out grants right now, so [AAIUH] probably need to partner with a large organization [with greater fundraising capacity]. But this large organization can't drown them, either. They have to build them up slowly." --UUSA staff member

On the program side, several KIIs called for more in-depth capacity development for all staff and partners on MHPSS topics, especially as they relate to social justice, structural racism, intergenerational trauma, gender and identity issues, and suicide. This priority jibes well with AAIUH's vision for the organization's future. The Recommendations section below contains several more potential ideas related to sustainability.

Financial Health: The organization has a strategic funding plan that includes diversified funding sources, multi-year funding and internal revenue generation. However, as mentioned

under Challenges, when asked about the sustainability of the achievements made, and potential expansion or the next phase of this project, in particular, doubts were expressed. Respondents' recommendations for the project mostly related to fundraising, as not to lose the momentum that was generated.

> "I would have wanted them to seek out grant opportunities to continue this work. They have the capability to apply for grants to continue this program and [we] would like to see them do so."

> "This program of Arthur Ashe, and the way they did it, is a story that needs to be told. They need to align with a solid PR [public relations] strategy because if people don't know about it, that will delay the positive effect. Nobody else is doing this work the way they do it." --UUSA staff member

Partnerships and community engagement

There is ample evidence that the project was built upon and benefited from the long standing engagement of AAIUH with various community groups and CBO partners. As mentioned above, this was seen as a key factor in its success. AAIUH has worked almost since its inception with barber shops and hair salons, and these were critical points of entry for the present project, as well. As noted, the project also necessitated AAIUH creating further linkages to engage more and different kinds of CBOs, including faith leaders and their congregations, individual local therapists, and one educational institution. The program counted on 14 new institutional partnerships, as well as individual partnerships, including with one art therapist and one licensed clinical social worker (LCSW).

Partners

Those marked with an asterisk were new partnerships established for this project.

- MA Therapy*
- Family Institute for Health*
- Flatbush Leadership Academy* [under The 67th Clergy Council (Godsquad)]
- Brooklyn Community Services*
- Kings Against Violence Initiative
- Hair Creations
- Quality Cuts Barbershop
- Haitian-American Community Coalition
- Mixteca
- Life of Hope*
- Maranatha SDA Church*
- Fellowship Missionary Baptist Church*
- Christian Fellowship SDA*
- Church of God of Prophecy*
- Royal Ambiance Salon
- Jeannette's Beauty Care Salon
- Dr. Cuts Barbershop
- Hermie's Salon
- Yours and Mine Salon
- Diaspora Community Services
- Brooklyn Perinatal Network
- Caribbean Women's Health Association
- Make the Road
- Arab-American Family Support Center
- Hebron Baptist Church*
- Uncommon Charter School: Brownsville Collegiate*
- Center for Court Interventions*
- Javere Pinnock (Art Therapist)*
- Stacey Wright (LCS)

The new partnerships with faith leaders came about through needs identified in the assessment phase. While young people said they confide mostly in their peers and teachers, many of their parents told AAIUH that they confided more readily with faith-based leaders, whether in the church or mosque.

> "...because of that, we thought it was important to build the church's capacity to offer mental health support. We did a workshop, and a church member, her son had committed suicide a couple of years ago, he never opened up about what he was going through. He said, 'I am not able to pay my rent.' And her response was, 'God will provide.' So we wanted to show [church members] that God also provides other resources that can be helpful for mental health." --AAIUH staff member

Each CBO partner was tasked to recruit 15 people to participate in the workshops but, according to the logframe, they generally exceeded this target, in particular the faith-based organizations. This was especially useful during the first year of COVID-19 because the barbers and salons were overextended due to other commitments with AAIUH. In this way the FBOs were seen as an important asset in reaching the participant targets.

The partnership with Uncommon Charter School: Brownsville Collegiate also came in response to a need identified in the assessment phase, to reach out to young people through schools and teachers.

"When we asked youth about who they confide in if they have problems, the first response was that they reach out to their peers, but the second one they mentioned the most was teachers. So we knew we had to get to the schools. This partnership was kind of a pilot [in that direction]."--AAIUH staff member

The pilot is seen by both AAIUH and Brownsville Collegiate as a success, and AAIUH staff say they are planning for greater engagement with educational institutions and actors in the near future.

MA Therapy and the Family Institute for Health served in the role of providing mental health clinicians and facilitators for every workshop. The original plan was for AAIUH or HDPI personnel to facilitate but AAIUH made the decision to build on local capacity, partnering with locally mandated-reporters with facilitation expertise. "If anything was 'triggering' in the workshops," in the words of one AAIUH staff member, "they could be the ones that knew what to do. The whole project would not have been what it was, without them. I know that moving forward, in …anything we do that's mental health-related, they will be our partners."

Again these relationships are seen as reciprocal. The partners were compensated monetarily, either as consultants or in the form of an honorarium. In the case of a mental

health provider, such as MA Therapy and Family Institute for Health, partnering with AAIUH also allowed them to get their name out to a group of 697 potential clients or referrers in the community.

The process to identify new partners was varied; some were established in part by word of mouth or recommendations and others through a more deliberate selection process. The capacity and appropriateness to serve as partners for this initiative was in large part determined in the assessment process, figuring out in an open forum with the community what entry points would be most appropriate.

> "They [AAIUH] have been a great partner. Initially they reached out and said, 'We are having a forum-style discussion,... and they said they would have a survey with young people. So we sent a couple of [youth we work with] to join the conversation. They started [asking about] mental health in the community, what they were experiencing during COVID, and …the young people came back and said that was such a great conversation." --CBO partner

> "The different stakeholders had to have lots of conversations about what our goals would be. And we knew we needed to establish a foundation, not expecting that people would be willing to partner automatically. We had to open up a conversation. So within that, we had to have a [common] understanding between the partners of how we were going to conduct a needs assessment, and how we could have the community rooted in the work from the beginning."--AAIUH staff member

> "They did a really good job with partnerships; they built on existing partnerships. That's always a strength when it's something that already exists. …[adding] the local therapists, that's been a really good resource for the program as well."
> --Advisory Group member

The various stakeholders spoke of these relationships as being of value in implementing future projects, a sign that sustainability is being fostered through partnerships. AAIUH staff spoke of their plans to leverage partnerships to engage in more outreach, and to help secure resources in support of MHPSS. An important strategy for AAIUH in keeping partners engaged was to enlist their help in developing communications materials: newsletters, videos, social media advocacy, etc. This was seen as a good practice for future initiatives.

> "KAVI is one of the partners, and there's [Flatbush Leadership Academy (FLA)], and these groups have a mission that's totally different from ours, and we have to learn from them, and them from us. We have to keep them involved as much as possible;

> you don't want them to have just one chance for involvement, and then two months later you need to reach out again for help. So I learned to just always keep them engaged. For example, with a web article we wrote, we went through the partnership, as a way of keeping [the partners] abreast of the project. Then [one partner] asked me to be a part of their youth summit, and I was a guest lecturer on their panel, speaking on behalf of the institute."--AAIUH staff member

AAIUH also maintains informal partnerships and relationships at local level with government bodies, though this was not linked to the UUSA grant per se. The organization has strong ties to the incoming NYC mayoral administration, and plans to advocate in a coalition for city support to further the MHPSS programming and other initiatives.

Conclusions and Recommendations

The evaluation finds that AAIUH and UUSA achieved considerable success toward their overall objective to enable vulnerable children and youth, and their families and communities, to better cope with the mental health and psychosocial risks and vulnerabilities due to COVID-19. The program reached its first stated objective, to strengthen resilience and mitigate the harmful effects of COVID-19, as noted by participants in post-program surveys and in KIIs with local partners. This was achieved through successful implementation of its second objective--engagement with affected communities and civil society in building capacity to better cope with MHPS risks and vulnerabilities. Critical to this success was the development of a results-based M&E framework for the programme implementation, the program's third objective. This framework proved useful to the implementing agency in achieving planned outputs and, in their own words, built their capacity in M&E.

Factors contributing to successful implementation include the unusually high capacity of the various stakeholders; creation and management of a flexible, responsive model rooted in identified community needs; the utilization and promotion of local capacity; high-value existing networks and appropriate new partnerships; and the well-crafted theory of change and M&E tools.

To further capitalize on this initial phase, the following recommendations are based on the evaluation findings, and in some cases, on global best practices for working with crisis-affected young people:

- Expand the reach of the MHPSS curriculum, not only in response to the COVID-19 pandemic, but as an ongoing initiative. The evaluation finds that the model is seen as

a unique and highly relevant contribution to community wellbeing ripe for scaling up and expansion into more and different MHPSS initiatives, with great potential for replication elsewhere.

    - Hold training-of-trainers workshops with community organizations, school guidance counselors, etc., and disseminate the curriculum for their use.

- Consult with a diverse range of young people to find ways to keep the MHPSS curriculum more relevant for female, male and other youth. In particular, consider approaches based in the arts and expression that participant young people say they want more of.

    - Train local artists, theatre people, dancers, rappers in MHPSS and ask them what to add to the curriculum.

- Consult young people periodically to make sure feedback mechanisms are fit for purpose. Feedback mechanisms bring accountability, build trust, and promote youth leadership, ownership and agency, to better inform the program. They can also provide AAIUH with early warning signs of various risks including abuse. Establishing robust feedback mechanisms is a first-priority best practice for youth-serving programs globally.[17]

    - AAIUH could also establish an internal youth advisory board with terms of reference created in a participatory manner, staying cognizant of young people's other obligations (home, school, work, etc.).

- Commit to the consistent collection of demographic data on participants at all phases of the program. Collection of disaggregated data is a first-priority best practice for social service provision globally, and aids with targeting, resource mobilization, M&E, etc.
- Work with young people to find ways to ensure gender parity in participation, and to bring more marginalized peers in the community who might be less likely to participate: youth with disabilities, younger youth, young people out of school, young parents, those with language barriers, young heads of households, LGBTQIA+, unhoused young people, etc. Global best practices for maximizing inclusion include:

[17] IASC, *With us & for us: Working with and for Young People in Humanitarian and Protracted Crises*, UNICEF and NRC for the Compact for Young People in Humanitarian Action, 2020

    - Partnering with local CBOs or youth groups serving the needs of LGBTQIA+ youth, persons with disabilities, unhoused, etc.
    - Partnering with CBOs working on sexual and reproductive health to advocate for, or provide, tailored MHPSS to young and expectant mothers.
    - In grant proposals, including budget lines for accommodation of young persons with disabilities.

- Consult with men and boys in the community to find ways of bringing more of their male peers, who may need an extra push, to engage in dialogue on mental health. Male participation was cited as a weakness by several respondents, and this recommendation also appears in the HDPI final report.[18]
- Consult with young people on how to incorporate more participatory media production in efforts around advocacy, accountability, PR, resource mobilization, etc. This tactic was seen as effective in keeping young people meaningfully engaged, and it became a feasible way to help maintain partnerships.

    - Engage young people in developing key advocacy messages pertaining to their mental health needs.
    - Find or create venues for young people to present publicly on results of MHPSS programs, ideally in spaces where they can dialog and advocate with duty-bearers (local leaders, donors, etc.) using the advocacy messages they have developed.

- Further invest in human resources to foster and maintain CBO partnerships and build their capacity on mental health and wellbeing. Hire a dedicated staff member(s) to manage the MHPSS work. This was mentioned as a necessity by many respondents.

    - AAIUH could also consider a formal partnership with a mental health service provider(s), with each agency playing to their own strengths.

- Conduct regular refresher trainings and additional sessions on issues related to mental health and wellbeing. Demand for MHPSS is evidently very high in the target communities, even outside the context of COVID-19.

[18] HDPI. Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021

- Develop additional curriculum modules. Many participants made this request, and the HDPI final report[19] lists ideas for topics that could be stand-alone curriculum components for specific target groups:

    - Self-care and self-help
    - Social/healing justice, oppressive authority/police/mass incarceration
    - Conflict resolution, restorative justice, traditional justice
    - Gendered mental health issues specific to girls/young women, boys/young men and others
    - Suicide prevention
    - Sexuality and mental health and wellbeing, also addressing sexual violence
    - Psychological first aid (PFA), cognitive behavior therapy (CBT), somatic therapies, and other approaches as appropriate
    - Sessions to practice role play and peer-to-peer skill development;
    - Visiting experts who could present on specific areas of interest, identified by participants.

- Work with a select number of schools, at first, to find feasible ways to integrate mental health into the school curriculum, and/or provide space in or near schools for MHPSS outside of school hours. Include young people in planning discussions. Many respondents spoke of the need to make further connections with education actors, as one of the most important ways to gain access to potential beneficiaries.
- Link to, or foster local and national networks on urban mental health, as a means of information sharing, evidence building and resource mobilization. Several respondents spoke of the high potential to leverage new and existing networks in order to expand the model's reach and raise funds for future programming. Consider convening a local working group on (youth) MHPSS with representatives from youth organizations and networks to enable coordination between partners.

- Raise the profile of the MHPSS model through some combination of media outreach, media production, presentation of findings at high-profile events, publication of results, etc.
    - Find ways to include meaningful participation of young people in raising awareness of the program.

[19] HDPI. Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021

- Maintain links with academia in public health, adolescent development, urban studies, etc., as a means of contributing to the evidence base, raising AAIUH's profile and further adapting and testing the model.
- Include budget lines for rigorous, independent impact evaluation in future MHPSS initiatives.This priority was not within the budget of the present grant, but the results so far point to potential positive impacts on mental health outcomes, at a reasonable cost.
- Publish papers about the work in a peer-reviewed journal(s).
- Develop a how-to manual for replicating the model, including the assessments, M&E, curriculum development, and evaluation research.
- Advocate in coalition with other organizations in the MHPSS space for city government funding for MHPSS programming. This is seen as a "low-hanging fruit" for resource mobilization, especially as a new mayoral administration comes in.
- Identify pathways to future careers for local young people in MHPSS as part of existing AAIUH initiatives in the health field. There is a clear need for more MHPSS personnel who are rooted in, and understand the intersectional needs of the local community. The program did expose a small group of young people to a mental health career panel.

    - Consider bringing in young people as AAIUH staff and volunteers, and discuss among established staff ways to help them succeed in the workplace.

Annex 1: Research tools

Inception phase KII questions

1. In a program that has been well-documented, what do you see as the added value of this evaluation? What will this evaluation do that the other reports have not done?
2. How can the evaluation be conducted in a way that is respectful of participants' (especially participating young people's) time and competing priorities?

Semi-structured interview questions for KKIs with AAIUH, UUSA, and the Advisory Group

1. If you think about the different pieces of this program, and the objectives of the program, was this the right combination of things in order to reach its goals? How should it have been different, if at all?
2. To what extent were the various stakeholders (participants, CBO partners, etc.) consulted during design, implementation?
3. How well do you think gender equality and cultural sensitivity were considered in the project?
4. What are the main things this program achieved, in your opinion?
5. What have been the keys to success, and what were the big challenges?
6. Was the program adequately funded? If not, what effects did underfunding have?
7. What can you say about the return on investment, thinking about the results that were achieved?
8. How would you say your (agency's) capacity has increased through this experience, if at all? How seriously did the program take that aspect?
9. What parts of this program could be taken to other locations, or expanded to cover bigger numbers of people?
10. What would be needed to sustain this project?
11. To what extent has the project built upon past engagement of AAIUH with community and CBO partners?
12. Thinking about any new partnerships or important relationships that came about, how did they happen? What lessons did you learn about finding the right partners?
13. Tell me about lessons you learned. You can talk about strategy, communication, program management, etc.

Additional questions for KIIs with AAIUH

14. Where do you want to go with your organization, and how does this initiative and any follow-on initiative fit with that vision?
15. Please elaborate on the specific tools and approaches utilized in the is program, for example the BEAM approach. What were the strengths and challenges related to these?

Additional questions for UUSA

16. How did the program perform against the objectives of the donor, as follows?
    a. Strengthen resilience and mitigate the harmful effects of COVID-19

b. Engage affected communities and civil society in building capacity to better cope with the mental health and psychosocial risks and vulnerabilities due to COVID-19;
c. Develop a results-based monitoring and evaluation framework for the program implementation;
d. Expand the donor base dedicated to national causes.

Additional questions for young people, CBO/school partners, community leaders

1. What effects has this experience had on you, or on the community?
2. As this phase of the program ends, what would be useful to address the mental health needs of young people and the community in the near future?
3. What roles would you see yourself playing in such programming, if any?

Followup survey questionnaire (approximately three months post-project, mid-January 2022)

Please select your age category:

- 18 or younger (Youth)
- Older than 18 (Adult)

What is your gender identity?

- Male
- Female
- Non-binary person
- Transgender person
- Prefer not to say

What is your racial identity?

- Asian
- American-Indian or Alaska Native
- Black or African-American (Afro-descendant)
- White
- Two or more races
- Prefer not to say

Since participating in the Institute's Mental Health & Wellness Workshops, I am...

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

I am more aware of my own mental health and wellness.

I feel more confident having conversations about mental health and wellness.

I am more familiar with localresources/services for support.

If yes, please share any additional changes or experiences.

What barriers continue to exist that impact your mental health and wellness? (If none, please write "none")

I am interested in participating in more mental health and wellness workshops.

- Yes
- No
- Maybe

I am interested in participating in a mental health and wellness leadership program to better support myself and my peers.

- Yes
- No
- Maybe

If we were to hold more workshops, which topics would you be interested in learning more about? (select all that apply)

- How to cope with stress
- Suicide prevention and support
- Owning your identity
- How to foster healthy friendships/relationships
- Sexual health

- Community or domestic violence
- Family dynamics
- Connecting to different mental health resources (e.g. art/dance/music therapy)

Please provide an email address to receive your e-gift card (processing will take up to one week).

Annex 2: Logical framework

Redacted from: Arthur Ashe Institute of Urban Health (AAIUH), *MHPSS Capacity Building Planning Document (Draft for Review) 5.20.2021*

Results statement/ Interventions	Location Target Groups	Indicators (no. and/or percentage to be added, following discussion)	End-line Target August 2021	Means of Verification	Outputs/Reach
Impact: Adolescents, youth, and their families and communities are empowered to improve their mental and emotional health and wellbeing, and are better able to cope with the risks and vulnerabilities due to COVID-19	Brooklyn (central, north, east) Youth/Students Barbers & Stylists CBO staff Faith-based Institutions Educators Parents/Caregivers	Youth/students participating in the training/workshops report greater knowledge of mental and emotional health, and improved self-care, active listening, coping and support skills Barbers/stylists, CBO staff, faith-based institutions, educators and parents/caregivers participating in the training/workshops report greater knowledge of mental and emotional health, and improved self-care, coping and referral skills, including to support children's	20 youth/student participants x 10 peers for a total of 200 youth/students engaged 50 youth/student participants in Youth Summer Programs 10 barber/stylist shops participating x 15 clients for a total of 150 engaged 6 CBOs participating x 15 community members for a total of 90 persons engaged 5 faith-based institutions participating x 15	Focus Group Discussions Rapid 3-month recall survey Evaluation	21 youth/peer leaders trained; 178 youth/students engaged in PTP workshop 158 youth/student participants in Youth Summer Programs. 7 participating barber shops/salons trained; 40 clients engaged 6 CBOs; 98 persons engaged 5 faith-based institutions; 157 persons engaged

		mental health responses	community members for a total of 75 persons engaged 25 educators/staff participants **Total 450**		24 educators/staff engaged 21 diverse participants (open forum workshop) **697 total persons (youth & adults) engaged in MHPSS workshops**
<u>Outcomes:</u> **1.** Youth/Students/ Peers are better able to recognize MHPSS needs and provide peer-to-peer support, including active listening; and better able to recommend their peers for additional help and professional services	Brooklyn (central, north, east) Youth/Students Barbers & Stylists CBO staff Faith-based Institutions Educators	Proportion youth/students/peers who indicate satisfaction with the MHPSS TOT course Proportion of youth/students/peers who complete the MHPSS TOT course and report improved MHPSS knowledge and awareness, including self-care, active listening, positive	20 youth/student participants x 10 peers for a total of 200 youth/students engaged 50 youth/student participants in Youth Summer Programs	MHPSS TOT course feedback questionnaire and knowledge test Focus Group Discussions Rapid 3-month recall survey Evaluation	Refer to post-workshop evaluation survey results.

2. Barbers/Stylists CBO staff, Faith-based Institutions, Educators/staff and Parents/Caregivers are better able to provide support and identify mental, psychosocial and emotional health needs for referral; and better able to identify referral pathways to access MHPSS services in the community.	Parents/Caregivers	coping and support skills Proportion of barbers/stylists, CBO staff, faith-based institutions, educators/staff and parents/caregivers who indicate satisfaction with the MHPSS TOT course Proportion of barbers/stylists, CBO staff, faith-based institutions, educators/staff and parents/caregivers who complete the MHPSS TOT course and report improved knowledge and awareness, including self-care, active listening, positive coping and referral skills	10 barbers/stylists shops participating x 15 clients for a total of 150 engaged 6 CBOs participating x 15 community members for a total of 90 persons engaged 5 faith-based institutions participating x 15 community members for a total of 75 persons engaged 25 students and staff/educator participants		
<u>Outputs:</u>					

1. Increased community capacity and engagement in mental health and reduced stigma in accessing MHPSS **2.** Increased capacity of Youth/Students, Barbers/Stylists, CBO staff, Faith-based Institutions, Educators to recognize mental, social and emotional health needs for support and recommendation or referral to access MHPSS services	Brooklyn (central, north, east) Youth/Students Barbers & Stylists CBO staff Faith-based Institutions Educators Parents/Caregivers	# of youth/students who complete MHPSS TOT course # of youth/students/peers who complete the MHPSS TOT course and subsequently convene peer-to-peer sessions, and active listening groups as well as outreach, to other MHPSS services and activities # of barbers/stylists CBO staff, faith-based leaders, educators/staff and parents/caregivers who complete the MHPSS TOT course and subsequently convene support sessions and/or safe spaces for dialogue and active listening groups, as well as outreach to other MHPSS services and activities	20 youth/student participants x 10 peers for a total of 200 youth/students engaged 50 youth/student participants in Youth Summer Programs 10 barbers/stylists shops participating x 15 clients for a total of 150 engaged 6 CBOs participating x 15 community members for a total of 90 persons engaged 5 faith-based institutions participating x 15 community members for a total of 75 persons engaged 25 students and staff/educator participants	Attendance tracking for MHPSS TOT course MHPSS TOT course feedback questionnaire Focus Group Discussions Rapid 3-month recall survey Evaluation	21 youth/students completed MHPSS PTP course 21 youth/students complete MHPSS PTP course and co-facilitate PTP workshops. 6 CBOs (98 persons engaged) 5 faith-based institutions (157 persons engaged) 7 barber shops/salons (40 persons engaged) 1 school (24 educators/staff engaged) 1 open forum workshop (21 diverse participants) **Total: 340 persons (adults) engaged**

nterventions/Activities: **1.** Conduct needs assessment and establish baseline with knowledge and understanding of mental health services and resources ● Conduct literature/ desk review of existing resources (i.e. surveys, reports, peer-reviewed articles) ● Conduct (informal) Key Informant Interviews with key community stakeholders ● Conduct Focus group Discussions ● Launch Rapid Survey Involving	Brooklyn (central, north, east) Youth/Students Barbers & Stylists CBO staff Faith-based Institutions Educators Parents/Caregivers Clients, Congregation, Community members	Needs Assessment data/analysis, based on: - Desk review of compiled literature review findings and materials - # of Key Informant Interviews conducted - # of Focus Group Discussions convened - Data from Rapid Survey of Children and Youth analyzed # of MHPSS TOT courses completed: # of Youth/Students participating # of Barbers and Stylists participating # of CBOs participating # of Faith-based institutions participating # of Educators/staff participating	Sample of various target groups in selected Brooklyn communities	Needs Assessment report completed and disseminated	Needs Assessment: 10 key informant interviews conducted; 13 participants 7 focus groups conducted; 45 youth/parents engaged 136 (youth) rapid respondents MHPSS courses completed: **357 total youth/students** 7 barber shops/salons 6 CBOs 5 faith-based institutions 24 educators/staff **16 total EIC** (2 flyers, 2 videos, 1 post-workshop

	Children and Youth	As per training plan	# of information, education and communication (IEC) materials developed and disseminated # of community workshops convened As per training plan	As per training plan	As per training plan	email w/ resources (sent after each workshop), 2 curricula (youth + adult), 1 PTP orientation presentation, 1 youth summit, 2 conference presentations, 2 web articles, 3 newsletters)
2.	Provide MPHSS training to youth/students, barbers/stylists CBO staff, faith-based institutions, educators/staff and parents/caregivers to recognize mental, social, and emotional health needs for support and recommendation or referral to	Brooklyn (central, north, east) Youth/Students Barbers & Stylists CBO staff Faith-based Institutions Educators Parents/Caregivers Clients, Congregation, Community members	# of community members reached with information, education and communication (IEC) materials # of social media engagements (e.g.		Progress report on communications and social media events and engagements Tracking of new partner engagement	**21 total workshops conducted** 5,000+ community members reached with information, education and communication (IEC) materials # of social media engagements (e.g. posts, impressions, retweets, likes, shares)

access MHPSS services **3.** Communicate and undertake social mobilization (community workshops, focus groups, information, education and communication (IEC) material distribution) **4.** Evaluate UNICEF USA supported MHPSS project implemented by AAIUH, including the impact of the culturally tailored mental health trainings	AAIUH social media platforms AAIUH partners/stakeholder networks As per the projects objectives, targets and interventions (log-frame)	posts, impressions, retweets, likes, shares) # of community members engaged in social media campaign # of new partnerships ToR completion Evaluation team identification / recruitment Data collection Report completion (quality) Dissemination	Within 3 months of project implementation	Time-calendar Final report submission	# of community members engaged in social media campaign 10 new partnerships (FLA, BCS, 5 churches, MA Therapy, Institute for Family Health, Uncommon Charter School, Center for Court Interventions)

Annex 3: Key informants interviewed

Kenya Kirkman, AAIUH
Faven Araya, AAIUH
Humberto Brown, AAIUH
Edison Sabala, UUSA
Yvonne Graham, UUSA
Anucha Browne, UUSA
Janai Jeter, 67 Clergy Council
Krishna Belbase, HDPI
Wayne Bleier, HDPI
Saudamini Siegrist, HDPI
Amber Elizabeth Gray, HDPI
Brandi Epps, Uncommon Charter School: Brownsville Collegiate
Brian Trezeant, Brooklyn Community Services
Amira Martin Crawford, MA Therapy

Annex 4: Documents and secondary data reviewed

1. AA MHPSS Training DIST
2. AAFC Research Project PPT Presentation
3. AAIPH Draft Rapid Assessment Tool_11 August 2020-revised 8-19-2020
4. AAIPH_ Theory of Change Diagram_zero - AAIUHComments
5. AAIUH MH FG (18+ mix).m4a (Video recording)
6. AAIUH MH FG (Boys 15-17) (Video recording)
7. AAIUH MH FG (Girls 15-17).m4a (Video recording)
8. AAIUH MH FG (Mothers).m4a (Video recording)
9. AAIUH MH FG (boys 12-14).m4a (Video recording)
10. AAIUH MH FG (fathers).m4a (Video recording)
11. AAIUH MHPSS Desk Review 1-2021
12. AAIUH MHPSS Desk Review Template_12 Nov 2020
13. AAIUH MHPSS FG Guide PARENTS 2.17.2021
14. AAIUH MHPSS FG Guide YOUTH 2.17.2021
15. AAIUH MHPSS Focus Group Guide_(KK)
16. AAIUH MHPSS Focus Group Guide_12 Nov 2020
17. AAIUH MHPSS Focus Group Summary 3.19.2021
18. AAIUH MHPSS Key Informant Guide - Prep Session
19. AAIUH MHPSS Key Informant Guide V2- FINAL
20. AAIUH MHPSS Key Informant Guide V2- FINAL
21. AAIUH MHPSS Key Informant Guide- FINAL
22. AAIUH MHPSS logframe_12 Nov 2020_Updated with Logic Model inputs in blue font
23. AAIUH MHPSS PROJECT EVALUATION TOR Final
24. AAIUH MHPSS RR Survey FINAL 3.29.2021
25. AAIUH MPHSS Training Plan 2021_4.8.2021
26. AAIUH Partner MOU MHPSS PTP_ FINAL
27. AAIUH UNICEF-Proposal-Draft-6-8-2020-FINAL (4)

28. AAIUH x NYU Langone PPT_10.19.2021
29. AAIUH-UNICEF Mid-Term Progress Report Final 1.28.2021
30. AAIUH-UNICEF Mid-Term Progress Report Final 1.28.2021 (1)
31. AAIUH-UNICEF USA Grant Midterm Progress Report 1.28.2021 (1)
32. AAIUH. AAIUH x UNICEF Engagement report draft
33. AAIUH. Actual vs Projected Reach Table
34. AAIUH. Connection, cultural competency and community. [Powerpoint presentation] Oct 2021
35. AAIUH. Default Report: Beyond the Stigma: MHPSS Evaluation 2021 (PTP). October 28, 2021
36. AAIUH. Default Report: Youth Mental Health and Wellness During the COVID-19 Pandemic. March 29, 2021
37. AAIUH. MHPSS logframe_12 Nov 2020_Updated with Logic Model inputs in blue font
38. AAIUH. Peer2Peer Workshops Eval Summary report 12.2021
39. APHA x MPHSS_ UPDATED ppt 10.21.2021
40. Arthur Ashe Institute for Urban Health Focus Group Guide_DRAFT 15 Oct 2020 (1)
41. Assessing perceptions of COVID-19 - Summary Data
42. BCID Research Project PPT Presentation.html
43. BK Youth Mental Health Resource Guide
44. Beuchner, Maryanne. UUSA AAIUH interview notes youth leaders
45. Beuchner, Maryanne. UNICEF USA Initiatives: Peer Leaders Making a Difference in Mental Health. October 22, 2021
46. Beuchner, Maryanne. UUSA AAIUH interview notes Edwin barber Oct 5 2021
47. COVID Survey-Youth experiences with remote learning 7.2020
48. COVID-19 Mental Health-Intimate-partner-violence
49. COVID-19 Refugee _ Immigrant Youth
50. Community Health Edu Workshop EVAL Summary Report 10.28.2021
51. Community Partners-UNICEF.html
52. Complex Trauma-Urban African American Children
53. DRAFT SAMPLE Workshop Agenda_MHPSS and COVID-19_Sept 2 2020
54. Desk Review Template_AAIUH UUSA_3 Nov 2020_Draft for circ
55. Draft MHPSS Desk Review_AAIUH_27 Oct 2020
56. Draft MHPSS logframe_AAIUH_30 Oct 2020_Updated
57. Excerpt from IASC MHPSS M_E Framework
58. FOCUS GROUP (Material).jpeg
59. Flyer Listening Sessions.png
60. Focus Group Workplan
61. Full 2021 MHM Toolkit
62. Gender_Sexuality Conformity Mental Health Implications in NYC
63. HDPI. Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. DRAFT Final Report Submitted to UNICEF USA October 2021
64. HDPI. Mental Health and Psychosocial Support Linked to the COVID-19 Crisis in the United States. Midterm Report, 2021
65. Inequity Impact on Mental Health of NYC Children (1)
66. Key Informant Interview Schedule.xlsx

67. Key Informant Summary Report 1.15.2021
68. LarrakiaHealingGroup_Resources_2016_EMAIL_LoRes
69. List of Potential Resources_
70. Listening Session Flyer - l-2.jpg
71. Listening Sessions_ Elevating the conversation (Responses).xlsx
72. Mental Health Disparities Among LBGT Youth in NYC
73. Mental Health Network
74. Needs Assessment Revised Draft May 17
75. P2P Beyond The Stigma Updated Flyer_ BCS
76. P2P Beyond The Stigma Updated video_ BCS (Video recording)
77. P2P Beyond The Stigma Updated video_ BCS (Video recording)
78. PFA training adapted 28 July 2020_UNICEF Migration
79. Peer2Peer Workshops EVAL Summary Report 10.28.2021
80. Peer2Peer Workshops EVAL Summary Report 10.28.2021
81. Physical Activity and Mental Health of High School Children in NYC (1)
82. Projected Reach.xlsx
83. RBM and M and E Orientation PP
84. Rapid Survey Brooklyn_22 Oct_DRAFT for review
85. Rapid Survey Response Email Addresses 3.29.xlsx
86. Revised_MHPSS_ToC_30 Oct 2020_Updated
87. Socioeconomic Distress_Mental Health Among NYC Adults
88. Suicide Mortality Risk Among Middle Aged in New York City
89. Suicide training
90. Tentative Training Schedule_
91. The Impact of COVID-19 on Youth_s Well-Being - Google Forms
92. Thrive NYC CBO-FaithToolkit-digital-1
93. UNICEF (April 2020) COVID-19 Operational Guidance for MHPSS Implementation and Adaptation_Field Test Version[2] (1)
94. UNICEF Logic Model 11.6.2020
95. UNICEF M_E Presentation 1.29.2021
96. UNICEF-Arthur Ashe MHPS Project Fact Sheet_cmts UNICEF
97. US Department of Housing and Urban Development. 7: Sustainability
98. AAIUH MH FG (Girls 12-14).m4a (Video recording)
99. UUSA AAIUH interview notes Edwin barber Oct 5 2021
1. UUSA AAIUH interview notes youth leaders Juzette and Briana
2. UUSA Arthur Ashe youth interview with Joshua - FLA
3. Young People_s Mental Health Report 2020 with Program Appendix 12.8.20
4. Youth Peer-To- Peer Program.xlsx
5. Youth(PTP) MPHSS Workshop

Annex 5: Evaluation calendar

- ToRs and recruitment completed 10/26/2021
- Inception phase 10/27 - 11/08/2021
- Data collection/tabulation 11/1-30/2021
- Data analysis and first draft preparation 12/08/2021
- Review of draft report 12/11-15/2021
- No-cost extension granted 12/30/2021
- Rapid online survey open period 1/9 -1/14/2022
- Review of second draft 1/18-25/2022
- Final draft submission 1/31/2022

Annex 6: Evaluation personnel

- Josh Chaffin (Independent) - Evaluation consultant, report author
- Krishna Belbase (HDPI) - Evaluation Advisor, coordinated ToR development and provided technical advice
- Saudamini Siegrist (HDPI) - Project Coordinator, reviewed drafts and provided comments
- AAIUH team (Kenya Kirkman, Faven Araya, Humberto Brown) developed survey tools, managed surveys and provided feedback on ToR, report drafts
- HDPI consultants (Wayne Bleier, Dr. Amber Elizabeth Gray) provided feedback on ToR, report drafts and survey tools