UPSTREAM! *Together* evaluation results from community efforts to prevent mental, emotional, and behavioral health problems

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ABSTRACT

Mental, emotional, and behavioral (MEB) health problems are prevalent globally. Despite effective programs that can prevent MEB problems and promote mental health, there has not been widespread adoption. *UPSTREAM! Together* was a planning project in three Colorado communities. Communities partnered with academic and policy entities to 1) translate evidence about MEB problem prevention into locally-relevant messages and materials and 2) develop long-term plans for broad implementation of interventions to prevent high-priority MEB problems. Community members recognized the need to talk about MEB problems to prevent them. The *UPSTREAM!* communities localized messages designed to start conversations and sustain attention on preventing MEB problems. The communities understood that prevention takes sustained community attention and advocacy, knowing that important outcomes may be years away. Long-term implementation plans aimed to strengthen families and enhance social connections among youth. Despite community readiness and capacity to implement evidence-based programs, there were few funding opportunities, delaying program implementation and revealing gaps between funding policies and community readiness. This community-engaged experience suggests an achievable approach, acceptable to communities, and worthy of further development and testing. Policies that cultivate and support local expertise may help to increase wider community adoption of evidence-based programs that promote mental health among youth.

1. Background

Mental, emotional, and behavioral (MEB) health problems are prevalent and burdensome. Globally, depression affects an estimated 264 million and there are almost 800,000 deaths from suicides (James et al., 2018; World Health Organization, 2019). Depression and anxiety disorders cost the global economy US$1 trillion per year.[2] In the United States, the National Survey on Drug Use and Health found that in 2017, 18.3 % of adults had any mental illness, and 4.2 % had a serious mental illness (Substance Abuse & Mental Health Services Administration, 2018). Approximately 29 % of individuals who received Medicaid

through expansion from the Affordable Care Act have either a mental health, substance use disorder or both (Blue & Rosenberg, 2017). MEB health problems are experienced at a young age: 50 % of lifetime cases of diagnosable mental health conditions begin by the age of 14 and 75 % begin by the age of 24 (Kessler et al., 2005). Stigma associated with MEB problems often prevents people from talking about them with ease and adds to the challenges communities face when attempting to improve MEB health (National Academies of Sciences, Engineering, & Medicine, 2016). Despite the substantial progress that has been made in both understanding how MEB problems develop and how they can be *prevented*, there is a persisting but closeable gap between what we know about

preventing MEB problems and what we do in practice and in policy (Boat, 2015; Furber et al., 2015; Jacka et al., 2013).

In 2009, the United States Institute of Medicine (IOM, now, the National Academy of Medicine) called on the nation to make prevention of MEB disorders and the promotion of mental health of young people a very high priority (Institute of Medicine, 2009). This report recommended that local community organizations and researchers form partnerships to develop and evaluate feasible prevention interventions that are acceptable to the communities and have evidence supporting their effectiveness. In 2019, the National Academies of Sciences, Engineering, and Medicine issued recommendations to support family cohesion and social connections, especially using strategies that intervene early in a child's development and support caregivers (National Academies of Sciences, Engineering, & Medicine, 2019). Evidence-based MEB prevention includes a range of school-based programs, family training or therapy programs, and community or home-based programs delivered across age ranges (Akin, Lang, Yan, & McDonald, 2018; Chilenski, Frank, Summers, & Lew, 2019; Hawkins et al., 2009; Lewis et al., 2012; McBain et al., 2021; Stice, Rohde, Gau, & Wade, 2010; Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006). Further contributing to the gap in prevention work, is the lack of sufficient implementation studies in many settings, especially "for situations in which we know what to do but less about how to do it" (Jacka et al., 2013).

UPSTREAM! Together responded to IOM recommendations by establishing three, diverse "communities of solution" wanting to plan, implement, evaluate, and sustain interventions to prevent priority MEB problems locally (Folsom Group, 2012; Institute of Medicine, 2009). Like elsewhere, Coloradoans experience the burden of MEB problems: Coloradans in poor physical health report poor mental health (33.7 %) at four times the rate of those in good physical health, and those in poor mental health report poor physical health (39.0 %) at four times the rate of those in good mental health (The Colorado Health Institute, 2018).

In 2016, the Colorado Health Foundation and the University of Colorado Department of Family Medicine funded *UPSTREAM! Together* as a collaborative planning enterprise (Eugene S. Farley Jr. Health Policy Center, 2018). Similar to the framework on MEB prevention workforce development (Furber et al., 2015), the planning program worked with communities to (a) define a priority problem locally and (b) match the community with an appropriate evidence-based program. The goals of the planning program were to: 1) form three communities of solution (the people who need to work together to solve a problem) (Folsom Group, 2012) and engage in a community-based participatory process to identify community organization leads; 2) develop community interventions consisting of messages and materials to increase local awareness; and 3) motivate action in communities around MEB prevention to: a) identify specific MEB issues to address, b) develop long-term, sustainable MEB prevention program plans and funding for broad implementation, and c) develop and support local leadership for ongoing MEB prevention efforts.

The key assumption underlying *UPSTREAM! Together* was that evidence-based programs will not be fully effective if implemented without local context and customizations identified and created in partnership with local communities (Neta, Brownson, & Chambers, 2018). This manuscript reports on the experience, results of the planning program, and lessons learned by three diverse Colorado communities during their preparation to prevent their priority MEB issues. We also propose changes we would make in future efforts to devise and initiate local efforts to prevent MEB problems.

2. Methods

The Eugene S. Farley, Jr. Health Policy Center, housed in the Department of Family Medicine at the University of Colorado, was the organizing entity for *UPSTREAM! Together*, building upon existing relationships with three active community organizations with missions to improve the health of the communities they serve (Table 1). These

Table 1
Lead Colorado community organizations and population characteristics.

	2040 Partners for Health	High Plains Research Network	San Luis Valley Area Health Education Center
Community Participants			
Youth (26 years old and younger)	3	1	4
Adults	11	13	10
Locale	Urban and suburban neighborhoods across three counties in metropolitan Denver	Five counties in rural northeastern Colorado	Five counties in rural southcentral Colorado
Population under 25 years old[a] (N, % of total population)	89,181(38.2%)	14,303(32.9%)	16,194(35.3%)
Race and ethnicity (all ages)[a]			
Hispanic or Latino (of any race)	43.9 %	16.7 %	47.1 %
American Indian and Alaska Native (non-Hispanic)	0.6 %	0.5 %	1.3 %
Asian (non-Hispanic)	3.8 %	0.7 %	0.7 %
Black or African American (non-Hispanic)	17.7 %	0.9 %	0.7 %
White (non-Hispanic)	30.7 %	78.7 %	48.7 %
Mental health			
[b]Women who were diagnosed with depression before pregnancy	7.4 %	13.6 %	9.4 %
[c]Parents who reported behavioral or mental health problems in children aged 1−14 years	24.5 %	12.2 %	17.9 %
[c]Parents who think their child has difficulties in one or more of the following areas: emotions, concentration, behavior or being able to get along with other people	22.7 %	17.4 %	15.2 %
[d]High school students who seriously considered attempting suicide during the past 12 months	16.1 %	18.4 %	15.4 %

Sources: [a]U.S. Census Bureau, 2013–2017 American Community Survey 5-Year Estimates (DP05); [b]Colorado Pregnancy Risk Assessment Monitoring System (PRAMS), 2011−13 and 2012−14; [c]Colorado Child Health Survey, 2012–2014, 2013−15; [d]Healthy Kids Colorado Survey, 2015.

community-academic partnerships were built upon long-held relationships with university researchers and a shared priority of MEB health. The three pioneering community organizations were 2040 Partners for Health (2040), the High Plains Research Network (HPRN), and the San Luis Valley Area Health Education Center (SLV AHEC). Each lead community organization served as the local *UPSTREAM! Together* hub, recruiting community members to serve on the local planning council,

arranging and convening meetings, and maintaining communication with community members and the Farley Health Policy Center team. Every lead organization intentionally sought out local youth interested in preventing MEB problems who were recognized in their communities as young leaders, and successfully recruited students to join each community's *UPSTREAM! Together* work. Overall, youth comprised 19.0 % of community participants, higher than the proportion of Colorado's population of youth aged 15–24 years old (13.5 %, 2016 population estimates) (U.S. Census Bureau, 2020). Community infrastructure support included:

- Funding for expenses related to managing community *UPSTREAM! Together* activities
- Stipends for community member participation in the local planning councils
- Materials to assist with community partners recruitment
- Facilitation team for multi-stage intervention development
- MEB topic experts and consultants
- Educational materials and resources related to MEB prevention
- Design and production of messages and materials for community interventions
- Long-term program planning consultation and support
- Evaluation support

2.1. Boot Camp Translation

We used the Boot Camp Translation (BCT) process to create locally relevant messages and materials for dissemination to prepare communities for action around the prevention of MEB health problems and to begin developing long-term MEB prevention programs and evaluation plans for future funding. BCT is a process that has successfully engaged community members and health care professionals in translating evidence-based medical information into messages and materials that are meaningful to community members (Westfall et al., 2016; Zittleman et al., 2009; Zittleman, Westfall, & Espinoza, 2021). Employing principles of community-based participatory research, BCT brings together academic researchers and local community members who take evidence-based guidelines and recommendations and translate them into language and a format that is accessible, understandable, meaningful, and engaging to community members and patients (Norman et al., 2013). The BCT process with each community included one all-day, in-person kickoff meeting that included a comprehensive educational session on MEB health problems and prevention, three half-day in-person meetings, and six 30-minute phone calls between the in-person meetings. Meetings were held locally, and each community was initially blinded to the BCT process of the other communities. With staggered start times beginning in April 2017, each BCT ran for about nine months. Each community-academic partnership used the BCT process to: 1) review principles and evidence supporting the prevention of MEB problems; 2) develop locally relevant and actionable messages and materials to increase awareness of MEB problem prevention, and prime communities to utilize resources to prevent MEB health problems; and 3) prioritize MEB health problem areas of focus and then develop future implementation plans for MEB prevention. Across the months of the BCT process, community members reviewed and interpreted public data about their community, debated prioritization of what was most important to them to focus on, clarified the evidence of potential programs, identified and aligned local assets that could be mobilized to implement programs, sequentially revised their thinking and plans, reached consensus about direction and strategy, and then iteratively developed, reflected on and finalized preferences for how and what they want to disseminate locally about MEB prevention. The process does not simply change a few words here and there; it creates all new messages and materials (examples of the process can be found in Westfall et al. (2016) or here https://www.youtube.com/channel/UCBofdYsXJDLdpL Y59S9SabQ).

During the prioritization step, the Farley Health Policy Center team provided the community-academic partnerships with matrices of evidence-based MEB-prevention program components (e.g., mentoring, nurse home visits, parenting skills training, classroom curriculum), abstracted from the Blueprints Program for Healthy Youth Development (Institute of Behavioral Science, 2020) and the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (phased out in August 2018). Rather than selecting one evidence-based program and forcing all of its various parts into the existing local community, each group reviewed and discussed these matrices to guide decisions around focus areas, and to identify elements of evidence-based programs for which they had necessary capacities to include in tailored, long-term MEB prevention programs.

2.2. Evaluation

An embedded qualitative learning evaluation allowed direct observations of meetings, conference calls, and presentations. The evaluation of *UPSTREAM! Together* had two aims: 1) develop for each community a tailored, multi-method evaluation plan for their prevention efforts that is robust, persistent, and relevant to identified prevention opportunities with measurable outcomes capable of longitudinal observation; and 2) execute a case-based learning evaluation to describe how each community worked together, and what was learned from the 15-month planning process. In addition to extensive facilitation notes and summary documents from each BCT process, additional documents and meeting notes were maintained throughout the planning process by the evaluator (DF) and other members of the Farley Health Policy Center team and were confirmed periodically with community members. The evaluation period commenced at the beginning of each BCT for the three communities and extended through the end of 2018 with each community working to obtain funds to implement developed programs. Community meeting notes, planning team notes, messages and materials, and products developed as part of the BCT process were systematically reviewed.

Consistent with community-based participatory research (CBPR) methods, community partners are active participants in the interpretation of the data they help to generate (Cashman et al., 2008). Iterative analysis of BCT meeting notes is embedded in the BCT process. Members of the Farley Health Policy Center team and BCT facilitators maintained extensive notes from each meeting. Community-specific summary notes were prepared and sent to each community team member for review, interpretation, and discussion at subsequent meetings (both phone and in-person). This cycle of note generation, review, and discussion was repeated over the course of the BCT with each community. The process supported partnerships' progression from thinking broadly to decisions that fine-tuned messages and target audiences (Ali, Combs, Kakar, Muvuka, & Porter, 2021; English et al., 2018; Zittleman et al., 2021). The final synthesis of these notes was the basis of their messages and materials. Because the evaluation was embedded in the process, the synthesis was part of the major results from the BCT process. Additional process notes and observational notes were maintained, shared, and analyzed with members the Farley Health Policy Center team and the BCT Facilitators and was focused on cross-community results. Interval and final results were iteratively reviewed and reported to the funders. Results were further reviewed by members of each of the community leadership team.

3. Results

3.1. What did the three communities create?

3.1.1. Community awareness and action

Each of the three communities completed the planning grant with

locally relevant messages and materials that aimed to first make a community more aware of the concept of the *prevention* of MEB health problems and then increase conversations around MEB health and prevention. Across communities, the goals were to prepare the community for action and culture change and prime the community to use the new, long-term program (when implemented). All three communities contended with finding language to penetrate stigma and stimulate and permit public conversations. The communities independently created different interventions that utilized a common form of dissemination—boxes—designed to start conversations and sustain attention on the prevention of MEB problems in their communities: table toppers, issues boxes, and baby boxes (Fig. 1).

3.1.2. Prevention priorities and long-term planning

Community members consistently demonstrated their ability to navigate the evidence among many differing approaches for MEB prevention. Further, they distinguished problems they wanted to prevent (e. g., depression, anxiety, or alcohol use) from protective factors they wanted to promote (e.g., social connectedness, prosocial behaviors, or emotional regulation). Each group of community members considered and identified their priority outcomes, working from a list of 34 possible youth mental, emotional, and behavioral health outcomes (both problems to prevent and protective factors to promote). The list of outcomes was created from the registries of evidence-based programs (Blueprints for Healthy Youth Development and the National Registry of Evidence-Based Programs and Practices). After prioritizing outcomes, community members reviewed a table of brief program descriptions (e.g., intervention, setting, methods, duration, target population) with evidence to address the priority outcomes. Even when working independently, the priority lists (Table 2) generated by the groups focused their attention on

Table 2

Community priorities for evidence-based mental, emotional, and behavioral health prevention interventions.

	Primary Prevention / Promotion Areas
San Luis Valley Area Health Education Center	**Positive relationships**
	o Close relationships with parents
	o Social connectedness
	Emotional well-being
	o Emotional regulation
2040 Partners for Health	**Positive relationships**
	o Close relationships with parents
	o Reciprocal parent-child warmth
	o Prosocial with peers
	o Social connectedness
High Plains Research Network	**Positive relationships**
	o Social connectedness
	o Positive social/prosocial behaviors-from problem behaviors
	Emotional well-being
	o Emotional regulation
	Education
	o Early cognitive development

prevention programs intended to enhance social connections (especially among youth) and strengthen families. In other words, they all chose to move "way upstream" to impact a range of MEB problems in their communities rather than "further downstream" to prevent one selected

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San Luis Valley Area Health Education Center	**2040 Partners for Health**	**High Plains Research Network**
"Table topper" boxes were designed for three different audiences (general audiences, families, and young adults) with MEB-prevention messages local statistics and resources, and conversation-starters designed to initiate discussions in public spaces like restaurants, student centers and in homes.	Inspired by tissue boxes, the "Issue Box" includes MEB-prevention messages and resources for help, and are placed in public spaces throughout the community, such as middle schools, physician waiting rooms, and recreation centers.	Based on the Finnish "baby boxes" for safe baby sleeping spaces, the "MEB Box Program" includes durable keepsake boxes filled (or re-filled) with age-appropriate MEB prevention information and resources, provided at targeted milestone stages over a child's life, from the parents of newborns through young adults.

Fig. 1. Boot Camp Translation messages and materials from each *UPSTREAM! Together* community.

MEB problem (e.g., bullying, depression, suicide).

3.1.3. Strong, trusting community teams

Vital to sustaining the local efforts during BCT and beyond, the community-academic partnerships worked to build trust among themselves sufficient to enable sincere conversations about their own sensitive, personal and family experiences, which revealed community members' motivation to provide leadership for prevention of MEB within their community. Community members were candid in their review of existing health data about their communities, providing localized interpretation and correction of data or noting other local data sources. When conversations drifted toward treatment and screening of MEB problems (instead of prevention), the groups were largely able to self-monitor and return the focus to prevention as an important goal distinct from community needs for treatment of MEB problems. They understood that responsibility for prevention of MEB problems is a community effort, dispersed over multiple sectors, organizations, and individuals. The community members recognized that working together in a sustained way is essential to preventing MEB problems. For example, the *UPSTREAM! Together* group in the San Luis Valley, while waiting for program funding, continued to reach out to work with other community efforts (such as a prevention coalition's "Family Skate Night") in which the *UPSTREAM! Together* academic and policy partners were actively involved.

3.2. What did we learn about partnering with communities?

3.2.1. Talking about MEB

The idea of preventing MEB problems was unfamiliar to most community members, unlike knowledge about preventing cancer or heart disease. There was an appetite across different generations and backgrounds to do something about the MEB problems in their communities, and a desire to prevent MEB problems. Stigma associated with MEB surfaced as significant problem to overcome. It was difficult to address the prevention of problems that couldn't be talked about. A common language that resonated with community members was also needed.

The BCT process about MEB problems and prevention successfully generated understanding and conversations about normalizing mental health problems and the importance of intervening earlier, "upstream" with children, adolescents, and parents to *prevent* MEB problems before adulthood. Language mattered. For example, the acronym "MEB" was welcomed in one community and resolved some stigma problems related to talking about mental health, but "MEB" was seen as confusing and unhelpful in another community that preferred talking about "issues" rather than MEB problems ("Everyone has issues.").

All three communities evolved to a consistent understanding about MEB problems:

- MEB problems are everywhere and many are preventable.
- Communities need words and ways to "start the conversation" about MEB issues ("When we can talk about it, we can prevent it.").

Distributing MEB prevention messages widely (including, restaurants, homes, schools, businesses, judicial system, healthcare system) to multiple audiences (including, youth, parents, grandparents, teachers, mentors) was considered necessary early work regardless of specific long-term plans.

The conversations in the communities also helped to organize thinking into a visual display of MEB expression (shown in Fig. 2), a visual tool of how the communities came to understand how MEB problems emerge and where opportunities for prevention lie.

3.2.2. Convening local assets

All three communities exhibited rich, local knowledge of existing, relevant and potential assets, and readily identified connections through local individuals to work with them to prevent MEB problems. These included particular churches, restaurants and other businesses, clubs, schools, social service agencies, public health programs, clinical enterprises, volunteer programs, and existing non-profit organizations positioned to serve as fiscal agents. Further, including teens and young adults in each of the BCT community-academic partnerships added essential voices to the conversations. Youth participants were notably engaged in the BCT process, showing up at in-person meetings and phone calls, sharing first-hand accounts of how MEB problems appear where they live, learn, and socialize, and actively participating in discussions about the content and form of messages and materials. Although community member BCT participation was not always at 100 %, the average participation for the full BCT process was 71 % across all the three communities (range, 62%–79%). One group experienced a notable drop in participation (to 43 %), especially from its youth, at the final in-person meeting.

3.2.3. Expectations for evaluation

Throughout this planning work, communities also helped the academic partners understand how to think about evaluating their MEB prevention work. Community members fluidly talked about evaluating their work, especially in terms of early formative evaluation data. They welcomed and benefited from additional resources and guidance from academic evaluation partners with these skills. During the BCT process, community members were receptive to and helped co-create a planning tool to help guide the evaluation of their MEB prevention work, both in implementation and outcomes (please see Appendix 1). For example, one community restaurant owner (and BCT participant) offered early on to survey customers about initial reactions to the MEB boxes placed on tables. With some assistance from academic partners, the BCT group led
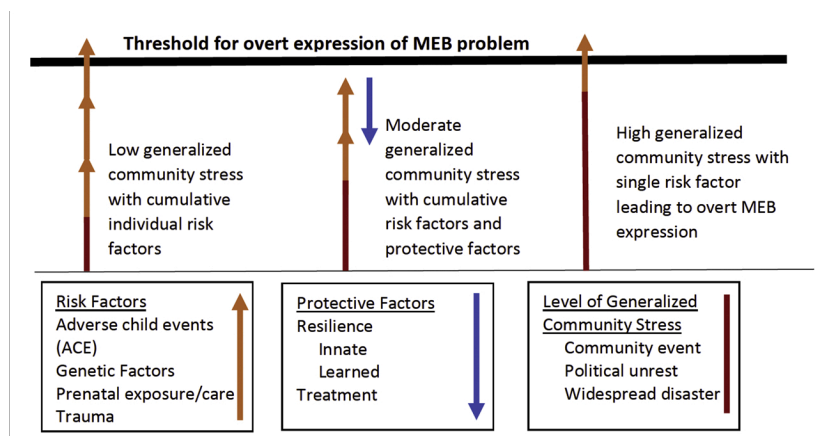

Fig. 2. Continuum of mental, emotional, and behavioral (MEB) health problem development and expression.

Notes: Three primary contributors to MEB problem expression emerged as foundational concepts useful to all three communities: 1) Individual risk factors that can increase MEB problem expression; 2) individual protective factors that serve to mitigate or lower the risk of overt MEB problem expression; and 3) general level of stress that impacts the entire community.

the design and implementation of the customer survey once MEB boxes were distributed locally.

3.2.4. Moving on to MEB prevention program implementation

There was some tension between the preparation work to prevent local MEB problems and the eagerness of community members to move into action. A recurrent message from the community members was akin to, "When are we going to just get going with this?" All three communities spotted existing organizations already operating programs pertinent to the prevention of MEB problems but with a fragmentation of effort. This exposed the inconvenient truth that the costs associated with developing and sustaining collaborative community work often accrue to multiple individuals and organizations while revenues to cover these costs are scarce or non-existent.

What was not accomplished by any of the three communities as their planning enterprises concluded was the alignment of prevention plans with financing. Transition funds (between communities being ready and funders being ready to invest) were needed to maintain precious progress. After 18 months of further effort from the end of the planning program, two communities secured implementation funding. One community secured funding to support a middle school-based prevention program linked to a local boys and girls club; a second secured pilot funding to support new mothers through recurring contacts and messaging using a "baby box" program, coordinated by a local non-profit organization. In both instances, it took approximately an additional 6 months to launch the programs.

4. Discussion

UPSTREAM! Together confirmed that there is capacity and an appetite within communities to work together to prevent important mental, emotional and behavioral problems. Community members understood the science of prevention and evidence-based programs, agreed about local priority MEB problems worthy of their attention, and united their local knowledge and expertise with generalized knowledge about the prevention of MEB problems. BCT was designed to develop a set of messages and materials based on a shared, in-depth understanding by community members of a health topic for wider distribution to the community. The *UPSTREAM! Together* BCT process achieved these aims for the prevention of MEB problems.

From the BCT process we know that it is difficult to talk about MEB problems. Stigma around mental health persists. BCT provides the time and process to help communities think about how to "start the conversation" about MEB and MEB prevention. Further, community members understand the importance of going upstream, selecting program components that work, and adapting those to fit their immediate needs and local conditions. Their resulting messages and materials maintained focus on normalizing conversations around MEB and the importance of prevention. Communities also helped to refine our collective understanding of how MEB is expressed in community settings.

UPSTREAM! Together illustrates and, in a small way, extends at a regional level the substantial knowledge base about multisector partnerships and polycentric governance; creating conditions to enable collaboration shaped by local conditions; collective problem solving; and engaging citizens in collective governance (Wageman, Creegan, Erickson, Immediato, & Landy, 2015). It is also an example of what Elinor Ostrom has concluded about communities that, with full knowledge, can sort out their own ways of stewarding their resources to sustain them over time (Ostrom, 2010). MEB prevention is a large, complex topic, not easily or obviously addressed by communities; however, BCT and partnerships with outside resources (e.g., funders, academic research partners, or policy partners) allowed these three communities to have necessary conversations and marshal their assets to create a community of solution.

4.1. Lessons learned

While principles and practices of community-based participatory research, community engagement, and pragmatic imbedded evaluations worked in *UPSTREAM! Together*, there are things we would do differently "next time":

1. Stretch the funded preparation period to 24 months and create more reflexive/reflective cycles of experiential learning and re-learning (Fig. 3).
2. Re-order the work to bring forward earlier, detailed consideration of specific prevention programs and thereby stimulate consideration of the resources/messaging and materials required for programs to prevent MEB problems. We would specify what key decisions must be made in each phase of the re-ordered work.
3. Incorporate some implementation steps earlier to move into action sooner and engage potential partners. This could constitute a staged implementation subject to modifications based on embedded evaluation.
4. Designate a community implementation team by the midpoint of the preparation processes.
5. Organize earlier face-to-face meetings of community members from the different communities, and intentionally plan a capstone meeting to include *UPSTREAM! Together* community members and representatives from interested institutions and organizations.
6. Include pilot-testing and evaluation of each community's prevention plan as an expense to be borne by funders of the planning period. This would permit moving into action, while seeking financing for full implementation.

This planning grant showed what communities can achieve in 15 months and what was still needed. Primarily, more time was needed to continue discussions about specific approaches to MEB prevention suitable for these communities. The process takes longer than anticipated, yet partnerships remain engaged and the groups have largely remained intact, with leadership being ceded to the community leadership teams. These findings appear to reaffirm the importance of focusing on a clear aim, investing in testing and standardization to enable responsiveness to the context, and ceding control of a model to allow local adaption and accelerate broad adoption (Onie, Lavizzo-Mourey, Lee, Marks, & Perla, 2018). Throughout *UPSTREAM! Together*, the communities claimed ownership over their accomplishments and leadership to continue moving forward. Community leads are coordinating efforts to prepare further proposals to fund their new, locally-tailored prevention programs. All communities continue to value and work with their academic partners to meld local knowledge and scientific methods in these efforts. A highpoint of their prevention work was a joint presentation of their planned programs by representatives from each community to a standing-room only crowd at a statewide health policy annual summit.

All three communities discovered there were few funding opportunities available for the programs they developed and experienced frustrations with acquiring implementation funding. This was typically a lack of synchrony between their being ready for action and funders requiring time to learn about MEB prevention and assess alignment with their own priorities and current strategies for making grants. More than a year after funding ended these community members continued to reach out to us for assistance and support, suggesting our partnership with them was valuable despite the inability to help secure funding for significant MEB prevention efforts of their choice.

Policies that support productive academic-community collaborations, effective community-engaged development processes, and community-endorsed prevention programs may help to bridge the gap between what we know about preventing MEB problems and what we do. Part of the community engagement process may need to include more purposeful messaging and outreach to local, regional, and state
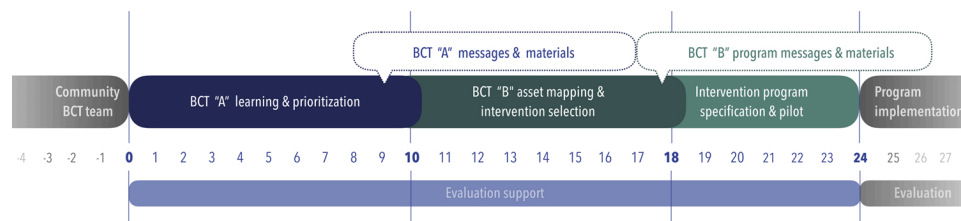
Fig. 3. BCT revised planning and implementation timeline.

policymakers to help demonstrate how community readiness to implement effective programs can align with policy goals to improve health, reduce burden, and serve constituents.

5. Conclusion

UPSTREAM! Together was an encouraging effort to help close the gap between what is known and what is being done to prevent mental, emotional, and behavioral problems by engaging three diverse Colorado communities. Customized community-wide communication campaigns were important mechanisms to normalize talking about MEB problems. Universities, foundations, and communities can do this work together with a relatively small cost to initiate and sustain collaboration. National and local policies that cultivate and support local expertise could help to increase wider community adoption of evidence-based programs that promote mental health among youth. This approach takes longer than alternative, more linear, "top-down" approaches; but the experience of *UPSTREAM! Together* suggests it is an achievable approach that is acceptable to communities, incorporates sustainability through community ownership and leadership, and is worthy of further development and testing. Investing in such efforts now can strengthen families and communities with long term benefits for communities everywhere.

Ethics approval and consent to participate

In accordance with the policies and procedures of the Colorado Multiple Institutional Review Board, this evaluation was deemed exempt from further human subjects research review.

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Data statement

The datasets analyzed during the current study are not publicly available because of the amount of identifiable information about individuals that is embedded in the data. To the extent possible, data can be made available from the corresponding author upon reasonable request.

CRediT authorship contribution statement

Douglas H. Fernald: Formal analysis, Methodology, Writing – original draft, Writing – review & editing, Visualization. **Linda Zittleman:** Conceptualization, Investigation, Writing – review & editing. **Emma C. Gilchrist:** Investigation, Data curation, Writing – review & editing. **Lina I. Brou:** Data curation, Formal analysis. **Linda Niebauer:** Project administration, Writing – review & editing. **Charlotte Ledonne:** Project administration, Writing – review & editing, Resources. **Christin Sutter:** Project administration, Writing – review & editing, Resources. **Maret Felzien:** Project administration, Writing – review & editing,

Resources. **John M. Westfall:** Conceptualization, Investigation, Writing – review & editing. **Larry A. Green:** Conceptualization, Investigation, Funding acquisition, Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no competing interests.

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Not applicable.

Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:https://doi.org/10.1016/j.evalprogplan.2021.10 2000.

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