Evaluation of Los Angeles County's Mental Health Community Engagement Campaign

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Preface

The Los Angeles County Department of Mental Health (LAC DMH) recently undertook a youth-targeted social marketing campaign that sought to increase community engagement around barriers to mental health access. LAC DMH's campaign utilized funds from Proposition 63, which was signed into law as the Mental Health Services Act (MHSA). The MHSA levied a 1 percent state-level tax on all California personal incomes over $1 million, resulting in a substantial investment in mental health. A portion of those funds is specifically allocated for prevention and early intervention (PEI) activities and cannot be used for other purposes (e.g., treatment, housing). LAC DMH dedicated some of these MHSA PEI funds to the development and implementation of a social marketing campaign. In partnership with the California Mental Health Services Authority (CalMHSA), LAC DMH requested an evaluation of the campaign. Through the current evaluation, LAC DMH sought to understand who was reached by the campaign and what the impact of that contact was.

RAND Health Care

This evaluation was undertaken by RAND Health Care, a division of the RAND Corporation, and funded by CalMHSA. A profile of RAND Health Care, abstracts of its publications, and ordering information can be found at www.rand.org/health.

CalMHSA

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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Summary

In May 2018, the Los Angeles County Department of Mental Health (LAC DMH) launched WhyWeRise, a social marketing campaign intended to promote community engagement with mental health issues and create a movement to address barriers to mental health access. The campaign targeted youth ages 14–24, with the goal of activating youth to advocate for well-being and access to quality mental health care as civil rights. The campaign also encouraged engagement with mental health along a continuum, from self-care to professional treatment services, and aimed to increase awareness of how to seek mental health care. The centerpiece of the WhyWeRise campaign was the WeRise event that took place from May 19 through June 10, 2018, an immersive experience in downtown Los Angeles in which visitors were exposed to an art gallery, a rally, performances, panels, and workshops.

To gain insight into the campaign's reach and impact, LAC DMH and the California Mental Health Services Authority (CalMHSA) commissioned RAND researchers to conduct an evaluation of WeRise and the first phase of the WhyWeRise campaign, which occurred during the period WeRise was active. The RAND team performed the evaluation by conducting and analyzing in-person interviews of event participants, fielding an online survey of youth throughout Los Angeles County, and analyzing Twitter data from Los Angeles users on the topic of mental health before and during the campaign.

Evidence suggests that the campaign attracted a large number of people. Our survey of more than 1,000 Los Angeles County youth found that as many as one in five young people in the targeted age group were aware of WeRise or WhyWeRise. This is a quite substantial reach for a campaign that had been in place only for a few weeks. In addition, WeRise was frequently brought up within a Twitter community that discussed common mental health topics.

Further, people exposed to the campaign seem to have benefited from the experience. Our in-person survey found that those who were present at the WeRise event for longer were more likely to express supportive and understanding attitudes toward people with mental illness. Our countywide survey of youth found that those who reported exposure to the campaign (at the event or online) were more likely to report feeling empowered and mobilized toward mental health activism. Those exposed to the campaign also reported an increased awareness of the challenges people with mental illness face, from stigma to treatment access. They were also more likely to know how to get help with mental health challenges. However, continued evaluation over time is needed to distinguish between causal effects of the campaign and other potential explanations for these relationships (e.g., people who are drawn to the campaign may already have greater mental health awareness).

The WhyWeRise campaign is ongoing. We offer the following recommendations for further strengthening the campaign.

Consider approaches to reducing negative stereotypes and increasing mental illness–related knowledge as a complement to those concerning inequalities in access, and consider focusing more attention on specific inequalities. Reducing negative stereotypes and gaining greater knowledge of symptoms are central to increasing social inclusion for those experiencing mental health challenges and increasing the likelihood that these individuals will seek treatment. And, because most people surveyed already agree that access to mental health is a right, Los Angeles County may also wish to consider focusing more centrally on other key issues related to unequal access to mental health, such as jail, homelessness, and trauma—topics already included in the campaign but about which there is less preexisting agreement.

Engage men, younger audiences, and those who do not already have a connection to mental health. The WeRise in-person event predominantly attracted female attendees. Males tend to make less use of mental health services and experience higher levels of stigma, so it may be particularly important to reach out to this group. Future events should also attempt to engage individuals who have lower awareness of mental health issues, as well as bring in greater numbers of high school– and college-age youth.

Build stronger social media connections between "mainstream" and social justice–oriented online communities. The @WeRise_LA Twitter handle was part of a Twitter community that discussed common topics in mental health circles, such as budget cuts for treatment, the link between mental health and gun violence, and high-profile suicides. This community was well connected with a second community that tweeted about mental health in the context of issues related to civil rights and unequal access. However, this second community was not tweeting about the campaign. We recommend that the campaign continue its current, effective methods of reaching this second community. However, given the alignment between the second community's interests in social justice and LAC DMH's goal of fostering a movement to address inequalities in access to mental health, the campaign would benefit from making further inroads into this group. This could be accomplished by directly reaching out to prominent individuals in the community and persuading them to tweet about the campaign.

Give it time. Our final recommendation is that the campaign keep going. Public attitudes tend to change slowly, and we evaluated the campaign only a few weeks after launch. Given early evidence that may be pointing to the campaign's success, it is reasonable to expect more progress as time goes on. Los Angeles County has continued the WhyWeRise campaign since the WeRise event, adding outdoor advertising (e.g., billboards, signs at bus shelters) and focusing on driving people to the messages and resources available on the WhyWeRise website. A public television documentary following youth through the WeRise event is in production. These continued efforts may sustain the changes we already observed, or even lead to further changes. In addition to continuing campaign activity, it would be helpful to conduct continued evaluation to see whether changes are enhanced or maintained and to more conclusively determine whether the campaign caused change.

Overall, the evaluation found evidence that Los Angeles County's mental health community engagement campaign had impressive reach into the Los Angeles youth community it targeted: One in five youth were exposed to the campaign in some way during the brief period we examined. There is early evidence that the campaign is associated with positive outcomes, such as supportive and understanding attitudes toward people with mental illness, awareness of the challenges people with mental illness face, knowledge of how to get help for mental health challenges, and, importantly, empowerment and mobilization toward activism around mental health issues.

Acknowledgments

Abbreviations

CalMHSA	California Mental Health Services Authority
EMM	Each Mind Matters
LAC DMH	Los Angeles County Department of Mental Health
MHSA	Mental Health Services Act
TAY	transition-age youth

Chapter 1. Background

Mental health problems are common and debilitating, but many people do not receive the mental health treatment they need (see, e.g., Eberhart et al., 2018; Walker et al., 2015). Recognizing this, the Los Angeles County Department of Mental Health (LAC DMH) recently undertook a youth-targeted social marketing campaign that sought to increase community engagement around barriers to mental health access. Social marketing campaigns around the globe have been effective in shifting attitudes related to mental health and increasing social acceptance of those experiencing mental health challenges (e.g., Collins et al., 2015; see Gaebel, Rössler, and Sartorius, 2017, for a review). Some of the most-effective social marketing campaigns in recent decades have used issues of social justice and community engagement to mobilize youth to action, at the same time changing their attitudes. These campaigns focus on unfair or discriminatory attitudes and practices that result in inequalities and other social problems. The most well-known example is the truth® anti-tobacco campaign that highlighted the targeting of youth with false statements and manipulations by the tobacco industry and encouraged youth advocacy against these practices (Zucker et al., 2000). The truth® campaign was "intended to empower young people with the feeling that they could take on the tobacco industry and its executives and be part of a tobacco-free generation" (Sly et al., 2001), and the campaign is credited with steady reductions in adolescent tobacco use over many years (Farrelly et al., 2005). Although little direct evidence specific to the mental health field exists, there is expert consensus within that field that campaigns with this focus are an effective method of addressing issues of social inclusion related to mental illness (Clement et al., 2010). These campaigns suggest that access to mental health care is a right and that stigma, social avoidance, and prejudicial attitudes toward individuals who have a mental illness prevent them from equal participation in society and from having their rights met.

LAC DMH's campaign utilized funds from California's Proposition 63, which was signed into law as the Mental Health Services Act (MHSA) in 2005. The MHSA levied a state-level 1 percent tax on all California personal incomes over $1 million, resulting in a substantial investment in mental health in the state. The MHSA made resources available to counties to support treatment for individuals with mental illness, as well as prevention and early intervention (PEI) services. A portion of those funds is specifically allocated for PEI activities and cannot be used for other purposes (e.g., treatment, housing). LAC DMH dedicated some of these PEI funds to the development and implementation of a community engagement campaign called WhyWeRise. Campaign activities targeted transition-age youth (TAY) between the ages of 14 and 24, with the goal of activating youth to advocate for well-being and access to quality mental health care as civil rights. The campaign also encouraged engagement with mental health along a continuum, from self-care to professional treatment services. The campaign was launched in

May 2018, during "mental health awareness" month, and is ongoing as of this writing. The campaign was composed of a website (whywerise.la); social media outreach through Facebook, Instagram, and Twitter; and, as its centerpiece, the multiweek WeRise event, an immersive experience in downtown Los Angeles in which visitors were exposed to an art gallery, rally, performances, panels, and workshops. The launch for WeRise was the Building a Movement for Wellbeing event on May 6, which brought together national, state, and local leaders in the mental health arena, including influencers and youth voices from Los Angeles County, who together issued a call to action. Subsequent WeRise events took place in a large immersive space in downtown Los Angeles and covered topics ranging from criminal justice, to meditation and yoga, to trauma. These events were initially planned for May 19–28, but, because of sustained interest, the experience was extended through June 10. Social media and a website were also used to promote the WeRise event, potentially broadening reach beyond attendees. Although WeRise and its promotion ended in early June, WhyWeRise outreach is ongoing as of this report.

WeRise included a 10,000-square-feet immersive art gallery showcasing more than 150 artists' work related to mental health; a community stage where experts, celebrities, leaders, and providers presented panels, workshops, performances, and other educational programming; an action center where attendees could register to vote and obtain resources that facilitate service or civic engagement; and an art lab where attendees could make art and participate in meditation, yoga, and family programming. WeRise was open to the general public during evenings and weekends and hosted school tours for students from middle school through college age during weekdays. The extension into June allowed WeRise to invite youth from foster care, juvenile detention, and alternative schools to attend tours and participate in other activities, such as family nights.

TaskForce, a Los Angeles–based creative agency, coordinated WeRise and tabulated data on attendance. The agency reported receiving 42,855 RSVPs for WeRise events and a door count of 26,596 gallery attendees. For the school tours, it received 2,177 RSVPs and counted 1,358 attendees. One of the goals of the campaign was to engage the public over social media. To quantify this, TaskForce tabulated WeRise's social media impressions across Instagram, Facebook, and Twitter. Social media impressions are the number of times a type of content is displayed—for instance, the number of news feeds an item appears in. In this way, impressions are a measure of the maximum potential reach of the content, although they are often repeated by the same person and often reflect a combination of reach and frequency of exposure, both of which are important to marketing ideas. TaskForce tabulated 380,114 Instagram impressions between May 24 and June 6, almost 1.5 million Facebook impressions over a 28-day period, and more than 1.4 million impressions for its Twitter page between May 4 and June 11. To place this in context, there are 8.3 million Los Angeles County residents age 14 or older (use of Twitter, Facebook, and Instagram is prohibited for those under 13, though not uncommon), and 1.6 million county residents are in the campaign-targeted age range of 14 to 24. Given this, the campaign might have reached about one-third of social media users (2.9 million out of 8.3

million), but the proportion could easily be much smaller or much greater, depending on the ages of those exposed and the extent of reexposure. Regular users of Twitter and Instagram tend to be in the targeted age range, while Facebook skews older.

LAC DMH, in partnership with the California Mental Health Services Authority (CalMHSA), requested an evaluation of the implementation of its MHSA-funded community engagement campaign. Through the current evaluation, LAC DMH sought to understand who was reached by WeRise/WhyWeRise and what the impact of that contact was. RAND's evaluation included the WeRise event and associated outreach, including the WeRise social media and website, as well as the portion of the closely associated WhyWeRise campaign that took place during WeRise. The latter primarily consisted of social media outreach during that time. RAND conducted an in-person survey of WeRise attendees; a social media analysis of Twitter conversations related to WeRise/WhyWeRise, mental health, mental illness, and well-being; and a web-based survey of a broader population of Los Angeles County youth in the age range targeted by WeRise/WhyWeRise. All evaluation activities were reviewed and approved by RAND's Human Subjects Protection Committee (an institutional review board). The current report describes the findings of RAND's evaluation. In Chapter 2, we describe the methods and findings of the in-person survey at the WeRise event. In Chapter 3, we present methods and findings of the analysis of Twitter conversations. In Chapter 4, we describe methods and results for our large survey of TAY youth in Los Angeles County. Finally, in Chapter 5, we provide an overall discussion of the findings, along with our recommendations and conclusions.

Chapter 2. Survey of WeRise Attendees

Our survey of WeRise attendees allowed us to evaluate who attended; their perceptions of the event; and their attitudes, beliefs, and intentions to act related to mental illness. We attempted to determine the impact of WeRise on these factors by examining them among those who had spent more versus less time at the event.

Method

RAND approached and surveyed event attendees in person at the WeRise venue on the first two weekends it was open, May 19–20 and 26–27, 2018. Youth (only) were also surveyed May 24–25 and June 6–7. On these dates, the gallery was closed to the public but open for school tours (on the 24th and 25th) and visits from youth in foster care and their foster families (on the 6th and 7th). The goal of sampling at these times was to ensure a diverse sample of the various targeted youth audiences. Eligibility for the survey was limited to those 14 years and older and English-speaking. Field staff approached all persons present in the gallery who appeared to be in the targeted age range and screened them for age and language. For some surveys conducted during school tours, the number of persons in the gallery was too large to employ this approach. In these cases, field staff spread out and approached subgroups from different parts of the room, attempting to enroll individuals from different classes and schools to maximize the diversity of the sample. Eligible individuals who agreed to participate were provided with a scannable paper-and-pencil survey to complete and return to field staff. Although field staff did not track ineligibles and refusals, they reported that refusals among those screened as eligible were rare. Participants received a $5 gift card as an incentive. These methods received human subjects approval from RAND's institutional review board.

The survey asked how participants learned of the WeRise event and measured demographics (including personal experiences with mental health challenges); perceptions of the WeRise event; and attitudes, beliefs, and knowledge related to mental illness. There were youth and adult versions of the survey; they were identical except that the youth version omitted a question about prior mental health problems. Surveys took two to three minutes to complete.

Perceptions of the WeRise Event

RAND used six items to assess perceptions of the event; for example, two of these items were "Today's event made you want to be more supportive of people experiencing mental health challenges" and "You would recommend today's event to a friend." Participants indicated extent of agreement on a five-point (strongly agree to strongly disagree) scale.

Mental Illness Attitudes and Beliefs, and Advocacy

RAND created two campaign-specific items to tap endorsement of key goals and beliefs targeted by WeRise. They were "Access to mental health is a right" and "People with mental health problems have trouble getting the treatment they need." These items are consistent with campaign content, which stated that easy access to quality care is a fundamental civil right, and everyone deserves to be well. For each item, RAND measured extent of agreement on a five-point (strongly agree to strongly disagree) scale.

RAND also employed a set of five previously validated items that tap general attitudes and beliefs related to mental illness and its treatment (Collins et al., 2015). Although not the main targets of the event, the constructs measured were implicit in the panels and materials present at the WeRise event. Some of these items were used in a statewide survey of a representative sample of California adults used in an evaluation of the Each Mind Matters (EMM) campaign (Collins et al., 2015); these allow informal (nonstatistical) comparison of WeRise attendees with others in the state. One item assessed awareness of mental illness stigma: "People with mental illness experience high levels of prejudice and discrimination." Two tapped negative stereotypes of those experiencing mental health challenges (e.g., "People with mental illness are capable people"). A fourth item measured mobilization: "You plan to take action to prevent discrimination against people with mental illness." All of these were responded to on a five-point (strongly agree to strongly disagree) scale. An additional item measured social distance (willingness to interact with individuals experiencing mental illness—a key indicator of mental illness stigma) and was responded to on a four-point (definitely willing to definitely unwilling) scale.

Responses to all items were recoded to reflect any agreement or willingness (e.g., agree or strongly agree) versus none. We report univariate and bivariate analyses and significance tests. Because the adult and teen populations are very different in nature (in terms of their demographic characteristics, detailed in the next section, and the way they came to be at WeRise—many youth were brought to the event rather than coming on their own), results for the two survey samples were analyzed separately.

Results

Surveys were collected from a total 528 individuals—298 adults and 230 teens. Teens were surveyed as follows: 134 during public event hours, 60 during school tours, and 28 during foster family events (eight additional youth surveys had missing or invalid dates, so this could not be determined). One additional teen survey was not subjected to analysis because of high numbers of blank items and implausible responses to some questions.

Characteristics of WeRise Attendees

Table 2.1 shows the demographic characteristics of the two samples. We found that many people surveyed already had a connection to mental health. About one in four persons in each sample was working for pay or volunteering in the mental health field. Moreover, nearly all of the adult sample, and three in four of the teen sample, reported having a friend or family member with a mental health problem. About half of the adults also reported that they had personally had a mental health problem (youth were not asked this question). By way of comparison, in a prior survey of a general population of California adults used to evaluate the EMM campaign (Collins et al., 2015) 53 percent reported that a family member had ever had a mental health problem (friends were not included in the question) and 26 percent reported that they had personally experienced a mental health problem.

More than three in four adults also fell outside the targeted age range for the WeRise event: most were between 25 and 49. Nearly all youth were in the appropriate age range (14–17); however, this was by design, as anyone younger was screened out as ineligible and anyone older was given the adult version of the survey. Both samples were made up of substantially more women than men. In the teen sample, blacks and Latinos were overrepresented and whites and Asians underrepresented, compared with their proportions in the Los Angeles County population ages 14–17. U.S. Census data indicate that 61 percent of 14–17-year-olds in Los Angeles County are Hispanic or Latino, 10 percent are Asian, 8 percent are black, 17 percent are white, and 4 percent are "other."[1] Among Los Angeles County adults ages 18–49 (the vast majority of those in our adult sample), 51 percent are Hispanic or Latino, 14 percent are Asian, 8 percent are black, 24 percent are white, and 3 percent are "other." Thus, the adult sample includes more blacks and "other" race/ethnicity individuals and fewer Latinos and whites than would be expected.

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[1] For this analysis, we used Public Use Microdata Sample files from the U.S. Census Bureau's American Community Survey.

Table 2.1. Characteristics of participants in the in-person survey

Characteristic	Teens (%)	Adults (%)
Mental health experience		
Volunteers or works for pay in the mental health field	25	26
Has a close friend or family member who has experienced mental health problems	76	90
Has ever had a mental health problem	N/A	48
Event type		
Foster	12	N/A
School tour	26	N/A
Regular	60	100
Age		
14–17	94	0
18–24	3	27
25–29	0	28
30–49	0	36
50–64	0	8
65+	0	1
Male	39	36
Race/ethnicity		
Latino	68	37
Asian, non-Latino	4	13
Black, non-Latino	13	17
White, non-Latino	10	19
Mixed or other	4	14

NOTES: N/A = not applicable. Totals do not always sum to 100 because of rounding and small amounts of missing data for particular characteristics.

How Attendees Engaged with the WeRise Event

Most commonly, the teen sample (43 percent) reported hearing about the event at their schools, far more than the percentage who were surveyed as part of school tours, suggesting that school-based outreach was highly effective in drawing visitors to the event. Also, 28 percent of teens came with a friend or family member who suggested it, and 11 percent heard about it through social media. The remaining youth indicated that they heard about the event through "some other kind of ad or announcement," "were just passing by," or "something else." At the time of the survey, 43 percent of teens had been at the event for between one and two hours, 30 percent had been there for less than one hour, and 26 percent for two hours or more. Twelve percent of teens surveyed were repeat visitors to the event.

Unlike teens, adults did not have the opportunity to learn about WeRise via a school announcement or other structured means. As a result, the ways adults heard about the event tended to differ from teens. Among adults, the largest group (44 percent) came to the event with

a friend or family member who suggested it; most others (35 percent) heard about it through social media. The rest learned about it in some other way. Thus, social media appears to have been an effective method of outreach for adult attendees, more so than for the teens. Like the teens, most adults (44 percent) had been at the event for one to two hours when surveyed, 40 percent for less than an hour, and 15 percent for two hours or more; 15 percent were repeat visitors.

Perceptions of the WeRise Event

Reactions to WeRise were almost universally positive among both teen and adult attendees (see Table 2.2); 91 percent of teens and 95 percent of adults said that they would recommend the event to a friend. Ninety percent or more of each sample said that the event made them want to be more supportive of those experiencing mental illness and that they felt empowered to take care of their own well-being. Many participants also said that the event made them want to help break down barriers that keep people from getting mental health treatment and reported that the event helped them better understand mental illness. More than seven out of ten participants reported that they planned to join the WeRise movement as a result of the event.

Table 2.2. Attendees had positive perceptions of the WeRise event and felt empowered to take action to help themselves and others

Statement	Teens (% agreeing)	Adults (% agreeing)
You would recommend today's event to a friend	91	95
Today's event made you want to be more supportive of people experiencing mental illness	92	90
Today's event made you feel empowered to take care of your own well-being	90	90
Today's event made you want to help break down barriers that keep people with mental illness from getting treatment	88	90
Today's event gave you a better understanding of mental illness	87	82
Because of today's event, you plan to be a part of #WeRiseLA, LA's well-being movement	72	78

Endorsement of Mental Health as a Right

Table 2.3 provides an overview of attendees' attitudes and beliefs related to mental illness. We will discuss each of the key findings in turn.

Table 2.3. Attendees showed awareness of the struggles and capabilities of people with mental illness, and willingness to include them in their lives

Statement	Teens (% agree/willing)	Adults (% agree/willing)
Access to mental health is a right	**60**	**80**
People with mental health problems have trouble getting the treatment they need	81	92
People with mental illness experience high levels of prejudice and discrimination	84	94
People with mental illness are capable people	71	87
People with mental illness are able to do things as well as most other people	67	76
How willing would you be to move next door to someone who has a serious mental illness?	89	91

As indicated in Table 2.3 and Figure 2.1, 60 percent of teen attendees and 80 percent of adults endorsed the central belief targeted by WeRise that access to mental health is a right. Although this is a positive indicator of the event's success, it was nonetheless the least-endorsed belief measured by our survey among teens and the third least endorsed among adults. Because this belief was at the center of the community engagement approach of WeRise, we examined the correlates of agreement with the item in each sample.

Figure 2.1. Most WeRise attendees, especially the adults, agreed that access to mental health is a right
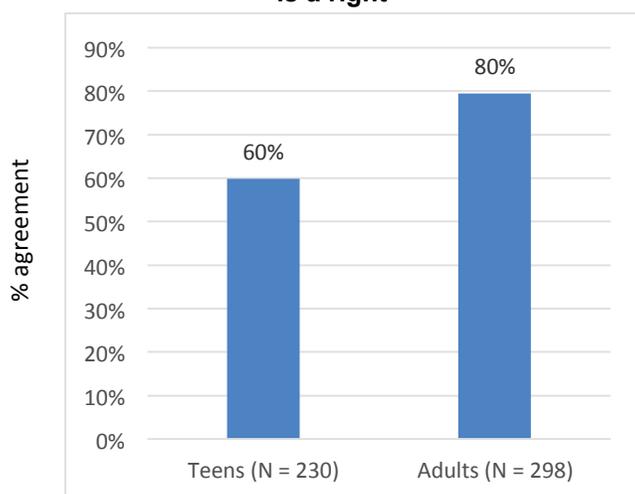
Across both teens and adults, males and those who had a close friend or family member with a mental health problem were more likely to agree that access to mental health is a right (see Figures 2.2 and 2.3).

Among teens only, those who worked or volunteered in the mental health field had higher rates of endorsement of mental health as a right (72 percent), compared with those who did not (57 percent). Foster youth and those on school tours were more likely to endorse mental health as a right, compared with teens attending during regular event hours (71 percent of foster and school tour visitors versus 52 percent of regular visitors). Although 86 percent of white teens endorsed mental health as a right, only 55 percent of Latino and 61 percent of black teens agreed. No racial/ethnic differences emerged for this item among adults.

Figure 2.2. Male attendees were more likely to see mental health as a right
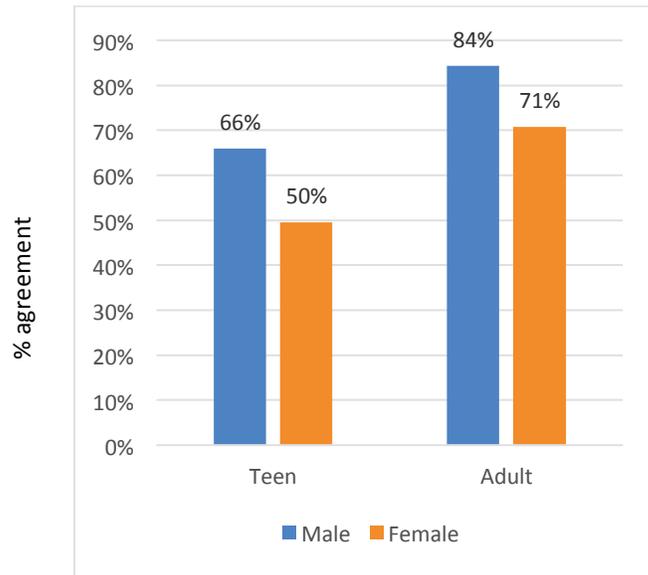
Figure 2.3. Attendees with a friend or family member with a mental health problem were more likely to see access to mental health as a right
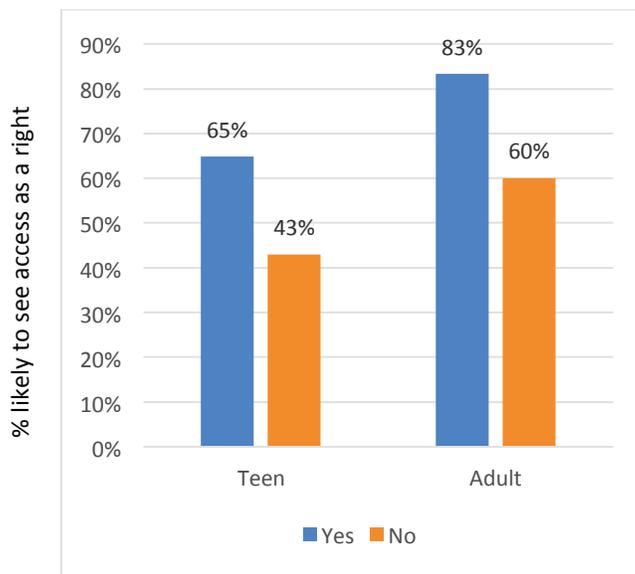
Other Attitudes and Beliefs Related to Mental Illness Among Attendees

As shown in Table 2.3, substantial majorities of each sample—81 percent of teens and 92 percent of adults—endorsed that people with mental health problems have trouble getting the treatment they need. This belief is consistent with the messaging of the WeRise event. Most WeRise attendees in both age groups also had high awareness of the prejudice and discrimination faced by individuals living with mental health challenges, with endorsement of this belief at 84 percent and 94 percent for teens and adults, respectively. By way of comparison, 79 percent of adults in California endorsed this item in the EMM 2014 survey (Collins et al., 2015), close to the teen sample's level of agreement but apparently less than that of adult attendees. However, the EMM sample was representative of Californians, whereas the current sample of WeRise attendees overrepresents those with a connection to mental health issues. At least 85 percent of event attendees in both age groups also agreed that they planned to take action to prevent discrimination (see Figure 2.4).

The majority of teens and adults at the WeRise event viewed people experiencing mental health problems as capable individuals, on par with most other individuals, although these beliefs were slightly less commonly endorsed than most other items on the survey. Importantly, 89 percent of teens in attendance and 91 percent of adults said that they would be willing to move next door to someone who has a serious mental illness. This item taps social distance, one of the most well-accepted indicators of mental illness stigma (or lack thereof) (Link et al., 1999). By way of comparison, 70 percent of the adults in California surveyed in 2014 indicated a willingness to do so (Collins et al., 2015).

Figure 2.4. WeRise attendees planned to take action to prevent discrimination against people with mental illness
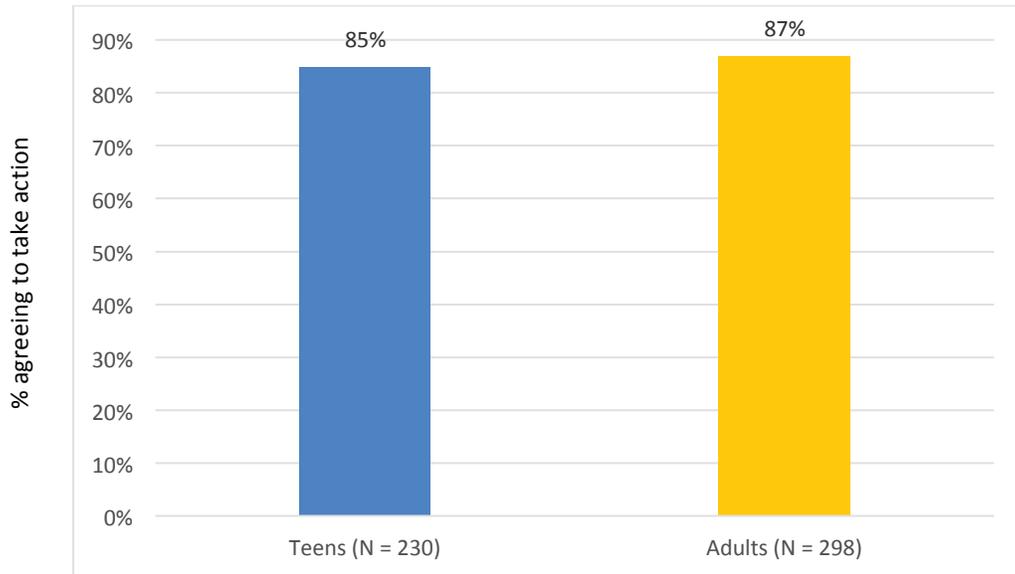
Potential Effects of WeRise Attendance

The analyses presented above suggest that the WeRise event might have led to greater awareness of mental illness stigma, reductions in social distance, and endorsement of the event's central messages. But it is also possible that the event simply attracted individuals inclined to endorse relatively positive beliefs about mental health because they are closely connected to those with mental health challenges or experiencing mental health challenges themselves (such as those with prior personal experience of a mental health problem). In an effort to shed further light on this issue, we conducted some additional analyses, comparing those who had been at the event for an hour or more to those who had arrived closer to the time of survey (which may indicate greater exposure to the event's messages or greater engagement with the event) and comparing those who had personally experienced a mental health problem with those who had not. Each item in the survey was compared across these groups. These analyses were conducted for the adult sample only, because of the difficulty of interpreting time-at-event data for teens (who were sometimes there for fixed periods because of school schedules, but not all that time was focused on the event) and because the personal-experience item was specific to adults.

Overall, our analyses revealed relatively few differences based on length of time at the event (see Table 2.4). However, a few key differences did emerge: Those who had been there longer at the time of survey were more likely to say that the event made them feel more supportive of those with mental health problems and to say that the event gave them a better understanding of mental illness (see Figure 2.5).

Table 2.4. There were a few differences in attitudes toward mental illness among those who spent more time at WeRise

Item	More Than 1 Hour (% agree/willing)	Less Than 1 Hour (% agree/willing)
People with mental illness experience high levels of prejudice and discrimination	96	90
People with mental health problems have trouble getting the treatment they need	94	89
People with mental illness are capable people	88	86
People with mental illness are able to do things as well as most other people	74	78
Access to mental health is a right	80.	79
You plan to take action to prevent discrimination against people with mental illness	89	84
How willing would you be to move next door to someone who has a serious mental illness?	91	91
Today's event made you want to be more supportive of people experiencing mental illness**	95	84
Today's event made you feel empowered to take care of your own well-being	93	87
Today's event gave you a better understanding of mental illness*	87	75
Today's event made you want to help break down barriers that keep people with mental illness from getting treatment	93	85
Because of today's event, you plan to be a part of #WeRiseLA, LA's well-being movement	81	72
You would recommend today's event to a friend	95	94

* $p < 0.05$, ** $p < 0.01$.

Figure 2.5. Those who were at the event for longer were significantly more likely to express support and understanding of people with mental illness
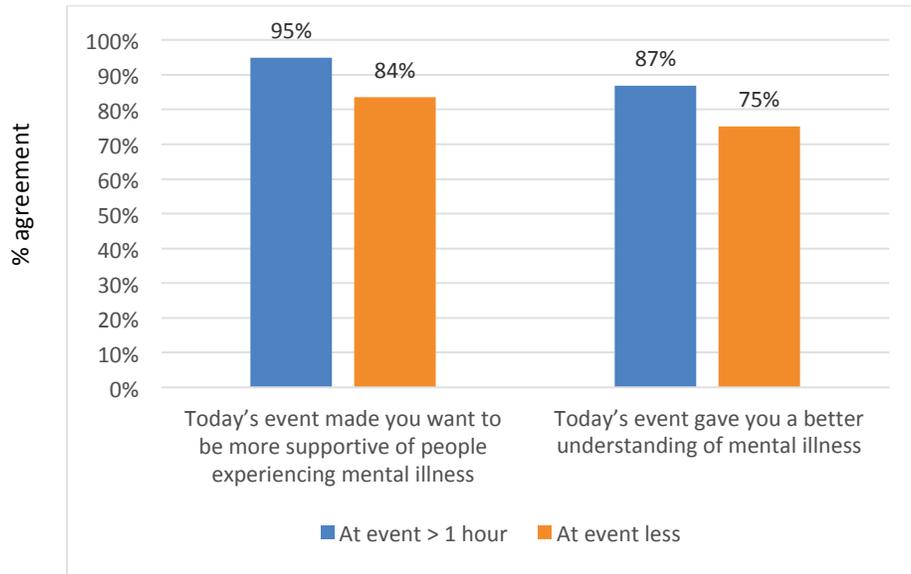
There were also differences depending on prior personal experience with mental illness (see Table 2.5). Those with personal experience were more likely to see those with mental illness as equally able to others, were more willing to live next door to a person with serious mental illness, and were more likely to say that the event made them feel more empowered to take care of their own well-being and to want to help break down barriers to treatment access.

Our findings that there were few differences based on time at the event and somewhat more differences based on prior personal experience with mental illness suggest that selection effects might have influenced our findings regarding positive attitudes and beliefs toward mental illness. In other words, although WeRise might be associated with some change in views, it also might have attracted individuals who already had informed and positive views of people with mental illness.

Table 2.5. There were a few differences in attitudes toward mental illness among those who had a mental health problem, compared with those who did not

Item	Mental Health Problem (% agree/willing)	No Mental Health Problem (% agree/willing)
People with mental illness experience high levels of prejudice and discrimination	97	91
People with mental health problems have trouble getting the treatment they need	95	90
People with mental illness are capable people	91	83
People with mental illness are able to do things as well as most other people*	81	70
Access to mental health is a right	82	76
You plan to take action to prevent discrimination against people with mental illness	89	83
How willing would you be to move next door to someone who has a serious mental illness?***	97	85
Today's event made you want to be more supportive of people experiencing mental illness	94	87
Today's event made you feel empowered to take care of your own well-being*	94	86
Today's event gave you a better understanding of mental illness	84	81
Today's event made you want to help break down barriers that keep people with mental illness from getting treatment*	94	85
Because of today's event, you plan to be a part of #WeRiseLA, LA's well-being movement	77	78
You would recommend today's event to a friend	97	93

* $p < 0.05$, *** $p < 0.001$.

Conclusions

WeRise was very positively evaluated by both teen and adult attendees at the event, and they reported feeling empowered, wanting to help break down barriers, and planning to take action. Most also endorsed the central idea of WeRise, that access to mental health is a right, although this belief was not as common as others. We cannot determine whether these beliefs were a function of the event itself or of the fact that the event attracted many people who had prior experiences with mental health problems (their own or others'). We found some differences in attitudes and beliefs between those who did and did not personally have experience with mental illness, but they were not manifest across all items. We also found some evidence that those who were at the event for longer were more likely to express support and understanding toward people with mental illness. The latter suggests that the WeRise event might have been partly successful in moving the dial regarding attitudes toward mental illness.

The event appears to have attracted a crowd from diverse racial and ethnic backgrounds. Whites were less likely, and blacks more likely, to be included in both samples, relative to their representation in Los Angeles County. And the teen sample also included a high proportion of Latinos, exceeding their representation in Los Angeles County as a whole. We cannot be sure, given our sampling method, that those we surveyed were representative of attendees, but the observations of evaluation field staff indicate that this is the case. If so, the event was very successful in reaching racial and ethnic minorities, an important goal, given the disparities in treatment access (McGuire and Miranda, 2008) that the WeRise event was, in part, designed to address.

Although the event successfully attracted diverse racial/ethnic groups, it attracted relatively few males. This may be, in part, due to the fact that males use social media, where WeRise was advertised, at lower rates (Smith and Anderson, 2018). However, it is important to reach males, given that utilization of mental health treatment is particularly low among men (see, e.g., Leaf and Bruce, 1987), perhaps as a result of greater mental illness stigma among males (Kessler, Brown, and Broman, 1981). Most importantly, the event largely attracted individuals who were already in some way involved with issues of mental health and mental illness. Large percentages of attendees either worked or volunteered in the mental health field or had personal experiences with mental health challenges. This indicates that the campaign successfully attracted people who can readily use the campaign messages in their own lives. However, it is also important that events such as WeRise engage and mobilize those who are not already aware of and attempting to address the problems faced by those experiencing mental health challenges.

Chapter 3. Analysis of "Mental Health" Tweets in Los Angeles County

An important goal of the WeRise/WhyWeRise campaign was to engage the online community in discussing mental health via social media. The campaign sought to use social media to generate buzz for WeRise and galvanize support for the campaign's movement. Therefore, our evaluation sought to examine whether the WeRise/WhyWeRise Twitter campaign was successful in increasing discussion of issues related to mental health. We also aimed to characterize the Twitter communities engaging in discussions of mental health and the topics they were talking about—in particular, whether these topics included issues related to inequality. Our evaluation focused on Twitter because the posts are public; although the campaign had presences on Instagram and Facebook, we do not have access to all relevant conversations, since many are private.

Methods

To better understand the impact, reach, and context of the campaign, the evaluation team analyzed a large data set of tweets from persons in Los Angeles County. We analyzed the impact of the Twitter campaign in two different ways. First, we assessed differences in Twitter data (i.e., the number and content of tweets) prior to the campaign, compared with during the height of the campaign, to examine whether the active campaign was associated with a change in the volume or content of discussions regarding mental health. Second, we examined the content and context of the conversation on Twitter during the campaign. Better understanding the context—the wider mental health conversation on Twitter—helped us get a richer sense of why and how the campaign affected social media discourse. Prior research has used the community lexical analysis techniques we used in the current evaluation and shown that the communities identified in the social media analysis match known communities and a priori expectations based on qualitative descriptions (e.g., Bodine-Baron et al., 2016; Helmus et al., 2018).

Data

The data used in these analyses were tweets from Twitter. Use and analysis of these data were reviewed by RAND's institutional review board and determined not to involve human subjects. The data were compiled and purchased from the Gnip Historical PowerTrack data archive. The data were pulled during two periods: prior to the WeRise/WhyWeRise campaign (pre-data) and during the campaign. The first tweet from the @WeRise_LA account driving the campaign occurred on May 3, 2018. The pre-data spanned the period from March 23, 2018, to May 2, 2018. The active campaign data were from May 3, 2018, to June 12, 2018 (two days after

the final day of the WeRise event)—encompassing the period during and immediately after the WeRise event, when the WeRise/WhyWeRise campaign was very active on social media. The data collection parameters included tweets that were geotagged to the Los Angeles area and include the phrases, hashtags, and accounts "werise," "we rise," #werisela, #whywerise, #whywerisechallenge, @WhyWeRise, @WeRise_LA, werise.la, "mental health," "mental illness," or "well-being." These key terms were generated by the evaluation team to (1) encompass any broad discussion about mental illness and mental health, whether or not it included the campaign or event, plus the broad discussion of the campaign's term of choice, "well-being" (the campaign avoided using the terms "mental health" and "mental illness," which can be stigmatizing and might limit interest in their targeted audience), and (2) any tweets that might explicitly reference the event or be tweeted by or retweeted from the event organizers (who used the hashtags and accounts noted in their communications). The pre-data included 40,513 tweets; 39,143 of these tweets included the phrase or phrases "mental health," "mental illness," or "well-being," and 1,370 tweets included one of the WeRise phrases or hashtags. The during-campaign data included 60,427 tweets; 58,151 tweets included the phrase or phrases "mental health," "mental illness," or "well-being" and 2,276 with "werise" or related phrases. We hereafter refer to these two sets of tweets as the "werise" and "mental health" tweets.

Approach

Because these data sets are too large for unassisted human analysis, we used two computer-assisted analytical methods: text analytics to understand what people are talking about, and network analysis to understand who is talking to whom. This gave us a very detailed, evidence-based way to visualize the data as a dynamic conversation about mental health.

Text Analysis

For our analysis, we used RAND-Lex, a suite of text analysis and machine-learning tools designed to help human analysts make sense of very large collections of language data (Bodine-Baron et al., 2016; Helmus et al., 2018). RAND-Lex is a human-in-the-loop approach that leverages what computers do best (be fast, reliable, and scale to lots of data) and what humans do best (make meaning and bring context to interpretation). RAND-Lex allows researchers to look at very large collections of text data (i.e., in the tens of millions of words) and conduct both descriptive and exploratory statistical tests to analyze and make meaning of those data sets.

We used three specific methods in our text analysis:

- *Keyness testing* to find conspicuously over present words that signal what a conversation is primarily about: A collection of text data (e.g., from a community of interest) is compared with a more general baseline text set (e.g., from other communities) to detect statistically meaningful patterns in word frequencies. If community X uses words such as

"well-being," "mental," "health," "programs," and "depression" at much higher rates than other groups, we may infer that the group is talking about mental health issues.

- *Collocates* to find word pairs and triplets, again to understand what the conversation is about: Collocate extraction looks for words that co-occur close to each other in nonrandom ways, and although they sometimes reflect habitual speech ("you know"), they also reflect proper names, place names, and abstract concepts. "LA" and "County" co-occur because there is a place named "LA County." Likewise, "substance" and "abuse" often co-occur because "substance abuse" is an important concept.
- *In-context viewing* for insight: To better understand conversations, we used RAND-Lex to pick words from keyness testing or collocate extraction and view all the examples in context. For example, the keyword "tumblr-tinted" was confusing until we saw how one community used the phrase to criticize people who look at mental health through "tumblr-tinted glasses."

Network Analysis

We used RAND-Lex's built-in network analysis capability (RAND-Net) to detect communities from the metadata in social media. The community-detection algorithm uses the frequency of interactions to infer social relationships. Individuals who interact (i.e., tweet with one another) on a regular basis are considered to be part of some kind of community. For example, a mental health professional might interact with a much wider community of people who share interests or concerns around well-being. We used two methods in our network analysis:

- *Community detection algorithm to find communities*: We used RAND-Net to sort through all the connections—all the retweets and "@s" that make Twitter interactive and social— to build a very large "mentions network." We then applied a community detection algorithm adapted to large networks to infer communities (Blondel et al., 2008). Communities gave us a social grouping to explore, allowing much more insight into the different kinds of communities and stakeholders in the discussion.
- *Network visualization to see relationships*: We used Gephi, a popular and very useful network visualization software package, to map out communities to better understand social relationships and interactions over social media.

Results

WeRise/WhyWeRise Campaign Influenced Outcomes

Increases in "Mental Health" and "Well-Being" Talk on Twitter During Campaign

There was a measurable but modest increase in talk about "mental health" and "well-being" during the WeRise/WhyWeRise campaign, compared with discussions prior to the campaign.

We cannot know for sure whether the measurable increase is due entirely to the campaign, or due in part to other confounding factors that occurred during the campaign time period, such as the high-profile suicides of Kate Spade and Anthony Bourdain in June 2018 and "mental health awareness" month in May.

The specific phrase "WeRise" and related phrases also had a measurable increase in presence during the campaign.

@WeRise_LA Was Well Connected in the Mental Health Community on Twitter

On Twitter, the number of connections (tweets, retweets) can be a proxy for influence within a Twitter community. Table 3.1 is a list of the most-connected Twitter accounts in the data set, reflecting tweets occurring during the campaign (note that the Twitter handles for these accounts have been removed for data-privacy reasons). During the campaign, the @WeRise_LA Twitter handle was the fifth most connected Twitter handle out of 38,496 that were tweeting about "WeRise" or "mental health" in the data set. Among this list of highly connected Twitter handles within the data set were many well-established Twitter accounts, which indicates that @WeRise_LA was able to quickly embed in the mental health community of Twitter users.

Table 3.1. WeRise was well connected and influential on Twitter

Twitter Account[a]	Weighted Degree of Connectedness
1	1,498
2	1,089
3	937
4	671
5 (WeRise_LA)	659
6	594
7	583
8	573
9	519
10	511

[a] Twitter handles were removed for data-privacy compliance.

Twitter Discussion During the Campaign

Many Clusters of Tweeters Were Discussing Mental Health

To better understand the influence of the campaign, we examined the network of communities participating in the discussion of "mental health" and "WeRise" during the campaign. The network map on the left side of Figure 3.1 is a visual representation of individuals participating in the discussion. Each black node represents an individual (a Twitter account), and the lines represent a connection between the individuals in a retweet, a like, or a comment.

Twitter accounts more closely spaced together represent a higher degree of connectedness, and Twitter accounts on the fringe of the figure represent less connectedness. Clusters of individuals that seemed to be highly connected are identified by the different colors. For example, the blue highlighted area is a cluster of individuals who were highly connected to one another, while the red cluster is also highly connected to one another but less to members of the blue community.

Figure 3.1. WeRise network community map
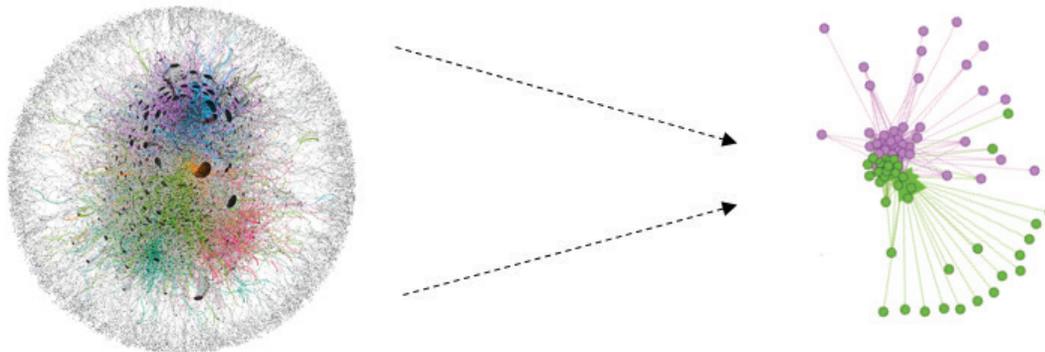
NOTES: The WeRise network map (left) shows clusters of highly connected individuals discussing WeRise or mental health. The WeRise community map (right) shows two key communities and their subcommunities within the WeRise network, shown at left, with some interaction between them.

The Campaign Was Part of Two Primary Community Discussions

From this larger discussion of mental health and WeRise illustrated in the network map on the left side of Figure 3.1, we were able to identify two primary metacommunities (metacommunities are communities of communities), which are illustrated in the community map on the right side of Figure 3.1. These communities were made up of the smaller user clusters seen in the network map. Metacommunities are higher-order groupings that reflect connections between groups. For example, imagine a community of library volunteers, a hospice group, a community development corporation, and a local faith-based charity—each of which is a community of individuals with a shared social connection. But between each of those communities there could be crossover and shared connections that define a higher-order "community involvement" metacommunity.

The purple nodes in the community map on the right side of Figure 3.1 represent a cluster of communities from the network map that make up metacommunity A of tweeters. The green nodes represent a cluster of communities from the community map that make up metacommunity B of tweeters. The handle @WeRise_LA was primarily associated with metacommunity A.

There were distinct differences in the membership and discussion in each of these communities. Although both metacommunity A and metacommunity B included individual

accounts, only metacommunity A included accounts of government and nongovernment organizations. The conversation in metacommunity A consisted of discussion on the following topics:

- strong response to budget cuts for substance abuse and mental health care
- arguments over the link between mental health and gun violence
- concerns about the high-profile suicides of Kate Spade and Anthony Bourdain
- strong response to Kim Kardashian's comment that "Mental Health is no joke" (Kardashian West, 2018)
- 605 retweets of the Dalai Lama's tweet: "Scientists warn that constant fear and anger are bad for our health, while being compassionate and warm-hearted contributes to our physical and mental well-being. Therefore, just as we observe physical hygiene to stay well, we need to cultivate a kind of emotional hygiene too" (Dalai Lama, 2018).

The second metacommunity, B, conversed about mental health in the context of civil rights, inequality, and social justice issues, such as gender, race, sexuality, and income. The discussion within this community generally indicated support of community members for each other and recirculated positions on issues discussed, but there was some criticism of specific Twitter users who violated group values of the community in some way. The topics of conversation included

- Marxist critique of capitalism
- labor rights
- immigrant rights
- debate about "Black Americans" versus "Africans"
- Black Lives Matter
- "mental health" when there are white shooters versus "terrorism" when there are black shooters
- sexual assault, rape culture, and toxic masculinity
- homelessness (especially in downtown Los Angeles)
- racism and bigotry from white people
- wealth and fame not protecting someone from suicide
- looking at suicide and depression through "tumblr-tinted glasses."

There is crosstalk happening between metacommunity A and metacommunity B. This is seen visually in the community map on the right side of Figure 3.1, with the overlap in the purple and green nodes (i.e., high connectedness yields dots closer together). We were unable to detect that @WeRise_LA had a presence in metacommunity B, because we do not see the specific #werisela hashtag appearing in the data for metacommunity B.

Conclusions

The WeRise campaign was associated with a moderate increase in Twitter discussion of mental health and well-being and a notable increase in discussion of WeRise. It is not possible to determine the extent to which the modest increase in mental health and well-being discussion was due to the WeRise campaign, compared with other events, such as high-profile suicides and "mental health awareness" month. The @WeRise_LA Twitter handle was part of a community that discussed common topics in mental health circles, such as budget cuts for treatment, the link between mental health and gun violence, and high-profile suicides. This community used the campaign hashtag, and there was strong connectedness of the @WeRise_LA Twitter handle within this community. This community was well connected with one that tweeted about mental health in the context of civil rights and social justice issues. This is significant, given the goal of WeRise/WhyWeRise of engaging youth in a movement to address inequalities in access to mental health. However, it does not appear that the WeRise/WhyWeRise messages were picked up as a cause by these individuals. We were unable to detect any of the specific WeRise/WhyWeRise campaign hashtags in the civil rights or social justice community's tweets.

Chapter 4. Survey of Los Angeles County Youth

The WhyWeRise campaign sought to reach beyond attendees at the WeRise events to members of the Los Angeles community, much like other movements, such as March for Our Lives, influenced many individuals who never attended a demonstration, and the truth® campaign influenced youth who did not engage in anti-tobacco advocacy. Therefore, our survey of a broader population of TAY in Los Angeles County sought to understand (1) the overall reach of the campaign's two components (WhyWeRise and WeRise) in its targeted population, and (2) how those who were reached were affected by the campaign with respect to their attitudes, beliefs, knowledge, and intentions related to mental illness.

Method

Data Collection

RAND designed and analyzed a survey of residents of Los Angeles County ages 14–24. The survey was conducted by Gfk Group (formerly Knowledge Networks) between June 21 and July 5, 2018, with human-subjects approval from RAND's institutional review board. Contact information for potential participants who were county residents and in the targeted age range was purchased from sample vendors. These individuals received an email describing a survey about their "thoughts and experiences on mental health-related issues" and an eligibility screener that was used to confirm the age and geographic requirements. The survey was completed online and was approximately seven minutes in length. Participants received 1,000 Gfk points, which is equivalent to $1 that can be redeemed as cash or used to purchase products. Respondents could choose to complete the survey in either Spanish or English.

Measures

The survey measured demographics (including personal experiences with mental health challenges); campaign exposure; and attitudes, beliefs, and knowledge related to mental illness.

Campaign Exposure

We asked all survey respondents, "Have you heard of WeRise or WhyWeRise, Los Angeles' well-being movement? (yes/no)." The question was accompanied by graphics of the logos associated with the campaign. Those who responded affirmatively were classified as WeRise/WhyWeRise exposed and were asked two additional questions about the nature of that exposure: whether they had attended "any of the WeRise events in downtown LA? (yes/no)," and whether they had "visited the websites werise.la or whywerise.la? (yes/no)." Those who had visited the website(s) or attended WeRise were classified as such. All those who reported

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campaign exposure but had not either visited the website or attended WeRise were classified as having "other" exposure to the campaign (likely through social media, radio, or word of mouth).

Mental Illness Attitudes, Beliefs, and Knowledge

RAND created nine campaign-specific items to tap endorsement of key goals and beliefs targeted by WeRise or WhyWeRise:

- Access to mental health care is a right.
- You have the power to change how our communities deal with mental health issues.
- You plan to help break down barriers that keep people with mental health challenges from getting treatment.
- People with mental health problems have trouble getting the treatment they need.
- Young people who have mental health problems are being sent to jail instead of getting treatment.
- Homelessness is a result of broken support systems for people with mental health problems.
- It should be easy and affordable for people with mental health problems to get treatment.
- If you needed help with a mental health problem you would know how to get it.
- Schools need to do more to support mental health and well-being.

Each of these is referenced on the WhyWeRise website. For each item, RAND measured extent of agreement on a five-point (strongly agree to strongly disagree) scale. Responses were recoded to reflect any agreement (agree or strongly agree) versus none.

RAND also employed a set of 13 previously validated items tapping general attitudes, beliefs, and knowledge related to mental illness and its treatment, including measures tapping stigma. Although not the main targets of the campaigns, the constructs measured are implicit in many of the WeRise/WhyWeRise messages and in the panels and materials present at the WeRise event. Because these items have been used in prior surveys (Evans-Lacko, Henderson, and Thornicroft, 2013; Jorm, Christensen, and Griffiths, 2006; See Change, 2012; Wyllie and Lauder, 2012), including in the evaluation of the EMM campaign in California (Collins et al., 2015), they also allow comparison of WeRise/WhyWeRise to other mental health–related campaigns. We also included three items measuring social distance (a key indicator of mental illness stigma) on a four-point (definitely willing to definitely unwilling) scale, two items measuring intent to conceal a hypothetical mental health problem on a four-point (definitely would conceal to definitely would not conceal) scale, and eight additional items measured on a five-point (strongly agree to strongly disagree) scale. Responses to all items were recoded to reflect any agreement, willingness, or concealment versus none

We conducted analyses to describe the characteristics of study participants (univariate estimates) and persons exposed to WeRise or WhyWeRise (multivariate logistic regression). The main results compared the mental health–related attitudes and beliefs of those who reported exposure to WeRise/WhyWeRise with those who did not, controlling for age, gender, education, race/ethnicity, language of survey, and whether the respondent had a friend or family member with a mental health problem. We also examined differences in these attitudes and beliefs depending on the type of exposure to WeRise/WhyWeRise (website, downtown Los Angeles event, or "other"), comparing each type with "no exposure"; these results should be considered exploratory, given the small sample sizes for these specific types of exposure. Although findings occasionally reached statistical significance, the small sample makes it uncertain how reliable they are, so the findings are provided to suggest potential effective elements for future campaigns to consider.

Sample weights were applied to account for any differential nonresponse that might have occurred. Geodemographic distributions for the target population were obtained from the Current Population Survey from the U.S. Census Bureau and the U.S. Bureau of Labor Statistics and the American Community Survey from the U.S. Census Bureau.

Data are weighted to represent ages 14–24 in Los Angeles County on the following variables:

- gender (male, female) by age (14–17, 18–20, 21–24)
- education (less than high school, high school, some college, bachelor's degree or higher)
- race (white, black, Asian, other)
- Hispanic origin (Hispanic, not Hispanic).

We report weighted percentages and odds ratios.

Results

Characteristics of the Sample

The sample was composed of 1,008 individuals. Their characteristics are shown in Table 4.1. Fewer males and individuals under 18 responded to the survey than would be expected based on Los Angeles County demographic characteristics, a bias corrected for by the analytic weights (see the last column of the table). After applying these weights, 35 percent reported that they had ever had a mental health problem, and 61 percent reported that a friend or family member had such a problem. In a prior survey of California adults age 18 years and older on a similar topic (Collins et al., 2015), RAND found that only 27 percent reported ever having had a mental health problem, and 53 percent reported that a family member had a mental health problem. Although that number is lower than that for the current survey, it is not directly comparable, since the question on the state survey did not include friends. State percentages might also be expected to

vary a bit from what is true of those residing in Los Angeles County (because of differing demographics, for example), but this suggests that the Los Angeles County youth survey was somewhat more likely to attract individuals who have experienced mental health issues, either directly or through friends and family. Our weights cannot directly correct for any potential overrepresentation of those with a personal connection to mental health, which could potentially bias our findings to some unknown extent.[2]

Table 4.1. Characteristics of the Los Angeles County youth sample, before and after weighting

Characteristic	N (Total = 1,008)	Unweighted Percentage	Weighted Percentage
Age			
14–17	152	15	34
18–20	411	41	27
21–24	445	44	39
Race/ethnicity and language			
White, non-Latino	226	22	20
Black, non-Latino	78	8	6
Asian, non-Latino	122	12	11
Latino, English survey[a]	492	51	56
Latino, Spanish survey[a]	24	2	2
Other	66	7	5
Gender			
Male	353	35	51
Female	655	65	49
Experience with mental illness			
Respondent has had a mental health problem[b]	325	38	35
Close friend/family member has had a mental health problem	650	65	61

[a] Surveys were available in Spanish and English. In prior work (Wong et al., 2016), we have found differences in the mental health–related attitudes of Latinos who prefer to be surveyed in English versus Spanish.
[b] Asked only of those age 18 and older.

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[2] Although the survey did not ask in which county supervisory district they resided, their zip codes are known. Sixty-five percent of participants are from zip codes that are completely within a district, while the remainder live in zip codes that cross districts. Looking at the 65 percent that could be unequivocally assigned to a district, we found that all districts were represented, with individual districts making up from 13 percent to 24 percent of the sample.

Campaign Exposure

Just over one in five Los Angeles County youth (22 percent) reported exposure to some component of WeRise/WhyWeRise (see Figure 4.1). Two percent of county youth attended WeRise, more than 4 percent visited the WeRise or WhyWeRise websites (werise.la, whywerise.la), and an additional 3 percent did both. Twelve percent of Los Angeles County youth (i.e., about half of those exposed) heard about the campaign in some other way (i.e., they were aware of the campaign but did not report attending the event or visiting the website). This awareness might have come through social media, radio promotions of the event and website, or word of mouth. This is strong reach for a campaign that existed for a very short period prior to our survey. By way of comparison, California's statewide EMM campaign, which focused on reducing the stigma of mental illness and was sustained over a much longer period, reached only 17 percent of adults in its first year and 38 percent in its second year (Collins et al., 2015). The latter percentage is in line with major mental health campaigns conducted internationally (Evans-Lacko, Henderson, and Thornicroft, 2013; Wyllie and Lauder, 2012). This suggests that the reach of WeRise/WhyWeRise was quite strong for a campaign that existed for a very short period prior to our survey.

Figure 4.1. WeRise/WhyWeRise reached 22 percent of Los Angeles County youth in just a few weeks
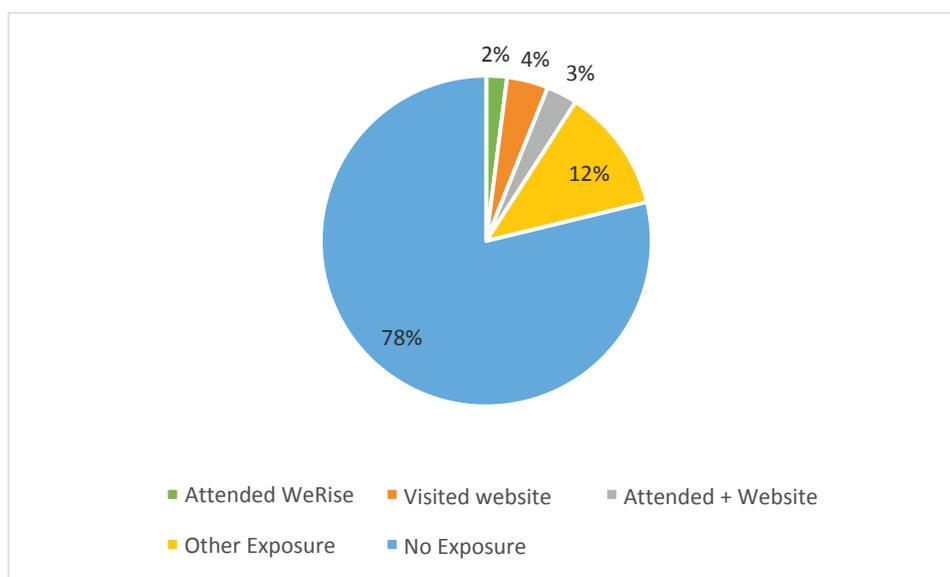
NOTE: The total does not sum to 100 because of rounding.

Predictors of Campaign Exposure

We examined the characteristics of those more likely to have been exposed to the campaign. Those who had a friend or family member who had a mental health problem were substantially more likely to report awareness of WeRise or WhyWeRise than others without this direct

experience with mental illness (25 percent versus 18 percent). Awareness was also greater among those ages 21–24, at 25 percent, compared with those ages 14–17 (20 percent) or 18–20 (21 percent). There were no differences in exposure based on education, race/ethnicity and language of surveys, gender, or past-year contact with someone experiencing a mental health problem. Although limited to only two characteristics, selective exposure to the campaign (i.e., greater exposure among those with a personal interest in mental health seeking out the campaign) might be the reason for any differences we observed between the exposed and unexposed groups, rather than the campaign's influence. To reduce this possibility, in all analyses below, we controlled for age, education, race/ethnicity and language, gender, and having a family member or friend with mental health problems.

Association of Campaign Exposure with Endorsement of Campaign Messages and Goals

The central goal of WeRise/WhyWeRise was to spur a youth movement to address inequalities in access to mental health. We found that youth exposed to the campaign (86 percent) were no more likely than those unexposed (83 percent) to agree that "access to mental health care is a right." However, they were more likely to report that they had "the power to change how our communities deal with mental health issues" and planned to "help break down barriers that keep people with mental health challenges from getting treatment" (see Figures 4.2–4.6 for significant differences; see the appendix for a summary of all outcomes by campaign exposure). If these are causal effects of exposure, the goal of mobilizing action around mental health disparities appears to have been attained, even if not as fully as intended. That is, in a group of individuals already holding nondiscriminatory attitudes and seeing access to mental health care as a right, the WeRise/WhyWe Rise event was associated with positive expectations that they could effect changes related to barriers to treatment and how communities deal with mental health.

Figure 4.2. Young people exposed to the campaign were more likely to report being mobilized to action around mental health issues
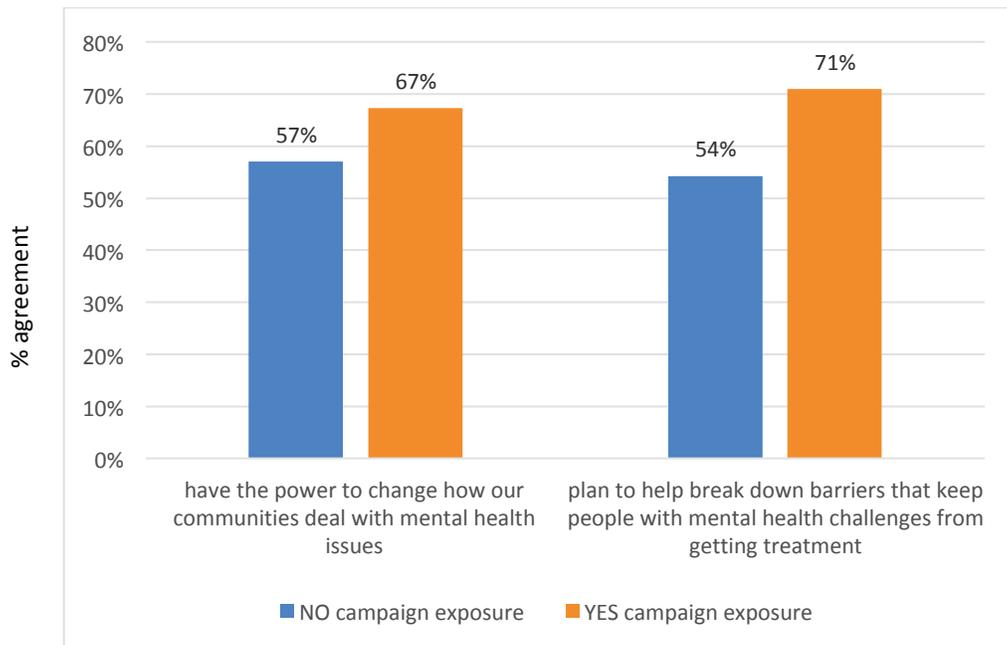
Youth exposed were also more likely to endorse many of the core WhyWeRise messages and themes—but not all (see Figure 4.3). Those exposed were no more likely to agree that mental health treatment should be easy to access and affordable or that schools should do more to support mental health and well-being than individuals who were unexposed to the campaign. However, those reporting campaign exposure were much more likely than those unexposed to recognize the barriers to treatment access faced by those with mental health problems and to believe that youth with mental illness often wind up in jail rather than treatment.

Figure 4.3. Young people exposed to the campaign were more likely to be aware of key mental health issues targeted by the campaign
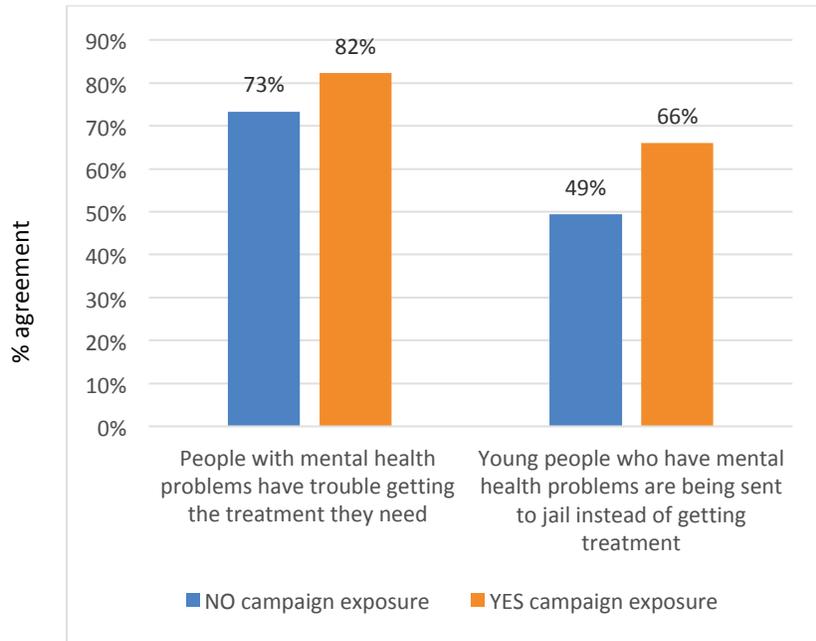
Finally, youth exposed to the campaign were more likely than others to say that they would know how to get help with a mental health problem if they needed it (see Figure 4.4). The WeRise event and the werise.la website both provided links to community organizations and other resources, and those exposed appear to have taken notice of these.

Figure 4.4. Those exposed to the campaign were more likely to know how to get help for a mental health problem
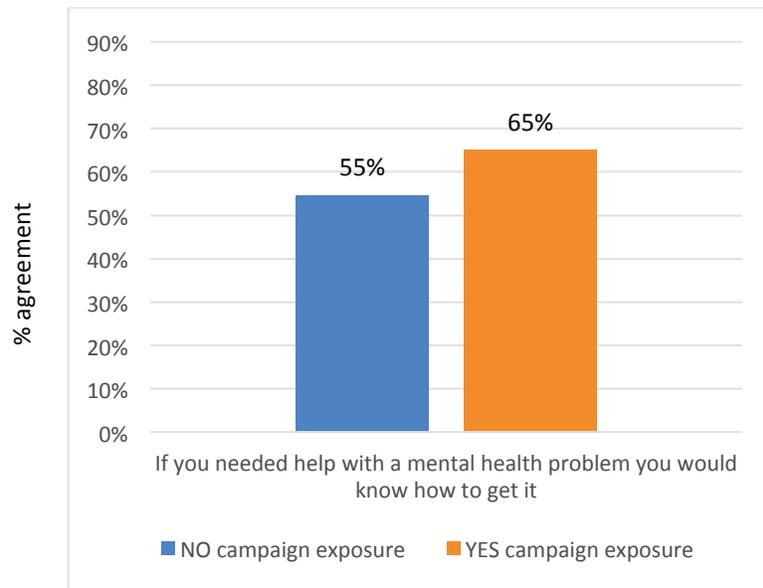
Association of Campaign Exposure with Mental Illness Attitudes, Beliefs, and Knowledge

Although inequality issues related to mental health were the primary focus, aspects of the campaign also directly or indirectly targeted reducing stigmatizing attitudes and beliefs about mental illness or improving knowledge regarding treatment, symptoms, and where to find help. Some of the content of the event gallery and panels and the WhyWeRise website addressed these issues, and stigma reduction is implicit in WeRise social media messages of inclusion and normalization of mental illness through a focus on the well-being of all people. Consistent with this, exposure to WeRise/WhyWeRise was associated with a number of differences along these dimensions.

Stigma Awareness

Youth exposed to WeRise/WhyWeRise were more likely to agree that people with mental health problems face high levels of prejudice and discrimination (see Figure 4.5). In spite of this greater awareness of stigma, those exposed to the campaign were no more likely to say that, if they had a mental health problem, they would try to hide it from friends and family members or from coworkers or classmates. This is contrary to what has been observed in evaluations of other campaigns, where increased awareness of stigma has appeared to backfire by causing greater concern about becoming the object of this stigma. A campaign in Ireland was associated with a nine-point increase in the percentage of individuals who would conceal a mental health problem from friends and family (See Change, 2012), and California's EMM campaign appeared to have

increased the percentage of individuals who would conceal such a problem from coworkers or classmates by 3 percentage points (Collins et al., 2015). It is unclear why WeRise/WhyWeRise was able to promote awareness of stigma without creating apprehension of becoming a victim of it. Possibly, the campaign's focus on empowerment and creation of a movement to address inequalities effectively increased stigma awareness without fostering a fear of being stigmatized oneself. Alternatively, it is possible that because WeRise/WhyWeRise had a civil rights orientation, the event attracted, and the campaign was noted and remembered by, individuals who were already engaged in social movements and thus inclined to fight inequalities related to mental illness, rather than feel potentially victimized by them.

Figure 4.5. Those exposed to the campaign were more likely to recognize that people with mental health problems face prejudice and discrimination
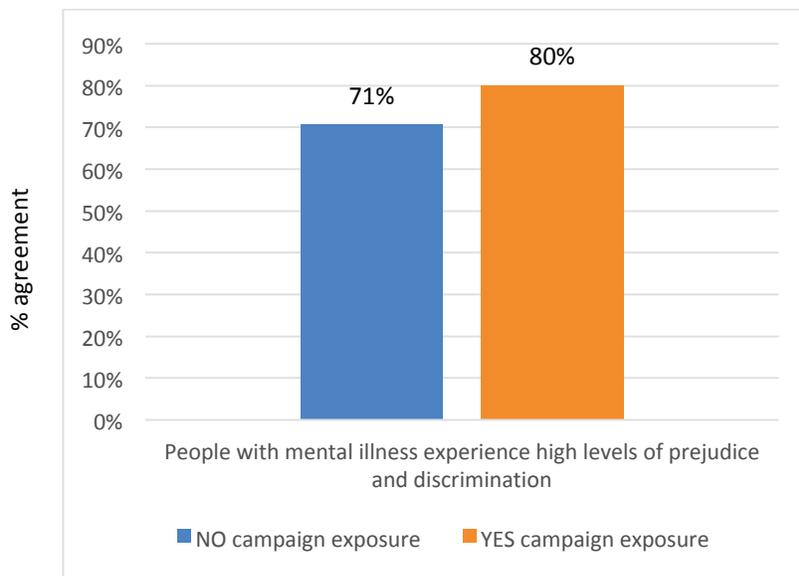
Social Distance

Social distance, the desire to avoid contact with individuals experiencing mental health challenges, is perhaps the most widely recognized aspect of stigma. Those exposed to WeRise/WhyWeRise reported less social distance than others in just one situation: They were more likely to express willingness to work closely on a job or project with someone who has a serious mental illness (see Figure 4.6). However, they were equally likely as those unexposed to say that they were unwilling to move next door to someone with a serious mental illness or to spend an evening socializing with such a person. California's EMM campaign was associated with positive reductions in social distance of between 2 and 5 percentage points after one year (Collins et al., 2015), and similarly large changes over time were observed after 10–20 months of the Like Minds, Like Mine campaign in New Zealand (Wyllie and Lauder, 2012).

WeRise/WhyWeRise was in place for a much shorter period than either of these efforts had been at the time of evaluation, and other campaigns have been associated with only small decreases in social distance, even over a period of three years (Evans-Lacko, Henderson, and Thornicroft, 2013).

Figure 4.6. Young people exposed to the campaign had greater willingness to work with individuals with serious mental illness on a job or project
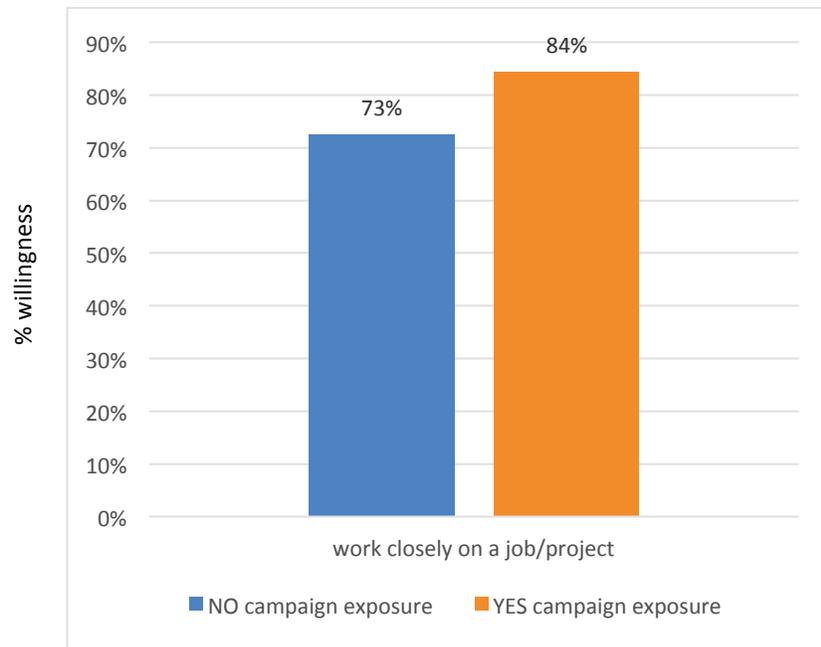
Negative Stereotypes

Those exposed to the campaign were no more or less likely to endorse negative stereotypes about people with mental health challenges, such as being a danger to others, not being capable people, and not being able to do things as well as others.

Mental Illness Knowledge

There were no statistically significant differences in self-reported awareness of the warning signs of mental health distress, recognition when someone is experiencing a mental health problem, or knowledge of how to support someone experiencing a mental illness.

Associations Specific to Subtypes of Campaign Exposure—Website, Event Attendance, and Other Elements

Patterns associated with exposure to different aspects of the WeRise/WhyWeRise campaign were mostly inconsistent across various items in the survey. Although some differences from those unexposed to the campaign reached statistical significance, the inconsistent patterns may

be a function of the small number of people who fell into each of the exposure groups, leading to unreliable estimation of effects. The only pattern that was consistent was that visitors to the WeRise/WhyWeRise websites were more likely than those unexposed to the campaign to endorse five of the nine campaign messages we studied. By way of comparison, few or no differences were observed when we compared individuals who attended the WeRise event or those who had "other" exposure to the campaign (i.e., nonweb and nonevent exposure) with those unexposed to the campaign.

As with other associations based on campaign exposure, these differences may be rooted in selective exposure to this aspect of the campaign. Those visiting the websites may be more intensively involved in the issues addressed by the campaign, and that involvement might have led them to take the step of visiting the websites. But given that the ideas tapped by this set of items were all explicitly stated and prominently featured on the websites, it is also possible that these sites were more effective at getting specific campaign messages across relative to the event or social media. For example, "The Problem" webpage on whywerise.la has a panel of six boxes with labels such as "schools," "prisons," and "streets." Each links to a statement such as the following (linked to the "prisons" box): "PRISONS AND JAILS have become warehouses for criminalized mentally ill youth, where more than 50% suffer from some condition."

Conclusions

Our survey of Los Angeles County youth in the age range targeted by WeRise/WhyWeRise revealed important associations between campaign exposure and respondents' attitudes and beliefs. Most notable among these was greater endorsement of items tapping empowerment and intended activism, which were central to the campaign's goals. Although the reach of the campaign was moderate, it was substantial for the few weeks that the campaign had been in place at the time of our survey, with more than one in five youth reporting awareness of WeRise/WhyWeRise.

We also observed associations between exposure and other beliefs directly targeted by the campaign, particularly among youth visiting the campaign websites. Youth exposed to the campaign were more likely to show awareness of barriers to care, stigma, and the issue of incarceration of those with mental illness. Youth exposed were also more likely to report that they would know how to get help if they had a mental health problem, consistent with the campaign's provision of information regarding connections to resources and care.

We did not observe any associations between exposure and the key WeRise/WhyWeRise message that access to mental health care is a right. Endorsement of this belief runs counter to how health care systems treat mental illness in the United States; although access to some level of mental health care is a legal right in every state, the public is not aware of the laws mandating this. It may be that such a fundamental shift in views is unlikely without shifts in these institutions or a longer campaign. Los Angeles County has continued the WhyWeRise campaign

since the WeRise event, adding outdoor advertising (e.g., billboards, signs at bus shelters), with the primary purpose of driving people to the WhyWeRise website. These continued efforts may help foster additional changes or sustain those that RAND observed. A public-television documentary that follows youth through the WeRise gallery is in production. Alternatively, even with continued campaign work and monitoring, we may not see a shift in views about mental illness as a right, because most respondents already believed this, leaving little room for improvement on either this survey or a future survey.

This survey had some limitations. First, the sample may not be representative of Los Angeles County youth, because participants who opt to complete a survey about mental health may be particularly attuned to the campaign and the issues it addresses. Indeed, we found that greater-than-expected numbers of participants had experience with mental health problems. As a result, the percentage of youth exposed to the campaign may be an overestimate if people with an interest in mental health were more likely to respond to our survey. Nonetheless, our analyses indicate that exposure was still substantial, 18 percent, among those who did *not* have a friend or family member who had experienced mental health challenges. Second, we are unable to determine the extent to which associations between WeRise/WhyWeRise exposure and attitudes toward mental illness are due to people with positive attitudes being interested in and remembering the campaign versus effects of the campaign on individuals exposed. It is likely that some portion of the associations we observed is due to each of these factors. For these reasons, we advise caution in interpreting the results of the survey.

Although we cannot confirm causality because of limitations in our study design, the evidence from RAND's survey of Los Angeles County youth is consistent with a conclusion that there has been a significant, positive influence of WeRise/WhyWeRise on a substantial percentage of youth in Los Angeles County, catalyzing them to action on the issues of mental health access and how systems (such as jails) treat those experiencing challenges to well-being.

Chapter 5. Discussion, Recommendations, and Conclusion

LAC DMH rapidly launched the WhyWeRise campaign during the May 2018 "mental health awareness" month, with the WeRise immersive experience as the centerpiece of this campaign. **The campaign attracted a large number of people:** Our survey of more than 1,000 Los Angeles County youth ages 14–24 found that as many as **one in five young people were aware of WeRise or WhyWeRise**. This is a quite substantial reach for a campaign that had only been in place for a few weeks.

Our in-person survey suggested that WeRise was successful in engaging racial and ethnic minorities, especially black and Latino teens. Our analysis of Twitter data also found that the WeRise/WhyWeRise campaign was associated with a moderate increase in Twitter discussion of mental health and well-being, although it is difficult to know how much of this to attribute to WeRise versus other events that were part of "mental health awareness" month. And the Twitter campaign was interacting with an online community of people who focus on mental health and inequality and civil rights, although it is not clear that the campaign messages were picked up by this group.

There is evidence that those who were exposed to WeRise or WhyWeRise might have benefited from the campaign. Our in-person survey at the event found that those who were present for longer were more likely to express supportive and understanding attitudes toward people with mental illness. Our large, countywide survey of youth found that those exposed to WeRise or WhyWeRise (either in person or online) were more likely to report feeling empowered and mobilized toward mental health activism—a key goal of the campaign. Those exposed to the campaign also had greater awareness of the challenges people with mental illness face, from stigma to treatment-access issues. They were also more likely to know how to get help for their own mental health challenges, consistent with one of the campaign's goals of connecting people to resources. However, we cannot know for sure whether these positive associations are due to the campaign. Continued evaluation over time is needed to distinguish between causal effects of the campaign and other potential explanations (e.g., people who are drawn to the campaign may already have greater mental health awareness).

Moreover, there is still room for progress in some domains. For instance, our large survey of county youth did not detect any reductions in negative stereotypes about those with mental illness or increases in mental illness–related knowledge—both of which may reduce stigma and increase the likelihood of treatment seeking (Wong et al., 2018). This is not surprising, because knowledge and stereotypes were not directly targeted by the campaign. What is slightly more surprising is that we did not find an association between exposure to the campaign and a belief that access to mental health care is a right—a key campaign message. Such a fundamental shift in views may require more time than the few short weeks of the campaign that this evaluation

examined. It should also be noted that a high number of individuals not exposed to the campaign (83 percent) already believed that access to mental health is a right and had other positive perceptions of people with mental illness, so there was not a lot of room to detect change. Given this, the campaign may want to consider adding some new core messages around the issue of unequal access to mental health, with a focus on ideas about which there is less agreement.

There is also evidence that **WeRise events predominately attracted people who were already interested in and knowledgeable about mental health**. Our in-person survey at WeRise found that large percentages of attendees worked or volunteered in the mental health field or had personal experiences with mental health challenges—rates among attendees were greater than those for California as a whole. This means that the campaign successfully attracted people for whom mental health was personally relevant, who can readily apply the knowledge and empowerment they get from the campaign to their own life situations.

Although engaging the existing mental health community is important, so is reaching beyond this community to engage new people. To this end, the campaign seems to have had better success engaging people through means other than the event, as our large, countywide survey found that exposure to WeRise or WhyWeRise was almost one in five even among those who did *not* have a friend or family member who had experienced mental health challenges.

Recommendations

The campaign should consider **using approaches aimed to reduce negative stereotypes and increase mental illness–related knowledge as a complement to those concerning inequalities in access**. Both negative stereotypes and knowledge of symptoms are thought to be central to increasing social inclusion for those experiencing mental health challenges and increasing the likelihood that these individuals will seek treatment for emerging symptoms (Jorm, 2000). To do so, it may be useful for Los Angeles County to pair any ongoing or future use of the campaign with other programs that have been shown to have these effects on youth. These include Active Minds, an on-campus, student-run program that aims to create discussion around mental health issues and educate students, faculty, and staff about on- and off-campus resources for promoting mental health (Sontag-Padilla et al., 2018); Mental Health First Aid, a program that trains members of the public to give early help to people with developing mental health problems and to give assistance in mental health crisis situations (Hadlaczky et al., 2014); and the National Alliance for Mental Illness's Ending the Silence (Wong et al., 2015), a 50-minute presentation that helps middle and high school students learn about the warning signs of mental health conditions and what steps to take if they or a loved one are showing symptoms of a mental illness. Because most people surveyed already agreed that access to mental health is a right, Los Angeles County may also wish to consider focusing more centrally on other key issues related to unequal access to mental health, such as jail, homelessness, and trauma—topics already included in the campaign.

Future events could focus on **engaging boys and men, younger audiences, and those who do not already have a connection to mental health**. The WeRise experience predominately attracted female attendees. Males tend to have lower utilization of mental health services and higher levels of stigma (Kessler, Brown, and Broman, 1981), so it may be particularly important to reach out to this group. Similarly, both the in-person survey and the survey of youth in Los Angeles County indicated that the WeRise audience was skewed toward a group that was older than the targeted audience. Most mental illnesses emerge early in life but are not treated until much later (Patel et al., 2007); capturing the attention of a younger audience may help to enroll affected individuals in treatment earlier and thereby reduce the burden of illness. The in-person events also predominately attracted individuals with a previous interest in mental health. Future events should make efforts to engage and mobilize individuals who have lower awareness of mental health issues. The school tours were an excellent strategy for engaging youth who did not necessarily have previous mental health knowledge, and LAC DMH should continue to use this and other creative strategies to reach out to those who are not already aware or mobilized.

The social media outreach was vital to the campaign's success. The campaign might consider working toward **building stronger social media connections between "mainstream" and social justice–oriented online communities**. Our Twitter analysis found that the @WeRise_LA Twitter handle was part of a Twitter community that discussed common topics in mental health circles, such as budget cuts for treatment, the link between mental health and gun violence, and high-profile suicides. This community was well connected with a community that tweeted about mental health in the context of civil rights and social justice issues. However, this social justice–oriented community was not tweeting about the campaign. We recommend that the campaign continue its current methods of reaching this second community, which are effective. However, given the alignment between the second community's interests in social justice and LAC DMH's goal of fostering a movement to address inequalities in access to mental health, the campaign would benefit from making further inroads into this group. This could be accomplished by directly reaching out to prominent individuals in the social justice–oriented community and persuading them to tweet about the campaign.

Give it time. Our final recommendation is for the campaign to keep doing what it is doing. Public attitudes tend to be slow to change, and we evaluated the campaign only a few weeks after launch. Indeed, social marketing campaigns must be continued for long periods (typically years) to create lasting change in social norms (Hornik, 2002), but this kind of change is possible with continued efforts. Given early evidence that may be pointing to the campaign's success, it is reasonable to expect more progress with more time. Los Angeles County has continued the WhyWeRise campaign since the WeRise event. Its continued social media efforts include posting video excerpts from interviews, panels, and performances and emphasize driving youth to the messages and resources available on the WhyWeRise website. In addition to the continued social media push, there are new components to the campaign: Outdoor advertising (e.g., billboards, buses, and signs at bus shelters) featuring a mix of artwork and statements aims to

pique curiosity and challenge assumptions about well-being and the mental health system. A hip-hop radio station campaign includes live DJ events several times a week—touring different colleges and schools—to promote mental health services and engage students in writing "messages of hope" to be shared with others on a campus wall. A documentary film is being produced that features students talking about their feelings and experiences at the May 2018 WeRise event. These continued efforts may sustain the changes we already observed, or even lead to further changes. In addition to continuing campaign activity, it would be helpful to conduct continued evaluation to see if changes are maintained.

Conclusion

Overall, the evaluation found evidence that Los Angeles County's community engagement campaign around mental health had impressive reach into the Los Angeles youth community it targeted: One in five youth were exposed to the campaign in some way during the brief period we examined. There is early evidence that the campaign may be associated with positive outcomes, such as increased supportive and understanding attitudes toward people with mental illness, awareness of the challenges people with mental illness face, knowledge of how to get help for mental health challenges, and, importantly, empowerment and mobilization toward activism around mental health issues.

Appendix. Los Angeles County Survey Outcomes by Campaign Exposure

Campaign Messages and Goals	NO campaign exposure (%)	YES campaign exposure (%)
Access to mental health care is a right	83	86
You have the power to change how our communities deal with mental health issues*	57	67
You plan to help break down barriers that keep people with mental health challenges from getting treatment*	54	71
People with mental health problems have trouble getting the treatment they need*	73	82
Young people who have mental health problems are being sent to jail instead of getting treatment*	49	66
Homelessness is a result of broken support systems for people with mental health problems	66	74
It should be easy and affordable for people with mental health problems to get treatment	86	84
If you needed help with a mental health problem you would know how to get it*	55	65
Schools need to do more to support mental health and well-being	84	87

Mental Illness Attitudes, Beliefs, and Knowledge	NO campaign exposure (%)	YES campaign exposure (%)
People with mental illness experience high levels of prejudice and discrimination*	71	80
Would you try to hide your mental health problem from family or friends?	44	51
Would you try to hide your mental health problem from co-workers or classmates?	73	66
[Willing to] move next door to someone who has a serious mental illness	66	70
[Willing to] spend an evening socializing with someone who has a serious mental illness	76	82
[Willing to] start working closely on a job or project with someone who has a serious mental illness*	73	84
A person with mental illness is a danger to others	19	23
I see people with mental illness as capable people	72	76
People with mental illness are able to do things as well as most other people	66	70
I am aware of the warning signs of mental health distress	63	72
I can recognize the signs that someone may be dealing with a mental health problem or crisis	61	70
I know how I could be supportive of people with a mental illness if I wanted to be	75	74

* Statistically significant difference ($p < 0.05$) between those exposed and not exposed to the campaign.

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