TIPPING POINT
COMMUNITY

# The Landscape of Mental Health Care and Needs

## Identifying Possible Areas for Tipping Point Investments to Improve Mental Health in the Bay Area

INTRODUCTION

# Mental Health and Poverty Alleviation

As a foundation focused on fighting poverty in the Bay Area, Tipping Point Community (Tipping Point) and its grantees are often grappling with the intersections of poverty and mental health. For over a decade, Tipping Point has supported grantee organizations to build the capacity to deliver high-quality, culturally appropriate mental health services to clients.

In the wake of the COVID-19 pandemic, and as the mental health landscape in the Bay Area has continued to evolve, Tipping Point considered whether to further invest in efforts focused specifically on improving mental health in the Bay Area as part of their mission to build community to advance the most promising poverty-fighting solutions.

Tipping Point engaged JSI Research & Training Institute, Inc. (JSI), to explore the landscape of mental health care and needs in the Bay Area, and to identify opportunities where future investment would improve mental health outcomes and thereby reduce poverty in the Bay Area.

This brief summarizes key findings of this exploration in an effort to share with the broader field of service providers, foundations, and nonprofit organizations working in poverty alleviation and mental health improvement.

## Sharing Insights with the Field

**Tipping Point and the research team's rationale for sharing what was learned includes:**

- **Behavioral health needs are surging and deeply linked with poverty.**
- **As other foundations and funders consider this issue, there is value in coordination and information-sharing.**
- **Mental health and poverty alleviation work is occurring in the context of many complex policy and funding changes. Amid this backdrop of change and uncertainty, there are opportunities to align efforts to maximize the impact of public funding.**
- **Importantly, we want to ensure that the learnings from the people who generously shared their time and expertise benefit the broader field.**

# Research Approach

In August 2021, Tipping Point engaged JSI to conduct a mental health landscape analysis in the Bay Area exploring how local philanthropy could improve the mental health system to better serve people experiencing poverty. The purpose of this research was to understand current mental health needs, systems, and strategies, and to identify interventions with the potential to leverage philanthropic funding to improve mental health in the Bay Area. JSI conducted extensive research in two phases:

## Phase 1

**August 2021 - November 2021**

### Landscape Analysis and Literature Scan

JSI conducted a landscape analysis of mental health funding and services in the six Bay Area counties where Tipping Point operates (San Francisco, Alameda, Marin, San Mateo, Santa Clara, and Contra Costa). JSI explored the following research questions:

1. **Where are the gaps in the provision of mental health care in the Bay Area?**
2. **How is the mental health funding and care system in the Bay Area currently organized?**
3. **What policy levers drive the organization and delivery of mental health care in the Bay Area?**
4. **How could philanthropic dollars make an impact on the delivery of mental health care or mental health outcomes in the Bay Area?**

JSI conducted a literature scan to understand funding streams, as well as county-specific health system metrics, followed by a series of interviews with leaders in mental health in the Bay Area. The research identified five promising areas for future exploration: specific subpopulations, workforce and continuum of care, prevention and early intervention, helping health systems achieve outcomes, and regional collaboration.

## Phase 2

**August 2022 - March 2023**

### Interviews with Experts, Identification of Gaps in Care and Systems, and Assessment of Potential Interventions

To develop a set of potential interventions for Tipping Point to invest in, JSI conducted interviews with subject matter experts, providers, and leaders in mental health in the Bay Area. This approach built on the Phase 1 research, and elevated new insights and needs based on policy and practice changes and the current conditions in communities. JSI also engaged people with lived experience to share their expertise through interviews, focus groups, and a survey.[1]

Through this initial research, JSI identified gaps in mental health care and systems and developed a broad set of 22 possible interventions for potential philanthropic investment. JSI and Tipping Point collaborated to refine interventions, consider their feasibility, and understand their alignment with Tipping Point's current work and strategic direction. Part of this process included an assessment of the current funding and policy landscape, and how the potential areas of intervention might complement or overlap with existing funding streams. Using this approach, Tipping Point and JSI narrowed the list of possible investment areas to three main interventions (described later in this brief).

[1] For the purposes of this effort, "lived experience" was defined as "experience with a mental health condition, being unstably housed, using/applying for Medi-Cal, and/or poverty (or being the family member of someone who meets this criteria)."

# Findings

**Vital mental health services are out of reach for many Californians, with disparities and affordability being major factors.**

There is a pressing need for comprehensive mental health resources, interventions, and systems-level change in California.

According to data from 2019, nearly one in seven adults in California experienced mental illness, while one in 26 dealt with a serious mental illness.[2] In 2019, approximately two-thirds of adults with mental illness and two-thirds of adolescents with major depressive episodes did not receive treatment.

The COVID-19 pandemic brought about further strain on mental health, exacerbating pre-existing challenges. Data from the peak of the pandemic show significant gaps in the need for care, and trends suggest that these gaps have worsened post-pandemic.[3]

Multiple surveys indicated a significant increase in adverse mental health conditions, substance use, and suicidal ideation during the pandemic.[4] However, the pandemic's toll on mental health was not evenly distributed. Low-income Californians, in particular, reported a deterioration in their mental and emotional well-being as a direct result of the pandemic's impact. Meanwhile, individuals who identified as Black and Latinx were more likely to report symptoms of anxiety or depression.[5]

These figures reflect significant gaps in accessing mental health services, with various barriers preventing individuals from receiving the care they needed.

**In 2019**

**1 in 7 adults** in California experienced mental illness[2]

**1 in 26** dealt with a serious mental illness[3]

**2 out of 3 of adults** with mental illness and adolescents with major depressive episodes did not receive treatment[4]

**More than 1 in 3 of the 1.5 million California adults** who did not receive necessary mental health care named cost as the primary reason[6]

One crucial barrier is the unaffordability of mental health services; in 2019, more than one in three of the 1.5 million California adults who did not receive necessary mental health care cited cost as the primary reason.[6]

Disparities in access were also evident among Native Hawaiian/Pacific Islanders, Asians, American Indians/Alaska Natives, African Americans, Latinos, and those identifying with multiple races.[7] Noncitizens and individuals with limited or no English proficiency faced significant challenges, with a substantial portion experiencing unmet needs for mental health services.[8] Taken together, it is clear that vital and needed mental health services were out of reach for many Californians.

[2] Holt, W. (2022, July). Mental Health in California 2022: Waiting for Care. California Health Care Foundation. [3] Vahratian, A., Blumberg, S. J., Terlizzi, E. P., & Schiller, J. S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic — United States, August 2020–February 2021. MMWR. Morbidity and Mortality Weekly Report, 70(13), 490–494. [4] Holt, W. (2022, July). Mental Health in California 2022: Waiting for Care. California Health Care Foundation. [5] Finocchio, L., Newman, M., Paci, J., Davis, C., Yegian, J., & Connolly, K. (2021, September). Regional Markets Almanac, 2020: Cross-Site Analysis — Medi-Cal Behavioral Health Services: Exceeds Supply Despite Expansions. California Health Care Almanac. [6] (n.d.). Adults Reporting Unmet Need for Mental Health Treatment in the Past Year Because of Cost. KFF. Retrieved July 6, 2023. [7] (n.d.). Mental Health Care in California: Inequities Persist. California Pan-Ethnic Health Network. Retrieved July 6, 2023. [8] Torralba, E. (2020, June 25). Nearly 2 million California adults don't get needed mental health care. UCLA Newsroom (University of California - Los Angeles). Retrieved July 6, 2023.

Addressing systemic challenges in mental health care is crucial. California's current payment systems and financing models are misaligned with the actual needs of individuals, hindering the delivery of quality care.[9] Compliance-driven reporting requirements and excessive paperwork place an undue burden on providers, diverting resources and time from delivering person-centered care and contributing to provider burnout.

### Poverty is both a cause and consequence of mental health problems.

The relationship between poverty and mental health is complex. Research indicates a bi-directional causal relationship, where poverty both contributes to mental health problems and is a consequence of poor mental health.[10,11] Poverty's social stressors, stigma, and trauma play a role in worsening mental health conditions. Conversely, mental health problems can perpetuate poverty through employment loss, underemployment, and strained social relationships.

Economic inequality further exacerbates mental health disparities.[12] Area-level income inequality was associated with a range of negative mental health outcomes, including depression, poor self-reported mental health, drug overdose deaths, incidence of schizophrenia, child mental health problems, juvenile homicides, and adverse child educational outcomes.

### The funding landscape is evolving, with billions in new government funding pouring into the mental health system.

At the time of this research, billions of state and federal dollars were beginning to pour into the mental health system through landmark policy changes and initiatives like California Advancing and Innovating Medi-Cal (CalAIM), the Children and Youth Behavioral Health Initiative (CYBHI), the California Governor's budget allocations, the 988 Suicide and Crisis Lifeline, and others.[13, 14, 15, 16]

The scale of these investments is exponentially larger than what most philanthropic organizations could consider investing, and the impacts of these funding streams, as well as what gaps might remain, are yet to be seen. For example, just the Children and Youth Behavioral Health Initiative accounts for $4.5 billion in funding from 2021-22 through 2026-27.[17]

> **"Our money is meant to ensure that the people who are most impacted, have the best opportunity … to be involved on the ground floor of design of the systems, and have the opportunity to infuse the design with their wisdom and experience about how it plays out in the real world."**
>
> *— California grantmaker*

In this environment, it can be difficult to understand and react to evolving investment needs. There are likely no "bite-sized" opportunities for making transformational change in this landscape, but there are some areas where philanthropic investment could make an impact. Investing in convening funders, elevating the voices of individuals who are most impacted by changes in the mental health system, and coordinating and aligning existing public funding are all places where philanthropy could invest to help state and federal dollars make the greatest possible impact.

[9] Mulkey, M., Bindman, A., Kronick, R., & Lucia, L. (2020). An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California. Healthy California for All. [10]Ridley, M., Rao, G., Schilbach, F., & Patel, V. (2020). Poverty, depression, and anxiety: Causal evidence and mechanisms. Science, 370(6522). [11]Knifton, L., & Inglis, G. (2020). Poverty and mental health: Policy, practice and research implications. BJ Psych Bulletin, 44, 193-196. [12]Simon, K., & Beder, M. (2018, June 29). Addressing Poverty and Mental Illness. Psychiatric Times. [13](n.d.). CalAIM: Our Journey to a Healthier California for All. DHCS. [14](n.d.). Children and Youth Behavioral Health Initiative. DHCS. Retrieved July 6, 2023. [15]Ghaly, M., & Baass, M. (2023, January 10). 2023-23 Governor's Budget. DHCS. [16](n.d.). 988 Suicide & Crisis Lifeline. SAMHSA. [17](2023, February 28). Overview of Major Recent Behavioral Health Initiatives. Legislative Analyst's Office.

# Opportunities for Philanthropy to Have Impact

Three key areas for potential investment were elevated as areas of great need that are appropriate for philanthropic funding and aligned with the mission and capabilities of a foundation like Tipping Point:

1. Peer Support Specialist (PSS) training programs;
2. community-rooted models; and
3. support for organizational capacity building.

## Investment Area 1

### Fund High-Quality Training for Peer Support Specialists

Peer support was one of the most commonly elevated solutions to the mental health crisis in California. Peer support specialists (PSS) hold promise for addressing many of the issues Californians seeking mental health support face, including a mental health workforce shortage, pervasive stigma from mental health providers, and a need for lower-threshold services.

The California Mental Health Services Authority defines a peer as "someone who self-identifies as having experience with the process of recovery from a mental illness or substance use disorder, either as a consumer of these services or as the parent, caregiver, or family member of a consumer."[18] Peer support services are defined by the California Department of Health Care Services (DHCS) as "culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals."[19] Peer support services are delivered by peer support specialists.

Recent policy changes by DHCS have created a certification process for PSSs to allow their services to be reimbursed by Medi-Cal.[20] Though many people have been providing peer support services for years, the new benefit creates the opportunity for PSS work to be paid for through Medi-Cal. This step from DHCS recognizes the significant and growing evidence base supporting the effectiveness of peer providers in improving various mental health outcomes, and creates a sustainable funding mechanism.

The California Mental Health Services Authority (CalMHSA) operates a State-approved PSS Certification Program to support consistency statewide. CalMHSA-approved training programs saw a massive increase in demand with the rollout of the peer support specialist certification.

One interviewee from a PSS training program reported that their staff has doubled and their cohort sizes have quadrupled since the launch of the peer support specialist certification requirement, resulting in around 360 certified peers trained per year vs. 45 per year previously, a 700% increase.

While this new Medi-Cal benefit presents an opportunity for PSS to receive reimbursement for their valuable work, it is not without barriers. There are costs associated with the training and certification process and there is often no job placement support embedded into the training programs. Also, many organizations forgo reimbursement through Medi-Cal due to the administrative burden billing poses or the insufficient reimbursement rates. Additionally, not all training programs are created equally. One interviewee emphasized the importance of peer leadership at training organizations and input from peers in curriculum development.

### Role Philanthropy Can Play

**Foundations and funders can help expand the reach of PSS by funding existing training programs with peer-developed curriculums to certify peers across Bay Area counties and support them in their journey in entering the workforce and advancing in their careers.**[3]

[18](2023, May 10). Medi-Cal Peer Support Services Specialist Program - Frequently Asked Questions. DHCS. [19](2021, December 10). Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Medically Need. DHCS. [20](2023, May 3). Medi-Cal Peer Support Services. DHCS. Retrieved July 6, 2023.

## Investment Area 2

### Support Community-Rooted Models, Especially for People Who Have Been Marginalized

**For the purposes of this research, community-rooted (or community-based) models are loosely defined as interventions and programs that:**

1. **May be tailored for specific populations (e.g., immigrant or refugee communities, trans individuals, specific racial or ethnic groups, etc.)**
2. **May be delivered in non-healthcare, non-clinical settings**
3. **Are usually not reimbursed by Medi-Cal. These types of models may also be known as community-defined practices (CDPs) or community-defined evidence practices (CDEPs).[23]**

People interviewed for the purposes of this research often raised the importance of community-rooted models for supporting mental health, particularly for groups who have been marginalized and who the current system does not serve well. There is a significant need for models "beyond clinic walls" that support wellbeing, destigmatize mental illness, foster connection, and use culturally meaningful practices. These models are particularly important in light of stigma and reluctance to see a "white coat" clinician.

It is well established that communities of color are less likely to receive needed mental health care services, and that they may be unserved, underserved or inappropriately served.[21,22] Communities of color and other marginalized groups face barriers to mental health care, including insurance access, stigma, language barriers, distrust in public governmental systems due to historic and present-day mistreatment, and a lack of providers who reflect their racial, ethnic, and cultural identities.

These models are often less treatment-focused and respond to systems and environments. Importantly, community-rooted models tend to acknowledge the reality of living through extremely stressful conditions and systems of oppression, such as racism, discrimination, poverty, displacement, social isolation, and violence. Providers of these models may include traditional healers, peers, community health workers (CHWs), and promotors.

Examples of community-rooted models include:

- **Support groups and healing circles (sometimes with a focus on cooking, gardening, or another communal activity)**
- **Community gardens for elderly immigrant communities to combat social isolation**
- **Bilingual/bicultural outreach workers**
- **Mental health apps for youth focused on movement, relaxation, mindfulness, and regulation**
- **Drumming circles and elders groups (e.g., at Indigenous and Native American organizations)**

[21] McGuire, T., & Miranda, J. (2008). Racial and Ethnic Disparities in Mental Health Care: Evidence and Policy Implications. Health Affairs.
[22] (n.d.). Racial/Ethnic Differences in Mental Health Service Use among Adults. SAMHSA.
[23] (2021, April 21). Concept Paper: Policy Options for Community-Defined Evidence Practices (CDEPS). California Pan-Ethnic Health Network.

Target populations for community-rooted models vary by local needs and should be thoughtfully tailored. People we interviewed identified the following as priority populations for community models: Black and African American communities; Asian American & Pacific Islander (AAPI) communities; Latino communities; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ+) individuals (particularly trans People of Color); pregnant people; and youth. Because of their inherent community focus and being tailored to specific populations, these models have the potential to alleviate inequities and disparities commonly observed in the mental health system.

Primary public funding sources for community-rooted models in California include the Mental Health Services Act (MHSA), the California Reducing Disparities Project (CRDP), and the Children and Youth Behavioral Health Initiative (CYBHI).[25, 26, 27] These funding sources are discretionary and do not represent sustained or guaranteed resources. Otherwise, there are limited funding sources for community-rooted models with private and philanthropic funding comprising a small portion of piecemeal funding.

Community-rooted models use a variety of measures to assess impact (e.g., quality of life, mood, access to resources, crisis situations) and cultural meaning (e.g., community connection, cultural knowledge and pride). In order for community-rooted models to be scaled, some people who were interviewed expressed a need for proof of concept and increasing evidence of impact to align with rigorous evidence requirements that are commonly needed for public program reimbursement (like Medi-Cal).

"A healing practice that has been used for centuries or even millennia is also a reasonable example of empirical evidence. For example, Native Americans were practicing population health, cognitive behavioral therapy, and group therapy (talking circles) for hundreds of years before it was discovered by Western medical model practitioners. CDEPs in BIPOC and LGBTQ+ communities are part of their very culture, history, values, and teachings."

*— California Pan Ethnic Health Network on Policy Options for Community-Defined Evidence Practices and the California Reducing Disparities Project[23] notes:*

However, people we interviewed cautioned that community-rooted models should not be held to the existing standards for clinical models as they are inherently and purposefully unique from these approaches. Importantly, funders and foundations can play an influential role in supporting community-rooted models by accepting and spreading a more expansive view of what counts as evidence and influencing public programs like Medi-Cal to support grassroots groups and CBOs that are implementing CDEPs.

## Role Philanthropy Can Play

**Investing in community-rooted models can support culturally competent care that supports well-being, destigmatizes mental illness, fosters connection, and uses culturally meaningful practices.Foundations and funders can also endorse a more expansive view of what counts as evidence and influencing public programs to support grassroots groups and community-based organizations.**

[24]As defined by the National Latino Behavioral Health Association, CDPs or CDEPs are "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."(n.d.). Addressing Disparities in Behavioral Health for Communities of Color: The Community Defined Evidence Project (CDEP). National Latino Behavorial Health Association. [25](2023, May 31). Mental Health Services Act. DHCS. [26]CRDP's five priority populations are: African Americans/Black, Asians and Pacific Islanders (API). Latinx, Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ+), and Native Americans). [27](2023, July 6). Evidence-Based and Community-Defined Evidence Practices Grants. DHCS.

## Investment Area 3

### Support Capacity Building for Community-Based Organizations

Community-based and peer-led organizations that deliver mental health services need support for internal capacity building and infrastructure that is not covered through reimbursable services or existing contracts. This includes support with Medi-Cal billing, training, and infrastructure; data and IT system development, management, and maintenance; staff training on diversity, equity, and inclusion to support quality service provision to diverse populations; and staff leadership development to support retention and internal advancement.

Acquiring funding for these types of expenses has always been difficult for small organizations, but the need is particularly acute as CalAIM and other policy changes require enhancements to existing infrastructure. Supporting these organizations in becoming more effective and sustainable will protect vital mental health resources for communities and ensure they don't get left behind as the Medi-Cal landscape evolves.

Typically, these types of infrastructure costs are covered by grant support and organizational fundraising, with some additional support from MHSA or County funds. New state funding through CalAIM has the potential to be used for these types of investments, but there are restrictions around who can access it and what it can be used for.

Making significant investments in capacity building and infrastructure for community-based and peer-run organizations can help equip these organizations to be successful in the "brave new world for behavioral health."

Staff leadership training can support promotion from within, which supports retention and employee satisfaction. Retaining employees is particularly important in the context of the current behavioral health workforce crisis. Training peers to serve in leadership or operational roles can provide growth opportunities and career pathways for peers, supporting living wages and better care for individuals.

**"The behavioral health field is really suffering from lack of people interested in the field and leaving the field. So to be able to develop our own internal resources and teams... the more we invest in our staff, the more they want to invest back in us.**

**"[Our staff vacancy rate] keeps us from drawing down revenue. We have to do everything possible to recruit and retain and grow and develop [internally], because it's not happening externally."**

*— Leader from a community-based behavioral health care organization*

Employee retention and improved data and billing systems can also enable organizations to more effectively draw down funding from existing sources and access new funding through CalAIM, which leads to a more sustainable organization. Improved data collection and monitoring tools can support improvements in care, including the ability to focus on populations with inequitable access and disparate outcomes. Improved staff capacity and training could allow organizations to move into new service areas, increasing their revenue and their ability to meet the needs of the community. By better understanding who they are serving, and translating increased revenue into a broader range of services, organizations will be equipped to advance equity and provide care to those with the greatest unmet needs.

Though this type of support has the potential to create lasting, sustainable change at an organizational level, it may not lead to trans-formational change at a systems level. This type of funding may translate into sustainability for organizations that are already billing Medi-Cal but are not maximizing their billing or need additional support as CalAIM takes effect, or for organizations that are not currently billing Medi-Cal but would start doing so with some support. There are some organizations that would not translate this type of investment into sustainable funding because they will not bill Medi-Cal regardless, if it does not make sense financially for them to do so given the level of infrastructure and compliance required.

> **"The more sophisticated and competent our staff, our outcomes increase, which makes us a lot more attractive to future funders, future contracts, and to be able to really advocate for the needs of the community. This is really about expanding our mission and doing it better, which is going to help the community, it's going to meet a greater proportion of the needs, and improve population health for those areas we're able to impact."**
>
> *– Leader from a community-based behavioral health care organization*

## Role Philanthropy Can Play

**Strengthening the capacity of community-based organizations can allow them to better retain and develop staff, enhance infrastructure, more effectively access and use funds, and move into new service areas, increasing their revenue and their ability to meet the needs of the community.**

## Investment Decision

In a time marked by large-scale investments and transformative changes in the mental health landscape in California, Tipping Point approached the prospect of investing in this space judiciously. The recent injection of over $4.4 billion by the state, combined with other public investments and new policies, are evidence of a shared desire to reform the mental health landscape in California. But the ecosystem needed to create change is a complicated one, ripe with complexities that go beyond the need for additional funding. It's a situation where the need for mental health services has outpaced availability and current systems are not set up to effectively impact the problem at scale.

**The recent infusion of over $4.4 billion by the state, combined with other public investments and new policies, have the potential to significantly reshape the mental health landscape in California.**

Addressing the mental health crisis requires transformational change across the healthcare continuum. And identifying interventions that can successfully operate within the current structure, scale to meet new and growing demands, and then become self-sustaining in the absence of ongoing philanthropic funding is difficult criteria to fill. It's a space that requires specialized knowledge and skills in effectively tackling the diverse range of challenges faced by individuals and communities.

This effort requires an expertise not supported by Tipping Point's existing strategies and one that would require an investment of time, intellectual capital, and staff. A separate mental health strategy could detract from current areas of work and would involve shifting funds from existing investments or taking on additional fundraising efforts to finance the new approach.

Balancing the potential benefits of investing in mental health against the potential drawbacks, Tipping Point's leadership concluded that current circumstances are not conducive to pursuing a separate mental health strategy alongside their current four investment areas (housing, early childhood, education, and employment).

Instead, they will continue to focus on building and deepening mental health capacity with current grantees, helping them take advantage of the opportunities this influx of funding brings to mental health service providers. Tipping Point will continue to leverage its model of finding and funding promising solutions by acting alongside other funders in California whose strategies and capabilities are better positioned to lead the efforts that will have transformative change in the mental health landscape.

## Closing

**Underlying this exploratory process were Tipping Point's awareness of the great unmet need for mental health care in the Bay Area, and their desire to be thoughtful about whether they could add value in the mental health space. They were aware of the risks of duplicating existing efforts or even causing harm by stepping into this area of work.**

**Though Tipping Point ultimately decided that they are not well-positioned to make new investments in mental health in the current environment, they will continue to monitor new policies and funding streams impacting the mental health space, as well as new areas of need and opportunity.**

# Appendix: Key Informants

We are grateful to the following individuals, and many others who wish to remain anonymous, for contributing their expertise to this work through interviews and surveys.

This work was also informed by individuals with lived experience who generously contributed their time and expertise through interviews, focus groups, and surveys.

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