Presentation by Ms. Ault:

Good morning. My name is Susan Ault and I’m director of children and family services for Ramsey County Human Services. Ramsey County is in St. Paul, which is here in the Twin Cities area. Ramsey County has been addressing racial disparities in child welfare for about four years now. We started an effort four years ago to begin looking at the issue and to engage communities of color. And for the last four years, we have been working in close partnership with five cultural consultants. They are leaders from cultural communities in Ramsey County and several of them are here today. Two of them will be on the panel and one of them is a facilitator.

One of the things we found is that community engagement and consumer involvement are two key things. And so I’m going to talk a little bit about how we let consumer involvement and community leadership drive what we’re doing and then how that interfaces with evidence-based practice. We’re really clear in Ramsey County that to take evidence-based practice as it is and apply it to a community isn’t really fair or respectful to that community.

First you need to talk to the community. So I’ll give you an example of how we did that and how we hooked it up with evidence-based practice and how we used another strategy that we learned from Casey Family Programs, called the PDSA – Plan, Do, Study and Act. And it’s a small-scale test of change. So rather than taking something and implementing it system-wide, we try it on a very small scale first. Try it with one family, have one worker do something, but that kind of small-scale change.

So, at any rate, our basic premise being that we wanted to come up with new strategies to prevent families from entering the child protection system in the first place, because that’s where our greatest disparities are. So we had focus groups with parents who are alumni of our system, and we talked to them about their experience in our system – what worked well, what didn’t work well for them, what helped them, what didn’t help them. But then we also asked them what could’ve kept you out of the system? And they told us some things about if only they had been able to access services, if only those services had been culturally specific, they would’ve availed themselves of those services prior to being referred to our system. And so we asked them what type of services those would be, and it gave us a lot of information. They talked about their difficulties with schools, and they knew those schools were the ones reporting them, and schools had issue with their child’s attendance in school. Those things were driving the families into the system and so they also talked about the importance of schools being more sensitive to them and their children.

So the next thing we did was to talk to one elementary school. (Now we’re on this theory of let’s try it small, let’s try it on one.) So we talked to one elementary school in a neighborhood that’s very diverse. It’s also very poor, and the school also has a high rate of reporting maltreatment, particularly neglect, because we believe we can divert neglect from the system. But once egregious
harm has happened or an injury of some type, that does require a system response. So we talked to
the school, and the school basically told us, “Yeah, we do report a lot of kids for child
maltreatment.” I encouraged that that wasn’t a bad thing necessarily, but let’s look at what that
really means. And so I asked them about their process. And their process is: you notice a family
who’s having difficulty; you know they need services, but you don’t know how to get services to
them. You don’t know how to talk to them about that so you put them under the microscope until
you get enough to report them to child protection because child protection will make something
happen. We will make them get services, and we’ll make sure the children are safe.
So I asked the school if they’d be willing to try something different. And they said they were. And
so about a year ago I placed one social worker in that elementary school.

I then wanted to think about has anyone ever done anything like this before. Is there any evidence
that this will work? Right now we’re operating on what parents told us they needed. And so I
began to think about things that I was aware of, and how things do happen - across my desk came a
document from the Center for the Study of Social Policy and Practice (Khatib Waheed is here today
from there). And they’d just published a lessons learned document on communities’ partnerships
for protecting children. The Edna McConnell Clark Foundation had been funding that work over
the last ten years in about 16 sites. And so as I began to look at that document, I began to recognize
what parents were telling us they needed. Now you have to remember that parents don’t really read
the literature and the research, they’re just telling us what they need in their lives and it matched up.

The major element of that strategy is an individualized response – meeting the family where they’re
at, finding out what they need and developing the case plan that’s driven by the family. Another
thing is a network of supports that one social worker or school social worker or whatever it is alone .
. . no one alone can really help a family to nurture their child and to keep those children safe. You
need a network of supports. And so we’ve begun convening a network of community-based
agencies in that neighborhood because we’re also trying to be very place-based with this because it
was about accessibility. So we’ve created that network, and the network really stepped forward and
it was a variety of different types of agencies – some service agencies. We also realized that we
needed to involve the housing code enforcement people because one of the things that happens to
people who live in poverty is they live in sub-standard housing and the housing deteriorates and
then the city comes in and condemns the housing and the family becomes homeless. And that’s
actually a scenario that happens pretty frequently for our families. And so we have people from the
city, the neighborhood, the district councils who have come together as a network of supports in
that neighborhood.

The other thing that’s important to this model is shared decision making. And that’s about the
community making decisions and about families making decisions. And things like family group
decision making, clearly another evidence-based practice that comes into play here.

The other part of the model is for the system itself to look at itself and how they do practice. That’s
a whole other piece of the work that we’re doing in Ramsey County, to look at what goes on within
our system. We’re looking at evidence-based practice there also, focusing on earlier kinship
searches, on using, with our families in the schools that I talked about, a program called
Strengthening Multi-Ethnic Families that has had wide application throughout the nation and is
particularly relevant to families of color. We’ve had great success with it with our families.
I have several handouts out on the table. There’s an overview of our work which I’m not really able to talk about today, that’s a whole half-day workshop. There’s information out there on strengthening multi-ethnic families, on community partnerships for protecting children, and there’s also information out there on a program here in Minnesota called Family Assessment, which was previously known as Alternative Response – you saw the slide in Dr. Wells’ presentation about that. These are all things that we are finding that as we implement these practices and as we take them to scale in our agency, we are beginning to see an impact on fewer, particularly African American, families having children in out-of-home placement. And so as we begin to talk with our families and look at what’s going on in the field, we really do see that you can bring those two pieces together and pretty effectively at that. Thank you.

Carl C. Bell introduces the next speaker, Harold Briggs.

Presentation by Professor Briggs:

Good morning, everyone. Listen, for the sake of brevity, what I’m going to do is to let you know that I’m on this panel to actually distinguish the use of EBPs, evidence based practices, from the process which is evidence-based practice from the standpoint of a process. I have a handout on the tables where you’re sitting. I would like for you to, as I point out these things, for you to follow along. I had an overhead projection experience that I was going to share with you, but environmentally I just can’t do that at this point so you just follow along with me and let me get to the point.

Some years ago, when I was in graduate school at University of Chicago, I had the fortune to train under Carl Bell in the field, and he was responsible actually for the application of this particular approach in the African American community with elderly people. What I’ll be talking about is the process that I’ve used in Chicago in child welfare, with the elderly, with people with developmental disabilities and mental illness issues, as well as the project that we’ve sponsored in St. Louis.

So on the first page, I offer you an alternative definition of evidence-based practice as a process based on the work of Eileen Gambrell, Leonard Gibbs and my instructors at the University of Chicago who taught me in the prototypes of the evidence-based practice process. Essentially, the process is different. The process essentially starts with the client’s values, wishes and expectations and it triggers the development of something called a COPES question – client-oriented practical evidence search. That question is used in order to run through electronic databases, and options are spewed out. Now these options come out very much like a physician’s PDR where there are strengths and there are limitations. The practitioner goes over the strengths and the limitations of each option, and the client is the one who vetoes or accepts the option based on the compatibility of the approach with who they are, how they live, and what they expect.

That’s totally different than evidence-based practices that does not allow for that component of informed consent. It doesn’t include research utilization, the search engine. It simply puts people in a program that has well-established research supports but, quite frankly, it doesn’t lend itself to three important domains. One being client collaboration, the second empowerment, and the third client self-determination, which we all know that to be his choice. So moving along, and I’m sorry to rush this, but I want to make sure that I get all the points in.
The two definitions I offer – evidence-based practice, the second one cultural competence. If you notice my definition of cultural competence, I suggest that we’re not only concerned with the acceptance of the difference from an individual perspective, but the cultural differences used as a basis to modify care, systems, and policies that address the unique needs of the person including social structural interventions to change communities and policies and practices that actually harm communities or really don’t contribute to this social justice. The definition of cultural competence that I offer here is one that allows you to engage in community building and infrastructure development while you’re seeking answers in supporting people in a personal way. In working with African Americans with respect to the child welfare, the juvenile justice and the mental health systems, we experience a high degree of disproportionality, racial discrimination, and a great deal of institutional racism that really gets in the way of us getting the types of effective care necessary. So in order to really establish change and to assist people in getting better we need to correct the social structure in which they’re operating. So let’s be very clear that we’re not working at the individual or interpersonal levels, we’re also looking at the organizational and systemic levels of practice.

So, on page 2, I offer a blended definition of evidence-based practice and cultural competence. And I call it evidence-based practice in the cultural context. It is a process that is instigated by the client’s expression of issues, values and expectations followed by the practitioner’s use of the best external evidence and clinical expertise. They [the practitioners] aid the client in choosing treatments based on their expectations and those that the client can readily infuse in their cultural social identities, practices and lifestyle, experiences that actually encourage the cultivation of resiliency.

Now the next slide, which says this is how EBT in a cultural context works was one that I went over two minutes ago when it begins with the COPES questions. It leads to the utilization of research in terms of electronic search engine. So you have the question, you have the database, then you have informed decision where you go over option “A” has a 90% chance of being effective, but it’s got some drawbacks; for example, assertive community treatment - if you use that, sometimes it requires a mandatory use of medication. Well, some people may not want to be medicated against their will. Another option could be, “Well, we’ve got reality therapy. We’re not exactly sure if that works or not,” but the client says, “That’s in line with where I want to go and who I am”. So in evidence-based practice is a process, do we select the one with the most established research supports? Or do we select the one compatible with the client’s wishes? Where do we go here? We go with the client. That being said, I suggest, based on my experience in Chicago, early experiences in Chicago and the work we’re doing in St. Louis, that we blend, that we synergize the EBP process in culturally specific care by initiating a few practice strategies, actually implementing a few practice strategies, beginning with validating and empowering the client to pursue their choices and values. This embraces the cultivating resiliencies seven stages that Carl has already discussed, and it allows for the incentives, the motivation, and the ideas that the client must put forward. It legitimizes them as a major player in the treatment process from the very beginning. We use the client’s perspective in order to form the COPES question as I said earlier. We incorporate those seven stages. I’m sorry; I guess I got ahead of my presentation.

The practitioner uses active listening of the client’s needs and tries to minimize their own bias not simply saying, “Well, you know, I know what these people need. If you give them all MST, they’ll be fine.” Well, no, in this model, quite frankly, and I need to stress this over and over again. In this model, the types of evidence that are available for review in sharing with the client may not all be
based on random controlled experiments. According to the User’s Guide to the Medical Dictionary 2002, there are a number of different types of research supports that could be drawn upon in order to address the client’s needs which means that we could use evidence from single case designs. Hello, did you hear me? I want to be clear that we’re not all using group designs in order to help my people.

Let me give you a methodological reason why you don’t want to do that. Have you heard of the ecological fallacy? That means going from a group explanation and saying that it fits the individual. These well-established, efficacious, research-supported group projects, quite frankly, are capable of being used in a way where people say, “Well, it’s effective, let’s try it with Mikey.” And quite frankly Mikey says, “Well, you know, I’m not going to do this” or he may not say, “I’m not going to do this.” He may just say, “I’m opting out.” And no one knows why. It’s because it didn’t connect with who Mikey saw himself as, and what Mikey does in terms of practices, in terms of healing, and health promotion and health maintenance.

So what we’re articulating here are a number of different strategies and tips that allow you to particularize and individualize your care in working with people. That you also, as you’re working at a personal level, do something at the agency and system level. Something called evidence-based management. Now, have you heard of that? We will have to come back with Susan about phase two of this conference. Evidence-based management does what Carl talks about in terms of leadership in management. It allows you to look at the culture of the environment as a place to be innovative, creative, and to experiment with different things. And if they work, keep them; and if they don’t, throw them out and start over. The point here is as you’re working in order to change behavior with clients and you’re considering their cultural context individually, you’re also considering the unique circumstances of the agency context in that you’re saying, “What works in this agency, or what do we need to include in this agency in order for this to work with these types of clients?”

So, again, you’re focusing on the research environment, the agency environment, cultivating a research culture as well as trying to test out, individually, the application of approaches that the client seems to think could work.

Thank you!

*Carl C. Bell introduces the next speaker, Professor Jacquelyn McCroskey.*

**Presentation by Professor McCroskey:**

Good morning! I’m going to try to talk really fast. First, I want to introduce the team from Los Angeles: Eric Marts, who’s from the Compton Project and I’m going to be talking more about that in just a minute; Harvey Kawasaki, who has a new job created in our Department of Children and Family Services as the director of the community-based support services; Angela Carter, who is deputy director for the Department; and for the purposes of today I’m claiming David Sanders even though he insists that he doesn't work in LA anymore, but he had a lot to do with the two things I
really want to talk about. Karen Bass, who, I guess, was unable to be here, who is just an extraordinary leader for families and particularly for child welfare services in our state assembly.

There are two things I want to draw your attention to: one is a handout in the folder on the Point of Engagement strategy which is basically our Department of Children and Family Services reform agenda, if you will, and the other is a handout on the table (out there) which I hope everybody will pick up. It’s called Healthier Communities, Stronger Families and Thriving Children Program. This is a very much hot-off-the-press idea – it’s our new prevention initiative in Los Angeles. It’s a non-service strategy. And I only say it that way because several people have said to me and wonder, “What do you mean a non-service strategy? What is that?” If you want to know, you’ll find out. I hope you’ll see in both of them the evidence base from the very beginning as well as the attempt to build in cultural competence in the biggest county in the country which has the most diverse population so you can never focus on one culture at a time by definition.

The other thing about LA is that LA is always different, we like it that way. So part of what we have to think about all the time is the sheer physical differences in our county, it’s 10 million people. We’ve divided our county into 8 regional areas, the smallest of our regions has a little less than half a million in population, the rest of them have over a million and some have two. It’s also a very mobile population, enormous recent immigration as well as over time immigration. By and large the cultural division of population is about 40% Latino, 40% white, about 11-12% Asian-Pacific Islander, and 8-9% African American. Although if you look at the child population, over 60% of the children are Latino, over two thirds of the births are Latino and if, you look at LA unified, 75% of the kids are Latino. So it’s pretty clear where it’s going.

Our department of children and family services, as you’ll see when you read both of these things, is working really hard and in a very serious way to transform itself. And it’s trying to transform itself - to be more family centered rather than child centered; to be a better partner, both with the other kind of government agencies and school districts, the other government agencies and with community-based groups, not just with CPOs but a very broad array of community-based groups. It’s trying to allow for more regional differences which is hard to do in a centrally administered system. It’s a continuous problem with us because you have everything from the high desert to Malibu to Compton, California in one county. All theoretically administered from downtown and allowing for regional differences is a very big part of this strategy, and empowering regional managers to be able to make those differences, and more preventive. DCFS is doing that, luckily, and the context of a county that’s trying to do the same thing and has been very seriously working at this for at least 20 years. We can talk a lot more about that if anybody wants to hear, but there’re a lot of partners in doing it. In some ways, actually, DCFS is late to the change process, it’s more advanced than some other places, but it benefits DCFS in a way in that their partner is ready to work with them and has been nudging them along for a long time – right, Dr. Sanders? - very calmly and kindly nudging.

I particularly want to talk about Point of Engagement and, as I said before, Eric Marts is the director of the Compton Project or the regional administrator of our Compton office or the Godfather of the idea of Point of Engagement. He’s been very, very active, along with a number of community-based organizations and agencies in the Compton area. Here is where I want to introduce, in addition, Patricia McKenna from Shields for Families, because Shields for Families is maybe one of the prototypical community-based agencies in LA County that is incredibly embedded in a local community, has a very broad range of services, a very broad range of partnerships, and has stepped
up very big time to help the Compton office in establishing a new office, establishing a new way of work and a new kind of partnership. It’s quite amazing actually. So what you have in the notebook is an initial study that Children and Families Research Consortium did looking at Point of Engagement and its implementation in two of our regional offices. Compton is the lead-off, but another nearby office that also services south-central LA, the Water Ridge Office. The Research Consortium is a consortium of the five universities in LA County that have graduate schools of social work. We have been working together with the department on training for about 15 years. About a year and a half ago, we established a consortium around research. I’m the research director [from University of Southern California], but the other schools that are involved are UCLA, Cal State LA, Cal State Long Beach, Cal State North Ridge. What we did to begin with, to look at Point of Engagement, because we’ve been hearing about it and sort of testing out the building blocks for a long time. They came together really in 2004 when the Compton office was set up. And the Compton staff, led by Eric, had the extraordinary opportunity to really do a door-to-door, kind of, in the Compton area of who are the people who are here, who care about children and families. Not just again the community-based organizations who want to contract with the department, but the groups that care about children and families. They also had the opportunity to ask staff who wanted to work in this office with the new philosophies. So they had many things going for them to begin with, not the least of which was Eric.

What POE does, to put it in a nutshell, it puts the strengths and needs of families and children at the center of the child welfare process. If that doesn’t sound different to you, you’re really lucky because over, our department was created in 1984, and over time we have pretty much looked at the system as the center of things. So we've looked at substantiation, we’ve looked at paperwork, we’ve looked at reporting, we’ve looked at case management, we’ve looked at case processing as sort of being the focal point around which you organize all of your activities. It doesn’t sound like it’s a big deal, but it’s a very big deal to put all of those things at the periphery and put children and families at the center. So what we did was talk to the frontline staff in these two offices and their community partners and engaged in an extended and very rich discussion about what it actually means for them to make this kind of transformation. And basically what they said was, “It changes everything. It changes everything from the moment I get to work in the morning to what I take home at night. It changes the needs for leadership and management, it changes the support systems needed, it changes my daily interactions, and most importantly, it changes my comfort talking to families, because I now,” one of the workers said, “I don’t have to worry about asking families what they need because I actually have something to offer.”

I want to tell you one story and then I will stop because I want to be respectful of the time. One of the workers told what I thought was a really moving story during this discussion. He said, “We got a call from the sheriff’s office on a drive-by shooting.” What happened was the mom was in the house making dinner, there was a child sitting on the front porch in a front porch swing and there was a drive-by shooting that mistakenly shot and killed a child on the front porch, an eleven-year-old. The family had five kids, and the police made a call to child abuse. This was a mom who was making dinner. The worker went out to the home and said, “I’m so sorry for your loss. If there’s anything I can do to help you. One of the things that you may see happening with your other children over time is they may be exhibiting symptoms of grief and loss that you don’t know what to do with. If that happens, please call me because I can put you in touch with people who can really help them.” She did call; he did put them in touch with people and at the culminating meeting, she said to him, “I just can’t thank you enough for your help. I don’t know what I would’ve done in this time of tragedy and loss.” And the worker’s comment to me was, “I’m not sure she even knew I
was from the Department of Children and Family Services. And that’s a really wonderful thing. POE allows me to do that and supports me in doing that.”

Carl C. Bell introduces the final speaker on this panel, Senator Patricia Torres Ray.

Presentation by Senator Torres Ray:

Good morning. It really is a privilege for me to be here. When I received this invitation from Dr. Wells, I thought extensively about what is it I could say to a group of friends, to a group of mentors, to a group of professionals that have done so much work in this area.

I came to this country 20 years ago, I am a case. I am a case because the people that embraced me and welcomed me to Minnesota were social workers. I came to this country from Colombia, South America, and I didn’t speak a word of English. Let me tell you, I’m a good case – I’m a senator today. And, very honestly, especially for those people who do not know me and people from out of state, I have to say that social workers who found me 20 years ago and gave me a hand and really taught me early about the importance of giving and the importance of serving in order to receive and in order to learn, was the best lesson that I’ve learned.

And so as I reflected about what could I really say to a group of researchers and practitioners that collectively have hundreds of years of experience of doing that for people and putting people like me in places like the senate. That was very challenging. What could I say to you about evidence-based practice within the context of cultural competency? I really had to think very, very hard. And I have to say to you, this has been my career for the last 20 years. Social work is what I’ve done. I learned from social workers at the very beginning about the need to work in social services and to really talk about cultural competency and disparities. That was the beginning of my career.

And I worked with Dr. Meyers, with Dr. Wells, with Dr. Wattenberg, with many people, with Dr. Sanders, and I learned a lot. And I could speak about some of those lessons, but I do not believe I am going to be saying anything new today. In fact, because you are in Minnesota you will be very nice to say, hmm, that was interesting. That’s what you will say when you go home. You know, you are in Minnesota – for those of you who are not from Minnesota, we’re very nice here. We don’t go out and say, “Oh well, I knew that, I’ve done that, what’s new about that?”

So I decided to talk about something that perhaps in my position today is relevant. I decided to extend an invitation to you today to do something about this. And that is, the implementation of evidence-based programs and practices requires funding and requires resources. And I want you to think about that very carefully. We can talk about evidence-based practices today, but if we don’t have the money to pay for those practices, then what? Then what is the point?

Let me tell you this, evidence-based practice within the context of cultural competency is expensive because it’s best practice, it’s quality practice. Dr. Briggs said, “Well what if I know, if I’m given the choice between something that works that is research based but my client doesn’t want it, I’ll go with the client.” Well, there goes your evidence-based practice. And you have to try it all over again.
So we talk about based practice, research-based practice. So as a legislator, I don’t believe that I can talk to you really about the work that I did with Dr. Meyers about the disparities. You know this better than I do. This is not new. I came here 20 years ago and people were talking about disparities and the need to implement culturally competent practice so that we can eliminate disparities.

Among this group, we are within the choir. Let me tell you, I talk to people in the senate in Minnesota, and when we talk about disparities, we have a long way to go. And we have done a lot of work in Minnesota. It goes back to the resources. It is not because of lack of work and commitment from the practitioners, it is not at all. It is that it requires a lot of work and a lot of resources. And when you really review the statistics and review the programs that we have in place today, what is most important to me is to realize that when we talk about children of color, predominantly African American, American Indian, and Latinos today, those infrastructures that serve children of color, those programs that are supposed to be there for children of color, those professionals that are serving children of color, simply do not have the resources to do what they know works best. Call it evidence-based research, practice, call it what you want, if you think about common sense only and just look at best practice, we simply do not have the resources that are necessary to serve these children.

Look at the buildings – if you really go and look at the buildings where we serve children, the hospitals, the foster homes where the children are placed, predominantly children of color, they are inadequate. I don’t want to blame anyone, but I just want to extend an invitation to you to really talk about what does it take, what does it really take, to serve children of color adequately? Do we need to do more research? Do we really, really need to continue working to make sure, to make absolutely sure, that what we do is evidence-based?

On top of that, social workers not only have to do that today, and this is my theory, this is a good group to talk about theory, my theory is that it is the market that drives much of this. Just like we talk in medicine about oh you really need to talk about evidence-based, this is all over, it’s not unique to our discipline, to the discipline of social work, but at the end of the day what we’re trying to do is save money. I said this from the policy perspective because that’s what we do. We’re trying to figure out how do we do the best thing for our children without spending money? I don’t think that that works.

And so, I want to invite people like you, I want to invite the choir, to really think about how do we advocate for resources that really can get us to the best practice, to the evidence-based practice? How do we give workers the flexibility to work with kids the way they know works? How do we really recruit, train social workers from those communities who have those life experiences? How do we do that? That requires money.

Let me tell you, I couldn’t be here, this is my case, I couldn’t be here if I hadn’t found my professors, if I hadn’t found Dr. Meyers and he was the one who said, “Patricia, why is it you don’t have your masters degree yet?” I said, “Well, you know, I really cannot afford to go to the University.” He said, “How come? You’re a professional.” I said, “Well, I think that’s the problem I don’t qualify for all of these programs at the University, so I can’t go.” And so he said, “Well, come and work with me. Become a fellow at the Roy Wilkins Center and you can do this.” And so this is the way many social workers and it would be great if the people in the state of Minnesota
could talk about how many social workers of color have graduated from the School of Social Work. OK? That’s evidence, that’s research based evidence practice. That’s culturally competent practice. How many social workers have graduated with scholarships from the University of Minnesota?

So, I just wanted to leave that with you. That I hope you can help us, those of us who really want to advocate for more resources for our children and I thank you for all the work that you do for our kids.

*Dr. Bell wraps up the panel discussion with a brief summary:*

We’re close on time. Just a few little comments from my side of life. I thought the presentation with Susan Ault was very interesting – a lot of synergy in the stuff that I’ve seen about community engagement as in the people doing our intervention with the Zulu people.

Harold, you raised some interesting questions as always, this notion of asking the individual, which practice do you want? I think if you had a . . . in the Zulu people of Durban, South Africa they’re the ones who developed the intervention. So I would think that they would choose that intervention. So I hear that if you’ve got evidence-based practices that have not been developed in a culturally sensitive context, absolutely, ask, ask, ask. If it has been developed from the people to be given back to the people, there’s probably less asking that you’ve got to do, but you’ve still got to ask. Although this issue of if it’s evidence-based and your client doesn’t want it - does that mean if a patient comes in with a heart attack and they want penicillin instead of nitroglycerin, I should give them penicillin? I don’t think it’s either/or, I think it’s both/and. But you raise a good point, but that’s a touchy one for me. Because I think you’re right, but I think you’re wrong, but I think you’re right, but I think you’re wrong. So it’s not either/or, it’s both/and.

As I listened to the LA presentation, I went back to Harold’s evidence-based management because it sounds like you guys have shifted your focus from your internal operations to what can we do to make ourselves more user-friendly, which I found absolutely fascinating.

And then in terms of Patricia Torres Ray and this whole issue of funding and resources, I harkened back to the political will and the effective system. How do you make it? . . . how do you execute? And you’re absolutely right, you’re absolutely right. If we don’t have the vehicle, what’s the point? So this was interesting.