

inSocialWork Podcast Series

Episode 91 - Dr. Shelley Craig and Dr. Brett Engle: Motivational Interviewing Implementation and Practitioner Skill Acquisition in an Agency Serving Sexual Minority Youth

[00:00:08] Welcome to living proof a podcast series of the University at Buffalo School of Social Work at www.socialwork.buffalo.edu. We're glad you could join us today. The series Living Proof examines social work research and practice that makes a difference in people's lives. I'm your host Adjoa Robinson and I'd like to take a moment to address you our regular listeners. We know you have enjoyed our podcast as evidenced by the more than 200000 downloads to date thanks to all. We'd like to know what value you may have found in the podcast. We'd like to hear from all of you practitioners researchers students but especially our listeners who are social work educators. How are you using the podcast in your classrooms. Just go to our Web site at www.socialwork.buffalo.edu/podcast and click on the contact us tab. Again thanks for listening. And we look forward to hearing from you. Welcome from the University at Buffalo School of Social Work. Did you know that winter's been canceled here in western New York. I'm looking out my sixth floor window here at the university. It's late February and there is not one flake of snow on the ground. Another illusion shattered. Hi I'm Peter Sobota.

[00:01:43] In this episode of our podcast series Dr. Shelley Craig and Brett Engle discuss the training and research study they conducted attempting to implement motivational interviewing and develop skill acquisition among staff members at an agency serving sexual minority youth in a very practical way Dr. Engle and Craig describe what they did in their project and why they chose the motivational interviewing approach for this vulnerable and at risk population. Doctors Craig and Engle describe how they adapted motivational interviewing skills to a strength base case management approach that was already in place at a particular agency based on their training and research study. Dr. Engle and Craig give voice to the unique needs of this population and how effective the application of this new approach was in assisting with those needs. In the latter part of our interview doctors Craig and Engle discuss the broader applications related to training and learning motivational interviewing based on their research. They conclude with the next steps and their wish list for further research with this population and with motivational interviewing applications Dr. Brett Engle Ph.D. is assistant professor at Barry University School of Social Work in Florida. His research interests include adolescent health risk behaviors the group modality process research utilizing discourse analysis and motivational interviewing and social learning theory based constructs of commitment language and other change talk. He is a member of the motivational interviewing network of trainers and is actively involved with the Association for the advancement of social work with groups. Dr. Shelley Craig Ph.D. is an assistant professor on the Faculty of Social Work at the University of Toronto Canada. Dr. Craig's research focuses on the Social Determinants of Health and Mental Health and the impact of the service delivery system on vulnerable populations. Her most recent work includes studying the efficacy of a health promotion program for minority youth involved with the criminal justice system. The HIV testing patterns of older Latinas HIV prevention for Latina transgender sex workers and the use of mental health services by urban gay lesbian bisexual and transgender youth.

[00:04:03] Both Dr. Craig and Dr. Engle bring extensive direct practice experience to add to their scholarly work. I'm Peter Sobota clinical assistant professor at the UB School of Social Work and I interviewed Drs. Craig and Engle by telephone a quick heads up before you listen to today's podcast. All of us refer to motivational interviewing in the shorthand of MI many times throughout the discussion with me today are Dr. Brett Engle and Dr. Shelley Craig. And they're here to discuss the research related to implementing their approach and building my skills and practitioners in an

agency setting specifically an agency that serves sexual minority youth. Thanks for joining us Brett and Shelley. Thank you for being here. Before I ask you to describe the specifics of your work I'm always interested in how to academics from different universities join forces. How did this happen. Brett and I actually went to school together in Miami and worked together for several years. So we're joining forces essentially by virtue of our similarity of some of the work that we've done and I think sort of a similar approach to work. So even though I am in Toronto now I'm still doing a significant amount of work in the South Florida area. So that's essentially how it can't shake each other and it it's kind of interesting because while we were at Florida International University either in the Ph.D. program and social welfare when that's the program we were in together. But during that whole time our research interests really did not really come together. Shelley has always had a more of a macro focus an infomercial told me about it.

[00:05:53] But and we're working specifically with the sexual minority population. And I have been much more coming from the clinical side and interested in health risk behaviors and also working with youth. So although we've known each other for a long time our research into it took us quite some time before we actually collaborated on the project. Actually you've kind of already addressed part of the next thing I was going to ask you. I was going to say I've looked at the title of the podcast and the work that you've done and I was going to ask you why MI and why sexual minority youth so why I've had an interest in motivational interviewing going back to oh about 2003 around the time that we both entered the Ph.D. program. So I've had kind of that focus. But it did take these many years I guess for us to see the application of MI with sexual minority youth and to see how it would be a natural fit. I'm sure we'll get into more of the details but I think I've seen it for a while in terms of this being something that would work with sexual minority youth because it is a very strength based approach that doesn't really emphasizes the non-judgemental and and is very much person centered. So I'm a big fan of MI for lots of populations but with a population that has been stigmatized as sexual minorities are I think MI particularly useful. Shelley would you like to speak to us. Sure. And I think it does represent I think MI sexual minorities in the ways that Brett described make sense.

[00:07:35] I know I have my direct practice experience has been around developing agencies and programs specifically for this population and it's still really I think an emerging area of both practice and research. And so when Brett and I were considering working together on this and whether or not it would make sense to fuse M-I with an intervention that I developed that is essentially a strength base case management for sexual minority youth. It really made sense because of the vulnerabilities of this population. Any intervention is essentially already strength based but for some of the youth that are significantly more isolated. The way the M-I I think helps develop trust and safety as well as move the adolescents to the next stage of development or meeting their identified goals. And I was really the way I think to really help the care coordinator for the case managers with particular clients that often were a little stuck which made sense by virtue of the significant risk factors that they were facing both from family school and in a variety of settings as well. So it really made sense that this would be a great addition to an existing program. Yeah. It does fit really well. It sounds like both of you have significant practice variance and you've kind of brought that together to inform your research. Okay thanks for the background. And I wonder now if we could get into it would you be willing now to start describing your work and tell us what you did. Yes of course so the way we started was to go into the this agency and train the care coordinators in motivational interviewing.

[00:09:30] So that was one of our tasks was really just to get them up to competency and we have some really nice measures to do that to be able to measure competency and my primarily the Mitie or the mighty the motivational interviewing treatment integrity coding system. So what does coding system does is allows us to measure an individual and interviewers MI skills by recording where you can do it live. It's nice to have a recording of the interviewer doing a. And sometimes it's

recommended to have up to like 20 minutes. But we've often done less than that where we can actually code essentially everything that the interviewer says. So there's two parts to the mighty. We have some global ratings of empathy and other in my spirit we call them concepts. And then there are these behavior count ratings where we actually code every specific utterance that the interviewer makes. So it roughly maps on to what a lot of folks may have heard others get familiar with their minds or are still open questions affirmations reflections and summaries not exactly the same but it roughly counts on that. So using the mighty was our big quantitative measure in terms of being able to do them pre and post test measuring of in this case the care coordinators MI skills. It wasn't the most rigorously designed style because it was again part of the intention of what we were doing was not just to do research but we wanted care coordinators to have the skills and so I've done several of these training research projects and they always kind of have this dual purpose where one thing is we really want the folks to have the skills. It's not just a research project.

[00:11:20] So one element of this study was to give them a pre-test. We had to do an interview very early on and then we measured their skills actually several times throughout the study. But toward the end we did it again and we just did a simple pre post test comparison on your skills Shelley do you want to chime in here. Sure I would of course agree with Brett. I think the the dual purpose is really important particularly when you're talking about community based agencies that don't have a lot of resources. So this is something that was offered just in kind essentially. And when you're talking about specifically vulnerable population so it's really practice based research. I think sort of participatory action framework but I think that that sort of larger approach that we had with something that was really important and that staffs case managers were the ones that were the target of this intervention certainly to develop their skills. And one of the things that I think that's really interesting and I know Brett started to was really talking about this the components of Am I really do map on nicely to strength's base case management which I talked about. But we've also just done essentially a qualitative just a qualitative in the same practice based research framework study in which we determine what of the youth who had been through this sort of motor. We have to think of a good term for it I guess with the strength base case management class M-I we were trying to identify which of the components were most beneficial to them and what was really important to them.

[00:13:01] And I think it just maps really nicely to that and MI approach because one of the things that the analysts who have been through the essentially graduates of the program they are one of the things that they found that was really important was this idea of sort of teaching how or advice giving that part of the intervention was something that was really important. And that is I think in the way that I understand MI of course Brett can correct me is an important component so Strache base case management in particular is a little bit more wide open. The individual determines what it is that they want to do and there isn't a lot of sort of directives hard or soft given to the participant. But for these youth who I think are particularly vulnerable they really liked the fact that they were guided. It was certainly the goals were what they determined were important in partnership with the case manager but they really liked that there's the teaching how are advice giving which I think is really something that M-I provides. And I think a really important way. So that was something I think that was really important and also the fact that they were able to gain confidence because of the trusting relationships with their case manager. And this I think is really part of the until that the relationship building and Brett addressed issues of empathy and really understanding where the young person is situated in terms of their personal context.

[00:14:39] So I think that that really I mean it's essentially just qualitative data at this point and it doesn't really look specifically at some of the identified outcomes but it does look at the relationship and I think the use of MI skills really was something that that really is I guess a really nice thing onto what was important for the adolescents that had graduated from the program and the three different things you just discussed. Those areas are qualities of their relationship with their

coordinators. Those were identified by the clients themselves by the clients themselves Yeah. So there are several levels to this research that we've done and one is this very quantitative pre post skill measure and my skill measurement of the care coordinators. Another one is what Shelley was just talking about this qualitative piece in which the clients themselves the youth describe how useful the services were to them and how and in what ways and instil another level was the care coordinators application of. So they started using the skills and then their kind of feedback to us about how the skills were useful to them and how they were utilizing them. And that's another kind of qualitative piece that was really that I think is one of the more well for me was one of the most interesting part of the whole project. Can you talk a little bit about what the what the care coordinators say about what they valued about the intervention. One of the things they were able to do was to have conversations and this actually shaped the training too because so the training went on it was over about six months. So as they were giving me feedback I was able to kind of tailor the training to what it was that they were experiencing.

[00:16:26] And one of the things that they were experiencing was something that Shelly was touching on which is that this service and this agency is not set up to you know this isn't substance abuse treatment. We're not there to address one specific issue. It's very open and it's really up to the clients to decide for themselves what they need. And we're there to help them with that. So in that way it requires some additional skill on the part of the care coordinators be able to figure out which behaviors are which in my terms we talk about targeted behaviors which targeted behaviour do we want to focus in on. And it's very important for it to be truly strength based to not be overly directive in that and to really bring it out of them so that kind of the trick was how do we help clients with what they want to be helped with. And at the same time address what we know to be some very serious health risk behaviors when those are there and so that was a really big trick right. Yes so that was one of the very interesting elements in terms of the qualitative piece is that they the care coordinators would come back and they would say well gosh I really want to ask them about going you know this one particular clan I want to ask them about going to see a gynecologist because she's 16 years old and has never been to a gynecologist before.

[00:17:40] So we start to utilise the MI skills to have these difficult conversations with the clients and that's always the tension with people who are warning and my isn't it at least in my experience is that usually the services are delivered by people who are knowledgeable and have experience and and really have a lot of good things to offer but to practice MI in the spirit that it's intended you really got to keep your mouth shut while you elicit and evoke from people what is important to them. Absolutely they like to refer to the writing reflex we want to tell them what to do and so a big part of MI I mean I always think in terms of it as much about what you don't do as what you do do so that's important you know there are a lot of those kinds of all of those lessons were definitely pertain to what we were doing here and even more because we're also we do talk about a menu of options in M-I and I think so one thing to keep in mind is that M-I has to be adapted to whatever setting you're in. So it may be a setting in which you really are going to talk about alcohol use and that's really what it's about and that's okay you can do that and you're just up front about that from the beginning. Or it may be upsetting much more like this one in which it's wide open and we just kind of have to be much more fluid and then looking for those target behaviors and once we see it though it's very important that we address it one that would come up for example was unprotected sex. If we hear a youth talking about engaging in risky sexual behaviors we do have an obligation to address that with them and I think MI allows us to do it in the most respectful way possible. It's curious to me because it sounds like the agency that you've implemented in was already fairly client centred to begin with. Do I have that right.

[00:19:32] Yes absolutely absolutely. Yeah because I was wondering not having a lot of experience with this myself in your experience what are the so-called typical or even maybe even preferred approaches that are utilized in agencies serving this population is a directive. Is it heavy handed or

is it more like the agency that you've implemented and where it's pretty client centered to begin it's really interesting actually because there aren't any evidence based on evidence informed programs for this population. So what that means is that there are actually very few independent agencies that serve this population in many cases there are programs that are part of the sort of larger array of programs that are offered to various populations within particularly within urban areas but so it's an interesting the way that services are delivered is fairly interesting and an issue and one of the challenges that sexual minority youth in most states it's very much state driven are not considered a vulnerable population. Just for those reasons because sexual orientation and gender identity are not identified as identifiable demographic areas so that it's a really interesting sort of cobbling approaches together is fairly interesting.

[00:21:02] So that said I would say that the agencies that are I would say independent and suited and really set up to serve the needs of this population again mostly found in urban areas and mostly not receiving much government funding are tend to be fairly client centred and I think part of that is because the history of these organisations is that often they're started by activists and so in that way the sort of that spirit carries through into the service delivery when the programs are offered in as sort of an adjunct or in addition to other programs that a larger organization is offering than they tend to be more directive and they tend to be focused more on almost like life skills approaches which is important. But I'm not entirely sure is at the core of what these adolescents always need. So it's an interesting. So this is essentially an attempt to provide some additional tools to clinicians who already have to be fairly flexible and nimble because the clients are all voluntary which is really interesting. And there is very little attrition in the program as well which again I think speaks to the sort of exceptional level of service delivery that these clinicians provide. But they also seem to be a sort of echo bread. They seem to be grateful to have another set of skills that they were able to use with clients when they needed to do so. So it's a very number of things that the youth identify that they need services is a significant range so many of them have been suicidal I would say over half has been homeless and you do have some who are looking specifically for help getting into college so they're not as high risk but a large majority of the population I would say sort of the standard risk profile is fairly high with sort of family rejection and lots of unsafe sexual behaviour is thought of. Unfortunately it's cutting some of those are issues as well.

[00:23:16] So as I said it becomes really important for the clinicians to be able to have both impressive levels of abilities to assess what's the most important and help work with the youth to identify what's the most important as well as really then provide the level of intervention because you have the same individual doing the assessment which I think is really important and delivering the entire intervention which again isn't always the case and some the larger agencies but I think it's critical because of the lack of safety and lack of trust that these adolescents typically have in service providers. So yeah and again for an outsiders view it seems to me that for example with the population you're describing that incorporating an MI approach would be a no brainer because of the collaborative white centers of vocative core values to begin with. So thank you for clarifying because I almost got the sense that you were attempting systemic and cultural change in an agency but because of agency and the population that you chose it sounds like you were building rather than trying to kind of promotes systemic change. Yes there was an easier sell in that way I suppose. Yeah I'm sure people who are listening to this are not I think always going to have the luxury of. I think the the the setting you chose to employ the SAT. And I think a lot of social workers are practitioners of all kinds are really trying to kind of bring an MI approach and implemented and build skills and practitioners in settings that are way too directive. And I'm wondering are there things that you learned that would give people insight into trying to implement what you're doing in agencies that might not be as receptive. Yeah that's very interesting because that's something I come across a lot.

[00:25:13] I come into this agency being very progressive and we might think of it as kind of a

constructivist type perspective that they have where approaches like narrative or solution focused or some of these others would fit very very nicely at the Alliance as well. But then M-I is a little bit more and I kind of think of it as being in the positivist tradition in that just in that it is directive with regard to when we identify a health risk behavior. We go after it whereas these more purely constructivist approaches are in a sense more truly even more truly person centered perhaps in that we're going where the person wants to go and I'm not going to try to take them in any particular direction. And so in my mind MI is actually again more in that positivist tradition in that at some point in time I the interviewer very well may identify something that's a concern to me and I think it's just a very you know how again I think of terms of health risk behavior. So I need to address it with him whereas the other approaches might not go there. So agencies have a similar kind of orientation and probably more often than not they're coming from. Well it's very hard to say but very often agency didn't come from the perspective. I can say and I can say OK I know a lot of very progressive agencies as well that a lot of agencies do come from this perspective of like no we're here to stop this problem. And so they are very directive in that regard.

[00:26:53] And so we will kind of come in with more of this constructivist perspective saying well you know we really need to meet the clients where they're at and if they don't want to change then that's not going to happen. So oftentimes I'm coming from that perspective but at the alliance I was actually coming from or the other perspective saying well you know when we see health risk behaviors we got to we need to address them. That is a very interesting dynamic coming into the culture of an agency. You really haven't addressed this. But as I listened to you describe what you've done you've really I think tapped into this whole kind of notion and ongoing development of how to think about this about how to train people to deliver M-I. And I think in my limited experience for example a lot of people will go to practitioners will go to a one or two day workshop and they'll get M-I 101 and then that's pretty much the end of it. It sounds like what you've done here in your intervention in your research is that you have moved in the direction that at least in my understanding Miller and Rolnick are moving into and kind of emphasizing the need for ongoing skill development over time with supervision and review. Does that make any sense. Yeah absolutely. I mean it's pretty well established within the network of trainers for example the meant that people in training research that's been done that it really does require ongoing practice and feedback to develop these skills and to usually utilize them with fidelity and unfortunately very often and in fact and more often than not people's exposure to M-I is much more in the workshop kind of format.

[00:28:37] There are very practical reasons for that and it takes considerably more resources or commitment to learning the approach if you have to put in an ongoing effort. But having said that it actually doesn't. I addressed this at a lot of training because people think that I think they overestimate what it's going to take to utilize and to learn this approach. We've actually implemented it at the FIU College of Medicine the last several years of first year medical students we're teaching it to them. It's always a big concern how well we don't have time but for the learner it actually doesn't take that much time. What they need to be able to do is to practice it so if you're working with clients and you want to learn this skill you can just do what you're doing. But if you can ideally record a session or over time several sessions with a client and then give it to a trainer who can then give you feedback. It doesn't take a lot of time but it is something that you need to do over time to allow for the person then to come back in and try it again and then get a little more feedback. And that sort of thing. And that was something that was to our advantage at the alliance because we did do it over. You know this first time around we did it over like six months which was a pretty good link. What do you think are the practical implications of the work you've done and that you're doing for social work practice for social work education or even more research. So I guess what I'm wondering is how you take the things that you learn by doing this and make broader applications for social work practice.

[00:30:14] Well I think that there are a few applications. One of the I think just fairly easy take away messages is that I believe that M-I can certainly work with other types of interventions which I know is what some of the other research says to enhance perhaps the uptake of both interventions and to really it can really map on to the needs of particularly vulnerable populations where there perhaps aren't as many interventions or there is an intimate as much research that has been conducted so that I think is really helpful in terms of thinking about the fact that it could that absolutely this and MI framework can be something that is can lead to additional sort of culturally competent practice with sexual minority youth. So I think that is one. It's my understanding and Brett would be able to correct me of course as usual but that perhaps M-I has not been used as much. With populations that are the most extreme or the ones who are perhaps involuntary or in many cases completely outside the safety net of services that adolescents are often in. And so I think that that for me is really helpful. And I think in terms of social work education it could be really helpful. And I know that we're all sort of fueling this but I'm certainly in my classes now building in M-I even though it's just one or two day training.

[00:31:52] But building an MI to help increase the student competence with regard to the utilization of this framework and really helping them realize how important the relationship and the relationship building is in addition to the strength based approach which in some cases is not is counter to some of the other things that we tend to teach in social work education. So I think it's very progressive. And with regard to research I think one of our next steps and I know we've discussed this is really then we've identified the components of the relationship that are developed through M-I that are very important to the sexual minorities. Actually sort of staying in and engaging fully in case management and the next step will then also be looking at some of those health outcomes and case planning goals and determining how MI has been impacted their completion of their care plan and the fact that they've met their goals and decrease the negative health risk behaviors as well as increasing positive behavior. So those are some ways that we've sort of been thinking about it but I know there's probably quite a few more. What do you think Brett. I think that's very well said and you talk about the relationship component of that care coordinators and their clients as well identified as being useful. I think that very much maps onto the whole approach I mean it's there there is this relational component to MI and then another part of it which is the more directive piece looking at health outcomes. So yeah I think that's I think that's exactly right. And in terms of contributing to research or referred for further research. One area in the literature that I think is somewhat underdeveloped is is a bit of creativity and identifying target behaviors or health risk behaviors.

[00:33:47] I think it's just something that is usually kind of set up for us or a research project to kind of go in with a target behavior already identified or at least a range of target behaviors and related ones. Because I've never heard of using MI to encourage you to go to the gynecologist for example that I mentioned earlier or to talk to a youth about them chatting online with say you have a 13 or 14 year old adolescent who is chatting online with a 30 year old male and like some of the risks associated with that. For most of us adults we kind of like alarm bells kind of go off but for a sexual minority youth they may have pretty compelling reasons for engaging in something like that. And so from my perspective this is a risky behavior and I would want to be able to have a conversation and try to guide the adolescent and encourage them essentially to try to have a conversation where they start to recognize whatever the risks may be of doing that. Can I say one more thing. Sure. I also think Brett it's very interesting. Of course everything you say is very interesting but it's very interesting because I really think the idea of and you discussed how M-I is typically used to address risk behaviours which is something I see that's critical for many populations. But within the larger sort of world of sexual minority youth research and practice there is sort of an ongoing discussion about not mythologizing is you just thinking about the risk behaviors. There's been a big push for resiliency based research too.

[00:35:33] And I'm sort of in the middle with regard to that because in fact is certainly with regard to the youth that we are working with which arm the majority Latino Haitian youth in particular there are a lot of significant risk behaviors that we can't pretend don't exist. MI. It's great that. But it is really interesting to think about the way that perhaps MI could impact positive behaviors. In addition some of the Schrader's like self efficacy in some of these making healthy choices. I think it would be interesting to look at both of those in the same study with the same adolescents to see how MI then can impact both negative and positive behaviors. And they think that also then maps has the sort of larger issue certainly we don't want to stigmatize an already stigmatized population but we want to provide interventions that are in many cases strength space and a balance of which is actually very challenging but a balance of addressing needs both negative risk behaviors as well as enhancing the strength that these youth already have. I mean there are still alive. So they're very strong. So it's a really interesting I think that that would be super interesting. Yeah I mean and it's nice to whenever possible address positive behaviors you know I mentioned before like going to college. You know so. And we certainly can use MI skills to encourage positive behaviors I guess and it's really hard in describing it at least I don't I don't think convey or give justice to what the approach actually looks like in practice because even though we're kind of revealing what the social worker or the interviewers kind of they're all teary or motive here which is to work on the decreases risk behavior they're doing it in the most respectful positive way strength based way possible.

[00:37:30] So any time an adolescent mentioned something about well you know what I really want to do is go to college and study to become an engineer or you know whatever they want to do. We're always taking that information. So that strength that the client expresses is something that we're constantly we're very closely attending to and reinforcing. And so when you hear it or watch a motivational interview that's what you see. And so it looks and in fact is very strength based. It's just that there is part of the underlying purpose is to guide the person and away from something that is actually at odds with. We call it like developing discrepancy with who this person is and who they want to become. Usually these health risk behaviors are at odds with that. And so we really want to develop that discrepancy and building on their strengths is a major way in which we do that. That was very well said. My understanding is that what really characterizes MI approach directives from an all knowing all wise clinician and so I'm glad you highlighted that because we have some people probably who might not be that familiar with these kind of core concepts of that nature. I think we're kind of getting near the end here. Are there things that you either of you would like to add.

[00:38:54] Well I would just touch on actually another topic Shelley touch on which is about this idea and I know any of us in social work education getting familiar now with this competency based standards from the council in social work education and that we're having to revamp our curricula to reflect that we are indeed increasing social work students competencies and various competencies. And I do find and as we're going through that process ourselves here at Barry University School of Social Work we are looking at and beginning to utilize some of the M-I measures like the mighty because it is something that we can have a student do a role play or in some cases even record a session with a client and then we can actually measure whether or not this person is utilizing the skills or not. And that pretty big difference from any kind of self report. Oh I think I'm yeah I do the skill really well which we know those measures are problematic or knowledge. Having them take a test and being able to describe the concepts those are very different measures from actually doing it and that we now have some tools that can validly support that this person is in fact utilizing the skills is kind of an exciting thing for a social work education. Well thank you both so much for sharing your ideas and your work with our listeners. I also just wanted to comment on something you said earlier in your discussion Brett you describe your work is in some ways not so rigorous but I kind of smiled myself because as I listen you your work and your work and yours and. You have research to practice and practice to research all in the same project. And I think that's really where it's at. And if that's not rigorous that's OK. I think it's still

extraordinarily valuable and really kind of the thing that I know we're trying to promote in our projects.

[00:40:59] So I just wanted to say that just as somebody was listening to both of you talk thank you so much. Thank you very much for the opportunity. Maybe we'll just redefine the regress. Good. Yes very good. All right. Thank you so much. Great. Thank you so much. You've been listening to Dr. Shelley Craig and Brett Engle discuss implementing motivational interviewing skills at an agency serving sexual minority youth. I'm living proof. Hi I'm Nancy Smyth. Professor and dean at the University at Buffalo School of Social Work. Thanks for listening to our podcast. For more information about who we are our history our programs and what we do we invite you to visit our website at www.socialwork.buffalo.edu. At UB we are living proof that social work makes a difference in people's lives.