Child Risk and Parental Resistance:

Can Motivational Interviewing Improve the Practice of Child and Family Social Workers in Working with Parental Alcohol Misuse?

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1. Introduction

Parental alcohol misuse is an area that is extremely difficult to research, and therefore all estimates of the numbers affected have a large margin for error. Alcohol Concern suggest that around 900,000 children, or 9% of all children in England and Wales, live with a parent with a serious alcohol problem (Brisby et al, 1997). Furthermore, there are strong grounds for believing that the extent of the problem and its impact on children is likely to increase. Younger women are drinking more, and in more problematic ways such as "binge" drinking (Alcohol Concern, 2004). These trends suggest the likelihood that more children will experience maternal alcohol misuse in utero, with the potential damage that can be associated with this. With women still undertaking the bulk of child care it also seems likely that more women with serious alcohol problems will be caring for children.

It would be surprising if these trends were not already beginning to have a significant impact on social services departments. There has been no national study undertaken into the extent and nature of parental substance misuse in social work cases. We are thus reliant upon local studies, in which variations over time and between areas make it difficult to draw firm conclusions on the national picture of alcohol misuse in social work caseloads. Most studies also conflate figures for drug and alcohol misuse into a proportion where "substance misuse" is identified. However, if evidence from a range of studies is considered two important findings emerge. Firstly, parental misuse of alcohol is widespread in social work caseloads. Incidence studies suggest that somewhere between a quarter and a third of cases going for allocation involve parental substance misuse (Cleaver et al, 1999), and that alcohol misuse is more common than drug misuse (Forrester and Harwin, forthcoming). Secondly, it is clear that the more serious the case the higher the proportion that involve substance misuse. Forrester and Harwin (forthcoming) found in four London authorities that while a quarter of child in need cases involved substance misuse, 40% of child protection registrations and 62% of care proceedings were substance misuse related. This broad pattern has been found in a range of other studies. Furthermore, recent research focussed on examining why there has been a significant increase in the number of care proceedings and care orders found that more cases involving substance misuse seemed to be an important factor (Statham et al, 2002).

There is a welter of evidence that misuse of alcohol by parents can be extremely harmful to children. It is associated with increased incidence of behavioural and emotional problems in childhood and adulthood (Velleman and Orford, 1999; Kroll and Taylor, 2002). At the extreme end – which social workers often deal with – there is also evidence that parental misuse of drugs or alcohol is over-represented in child deaths and serious abuse (Reder and Duncan, 1999). Retrospective studies of adults who are homeless, in prison or who have substance misuse problems themselves consistently find high proportions with parents who misuse drugs or alcohol.

Studies in which researchers have talked to children affected by parental misuse of drugs or alcohol report similar experiences (Bancroft et al, 2005; Velleman and Orford, 1999). Children describe unpredictability and emotional volatility, parental difficulties in prioritising the child's needs, violence and arguments within the home and a sense of shame and stigma. Alcohol misuse is strongly associated with violence within the home, primarily by men toward women though often also involving children (Cleaver et al, 1999).

However, the picture is not one of unmitigated gloom. Most children with a parent with an alcohol problem appear to go on to live happy and well adjusted adult lives (Velleman and Orford, 1999). The resilience and protective factors that allow children to achieve these positive outcomes have been considered extensively elsewhere

(Velleman and Orford, 1999; Newman and Blackburn, 2002). Key protective factors include having a parent in the household who does not misuse and substance misuse that is not associated with violence. Resilience factors include experiencing success outside the home and having social supports outside the family. These are important findings in providing a balanced appreciation of the rather alarming figures on the extent of the problem. Misuse of alcohol by parents places children at increased risk of serious harm. It does not follow that such harm is inevitable. Nonetheless, it is clear that children living with a parent who has an alcohol problem are at increased risk of poor outcomes.

How prepared are social workers for working with parental alcohol misuse?
The high proportion of cases involving alcohol misuse, and the strong evidence of the potential harm that can be associated with the issue, would suggest that working with parental alcohol misuse should be a key aspect of training for child and family social workers. Yet what evidence there is indicates that this is not the case.

The Social Care Institute for Excellence (2003) looked at training needs within a general review of services for alcohol, drugs and mental health problems in families. They found “little evidence of specific alcohol training” (pg 26) and noted a general lack of confidence amongst workers in dealing with parental substance misuse and mental health problems.

Harwin and Forrester (2002) examined training needs as reported in interviews and questionnaires with 89 social workers allocated to cases involving substance misuse in four London local authorities. Most of the workers (52%) reported that they had received "little" or "no" training in substance misuse on their social work courses. This is particularly concerning as the bulk of the workers were recently qualified. Furthermore, there had been little subsequent training to make good this deficit. If workers reported any training it was generally only basic drugs awareness. None of the workers reported having been taught particular methods for working with parents who misused alcohol. Furthermore, this serious training deficiency was not mitigated by specialist input from alcohol or drug misuse workers. At allocation 79% of cases did not have a substance misuse professional involved, and over the next two years most cases did not have specialist input at any point. This was more likely to be true in relation to alcohol misuse.

These factors contributed to social workers in this study often saying that they felt “stuck” in working with families. The most common reason given for this was that the parent was "denying" or "minimising" their alcohol misuse. This could lead to an impasse in work with a family, and a situation where workers were anxiously monitoring the situation and waiting for something to go wrong. A typical quote was:

> *“It’s difficult when they’re just in a denial. You find that you’re stagnant and you can’t do nothing. Because until they admit it, you could be pushing all the surfaces you can push. It doesn’t mean that it’s going to work”.* (Harwin and Forrester, 2002; pg 35)

Indeed, Forrester and Harwin go on to suggest that parental denial is extremely wide-spread in the interactions between child and family workers and parents who misuse drugs or alcohol and that its impact on the work is so great that they describe it as the “central organising principle” of work with substance misuse (Forrester and Harwin, forthcoming). By this they mean that the resistance and denial by parents shapes the nature of the social work intervention throughout, often leading to greater use of authority and legal interventions.

Kroll and Taylor (2002) reported on 40 interviews with workers from a range of agencies that dealt with parents who misused drugs or alcohol. They also found that "denial" was a central issue for workers. They expressed the difficulties thus:

> *"Secrecy and denial seemed central and pervasive characteristics of both the relationship between parents and children, and between parents and professionals. In some ways an atmosphere of secrecy and distrust in the home could often be mirrored in relationships between clients and workers. What appeared to emerge here was a problematic dynamic. Professionals were attempting to help, conscious that the first step in the process needed to be proper engagement. However, they were being viewed by parents as intrusive and potentially threatening, in terms of their child protection role. Although parents often seemed to want to sort things out, their natural fears frequently got in the way of real disclosure." (pg 221)*

"Denial" is clearly therefore an issue of central importance in this area. Indeed, "denial" may be considered to be one manifestation of a broader problem in engaging and working with non-cooperative parents. For the purposes of this report we will describe the full gamut of client non-cooperation as "resistance". This includes denial and minimisation, but would also cover aggression, non-communicativeness and any other aspect of non-cooperation.

These behaviours are not confined to clients who misuse alcohol, though they may be particularly important for working with this issue. Indeed, "resistance" is a common, perhaps even a ubiquitous, feature of social work practice in a wide range of settings. It is therefore likely that effective ways of understanding and working with resistance will be of more general applicability than just work with alcohol misuse.

In light of these considerations the current study explores the potential of motivational interviewing (MI) as an approach for social workers to use for parents with alcohol problems, but with an awareness that the approach may have wider applicability.

"Denial", resistance and motivational interviewing

Motivational interviewing was developed in response to problems of denial or minimisation in alcohol treatment (Miller and Rollnick, 2002). Crucially, however, in MI resistance is conceived of not as a psychological attribute within the person, but as a *product of the client-counsellor relationship*. To support this view Miller and Rollnick review evidence that suggests that counsellors can increase or reduce the amount of resistance expressed by clients by using different counselling approaches. A confrontational style of interaction tends to produce more "resistance" (such as instances of client's denying or minimising their problem). "Confrontational" styles of counselling include challenging clients (at one extreme), but also include attempts to persuade the client that they have a problem or direct them to take certain actions. In contrast, empathic, non-judgemental and client centred listening reduces the amount of resistance found in counselling sessions.

Furthermore, not only can counsellors (and therefore presumably also social workers) vary the amount of resistance produced in working with clients, but also there appears to be a relationship between the amount of resistance produced and outcomes for clients. The more resistance produced in counselling sessions, the worse the outcomes for clients.

As MI is an approach focussed on reducing resistance, its fundamental foundation is therefore client-centred and empathic counselling skills. However, MI goes beyond empathic and client-centred approaches. Miller & Rollnick, the originators of MI,

define MI as 'a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence' (Miller and Rollnick, 2002, pg 32). It is crucial to emphasis that while it is client-centred, MI is a *directive method*. While emphasising the importance of skilled listening as a foundation for effective engagement with clients, MI also retains an awareness that to help people change their behaviour good listening may not be enough on its own. For instance, when talking to someone with a serious alcohol problem, confronting them about it is likely to create resistance, but simply agreeing with their denial of the problem may be almost as counter-productive.

MI therefore pays particular attention to skilful ways in which helpers can guide discussions to help clients to explore and, hopefully, resolve *ambivalence.* Ambivalence is seen to permeate difficulties in a wide range of behaviours that people find difficult to change. For instance, even if drinking is causing someone enormous problems, it may also have very significant rewards or the prospect of changing may have potential down-sides. Skilful exploration of ambivalence is at the heart of MI.

The skills involved in exploring ambivalence are beyond the scope of this report. Miller and Rollnick (2002) provide a very accessible guide to MI. The skills they describe are essentially those of good counselling with a specific purpose (i.e. to help resolve ambivalence in the interests of behaviour change). They include asking open questions, affirming positives, reflecting back the meaning of what has been said and summarising statements. However, it is worth commenting on the nature of the skills of MI.

One of the insights of MI is that it is very difficult to be non-directive, and indeed it is often not appropriate. Within MI a range of ways of responding to clients are developed in depth. These are intended to be used to minimise the amount of resistance expressed by clients and to maximise the amount that clients talk about reasons for or commitment to changing. However, under-girding these skills is a set of values, referred to as the “spirit of motivational interviewing”. Miller & Rollnick stress that MI is more than a set of techniques: it is a 'way of being with people' (p.34). There is a fundamental spirit underlying MI, a key component of which is the non-judgemental, collaborative nature of the interview: 'the counselor avoids an authoritarian one-up stance … communicating a partner-like relationship' (p.34).

The skilled helper needs to be able to direct the discussion in a way that not only reduces resistance, but that also encourages people to talk about changing their behaviour. It is this combination of a client centred ethical foundation with a directive set of skills that makes MI such a potentially promising method for use by social workers.

Evidence for the effectiveness of MI

Motivational interviewing has proven to be an effective method of intervening in a wide range of problem behaviours. Hettema et al (2005) review 72 controlled trials of the use of MI. This included the use of MI in relation to alcohol problems, drug misuse, diet and exercise, taking medication, dual diagnosis, mental illness treatment, eating disorders, HIV risk behaviour and a range of other issues. MI was consistently found to be effective, producing demonstrable change that was as great or greater than alternative treatments.

A number of features make MI appear particularly likely to be useful within social work. Firstly, many of the interventions reviewed were brief interventions – sometimes as short as one 15 minute session. MI works, even when used in short

term work. It appears to work even better if follow-up sessions are provided (Hettema et al, 2005).

Secondly, MI has proved effective in a wide range of settings, used by different professional groups, in different countries for different problems. There seems to be something almost universal about the MI approach that helps people overcome problem behaviours. The only exception to this picture appears to be very heavy smokers, such as pregnant women who have not been able to stop (Tappin et al 2005).

Thirdly, MI is particularly effective with black and ethnic minority clients. Hettema et al found effect sizes two to three times greater for black clients compared to white clients. The reason for this needs to be explored further, but the finding has profound implications for anti-discriminatory approaches in social work practice (ADP). Often "ADP" is talked about in a rather abstract way. It seems likely that the respectful approach of MI and the focus on trying to understand the client's viewpoint are a way of making ADP a reality in practice.

Fourthly, the focus of MI on working with resistance means it has proved of particular interest for those working with mandated or coerced clients. MI is, for instance, becoming increasingly used in the criminal justice system. There are complexities in using counselling within a setting with a social control function. However, the apparent success that MI has demonstrated in even rather unpromising settings with coerced clients suggests that it may have considerable potential for use in the social control aspects of social work such as child protection work.

Challenges to using MI within child and family social work

Two sets of challenges can be identified for the application of MI within social work. The first set relate to the ways in which MI might need to be adapted or understood within child and family social work settings. They might be considered to be theoretical issues in applying MI. The second set are more practical issues around how skills can be learnt, practice changed and outcomes evaluated. The theoretical issues require exploration of the appropriateness and limitations of MI as a social work method; the practical issues consider difficulties in changing practice and would apply, to some degree, to any approach.

The theoretical issues in using MI in child and family social work primarily relate to the fact that social workers are not counsellors. This creates a variety of different challenges. Social workers have a social control function, and as such a responsibility to be clear with parents about the worker's views and the likely consequences of failures to carry out certain tasks. Their client is the child, and this may at times conflict with the parent's needs and rights. For instance, a parent may be addressing their alcohol misuse, but a social worker needs to consider the possibility of future relapse and the timescale for change and whether it is swift enough for the child. In an assessment social workers may be collecting information that could be used against a parent's interests. For instance, they may feel that admission of serious alcohol abuse means a child should be removed. These and other considerations highlight the potential complexity of using MI within child and family social work settings.

There are also important practical issues around skills acquisition. To inform the development of the training we carried out a review of research on the impact of training, and issues in transferring skills into practice, in relation to three specific areas (a) child and family social workers' practice, (b) working with alcohol problems and (c) learning MI.

A common theme in all three areas was that there was comparatively limited research, and many of the published studies had methodological limitations. Common methodological flaws in studies included a reliance on trainees self-reports or use of “outcome” measures that were not likely to be strongly related to the effect of the training (e.g. professional records (Rutter and Hagart, 1990) or re-referral rates to child protection services (Antle, 2003)).

A common problem identified within the literature was around the transfer of skills learnt in a training course into practice. A number of studies found that even well evaluated courses were not necessarily put into practice. Factors that appeared to make transfer of training more likely could be divided into those within the training and those after training. Within-training factors supporting the transfer of training included:

- Support for perceptions of self-efficacy amongst participants (Gist et al, 1991),
- minimising the distance between the use of skills in the training situation and the realities of practice (Dickson and Bamford, 1995),
- perceptions of the usefulness of the skills taught (Wehrman et al, 2002)

Factors after training supporting the transfer of skills included:

- Supervisor support post-training, including providing incentives to use skills or giving feedback (Gregoire et al, 1998; Wehrman et al, 2002)
- Opportunities to use skills (Wehrman et al, 2002)
- Peer support in the use of skills (Wehrman et al, 2002)
- Time to put new skills into practice (Milne et al, 2000)

An unexpected finding in the study by Wehrman et al, was that those participants who reported they were most familiar with the content of the training post-training reported using the knowledge least.

Overall, as Milne et al (2000) conclude, while it is clear that a variety of factors may be associated with the successful transfer of training into practice, little is known about the relative impact of these factors and research that manipulates some of the factors systematically would be helpful.

Responding to the theoretical and practical challenges

We take these challenges seriously. We feel that it is possible to formulate a vision of motivational interviewing within child protection social work that addresses these very real issues, and that therefore opens up a space for skilled interventions with parents that nonetheless retain a focus on the child. However, rather than making a theoretical argument for the potential that MI has to address some of these issues, we propose to explore empirically issues in applying MI skills in such settings. Thus the study explores questions such as: how do social workers experience using MI in these difficult situations? How do they approach resolving such dilemmas? Does this require changing their practice, adapting MI or some combination? A key focus of the current study is therefore the practical working-through of theoretical challenges such as the ones discussed above. Furthermore, practitioners may discover obstacles – and perhaps ways of dealing with them – that we had not envisaged. Once again, the current research focuses on understanding the nature of MI as practiced in the real world of child and family social work.

However, as outlined above, the challenges to using MI in social work settings are not just theoretical. They are also practical. Issues about how social workers – and others – should learn particular skills are also crucial. The proposed study aims to explore not just issues in adapting MI for child and family social work, but also how social workers might best be helped in changing their practice. In light of the evidence discussed above, the following were identified as the aims of the study.

Aims of the study

- To evaluate the impact of a 2-day workshop in MI on the practice of child and family social workers

- To investigate what helped or hindered in skills acquisition. In particular, what contribution does follow-up supervision and consultations make to skills development?

- To explore qualitatively the opportunities and challenges that MI might have when used in child and family social work settings based on practitioners' experiences of using MI in practice

To investigate these issues a mixed methodology was developed. This had three main elements. Firstly, there were pre- and post-training measures of practice. These were designed to measure the impact of the workshops: did a 2-day workshop on MI make a measurable difference to practice? They included measures of simulated practice, use of validated instruments and descriptions of work with current cases. Secondly, within the study there was embedded a random controlled trial of the impact of additional supervision and consultation. This was intended to allow us to explore, qualitatively and quantitatively, the impact of additional input over and above the training workshop. It answered the question: was follow-up after the training important in developing skilled practice? Thirdly, qualitative interviews with participants explored issues in applying MI-skills in practice. These interviews were intended to explore the process of skills acquisition (What helped and what hindered in the development of skills?) and the impact of using MI skills in child and family social work settings (Were MI skills helpful? What challenges were identified? How were they dealt with?). The methodology is described fully in section 3. However, in the next section the pilot study is briefly outlined as it contributed significantly to the project.

2. The pilot study

The original proposal for the study was to compare a 2-day training programme in "Assessment of parental alcohol misuse" with a 4-day programme that had an additional 2 days of training in MI. In order to help in the development of the programme and to explore the practicalities of organising it the workshop was piloted. This was evaluated through qualitative questionnaires and a follow-up consultation one month after the training.

A major problem for the pilot study was recruiting participants. The original intention of involving one local authority did not provide sufficient participants. Eventually the programme was opened to four local authorities, and extensive efforts were made to advertise it. Nonetheless, only 7 participants attended the course. Feedback from both those who attended and individuals who had expressed an interest but had not participated highlighted difficulties in getting time to attend a 4-day course. Furthermore, while participants were very positive about the training, they reported difficulties putting the skills into practice and suggested that support in doing this might have been helpful.

This feedback suggested that a 2-day course might have a higher take-up. Other considerations supported a change in the structure of the proposed intervention. Firstly, our concerns that training workers in MI might lead them to be excessively focussed on parents were allayed by feedback from participants that suggested that they retained their focus on children. Secondly, a review of the literature on training suggested that a crucial issue in training effectiveness is support for the transfer of training into practice. We believed this would be a useful focus for study. Thirdly, moving to training both groups in MI would allow a larger volume of evidence on the impact of MI training on practitioners' practice to be gathered. We therefore moved toward a design that compared a 2-day MI workshop alone with a workshop plus telephone supervision and group consultations.

3. Method

Sample selection
Senior managers in seven London local authorities gave permission for social workers to attend training if they wished. In six authorities information was circulated and workers chose to attend. They were encouraged to attend with a line manager, and a number did so. In one local authority senior management support resulted in teams being instructed to send social workers and managers. To maintain anonymity this authority is referred to as “North Borough”.

42 individuals participated in the training (30 workers and 12 managers). Participants were cluster randomised to one of two 2-day training workshops. The training workshop used a combination of didactic and experiential learning. There was a focus on participants role-playing around problem behaviours and/or simulated client situations. Much of the workshop was generic, but in the second day practice examples and discussion focussed on applications in child and family social work settings.

To investigate the impact of additional supervision and consultation half the sample were cluster randomised to a “workshop plus” group. Participants in the "workshop plus" received 3 telephone supervisions from one of two social workers experienced in MI plus 2 group consultations (i.e. fortnightly input). Individuals were informed whether they were to receive more input at the end of the training. The "workshop only" or control condition received only the workshop.

Data Collection and Related Study Procedures
There are no validated instruments for evaluating social work practice in a British context and instruments that have been validated with alcohol counsellors need to be used with caution and/or adapted for use in evaluating social work. Given the limited sample size and this lack of available validated instruments, much of the information was collected using qualitative methods.

There were three areas of study data collection as follows:

1. Stage 1 data collection
Prior to intervention, all participants completed an initial researcher-administered interview which included standardised and semi-structured components. The following information was collected:

A. Profile of individual worker

1. Social worker questionnaire
   (a) Basic descriptive information on social workers
   (b) Baseline information on previous input around alcohol (including Likert scales for self-rating of knowledge and skills)

2. The full AAPPQ measure of commitment to working with problem drinkers (Cartwright, 1980) and Situational constraints questionnaire (Orford, pers comm)

3. Interview questions on previous training and current practice

B. Exploration of current or recent (<12 months) practice with all families in which alcohol misuse is an issue

4. Questionnaire on each case to explore their views on their
   a) Relationship with parents
   b) Resistance
   c) Confidence in their assessment
   d) Interagency working
   e) Impact of working with this family on the worker
   f) Their perception of the place of alcohol in the case

5. Interview questions for each family covering:

   (a) Interagency working (particularly substance misuse professionals)
   (b) Assessment
   (c) Relationship with parents

C. Exploration of the level of current skills (assessment and direct work)

6. Vignette questionnaire for risk assessment
   In order to explore whether learning MI changed participants' assessments of risks to children, they were presented with a vignette and then asked a range of closed questions (eg level of risk, what action might they take). Vignette order randomised.

7. Helpful response questionnaire (HRQ)
   The HRQ has been widely used in evaluations of counselling, and in a limited number of studies of social work training. A version of the HRQ was developed for child and family social work, with a focus on alcohol misuse related issues. Participants completed the same questionnaire prior to the training and at follow-up.

8. Interview questions on dealing with resistance (Parental Resistance Scenario (PRS))
   The Parental Resistance Scenarios (PRS) were developed specifically for this study and focussed on types of resistance commonly found in child and family social work with parents with alcohol problems. Two scenarios were developed and assigned in random order for the first and second interviews. For each scenario social workers were provided with three different "resistance" comments the parent might make and asked for their response to each. Responses were taped and coded (see below).

2. The content and process of the training, supervision and consultation.

Description and evaluation of these was carried out in six ways. Firstly, an observational study of the content of the training workshops and of the group consultations was undertaken by a researcher not themselves involved in the delivery of training (CW). Secondly, the training ended with a group evaluation and discussion, for which notes were taken by CW. Thirdly, this was followed by a meeting of all those involved in providing or observing the training to discuss how it had gone and identify any particular issues arising. Notes were taken of this conversation. Fourthly, practitioners completed brief qualitative evaluation forms relating to the training. Fifthly, the telephone supervisors kept notes on the content and process of each telephone supervision. Sixthly, CW attended and kept notes of each of the group consultations.

3. Stage 2 data collection

Three months after the training social workers were interviewed again. This involved repeat administration of the validated instruments (AAPPQ, Situational Constraints), vignettes to explore practice (HRQ, Parental Resistance Scenario and Risk Assessment Vignette) and questionnaires relating to their current work with cases involving parental alcohol misuse. In addition a semi-structured interview covered:

- Their perception of the impact of the MI training on their practice.
- Factors that supported or hindered change in their practice.
- Their views on the training and where appropriate the follow-up.
- Their experiences of using MI-related skills in their work, including particular challenges or opportunities identified.

In addition participants completed an assessment interview with a standardised, simulated client. Four 'clients' were constructed, and played by three social work students and one social worker trained for the task. Scenarios were randomly assigned equivalently within each group in order to prevent contamination and also to permit examination of pre-specified practice challenges. These sessions were audio-recorded and analysed using an adapted version of an existing process measure for MI-consistent behaviour (the MITI (Moyers et al, 2003)).

Data analysis

Quantitative information was entered onto SPSS (ver 12.0) and qualitative information was analysed using NVivo (ver 2.0.16).

The HRQ questions were rated using two measures. The 5-level measure of empathy used in previous studies of counselling skills was used (Carkhuff, 1969, pgs 315-317). This has the following levels:

Level 1: "the helper does everything but express that he is listening, understanding or being sensitive to even the most obvious feelings of the helpee in such a way as to detract significantly from the communications of the helpee" [referred to in tables as "obstructing"]

Level 2: "the helper tends to respond to other than what the helpee is expressing or indicating" [referred to in tables as "not listening"]

Level 3: "the helper… does not respond accurately to how that person really feels beneath the surface feelings; but he indicates a willingness and openness to do so. Level 3 constitutes the minimal level of facilitative interpersonal functioning" [referred to in tables as "minimal listening"]

Level 4: in addition to Level 3 "the helper's response adds deeper feeling and meaning to the expressions of the helpee" [referred to in tables as "empathic listening"]

Carkhuff also proposes a Level 5 ("the helper is responding with a full awareness of who the other person is and with a comprehensive and accurate empathic understanding of that individual's deepest feelings") however this did not appear an appropriate level for the limited information in the HRQ.

The advantage of using the Carkhuff ratings is that they have been used in other research. The disadvantage is that this is mostly in relation to counselling, and as Nerdrum and Lundquist (1995) point out these levels of listening may not always be

appropriate in social work situations. The HRQ was therefore also rated using an adaptation of Nerdrum and Lundquist's (1995) categories of social work responses developed in a qualitative study of social work management of interactions. We refer to this as the "management of role" rating for the HRQ. The 3 levels for this measure were:

1 = *"Correcting the client's experience"* (this included challenging, disagreeing or over-ruling without providing any indication of having heard or understood what the client was saying),

2 = *"Administration of the client's experience"* (this involved an indication of having heard and responding to what was said by client, but with imposition of own or agency agenda in response),

3 = *"Acknowledgement of client's experience"* (this involved an indication of understanding and invitation to explore the client's experience in greater depth, without imposing own or agency agenda).

For both the empathy and the agenda negotiation rating for the HRQ an average score over the 6 questions was calculated.

For the Parental Resistance Scenario we developed our own coding system based on two readers discussing types of response found in a sub-sample of cases (n=12) prior to coding the whole sample. This resulted in the following categories:

1. *Imposing own agenda:* Worker uses authority to press own point or ignores what was said e.g. direct challenge
2. *Negotiating own agenda:* Worker shows evidence of having listened; responds to what person has said but maintains own agenda (e.g. exploring the truth of what has been said by client)
3. *Exploring client's agenda:* Worker responds by exploring parent's agenda/views
4. *Exploring emotional content:* Worker responds by exploring parent's agenda, and with attempt at understanding emotional content of parent's views

An overall total score – termed the "Agenda negotiation" score - was calculated over the 3 responses (i.e. from 3 to 12).

For all of these ratings (for the HRQ and PRS), a sub-sample of 12 were independently rated by a second researcher. For all three measures, $r > 0.7$ was found for all questions, with r between 0.8 and 0.96 for most questions. This suggests these rating systems were reliable.

The risk assessment vignette was designed to assess whether training in MI led to changes in participants' assessment of risk to children, and in particular to identify any increase in failure to perceive or respond to potentially serious risks. The order of the vignettes was randomised. For each vignette participants were asked to rate the immediate risk of harm, risk over the next 6 months and risk over the course of childhood (should the child remain at home). Ratings were from 1 (very serious) to 4 (not concerning). Workers were also offered the following range of possible responses: close referral; assessment needed but not allocation; allocate as child in need; allocate as child protection; remove child. The scenarios in these cases were designed by DF so that the risks clearly required allocation, but that the positive or protective factors suggest immediate removal *or* failure to allocate to be inappropriate. The study was therefore particularly interested in identifying instances

when workers decided either not to allocate the child or to remove them. These might indicate inappropriate responses.

The simulated client sessions were rated using an adapted version of the MITI (Moyers et al, 2003) (i.e. with one additional measure - "management of the interview"). The adapted version of the MITI involves 8 dimensions each rated from 1 to 7 on a Likert-style scale. Tapes were independently rated by a rater experienced in using the rating system, independent of the project and blind to participants' group affiliation and by a project researcher. For any interview, where the independent raters disagreed by 3 or more points on any dimension or 2 points on 3 or more a third independent rating was made. Overall the first two rater's ratings proved very reliable ($r>0.6$) for all dimensions except "giving information". Where there was disagreement there was a strong level of correlation between the first and third rater (again excluding "giving information" - there appeared to be particular challenges in rating this dimension). The rating of the first rater was therefore used to measure MI skill. An average score for all dimensions except "giving information" was used as the measure of level of MI skill. "Giving information" is not analysed as an outcome measure due to the reliability problems.

The qualitative analysis of the interviews with participants involved two researchers independently reading transcripts of 12 second stage interviews. Following this a series of themes and sub-themes were identified. A researcher then coded all the interviews using NVivo identifying themes and sub-themes in relation to the areas of interest for the study. Finally, a second researcher read a sample of 14 interview transcripts. No new themes were identified and there was a very high level of agreement on the presence of themes or sub-themes for coding. The NVivo codings are then used to present information on examples of particular themes and how common they were. It also enables the relationship between particular themes and outcome data stored on SPSS to be analysed. The qualitative data is therefore analysed in relation to the level of skill of MI demonstrated in the simulated interview.

4. RESULTS SECTION

The results are divided into six main parts. The first describes the sample. The others each address a key study question. They are:

4.1 Description of the sample

4.2 What were the baseline (i.e. pre-training) skills, knowledge and attitudes of participants in working with parents with alcohol problems?

4.3 What was the impact of the training on the skills and practice of participants? This considers:

- *Quantitative evaluation (particularly of simulated practice)*
- *Qualitative accounts from interviews*

4.4 What factors helped or hindered practice change? This considers:

- *What was the impact of the additional supervision and consultation for the "workshop plus" group*
- *Other factors that helped or hindered change*

4.5 What were the challenges and opportunities in using MI and child and family social work settings with parental alcohol misuse?

For several sections there is both quantitative and qualitative information. In general the quantitative findings are presented first, followed by qualitative evidence.

4.1 DESCRIPTION OF SAMPLE

42 social workers and managers participated in the research. Data was collected for 40 participants (95%) at stage 2 and the following analysis relates to this group. The two participants who were not interviewed were in the "workshop plus" group and both were from one local authority (henceforth referred to as "North Borough" to protect anonymity). However, there is nothing in their profile at stage 1 that suggests that they were unusual.

The participants were primarily social workers (30), though 5 were senior practitioners (combining supervision of staff and a caseload) and 5 were team managers (only supervising staff). Nine were men and 31 women. There was a wide range of ethnicity. All were qualified social workers. There was a wide range of experience - from less than one year to 23 years. Half had been qualified less than 3 years. None had experience of working in substance misuse settings. Fourteen had experience of supervising staff and/or students. Twelve attended with their line manager; 23 did not and 6 were the line manager.

All participants worked in child and family social work for local authorities in London. Thirteen came from one local authority ("North Borough"), while 27 came from a range of other London local authorities.

Eighteen came to the first training, but this includes 2 who did not participate in the post-training evaluation. Twenty-four came to the second. The difference in numbers

was primarily due to differences in the sizes of the clusters randomized to training sessions, though there were 3 cancellations for the first training session.

Participants were asked about their training on alcohol use and misuse. Four had had no training, 5 had only received training before qualifying, 14 had last had training on their social work course and 16 had received training since qualifying (information was missing for 1). Examination of the nature of the training in interviews found that it had been minimal. Nonetheless, self-assessment of skills and knowledge in this area found around two-thirds felt they had sufficient skills. Nine reported having some training in MI, though in the qualitative interviews it was established that participants could recall little or nothing about MI.

4.2 WHAT WERE THE PRE-TRAINING SKILLS, KNOWLEDGE AND ATTITUDES OF PARTICIPANTS?

Description of cases worked with involving alcohol
At stage 1, 37 participants provided information on a current or recent case involving parental alcohol misuse (PAM), with 15 providing information on two cases. Information was thus collected on a total of 52 families. 37 of the families were currently being worked with and 15 had been closed in the last 12 months.

Participants were asked to complete a questionnaire on each family. This covered the statutory basis and the worker's assessment of concerns in the family, and their evaluation of a range of aspects of their work with the family, including engagement of parents, liaison with substance misuse professionals and other agencies and their assessment of the level of drinking. Within each of these areas social workers expressed agreement or disagreement to a number of statements using a Likert scale (from 1 (strongly agree) through to 5 strongly disagree).

Seriousness of cases: The cases were generally relatively serious: 19 were child protection cases and 4 were subject to care proceedings. The concerns about the children reflected this. For 38% of cases concerns were rated by the worker as "very serious" and for an additional 34% they were rated as "serious".

Relationship with parents: Exactly half reported enjoying working with the parents; only 13% did not. An even higher proportion felt that they had a good relationship with the parents (61%); only 18% felt they had a poor relationship with the parents. In 13% of families the worker reported not wanting to meet the parents.

Assessment: In 65% of cases the worker reported having a common understanding with the parents. Despite this in 72% of families the worker felt that the parent was not honest about their drinking, and in 44% of cases the worker felt that they could not trust the parent. Unsurprisingly, in the light of this, workers did not appear confident in their assessments. Only 22% felt they had a good idea of how much the parent was drinking while only 39% felt they had an idea of what might happen in the future

Resistance: Participants were also questioned about the presence of various behaviours that might be considered to be types of "resistance":

- 37% of parents were identified as threatening
- 44% were considered "passive"
- 41% had confrontations with the worker
- 61% involved the parent denying or minimizing their misuse

Confidence in skills: Despite the difficulties identified, most workers were confident of their ability to work with the case:

- In 63% of cases workers were confident of their ability to engage the parents
- In 52% they felt that their knowledge of alcohol use was good enough, and in a similar number (54%) felt they could understand why the parent/s drank
- Nonetheless in a fair proportion (41%) workers considered working with the family stressful

Simulated Practice Measures

Helpful Responses Questionnaires (HRQ)
As noted in the method section the HRQ responses were rated in two ways. A modified version of Carkhuff's (1969) 5-level expression of empathy rating was used. This has been used more often for counsellors. In addition, a rating specific to social work settings was developed based on Nerdrum and Lundquist (1995) qualitative research on social work responses. We refer to it as the "management of role" rating.

HRQ Level of empathy rating
At the first stage the ratings for expression of empathy (from 1 low to 4 high) are set out below (nobody scored 4 or 5 for any answer, so these columns are omitted):

Pre-training HRQ Level of empathy rating

HRQ	1	2	3	Mean
	"Obstructing"	"Not listening"	"Minimal listening"	
Q1	6	29	5	1.97
2	25	13	2	1.42
3	1	17	21	2.51
4	28	8	4	1.40
5	23	8	8	1.62
6	29	7	4	1.37
Total	112	82	44	1.72

HRQ "Management of role" rating
The analysis of the management of the agenda ratings for the HRQ are set out below:

Pre-training HRQ management of role rating

HRQ	Correct	Administer	Acknowledge	Mean
Q1	21	15	4	1.57
2	32	8	0	1.20
3	0	38	1	2.03
4	29	11	0	1.25
5	21	16	3	1.55
6	29	11	0	1.27
Total	132	99	8	1.49

It is clear that for most questions a challenging approach associated with correcting was the most common response. There were relatively few empathic and acknowledging responses. Nerdrum and Lundquist (1995) make the point that each

of the responses may be appropriate for social workers in particular settings. Nonetheless the results from the HRQ suggest a relatively confrontational approach is present prior to training.

What is striking here is that these are *very* low levels of empathy. They do not even approach the level identified by Carkhuff as the basic level for helpful interaction. This is best illustrated through some examples. Below are responses selected at random from different participants for each of the six questions from the HRQ at stage 1:

Pre-training HRQ case examples and sample responses

	The client's situation and comment:	The worker's response:
Q1	A 23 year old father telephones you to say: "I'm not going to be able to keep my appointment at the child protection conference tomorrow ; we just learned that my Dad has cancer"	The conference is important for you to attend. Unfortunately we can't postpone it. If you can make it to the conference it would be greatly appreciated. I hope things work out for your father
Q2	A 16 year old (female) looked after young person tells you: 'It really sucks that you're not supposed to drink until you're 18. It's stupid. I can get married, but to have a drink I have to get a fake ID'.	Unfortunately, it's the law. Its to try and protect young people. [I would then try to establish where the fake ID came from].
Q3	A 41-year old woman says to you: I have to get off the street and get some other kind of life. It's not safe on the streets any more; it's too weird.	What do you mean by weird?
Q4	A 25 year old with his third drunk in charge says: There's no way I was drunk this time. I felt absolutely fine. The cops are just watching for my car now and pulling me over for anything.	Don't they do a breathalysing test when they suspect you've had too much to drink?
Q5	A 32 year old woman says: Last night Joe came home drunk again, and kicked in the TV set while the kids were still watching it, and then he knocked me down. He scared us all half to death.	What did you do with the children? Did you call the police?
Q6	A 22 year old drug user says: Who are you to tell me about drugs? What do you know about heroin? Have you ever fixed?	I am not trying to tell you that I know exactly what it is like, but lets look at known effects

Parental resistance scenario
The vignettes for the parental resistance scenario (PRS) were coded using a scheme developed specifically for the current study. The overall profile at stage 1 was:

Pre-training responses to Parental Resistance Scenarios

PR Scenario	Impose own agenda	Negotiate own agenda	Explore client's agenda	Explore client's emotions
Q1	28	9	1	
2	18	20	2	
3	13	23	3	1

As for the HRQ, the clear finding here is a tendency to meet resistance through challenges, often very direct, with very few empathic responses noted.

KEY FINDINGS FROM PRE-TRAINING ASSESSMENT

- Workers rated their skills relatively highly – both in self-assessment and in relation to the cases they were working with

- Participants were working with a range of serious cases involving alcohol misuse

- Within these cases, issues of parental denial and minimisation appeared particularly prominent, and contributed to difficulties in carrying out effective assessments

- Workers appeared to use a highly confrontational style of interaction with parents. Even when not confronting parents, listening skills appeared to be low. There was little indication of use of open questions and virtually no use of reflections

These findings point to the potential contribution that MI might make to work within child and family social services, however they also suggest that the starting point for developing skills may be lower than anticipated.

4.3 WHAT WAS THE IMPACT OF THE WORKSHOP ON THE SKILLS AND PRACTICE OF PARTICIPANTS?

Quantitative evidence

Description of cases worked with
At stage 2, 19 workers were able to provide information on current cases, with 8 of the 19 able to provide information on two current cases. This provided a sample of 27 families worked with. Workers completed the same questionnaire for each family as at stage 1. 12 were the same family as rated at stage 1.

The seriousness of the cases was comparable in relation to both statutory basis and social worker rating of concern.

Evaluation of aspects of the case
No statistically significant changes were found in relation to work with alcohol specialist and other specialists, relationship with parent or parental behaviour.

Confidence in assessment: There was a significant increase in social workers' confidence in their assessment (t=-2.069; df= 38; p=.042).

Impact on the social worker: The biggest impact was on the worker's perception of themselves in relation to the cases. There was a significant shift toward a more positive rating of their involvement in the case (t=2.493; p=.015). A particularly important component of this was a strongly significant tendency to rate the work as less stressful (t=-3.029; p=.003). Workers were also significantly more likely to rate their knowledge of alcohol misuse as adequate (t=2.413; p=.018). There was also a trend for them to feel more confident about their skills in working with the family.

Measures of simulated practice (HRQ and Parental Resistance Scenario)

HRQ empathy rating (5-point scale)
There were very significant post-training effects for all but question 3. All were in the direction of greater expressed empathy. As might be expected the change for the overall score of empathy was highly significant (independent samples t-test):

Post-training HRQ empathy ratings

HRQ	1	2	3	4	Mean	Change	p
	Obstructing	Not listening	Minimal listening	Empathic listening			
Q1	21	17	38	0	2.45	+0.48	.000
2	15	12	9	2	1.95	+0.53	.007
3	1	11	23	3	2.74	+0.23	.090
4	12	7	15	2	2.19	+0.79	.000
5	11	4	23	0	2.32	+0.70	.000
6	14	9	13	1	2.03	+0.66	.000
Total	74	60	121	8	2.28	+0.56	.000

HRQ "Management of role" rating (4-point scale)
There were also significant differences in the management of the social work role. Once again, all but one question moved away from direct challenges toward greater empathic or collaborative work. This change was generally significant (t-test):

Post-training HRQ management of role ratings

HRQ	Correct	Administer	Acknowledge	Average	Change	p
Q1	10	19	9	1.97	+0.40	.006
2	26	10	2	1.37	+0.17	.110
3	0	32	6	2.16	+0.13	.058
4	15	18	3	1.67	+0.42	.003
5	12	20	6	1.84	+0.29	.039
6	16	18	3	1.65	+0.38	.003
Total	79	117	29	1.78	+0.19	.000

The total score for "agenda negotiation" showed a very noticeable shift between stage 1 and stage 2, from an average of 4.66 to 6.02 (i.e. toward greater negotiation of agenda). This was highly significant (t= -3.994; df= 36; p<0.000).

Post-training Parental Resistance Scenario ratings

PR Scenario	Impose own agenda	Negotiate own agenda	Explore client's agenda	Explore client's emotions	Average	Change	p
Q1	22	8	7	2	1.76	+0.45	0.005
2	17	11	11	1	1.90	+0.30	0.123
3	6	20	6	8	2.40	+0.60	0.004
Total	45	39	24	11	2.01	+0.48	<0.000

Assessment of risk scenarios

As noted in the method section, the impact of the training on participants' assessments of risk were explored. This was undertaken to investigate whether training in MI might lead participants to focus on parents and as a result fail to identify risks to children. Participants rated vignettes in relation to perceived level of risk and possible responses.

Overall there was virtually no change in level of perceived harm over 6 months or over the whole of childhood, but there was a significant reduction in the perception of immediate harm (df=39; t -3.326; p=.002). This brought participants more in line with the "expert" judgement of risk made independently by DF.

There were no statistically significant differences in the likelihood of any of the responses to risk. There was virtually no change in the proportion of people choosing either to close the referral or to remove the child. Overall therefore the training had no appreciable effect on assessment of risk – and what little effect there may have been appears likely to have been positive.

AAPPQ and Situational Constraints

The Alcohol Attitudes and Problem Perception Questionnaire (Cartwright, 1980) and the situational constraints questionnaire were administered before and after training. The were no changes post-training in the situational constraints questionnaire. As can be seen in the table below, there were significant positive changes in the AAPPQ, particularly related to greater knowledge of alcohol misuse and perception of role legitimacy in dealing with alcohol misuse issues post- training.

AAPPQ scores before and after training (t-test)

	Average Before	Average After	Change	p
Knowledge	4.05	4.59	+0.54	.008
Role legitimacy	4.72	4.98	+0.27	.024
Support in work	5.25	5.18	+0.07	.689
Motivation	4.56	4.50	-0.06	.759
Confidence	5.14	5.21	+0.07	.907
Enjoyment	4.49	4.35	-0.14	.216
Total score	120.6	143.7	+23.1	<0.000

How skilled were they in using MI?

34 interviews with simulated clients were undertaken (85% of participants). Rating used an adapted version of the MITI (see method section). The MITI is rated from 1 (low or no skill in MI) through to 7 (expert); 5 has been suggested as the threshold for MI starting competence for an MI counsellor (Moyers et al, 2003). However, it is important to take account of the fact that the scenario (a first meeting with a mother during care proceedings) is one in which using MI might be more challenging than a counselling situation, given the role of the social worker. Indeed, the scenario was deliberately constructed to allow the possibility of resistance, depending on the approach of the social worker. It has therefore been decided that the following thresholds will be used to analyse MI competence:

- 4 plus: threshold competence – indications of ability to use MI skills appropriately; some passages of skilled practice; generally good listening
- 2 to 4: elements of competence – some listening skills, but not practicing MI
- Less than 2: low or no skills demonstrated

These thresholds are used to structure the analysis of the results of the simulated interview and also aspects of the qualitative interviews.

The scores for aspects of MI that are used in the MITI rating, plus two developed in other research, are set out in the table below. A picture emerges of some level of skill in relation to the basic listening involved in expressing empathy, using open questions and avoiding non-MI behaviour. However, there was considerably less evidence of competence in the more complex skills involved in using reflections, exploring issues of substance and managing the interview.

Quality of MI in simulated interviews

	Low or no skill (<2)	Elements of competence (2-4)	Threshold competence (>4)	Mean
Empathy / understanding	7	8	17	3.67
Spirit MI Adherent Behaviours	13	6	15	3.21
MI non-Adherent Behaviour	13	8	18	3.97
Open questions	9	6	19	3.53
Reflections (simple & complex)	21	4	9	2.44
Exploration of issues of substance (engagement)	20	5	9	2.36
Management (strategic handling & structure)	20	9	5	2.38
Skill / overall quality	20	9	5	2.38

An overall level of MI skill was calculated based on an average of the other scores. This found a very wide range of abilities (see table below). Only 2 participants had averages over 5, though a further 8 had ratings over 4 and were thus showing some MI-consistent skills. This represents a quarter of all participants. At the other end of the range there were 9 participants whose average score was strikingly, one might even say startlingly, low. A score of less than 2 indicates little or no evidence of listening to the simulated client.

Level of overall skill in MI from interviews with simulated client

Score	Description	n
2 or less	Very low or no skill in MI	9
2-4	Indication of listening skills and some use of MI	15
4 or more	Indications of MI competence	10

KEY FINDINGS FROM QUANTITATIVE POST-TRAINING ASSESSMENT

- There were strong indications in the simulated practice of significant post-training changes toward greater listening, more empathy and less confrontation

- This did not appear to have had a negative impact on individuals' focus on risks to children

- Participants also had significantly increased AAPPQ scores and reported greater confidence in their assessments and lower stress levels with current cases

- Nonetheless, overall the level of MI skills identified in the interview with the simulated client was comparatively low. A quarter of participants had achieved some level of competence. However, many had only basic listening skills. And 9 individuals demonstrated virtually no listening skills and a confrontational approach.

QUALITATIVE ACCOUNTS OF PRACTICE POST-TRAINING

Self-reported impact of the training on practitioners' practice

As well as differing in the extent of change that they described, there were both similarities and differences between the groups of participants with high, middle or low levels of MI skill in their description of what had changed in their practice. These are explored in detail below, but the differences can be summarised at this point. The competent participants tended to talk about MI as creating better relationships with clients or producing genuine partnership with parents. Four said that they now considered the use of MI as synonymous with good practice.

In contrast, the middling group were particularly likely to identify MI as a way of reducing resistance. Most in this group also described MI as a way of getting better information from clients. This advantage was rarely mentioned by members of the other groups.

As might be expected, the group who scored low in MI skill had the least to say about the advantages of MI. However, it was interesting to note that when they did talk about it they tended to view it as an "extra tool" that they could use. MI was rarely talked about in this way by members of the competent group. Members of the low skill group (in particular) and some in the middle skill group described changes such as not interrupting clients as much and being less confrontational. These appear to be relatively basic listening skills.

Evidence of impact on practice

Participants provided considerable qualitative evidence about the impact of the MI training on their work with clients. This is divided into four sections: the impact of the training on:

- the worker's practice,
- relationships with clients,
- outcomes for clients,
- the worker themselves.

How did the training impact on the practice of workers?

Thirty two participants identified positive changes in their practice following the training. The most common change identified was the use of reflective listening. 20 participants identified this as something that they took from the training:

> *I think the feeding back of what he'd said and re framing that and putting it back to him really kept the conversation focused and on track. Whereas usually he's a very garrulous man and quite argumentative. And unfortunately I'm quite argumentative and so often we would have hour-long conversations that had no outcome.*

The next most common change was a more general change toward letting the client take the lead. 15 participants provided evidence in relation to this:

> *I think it was more giving the young person an opportunity to sort of speak, because I think what happens a lot is that we do all the talking and questioning, you know what I mean? Trying to get to the bottom of things whereas I think with motivational interviewing it sounded to me more that you want to put it back on the person involved*

A related change, noted by 10 participants, was a move toward letting client's find their own solutions:

> *Prior to the training I was trying to come up with strategies and I felt almost responsible for providing professional advice but in this telephone call, I really just let her talk and reflected a lot back and used summaries and affirming statements…*

Eight workers identified this as being part of a move toward being less authoritarian:

> *I think sometimes if you go in a different way and say 'right these are our concerns and there has been no change and the local authority is now about to do this' I mean you know you expect them to sort of say 'I love my children you are not going to do this, how dare you think that da-de-da, you will not do this' but it was a different way and yes and managed more sensitively.*

Nine participants mentioned using affirmations and moving from a focus on problems as being important changes:

> *I tried to focus on the positive as well, it was more like 90% was focusing on the negative and then 10% was on the positive so I've tried to change that around a little bit, so yes, just really listening to them, focusing on the positive, spending time with them*

And the issue of spending more time with parents was identified by five workers as an outcome of the training:

> *think I've been more patient when I'm talking to a mother in particular, … tried everything else, try and get what I needed but I've actually been spending more time, more valuable time to get more quality responses rather than just the quantity.*

A further common positive from the training was the reconceptualisation of resistance as an understandable response to a situation:

> *But the first time I went and saw her was about three weeks after the training, and it was quite useful actually because I had kind of expected the resistance so I kind of planned what I was going to say, how I was going to go about it and I think it was really helpful.*

Thus a picture of a range of positive changes in practice resulting from the training was identified, with evidence for some changes provided in relation to 32 participants.

What impact did changes in practice have on relationships with clients?
Eighteen participants gave a total of 32 examples of the impact that the training had had on their relationship with clients. All of these were positive. These were heavily skewed toward higher skill participants: 14 were in the competent group, 13 in the middle skill and 5 in the low skill.

MI was seen to be useful for angry or threatening clients:

> *so with the client with contact, you know, she was hanging up the phone, she was threatening to go to the solicitors and take drastic action, when I rang her*

back and used the technique … she apologised and then said you know, … this is what we're going to do.

More generally participants identified MI skills as leading to better engagement with clients:

It was incredible, she just totally opened up; we had a phone call for half an hour… and at end of telephone call, mum said she now felt able to cope. Who knows whether it would have happened anyhow, maybe she was just having a good day…the conversation turned around differently when I stopped trying to give her all the answers, when I just let her talk.

And as a result participants often talked of better relationships with clients following the training:

I think she really appreciated it, as a teenager she complained but I was asking her to really reflect on things and tell me her feelings and I was summarising all this, and she found it difficult to do because she's not used to it, but the relationship between me and her has really developed, and I've developed a good relationship with her, I've an understanding of what her triggers are now.

A key aspect of this, mentioned by 12 participants, was that they thought clients felt listened to and heard:

And so feeding back, so he was actually understanding that I had heard what he was saying because I was feeding back to him in a different way. So he could leave that point and move on…Rather than getting himself stuck on one point until he felt he had won that point, or trying to change my mind or something. So really it took my personality out of the equation which was needed in that situation.

An important side effect of this improved relationship was that workers felt they obtained more or better information from parents:

I think she feels as though like …she can share openly with me as her social worker and that it isn't always about business

What influence did this have on outcomes for clients?

There were 22 cases in which participants discussed the outcomes for clients. For most of these (16) the outcome seemed to be positive, though it was often difficult to disentangle the impact of MI skills and other factors. Some examples of positive changes included:

It had a really good impact on the girl - she hasn't attempted suicide in the last 3 weeks nor has she bought paracetamol

Or another participant commented:

the house has been, not completely transformed but it has certainly improved a whole lot, but we are not as concerned as we would have been and she has started work and the child is at nursery and we just touch wood that things are going OK at the moment. She seems a lot more motivated and I think I am really trying to encourage that and say 'you are doing really well'.

A positive feature that was mentioned several times was that clients had started to cooperate in attending other services. One participant suggested that while initial discussions with clients, particularly on the phone in a busy duty team, were taking longer, the net result was that referrals were often diverted from needing further work.

However, in many instances it was difficult to disentangle the impact of MI from other aspects of the case:

> *Yes, I have another case [where I] tried to use my motivational interviewing. The baby was only ten weeks old but I could not engage [before the baby was born]… She did engage for a couple of months [after the baby was born] and then still using these skills I assisted her in looking at things. Basically she has [significant alcohol issues]… and became very difficult to engage and I was saying in our group sessions that I didn't know if motivational interviewing, or using those techniques and getting her to reflect on the situation, got her to a point where she thought actually I can't do this and then she withdrew, or whether or not it just didn't help at all and it had no impact on her.*

Finally, there were a small number of cases where little or no impact was identified:

> *the other one I am thinking of was not hugely successful. In that I was, it's with a thirteen-year-old boy who was very resistant, more so than I have ever come across in my professional career.*

As might be expected there was a tendency toward more competent participants being more likely to discuss outcomes for clients. Eight of the cases were from the competent group, 10 from the middle skill and 4 from the low skill group. Perhaps surprisingly there was no relationship between level of skill and whether "outcomes" for cases appeared good or bad. 3 of the 4 from the low skill group were described as positive outcomes. This highlights the complexity involved in using qualitative data to explore "outcomes".

How did the training impact on the workers?
A feature of MI identified by 8 workers was that it had had an impact on their experience of being a social worker. These workers talked about enjoying their work more and feeling less stressed:

> *I don't feel so phased, I mean there is always that slight anxiety when you are meeting people for the first time, you never know how they are going to be. People have the potential to be violent, upset whatever, but I do feel less concerned about that.*

A key aspect of this was that they felt under less pressure to resolve their client's problems:

> *The advantage is that I don't feel pressure. I don't feel the pressure's on me to wanting them to make that change. I don't feel as if like I'm the one who's searching for the end result. It's more like the client is searching for the end result and I can only cheer them on and motivate them to go and help them make that change and that difference. So in that sense it kind of gives myself a more positive role for them*

Some workers felt the training had empowered them to reject what they perceived as unrealistic expectations from their organization or other agencies:

> *I think for myself, I have just adopted the role that, you know what, if I can't get this information I can't get it, and stop giving myself a hard time.*

Levels of MI skill and differences in descriptions of practice

There were significant differences between the groups in the aspects of MI that they had used with clients. Most obviously, both the competent and middle skill groups provided far more evidence of using MI skills than the low skill group. This was not because they talked about more cases (there was little difference in this), but because they provided more information on the cases that they did talk about. As an indicator of this, the thematic analysis coded 87 practice issues in the competent group, 96 in the middle group but only 41 in the low skill group. As well as having similar tendencies to talk at greater length about cases in the two groups, the types of issues identified were similar for the competent and middle skill groups. Thus, the issues identified above were generally prevalent equally in both groups. In contrast, both differed in important ways from the issues identified within the low skills group.

The biggest difference was that those in the middle and competent groups often gave examples of skills they had used in cases. Thus 9 in each group talked about reflective listening. In contrast only 2 in the low skill group talked about reflective listening, and for at least one of these there was a question mark about whether they were using reflections in a way that was consistent with MI based on their own account. Five in the middle and competent skill groups also talked about using open questions. This was not mentioned by those in the low skill group. Those in the middle and competent groups were also more likely to talk about letting the client explore issues themselves, letting the client take the lead and becoming less authoritarian.

An issue identified in the low (2 participants) and middle (3) skill groups but not mentioned by those in the competent group was not directly focussing on the problem, that is letting the client talk about what they wanted to talk about. It is, of course, open to question whether this was an intended outcome of the training. It is certainly not part of MI to not focus on an issue, though the MI emphasis on working with clients does entail taking seriously their definition of "the problem".

A final difference was that the 8 workers who talked about MI having had a positive impact on their professional identity and job satisfaction were strongly concentrated amongst those with the highest skills in MI: 6 were in the competent group and 2 in the middle skill group. This may therefore be indicative of a change that might occur with skilled MI.

KEY FINDINGS FROM QUALITATIVE DESCRIPTIONS OF POST-TRAINING PRACTICE

- There was a large amount of qualitative evidence indicating changes in practice toward more MI-consistent skills such as reflective listening and use of open questions

- This was related to descriptions of improved relationships with clients (particularly parents but also older children)

- There were suggestions that this might be linked to positive outcomes in some cases, though disentangling reasons for changes was difficult

- For a minority of participants the use of MI had significantly reduced their stress levels. This seemed to be associated with higher levels of MI-competence.

4.4 WHAT FACTORS HELPED OR HINDERED PRACTICE CHANGE?

There are two main parts to this section. As outlined in the method section, the study had embedded within it random allocation to a "workshop plus" group. This group were provided with additional supervision and group consultations over the next 3 months. The first part of this section explores the impact of this, starting with the quantitative data and then looking at qualitative evidence on the impact of the additional input. The second part of this section looks at other factors that might have influenced practice change. Again this has a quantitative and a qualitative sub-section.

ANALYSIS OF THE IMPACT OF THE ADDITIONAL CONSULTATIONS AND SUPERVISIONS

Comparison of baseline measures for the "workshop plus" and control groups
There was no difference in the gender, ethnicity or qualification of those in the different groups. They were also equally divided between the two training sessions and in the proportion of managers and workers. There were some differences that were not statistically significant but worth noting in relation to the following:

- The "workshop plus" group were slightly less experienced (6.23 to 7 years)
- They were more likely to come from North Borough (9 of the 13 from North Borough had follow-up (NS but a trend (Chi squared= 2.849; df=1; p= .091))

There were no significant differences between the groups in relation to the HRQ or parental resistance scenarios, the AAPPQ or situational constraints scores or the risk assessment vignettes at stage 1.

Second stage findings comparing "workshop plus" and "workshop only" groups
There were no differences – significant or trend – between the groups in relation to:

- AAPPQ and Situational Constraints
- Risk assessment vignettes
- HRQ (empathy or agenda management ratings)
- Parental resistance scenarios

Cases worked with
Of the 27 families, 12 were in the workshop plus group and 15 the control. Information was missing in relation to some parts of the questionnaires, and therefore the comparison groups were very small for statistical analysis.

The following were significant differences between the groups (in expected direction):

- Working together well with substance misuse professionals (t=2.116; df= 24; p=0.045)
- The worker feeling their knowledge of alcohol misuse was good enough (t=2.115; df= 21.56; p=0.046)

There was no general trend toward differences between the groups.

MI skillfulness
There was no significant difference between the "workshop plus" and "workshop only" groups. However, care needs to be taken as the numbers involved are small. There were some possible indications of better practice, particularly in the use of

reflections and the exploration of issues of substance, though these were not very large differences.

Comparison of "Workshop plus" and "Workshop only" groups in MI skilfulness

	Follow-up?		t	df	Sig. (2-tailed)
	yes	no			
Empathy / understanding	3.76	3.59	.361	32	.721
Spirit MI Adherent Behaviours	3.29	3.12	.391	32	.698
MI non-Adherent Behaviour*	4.12	3.94	-.290	32	.774
Open questions	3.76	3.29	.981	32	.334
Reflections	2.82	2.06	1.452	32	.156
Exploration of issues of substance (engagement)	2.65	2.06	1.463	31	.154
Management	2.59	2.18	1.066	32	.294
Skill / overall quality judgement	2.59	2.18	1.066	32	.294
Overall MI Skill (average score)	3.29	2.89	0.966	32	.341

* transposed: high = good MI

Overall the follow-up had little or no significant impact, though it is possible that a larger sample might have produced significant findings. The next sections explore what factors might be associated with MI performance at stage 2.

Was level of participation in the supervision and consultations important?
Given the null finding for additional input it appears important to explore possible reasons. One factor to be considered is that not all those in the "workshop plus" group participated in all the sessions. In the table below the number attending one or both consultations, and the number of phone supervisions successfully carried out are noted, as is a total level of participation for each participant calculated by adding the two together.

Number of telephone interviews and group consultations undertaken

	Consultations attended (of 2)	Phone supervisions (of 3)	Total contacts
0	6	7	2
1	10	5	5
2	4	8	5
3			8
4 or 5			0

This is a mixed level of participation in the follow-up. No participant received more than 3 inputs, 5 received only 1 and 2 received none. This important finding is discussed further below.

What factors were associated with extent of participation in the follow-up?
Regression analysis was carried out with "participation" (i.e. total number of post-training contacts) as the dependent variable. No factor appeared to predict the extent of participation in the follow-up at stage 1.

Did amount of input received post-training influence skills?
In order to explore whether extent of participation in post-training input was related to skill post-training, t-tests were carried out with “participation” as the independent variable and various outcome measures. There was no relationship with skill in using MI, the HRQ or the parental resistance scores.

Qualitative evidence on the impact of additional input post-training
The evidence from interviews with participants produced a more mixed picture of the contribution of the additional consultations and telephone supervisions. When workers were asked about them most said they had found them helpful to some degree. In particular they highlighted the benefits of hearing about other people’s successes or failures:

> *I thought it was interesting to hear the points from the other social worker, more really just because her role was so different from mine and it was interesting to see how she had made efforts to incorporate MI. And it was interesting to get her feedback from my cases, again because her role was so different.*

Two participants had found the consultations particularly helpful in providing an impetus to try-out skills from the training, and in particular felt the consultation increased their confidence in using the skills:

> *before I went to that consultation I kind of felt unprepared for actually still using the motivational interviewing techniques in the workplace, but after listening actually to what other people were doing and how they were using the skills and everything like that, I found it much easier after that. Then after that consultation I had lots more success in actually not just doing the summarising back that you talk about in motivational interviewing but then actually directing that summarising back to get a conversation to go into the direction we wanted to go into.*

However, a number of participants reported finding it difficult to make it to the consultation session:

> *I think they just clashed with other things. We do operate a duty system here that’s two weeks in every five, so that takes, so you only have three weeks then to do your own work. So I think the pressure as always, social workers have pressure in different ways.*

There was relatively little feedback about the telephone supervisions, despite explicit exploration of their impact. They often appeared to have had a low priority for respondents, who reported finding it difficult to focus on the conversation in a busy office:

this is a busy office and you kind of set time aside and you get on the telephone and you know that actually somebody else is waiting to talk to you or there is another phone call that you need to make, so I suppose it is about a time thing really. So yes, I mean I think it is a good idea but I don't know that it was useful.

Nonetheless five noted that they were a helpful way of keeping them focused on trying out the skills in practice. For instance:

It was useful as a reminder but I think also it was, I think [the phone supervisor] called me and I think he probably uses it, or uses aspects of it anyway. Because it is quite nice to be on the receiving end and receive a practical reminder rather than just being reminded that you've done the training and have you implemented it.

Overall, while participants reported positively on the follow-up they were rarely able to specify specific ways in which it had helped them to improve their use of MI skills in practice. The one way in which it was most often considered to have been helpful was by forcing participants to focus on using the skills because they knew they had a phone conversation or consultations coming up:

To be brutally honest it just means that you think about it more often than you probably would have done otherwise.

Level of MI skill and the impact of additional input
Interestingly, while the follow-up did not have a statistically significant relationship with MI skill there were indications of a relationship in some aspects of the qualitative data. The 3 individuals with the highest MI scores had all been in the "workshop plus" group, and all talked positively about the impact of the follow-up input. Thus while the follow-up did not have any general significant impact, it may have assisted in the development of the most skilled practice.

Data collected from the telephone supervisions
Notes were taken during and after telephone supervisions. Both supervisors were struck by not only the fact that it was often very hard to arrange telephone supervisions, but also that even when arranged they were often cancelled or workers were not there when phoned. Furthermore, often when workers did answer the phone they appeared to have forgotten that they were due to talk. The level of preparedness varied widely, with some having cases or issues to talk about. However, most did not have specific issues to discuss.

In addition, following each session the supervisor rated the individual's likelihood of change toward MI-consistent practice from 1 (very unlikely) through 3 (somewhat likely) to 5 (highly likely). The ratings were compared with the outcomes. There was a high correlation between the supervisor's rating after the first phone conversation and the eventual level of MI measured. Most strikingly the 3 individuals rated as "5" after the first telephone supervision were amongst the 4 with the highest level of skill in MI. There was a relationship between ratings of further phone conversations, but the relationship was less striking.

KEY FINDINGS FROM THE ANALYSIS OF THE IMPACT OF THE ADDITIONAL CONSULTATIONS AND SUPERVISIONS

- Post-training supervision and group consultations had no measurable impact on overall skill levels

- There were some indications that it might have made a difference for some individuals, particularly for those participants who achieved competence

- There was a comparatively low level of participation in follow-up consultations and telephone supervision.

4.5 WHAT FACTORS *WERE* ASSOCIATED WITH PARTICIPANTS SKILLS AT STAGE 2?

If the follow-up did not predict skills at stage 2, were there any factors that did?
Individual t-tests were carried out with skill in MI in the simulated interview ("MI skill") as the dependent variable. None of the characteristics of the participants (gender, ethnicity, qualification, current position, experience) were related. Neither were whether the participant came from North Borough or whether they attended with their line manager or not.

Whether the participant attended the first or second training appeared to have a significant impact on their MI skills at stage 2 (t=3.374; df=27; p=0.002).

Self assessed skills at stage 1 were not related to outcome measures. While the AAPPQ overall score at stage 1 was not related to outcomes, the theme of support for work with alcohol use was strongly statistically related to MI skills at stage 2 (r=-.504; p=0.005; n=29). However, the relationship was in an unexpected direction - the more support participants stated that they felt in relation to working with alcohol use, the less skilful they were at MI at second stage. There was no relationship with situational constraints scores.

A regression analysis was carried out including the two factors found to be associated with MI skill (i.e. which training attended and AAPPQ "level of support"). Both remained significant:

Factors associated with higher MI skill post-training

	Standardized Coefficients	t	Sig.
	Beta		
First or second training?	-.476	-3.305	.003
Support for alcohol work (AAPPQ)	-.427	-2.967	.006

Data collected in relation to the process of the training sessions
Given the significant finding in relation to which workshop was attended, it is worth examining the evidence on differences between the sessions. As noted in the method section, information was collected through both contemporaneous note-taking by a participant observer and in notes of a meeting held between the trainer and three members of the research team immediately after the training session.

These sources suggested a noticeable difference between the two training sessions. The first one appeared somewhat more positive to all the research team. The team noted a number of participants who appeared to have found the ideas of MI particularly salient for them and had become "champions" for MI within the group. There was nobody like this in the second session. The clearest example of this was that a number of reservations about MI were expressed in both sessions, however in the first training there was a tendency for other participants to argue for the positives of MI. In the second training session this rarely happened, and the trainers would often have to respond by trying to draw out or even explain positives in response to reservations. The second training session also had more people attending it (24 to 18), largely due to drop-outs from the first session. As a result it was also carried out in a larger room. These two factors may have influenced the group dynamics. There was less discussion in the group in the second training session.

Interview evidence on what influenced changes in practice

What factors helped participants to change their practice?
The most common factor cited by respondents as being associated with changing their practice was trying to use MI and finding that it worked for them. Fifteen respondents cited this, for instance:

> *as I made some efforts to use some of these techniques I did notice "okay, yeah it works a bit" so I think that kind of seeing examples of it and … practice and seeing it, yes, if actively you really do make the effort to put some of these techniques in it will make a difference. Maybe not always, but pretty much part of it does.*

A number of participants (9) noted aspects of the training that had been particularly effective for them. These included the trainer's style or ability and the practical exercises and role-plays. There was no particular pattern about which participants noted aspects of the training as helpful.

Eight participants identified a perceived fit between the values of MI and their own beliefs and style of work as important in taking-up MI. For instance:

> *I wasn't quite aware about when I went on it was it going to be as person centred as it was, so I was quite excited …I know something about this, it kind of made me a bit more confident about attending.*

Finally, 5 participants mentioned MI building on previous training they had received, and specifically non-directive counselling skills.

What factors hindered participants in changing their practice?

Lack of time
By far the most common reason given for having difficulties in putting MI into practice was time constraints. Three-quarters of all participants identified this as a challenge (30).

Time constraints and the need to obtain specific information as set out in the Assessment Framework were inter-twined problems in initial contact for families:

> *you have probably got 4 or 5 other interviews to do in a day and yes, you can recognise all the feelings and everything like that but all these things take time and to get somebody to come along naturally to the point that you want them to be at will naturally take more time than you just asking them questions and getting an answer.*

This was identified as a particular issue when developing a new way of working:

> *I think time issues are probably an awful lot less [if] you are just that much better at it. And I think people's anxieties are [I'm] not very good at this and if I have to think about where this is going and what kind of questions I ask here and where are they and whatever, then inevitably it takes time and you are going to let it go on and on. But that's about experience.*

A number of participants suggested that the empathic methods of MI were in line with good social work practice, and that the timescales and "tick boxes" of government assessment frameworks were less important than doing good work with clients:

[Current practice] is focussed on following procedures and obtaining facts; it doesn't really focus on the way people think and feel. MI gives you a much more holistic picture of the situation. If you could employ it throughout practice, it would make for better quality... I think unfortunately time constraints and organisational structure prevent workers from using it.

However, as indicated in the above quote, this led to a conflict between the work that they wished to do and the work they felt required to do. For several individuals this conflict was leading them to consider moving out of child protection into more therapeutic work.

MI is what I do anyway
Seven participants felt that the training had not had much impact on them because they felt they already practiced using the skills of MI.

I think I found it more like in some ways a bit of a refresher of good skills to use when working with people that are kind of difficult, resistant clients. And I have to say that it definitely hasn't made any dramatic difference in my practice.

Challenge of learning new skills
In contrast to the participants who identified MI as "what I do anyway", 13 workers felt that the main problem had simply been that it was too difficult to change their current practice:

Also it's difficult to let go of old things it's sometimes hard to change! You need to have confidence to think that this is probably a better way.

This was often combined with a perception that they had had limited opportunities to try out the skills of MI.

Absence of support
As Sherlock Holmes observed of the Hound of the Baskervilles, sometimes it is the dog that does not bark that is of most significance. What was very striking is that overall no worker reported strong support in skills development – whether in MI or other areas. Skills and professional development were rarely covered in supervision. There was very little linkage between supervision and training – even when the manager had attended the same course. There were no instances of supervisors carrying out live supervision, observing practice or working with recorded practice. Similarly the peer support was limited, and few workers appeared to have followed-up the references or websites provided.

Attending with managers or colleagues
An attempt was made to encourage workers to attend with their line managers. 12 of the participants did so (plus 6 who were managers and attended with workers from their team). However, this rarely made any difference to their experience of developing skills in MI. For most participants MI was never discussed in supervision. When it was discussed it did not appear to have been in depth:

It may have just been a discussion. I think he did ask me how I was using it and I said I needed to read up on the stuff and then I would. As with so many things in social work, you know, there's so much to do that certain things, as much as it's important, it starts to lose that importance against other things.

This was also reflected in the accounts of the managers themselves. Most described little, if any, follow-up discussion of MI after the training.

Workers talked more positively about discussing it with colleagues. In particular, several presented key aspects of the training in team meetings. This appeared helpful, though to a limited degree:

> *so we discussed it in an [internal] meeting and we discussed how we thought it was useful, that it was useful … We talked about it in terms of our practice but that was really the only time that we discussed it.*

In general while having colleagues or managers who had been on the training was associated with greater chance of having talked about MI after the training, this was rarely in any depth:

> *we talked about it even if it was just a jokey way, which was quite often. Not in a derogatory way but just if you overhead somebody on the telephone and they'd asked a particularly [MI] question then after they'd put the phone down there was a slight amount of [piss] taking about it. But it did, it kept it at the top of the agenda. Well near the top of the agenda. So I think it was useful to do it as a team thing.*

Level of MI skill and factors influencing changes in practice
There were some interesting differences, and some equally important similarities between individuals in the different MI-skill groups in the process of change (or the process of lack of change, as it appeared to be for some).

Firstly, there were some indications of pre-existing differences between the groups that were identified in discussing MI but were not picked up in the analysis of skills, attitudes and previous knowledge. While the numbers were small, individuals in the competent group were more likely to say that MI accorded with their own values (3 plus 4 in the middle group compared to 1 in the low skill group) and they were particularly likely to identify previous training in non-directive counselling as having provided a foundation for the use of MI (3 of 5 who mentioned this were in the competent group).

Previous counselling as a foundation for learning MI appeared to be in stark contrast to the belief that "MI is what I do anyway". Five of the 7 who said this were in the low competence group. (The remaining 2 were in the middle group). This is an important finding, because a score of 2 or less suggests that these practitioners were not doing anything remotely like MI. The perception that they were has a number of implications, because this was a perception for half of the individuals in the very low competence group. Indeed, it is interesting to compare it with those who identified a lack of confidence in their skill as a barrier. This group – who perceived MI as something new and difficult to do – tended to have relatively high skill (3 in competent group, 3 in middle group and 1 in low skill group). This is discussed further below.

The only other barrier to skills development that appeared related to poor performance was reporting having had limited opportunities to try out the skills of MI (1 in competent group, 4 in middle group and 3 in low skill group). This was a particular issue for managers. However, for most it is not possible to disentangle whether the lack of opportunity contributed to the low level of skill, or whether the low level of skill contributed to a feeling that it could not be used with clients.

There were two important issues that had complex relationships to skill level: the importance of trying out the skills and the challenge of lack of time.

Those who cited trying out skills and finding that they worked were distributed evenly across the groups. However, the skills they described differed. The high competence – particularly those at the higher range of competence – described trying out a range of MI skills. In contrast, those in low or middle groups tended to identify a relatively straightforward skill – such as open questions, listening without interrupting or asking a client what they thought should happen. Trying out skills appears associated with skills acquisition, whatever the level of skill being used.

The impact of time pressure was also found equally across all three groups, however again group members talked about it in different ways. A common theme was that it was considered a real and challenging issue for everyone who talked about it. However, amongst those with lower skill levels it tended to be given simply as the reason why they had not had the opportunity to use MI. Amongst competent practitioners there was a more complex response. Most felt MI took longer, and that this could conflict with managerial imperatives. For instance, one of those with a very high MI score commented:

> *We have a lot of information to cover, a lot of practical points that needs to be ticked off, if you will. And that's only going to get more so, we've got a new computer system that is just about to go live which is extremely prescriptive. And I think this is part of the thing from the Labour Government coming [top down] it's very much about indicators, you need to cover your indicators. You need to go out on that visit, you need to cover A through F and then come back and your manager will say right what's the situation. And if you are not able to bring that information to them there's [trouble] ……. So if the whole interview was around motivational interviewing, which I appreciate you can direct that interview, but certainly not as directive as sometimes you need to be.*

As noted above, some in the competent group suggested that this was in part about developing skills in this area. Others responded to this by choosing when and where to use MI, for instance not tending to use it in initial information-gathering but more in cases allocated for work. Others felt that the extra time that the interview took was justified by better outcomes, and less work at a later point – whether by providing a good start to work with parents or by reducing the need for re-referrals.

A final response that was common in the high skill group was a rejection of the pressures of timescales and performance indicators, and an assertion that the skills of MI, and in particular putting the client first, should take precedence. This was not always a comfortable position: as noted earlier high skill practitioners were particularly likely to be actively seeking jobs out of field social work settings.

KEY FINDINGS FROM THE ANALYSIS OF FACTORS INFLUENCING SKILL LEVELS POST-TRAINING

- The workshop attended appeared to make a significant difference to skills post-training. The difference in the numbers attending, pre-existing dispositions of some participants and the nature of the group discussions in the different workshops were possible contributory factors to this.

- There were some common themes across participants with all levels of post-training MI skill. These included:
    - The most important challenge in skills development was to try to put a skill into practice
    - Social workers were working under considerable pressure
    - There was little support for skills development
    - This did not appear to be influenced by attending training with managers
- There were however some important differences between MI-competent practitioners and the rest. These included:
    - Competent practitioners were unlikely to think that “MI is what I do anyway”. This was particularly likely to be the view of those with low skill in MI.
    - In contrast, MI-competent practitioners tended to identify the challenge of changing as a potential barrier, and in particular would talk about lack of confidence in their ability to develop MI skills

4.6 THE USE OF MI IN CHILD AND FAMILY SOCIAL WORK

A key aspect of the study was to explore issues in using MI in child and family social work settings. We were therefore interested in participants' experiences of using MI, or aspects of MI, in their work.

Quantitative analysis

Which MI skills were considered most useful?

Participants were asked about five core skills in MI (using open questions, reflective listening, summary statements, affirmations and eliciting change talk). For each they were asked to rate how helpful they found it and how often they used it.

The general picture was relatively consistent across all 5 areas. A small number of participants found every skill unhelpful (2 or 3 for each), a more noteworthy proportion rated each area as neither helpful nor unhelpful (7 to 18), however for most aspects most participants rated the aspect helpful (from 15 to 28). The skill found most helpful was using open questions (28 rated this as helpful) while the one that fewest found helpful was eliciting change talk (only 15). There were very strong correlations between self-rated helpfulness and self-rating of how often a particular skill was used.

The results for those with competent MI skills were compared to the rest of the sample. There were some interesting – and unexpected – results. Competent participants rated each area of MI as *less* helpful and they suggested that they used it *less* often than non-competent participants. In some areas this was significant (for instance helpfulness of open questions ($r=0.446$; $p=0.008$); helpfulness of change talk ($r=0.333$; $p=0.055$); how often they use open questions ($r=0.443$; $p= 0.009$)). However, the pattern was strong across all areas. This unexpected finding is discussed further below.

What were the barriers to using MI in child and family social work?

Workers were asked to rate their agreement or disagreement with various potential strengths or limitations of MI identified in training and consultations. (1=very strongly agree through to 5= strongly disagree). The results are set out below. They suggest that the MI focus on empathy and the transferability of MI scored highly; the difficulty in doing it in an assessment is an area of difficulty. The sense that MI is "what I do anyway" may be either a strength or an obstacle, depending whether it is true.

Once again, responses to these statements were analysed by whether the participant had achieved MI competence or not (see table on next page). Statistical significance was not found for any of the statements (paired t-test). However, it is interesting to note that where there was a difference, the MI-competent practitioners were more critical of MI (for instance, more feeling it took too long or was difficult to use in child and family settings). However, perhaps the most interesting finding was the response to “MI is what I do anyhow”: 29% (7 of 24) of those who had not demonstrated MI-competence suggested this, compared to only 10% (1) of the competent practitioners. This reiterates the finding from the qualitative analysis of skills development noted above.

These findings are discussed further below. However, they demonstrate some of the difficulties involved in using self-reported skills in evaluating training. They therefore provide a useful reminder of these issues in interpreting the qualitative accounts.

How workers rated various statements in relation to MI and social work

	Average rating	% Agreeing with statement	
		Not MI-competent n=24	MI-competent n=10
MI would be more appropriate for long term work than short term work	3.05	29%	30%
MI is what I do anyhow	2.89	29%	10%
We don't have the right support at work to use MI	3.55	21%	30%
It's difficult to use MI in C&F settings because the social worker's role is very different from that of a counsellor	3.37	12.5%	30%
MI's focus on empathy toward clients fits in well with best practice	1.87	92%	100%
MI takes too long	3.32	8%	44%
MI is a transferable skill that can be used in a wide range of settings	1.50	92%	100%
Much of my work is assessment. MI will not be easy to use in an assessment	3.68	12.5%	20%

Qualitative analysis

Who MI could and could not be used with

As the focus of the training was on parental alcohol misuse it is unsurprising that it was the most common issue with which MI was tried. MI was described in relation to 13 families in which alcohol misuse was an issue. The outcomes were generally positive. As noted above, it helped with engagement and with understanding what was going on for the client. However, it was often difficult for participants to disentangle the impact of using MI skills from other factors:

> *I think it was just slight really, because they were open from the off set. I think what the slight is that they know what their short comings were but it was to get them to look at dealing with certain problems in a different way basically.*

However, workers were encouraged to try MI with other cases if they felt it might be useful, and they tried it with a range of other issues. Workers talked about using MI with domestic violence in 8 families, and this appeared to be a particularly promising area for the use of such skills:

> *two or three that I have actually used it successfully I would say is it is not round alcohol misuse, it was round domestic violence and actually getting somebody to - through using the skills - look at what the best outcomes are going to be actually for kind of her children.*

Workers also found it particularly helpful with teenagers who were difficult to engage. Twelve mentioned such cases:

> *the girl had behaviour difficulties as well and became aggressive very easily. She had a very, very good support from her family and from, especially from*

her older sister. And I used the same [i.e. MI] and her sister was with me at the time and she was saying 'Oh my God, I mean you are about the fifth Social Worker but the way how you asking is very different from what the others used to ask'. And I tried to explain to her, to the sister about the motivational interviewing

Some workers – particularly those who had found the training most helpful – had started to use MI in most or all of their cases. They had therefore used it on a very wide range of issues, generally with indications of success. In total 18 participants gave a further 38 examples of times when they had used MI. Issues dealt with using MI included discussing contact arrangements with parents, negotiating the accommodation of a young person into care, working on parenting skills, undertaking assessments, working with neglect cases and disputes with neighbours. Some even talked about using MI with their children or friends.

One area in which there did appear to be difficulties in using MI was with clients with communication difficulties. One participant described trying to use MI through an interpreter and finding this impossible. Another had found it difficult using MI with someone with limited English.

Tensions between a child focus and a parent focus

A particular focus of the study was to explore the issues involved in using MI within a child and family social work setting. The primary challenge identified in using MI – apart from those involved in changing one's practice (discussed below) – was managing the conflict between one's role in protecting the child and working with the parent. A high number of participants discussed conflicts in using MI with a parent when the social worker's client was the child. While the central dynamic was around using MI in working with parents while retaining focus on the child, this manifested itself in various ways.

An important conflict identified by 4 participants was whether the level of change, and the time taken to achieve it, was likely to be acceptable to the child:

I think it is trying to work within the child's time line, it can be quite a slow process and that mightn't be fast enough really for what the child needs.

However, while this was identified as a serious and important concern by these participants, there were no examples of cases in which this had actually been a difficulty. This does not mean that this is not a genuine challenge. However, the empirical evidence identified this as an issue that practitioners considered potentially difficult rather than providing evidence on their management of it in practice.

A tension that did occur in practice, that was discussed by 12 participants and that was a different manifestation of the parent/child challenge, was one between an MI focus on being positive and supportive and a child protection requirement to be clear and if necessary confront certain forms of parental behaviour:

you are really trying to highlight the positives but then you kind of go 'but we are still really concerned and your child is still experiencing very serious case of maltreatment, we could consider proceedings and we do feel that we need to'

This was a challenge that those who scored highly in MI skill were particularly likely to identify. They suggested it was especially acute at the "heavy end" of child protection, and in initial engagement with parents:

if you are in a situation where you are going in and saying "have you hit this child?" then you can use motivational interviewing but if they are resistant all the way through then you are going to need to confront them because you need to know before you leave that session if that child is going to be safe or not.

However, several of those in the high skill group had tried out various ways of using MI skills while trying to be clear about concerns. It was striking that in the high skill group - in contrast to several members of the low skill group - there was nobody who talked about avoiding confronting difficult issues. Instead, participants talked about strategies for (a) minimising the resistance caused by raising difficult issues through the way in which concerns were raised and (b) using MI skills in dealing with resistance produced by raising such issues. An interesting example of both of these, that is worth quoting at length, was provided in one account of a meeting in which the social worker was to tell a mother that the worker did not feel the child could return home - a situation as full of confrontation and potential resistance as can be imagined:

I first just kind of introduced myself and introduced my role and then I just kind of said …"I want to let you start, can you just kind of share maybe anything you're feeling about your daughter, how you're feeling now, any concerns that you have, where you want to see it going?", so she just kind of talked for a while and she's quite dramatic, … so I had no problem getting her to talk and she cried a few times, and then I was able to say "okay, so I think this is what you're saying" which again I felt was good to focus it back to what we were talking about, and then I said "basically this is where I am, I'm going to be very up front with you and kind of said that I don't necessarily think that the child coming back here is appropriate and this is why". And then I also said, "I certainly think that your relationship is very important and I would like to make sure that that continues and that it's maintained and nurtured". … So kind of letting her speak first really helped open the door for the points I needed to say. And then I think I was empathetic, well I tried to be empathetic with her as far as her depression and her feelings about not having the child with her. So yes, I mean so I guess letting her talk, being empathic, and then I did a little bit of rephrasing on some points, so I think all those things really helped. And especially the part about letting her talk first and then being able to say what I think, that was pretty good

.

Another worker gave an example of using many of the same skills but structuring the interaction differently. She started by being clear about concerns - being open and honest - and then used the MI skills. Once again, this was a very high risk case:

they were hostile towards social services, resistant to change, telling lies, all the rest of it. And actually they were very resistant, I was seeing the family twice a week, I felt I had built up a good open working relationship with them, they didn't particularly like social services, they didn't really want my involvement, but over time I worked with them and I did a lot of reflecting and a lot of paraphrasing with that family and they did, something clicked, they decided 'yes, now is the time we have got to' they knew the score, I clearly said [at the beginning] 'if they didn't engage the services it is likely their child would be removed' and was very straight and very open and very honest, because that wall had been put up.

Amongst those in the high skill group who had tried to use the skills of MI in these settings there was a universal feeling that they had been helpful in reducing resistance and increasing parental engagement:

> *I do actually feel parents aren't as resistant any more. I think maybe the way I worked previously has caused more resistance rather than parents actually being resistant. … In the past when I have done child protection investigations I have been very direct in the way I have approached things and it has led to confrontation with parents at times. Since starting to do it in a more open-ended question manner the amount of confrontation I am coming into with parents, it is still there but it is minimal, it is minimal, it has been drastically reduced.*
>
> Or
>
> *that antagonistic relationship that has been … between social workers and service users now that relationship where they feel social services is there to blame more, you know, it's removed that aspect.*

KEY FINDINGS FROM THE DESCRIPTIONS OF THE USE OF MI IN CHILD AND FAMILY SOCIAL WORK SETTINGS

- Quantitative and qualitative data suggested that MI-competent participants were more likely to have critically engaged with MI. They were more moderate in their assessment of MI, and more able to identify challenges in using MI

- MI or aspects of MI appeared to have wider applicability than solely parental alcohol misuse. It was used with apparent success with a range of other issues. Domestic violence and teenagers with challenging behaviour appeared particularly promising groups for the use of MI.

- Competent workers had developed a variety of promising strategies for incorporating MI skills into challenging and difficult situations. They continued to value being "open and honest" with clients, particularly around concerns for children, but had explored ways of using MI-related skills while doing this.

5. Discussion

Limitations and strengths

The study has a number of limitations that should be born in mind in interpreting the results. The sample is comparatively small, particularly for the between-groups comparisons. This makes false positives and the failure to identify significant relationships that would occur in larger samples more likely. It is also a London-based sample. The composition of the workforce may be different in other areas, for instance with fewer workers trained abroad, with implications that are difficult to predict. There may also be different practices and issues within London; a different picture might be obtained in, for instance, a rural area. In addition, the sample is a convenience sample. It is composed of volunteers, who might be expected to be interested and motivated compared to other workers.

An important data collection limitation is that the comparative lack of evaluative work in the area of child and family social work means that there were no validated measures that could be used in the study. The pre-existing instruments that were used have not been validated on social workers. Furthermore an important source of information was various measures based on simulated practice. Simulated practice is not real practice. There are likely to be performance effects related to attempts to be seen to do what is “right”, and these will be amplified following training that made explicit the interests of the research team. These may have contributed to the changes in the HRQ and PRS scores, and therefore care should be taken in assuming that these identified changes might represent the same level of change in actual practice. Similarly, the qualitative data collection post-training may have been influenced by participants’ exaggerating the impact of the training on the basis that this was what the researchers were interested in. (Though some reassurance in relation to this is the high proportion prepared to say that the training had had little influence on them). Finally, the HRQ was repeated and so there may be practice effects.

On the other hand the study has a variety of strengths. Firstly, the study design (i.e. a pre- and post-training study of change in skills with an imbedded controlled trial of additional post-training input) and the different types of data collected (i.e. validated instruments, a range of measures of simulated practice, ratings of current cases and qualitative information from interviews and from observations) have allowed a rich set of data to be collected. Thus, the scores in simulated practice situations can be compared against one another (e.g. HRQ, PRS and MI scores) and against information from the social worker's interview, validated instruments and other sources (such as the impressions of the telephone supervisors). Secondly, the design had a controlled comparison for the “workshop plus” group, and this ensures some rigour about the impact of the follow-up.

Key Findings

The first and most striking finding was the high level of confrontation and the low level of listening shown by social workers in the various simulated vignettes prior to the training. This was important in its own right, as it indicates the prevailing nature of current social work may be confrontational, but it was also important in interpreting the other findings, as discussed below. It was interesting to note that the ratings for the HRQ showed much lower levels of listening than comparable research with counsellors, but that pre-training the levels were almost identical to those in Nerdrum and Lundquist's (1995) study of social workers.

Secondly, the training showed evidence of contributing to measurable and qualitative change over time. Changes in the AAPPQ measure, in reports on cases and from the

qualitative interviews suggested a measurable change toward greater confidence and less stress in working with parental alcohol misuse. However, most striking was that the workshops moved most workers toward less confrontational approaches and more listening to parents. This move was supported by evidence from simulated practice and from social workers' own accounts of their practice. Taken together these are impressive outcomes 3 months after a 2-day training. They also compare favourably to other studies that have used similar outcome measures. For instance, Nerdrum and Lundquist's study – which provided considerably more input than the 2-day workshop of the current study (50 hours over 10 weeks) – found a change in HRQ score of +0.33 (compared to +0.56 in the current study).

Thirdly, there was considerable qualitative evidence that this less confrontational approach was having a positive impact. There were strong indications that it had had a positive impact on participants' relationships with parents. There was also some suggestions of improved outcomes for parents, for young people and in some instances for the social worker themselves in terms of less stress and more job satisfaction. Evidence from the interviews and the risk assessment vignette suggested that the benefits of a less confrontational approach were achieved without a reduction in focus on the child. This beneficial change was most noticeable amongst those with the highest level of skill in MI post-training.

Fourthly, despite these changes the overall level of skill in MI was relatively low. Only 10 practitioners achieved something approaching beginning level competence, and most did not achieve anything like skill in MI. A 2-day workshop does not appear to be sufficient to facilitate a style of work that is MI-consistent, at least for most practitioners in this setting.

Fifthly, the additional input of telephone supervision and group consultations was not effective. Participation rates were low, and participation itself appeared to have a limited impact. Social workers reported finding it difficult to prioritise such input. Interestingly, similar problems have been found in other studies. For instance, Miller and Mount (2001) offered 6 follow-up consultations to counsellors in probation but on average participants attended less than one. Thus, while there is evidence that follow-up input is helpful there appear to be difficulties in achieving acceptable levels of participation.

Finally, in this context it is not possible to draw firm conclusions about the complexities of using MI in child and family social work settings. Nonetheless, analysis of the interviews of participants with the higher scores in MI in the simulated interviews suggested that many were using MI skills with high degrees of success with a range of clients and situations. These participants were particularly likely to report the benefits of MI as a way of working. Some talked insightfully about the complexity of using MI in practice and about strategies for using MI in child protection work in particular. This provides evidence that supports further work in developing MI as a way of working for child and family social workers, not only for working with alcohol misuse but also for a broader range of issues.

Implications of findings

Low listening skills at stage 1

The low level of listening and the high level of confrontation identified at stage 1 provides the baseline for evaluating the impact of the training, and as such informs the interpretation of our findings. For instance, it appears likely both that the significant shifts in practice reported as a result of the training and the few practitioners who achieved MI competence may be related to the relatively low level

of baseline listening reported. However, it is also a finding in its own right. The bulk of research on child protection has relied on retrospective interviews with participants. There are few if any studies providing information on what social workers actually say to clients in either real or simulated settings. As such, the current findings provide important information on the quality and nature of social workers' responses to clients' problems.

There is no doubt that the social work role in areas such as child protection is extremely challenging. Social workers are not counsellors; they are employed by the state and their focus is necessarily on the child. However, in their role they are expected to be able both to confront parents and to engage them. The task of social workers requires being able to empathise and work with parents while retaining a focus on the child and their welfare. The dilemma, discussed by participants both in the training and in the follow-up interviews, is how to be honest and clear with parents without creating hostility; how to be empathic without colluding with unacceptable behaviour; how, in short, to reconcile the different imperatives of the role within their practice.

An unexpected finding from the study was that in carrying out this task social workers tended to be highly confrontational and rarely showed what might be considered to be good listening skills. The picture was so consistent that it can not be about individual practice, it is a systemic issue. The interviews with social workers, and evidence from the notes on the training and supervision sessions, provide some suggestions about factors that might contribute to this approach being predominant. Three appear particularly important.

Firstly, the development of confrontational approaches appears to be in part an attempt to avoid the dangers of collusion with clients. It is worth exploring the imperatives to avoid collusion, as well as the comparative lack of guidance for social workers about the micro-skills involved in working in partnership while avoiding becoming parent-focussed.

Historically, a number of child death inquiry reports have pointed out the risks of a focus on parents and their needs (Laming, 2002; DH, 1990), and commentators have noted that a move away from an overly trusting approach to parents may be seen as one of the key insights in the development of effective child protection (Littlechild, 1998). It was noteworthy that team managers and senior practitioners were particularly likely in our study to emphasise the importance of an ability to confront parents. They may be seen to be the key shapers of practice in teams, and as such their commitment to the importance of avoiding collusion may be particularly important.

In contrast to the findings of inquiries into child deaths, social workers have consistently been criticised by both research studies and policy makers for a tendency to be "heavy handed" in carrying out child protection investigations (DH, 1995). However, the only practical recommendation has been to consider fewer cases to be child protection and treat more as family support, or to use a "lighter touch" - though without defining clearly what this means (DH, 1995). As pointed out by Spratt (2000, 2001, 2004) re-labelling a case does not in itself remove the element of risk to a child, nor the difficult balance that the worker needs to manage between working in partnership with parents and avoiding colluding with them where there are concerns. In fact, there is very little guidance on how this should be managed. Official guidance recognises the importance of both partnership and protection, but provides little detail on how the two should be combined in working with a family and nothing on the micro-skills involved in interacting with parents in these difficult circumstances.

Even research studies specifically focussing on partnership working have had little if anything to say about the micro-skills of how one builds a partnership (Thoburn et al, 1995; Brandon et al, 1999).

This lack of guidance for workers at managing this most difficult of relationships is replicated at the level of social work theory. Reviewing key social work textbooks it becomes apparent that most social work approaches are imported from therapeutic settings, and they have little to say about working with resistant clients (see for instance Payne, 2002). Even approaches developed within social work, such as task-centred or radical approaches, start with the assumption that the client wishes to engage with the social worker (Payne, 2002). There are exceptions, such as Trotter's textbook on working with involuntary clients (Trotter, 2002), however by and large there is remarkably little written about how to engage and work with resistant clients.

In these circumstances it would appear that child and family social work has developed a mode of operating that prizes clarity about concerns over partnership with parents and empowerment. Workers are assailed both by arguments for being open and up-front about concerns, and by those for greater partnership and support for parents. But they are provided with little guidance on how to combine the two in practice. In these circumstances, the emphasis appears to be on ensuring parents are not colluded with at the expense of a listening or partnership approach.

A second major factor that workers often mentioned and that appeared to be linked to the low levels of listening skills demonstrated might be termed the "managerialist" tendency in modern social work practice (Beresford and Croft, 2004). Many participants described a work setting that was not supportive of client-centred practice. Overwhelmingly the most important reason social workers gave for not developing their skills in MI was a lack of time. They talked of high pressure environments, with tight deadlines, a great deal of paperwork and little support for individual professional development. Furthermore government initiatives appeared to have resulted – perhaps inadvertently – in a focus on "tick-box assessments" and completion of forms within tight timescales. In particular, the Assessment Framework (Department of Health, 2000) which was intended to ensure good quality assessments was often being used as a bureaucratic exercise that defined questions to be asked, rather than a framework for skilled assessment. This was perceived to militate against the client-centred listening skills the current initiative was designed to promote. Supervision often reflected this, with a tendency to focus on whether tasks had been completed. In such circumstances, initiatives aimed at developing better inter-personal skills seem likely to encounter difficulties in supporting the transfer of skills into practice. This is likely to have contributed to the lack of listening skills demonstrated at stage 1.

The third systemic factor that appeared to contribute to the low level of listening skills demonstrated by social workers was that the findings suggested a lack of focus within child and family social work on skills development and the development of professional practice. This is important because the low level of listening and high level of confrontation identified was not solely about workers choosing to confront clients. It was often about offering advice, making alternative suggestions and other responses that Gordon (1970, in Miller and Rollnick, 2002) labelled as "roadblocks" to effective listening. In other words, while some of the low level of listening was due to a confrontational approach, much seemed linked to low levels of listening skills.

An important indication of a lack of attention to skills development within the profession was the almost complete lack of supervisory focus on this area. Whether social workers attended with their line manager or not they reported little attention

given to their skills in working with parents in the months after the training. None reported their line manager observing their practice, or using audio or video-recorded practice to focus on skills development. Indeed, a striking feature of the interviews with the managers was their inability to provide evidence on the direct work with clients of those they worked with. There were exceptions, but in general managers appeared to evaluate workers either through outcomes for cases or through the way in which workers discussed cases in supervision. A further finding that suggested a lack of professional focus on skills development was the problems encountered in engaging workers in the follow-up telephone supervision and consultations. It is clear that follow-up skills development for social workers requires a different format to be effective, and this is discussed further below. Nonetheless, the lack of engagement with the follow-up appeared to suggest a general absence of focus on skills development within social work. Overall, the research painted a picture of a profession that spends little time systematically focussing on developing the skills of its practitioners.

The finding from pre-training that social workers tend not to demonstrate good listening skills, and that they are often very confrontational in their interactions with clients, has implications for improving practice generally and the use of MI specifically. These are considered below. However, there is a further implication that is worth noting.

In the introduction, the high level of denial, minimization and general resistance that social workers encounter in working with parents with alcohol problems was highlighted. The finding that social workers tend to be confrontational and rarely use listening skills opens up the possibility that – to some degree at least – social workers are inadvertently causing or contributing to the resistance that they are finding so difficult. There was also important evidence to support this from the qualitative accounts after the training. Workers consistently talked about encountering far less resistance when using the skills of MI, or even when using basic listening skills, and the more skilled they were in MI the more true this appeared to be.

This is not to say that the resistance that social workers encounter in this area is solely produced by them. As noted above, their role is particularly difficult and prone to create resistance. However, in this context it is all the more important that they are highly skilled in understanding and working with resistance. At present they do not appear to be so. This may inadvertently be contributing to the very real practice problems they encounter in their work, and to the negative experiences of child protection investigations so vividly described in interviews with parents and children in research studies (for example, Farmer and Owen, 1995; Cleaver and Freeman, 1995).

Evaluating the impact of the training: is the glass half empty or half full?
On the one hand it can be argued that the evidence of very significant change in simulated practice, 3 months after a 2-day course, combined with the qualitative reflections of the positive impact that these changes had on work with families, is extremely encouraging. On the other hand, few achieved competence in MI practice, and this may be considered disappointing. In fact, as noted above, these findings are likely to be related. The significant changes achieved are likely in part to be a product of the comparatively low starting point for many practitioners; the failure to reach skilled practice by most practitioners – or indeed any level of skill for many – may be a product of the same thing.

An important question to start with is whether a 2-day training course is sufficient for training MI. The unequivocal answer for child and family social workers is “no”.

However, there were factors that made change more – or less – likely. The significant difference between the two training courses was an unexpected finding. It is not possible to be certain why this was so, but two factors seem likely to be important. The first training session had more individuals who already talked about having training in counselling. These individuals disproportionately went on to demonstrate skill in MI. It seems likely that a 2-day training course only has any chance of success if it is working with individuals who already have some level of competence in listening skills. In addition having a smaller number of participants and having some who were enthusiastic about MI and "championed" it in the training appeared to be important for creating a particularly successful training workshop.

The impact of the follow-up provision was disappointing. The findings suggest that both telephone supervision and group consultations are difficult for social workers to make use of. Nonetheless, there were indications that some sort of follow-up was helpful, particularly for those who achieved competence in MI. It seems likely that the type of follow-up being provided is the problem rather than the need for follow-up. It is possible that something more formal – such as a follow-up training day or days booked at the time the first workshop was being booked – might be more useful.

Finally, there were interesting indications of factors associated with participants being more - or less - likely to develop skills in MI. Perhaps most interesting, because it appears at first somewhat paradoxical, was that the low skill participants were particularly likely to consider that MI was what they did anyway - despite ample evidence that this was not so. They also rated various aspects of MI as more useful and themselves as using them more often than the skilled participants. In contrast, those in the competent group were more likely to talk about MI as being challenging or difficult, to be critical of elements of MI and to highlight a lack of confidence in developing their skill. These findings can be interpreted in different ways. Certainly they point to the inadequacy of using self-reported skills as a measure of actual skill. This is important because this remains the most common form of evaluation of training impact (Walters et al, 2005).

However, at a deeper level the findings point to a challenge for those interested in facilitating changes in practice, whether as trainers, supervisors or in other capacities. As noted in the introduction, there is a body of evidence highlighting the importance of practitioners feeling confident that they can change. Yet Wehrman et al (2002) found, in a similar way to the current study, that those who rated themselves as having the best knowledge of the materials covered on a course were the least likely to use the skills in practice. It would appear that for the trainer, or anyone else interested in skills acquisition, there are three potentially competing imperatives. Firstly, the skills being taught need to appear salient to the trainee: they need to think there is a potential gain from using them. Secondly, they need to feel that learning them is a *challenge*. If they do not, they have no impetus to change their current practice. Thus, for instance, Miller and Mount (2001) found that a 2-day workshop increased self-rated skills far more than skills in practice situations. As such, they suggest that 2-day training may act as an "inoculation" against further learning, because it may give participants the feeling that they are skilled without the reality. Finally, participants need to feel that they are able to master the new skills. Thus a challenge in training child and family social workers MI is ensuring that they do *not* feel that it is what they do anyway, that they think it worthwhile to learn the skills and that they feel able to learn them if they try.

A second important factor appeared to be which workshop was attended. This is an interesting finding, partly because it was not anticipated and partly because it was in accord with the notes taken during and at the end of the sessions. There are a

number of factors that might have contributed to this difference, however the fact that the discussions within the group appeared more positive about MI from an early stage was striking. This may have been because a larger group, in a larger room, for the second workshop had a different dynamic. However, an important contribution appeared to be the fact that some vocal group members supported MI from an early stage in the first workshop. And these individuals were particularly likely to score highly in MI at follow-up. There is increasing recent interest in whether workshops "work" in developing skills (e.g. Walters et al, 2005). This finding suggests that the answer may be that they vary in effectiveness. It points toward a focus on what makes some workshops work while others do not.

Using MI and related listening skills in child and family social work

Of course, care needs to be taken in interpreting qualitative evaluations of practice. Nonetheless, the very striking and consistent descriptions of improved listening, better relationships with parents, less resistance encountered and indications of better outcomes in the work – including reduced stress for the worker - all point toward the huge importance of listening skills in child and family social work, and particularly child protection work. Furthermore, there was no indication –in the risk assessment vignette, the simulated client interviews or the interviews with social workers – that the use of listening skills resulted in collusion with clients. Indeed, it was the more highly skilled workers who were most interested in ensuring that empathic listening did not result in collusion or loss of focus on the key issues. It was only those low in MI skill who talked about letting clients change the topic and lead the conversation.

There were also indications of the potential that MI might have within this field from the few practitioners who achieved competence or close to competence. The skilled workers gave a number of examples of having worked with complex and challenging cases using MI. They appeared to have found the approach helpful and to have negotiated challenges around using MI in the social work role with considerable skill. In particular, they had found ways to combine being "open and honest" about concerns with careful and empathic listening to the responses of parents.

What is to be done? Or the implications of the findings in relation to skills acquisition

The most important implication of the study is that urgent attention needs to be given to ensuring that child and family social workers are able to use basic listening skills such as open questions, reflections and summary statements in their practice. The move toward a more empathic and listening approach seemed to be linked to better practice and outcomes for all concerned. It was therefore extremely encouraging to find that a 2-day workshop was able to have such a positive impact in this respect.

Nonetheless, the low level of listening skills demonstrated is clearly grounds for turning attention to the training of listening and communication skills in social work education. As Carpenter (2004) has recently noted, there is very little systematic research on the effectiveness of aspects of social work training. SCIE (2003) in their review of communication skills training on social work courses similarly were not able to provide a clear picture of what was taught and found few attempts to measure its effectiveness. Given the centrality of communication skills to social work (Dickson and Bamford, 1995) this is a lamentable state of affairs. The current study makes a number of contributions in this area.

Firstly, it has used simulated practice in a variety of ways to measure the acquisition of skills. This is comparatively rare within the social work literature, however given the manifest problems identified in self-reported skills assessment in the current

study - and the obvious difficulties in measuring actual practice - this appears a promising approach for measuring the impact of training for social workers. Secondly, the combination of types of data gathered allowed both *whether* and *why* change had occurred to be examined. This considerably enriched the study. Thirdly, the use of vignettes and in particular the interview with a simulated client proved remarkably useful as an approach not only for evaluating training but also for understanding social work practice. Because of the obvious problems in accessing directly interviews between social workers and clients, almost all research in this area relies upon retrospective accounts of practice. A striking finding from the current study was that using simulated practice situations provided rich evidence on how social workers talk to clients. There appears to be little or no research published on how social workers talk to clients, particularly in difficult situations such as child protection investigations, based on contemporaneous evidence. Given the complex imperatives of the role discussed above, developing a better understanding not only of what micro-skills social workers use but also how they influence outcomes seems vitally important research. Interviews with simulated clients might be an important way to explore this.

Thirdly, if one wishes to create social workers competent in MI then clearly greater input is required than a 2-day training course. For instance a series of follow-up training days, including if possible discussion of actual practice recorded on tape might be optimal (Walters et al, 2005). From the experience of this project, this would either require strong support from senior management within one or more local authorities or for the programme to be tied in to a qualification, such as the Post-Qualifying Masters in Social Work programme. There may be greater potential for exploring training social work students MI than with current field-workers, particularly if the teaching could be tied-in to assessed competence (Miller and Mount, 2004).

Conclusion

This study started out with a clear rationale. Resistance is a big problem within child and family social work with parents with alcohol problems. A key feature of MI is that it provides an understanding of resistance and the skills likely to reduce it. The study therefore proposed to train social workers in MI and explore the outcomes.

The findings of the study strongly support the original rationale for the research. Indeed, they highlight the urgent need for further work in this area. Not only was resistance a widespread phenomenon – not just in relation to alcohol misuse but the whole gamut of cases - but an unexpected finding was the extent to which social workers were often likely to be contributing to creating it. Teaching even the basics of MI made a measureable difference to simulated practice and appeared to have a positive impact on work with real families.

Yet the findings also identified the scale of the task ahead. The deeply engrained tendency toward a confrontational approach lacking in empathy, and the systemic lack of support for the development of communication skills within the profession, suggest that changing social work practice toward one more congruent with MI will be a substantial task. However, the study also provides strong indications of some of the positive outcomes that may be achievable in engaging and working with vulnerable parents and children using MI. It therefore provides support for further work to explore training child and family social workers in MI, not only for working with cases involving parental alcohol misuse but for a wide gamut of issues involving engaging resistant clients and helping individuals change problematic behaviours. As such, it offers great promise as a way forward for social work, for these issues of resistance, behaviour change and confrontation go to the heart of social work with children and their families.

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