Islington social workers | doing what counts and measuring what matters

One Minute Guide - Motivational Social Work (MSW) Coding Tool

What is the MSW Coding Tool?

Motivational Social Work (MSW) is grounded in principles of *Motivational Interviewing (MI), Task Centred Social Work (TCSW),* and *Motivational Risk Assessment & Management (MRAM).* MSW is a relationship based model of practice that **aims to reduce resistance and ambivalence in service users (See – One Minute Guide – Motivational Social Work (MSW))**.

The evidence base for Motivational Social Work (MSW) identifies seven key elements essential to effective social work practice: ***evocation, collaboration, autonomy, empathy, purposefulness, clarity about concerns and child focus***. **These seven elements are social work values that can be measured as behaviours during practice and form the foundation of the MSW Practice Evaluation Framework (See One Minute Guide).**

How is the MSW Coding Tool used?

The MSW Coding Tool is used to code the audio tape of the practice observation. The person that codes the audio tape is different from the person that undertakes the practice observation. Practice evaluators receive special training to enable them to use the MSW coding tool reliably.

The evaluator listens for the verbal anchors that indicate the extent that each of the practice skills are evident during the observation. Each skill is rated as one (low) to five (high) (See Appendix A). A proficient social worker should score three or over in each category as a minimum standard. In Islington we are aiming for 3.5 or over.

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APPENDIX A – MSW Coding Tool (Abbreviated Version – excludes verbal anchors)

Purposefulness				
Low				High
1	2	3	4	5
There is no clear aim to the interview and it is not obvious what the worker is trying to achieve.	There is some sense of purpose but the interview has substantial chunks where the purpose is unclear, or where the interview is formulaic.	The session has a clear overall sense of purpose. However, either this is imposed without significant negotiation or it is not sustained throughout	The interview has a clear negotiated sense of purpose and this is evident through most of the interview.	The interview has a clear sense of purpose that Is negotiated and understood by all parties throughout. Worker shows evidence of planning and there is flexibility in response to the client's agenda.

This scale measures the extent to which the worker maintains a clear focus for the session. Focus is a complex concept, as it is necessary to good practice but needs to be negotiated. In most interviews a shared negotiation of purpose is ideal, but it can be appropriate to impose a clear agenda (for instance, if there are important issues that need to be discussed) or to follow the client's agenda (for instance, if they make important disclosures).

Low on Scale

Social workers low on *purposefulness* fail to provide structure or clarity to the session and the reason for the visit may remain unclear throughout. The conversation may sound like an informal chat between peers rather than a professional visit. Sessions low on *purposefulness* are likely to have an aimless quality and the listener will be unable to identify what the worker is trying to achieve. Alternatively, the worker may make some attempt to state a purpose but fails to retain a focus on this.

High on Scale

Social workers high on *purposefulness* know from the outset what they are trying to achieve and are transparent in their focus on this. They also recognise the need to create a shared agenda which incorporates the client's needs. Workers high on *purposefulness* view the session as a professional intervention and are working towards a specific aim. They are able to respond flexibly to the client's contributions whilst maintaining a clear focus throughout.

Clarity about Issues or Concerns				
Low				High
1	2	3	4	5
Worker fails to cover significant issues or concerns, or to respond to relevant disclosures made during the session.	Worker fails to provide sufficient focus or clarity around issues or concerns. May refer to them indirectly.	Issues or concerns are raised as appropriate, but with limited opportunities for exploration or discussion.	Worker raises issues and concerns during the session and attempts to explore the client's perspective.	Worker ensures that issues and concerns are raised during the session and the client is meaningfully engaged in discussion throughout.

The scale measures the extent to which the worker is clear about the reasons for social work involvement and able to engage in meaningful dialogue with the client about issues or concerns. Social workers should always be involved with a family or child for a reason. This measure identifies the worker's ability to raise such issues and have them incorporated into helpful discussions.

Low scores would indicate interviews where it was difficult or impossible to be clear what concerns or problems led to the social worker's involvement. High scores would see concerns integrated into helpful conversations without interviews becoming inappropriately problem-saturated. It is possible that there will be some interviews where it is not possible to code for Clarity. We are also interested to see how it relates to Purposefulness.

Low on Scale

Social workers low on *clarity about issues or concerns* fail to make the reasons for social work involvement explicit. This might include not raising issues or concerns, or failing to respond to significant disclosures during the interview. Workers low on *clarity about issues or concerns* may appear to lack confidence in raising difficult subjects so avoid them where possible.

High on Scale

Social workers high on *clarity about issues or concerns* ensure that issues or concerns are made explicit during the session. They are comfortable with their professional role and are able to raise issues confidently or respond appropriately to disclosures. Workers high on *clarity about issues or concerns* recognise the need to engage clients meaningfully in the discussion and are interested in their perspective of the issues or concerns. They are able to challenge appropriately whilst acknowledging an alternative point of view.

Child Focus				
Low				High
1	2	3	4	5
Fails to consider the child or issues relating to them. May be focused on the parents needs at the expense of the child's.	Issues relating to the child are raised superficially or briefly.	Worker incorporates the child into discussions but does so in a generic fashion with missed opportunities for exploration with the parent.	Child is meaningfully integrated into the discussion with some attempts to draw on the parent's perspective.	Child is meaningfully and consistently integrated into the discussion in order to enhance the parents understanding of the child's needs.

This scale is intended to measure the extent to which the worker ensures the child is 'present' in the conversation.

Low on Scale

Social workers low on *child focus* fail to consider the child or issues relating to the child throughout the session. They may become drawn into discussing parental issues or concerns without relating these to the needs of the child. Workers low on *child focus* will fail to identify the child as possible motivation for parental change, focusing *what* needs to change rather than *why*. Alternatively discussions about the child may focus solely on the worker's perspective of what is in their best interests. Worker imposes simplistic formulation of what is in the best interests of the child, without incorporating parental contributions. May involve compartmentalised or tokenistic identification of issues for the child.

High on Scale

Social workers high on *child focus* ensure that the child is appropriately integrated into the discussion. They recognise that addressing issues and concerns relating to the parent is ultimately to meet the needs of the child. They are curious about the parent's views of the child's situation.

Workers high on *child focus* identify the child as a possible source of motivation for change and do not miss opportunities to explore this in depth.

Evocation				
Low			High	
1	2	3	4	5
Clinician actively provides reasons for change, or education about change, in the absence of exploring client's knowledge, efforts or motivation.	Clinician relies on education and information giving at the expense of exploring client's personal motivations and ideas.	Clinician shows no particular interest in, or awareness of, client's own reasons for change and how change should occur. May provide information or education without tailoring to client circumstances.	Clinician is accepting of client's own reasons for change and ideas about how change should happen when they are offered in interaction. Does not attempt to educate or direct if client resists.	Clinician works proactively to evoke client's own reasons for change and ideas about how change should happen.

This scale is intended to measure the extent to which the clinician conveys an understanding that motivation for change, and the ability to move toward that change, reside mostly within the client and therefore focuses efforts to elicit and expand it within the therapeutic interaction.

Low on Scale

Clinicians low on this scale have only superficial interest in the client's ambivalence or reasons for change, and miss opportunities to explore these in detail. They may make assumptions about the client's intent to change (or not change) without exploring this in detail, or may ignore the client's ideas when they are offered. Clinicians low in Evocation may rely on persistent fact gathering or information-giving as a means of facilitating change, and often convey a distrust of the client's current knowledge base about the problem under consideration. Clinicians on the low end of this scale do not respond to change talk when it is offered, or do so in a perfunctory manner. They are likely to provide the clients with reasons to change, rather than eliciting them.

High on Scale

Clinicians high on this scale are curious about their clients' personal and unique ideas about why change is a good idea or might not be. They not only follow up on these ideas when the client offers them, but also actively seek to explore them when the client does not. Although they might provide information or education, clinicians high in evocation do not rely on it as a means of helping clients to change. Instead, they prioritize exploration of the client's personal reasons for change and the means to go about it, and do not allow this exploration to be neglected amid other content or information in the session. Clinicians high on the Evocation scale understand the value of hearing the client's own language in favor of change, and actively create opportunities for that language to occur.

Collaboration				
Low			High	
1	2	3	4	5
Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration is absent.	**Clinician responds to opportunities to collaborate superficially.**	**Clinician incorporates client's goals, ideas and values but does so in a lukewarm or erratic fashion. May not perceive or may ignore opportunities to deepen client's contribution to the interview.**	**Clinician fosters collaboration and power sharing so that client's ideas impact the session in ways that they otherwise would not.**	**Clinician actively fosters and encourages power sharing in the interaction in such a way that client's ideas substantially influence the nature of the session.**

This scale measures the extent to which the clinician behaves as if the interview is occurring between two equal partners, both of whom have knowledge that might be useful in the problem under consideration.

Low on Scale

Clinicians low in *Collaboration* do not work towards a mutual understanding during the session. They rely on one-way communication based on the clinician's authority and expertise for progress. They may be dismissive, overly passive or so acquiescent that they do not make a genuine contribution to the interaction. These clinicians rely on their knowledge to respond to the client's problem and do not appear to value the client's knowledge. They are often ahead of their clients in prescribing both the need for change and the means to achieve it. Their interactions with clients appear more like wrestling than dancing.

High on Scale

Clinicians high in *Collaboration* work cooperatively with the client toward the goals of the interview. They do not rely on dominance, expertise or authority to achieve progress. They are curious about client ideas, and are willing to be influenced by them. These clinicians can hold the reins on their own expertise, using it strategically and not before the client is ready to receive it. Clinicians high in *Collaboration* appear to be dancing with their clients during an interview—one moment leading, the next following—in seamless motion.

Autonomy/Support				
Low			High	
1	2	3	4	5
Clinician actively detracts from or denies client's perception of choice or control.	**Clinician discourages client's perception of choice or responds to it superficially.**	**Clinician is neutral relative to client autonomy and choice.**	**Clinician is accepting and supportive of client autonomy.**	**Clinician adds significantly to the feeling and meaning of client's expression of autonomy, in such a way as to *markedly expand client's experience of own control and choice.***

This scale is intended to convey the extent to which the clinician supports and actively fosters client perception of choice as opposed to attempting to control the client's behavior or choices. Scores on the autonomy scale include the avoidance of particular behaviors and proactively pursuing strategies to enhance autonomy or support.

Low on Scale

Clinicians low on Autonomy/Support view the client as incapable of moving in the direction of health without input from clinician. They may assume that the client will change their behavior in the direction that the clinician thinks is best. The clinician may explicitly tell that client that he or she has no choice. In addition, the clinician may imply that external consequences (such as arrest, coercion from others) have removed choice. Clinicians may also insist that there is only one way to approach a target behavior or they may be pessimistic or cynical about the client's ability to change. Clinicians low on Autonomy/Support may convey choices but do so dismissively or with sarcasm.

*Note: Do not lower Autonomy/Support scores if the clinician is empathizing with the client's perceived lack of choices, hopelessness or resentment about current circumstance.

High on Scale

Clinicians high on Autonomy/Support ensure, either directly or implicitly, that the topic of choice and control is raised in session. They view the client as having the potential to move in the direction of health. Clinicians high on this scale work to help the client recognize choices with regard to the target behavior. In addition, clinicians may explicitly acknowledge that the client has the choice to change or maintain the status quo. They may also express an optimism about the client's ability to change.

Empathy				
Low			High	
1	2	3	4	5
Clinician has no apparent interest in client's worldview. Gives little or no attention to the client's perspective.	**Clinician makes sporadic efforts to explore the client's perspective. Clinicians' understanding may be inaccurate or may detract from the client's true meaning.**	**Clinician is actively trying to understand the client's perspective, with modest success.**	**Clinician shows evidence of accurate understanding of client's worldview. Makes active and repeated efforts to understand client's point of view. Understanding mostly limited to explicit content.**	**Clinician shows evidence of deep understanding of client's point of view, not just for what has been explicitly stated but what the client means but has not yet said.**

This scale measures the extent to which the clinician understands or makes an effort to grasp the client's perspective and feelings: literally, how much the clinician attempts to "try on" what the client feels or thinks. Empathy should not be confused with warmth, acceptance, genuineness, or client advocacy; these are independent of the empathy rating. Reflective listening is an important part of this characteristic, but this global rating is intended to capture all efforts that the clinician makes to understand the client's perspective and convey that understanding to the client.

Low on Scale

Clinicians low in *Empathy* show indifference or active dismissal of the client's perspective and experiences. They may probe for factual information or to pursue an agenda, but they do so to "build a case" for their point of view, rather than for the sole purpose of understanding the client's perspective. There is little effort to gain a deeper understanding of complex events and emotions, and questions asked reflect shallowness or impatience. They might express hostility toward the client's viewpoint or directly blame the client for negative outcomes.

High on Scale

Clinicians high in *Empathy* approach the session as an opportunity to learn about the client. They are curious. They spend time exploring the client's opinions and ideas about the target behavior especially. Empathy is evident when providers show an active interest in understanding what the client is saying. It can also be apparent when the clinician accurately follows or perceives a complex story or statement by the client or probes gently to gain clarity.