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Practitioner Perspectives on the Impact of Collaborative Documentation on the Therapeutic Alliance

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MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

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Abstract

Collaborative documentation (CD), also known as concurrent documentation, is the practice of creating the case record in the presence of the client. This is often done in collaboration with the client, where the client has input into what is written in the clinical record. This practice is relatively new, and there is disagreement among practitioners about how this can impact the therapeutic alliance between the practitioner and the client. Some say that it could harm their relationships with the clients they serve, others report improvements in the therapeutic alliance. This study explored the relationship between the practice of CD and the quality of the therapeutic alliance. Five practitioners were selected who use CD in providing mental health services. Each was interviewed utilizing an interview schedule based on the short form of the Working Alliance Inventory- short (WAI-s) (Horvath & Greenberg, 1989). Findings included variance in the practitioner perceptions of the impact of CD on the therapeutic alliance, but did support that when certain ways of practicing CD are used the impact can be a positive one. Some practitioners were more skeptical of the positive impact of CD on the therapeutic alliance, but most agreed that it is helpful in gaining improved agreement between practitioner and client on goals.

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Table of Contents

Introduction

Supervisors and administrators are frequently concerned with issues of documentation in clinical practice. They would like to see quality notes done in a timely fashion with plenty of time left to facilitate increases in quality client contact (Reilly, Mckelvey-Walsh, Freundlich, & Brenner, 2011). There are good reasons they should be concerned with documentation even beyond administrative or funding issues. Quality of care is affected by the quality of documentation (Cox, et al., 2003). Case notes can be used in clinical training (Prieto & Scheel, 2002). Practitioners often complain that they do not have time to complete case documentation within timeliness guidelines, and often are stressed, busy, and find little time left to document client interactions in a quality way. Clients with involvement in court systems and who have concerns about pre-existing conditions are also often interested in the content of what is written about their lives.

To address these issues some agencies have adopted the practice of collaborative documentation (CD), in which the case note is generated collaboratively with the client in order to ensure accuracy and timeliness of the note as well as increase efficiency of the practitioner (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.).

Many practitioners have negative initial reactions to the idea of writing case notes with clients present, worrying about their ability to engage with clients (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Grantham, 2010; Mental Health Weekly, 2010). Initial CD pilot projects (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.) report that the therapeutic relationship between clients and practitioners who use CD is

improved from before its implementation. While these results look promising, there are no references to the practice in any peer reviewed research articles in the social work field. One possible exception was in Jenson, Pine, Spath, and Kerman (2009), who report, "In the initial comprehensive assessment conducted with each family at intake, staff members documented these strengths with parents and included them in the case record" (p. 343) but this appears to only be documenting the treatment planning as opposed to doing ongoing CD. Jenson, Pine, Spath, & Kerman (2009) go on to illustrate that this practice of documenting strengths of the parents assists in building the working alliance. These authors (2009) again refer to the practice of collaborating with parents to do assessments and treatment planning as important to building the therapeutic alliance. While these sounded like the study may have utilized collaborative documentation, Spath indicated that no form of CD was specifically utilized in the study (personal communication, October 31, 2011).

A commonly cited reason that practitioners are skeptical of CD is fear of degradation of the therapeutic alliance (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.). However, early pilot projects have indicated an increase in therapeutic alliance (Grantham, 2010; Martin, Garske, & Davis, 2000; Midwestern Colorado Center for Mental Health Standardized Documentation Team; Mental Health Weekly, 2010, Schmelter, n.d.), so it was of interest to explore the relationship between the practice of CD and therapeutic alliance. This is even more salient when it is noted that therapeutic alliance has been identified as a strong predictor of positive client outcomes (Bordin,

1979; Duff & Bedi, 2009; Jenson, Pine, Spath & Kerman, 2009). This study explored the relationship between the practice of CD and the quality of the therapeutic alliance.

Literature Review

Collaborative Documentation

For purposes of this study the terms collaborative documentation and concurrent documentation will be used synonymously. No distinction between the two terms is apparent in the limited literature (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.). Most of the available pilot studies appear to be done in consultation with MTM Services, as contracted with the National Council for Community Behavioral Healthcare (NCCBH) (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.). Earlier MTM documents seem to use "concurrent" while later documents seem to use "collaborative" (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.). One definition of collaborative, or concurrent, documentation is "a model of documenting the session content and process with the consumer/family 'at the same time' he/she/they are still present in the session with the service provider. It involves incorporating an active discussion at the end of the service encounter and documenting the information provided in the electronic clinical record (ECR)" (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.).

Preliminary results (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter,

n.d.) have indicated that the use of CD has resulted in an increase in the quality of care. Fewer "no shows," increased practitioner efficiency, improved therapeutic alliances and less staff burnout are listed as some of the positives involved in CD (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.).

There is little to be found in the literature that refers to the practice of CD. This researcher searched for "collaborative documentation" using quotes in both Social Work Abstracts and Family Studies Abstracts and no results were found. This researcher used the same terms in Academic Search Premier, which yielded four results. Of these four, one was rejected because collaborative documentation referred to a collaborative community process for doing community research (Kelly, Azelton, Lardon, Mock, Tandon, & Thomas, 2004), one was rejected because collaborative documentation referred to interprofessional access to patient records (McLaney, Strathern, Johnson, & Allen-Ackley,2010), and one was rejected because collaborative documentation referred to simultaneous access to client record editing (Knaup, Garde, & Haux, 2007). The remaining result was a profession related magazine but not a peer reviewed academic journal (*Mental Health Weekly Review*, 2010). This researcher searched for "concurrent documentation" in quotes through Social Work Abstracts and Family Studies Abstracts and no results were found.

This researcher used the same terms in Academic Search Premier, which yielded five results. Of these five, one was rejected because concurrent documentation referred to software processes (Pei & Petry, 1980), and one was rejected because it referred to simultaneous access to client record editing (Philipp, Jantke, Finkeissen, Beedgen,

Linderkamp, & Wetter, 2005). The remaining three results were in professionally related magazines but not peer reviewed academic journals (Grantham, 2010; *Mental Health Weekly Review*, 2008 & 2010). A search of "collaborative documentation" in quotes in PsycInfo yielded an additional result that was excluded because CD referred to multiple user editing access in a computer program for education research editing (Cogan-Drew, 2009). A search of "concurrent documentation" in quotes in PsycInfo yielded only a dissertation in which concurrent documentation refers to the author's other studies in process at the time of the publication of her dissertation (Freed, 2010). Health Reference Center did not provide any additional resources not previously covered from the other databases. This researcher was able to identify no peer reviewed academic journal articles that referred to CD as defined in this study. As evidenced by the limited literature about CD, this is an exploratory study of the practice.

Factors influencing the therapeutic alliance

Some CD pilot projects have pointed to benefits in the therapeutic alliance such as fewer no shows and greater agreement on goals (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.); initial clinician reactions tend to be of fear that the practice will damage the therapeutic alliance (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.). Therapeutic alliance research seeks to identify how to improve the therapeutic alliance due to its importance to outcomes (Duff & Bedi, 2009; Jenson, Pine, Spath & Kerman, 2009). This researcher has identified the aspects of therapeutic alliance literature which would appear to be relevant to CD.

The therapeutic alliance is a collaborative relationship which includes similarities in goals, tasks, and the affective bond between client and therapist (Bordin, 1979; Jenson, Pine, Spath & Kerman, 2009; Martin, Garske, & Davis, 2000). That the quality of this relationship is indicative of favorable outcomes is well established (Bordin, 1979; Duff & Bedi, 2009; Jenson, Pine, Spath & Kerman, 2009). Bordin's (1979) constructs of the therapeutic alliance have been widely used to study the quality of the therapeutic relationship. Different versions of the Working Alliance Inventory (WAI) are widely used in measuring the therapeutic alliance (Duff & Bedi, 2010; Gellhaus Thomas, Werner-Wilson, & Murphy, 2005; Hersoug, Høglend, Havik, & Monsen, 2010; Horvath & Greenberg, 1989; Jenson, Pine, Spath & Kerman, 2009; Knerr, et al., 2011; Martin, Garske, & Davis, 2000). The WAI measures the working alliance based on Bordin's (1979) constructs of agreement on goals, agreement on tasks, and the affective bond (Horvath & Greenberg, 1989). Agreement of goals refers to how well the client and practitioner are able to agree on the goals of the working alliance; similarly how well client and practitioner agree on the tasks involved in achieving those goals are important (Bordin, 1979). The affective bond is how the client and practitioner relate (Bordin). Bordin (1979) views the working alliance as central to all forms of psychotherapy and conceptualizes the different types of psychotherapy around how the working alliance is distinguished.

Some practitioner behaviors have been identified which have been shown to correlate with stronger therapeutic alliances (Duff & Bedi, 2010). Validation refers to a grouping of behaviors which serve to validate the client’s feelings, experience, or perspective (Bordin, 1979; Bedi, 2006; Duff & Bedi, 2010). Validation has been shown

to correlate with strong working alliances (Bedi, 2006; Duff & Bedi, 2010). Duff and Bedi (2010) identified specific validation behaviors as asking questions, making encouraging comments, identifying and reflecting back client's feelings, making positive comments about the client, and validating the client's experience. One way of validating client experience that is helpful in repairing a decline in the working alliance is reevaluating goals to be more appropriate to client progress (Hersoug, Høglend, Havik, & Monsen, 2010). Some basic interpersonal skills were positively correlated to a strong working alliance, such as eye contact, smiling and greeting the client, referencing previously mentioned details, honesty, sitting still, and facing the client (Duff & Bedi, 2010).

Therapist self-disclosure was not correlated in a statistically significant way to working alliance, perhaps due to variability in therapist judgment or skill in self-disclosure or clients' valuing of this as important (Duff & Bedi, 2010). Providing verbal prompts and letting the client decide what to talk about were also not statistically significantly correlated to a strong working alliance (Duff & Bedi, 2010). Another behavior which did not correlate to a strong working alliance was "keeping administration outside of session time" (Duff & Bedi, 2010). This category arose through the process of multivariate concept mapping in one of Bedi's (2006) previous studies in which clients were surveyed and their responses were grouped into categories. The category included scheduling sessions, paperwork, and fees (Bedi, 2006). The lack of high levels of personal distress on the part of the client is predictive of a strong working alliance (Knerr, et al., 2011; Hersoug, Høglend, Havik, & Monsen, 2010).

Clients' early experiences of negative transference tend to predict weaker therapeutic alliances (Hersoug, Høglend, Havik, & Monsen, 2010).

The therapeutic alliance is crucial to favorable outcomes (Bordin, 1979; Duff & Bedi, 2010; Jenson, Pine, Spath & Kerman, 2009). The controversy over the adoption of the practice of CD seems to center around this issue. Proponents claim the therapeutic alliance can benefit from CD, and skeptics worry that it will be damaging to the therapeutic alliance (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.). Given that the strength of the therapeutic alliance appears to be a more robust predictor of positive outcomes than choice of modality (Bordin, 1979) and that some behaviors have been identified which correlate to strong therapeutic alliances (Bedi, 2006; Duff & Bedi, 2010; Knerr, et al., 2011; Hersoug, Høglend, Havik, & Monsen, 2010), it would appear that striving for a strong therapeutic alliance would be the most advantageous and empirically supported method for maximizing positive outcomes which is to some degree in the control of the practitioner. Practitioners therefore have a responsibility to explore the therapeutic alliance as much as choice of modality. It is therefore important to evaluate all clinical behaviors through the lens of the therapeutic alliance literature. Duff and Bedi's (2010) finding that the behavior of "keeping administration outside of session time" was not statistically significantly correlated with a strong therapeutic alliance allows for the possibility that CD may not actually be harmful to the therapeutic relationship. In light of the pilot projects, it would appear that there is some feasibility that CD could benefit the therapeutic alliance.

The case can be made that CD addresses two of the three concepts of the therapeutic alliance as postulated by Bordin (1979). CD can effectively contribute to improved goal agreement (Bordin, 1979) by making sure the client and the practitioner are in agreement in real time while the practitioner is documenting them (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Grantham, 2010; Mental Health Weekly, 2010, Schmelter, n.d.). The conversation between the client and the practitioner as they come to agreement on goal setting offers the opportunity to address goals in a way in which the client perceives increased goal agreement (Bordin, 1979). Likewise the client and practitioner must spend the last few minutes of the session (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter) coming to agreement on the tasks (Bordin, 1979) which were accomplished during the session. This also may involve conversation that might help or hinder the affective bond, or the interpersonal relationship built on mutual trust (Bordin, 1979) between client and practitioner. If the evidence is mixed as to whether or not doing administrative tasks in session is important to a strong therapeutic alliance (Bedi, 2006; Duff & Bedi, 2010), then perhaps the first two dimensions of the therapeutic alliance give importance to the question of how CD impacts the affective bond in particular and the therapeutic alliance as a whole. The purpose of this study is to explore the impact CD has on the therapeutic alliance.

Conceptual Framework

CD is reported to increase client participation in the working alliance (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health

Standardized Documentation Team, n.d.; Schmelter), which builds on the strengths the client has in order to develop better solutions. The strengths perspective is important to social work values. (Miley, O'Melia, & DuBois, 2009). A strengths based empowerment conceptual framework will inform this study of CD.

Collaboration between clients and practitioners influences practitioner conceptualizations of clinical practice (Miley, O'Melia, & DuBois, 2009) and has been identified as important to the therapeutic alliance (Sullivan, Skovholt, & Jennings, 2005). This is in contrast to previous models which put the professional in the role of being an expert, in which it would make sense to document after the contact with the client has concluded. Collaboration has been identified as a critical consideration in defining empowerment (Bolton & Brookings, 1996). Collaboration enlists clients in the process of working towards their goals (Miley, O'Melia, & DuBois, 2009). It is important to allow the client's story to be heard, and drive the client's work (Cowger, 1994; Miley, O'Melia, & DuBois, 2009). Praxis, the process of acting, reflecting, and responding or changing as necessary (Miley, O'Melia, & DuBois, 2009), is supported by CD and can be improved to include the client in the process by soliciting client feedback on the process and progress of the work towards improving client systems.

It is quite possible that the use of CD in assessment and beyond would be a step towards an empowerment approach. It is important for the client to own the assessment process (Cowger, 1994). Clients are empowered by being actively engaged in the decision making process. (Linhorst, Hamilton, Young, & Eckert, 2002). Assertiveness is important to empowerment (Bolton & Brookings, 1996), so when content of the assessment is determined by the priorities of the client (Cowger, 1994) the approach is

more empowering. The use of CD may well be one thing that helps to ensure that the client's goals drive the treatment because the client knows what is being recorded in real time (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter).

Another facet of empowerment as identified by Bolton and Brookings (1996) is a goal orientation. Client set goals in treatment planning (Linhorst, Hamilton, Young, & Eckert, 2002) and progress on goals can easily be kept in the progress note. The client has the opportunity to take increased ownership of the goal orientation when progress is measured and recorded collaboratively. This increases the access the client has to information which belongs to him or her, and this increase of knowledge is a factor in increased power (Miley, O'Melia, & DuBois, 2009). With certain exceptions, clients have the right to view their records, so the practice of CD directly facilitates client's access to this, emphasizing the aspect of client rights in empowerment theory. Recognizing successes along the way is important to the empowerment framework (Miley, O'Melia, & DuBois, 2009). This also is facilitated by the use of CD especially when progress is specifically tracked in the progress notes.

Other factors which contribute to increased empowerment include commitment, autonomy, and avoiding victim blaming (Bolton & Brookings, 1996; Miley, O'Melia, & DuBois, 2009). Commitment is important to empowerment, defined by Bolton and Brookings, (1996) as "to be completely engaged in whatever one is doing" (p 256). CD would be one additional way in which clients can increase their engagement in meeting their goals (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter). Autonomy is one

of the defining characteristics of empowerment (Bolton & Brookings, 1996). Empowerment contributes to clients' ability to exercise control (Miley, O'Melia, & DuBois, 2009). Victim blaming, an impediment to empowerment (Cowger, 1994; Miley, O'Melia, & DuBois, 2009), is more difficult when the practitioner is documenting collaboratively.

Method

Research Design

This study explored the relationship between the practice of CD and the quality of the therapeutic alliance. This was a qualitative research design with a semistructured interview schedule (Appendix A). It adapted the WAI-s (Horvath & Greenberg, 1989). While it was proposed that practitioner responses could be used to generate a hybrid WIA-s score to be used to evaluate the degree to which CD impacts the working alliance in the perceptions of the participants, the limited number of participants rendered this quantitative aspect of the study statistically meaningless. The WAI-s was used with permission (Appendix B).

Sample

This study included a convenience sample of five practitioners who are using CD in providing mental health services. Participants were solicited via agencies known to practice collaborative documentation and provide Targeted Case Management (TCM), Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment Services (IRTS), Care Coordination (CC), and psychotherapy. Participants were all experienced in the mental health field, ranging from almost 10 years to over twenty years.

Participants' experience with collaborative documentation ranged from one and a half months to five years. This researcher asked the executive directors of these agencies to forward a solicitation email (Appendix C) to appropriate programs, and participants responded directly to this researcher. This was a convenience sample due to the limited number of practitioners utilizing CD in the area as a result of the novelty of the practice.

Protection of Human Subjects

Participants and their responses were kept confidential but the limited number of practitioners who utilize CD could have posed some risk for identification, especially as this sample was informed by agencies that are practicing CD. This risk was minimized by emailing executive directors of the participating agencies a solicitation message (Appendix C) to be forwarded to appropriate programs without informing the agencies of who is or is not participating. Participants responded directly to this researcher, so agency managers would not know who participated. Agencies electronically signed a consent form (Appendix D). Participants signed a consent form (Appendix E). Interviews were recorded on an mp3 player which remained in the researcher's possession and locked until files were uploaded to a password protected iPod. These mp3 files were transcribed by this researcher. Paper documents were kept in a locked filing cabinet in this researcher's locked home, and electronic documents were kept on this researcher's password protected computer. No individually identifiable responses were shared with administrators of the programs.

Data Collection Instrument and Process

In this study the researcher used a structured interview schedule (Appendix A) to interview the participants. The researcher used the Working Alliance Inventory – Short

(WAI-s) (Horvath & Greenberg, 1989) in creating the interview schedule. The WAI-s has been shown to be reliable and valid in intended use as a quantitative measure (Horvath & Greenberg, 1989), though not in the way this study used it to structure an interview schedule. However, face validity and reliability are high due to the clarity of the questions especially as they are directly based on such a valid, reliable, and widely used tool (Duff & Bedi, 2010; Gellhaus Thomas, Werner-Wilson, & Murphy, 2005; Hersoug, Høglend, Havik, & Monsen, 2010; Horvath & Greenberg, 1989; Jenson, Pine, Spath & Kerman, 2009; Knerr, et al., 2011; Martin, Garske, & Davis, 2000). The researcher interviewed participants to evaluate practitioner's values about the therapeutic alliance and their initial reactions to practice of CD. The researcher explored participants' current opinions and if they have changed, and those changes. The researcher asked participants to quantify the effect that CD has had on the different aspects of the working alliance using the questions which are based on the twelve items in the WAI-S Therapist edition (Horvath & Greenberg, 1989). The researcher also asked participants to elaborate on how they thought CD impacted each item of the WAI-s and how they would speculate that it could impact the working alliance.

Data Analysis

Participant's reported perceptions were scored on a scale of negative seven to positive seven, consistent with Horvath and Greenberg's (1989) WAI-s key to show the impact the participants perceived the practice of CD to have on the working alliance, in either a negative or positive direction. The two items on the WAI-s (Horvath & Greenberg, 1989) which are reverse coded were worded to eliminate the reverse in order to reduce confusion. This researcher categorized participant responses to the elaborations

and speculations of how they think CD has and could impact the working alliance according to the interview schedule. Content analysis was used to identify themes into which to group individual responses for the more elaborative and speculative responses (Berg, 2008).

Findings

After transcriptions were produced from the recorded interviews, content analysis yielded the themes of why practitioners chose to use CD, skill in the use of CD, how CD is used with clients, benefits and liabilities, and the impact on the therapeutic alliance.

Why Practitioners Decided to Use Collaborative Documentation

Practitioners reported their reasons for choosing to use CD in ways that followed two main themes. One was that it was either suggested or mandated by management; the other was that they became aware of the practice while looking for ways to manage their time. Some participants felt pressure from management, saying, "I don't see myself as having any choice in the matter," or explaining that "we weren't involved" in the decision to use CD. Another tried it in order to have the integrity to criticize it, saying, "...I thought I wouldn't like it, so I wanted to try it right away, and find out, with the idea that eventually I can see that this is the way things are going." Another reported,

> Partly pragmatic because there was such a pressure for time and I couldn't keep up with the paperwork. It was suggested to me as a way to, the pros were sold to me and I decided to give it a try and it was easier than I thought... I used it before management told me to.

It is clear that the idea to try CD came from management at least in part in all cases, though practitioners perceived varying degrees of how mandatory the practice should be.

Confidence and Skill in Using Collaborative Documentation

Despite that all participants had significant experience in the mental health field, there was a broad range of experience using CD. Some reported minimal training in the practice and report, "It's a frustrating thing to get involved in at first." One expressed optimism that experience would bring increased confidence when this researcher asked about confidence in using CD: "I really hope that in the next year to be more confident and comfortable. But not yet." An experienced user of CD reported:

> I feel very confident. The reason I feel confident is because I know why it is required of me. And then I develop the skill. Maintaining your own intentions as a therapist becomes a trick. Can you make it work for you? Can you find a place where you are comfortable in it? But that's the way it's gonna be.

Another participant noted the struggle with putting together a note that was complete during the session, saying, "I'm not at the point where I can formalize sentences. I feel like I need to be listening all the way while they're talking... I'm just taking notes, so that's not documentation that is needed for the noting." In contrast, an experienced user of CD reported, "I know that collaborative documentation does not set my agenda: what I feel is right and the client's needs at that moment, that's what sets the agenda. No matter what it's just another tool of technology."

Assessment and judgment about when to use CD came up as a factor in determining competence in using CD, saying:

> As I mature …I trust my gut more, or you could say my own transference, my own stuff, the productive part of transference I trust my gut more with the therapeutic relationship, and if I see somebody who's in an acute state of stress I

> have to sort of quickly need to find a balance: well this is something we've gotta do to because the powers that be want some information about why you're here and I type that in and then as I'm doing that I'm gauging to see does the person feel comfortable with this are they frustrated or resentful or are they in a state of stress and I need to attend to that and I'll address it directly, hey, is this okay with you ... so it's a therapeutic interaction.

The immediate environment matters also, as reported by one participant: "depending on the environment that we're in, you're not going to do it in court… it works only in certain situations when it's comfortable for both of us." Several participants reported high competence in typing which helped them feel more confident and competent in doing CD. One noted greater client receptivity to CD as practitioner confidence increases, saying, "they've actually responded better to it now that I'm a little bit more comfortable with it."

How participants use collaborative documentation with their clients. Several practices emerged from the data as important to the skillful use of CD. An accurate, balanced explanation of the practice to clients is important. One participant told of a colleague who noted that no clients wanted any part of it, and then found out the colleague was presenting it as a way to save paperwork. The participant has only had two clients refuse based on their own preferences, and presents the practice as a way to collaborate on the note and make sure it is clear, and that the client knows what is being recorded.

A second participant suggested the desire to begin to involve the client in the decision to use CD: "I guess now that I think about it it would be nice for me to ask

them, how would you like me to document this session?" Some participants spoke of better results when saving the documentation for the end of the session, as suggested in training materials (Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.). One reported: "I found out it's not working as I sit there and type while we're talking... after a couple of weeks of doing that I decided that we're going to talk I'm going write some notes, and then we're going to document."

Client participation is hinted at by the name, collaborative documentation, and this was noted as part of the practice by one participant:

> Actually the way that I do it they essentially have final say. If they ask me to change something I change it until we agree. I will not put something in that's inaccurate; however I will make sure we are in agreement. And so in that way collaborative is a good word for it.

Others give clients varying degrees of editorial license. Some note the importance of this collaboration as a way to maintain clinical clarity, "if I'm off base we can correct it, and the person might actually take a risk and tell me why." It was described as a part of the overall collaboration between client and practitioner by one participant: "We're both problem solving for what is going on. It feels like a mutual agreement."

Benefits and Liabilities

As with any clinical or technological tool, there are benefits and drawbacks to the use of CD. Time management is one of the most often cited reasons in why CD is considered, so it was no surprise that it came up in the data collection process. This is important because being busy and behind schedule is almost assumed when thinking about social work as a field. One participant noted, "it was always the nature of the work

of social work to be always behind." For some participants this represented the only advantage they expected to gain from practicing CD. Some found no particular time savings. One reported that in the session "it is very time consuming, it's very difficult, and I think it's very unwieldy and to do that because you're putting the brakes on a system." Another, who sometimes sees clients very briefly in their homes said, "I don't know if it is a time saver or not, I used to be able to drop in on clients... now it's like you take out the computer so it's not exactly a time saver." Others have found some time savings, but spoke about it less than other benefits, though one did say that it is "nice to be more efficient and walk out at the end of the day and not have notes to do."

Quality of the documentation was identified as another benefit of using CD. One participant noted, "I didn't think I'd have better documentation... and you know it is a little bit better it is a little more comprehensive." Another talked about increased accuracy: "it's a part of basic communication skills. To be accurate, so that we're not just comparing words and ideas in our heads." These appear to be related to the actual collaboration with the client to generate the note as opposed to just avoiding writing the note a long time later.

Some pointed out the client centeredness of the practice due to clients knowing what is reported. Clients with legal challenges are empowered by this aspect of CD:

> Clients who are involved in the legal system when there's any chance for the record being subpoenaed, we are very responsible for letting the clients know where that material may be going. So from the get go, when I'm going over informed consent and limits to confidentiality, and all those kinds of things, I am

> so clear, about that, and those clients are very much interested in collaborative documentation. And being a part of what goes in.

Similarly, of clients who are fearful of what is written in the record about them, one participant noted, "a couple of my more paranoid people absolutely love it."

One participant pointed out a surprising benefit of using CD that was different from others noted in the literature and other participants:

> "It's also giving me a better sense of boundaries too…. It's also making me aware of what it is that I'm doing, and not doing sometimes, understanding my relationship because I used to not have such good boundaries with my clients I used to have my empathy used to be so much that I'd handhold before and I used to not have that much sense about that and I think that collaborative documentation has really helped me to understand that boundary too... when I'm documenting more work that I'm putting in than my client, that I'm seeing that for myself and I need to stop and take a look and then see where is the point where my client is putting in their work and what's the process that's going on what is the relationship between myself and my client. And who is putting in what work.

There are some drawbacks that were mentioned. Some noted the computer can be cumbersome to log into and set up. Some also talked about how doing two things at once was detrimental to staying engaged with the client. Increased stress was explained by one:

> I think it is important for a therapist to be aware that you are paying a price for collaborative documentation. But you also can gain something if you can figure it out in your head. The price is the stress level because you are trying to do apples

> and oranges, in other words concerned with left brain activity... answering the question to put the question in a box on the forms, and then at the same time I'm trying to do relational work with the client with more sensory right brain stuff. So that causes me a lot of stress.

Collaborative Documentation and the Therapeutic Alliance

As stated above, the therapeutic alliance is a collaborative relationship which includes similarities in goals, tasks, and the affective bond between client and therapist (Bordin, 1979; Jenson, Pine, Spath & Kerman, 2009; Martin, Garske, & Davis, 2000). It makes most sense to explore the effect of CD on the therapeutic relationship as perceived by study participants looking at each of these factors independently.

Collaborative documentation and agreement on tasks. Participants frequently talked about how the use of CD improved clarification of the work being done with clients. One pointed out how before CD clients left each appointment with less clarity in what steps to take before the next appointment: "it's clarified it. We've been much clearer, it's not 'aright I'll see you in two weeks', it's 'okay now, you're gonna call your sister and … since I'm writing it down it's more concrete." Another noted, "I want to make sure that what I do is what they agree that they want to be doing, want to be working on." This view was not unanimous, though, as one participant suggested, "I don't see how it would help a client. Or help the client with receiving it." CD has the potential to remind the practitioner of what work the practitioner and client are doing in order to better attend to the client: "It's helped my confidence (in the usefulness of our current work together) a lot because my short term memory is a little fuzzy. So it helps me remember…It's good moment to moment reminders of what's going on." The ability

to demonstrate to clients what they have achieved is also important, "Collaborative documentation has allowed me to show them that they are able to do these things." One participant pointed out that "when it's clarified and more concrete, it's also prioritizing," which also supports the ways staying on track and attending to the details can support the therapeutic relationship. It was also suggested that whether or not clients believe the way we are working on their problems is correct "should be a topic of conversation whether you are documenting or not. It (CD) helps me remember to have that conversation, but, I think, it should have been anyway."

Collaborative documentation and the affective bond. While documentation may not sound relational, it does appear to have some impact on the affective bond. As one practitioner put it, "it's a concrete tool to do the subjective work." One part of the WAI (Horvath & Greenberg, 1989) asks if the practitioner believes the client "likes" the practitioner, and this question generally surprised the participants. While the impact of CD on client's liking the participants was reported as minimal, other items which explored the affective bond did appear to show some positive influence on the therapeutic relationship. One participant cited overhearing one client say to another while walking out of the office, "Oh isn't (the participant) great, because (the participant) lets you help write the note." Another pointed out that while it may not be important that practitioners are liked by their clients, CD might have a slightly positive effect on the client's investment in the process of therapy.

One participant pointed out that since CD intrudes on the time with the client it undermines practitioner's confidence in their ability to help their clients. Another pointed out that being less engaged with clients might have led to missing things the client was

trying to communicate. In contrast one other participant discussed how easy it is to get into a routine with some clients and CD helps to maintain focus. Another says, "in collaborative documentation I see them a lot more clearly now. Now it forces me to be on top of things but also listen to the client."

Mutual trust. Due to the transparency of the practice of CD, clients have a better idea of the objective data that is recorded about them. This can have a positive effect on trust between client and practitioner according to some participants. One states, simply, "I think there's an improvement in the trust level because they are a part of what goes in the record." Another described how CD can improve mutual trust between client and practitioner, "I would say that it's increased the opportunities that it (trust) might grow." Similarly CD can empower the client within the therapeutic relationship:

> "Now documentation has become a part of treatment here. It's a note with a client instead of about a client. And that in itself is validating it's a partnership rather than, uh, it shifts the power differential in a positive way."

In contrast, two participants rated the impact of CD on mutual trust negatively, one enthusiastically stating, "If we had negative numbers!" with which to describe how negatively CD impacts trust between the practitioner and client.

Engagement. Many respondents worried about the impact of CD on the engagement process with clients, at least initially. One reported this initial concern, that clients "were my main strength, my paperwork is not my main strength and that's not why I got in the field. And so I wanted to make sure my clients were okay with it..." Another more candidly stated, "I had an emotional response once I thought about it: but

crap, this might get in the way of me communicating with the person." For some these fears proved unfounded:

> I really care for my clients a lot. I just have a lot of empathy for them. When it came to collaborative documentation I felt like 'oh god this is going to ruin us,' and I thought 'they're just going to hate this.' But... um... I found the exact opposite, you know? Which is kinda nice.

Another stated similarly:

> When I first heard about it I thought this is going to be intrusive. I thought it was going to be offensive trying to be typing and talking at the same time. I was just concerned that my clients were going to be uncomfortable with it. And those things did not happen. Part of that is because you're not typing during the session while they're talking, you're not typing the whole time, it's right at the end.

In contrast one experienced user of CD reported that it can be detrimental to engaging with clients due to increased stress on the practitioner trying to do too much at the same time: "I think that there's a price to be paid and I think that therapists pay it in stress and the client pays it therefore." Another user of CD explained that, "I really love engaging like this, and having to look downward (at a laptop) is less of this" while gesturing to demonstrate eye contact.

Collaborative documentation and agreement on goals. It is here that participants were most uniformly positive about the impact of CD on the therapeutic relationship. This appears to be a result of the practitioner and client having the reminder of what the goals are during the client encounter. This helps them both to remember the goals and the focus of the work, as one participant reported,

> I think they're less doubtful, and I'm less doubtful too. I used to be out there thinking, 'what the heck are we working on?' Now with collaborative documentation we always have a focus with the goal in mind and that's kind of nice.

Another, who was skeptical of other benefits of CD, suggested, "…in that sense I think it's helpful… I do DBT work… so that's all about documentation of symptoms and skills. I think that's helpful." Another participant said the focus CD provides is helpful in developing goal plans more collaboratively:

> …you know when you're so far behind in paperwork, that you just come up with goals, you know, for a client? But you have an idea of what their goals are based on what their needs are. Well here, you're kinda talking about what their needs are and what they want but you want to talk more about what they want, in collaborative documentation, … 'What is it that you want, but keep in mind, we're talking about your mental health here.'

CD also appears to have the potential to generate conversation about the differences of opinion that may arise between client and practitioner about the true nature of the problems with which clients present:

> …it's a way to introduce an understanding that they might be different. At first when people come in I trust what they're saying... So it gives me a record of this is what they're saying; this is what I have to honor. That's cool. And then looking at behaviors and trends and patterns or thinking with our therapeutic lens, or a little skepticism, whatever, they can provide evidence to speculate what else

> might be going on. And then to gradually maybe reflect that back to people when they're ready.

Clearly this involves skill beyond the use of CD, but it appears CD is helpful in prompting the conversation about differences. Similarly, another participant, who co-author's notes with clients and has sometimes had to negotiate changes in what ultimately is submitted, explained disagreements with clients:

> … there are times when I'm truly believing that moving in direction A in the long run would be better for an individual, and that client is sure that it's direction B, and sometimes that happens. And they have the right to make their choices. And so that ends up being one that change what gets put into the note etc., but I have an agreement with all of my clients that if I have a strong opinion about something, then they have a right to know it. And that's sort of my job and it's not fair even if it might make for an uncomfortable interaction. So …I think it helps us to be very clear about what each of us is thinking; therefore how to get there, how to get to the change. That could be positive for a client.

In these practitioners' perspectives, there were positives and negatives associated with each of the three factors of the therapeutic alliance. Negatives tended to be expressed with greater emotion, such as the statement, "If we had negative numbers!" to describe the impact of CD on mutual trust with clients. Enough practitioners perceived that there were benefits to agreement on tasks and goals and even to the affective bond that it would be worthwhile to continue to study the practice in more depth.

Discussion

Collaborative documentation is a relatively new practice, with little literature to inform its use. This study found that there is diversity of opinions on how CD impacts the therapeutic alliance. CD does not appear to hinder any of the behaviors Duff and Bedi (2010) found to be significant predictors of a strong therapeutic alliance. Bordin (1979) identified the major components of the therapeutic relationship as task agreement, goal agreement, and the affective bond between clients and practitioners. The practitioners interviewed in this study all reported the potential for CD to enhance goal agreement, with mixed reports of how CD can impact the affective bond and task agreement. More practitioners who were interviewed reported a favorable impact on the affective bond and agreement on tasks than reported unfavorable ones.

Implications for Social Work Practice

While this study lacks a sufficient sample size to draw any generalizable conclusions, it appears to demonstrate that there are practitioners who perceive an improvement in the therapeutic alliance from their practice of CD. However, some reported a detrimental effect to the therapeutic relationship. This seems to show that it is reasonable to believe that CD could have an impact on the therapeutic relationship in either direction. Practitioners who perceive CD to be beneficial to the therapeutic relationship spoke a lot about how to use it as a way to clarify goals, remind themselves to engage in specific interventions, introduced the practice effectively, and were watchful in how to avoid letting it get in the way. They saw it as a tool that can be used in some but not all circumstances. Those who perceived CD to be detrimental to the therapeutic relationship were passionate about protecting the rights of their clients, and brought up important factors such as the systemic problems which have placed insurance companies

and government agencies into power. The individual clinical social worker has the responsibility to evaluate the practice while using it and decide how to use it for the client's best interests.

Strengths and Limitations

The strength of this study was that it is very practical in its applicability to everyday social work practice. CD is a practice that shows some promising benefits to clinical practice such as efficiency and the possibility of improved clinical services (Grantham, 2010; Mental Health Weekly, 2010; Midwestern Colorado Center for Mental Health Standardized Documentation Team, n.d.; Schmelter, n.d.). There is little in the literature to document these claims outside of these documents which appear to promote the practice of CD and are not peer reviewed.

The major limitations of the study include that the scope of the project limited the ability to do a more robust measurement of a larger sample. The small sample size and the fact that it is a convenience sample were also limiting factors in the generalizability of the study. The fact that the researcher is employed at one of the participating agencies introduced the potential for bias. There also may be some bias introduced by the solicitation process in that practitioners who practice CD but do not like it may not have felt free to participate.

Suggestions for Future Research

The qualitative nature of the study may inform further quantitative research but is limited in terms of its ability to make meaningful conclusions. This was complicated further by the difficulty participants had in generalizing their caseloads to one response in general. It would be advisable to do a larger study in which clients of practitioners who

utilize CD would be surveyed with the WAI-S for clients (Horvath & Greenberg, 1989) and compare these results with clients of those same practitioners but for whom CD was not utilized.

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Appendix A
Interview Schedule

How long have you been using CD?

How did you decide to adopt CD?

How did you feel about it when you first heard about it?

What were the drawbacks you expected to find in the use of CD?

What were the benefits you expected to find in the use of CD?

How do you feel about using CD now? How did it happen that you changed your feelings about it?

How confident do you feel about using CD on a scale of 1-7?

How have your clients responded to your use of CD? Do they like it?

What have the benefits been of using CD?

What have the drawbacks been of using CD?

How has CD impacted the degree to which you and your clients agree about the steps that should be taken to improve their situations? To what degree from 1 to 7 has it impacted you and your clients agree about the steps that should be taken to improve their situations? How *could* CD impact agreement between practitioners and clients about the steps that should be taken to improve clients' situations?

How has CD impacted you and your clients' confidence in the usefulness of your current work together? To what degree? How *could* CD impact you and your clients' confidence in the usefulness of your current work together?

How has CD impacted how much your client's like you? To what degree? How *could* CD impact how much your clients like you?

How has CD impacted you and your clients' doubts about what you are trying to accomplish? To what degree? How *could* CD impact you and your clients' doubts about what you are trying to accomplish?

How has CD impacted your confidence in your ability to help your clients? To what degree? How *could* CD impact your confidence in your ability to help your clients?

How has CD impacted the degree to which you and your clients are working towards

mutually agreed upon goals? To what degree? How *could* CD impact the degree to which you and your clients are working towards mutually agreed upon goals?

How has CD impacted your appreciation of your clients as individuals? To what degree? How *could* CD impact the degree to which you appreciate your clients as individuals?

How has CD impacted agreement between you and your clients on what is important to work on? To what degree? How *could* CD impact the degree to which you and your clients agree on what is important to work on?

How has CD impacted the mutual trust between you and your clients? To what degree? How *could* CD impact the degree to which you and your clients have built a mutual trust?

How has CD impacted the differences between your and your clients' ideas about what their real problems are? To what degree? How *could* CD impact the degree to which you and your clients have different ideas of what their real problems are?

How has CD impacted the establishment of a good understanding between you and your clients of the kind of changes that would be good for your clients? To what degree? How *could* CD impact the establishment of a good understanding between you and your clients of the kind of changes that would be good for your clients?

How has CD impacted your clients beliefs that the way you are working with their problems is correct? To what degree? How *could* CD impact the degree to which your clients believe the way you are working with their problems is correct?

Appendix B

Working Alliance Inventory Limited Copyright License

SFU SIMON FRASER UNIVERSITY
THINKING OF THE WORLD

Mr. J. Mark Kaufman
University of St. Thomas & St. Catherine University
School of Social Work
2115 Summit Avenue
St. Paul Minnesota
55105
USA

October 30, 2011

LIMITED COPYRIGHT LICENSE (ELECTRONIC) # 20113010.1

Dear Mr. Kaufman

You have permission to use the Working Alliance Inventory (WAI) for the investigation:

"Practitioner Perspectives on the Impact of Collaborative Documentation on the Therapeutic Alliance"

This limited copyright release extends to all forms of the WAI for which I hold copyright privileges, but limited to use of the inventory for not-for-profit research, and does not include the right to publish or distribute the instrument(s) in any form.

I would appreciate if you shared the results of your research with me when your work is completed so I may share this information with other researchers who might wish to use the WAI. If I can be of further help, do not hesitate to contact me.

Dr. Adam O. Horvath
Professor
Faculty of Education and
Department of Psychology

Ph# (778) 782-3624
Fax: (778) 782-3203
e-mail: horvath@sfu.ca
Internet: http://www.educ.sfu.ca/alliance/allianceA

Appendix C

Solicitation Email

Subject: Invitation to participate in research on the effect of collaborative documentation: Participants will receive a $15 gift card.

Body:

As an MSW student at University of St. Thomas & St. Catherine University, I am studying the effect of Collaborative/Concurrent Documentation on the Therapeutic Alliance. I am looking for practitioners within the mental health field who have knowledge of this practice to interview for about one hour. Participants who are interviewed will receive a $15 Target Gift Card.

Please consider participating in this important research. To do so contact Mark Kaufman:

Kauf0037@stthomas.edu

I look forward to hearing from you!

Appendix D

Institutional Review Board
University of St. Thomas

Agency Consent Form

Researcher: Please provide your agency with the information about your project and have your agency contact complete this form.

Agency: Please read this form and ask any questions you may have before agreeing to allow this study to take place at your agency. Please keep a copy of this form for your records.

Project Name	Practitioner Perspectives on the Impact of Collaborative Documentation on the Therapeutic Alliance	IRB Tracking Number	292056-1

General Information Statement about the study:

This study will explore the impact of collaborative documentation on the therapeutic alliance from the perspective of practitioners. This researcher will interview practitioners to explore how they perceive the impact of the practice of collaborative documentation on the therapeutic alliance.

Your agency is invited to participate in this research.
The agency was selected as a host for this study because:

Your agency utilizes concurrent/colaborative documentation in service to clients.

Study is being conducted by:	J. Mark Kaufman
Research Advisor (if applicable):	Philip Auclaire
Department Affiliation:	School of Social Work

Background Information
The purpose of the study is:

MSW Clinical Reseach Paper towards the completion of MSW degree.

Procedures
Study participants will be asked to do the following:
State specifically what the subjects will be doing, including if they will be performing any tasks. Include any information about assignment to study groups, length of time for participation, frequency of procedures, audio taping, etc.

Participants will be asked to be interviewed for about one hour about their perceptions of the impact of collaborative documentation on the therapeutic alliance.

Risks and Benefits of being in the study

The risks involved for subjects participating in the study are:

None

The direct benefits the agency will receive for allowing the study are:
None.
Compensation Details of compensation (if and when disbursement will occur and conditions of compensation) include:
Particpants who are interviewed will be awarded a $15 gift card at the time of the interview.
Confidentiality The records of this study will be kept confidential. The types of records, who will have access to records and when they will be destroyed as a result of this study include:
Interview notes, audio recording, and transcripts. Notes and audio recordings will be stored in a locked filing cabinet in this researcher's home. Transcripts will be stored electronically on a password protected computer.
Voluntary Nature Allowing the study to be conducted at your agency is entirely voluntary. By agreeing to allow the study, you confirm that you understand the nature of the study and who the participants will be and their roles. You understand the study methods and that the researcher will not proceed with the study until receiving approval from the UST Institutional Review Board. If this study is intended to be published, you agree to that. You understand the risks and benefits to your organization.

Should you decide to withdraw, data collected about you	will NOT be used in the study

Contacts and Questions You may contact any of the resources listed below with questions or concerns about the study.	
Researcher name	J. Mark Kaufman
Researcher email	
Researcher phone	
Research Advisor name	Philip Auclaire
Research Advisor email	
Research Advisor phone	
UST IRB Office	651.962.5341

Statement of Consent			
I have read the above information. My questions have been answered to my satisfaction and I consent to allow the study to be conducted at the agency I represent. By checking the electronic signature box, I am stating that I understand what is being asked of me and I give my full consent.			
Signature of Agency Representative ☐ *Electronic signature*		Date	
Print Name of Agency Representative			

Institutional Review Board
University of St. Thomas

Signature of Researcher ☐ *Electronic signature**		Date	
Print Name of Researcher	J. Mark Kaufman		

*Electronic signatures certify that:
The signatory agrees that he or she is aware of the polities on research involving participants of the University of St. Thomas and will safeguard the rights, dignity and privacy of all participants.

- The information provided in this form is true and accurate.
- The principal investigator will seek and obtain prior approval from the UST IRB office for any substantive modification in the proposal, including but not limited to changes in cooperating investigators/agencies as well as changes in procedures.
- Unexpected or otherwise significant adverse events in the course of this study which may affect the risks and benefits to participation will be reported in writing to the UST IRB office and to the subjects.
- The research will not be initiated and subjects cannot be recruited until final approval is granted.

Appendix E

Letter of Consent

CONSENT FORM
UNIVERSITY OF ST. THOMAS
GRSW682 RESEARCH PROJECT

Practitioner Perspectives on the Impact of Collaborative Documentation on the Therapeutic Alliance

I am conducting a study about the relationship between the use of collaborative documentation and the therapeutic alliance. I invite you to participate in this research. You were selected as a possible participant because you are a practitioner who practices collaborative documentation. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by J. Mark Kaufman, a graduate student at the School of Social Work, St. Catherine University & University of St. Thomas and supervised by Dr. Philip Auclaire, Ph. D.

Background Information:
The purpose of this study is to identify how collaborative documentation is related to the therapeutic alliance.

Procedures:
If you agree to be in this study, I will ask you to participate in an interview which will not exceed 60 minutes. An audio recording will be made of the interview for my own reference. The recording will be transcribed. If an outside transcriber is used that service will be bound by a confidentiality agreement. The audio recording will be destroyed after this project is completed. Results will be coded according to themes. Several items in the interview are scaled and the results of these scales will be analyzed statistically.

Risks and Benefits of Being in the Study:
The study has no risks. The study has no direct benefits to you such as compensation or recognition.

Confidentiality:
All the records of this study will be kept confidential. Your name and any identifying characteristics will be confidential. Research records will be kept in a locked file in my home. I will also keep the electronic copy of the transcript in a password protected file on my computer. I will delete any identifying information from the transcript. The audiotape and transcript will be destroyed by June 1, 2012.

Voluntary Nature of the Study:
Your participation in this study is entirely voluntary. You may skip any questions you do not wish

to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used in the study.

Contacts and Questions
My name is J. Mark Kaufman. You may ask any questions you have now. If you have questions later, you may contact me at _____. Dr. Philip Auclaire will be advising me in this study, and he can be reached at _____You may also contact the University of St. Thomas Institutional Review Board at _____ with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:
I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio recorded.

_____ _____
Signature of Study Participant **Date**

_____
Print Name of Study Participant

_____ _____
Signature of Researcher **Date**