COLLABORATIVE DOCUMENTATION: THE IMPACT OF SHARED RECORD KEEPING
ON THERAPEUTIC ALLIANCE

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ABSTRACT

COLLABORATIVE DOCUMENTATION: THE IMPACT OF SHARED RECORD KEEPING ON THERAPEUTIC ALLIANCE

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Concurrent collaborative documentation, or simply collaborative documentation, is a form of record keeping whereby the psychotherapist prepares progress notes in a transparent, collaborative manner with the client during the therapy session. In recent years, this emerging clinical record-keeping practice has been promoted as a partial solution to managing time and the copious volume of records mandated by stakeholders in public behavioral health and managed care settings where psychotherapy services are delivered. This is in contrast to the typical method of completing record keeping after the conclusion of the traditional psychotherapy session. Proponents of collaborative documentation reason that the practice saves time, increases clinician capacity to see more clients, and improves compliance with agency productivity and performance standards. Seemingly born out of quality improvement objectives, collaborative documentation does not offer a theoretical rationale for its use as a psychotherapy process tool, and given its embryonic state, there has been little opportunity to empirically demonstrate the mechanisms responsible for outcomes with its use.

This research intended to examine the relationship between collaborative documentation and therapeutic alliance factors with the aim of understanding the strengths and limitations of using record keeping to improve outcomes in psychotherapy. Specifically, the relationship
between collaborative documentation and the formation and maintenance of the therapeutic alliance was explored. Two community mental health agencies in Northern Arizona were selected to participate based on their documentation practices, and 60 client-therapist dyads at each agency were anticipated to participate at each agency. Participating clients completed the Working Alliance Inventory—Short Form Revised, a psychometrically reliable and valid instrument for measuring alliance. Regrettably, the desired sample size was not achieved and thus the planned statistical analysis was not possible. However, follow-up interviews revealed potential support for the use of collaborative documentation. For example, the practice appeared to improve trust through increased transparency, and created a platform for providing feedback to clients that prompted insights into behaviors and cognitions more quickly than before. Ultimately, therapist comfort level and skills appeared to influence the adoption of a collaborative documentation process. The methodological challenges, implications for collaborative documentation, and recommendations for future research will be discussed.
Acknowledgments

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accomplished when you set a goal for yourself, even when you run against countless barriers. (Those are the time times I encourage you to lean back on your supports, pause, reflect, practice good self-care, and jump back in).

To my parents and family, whose commitment and belief in our family carried me through the hardest phases of being a doctoral student and parent. And especially to Denise and Steve, for your tremendous sacrifices that have made our family stronger and wiser. Without your support, this dream to achieve my Ph.D. would not have been realized, and very few parents can say that they have contributed so meaningfully to reaching such a goal. And to Rick, thank you for being my champion and forever encouraging me to be my best self, and being there when it counted. I love you all. To my friend, Tim Buschmann, who has enriched my doctoral journey in important ways. Your deep understanding of the human condition and the ways in which you approach others with care and empathy is something we should all strive for. And to my other dear friends and family, who were a major source of emotional support, wisdom (and much needed humor) over the past several years, especially Morgan, Becky, Jayden, Tracey, Patrick, and Leah.
# Table of Contents

Chapter 1 ............................................................................................................................. 1  
Significance of the Study ................................................................................................ 3  
Collaborative Documentation in Practice ................................................................... 6  
Research Questions ....................................................................................................... 9  
Organization .................................................................................................................. 10  

Chapter 2 ........................................................................................................................... 13  
The Emergence of Collaborative Documentation ......................................................... 15  
The Working Alliance in Psychotherapy ...................................................................... 17  
Collaboration .................................................................................................................. 25  
Feedback ....................................................................................................................... 29  
The Role of Transparency ............................................................................................. 36  
The Role of Technology ................................................................................................. 39  
Empirical Findings in Collaborative Documentation ................................................... 42  
Conclusion .................................................................................................................... 44  

Chapter 3 ........................................................................................................................... 46  
Design ........................................................................................................................... 46  
Sampling ....................................................................................................................... 48  
Setting ........................................................................................................................... 50  
Participants .................................................................................................................... 52  
Apparatus ...................................................................................................................... 64  
Independent Variable ................................................................................................. 64  
Dependent Variables ................................................................................................. 68  
Qualitative Measures ................................................................................................. 71
<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Collaborative Documentation Training</td>
<td>192</td>
</tr>
<tr>
<td>J</td>
<td>Study Packet Instructions</td>
<td>205</td>
</tr>
<tr>
<td>K</td>
<td>Collaborative Documentation Scripts</td>
<td>208</td>
</tr>
<tr>
<td>L</td>
<td>Therapist Interview Recruitment Script</td>
<td>209</td>
</tr>
<tr>
<td>M</td>
<td>IRB Approval Letters</td>
<td>212</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction

In recent years, a clinical record-keeping practice known as *concurrent-collaborative documentation* has emerged and been promoted as a partial solution to managing the copious volume of records mandated by stakeholders in public behavioral health and managed care settings in which psychotherapy services are delivered. Concurrent collaborative documentation, or simply collaborative documentation, is a form of record keeping whereby the psychotherapist prepares progress notes in a transparent, collaborative manner with the client during the counseling session. This contrasts with the typical method of completing record keeping after the conclusion of the traditional 45- to 50-minute psychotherapy session. Proponents of collaborative documentation maintain that the practice saves time, increases clinician capacity to see more clients, improves compliance with agency productivity and performance standards, and helps clients achieve greater clinical buy-in (MTM Services, 2012).¹

The principal advocates for collaborative documentation practices are consultants working to restructure complex service delivery systems using available technologies with an overarching goal to improve efficiency and productivity. The emphasis on cost containment does little to support the use of collaborative record keeping from a client-centered perspective. Yet supporters of the practice further reason collaboration through documentation improves outcomes through increasing transparency, allowing clients to actively participate in treatment, shifting more control to clients, and lastly, increasing feelings of trust and strengthening the emotional bond between client and therapist (MTM Services, 2012; Schmelter, 2010, 2012).

¹ This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 63, Copyright Elsevier (2015).
Seemingly born out of quality improvement objectives, collaborative documentation does not offer a theoretical rationale for its use as a psychotherapy process tool, and given its embryonic state, there has been little opportunity to empirically demonstrate the mechanisms responsible for outcomes with its use.2

This research sought to understand the emerging practice of collaborative documentation as a psychotherapy process tool, which to date, has not been done. Specifically, the relationship between collaborative documentation and the formation and maintenance of the therapeutic alliance will be explored. The therapeutic alliance, or working alliance, is a psychological construct first introduced by Bordin (1979) to describe the important dimensions of the relationship between client and therapist. The construct, although rooted in principles of psychoanalytic theory, is widely considered to be pantheoretical and generally applicable irrespective of one’s theoretical orientation or paradigm for understanding client-therapist relationships. The therapeutic alliance subsumes aspects of the relational bond between the client and therapist, as well as the degree of agreement between the client and therapist regarding the goals and tasks of psychotherapy (Bordin, 1994).

The therapeutic alliance was chosen for a theoretical foundation due to the tripartite structure of the construct—bond, task, and goal—that appear to correspond to characteristics of collaborative documentation purported to benefit the client-therapist relationship. Stated differently, if collaborative documentation does contribute to improved client-therapist relationships by way of improving the agreement on the goals and tasks of therapy, an instrument that measures the alliance may detect those changes. Similarly, if collaborative documentation

2 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 64, Copyright Elsevier (2015).
leads to improved feelings of mutual trust, respect, and commitment (i.e., the bond experienced between client and therapist), a measure of therapeutic alliance may also reflect those differences.

Beyond the fitness of the construct to the inherent features of collaborative documentation, the therapeutic alliance has consistently been found to be the most robust and reliable predictor of psychotherapy outcomes (Duncan, Miller, Wampold, & Hubble, 2009; Horvath, Del Re, Flückiger, & Symonds, 2011). For this reason, a clear understanding of the impact of mental health professionals’ tools for delivering psychotherapy is essential. Without empirically investigating the impact of collaborative documentation on the psychotherapy relationship, we risk, at best, imposing an intervention upon clients that serves to support only managed care agendas for increased productivity; at worst, we fail to systematically distinguish the components of collaborative documentation that facilitate or damage the therapy relationship, and clients are harmed in the process. Any conclusions drawn from such an investigation must therefore balance client needs with those of the institution of mental healthcare.

Significance of the Study

The emergence of managed behavioral healthcare throughout the latter half of the twentieth century was driven largely by a need to contain the high cost of delivering both behavioral health and medical services. The incipient health management organization (HMO) of the 1940s—The Kaiser-Permanente Health System—became the prototypical model that stimulated the passage of the Health Maintenance Organization Act of 1973 (Cummings, 2001). This historic milestone in the evolution of healthcare spawned dozens of HMOs, and indeed changed the landscape of healthcare delivery. While healthcare costs were spiraling out of control, HMOs strove to find ever more efficient ways of delivering health services (Cummings,
Increasingly, both mental health and medical professionals were becoming aware of the overlap and comorbidities between medical ailments and mental health conditions. Because the majority of mental health services in the United States have been delivered through general medical practitioners (B. F. Miller, Petterson, Burke, Phillips, & Green, 2014), integrating healthcare (often through the colocation of providers and interdisciplinary treatment teams), was found to be an effective solution for containing costs, as well as improving patient outcomes on both the medical and behavioral health sides of practice (American Hospital Association, 2012; Peek, Cohen, & deGruy, 2014).

A significant challenge lies in the implementation of integrated care when collaborative medical-behavioral models are adopted; the typical behavioral health professional is underprepared for the fast-paced environment of medical practice (Funderburk et al., 2010). One such strategy for facilitating a united process between treatment providers is by bridging disciplines with shared electronic health records (EHR) systems, which can improve efficiency, reduce error, improve clinical collaboration within and between disciplines, and improve clinical standards. EHR notes are typically written by the health service provider toward the end or after the treatment session; however, little research has focused specifically on how technology within therapy sessions impacts client-therapist interactions and psychotherapy outcomes (Steinfeld & Keyes, 2011). Medicine has been quick to adopt technologies to enhance delivery of clinical care, improve collaboration between clinical professionals, and improve the experience of patients in meaningful ways; while the literature on EHR utilization in the area of bioinformatics

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proliferates (Hayrinen, Saranto, & Nykanen, 2008), psychologists have been slower to embrace such technologies for psychotherapy (McMinn, Bearse, Heyne, Smithberger, & Erb, 2011).4

There is little debate regarding the value of collaboration between mental health professionals as a result of EHR utilization, especially as EHRs are used in multidisciplinary settings (Steinfeld & Keyes, 2011). Although EHRs vary in design and complexity, they share the common feature of storing large amounts of patient care-related information in an electronic database. The ability for professionals to collaborate amongst themselves about client care is limited only to the degree that the EHR database is accessible to multiple providers. In this way, a client’s psychotherapist has immediate access to useful types of information from ancillary treatments. For example, a psychotherapist may benefit by having access to progress notes from a client’s recent visit to a psychiatrist for medication management; this information may inform the direction of therapy for the session. In addition to better care coordination, and time- and cost-saving benefits of interagency communication around client care, some direct benefits to clients may also be realized.4

Clinical record keeping is a compulsory practice in delivering psychotherapy services, and due to its administrative nature, has traditionally been perceived as separate from direct client service and outcomes. Practice standards and guidelines around record keeping are typically framed from the perspective of risk management and continuity of care, but are rarely described as a mechanism for facilitating the therapy process beyond tracking of client progress and outcomes. In many practice settings, record keeping may also represent a source of inefficient time use by therapists. Progress notes postponed to the end of the day can cause a

4 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 65-66, Copyright Elsevier (2015).
workflow bottleneck that may result in record inaccuracies and may contribute to clinician stress or burnout (Schmelter, 2010). With managed care placing growing demands on mental health professionals to deliver accurate and timely records while maintaining a high level of productivity, organizations are adopting EHR systems (Lenert, Dunlea, Del Fiol, & Hall, 2014) to contain spiraling health-care delivery costs by increasing efficiency in documentation, while improving communication and collaboration between professionals.5

The emerging practice of collaborative documentation is purported to have therapeutic benefits, a claim that has not been examined through peer-reviewed empirical studies. The mechanism responsible for the purported benefit of co-authoring records with clients during psychotherapy appears to have face validity but is speculative. The therapeutic alliance may prove useful in understanding how this practice positively or negatively impacts psychotherapy outcomes through an understanding of the relationship between collaboration, transparency, and obtaining feedback during record keeping.

**Collaborative Documentation in Practice**

At the time of this writing, a standardized program does not exist for training, implementation, and delivery of collaborative documentation. The National Council for Behavioral Health, a national not-for-profit organization whose mission is to promote integrated healthcare and widespread access to behavioral health services, contracts with MTM Services to consult with community behavioral health agencies in order to implement collaborative documentation. MTM Services appears to be the predominant consulting firm promoting collaborative documentation, and according to the company’s website, several training DVDs are

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available for purchase that include case studies and resources to aid agencies in adopting collaborative record-keeping practices. Alternatively, employees of MTM services have provided several professional presentations that are available in the public domain.

According to the MTM Services’ president, David Lloyd, collaborative documentation should occur at the end of a clinical service, which may include a progress note, diagnostic assessment, treatment plan, or assessment update. Additionally, a transition statement should be utilized that functions as a signal to the client that the formal session is ending and the mental health professional will begin to collaboratively and concurrently document the encounter with the client present. Examples of transition statements include, “We’re getting close to the end of the session. Let’s stop here and review what we talked about” (Lloyd, n.d., slide 21); or “Now let’s work together to document the important accomplishments/ideas/work that we have done today,” and “What you shared is important. I want to capture this information” (Midwestern Colorado Center for Mental Health, n.d., p. 9).

Additional elements of collaborative documentation may be assembled from supplemental information provided by MTM Services. For example, MTM Services shares literature pertaining to pilot project trainings by behavioral health clinics across the United States who have adopted and implemented collaborative documentation. What is not clear is whether or not MTM Services endorses the agencies’ training approaches. However, one such training document produced by Midwestern Colorado Center for Mental Health (n.d.) and cited by Lloyd, (n.d.), described the benefits of collaborative documentation as proactively clarifying goals and objectives; clarifying the therapeutic interventions provided; and providing feedback with regard to client progress from the therapist. The agency further identified that collaborative documentation represented “an appropriate extension of the therapeutic interaction that could
serve to focus the client/family on what just occurred in the session as well as their next steps in the process of recovery/resiliency” (Midwestern Colorado Center for Mental Health, n.d., p. 2).

Midwestern Colorado Center contends that proper client-therapist role induction to the process of collaborative documentation is critical to achieve client buy-in. They recommend providing every new client with a semi-structured introduction to include the following elements:

1. The term “concurrent [collaborative] documentation”

2. Explain this term—this is a team effort between client and service provider to create a record that documents the session content and process “at the same time” with the [client] while he or she is still present in the session with you.

3. Frame it more as an “invitation” to their participation in treatment rather than a “requirement.”

4. Explain that you will be reviewing the following things as you document:
   - The goals and objectives addressed during the session;
   - The therapeutic interventions provided by the direct care staff;
   - Feedback regarding progress made and an indication of the client’s perceived benefit of the service.

5. Enumerate the benefits to their participating this way:
   - Involves [client]/family in the therapeutic process and recording of session content and process (review, feedback, description, insight);
   - Empowers [client]/family to know and determine the course of clinical assessment, interventions, and progress of therapy;
   - Real-time feedback will increase [client]/family “buy-in” to therapy;
• Cutting out-of-session documentation time results in increased hours per clinician per year for direct service, thus serving more [clients]/families. (Midwestern Colorado Center for Mental Health, n.d., pp. 5–7)

The agency qualifies that therapists should use “positive terms” in their scripts to clients, taking special note not to apologize for the practice or “blame” the agency, as this may serve to undermine the process and therapeutic value (Midwestern Colorado Center for Mental Health, n.d.).

Special accommodations were also indicated in the method. Apparently, the process of concurrently documenting with the client is permissible during the “core” therapy encounter as well as during the last 10-15 minutes of the documentation phase of the session. As Lloyd (n.d.) and Midwestern Colorado Center for Mental Health (n.d.) explain, therapists have discretion to take notes throughout the session based on the needs of the client. Furthermore, “The [collaborative documentation] technique will vary from staff to staff based on what works best for each individual direct care staff” and “the [therapist] must be able to judge how much time is needed for this type of activity based on the individual client’s level of functioning” (Midwestern Colorado Center for Mental Health, n.d., p. 9). Beyond the obvious methodological challenges that the above description of collaborative documentation present from an empirical standpoint, the consequences of the variable application of collaborative documentation on clients demand further examination if the practice is to be used to influence psychotherapy process.

Research Questions

The purpose of this dissertation is to examine the relationship between collaborative documentation and therapeutic alliance factors. Therefore, this research was guided by the primary question of whether differences exist between collaborative documentation and post-
session documentation in how clients perceive the counseling relationship. It was predicted that the practice of collaborative documentation would result in a strengthening of the therapeutic alliance when compared to the practice of traditional post-session documentation. A secondary query within this research was to explore the components of collaborative documentation deemed critical in the formation of the alliance between client and therapist, which was planned to be accomplished by conducting in-depth interviews with client-recipients of collaborative documentation.

**Organization**

The remainder of the dissertation will be organized as follows. Chapter 2 represents a review of the literature with the aim of providing the reader with a theoretical framework for understanding the study’s variables and their relationships. Because collaborative documentation possesses interdisciplinary elements, the review of literature spans various bodies of professional literature, including psychology, medicine, nursing, and bioinformatics. Given the nascent state of collaborative documentation, especially regarding being used as psychotherapeutic tool, a limited number of references to popular press or non-peer-reviewed sources have been published. Indeed, only a single study emerged from the peer-reviewed literature that identified collaborative documentation, psychotherapy, and a measure of the therapeutic alliance as variables.

In Chapter 3, the research methods will be described, including the design, participants, setting, independent variable, dependent variable, and instrumentation. Specifically, the present study used a mixed-methods approach consisting of a quasi-experimental, non-equivalent control-group design for the quantitative component and semi-structured qualitative interviews for the qualitative component. A convenience sample was utilized and consisted of volunteers
who received psychotherapy at two community behavioral health agencies in Arizona within general mental health programs. The target population was client-therapist dyads who were the recipients and providers of psychotherapy services. The specific procedure and variables will be described as they were conceived in the development of this project, in addition to a description of modifications made to the project’s active phase of data collection due to concerns with volunteerism and organizational barriers. As will be shown, the Principal Investigator was unable to achieve the desired sample size, and therefore additional measures were added to supplement the findings in the absence of useful quantitative data.

Chapter 4 will provide a description of more specific data analysis procedures and their results. Data was analyzed using a mixed-methods approach. A multivariate analysis of variance was anticipated to determine the degree to which differences exist in the combination of Working Alliance scales administered to a group of clients who received collaborative documentation and those who received post-session documentation in a community behavioral healthcare setting. Nesting effects were to be explored by utilizing multilevel modeling techniques. Additionally, qualitative interviews were to be analyzed using thematic analysis to distill themes in the data. The qualitative analysis aimed to clarify the features of collaborative documentation found to mediate the client-therapist alliance while providing a richness to the overall analysis. Unfortunately, due to the concerns noted above, the Principal Investigator was unable to perform the planned analyses as designed. Instead, therapists who participated in the study were invited for follow up interviews to determine the strengths and limitations of collaborative documentation in clinical practice. Accordingly, descriptive statistics will be provided, when available, in addition to data acquired from a limited number of interviews with the therapists involved in the study.
Finally, Chapter 5 will provide a discussion with the intent of integrating the study’s findings with theoretical considerations and recommendations for future research. Although the study did not achieve the desired outcome in answering the initial research questions, an abundance of pragmatic and clinically useful lessons were learned in conducting research with active clinical samples that form the basis of recommendations for future research and specifically for student researchers. Chapter 5, then, seeks to make sense of complex research procedures when significant barriers are encountered.

Finally, related to conducting research, this author believes in the responsibility to disclose to the reader the researcher’s known operating assumptions and worldviews. Largely, this author adopts a phenomenological epistemology that approaches knowledge as unique to the observer and situated within the context of complex human interactions and environments. As our understandings and perspectives shift, so too must our approach to understanding phenomena. Additionally, our contemporary research exists against the backdrop of evolving understanding of people and their interactions. That which is appropriate at the time of this writing may not be so in the future, especially regarding specific language used to describe psychological and social phenomena, as well as people. Ultimately, the sample described in this study is comprised of real people undergoing treatment in a clinical setting. This author used person-first language and equitable descriptions of individuals.
Chapter 2

Review of Literature

What I had known implicitly was now evident: Privacy was not secrecy, and individual-oriented, collaborative exploration with a client of his or her world facilitated joint openness to discovery.

- Constance Fischer, 2006, p. 231

This chapter seeks to explore the emerging practice of collaborative documentation and its likely impact on the psychotherapy process, with an emphasis on potential client benefits, such as a stronger therapeutic alliance and enhanced progress toward treatment goals. A theoretical framework will be introduced to explain the hypothesized relationship between the practice of collaborative documentation and psychotherapy outcomes through the strengthening of the therapeutic alliance, which includes aspects of client-therapist collaboration, transparency, and utilization of client feedback. As such, this chapter represents a review of research across several strands of literature within the fields of psychotherapy and allied medicine that may support the use of an understudied but burgeoning record-keeping practice used as a tool for improving client-therapist relationships.

First, the emergence of collaborative documentation will be discussed from its apparent inception as a means of balancing the demands of clinical practice in managed healthcare and the realities of providing quality client care. As will be shown, the predominant consulting firm promoting collaborative documentation, MTM Services, advertises clear benefits to using the practice as realized by the organization, their staff members, and their clients. The use of collaborative documentation as a tool for improving the client-therapist relationship appears to

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6 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 64, Copyright Elsevier (2015).
be based on an assumption that has not been empirically verified. Principally, the assumption is that collaborative documentation positively impacts the therapeutic relationship via improved client engagement, increased transparency, and opportunities for feedback and collaboration between the client and therapist; and furthermore, that collaborative documentation is not harmful to the therapeutic relationship for the same reasons.

Next, a deeper explanation of the therapeutic alliance construct will create a foundation for the reader to understand how the purported benefits of collaborative documentation fit within the framework of theoretical construct. These purported benefits of collaborative documentation will be examined, in turn, in the context of relevant literature, including client and therapist behaviors that influence the therapeutic alliance, feedback leading to improved agreement on the work of therapy, and client engagement enhancing the mutual trust and agreement between client and therapist.

The notion of collaboration between clients and therapists will then be examined against the backdrop of literature in both the medical and mental health fields. In medicine, patient-centered care is facilitated through the process of shared decision-making. Collaboration in the mental health field between a client and therapist can take other forms, such as using feedback and checking in with clients to ensure a consensus between client and therapist that goals are in alignment. A parallel line of research investigating the impact of sharing psychological assessments (e.g., personality assessment results) with clients may also provide some clues as to how collaborative documentation may positively influence the therapeutic encounter. As such, relevant research and models of the therapeutic use of assessments will be discussed.

Closely related to the concept of explicitly sharing assessment or other clinical information with clients is the notion of transparency. Transparency in sharing sensitive clinical
information with clients has not been extensively examined in psychology; however, recent research has been underway to explore the use of collaborative documentation in medical practice through online portals in which patients may download and view their doctors’ notes (Delbanco et al., 2012). The attitudes of doctors and patients will be reviewed for parallel insights that may inform an understanding of the interaction between therapists, psychotherapy clients, and the clinical record. Finally, a study directly examining the impact of collaborative documentation on the therapeutic alliance in a community behavioral health sample will be critically evaluated.

The Emergence of Collaborative Documentation

The National Council for Behavioral Health (National Council), a lobbying and advocacy group for community mental health and substance abuse treatment organizations in the United States, began piloting a method of collaborative documentation in response to the need to balance productivity, same-day access to care, and patient-centered care initiatives, such as meaningful use of electronic records across the National Council’s member clinics. In conjunction with their allied consulting firm, MTM Services, the National Council claims concurrent collaborative documentation will “eradicate post-session documentation time while increasing person-centered engagement of clients in their recovery by involving them in the creation of their clinical documentation” (“Same day access to behavioral health services,” 2014).7

MTM Services appears to be the dominant voice regarding collaborative documentation due to the company’s association with training clinics to promote widespread use of

7 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 66, Copyright Elsevier (2015).
collaborative documentation processes. In an address to the National Council, Bill Schmelter, a consultant with MTM Services, described collaborative documentation as, “a clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understandings of important issues” (Schmelter, 2012, slide 2). Furthermore, MTM Services’ Access and Engagement Project surveyed 10 participating clinics at which collaborative documentation was being piloted and reported generally favorable reception by an unspecified number of clinicians and clients using this documentation process. The consulting firm was especially focused on reporting improvements in clinic productivity and efficiency: Therapists using collaborative documentation spent up to nine fewer post-session hours on paperwork, and conversion to collaborative documentation was accompanied by a 25% drop in staff sick time (MTM Services, 2012). The firm reported findings that approximately 82% of surveyed clients indicated having the therapist review the progress note with them was helpful or very helpful; 80% reported feeling involved or very involved in the experience of collaborative documentation compared to past experiences in therapy; and 77% reported that they would want their providers to continue using collaborative documentation into the future. Additionally, MTM Services claims that one member clinic piloting collaborative documentation found no differences in ratings on a measure of the working alliance as a result of using collaborative documentation or post-session documentation (MTM Services, 2012).

The implication that collaborative documentation reduces paperwork time and thus contributes to a reduction in clinician stress is important, but by no means speaks to the

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8 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 66-67, Copyright Elsevier (2015).
practice’s ability to facilitate client change. Stated differently, if collaborative documentation is truly good for clients because they become more involved and engaged in treatment, where is the evidence? The findings reported by MTM Services were not peer reviewed, and their methodology and instruments were not disclosed, making it difficult to critically evaluate their assertions for the use of collaborative documentation from the client perspective.9

Though it is not explicitly stated, the use of collaborative documentation using EHRs to benefit clients appears to rely on multiple assumptions: (a) collaboration allows clients to engage in their care in a meaningful way, thereby improving the alliance between the counselor and client; (b) conversely, client participation in the administrative details of psychotherapy is not harmful to the therapeutic alliance; (c) collaboration offers a means of obtaining feedback from the client, allowing for better clinical outcomes; and (d) the use of technology in the psychotherapeutic encounter is beneficial and not harmful. To examine these underlying assumptions, we turn next to a brief overview of the psychotherapy, medical, and informatics literature regarding presumed factors operating in collaborative documentation.9

The Working Alliance in Psychotherapy

The therapeutic alliance, or working alliance, is one of the most studied topics in psychotherapy research (Norcross, 2010). The working alliance is based on Bordin’s (1979) pantheoretical notion derived from psychoanalytic theory and is defined as “an agreement on goals, an assignment of task or series of tasks, and the development of bonds” (p. 253). This has become a useful definition of the construct adopted by many who study the phenomenon (Shaw & Murray, 2014) and, according to Bordin (1979), is found in various forms across all

9 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 67, Copyright Elsevier (2015).
psychotherapies. In addition, the working alliance is a likely contender in helping to explain the relationship between potentially improved psychotherapy outcomes and the use of collaboration through documentation.  

Bordin (1994) elaborated on the differences between the goals, tasks, and emotional bond components of the working alliance. A strong alliance is achieved through goals by attentively identifying a change goal that accurately captures the nature of the client’s problem. This is achieved through carefully negotiating with the client in a reciprocal manner. The tasks of psychotherapy delineate specific activities proposed by the therapist and client in an attempt to achieve the change goal. A strong alliance throughout these tasks necessitates that client and therapist be in agreement on the best course of action for a particular problem. Lastly, the bond describes the experience of mutual commitment, agreement, and feelings of trust and respect between the client and therapist (Bordin, 1994). In this way, the strength of the alliance is partly related to trust and respect and partly to the tasks and goals of psychotherapy having been appropriately negotiated. All three components—goal, task, bond—contribute to the strength of the therapeutic working alliance that may be potentially mediated by collaborative documentation.  

Different schools of psychotherapy emphasize the roles of the client or psychotherapist as the responsible agent in the change process, and Bordin (1994) characterized the strength of the alliance by the degree to which the client views opportunities for collaboration in solving a particular problem, rather than being relegated to the role of a passive recipient of care. Tryon (2013) articulates this notion: “Patients bring their problems and therapists bring their  

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10 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 67-68, Copyright Elsevier (2015).
professional skills to psychotherapy, and they work together to ameliorate patients’ concerns” (p. 371). Psychoanalytic traditions, sharing an origin with medical traditions, may situate the psychotherapist in an expert role and thus assume more responsibility for the client’s change. Alternatively, a person-centered therapist may assume much less responsibility and defer to the client’s expertise in the change process (Bordin, 1979, 1994). Regardless of one’s theoretical orientation, the formation and strength of the working alliance has been shown to be a key ingredient in psychotherapy.11

The strength of the therapeutic alliance has been found to be the most robust and reliable predictor of psychotherapy outcomes (Duncan et al., 2009; Horvath et al., 2011). For example, Owens, Haddock, & Berry (2013) reported that patients diagnosed with psychotic disorders who rated the therapeutic alliance as stronger reported fewer difficulties regulating their emotions. Patients, when upset, demonstrated better ability to understand their emotions, realign behaviors with goals, and employ emotional regulation strategies, such as decreasing or increasing emotional expression. A stronger alliance was thought to represent better emotional attunement between patients and providers, allowing for more effective feedback-response interactions that resulted in improved emotional regulation by patients.11

Notably, the client’s perception of the alliance is the stronger predictor of psychotherapy outcomes (Bedi, Davis, & Williams, 2005), and therefore, client perception is more central to evaluating the strength of the working alliance. The relationship between alliance and psychotherapy outcomes has been supported through numerous replications and meta-analysis. Horvath et al. (2011) found moderate but highly reliable coefficients between alliance and

11 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 68-69, Copyright Elsevier (2015).
psychotherapy outcomes included in their review of over 200 reports \( (r = 0.275, p < 0.0001) \). The authors also analyzed moderators including instrumentation used to measure alliance and outcomes, whether psychotherapists or clients rated the alliance, the point in time during the therapy when the alliance was rated, as well as the type of therapy employed. Horvath et al. (2011) found the following:

This result strongly supports the claim that impact of the alliance on therapy outcome is ubiquitous irrespective of how the alliance is measured, from whose perspective it is evaluated, when it is assessed, the way the outcome is evaluated, and the type of therapy involved. The quality of the alliance matters. (p. 13)

Facilitation of a strong therapeutic alliance is also recommended as a strategy to prevent clients’ premature termination of therapy, along with other strategies, such as facilitation of emotional expression, motivation enhancement, case management, appointment reminders, treatment negotiation and contracts, and patient selection and preparation. Maintenance of the therapeutic alliance includes such tasks as addressing relationship problems as they arise, taking responsibility for some of some of the problems, and working openly with negative emotions (Ogrodniczuk, Joyce, & Piper, 2005).\(^{12}\)

Ruptures of the therapeutic alliance occur when feelings of tension develop or when collaboration on goals and tasks breaks down (Swank & Wittenborn, 2013). Ruptures can lead to impasses within the psychotherapy process during which forward movement in treatment is stalled. Ruptures, when repaired, can strengthen the therapeutic process (Safran, Muran, & Eubanks-Carter, 2011). Ruptures that are not repaired may lead to premature termination of

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treatment and other undesirable therapeutic outcomes, including client feelings of distrust and discouragement (Coutinho, Ribeiro, Sousa, & Safran, 2014).  

**Therapist and client behaviors impacting the alliance.**

While the meta-analysis by Horvath et al. (2011) did not reveal significant differences in the strength of the relationship between alliance and outcomes as a result of who rates the alliance (therapist, client, or independent observer), Bedi et al. (2005) cite previous research indicating low-to-moderate correlations between the client’s rating and those of the therapist. With such discrepancies in mind, the authors hypothesized different factors were at play for what was deemed important in the alliance between the client and therapist. A surprising finding by the authors was that psychotherapy clients generally placed the responsibility of alliance formation and maintenance exclusively on the therapist, even when the therapist attempted to use role induction strategies to emphasize client responsibilities in psychotherapy. Furthermore, the types of factors clients look for in assessing alliance strength with a therapist are consistent with basic psychotherapy microskills—demonstrations of caring, warmth, and attending—as well as the therapist’s personal characteristics and the environment or psychotherapy setting (Bedi et al., 2005).  

In Bedi et al.’s (2005) qualitative study, the researchers sought to understand client perceptions of therapist behaviors that comprise the psychotherapeutic alliance. While previous studies had looked at similar components of the alliance from the client perspective, few had examined those deemed most critical for the formation of the therapeutic alliance (Bedi et al., 2005). Upon sorting participant responses into themes, 25 categories emerged, describing the

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13 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 70, Copyright Elsevier (2015).
characteristics deemed most critical to the formation and strengthening of the working relationship in psychotherapy. Consistent with previous research, Bedi et al. (2005) found that participants placed most of the responsibility for alliance formation on the therapist, and furthermore, these critical characteristics differed from what therapists typically considered to be important. A surprising finding was that participants believed therapists’ personal characteristics (e.g., dress and grooming) and the office environment (e.g., decor and visible books pertinent to therapists’ specialty) were related to the formation and strength of the relationship (Bedi et al., 2005).14

Bedi et al. (2005) revealed that characteristics not typically thought to be related to alliance might indeed relate to how clients connect to therapists. Similarly, the authors found that providing services extending beyond what would normally be expected from a therapist (e.g., offering refreshments during sessions, therapists making themselves available after hours for phone calls, etc.) was also deemed important in alliance formation from the client perspective.14

Similarly, Fitzpatrick, Janzen, Chamodraka, & Park (2006) investigated client-identified critical incidents in the formation of the relationship between therapist and client. The researchers interviewed 20 individuals who participated in psychotherapy in a college setting and found that five critical incidents emerged: therapists facilitated the client’s examination of the problem from a new perspective; second, therapists self-disclosed personal information or disclosed positive views of the client; third, therapists correctly identified and attended to a client’s need or desire; and fourth, the therapist recommended an activity outside of therapy that

14 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 70-71, Copyright Elsevier (2015).
was useful. Interestingly, the fifth category described how therapists created opportunities for
clients to work through problems and included the degree to which clients were invited into a
collaborative and active role with the therapist. The researchers went deeper in exploring the
meaning clients attached to the critical incidents previously identified and one such ascribed
meaning related to the notion of the client’s own importance in session. In other words, clients
indicated that feeling at the center of the process was critical for a positive relationship with their
therapist (Fitzpatrick et al., 2006). Notably, the authors utilized a small sample and a
methodology that limits the generalizability of their findings. Yet their findings speak to a
broader issue that although collaborative documentation appears to cultivate an environment
favorable for engaging clients in an active and collaborative process, the practice may also have
the unintended consequence of shifting the client’s perceived self-importance by introducing an
administrative task into the session in a manner detrimental to the therapeutic relationship.15

The impact of therapists’ activities that support the therapeutic alliance but are not
usually measured as part of the therapy process may be reasonably broadened to include
administrative aspects of psychotherapy usually kept to the periphery of what is traditionally
considered the psychotherapy process. Specifically, collaborative documentation garners
favorable endorsements by clients in some managed care settings (MTM Services, 2012); yet,
how clients understand the role of this style of collaboration on psychotherapy work is unclear.

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Client perceptions of the use of collaborative documentation may impact the working alliance positively, negatively, or not at all.\textsuperscript{16}

In a more recent study, Duff and Bedi (2010) investigated the degree to which therapist behaviors, as deemed critical by clients, relate to a measure of the working alliance. The authors found several counseling behaviors related to validation and physical attending in psychotherapy to be moderately to strongly correlated with the therapeutic alliance. For example, questioning, encouraging, reflecting, making positive comments about clients, providing validation, making appropriate eye contact, and referencing prior sessions were all related to a client-rated alliance measure (Duff & Bedi, 2010). In a similar manner, collaborative documentation requires a degree of reflecting, summarizing, and drawing from previous material, suggesting that the practice of collaborative documentation may be compatible with the same validation behaviors clients perceive as important to alliance formation (Bedi et al., 2005) and positively correlate with the therapeutic alliance (Duff & Bedi, 2010).\textsuperscript{17}

Emotions may also play a role in how clients understand the development of the alliance in psychotherapy. Fitzpatrick, Janzen, Chamodraka, Gamberg, and Blake (2009) conducted a qualitative study to identify critical incidents in the formation of the therapeutic alliance in a sample of clients with depression, which were then compared to findings from prior research using a sample of healthy clients. Among the authors’ findings were that clients with depression tended to focus more on therapists’ behaviors that contributed to the alliance, while less distressed or healthy clients in the comparison study tended to focus on the positive aspects of

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\textsuperscript{17} This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 71, Copyright Elsevier (2015).
their own coping behaviors. The study also revealed responses that researchers categorized as positive emotional reactions to incidents deemed important to the alliance during psychotherapy. For example, study participants related feeling relaxed and comfortable in response to some alliance-forming incidents (Fitzpatrick et al., 2009).18

Duff and Bedi (2010) did find four therapist behaviors unrelated to the therapeutic alliance. Administrative tasks, such as completing paperwork, outside of the therapy session was one such behavior not significantly related to the therapeutic alliance and may have multiple implications. This finding may suggest that the formation or strengthening of the working alliance is not related to any administrative task in psychotherapy. Conversely, this non-significant finding may imply that completing paperwork outside of session is a hidden component of psychotherapy that is inaccessible to the client but which, nonetheless, has an impact on the alliance. Either implication should be weighed against the understanding of traditional post-session note taking as a more administrative task, whereas collaborative documentation is a psychotherapeutic process in its own right due to the emphasis on validation and ensuring goal/task agreement. Collaborative forms of documentation and post-session documentation constitute qualitatively different activities, with the former assimilating psychotherapy techniques and the latter being devoid of any client participation.18

**Collaboration**

In the medical field, patient-centered care is facilitated through shared decision making. Shared decision making is a process by which medical practitioners facilitate patient decision making by helping patients arrive at the best possible course of action for a given medical

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decision in light of the patient’s values and preferences (Lenert et al., 2014). The practice of shared decision making often involves the use of decision aids (e.g., materials such as brochures or slide presentations used to educate patients about a condition, treatment options, and relevant risks and benefits) and value clarification exercises aimed at facilitating patient self-awareness in the decision process, all of which allow the doctor and patient to engage in a productive discussion about how to proceed. The use of such tools has been found to improve patients’ understanding of the relevant risks and benefits of medical procedures and lead to less indecision about the chosen course of treatment (Lenert et al., 2014).19

The shared decision-making protocol in medical practice may be a useful proxy for understanding the utility of collaborative documentation in psychotherapy. Furthermore, a meta-analysis by Carlier et al. (2012) found that using routine outcome monitoring (i.e., using client feedback to inform care) consistently improved communication between the client and provider across the included studies. The authors found further evidence that providers more quickly adjusted the course of treatment when issues were discovered as a result of obtaining feedback, though this effect was stronger and more consistent in briefer treatments than more prolonged treatments (Carlier et al., 2012). Obtaining feedback, then, can strengthen goal consensus and collaboration, which falls within the pantheoretical construct of the working alliance defined by Bordin (1979). Arguably, psychotherapists can use documentation notes as a mechanism for checking in with clients to produce stronger consensus on the goals and tasks of therapy.20

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20 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 77, Copyright Elsevier (2015).
Extending Bordin’s working alliance, Tryon and Winograd (2011) provided an operational definition of goal consensus, which includes elements of general agreement on goals; the client’s understanding of the expectations of therapy; the level of discussion and mutual understanding of the goals, including specificity of the goals; the level of client commitment to identified goals; and an agreement on the origins of the client’s problem, including the client’s understanding of personal agency in solving the problem. Also conceptually related to the working alliance construct is the notion of collaboration, which in the psychotherapy literature has been defined as the degree of mutuality in addressing issues in therapy, the client’s level of cooperation, and the assignment of roles in therapy (G. S. Tryon & Winograd, 2011).77

Tryon and Winograd (2011) conducted a meta-analysis investigating the relationships between goal consensus, collaboration, and psychotherapy outcomes. The authors found a significant and substantial relationship between client-therapist goal consensus and psychotherapy outcomes with an average effect size of \( r = 0.34 \) across 15 studies comprising a total sample of 1,302 participants. The authors also found a significant relationship between client-therapist collaboration and psychotherapy outcomes, with an average effect size of \( r = 0.33 \). This correlation was based on 19 studies with a total sample of 2,260 participants. When exploring the relationship between goal consensus and collaboration, only four studies met the inclusion criteria for the analysis, producing a relatively smaller total sample size of 340 participants. The resulting comparison produced an average effect size of \( r = 0.19 \), representing a small-to-medium effect, but the discovered relationship is precarious because further analysis indicated only a handful of studies with findings of a non-significant relationship would have resulted in a non-significant aggregated effect size across the studies comprising the analysis (G. S. Tryon & Winograd, 2011). This small relationship is a curious finding given the intuitive
relationship between goal consensus and collaboration (both of which may also be captured in
the working alliance construct). A larger sample including more studies comparing goal
consensus and collaboration may yield findings of a stronger, more stable relationship.21

The perception of what constitutes collaboration may also differ across clients. Bachelor,
Laverdie’re, Gamache, and Bordeleau (2007) sought to better define the parameters of
collaboration from the client perspective in a qualitative study using content analysis to
categorize participant responses. The authors found that characteristics of collaboration
considered important during psychotherapy did not constitute a unitary definition; rather,
definitions varied in terms of whom the client deemed most responsible for collaboration. From
the cross-comparison of responses, clients fell into one of three collaboration modes. Clients
who placed a stronger emphasis on their own role in psychotherapy, which included greater
levels of self-disclosure, limited prompting from the therapist, and taking initiatives, were all
characteristic of what the authors defined as the active collaborative mode (Bachelor et al.,
2007). The mutual collaborative role described a more balanced approach whereby the client
and the therapist equally contributed to the work in therapy. Lastly, the dependent collaborative
mode described clients who considered the therapist to be the primary agent in the therapeutic
work, which usually emphasized the therapist as an interventionist (Bachelor et al., 2007). These
findings suggest that an investigation exploring the relationship between collaborative

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documentation and alliance formation will be obliged to consider the possibility that clients will differ in their expectations of roles and responsibilities for collaborative behaviors.\textsuperscript{22}

**Feedback**

Obtaining feedback regarding client progress has been shown to improve overall clinical outcomes, especially with clients who are identified as being at risk for treatment failure (Shimokawa, Lambert, & Smart, 2010; Whipple et al., 2003). Curiously, obtaining feedback in psychotherapy is an underutilized practice (Lambert, 2013), and regrettably mental health providers unreliably predict their own abilities and their clients’ improvement in psychotherapy. For example, Walfish, McAlister, O’Donnell, & Lambert (2012) identified a self-assessment bias in operation for equally credentialed and qualified mental health professionals in that none of the clinicians surveyed self-rated their abilities below the 50\(^{\text{th}}\) percentile; the average rating fell in the 80\(^{\text{th}}\) percentile; and over 25\% of clinicians rated their abilities at or above the 90\(^{\text{th}}\) percentile. The same sampled clinicians, on average, assessed that approximately 77\% of their clients improved as a result of attending therapy with them; over two-thirds of these clinicians also believed 80\% or more of their clients improved (Walfish et al., 2012). While the above-noted self-professed abilities are indeed impressive, this researcher agrees with the authors’ conclusion that the self-ratings are statistically improbable and more likely evidence self-assessment bias than true abilities.

In contrast, allied health professionals might rely on highly objective feedback data to inform their interventions and treatment direction (e.g., blood work, imaging, etc.), yet as Sapyta, Riemer, & Bickman (2005) point out, psychotherapy clients’ irregular reports are the primary

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29
source of feedback for mental health professionals. Fortunately, a movement in psychotherapy research has been underway for the past several decades to develop and implement reliable and valid feedback measures to inform therapy processes and to facilitate improved outcomes. For example, the Institute for the Study of Therapeutic Change (ISTC) has focused efforts on measuring change in psychotherapy while developing and testing practical feedback instruments, including the widespread use of therapeutic alliance measures during psychotherapy sessions (Miller, Duncan, Sorrell, & Brown, 2005).

The practice of obtaining feedback and monitoring outcomes appears to be related to quality assurance in that clinicians can alter their practice proactively during therapy through the early identification of treatment failures or ruptures in the therapeutic alliance. These strategies are consistently shown to have therapeutic benefits, as Shimokawa et al. (2010) demonstrated in a meta- and mega-analytic study investigating outcome enhancement and treatment failures; however, the implication is that feedback flows in one direction from the client to the therapist.

Other forms of obtaining and sharing feedback do exist in the psychotherapy literature that more closely approximate features of collaborative documentation, especially with regard to collaborative forms of feedback. For example, although the sharing of testing data with clients has raised concerns as to the potentiality of harm (Fischer, 1972; Riddle, Byers, & Grimesey, 2002), using psychological assessment results as a feedback mechanism to improve treatment process and outcomes has been in practice since the 1970s. Providing assessment feedback to clients is markedly different than the feedback monitoring discussed thus far in one critical way: information appears to flow collaboratively and bi-directionally between the therapist and client as a means to facilitate therapeutic gains. Various models have emerged in the therapeutic use of
psychological testing to this effect, including collaborative assessment and therapeutic assessment (Poston & Hanson, 2010).

**Collaborative assessment.**

*Collaborative Assessment*, rooted in constructivism and in the existentialist psychological tradition, can be traced, in part, to the work of Constance T. Fischer in the 1970s. Fischer (1970) appealed for a deeper understanding of clients through the co-creation of diagnostic impressions, rather than a reliance on a historically medically-oriented, concrete impression whereby the psychologist was positioned as the expert. She explained, “…it is the client [her or] himself who is in the best position to confirm or clarify the evaluator’s impressions” (Fischer, 1970, p. 71).

Fischer (1970) introduced a procedural framework to reform the existing psychological assessment paradigm in a manner to encourage the use of clients as co-evaluators. This was to be achieved first through remaining transparent about the referral source and questions, which Fischer termed coadvisement. Second, Fischer (1970) recommended sharing impressions by which the tester engages in a dialogue with the client “in order to approximate the client’s experience” (p. 71). Within this element, the tester is encouraged to draw from multiple observations in succession until the tester and the testee reach a place of mutual closure. Third, the use of psychological jargon was discouraged. Instead, writing everyday language is encouraged so that the testee may (a) read and interpret descriptive-based findings and conclusions, and (b) judge the credibility of the conclusions for themselves. Fourth, the client’s critique of the written evaluation is essential in fostering self-determination. Fischer suggested that this critique occur at all stages of testing—prior to, during, and following. She explained, “He [or she] must read the report, dictate his [or her] addendum, clarification, or protest to be added to the report, and decide with which persons he [or she] is willing to share the written
evaluation” (Fischer, 1970, p. 74). Lastly, a client’s designation of report receivers should be requested by the testee as an extension of informed consent. As such, the testee should be informed as to the information to be disclosed so that the testee may determine to whom the information shall be released. This collaborative approach necessarily produces an environment in which a greater coherence is reached, and as Fischer (2000) later noted, “The assessor, however, is responsible both for being able to document the sources and coherence of impressions and for being disciplined, especially in regard to using his or her own life as a resource” (p. 13).

Although dated, Fischer’s (1970) procedural framework is remarkably congruent with the tenants of collaborative documentation. Notably, sharing impressions is a hallmark feature of collaborative documentation whereby the therapist and client discuss impressions as a means of concurrently summarizing, clarifying, and soliciting feedback from the client. Note takers are also encouraged to avoid jargon and produce records in a manner comprehensible to clients. Lastly, while the therapist and client may disagree about the source of difficulties experienced by the client, the therapist is encouraged to reach a collaborative consensus with the client when documenting the pertinent details of the session.

The concept of withholding information from clients, as Fischer (1972) described, may have emanated from the natural sciences by way of psychiatry and the medical traditions whereby the professional assumes responsibility as expert and change agent for the client and that data is thought to be purely objective. In other words, the client has neither the training nor the knowledge to effectively interpret what is in the client’s own best interest. This position represents a treatment paradigm antithetical to collaborative assessment, and by extension, perhaps collaborative documentation. Fischer (1972) explains further, “It is the difference
between telling me that I am a hostile person, as opposed to acknowledging my being impatient and irritable when I perceive bureaucrats as unnecessarily impeding a good cause” (p. 367). Alternatively then, positioning the client in the role of coassessor and using common language in reports has the effect of leading clients to practical data about themselves as well as a degree of shared privacy in that the resulting reports will be meaningful and useful for the client (Fischer, 1972, 2000).

**Therapeutic assessment.**

Dana & Graham (1976) summarize research on providing feedback of client-relevant information directly to clients. *Feedback*, in the authors’ description, referred specifically to testing or interview data communicated directly to the client. However, Finn and Tonsager (1997) pioneered the early work in using assessment feedback as a means of improving the therapeutic relationship and therapeutic outcomes. The *Therapeutic Assessment* (TA) method possesses several distinguishing characteristics that set the method apart from traditional assessment, or the so-called *information-gathering approach*. First, the goal of assessment is shifted from that of professional information sharing and decision making to providing clients with pertinent information that facilitates the client in making change. In other words, clients are provided with clinical and diagnostic information to help them change a behavior rather than to provide for diagnostic clarity between professionals. Second, the former notion of data collection, interpretation, and recommendation is re-conceptualized to position clients in the center and in a collaborative role with the assessor. In this way, the client is invited to actively provide feedback to the assessor regarding the obtained data, rather than the assessor making unilateral interpretations from the test data in a vacuum. The authors note, “Such tactics markedly reduce the power imbalance between assessor and client found in the traditional
assessment approach, with the goal of helping clients cocreate new understandings of themselves that will resolve problems in living” (Finn & Tonsager, 1997, p. 378). Third, both the client and assessor’s subjective experiences during the testing are considered. Last, the assessor’s advanced training and knowledge in the area of assessment, psychometrics, and personality are not minimized; rather, there exists a recognition that the assessor remains a participant-observer within the assessment process (Finn & Tonsager, 1997).

In the development of TA as a model for using assessment as a form of intervention (as opposed to information gathering), Finn and Tonsager (1992) previously studied the effect of sharing MMPI-2 assessment data directly with patients and found that clients who received feedback compared to non-feedback controls experienced increased levels of self-esteem and hopefulness, as well as realized decreased level of symptomatic distress. Later, Newman and Greenway (1997) obtained similar results using the therapeutic assessment method with MMPI-2 data in a college counseling sample. The authors found improved self-esteem and decreased symptomatic distress in the therapeutic assessment group compared to the control group who received assessment results only after administration of the outcome measure. Both studies support the notion that providing feedback to clients might prove therapeutically beneficial, and similar work has continued to appear in the literature.

More recent research has investigated the relationship between collaborative forms of assessment feedback and the therapeutic alliance, a central construct in the present study. Researchers at the University of Arkansas expanded on Finn and Tonsager’s (1997) work by investigating the impact of TA on treatment outcomes and on the therapeutic alliance. The authors found that clients who received collaborative feedback using the TA method were more likely to complete their assessments and furthermore, were more likely to continue with
psychotherapy at the same agency, than were those who did not receive collaborative feedback during assessment (Ackerman, Hilsenroth, Baity, & Blagys, 2000). The authors additionally found that the use of TA not only improved the therapeutic alliance during the assessment process, but that those effects also carried over into the early psychotherapy relationship. Statistically significant and highly positive correlations on a measure of the therapeutic alliance were found between the feedback session (the point at which clients received assessment feedback) and the early therapy relationship (measured at session number three). Notably, the strongest correlations were observed for the Bond \((r = .70)\) and the Goals and Tasks \((r = .67)\) subscales of the alliance measure; however, the overall alliance score was also strong \((r = .63;\) Ackerman et al., 2000). Later, Hilsenroth, Peters, & Ackerman (2004) expanded the research and hypothesized that collaborative assessment feedback would lead to stronger alliance ratings beyond the early stages of psychotherapy and maintained at the later stages (beyond nine sessions). Among the authors’ findings were that assessment feedback (a) did not harm the psychotherapy alliance at any time during psychotherapy and (b) was positively related to the alliance at all stages of psychotherapy (Hilsenroth et al., 2004).

The above findings suggest that the sharing of clinical impressions in a collaborative manner with clients, regardless of whether it occurs during formal assessment or later during psychotherapy, is beneficial with regard to the alliance between client and therapist.

A meta-analysis by Poston & Hanson (2010) sought to fill a gap in the literature by examining the effects of assessment and test feedback on psychotherapy process and outcomes. The authors hypothesized that assessment and testing data, when combined with a form of personalized, collaborative feedback, would be beneficial to clients through positively impacting various treatment processes and outcomes (i.e., therapeutic benefit). The authors found a robust
and statistically significant effect size ($d = 0.423$) across the included studies, providing evidence for collaborative feedback having a positive influence on overall therapeutic benefit, as indicated by gains in treatment process and/or outcomes. When process and outcomes were evaluated as a categorical dependent variable, the authors found a greater effect for the process category ($d = 1.117$) than for the outcome category ($d = 0.547$). The authors further investigated the impact of study variables for the included studies. They found that each study’s design (e.g., no-treatment control vs. a comparison group control) and the type or focus of the study (e.g., process vs. outcome) accounted for more of the variance in the obtained therapeutic benefits than did using assessment data for feedback. More specifically, psychological testing without providing feedback to clients was indistinguishable from no treatment at all. The authors concluded that, “If tests are used collaboratively—and if they are accompanied by personalized, highly involving [sic] feedback—then clients and treatment appear to benefit greatly.” A noteworthy strength of the Poston & Hanson (2010) meta-analysis was in their moving beyond simply reporting their effect size in relation to the standard benchmark of small, medium or large; the authors additionally compared their observed effect to other psychotherapy outcome research and reported a similar magnitude to those found in substance abuse treatment, cognitive-behavioral therapy, and general psychotherapy.

The Role of Transparency

The concern about openly sharing sensitive treatment records with patients has been raised in the medical arena. Delbanco et al. (2012) reviewed an emerging practice in the medical field of sharing doctors’ office notes with patients. Using an electronic portal technology called OpenNotes, patients at three primary care centers were invited to review and comment on their doctors’ notes following patient visits. Both patients and doctors were surveyed before and after
reading notes regarding their attitudes and perceptions of sharing notes and the impact this may have on doctor-patient relationships, as well as doctors’ workflow. Prior to beginning to share notes through the online portal, doctors who participated in the surveys cited worries about confusing their patients and disrupting their own workflow; however, they also predicted improved communication. The patients, conversely, expressed very few concerns prior to using OpenNotes and were generally enthusiastic about the potential benefits (Delbanco et al., 2012).23

Delbanco et al. (2012) found that a large number of patients accessed at least one OpenNote entry (84%, 92%, and 47% across the three centers), and the majority of those who did access a minimum of one note held favorable views of the practice, with only a few patients citing disadvantages during the post-intervention questionnaire. Approximately one-third of patients who used the note sharing portal ‘agreed’ or ‘somewhat agreed’ with having concerns about privacy using OpenNotes. Doctors’ perceptions in the post-intervention questionnaire were mixed, however, with half as many endorsing positive benefits to patients having access to their records, and the remaining feeling uncertain as to how OpenNotes might affect their patients. Interestingly, doctors who took advantage of open-ended survey questions “frequently commented about strengthened relationships with some of their patients (including enhanced trust, transparency, communication, and shared decision making) … patients seemed more activated or empowered” (Delbanco et al., 2012, p. 466).23

The OpenNotes study is suggestive of some of both the presumed benefits and concerns that clients in psychotherapy may realize through the use of collaborative documentation. Some of the patients in the Delbanco et al. (2012) study reported taking proactive steps toward

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improving their health after reading straightforward findings documented by their physicians; they reported that they were more willing to comply with medication regimens; and the majority reported a desire to be able to add to the doctors’ notes if the OpenNotes program was to continue.24

Kahn (2014), in an opinion article for the Journal of the American Medical Association, contends mental health patients should be afforded the same level of transparency and involvement in their records as primary care patients. Kahn suggests transparency in record keeping through inviting clients to read notes, which allows clients to address issues more actively, reduces stigma; can lead to client’s feeling validated; and depending on how clinicians’ notes are written, can represent a more person-centered and strength-based narrative that clients may perceive as humanizing rather than pathologizing. Clients may also have the opportunity to request an amendment to their records to better reflect their perceived experience in session.24

This perspective is not without critics, however. In response to Kahn’s (2014) commentary, (Ritter, 2014) wrote to the editor advising a reconsideration of the implications for note sharing with clients who are minors or perhaps families with complex issues. Indeed, while transparency may be beneficial to some clients, actively inviting inspection of clinical records as a therapeutic tool with other clients may be contraindicated or harmful with other clients, should the records contain information that the client finds distressing. With insufficient research on the active sharing of clinical notes with psychotherapy clients, clinicians would benefit from careful consideration of the risks and benefits of using documentation as a therapeutic tool for each client.24

24 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 74-75, Copyright Elsevier (2015).
All of the studies regarding documentation cited above have dealt with the sharing of notes in an asynchronous manner; that is to say, patients or clients are invited to read what medical or mental health providers document after the service. While this has been shown to be favored by the recipient of care, collaboration in psychotherapy means something different. Asynchronous feedback has certainly been shown to contribute to increased transparency—feelings of validation, reduced stigma, and gains in client action—with the client’s role in collaboration deemphasized. Collaborative documentation, alternatively, actively solicits the client’s participation in generating a meaningful, shared account of what occurred in session, including the quality of the emotional bond between the therapist and client and progress toward the agreed-upon goals and tasks. The intersection between collaboration and transparency could feasibly facilitate feelings of trust and emotional bonding between the therapist and client. The impact of meaningful engagement in record keeping between the client and therapist upon psychotherapy outcomes is less clear.25

The Role of Technology

Involving clients in an administrative task such as note taking may raise some concern about potential harm by inserting technology between the client and the therapist. While this is a relatively new phenomenon as it relates to psychotherapy, physicians and other medical providers have been investigating the use of EHRs and computers during patient examination for some time (Hayrinen et al., 2008). For example, Doyle et al. (2012) found that medical providers initially reported hesitation in using a computer during patient examinations to document the encounter because it might reduce the quality of the doctor-patient relationship;

25 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 75, Copyright Elsevier (2015).
however, these fears dissipated upon engaging the client by first introducing them to the idea of using EHRs during the examination and by inviting the patients to look at the screen with the physicians. Many physicians in the study reported that the practice of collaborating with their patients led to clients holding perceptions of increased responsibility for their records and care (Doyle et al., 2012).  

Similar concerns may arise for therapists when technology is introduced into initial psychotherapy intake sessions. Wiarda, McMinn, Peterson, and Gregor (2014) compared three groups—therapists using an iPad, or a computer, or paper and pencil—on therapeutic alliance strength while completing an initial intake assessment in both a primary care setting and a community behavioral health setting. The authors found no statistically significant difference on client-rated therapeutic alliance ratings between the three technology conditions in either setting. These findings suggest that the alliance is not harmed by the use of some technologies during intake interviews. Whether the Wiarda et al. (2014) findings apply to ongoing psychotherapy sessions, which are comprised of different tasks and goals that may constitute a qualitatively different client experience, is unclear.  

The use of computers during clinical encounters appears to be a clinician concern not widely shared by clients. In an early review of the psychiatric literature on the then-emerging practice of direct patient computer interviewing, Erdman, Klein, and Greist (1985) noted that many clinicians believed the practice to be inhumane or impersonal. On the contrary, the majority of clients surveyed held favorable opinions of using computers for diagnostic and other clinical interviews: “The argument that computer interviews are inhumane must rest therefore on

26 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 72, Copyright Elsevier (2015).
philosophical as opposed to empirical grounds, that is, computer interviewing is still inhumane to subjects, even though the subjects do not mind” (Erdman et al., 1985, p. 762).27

Studies examining the specific impact of technology on clients during the delivery of psychotherapy services are sparse (Perle, Langsam, & Nierenberg, 2011); however, some lines of research have explored the impact of psychotherapy delivered via the Internet and found weaker alliance ratings in online samples compared to those receiving psychotherapy face-to-face (Lovejoy, Demireva, Grayson, & McNamara, 2009). An early study found non-significant differences between recipients of Internet-based and in-person psychotherapy recipients (Cook & Doyle, 2002). However, the study was weakened by a small sample size, and the results were published as part of the authors’ preliminary findings. Alternatively, Rees & Stone (2005) investigated the attitudes of psychologists with regard to the use of videoconference technology to deliver psychotherapy. As the authors predicted, psychotherapy practitioners who were asked to rate the alliance after viewing brief, recorded psychotherapy samples provided higher ratings for samples in which the client was face-to-face with the therapist compared to those who received videoconference-based psychotherapy. Notably, although ratings by clients and therapists of the same therapy session have been found to be moderately correlated, the clients’ ratings tended to be generally more favorable (Tryon, Blackwell, & Hammel, 2007) and were the better predictor of psychotherapy outcomes (Horvath et al., 2011; Lo Coco, Gullo, Prestano, & Gelso, 2011).

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27 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 73, Copyright Elsevier (2015).
Empirical Findings in Collaborative Documentation

In the only study found in the peer-reviewed literature investigating any aspect of collaborative documentation as it has been defined and conceptualized in this chapter, Stanhope, Ingoglia, Schmelter, and Marcus (2013) looked at the role of person-centered planning and collaborative documentation on engagement in recovery-oriented services. Person-centered planning practices in community mental health seeks to engage clients to collaborate on setting outcome goals, self-identify roadblocks to success, and utilize a strengths-based approach along the continuum of assessment and treatment planning (Stanhope et al., 2013). This is similar to the way in which collaborative documentation seeks to meaningfully engage the client in care through record keeping. In this way, collaborative documentation may be an extension of person-centered planning.28

Stanhope et al. (2013) randomly assigned 10 clinical mental health centers (CMHCs) to one of two groups—an experimental group where staff at the centers was trained in person-centered planning and collaborative documentation, or a control group where staff were told to provide treatment as usual. The researchers analyzed agency data on no-show rates, provider-rated medication compliance, and clinician-rated client progress, and reported that the experimental groups’ clinical activities were associated with decreased agency no-show rates and higher medication compliance. The authors concluded that their study supported the hypothesis that clients will be more engaged in services that are aligned with clients’ self-defined goals and when clients perceive more control over those services (Stanhope et al., 2013). The analysis should be interpreted carefully, however, as the control group sites were also reported to be

28 This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., p. 73, Copyright Elsevier (2015).
undergoing agency-wide initiatives outside of person-centered planning and collaborative
documentation strategies in an attempt to improve service engagement by their consumers. For
example, centralized scheduling and consumer re-engagement strategies are sometimes
implemented in CMHCs to reduce no-show rates and recapture clients who have become
inactive with services. Provided that the outcomes measured in the study involved service
engagement, the control group may actually have constituted a different treatment and therefore
have confounded the findings.27

The previously cited study provides some movement in understanding the role of
collaborative behaviors in service planning and documentation, yet it is also representative of the
embryonic state of research on this topic. Stanhope et al. (2013) explicitly acknowledged that
one of the study’s limitations was the use of service engagement rather than the client’s self-
identified goal as an outcome measure. Measuring a client’s progress as a function of
participation in the service provider’s menu of services is inconsistent with person-centered
planning, potentially rendering the study methodologically flawed. The decision by Stanhope et
al. (2013) to use service engagement as an outcome measure would seem counterintuitive given
the researchers’ intervention highlighting person-centered planning, that is until one recognizes
the overarching limitation of all literature on the topic: collaborative documentation continues to
be framed and supported from the perspective of what is good for the organization rather than the
client. Empirical studies aimed at elucidating the hypothesized relationships between the use of
collaborative documentation as a therapeutic tool to strengthen the working alliance and improve
psychotherapy outcomes continue to be stagnant.29

29 This segment was published in Electronic record keeping and psychotherapy alliance: The role
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Conclusion

Collaborative documentation is an emerging record-keeping practice intended to solve many of the challenges endemic in an increasingly complex behavioral health-care system. Supporters of the practice emphasize how agencies may realize drastic improvements in documentation quality and accuracy, thereby improving agency productivity and reducing clinician stress by facilitating timely record keeping. The benefit to clients as a result of therapists concurrently and collaboratively authoring records is often discussed as a secondary benefit to agency gains. While benefits to the agency may be easier to quantify and track, measuring the emotional impact and therapeutic benefit to the client is a complex task.\(^{28}\)

Findings on the factors contributing to successful alliance formation, as well as the relationship between therapeutic alliance and psychotherapy outcomes, suggest the benefit of further examination into how psychotherapists use the emotional and collaborative characteristics of therapeutic alliance to build productive therapeutic encounters. Given that therapists in managed care settings will continue to be expected to see higher volumes of clients, demonstrate positive outcomes through their interventions, and have fewer resources with which to accomplish this, exploration of the ways in which technology can be used more meaningfully to benefit clients is warranted. Collaborative documentation may provide part of the solution with its ability to function as a tool for obtaining feedback concerning clients’ perspectives on emotional climate, health of the therapeutic relationship, usefulness of treatment activities, and progress toward treatment goals, which can inform the therapeutic encounter to improve treatment outcomes.\(^{30}\)

\(^{30}\) This segment was published in Electronic record keeping and psychotherapy alliance: The role of concurrent collaborative documentation, DiCarlo, R., & Garcia, Y. E., pp. 79-80, Copyright Elsevier (2015).
Existing technologies that seek to enhance efficiency in evolving mental health practices carry with them exciting potential, but should lead clinicians to pause and reflect on possible emotional risks and benefits to clients. Literature across multiple lines of research indicates that collaborative documentation may have the potential to be a helpful tool to engage psychotherapy patients in mental healthcare in a meaningful way. But before therapists fully pull back the curtain and engage clients with what has traditionally been considered an administrative task of record keeping, further research is needed. The practice lacks a guiding theory supporting its use as a psychotherapy process tool. As such, proponents of collaborative documentation have failed to provide an adequate description of the mechanisms underlying its purported effect on psychotherapy outcomes. A consensus is needed regarding which features constitute the practice of collaborative documentation. Decisions must be made about whether to standardize collaborative documentation across applications, or to develop a set of guiding principles amenable to variations based on clinician or client preference. Finally, the relationship between collaborative documentation and psychotherapy outcomes should be tested against a theoretical model if collaborative documentation is to move into the ranks of a psychotherapy practice—or better, an evidence-based technique.31
Chapter 3

Methods

This chapter describes the research method and design, sampling method, description of the participants, variables, measures, and procedures used in this study. Ethical considerations will be discussed within the context of social and behavioral science research, with a special emphasis on conducting research within community behavioral health settings that introduce unique challenges for researchers and academics. Additionally, due to circumstances during the execution of this study’s procedures, several adjustments were needed throughout the study. For example, the initial conception and approach to this study relied heavily on the collection and analysis of quantitative data. Although the study’s carefully designed process was executed as intended, the primary study site experienced extensive barriers in recruiting willing participants. As such, modifications were implemented at multiple points throughout the study. This chapter will discuss both the intended design and procedure as well as the final procedural outcomes to inform future researchers who seek to conduct studies in this challenging and dynamic population. Suggestions for conducting research in such settings will be expanded upon in later chapters.

Design

The present study seeks to understand the impact of clinical documentation practices on the client-therapist alliance in psychotherapy. To explore this relationship, a mixed methods approach was utilized. First, a quasi-experimental, between-subjects, static-group comparison group design was employed to determine if measures within the client-therapist alliance differed as a function of whether the treating therapist used a collaborative or post-session documentation practice. Second, qualitative interviews were conducted on a randomly selected subset of
participants who were found to have extreme scores on the dependent measure (i.e., those who had the highest ratings on the Working Alliance Inventory) to explicate the salient features of collaborative documentation that may impact the therapeutic alliance.

A quasi-experimental research design was chosen for this study’s quantitative component due to its ability to explore cause-and-effect relationships between categorical variables that would otherwise be difficult to control (Gall, Borg, & Gall, 2007). A true experimental design was ruled out due to the infeasibility of obtaining an adequate sample of psychotherapy clients to form groups who differed on the basis of her or his therapist’s method of documentation within the target population. Furthermore, a nonequivalent control-group design that utilized a pre-test to strengthen the overall design and analysis would be illogical, as the therapeutic alliance construct ostensibly represents the strength of the relationship between client and therapist; any pre-test measure of alliance would theoretically be zero and of little statistical value later in the analysis. Research has demonstrated that the development of the therapeutic alliance, once established early during psychotherapy, remains largely stable across the therapeutic encounter (Gelso et al., 2012). Additionally, a measurement of alliance taken early in psychotherapy (i.e., measures taken at approximately session number three) remained strongly correlated with psychotherapy outcomes (Gelso et al., 2012). These results suggest that regardless of the strength of the alliance later in therapy, the establishment of a strong alliance early in psychotherapy is predictive of positive psychotherapy outcomes and should remain a suitable point of measurement in the present study.

As such, a convenience sample of psychotherapy clients whose therapists were required to use collaborative documentation versus those who exclusively practiced post-session
documentation formed the basis for assignment into the two groups. The qualitative component was chosen to corroborate and strengthen the inferences drawn from the quantitative data.

**Sampling**

Covariates thought to influence the therapeutic alliance have been explored in the literature. Controlling for pre-treatment functioning is a concern, and findings on its use as a covariate have been mixed. While some studies have suggested that levels of symptomatic distress were positively correlated with higher alliance ratings early in the therapeutic relationship (Eaton, Abeles, & Gutfreund, 1988; Marziali, 1984), other studies found no relationship (Gibbons et al., 2003) or negative correlations between pre-treatment functioning and early alliance (Stinckens, Elliott, & Leijssen, 2009). These studies indicated that the need to plan a study to control for client symptomatic distress is ambiguous. Because the use of an outcome measure or a repeated measures design was outside the scope of this study, placing more stringent limitations on the sample was necessary to improve statistical power and generalizability. For example, client-participants were excluded if they were seriously mentally ill or had active drug or alcohol problems at the time of participation.

The focus of the present study was on elucidating aspects of alliance formation as it relates to documentation practices in the general adult outpatient mental health population. In order to reduce confounding variables such as severe cognitive or functional impairments, developmental differences, the influence of mandated treatment, the influence of drugs or alcohol, and extremes in symptomatic distress, specific inclusion and exclusion criteria were used to more clearly define the sample and improve the generalizability of any findings.

A convenience sample was utilized on two levels. First, therapists at the two selected agencies were recruited for participation. Second, clients entering the two participating agencies
during the data collection period were recruited for participation. In order to approximate a representative sample of client-therapist dyads within each agency, all therapists and clients who met the inclusion criteria were recruited for participation. As such, all new clients who entered treatment were identified for inclusion in the study and if agreeable, assigned to a participating therapist. Of note, clients who declined participation were still assigned to a therapist, and that therapist may or may not have been a participant in the study. Clients entering treatment at the participating agencies were assumed to approximate random assignment at the client-participant level, as they did so in no predictable order and were assumed to be independent of one another.

A Multivariate Analysis of Variance (MANOVA) was planned for this study. As will be discussed below, there was one independent variable with two factors, and two dependent variables in this study. According to VanVoorhis and Morgan (2007), statistical power can be achieved to perform a MANOVA with 30 cases per cell. Stated differently, for every dependent variable, a minimum of 30 cases is needed at each level of the independent variable in order to reliably detect statically significant differences between and within groups. Therefore, this study was estimated to require 120 participants, or 60 in each group. Data collection was anticipated to end upon obtaining the desired sample size. A subsequent analysis using the software package G*Power 3.1™ estimated that with 95% power, a smaller total sample size of only 81 cases were required to detect a small effect (.20), 35 to detect a medium effect (.50), and 23 to detect a large effect (.80; effect size conventions provided by Cohen, 1992).

Due to the complexity of the study’s design, the specific recruitment process is described in further detail in the procedures section.
Setting

Two community behavioral health agencies in the state of Arizona were selected for inclusion in the study on the basis of their respective documentation practices and that met the following criteria: (a) the agency was managed and regulated by a Regional Behavioral Health Authority (RBHA) contracted through Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS); (b) the agency was licensed by the ADHS/DBHS Office of Behavioral Health Licensure (OBHL); and (c) the agency utilized an electronic health records (EHR) system for clinical progress note documentation. Although it was not a prerequisite for the study, both agencies ultimately selected for participation were operated by the same managed care organization that functions as the state’s RBHA, which is tasked with providing oversight in the delivery of behavioral health services to recipients of the state’s Medicaid program. This created an unplanned design advantage in that the comparison groups were further equalized by having similar policies and procedures in place for provisions of care, in addition to being in close physical proximity to one another with adjacent treatment areas. The agencies are hereafter referred to by their comparison group title to improve the privacy of the sites’ staff, clinicians, and clients.

Collaborative documentation group.

The first agency was assigned to the collaborative documentation group, or CD Group. The CD Group is situated in a rural area of Arizona and predominately serves individuals who are recipients of the Medicaid system. The agency additionally accepts private insurance and receives funding through grants and state-funded programming dollars.

The CD Group was selected based on the following criteria being met: (a) the professional mental health providers delivering psychotherapy services had previously received
training on collaborative documentation; and (b) the agency’s service delivery culture was such that collaborative documentation was mandated for providers of psychotherapy and routinely monitored for compliance of concurrent documentation using an objective measure. The CD Group utilized Key Performance Indicators (KPIs), or various metrics by which the agency and staff are measured against agency initiatives and objectives. For example, one KPI was the percentage of client no-shows per month. Another KPI was the rate of compliance with concurrent documentation, which the agency measured as the percentage of time that a clinician completed a psychotherapy progress note within 15 minutes of the scheduled end of a therapy session. A therapist at the CD Group may be notified by administration if her or his KPI for concurrent documentation dropped below 85% for the month.

**Post-session documentation group.**

The second agency was assigned to the *post-session documentation group*, or PS Group. The PS Group is located within 100 miles of Agency A and services a more heavily populated region, but has similar funding sources in that the agency also serve Medicaid system recipients, accepts private insurance, and receives grants and state-funding.

The PS Group was selected based on the following criteria being met: (a) the agency agreed not to utilize any form of collaborative documentation during psychotherapy for the planned duration of the data collection period; and (b) the agency agreed to use post-session documentation practices.

The two participating agencies were matched on all other dimensions, wherever possible, including but not limited to the socio-demographic makeup of the treatment population (as indicated by general descriptive data the agencies provided regarding their treatment populations) and community in which they operate; the delivery modality of psychotherapy
services; the general provision of mental health services; and the type of electronic medical record system employed. The participating agencies were requested to provide aggregate data that spoke to their general mental health treatment population to determine the representativeness of the sample obtained.

Participants

The target population in the present study is client-therapist dyads operating in managed care organizations that use collaborative documentation in the delivery of psychotherapy services. The accessible population is mental health professionals working within the community behavioral health system in Arizona and who actively treat psychotherapy clients. As indicated previously, two community behavioral health agencies in Arizona were recruited for participation. This study was additionally comprised of two classes of participants: therapist-participants (the clinical staff at each agency) and client-participants (the clients of the respective agencies). Both classes of participants were recruited independent of the other. For brevity, the two classes will be hereafter referred to as therapists and clients.

Therapists.

The agencies participating in this study organize their clinical staff by the treatment population for whom they provide services. Programs may include services for General Mental Health, Chemical Dependency, Child and Family, and the Seriously Mentally Ill (SMI). Therapists typically work in a single program and are assigned clients based on the client’s presenting need, which is most often reflected in their principal (or treatment) diagnosis. For example, clients with a Mood Disorder or Anxiety Disorder would be assigned to the General Mental Health program, while a client with an Alcohol Use Disorder would be assigned to a therapist within the Chemical Dependency program, and a child with Attention-
Deficit/Hyperactivity Disorder would be assigned to the Child and Family program. There are some exceptions to this, however, such as a therapist who may work with both mental health and substance abuse clients. Clinicians who predominately provide psychotherapy services to the general mental health population were selected for this study, as the target population for this study was general mental health clients. Notably, there was limited research supporting the use of the Working Alliance Inventory (this study’s chosen dependent measure) in other clinical populations, such as individuals suffering from substance use disorders or psychotic disorders.

Therapists in this study were mental health professionals who were required to meet the following inclusion criteria: (a) eligible to provide billable psychotherapy services under ADHS/DBHS and OBHL rules and regulations; (b) possess a doctoral or master’s degree in psychology, counseling, social work, or related field; (c) licensed or license-eligible in the state of Arizona by the Arizona Board of Behavioral Health Examiners (AzBBHE) or the Arizona Board of Psychologist Examiners; and (d) maintain a case load of psychotherapy clients that comprises 50% or more of the therapists’ billable hours.31

Therapists recruited for this study completed a demographic questionnaire developed by the Principal Investigator. The purpose of this questionnaire was twofold: to determine that individual therapists met inclusion criteria and to provide descriptive statistics about the sample. Therapists were asked to report on their (a) professional identity (e.g., Psychology, Counseling, Social Work, etc.); (b) degree type (e.g., M.A., M.C., M.S.W., Ph.D., etc.); (c) license type (e.g.,

31 An exception was made to include non-license-eligible therapists who are qualified to provide and bill for psychotherapy services as defined by ADHS/DBHS and OBHL, and who receive a minimum of one hour per week of supervision from a mental health professional licensed at the independent level in Arizona. This provision is made explicit due to the presence of therapists, psychology residents, or counselors-in-training who are licensed (or license-eligible) in other states who do not meet Arizona’s licensure requirements, but are otherwise equally qualified therapists; or to allow for recent graduates who are in the process of seeking licensure.
Licensed Professional Counselor, Licensed Clinical Social Worker, Licensed Psychologist, etc.); (d) years of practice at the professional level; (e) self-identified theoretical orientation (e.g., cognitive, behavioral, psychoanalytic, etc.); and (f) any certifications held for a technique or sub-specialty (e.g., CBT, EMDR, Solution-Focused, Psychodynamic, etc.). The demographic questionnaire can be found in Appendix A.

**Therapist demographics and background.**

Therapists who participated in the study included seven therapists from the CD Group and five from the PS Group, for a total of 12 therapists. Due to the small number of therapists, their demographic information is reported in aggregate to decrease the likelihood the therapists will be identifiable in this paper. Therapists who participated in the study included nine women and three men whose mean age was 50-years-old ($SD = 13.8$). Licensure status of the therapists included one Licensed Professional Counselor, two Licensed Associate Counselors, and three Licensed Clinical Social Workers; the remaining six therapists were working towards professional licensure under weekly supervision. There was also a range of self-identified theoretical orientations, including cognitive behavioral therapy ($n = 8$), solution-focused ($n = 2$), and humanistic/person centered ($n = 2$). The mean number of years in practice post-degree was 9.5 years ($SD = 11.12$, $Mdn = 4.5$), and ranged from less than one-year to 32-years.

**Clients.**

Clients enrolled at the two agencies were considered for participation based on the following criteria: (a) enrolled in individual, outpatient psychotherapy with a therapist at a participating agency; (b) is 18 years or older; (b) consents to participation; (c) is assigned a principal or treatment diagnosis listed in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5); (d) agrees to participate in individual psychotherapy with a
therapist who is also participating in the study; and (e) can read and understand the consent documents. Clients were excluded from participation in the study based on the following criteria: (a) seeking psychotherapy services to address a substance use problem, or whose principal diagnosis is identified as Substance Use Disorder as defined by the DSM-5; (b) meets, or is suspected to meet, criteria to be classified as seriously mentally ill (SMI) under ADHS/DBHS guidelines; (c) possesses a developmental or cognitive disability (as indicated by diagnostic information provided) that would prevent them from participating in a psychotherapy process; (d) unable to act as their own legal guardian; (e) mandated by the judicial system to attend treatment; (f) determined to be more appropriate for a higher level of care, such as inpatient or residential care; or (g) assessed to be acutely suicidal or homicidal.

Most of the exclusion criteria were inherently satisfied through the participating agency’s own enrollment process. For example, clients who seek treatment at community behavioral health agencies first undergo an eligibility screening to sign consent documents and to identify the client’s payee, or funding source. Secondly, and if determined financially eligible for services, the client is referred for an intake assessment by a qualified behavioral health professional trained in assessment and diagnosis. During the approximately two-hour intake assessment, the client undergoes a mental health assessment, the principal (or billing) diagnosis is assigned, a treatment plan is completed, and the client is referred to the most appropriate program to meet the client’s individualized mental health needs. The eligibility screening and intake assessment, then, acted as the preliminary screening for participants insofar that only clients referred to the general mental health program were recruited for participation. Notably, the general mental health program then excludes child and family services, substance abuse programs, and services for those who are determined to be, or who might become, eligible for an
SMI designation. Furthermore, ADHS/DBHS mandates that any new or existing client identified as potentially meeting criteria for SMI must undergo an SMI determination, a higher-order review process by which a qualified medical professional (e.g., psychiatrist) classifies the individual as having a Serious Mental Illness based on meeting specific criteria. As such, the pool of eligible client-participants was limited to a subset of the overall behavioral health population and the population of interest in this study.

Additionally, clinical data from the agency was collected for each client consenting to participation in the study. The client’s treatment diagnosis (sometimes referred to within the agency as the enrollment diagnosis or billing diagnosis) served to verify that a client met the diagnostic inclusion criteria. The client’s Global Assessment of Functioning (GAF) Scale score was also considered. The GAF score is routinely used in clinical practice to estimate a client’s overall functional impairment resulting from mental health symptoms. The GAF scale was introduced in the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition* [DSM-IV] as a means of abetting clinical judgment, and as Støre-Valen et al. (2015) noted, research has produced mixed findings on the scale’s inter-rater reliability. The American Psychiatric Association abandoned the GAF Scale in the more recent DSM-5; however, the agencies in this study continue to use GAF Scale scores as means of communicating a client’s overall level of functional impairment and as one criterion for determining SMI program eligibility. Most notably, ADHS/DBHS requirements state that a person assigned a GAF score of 50 or less shall prompt an SMI determination. Clients who are assessed with a GAF score of 50 or less were excluded from participation, regardless of the final SMI determination. Additional demographic data collected from the agency regarding each consenting client included: (a) age, (b) gender, (c) marital status, (d) sexual orientation, (e) ethnicity, (f) level of education, and (g) income. These
data were collected at intake for all recipients of behavioral healthcare at participating agencies. One exception to the agencies’ data collection process is that clients not enrolled through Medicaid (e.g., private pay or private insurance holders) were not required to report income.

In mapping out the study’s timeline, the Principal Investigator conducted preliminary meetings with the clinical directors at both agencies to estimate the length of time needed to obtain the desired sample size. The agency assigned to the CD Group indicated that approximately 20 clients per week were enrolled in the general mental health program. The PS Group agency cited similar enrollment numbers. Conservatively estimating that one-third of the potentially eligible clients would be not be captured due to a combination of meeting one or more exclusion criteria, a lack of volunteerism, and unknown factors, a 16-week recruitment and data collection period was initially anticipated. In other words, 480 potentially eligible clients between the two agencies would be screened for participation over a 16-week period, but only about 320 might be consented into the study.

Another factor for consideration in the study’s timeline was that clients who ultimately became participants would not reach the data collection point until their third psychotherapy session. Indeed, a range of literature exists on psychotherapy dropout rates. For example, a meta-analysis by Swift & Greenberg (2012) boasted an impressive number of studies that represented over 80,000 patients who received various psychotherapy interventions, and their sample included both efficacy studies and effectiveness studies. The researchers found that clients prematurely dropped out of treatment at a rate between zero and approximately 74%, with a weighted mean dropout rate of 19.7%. Given the variability between studies, the researchers tested several moderators and found significant differences in the dropout rate based upon factors related to treatment, client characteristics, therapist characteristics, and the study’s design.
Specifically, higher dropout rates were observed when treatments were not time-limited (as opposed to a time-limited approach); non-manualized; were based in university counseling centers; were focused on diagnoses such as eating disorders and personality disorders; if the client was younger and less educated; and when less experienced therapists provided treatment (Swift & Greenberg, 2012).

A more recent study by Kegel & Flückiger (2015) found significant differences in dropout rates amongst a sample of 296 outpatient psychotherapy recipients in Switzerland. One of the authors’ findings was that clients who did not complete therapy were more likely to have rated the therapeutic alliance lower than those who did reach therapy completion. While the authors used a global measure of alliance comprised of only three items, their findings appear to support the notion that the client-therapist relationship is an important determinant in clients remaining in treatment.

Researchers who study psychotherapy attrition and dropout are careful to note that a great deal of variability exists in how “dropout” or “early withdrawal” is operationally defined across studies, a likely contributing factor in the ranges in dropout rates. Studies dating back to the 1950s suggested that about 35% of clients receiving psychotherapy never returned following their first session (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Zimmermann, Rubel, Page, & Lutz, 2016).

Given concerns about attrition, especially while utilizing a community-based sample, the Principal Investigator anticipated additional data loss between client recruitment and third-session data collection. A conservative prediction was therefore made in that one-half of the 320 (i.e., 160 from the CD Group and 160 from the PS Group) clients who might have participated were not expected to reach maturation in the study before prematurely terminating therapy,
leaving a projected sample of approximately 160 clients (40 more than the target sample size of 120). Additionally, the timeline allowed for clients to reach study maturation (the point at which the client reached the third session of psychotherapy) at different intervals throughout the data collection period. For example, clients consenting to participation during Week 1 of data collection would reach maturation at Week 5, at the soonest; while clients consented in Week 12 might reach maturation by the last week, Week 16. The procedure also permitted clients to be consented at Week 16, as those clients might reach maturation four weeks later. There were additional scenarios subsumed within the design to allow for missed appointments or delays in scheduling.

Notwithstanding the Principal Investigator’s efforts to predict and control for sampling problems with such a challenging research population, there were considerable difficulties in obtaining the desired sample size. Recruitment and data collection began in the Fall of 2016 and ended during early 2017.

A total of 27 clients volunteered for the study and signed consent documents. Two of the clients volunteered in the CD Group, while the remaining 25 volunteered for the PS Group. A total of seven client-therapist dyads reached maturation in the study and completed the measures, one from the CD Group and six from the PS Group. In the PS Group, there were three separate therapists who treated the six clients, with the first therapist treating three clients, the second treating two clients, and the third therapist treating one client. To protect the confidentiality of the single client-therapist dyad in the CD Group, clinical and demographic data will be reported for both groups combined. Additionally, descriptive statistics were not reported for the small group of therapists who comprised the final sample of completed client-therapist dyads due to the potential for identification.
Client sample demographics.

Although approximately 25% of participating clients completed the study’s measures, all participants had demographic data collected for the purposes of describing the final sample. Table 3.1 provides a summary of combined sample’s demographic makeup.\(^{32}\)

\(^{32}\) Descriptive statistics are reported in descending order without regard to the assigned label (e.g., gender, sexual orientation, ethnicity, etc.), unless the variable was naturally hierarchical (e.g., level of education).
Table 3.1

CD Group and PS Group Client Demographics
<table>
<thead>
<tr>
<th></th>
<th>( f (n = 27) )</th>
<th>( M (SD) )</th>
<th>( Mdn (Min-Max) )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>27</td>
<td>34.8 (12)</td>
<td>29 (21—60)</td>
</tr>
<tr>
<td><strong>Gender Identification</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transgender</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Not Hispanic</td>
<td>20 (74%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hispanic/Latino(a)</td>
<td>5 (19%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>American Indian</td>
<td>2 (7%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heterosexual</td>
<td>15 (56%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bisexual</td>
<td>5 (19%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gay</td>
<td>1 (4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lesbian</td>
<td>1 (4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Declined</td>
<td>4 (15%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single/Never Married</td>
<td>12 (44%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Married</td>
<td>7 (26%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Divorced</td>
<td>3 (11%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Separated</td>
<td>1 (4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Declined</td>
<td>3 (11%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Diploma/No GED</td>
<td>6 (22%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>High School Graduate/GED</td>
<td>6 (22%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Some College/No Degree</td>
<td>7 (26%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Vocational/Technical</td>
<td>2 (7%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>4 (15%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>1 (3%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Declined</td>
<td>1(4%)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Income (monthly)</strong></td>
<td>- 1012.00</td>
<td>710 (0—5000)</td>
<td></td>
</tr>
</tbody>
</table>
Client sample clinical and diagnostic data.

The combined client sample was comprised of a range of clinical diagnoses. The distribution of primary diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition were as follows: 51.9% with mood disorders (n = 14; Major Depressive Disorder, Bipolar I Disorder, Persistent Depressive Disorder, Mood Disorder Not Otherwise Specified), 22% with adjustment disorders (n = 6; Adjustment Disorder with Depressed Mood, Adjustment Disorder with Anxiety, Adjustment Disorder With Mixed Depressed Mood and Anxiety), and 18.5% with anxiety disorders (n = 5; Posttraumatic Stress Disorder, Other Specified Trauma and Stressor Related Disorder, Generalized Anxiety Disorder). Additionally, there was one person diagnosed with Attention-Deficit/Hyperactivity Disorder (3.7%) and one person with a personality disorder (3.7%; Borderline Personality Disorder). Clients who had a secondary diagnosis assigned comprised 74% of the total sample (n = 20). Of those with a secondary diagnosis, the most common was an anxiety disorder (42%; n = 8), followed by a Substance Use Disorder (31.5%, n = 6; Alcohol Use Disorder, Cannabis Use Disorder, Amphetamine-type Use Disorder). The remainder had mood and adjustment disorders (n = 2 each), or Attention-Deficit/Hyperactivity Disorder (n = 1).33

The Global Assessment of Functioning (GAF) Scale is described as a “hypothetical continuum” against which a person’s social, occupational, school, or symptomatic functioning can be compared (American Psychiatric Association, 2000, p. 34). The scale ranges from 1–100, with the low end representing a person assessed to be persistently or severely dangerous or

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33 Client diagnoses represent the diagnoses assigned at the time of data extraction in February 2017, the time at which data were analyzed. Of note, the principal diagnoses are assigned by the intake therapist who conducted the initial assessment with the client. The client’s therapist or other providers may change the diagnosis at any time during treatment, as clinically indicated.
unable to attend to activities of daily living, and the high end representing superior functioning in all domains. The scale’s functional descriptors are organized by increments of 10 and represent increasingly positive or adaptive functioning across the continuum, with scores of 50 and lower indicating serious symptoms (e.g., a person with active suicidality or depression that prevents normal social interactions may qualify for a score of 50; American Psychiatric Association, 2000). The GAF Scale scores for all clients in this study ranged from 51 to 80, with a mean score of 62 ($SD = 6.4; Mdn = 60$). The findings from GAF scores suggested that the average client in this study’s sample experienced mild-to-moderate psychological symptoms, or mild-to-moderate difficulties in social, occupational, or school functioning.

**Apparatus**

Client-therapist psychotherapy sessions occurred in private therapy offices within each agency. The therapists’ offices included seating for the client, a desk, and a computer terminal for which the therapist had access to the client’s EHR during the session. The client and therapist in the PS Group were asked to be physically situated in a manner consistent with collaborative documentation practices. Specifically, during collaborative note taking, the therapist and client were instructed to have an unobstructed view of the computer screen. There was no requirement for the client to have access to the computer screen during other portions of the psychotherapy session. Specific instructions for physical space orientation were not provided to the PS Group therapists.

**Independent Variable**

Documentation practices can vary by setting and practitioner; however, most share the aim of documenting clinically relevant client information. Clinically relevant information may include, but is not limited to, the client’s therapeutic needs, assessment data, objective and
subjective observations, progress toward goals, and therapeutic plans. This study was interested in exploring how a novel documentation practice impacted the relationship between the client and therapist. The independent variable in this study was the documentation style and included two conditions: *post-session documentation* and *collaborative documentation*.

**Post-session documentation condition.**

Post-session documentation involves the asynchronous documentation of the clinical encounter following completion of a psychotherapy session. Although clients may request their records at any time and discover what was written by the therapist, this process lacks a collaborative, editorial, or iterative feedback process central to the aim of collaborative documentation. For this study, post-session documentation was operationally defined as: *completion of a psychotherapy progress note following the conclusion of the therapeutic encounter and the client’s departure*.

**Collaborative documentation condition**

Collaborative documentation has been described as “a clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understandings of important issues” (Schmelter, 2012, slide 2). Essential to the documentation process is that (a) clients understand what is being written about their therapeutic encounter during their session; (b) clients are invited and encouraged to offer input; and (c) therapists use the documentation time as a means of clarifying issues and adjusting their documentation accordingly. For the purposes of this study, collaborative documentation was operationally defined as: *completion of a psychotherapy progress note by the conclusion of the therapy encounter in a collaborative, transparent manner in concert with the*
client. Extended further, client-therapist collaboration must include at least one instance of soliciting feedback or clarifying important or salient aspects of the session in a manner that is translated into documentation. Furthermore, the therapist must additionally ensure through a verbal acknowledgment that the client understands what was included in the documentation for that session before the client is dismissed. During this study, therapists in the CD Group were required to use collaborative documentation in every single session with clients.

**Collaborative documentation fidelity.**

Fidelity of the collaborative documentation condition within the independent variable presents certain research challenges, and unfortunately, no procedure or process has been adopted to standardize collaborative documentation. Agencies and therapists may vary in their collaborative documentation practices, and indeed, therapists may invariably apply components of collaborative documentation from session-to-session. While the supporters of collaborative documentation insist that the practice should not be implemented unilaterally with all clients and client problems, a degree of standardization is required to adequately study the phenomenon. For this reason, the CD Group was selected specifically for the collaborative documentation condition because the agency adopted the concurrent collaborative documentation model piloted by the National Council on Community Mental Health. Additionally, the principle investigator conducted a two-hour training on collaborative documentation with the CD Group agency to facilitate a more standardized process prior to data collection.

To measure fidelity, a task analysis checklist was created specifically for this study to assess the therapists’ adherence to the practice of collaborative documentation. The checklist attempted to capture, in a binary fashion, the salient features hypothesized to be most important in the use of collaborative documentation. The binary task list items were adapted from training
materials available online through MTM Services and other agencies who conducted pilot programs. Furthermore, the items within the checklist were matched to training goals established for the collaborative documentation training conducted by the principle investigator.

A separate therapist and client version was created. Examples of therapist task list items included:

- During your first session together, did you inform your client that she or he would be participating in developing a note together that described your session?

- Did you inform your client that the note would include your assessment?

- Did you use a transition statement to begin wrapping up the session and start the note taking portion (For example, “We’re getting close to the end of session, let’s stop here and review what we’ve talked about”)?

Examples of client task list items included:

- During your first session together, did your therapist inform you that you would be participating in developing a note together that described your session?

- Did your therapist inform you that the note would include the therapist’s assessment?

- Did your therapist inform you that you could agree or disagree with the therapist’s assessment and that your comments would be included in the note?

- Did your therapist summarize or read directly for you the note you developed before it was finalized?

- Did you provide feedback about how the session went?

The Task Analysis Checklist for the therapist and client can be found in Appendix B, and the specific scoring procedure for the checklist will be described in Chapter 4.
Dependent Variables

History of Instrument.

The Working Alliance Inventory (WAI) is a 36-item self-report instrument to measure the quality of the alliance developed by Horvath & Greenberg (1989) based on Bordin's (1979) generic construct. The WAI has demonstrated adequate reliability and validity (Horvath & Greenberg, 1989) and has been identified in meta-analyses as one of four “core” alliance measures used in over two-thirds of alliance-rated research (Horvath et al., 2011). However, the WAI has been criticized for its three-factor structure, which demonstrates redundancy between the Task scale and Bond scale (Andrusyna, Tang, DeRubeis, & Luborsky, 2001; Falkenström, Hatcher, Skjulsvik, Larsson, & Holmqvist, 2015) and intercorrelations amongst all three subscales (Hatcher & Gillaspy, 2006). Tracey & Kokotovic (1989) conducted a factor analysis supporting a bilevel model including one group factor comprised of the task, goal, and bond dimensions, in addition to one general alliance factor. From this, the authors developed the WAI-Short Form (WAI-S), a 12-item instrument with similar psychometric properties that can be administered more quickly (Tracey & Kokotovic, 1989).

Several explanations have been proposed for the strong correlations, especially between the Goal and Task subscales of the WAI. Hatcher & Gillaspy (2006) speculated that the theoretical and practical distinction researchers make between the subscales may not be as apparent to psychotherapy recipients, at least in a manner that can be clearly distinguished by those responding to the measure. Alternatively, working toward goals may correspond directly with the tasks needed to reach those goals. With regard to the relationship between the Bond scale and the Task and Goals scales, the authors note that they may have a reciprocal relationship.
in that “The development of the bond may enhance the agreement on goals and tasks and vice versa” (Hatcher & Gillaspy, 2006, p. 13).

Addressing the concerns of redundancy amongst alliance subscales, Hatcher & Gillaspy (2006) investigated the factor structure of the 36-item WAI and the WAI-S using large, independent samples. The authors developed the WAI-Short Form Revised (WAI-SR), which is comprised of 12 items that obtained better differentiation between the Task and Goal subscales than was found in the WAI-S, and as Tryon et al. (2007) noted, was an improved measure of Bordin’s (1979) theoretical construct. Hatcher & Gillaspy (2006) found that in two independent samples, WAI-SR total score alphas were .91 and .92. The Bond, Goal, and Task subscales had coefficient alphas that ranged from .85 to .90. Furthermore, the subscales within the WAI-SR correlated strongly with the subscales from the original 36-item WAI (Goal = .88 – .91; Task = .79 – .80; and Bond .60 – .61), making the WAI-SR a briefer measure with comparable psychometric properties. Regarding the subscales, the authors found evidence that modifications made to the WAI-SR produced greater differentiation between the Task and Goal scales when compared to the WAI-S. Convergent validity was also found to be good with other widely used alliance measures, including the California Psychotherapy Alliance Scale (Marmar, Gaston, Gallagher, & Thompson, 1996) and the Helping Alliance Inventory (Luborsky et al., 1996).

Working Alliance Inventory—Short Form Revised (WAI-SR).

The WAI-SR (client version) was chosen for the present study due to the measure’s psychometric properties and relatively short administration time. Although therapist-rater versions of the instrument exist and demonstrate acceptable psychometric properties (Horvath & Bedi, 2002), and some have argued for the use of a client-therapist shared-view alliance factor (Hatcher, Barends, Hansell, & Gutfreund, 1995), a therapist rating was omitted to reduce
unnecessary demands on the session. Forgoing a therapist rating is further supported by findings from Horvath et al. (2011) who noted that the type of alliance and outcome measures utilized and by whom the rating was provided by (the client, therapist, or an independent observer) did not significantly moderate differences amongst the measure’s subscales or in their relationships to various outcome variables. Additionally, Lo Coco et al. (2011) found that the therapist-rated therapeutic alliance was correlated with later psychotherapy outcomes. Taken together, the client’s rating of the alliance appears to be comparable, if not better, than the therapist’s when used to predict outcomes. What remains unknown is the relationship between the chosen dependent measure and the present study’s independent variable, documentation condition.

The WAI-SR consists of 12 items—four items for each subscale—presented on a 5-point Likert scale ranging from seldom to always. Some items are worded in such a manner that the respondent is asked to “mentally fill in” the therapists’ name while reading the item. For example, an item within the Goal scale states, [Therapist’s name] and I collaborate on setting goals for my therapy; or [Therapist’s name] and I are working toward mutually agreed upon goals. Other items, such as those found within the Task scale, are complete statements such as, What I am doing in therapy gives me new ways of looking at my problem. The instructions preceding the items ask the respondent to “think about your experience in therapy, and decide which category best describes your own experience.”[^34]

Some researchers continue to disagree about the empirical differentiation between the Task and Bond scales within WAI-SR. In general, correlations between Task and Bond tend to be very high across studies using diverse clinical samples. For this reason, consistent with the methodology of Smits, Luyckx, Smits, Stinckens, & Claes (2015), the Task and Goal subscales

[^34]: Items copyright © 1981, 1986 Adam Horvath. Used with permission.
were combined into one scale—renamed *collaboration*—and the Bond subscale. The WAI-SR can be seen in Appendix C.

**Qualitative Measures**

To obtain a comprehensive understanding of the salient aspects of collaborative documentation, semi-structured qualitative interviews were planned for this study. Extreme cases—that is, cases for which statistically extreme scores exist in the dependent variable in either the high or low direction—would be identified through a preliminary analysis of the quantitative data. From the resulting cases for which consent was provided, five client-participants were to be randomly selected to participate in interviews. The central aim of the interviews was to extract components of collaborative documentation that clients believed to be advantageous or disadvantageous regarding their psychotherapy encounter, while additionally analyzing the context in which the individual’s environment and personological factors influenced them. Data obtained from qualitative interviews were to be used to corroborate quantitative findings and enhance the richness of the analysis. As Lerner & Tolan (2016) note, utilizing a mixed-method approach whereby qualitative data is used to triangulate quantitative findings has the potential to develop nuanced conceptualizations of the complex interactions between individuals, their environments, and the phenomenon under study. The development of interview questions was informed both by training documents obtained from MTM Services and a review of the literature within the areas of bioinformatics, medicine, nursing, and psychotherapy. A copy of the interview guide can be found in Appendix D.

Unfortunately, there were no client volunteers for individual interviews. As will be discussed in later sections, the study’s procedure was modified to include interviews with therapists to obtain their perspectives on the use of collaborative documentation.
Procedures

Conducting research using a clinical sample in a community behavioral healthcare setting presented challenges beyond what might be required of researchers using survey or archival data. Foremost, client confidentiality and privacy required significant planning to ensure that safeguards were in place. Additional planning was needed because collaborative documentation was neither a standardized nor a uniform process. To address these concerns, the Principal Investigator organized the study’s procedure into three distinct phases. Phase I included the recruitment of the two agencies for the study; recruitment and training of study personnel within each agency; and recruitment, orientation, and training of therapists within each agency. Phase II involved the active recruitment and consenting of clients into the study, as well as the tracking of study participants and data collection once the participants reached maturity in the study. During Phase III, the final phase, clinical data from the individual agencies’ EHR system was extracted, interview participants were identified and recruited, and qualitative interview data was collected. The following flowchart depicts the three stages as initially conceived during the planning of the study.\(^{35}\)

\(^{35}\) Importantly, modifications were made throughout the study to accommodate specific changes and needs at the two study sites that were not reflected in the chart.
Additionally, a mock pilot study was conducted to test the training materials, procedures, and processes within the study. Each phase will be discussed in detail, in addition to supplementary procedures required to ensure compliance with the collection of PHI in accordance with human subject research ethics and HIPAA guidelines.

**Mock pilot study.**

Prior to start of the study, the Principal Investigator piloted the study’s materials on a group of six graduate students. The students were invited through the university’s List Serve and the pilot occurred on a Saturday morning during the Fall semester; coffee and light refreshments were provided.
The Principal Investigator provided the students with initial drafts of the study’s consent documents, instruction sheets, and orientation materials. The mock pilot lasted approximately two hours, which included a one-hour collaborative documentation presentation. Students were provided with a feedback form enabling them to share which components of the training worked well and where improvements could be made. Students were especially encouraged to share their opinions regarding the flow and logic of the study’s steps for the various roles (e.g., therapist, client, study personnel). Additionally, the students were asked to execute specific procedures related to the data collection process for the purposes of (a) estimating the future timing of data collection during therapy sessions, and (b) anticipating any problems with the data collection procedure.

The feedback provided by students regarding the training and procedures component was generally positive. For example, most students commented that the project was well designed, thorough, and organized. Specifically, the students shared that the instruction sheets (explained later) for the individual study roles were likely to be an asset to study participants and personnel. They made minor suggestions on how to improve the readability and flow of the documents.

The initial draft of the collaborative documentation training, presented as a PowerPoint presentation to the students, was positively received. Students noted, however, that certain aspects of the presentation could be modified to better suit the audience. For example, two students identified that the discussion surrounding the therapeutic alliance was excessive and was predicted to be of limited interest or utility to the therapist participants. Alternatively, two other students indicated that the coverage of the theoretical foundation was quite helpful in grounding the practice of collaborative documentation. These students estimated that they achieved better “buy in” to the practice by understanding how collaborative documentation might be helpful to
clients. A clear consensus regarding the presentation was that therapists in community behavioral health settings would likely resist practicing collaborative documentation due to time constraints and work demand. Of note, at least three of the students who participated had a history of working in managed-care settings and thus brought helpful perspectives to the mock pilot.

Finally, the students role-played therapist-client dyads and completed the study’s measures in accordance with the administration procedures outlined in the instruction sheets. The six students comprised three dyads, with one student playing the therapist and the other the client. The students completed the packets and then reversed roles to complete the exercise a second time, for a total of six completed mock study packets. Most packets were completed in approximately five minutes, with the longest taking 10 minutes to complete. The students commented that the instructions were simple to follow. They offered feedback on the best ways to instruct clients to complete the packet in a manner consistent with the privacy and confidentiality measures developed by the Principal Investigator.

Based on the feedback provided by the students who attended the mock pilot, the Principal Investigator made modifications to some of the training and procedural materials. Ultimately, several slides within the collaborative documentation training that discussed the theoretical underpinnings were removed or simplified. Additionally, the instruction sheets were slightly modified to achieve more clarity. The informed consent documents were also updated to reflect the estimated time frames for completing study materials. Lastly, new procedures regarding the collection of study packets were implemented.
Phase I: Agency recruitment, orientation and training.

As indicated above, agencies were selected based on their reported record-keeping practices. Study sites were recruited by emailing an advertisement to pre-identified public behavioral health agencies across Arizona, first targeting sites that were understood to be using collaborative documentation with clients. Appendix E contains a copy of the recruitment advertisement. Three sites were identified as potentially meeting this criterion. While the three sites expressed initial interest in the study, one of the sites ultimately declined participation for an undetermined reason. The two remaining sites were further vetted, both for their fitness to the study’s design and procedures, as well as the degree to which the site’s service population could be matched to the comparison site (i.e., similar demographics and treatment practices). Upon further examination, one site was ruled out due to administrative concerns that had the potential to interfere with the fidelity of collaborative documentation. The remaining site was determined to meet all the inclusion criteria and therefore was accepted as the Collaborative Documentation (CD) Group.

The site that became the Post-Session Documentation (PS) Group was among the sites that responded during the initial recruitment effort, and that did not use collaborative forms of record keeping at the time of study recruitment. Additionally, the PS Group not only met the inclusion criteria, but serendipitously was also under the purview of the same managed-care organization as the CD Group. This was helpful in that they had similar organizational structure and they followed similar protocols for service delivery. More so, both agencies were supportive, if not governed, by integrated healthcare initiatives.

Following the initial selection of the two sites, the Principal Investigator participated in a 60-minute meeting with each site’s administration and stakeholders to review the objectives,
methods, and procedures for the study. The CD Group agency meeting included the Chief Executive Officer and the Chief Clinical Operations Officer. The PS Group agency meeting included the Clinical Director of the General Mental Health and Substance Abuse program, and the agency’s Chief Psychologist. The purpose of the meetings was to understand the agencies’ policies and procedures surrounding clinical documentation practices and to identify key personnel who were to become involved in aspects of the study. Both sites were determined to have processes in place that were conducive to the goals and procedures of the study and that made data collection at the sites logistically possible. Of special importance was that the CD Group site expressed interest in implementing agency-wide collaborative documentation practices for their clinicians and viewed this study as a catalyst to achieving that goal.

**Study coordinators.**

An internal agency *Study Coordinator* was assigned at each site. The study coordinator was considered research personnel and was responsible for (a) facilitating the collection and secure maintenance of all study materials for the Principal Investigator; (b) assisting with study-related orientations and trainings; (c) assisting with setting up alerts on individual clients’ EHR identifying them as study participants; (d) appraising the Principal Investigator of any problems or concerns throughout the study, especially related to data collection, participant grievances, or confidentiality breeches; and e) assisting the Principal Investigator in extracting data related to study variables. Notably, the study coordinators were not responsible for the recruitment or consenting of study participants, nor did the study coordinators have access to data collected by the Principal Investigator beyond clinical information for which they would normally have access as related to their job duties at the agencies.
The Study Coordinators were individuals selected based on their respective roles and their ability to facilitate the goals of the study. The CD Group selected an administrative assistant, while the PS Group utilized a clinical administrator. Coordinators received copies of all study-related materials to familiarize them with procedures. The Principal Investigator met with the Coordinators at both agencies to review the procedures in detail. Each study coordinator received a set of instructions as a reference guide tailored to their respective sites (see Appendix F) and were provided with a $100 prepaid Visa card as compensation for their assistance with the study.

**Study personnel.**

This study was unique in that an outside researcher sought to collect psychotherapy data from clients entering a community behavioral health agency. The feasibility of providing informed consent was of concern given the desired sample size, site locations, and the invariable manner in which clients entered the behavioral healthcare system for treatment. The Principal Investigator sought to remedy this issue by enlisting Study Personnel at each site to facilitate the recruitment and consenting of clients into the study. Potential Study Personnel were identified by each agency’s administration. The CD Group identified Intake Workers for this role, while the PS Group chose Case Managers.

A recruitment email was sent to each agency’s identified staff inviting them to participation in the study (see Appendix G). In accordance with ethical research practices, all research investigators are required to successfully pass a course on human subject research. Therefore, those that responded to the recruitment email were asked to satisfactorily complete the Collaborative Institutional Training Initiative’s (CITI) online training for human subject research and sign an Individual Investigator Agreement. Training modules included *Students in*
Research, The Federal Regulations, Assessing Risk, Informed Consent, Privacy and Confidentiality, and Northern Arizona University (a school-specific module). The Principal Investigator developed an instruction guide for accessing the training and correctly registering for this study (also included in Appendix G). The training took approximately 90 minutes to complete and required a minimum passing score of 80%. Study Personnel were each compensated for their time with a $50 prepaid Visa card.

A total of five Study Personnel were recruited and included three Intake Workers at the CD Group agency and two Case Managers at the PS Group agency. All Study Personnel signed an Individual Investigator Agreement and completed the CITI training modules. The average score on the CITI training for the five workers was 95.2% (M = 23.8; 23—25), suggesting that they demonstrated a very good understanding of human subject research and ethical research practices.

Once Study Personnel were accepted, the Principal Investigator conducted a one-hour training to review the study’s procedure, which included steps for client recruitment, informed consent, and client tracking. Study Personnel were informed that their duties were to include (a) identifying new clients as potential study participants using the study’s inclusion and exclusion criteria; (b) following a recruitment script for every eligible client who meets the study’s criteria during the recruitment period; (c) providing informed consent to client participants, including providing additional information or answering any questions; (d) alerting the agency’s Study Coordinator after every consented client; (e) assigning consenting clients to an appropriate therapist; and (f) storing and delivering completed informed consent documents to the Study Coordinator in accordance with the procedures outlined for secure maintenance of Protected Health Information. The Study Personnel were provided with an instruction sheet outlining the
above procedures to be used as a reference guide, which can be seen in Appendix H. Following the training, Study Personnel were given a training quiz to assess their understanding of the study’s procedures and their respective roles, a copy of which can also be found in Appendix H. All Study Personnel received a perfect score on the quiz, suggesting that they understood the important procedural steps, roles, and responsibilities pertaining to the study.

Therapists.

Therapists within the general mental health program at each agency were identified by the agency’s administration during the initial meeting. The Principal Investigator conducted an orientation for the therapists at each agency to describe the study and the therapists were invited to participate in the study during the orientation. Therapists who initially agreed were provided informed consent for their role in the study.

Upon obtaining consent, therapists at each site participated in a 60-minute group orientation to learn the study’s procedures, which included client recruitment through the Study Personnel, completion of the Task Analysis Checklist, confidential data collection, confidentiality, and communication with the Principal Investigator.

Therapists at the CD Group agency were informed that their role included the following: (a) conduct individual therapy sessions with clients who were also consented into the study; (b) administer study materials; and (c) conduct all therapy sessions with study participants using collaborative documentation consistent with the training provided by the Principal Investigator. Therapists at the PS Group agency were assigned the same roles, with the exception that PS Group therapists were not to use collaborative documentation. Therapists at both agencies received an instruction sheet summarizing the procedures as a reference, which can be seen in Appendix. At the end of the orientation, the therapists completed a training quiz to assess their
knowledge in the study’s procedures related to the therapists’ role, a copy of which can be found in Appendix. All therapists across both agencies earned perfect scores. A copy of the training quiz for both agencies can also be found in Appendix H.

**Collaborative documentation training.**

Attempts were made to standardize the practice of collaborative documentation for the purpose of studying the practice’s relationship to the therapeutic alliance. As such, the Principal Investigator developed a training presentation consistent with materials reviewed from MTM Services, as well as other pilot studies conducted at behavioral health clinics across the United States that implemented the practice. As described earlier, the training was delivered to a group of six graduate students who offered suggestions on how to improve and clarify the presentation. The final training delivered to the CD Group agency had a duration of two hours and included handouts to be used as resources for conducting collaborative documentation during psychotherapy sessions.

Several objectives were created for the training. Although the training was targeted toward study participants (i.e., therapist-participants), the presentation was delivered to all clinical staff at the CD Group agency. The following training objectives were designed to be sufficiently broad for the entire audience, while also capturing critical components needed for the study’s overall goal:

- Define *Collaborative Documentation* in a client-centered manner.
- Discover the benefits of shared note taking.
- Apply collaborative documentation in an effective manner with clients.
- Adjust clinical assumptions or fears in using collaborative documentation.
- Adapt clinical language to a shared format.
- Practice learned skills.  

36 A role-play exercise was planned for the training to facilitate learning objectives, but unfortunately, the exercise was abandoned because it was not logistically possible given that the training was attended by over 60 clinical staff members.
The Principal Investigator was especially concerned with helping clinicians reduce their overall resistance to the practice of collaborative documentation. Clinical staff were predicted to be most resistant on grounds that more tasks were being added to their already brimming responsibilities, and that they would make unhelpful assumptions that clients would feel offended by collaborative documentation. To achieve a more receptive learning environment, emphasis during the training was placed on the Principal Investigator’s own experiences using collaborative documentation in a community healthcare setting. For example, acknowledgment was given to the frequent incongruity between an administrator’s expectations of clinical workload and that of an individual therapist’s caseloads when the number of clients exceeds what is logistically possible to manage. A good portion of the presentation facilitated the exploration of client and therapist assumptions surrounding the use of collaborative documentation, along with alternative views to adopt. A copy of the PowerPoint presentation slides can be found in Appendix I.

The PS Group agency did not receive the collaborative documentation training during the active portion of the study. However, the Principal Investigator returned to the agency following the completion of data collection during the Spring 2017 semester to conduct the training.

**Phase II: Recruitment, tracking and primary data collection.**

Given the complexity of the recruitment process as well as maintaining protected health information (PHI), Phase II of the study was designed to create a structured method for bringing participants into the study and increasing the security of their private and confidential information. A secondary purpose of Phase II’s design was to increase client and therapist
confidence that both their clinical and counseling process data would not be accessible to any individual beyond the Principal Investigator. Therapists required assurances that their therapy process would not be negatively scrutinized by agency administration, and clients needed to feel confident that their therapists would not treat them differently because of how the client rated the therapist. Certainly, the perception that client and therapist data was not secure would serve to undermine the stability of the data collection.

**Security provisions.**

The Principal Investigator sought to securely maintain data in a manner consistent with professional research ethics and in compliance with the law and HIPAA requirements. Study data, which included both therapy process information (e.g., Working Alliance Inventory; CD Task Checklist) and PHI (clinical and demographic information), was handled with the upmost care. The two participating agencies were blind to the therapy process data collected and had access only to PHI that would otherwise be available to the agency in the clinical treatment of their population. All other data, including interviews, transcriptions, and measures were accessible exclusively to the Principal Investigator. This required special materials to increase the separation between the agency and the desired data. The Principal Investigator, in collaboration with Northern Arizona University’s Institutional Review Board (IRB), designed specialized data collection and storage methods to increase security for this study, which are described next.

All participants were assigned a confidential study identification number. Embedded within each study ID number was a method for identifying both the client and their corresponding therapist. A codebook maintained by the Principal Investigator served to match
the client-therapist dyads to their clinical data later in the procedure. No other study data was stored within the codebook.

Questionnaire data completed by clients and therapists during session were enclosed in Tyvek™ high-strength, tamper-evident envelopes while at the agencies. If the seal was broken, the word “OPENED” appeared in red print across the seal. After materials were completed and sealed within the envelopes, therapists were instructed to deliver the completed envelopes to the Study Coordinator’s secure mail tray in the records room by the end of their work shift. At the end of each business day, the Study Coordinator was instructed to secure any completed envelopes in a HIPAA-compliant locking document bag supplied by the Principal Investigator. Only the Principal Investigator and the Study Coordinator had copies of the key. Furthermore, the Study Coordinator was required to keep the security bag in her or his office behind a locked door, with the key to the bag stored in a separate, secure location. The Principal Investigator collected the contents of the bags at regular intervals during the data collection period. Once collected, the study materials were stored in the Principal Investigator’s private fire-rated safe.

Informed consent and HIPAA authorizations contained the internal agency identification number of the study participants, in addition to their written name, address, and contact information. Both forms were also stored in the Principal Investigator’s safe. While internal identification numbers were later used to link the participant’s clinical data to their arbitrarily assigned study identification number, corresponding identification numbers were stored only in the codebook. Informed consent documents for therapists were collected and maintained in the same manner described for clients.

The Principal Investigator prepared a list of internal agency client numbers for all study participants who consented to treatment. When all study envelopes were collected, the Study
Coordinator was provided with the list of clients for whom clinical and demographic data was desired. This was done during an in-person meeting, and the data were transferred to the Principal Investigator’s personal laptop using a flash drive. The data was added to a de-identified spreadsheet using the participants’ study identification numbers. Demographic data collected for therapists using the questionnaire were additionally added to the de-identified spreadsheet. The original therapist questionnaires were stored in the same secure manner described for the other sensitive materials.

For additional security, the codebook file and de-identified study data file were stored in separate, 256-bit-encrypted disk images on the Principal Investigator’s laptop drive. The laptop had a second layer of security in that Full Disk Encryption (FDE) was enabled and utilized an XTS-AES 128-bit encryption scheme. The disk image and computer login passwords were unique and known only to the Principal Investigator. In the event the computer was stolen or otherwise compromised during the study, it would be extremely difficult, if not impossible, for an unauthorized person to access any data contained on the hard drive. Due to the risk of total study data loss in the event of an equipment failure or theft, a backup of the above files was copied on an encrypted external Solid State Drive (SSD) and stored in the Principal Investigator’s safe.

In addition, the Principal Investigator’s laptop was configured to lock after five minutes of inactivity and the login password was changed every three months. Antivirus software, the laptop’s operating system, and other appropriate applications were configured to automatically update and update at regular intervals to ensure security protocols were current. System logging was also reviewed monthly. Identifiable data was never exposed to a wireless or wired network. Any analysis or other use of identifiable data was done so with the laptop disconnected from any
network. The laptop was not backed up to a remote or cloud-based server at any point during the study to ensure that study data was not inadvertently stored on another device that fell outside the parameters of the data security measures. A second layer of protection for inadvertent backups was further ensured by storing study data within an encrypted disk image. If a backup had occurred, the same security protocols would have protected against an unauthorized individual accessing the data.

Interview data, including audio recordings and transcripts, were handled separately. Clinical, demographic, or other study data were not linked to individuals who participated in interviews. Interviews were recorded in private offices using an Olympus™ Digital Voice Recorder with an external Micro-SD™ card. Interview subjects were assigned an arbitrary pseudonym for use during the interview, and their true names were cross-referenced in the codebook for future identification, if needed. Consent forms for interview subjects were stored in a manner consistent with forms from other participants, as previously described. All interviews were transcribed solely by the Principal Investigator within 24 hours of the interview. The recordings were transferred to the Principal Investigator’s encrypted SSD for storage, and the original recordings on the recording device were destroyed in a secure manner.

At the conclusion of the study, specific materials were securely destroyed. Paper documents were securely destroyed using a HIPPA-compliant cross-cut shredder, while digital media files were destroyed using the seven-pass Department of Defense 5220-22 M standard for erasing digital media. Materials slated for secure destruction at the end of the study included (a) therapist demographic questionnaires; (b) study packets including the instruction sheet, WAI-SR, and Task Analysis Checklist; and (c) interview recordings. All consent forms, HIPPA authorizations, de-identified interview transcripts, and the codebook are scheduled for
destruction seven years following the conclusion of the study. Those materials will be stored in the Principal Investigator’s safe and encrypted SSD. The Principal Investigator will indefinitely retain the data sheets containing the de-identified study data.

**Recruitment and tracking.**

For the duration of Phase II, all new agency clients who completed an intake, met the inclusion criteria, and were referred to the general mental health program prompted the recruitment process. Notably, intake assessments were conducted by specialized intake therapists at the respective agencies, who also assigned clients an initial diagnosis. In accordance with their respective instruction sheets, Study Personnel followed a recruitment script inviting client participation in the study. Study Personnel at both agencies were instructed to read or closely paraphrase the following script:

>[Agency name] is participating in a research project to find out how different record-keeping practices affect the relationship between clients and their therapists. Our hope is that a better understanding of record-keeping practices will help improve clinical care for people in therapy. We are seeking volunteers, and if you are interested in participating, all you would need to do is spend an additional 10 minutes completing a survey at one of your sessions later on. Would you like to know more about the study?

If a client responded with initial agreement, Study Personnel were instructed to read or closely paraphrase a follow-up script:

>Great, thanks so much for your willingness. Just so you are aware, the researcher of the study is asking you to complete a couple of questionnaires at the end of your third therapy session with your therapist. Neither your therapist nor [Agency Name] will know what you wrote. Additionally, if you agree to the study, the researcher will be asking the [Agency name] to provide some of your basic clinical information, which is already part of your record. If you’re willing, we can take a look at the agreement now.

If the client was still in agreement, Study Personnel were instructed to proceed with the informed consent process. The informed consent process entailed reviewing the informed consent document in full detail with the client while allowing ample time to answer questions or
concerns. The clients were additionally invited to review the consent document at home and decide later, or to call the Principal Investigator to discuss any concerns.

An additional consent step was required because PHI was being sought for active treatment clients. Clients were required to sign a HIPPA-compliant authorization form permitting the Principal Investigator access to the client’s clinical PHI for the purpose of research. Although the Principal Investigator did not specifically seek substance-abuse-related information for clients, the HIPPA authorization included permission to access such information. This was important because if a client presented with a secondary Substance Use Disorder diagnosis (e.g., if substance abuse was in remission or not the focus of treatment), the Principal Investigator would be blocked from collecting that client’s PHI regardless of whether they met other inclusion criteria for the study.

The signed consent document and HIPPA authorization were sent by Study Personnel to the Study Coordinator by the end of every work day. The Study Coordinator was required to maintain the forms in accordance with the Principal Investigator’s security process (described below). The Study Coordinator then placed an alert on the client’s electronic health record as to readily identify them as study participants. The alert was a standardized message created by the Principal Investigator:

ATTENTION: THIS IS A STUDY PARTICIPANT. Primary therapist should administer study materials during third psychotherapy session. Contact [Study Coordinator’s name] for questions.

Therapists were provided with a designated set of study envelopes. Each envelope and the documents within were associated through a coding scheme that permitted the confidential tracking of individual clients in a manner that distanced the Principal Investigator from identifying client information. Furthermore, each individual client-participant was associated
through the coding to the therapist-participant from whom they received therapy. The tamper-evident envelopes contained the following documents that were color-coded to facilitate correct routing:

**Blue Packet**

1. Client Cover Sheet/Instructions (both groups; see Appendix J)
2. Client Task Analysis Checklist (CD Group only).
3. WAI-SR questionnaire (both groups).

**White Packet**

4. Therapist Cover Sheet/Instructions (both groups; see Appendix J)
5. Therapist Task Analysis Checklist (CD Group only).

Therapists were given instructions on how to begin and maintain treatment with clients who were participants in the study, including role induction for collaborative documentation. The first meeting between a client and therapist was anticipated to occur within five to seven business days following the intake session. Therapists in the CD Group were instructed to follow specific instructions for therapy sessions with client participants, beginning with the first session:

1. After your normal introduction, read verbatim the *Collaborative Documentation Introduction Script* (see appendix K), and then conduct the session in your typical fashion while also engaging in behaviors consistent with collaborative documentation (as taught in Phase I of the study).
2. After the first 45-50 minutes of the session, read the *Collaborative Documentation Transition Script* (see Appendix K) aloud to the client in order to transition from the

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talking portion of the session to note taking. Follow all other guidelines pertinent to collaborative documentation, as indicated in the training and instructions.

3. During client’s second consecutive session, follow the same protocol as in session one; however, the Collaborative Documentation Introduction Script will not be read to the client. The Transition Script will still be read (or paraphrased) after the first 45-50 minutes.

4. At the onset of the client’s third therapy session, remind the client of her or his involvement in the study. If the client maintains consent, inform the client that study data will be collected at the end of the session. The session will be conducted the same as above.

5. At the conclusion of session three and after your progress note has been finalized, open one of the premade study envelopes and remove contents. Ask the client to complete the blue packet. Emphasize that you will not see client’s responses and they will be kept confidential. While the client completes the blue packet, you should complete the white packet. Allow adequate space and privacy for the client to complete her or his packet. Under no circumstances should you ask the client to discuss their responses and do not permit the client to share their responses with you. If the client asks any questions about the materials, refer them back to the instructions on the first page of the packet or at the top of the questionnaires. You should not provide further instructions beyond what is available for them to read.

6. Once all materials are completed by you and the client, hand your white packet to the client and ask them to place it along with their blue packet in the envelope and seal the tamper-evident seal (the first page of both packets is a cover page containing no private
information). Inform the client that you will not reopen the envelope and that the Study Coordinator will check for evidence of tampering.

7. After dismissing the client, return the completed envelope to the Study Coordinator’s secure mail tray by the end of the business day.

Therapists in the PS Group had similar instructions with the exception that there were no instructions for collaborative documentation. The PS Group therapists were instructed to conduct the first three sessions with clients in their usual fashion. They were specifically asked not to use collaborative documentation. The therapists had the same study packets that took about half the time to complete, as the packets did not include the Collaborative Documentation Task Analysis Checklist.

**PHI data collection.**

Following the completion of Phase I and Phase II, after all study packets have been completed, the Study Coordinators at each agency assisted the Principal Investigator with collecting the PHI variables from the participants’ electronic health record. The Principal Investigator provided the Study Coordinators with a list of internal agency client identification numbers obtained from the completed consent forms. In accordance with the security guidelines outlined previously, the Study Coordinators provided the requested data for all consented clients.

**Identification of interview subjects.**

As indicated previously, only two clients agreed to participate in the CD Group. Of those two clients, only one signed the portion of the consent permitting the Principal Investigator to contact her or him. Only an email address was provided by the client, and she or he did not respond to invitations for an interview.
Given the lack of volunteers, the Principal Investigator sought to interview therapists who used collaborative documentation during the data collection period. As this was not in the project’s original design, an addendum was submitted to the IRB to extend interviews to therapist participants. The revised plan was approved, and the Principal Investigator sent a recruitment email to the seven therapist-participants at the CD Group agency inviting them for interviews (see Appendix L). Inclusion criteria for therapist interview subjects included (a) participation in Phase I and Phase II of the study, (b) completion of the collaborative documentation training by the Principal Investigator, and (c) the use of collaborative documentation with at least one client since receiving the training. Three therapists replied; three therapists were interviewed. A second and third recruitment email was sent over a two-week period to the remaining therapists, and additional invitations were made by the General Mental Health Program Supervisor during meetings; however, there were no further volunteers. All interviews were conducted early in the Spring 2017 semester during the same week using a semi-structured interview guide (see Appendix L). Interviews were approximately one hour each. The interviews were recorded, transcribed, stored, and analyzed in accordance with the security measures previously identified.

Data Analysis

Research question 1.

Does the combination of the collaboration and bond factors that comprise the working alliance differ as a result of using collaborative documentation compared to post-session documentation?

In order to answer the first research question, a quantitative analysis of grouped data will be utilized to understand the impact of clinical documentation style on the client-therapist
alliance. A multivariate design was chosen because of its ability to simultaneously examine the relationship between two or more dependent variables. A multivariate analysis of variance (MANOVA) is a statistical procedure that analyzes the differences between means and provides a measure of the statistical significance of any group differences (Tabachnick & Fidell, 2013). A MANOVA was chosen for this analysis to answer the question of whether the combination of scales within the alliance measure will vary as a function of the documentation practice. A one-way MANOVA will be conducted in which the documentation practice (Collaborative vs. Post-Session) functions as the between-subject factor. The two dependent factors will be comprised of the collaboration and bond (renamed) scales within the Working Alliance Inventory, Short Form Revised (WAI-SR), a measure of the client-therapist alliance.

Additionally, the nature of the present research topic suggests that any obtained data may be organized into hierarchical data structures. As McCoach (2010) explains, standard errors may be incorrectly estimated and may therefore produce inflated Type I error rates when nested data are assumed to be independent. For example, nesting effects may occur in that individual participants may organize on one level, therapists on another, the agency at yet a higher level, and so on. For this reason, hierarchical linear modeling will be built into the analysis to test for such effects. If nesting effects are present, the subsequent analyses will account for this.

It is hypothesized that the use of collaborative documentation will result in a significant multivariate effect on the collaboration and bond scales of the therapeutic alliance combined.

**Research question 2.**

Which components of collaborative documentation are critical in the formation of the alliance between client and therapist?
In order to answer the second research question, qualitative interview data will be collected and processed using thematic analysis, a process described by Braun & Clarke (2006) as “a method for identifying, analyzing, and reporting patterns (themes) within the data” (p. 79). Thematic analysis involves an iterative process of moving through various phases and states of the collected data. For example, after transcribing and reviewing the interview data, initial codes representing noteworthy features are generated. Next, themes are generated from the initial codes that are thought to represent aspects of the research question. The themes are then further analyzed at different levels to produce a thematic map before undergoing further defining and naming. In qualitative research methods, data from multiple sources are assessed for similarities or differences in an analytic process known as triangulation. When findings from multiple data sources converge, the consistency, or validity, of the findings are improved (Guest, MacQueen, & Namey, 2012). Ultimately, the themes are compared against the existing research questions and pertinent literature to form a rich analysis (Braun & Clarke, 2006).

A hypothesis is not identified for this component of the study, as the analysis is exploratory in nature. It is anticipated that the salient features of collaborative documentation emerging from themes within the interview data will be congruent with themes identified in the literature summarized in Chapter 2.

**Ethical Considerations**

Several ethical concerns were identified in formulating this study. First, because data will be collected on recipients of behavioral healthcare providers and their clients within community behavioral health agencies, certain precautions are warranted. Clients may have concerns with an outside researcher collecting private health information (PHI) for nonclinical purposes. Therapists may also have concerns with information collected regarding their
performance as healthcare providers, or furthermore, the potential for the dissemination of performance-related information to their employer. Similarly, client-participants may have concerns about sharing their feelings about their therapist with an outsider. Procedures to safeguard client-participants and therapist-participants from unnecessary disclosures of sensitive information were built into the study’s design, such as the use of sealed envelopes to facilitate privacy during data collection. Additionally, participating agencies will be prohibited under the consent agreement from obtaining the Principal Investigator’s raw data or any results that can identify a single therapist’s performance with regard to the quality of her or his therapeutic relationships. The agencies will, however, be provided with a written report at the conclusion of the study containing aggregated results for their own internal use.

The generalizability of findings will be limited to the setting under investigation: community behavioral health centers in Arizona. Inferences to any relationship between documentation style, therapeutic alliance, and/or psychotherapy outcomes extending to other behavioral health settings or populations (e.g., private practice, in-patient facilities, forensic applications, children, etc.) should be interpreted cautiously, as client-provider relationships are defined or understood differently across settings. A representative design was utilized to improve generalizability from the study’s sample to the broader population of community mental health clients. Furthermore, there are limitations with regard to generalizing results from a MANOVA when random sampling has not been utilized (Tabachnick & Fidell, 2013). Descriptive statistics for the study’s sample were generated to assist readers in interpreting the significance of any findings.
Conclusion

Studying therapeutic relationships with a clinical sample using protected health information, a novel and unstandardized documentation practice, and within a demanding community healthcare practice required intensive planning and extensive use of materials. This chapter delineated the methods and procedural steps involved in such an undertaking.

Importantly, given the complexity described, modifications were needed throughout the project’s implementation. These modifications included shifting data collection methods and content, as well as adapting to the changing needs of the researcher and the agencies under investigation. While the outcome anticipated was not achieved, Chapter 4 will present revised data collected to answer important questions related to the study’s design and execution of collaborative documentation.
Chapter 4

Results

In this chapter, relevant data and their analysis will be discussed. As previously described, significant modifications occurred after this study’s initial Northern Arizona University’s Institutional Review Board (IRB) approval. Principally, the measures in this study intended to help answer the primary quantitative research questions were not collected in sufficient numbers to yield a meaningful statistical analysis. Regrettably, only one client-therapist dyad in the Collaborative Documentation (CD) Group returned a study packet, and only six returned a packet from the Post-Session Documentation (PS) Group. Additionally, only one client at the CD Group agency consented to be contacted for a follow-up interview, and that client did not return email requests for an interview. Chapter 4 will therefore review the initial research questions and data will be reported, where available. Additionally, new data will be presented from interviews conducted with the therapists at the CD Group agency.

Research Question 1

The central aim of this study was to identify the degree to which collaborative documentation impacted the therapeutic alliance. The measure selected to answer that question was the Working Alliance Inventory, Short Form Revised (WAI-SR), a 12-item self-report measure whose items were presented on a five-point Likert scale. Research Question 1 stated, Does the combination of the collaboration and bond factors that comprise the working alliance differ as a result of using collaborative documentation compared to post-session documentation?

38 The initial IRB approval and addendums can be seen in Appendix M.
Planned analysis for research question 1.

A Multivariate Analysis of Variance (MANOVA) was planned to explore whether the Collaborative Documentation (CD) Group and Post-Session Documentation (PS) Group differed on the alliance measure. There was initial concern that the subscales within the Working Alliance Inventory, specifically the task and goal scales, were too highly correlated to detect meaningful differences. As such, the Principal Investigator intended to combine the two overlapping scales and compare the resulting composite score to the third scale, the bond scale. The result would be two dependent variables: the first a task-goal composite renamed to collaboration, and the second bond. The Principal Investigator anticipated that a MANOVA would be more powerful than other types of analyses in detecting statistical differences between the comparison groups on the revised scales, should differences exist. For example, a MANOVA tests differences between comparison groups using a linear combination of the selected dependent variables, thereby increasing the likelihood that group differences will be detected. By comparison, a univariate Analysis of Variance (ANOVA) in which the dependent variables are tested separately increases the probability of making a Type I error (Tabachnick & Fidell, 2013). Although the power of a MANOVA suffers when dependent variables are even moderately correlated (Tabachnick & Fidell, 2013), the benefits and drawbacks between the MANOVA and ANOVA were considered, and a MANOVA was planned.

It was hypothesized that the use of collaborative documentation would result in a significant multivariate effect on the collaboration and bond scales of the therapeutic alliance combined. A MANOVA was not performed due to a lack of available data from the CD Group; therefore, Research Question 1 could not be answered. However, data were available to report descriptive statistics of the WAI-SR measures for those that were collected. Table 4.1
summarizes the findings from seven completed measures. Both the original subscales and the planned composite subscale is reported.

<table>
<thead>
<tr>
<th>Scales</th>
<th>M</th>
<th>SD</th>
<th>Mdn</th>
<th>Range</th>
</tr>
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<td>15.7</td>
<td>3</td>
<td>16</td>
<td>10—20</td>
</tr>
<tr>
<td>Goal</td>
<td>17.4</td>
<td>2.4</td>
<td>17</td>
<td>14—20</td>
</tr>
<tr>
<td>Bond</td>
<td>17</td>
<td>2.9</td>
<td>18</td>
<td>12—20</td>
</tr>
<tr>
<td>Total (Task + Goal + Bond)</td>
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<td>7.9</td>
<td>51</td>
<td>36—60</td>
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<tr>
<td>Collaboration (Task + Goal)</td>
<td>33.1</td>
<td>5.1</td>
<td>33</td>
<td>24—40</td>
</tr>
</tbody>
</table>

*Figure 4.1: Working Alliance Inventory—Short Form Revised (WAI-SR)*

Because the WAI-SR is not a standardized measure, cut-off scores or interpretive ranges are not provided by the instrument’s publisher (Horvath, n.d.). Furthermore, interpretations cannot be made based on differences in mean scores between the comparison groups as the reported scores are predominately from one agency.

**Fidelity**

Fidelity was anticipated to be a critical component of this study, as collaborative documentation lacked a unifying method of engaging in the practice. As was discussed previously in Chapter 3, a Task Analysis Checklist was developed based on the features assessed
to be most critical to successful implement collaborative documentation. Unfortunately, only one study packet was returned at the CD Agency.

Individual Task Analysis Checklists were to be scored by calculating the quotient of yes responses to no responses, with higher scores indicating greater adherence to collaborative documentation as reported by the individual completing the checklist. Given that both the therapist and client were assessing the adherence to collaborative documentation across the same dimensions and within the same session, the Principal Investigator sought to develop a measure to indicate the degree of agreement between the two raters. As such, a paired score was to be computed by calculating the absolute value of the difference between the therapist and client scores. A paired score of zero would indicate a perfect agreement between the therapist and client checklists, suggesting that the two members of the dyad generally agreed that collaborative documentation was executed as intended. Paired scores approaching 1 indicated increasing levels of disagreement between the two members of the dyad as to whether various events related to collaborative documentation occurred during the session. The analysis was intended to provide context for scores obtained on the alliance measure. In other words, if fidelity to the practice of collaboration was low, any conclusions drawn about the relationship between collaborative documentation and the therapeutic alliance would be dubious.

The therapist who completed the Task Analysis Checklist indicated 90% compliance with collaborative documentation tasks; while the client indicated that the therapist had 100% compliance. A paired score for the dyad was 0.1, suggesting high adherence to collaborative documentation.
Research question 2

A secondary aim of this study was to understand the ways in which collaborative documentation benefited (or not) the client-therapist relationship. Research question 2 asked which components of collaborative documentation were critical in the formation of the alliance between client and therapist?

Planned analysis for research question 2.

Upon completion of the initial data collection in the study, the Principal Investigator sought interviews with clients who participated in collaborative documentation. An interview guide was developed, and one-hour interviews with approximately six study client-participants from the CD Group were anticipated. A pool of interview participants was to be created from the original sample based on scores obtained on the Working Alliance Inventory measure. The intent was to capture low, middle, and high scorers who were hypothesized to represent a balanced subset of clients who had a range of positive and negative experiences with their respective therapists. In other words, the Principal Investigator sought to elucidate the experiences of those who had negative, neutral, and positive experiences with their therapists, and hopefully by extension, the process of collaborative documentation. Upon identifying the three groups of scorers, participants from each group would be randomly selected and invited for interviews until two participants were obtained from each group. The recruitment process was conditional upon the clients having checked a box on their informed consent document permitting follow-up contact for interviews.

Interviews were to be recorded, transcribed, and analyzed by the Principal Investigator following the security guidelines outlined previously. Interview data would be analyzed using thematic analysis, whereby themes are identified, clarified, and then compared to other data
points and existing research to produce a more complete picture of the phenomenon under investigation. Given the exploratory nature of thematic analysis, a specific hypothesis was not generated; rather, it was anticipated that the data obtained from interviews would supplement and enrich data obtained from the quantitative measures.

Unfortunately, only two clients agreed to participate for the CD Group, only one of whom consented to be reached for a follow-up interview. That individual did not respond to recruitment efforts by the Principal Investigator; therefore, client interviews were not conducted. However, as will be discussed next, modifications were made to the project in order to obtain further information about collaborative documentation.

**Therapist Interviews**

A central focus of this study was to provide a basis for understanding the impact that collaborative documentation had on clients. As was shown in Chapters 1 and 2, proponents of collaborative documentation readily identify how the practice positively impacts agency workflow, reduces clinician stress, and improves timeliness and accuracy of clinical record keeping. And while collaborative documentation was purported to improve the overall quality of the therapeutic relationship, research to date has not supported such claims. While the aim of this study was not to provide support for the practice from an organizational or staff perspective, in the absence of available data as planned, the Principal Investigator sought information from the perspectives of the therapists who were trained by the researcher to use the practice. The purpose for doing so was twofold: first, therapists who attempted collaborative documentation for the study likely possessed information helpful in understanding how the practice helped or harmed their clients; and second, their experiences might lead to insights about the project’s
design and procedures that made studying collaborative documentation in a clinical setting so
difficult.

Early during the Spring 2017 semester, the Principal Investigator submitted an addendum
to the IRB requesting a modification to the existing research study by extending interviews to
therapists who were part of the original study. A 17-item semi-structured interview guide was
developed with the aim of drawing out therapists’ attitudes and experiences using collaborative
documentation. A copy of the interview guide can be found in Appendix L. The modifications
were approved by the dissertation chair and IRB, and interviews were conducted in early spring.
There were seven therapists who participated in the original study. The Principal Investigator
sent a recruitment letter via email directly to the seven therapists in anticipation of obtaining five
interviews. Additionally, the therapists’ supervisor sent follow-up emails and discussed
participation at their team meetings to further encourage participation. The Principal
Investigator sent a final email before the end of the study, but there were no further responses.
Ultimately, three therapists agreed to participate; the interviews lasted approximately one hour
each.

Interview questions were designed to tap both the therapists’ perceptions and attitudes of
the practice, as well as the therapists’ understanding of their clients’ attitudes when receiving the
practice. There were additional questions focused on discussing specific behaviors that occurred
or did not occur during collaborative sessions. Although a more systematic analysis was planned
for client interviews, the data generated from the three therapist interviews were not of sufficient
breadth to warrant an exhaustive analysis. Guest et al. (2012), however, recommend a targeted
analysis in such cases in which “high-level themes that have meaningful and practical
implications” become the focus of examination (p. 11).
Interviews were conducted with three female therapists from the CD Group agency who were part of the initial study. They were assigned pseudonyms to protect their privacy. Christine, Sam, and Jane discussed a range of topics related to their experiences using collaborative documentation. First, the therapists’ general understanding of their practice of collaborative documentation will be discussed to provide context for their responses that follow. Second, their self-reported adherence to the process of collaborative documentation as trained by the Principal Investigator will be discussed, also with the aim of providing context. Next, a broad thematic analysis of the interview data will be provided. Finally, the therapists’ recommendations and general experiences will be discussed. Further discussion regarding the implications of the findings, however, will be reserved for Chapter 5.

**Background Information**

The three therapists were asked to discuss their understanding of collaborative documentation. Specifically, they were asked to define collaborative documentation. The purpose of this interview question was to assist in understanding the degree to which therapists integrated a clear understanding of the practice through the training provided. Concern would be warranted if, for example, therapists had an inconsistent definition of collaborative documentation. In general, Christine, Sam, and Jane provided a consistent response. Jane and Sam appeared to focus their definition more on specific behaviors related to collaborative documentation, such as “doing notes with the client,” “[the client] can say if they agree or disagree about your assessment,” and “discuss what they got out of session.” Meanwhile, Christine appeared to have a more integrated understanding of the practice, as she cited both the organizational and therapeutic benefits. For example, she named the features of collaborative documentation as “feedback,” “clients have more control,” “clients feel included,” “clients can
be more active,” and “method to increase efficiency during sessions.” Overall, the therapists appeared to have a satisfactory understanding of what collaborative documentation is.

Although the therapists were not able to use collaborative documentation with any client-participants during the study, they did report using the practice with other clients who were seen for routine treatment. Of note, the CD Group agency mandated that therapists use collaborative documentation in sessions, regardless of research that was being conducted at the site. It was therefore notable that the therapists reported a relatively low compliance with using collaborative documentation. One therapist, for example, reported that she attempted the practice with about 30 clients, but estimated that she used collaborative documentation successfully with only 10 clients. Another therapist reported using collaborative documentation with 24-36 clients for the duration of the study. The final therapist estimated that she used collaborative documentation with 15 clients, but acknowledged she followed the protocol outlined for the practice with only one of the 15.

Therapists were asked to reference the Task Analysis Checklist received at the beginning of the study, as the list served to enumerate the various behaviors required to standardize the process of collaborative documentation. The checklist was initially conceived to be a quantitative measure assessing the fidelity of collaborative documentation, as indicated by the agreement between client and therapist regarding whether specific behaviors occurred during the session. For the purposes of interviews, however, therapists were asked to estimate how closely they engaged in collaborative documentation behaviors for the clients they referenced in the interviews. Christine estimated that she met 75% of the items for about two-thirds of her clients, while it was only about 50% for the remaining third. Sam estimated that her compliance with the items ranged from 25-60%. Jane believed that she was at or above 90% compliance.
The therapists were asked why they were unable or unwilling to adhere to collaborative documentation consistently. The consensus was that they forgot from session-to-session all the components of collaborative documentation that were important. Furthermore, two of the therapists disclosed that they did not use the instructional guides provided by the Principal Investigator, or that they forgot to use them.

In summary, although therapists appeared to have an appropriate understanding of collaborative documentation, the therapists irregularly engaged in behaviors related to the practice. Next, the themes that emerged from the interviews will be discussed. The higher-order themes can be organized into two broad categories—perceived benefits and openness. Themes within perceived benefits included the ways in which therapists viewed collaborative documentation as positively influencing the counseling process as well as contributing to gains to the organization or therapist. Themes that appeared to describe the ways in which therapists’ and clients’ attitudes toward collaborative documentation influenced their willingness to use the practice were categorized as openness.

**Perceived benefits.**

Therapists identified the aspects of collaborative documentation that were beneficial either at the organizational or personal level, or directly benefited the client. Therapists cited benefits such as the degree to which the practice improved their own accuracy by clarifying ideas and summarizing, and how the practice led to workflow efficiencies that saved them time. These themes can be thought of as personal (therapist) or organizational benefits because they serve to benefit the employee or behavioral healthcare system. Alternatively, themes related to direct client benefits also emerged. These trends were inclusive of collaborative documentation facilitating a helpful feedback process through greater transparency, as well as the ability for the
practice to increase trust and rapport between the client and therapist. Each broad theme related to the perceived benefits will be discussed and elaborated upon using interview responses.

**Time management.**

A frequently endorsed benefit to collaborative documentation was the significant time-savings benefit compared to post-session documentation practices. Therapists unilaterally agreed that this was the primary benefit to them as clinicians working within the context of dense caseload and institutional demands. Sam, for example, noted that getting progress notes done on time had improved her workflow dramatically. As she explained, “There is something that is easy about it—knowing you’ll have everything done and have a fresh start when the next client comes in.” Jane was in agreement, also citing collaborative documentation’s time-saving benefits.

Christine provided more anecdotal information about how the practice changed her work day. She explained that she had been with the agency for approximately one year and recalled that last fall, she spent an average of two hours per night beyond her scheduled shift to complete notes. After using collaborative documentation for the study’s duration, she realized an immediate time-savings benefit—she stated she could not recall the last time she had stayed late. Christine noted that she may occasionally come into work early to tie up loose ends or engage in outreach activities, but never to do documentation. Secondary to the time savings, Christine indicated that using collaborative documentation “definitely cut down on stress and worry; I can focus on other things besides, ‘oh, I got to get that note done.’” Upon further examination of Christine’s experiences, the Principal Investigator discovered that she had consistently been doing concurrent documentation—that is, she always submitted her note by the end of a
psychotherapy session—but most of the time did not appear to engage in a collaborative process with the client, such as soliciting feedback and summarizing the note.

Accuracy and clarification.

An additional cited benefit of collaborative documentation by the interview participants was the accuracy gained from completing notes in real time. The therapists were asked whether clients believed the summaries provided at the end of sessions were accurate, and all three therapists assessed that clients believed they were accurate. For example, Jane explained that none of her clients offered suggestions for changing the notes once she summarized them. She also commented that she appreciated hearing what clients had to say about how they perceived the session. As Jane put it, “Most of the time we were pretty in synch…Sometimes I would have emphasized different things, but maybe seventy-five percent or eighty percent of the time we’re on the same page.” Jane found this process of clarification to also facilitate the clients’ acceptance surrounding her recommendations. She stated, “I would have picked out things—like things I thought might be important to put in and would ask them what they thought about it. They would concede to what I had recommended.” Jane believed that through clarification, clients were able to process therapeutic information in a more positive manner that led to greater acceptance.

Christine reported a similar experience with observing gains in accuracy. She found that clients mostly reported that her summaries were accurate. As she stated, “There wasn’t a lot of disagreement about assessment with these folks. Sometimes they’d ask me to include things so they wouldn’t forget and remind me to talk about it next time…that was really frequent.” In this way, collaborative documentation became another tool for tracking topical content through more
accurate record keeping. Christine additionally found that clients found her summaries to be “relevant and important.”

**Feedback and transparency.**

Therapists who were interviewed made multiple references to the ways in which collaborative documentation served as a useful tool for feedback beyond the process individual therapists might have engaged in otherwise. This level of transparency in record keeping not only helped communicate critical ideas and themes in a client’s therapy, but also appeared to serve as encouragement to therapists to use feedback during sessions when they otherwise might not have.

Christine had the most to say about using feedback in session. She described that for herself, she often had a preconceived notion of who would be receptive to hearing feedback compared to those who may be put off by the therapist being too transparent with her impressions. Christine provided an example of one client who was especially receptive to collaborating in this manner. The client often stood behind Christine when she typed her notes and would make comments throughout the process. Christine discovered that through the client reading the therapist’s assessment, she became more fully aware of her own problems; the client developed insight into her emotions and behaviors. For example, Christine and the client were once discussing the way in which the client responded during a social interaction. Christine discovered that through reviewing the progress note together, the client agreed with the therapist’s appraisal of the interaction in that the client was making illogical assumptions that negatively influenced her behavior. Christine explained further, “The client responded enthusiastically, ‘I know, that was totally an illogical thought process!’” Through this dialogue, the client was able to recognize an unhelpful thought process and effect change.
Christine provided another anecdote related to collaborative documentation facilitating feedback. She discussed the same client who looked over her computer screen. The client was discussing that she had a “confrontation” with someone. Christine explained, “We talked about it, and she was able to identify [confrontation] wasn’t the right term or the right term that would have applied…The way that she was thinking about how she was doing things and the way she was actually doing them—her own verbiage—it was sort of a realization. And so she was being really judgmental with herself…I actually pointed out that she was being assertive when she assessed it was confrontational.” Christine noted that the client was accepting of the therapist’s attempt to help her reframe the behavior in a therapeutic manner. Christine felt that the collaborative feedback portion of the session helped facilitate this interaction. In the past, she posited, she might not have caught the discrepancy in the client’s thoughts and behaviors, nor would she have necessarily confronted the client about the concern.

**Trust and rapport building.**

Another important cited benefit of collaborative documentation that emerged from the therapists’ interviews described the ways in which the practice facilitated trust and rapport building between client and therapist. The therapists noted how the sharing of records and asking for input made building rapport easier. As Christine noted, “Trust was increased and [the clients] felt as if they were an important part of sessions…not that we were just sitting here typing about them and they didn’t know what was happening.” Christine was asked specifically what behaviors she observed in her clients that led her to conclude clients were more trusting. Christine explained that multiple clients were better able to “speak up” about something they agreed or disagreed with. For example, one client very explicitly asked Christine not to include
something she had written in the progress note and they were able to have a therapeutic
discussion about the relevance of the statement. Christine assessed that her client felt validated.

Like Christine’s impression, Jane found collaborative documentation to help foster
stronger connections with some clients. As she explained further, “It’s another way of
connecting with your client and listening to their thoughts about sessions. And a way of maybe
expressing more about how [the therapist] views things.” However, Jane offered a caution that
rapport may be inadvertently harmed by using collaborative documentation improperly. She
emphasized that therapists should not type notes during the “talk” portion of the therapy session;
rather, the note should be typed only at the end of the session. Jane explained that she disliked
“physical barriers” between herself and her clients because she assessed that they would not feel
heard. Jane expressed concern with becoming overly invested in note writing, as she believed
that maintaining eye contact with the client was a critical counseling skill that improved trust and
feelings of connectedness.

Finally, Sam commented about the ways in which collaborative documentation served to
validate clients, which led to improved trust between herself and her clients. She explained
further, “Yeah, I think that us working together maybe made [the clients] feel that what they had
to say was important. Nobody ever said that directly, but I felt it.” Sam indicated that she varied
between taking notes throughout the session and only typing near the end of the session. In
either scenario, Sam reported that clients did not issue any complaints about her use of note
taking during sessions.

**Openness.**

The category of openness captured themes related to therapists’ perceptions surrounding
the general acceptance of collaborative documentation. This includes both client and therapist
behaviors related to approaching or avoiding the practice, therapists’ discomfort with changing their own therapeutic process, and therapists’ general confidence and skills that might facilitate or hinder adopting collaborative documentation practices. Again, themes will be discussed in greater detail and supplemented with interview data, when available.

**Client ambivalence.**

An interesting report by all three therapists was that some clients were ambivalent to engaging in collaborative documentation. As Christine explained, “[Some] don’t care and say to just go ahead and do the note without them; they were disinterested.” Sam also noted that some of her clients were entirely uninterested in engaging in any sort of feedback or collaboration regarding clinical record keeping. Sam stated, “It just seems like the clients are not that interested in knowing what’s in their notes. They’d just rather keep talking about what we were discussing.” Another of Sam’s clients appeared indifferent because she placed trust and confidence into what Sam was doing as her therapist. For example, when Sam asked to review the note with the client, the client simply stated, “No, I trust you.” The therapists were reminded about the materials provided by the Principal Investigator at the beginning of the study, specifically the handout with statements that can be used to engage clients further in the process. Notably, the therapists all indicated that they forgot about the handout or did not have it readily available during sessions. Although these clients appeared ambivalent to the practice of collaborative documentation, another hypothesis may be that the clients had not sufficiently “bought in” to the process, or were not convinced of the potential benefits.

**Therapist acceptance and change.**

Therapists generally expressed positive responses to adopting collaborative documentation practices, even when they determined that their clients might not favor the
They seemed to relate their acceptance to any other new process in that it takes time to get used to, but with practice, becomes easier. Jane, for example, was most vocal about this. She stated, “For the most part, I would say I had very positive feelings about doing it. For me it’s just getting over the hump of introducing [collaborative documentation] to a client. It’s just pushing myself through it.” Jane further indicated that the most difficult aspect of the process occurred at the transition between doing therapy and doing documentation in a collaboration manner with the client. She explained, “It just felt a little awkward trying to make the transition versus what I have done for 25 years… I don’t know what the hesitation is. Maybe I don’t want to change things up—for me [laughs], not for my client. Old habits die hard.”

Christine also acknowledged the difficulties associated with attempting a new process. As she explained, “I was hesitant at first. It made me hesitant about what I put [in my notes]. If it was me, would I want to read that about myself? It made me think a lot about how I write my notes. It then became comfortable very quickly once I changed my mindset.” Christine was asked how long it took to feel comfortable with collaboratively documenting, and surprisingly, she reported she felt comfortable after only two sessions. She attributed the experience partially to the clients who were open and receptive to the practice.

**Therapists’ confidence and skills**

Therapists who participated in interviews discussed their ability to approach clients with collaborative documentation. This ability to approach appeared to relate to therapists’ confidence in their own abilities and skills. This was discussed above regarding Christine’s preconceived notion that certain clients would reject a collaborative process. Indeed, all three therapists identified engaging in some form of an appraisal process in which they attempted to predict which of their clients would accept collaborative documentation versus those who would
reject the approach. Two of the three therapists initially professed certainty that their predictions did not influence their disposition in approaching or avoiding inviting certain clients to engage in collaborative documentation; however, Sam was quite clear that her appraisals did influence her decision to engage clients in this manner.

Sam actively avoided collaborative documentation with select clients whom she assessed might be averse to the process. Her avoidance of the task appeared partially influenced by her overall confidence as a therapist. Sam had plenty to say about the matter and was quite candid about her own confidence and skills that influenced her statements. Sam provided an example of a regular client who presented with poor hygiene and who had difficulties regulating his strong emotions during sessions. Sam expressed feeling anxious about indirectly confronting the client by allowing him to see her progress notes. She explained that if she wrote something perceived as overly-critical, for example a concern about the client’s mental status, the client would become angry or offended and not want to return for therapy. Sam felt this was further exacerbated by the fact that the revelation might come out in the final moments of the session, when she would not have sufficient time to process the information with him.

Sam fully acknowledged that she had difficulties with confrontation as a general therapeutic skill. For example, she noted, “It seems it’s a lot easier if it’s a lighter session where they just want to come in and share news of their life, versus something bad or like a loss or something.” Sam summarized her feelings about the issue and noted, “You’re not doing this job to try to hurt their feelings; you want to be as encouraging as possible. It could come across as hurtful when it’s not supposed to be.” In this way, the content of what the client shared influenced her decision to invite collaboration and transparency into the session.
She provided another example of a client whose husband intended to leave her. As Sam explained further, it appeared her concerns were also related to feeling pressured by time constraints: “It’s hard then to have three minutes to wrap it up and get them out the door. The timeline, that’s the pressure. Because even when I feel comfortable bringing it up to them, there’s the timeline and they only have two minutes to respond before I must walk them back to the lobby…that’s where the pressure is. You want to give them more time to start talking about things.” Later, Sam stated, “You want them to have enough time to share their feelings. They can be upset and you’d say, ‘Okay it’s time to go now.’ It’s not a positive ending.” Therefore, in addition to Sam’s skills with confrontation, session management appeared to be of concern.

Jane endorsed similar concerns about approaching some clients. She explained that depending on the personality of the individual client, she may introduce collaborative documentation or simply continue her session in her normal manner. She added, “There are certain clients who can be intimidating—they have these strong personalities—and my own issues go into that decision to not use collaborative documentation. For me it would be uncomfortable to introduce it.” Jane also seemed to assess her individual client’s motivation in determining whether to broach the idea of collaborative documentation. Jane offered, “Maybe I select the people that I felt would be more open to it, versus clients that were there more to talk and vent—not really engaged to work on an issue.”

Like Sam, Jane too identified problems with session management and timing. Jane explained that her practice has historically consisted of allowing clients to talk to the very end of sessions. She preferred to give clients the full session time as they frequently had a lot to say. Jane struggled a great deal with ending on time, or modifying her session to accommodate a collaborative feedback component within the session’s time frame. Jane additionally attributed
this to having difficulties interrupting clients who were verbose in session. When asked if the transition script was helpful in achieving better session management, Jane believed the script helped at times. Notably, Jane prioritized the client’s need to talk about a significant issue over ending the session on time, stating, “I try to look at what is best for the client at the time.” Despite this, Jane openly acknowledged her need to “push” herself more to end on time.

Interestingly, Christine initially assessed that her belief about certain clients did not influence her ability to practice collaborative documentation. Later in Christine’s interview, however, she expressed that her use of collaborative documentation with certain clients depended on the rapport she had with the individual, as well as how the client had responded in previous sessions to openly discussing issues. As she explained, “For some people, I was much more cautious and hesitant to do it because I thought it might damage the rapport that was already fragile.” Christine appeared to have a sense very early in the therapeutic process which of her clients would accept collaborative documentation compared to those who might, as she described, “push back.”

Finally, therapists expressed a degree of hesitation in using collaborative documentation secondary to concerns that inviting clients to collaborate in record keeping appeared to trigger unproductive client behaviors. All three therapists independently cited a belief that summarizing the note led the client to want to readdress previously addressed materials. For example, an issue resolved earlier in therapy would be “rehashed” near the end of the session when there was little time left to process. Although the therapist identified that the topic had been addressed, the client became “reinvested” and overtook the final minutes in the session. As Christine explained, “They want to squeak more time out of therapy.” Sam described the same phenomenon as the clients becoming “greedy for time.”
In summary, therapists who participated in interviews identified several factors related to approaching or avoiding collaborative practices. Therapists assessed that some clients were ambivalent to the process and thus placed the responsibility of record keeping back onto the therapist. Therapists also discussed their own acceptance of a new process interfering with their own longstanding therapeutic processes and approaches, making collaborative documentation less likely to occur. Closely related to change or acceptance was therapists’ perception of their own therapeutic skills, which appeared to influence their confidence in inviting clients to participate in her or his record. Lastly, therapists avoided collaborative documentation due to concerns of prolonging therapy sessions beyond the normal therapy hour because inviting feedback led to clients effectively reprocessing closed topics.

**Agency support.**

Therapists were asked during the interviews to reflect on their experience using collaborative documentation at the agency, and specifically, whether they believed they had adequate supports from the agency to implement collaborative documentation as outlined. Although not representative of an emergent theme from the interview data, therapists provided useful responses to inform the future implementation of collaborative documentation. The three therapists will not be referenced by name to further protect the confidentiality.

In general, therapists expressed a belief that the agency was committed and supportive of collaborative documentation initiatives. One therapist attributed this directly to her supervisor, who made collaborative documentation a positive experience for the entire general mental health therapy team. For example, the supervisor used collaborative documentation as a platform to advocate for therapists managing their session time and practice good self-care. If therapists are taking 75 minutes to complete a session that should only take 50 minutes, she explained,
therapists will experience more stress and pressure at the end of the day to complete notes. Collaborative documentation created an opportunity for stronger session management, especially with adding a degree of predictability to the session because of the transition prompts (e.g. “Okay, we’re getting close to the end of session…”). The supervisor often reminded the team of the many cited benefits of using collaborative documentation during sessions.

Another therapist discussed that there were rumors circulating that therapists would be punished for not meeting Key Performance Indicators related to concurrent documentation (e.g., completing notes within 10 minutes of end-of-session). The therapist opined that if true, this was not an encouraging approach and would certainly lead to more resistance to the practice. The therapist explained, “I was told it was going to be punitive that if we didn’t do it, there would be action plans…which I felt was not supportive. It was kind of like a learning curve. It’s not like tomorrow I can do [collaborative documentation] with everyone.” The therapist indicated that she put little weight on the rumored threat because her supervisor did not state that. She summarized, “For me the biggest thing would be to expect us to do collaborative documentation tomorrow; that would be a lot.” All three therapists additionally cited the training as an important aspect of feeling supported by the agency to use collaborative documentation, as previously they had not been formally trained on processes that were mandated by the agency.

**Therapist recommendations.**

Therapists discussed what was most helpful to them in using collaborative documentation, as well as what they assessed was needed to maintain or strengthen their use of the practice. As such, therapists offered several recommendations related to tools, resources, and training.
First, the therapists identified that the use of the introduction script and transition statements, when utilized, was a helpful tool themselves. The introduction script used in this study was adapted from other agencies that had implemented collaborative documentation and sought a more standardized method of introducing the practice to clients. The transition statements were a collection of recommended comments that might be used to help prime the client that a change from “talk therapy” to collaborative documentation was about to occur. In other words, tools facilitated role induction and session management. While the tools were used in this study for the purposes of standardizing collaborative documentation, in real practice they might be used informally or paraphrased. Regardless, the therapists found them useful in their own practice and advocated for their continued use.

Second, therapists believed that collaborative documentation provided a framework for managing sessions. For example, if a topic had not been broached during the talk portion of the session, collaborative documentation created another opportunity to address the content. As one therapist explained, “It gave me a time and a place to [discuss important issues with the client] when I wasn’t sure about when to do it before.” Therapists encouraged those coworkers who were otherwise disinclined to use collaborative documentation to do so as a means to organize feedback to clients. Relatedly, the therapists suggested emphasizing this feature of collaborative documentation in future trainings.

Third, therapists spoke to the need for physically arranging their therapy spaces to accommodate collaborative documentation. This was something the therapists believed they had control over, as the agency gave therapists license to arrange office space as they saw fit, conditional that the orientation of office furniture was consistent with agency policies and procedures related to safety and security (e.g., therapists were required to have an unobstructed
path to exit the office in the event of a dangerous client or an emergency). One therapist was especially keen sharing the ways in which she made collaborative documentation work for her interests, not against her. She even brought resistant coworkers into her office to display how she physically changed the space to accommodate a more collaborative process.

Fourth, therapists noted that there was a clear benefit to discussing collaborative documentation with colleagues. Therapists found that when they shared success stories and failures, they found support and solutions from one another and felt encouraged to work toward improving the process. One therapist noted that she was struggling with how to find the best transition point during sessions and went to a colleague for advice. The colleague advised how she had modified one of the transition statements and obtained a better response in session. Opportunities for collaboration and support is therefore advisable.

Finally, therapists unanimously identified a critical need for additional training using collaborative documentation. While the therapists believed that the initial training by the Principal Investigator was a good primer into the practice, further training was needed to crystalize the skill set. Within the recommendation, the therapists believed that the training could be strengthened by including a life demonstration. Furthermore, they assessed that within the context of the training environment, further opportunities to practice and address specific barriers or scenarios that arose in collaborative sessions would strengthen adherence to the practice because therapists would feel more confident in using collaborative documentation.

**Conclusion**

In summary, the data that ultimately resulted from this study differed greatly than what was initially anticipated. The lack of quantitative data eliminated the need for a statistical analysis as planned; however, some descriptive statistics for the study’s primary measure, the
Working Alliance Inventory, may be useful to future researchers and thus was included in this chapter. Furthermore, the qualitative data from client interviews as initially planned was not realized. Alternatively, therapists at the agency using collaborative documentations were interviewed and provided useful data in understanding features of collaborative documentation that worked well and those that were problematic. Next, Chapter 5 will discuss the findings from therapist interviews and the implications for this and future research projects in community behavioral health settings.
Chapter 5

Discussion

Many of these patients have some awareness that their behavior is troublesome, but a deep sense of shame inhibits their acknowledging it. Inviting them to read accurate and nonjudgmental notes may help diminish their shame. Even patients with severe personality disorders can be relieved to know that the turbulence and unhappiness that permeates their lives reflects suffering from a familiar clinical entity shared by others, rather than ‘being a bad person.’

-Kahn, 2014, p. 2

The purpose of this study was to identify the ways in which an emerging practice of record keeping impacted therapeutic processes. Collaborative documentation, which materialized out of the need to address growing problems in healthcare delivery, was introduced as a partial solution to improve session management within the context of behavioral health services. Although the application of shared forms of record keeping varies across setting, the practice has been used in community mental healthcare environments to more efficiently document clinical encounters, while at the same time inviting the client’s participation in the process. Several primary benefits to collaborative documentation have been cited, including the ways in which the practice saves time, reduces clinician stress, and increases accuracy in record keeping. When taken at face value, there appears to be legitimacy to those benefits, and clinics that have adopted collaborative documentation have cited gains in all the areas cited.

What is less clear about collaborative documentation is the impact the practice has on the relationship between the client and therapist. Proponents of collaborative documentation have developed ideas about how engaging clients collaboratively in record keeping serves to invest the clients in their clinical care, encourages transparency, and fosters clarification and feedback; all of which are purported to improve the therapeutic relationship. Anecdotally, clinicians across the spectrum of healthcare report how shared record keeping benefits clients in the above ways.
The headlining quote at the beginning of this chapter captures the spirit of such impressions. These claims also appear to be valid, but are largely untested by scientific standards.

This research intended to explore the components of collaborative documentation supposed to benefit the therapeutic relationship. The desire to understand this phenomenon developed out of the need to identify whether a productivity strategy could, and should, be used as a therapeutic process tool. Indeed, if such a tool facilitated trust, agreement, and bonding between clients and therapists, the broader treatment community would be interested to know that, and arguably, would be more interested to know if the practice harmed the relationship. Moreover, psychotherapy research evidences the important association between the therapeutic relationship and positive client outcomes (Duncan et al., 2009; Horvath et al., 2011). As behavioral healthcare costs are rising and mental health professionals are increasingly pressured to weigh the costs against the benefits of treatments (Baker, McFall, & Shoham, 2008), therapists would certainly benefit from tools that help improve outcomes for their clients while containing organizational costs.

To evaluate how the practice of collaborative documentation impacts the client-therapist relationship, a well-studied psychotherapy construct—the therapeutic alliance—was selected as a theoretical framework to understand the phenomenon. As discussed in previous chapters, the therapeutic alliance is one of the more heavily studied constructs in psychotherapy research (Norcross, 2010) and describes the quality of the relationship between the client and therapist. Furthermore, the alliance is frequently conceptualized as being comprised of bonds established and maintained between client and therapist, as well as their general agreement surrounding what will occur in therapy (Bordin, 1979, 1994). While researchers vary in the instruments used to
measure the alliance, the Working Alliance Inventory-Short Form Revised (WAI-SR) was selected for this study due to the measure’s brevity and good psychometric properties.

The primary hypothesis was that the use of collaborative documentation would result in a strengthening of the therapeutic alliance. To test this hypothesis, a quasi-experiment was designed in which two groups of therapists—one that used collaborative documentation and another that used the status quo, post-session documentation—completed the alliance measure with their clients. If collaborative documentation had an impact on the client-therapist relationship, statistically significant differences in mean scores between the groups would be observed. A secondary task within this study was to help explain those differences if, in fact, they occurred. This was to be achieved by conducting in-depth interviews with client participants with the aim of drawing out the salient features of collaborative documentation by analyzing themes in the interview data. In this way, the study adopted a mixed-method design.

Given the nature of conducting research using a clinical sample within a complex and multifaceted healthcare system, challenges were anticipated and planned for. The study’s materials and procedures were thoughtfully designed to balance the need to standardize the process of collaborative documentation in a manner conducive to empirically studying the phenomenon, while at the same time reducing any negative impact by the research on the participating sites, clinicians, and clients. Additionally, working with protected health information (PHI) compelled the use of specialized procedures and materials to increase security and privacy for the participants that would otherwise not be required of researchers working with archival data or using a university student sample. Although many contingencies were planned for, the study suffered in unpredictable ways throughout the process.
This final chapter will be comprised of two primary discussions. First, data obtained from therapist interviews will be discussed in the context of the theoretical framework offered in Chapter 2. While the method and type of data ultimately collected was never intended to answer the research questions identified in this study, the participating therapists appeared to have relevant insights about the current state of collaborative documentation and perhaps future use of the record-keeping practice. Second, the study’s limitations will be discussed, as well as recommendations for future researchers who wish to design experiments or collect data using similar clinical samples. The discussions may be of interest to future researchers who embark on studying this phenomenon, for proponents of collaborative documentation who seek to implement the practice in clinical settings, and for healthcare workers who wish to apply what is known about collaborative documentation to their own clinical work to the benefit of the people they care for.

**Interview Discussion and Future Research**

Interviews were conducted with three therapists who were members of the original study in the absence of client volunteers. The hope was that therapists had insights based on their work with clients during the study’s data collection period. As such, only therapists who acknowledged using collaborative documentation with clients were invited for interviews. The therapists discussed the ways in which collaborative documentation saved them time versus traditional forms of documentation, appeared to benefit clients by improving the accuracy of the client’s written record by providing transparency about what was included in the note, and for a similar reason, provided increased opportunities for feedback. Lastly, therapists identified gains in trust between the client and therapist as a result of involving clients in record keeping, which therapists perceived as contributing to greater rapport with their clients.
A frequently cited benefit when using collaborative documentation was that the practice saved a significant amount of time compared to the existing method of post-session documentation. When engaged in collaborative documentation, therapists found that submitting the note before the client left the session was associated with having more time at the end of the workday for other activities, and consequently, less stress. This was consistent with the benefits cited previously by MTM Services during pilot studies. Specifically, MTM Services reported that clinicians spent nine fewer hours per week on clinical documentation. While therapists were unable to reliably quantify their own time savings, one therapist reported that switching to a collaborative record-keeping practice was accompanied by a change in her work habits, such that she could not recall the last time she had to work late.

During interviews, the Principal Investigator discovered that the therapists were not only referring to engaging in a collaborative session with clients when completing notes before the end of session, but also to finalizing notes in the client’s presence without collaborating or providing feedback about the session. It appears that time-saving benefits can be achieved without collaboration during psychotherapy by simply submitting the clinical progress note before the client walks out. As the therapist Christine indicated, completing her notes concurrently led to significant improvements in her workflow with less hours spent at work, and was accompanied by a reduction of stress and worry about getting her work done. Christine also acknowledged a relatively low success rate with implementing collaborative documentation during her sessions. What is striking about this discrepancy is what clients are doing while therapists are concurrently documenting and bypassing the collaborative component. If clients were not engaged in therapy or documentation of their therapy, what then were they doing while their therapist typed notes?
An initial concern of the Principal Investigator was that collaborative documentation may prove harmful to clients if they perceived that therapists were coopting their sessions for an administrative record-keeping task. Unless there was a perceptible therapeutic benefit, clients would likely view the practice with skepticism. More concerning now is the possibility that therapists will adapt their practice as to appear compliant with their agencies’ mandates to use collaborative documentation when, in fact, they are simply using clinical time to write notes without input from the client. The client, in this scenario, is left to sit silently while the therapist attends to their record keeping. While this is not likely the scenario for all sessions and for all therapists, the finding speaks to the need to develop strategies to more closely monitor compliance with the collaborative aspects of concurrently documenting sessions, while at the same time supporting clinicians so that they feel comfortable using the process. Furthermore, the ethical and professional implications of billing for non-clinical activities should be considered.

The consensus by therapists was that notes summarized back to clients tended to be accurate and appropriate. This was based primarily on that clients did not disagree with the summaries. For the therapist Jane, clients tended to “concede” with her impressions, but if there was any question about her impressions of the client, the process of collaborative documentation opened a dialogue that allowed clients to process the information in a more positive manner. In this way, clarification between the therapist and client allowed clients to reach new insights. Meanwhile, Christine’s experience with the gains in accuracy resulting from collaborative documentation appeared to help her and the clients keep track of topical content that could be addressed in future sessions. In this way, involving clients in the record-keeping aspect of therapy had pragmatic value. Rather than simply documenting an area to address in the next
session, Christine leveraged collaborative documentation in a manner that clients perceived as more meaningful and relevant.

Feedback and transparency appeared to be related concepts, as to be transparent about what is written of clients also serves to feed back information about the therapists’ impressions of the client and the therapeutic process unfolding. The manner in which collaborative documentation facilitated session feedback was discussed in interviews, though the concept only seemed relevant to one therapist. What was discovered was that feedback through collaborative documentation helped clients gain insights into their behaviors through reviewing the content of the session in a therapeutic manner. Seeing the assessment portion of the note, for example, was meaningful for one client. The client concurred with the therapist’s interpretation that the client was engaged in an unhealthy thought process. The therapist acknowledged that she might not have directly confronted the client on this issue during that session, but because the reviewing of the session note led to greater transparency, the client experienced a more immediate insight into the behavior. In this way, collaborative documentation may serve to make some therapeutic processes more efficient, or at a minimum, provides structure and a platform for delivering feedback.

Similar to the notion that collaborative documentation led to efficiencies in reaching therapeutic insights, the process may also help to accelerate trust and rapport. Therapists believed that collaborative documentation led to increased trust, as clients understood exactly what was being written and understood that they could challenge the therapist on their assessment. The therapists also seemed to hold that client engagement in recordkeeping fostered a sense by clients that they were an important part of the session, which further increased that sense of trust and led to stronger rapport during the session. Anecdotally, the same was true by
way of validation; collaboration led clients to feel heard and understood by their therapists. This finding appeared similar to the notion of client-therapist bonding, one of the components discussed by Bordin, (1979) in his framing of the therapeutic alliance. As discussed in Chapter 2, bonding refers to the mutual feelings of trust and respect between the client and therapist; that there is a shared sense of commitment or being a part of the process together. Had the clients completed the alliance measure in the study, differences on the bond scale might have supported the hypothesis that using a collaborative method versus post-session documentation strengthened the therapeutic alliance.

Trust may have also interfered with the successful execution of collaborative documentation, or interfered with gaining initial investment in the process for clients. A common concern cited by therapists was that clients were ambivalent to the process of collaborative documentation. This was realized in two ways. For some clients, the high level of trust in the therapeutic relationship led the client to defer to whatever the therapist wished to document, without a strong need to discuss or challenge the therapist on the assessment. For other clients, they simply professed a lack of interest in utilizing the process in a therapeutic manner. Barriers to client engagement are not uncommon in psychotherapy, nor are they unique to collaborative documentation.

This potential concern of client disinterest or ambivalence with collaborative documentation speaks to the need to find novel ways of engaging clients, if collaborative documentation is to be successful. Of note, therapists were provided with tools to facilitate engagement, which was also discussed in the collaborative documentation training. Therapists in the study did not appear to take full advantage of these tools. What is not clear is the degree to which therapists failed to use the tools and suggestions because they were not readily available
when needed, or whether therapists were generally not invested in making the process work. In a sincere moment during an interview with one therapist, for example, she admitted that she would likely discontinue using collaborative documentation at the end of the study, unless the agency compelled her to continue. To be sure, both clients and therapists represented sources of resistance to the process of collaborative documentation that will require further study to understand.

There were other challenges with implementing collaborative documentation effectively that went beyond a lack of investment. For some therapists, using collaborative documentation was incompatible with existing skill sets. One therapist, for example, discussed that assertiveness during sessions was a challenging task even before the introduction to collaborative documentation. Sam identified that she had difficulty confronting clients on difficult issues and dreaded triggering emotional responses in the clients. She provided the example of confronting a client about his poor hygiene, or for another client, her bad attitude that day. The more offensive Sam perceived the confrontation, the less likely she would be to address the issue. Sam did not find that collaborative documentation was a useful tool to share her clinical impressions with clients. As she noted, “You’re not doing this job to try to hurt their feelings. You want to be as encouraging as possible. It could come across as hurtful when it’s not supposed to be.”

Indeed, Sam’s experience may be a training issue not unique to collaborative documentation. Sam’s experience also speaks to the need to increase training when implementing collaborative practices, whether for shared record keeping or otherwise. Beyond just researching components of collaborative documentation, there may be opportunities to imbed collaborative documentation into counselor training programs as an additional mechanism for providing structured feedback to clients.
Interestingly, there was a perception by therapists that clients were predisposed to accepting or not accepting collaborative documentation. This appeared to be based on the therapist’s appraisal of their client’s ability to accept feedback in general, or alternatively, to the client’s capacity for insight. In other words, if the therapist assessed that a client was receptive to feedback, the client would also be open to collaborative documentation. For example, Christine indicated that she was more reticent in approaching clients with collaborative documentation whom she understood to be less receptive to feedback. Similarly, Jane avoided approaching specific clients whose personalities were assessed to be incompatible with collaborative documentation. Sam was generally avoidant of the practice due to generalized fears that clients would not be open to the method, or would be easily offended by her evaluation of them. For Jane, the issue did not appear to be an inability to be assertive in session; rather, she had difficulties with session management. She found the initiation of transitioning from the traditional “talk” portion of the session to a collaborative documentation encounter quite challenging. Another possible explanation for this, at least in Jane’s case, is that she had assessed the client’s needs and prioritized session activities accordingly. As she noted during her interview, “I felt if they really needed to talk, that was more important at that time. I try to look at what is best for the client at that time.” In this way, Jane used her clinical judgment to determine collaborative documentation was not in the client’s best interest.

Insofar as therapists assess the compatibility of collaborative documentation for their individual clients, the practice will likely be used inconsistently. Sometimes these obstructions to using collaborative documentation represented admitted deficits in specific skills related to therapy process, such as the ability to confront clients. Indeed, the same skill limitations would be problematic in other aspects of therapy, and therefore was not specific to collaborative
documentation. Interested researchers may benefit from monitoring fidelity to the practice throughout the data collection process, and those teaching the practice may better facilitate effective use by developing strategies for pushing through both client and therapist resistance.

**Methodology Discussion and Future Research**

Chapter 3 described the methods initially designed for this study to best understand collaborative documentation. The design took into consideration anticipated challenges in working with a clinical sample within a community-based treatment setting. The logistics of a student researcher collecting protected health information (PHI) and psychotherapy data in such a setting required careful forecasting of the many ways in which the data might be spoiled. Although the study evolved since the initial design in response to changing conditions at the agencies, the study ultimately suffered most due to poor participation in the collaborative documentation group (CD Group). The post-session documentation group (PS Group) also had low participation; however, an adjusted statistical analysis was possible had the CD Group reached a similar size. Due to the unpredicted low sample size, the research questions sought by the Principal Investigator were not answered.

**Volunteerism.**

The most surprising finding was the extremely low participation rate for the study. The target sample size based on a power estimation was 120 participants. The Principal Investigator made a very conservative estimate for the rate at which clients might agree to participate based on preliminary figures collected from the agencies before the study began. As discussed in Chapter 3, the Principal Investigator estimated that 480 clients between the two agencies during the three-month study period would initially meet the study’s eligibility criteria. About one-third
of those clients were predicted to be excluded based on identified criteria, and about one-half of the remaining clients, if consented, would reach maturation in the study.

With such a conservative approach, the sample size was thought to be overestimated but likely obtainable in the time frame allotted. Yet the study produced only 27 participants in a three-month period—two from the CD Group agency and 25 from the PS Group agency—or about 23% of the desired sample. To help understand what went wrong, clinical enrollment data was sought from both agencies, and to the Principal Investigator’s astonishment, both agencies reported that exactly 179 individual clients were enrolled in each of the agency’s general mental health programs during the study’s data collection period. In other words, there was a pool of 358 potentially eligible clients, a figure not far off from the early prediction of 480 clients.

Given the total number of clients who completed an intake and were enrolled in the general mental health programs, the participation rate at the CD Group and PS Group agencies were 1.1% and 14%, respectively. Why so few clients volunteered for the study was curious.

Throughout the data collection phase, the Principal Investigator met with Study Personnel to identify procedural problems related to participant recruitment and consenting. The feedback provided was that clients were tentative about a nonemployee having access to their clinical information. The clients cited concerns about how the data would be used or whether the researcher would be able to identify them. Interestingly, the PS Group agency did not report similar concerns. While clients asked questions surrounding the protection of their sensitive information, their concerns were appeased by the Study Personnel and ultimately did not prevent the clients from volunteering in large numbers. This discrepancy between the rates of consent at the sites may highlight individual differences in the recruitment approach and efforts by Study
Personnel. Although the Study Personnel at the CD Group agency acknowledged following the recruitment script, their success rate was much lower.

Future studies may be well served by having the Principal Investigator on-site to oversee or directly engage in participant recruitment and the informed consent process. Given the way clients enter treatment into the various mental health programs at the agencies, being on-site may present logistical challenges. For example, clients may enter the general mental health program at different rates depending on the day or week. Simply being at the agency would not necessarily result in increased participation. One solution that was offered by the CD Group agency was to produce a video of the Principal Investigator briefly introducing the study. While the Study Personnel would complete the formal informed consent process, the operating assumption was that clients being able to “put a face with the name” would soften their concerns about volunteering. The outcome based on such an approach is speculative, but certainly worth consideration if the researcher cannot be on-site for extended periods of time.

There were other solutions to addressing volunteerism. Assuming momentarily that the true reason for low volunteerism was a fear of an independent researcher having access to their PHI, the benefits and risks of obtaining the clinical and demographic variables could be reassessed. Notably, the Principal Investigator sought the PHI in order to describe the study sample and to test for differences between the two groups. For example, if the CD Group and PS Group differed significantly in their demographic or clinical characteristics, the validity of any conclusions drawn about collaborative documentation having an impact on the therapeutic relationship would be precarious. However, giving appropriate weight to the benefits and drawbacks to such an analysis might have resulted in the Principal Investigator forgoing the analysis and simply noting limitations in the findings. Future researchers interested in this
subject are encouraged to consider the need for such analyses in the context of the study’s overarching goals and purpose.

Yet another, and perhaps more obvious solution, is to extend the study’s timeline to allow for more data collection. If the above concerns regarding client hesitation were sufficiently addressed, a six-month data collection period may be sufficient to capture the sample size needed.

**Fidelity.**

A second area of concern in the present study was the degree to which therapist-participants adhered to the practice of collaborative documentation at the CD Group agency. As previously noted, therapists participated in a two-hour training, received resources for conducting collaborative documentation sessions, and completed training quizzes to facilitate learning. Based on formal feedback during therapist interviews, as well as informal feedback obtained from the agency, the therapists largely did not use collaborative documentation. The possible reasons for this low adherence to the practice were discussed earlier with regard to client and therapist acceptance and therapists’ existing skills. Although the CD Group agency professed a desire to have systemic collaborative documentation practices, it would appear that clinicians had not fully embraced the imperative by the end of the study.

The two-hour training was likely insufficient in helping therapists feel confident in using collaborative documentation. Therapists who were less experienced in areas of therapeutic practice, such as the ability to be transparent and confront clients, may have experienced discomfort with collaborative documentation more profoundly than did their colleagues. For these reasons, more attention should have been given to the training component of this study. A stronger approach would have been to conduct several workshops over a month-long period
leading up to the recruitment and data collection phases. For example, the training might have been more productive to include an informational component, followed by a demonstration, and then capped with one or two practice sessions in which colleagues could try out the skills learned in mock sessions. The Principal Investigator did meet monthly with the therapists during their team meetings to discuss challenges and to brainstorm solutions; however, formal training objectives might have been useful to integrate into the meetings. Many of these potential solutions, however, were impractical for this study given both the agency’s and the researcher’s resources.

Limitations.

The present study sought to understand how a relatively unstudied phenomenon emerging in managed-care settings, collaborative documentation, impacts the quality of the relationship between clients and their therapists. Because the process has not received much empirical attention, the Principal Investigator attempted to standardize the process to the extent possible. This was partially accomplished by reviewing the existing materials through relevant agencies and companies who have used the record-keeping method in any form. MTM Services, for example, has been a bastion of collaboration documentation, as they produce and sell training materials and consult with agencies who seek to adopt the practice. Although the Principal Investigator sought to involve MTM Services in this project, we were unable to connect in a way that would have strengthened the goals and outcomes in this project. Notably, MTM Services produced a DVD series on concurrent collaborative documentation that was out of circulation during the time frame needed for this study. Regrettably, the DVDs may have contained information critical in achieving a greater degree of standardization regarding the correct use of collaborative documentation. Furthermore, there may be components of collaborative
Clients at both agencies participated in an intake assessment by an intake therapist at their first visit, during which time the clients were assigned a principal diagnosis. Intake therapists are behavioral health professionals or paraprofessionals who are trained in assessment and diagnosis. Because intake assessment information (i.e., treatment diagnosis and GAF score) became the basis for study inclusion or exclusion, potentially eligible or ineligible clients may have been included or excluded in the study as a result of misdiagnosis. A notable limitation in this study’s design was that there was no independent verification for client diagnoses.

Therapist interviews also represented a limitation in the present study. Only three individuals participated, making a meaningful analysis of interview data problematic. Any conclusions drawn from the few interviews may represent views and perceptions unique to the agency from which they were derived. The opinions of the interview subjects should not be interpreted as representative of all therapists or healthcare workers who use collaborative documentation. The therapists’ perceptions of the practice may have also been greatly influenced by ecological factors within the agency that do not exist elsewhere.

Reliability and validity were concerns during the qualitative portion of this study. According to Guest et al. (2012), reliability in qualitative research is deemphasized, as replication is often not among the goals of this method. Rather, transparency is needed to allow future researchers the opportunity to approximate to the degree possible the qualitative components of the study. Similarly, the degree to which data conforms to expected values constitutes the validity, or credibility, of the findings. The qualitative portion of this study was inductive in that the aim was to draw out important themes thought to relate to strengths and
limitations of collaborative documentation. The themes identified were similar to those previously reported in the public domain, suggesting a greater degree of credibility in the findings. This, however, represents both a strength and a weakness regarding qualitative research. The very questions used to solicit the information were informed by what was believed to be true about the practice of collaborative documentation. Ultimately, the reader is left to judge the consistency and reliability of the data, and to that end, the Principal Investigator was transparent throughout this paper regarding the specific methods and protocols used. As previously noted, the interview guides and probes can be found in the appendices.

As a personal disclosure, the Principal Investigator is a former employee of one of the research sites. This author is unaware of any biases that may have impacted the study as a result of this past relationship; however, the relationship did facilitate easier entrance into and within the facility. Regardless, conclusions drawn from interview data may have been impacted by the author’s past experience with the agency.

Conclusion.

The study was based on a practice that has received minimal empirical investigation. To the best of this author’s knowledge, the practice of collaborative documentation originated as a productivity tool that has evolved—whether purposefully or by happenstance—into a therapeutic process. For this reason, attempts to study collaborative documentation will remain a challenge unless the administrative aspects of the method can be reconciled with the therapeutic effects it claims. In many ways, collaborative documentation suffers from an identity crisis. Should collaborative documentation remain an administrative record-keeping practice, further scrutiny is not necessarily warranted. If the practice is to become a therapeutic process or technique—one that carries with it organizational benefits as an artifact—then a greater understanding of the
mechanisms behind the practice’s benefits or risks to consumers is needed. While this study did not achieve the goal of better understanding the ways in which collaborative documentation impacts the therapeutic relationship, there is evidence that the practice is promising as a therapeutic device and that further investigation is necessary.
References


Same day access to behavioral health services. (2014). Retrieved from http://www.thenationalcouncil.org/areas-of-expertise/same-day-access/


Appendix A

Therapist Demographic Questionnaire

1. What is your professional identity?
   a. Psychology
   b. Counseling
   c. Social Work
   d. Other: ________________________________

2. What is your degree type?
   a. M.A.  
   b. M.C.  
   c. M.S.  
   d. Ed.S.  
   e. M.S.W.  
   f. Ph.D.  
   g. Psy.D.  
   h. Ed.D.  
   i. Other: ________________________________

3. Licensure type/status:
   a. L.P.C.  
   b. L.A.C.  
   c. L.C.S.W.  
   d. B.C.B.A.  
   e. Licensed Psychologist  
   f. Other: ________________________________

4. Years in practice post professional degree: _________

5. Primary theoretical orientation (choose only one orientation that most often informs your treatment with clients):
   a. Cognitive-Behavioral
   b. Behavioral
   c. Humanistic/Person-Centered
   d. Solution-Focused
   e. Psychodynamic/psychoanalytic
   f. Other: ________________________________

6. Gender
   a. Transgender
   b. Female
   c. Male
   d. Other: ________________________________

7. Age: _______________
## Appendix B

### Task Analysis Checklist, Therapist Version

The following is a list of things that may have occurred or had been present during your sessions. Please indicate with a mark in the appropriate column for each item which things occurred or were present. Please be honest with your responses, even if you feel you did not follow the study protocol exactly.

<table>
<thead>
<tr>
<th>THERAPIST</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During your first session together, did you do the following:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Informed your client that they would be participating in developing a note together that described their session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Informed your client that the note would include your assessment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Informed your client that they could agree or disagree with your assessment and that their comments would be included in the note?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Explained to you client that they could discuss any agreements or disagreements they had in order to clarify issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Explained to your client that it was important for them to speak up with their ideas and opinions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Informed your client that you would place any plans or homework in the plan?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>During the current session, did you do the following:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Used a transition statement to begin wrapping up the session and start the note taking portion? (For example, “We’re getting close to the end of session, let’s stop here and review what we’ve talked about.”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Invited your client to document with you the important aspects of the therapy session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Asked your client for feedback about how the session went?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Summarized or read directly for your client the note you developed before it was finalized?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Accurately documented your client’s thoughts or ideas within the note, even they disagreed with you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>During the current session, did your client do the following:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Provided you with any input during the note taking portion of the session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Provided you with feedback about how the session went?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Expressed either agreement or disagreement about what was written?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Appeared to understand what was documented about our session before the note was finalized?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The following was true or not true of the therapy environment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. My client was able to see my computer screen when I was writing our note.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. I was able to make eye contact with my client for the majority of the session.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. I faced my client in an unobstructed manner while talking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. I only wrote notes when my client and I were documenting the session together.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. I wrote notes at various times throughout the session.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your time. This concludes the therapist’s portion of the study materials. Please wait for your client to finish, then allow the client to take your form and their blue packet and enclose them both in the tamper-proof envelope and seal. Please return the envelope to the Study Coordinator, [name], as soon as possible.
The following is a list of things that may have occurred or had been present during your therapy. Please indicate with a mark in the appropriate column for each item which things occurred or were present.

<table>
<thead>
<tr>
<th>During your first session together, did your therapist do the following:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Informed you that you would be participating in developing a note together that described your session?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Informed you that the note would include the therapist’s assessment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Informed you that you could agree or disagree with the therapist’s assessment and that your comments would be included in the note?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Explained that you could discuss any agreements or disagreements you had in order to clarify issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Explained that it was important for you to speak up with your ideas and opinions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Informed you that she or he would place any plans or homework in the plan?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During the current session, did your therapist do the following:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Used a transition statement to begin wrapping up the session and start the note taking portion? (For example, “We’re getting close to the end of session, let’s stop here and review what we’ve talked about.”)</td>
<td></td>
</tr>
<tr>
<td>8. Invited you to document with them the important aspects of the therapy session?</td>
<td></td>
</tr>
<tr>
<td>9. Asked you for feedback about how the session went?</td>
<td></td>
</tr>
<tr>
<td>10. Summarized or read directly for you the note you developed before it was finalized?</td>
<td></td>
</tr>
<tr>
<td>11. Accurately documented your thoughts or ideas within the note, even if you disagreed?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>During the current session, I believe:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. I provided some input during the note taking portion of the session.</td>
<td></td>
</tr>
<tr>
<td>13. I provided feedback about how the session went.</td>
<td></td>
</tr>
<tr>
<td>14. I expressed either agreement or disagreement about what was written.</td>
<td></td>
</tr>
<tr>
<td>15. I understood what was documented about our session before the note was finalized.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The following was true or not true of the therapy environment:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16. I was able to see the therapist’s computer screen when she or he was writing our note.</td>
<td></td>
</tr>
<tr>
<td>17. I was able to make eye contact with my therapist for the majority of the session.</td>
<td></td>
</tr>
<tr>
<td>18. My therapist faced me in an unobstructed manner while talking.</td>
<td></td>
</tr>
<tr>
<td>19. My therapist only wrote notes when we were documenting the session together.</td>
<td></td>
</tr>
<tr>
<td>20. My therapist wrote notes at various times throughout the session.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Working Alliance Inventory, Short Form Revised

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.
   1  2  3  4  5
   Seldom  Sometimes  Fairly Often  Very Often  Always

2. What I am doing in therapy gives me new ways of looking at my problem.
   1  2  3  4  5
   Always  Very Often  Fairly Often  Sometimes  Seldom

3. I believe ____ likes me.
   1  2  3  4  5
   Seldom  Sometimes  Fairly Often  Very Often  Always

4. ____ and I collaborate on setting goals for my therapy.
   1  2  3  4  5
   Seldom  Sometimes  Fairly Often  Very Often  Always

5. ____ and I respect each other.
   1  2  3  4  5
   Always  Very Often  Fairly Often  Sometimes  Seldom

6. ____ and I are working towards mutually agreed upon goals.
   1  2  3  4  5
   Always  Very Often  Fairly Often  Sometimes  Seldom

7. I feel that ____ appreciates me.
   1  2  3  4  5
   Seldom  Sometimes  Fairly Often  Very Often  Always

Collaborative Documentation Study
WAI-SR Questionnaire, CD Group
Items copyright © Adam Horvath
8. _____ and I agree on what is important for me to work on.
   
   Always  Very Often  Fairly Often  Sometimes  Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.
   
   Seldom  Sometimes  Fairly Often  Very Often  Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.
    
    Always  Very Often  Fairly Often  Sometimes  Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.
    
    Always  Very Often  Fairly Often  Sometimes  Seldom

12. I believe the way we are working with my problem is correct.
    
    Seldom  Sometimes  Fairly Often  Very Often  Always

Note: Items copyright © Adam Horvath.
Appendix D

Client Interview Guide, CD Group

Collaborative Documentation Study
Semi-Structured Interview Guide for CD Group Clients

1. What is your understanding of collaborative documentation? What does it mean?
2. How did you feel about your therapist sharing notes with you during the session?
   • What thoughts did you have regarding the process while it was occurring?
3. What did you find helpful about collaborative documentation?
   • What was unhelpful about it?
4. Did your therapist take notes or document during the main portion of your session, or at the end?
   • How did that impact your experience in therapy?
5. How accurate was your therapist’s summary of what had occurred in therapy?
6. How comfortable were you in having a frank conversation about what had occurred in therapy with your therapist?
   • What types of information did you have a discussion about?
7. Did you feel that collaborating in recordkeeping with your therapist was a good use of your time in therapy?
   • Why or why not?
   • How did this impact your feelings towards the therapist? Towards the process?
8. Imagine you had a friend in therapy whose therapist did not use collaborative documentation. What would you tell him/her about the process?
   • Would you be likely to encourage your friend to ask for the therapist to do this? Why or why not?
9. What could your therapist do better with regard to sharing clinical information with you during your session?
10. Given the choice, would you prefer your therapist to continue using collaborative documentation?
    • Why or why not?
Appendix E

Study Site Recruitment Advertisement

<table>
<thead>
<tr>
<th>Request for Research Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative Documentation: A Client-Centered Impact Study</td>
</tr>
</tbody>
</table>

Concurrent-Collaborative documentation, or simply collaborative documentation (CD), is a form of record keeping whereby the therapist prepares progress notes in a transparent, collaborative manner with the client near the end of therapy session. This is in contrast to the typical method of completing record keeping after the conclusion of a traditional 45- to 50-minute therapy session. Proponents of CD maintain the practice saves time, increases clinician capacity to see more clients, and improves compliance with agency productivity and performance standards. The efficient management of the copious volume of record keeping holds a secondary benefit of decreasing clinician stress and burnout.

Similar positive benefits have been cited regarding CD’s therapeutic benefits. For example, CD is said to facilitate the therapist and client reaching a consensus on the important features of the session; allow for greater trust through transparency; and in providing a mechanism for feedback about needs and progress during therapy.

Unfortunately, the purported therapeutic benefits of CD have not yet been empirically demonstrated. Research consistently shows that the strength of the therapeutic relationship predicts successful outcomes in therapy. In fact, it may be more important than the therapeutic technique utilized by the therapist. Understanding how the emerging practice of CD impacts therapeutic relationships is becoming vital, as the practice is increasingly implemented in community healthcare settings.

The Principal Investigator is seeking community behavioral health agencies to participate in a future research study. Your agency's participation will help provide an empirical foundation to better understand the relationship between a collaborative record keeping practice and client-therapist relationships. The project was approved by NAU’s IRB.

Projected benefits of participation

- Acquire an evidence-based understanding of a common practice in public behavioral healthcare.
- Discover the salient features of CD that help support or interrupt the therapeutic alliance.
- Obtain actionable data that can be used to enhance productivity while improving client/consumer outcomes in psychotherapy.
- Improve provider commitment to agency imperatives.
- Free training on collaborative documentation from a researcher and clinician who understands community healthcare and its challenges.
- Study personnel will receive additional training on human subjects research.

Foreseeable risks of participation

- Therapists and clients will be asked to provide protected health information (PHI).
- Therapists and clients may feel uncomfortable disclosing their feelings or attitudes about their therapeutic work.

Time commitments for participation

- 60-minute initial orientation with participating therapists.
- 90 minutes training for designated study personnel who will receive $100 gift card for participation.
- 5-10 minutes during sessions to complete questionnaires at the end of one therapy session, per client.
- 10 minutes per client for recruiting/consenting by study personnel.

For participation or to receive further information, please contact the Principal Investigator, Robert DiCarlo, at [xxx] xxx-xxxx or email@nau.edu
Appendix F

Study Coordinator Instructions, CD Group

CD Group - Study Coordinator Instructions

Thank you for your assistance in this study. As the Study Coordinator for your agency, you are being asked to perform certain functions to assist the Principal Investigator (PI) in accessing the agency for the purposes of a research study involving both therapists and clients. In other words, your role is conceptualized as a point-of-contact person for the PI. In appreciation of your time and effort, the PI will provide you with a $100 prepaid Visa card at the conclusion of the data collection period.

What you will be responsible for:
- Facilitate the collection and secure maintenance of all study materials for the Principal Investigator (PI).
- Assist PI with scheduling of study-related orientations and trainings.
- Assist with placing alerts on client’s electronic health records to inform agency staff.
- Inform the PI of any problems throughout the data collection process.
- Assist PI with extracting client protected health information from the electronic health record of each client-participant.

What you will NOT be responsible for:
- Administering study-related materials to participants.
- Providing informed consent to participants.
- Accessing data collected for the study not already part of clients’ protected health information within the agency.
- Engaging in any substantive study-related activities.

General Overview of Procedures:

The present study seeks the participation of both agency therapists (termed “therapist-participants”) and clients (termed “client-participants”). The PI will be investigating the ways in which record keeping practices affect aspects of the therapy clients receive.

Intake workers at your agency will be enlisted as Study Personnel and will be responsible for recruiting and providing informed consent to client-participants. Intake workers are not considered study participants; rather, they are more similar to study assistants.

When a client-participant becomes part of the study (during their intake), the intake worker will send an email to the Study Coordinator identifying the client as such. In response, the Study Coordinator shall place an alert notification on the client’s electronic health record:

```
ATTENTION: THIS IS A STUDY PARTICIPANT. Primary therapist should administer study materials during third psychotherapy session. Contact [Study Coordinator’s name] for questions.
```

Collaborative Documentation Study
Study Coordinator Instructions

160
The intake worker will place completed informed consent and HIPAA authorization forms in the Study Coordinator’s secure mail tray. The Study Coordinator shall check mail tray for completed forms at the end of every business day.

Therapist-participants will receive an orientation on the study’s procedures. Depending on your agency, the therapist-participants may additionally undergo specialized training related to the objectives of the study.

Client-participants will complete a set of questionnaires related to the subject under investigation related to this study during their third therapy session. The therapist-participant will complete questionnaires at the same time. Both the client-participant and therapist-participant will enclose the questionnaires in a tamper-proof envelope provided by the PI.

The Study Coordinator will retrieve any completed envelopes from therapist-participants, which will be placed in the Study Coordinator’s secure mail tray, at the end of each day during the data collection period. Because of the sensitive nature of the materials, the envelopes, consent forms, and HIPAA authorizations shall be stored in a HIPAA-compliant locking document bag provided by the PI. The document bag will remain in the possession of the Study Coordinator and will be clearly labeled with the PI’s contact information. The Study Coordinator and the PI will have the only keys to the bag.

Please notify the PI immediately if any of the tamper-evident envelopes collected show evidence of damage to the seal. If broken, the seal will reveal the word “OPENED” in red lettering.

The document bag containing completed envelopes should be stored in a secure location in your office and should be locked at all times, except when adding materials. The key should not be shared with others and kept in a secure location separate from the bag. The bag should not be taken outside of the agency.

The PI will arrange to collect the completed envelopes in person at regular intervals, at a designated time during the study, or if the Study Coordinator informs the PI that the bag has reached capacity.

At a designated point during the study, the Study Coordinator will assist the PI with accessing the client-participants’ electronic health record. The PI will provide the Study Coordinator with a list of internal agency client ID numbers corresponding to needed clients. The Study Coordinator shall extract the following data for each client ID number, to be stored as an electronic file temporarily on a USB Flash Drive (provided by the PI):

1. All numerical diagnoses (with primary diagnosis denoted).
2. Global Assessment of Functioning Score.
3. Age.
4. Gender.
5. Sexual Orientation.
7. Ethnicity.
8. Level of Education.

The data will be transferred to the PIs encrypted laptop on site, and then the Flash Drive will be erased in a secure manner.

At a point later in the study, the PI may contact the Study Coordinator to assist in providing private office space to conduct follow up interviews.

Should you have any questions at any time, please feel free to contact:

**Robert DiCarlo**
Principal Investigator
Phone Number
Email

**Dr. Evie Garcia**
Faculty Supervisor
Phone Number
Email
PS Group - Study Coordinator Instructions

Thank you for your assistance in this study. As the Study Coordinator for your agency, you are being asked to perform certain functions to assist the Principal Investigator (PI) in accessing the agency for the purposes of a research study involving both therapists and clients. In other words, your role is conceptualized as a point-of-contact person for the PI. In appreciation of your time and effort, the PI will provide you with a $100 prepaid Visa card at the conclusion of the data collection period.

What you will be responsible for:
- Facilitate the collection and secure maintenance of all study materials for the Principal Investigator (PI).
- Assist PI with scheduling of study-related orientations and trainings.
- Assist with placing alerts on client’s electronic health records to inform agency staff.
- Inform the PI of any problems throughout the data collection process.
- Assist PI with extracting client protected health information from the electronic health record of each client-participant.

What you will NOT be responsible for:
- Administering study-related materials to participants.
- Providing informed consent to participants.
- Accessing data collected for the study not already part of clients’ protected health information within the agency.
- Engaging in any substantive study-related activities.

General Overview of Procedures:

The present study seeks the participation of both agency therapists (termed “therapist-participants”) and clients (termed “client-participants”). The PI will be investigating the ways in which record keeping practices affect aspects of the therapy clients receive.

Case managers at your agency will be enlisted as Study Personnel and will be responsible for recruiting and providing informed consent to client-participants. Case managers are not considered study participants; rather, they are more similar to study assistants.

When a client-participant becomes part of the study (during or shortly after their intake), the case manager will send an email to the Study Coordinator identifying the client as such. In response, the Study Coordinator shall place an alert notification on the client’s electronic health record:

Collaborative Documentation Study
Study Coordinator Instructions
ATTENTION: THIS IS A STUDY PARTICIPANT. Primary therapist should administer study materials during third psychotherapy session. Contact [Study Coordinator’s name] for questions.

The intake worker will place completed informed consent and HIPAA authorization forms in the Study Coordinator’s secure mail tray. The Study Coordinator shall check mail tray for completed forms at the end of every business day.

Therapist-participants will receive an orientation on the study’s procedures. Depending on your agency, the therapist-participants may additionally undergo specialized training related to the objectives of the study.

Client-participants will complete a set of questionnaires related to the subject under investigation related to this study during their third therapy session. The therapist-participant will complete questionnaires at the same time. Both the client-participant and therapist-participant will enclose the questionnaires in a tamper-proof envelope provided by the PI.

The Study Coordinator will retrieve any completed envelopes from therapist-participants, which will be placed in the Study Coordinator’s secure mail tray, at the end of each day during the data collection period. Because of the sensitive nature of the materials, the envelopes, consent forms, and HIPAA authorizations shall be stored in a HIPAA-compliant locking document bag provided by the PI. The document bag will remain in the possession of the Study Coordinator and will be clearly labeled with the PI’s contact information. The Study Coordinator and the PI will have the only keys to the bag.

Please notify the PI immediately if any of the tamper-evident envelopes collected show evidence of damage to the seal. If broken, the seal will reveal the word “OPENED” in red lettering.

The document bag containing completed envelopes should be stored in a secure location in your office and should be locked at all times, except when adding materials. The key should not be shared with others and kept in a secure location separate from the bag. The bag should not be taken outside of the agency.

The PI will arrange to collect the completed envelopes in person at regular intervals, at a designated time during the study, or if the Study Coordinator informs the PI that the bag has reached capacity.

At a designated point during the study, the Study Coordinator will assist the PI with accessing the client-participants’ electronic health record. The PI will provide the Study Coordinator with a list of internal agency client ID numbers corresponding to needed clients.
The Study Coordinator shall extract the following data for each client ID number, to be stored as an electronic file temporarily on a USB Flash Drive (provided by the PI):

1. All numerical diagnoses (with primary diagnosis denoted).
2. Global Assessment of Functioning Score.
3. Age.
4. Gender.
5. Sexual Orientation.
7. Ethnicity.
8. Level of Education.

The data will be transferred to the PIs encrypted laptop on site, and then the Flash Drive will be erased in a secure manner.

At a point later in the study, the PI may contact the Study Coordinator to assist in providing private office space to conduct follow up interviews.

Should you have any questions at any time, please feel free to contact:

**Robert DiCarlo**  
Principal Investigator  
Phone Number  
Email

**Dr. Evie Garcia**  
Faculty Supervisor  
Phone Number  
Email
Appendix G

Study Personnel Recruitment Email and CITI Training Instructions

Request for Study Personnel
Collaborative Documentation in Community Behavioral-Healthcare

Greetings! My name is Robert DiCarlo and I am a doctoral candidate at Northern Arizona University in the Educational Psychology Department. I am in the process of beginning a research study in which your agency has agreed to participate. You are being requested by your agency and myself to facilitate aspects of this study. Primarily, you will be providing informed consent to eligible client participants during intake sessions and will assist with collecting and routing study materials to the appropriate site personnel. The study’s data collection period for which you will be involved is anticipated to take approximately one month to complete and your agency has agreed to adjust scheduling to allow for the extra time these tasks may take during client intakes. For those clients who may be eligible for participation, it is expected to take approximately 10 minutes per client to provide informed consent. Not all incoming clients will be eligible for study participation.

You will be provided with a detailed orientation to discuss the study’s procedures before data collection begins. In the meantime, all study personnel must complete an online tutorial on Human Subjects Research through the Collaborative Institutional Training Institute (CITI) to work in this study.

I recognize that I am asking a lot of intake workers who already have limited time to complete their day-to-day responsibilities. In appreciation for your time and effort, you will be given a $50 prepaid Visa card upon proof of successful completion of the training tutorial. At the end of the study’s data collection period, participating employees who complete the study’s objectives will be given another $50 gift card, for a total of $100.

If agreeable, please complete the instructions that follow. Additionally, sign and return the Individual Investigator Agreement (the last two pages of this document).

Please follow the instructions below carefully to complete the tutorial registration process and begin your training. It is expected to take most people 60-90 minutes to complete and can be done from any computer with internet access.

CITI Training Instructions

1. Create a user account at www.citiprogram.org beneath “Create an Account.”

Create an account

Access requires registration as an affiliate of a subscribing CITI institution or as an unaffiliated learner.

Register

1
2. Create an affiliation with Northern Arizona University and agree to terms of service.

3. Complete personal information.

4. Create username and password. Write them down here for future reference, if you prefer:

   My username: _____________________________

   My password: _____________________________

5. Add your country of residence (e.g., USA).

6. Select “No” for continuing education. (If you select “Yes,” you will be required to pay for credits.) Alternatively, if you desire CEs for professional licensure, you may do so at your own expense.

7. Complete the requested information. **Only complete the required fields. Be sure to use the following information in completing the form:**

   a. Institutional email address: use your preferred email address.

   b. Role in research: select “Recruiter”

   ![Role in Research](image)

   c. Office phone: use your preferred telephone number.
d. Which course do you plan to take: **Basic Human Subjects – Social & Behavioral Focus**.

![Dropdown menu for course selection]

e. All other non-required fields you may leave blank.

8. When prompted, only select the first option for conducting research with **live human beings**. Do not select other options, as this will unnecessarily increase the time to complete your tutorial.

9. When prompted, indicate that you **have not** previously completed the basic course.

![Checkbox for completion status]

10. Next, select **Group 2: Social & Behavioral Research**.

11. When prompted, select **Finalize Registration**.

12. You will be redirected to the Main Menu. Select your new course in the list "**Social & Behavioral Research**" to begin the tutorial.
Request for Study Personnel
Collaborative Documentation in Community Behavioral Healthcare

13. Before beginning, click the Integrity Assurance Statement link and follow the prompts to complete:

Complete The Integrity Assurance Statement before beginning the course

14. You may now begin the modules by selecting the first link. **DO NOT COMPLETE THE SUPPLEMENTAL MODULES AS THEY ARE NOT REQUIRED.**

15. There is a quiz after each module that must be completed. **Please complete all core modules.**

16. Save your certificate. Email the training completion certificate AND the completed and signed Individual Investigator Agreement to:

Robert DiCarlo: email@nau.edu

If you have any questions or have any difficulties with the process, please do not hesitate to contact me at: xxx-xxxx-xxxx

---Individual Investigator Agreement begins on next page. Sign and Return---
Appendix H

Study Personnel Instructions, CD Group Agency

Intake Worker Instructions – CD Group

General Overview:

- The Principal Investigator, Robert DiCarlo, is a doctoral candidate at Northern Arizona University’s Counseling Psychology Ph.D. program and is being supervised by Dr. Evie Garcia. The study was approved by Northern Arizona University’s Institutional Review Board on October 11, 2016.

- In this study, your role is as the “Intake Worker.” You will be responsible for identifying new clients as potential study participants and providing them with informed consent, assigning the client to a qualified therapist who is also participating in the study, and coordinating with your agency’s administration to set up tracking and retention of documents.

- Clients who participate in this study are the “client-participants” and they will be receiving therapy services at your agency. During their third consecutive therapy session, the client-participant will be asked to complete some questionnaires about their experience with their therapist. This will take about 5-10 minutes to complete.

- Another role in this study, which will not involve you, is that of the “therapist-participant.” The therapist-participant is responsible for conducting therapy with the client-participants, and administering and completing the study materials.

- You will be provided with informed consent for your role in the study.

- Because you will be consenting clients in this research study, you are considered “study personnel” and thus are required to complete a tutorial and pass a test on conducting ethical Human Subject Research. The tutorial will take approximately 1-2 hours to complete and will be provided at no cost to you. You must pass the test prior to the start of the study.

- You will be informed about the general study procedures related to your agency’s role in this study. The purpose of this information is to help you answer any participant questions that may arise regarding consent.

- You will receive a set of premade study materials consisting of blank informed consent documents. Please keep these where you conduct intake sessions.

- You will be asked to thoroughly review and understand the client-participant informed consent document.
• You will be asked to allow potential participants sufficient time to review and ask questions about the informed consent document before signing. Your agency has agreed to make accommodations for this time in your intake schedule.

PROCEDURE:

A. Identifying client-participant candidates:

1. All clients undergoing an intake are eligible for the study if they meet the following inclusion criteria. Please note that you may have to complete your intake assessment to know if the client qualifies.
   a. 18 years or older.
   b. Speaks and understands English.
   c. Can read and comprehend informed consent and authorization study forms.
   d. Primary/principal diagnosis is general mental health (not Substance Abuse).
   e. Assigned to the General Mental Health program (not SMI, Substance Abuse/Chemical Dependence, or Child and Family programs).
   f. Does not have a pending SMI determination.
   g. Will be receiving individual “talk” therapy with a qualified clinician.

2. Participant candidates must be seeing a new therapist for the first time to be eligible for inclusion in the study. If the client is returning to the clinic from a prior treatment episode and is unwilling to be assigned to a new clinician, that client is not eligible for the study.

B. Identifying client-participant candidates:

If the above conditions are met and you assess that clients are eligible for inclusion in the study, please proceed with participant recruitment. Please read the following script to any client who meets the above inclusion criteria:

[Agency name] is participating in a research project to find out how different record-keeping practices affect the relationship between clients and their therapists. Our hope is that a better understanding of record keeping practices will help improve clinical care for people in therapy. We are seeking volunteers, and if you are interested in participating, all you would need to do is spend an additional [5-10 minutes] completing a survey at one of your sessions later on. Would you like to know more about the study?*

If client responds in affirmative, state: Great, thanks so much for your willingness. Just so you are aware, the researcher of the study is asking you to complete a couple of questionnaires at the end of your third therapy session with
your therapist. Neither your therapist nor [Agency Name] will know what you wrote. Additionally, if you agree to the study, the researcher will be asking the [Agency name] to provide some of your basic clinical information, which is already part of your record. If you’re willing, we can take a look at the agreement now.

If still Yes: Proceed with Informed Consent and authorization documents.

If No: Thank you for your consideration anyway. Proceed with conclusion of intake in your usual manner.

C. Informed consent and HIPAA authorization documents

When a client has agreed to the above, proceed with the following steps:

1. Provide a blank copy of the Client-Participant Informed Consent document, which includes a HIPAA-compliant authorization to share protected health information with the PI.
2. Allow the client to read the entire document. If the client is unable to read and understand the document themselves, they should be informed that they are not eligible to participate in the study. Answer any questions raised by the client.
3. Review with the client the HIPAA Authorization attached to the last page of the consent and ensure they have signed and dated the document. If they have questions about the substance abuse information being requested, you may explain the following:
   a. The PI is only seeking diagnostic information. If past or future health records list a substance abuse diagnosis, even if not the focus of treatment, the PI would be unable to obtain other needed information for the study. Remind the participant that the information will be kept in strict confidence.
4. Once they have finished reading, ask the following:
   a. Do you have any questions about the study or anything in the consent document or authorization form?
   b. Do you understand what you are consenting to with regard to this study?
   c. Do you consent to participate in this study as described?
5. If anything is unclear from the above:
   a. Review the unclear items with them.
   b. If they wish to discuss the study further with the Principal Investigator before signing, please allow them the opportunity to contact the PI during the intake using the contact information on the last page.
   c. If the PI is unavailable, they may leave a message on the PI’s confidential voicemail. Please provide them with a copy of the informed consent document and proceed with your intake in your normal manner. If the client requests a copy of their signed HIPAA authorization, please provide them with one.
6. If the client signed the documents, please do the following:

Collaborative Documentation Study
Intake Worker Instructions
a. Send an email to your site’s Study Coordination, [name], to inform her that client has consented to participate in the study.
b. Retain the signed copy and legibly write the client’s internal agency ID number on the top right corner of the first page of the document.
c. Place completed forms in your agency’s designated Study Coordinator’s [(name)] secure mail tray by the end of every day.
d. Provide a blank copy of the informed consent document to the client. They do not need to sign their copy. Emphasize that the PI and the Faculty Advisor’s contact information is on the last page.

7. Assign the client-participant to a participating therapist in your usual manner.
8. The Study Coordinator will place an alert on the client’s electronic health record within 24 hours that identifies the client as a study participant.

Should you have any questions at any time, please feel free to contact:

Robert DiCarlo Dr. Evie Garcia
Principal Investigator Faculty Supervisor
Phone number Phone number
Email Email
Case Manager Instructions – PS Group

General Overview:

- The Principal Investigator, Robert DiCarlo, is a doctoral candidate at Northern Arizona University’s Counseling Psychology Ph.D. program and is being supervised by Dr. Evie Garcia. The study was approved by Northern Arizona University’s Institutional Review Board on October 12, 2016.

- In this study, your role is as the “Case Manager.” You will be responsible for identifying new clients as potential study participants and providing them with informed consent, assigning the client to a qualified therapist who is also participating in the study, and coordinating with your agency’s administration to set up tracking and retention of documents.

- Clients who participate in this study are the “client-participants” and they will be receiving therapy services at your agency. During their third consecutive therapy session, the client-participant will be asked to complete some questionnaires about their experience with their therapist. This will take about 5-10 minutes to complete.

- Another role in this study, which will not involve you, is that of the “therapist-participant.” The therapist-participant is responsible for conducting therapy with the client-participants, and administering and completing the other study materials.

- You will be provided with informed consent for your role in the study.

- Because you will be consenting clients in this research study, you are considered “study personnel” and thus are required to complete a tutorial and pass a test on conducting ethical Human Subject Research. The tutorial will take approximately 1-2 hours to complete and will be provided at no cost to you. You must pass the test prior to the start of the study.

- You will be informed about the general study procedures related to your agency’s role in this study. The purpose of this information is to help you answer any participant questions that may arise regarding consent.

- You will receive a set of premade study materials consisting of blank informed consent documents. Please keep these where you will be recruiting and consenting clients.

- You will be asked to thoroughly review and understand the client-participant informed consent document.
• You will be asked to allow potential participants sufficient time to review and ask questions about the informed consent document before signing. Your agency has agreed to make accommodations for this time during your appointment with the client.

PROCEDURE:

A. Identifying client-participant candidates:

1. All clients undergoing an intake are eligible for the study if they meet the following inclusion criteria.
   a. 18 years or older.
   b. Speaks and understands English.
   c. Can read and comprehend informed consent and authorization study forms.
   d. Primary/Principal diagnosis is general mental health (not Substance Abuse).
   e. Assigned to the General Mental Health program (not SMI, Substance Abuse/Chemical Dependence, or Child and Family programs).
   f. Does not have a pending SMI determination.
   g. Will be receiving individual “talk” therapy with a qualified clinician.

2. Participant candidates must be seeing a new therapist for the first time to be eligible for inclusion in the study. If the client is returning to the clinic from a prior treatment episode and is unwilling to be assigned to a new clinician, that client is not eligible for the study.

B. Identifying client-participant candidates:

If the above conditions are met and you assess that clients are eligible for inclusion in the study, please proceed with participant recruitment. Please read the following script to any client who meets the above inclusion criteria:

[Agency name] is participating in a research project to find out how different record-keeping practices affect the relationship between clients and their therapists. Our hope is that a better understanding of record keeping practices will help improve clinical care for people in therapy. We are seeking volunteers, and if you are interested in participating, all you would need to do is spend an additional [5-10 minutes] completing a survey at one of your sessions later on. Would you like to know more about the study?"

If client responds in affirmative, state: Great, thanks so much for your willingness. Just so you are aware, the researcher of the study is asking you to complete a couple of questionnaires at the end of your third therapy session with your therapist. Neither your therapist nor [Agency Name] will know what you...
wrote. Additionally, if you agree to the study, the researcher will be asking the
[Agency name] to provide some of your basic clinical information, which is
already part of your record. If you’re willing, we can take a look at the
agreement now.

If still Yes: Proceed with Informed Consent and authorization documents.

If No: Thank you for your consideration anyway. Proceed with concluding
your appointment in your usual manner.

C. Informed consent and HIPAA authorization documents

When a client has agreed to the above, proceed with the following steps:

1. Provide a blank copy of the Client-Participant Informed Consent document, which
includes a HIPAA-compliant authorization to share protected health information with
the PI.
2. Allow the client to read the entire document. If the client is unable to read and
understand the document themselves, they should be informed that they are not
eligible to participate in the study. Answer any questions raised by the client.
3. Review with the client the HIPAA Authorization attached to the last page of the consent
and ensure they have signed and dated the document. If they have questions about the
substance abuse information being requested, you may explain the following:
   a. The PI is only seeking diagnostic information. If past or future health records list
      a substance abuse diagnosis, even if not the focus of treatment, the PI would be
      unable to obtain other needed information for the study. Remind the
      participant that the information will be kept in strict confidence.
4. Once they have finished reading, ask the following:
   a. Do you have any questions about the study or anything in the consent document
      or authorization form?
   b. Do you understand what you are consenting to with regard to this study?
   c. Do you consent to participate in this study as described?
5. If anything is unclear from the above:
   a. Review the unclear items with them.
   b. If they wish to discuss the study further with the Principal Investigator before
      signing, please allow them the opportunity to contact the PI during the
      appointment using the contact information on the last page.
   c. If the PI is unavailable, they may leave a message on the PI’s confidential
      voicemail. Please provide them with a copy of the informed consent document
      and proceed with your appointment in your normal manner. If the client
      requests a copy of their signed HIPAA authorization, please provide them with
      one.
6. If the client signed the documents, please do the following:
a. Send an email to your site’s Study Coordinator, [name], informing him that client has consented to participate in the study.
b. Retain the signed copy and **legibly write the client’s internal agency ID number on the top right corner of the first page** of the document.
c. **Place completed forms in your agency’s Study Coordinator’s ([name]) secure mail tray by the end of every day.**
d. Provide a blank copy of the informed consent/HIPAA form to the client. They do not need to sign their copy. Emphasize that the PI and the Faculty Advisor’s contact information is on the last page.

7. Assign the client-participant to a participating therapist in your usual manner.
8. The Study Coordinator will place an alert on the client’s electronic health record within 24 hours that identifies the client as a study participant.

Should you have any questions at any time, please feel free to contact:

<table>
<thead>
<tr>
<th>Robert DiCarlo</th>
<th>Dr. Evie Garcia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Investigator</td>
<td>Faculty Supervisor</td>
</tr>
<tr>
<td>Phone number</td>
<td>Phone number</td>
</tr>
<tr>
<td>Email</td>
<td>Email</td>
</tr>
</tbody>
</table>

Collaborative Documentation Study
Case Manager Instructions, PS Group
CD Group Agency
STUDY PROCEDURES TRAINING QUIZ – STUDY PERSONNEL

NAME: ____________________________________________

The following questionnaire is intended to help solidify your understanding of the training on the study procedures that you just received.

Please keep in mind that there are no “right” or “wrong” answers to any of the questions. The purpose is to stimulate thought about the training and to help clarify the process for which you have agreed to participate in with agency clients. We will discuss the responses as a group. Please feel free to take notes on this page for later use. I will make copies and return your questionnaire before the study begins.

1. Please describe the role of the intake worker in this study.

2. Please describe the role of the client-participant in this study.

3. Please describe the role of the therapist-participant in this study.

4. Place a mark next to all criteria that must be met for a client-participant to be considered eligible for participation in the study:

   ___ 18 years or older.
   ___ Assigned to the Child and Family program.
   ___ Has limited English proficiency.
   ___ Has a primary diagnosis that is Substance Abuse/Chemical Dependency.
   ___ Is not SMI.
   ___ Assigned to the General Mental Health program for “talk” therapy.
   ___ Has pending SMI determination.
   ___ Is not receiving psychotropic medication.
CD Group Agency

STUDY PROCEDURES TRAINING QUIZ – STUDY PERSONNEL

5. Please respond to these true/false questions:

a. T F Client-participants who wish to be seen by a therapist for whom they have been previously treated by are eligible for participation in the study.

b. T F Client-participants who have a substance abuse/chemical dependency diagnosis as their principal diagnosis should be consented to participate in the study.

c. T F If a potential client-participant asks to discuss the study further with the Principal Investigator, you should allow them to contact the PI.

d. T F Client-participants can expect to spend 30 minutes to complete questionnaires after one of their therapy sessions.

e. T F My agency will have access to the client-participant’s responses to questionnaires.

f. T F I should follow the script recruitment script after identifying a potential client-participant candidate.

g. T F I am required to make a copy of the signed informed consent document for the client-participant.

h. T F I must write the client-participant’s internal agency ID number on the top right corner of the signed informed consent document.

i. T F I should send the completed informed consent documents to the client-participant’s assigned therapist.

j. T F As an intake worker, I am considered Study Personnel and therefore must complete the Human Subjects Research tutorial.

6. Please identify three questions you should ask a client-participant candidate before they sign the Informed Consent document:

a. 

b. 

c. 

---

Collaborative Documentation Study
Intake Worker Training Questionnaire, 8.28.16
Study Personnel Training Quiz, PS Group Agency

PS Group Agency
STUDY PROCEDURES TRAINING QUIZ – STUDY PERSONNEL

NAME: __________________________________________

The following questionnaire is intended to help solidify your understanding of the training on
the study procedures that you just received.

Please keep in mind that there are no “right” or “wrong” answers to any of the questions.
The purpose is to stimulate thought about the training and to help clarify the process for
which you have agreed to patriciate in with agency clients. We will discuss the responses as a
group. Please feel free to take notes on this page for later use. I will make copies and return
your questionnaire before the study begins.

1. Please describe the role of the case manager in this study.

2. Please describe the role of the client-participant in this study.

3. Please describe the role of the therapist-participant in this study.

4. Place a mark next to all criteria that must be met for a client-participant to be
considered eligible for participation in the study:

   ___ 18 years or older.
   ___ Assigned to the Child and Family program.
   ___ Has limited English proficiency.
   ___ Has a primary diagnosis that is Substance Abuse/Chemical Dependency.
   ___ Is not SMI.
   ___ Assigned to the General Mental Health program for “talk” therapy.
   ___ Has pending SMI determination.
   ___ Is not receiving psychotropic medication.

Collaborative Documentation Study
Case Manager Training Questionnaire, 8.28.16
5. Please respond to these true/false questions:

a. T  F  Client-participants who wish to be seen by a therapist for whom they have been previously treated by are eligible for participation in the study.

b. T  F  Client-participants who have a substance abuse/chemical dependency diagnosis as their principal diagnosis should be consented to participate in the study.

c. T  F  If a potential client-participant asks to discuss the study further with the Principal Investigator, you should allow them to contact the PI.

d. T  F  Client-participants can expect to spend 30 minutes to complete questionnaires after one of their therapy sessions.

e. T  F  My agency will have access to the client-participant’s responses to questionnaires.

f. T  F  I should follow the script recruitment script after identifying a potential client-participant candidate.

g. T  F  I am required to make a copy of the signed informed consent document for the client-participant.

h. T  F  I must write the client-participant’s internal agency ID number on the top right corner of the signed informed consent document.

i. T  F  I should send the completed informed consent documents to the client-participant’s assigned therapist.

j. T  F  As a case manager, I am considered Study Personnel and therefore must complete the Human Subjects Research tutorial.

6. Please identify three questions you should ask a client-participant candidate before they sign the Informed Consent document:

a. ________________________________________________

b. ________________________________________________

c. ________________________________________________
**General Overview:**

- In this study, your role is as the “therapist-participant.” You will be conducting individual therapy sessions with your clients (the “client-participant”) in a manner consistent with the collaborative documentation training you previously received.

- You will administer study materials for all new therapy clients you see during the study’s data collection period. You will be notified by the agency when data collection is complete.

- If you have provided therapy for a client-participant during a previous treatment episode (i.e., returning client), the client-participant is not eligible for the study. Only administer study materials to clients for whom you are treating for the first time in individual general mental health therapy.

- You have received a set of pre-assigned study envelopes. Please keep the envelopes where you conduct therapy sessions. Please do not trade envelopes with other therapists, as they are uniquely coded to you. There is one study envelope per client-participant. You will complete one packet per study participant.

- All client-participants will be flagged in the client’s electronic health record. Every time you access a client-participant’s record, you will be notified of their participation in the study.

- Conduct all therapy sessions with client-participants using collaborative documentation through the duration of the data collection period. If needed, reference the training materials provided by the Principal Investigator.

- Although you will use collaborative documentation as described in every session, study materials (i.e., questionnaires) will only be administered at the end of the THIRD SESSION with each client-participant. If you forget to administer the study materials at the end of the THIRD SESSION, please attempt to do so after either session 4, 5, or 6. Please do not administer the materials beyond the SIXTH SESSION.
Procedure:

1. Session #1 (post-intake)
   a. Read the Collaborative Documentation Introduction Script aloud to the client at the onset of your first session with the client-participant. Ensure your client has an opportunity to discuss any concerns with you before beginning the session.
   
   b. After the first 45-50 minutes of the session, read the Collaborative Documentation Transition Script aloud to the client to help identify when you are transitioning from the talking portion of the session to note taking.
   
   c. During note taking, invite the client to be involved in the process. Allow them to sit near you so that they can see the computer screen as you type. Ask questions to engage them. For example, you might ask:
      • What did you see as the most important aspects of the session today?
      • What did you learn today?
      • How did you feel the session went?
      • What do you feel we accomplished today?
   
   d. Ensure the following is done during the note-taking phase:
      • Summarize or read directly each aspect of the progress note to the client-participant.
      • Ask if they agree or disagree with anything.
      • Discuss and document any agreement or disagreement within the note.
      • Finalize/submit the note in the presence of the client.

2. Session #2
   a. Repeat steps (1)(b), (1)(c), and (1)(d) above.
   
   b. Note you do not have to read the introduction script completed in Step 1 above. If you feel your client needs a reminder, you may summarize the intro script or re-read it.

3. Session #3
   a. Explain to the client that you will be asking them to complete the study materials at the very end of this session. Reassure them it will take 5-10 minutes to complete and that their responses will be kept confidential in a tamper-proof envelope that will only be reopened by the Principal Investigator.
   
   b. Repeat steps (1)(b), (1)(c), and (1)(d) above.
   
   c. After you have finalized your note, do the following:
      • Open one of the pre-made study envelopes.
• Ask the client-participant to complete the blue packet. Emphasize that you
will not see their responses and they will be kept confidential.
• While the client-participant completes the blue packet, you will
complete the white packet.
• Allow adequate space and privacy for your client to complete their
packet.
• Do not share or discuss your responses with the client-participant.
• Do not permit the client-participant to share their responses with you.
• If the client-participant asks any questions about the materials, please
refer them back to the instructions on the first page of their packet or
at the top of each questionnaire. Please do not provide further
instructions beyond what they have read.
• Once all materials are completed, hand your white packet to the
client-participant and ask them to return it along with their blue
packet to the envelope and seal the tamper-proof seal. Tell the client
you will not reopen the envelope and that the Study Coordinator will
check for evidence of tampering.

d. Return the sealed envelope to your agency’s designator Study Coordinator,
   [name], as soon as possible.

4. Remember, if you forget to complete the materials at the end of the SESSION 3, please
try again at the conclusion of SESSION 4, 5, or 6. Do not attempt to complete materials
after SESSION 6.

5. Should you have any questions at any time, please feel free to contact:

   Robert DiCarlo          Dr. Evie Garcia
   Principal Investigator  Faculty Supervisor
   Phone number            Phone number
   Email                   Email
PS Group - Therapist Instructions Overview

General Overview:
- In this study, your role is as the “therapist-participant.” You will be conducting individual therapy sessions with your clients (the "client-participant") in a manner consistent with your usual therapy process.

- You will administer study materials for all new therapy clients you see during the study’s data collection period. You will be notified by the agency when data collection is complete.

- If you have provided therapy for a client-participant during a previous treatment episode (i.e., returning client), the client-participant is not eligible for the study. Only administer study materials to clients for whom you are treating for the first time in individual general mental health therapy.

- You have received a set of pre-assigned study envelopes. Please keep the envelopes where you conduct therapy sessions. Please do not trade envelopes with other therapists, as they are uniquely coded to you. There is one study envelope per client-participant. You will complete one packet per study participant.

- All client-participants will be flagged in the client’s electronic health record. Every time you access a client-participant’s record, you will be notified of their participation in the study.

- Conduct all therapy sessions with client-participants in your usual manner through the duration of the data collection period. If needed, reference the orientation materials provided by the Principal Investigator.

- Study materials (i.e., questionnaires) will only be administered at the end of the THIRD SESSION with each client-participant. If you forget to administer the study materials at the end of the THIRD SESSION, please attempt to do so after either session 4, 5, or 6. Please do not administer the materials beyond the SIXTH SESSION.

Procedure:
1. Session #1 (post-intake)
   a. Conduct your therapy session in your usual manner, using your usual therapy process.

   b. If you typically implement Collaborative Documentation in your sessions, please do not do so with client-participants for the duration of the study.

2. Session #2
   a. Conduct your therapy session as indicated above.

Collaborative Documentation Study
Therapist Instructions, PS Group
3. Session #3
   a. Explain to the client that you will be asking them to complete the study materials at the very end of this session. Reassure them it will take about 5 minutes to complete and that their responses will be confidential in a tamper-proof envelope that will only be reopened by the Principal Investigator.

   b. Conduct your therapy session as indicated in Step 1 and Step 2 above.

   c. **After you have completed your entire session, do the following:**
      - Open one of the pre-made study envelopes.
      - Ask the client-participant to complete the blue packet. Emphasize that you will not see their responses and they will be kept confidential.
      - While the client-participant completes the blue packet, you should complete the white packet.
      - Allow adequate space and privacy for your client to complete their packet.
      - Do not share or discuss your responses with the client-participant.
      - Do not permit the client-participant to share their responses with you.
      - If the client-participant asks any questions about the materials, please refer them back to the instructions on the first page of their packet or at the top of the questionnaire. Please do not provide further instructions beyond what they have read.
      - **Once all materials are completed, hand your white packet to the client-participant and ask them to return it along with their blue packet to the envelope and seal the tamper-proof seal. Tell the client you will not reopen the envelope and that the Study Coordinator will check for evidence of tampering.**
      - Dismiss your client.

   d. Return the sealed envelope to your agency's designator Study Coordinator, [name], as soon as possible.

4. Remember, if you forget to complete the materials at the end of the SESSION 3, please try again at the conclusion of SESSION 4, 5, or 6. Do not attempt to complete materials after SESSION 6.

5. Should you have any questions at any time, please feel free to contact:

   - **Robert DiCarlo**
     - Principal Investigator
   - **Dr. Evie Garcia**
     - Faculty Supervisor
   - **Phone number**
   - **Phone number**
   - **Email**
   - **Email**
The following questionnaire is intended to help solidify your understanding of the training on Collaborative Documentation and the study procedures that you just received.

Please keep in mind that there are no “right” or “wrong” answers to any of the questions. The purpose is to stimulate thought about the training and to help clarify the process for which you have agreed to participate in with your clients. We will discuss the responses as a group. Please feel free to take notes on this page for later use. I will make copies and return your questionnaire before the study begins.

1. Please describe the difference between traditional documentation practices and Collaborative Documentation practices.

2. Please describe the role of the therapist-participant in this study.

3. Please describe the role of the client-participant in this study.

4. Place the following therapist-participant procedure steps in the correct chronological order by marking the correct number in the space provided:
   
   _____ Administer study materials (e.g., questionnaires).
   _____ Read Introduction Script.
   _____ Conduct talk portion of therapy session.
   _____ Read Transition Statement.
   _____ Dismiss the client.
   _____ Collaboratively document the session.
5. Please respond to these true/false questions:

   a. T  F Therapist-participants must read to the client from the provided introduction script during the first session.
   b. T  F The therapist-participant will review the client-participant responses to the questionnaires.
   c. T  F The therapist-participant and the client-participant discuss responses to the questionnaire if the client-participant requests to do so.
   d. T  F The therapist-participant completes her or his questionnaire after the client leaves.
   e. T  F If the therapist-participant forgets to introduce the questionnaires by the third session, the questionnaires may be introduced during the 4th, 5th, or 6th session.
   f. T  F Indicating the session in which the questionnaires were completed is important.
   g. T  F The therapist-participant must summarize or read the progress note to the client participant.
   h. T  F Suggestions, comments, and disagreements expressed by the client should be included in the progress note.
   i. T  F A client or therapist may opt out of the study at any time.
   j. T  F It is acceptable to administer the study materials after the Seventh Session with the client.
   k. T  F If I have seen a client-participant during a previous treatment episode before the study’s data collection period, I should administer the study materials as indicated on the third session.
6. Please identify three questions that the therapist-participant might ask the client-participant in order to engage the client-participant in the Collaborative Documentation process:
   a. 
   b. 
   c. 

7. Please describe how therapist-participants will identify which clients have agreed to participate in the study.

NOTES:
Therapist Training Quiz, PS Group Agency

PS Group Agency
STUDY PROCEDURES TRAINING QUIZ

The following questionnaire is intended to help solidify your understanding of the training on the study procedures that you just received.

Please keep in mind that there are no “right” or “wrong” answers to any of the questions. The purpose is to stimulate thought about the training and to help clarify the process for which you have agreed to participate with your clients. We will discuss the responses as a group. Please feel free to take notes on this page for later use. I will make copies and return your questionnaire before the study begins.

1. Please describe the role of the therapist-participant in this study.

2. Please describe the role of the client-participant in this study.

3. Place the following therapist-participant procedure steps for the THIRD SESSION in the correct chronological order by marking the correct number in the space provided:
   
   ___ Administer the study materials.
   ___ Have client seal study materials in envelope.
   ___ Conduct your session as usual.
   ___ Inform client you will be asking them to complete study materials at end of session.
   ___ Return envelope to Study Coordinator.

4. Please respond to these true/false questions:

   a. T  F  The therapist-participant will review the client-participant responses to the questionnaires.

   b. T  F  The therapist-participant and the client-participant discuss responses to the questionnaire if the client-participant requests

Collaborative Documentation Study
PS Therapist Training Questionnaire
PS Group Agency
STUDY PROCEDURES TRAINING QUIZ

to do so.

c. T F The therapist-participant completes her or his questionnaire after the client leaves.
d. T F If the therapist-participant forgets to introduce the questionnaires by the third session, the questionnaires may be introduced during the 4th, 5th, or 6th session.
e. T F Indicating the session in which the questionnaires were completed is important.
f. T F A client or therapist may opt out of the study at any time.
g. T F It is acceptable to administer the study materials after the Seventh Session with the client.
h. T F If I have seen a client-participant during a previous treatment episode before the study’s data collection period, I should administer the study materials as indicated on the third session.
i. T F If I use collaborative documentation as part of my usual therapy workflow, I should continue to do so during the course of this study.

5. Please describe how therapist-participants will identify which clients have agreed to participate in the study.

NOTES:
Appendix I

Collaborative Documentation Training Slides, CD Group Agency

COLLABORATIVE DOCUMENTATION IN COMMUNITY BEHAVIORAL HEALTHCARE

Robert DiCarlo, MA, LAC, NCC

OBJECTIVES
- Define Collaborative Documentation in a client-centered manner.
- Discover benefits of shared note-taking
- Apply collaborative documentation in an effective manner with clients.
- Adjusting clinical assumptions or fears in using the method.
- Adapting clinical language to a shared format.
- Practice!

RECORD KEEPING ETHICS: COUNSELORS
- Create, safeguard, and maintain documentation necessary for rendering professional services
- Sufficient and timely documentation to facilitate the delivery and continuity of services
- Accurately reflects client progress and services provided
- Limit clients’ access to records only when compelling evidence exists that such access would cause harm to the client

2014, American Counseling Association Code of Ethics

RECORD KEEPING ETHICS: PSYCHOLOGISTS
- Facilitate provision of services later by them or by other professionals
- Meet institutional requirements
- Ensure accuracy of billing and payments
- Ensure compliance with law

2010, APA Ethical Principles of Psychologists and Code of Conduct; Standard 6.01.

RECORD KEEPING ETHICS: SOCIAL WORKERS
- Accurate and reflect services provided.
- Sufficient and timely in order to facilitate delivery of services and to ensure continuity.
- Protects privacy to the extent possible.
- Only information directly relevant to services.

2008, National Association of Social Workers; Standard 3.04

CLINICAL WORK FLOW
- Assessment
- Diagnosis
- Plan: Goals
- Plan: Objectives
- Services: Interventions
- Document
- Document
- Document
- Document

192
BALANCING NEEDS

Organizational Benefits

Client/Therapeutic Benefits

BALANCING THE NEEDS

Client & Therapist

Agency

Client & Therapist

Agency

Productivity

Timeliness

Accuracy

Cost Containment

Alliance

Trust

Change/Growth

Work/personal balance

TRADITIONAL DOCUMENTATION (POST-SESSION)

Conduct 45-50 minute psychotherapy session

Client departs

Therapist completes progress note asynchronously

Client may request record later

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• Arrive at 7 am to review emails you couldn’t get to yesterday.

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• Your 8 am client is 30 minutes early.

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• Take your 8 am client at 7:35; you’re ahead!
• Client leaves at 8:25 am.
• You’ve earned 35 minutes!

• You just got an email. A friendly reminder from your supervisor. Don’t forget about your continuing education due by tomorrow.

• Complete continuing ed. online for 35 minutes. You’re done!

• It’s 9 am. You’re next client is here.
• Answer two emails before getting her.

• You’re seeing your 9 am.
• You remember you didn’t do your progress note for your 8 am.
• You’ll do it at lunch.

• You’re 9 am told you she was suicidal at 9:55 am.
• Activate crisis team.
• Lose 18 minutes.
• You’re 10 am is waiting. Impatiently.
A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• Get your 10 am at 10:20 am.
• Anticipate being late for your 11 am.
• No lunch after all.

12:50 pm.
• You’ve answered three emails, but 12 have come in since.
• You ate a protein bar but you’re still hungry.

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• Fast forward. It’s 4:50 pm.
• 6 of your 8 clients showed.
• You haven’t done any notes.
• You had dinner plans at 6 pm.

Likely your client is going inpatient; better prioritize your crisis notes.
• Attempt to finish your 5 other progress notes.
• You finish 3, but not to worry—you’ll come in early tomorrow
• You’ve got 15 new emails before you shut down your computer.
• You’re 20 minutes late to dinner.

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• It’s tomorrow. Repeat.
• Don’t worry, you’ll come in Saturday to tie up loose ends.

A DAY IN THE LIFE OF AN 8-TO-5 COMMUNITY BEHAVIORAL HEALTHCARE EMPLOYEE

• A time void?
• A necessary evil?
• A clinical tool?
• A therapeutic tool?
COLLABORATIVE DOCUMENTATION
- A form of record keeping whereby the therapist prepares progress notes in a transparent, collaborative manner with the client during the therapy session.

- “A clinical tool that provides clients with the opportunity to provide their input and perspective on services and progress, and allows clients and clinicians to clarify their understandings of important issues” (Schmelter, 2012).

COLLABORATIVE DOCUMENTATION
- Necessitates cooperation between client and therapist
- Encourages a multidirectional flow of information
- Clients provide input and perspectives

COLLABORATIVE DOCUMENTATION
- Completed concurrently (in-session) with client present
- Clarification of important aspects of session
- Complimentary with electronic record keeping
CITED BENEFITS

- Saves time
- Increases capacity
- Increased accuracy (compliance)
- Increased timeliness (compliance)
- Improves quality of life for therapist

CITED BENEFITS OF CD

- Therapists spent less than 9 fewer post-session documentation hours per week.
- Increases service capacity to 20%
- Conversion to collaborative documentation led to 25% drop in staff sick time

MTM Services pilot study data (n.d.)

WHAT DO CLIENTS SAY?

HOW HELPFUL WAS IT TO YOU TO HAVE YOUR PROVIDER REVIEW YOUR NOTE WITH YOU AT THE END OF THE SESSION?

- Very Helpful
- Helpful
- Neutral
- Not Helpful
- Very Unhelpful
- No Answer

MTM Services data (n.d.)
N = 7833

HOW INVOLVED DID YOU FEEL IN YOUR CARE COMPARED TO PAST EXPERIENCES (EITHER THIS AGENCY OR OTHERS)?

- Very Involved
- Involved
- Same
- Not Involved

MTM Services data (n.d.)
N = 6816

HOW WELL DO YOU THINK YOUR PROVIDER DID IN INTRODUCING AND USING THIS NEW SYSTEM?

- Very Good
- Good
- Average
- Poor (0%)
- Very Poorly
- No Answer

MTM Services data (n.d.)
N = 6816

MTM Services data (n.d.)
N = 7833
IN THE FUTURE, WOULD YOU WANT YOUR PROVIDER TO CONTINUE TO REVIEW YOUR NOTE WITH YOU?

- Yes: 77%
- Unsure: 5%
- No: 18%

N = 6,167

MTM Services data (n.d.)

POSSIBLE THERAPEUTIC BENEFITS
- Improves client engagement in therapy
- Clarification of important aspects of therapy
- Transparency
- Facilitates bonding and trust

THERAPEUTIC ALLIANCE → PSYCHOTHERAPY OUTCOMES
- Agreement on Tasks
- Agreement on Goals
- Feeling Heard
- Empathy
- Commitment
- Trust
- Respect
- Feedback

Horvath, Del Re, Fluckiger, & Simmonds, 2011

THERAPEUTIC ALLIANCE → PSYCHOTHERAPY OUTCOMES
- The strongest predictor of positive psychotherapy outcome is the strength of the therapeutic alliance.
- Clients improvement is significantly improved when feedback is sought.

Duncan, Miller, Wampolt, & Hubble, 2010; Horvath, Del Re, Fluckiger, & Simmonds, 2011; Lambert, 2010

COLLABORATIVE DOCUMENTATION STEPS OVERVIEW
1. Role Induction: Introduce clients to shared note taking
2. Conduct your session as you normally would.
3. After about 45-50 minutes, transition into note taking.
4. Engage client in the process.
5. Finalize your note with the client present.
6. End the session.
INTRODUCING CLIENTS:
ONSET OF SESSION

- Use the term “collaborative documentation” or a variation.
- Inform client they will be participating in developing a note that describes your session together.
- Frame it as an invitation rather than a requirement.
- Note that your assessment will be included in the discussion.

- Inform client they can agree/disagree with that assessment and their comments will be included.
- Discuss that you seek to clarify issues through discussion.
- Emphasize that it is important they speak up with their ideas/opinions.
- Inform client you will place plans/homework in the note.

MIDWESTERN COLORADO CENTER FOR MENTAL HEALTH
SAMPLE SCRIPT

“Because this record is your record, and in an attempt to build therapeutic trust, we will develop a note at the end of our session that describes what we talked about during this session. This note needs to include a description of what we discussed and did during the session. I will include my assessment, but if you have either support or disagreement with what I wrote let me know and I will include your comments. We could also discuss any agreements or disagreements you have, to help clarify issues. It is important for you to speak up with your ideas and opinions. We will also place in the note any plans we develop for the next meeting and any homework you or I need to do to help with your treatment.”

Adapted from Midwestern Colorado Center for Behavioral Health

TRANSITION INTO NOTE

- We’re getting close to the end of session. Let’s stop here and review what we talked about.
- Now let’s work together to document the important accomplishments/ideas/work that we have done today.
- What you shared is important. I want to capture this information.

NOTE TAKING

- Invite clients to sit next to you at the computer.
- Make eye contact when not typing/reading.
- Ask engaging questions to help client participate.
- Summarize or read directly each element of the note.

- Ask if they agree or disagree with anything.
- Document differences of opinion collaboratively.
- Finalize/submit the note with the client.
IDEAS FOR ENGAGEMENT

- What did you see as the most important aspects of our session today?
- What did you learn today?
- How do you feel the session went?
- What do you feel we accomplished today?
- How would you describe your mood today?

CLINICIAN FEARS & ASSUMPTIONS

ASSUMPTION | ALTERNATIVE
--- | ---
It will be disruptive to session flow. | Proper introduction will help clients anticipate flow and tasks during session.
Proper introduction will help clients anticipate flow and tasks during session. | It may help add structure and predictability to your sessions.

ASSUMPTION | ALTERNATIVE
--- | ---
Collaborative documentation seeks to involve clients in a meaningful and therapeutic way. | Jargon-free, person-centered notes may be of more therapeutic value to clients.
Clients don’t have the clinical knowledge to interpret what is written. | Jargon-free, person-centered notes may be of more therapeutic value to clients.

ASSUMPTION | ALTERNATIVE
--- | ---
You do this anyway. Why not have an open, therapeutic discussion about it? | Framing notes in a non-judgemental manner may bring relief to clients who may feel a deep sense of shame because of their behaviors.
Clients won’t appreciate being labeled. | You do this anyway. Why not have an open, therapeutic discussion about it?
Clients will feel shamed. | Framing notes in a non-judgemental manner may bring relief to clients who may feel a deep sense of shame because of their behaviors.
CLINICIAN FEARS & ASSUMPTIONS

ASSUMPTION
Clients will be devastated to see what you think of them.

ALTERNATIVE
Clients may feel comforted, as their own self-evaluations may be much more critical than yours.
Clients may come to realize their self-impressions are unwarranted.
Worry is reduced.

Kahn, 2014

ASSUMPTION
Clients won't be able to speak up if you got something wrong in the record.

ALTERNATIVE
This discounts the benefits for clients to fact-check their own histories.
Promotes self-advocacy and assertiveness skills.

Kahn, 2014

ASSUMPTION
Confrontation is difficult for me as a therapist.

ALTERNATIVE
Confrontation is a therapeutic skill not unique to documentation.
Collaborative documentation provides a structured way of providing feedback, including confrontation.

Kahn, 2014

ASSUMPTION
It's not fair to my client for me to be documenting when they're having a crisis or need my full attention.

ALTERNATIVE
Yes.
Collaborative documentation is not appropriate in every therapeutic encounter.

Kahn, 2014

ASSUMPTION
Collaborative documentation will make my client who is paranoid or otherwise delusional more paranoid.

ALTERNATIVE
Maybe.
Alternatively, it may increase transparency to the degree your client has little to draw inappropriate conclusions about, thus improving trust.

Kahn, 2014

OTHER FEARS OR ASSUMPTIONS!

What hesitations do you have as clinicians in using this practice?
**OTHER FEARS OR ASSUMPTIONS!**

What hesitations do you anticipate your clients having in accepting this practice?

Kahn, 2014

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**ADAPTING CLINICAL LANGUAGE**

Let's review some ways to think about writing clinical notes differently.

Kahn, 2014

---

**ADAPTING CLINICAL LANGUAGE**

Ms. Jones and I continued our discussion on her tendency to use 'black-or-white-thinking' in ways that make her relationships at work problematic.

Kahn, 2014

---

**ADAPTING CLINICAL LANGUAGE**

Mr. Smith and I continue to 'agree to disagree' about his conviction that his apartment is bugged.

Kahn, 2014

---

**ADAPTING CLINICAL LANGUAGE**

Ms. Williams expressed dissatisfaction with my treatment decisions quite clearly, but preferred not to talk about that today. I encouraged her to discuss our disagreements in the future.

Kahn, 2014

---

**ADAPTING CLINICAL LANGUAGE**

Avoiding shaming clients:

Mr. Martin and I continued our discussion of his addictive behavior and reviewed techniques for dealing with it.

Kahn, 2014
ADAPTING CLINICAL LANGUAGE

On Personality Disorders:

“Many of these patients have some awareness that their behavior is troublesome, but a deep sense of shame inhibits their acknowledging it. Inviting them to read accurate and nonjudgmental notes may help diminish their shame. Even patients with severe personality disorders can be relieved to know that the turbulence and unhappiness that permeates their lives reflects suffering from a familiar clinical entity shared by others, rather than ‘being a bad person.’”

Kahn, 2014

ADAPTING CLINICAL LANGUAGE

Before:

- “Client is in denial about her role in conflict.”
- “Client is in denial about her role in conflict.”
- “Client lacks insight into how she can be more responsive in meeting spouse’s needs.”
- “Client lacks insight into how she can be more responsive in meeting spouse’s needs.”
- “Client struggles to understand the needs of her spouse and what she can do to improve their situation.”

After:

- “Client has difficulty identifying her behaviors that contribute to conflict in the relationship.”
- “Client has difficulty identifying her behaviors that contribute to conflict in the relationship.”
- “Client struggles to understand the needs of her spouse and what she can do to improve their situation.”

CONTRAINDICATIONS?

In what types of clinical encounters do you foresee collaborative documentation being unhelpful or contraindicated?
QUESTIONS/CONCERNS

- What other thoughts, concerns, or questions do you have about using this method of record keeping?

DEMONSTRATION

- One volunteer to play a client role.
- Discuss a current issue/problem you are comfortable discussing in front of the group.
- Five-minute session followed by collaborative documentation.

GROUP PRACTICE

- Break into dyads: One partner role plays therapist, while the other role plays client.
- Handouts:
  - Collaborative Documentation Intro/Transition Scripts.
  - Vignette description.
  - "Therapist" reads intro script.
  - "Client" will talk for about 5 minutes based on vignette.
  - "Therapist" reads transition script.
  - Therapist and Client collaborative document.

DISCLOSURES

- Collaborative documentation is not this presenter’s concept. It is being used across the nation in various capacities.
- Initially launching Open Access initiatives, including the use of concurrent collaborative documentation.
- As a researcher, this presenter is studying the therapeutic effects of collaborative documentation in community behavioral healthcare settings.
- I am presently participating in a research project in which this presenter is the Principal Investigator. The project was approved by Northern Arizona University’s Institutional Review Board (IRB) on October 11, 2016.

REFERENCES

American Psychological Association (2010). Ethical principles of psychologists and code of conduct. Washington, DC.
THANK YOU FOR YOUR TIME

For more information, please contact:
Robert DiCarlo, M.A.
Principal Investigator
(928) 699-4892
rcd23@nau.edu
Appendix J

Study Packet Cover Sheet/Instructions, Client Version (identical for both groups)

CLIENT

Dear Study Participant,

Please complete the attached questionnaires. Your therapist should not see your responses. Please do not discuss your responses with your therapist at this time. Once completed, place the materials along with the pages your therapist completed into the tamper-proof envelope provided. Seal the envelope and return to your therapist. The envelope will only be reopened by the Principal Investigator.

If you have any questions at any time, please contact:

Robert DiCarlo  
Principal Investigator  
(XXX) XXX-XXXX  
email@nau.edu

Dr. Evie Garcia  
Faculty Supervisor  
(XXX) XXX-XXXX  
email@nau.edu

Participant ID

Collaborative Documentation Study  
Client Instructions, CD Group
THERAPIST

Please complete the following items at the end of your third session, AFTER you have submitted your clinical note and while your client is still present.

Procedure Overview:
1. Provide the blue packet labeled “CLIENT” to your client and ask them to complete.
2. You complete the page(s) attached to this document while your client completes the blue packet.
3. If your client asks you questions while completing the packet, please refer them back to the instructions on their packet and ask them to do their best. Please do not attempt to explain the materials further.
4. Allow adequate space and privacy for your client to complete their packet.
5. Do not share or discuss your responses with your client.
6. Do not permit your client to share or disuses their responses with you.
7. Once all materials are completed, hand your white packet to the client-participant and ask them to place it along with their blue packet to the tamper-proof envelope and seal. Tell the client that only the Principal Investigator will reopen the envelope.
8. Return the study envelope to the Study Coordinator, [name], as soon as possible.

Participant ID

If you have any questions or concerns at any time, please contact:

Robert DiCarlo
Principal Investigator
(XXX) XXX-XXX
email@nau.edu

Dr. Evie Garcia
Faculty Supervisor
(XXX) XXX-XXX
email@nau.edu
THERAPIST

Please complete the following items at the end of your third session, AFTER you have submitted your clinical note and while your client is still present.

Procedure Overview:

1. Provide the blue packet labeled “CLIENT” to your client and ask them to complete.
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3. If your client asks you questions while completing the packet, please refer them back to the instructions on their packet and ask them to do their best. Please do not attempt to explain the materials further.
4. Allow adequate space and privacy for your client to complete their packet.
5. Do not share or discuss your responses with your client.
6. Do not permit your client to share or disuse their responses with you.
7. Once all materials are completed, hand your white packet to the client-participant and ask them to place it along with their blue packet to the tamper-proof envelope and seal. Tell the client that only the Principal Investigator will reopen the envelope.
8. Return the study envelope to the Study Coordinator, ______________________, as soon as possible.

Participant ID

If you have any questions or concerns at any time, please contact:

Robert DiCarlo                      Dr. Evie Garcia
Principal Investigator             Faculty Supervisor
(xxx) xxx-xxxx                      (xxx) xxx-xxxx
email@nau.edu                      email@nau.edu

Collaborative Documentation Study
Therapist-Participant Packet, PS Group
Appendix K

Collaborative Documentation Scripts

INTRODUCTION SCRIPT: READ AT ONSET OF SESSION

This is your record, and because we are trying to build therapeutic trust, I want your input. So we will develop a note at the end of our session that describes what we talked about during this session. This note needs to include a description of what we discussed and did during the session. I will include my assessment, and if you agree or disagree with what I write, let me know and I will include your comments. We could also discuss any agreements or disagreements you have, to help clarify issues. It is important for you to speak up with your idea and opinions. We will also place in the note any plans we develop for the next meeting and any homework you or I need to do to help with your treatment.

TRANSITION SCRIPT: READ ABOUT 50 MINUTES INTO SESSION

We’re getting close to the end of session. Let’s stop here and review what we talked about. We can work together to document the important ideas that we’ve worked on this session.

-Continued on back

Collaborative Documentation Study
Introduction Script, 7.20.16; Revised 8.28.16
Appendix L

Therapist Interview Recruitment Script

Greetings,

Thank you for your gracious participation in the Collaborative Documentation Study at Spectrum Healthcare. Your participation has been an important step in understand the emerging practice Collaborative Documentation (CD).

I am seeking volunteers to be interviewed regarding their experiences using CD during the study period. I would like to better understand your unique perspectives on what worked, what was difficult, and what you liked or disliked about CD.

Participation in interviews is VOLUNTARY. If you participated in other aspects of the CD study, you are NOT required to participate in follow up interviews. To be eligible for the interview, the following conditions must be met:

1. You have previously consented to be in the CD study by this doctoral student researcher;
2. You have attended the CD Training by this researcher (either in person or by archived video) on or after November 9, 2016;
3. You have used CD with at least one client since receiving the CD training.

Interviews will take approximately one hour and will occur at Spectrum Healthcare in a private office in February 2017 at a time of your convenience. If you agree to participate, your interview can be arranged to occur before or after your work shift to reduce any interruption to your work day.

I am happy to provide additional details to potential volunteers. You are welcome to contacting me using the information below. General information about the interviews include:

- Interviews will be audio recorded. After the interviews are analyzed, the recordings will be destroyed in a secure manner.
- You will only be referred to in the recordings by a pseudonym.
- No identifying information or statements will be used in my write ups of the interviews.

If interested, please call (xxx) xxx-xxxx or email email@email.com You can review the attached informed consent document for additional information.

Respectfully,

Robert DiCarlo, M.A., L.A.C., N.C.C.
Doctoral Candidate in Counseling Psychology
Department of Education Psychology
Northern Arizona University

Collaborative Documentation Study
Therapist Interview Recruitment Script
Collaborative Documentation Study
Semi-Structured Interview Guide for CD Therapists

1. What is your understanding of collaborative documentation? What does it mean?
2. Approximately how many clients have you used CD with since you received the training by me in November 2016?
3. How closely would you say you followed the CD protocol as outlined by the study procedures (subject will be offered a copy of the initial study procedure sheet and “Therapist-Participant Checklist” for review).
4. How did you feel about sharing notes with your clients during the session?
   - What thoughts did you have regarding the process while it was occurring?
5. What did you find helpful about collaborative documentation?
   - What was unhelpful about it?
6. Did you take notes or document during the main portion of your session, or at the end?
   - How did that impact your experience delivering therapy?
7. Without identifying your clients or their specific clinical problems, what sort of feedback did clients provide about the quality of your collaborative summaries at the end of sessions?
   - What feedback did your clients give about the accuracy of your summary?
   - Can you think of any specific examples of feedback you received with a recent case (do not provide identifying information about your client)?
8. How comfortable were you in having a frank conversation about what had occurred in therapy with your client?
   - What types of information did you discuss (do not provide any identifying information about your client)?
9. Did you feel that collaborating in recordkeeping with your client was a good use of your time in therapy? Why or why not?
   - How did this impact your feelings towards the process of CD? To the therapy process?
10. Imagine you had a colleague who DID NOT use CD with her or his clients. What would you share with her/him about your own experience using CD?
    - Would you be likely to encourage your colleague to use CD? Why or why not?
11. What did you like the least about CD? Why?
12. Did your clients have anything negative to say about CD? What did they share?
13. Did your clients have anything positive to say about CD? What did they share?
14. What would need to be different about CD to make it a more useful tool for you as a therapist?
15. Did you feel you have the tools/skills/resources to effectively use CD?
16. Did you feel you had sufficient support from Spectrum to effectively use CD?
17. Do you plan to continue using CD in your clinical practice? Why or why not?
Appendix M

IRB Approval Letters

To: Robert DiCarlo, MA
From: NAU IRB Office
Date: October 12, 2016

Project: COLLABORATIVE DOCUMENTATION IN COMMUNITY
BEHAVIORAL HEALTH: THE IMPACT OF SHARED RECORD
KEEPING ON THERAPEUTIC ALLIANCE

Project Number: 922041-1
Submission: New Project
Review Level: Expedited Review
Action: APPROVED WITH CONDITIONS
Project Status: Active - Open to Enrollment
New Approval Expiration Date: October 11, 2017

Review Category(ies): Expedite Approval (45 CFR 46.110 Category 5): Research
involving materials (data, documents, records, or specimens)
that have been collected, or will be collected solely for nonresearch
purposes (such as medical treatment or diagnosis).

Expedite Approval (45 CFR 46.110 Category 6): Collection of data
from voice, video, digital, or image recordings made for research
purposes.

Expedite Approval (45 CFR 46.110 Category 7): Research on
individual or group characteristics or behavior (including, but not
limited to, research on perception, cognition, motivation, identity,
language, communication, cultural beliefs or practices, and social
behavior) or research employing survey, interview, oral history,
focus group, program evaluation, human factors evaluation, or
quality assurance methodologies.

Condition to approval: An amendment will be submitted by the PI
to implement security measures recommended by the IT team, if
any additional protections are necessary.

This submission meets the criteria for approval under 45 CFR 46.110, 45 CFR 46.111 and/or 21 CFR 50
and 21 CFR 56. This project has been reviewed and approved by an IRB Chair or designee.

- No changes to a project may be made prior to IRB approval except to eliminate apparent immediate
  hazard to subjects.
- Northern Arizona University maintains a Federalwide Assurance with the Office for Human
  Research Protections (FWA #0000357).
- All research procedures should be conducted in full accordance with all applicable sections of the
  guidance.
- The current consent with the IRB approval stamp must be used to consent subjects.
• The Principal Investigator should notify the IRB immediately of any proposed changes that affect the protocol and report any unanticipated problems involving risks to participants or others. Please refer to Guidance Reporting Local Information.

• The Principal Investigator is responsible for monitoring and maintaining the integrity of the approved research protocols, immediately reporting any adverse events, and submitting all required reports in a timely manner. Please refer to Guidance Investigators Responsibility after IRB Approval.

• For projects that wish to continue after the expiration date listed above please submit a Continuing Review Progress Report, forty-five (45) days before the expiration date, to ensure timely review of the project.

• All documents referenced in this submission have been reviewed and approved. Documents are filed with the HRSP Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HRSP Office.
To: Robert DiCarlo, MA
From: NAU IRB Office
Date: December 5, 2016

Project: COLLABORATIVE DOCUMENTATION IN COMMUNITY
BEHAVIORAL HEALTH: THE IMPACT OF SHARED RECORD
KEEPING ON THERAPEUTIC ALLIANCE

Project Number: 922041-2
Submission: Amendment/Modification
Review Level: Expedited Review
Action: APPROVED
Project Status: Active - Open to Enrollment
Approval Expiration Date: October 11, 2017

Review Category/ies:

Expedites Approval (45 CFR 46.110 Category 5): Research
involving materials (data, documents, records, or specimens)
that have been collected, or will be collected solely for nonresearch
purposes (such as medical treatment or diagnosis).

Expedites Approval (45 CFR 46.110 Category 6): Collection
of data from voice, video, digital, or image recordings made
for research purposes.

Expedites Approval (45 CFR 46.110 Category 7): Research on
individuals or group characteristics or behavior (including, but not
limited to, research on perception, cognition, motivation, identity,
language, communication, cultural beliefs or practices, and social
behavior) or research employing survey, interview, oral history,
focus group, program evaluation, human factors evaluation, or
quality assurance methodologies.

This submission meets the criteria for approval under 45 CFR 46.110, 45 CFR 46.111 and/or 21 CFR 50
and 21 CFR 56. This project has been reviewed and approved by an IRB Chair or designee.

- No changes to a project may be made prior to IRB approval except to eliminate apparent immediate
  hazard to subjects.
- Northern Arizona University maintains a Federalwide Assurance with the Office for Human
  Research Protections (FWA #00000357).
- All research procedures should be conducted in full accordance with all applicable sections of the
  guidance.
- The current consent with the IRB approval stamp must be used to consent subjects.
- The Principal Investigator should notify the IRB immediately of any proposed changes that affect the
  protocol and report any unanticipated problems involving risks to participants or others. Please refer
  to Guidance Reporting Local Information.
• The Principal Investigator is responsible for monitoring and maintaining the integrity of the approved research protocols, immediately reporting any adverse events, and submitting all required reports in a timely manner. Please refer to Guidance Investigators Responsibility after IRB Approval.
• For projects that wish to continue after the expiration date listed above please submit a Continuing Review Progress Report, **forty-five (45)** days before the expiration date, to ensure timely review of the project.
• All documents referenced in this submission have been reviewed and approved. Documents are filed with the HRSP Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HRSP Office.
To: Robert DiCarlo, MA
From: NAU IRB Office
Date: January 25, 2017

Project: COLLABORATIVE DOCUMENTATION IN COMMUNITY
BEHAVIORAL HEALTH: THE IMPACT OF SHARED RECORD
KEEPING ON THERAPEUTIC ALLIANCE

Project Number: 922041-3
Submission: Amendment/Modification
Review Level: Expedited Review
Action: APPROVED
Project Status: Active - Open to Enrollment
New Approval Expiration Date: October 11, 2017

Review Category/ies:

- Expedite Approval (45 CFR 46.110 Category 5): Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).
- Expedite Approval (45 CFR 46.110 Category 6): Collection of data from voice, video, digital, or image recordings made for research purposes.
- Expedite Approval (45 CFR 46.110 Category 7): Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

This submission meets the criteria for approval under 45 CFR 46.110, 45 CFR 46.111 and/or 21 CFR 50 and 21 CFR 56. This project has been reviewed and approved by an IRB Chair or designee.

- No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.
- Northern Arizona University maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00000357).
- All research procedures should be conducted in full accordance with all applicable sections of the guidance.
- The current consent with the IRB approval stamp must be used to consent subjects.
- The Principal Investigator should notify the IRB immediately of any proposed changes that affect the protocol and report any unanticipated problems involving risks to participants or others. Please refer to Guidance Reporting Local Information.
• The Principal Investigator is responsible for monitoring and maintaining the integrity of the approved research protocols, immediately reporting any adverse events, and submitting all required reports in a timely manner. Please refer to Guidance Investigators Responsibility after IRB Approval.
• For projects that wish to continue after the expiration date listed above please submit a Continuing Review Progress Report, forty-five (45) days before the expiration date, to ensure timely review of the project.
• All documents referenced in this submission have been reviewed and approved. Documents are filed with the HRSP Office. If subjects will be consented the approved consent(s) are attached to the approval notification from the HRSP Office.