DEPARTMENT OF MENTAL HEALTH
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QUALITY ASSURANCE
POLICY AND TECHNICAL DEVELOPMENT

COLLABORATIVE DOCUMENTATION MANUAL

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Chapter 1:

What is Collaborative Documentation?

Collaborative Documentation is a process in which practitioners (including social workers, psychologists, and case managers) and clients work together to document assessments, treatment plans, and progress notes. Collaborative Documentation emerged from client centered approaches to treatment and emphasizes the client's role in the decision-making process. It focuses on ensuring that the client's personal goals and needs are addressed in treatment. Ultimately, Collaborative Documentation is a practice by which documentation of services is accomplished, and should not be regarded as a formalized EBP.

Why Use Collaborative Documentation?

Clinically, Collaborative Documentation yields clinical benefits such as enhanced mutual understanding between the practitioner and client and a greater sense of engagement and commitment by the client. Collaborative Documentation allows clients to have greater ownership and responsibility in their treatment. The collaborative process enhances the rapport between client and practitioner and increases clients' understanding of and involvement with their treatment. Empirical support for Collaborative Documentation includes a controlled study with three community mental health clinics serving the chronically mentally ill which found Collaborative Documentation to have a significant effect on the reduction of no-show's and an increase in medication adherence.

Administratively, Collaborative Documentation allows practitioners to complete their documentation during the session in a clinically efficient way. This ensures all documentation is completed in a timely manner and reduces the stress of incomplete documentation. This greatly facilitates the administrative processes of clinics and allows practitioners freedom from the concern of documentation timelines. Collaborative Documentation allows for more face-to-face clinical time with clients and, thus, increases clinic capacity.

Chapter 2

Basic Elements of Collaborative Documentation

Establishing Objectives of Treatment with the Client

Collaboratively formulating and monitoring the objectives of treatment is an ongoing process in Collaborative Documentation. This occurs at the point of developing the Client Treatment Plan with the client and also at every session thereafter. Typically, objectives are defined for a year. With Collaborative Documentation, the year-long objective is segmented into days, weeks or months which allows for a more focused and concrete analysis of how the client is progressing towards treatment objectives in each session. During each session, the client and practitioner will review the objective for the session along with identifying any progress related to the prior session. Through this process, interventions are continuously monitored and can be adjusted as needed.

Reviewing Documentation with the Client and Making Revisions as Needed

At the end of every session documentation is reviewed with the client, either by repeating what the clinician is in the process of documenting, or showing the client what is being written on the computer screen. This process may involve explaining terms to the client or rewording technical language into plain language better understood by the client. This is an opportunity for the practitioner and client to ensure they have a shared understanding of what occurred in the session. Each practitioner will conduct this process in their own way that feels comfortable; there is not a set of sequenced steps that needs to be followed. Over time, practitioners are likely to find processes that work well for them and, with practice, documenting collaboratively will become easier as the practitioners' skill develops. The practitioner is never expected to defer his/her professional judgment to the clients' opinions and may collaboratively document differences in opinion and final decisions that the practitioner makes.

The Seven Percent Rule

Although there is not a clear formula to determine whether a particular client is appropriate for Collaborative Documentation (for example, the client's diagnosis), it is estimated that about 7% of community mental health clients are not appropriate candidates for Collaborative Documentation. This is called the 7% rule. Reasons a client may not be appropriate includes refusal, not sufficiently oriented (to time, place, or person), inability to establish rapport, and severe paranoia. In addition to the 7% rule, there may be specific sessions in which the client is unable to participate in Collaborative Documentation. These include sessions in which a normally stable client is presenting as psychotic, highly agitated, or in extreme distress. The decision of

whether or not to document collaboratively is based on the practitioner's clinical judgment, assessment of the situation, and level of comfort in using Collaborative Documentation. It is important to keep in mind that as clinicians gain experience, they will become more comfortable in using Collaborative Documentation with a wider range of clients and situations.

Chapter 3:

How to start using Collaborative Documentation

Determine personal level of comfort:

It is important to remember that Collaborative Documentation is ultimately just documentation, although with clinical benefits. It is important for practitioners to feel comfortable with the process. Some practitioners will easily begin using collaborative documentation, while others may take more time to feel comfortable. Collaborative Documentation is <u>not</u> a formal evidence based practice and does not have required steps to maintain fidelity to the model. It is okay to perform only parts of Collaborative Documentation when beginning. For example, a practitioner may first focus on developing shared treatment objectives with the client and may not do the actual documentation with the client. Practitioners first attempts should be at their own pace, keeping in mind that with practice the process will become more comfortable and efficient. Practitioners may want to consider first using this approach with one or two select clients (see 7% rule above for selecting clients) then expanding the approach to more clients on their caseload.

The Collaborative Documentation Learning Curve and Expected Challenges:

Practitioners usually feel a little awkward when they first begin using Collaborative Documentation. Generally, it has been found that within six weeks of implementing Collaborative Documentation, practitioners feel less awkward and have overcome any challenges they experienced. For instance, the transition from the clinical portion of the session to the collaborative documentation potion may initially feel like it is impeding the therapeutic rapport of the session.   However, with practice this transition will become smoother and more integrated into the session. Likewise, with practice, the practitioner will become more adept at collaborating with the client in organizing the structure of the session to address weekly or monthly objectives (as opposed to the typical yearly objectives on the Client Treatment Plan), and then reflecting that structure in their collaborative documentation on the progress note. It is likely that each practitioner will experience their own unique challenges when beginning to use Collaborative Documentation. It is important to keep in mind that with practice, these challenges are usually resolved.

Common Obstacles Encountered By Clients and How to Respond:

Clients may experience their own obstacles as practitioners implement Collaborative Documentation. Some clients may not be interested in Collaborative Documentation. Common initial concerns from clients include: feeling like it takes away from the "talk time" with their therapist; feeling like it is not relevant to their care; or feeling like practitioners needing to get "paperwork" done is more important than them. If a client has a concern similar to these, it might be helpful to review the clinical benefits of Collaborative Documentation. Benefits to review might include: establishing a clear

understanding of what was accomplished in the session; ensuring the practitioner and client understand what the other expressed in the session; increasing the client's sense of responsibility and ownership in his/her treatment; and ensuring the client feels he/she is moving toward personal goals. For some clients, reviewing the empirical evidence that the majority of clients report a positive experience with Collaborative Documentation may also be helpful.

Obstacles may also occur after Collaborative Documentation has been initiated. In some situations, client's may disagree with an observation made by the practitioner (for instance regarding hygiene), leading to a concern about what is to be documented. In other situations, clients may be experiencing a heightened level of psychiatric or emotional disturbance making it difficult for them to meaningfully participate in collaborative documentation. The following principles may be helpful to address a wide range of difficult situations arising while using Collaborative Documentation:

1) **Agree to disagree** when a difference of opinion between client and practitioner is encountered. In this situation, the practitioner documents his/her opinion as well as the opinion of the client who disagrees.

2) **Be transparent** when it appears that Collaborative Documentation is not appropriate because the client appears to be too upset or documenting collaboratively may further upset the client. In this situation, let the client know that you will not be documenting collaboratively as opposed to simply documenting later without his/her knowledge.

3) **Partial collaborative documentation is better than none**. If documenting specific symptoms or clinical impressions with the client is too difficult, try to utilize other aspects of Collaborative Documentation. For example, you may be able to collaboratively document specific activities that were done in the session, as well as collaboratively work on future session goals and the plan for the client's weekly activities.

Chapter 4:

Implementation with Specific Populations and Programs

Los Angeles County DMH piloted Collaborative Documentation in several different settings. Below are findings from the pilot.

<u>Olive View Urgent Care/Triage:</u> In the Urgent Care Center environment, Collaborative Documentation was reported to assist with client engagement. In particular, practitioners reported that clients were appreciative of being informed of the Urgent Care process. In addition, although typically only seen once and then referred, clients still responded positively to being included in the decision-making process regarding their treatment. Clients felt supported and validated. These benefits were also observed in a few crisis situations. In the Urgent Care environment, there often is not access to computers while meeting with the client. In these cases documentation was handwritten on a pad of paper, reviewed with the client, and then rewritten in the electronic health record after meeting with the client. While this was still more efficient than non-collaborative documentation, it did require some "other time".

<u>Valor Program/Homeless Veterans:</u> Practitioners using Collaborative Documentation with the homeless veteran population at the Valor program reported very positive client responses. Collaborative Documentation appeared to foster a greater sense of trust in the therapeutic process which is key for this population. Veterans felt empowered and in control of their own account of events using Collaborative Documentation. They enjoyed identifying clinical terminology which helped give insight into their own thought processes. Collaboration Documentation strengthened the client/practitioner relationship. Obstacles in using Collaborative Documentation with this population included less consistent appointment-keeping and a greater incidence of cognitive deficits which impacted participation in the documentation process.

<u>Full Service Partnership (FSP) Programs/Field Based:</u> Practitioners reported a positive response by clients using Collaborative Documentation with field-based clients. Practitioners noted that clients were able to derive greater insight by completing documentation with practitioners. The unpredictable environment of FSP made collaborative documentation difficult. However, over time

practitioners were able to adjust. Typically the note was written collaboratively with the client on a note pad, and then rewritten in the electronic health record at a later point.

Office based—Children, Family, and Collaterals: Practitioners reported success working with families and children using Collaborative Documentation. A challenge identified when using it with children was the impatience and inattention of some children. Strategies to generate narratives with children included asking questions such as "What would you tell your parent we did in our meeting today" then discussing and clarifying the child's response with the child. Activities including playing with a nerf ball or doing jumping jacks while writing the note also assisted with keeping the child engaged and interested.   When writing notes for family or collateral sessions, the collaborative process was used (unless the practitioner felt there was a clinical reason to not do so).

Office based--Adults: Collaborative Documentation with adults in office based settings yielded consistently positive results. One common challenge reported was the client's inability to see the computer screen while documenting collaboratively. Usually, practitioners were able to adjust screens or processes over time in order to address this concern.