“I think it’s something that we should lean in to”: The use of OpenNotes in Canadian psychiatric care contexts by clinicians

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Abstract

Background: OpenNotes is the concept of patients having access to their health records and clinical notes in a digital form. In psychiatric settings, clinicians often feel uncomfortable with this concept, and require support during implementation.

Objective: This study utilizes an implementation science lens to explore clinicians’ perceptions about using OpenNotes in Canadian psychiatric care contexts. The findings are intended to inform the co-design of implementation strategies to support the implementation of OpenNotes in Canadian contexts.

Method: This qualitative descriptive study employed semi-structured interviews which were completed among health professionals of varying disciplines working in direct care psychiatric roles. Data analysis consisted of a qualitative directed content analysis using themes outlined from an international Delphi study of mental health clinicians and experts. Ethical approval was obtained from the Centre for Addiction and Mental Health and the University of Toronto.

Results: In total, 23 clinicians from psychiatric settings participated in the interviews. Many of the themes outlined within the Delphi study were voiced. Benefits included enhancements to patient recall, and empowerment, improvements to care quality, strengthened relational effects and effects on professional autonomy and efficiencies. Despite the anticipated benefits of OpenNotes, identified challenges pertained to clarity surrounding exemption policies, training on patient facing notes, managing disagreements, and educating patients on reading clinical notes.

Conclusion: Many benefits and challenges were identified for adopting OpenNotes in Canadian psychiatric settings. Future work should focus on applying implementation frameworks to develop interventions that address the identified challenges.

Keywords

OpenNotes, psychiatry, mental health, patient portals, patient-centered care, qualitative research, nursing informatics, clinical informatics, digital health

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Introduction

The electronic sharing of clinical documentation with patients and families is commonly referred to as the concept of OpenNotes. OpenNotes, a movement spearheaded in the United States, aims to promote transparent communication between clinicians, patients, and families. Recently, through the 21st Century Cures Act, OpenNotes was enacted into U.S. federal law, mandating health systems and clinicians to provide patients with timely and convenient electronic access to their notes. Across many settings, sharing notes with patients has been associated with positive effects on care through improved understanding of care plans, sustained adherence to treatment plans, and increased empowerment and engagement. In psychiatric contexts, research has shown that some clinicians are concerned that sharing clinical notes with patients may pose negative consequences; however, studies have noted that OpenNotes can be used to drive the therapeutic process, improving the patient-clinician relationship through increased trust and transparency. Despite the enactment of 21st Century Cures Act, exceptions exist in psychiatry where clinicians may prohibit the sharing of psychotherapy notes if they believe it may cause harm to patients.

In Canada, adopting OpenNotes by healthcare systems is inconsistent and limited. Although the COVID-19 pandemic accelerated the push for healthcare organizations to provide patients with timely, electronic access to their personal health information (e.g., COVID-19 test results, immunization records, etc.), limitations exist. Few organizations have provided their patients with access to their clinical notes online and many organizations only share certain types of notes. In Ontario, the Personal Health Information Protection Act (PHIPA) stipulates that patients have the right to access and correct their paper health records. Despite this, many patients are either not aware that they can access their health records or are subject to financial and administrative barriers in doing so. In Canadian psychiatric settings, few organizations have granted patients with electronic access to their clinical notes. While research has demonstrated innumerable benefits when notes are openly shared with patients, the notion that providing this access will do more harm than good for patients receiving psychiatric care prevails. A variety of OpenNotes implementation resources have been developed for U.S. contexts; however, these have had limited applicability to Canadian environments. To bridge this gap, tailoring implementation strategies to the Canadian psychiatric environment is needed to enhance uptake of OpenNotes.

To promote the adoption of OpenNotes in Canadian psychiatric settings, there is a need to understand clinicians’ perceptions of sharing clinical notes electronically with patients. Considering the limited implementation of OpenNotes in these settings, it is of value to identify the barriers which hinder the uptake of OpenNotes by psychiatric clinicians. By leveraging an implementation science framework or guideline (e.g., The Consolidated Framework for Intervention Research (CFIR)), interventions may be developed to bridge knowledge gaps in opening up psychiatric notes for patients receiving care.

Research aim

This paper reports on the findings from the first phase of a three-phased initiative aiming to develop interventions that can support the implementation and adoption of OpenNotes in Canadian psychiatric settings. In the first phase of this study, we used an implementation science lens to explore clinicians’ perceptions and attitudes about the use of OpenNotes in Canadian psychiatric care contexts. The findings from this first phase will be used to inform the subsequent phases of this work where implementation strategies will be co-designed with clinicians to support the adoption of OpenNotes in Canadian contexts.

Methods

Study design

A qualitative descriptive design was used to explore clinicians’ perceptions and attitudes about using OpenNotes in psychiatric settings. Qualitative descriptive design is often used by researchers to obtain a comprehensive and descriptive understanding of an event or phenomenon and how an individual experienced such event or phenomenon. Reporting of this work was completed using the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist. Ethical approval was obtained from the Research Ethics Board at the Centre for Addiction and Mental Health and the University of Toronto.

Setting, sample and recruitment

Participants were recruited through snowball sampling techniques, where the study team specifically reached out to participants through organizational listservs (e.g., healthcare organizations, professional associations, universities, etc.), social media networks, and the professional network of the research team. Participants recruited through these networks shared the study information with their colleagues and peers to support further recruitment. Stratified purposeful sampling was conducted to group participants into three categories based on their self-reported experience with OpenNotes (i.e., sharing the clinical notes they document with their patients electronically): (1) no experience; (2) <1 year of experience; (3) ≥1 year(s) of experience. The use of this sampling strategy allowed the research team to ensure relatively equal proportions of those...
without OpenNotes experience and those with OpenNotes experience were represented in the pool of interview participants. Participants were eligible to participate if they worked in an Ontario psychiatric setting, provided direct patient care, and documented in an electronic health record.

Data collection

Semi-structured interviews (45–60 minutes each) were conducted from March to May 2021. Drawing from the domains of CFIR, an interview guide (Appendix 1) was developed and piloted on three occasions with members of the research team who self-identified as meeting the inclusion criteria for the study. The questions within the interview guided were shaped by the five domains of the CFIR implementation science framework: (1) intervention characteristics, (2) outer setting, (3) inner setting, (4) characteristics of individuals, and (5) process of implementation.21,22 By embedding the CFIR domains into the design of the interview questions, we ensured the study leveraged implementation science best practices to support and inform subsequent phases of this work. From the pilot interviews, minor changes were made based on participant feedback. In addition, it was suggested there be different versions of the interview guide based on the self-reported level of experience participants had in sharing clinical notes. For participants with reported experience (<1 year and ≥1 year) with sharing clinical notes, 11 questions were asked to understand their experiences in using OpenNotes in clinical practice, and skills and knowledge that are necessary for adopting OpenNotes. Those who self-reported no experience, received similar questions that explored hypothetical perceptions of sharing clinical notes. Due to the COVID-19 pandemic, the interviews took place virtually by video- or tele-conference. The interviews were conducted by three members of the research team (IK, BL, and KD) with backgrounds in nursing, mental health, and health informatics. Demographic information (e.g. clinical profession, gender, age, etc.) was collected using REDCap.27 As a token of appreciation for dedicating their time and expertise, participants were compensated with a $30 CAD honorarium. All interviews were audio recorded and transcribed verbatim by a transcription service. Interviews were conducted until theoretical data saturation was reached (as determined by the broader study team and steering committee). Saturation was defined as the point at which participant interviews did not yield new data or themes.28

Data analysis

Descriptive statistics were calculated for demographic information using Microsoft Excel. Directed content analysis was used to identify themes from the interview transcripts29 using NVivo 11. Using the themes derived from a Delphi study conducted by Blease et al. (2021) on the use of OpenNotes in mental health settings,30 preliminary codes were developed by two research members (IK and BL). The Delphi study utilized the collective knowledge of an international panel of experts (i.e. clinicians, administrators, patient advocates, etc.) to understand their views on providing psychiatric patients with access to their clinical notes.30 The consensus views of experts highlighted various anticipated benefits and challenges of using OpenNotes, which were directly used as coding categories in this qualitative analysis. Subsequently, in this study, the themes identified from the participant interviews were grouped under two broader themes, “benefits” and “challenges.” Further to this, the findings from the interviews were mapped to the granular themes outlined within the Delphi study. The initial code book was piloted by applying it to one of the transcripts. The results from this pilot were reviewed by two additional members of the research team (NS and GS) and the entire team reviewed the data analysis plan. All transcripts were coded by at least two members of the research team and outstanding discrepancies were resolved through discussion. Inductive coding was performed for items that did not correlate to existing codes. To enhance credibility, member checking31 was conducted with our patient partner (RM) who reviewed and provided feedback on the findings, along with the broader study team.

Results

A total of 23 psychiatric clinicians participated in the interviews and a summary of their demographic characteristics is presented in Table 1. Most participants were case managers/support workers (n = 7, 30.4%) and nurses (n = 6, 26.1%) and worked in their healthcare profession for less than five years (n = 12, 52.2%). Additionally, participants practiced in a range of healthcare settings including, outpatient services, home and community care, and hospital settings including psychiatry, community, and pediatric and adult tertiary centers. Furthermore, nearly an equal proportion of participants did not have experience (n = 12, 52.2%) and had experience (n = 11, 47.8%) with OpenNotes.

Perceived benefits of OpenNotes

Interview participants voiced a range of perceived benefits associated with OpenNotes. The main themes and supporting quotes pertaining to the perceived benefits of OpenNotes as outlined by Blease et al. (2021)30 are summarized in Table 2.

Effects on patient understanding, recall and empowerment. In this theme, participants highlighted how OpenNotes can help patients better understand and take control of their care. As outlined in Quote 1A, participants remarked how patient engagement may be enhanced through the collaborative dynamic created by sharing clinical notes. This serves to break down hierarchical power
imbalances between clinicians and patients, fostering patient empowerment. In addition, better recall of information from clinical encounters further relates to the theme of patient engagement, as participants (Quote 1B) commented that patients are more likely to be involved with their care if they use clinical notes as a reference tool to remember their prior discussions.

In addition, having access to clinical notes may also facilitate a greater understanding of specific diagnoses and treatments if patients can easily access this information. As noted in quote 1C, patients commonly do not understand the complexities of psychiatric diagnoses. Therefore, accessing clinical notes provides patients with the ability to review diagnoses and treatment-specific information. Lastly, improvements in communication between clinicians and patients were viewed as an imperative benefit by the interview participants (Quote 1D). The facilitation of open and honest information through the sharing of clinical notes can reduce communication barriers and encourage patients to have conversations with their clinicians.

Effects on professional autonomy and healthcare efficiencies. Participants expressed how OpenNotes may impact efficiency of writing notes through the need to consider patients as an additional audience. For example, in quote 2A, a psychologist commented on how their note-writing practices may shift, while keeping in mind that the notes can be viewed by other clinicians, as well as patients. These expectations may differ based on the patient’s diagnosis and clinical program. Furthermore, as demonstrated in quote 2B, participants commented on how OpenNotes may require time to adapt to regular practices; overall, it would have a positive impact on accountability to both stakeholders and the organization.

Quote 2B: “I imagine it wouldn’t really change much because we have to do documentation anyway. It’s not like if we wrote it with the patient reading it in mind, we would make the note longer. I think it’s more to shift the physician’s mindset into one that’s, oh, my notes will be read by my patients, I should write it from that perspective. But I don’t think that would impact the time or efficiency unless they have to start learning to adjust their language. So, in the beginning maybe it will take a little longer. But afterwards I don’t think it’s that much different” (P23, Psychiatry Resident).

Quality of care, outcomes and patient safety. Participants underscored the benefits that OpenNotes would have on the overall care that patients would receive. By providing patients with access to their notes, participants believed this would help identify and correct any errors or misinterpretations that clinicians might document. Quote 3A highlights an experience of how sharing notes can help identify and guide a conversation on addressing errors such as those related to preferred gender pronouns. With regards to clinician misinterpretations, participants stated that this would allow for more candid

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Table 1. Demographic characteristics of interview participants.

| Variable                           | N = 23 (%) |
|------------------------------------|------------|
| Clinical profession                |            |
| Registered nurse/nurse practitioner| 6 (26.1)   |
| Social worker                      | 3 (13.0)   |
| Case manager/support worker        | 7 (30.4)   |
| Psychologist                       | 2 (8.7)    |
| Psychiatrist                       | 1 (4.3)    |
| Psychiatry resident                | 4 (17.4)   |
| Age                                |            |
| <30                                | 9 (39.1)   |
| 30–39                              | 10 (43.4)  |
| 40–49                              | 2 (8.7)    |
| >50                                | 2 (8.7)    |
| Gender identity                    |            |
| Female                             | 19 (82.6)  |
| Male                               | 4 (17.4)   |
| Non-binary                         | 0 (0.0)    |
| Years of experience in clinical profession |        |
| <5                                 | 12 (52.2)  |
| 6–10                               | 3 (13.0)   |
| 11–15                              | 5 (21.7)   |
| 16–20                              | 0 (0.0)    |
| >20                                | 3 (13.0)   |
| Experience in sharing clinical notes*|          |
| No experience                      | 12 (52.2)  |
| <1 Year of experience              | 2 (8.7)    |
| ≥1 Year of experience              | 9 (39.1)   |

*Experience in sharing clinical notes is defined as whether the clinician has electronically shared the clinical notes that they document in an electronic health record with their patient(s).
Table 2. Clinician’s views on the benefits of using OpenNotes based on themes identified from Blease et al. (2021) 

| Theme                                                                 | Sub-theme                                                 | Exemplar quotes                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Effects on patient understanding, recall and empowerment               | Improve patient engagement in treatment                   | Quote 1A: “I like what you said, too, about empowering individuals to engage in their care. I feel like that is one of the biggest struggles that we have right now, especially in my program, because that is our goal, to work collaboratively with individuals to basically take control of their own mental health and wellness. It’s hard when I am the one documenting everything and they are basically just doing what I say is their homework. But if they were to access their notes on an ongoing basis and on their own time, I feel like it would be easy for them to engage and basically take control of their own care, basically. I feel like that would be a wonderful tool, for sure” (P12, Case Manager). |
|                                                                       | Improve patient recall about clinical visit discussions and assigned homework | Quote 1B: “So, I think if the clients had access to these goals and could remind themselves a bit more often and remind maybe us that this is what we’re working on too, it would be a great partnership of working together towards their recovery” (P6, Support Worker). |
|                                                                       | Improve patient understanding about their diagnosis and care plan | Quote 1C: “Another pro is it might help them actually learn more about their own mental illness. A lot of times our patient comes here, and we ask them, do you know what bipolar disorder is, and a lot of the times they lack thorough knowledge, so I think it would empower them to learn more about what their illness is, what their medications are, things like that, that might make them more compliant with their treatment” (P3, Nurse). |
|                                                                       | Improve patient–clinician communication                   | Quote 1D: “But again, I think that conversation is likely to be more open. There is nothing they don’t know about what we were thinking. And that’s a lot of the times too, where you go to a psychiatrist and they just kind of stare at you and say what they think you need. And you have no idea what they’re thinking about even. That happens in all areas of healthcare. But this would really just break down a lot of those barriers for the folks who are already kind of on edge around healthcare and what we doing, do they really want to help me. I think that this would really make that so much better” (P4, Support Worker). |
| Effects on professional autonomy and healthcare efficiencies           |                                                                           | Quote 2A: “I work with psychology residents and what I share with them is any time they write a note, to think about the stakeholders involved in that note. So, what is the [organization] going to think of this note? What is the client going to think of this note? What are other clinicians going to think of this note? And what’s important for those various stakeholders? And then deciding what you write based on that. I also talk about what would happen if this note were to come up in a legal setting. How is this going to be perceived? Does this have the potential to be misunderstood? Those are the things I think about and try to pass on to others” (P17, Psychologist). |
Table 2. Continued.

| Theme                              | Sub-theme                                           | Exemplar quotes                                                                                                                                                                                                 |
|-----------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Quality of care, outcomes and     | Help correct clinician                              | Quote 3A: "There was a case where I was supervising a nurse practitioner, and for a transgender client the pronouns were incorrect, and then they asked for that to be fixed. That I think is a totally reasonable situation, and it was good that it was caught" (P21, Psychiatrist). |
| patient safety                    | misinterpretations and errors in notes              | Quote 3B: “I think even just the whole journey through mental health programs is quite a journey. OpenNotes would provide a lot more openness throughout the whole process and this would be really future reaching, maybe patients would even feel safe sharing those notes with future professionals to add to continuity” (P06, Support Worker). |
|                                   | Help to close the feedback loop in care            | Quote 3C: "I think by us being reluctant, without having evidence to support our reluctance, we are stigmatizing patients. If we normalize it, we are comfortable with it, and we practice it like anyone else while ensuring safety concerns, I think that would go nicely with many people, and would encourage them [patients] to engage further in the plan” (P22, Psychiatry Resident). |
|                                   | Reduce patient stigmatization                       |                                                                                                                                                                                                             |
| Relational effects                | Diminish patient anxiety about what clinicians     | Quote 4A: "They feel that we’re hiding things and I don’t think that’s how it should be. It’s their life. It’s a conversation and a thing that we’re both a part of. I honestly would love it and I think that it would be an opportunity too for clients to question us and say hey, why would you say that. And a good conversation for us to have that instead of us just deciding this is what their life is like and what I’ve decided from my outside observation and really being more collaborative” (P04, Support Worker). |
|                                   | write about them                                    | Quote 4B: "I sometimes use it [sharing clinical notes] as an advocacy kind of tool. The client is presenting and they’re really struggling to take time off work and I’m seeing them every week and they’re a mess. I’ll say you should know that you can always access my records if you need that to take time off. I’ll also say if you need a doctor’s note or anything like that, I’m happy to provide that” (P17, Psychologist). |
|                                   | Improve therapeutic alliance                        | Quote 4C: “I know sometimes we just think oh, a word is a word, but to a client, it can mean a lot so being reflective of how we’re stating things and how it’s written is really important. Client-centered is something that’s a bit new as well in terms of if we look back over the last decade. There are a lot of skills, like I said, being non-judgmental, being empathetic, and listening, actively listening. I think those are all skills right there that if you practice in that way with the client face-to-face, your notes will also reflect that practice as well” (P10, Case Manager). |
|                                   | Increase use of patient-centered language           |                                                                                                                                                                                                             |

Discussions on misinterpretations and how it may be resolved or updated, if appropriate. Moreover, the concept of “closing the loop” was largely discussed throughout the interviews. As outlined in Quote 3B, participants reiterated the openness that sharing clinical notes would create, whereby patients would be able to reflect on their care plans and actively engage in more meaningful discussions with their clinicians. Lastly, sharing clinical notes was seen as a method to reduce the stigma that exists for psychiatric care. Quote 3C demonstrates how refusing to share
clinical notes may perpetuate implicit stigma by clinicians. Through active sharing of notes, participants highlighted how doing so would enhance transparency surrounding what clinicians document and reduce patient stigmatization.

Relational effects. It was commonly discussed how sharing notes would increase clinician–patient rapport and trust, and reduce patient anxiety surrounding what is being documented. It was expressed that by prohibiting patients from accessing their clinical notes, clinicians and healthcare organizations may inadvertently add to patients’ feelings of distrust. Some participants (Quote 4A and Quote 4D) perceived that the notes they document ultimately belong to the patient and that restricting access to the notes would hinder the patient’s care and relationship with their clinician. As such, sharing clinical notes with patients was viewed as a vehicle for promoting transparency and trust between the clinician and patient. Moreover, OpenNotes was described as beneficial to the clinician–patient relationship, as it could strengthen the therapeutic alliance. In Quote 4B, one clinician viewed OpenNotes as a patient advocacy tool, where patients receiving psychiatric care can use their clinical notes to support their well-being. Lastly, clinicians who had experience using OpenNotes reported to be more mindful and conscious of the language they use when documenting notes. Among these clinicians, various documentation styles and practices (e.g., Strength-based practices, recovery-oriented language) were described. For instance, when documenting, participants often questioned why they are documenting something and how the language they use may be interpreted by the patient (Quote 4C). This practice supported clinicians in being cognizant of language that may be perceived as judgmental and demoralizing, thereby shifting their practice to use more compassionate language.

Quote 4D: “As I think about OpenNotes, OpenNotes actually speaks to that. If we really embrace that concept, take away the jargon, take away the short forms, and make it plain everyday language in how we document or communicate, then that barrier about misunderstanding and not understanding would likely be easy to overcome” (P11, Nurse).

Challenges

Many challenges that were outlined by Blease et al. (2021) were also identified in our current study. A summary of these findings is outlined in Table 3.

Clarity about provider exemption policies. Among these interviews, many participants brought up various clinical scenarios in which withholding notes may be required. For example, one participant described how patients in delusional states may misinterpret what is written in their clinical notes and how this could escalate their delusions (Quote 5A). Furthermore, there were concerns about how reading notes could be potentially triggering for patients who experience suicidal thoughts. Although clinicians aim to document information objectively, there may be some degree of misinterpretation when patients read these notes, and this can be harmful. This could be potentially problematic for cases of intimate partner violence (IPV). For example, when clinicians described documenting information related to IPV, the clinical notes often did not include details about the physical abuse but rather, included information that inferred domestic violence and described safety planning discussed during the session (Quote 5B).

Additionally, clinicians reiterated that exclusions should be permitted to minimize harm to patients when there is clear justification to do so. For example, with pediatric populations, many clinicians expressed apprehension about sharing specific notes. As shown in Quote 5C, when the participant suspected a patient to have signs of autism spectrum disorder, they were wary of documenting such suspicions due to the fear of alarming or upsetting their patients. This circumstance may justify clinicians’ discretionary ability to withhold notes based on their clinical impression and judgment. Participants also experienced uncertainty and hesitation regarding access to notes by adolescents and their parents. Especially when the patient is a mature minor, participants described that there may be certain circumstances where the content of the notes might be inappropriate for the parent (Quote 5D). Thus, guidance on excluding the sharing of clinical notes was desired.

Quote 5D: “I always have a fear that I will share a note with a 17-year-old, but mom and dad might get a copy of that note just by nature of whatever platform we use, or it comes in the mail. And I recognize that the content might not be appropriate for the parents, it’s for the young person. So, I’m very mindful…” (P15, Nurse).

Clinician Training on Writing Notes. Several participants highlighted the limited training and subsequent challenges of writing notes that are not only understandable and informative but can also demonstrate empathy and compassion towards the patient. For example, some clinicians frequently expressed how they write lengthy, detailed notes consisting of many acronyms. However, as mentioned in Quote 6C, it is unclear how this structure of notes may be useful for patients who may prefer a more succinct summary of the encounter. Thus, providing guidance on how to reduce the complexity and use of jargon/acronyms may be beneficial.

Quote 6C: “The long notes that have too much detail, I find myself not enjoying reading them because there’s too much information. You can’t quite understand what the point is of the note. So, I think it needs to be concise. I think, for me, a point-form note is easier to understand. Just because a point-form note gives you points, so you know what the point of the note is. So, that’s what I think. But I think the acronyms is a big one. No acronyms” (P06, Support Worker).
| Theme                                | Sub-theme                        | Exemplar quotes                                                                                                                                                                                                 |
|--------------------------------------|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clarity about provider exemption policies | Permissible exclusions           | Quote 5A: "... People in delusional states misinterpreting your notes or exaggerating their delusion. Or, I have a client who, when we talk about his delusions, we don’t call them delusions we address them as a very real experience for him, because otherwise we get down another rabbit hole and we’re not able address the impact it’s having on his life” (P07, Support Worker).  
Quote 5B: “For instance, a client comes in, the session is about her relationship with her partner, and he beat her over the weekend. Not going to write that. I might discuss safety with her, but I’m not going to write, ‘her boyfriend beat her’. I might say, ‘client and her partner had a conflict over the weekend, her daughter wasn’t home’. You can infer what that means, I gave you the facts, they had a conflict, you don’t need the details. For me, I don’t think it would change anything because I’ve been very clear with my clients” (P13, Support Worker).                                                        |
| Clinician discretion                  |                                 | Quote 5C: ‘There are other notes where I probably don’t want my young people to see them because they might have…. I suspect there’s autism and this should be evaluated in the future, but I know I can’t even use that word with the client because that would be very upsetting for them. There’s other notes where I leave the notes for myself and for practice, but I wouldn’t share with them if it would actually impact their medical care” (P15, Nurse). |
| Clinician training on writing notes   | Writing understandable notes     | Quote 6A: “So, I think it would be important to have a consistent way of putting notes in. Let’s say as an agency we all decide that we use the client’s name when we talk about the client. Or as an agency we’re going to use client and not their name. So, a consistency because then clients will be like, well, how come you’re all writing different things, and it looks different from program to program? So, I think that would be important. And I think there are different styles of inputting notes” (P06, Support Worker).  
Quote 6B: “I think it’s something that we should lean in to and I think it’s something that I would want to do. I wouldn’t want to be the only one on my team doing it. I need the support of my team and my colleagues to do something new and lean on them and be able to get that support from reluctance and anxieties around, again, who knows what the response is going to look like and being nervous about what those conversations are going to look like and getting the support that you’re doing it correctly, because it’s tricky. So, I think it would have to be an all-in thing, where everybody is doing it together and being able to support each other with something new” (P07, Support Worker). |

(continued)
Table 3. Continued.

| Theme                                      | Sub-theme                                                                 | Exemplar quotes                                                                                                                                                                                                 |
|--------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Documenting sensitive information in a     |                                                                           | Quote 6D: “The part that I have the most hesitation with the concept is the assessment part of the note that I would have. In typical primary care fashion, I usually have a SOAP note, so I have subjective information I gather, objective information, assessment. You guys have been through it all. You know. I don't think that I would necessarily want to share with them the information that I gathered, because I think that it takes some time and effort to be able to decipher why I might want to have that information. So, for example, if I wrote in my note that someone was well-groomed, I would be concerned that they would interpret that, that I’m judging them” (P08, Nurse).|
| patient-centered manner                    |                                                                           | Quote 6E: “The other piece, like I said, is I have to be always mindful of how I write about people because I don’t want to be judgmental. I don’t want to add more stigma to them. I don’t want to imply anything. If their room is messy, I’ll go in and say I see leftover food on the bed, I see this and I see that. I try to be objective about what I see” (P11, Nurse). |
|                                           |                                                                           | Quote 6F: “And if we don’t have clarification of who am I writing notes for, when a client reads some of the notes that I’ve written, especially over the years that I’ve changed my style, like, it’s not written for them. There’s jargon in there that they’re not going to understand, there’s ways that I write things because I know that the nurse is going to read it and I want the nurse to follow-through on my treatment plan or whatever our treatment plan is” (P07, Support Worker). |
|                                           |                                                                           | Quote 6G: “Yeah. So, I think that’s where noticing, but in my own notes it would be much easier to say, wondering about BPD traits, allow me to monitor. Versus having to describe everything I saw. It’s much easier to label it as what you’re thinking than writing around it. It would be like autism diagnoses in older teens. I have a couple of patients that are on the spectrum. But for one of them even the word autism is so triggering that the session is terminated if you accidentally use that word. But I need to document in my notes, …..., autism, highly suggestive of autism, do not use word with patient. That would never be a chart that I could … technically, I would have to edit everything and remove that” (P15, Nurse). |

(continued)
| Theme                           | Sub-theme          | Exemplar quotes                                                                                                                                                                                                 |
|--------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Managing disagreements         | Informing patients | Quote 7A: “It’s always coming back to the conversation, always clarifying. When you [patient] read that, what is upsetting for you? Was it because it was untrue, or was I [clinician] not being respectful to you? Why was it upsetting? Really, trying to get to the heart of that, or why you were offended, and I really want to remedy that. There will be disagreements, and I have had many days where I’ve had to say to my patient, okay, [Name], can we agree to disagree? Really, there’s nothing else to say because we don’t see things from the same vantage point. I hear you; I appreciate what you’re saying, and I understand what you’re saying. But clinically, this is what I need to do for you, and I’m obligated to do this, so I think we’re on different sides” (P11, Nurse). |
| Instructing clinicians         |                    | Quote 7C: “Other times, with certain patients, I think they may get hung up on very small details in a note, and I don’t think it helps their care at all, and it can take up a lot of time to be asked to correct things that genuinely are a mistake, and they do happen sometimes. Well, I don’t know if it’s a mistake, or my interpretation of what someone says is not what they think they said, and/or I write down the wrong date. It’s hard to know what happened because we don’t have the original interaction recorded. But occasionally, I’ve had people that are very detail focused that would comb through the note, look for any small discrepancy, and it can take up a lot of time” (P20, Psychiatry Resident). \ Quote 7D: “But there’s no way because of time constraints that we could ever do that (provide education about OpenNotes). It’s just not humanly possible unless the funding model radically changed, and we could take as much time as we needed with somebody. As you know, time is a limited resource. And as providers, we must do what we can to promote efficiency without losing the caring piece. And those things are always intention” (P08, Nurse). |
| Providing patients with basic  | Accessing notes    | Quote 8A: “The other piece for the patients and families is how to maybe teach them how to use it. Certainly, if I have access to my chart, I’m a patient, but I’m calling my doctor every day. Do you know what I mean? There are forums, there are team reviews, there are care planning sessions, and there are family meetings. How do we help them to use the forum they have to bring the information forward that they’re seeing in the chart? So, it’s almost copying them, so they actively are charting the course while they’re in here to what they’re now having access to. It’s almost, with an open chart, they now have this whole thing, and they don’t know what to do with it” (P11, Nurse). |
| mental health notes            |                    | Quote 8C: “I think it would be very important for people to understand, for clients to understand what OpenNotes is, if whenever we go, we get to use them. And the processes to if you disagree, absolutely, letting people know that it’s okay to disagree. Because a lot of people are very concerned that if they say something, then they’re going to lose all the services, and that’s it, that’s the end of the support. So, I think it’s about explaining to people that this is what OpenNotes is, that means you can access your note” (P06, Support Worker). \ Quote 8D: “I just wanted to make sure that any information that is shared would be after a clinician would have had that discussion with that client, so it’s not like they would be receiving information online for the first time without that support...” (P01, Nurse). |
While some documentation may be easier to adjust, describing symptoms or diagnoses may be more difficult. Several participants highlighted the difficulty of using more patient-centered language for subjective assessments such as the Mental Status Exam. For example, one participant (Quote 6D) expressed concern about documenting a patient’s behavior or physical presentation as they fear it may be perceived as judgmental, despite their best intentions. With these concerns, many clinicians opted to reduce detail within their notes (Quote 6F) and/or use more objective language when describing their assessments (Quote 6E). However, adopting such practices may harm both patient and clinician safety and create confusion among the care team. As outlined in Quote 6G, removing critical information that may be deemed sensitive for the patient to read may result in documentation that is insufficient to support care continuity.

The difficulty associated with practice changes would likely require systemic changes at training and practice levels. Many clinicians often shared that they learn from others or follow the guidelines for documenting as outlined or mandated by the organization. For example, participants (Quote 6A/6B) spoke about how it would be useful for organizations to provide consistent and clear guidelines on how the notes should be presented and written through formal education and peer support.

Managing disagreements. Participants commonly discussed the need for managing and resolving disagreements, which may arise when patients review their psychiatric notes. Some clinicians were wary that patients may be dissatisfied with what is documented about them and may focus on minute details, impeding the progression of their care (Quote 7C). Furthermore, in some instances, patients and family members may be viewing clinical notes under strained and stressful situations (e.g., Consent and Capacity Hearing). Although these circumstances are specific to a small patient population, the clinicians were still apprehensive of discussions that may emerge where patients actively contest to or refuse what is documented about them. As such, efforts spent resolving disagreements may disrupt valuable time for delivering care (Quote 7D).

To assist clinicians in resolving disagreements with patients, some participants with previous experience with OpenNotes shared insights on how they work through these conflicts. One participant (Quote 7A), stated to ask patients a series of questions about why they were upset and whether what was documented was untrue or misinterpreted, utilizing a compassionate lens to better understand the patient’s perspective. Another participant (Quote 7B) proactively manages disagreements, whereby they warn the patient of the medical and technical jargon within the note and prompt them to inquire if they have questions or concerns. Thus, many participants voiced the need for training on initiating and leading these discussions in a constructive and proactive manner.

Quote 7B: “I think the main shift for me that’s been helpful is actually telling the patient that they’re able to read it. If they have questions about it, I will say sometimes there is technical language in there. So, if you find something that’s offensive or hurtful, ask me about it first so I can help to explain because I do tell them that the note that you’ll see is written for your doctor so it’s in medical language” (P21, Psychiatrist).

Providing patients with basic information. Many participants also spoke about the need to help patients understand the opportunity of OpenNotes and the knowledge required to meaningfully use it. As demonstrated in Quote 8A, some patients may be unsure of how to properly use these notes as part of their overall care. Similarly, another participant (Quote 8B) mentioned that many patients are unaware of the purpose and need for clinical documentation, which may lead to them feeling suspicious about the level of detail included in their notes. Considering this, providing education on the advantages of understanding clinical benefits could be useful.

Quote 8B: “Actually, I feel like a lot of families don’t actually know that we are really even keeping track of all of that stuff. Some patients don’t even know that we are. Some people are like why are you writing down everything that we talk about? I’m like, well, I kind of have to” (P04, Support Worker).

Moreover, there was a discussion about the need to manage patient expectations when reading notes. For example (Quote 8C), it is likely that sections of the notes (e.g., diagnosis, impression) may not reflect patients’ perceptions of their own experiences, which may cause disagreement. If patients experienced previous trauma within psychiatric settings, adverse outcomes associated with using OpenNotes could occur if feelings are not expressed. Thus, ongoing support is needed to sustain a positive patient–clinician relationship when using OpenNotes. As described in Quote 8D, a suggestion was made for clinicians to initially review notes with the patients. Lastly, depending on the discipline and model of care being delivered (psychotherapy, etc.), the structure of notes can vary drastically. There was some discussion (Quote 8E), surrounding the length of notes and formats that can impact readability. Reading lengthy notes may be confusing to patients, as such, other participants have suggested summarizing the notes through bullet points.

Quote 8E: “I think from a practical standpoint the best advice that I got in this field early on, was to learn how to do a five-minute note, which from a workload standpoint really helps to manage your workload. At the same time though, I think that there is some value there in terms of sticking to what’s most important in the note. And if you don’t need to go into a lot of detail then you can complete 95% of notes within that quick timeframe. That’s my take on it, for better or worse. There are certainly times where I could probably include more detail but that happens” (P17, Psychologist).
Discussion

Principal findings

To our knowledge, this is the first study examining clinicians’ perceptions regarding electronically sharing clinical notes with patients in the Canadian psychiatric context. The qualitative data generated from this study represents critical information operationalized from the five domains of CFIR. Congruent with themes outlined in Blease et al. (2021), the 23 clinician interview discussions supported the findings from the Delphi study on the perceived benefits and challenges of using OpenNotes.

Benefits

Our findings support the goals of OpenNotes, whereby sharing clinical notes can enhance transparency and communication. For example, interview participants spoke about the impact of sharing clinical notes on the patient-clinician relationship, quality of care, and patient empowerment and engagement. These findings support the generalizability of the Delphi study in Canadian settings. Correspondingly, these themes reflect outcomes of utilizing best practices for patient-centered communication (PCC). These outcomes include building a trusting relationship, understanding patient needs, and collaborating with the patient to address their needs. The importance of PCC is further reflected in a study of therapists who expressed the impact of OpenNotes on the ability to encourage more meaningful discussions and correct misinterpretations and mistakes within the notes.

The perceived benefits presented within this study stem from the Canadian psychiatric context, in which using OpenNotes is not legally required. Although most OpenNotes literature is predominately from the United States and Sweden, these countries require clinical notes to be made accessible to patients electronically. Conversely, a study of clinician’s perceptions of OpenNotes in the Netherlands, a country where OpenNotes is not mandated, found that less than one-quarter of clinicians saw no benefit to sharing clinical notes. Generally, the findings favorably advocate for OpenNotes in Canadian psychiatric settings, however the perceived benefits brought forth by participants are not without their challenges.

Challenges and practice implications

Despite the value of OpenNotes, our participants identified populations where clear permissible exclusion policies may be needed to prevent detrimental effects from viewing notes. For example, consistent with Manning (2021), the current study identified safety concerns for people who experience IPV. Despite the need to document patient information to provide care, the threat of harmful retaliation by the violent partner if they access the patient’s notes can be high. Moreover, given the rapid implementation of health information systems in clinical settings, concerns have arisen with regards to patient privacy and safety protection from other individuals who may have access to patients personal health information and clinical notes. While OpenNotes fosters patient empowerment and engagement in their care, the privacy and safety concerns it may pose to vulnerable groups (e.g. victims of IPV, mature minors/adolescents, etc.) requires further consideration beyond standard procedures of information blocking or lock boxes.

Further to this, having policies for the withholding of notes may prevent some negative outcomes. Previous research examining veterans within a mental health setting, found that 8% and 18% reported to feel upset after viewing their clinical notes often and sometimes, respectively, highlighting the need for clinicians to be mindful of notes which elicit such feelings. However, as outlined by Blease et al. (2021), permitting clinicians to withhold notes may hinder the patient–clinician relationship, eroding feelings of trust and reinforcing power imbalances. Considering this, further research is needed to assist clinicians in understanding patient risk factors that may contraindicate the viewing of clinical notes.

Clinicians also voiced concerns about sharing clinical notes with pediatric and adolescent patients and their families due to family relationships, lack of clear legislation and ambiguity of psychiatric-specific diagnoses. One possible solution is to have clear exemptions policies. In one study, the decision to share notes with patients over 12 years of age was based on the clinicians’ impression of the patient’s maturity and vulnerability. Thus, approaches, such as those related to the use of privacy and harm prevention exemption policies, should be further explored, especially as it relates to clinical notes that may be deemed sensitive or harmful when viewed by the patient or by their parent(s) or legal guardian(s).

In addition, ensuring language within clinical notes is understandable and conducive to patient care was a second challenge brought forth by clinicians. This is primarily related to varying clinical documentation styles (e.g. documenting objectively whereby the clinical notes contain measurable and observable information vs. subjectively where clinical notes consist of personal perceptions, opinions, and emotions) and the need to reduce medical jargon in clinical notes. A scoping review by Schwarz et al. (2022), found that other studies reported similar concerns surrounding patients understanding of medical terminology/jargon and the potential for patients to misunderstand or misinterpret what is documented about them. Moreover, the notion that patients would misunderstand, disagree with, or be offended by clinical notes was a recurring theme throughout the literature review. The actual and perceived concerns of sharing notes brought
forth in this study and in other studies, highlight the need for greater clinician education and training on writing patient-centered notes. Such training should reiterate the importance of writing notes in a truthful, compassionate, and neutral manner, free of personal judgment. Further to this, future implementations of OpenNotes in psychiatric settings should prioritize supporting effective clinical practice and behavior change in relation to how notes are written and how they are communicated to or with the patient.

Additionally, when considering the use of language in clinical notes, Park et al. (2021) identified stigmatizing language used within clinical notes that may harm the therapeutic relationship. Such language includes the use of stereotypes, questioning the credibility of patients, and authoritative language. In light of this, opportunities for patient and clinician training, patient feedback on notes, and manager auditing can be strategies to overcome language challenges. Implementing a practice of receiving feedback from patients on clinical notes may enhance a clinician’s ability to enhance respective therapeutic language. For example, a strengthened relationship was discovered between clinicians and patients if a focused inspection of notes occurred to enhance both parties’ understanding of the content. Furthermore, participants expressed they would feel more confident in their note writing abilities with auditing and managerial feedback.

This study also has implications for the field of implementation science. More specifically, this manuscript demonstrates how an implementation science framework (CFIR) can be practically embedded and operationalized in a qualitative descriptive study. While there is generally an agreement on the potential benefits of employing an implementation science framework within the healthcare context, there is less information on how to actually do so. The current manuscript describes how qualitative methods, leveraging research already conducted in the field (Bleas’s Delphi study), can be very practically used in the context of OpenNotes in mental health settings.

Limitations

Several limitations should be considered in the interpretation of these results. Foremost, these interviews were conducted during the COVID-19 pandemic, and it is unclear how the use of virtual care has impacted the challenges or concerns of OpenNotes. Secondly, with regard to our sampling strategy and overall sample, while a snowball sampling technique was used to recruit clinicians, our sample size was small. Despite this, some studies have shown that data saturation can be achieved with small sample sizes. Furthermore, alongside the immense burden of the pandemic on clinicians, it is unclear if those who volunteered to participate in this study are representative of the broader Canadian psychiatric clinician population, especially given that our sample of clinicians were predominantly female, younger in age, and less experienced with OpenNotes. Geographically, most of our participants were from the Greater Toronto Area, which primarily contains large urban academic-affiliated teaching hospitals. Future work should focus on expanding the geographical reach to those in community or rural settings.

Conclusion

This study explored clinicians’ perceived benefits and challenges of using OpenNotes in a Canadian psychiatric setting. As the implementation of patient portals progresses in Canada and access to electronic personal health information becomes more widespread, future research is needed to better explore how the perceived and actual experiences of sharing clinical notes with patients might compare or contrast among clinicians. Moreover, the benefits and challenges of adopting OpenNotes into practice identified within this study can be used to inform the initial development of implementation interventions and strategies to support OpenNotes uptake. In developing such strategies, conceptual implementation science theories, guidelines and frameworks should be leveraged to support practice reform for OpenNotes use. Furthermore, as per recommendations for digital health implementations, engaging end-users in the design and implementation of digital technologies, such as those which enable OpenNotes functionality, can facilitate improved implementation. As outlined by previous studies, clinicians are likely to change behavior self-drivingly if they believe the new intervention is beneficial and relevant to their professional responsibilities. In conclusion, the findings from this study can be used as a knowledge base for designing tailored implementation strategies to target existing barriers in a local context, bridging the implementation gap of OpenNotes.

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**Appendix**

**Clinician Interview Guide & Questions**

Thank you for agreeing to participate in this interview.

Before we begin, I want to remind you that your participation in this interview is entirely voluntary. Should you feel uncomfortable at any point, or wish to withdraw, please let me know.

It is my hope that you will feel comfortable to speak freely and honestly. There are no “wrong” answers just opinions and perspectives that I look forward to hearing. As a reminder, this interview will be audio recorded. In order to protect your confidentiality, please do not use your name or any identifying information.

**Overview of OpenNotes (for those without or with limited experience with OpenNotes):**

OpenNotes is the sharing of clinical notes that healthcare professionals document (e.g. admission notes, progress notes, discharge notes) with patients and families. Patients can choose to view these notes through a patient portal at anytime, anywhere.

The OpenNotes movement began in 2010 and aims to promote and examine the effects of fully transparent communication in health care. It helps patients, families, and clinicians to prepare and share meaningful notes describing their interactions. In mental health settings, there are a few organizations that have begun to share mental health notes with their patients and families.
Today, I am going to ask you about your thoughts and needs regarding the use of OpenNotes in delivery of mental health care. Do you have any questions for me?

Questions:
Have you ever had the mental health notes that you have written be made available through a patient portal (sometimes called OpenNotes)?

If yes, follow this guide: (50 minutes total)

1. (5 minutes) For how long have you been sharing mental health notes with your patients and how often do you do so with your patients?
   - Prompt: Are there specific types of notes that you decide to share? How do you decide to whom or which parts of the notes to share?

2. (10 minutes) Can you share some of your initial thoughts about sharing mental health notes with your patients? What influenced you/led you to begin sharing your notes with patients?

3. (5 minutes) In your experience, how often are patients and their caregivers accessing their mental health notes? What impact does this have on your patients?
   - Probe: In your experience, do you see any challenges with patients and their caregivers accessing their mental health notes?

4. (5 minutes) How do you think sharing mental health notes has impacted your delivery of mental health care?
   - Probe: Do you think OpenNotes has impacted your ability to deliver care compassionately?

5. (5 minutes) What are your thoughts on the influence of Open Notes on the patient–clinician relationship? Probe: In particular, do you think OpenNotes has impacted your ability to deliver care compassionately?

6. (5 minutes) Have you experienced any challenges in sharing mental health notes with your patients? What are some of those challenges?

7. (10 minutes) Are there any aspects of sharing mental health notes that make you feel uncomfortable? (e.g. privacy, safety, patient’s rapport)
   - Probe: Are there certain types of notes that you do not share with patients and families? Which ones and why?

8. (10 minutes) What skills and knowledge would be useful for healthcare providers when considering the uptake and use of OpenNotes for mental health care?

9. (10 minutes) What would help healthcare providers continue to share mental health notes with their patients and families?
   - Probe: How could OpenNotes be made better? (e.g. improvements, recommendations)
   - Probe: What resources/tools/policies/educational prompts would be helpful to providers?

10. (5 minutes) What do you think would be effective ways to share or mobilize this information with other healthcare professionals in Ontario?

11. Is there anything else that you would like to share with me about sharing mental health notes?

If no, follow this guide: (50 minutes total)

1. (10 minutes) Based on the description of OpenNotes I provided earlier, can you share some of your initial thoughts about using OpenNotes with your patients for mental health care?

2. (5 minutes) Is this something you would like to start using with your patients or have you actively chosen not to use? Why or why not? How so?

3. (5 minutes) How do you think sharing mental health notes with patients and families would impact their care?
   - Probe: Do you see any benefits or challenges with patients and their caregivers accessing their mental health notes?

4. (5 minutes) How might sharing mental health notes with patients and families impact your delivery of care?
   - Probe: Do you think OpenNotes would impact your ability to deliver care effectively in terms of workflow and time etc.?

5. (5 minutes) How do you think OpenNotes may influence the patient–clinician relationship? Do you think OpenNotes has impacted your ability to deliver care compassionately?

6. (5 minutes) Are there any aspects of OpenNotes that can make you feel uncomfortable? (e.g. privacy, safety, patient rapport)

7. (10 minutes) What skills and knowledge would be useful for healthcare providers in considering the uptake and use of OpenNotes for mental health care?

8. (5 minutes) If you were able to take up OpenNotes in delivering mental health care, what would help healthcare providers like you share mental health notes with their patients and families?

9. (5 minutes) What do you think would be effective ways to share or mobilize this information with other healthcare professionals in Ontario?

10. Is there anything else that you would like to share with me about sharing mental health notes?

Those are all the questions I have for you today.

Once again, thank you for participating in this interview today.