



Digital Health Records and Interprofessional Communication in Mental Health and Social Care

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Abstract

Digital health records resolve interprofessional communication barriers arising from fragmented and sparse text documentation. Systems linking psychologists, social workers, pharmacists, and health information technicians offer integrated care plans, broaden patient consent, and foster patient-provider collaboration. Coordination gains exceptional value for complex cases necessitating diverse stakeholder engagement and embedded clinical teams. For psychologists, improved assessment-aligned documentation streamlines integrated care contribution while promoting privacy consents and enhancing self-report visibility. Social workers access coordinated care plans and referrals, aiding timely intervention. Pharmacists share medication information, reconcile discrepancies, and document adverse events, supporting clinical decision-making and safety. Health information technicians establish metadata frameworks and access controls, ensuring care plan quality and traceability and enabling audit support for clinicians. Enhanced coordination improves timeliness, data availability, patient safety, and outcome tracking. Considered governance and process designs mitigate interprofessional workflow burdens and preserve patient trust.



Keywords- Digital Health Records, Interprofessional Communication, Mental Health, Social Care, Electronic Health Records, Integrated Care, Collaboration, Information Sharing, Patient-Centered Care, Multidisciplinary Teams

1. Introduction

Digital health records (DHR) are defined as structured repositories for storing health information on patients, designed for digitization from paper records and integrated use across organizational boundaries (Øvretveit, 2017). Every record has a lifecycle encompassing creation, access, update, and deletion. To ensure interoperability, application programming interfaces (APIs) and standardized vocabularies are essential to share core content and accompanying metadata specifying further details around item categorization, role, and detail (Rudberg et al., 2023).

DHR aim to improve interprofessional communication within the sectors of mental health and social care in the United Kingdom by facilitating coordinated input from multiple stakeholders, including psychologists, social workers, pharmacists, and health information technicians. Figure 1 illustrates the care actors and displays the links and exchanges supporting teamwork in the allocation and provision of services. Digital records can also address specific issues shaping work practices and information exchange flows across these professions (Martin & P Hirdes, 2014).

2. Digital Health Records: Fundamentals and Scope

Digital health records are defined as the systematic collection and storage of digital health data about an individual that can be shared across stakeholders involved in their care (A H Masoli et al., 2023). They are foundational to digital health, a multidisciplinary field encompassing technology and health (Janssen et al., 2023).

The core components of digital health records include a defined content model that specifies the particular kinds of information captured; a governance framework that details the rights, responsibilities, and rules of engagement among stakeholders; an interoperable platform for exchanging digital health records between information systems; a set of extensive standards that prescribe formats, structures, vocabularies, identifiers, semantics, and workflows; a digital health identifier that uniquely identifies the individual attached to a particular record; and an agreed-upon lifetime policy that governs the retention, revision, and disposal of a record. Digital health records may take various forms, including personal health records and electronic health records. Personal health records, controlled by the individual, empower them to manage their own care narratives, share selected information with relevant stakeholders, and contribute new information. Electronic health records, under the care of designated health information custodians, foster communication between health professionals



involved in a person-centred care process, provide a comprehensive view of their health status, and assist in the evaluation of health services received and their outcomes.

3. Interprofessional Communication: Roles and Interfaces

Interprofessional communication is a crucial element of mental health and social care, enabling multiple professionals to coordinate assistance and collaborate around shared clients. This section maps the relevant roles in these services and describes how health records interact with them. To convey relevant details, it relies on a model of interprofessional communication as a succession of exchanges driven by topical changes, within a framework of implicit and explicit data sharing agreements that govern consultants' collaborative communications (Rudberg et al., 2023).

Psychologists, social workers, pharmacists, and health information technicians all contribute to this collective effort. Digital records open numerous opportunities for interprofessional collaboration, while also introducing additional demands for documentation and attention. The perspective of each discipline on collaboration, the effect of digital records on professional practices, and the anticipated duration of these transformations in each role (Sphritz & Leblond, 2017) are therefore examined.

4. Impacts on Psychologists, Social Workers, Pharmacists, and Health Information Technicians

The implementation of digital health records markedly influences the work of mental health professionals. For psychologists, interprofessional collaboration becomes increasingly crucial as documentation expectations intensify to provide sufficient context for the sharing of patient information (Cherrill & Linsley, 2017). Social workers document various steps in case management, identifying the client's circumstances, care options, risks, and fellow professionals involved. Pharmacists share medication records including reconciliation of prescribed versus dispensed medications, patient-reported modifications, and adverse events. In contrast to mere record-keeping, professionals also engage in interprofessional work, including reviewing records and contributing information. For health information technicians, documentation encompasses metadata ensuring data quality and a clear audit trail of access and modifications across various media and controlled vocabularies. Information is maintained in accordance with explicit institutional policies allowing clinicians easy access within their daily workflow.

Digital health records sharpen Carleton University's focus on defining the interprofessional team, with implications for integrated training and collaborative learning. Psychologists, social workers, and pharmacists serve on interprofessional mental health teams across diverse settings and client population. Health information technicians have other professional avenues personally distinct from mental health, yet their role remains integral to the



functioning of interprofessional care. Consequently, attention will continue to shape the design of applied learning activities in these areas (Chen et al., 2015).

4.1. Psychologists: Documentation, Assessment, and Collaboration

Documentation is a critical part of any therapeutic enterprise in the psychologist's workflow that can also have a major effect on care delivery. The data and information created by the process of assessment, for example, is essential to effective analysis of the client situation—diagnosis, risk analysis, goal setting—and thus to the value of any service offer made to the client. Subsequently, the data and reasoning underpinning clinical judgements, service offers, and other key events and decisions in the clinical process—the content of integrated, progressive, and collaborative notes—determine how much pause, reflection, or second opinion interventions receive when passed to a clinician only indirectly involved in the client's clinical care. With busy schedules prevailing, data sufficiency completely determines whether assessment material is revisited prior to the supervision meeting or not. The richness of inter-discipline sharing furthermore determines the regularity and value of inter-discipline collaborative supervision services, with consultative requests valorising both the referent and requesting position. All these factors have been recognised in the Assistant Psychologist and Clinical Psychologist roles recognised by the Health Professions Council of South Africa.

The data and information created in the course of assessment does serve to fulfil statutory requirements and also, more informally, to signal the presence and nature of demand for a service. However, the primary effect is what is termed the “Assessment Itch” : when obligations prevent meaningful progression, revisiting assessment data represents the notable part of the work that can be gravitated towards. Caution does apply at times: involvement in settings that are recognised as clearinghouses for significant risk material can attract searchlight attention, diminishing policy freedom while increasing exposure to varying demands—whether facilitative or punitive—ranging from the Department of Home Affairs to the US Federal Bureau of Investigation. Documentation has implications for client participation. The by-product of client-centered profiling, for instance, is that without careful selection and balance, documentation could overemphasize terms like “Not Seen” in such a way as to elevate the risk of non-progression, which then by inference reflects back on both the client's and the organisation's capacity for execution.

Collaboration with other professions highlights the implications for attendance at professional cross-disciplinary meetings and the mutual influence of inter-discipline shape on organisation focus. In order for a simultaneous Art of Documenting to be supported across the numerous disciplines involved, the question of what falls under the scope of the organisation and therefore reflects their interest arises. The emphasis of the client-centered check-in approach means that on one site the tripartite, unrestricted Art of Documenting is further permitted to flourish. The varied client, context, and situation combinations generate an array of angle



covers that enrich the work and add a portable curriculum item while, counter-intuitively, decreasing valve strain. The recorded documentation retains mutual relevance while remaining outside the collaborative injection-preparation component of the clearly-defined cross-disciplinary approach.

4.2. Social Workers: Case Management and Coordinated Care

Documentation of the case is essential for effective case management and coordination of care, enabling knowledge sharing among professionals (Falconer et al., 2018). Around the world, social workers utilize a variety of models that require ongoing information exchange with fellow practitioners from various sectors of health and social care, including primary health care, mental health, child welfare, developmental disabilities, domestic violence, family preservation, substance misuse, and community development. Case-management approaches emphasize client-centred practices and integrated service delivery across health and social sectors in the preparation of care plans and risk assessments, prioritization of referrals, and, later, the monitoring of action taken by others throughout a person's engagement with the profession. Information-sharing practices may also include the provision content from a dedicated intervention within another discipline; for example, a clinical psychologist may document the assessed psychometric functioning of a child referred for age-appropriate play skills (Stephanie Jones et al., 2022). Inter-professional cooperation in case management widens the range of strategies considered, provides access to alternate approaches, and is warranted across multiple services, such as child welfare and developmental disabilities (Øvretveit, 2017).

4.3. Pharmacists: Medication Management and Safety

Pharmacists offer medication management and safety services, which are essential in health care. They contribute to interprofessional decision-making with respect to medication therapy. Digital health records support these functions by providing access to current medication records, enabling accurate medication reconciliation and safe prescribing, facilitating reporting of adverse events, and ensuring that clinical documentation related to pharmacotherapy is visible to all authorized users (Goundrey-Smith, 2018).

Pharmacists require up-to-date knowledge of patients' complete current medication regimens to deliver these services effectively. Access to this information allows for a timely assessment of possible drug interactions and duplicate therapies during the medication-use process. Digital health records allow interprofessional medication decisions to be made in a timely manner, improving the efficiency and safety of treatment. Inaccurate medication lists expose patients to significant safety risks due to prescribing errors and hampers continuity of care, medication therapy decisions, and renewals (W Bates et al., 2022). Access to an official



record of previous and current medications assists the determination of the need for changes to the medication regimen.

4.4. Health Information Technicians: Data Stewardship and Accessibility

Data stewardship encompasses the management of a data asset throughout its lifecycle within organizations. The data lifecycle refers to the creation, access, sharing, evaluation, archival, and deletion of data. The characteristics of the data itself, the obligations towards the data, and the role of the data within a specific business process influence accessibility and the underlying data governance model. Metadata also determines accessibility; it communicates information about the data, making it findable and understandable, in addition to enabling data-fitting processes (Grando et al., 2020). Because data stewards utilize knowledge about these aspects of data and their organizations, they are responsible for data quality, auditing and monitoring access, sharing knowledge about data and tools via formal and informal channels, providing customized access to tools such as application programming interfaces, and connecting individuals with data expertise (Cherrill & Linsley, 2017).

5. Benefits of Digital Health Records for Interprofessional Teams

Improved interprofessional communication is particularly important in mental health and social care. Poor coordination and insufficient information sharing between disciplines impede care transitions and treatment adherence. Digital health records have the potential to address some of these problems by providing an integrated platform for documentation accessible to all team members. Benefits for team functioning can accrue through improved coordination around formal client assessments or similar time-sensitive information; greater capacity to consult, over a range of different topics, on clients with physical and mental health conditions; and enhanced tracking of client visits and adherence to treatment recommendations (Xin Nie et al., 2023).

Psychologists, social workers, pharmacists, and health information technicians are the four professional groups involved in applying digital health records to interprofessional communication in mental health and social care. Each group is affected by the implementation in specific ways: psychologists are chiefly concerned with documentation of assessments and expert consultations; social workers primarily record case-management activities and develop coordinated care plans; pharmacists track medication management; and health information technicians maintain data quality, access control, and general usability (Stephanie Jones et al., 2022). By reducing the burden of formal documentation, the technology stands to bolster the involvement of social workers and psychologists in a multidisciplinary approach to care.



6. Challenges and Risks: Privacy, Security, and Workflow Strain

Digital care records—records providing data, knowledge, and experience relevant to patient health care (Ser et al., 2014) —support interprofessional coordination and community connectivity. Within a digital care record environment, patient care and community connectivity are enhanced. Yet implementation brings challenges, including privacy, consent, and security concerns, and workflows may become constrained (Papoutsis et al., 2015).

Risk models identify threats and defence mechanisms in three domains: security (unauthorized access and interaction), privacy (disclosure of information about the patient, clinician, or organisation), and governance and consent establishment (existence and adequacy of access restrictions and consent provisions). Security concerns concern documentation pertaining to a patient's health status and care trajectory, as well as risk assessment results. Privacy and consent concerns affect documentation of sensitive information such as psychoactive medications, previous illegal substance abuse, and current unresolved issues (Mattheus van Rijt et al., 2021). In cases of multiple health information technology implementations within the same organisation, concern arises regarding further access and possible daily or extensive outflow of data.

7. Best Practices for Effective Use of Digital Health Records

Effective use of digital health records (DHRs) can be facilitated through standardised documentation that enables generation of meaningful interdisciplinary reports reflecting the informal communication practices governing DHR-enabled care, while allowing the obligatory organisational forms to be completed with minimum effort. Role-based access permits interdisciplinary visibility without unnecessary exposure to irrelevant documentation. Audit trails establish accountability for the timeliness and contents of entries, thereby improving communication without increasing the risk of unintended disclosures. Structured templates for interdisciplinary communication define the scope of the input, making records easier to use and reducing uncertainty about author intention. The application of simple, clear, unambiguous symbols and recognised protocols constitutes effective documentation, presentation, and dissemination across DHRs; regular monitoring ensures time-critical care activities receive appropriate attention when workload volume is high (A H Masoli et al., 2023).

8. Policy and Governance Considerations

Effective implementation of digital health records in mental health and social care requires attention to policy, governance, and other components. Mental health and social care professionals must comply with legislation and regulations that govern the practices of documenting and sharing personal information (Grando et al., 2020). Mental health and social care organizations need to establish clear local policies and governance frameworks to



ensure compliance with broader outlines while considering individual circumstances and needs. Particular attention must also be given to stakeholder engagement to identify practice issues effectively and develop procedures that accommodate and respect the policies of diverse players in the mental health and social care ecosystem.

Principles of patient-centred and hazard-free practices apply equally when managing electronic communication. Different models specify approaches to obtaining mental health consent for sharing personal information, each with merits and challenges for comprehensive use of digital records (A H Masoli et al., 2023). Outside the protective umbrella of standardization, many organizations develop ad hoc procedures for formulating documents, auditing records, establishing accessibility rights, modifying templates for direct clinical input, and tracing completion. Such an approach may lead to practices that do not meet legal and service requirements; local policies and ongoing adjustment would provide better assurance of adherence.

9. Training and Change Management Implications

Digital health record systems and capabilities represent a high-value, low-risk priority for interprofessional team-based mental health and social care in South Australian and national reforms. Care providers—including psychologists, social workers, pharmacists, and health information technicians—stand to benefit through enhanced care coordination in the face of escalating demand. Coordination improvements will increase both practitioner and client safety, support traceable care approaches, and clarify team contributions. These systems unlock new forms of progress monitoring regarding literacy, developmental, and social-emotional needs, extending and augmenting long-standing practice efficiency aspirations.

Regaining competitive capability following the COVID-19 pandemic is a priority in health, education, and social services. The volume of children requiring comprehensive evaluations of developmental, literacy, and social-emotional needs has surged. As demand has shifted from universities and training colleges to birth-to-five and schooling-age services, practices supporting the entire age range have experienced unprecedented throughput with children graduating before the conclusion of formal assessment.

Complex and multifaceted diagnoses where all unusual features are not manifest on the first contact frequently produce a level of request-for-service documentation beyond the prompt-three-word standard envisaged (Xin Nie et al., 2023). Interprofessional record systems assist in clarifying what information constitutes an adequate request for service or referral in specific contexts. The potential to share routinely documented case-management records contributes further.



Owing to historical and contemporary reasons, increased observational-layer capability for children directly passes on observation to educational and social-service colleagues without the need for record duplication (Navarro Martínez et al., 2022).

10. Evaluation Metrics and Quality Improvement

Evaluation frameworks enable the identification of process, structural and outcome indicators related to interprofessional coordination, inform priority setting and improvement objectives, and are essential for gauging trends and quantifying progress. When evaluations are integrated into the deployment plan, processes can be adapted based on feedback to better meet expectations and thereby ensure continued stakeholder engagement throughout implementation. Continuous improvement methods are then used on a cyclical basis to review indicators, analyze root causes, select new objectives, and define associated support processes (“plan”, “do”, “check”, “act”) (W. Knight et al., 2014).

11. Conclusion

Digital health records (DHRs) hold the potential to enhance interprofessional communication (IPC) between and among psychologists, social workers, and pharmacists in mental health and social care (Stephanie Jones et al., 2022). Further, the introduction of electronic health records (EHRs) contributed to an increased volume of documentation performed by psychologists, social workers, and pharmacists. The systematic review also revealed that these roles experienced different workflow impacts following the introduction of digital health records, leading to a consequent variation in IPC (Hellzén et al., 2022). Digital health records format health information collected by various care providers about a patient, thus supporting interprofessional collaboration, timely service provision, and coordinated care by clarifying the client’s situation and salient care steps already undertaken.

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