

**There is no single “best” note format for mental health**, because the *best* method is the one that (1) supports clinical clarity, (2) reduces cognitive load, (3) aligns with your therapeutic model, and (4) meets regulatory and billing requirements **without distorting the work**.

But that doesn’t mean all formats are equal. Some formats are *designed* for medical encounters, while others are *designed* for psychotherapy. When I look at them through a trauma-informed, minimal-burden lens—the lens we already use in Mindline—the differences become very clear.

Below is a breakdown that cuts through the noise.

## **What Each Note Type Is *Actually* Built For**

### **SOAP (Subjective, Objective, Assessment, Plan)**

- Origin: **Medicine**, not psychotherapy.
- Strengths:
  - Great for documenting **symptoms, vitals, observable changes**, and **medical decision-making**.
  - Familiar to insurers and multidisciplinary teams.
- Weaknesses in mental health:
  - Forces psychotherapy into a **medicalized frame**.
  - “Objective” is often artificial in talk therapy.
  - Encourages symptom-chasing rather than process-tracking.
  - Can distort relational or experiential work.

SOAP is excellent for psychiatry, primary care, and integrated care—but it’s a poor fit for relational, process-oriented therapy.

### **BIRP (Behavior, Intervention, Response, Plan)**

- Origin: **Behavioral health**.
- Strengths:
  - Designed for **psychotherapy encounters**.
  - Tracks what the client did, what you did, how they responded, and what happens next.
  - Naturally aligns with **evidence-based practice, trauma-informed care**, and **progress monitoring**.
  - Reduces cognitive load because it mirrors the flow of a session.
- Weaknesses:
  - Can feel too structured for depth-oriented or psychodynamic work.

- “Behavior” sometimes gets misinterpreted as only observable behavior rather than internal experience.

BIRP is one of the most widely used formats in mental health for a reason: it fits the work.

### **DAP (Data, Assessment, Plan)**

- Origin: A simplified SOAP for therapy.
- Strengths:
  - Minimalist.
  - Good for clinicians who want fewer boxes.
- Weaknesses:
  - “Data” is vague.
  - Lacks explicit space for **intervention** or **client response**.
  - Easy to under-document.

DAP is fine for low-acuity outpatient work but often too thin for trauma-informed or insurance-audited settings.

### **GIRP (Goal, Intervention, Response, Plan)**

- A variation of BIRP that centers **goals**.
- Strengths:
  - Excellent for treatment-plan alignment.
  - Makes progress explicit.
- Weaknesses:
  - Can feel repetitive if goals don’t change often.

GIRP is great for agencies or programs with strict treatment-plan tracking.

### **The Real Question: What Format Best Serves Mental Health?**

If we strip away tradition and look at:

- clinical usefulness
- trauma-informed practice
- cognitive load
- audit defensibility
- therapeutic alignment

...the formats fall into two categories:

### **Medical Model Notes**

- SOAP
- DAP (a simplified SOAP)

These are best for:

- psychiatry
- integrated care
- symptom-driven encounters

**Psychotherapy Model Notes (I am VERY much leaning more towards this, but for a production system, we need a system that will allow the purchaser to use what they want).**

- BIRP
- GIRP
- PIRP (Problem, Intervention, Response, Plan) (I really could be convinced to start using this over BIRP)

These are best for:

- trauma-informed therapy
- relational work
- process-oriented modalities
- EMDR, IFS, ACT, DBT, etc.
- documenting change over time

**So what's the "best" format for mental health?**

**For psychotherapy, BIRP (or its cousin GIRP) is the most clinically aligned, defensible, and cognitively efficient format.**

Why:

- It captures the *actual flow* of a therapy session.
- It documents **interventions** clearly (critical for audits).
- It captures **client response**, which is the heart of progress.
- It avoids the medicalization trap of SOAP.
- It supports trauma-informed, minimal-burden documentation.
- It scales beautifully across modalities.

In other words: **BIRP is already the gold standard for mental health clinicians who want clarity without medical distortion.**

And given our mission with Mindline—minimal, trauma-informed, clinician-centered architecture—BIRP is philosophically and practically aligned.

## **NOTE TYPES & TEMPLATES**

### **What types of notes do I actually write?**

- **Progress notes** (BIRP format – for now – again, I could be convinced to start using PIRP)
- **Initial assessments / diagnostic evaluations**
- **Treatment plan updates**
- **Crisis notes** (rare but necessary)
- **Administrative notes** (cancel/no-show, coordination of care, etc.)
- **MSE** (Mental Status Exam – separate from the clinical note, but can still be attached to the appointment)

I *do not* use SOAP because it's a medical model that doesn't match psychotherapy. BIRP is my preferred structure because it mirrors the flow of a therapy session and supports trauma-informed documentation.

### **How structured vs. free-form?**

#### **I prefer a hybrid:**

- **Light structure** (BIRP headings)
- **Free-text fields** under each section

Rigid templates increase cognitive load and distort the clinical voice. Blank boxes with no structure lead to inconsistency and missed required elements.

The sweet spot is:

- Minimal structure
- Maximum flexibility
- No forced dropdowns unless legally required

### **What MUST be in every note?**

The system should auto-populate anything that is not part of the clinical narrative.

#### **Automatically included:**

- Date/time of service

- Patient name
- Provider name & credentials
- Service type (individual, couples, telehealth, etc.)
- Location (office, telehealth, etc.)
- Duration
- Diagnosis (pulled from treatment plan)

**Clinician-entered:**

- BIRP or PIRP content
- Risk assessment (if applicable)
- Progress toward treatment goals
- Any changes to diagnosis or plan

**Optional but INCREDIBLY helpful:**

- Quick-select interventions (e.g., CBT, EMDR, grounding)
- Quick-select client responses (e.g., engaged, avoidant, dissociated)

**COMPLIANCE & LEGAL**

**Do notes need to be locked after a certain time?**

Yes — but with nuance.

**Ideal workflow:**

- Notes remain editable indefinitely *until signed*
- Once signed, they lock
- If an edit is needed later, the system creates an **addendum**, not an overwrite

This protects legal integrity without punishing clinicians for being human.

**Digital signatures?**

Yes.

- Provider signature required
- Supervisor co-signature only if the clinician is under supervision

The system should support:

- Electronic signature
- Date/time stamp

- Addendum signatures

### Supervision workflows?

Yes, but simple.

#### If I supervise:

- I need a queue of notes awaiting review
- I need the ability to approve or request changes
- I need a clean audit trail

#### If I'm supervised:

- My notes should route automatically to my supervisor
- I should see their comments and approval status

## WORKFLOW & UX

### When do I write notes?

- Usually **right after the session**
- Sometimes **end of day**
- Rarely **during the session** (except for brief bullet points)

This means:

- The note screen must load instantly
  - What “the note screen must load instantly” *actually* means - When a clinician finishes a session and clicks “**Write Note**”, the system should open the note editor **immediately** — not after a spinner, not after a page transition, not after loading animations, not after fetching unnecessary data.
- It must not require navigating through multiple pages
- It must not interrupt the clinical flow

### Do I copy forward from previous sessions?

Yes — **but carefully.**

Copy-forward should:

- Bring forward *structure*, not narrative
- Bring forward *treatment goals*
- Bring forward *interventions used frequently*
- Never duplicate entire notes (risk of audit failure)

A “smart carry-forward” is ideal:

- Pulls forward goals
- Pulls forward plan
- Leaves narrative blank

### **Quick notes vs. full documentation?**

Absolutely need both.

#### **Quick notes:**

- Cancelled
- No-show
- Rescheduled
- Brief collateral contact
- Medication change reported by client

#### **Full notes:**

- Standard psychotherapy sessions
- Crisis sessions
- Intake assessments

Quick notes should take **under 10 seconds**.

### **WHAT MATTERS MOST**

**What would make me LOVE the note-taking system?**

- **Minimal cognitive load**
- **Fast, frictionless workflow**
- **BIRP structure that doesn't get in the way**
- **Auto-population of all non-clinical data**
- **Smart carry-forward**
- **Instant save, no spinning wheels**
- **Addendum support**
- **Clean, readable formatting**
- **No clutter, no unnecessary fields**

### What frustrates me about current systems?

- Too many required fields
- SOAP forced on psychotherapy
- Slow loading
- Clicking through multiple screens
- Dropdowns for everything (sometimes checkboxes are better)
- Notes that lock too early
- No addendum support
- Ugly formatting
- Systems designed for medicine, not therapy
- No way to save notes and come back to them later (or no autosave)

### What would make this amazing?

- A **minimalist BIRP or PIRP note** that feels like writing in a clean notebook
- Smart defaults
- Zero clutter
- A system that respects the clinician's time and the client's story
- A trauma-informed design that avoids cognitive overload
- A workflow that feels like it was built *by* a therapist, *for* therapists

### How Mindline Should Handle Note Types (Clear Summary for Claude)

The core problem: Clinicians can't be required to change the appointment type *before* writing a note. That adds work, increases cognitive load, and isn't realistic for no-shows, crises, collateral contacts, or unexpected discharges.

So the note type must be chosen **at the moment the note is created**, not at scheduling.

Here's the model that solves this cleanly:

#### 1. When the clinician clicks "Write Note," Mindline asks a single, tiny question:

**"What kind of note are you writing?"**

This is a lightweight selector — not a workflow. It appears instantly and disappears instantly.

Options include:

- Progress Note (BIRP)
- Intake / Biopsychosocial
- Crisis Note
- Discharge Summary
- Collateral Contact
- No-Show / Late Cancel
- Treatment Plan Update

This avoids forcing clinicians to adjust appointment types.

## **2. Mindline pre-selects the most likely note type automatically**

The system predicts the correct note type based on:

- Whether this is the first appointment
- Whether the client attended
- Whether the clinician marked “crisis”
- Whether a discharge was initiated
- Whether the clinician clicked “cancel/no-show”
- Whether the clinician opened the Tx Plan screen first

The clinician can override with one click, but usually won’t need to.

## **3. After the clinician confirms the note type, the editor loads instantly**

Because the system:

- Already knows which template to load
- Already has the template cached
- Doesn’t need to fetch anything before rendering

This preserves the “instant load” experience.

## **4. Quick notes don’t open the full editor**

If the clinician selects:

- No-show
- Late cancel
- Collateral contact

Then the selector *becomes* the note:

- A tiny text box
- Auto-generated default text
- One click to save

No template. No editor. No friction.

## **5. Crisis and discharge notes can be triggered automatically**

If the clinician:

- Marks the session as a crisis
- Initiates a discharge

Then the selector defaults to:

- Crisis Note
- Discharge Summary

Again — no extra work.

## **Why this approach works**

- Clinicians never have to change appointment types
- The system adapts to real-world session variability
- Note creation stays fast and intuitive
- The editor still loads instantly
- The workflow remains trauma-informed and low-burden
- Mistakes are minimized
- Flexibility is maximized

This is the simplest, most clinician-centered way to handle note types without slowing down documentation.

## **Intervention Quick-Select**

**Goal:** Include the interventions clinicians use *constantly*, across modalities, without overwhelming them. Everything else should be available via search or manual entry.

### **Tier 1: Core Interventions (quick-select – check boxes? That would allow for multiple interventions in a session.)**

These appear in nearly every therapy session, regardless of modality.

- Psychoeducation
- Cognitive restructuring / reframing
- Behavioral activation
- Grounding techniques
- Mindfulness / breathing exercises
- Emotional regulation skills
- Coping skills training
- Safety planning (when relevant)
- Supportive counseling
- Validation / normalization
- Motivational interviewing
- Treatment plan review / goal alignment

These are universal, high-frequency, and low-controversy.

### **Tier 2: Modality-Specific High-Frequency Interventions**

These are used often enough to justify quick-select, but not universal.

#### **CBT**

- Thought records
- Cognitive distortions identification
- Exposure planning (non-hierarchy)

#### **DBT**

- Distress tolerance skills
- Interpersonal effectiveness skills
- Chain analysis

## **ACT**

- Values clarification
- Cognitive defusion
- Acceptance strategies

## **EMDR**

- Resourcing / stabilization
- Bilateral stimulation
- Target identification

## **IFS**

- Parts identification
- Unblending
- Self-energy access

## **Solution-Focused**

- Miracle question
- Scaling questions
- Exception finding

These should be collapsible under a “modalities” section so they don’t clutter the main picker. Is there a way to have this editable by the admin? Or is that for another phase of coding? Maybe a future feature?

## **Tier 3: Crisis / Risk Interventions**

These should appear only when relevant (e.g., if risk is marked).

- Suicide risk assessment
- Crisis de-escalation
- Safety contracting
- Emergency resource coordination
- Lethal means counseling

These should not appear in the main picker unless triggered by context.

## **Tier 4: Administrative / Clinical Process Interventions**

These are technically interventions but shouldn’t clutter the main list.

- Coordination of care

- Documentation review
- Referral discussion
- Medication adherence discussion
- Homework assignment

These can live in a secondary “clinical tasks” category.

### **Design Principles Claude Should Follow**

1. **Keep Tier 1 always visible** These are the bread-and-butter interventions.
2. **Make Tier 2 collapsible by modality** Clinicians should only see what they use.
3. **Trigger Tier 3 only when risk is flagged** Trauma-informed, low-burden design.
4. **Allow search for everything else** No giant lists.
5. **Allow clinicians to “favorite” interventions** Personalization reduces cognitive load dramatically.



## First Principle: Notes Are Their Own Primary Object

This is the key shift in an EMHR

**Notes should not be stored inside:**

- appointments
- billing records
- encounters
- sessions

Those objects *reference* notes — but notes stand alone.

Why?

Because in mental health:

- A note may exist **without** an appointment (collateral, crisis, walk-in, discharge).
- A note may exist **without** billing (no-show, late cancel, pro bono, supervision).
- A note may exist **without** a scheduled session (client calls in crisis).
- A single appointment may produce **multiple** notes (rare but possible).
- A single note may relate to **multiple** appointments (e.g., extended crisis).

If we tie notes to appointments or billing, we break flexibility and create edge-case chaos.

So the correct architecture is:

**Notes are a top-level entity. Everything else references them.**

### The Data Model (Mental-Health-Aligned)

#### 1. Note (primary object)

- note\_id
- client\_id
- clinician\_id
- note\_type
- created\_at
- signed\_at
- content (JSON or structured)
- status (draft, signed, addendum)
- linked\_appointment\_id (nullable)

- linked\_billing\_id (nullable)
- linked\_supervisor\_id (nullable)

## 2. Appointment

- appointment\_id
- client\_id
- clinician\_id
- date/time
- status (attended, no-show, late cancel, etc.)
- **note\_id (nullable)**

## 3. Billing

- billing\_id
- client\_id
- clinician\_id
- CPT code
- modifiers
- amount
- **note\_id (nullable)**

## 4. Supervision

- supervision\_id
- note\_id
- supervisor\_id
- status (pending, approved, returned)

This structure gives maximum flexibility with minimal complexity.

## Why Notes Must Be Independent

### 1. Because mental health documentation is not always tied to a billable service

Examples:

- Crisis call
- Collateral contact
- No-show

- Late cancel
- Discharge summary
- Treatment plan update
- Coordination of care

These are clinically required but not always billable.

## **2. Because billing is not always tied to a note**

Examples:

- Administrative fees
- Missed appointment fees
- Bundled services
- Insurance carve-outs

## **3. Because appointments don't always produce notes**

Examples:

- Client cancels before session
- Client never shows
- Clinician marks “no documentation needed” for certain admin tasks

## **4. Because clinicians sometimes need to write notes outside the appointment flow**

Examples:

- Client messages with safety concerns
- Collateral call with psychiatrist
- Emergency session not on the schedule

If notes are tied to appointments, we force clinicians into workarounds.

## **So how do we link notes to appointments and billing?**

**Simple: notes reference appointments and billing, not the other way around.**

This allows:

- A note to exist without an appointment
- A note to exist without billing
- A note to be linked to an appointment later
- A note to be linked to billing later

- A note to be linked to *multiple* billing lines (rare but possible)

This is the most flexible, clinician-friendly, trauma-informed architecture.

### **Where do notes appear in the UI?**

#### **1. Inside the appointment**

- If a note exists → show it
- If not → “Write Note” button

#### **2. Inside the client chart**

- All notes listed chronologically
- Filter by type (progress, intake, crisis, etc.)

#### **3. Inside billing**

- Billing line shows linked note (if any)
- Clicking opens the note

#### **4. Inside supervision**

- Notes awaiting review
- Notes approved
- Notes returned

The note appears *everywhere it’s relevant* — but is stored only once. They should be stored as their own entity and *linked* to appointments and billing.

This gives:

- Maximum flexibility
- Minimal cognitive load
- Clean architecture
- Trauma-informed workflow
- No forced appointment editing
- No forced billing editing
- No “encounter” baggage

This is how a mental-health-first EMHR should behave.

