

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.

