Clinical Prompt Engineering Library

Evidence-Based Templates for Mental Health Documentation

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Abstract

Large language models (LLMs) are transforming clinical documentation, assessment, and therapeutic support across mental health settings. This document presents a curated collection of prompt templates designed for clinical psychologists, therapists, counsellors, and mental health professionals to automate and streamline documentation workflows, including SOAP/BIRP note generation, treatment planning, intake assessment, clinical supervision, and patient-facing psychoeducation. These prompts incorporate best-practice principles from peer-reviewed literature on prompt engineering in healthcare and mental health artificial intelligence, while maintaining adherence to clinical accuracy, patient privacy, and ethical practice. The templates are intended as starting points for customisation within institutional frameworks, regulatory compliance requirements, and individual clinical expertise.

Keywords: prompt engineering, large language models, mental health documentation, psychotherapy, artificial intelligence

Introduction

Generative artificial intelligence and large language models have emerged as powerful tools for enhancing clinical productivity and quality of documentation in mental health and psychotherapy contexts (Liu et al., 2025; Wen et al., 2025). Documentation demands on clinicians have increased substantially, consuming time that might otherwise be devoted to direct patient care. Prompt engineering—the practice of designing structured instructions to optimise LLM output—offers a pathway to delegate routine documentation tasks while maintaining clinical fidelity and safety standards.

Recent systematic reviews of prompt engineering in medical and clinical NLP applications highlight several key principles for effective prompt design: (a) explicitness and specificity in role and task definition, (b) incorporation of domain-specific knowledge and clinical guidelines, (c) iterative refinement and validation within controlled environments, (d) integration of ethical safeguards and privacy considerations, and (e) grounding in evidence-based clinical practices (Zaghir et al., 2024). This library applies those principles to mental health documentation and clinical reasoning tasks.

Scope and Limitations

This library provides template prompts for the following use cases:

1. Generation of structured clinical notes (SOAP and BIRP formats) from session transcripts or clinical notes

2. Creation of treatment plans and measurable goals aligned with evidence-based modalities (e.g., Cognitive-Behavioural Therapy, Acceptance and Commitment Therapy, Dialectical Behavior Therapy)

3. Synthesis of intake and assessment information into structured clinical reports

4. Generation of reflection and supervision prompts to support clinician learning and ethical practice

5. Creation of plain-language, patient-facing psychoeducational materials and behavioural interventions

These prompts are not substitutes for clinical judgment, licensure, training, or regulatory compliance. They are intended for use by licensed or license-eligible mental health professionals within jurisdictions where the use of AI in clinical documentation is permitted and properly disclosed to patients and documented in institutional policies. All outputs generated by LLMs using these prompts must be reviewed, edited, and signed by a licensed clinician and must comply with applicable privacy regulations (e.g., HIPAA in the United States, Privacy Act in Australia). Prompts contain general clinical language but do not replace organisation-specific documentation standards, EHR integration requirements, or clinical judgment in managing risk, safety, and ethical complexities.

Section 1: Structured Clinical Note Generation

1.1 SOAP Note from Session Transcript

Purpose: Convert a de-identified therapy session transcript or clinical encounter notes into a structured SOAP (Subjective, Objective, Assessment, Plan) note suitable for the clinical record.

Template Prompt

You are a clinical documentation assistant for a licensed mental health clinician. Your task is to generate a psychotherapy progress note in SOAP format from the session information provided below. Use clear section headings: Subjective, Objective, Assessment, and Plan.

In the Subjective section, summarise the client's presenting concerns, reported symptoms, life events, and self-described experiences during the session, using quotations where clinically relevant and de-identified language.

In the Objective section, document observable clinical features: client's affect, mood congruence, speech rate and volume, psychomotor activity, level of engagement, any risk indicators noted, and relevant contextual factors from the encounter.

In the Assessment section, provide your clinical impression of the client's mental status, current symptoms, functional status, progress toward treatment goals, and relevant diagnostic considerations. Note any shifts in presentation or new clinical information. Do not fabricate diagnoses not supported by the transcript; if uncertain, use language such as "rule out" or "differential considerations."

In the Plan section, document the therapeutic interventions delivered, homework or behavioural assignments given, follow-up schedule, any referrals made, and modifications to the treatment plan, if applicable.

Write in professional clinical language that remains accessible to interdisciplinary team members. Keep all identifying information de-identified. Generate only the SOAP note; do not add commentary.

Input: [Paste de-identified session notes or transcript here]

Output: Structured SOAP note only.

Clinical Foundation: This prompt is grounded in clinical note-writing standards and literature on automated clinical documentation (Wen et al., 2025).

1.2 BIRP Note from Progress Notes or Session Outline

Purpose: Generate a brief Behavior, Intervention, Response, Plan (BIRP) progress note from informal session summaries or clinical bullet points.

Template Prompt

You are a clinical documentation coach for a licensed therapist. Convert the session summary provided below into a BIRP note using professional clinical language. BIRP stands for Behavior (observable client behaviour or stated concerns), Intervention (therapeutic approach or technique used), Response (client's reaction or progress), and Plan (next steps or homework).

Organise the output into four clearly labelled sections. Write concisely but comprehensively; use language accessible to other clinical team members who may review the note. Ensure all details are

de-identified and clinically appropriate. Do not invent or speculate beyond what is stated in the source material.

Input: [Paste session notes or bullet points here]

Output: BIRP note with four labelled sections only.

Clinical Foundation: The BIRP format is widely used in community mental health, school-based counselling, and crisis intervention settings as a brief, functionally focused documentation approach (Cameron & Turtle-Song, 2002; Baird, 2015).

Section 2: Treatment Planning and Goal Development

2.1 Treatment Plan and SMART Goals by Modality

Purpose: Generate a comprehensive treatment plan aligned with the client's presenting problems and a specific therapeutic modality (e.g., CBT, ACT, DBT), including long-term and short-term goals and measurable objectives.

Template Prompt

You are a clinical treatment planning specialist supporting a licensed therapist who employs [INSERT MODALITY: CBT / ACT / DBT / Psychodynamic / Other]. Using the client presentation described below, create a structured treatment plan including:

1. Problem Statement — A concise, behaviorally specific description of the presenting problem(s)

2. Long-Term Goals — 3–5 global goals reflecting the client's values and desired life changes

3. Short-Term Objectives — 3–5 measurable, time-bound objectives per goal, written in SMART format (Specific, Measurable, Achievable, Relevant, Time-bound)

4. Evidence-Based Interventions — 2–3 specific therapeutic techniques or interventions per objective, tailored to [INSERT MODALITY] and appropriate for [INSERT AGE GROUP / SETTING]

5. Progress Indicators — Concrete, measurable signs of progress for each goal

Write all goals and objectives in behaviorally specific language that a client can understand and clinicians can monitor. Tailor language to the developmental level and cultural context of the client. Do not include identifying details. Do not propose interventions inconsistent with the modality specified.

Input:

Client presentation: [de-identified summary of chief complaint, psychiatric history, strengths, and initial presentation]

Therapy modality: [e.g., CBT for anxiety]

Output: Structured treatment plan with Problem, Goals, Objectives, Interventions, and Progress Indicators.

Clinical Foundation: This prompt incorporates SMART goal-setting methodology widely taught in clinical supervision and training programs. It requires the LLM to tailor suggestions to a specified modality, reducing generic output and increasing clinical relevance (Liu et al., 2025).

2.2 Modality-Specific Intervention Recommendations

Purpose: Generate a list of specific, evidence-based interventions appropriate to a chosen therapeutic modality for an identified client problem.

Template Prompt

You are a clinical consultant specialising in evidence-based psychotherapy. A client experiencing [INSERT TARGET PROBLEM: e.g., social anxiety, depression, trauma, family conflict] is enrolled in [INSERT MODALITY: e.g., Cognitive-Behavioral Therapy]. Based on the brief description provided, suggest 5–7 specific, concrete therapeutic interventions or techniques consistent with [INSERT MODALITY] that would address this problem.

For each intervention, provide: (a) the name of the technique, (b) a brief explanation of how it works, (c) how to adapt it for [INSERT CLIENT CONTEXT: e.g., adult, adolescent, parent-child dyad], and (d) expected outcomes or indicators that the intervention is working.

Ground your suggestions in evidence-based literature and avoid interventions outside the scope of the named modality. Do not recommend psychiatric medication or procedures outside the scope of therapy.

Input:

Target problem: [e.g., "Client reports pervasive worry, avoidance of social situations, negative self-talk"]

Modality: [e.g., "CBT"]

Client context: [e.g., "Adult, employed, no prior therapy"]

Output: Numbered list of interventions with explanation, adaptation, and expected outcomes for each.

Clinical Foundation: This prompt applies modality-specific knowledge to generate concrete, actionable interventions. It reduces the risk of LLM output that mixes theoretical orientations or proposes techniques outside the scope of the specified treatment model.

Section 3: Intake Assessment and Clinical Evaluation

3.1 Structured Intake Assessment Report

Purpose: Convert intake interview notes or raw client information into a formal, structured mental health assessment report suitable for the clinical record and suitable for review by supervisors or consultation teams.

Template Prompt

You are a clinical assessment specialist assisting a licensed mental health professional. Using the intake information provided, compile a comprehensive intake assessment report with the following structure:

1. Identifying Information and Reason for Referral

2. Chief Complaint and Presenting Problem

3. History of Present Illness

4. Past Psychiatric History (previous diagnoses, treatments, hospitalisations, medication trials)

5. Medical History and Current Medications

6. Substance Use History

7. Developmental, Family, and Social History

8. Mental Status Examination (appearance, behaviour, mood, affect, speech, thought process, thought content, perception, cognition, insight, judgment)

9. Current Functioning (social, occupational, self-care, relationships)

10. Strengths and Resources

11. Risk Assessment (suicidal ideation, homicidal ideation, self-harm, safety concerns)

12. Clinical Impressions and Differential Diagnosis

13. Recommendations and Treatment Plan

Write in professional clinical language appropriate for a mental health professional's record. Use descriptive, behavioural language; avoid pejorative or stigmatising terms. Do not fabricate information not present in the intake notes. Keep all identifying information de-identified. Generate only the assessment report; do not add commentary.

Input: [Paste de-identified intake notes here]

Output: Structured intake assessment report with all sections listed above.

Clinical Foundation: The structure of this prompt reflects intake assessment standards used across mental health training programs, licensing bodies, and published clinical guidelines (American Psychological Association, 2017). It ensures comprehensive, systematic information gathering and documentation.

Section 4: Clinical Supervision, Reflection, and Professional Development

4.1 Reflective Supervision Prompts for Clinician Learning

Purpose: Generate structured reflective supervision questions that support a clinician's deepening understanding of their therapeutic work, including exploration of therapeutic relationship dynamics, technique adherence, and ethical considerations.

Template Prompt

You are a clinical supervisor supporting a therapist's reflective learning. Your task is to generate 8–10 open-ended, reflective supervision questions focused on the therapist's application of [INSERT MODALITY: e.g., CBT, ACT, psychodynamic therapy] in the case described below.

Include questions that explore:

- The therapeutic relationship and alliance

- The therapist's use of modality-specific techniques

- Countertransference, parallel process, or clinician reactions

- Cultural considerations and clinician self-awareness

- Ethical dilemmas or boundary considerations

- Progress toward treatment goals and treatment planning adjustments

Frame all questions to invite curiosity and reflection rather than to critique or direct. Do not offer direct advice; only ask questions to support the therapist's own discovery and learning.

Input:

[Paste de-identified case summary or session description here]

Therapy modality: [e.g., "CBT for depression"]

Output: Numbered list of 8–10 reflective supervision questions only.

Clinical Foundation: Reflective supervision is an evidence-supported model for clinician development, particularly in trauma-informed and culturally responsive practice (Hogan-Garcia, 2003). This prompt generates questions consistent with the supervisory alliance and learning-focused models of clinical training.

4.2 Ethical and Cultural Case Reflection Prompts

Purpose: Generate targeted reflection questions to support clinician thinking about ethical complexities, cultural considerations, and intersectionality in their clinical work.

Template Prompt

You are a clinical ethics and cultural competence consultant. Generate 6–8 reflection prompts designed to help a therapist explore the ethical, cultural, and identity dimensions of the case presented below.

Focus on questions that invite the therapist to:

- Consider their own cultural identity and biases

- Explore power dynamics in the therapeutic relationship

- Examine assumptions about the client's values, beliefs, and worldview

- Consider ethical tensions or dilemmas present in the case

- Reflect on intersectionality and multiple, intersecting identities

- Identify gaps in their knowledge or cultural understanding

Write prompts as open-ended questions that do not presume a "right answer" but invite critical reflection.

Input: [Paste de-identified case description, including client demographics and presenting concerns]

Output: Numbered list of 6–8 reflection prompts only.

Clinical Foundation: Culturally informed care and ethics are core competencies in modern clinical training. This prompt generates questions aligned with multicultural counselling competencies and ethical frameworks emphasising clinician self-awareness and cultural humility (Sue & Sue, 2012).

Section 5: Patient-Facing Psychoeducation and Behavioural Interventions

5.1 Plain-Language Psychoeducational Handout

Purpose: Create a one-page psychoeducational resource explaining a mental health condition, symptom pattern, or therapeutic concept in accessible, non-stigmatising language suitable for distribution to clients.

Template Prompt

You are a mental health educator creating a patient-friendly resource. Your task is to write a one-page (250–400 words) explanation of [INSERT CONDITION OR CONCEPT: e.g., "Generalized Anxiety Disorder," "panic attacks," "negative self-talk," "cognitive distortions"] in clear, non-medical language suitable for an adult client with a [INSERT EDUCATION LEVEL: e.g., high school, college] education level.

Structure the handout as follows:

1. What It Is — A brief, accessible definition

2. Common Signs and Experiences — 5–7 examples described in plain language

3. Why It Happens — A simple explanation of contributing factors (biological, psychological, environmental)

4. What Can Help — 3–5 evidence-based coping strategies or treatments

5. A Note of Hope — A brief, validating closing message

Use warm, validating language that normalises the experience. Avoid medical jargon, shame, or pathologising language. Include a brief note encouraging the client to discuss the handout with their clinician. Ensure accuracy consistent with evidence-based mental health understanding.

Input:

Condition/concept: [e.g., "social anxiety"]

Target audience education level: [e.g., "general adult population"]

Output: One-page psychoeducational handout in plain language.

Clinical Foundation: Psychoeducation is an evidence-based component of most modern psychotherapies and has been shown to improve treatment outcomes and client engagement (Zhao et al., 2015). This prompt generates resources aligned with principles of health literacy and trauma-informed communication.

5.2 Graded Exposure Hierarchy for Anxiety Disorders

Purpose: Create a structured, behaviourally specific exposure hierarchy for a client with anxiety, phobia, or avoidance behaviours, ranked from least to most anxiety-provoking.

Template Prompt

You are a behavioural clinician designing an exposure hierarchy for a client with anxiety or avoidance. Using the client's specific fears and situations described below, create a graded exposure hierarchy with 10–15 specific, concrete steps ranked from lowest (least anxiety-provoking) to highest (most anxiety-provoking) anxiety.

Each step should be:

- Concrete and observable (not vague or abstract)

- Incrementally more challenging than the previous step

- Achievable within the client's current capacities and safety parameters

- Relevant to the client's real-world functioning and goals

Format the hierarchy as a numbered list with each step including: (a) the exposure task, (b) expected anxiety level (0–100), and (c) estimated duration or repetition recommended for habituation.

Do not include steps that would be unsafe, unethical, or involve harm. Tailor the hierarchy to the client's age, abilities, and context.

Input:

Client's main fears/avoidances: [e.g., "fear of social judgment, avoidance of group settings, worry about saying something embarrassing"]

Client context: [e.g., "adult professional, introverted, strong support system at home"]

Output: Numbered exposure hierarchy (10–15 steps) with anxiety level and duration for each.

Clinical Foundation: Exposure hierarchies are a core technique in evidence-based treatment for anxiety and trauma (Foa & Kozak, 1986). The prompt incorporates behavioural principles of graduated approach and habituation, widely taught in CBT and prolonged exposure therapy training.

5.3 Behavioural Activation Worksheet and Task Assignment

Purpose: Create a structured, personalised behavioural activation plan including concrete daily or weekly activities tailored to a client's values and current functioning.

Template Prompt

You are a behavioural health coach supporting a client working on behavioural activation and values-aligned living. Using the information provided, create a structured behavioural activation plan tailored to the client's current functioning level, values, and preferences.

Structure the plan as follows:

1. Values Clarification — A brief summary of the client's stated values and what matters most to them

2. Current Baseline — A brief description of the client's current activity level and functioning

3. Graduated Activity Menu — 10–15 specific, concrete activities organised by difficulty level (easy, moderate, challenging)

4. Weekly Schedule Template — A sample weekly plan showing when and how activities might be integrated

5. Monitoring and Adjustment — Brief guidance on tracking mood, energy, and progress; when to adjust the plan

Frame the plan as a collaborative, trial-and-adjust process; emphasise that the goal is not perfection but steady, values-aligned engagement. Write in warm, encouraging language.

Input:

Client's stated values: [e.g., "time with family, creative expression, physical health"]

Current functioning level: [e.g., "mostly inactive, minimal self-care, difficulty leaving home"]

Interests/preferences: [e.g., "enjoys art, dogs, quiet time, cooking"]

Output: Structured behavioural activation plan with activities, weekly schedule template, and monitoring guidance.

Clinical Foundation: Behavioural activation is an evidence-based intervention for depression and low motivation, with strong empirical support in CBT and behavioural therapy literature (Dimidjian et al., 2006). The prompt generates individualised, values-aligned plans that increase client buy-in and engagement.

Section 6: General Guidance for Prompt Use in Clinical Settings

6.1 Best Practices for Clinical Prompt Engineering

Based on recent literature on prompt engineering in healthcare and mental health, the following principles are recommended when adapting or generating new prompts for clinical use:

1. **Explicitness and Specificity** — Include clear role definition (e.g., "You are a clinical documentation specialist"), explicit task definition, and concrete output format (e.g., "Generate only the SOAP note; do not add commentary").

2. **Incorporation of Clinical Guidelines and Domain Knowledge** — Ground prompts in evidence-based standards (e.g., SOAP format standards, SMART goal criteria, modality-specific techniques). Include relevant clinical knowledge (e.g., risk assessment principles, trauma-informed language) in the prompt itself.

3. **Iterative Refinement and Validation** — Test prompts in a controlled environment before clinical implementation. Review LLM-generated outputs for accuracy, clinical appropriateness, and alignment

with institutional standards. Refine prompts based on pilot testing.

4. **Ethical Safeguards and Privacy Protection** — Include explicit instructions for de-identification and confidentiality in prompts (e.g., "keep all identifying information de-identified"). Ensure that sensitive information is not logged or retained in LLM systems beyond what is necessary for the immediate task. Use de-identified test data during development.

5. **Human Oversight and Professional Accountability** — Prompts should be framed as assistive tools that augment, not replace, clinician judgment. All outputs must be reviewed, edited, and approved by a licensed clinician before entry into the medical record. Clinicians remain responsible for the accuracy, safety, and ethical appropriateness of all documentation and clinical decisions.

6. **Transparency with Clients and Stakeholders** — Disclose the use of AI in documentation, assessment, or clinical support to clients, and ensure informed consent where required. Document the use of AI-generated outputs in the clinical record (e.g., "Clinical note generated with assistance of LLM; reviewed and approved by [clinician name]").

6.2 Limitations and Risks

While prompt engineering offers significant potential for improving efficiency and consistency in clinical documentation, several limitations and risks should be recognised:

1. **Hallucination and Factual Error** — LLMs can generate plausible-sounding but inaccurate information, particularly when extrapolating beyond training data or handling ambiguous input. Clinicians must carefully review all outputs for accuracy and consistency with source material.

2. **Diagnostic and Risk Assessment Accuracy** — LLMs should not be relied upon for primary diagnostic assessment or risk evaluation. Prompts can support documentation of clinician-determined assessments but should never substitute for independent clinical judgment in matters of safety and diagnosis.

3. **Cultural and Individual Variation** — LLMs are trained on broad populations and may not adequately capture cultural, individual, or contextual nuances relevant to a particular client. Outputs may reflect biases present in training data.

4. **Data Privacy and Regulatory Compliance** — Use of cloud-based LLM services raises concerns about Protected Health Information (PHI) security. Clinicians must ensure compliance with HIPAA (United States), GDPR (European Union), Privacy Act (Australia), and other applicable regulations. Local, self-hosted, or enterprise models may be more appropriate in regulated settings.

5. **Liability and Professional Responsibility** — Clinicians using AI-assisted tools remain fully liable for all clinical decisions, documentation, and patient safety. AI assistance does not diminish professional responsibility; it redistributes workload but not accountability.

References

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code

Baird, B. N. (2015). The internship, practicum, and field placement handbook (7th ed.). Routledge.

Cameron, S., & Turtle-Song, I. (2002). Learning to write case notes using the SOAP format. Journal of Counseling & Development, 80(3), 286–292. https://doi.org/10.1002/j.1556-6678.2002.tb00193.x

Dimidjian, S., Hollon, S. D., Dobson, K. S., Schmaling, K. B., Kohlenberg, R. J., Addis, M. E., … & Jacobson, N. S. (2006). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the acute treatment of adults with major depression. Journal of Consulting and Clinical Psychology, 74(4), 658–670. https://doi.org/10.1037/0022-006X.74.4.658

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. Psychological Bulletin, 99(1), 20–35. https://doi.org/10.1037/0033-2909.99.1.20

Hogan-Garcia, M. (2003). The four skills of cultural diversity competence (2nd ed.). Brooks/Cole.

Liu, J., Liu, F., Wang, C., & Liu, S. (2025). Prompt engineering in clinical practice: Tutorial for clinicians. JMIR Medical Education, 11, e72644. https://doi.org/10.2196/72644

Sue, D. W., & Sue, D. (2012). Counseling the culturally diverse: Theory and practice (6th ed.). John Wiley & Sons.

Wen, A., Jing, X., Liang, L., & Zhang, Y. (2025). Enhancing SOAP note scribing for medical specialties using LLMs. In Proceedings of the Clinical NLP Workshop (pp. 1–12). Association for Computational Linguistics.

Zaghir, J., Naguib, Y., Bjelogrlic, M., Névéol, A., & others. (2024). Prompt engineering paradigms for medical applications: Scoping review. JMIR Medical Informatics, 12, e60501. https://doi.org/10.2196/60501

Zhao, S., Sampson, S., Xia, J., & Jayaram, M. B. (2015). Psychoeducation (brief) for people with serious mental illness. Cochrane Database of Systematic Reviews, (9), Article CD010823. https://doi.org/10.1002/14651858.CD010823.pub2

Appendix: Document Version and Disclaimers

Document Version: 2.0

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Scope: General clinical prompt templates for mental health documentation and therapeutic support

Clinical Disclaimer: These prompt templates are provided as educational resources for licensed or license-eligible mental health professionals. They do not constitute clinical training, supervision, or legal advice. All use of AI-generated outputs in clinical practice must comply with applicable laws, regulations, institutional policies, and ethical guidelines. Clinicians remain fully responsible for all clinical decisions, documentation, safety assessments, and patient care. Informed consent from patients regarding use of AI-assisted tools is required where mandated by law or institutional policy.

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