

ConfideAI: A Privacy-Preserving AI Assistant for Mental Health Clinicians

Project Description and Documentation Overview

ConfideAI (confideai.ai) is a web-based application developed to support licensed mental health clinicians—particularly independent practitioners—in generating structured clinical documentation, treatment planning resources, supervision reflections, and client psycho-education materials. The tool processes user-provided session notes, transcripts, or case descriptions to produce modality-aligned drafts, with strict emphasis on confidentiality, input fidelity, and adjunctive (not substitutive) use.

The system architecture employs hardware-secured Trusted Execution Environments (TEEs) for processing, ensuring that clinical content is protected by hardware-level isolation during computation. Only non-sensitive metadata (e.g., timestamps) is retained on ConfideAI servers; clinical content is not stored on ConfideAI infrastructure. Users receive cryptographic attestation of isolation. The design aligns with HIPAA principles (Business Associate Agreement is underway), and places export control with the clinician.

1. Confidentiality and Security Architecture

Content is processed exclusively within TEEs, providing hardware-enforced isolation and encryption during computation. No PHI is stored on conventional servers. Detailed technical specifications appear in the project's Privacy Policy (available via the application). This approach supports ethical obligations to protect client confidentiality while enabling AI-assisted documentation.

2. Theoretical Orientations: Customisation for Clinical Practice

Clinicians select from established theoretical orientations to inform output generation. The selected lens modifies system prompts, incorporating relevant concepts, terminology, and frameworks where clinically appropriate. Available orientations include:

- Integrative/Eclectic
- CBT (Cognitive Behavioural Therapy)
- ACT (Acceptance and Commitment Therapy)
- DBT (Dialectical Behaviour Therapy)
- Mindfulness-Based
- Trauma-Focused
- EMDR (Eye Movement Desensitisation and Reprocessing)
- IFS (Internal Family Systems)
- Somatic/Body-Oriented
- Person-Centered/Humanistic
- Existential
- Psychodynamic
- Jungian Analytical Psychology
- Narrative Therapy
- Solution-Focused Brief Therapy (SFBT)

The default "Integrative/Eclectic" supports flexible, client-tailored application. Selections apply dynamically per template or session, promoting alignment with the clinician's therapeutic approach while preserving professional judgment.

3. Prompt Library: Evidence-Informed Templates

The library (version 3.0, December 2025) contains curated prompts across five categories. Each prompt is engineered to generate clinically relevant, structured outputs strictly from clinician input, with explicit safeguards against fabrication, speculation, or deviation from provided material. Prompts use professional language accessible to interdisciplinary teams.

Clinical Notes

- **SOAP Note from Session Transcript** — Converts transcripts or notes into Subjective (client-reported concerns, symptoms, quotations), Objective (observable features: affect, engagement, risk indicators), Assessment (clinical impression, progress, diagnostic considerations with cautious language like "rule out"), Plan (interventions, homework, follow-up). Grounded in structured documentation standards for continuity and clarity (Cameron & Turtle-Song, 2002).
- **BIRP Note from Progress Notes** — Structures informal summaries into Behaviour (observable/client-stated concerns), Intervention (techniques applied), Response (client reaction/progress), Plan (next steps/homework). Suited to brief, functional documentation in community, school, or crisis settings (Cameron & Turtle-Song, 2002; Baird, 2015).

Treatment Planning

- **Treatment Plan and SMART Goals by Modality** — Generates problem statements, 3–5 long-term goals (values-based), 3–5 short-term SMART objectives per goal, 2–3 modality-tailored interventions per objective, and measurable progress indicators. Tailors to clinician-specified approach (e.g., CBT, ACT); uses behaviourally specific, client-accessible language. Incorporates SMART framework for clarity and tracking in psychotherapy planning.
- **Modality-Specific Intervention Recommendations** — Provides 5–7 concrete, evidence-based techniques for a problem and named modality, each with name, mechanism, client-specific adaptations, and expected outcomes. Restricts to scope of the identified approach to maintain theoretical consistency.

Assessment

- **Structured Intake Assessment Report** — Compiles intake notes into sections: Identifying Information, Reason for Referral, History of Presenting Problem, Psychiatric/Medical/Substance/Family/Social/Developmental History, Mental Status Examination, Risk Assessment, Strengths/Resources, Diagnostic Impressions, Recommendations. Marks unprovided information explicitly (e.g., "Not assessed"). Reflects standard intake/reporting formats in

training and guidelines (American Psychological Association, 2017; American Psychiatric Association, 2015)

Supervision

- **Reflective Supervision Prompts** — Produces 8–10 open-ended questions tailored to case and modality, covering therapeutic alliance, technique application/adaptations, cultural/intersectional factors, ethical dilemmas, countertransference, and clinician growth. Frames questions to foster curiosity and self-reflection (Hogan-Garcia, 2003).
- **Ethical and Cultural Case Reflection Prompts** — Offers 6–8 prompts examining cultural biases, intersectionality, power dynamics, ethical complexities, and clinician positioning. Aligns with multicultural counselling competencies (Sue & Sue, 2012).

Patient Education

- **Plain-Language Psycho-educational Handout** — Develops 250–400 word, accessible resources (Title, Introduction normalising experience, Common Signs, Why It Happens, Helpful Strategies, When to Seek Help). Uses validating, jargon-free language; encourages clinician discussion. Psycho-education enhances engagement and outcomes (Zhao et al., 2015).
- **Graded Exposure Hierarchy for Anxiety** — Constructs 10–15 ranked steps (task, expected anxiety 0–100, duration/repetition), tailored to client fears/avoidances. Core behavioural technique for anxiety/trauma treatment (Foa & Kozak, 1986).
- **Behavioural Activation Worksheet** — Creates personalised plans (Introduction, Values/Goals extracted, graded activities, schedule template, monitoring/adjustment). Links activities to values; supports depression/motivation intervention (Dimidjian et al., 2006).

Prompts integrate with the orientation selector and export in multiple formats for EHR/local records.

Purpose and Professional Alignment

ConfideAI aims to alleviate administrative burdens while upholding confidentiality, ethical standards, and evidence-informed care. Templates reflect practices from peer-reviewed literature on documentation, goal-setting, supervision, and psycho-education. All outputs remain adjunctive; clinicians retain full responsibility for accuracy, judgment, and compliance.

References

- American Psychiatric Association. (2015). *The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults* (3rd ed.). American Psychiatric Publishing.
- American Psychological Association. (2017). *APA Guidelines for Psychological Assessment and Evaluation*. American Psychological Association.

- Baird, B. N. (2015). *The Internship, Practicum, and Field Placement Handbook: A Guide for the Helping Professions* (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.
- 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.
- Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, 99(1), 20–35.
- Hogan-Garcia, M. (2003). *The Four Skills of Cultural Diversity Competence: A Process for Understanding and Practice*. Brooks/Cole.
- Sue, D. W., & Sue, D. (2012). *Counseling the Culturally Diverse: Theory and Practice* (6th ed.). Wiley.
- Zhao, S., Sampson, S., Xia, J., & Jayaram, M. B. (2015). Psychoeducation (brief) for people with serious mental illness. *Cochrane Database of Systematic Reviews*, (4), CD010823.

Access and Feedback

Beta access is available at <https://confideai.ai> (Google sign-in). Request participation or discuss needs by emailing support@confideai.ai with a brief practice description. Input on templates, orientations, or features is welcomed to refine clinical utility.

ConfideAI — Developed for the mental health community.

ConfideAI SOAP Notes

Input Example (Session Chronology)

Client: Alex Rivera (28, Male, Him)

Date: 01/01/2026

- Arrived on time, casual clothes, good EC but tense – fidgeting hands, shoulders elevated
- Reviewed conf + limits → nodded “makes sense,” signed all forms
- Opened: “What brings you here?”
- → long pause, big sigh
- → “feeling overwhelmed, everything piling up”
- Described low mood ≈4–5 mo, much worse last 2 mo
- Mood avg 4/10
- + racing thoughts, restless, low energy, irritable esp at work
- Sleep: 1–2 hr latency, wakes frequently
- When stressed → passive SI (“easier if I wasn’t here”) – no plan, no intent, no means
- → safety assessed → no acute risk
- Teared up describing job → recent layoffs threat, workload ↑↑ since promotion last yr
- → offered tissue, affect softened, shoulders dropped a bit
- Noted timeline: symptoms ↑ after promotion (last year) → then breakup 3 mo ago → big hit
- No prior tx, no meds ever
- Fam: mom anxiety (on meds), dad ?
- Lives alone, single, friends supportive but feeling distant lately
- Work FT marketing
- Used to read + hike, now no energy for either
- Strengths noted: “pretty resilient,” close w/ sibling, knows exercise helps when they can do it
- Client goals: ↓ anxiety, fix sleep, lift mood, process breakup, get better coping tools
- → agreed, seemed motivated
- Psycho-ed: anxiety ↔ depression cycle, how stressors feed it
- → receptive
- HW: try 5 min breathing once/day, no pressure
- → “willing to try”
- Reviewed crisis, they took photo of card
- End of session: looked slightly less tense, small smile on way out
- Good initial rapport, engaged throughout
- Impression: Adj dx w/ mixed anx + dep mood features
- r/o GAD vs mild MDD
- Plan: weekly CBT lens, monitor SI + sleep/mood, build coping

ConfideAI SOAP Notes

Output Example: CBT Modality

Initial Session

Subjective

Client presented reporting feeling "overwhelmed, everything piling up" with depressed mood persisting approximately 4-5 months, significantly worsening over the past 2 months. Rated current mood as 4/10. Reported symptoms include racing thoughts, restlessness, low energy, and increased irritability, particularly at work. Described sleep difficulties with 1-2 hour sleep latency and frequent nighttime awakenings. When stressed, endorsed passive suicidal ideation ("easier if I wasn't here") but denied specific plan, intent, or means.

Client identified work stress as significant trigger, describing recent layoff threats and increased workload following promotion approximately one year ago. Became tearful when discussing job situation. Noted symptom exacerbation timeline: symptoms increased after promotion, then worsened further following romantic breakup 3 months ago. Reported no prior mental health treatment or medication history. Family history includes maternal anxiety (medicated) and unknown paternal mental health history. Lives alone, single, with supportive friends though reports feeling "distant lately." Works full-time in marketing. Previously enjoyed reading and hiking but currently reports "no energy for either." Identified personal strengths including being "pretty resilient," close relationship with sibling, and awareness that exercise helps when able to engage. Stated treatment goals include reducing anxiety, improving sleep, lifting mood, processing breakup, and developing better coping tools.

Objective

Client arrived on time, dressed in casual attire. Maintained good eye contact but appeared tense with observed fidgeting hands and elevated shoulders. Affect was initially constricted and mood was congruent with reported symptoms. Speech rate and volume were within normal limits. Psychomotor activity included noticeable restlessness. Engagement was good throughout session. Became tearful when discussing work stress, with affect softening and shoulder tension decreasing slightly after emotional expression. No acute risk indicators present following safety assessment. Demonstrated receptive attitude toward psycho-education and treatment recommendations. Session concluded with client appearing slightly less tense and offering small smile upon departure.

Assessment

Mental status examination reveals depressed mood with anxious features, including racing thoughts and psychomotor agitation. Cognitive patterns indicate negative automatic thoughts related to work performance and self-worth. Functional impairment evident in reduced engagement in previously enjoyed activities and social withdrawal. Symptoms appear consistent with adjustment disorder with mixed anxiety and depressed mood, with differential considerations including generalised

anxiety disorder versus mild major depressive disorder. Symptoms appear maintained by cognitive distortions regarding work performance and recent interpersonal loss, with behavioural activation deficits contributing to low mood cycle. Client demonstrates good insight and motivation for treatment. No acute safety concerns identified at this time.

Plan

Initiated weekly cognitive behavioural therapy focusing on psycho-education regarding anxiety-depression cycle and stressor relationships. Provided crisis resource information and client photographed contact card. Assigned behavioural experiment: practice 5-minute breathing exercise once daily without performance pressure. Treatment plan will focus on cognitive restructuring of work-related automatic thoughts, behavioural activation to increase engagement in valued activities, sleep hygiene implementation, and development of adaptive coping strategies. Will continue to monitor suicidal ideation, sleep patterns, and mood fluctuations. No medication referral indicated at this time. Next session scheduled for one week to review homework compliance and begin cognitive conceptualisation.

ConfideAI SOAP Notes

Output Example: Jungian Modality

Initial Session

Subjective

Client presented with concerns of feeling "overwhelmed, everything piling up" with symptoms persisting approximately 4-5 months, significantly worsening over the past 2 months. Reported average mood rating of 4/10, accompanied by racing thoughts, restlessness, low energy, and increased irritability, particularly in work contexts. Sleep disturbances include 1-2 hour sleep latency and frequent nighttime awakenings. Client described passive suicidal ideation ("easier if I wasn't here") during periods of heightened stress but denied specific plan, intent, or means.

Significant life stressors identified include recent threat of workplace layoffs and substantially increased workload following a promotion approximately one year ago. Client became tearful when discussing job concerns, noting that symptoms intensified after the promotion and were further exacerbated by a romantic breakup 3 months ago. No prior mental health treatment or psychotropic medication history reported. Family history includes maternal anxiety (medicated), paternal mental health status unknown.

Client lives alone, currently single, and reports supportive friendships though feeling "distant lately" from social connections. Previously enjoyed reading and hiking but currently experiences "no energy for either." Identified personal strengths include self-described resilience, close relationship with sibling, and awareness that exercise provides benefit when able to engage.

Objective

Client arrived on time, casually dressed, with good eye contact but observable physical tension manifested through fidgeting hands and elevated shoulder posture. Affect initially constricted and anxious, becoming more congruent and softened when discussing emotional content. Speech rate and volume within normal range, though initial responses included prolonged pauses and sighing. Psychomotor activity indicated mild agitation through persistent fidgeting.

Engagement level was strong throughout session, with client demonstrating motivation for treatment as evidenced by active participation in goal-setting and homework agreement. Safety assessment conducted regarding passive suicidal ideation - no acute risk identified. Client appropriately reviewed and signed confidentiality and limits documentation. Session concluded with client appearing slightly less tense and demonstrating a small smile upon departure.

Assessment

From a Jungian analytical perspective, client presents with what appears to be a neurotic constellation involving tension between conscious adaptation demands and unconscious compensatory processes. The symptoms suggest a state where the individual's relationship with the unconscious may be out of balance, manifesting as depression and anxiety. The timing of symptom exacerbation following both professional advancement and romantic separation suggests potential activation of archetypal patterns related to achievement (Hero archetype) and relationship (Anima/Animus dynamics).

Client's description of feeling overwhelmed by "everything piling up" may indicate difficulty with psychic integration, where conscious ego is struggling to assimilate both external demands and internal unconscious material. The loss of previously enjoyed activities (reading, hiking) suggests possible dissociation from the Self's natural expression and connection to symbolic life.

The constellation of anxiety and depressive features appears consistent with an adjustment disorder with mixed anxiety and depressed mood. Differential considerations include rule out Generalised Anxiety Disorder versus Mild Major Depressive Disorder. The presence of passive suicidal ideation without plan or intent suggests psychological distress rather than acute psychiatric crisis, potentially representing what Jung might describe as a "dark night of the soul" phase in the individuation process.

Plan

Continue weekly psychotherapy utilising a Jungian analytical framework with focus on:

1. Exploring the symbolic meaning and archetypal patterns activated by recent life transitions (promotion, breakup)
2. Facilitating exploration of collective symbols and archetypes through dream work and creative expression to access deeper psychological insights
3. Supporting integration of conscious and unconscious aspects of psyche to achieve greater balance and personal growth
4. Monitoring sleep patterns, mood fluctuations, and passive suicidal ideation
5. Building coping strategies including breathing exercises (5 minutes daily as homework)
6. Exploring the client's relationship with work and achievement through the lens of persona development and shadow integration
7. Assessing family constellation and intergenerational patterns, particularly regarding anxiety

