Automated Clinical Interventions: Screening, Reporting, and Other Ethical Obligations

Allan Edward Barsky, JD, Ph.D.
Florida Atlantic University
abarsky@fau.edu

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Abstract

Automated interventions programs (AIPs) offer clients potential benefits in relation to the accessibility, flexibility, and effectiveness of particular types of clinical services. Although social workers have various obligations to report, warn, or protect others from harm for in-person clinical services, relevant laws and ethical standards do not provide social workers with clear guidance on whether these obligations apply when social workers engage clients through AIPs. This article explores how social workers can balance concerns about client confidentiality, safety, and reporting obligations when using AIPs as part of their work with clients.

Keywords: confidentiality, automated interventions, duty to report, duty to protect, ethics

Social workers offer clients confidentiality to foster trusting work relationships (Reamer, 2018). Respecting a client's right to privacy encourages clients to open up and share information that might otherwise feel too embarrassing or risky to disclose. Although social workers have an ethical duty to protect confidentiality, protecting confidentiality is not an absolute duty. In many instances, confidentiality must be balanced with the interests of ensuring safety and protecting lives. Standard 1.07(c) of the National Association of Social Workers (2018) Code of Ethics, for instance, allows for exceptions to confidentiality when there is risk of "serious, imminent harm" to the client or others. Some states impose a legal "duty to warn" potential victims of serious, imminent harm. Some states impose a legal "duty to protect" potential victims (Author, 2019). Thus, social workers may need to share confidential client information with law enforcement, family members, or others in order to ensure that the client or others are protected from serious, imminent harm. All states impose legal duties on social workers to report reasonable suspicions of child abuse or neglect. Various states also impose legal duties on social workers to report reasonable suspicions of abuse, neglect, or exploitation of elders and adults with disabilities who are dependent on others for their care (Felton & Polowy, 2015; National Adult Protective Services Association, n.d.). There is significant literature and guidance concerning the limits of confidentiality when social workers gather information directly from clients. However, an area that requires further inquiry is how the duties of confidentiality, protection, and warning relate to information gathered through the use of technology, particularly mobile apps, websites, or computer programs that are used for automated clinical interventions. In other words, to what extent should

reporting responsibilities be built into automated intervention programs (AIPs)?

The first section of this article describes the potential uses and benefits of AIPs in client care. The second section examines the importance of ensuring that AIPs have sufficient safeguards for protecting client privacy and confidentiality. The third section explores the ethical obligations of AIPs to warn, protect, or report when social workers have reasonable suspicions of potential harm, such as situations involving suicidal ideation, homicidal ideation, or maltreatment of children, people with disabilities, or older adults. The conclusion offers general guidelines for how social workers can balance concerns about client confidentiality, safety, and reporting obligations when using AIPs as part of their interventions with clients.

Automated Intervention Programs

AIPs refer to digital technologies used to engage clients directly in helping processes such as automated counseling, psychoeducation, guided problem-solving, conflict resolution, or psychotherapy (Author, 2019). AIPs may be offered through various technological platforms including automated voice calls, text-messaging, mobile apps, Internet-based video or text, social robots, and avatars (computer-generated embodiments of social workers or other helping professionals) (Craig et al, 2018; Goldkind, Wolf, & Freddolino, 2018; Leff et al., 2014; Santoni de Sio, & van Wynsberghe, 2016). AIPs are programmed to communicate with clients in an interactive manner, using a combination of listening, assessment, and change-oriented skills to engage and help clients. AIPs do not include teleconferencing, videoconferencing, or other communication technologies, as these methods of technology make use of a social worker or other professional to facilitate the intervention (i.e., the interventions *per se* are not automated).

AIPs are being used to address a broad range of physical, mental health, and social concerns, including pain management, smoking cessation, anxiety, post-traumatic stress disorder, and family conflict (Author, 2017; Kazdin, 2015; Possemato et al., 2015). AIPs and traditional methods of clinical intervention are not mutually exclusive. Technology-mediated services and traditional in-person services may be used in combination as part of an integrated approach to client care (Hilty et al., 2018; Kluge, 2011). The tenets of evidence-based practice suggest that social workers should select AIPs on the basis of whether they are effective and a good match for the particular client, given the client's strengths, needs, concerns, goals, and preferred methods of receiving help (National Association of Social Workers [NASW], 2018; White, 2019). According to Standard 1.03 of the NASW Code of Ethics, social workers should inform clients about options for intervention – with and without technology – and allow clients to choose the combination of methods that they prefer.

AIPs may be individualized for use by particular clients. For instance, an AIP could be programmed to make use of the client's name, address particular issues identified in an intake or assessment interview, and offer interventions specifically designed for a client's concerns, goals, and cultural background. Frequently, AIPs are offered on a "one-size fits all" basis. Massive Open Online Interventions (MOOI) are freely available to anyone around the globe who chooses to make use of the automated program (Muñoz et al, 2015). An example of a MOOI is an app that provides users with a guided meditation or other relaxation techniques. MOOIs do not necessarily require referrals or oversight from social workers or other professionals.

The primary benefits of AIPs include accessibility, affordability, and flexibility (Kazdin, 2015). In terms of accessibility, clients may use AIPs in a location and at a time of their own choosing and convenience. AIPs may incorporate technological accommodations that ensure appropriate access for clients who are blind, deaf, paralyzed, or otherwise disabled (e.g., voice activation, text-to-voice and voice-to-text translations). Timely and affordable access for services may be particularly important for mental health concerns such as anxiety, substance misuse, anxiety, and depression (Kazdin,

2015). AIPs may be programmed to offer services in multiple languages and dialects. Although the initial costs of developing AIPs may be high, the fact that AIPs may be used with many people across many countries can make the cost-per-client significantly less expensive than providing one-to-one in-person services (Muñoz et al, 2015). In terms of flexibility, AIPs may offer clients the ability to use some or all of the services in the sequence that they desire. Clients may also repeat certain parts of the programs on an as-needed basis. Rather than attending sessions on a weekly or other fixed basis, they may individualize how they use the programs, including the pacing an intensity of the programs and how they fit with other services they are receiving (Hilty et al., 2018). Finally, AIPs can offer standardized interventions based on theory and research evidence (Kazdin, 2018). Because AIPs can be programmed in a manner that ensures adherence to particular intervention skills, strategies, and protocols, it may be easier to determine which aspects of the intervention contribute to particular client outcomes.

Protecting Client Confidentiality

When social workers engage clients in clinical services they incur legal and ethical obligations to respect client confidentiality (e.g., NASW Code of Ethics, 2018, Standard 7; Health Insurance Portability and Accountability Act [HIPAA], 1996, and state clinical social work licensing laws). These ethical standards and laws do not specifically address the obligations of AIPs to protect client confidentiality. Similarly, they do not address whether and how AIPs should address safety issues. There is no regulatory process for AIPs; one does not have to be a mental health professional to design, offer, or sell AIPs for use with clients (Kramer, Kinn, & Mishkind, 2015). Given the lack of regulation, AIPs are like the "wild west" of clinical social work and mental health services. In the absence ethical or legal guidance, social workers and others could develop AIPs and refer clients to use them without regard to whether reporting or protection requirements should be built into the AIPs.

When discussing potential use of AIPs with clients, social workers should ensure that clients have sufficient information about the AIPs to be able to make informed choices about whether to use the AIPs under consideration (NASW, 2018, Standard 1.03). This information should include the extent to which the AIPs protect the user's confidentiality as well as under what circumstances information may or must be shared with others (Maheu et al, 2018). For instance, will the AIP's owner collect client information and use it for research? Will the owner sell certain information to others for advertising or other purposes? And is the information gathered subject to disclosure through subpoena's or other court orders (Author, 2019)?

When AIPs require clients to share sensitive information, it is particularly important for AIPs to safeguard client confidentiality. Consider an AIP that clients may use to screen for and assess problems related to substance use or addictions. Clients may reasonably expect that information that they submit to this AIP will be protected. If the information could be accessed by family members, employers, the criminal justice system, advertisers, or others, the client should know this and have the ability to choose some other form of assessment. Alternatively, it may be possible for the client to use the AIP on an anonymous basis, that is, without submitting identifying information. Consider a web-based assessment tool. It may be possible for the client to log in with a pseudonym and not provide any identifying information. The client could also be advised to use a private browser to that the client's IP address and location cannot be identified. Research on the use of an AIP for combat veterans with post-traumatic stress disorder suggested that clients appreciated the AIP because it gave them anonymity and privacy (Possemato, 2015). Use of the AIP was also viewed as a potential stepping stone to in-person therapy (Possemato, 2015).

For AIPs that do not gather sensitive information, confidentiality protections may be less important. Consider a client using a device that monitors physical activity and prompts the client to exercise according to the client's goals and exercise

plan. The client may not view this information as particularly sensitive and may not have concerns about whether the AIP is gathering or using this information. Still, social workers referring the client to use such an AIP should discuss potential confidentiality concerns (Maheu et al., 2018), as well as the benefits of using this device.

Obligations to Warn, Protect, or Report

As noted earlier, social workers have various obligations to warn, protect, or report (OWPRs) in situations such as suicidal ideation, homicidal ideation, reasonable suspicions of child abuse and neglect, and reasonable suspicions of abuse or neglect of vulnerable adults (e.g., due to disabilities or dependency). Although these obligations are relatively clear when referencing information gathered directly by the social worker, to what extent do they apply when the worker has referred clients to use an AIP? Are social workers ethically obliged to ensure that AIPs are programmed to screen for abuse, neglect, suicidal ideation, and homicidal ideation? Further, are social workers ethically obliged to review information gathered by AIPs in order to screen for risks that might give rise an OWPR?

Unfortunately, the NASW Code of Ethics and laws governing OWPRs do not speak directly to these questions. Ethical and legal duties owed by social workers when engaging clients directly are not automatically transferred to duties arising when clients use AIPs. To explore what duties might arise, however, it may be useful to explore the principles of malpractice. Malpractice lawsuits against social workers may arise when clients believe they have experienced harm as a result of substandard social work practices. To establish malpractice in a court, clients must prove the following components:

- The social worker owed a duty of care to the client,
- The social worker breached the duty of care,
- The breach led to the harm experienced by client, and
- The harm experienced was proximate (closely connected) to the breach (Reamer, 2018)

In terms of the first component, when a social worker offers services and a client accepts them, the social worker incurs a duty of care. This duty means that the social workers should act within reasonable standards of care, making use of knowledge, theory, skills, and ethical practices that one would ordinarily expect of social workers with the same professional roles and areas of expertise. Thus, when social workers invite clients to use AIPs as part of the helping process, they should consider what a reasonable social worker, acting prudently, would do in relation to issues related to suicidal ideation, homicidal ideation, and other reporting and protection obligations. Would it be reasonable to expect that the AIPs would screen for these risks? Would it be reasonable for the AIPs to include mechanisms by which risks would be reported to the social worker, child or adult protection authorities, law enforcement, or others, so that appropriate actions could be taken to protect people from harm?

The answers to the preceding questions depend on the circumstances, including the purpose of the particular AIP. For AIPs designed to engage clients in psychosocial assessments, for instance, it would be reasonable to expect that these assessments would include screening for child abuse, suicidal ideation, and other risks. It would also be reasonable to expect that the outcomes of these screening questions would be shared with the referring social worker or designated others so that they could fulfill their OWPRs. Similarly, for AIPs designed for work with people who may be at high risk for issues such as homicidal ideation, it might be reasonable to expect that the AIPs include provisions for screening and reporting relevant risks.

For AIPs that facilitate interventions, but are not designed to assess, screening and reporting provisions may not be necessary. Consider a *life-skills* app that teaches children life skills through the use of games or a *positive-messaging app* designed to help clients maintain positive thinking

and behaviors. Because these apps are not intended to gather information about the client, it may not be reasonable to expect the app to screen for and report particular risks.

As a guiding principle, social workers should consider the function of the AIP and whether screening for risks would be reasonably expected if the same functions were being provided by the social worker without the use of technology. If the social worker would not screen for risks when conducting a similar intervention without technology, then it would be reasonable to use an AIP that does not screen for risks. If the social worker would screen for risks when conducting a similar intervention with technology, then it would be reasonable to use an AIP that screens for risks. It would also be incumbent on the social worker to ensure a mechanism for OWPRs (e.g., the AIP shares information with the social worker who decides what would be an appropriate response). Automated reports to police or protection authorities could be problematic. Although technology, including artificial intelligence, is continuously improving, automated screening may be fraught with challenges. Consider, for instance, a client who threatens to kill himself, but the client may be joking or using sarcasm. If the AIP does not pick up the joking or sarcasm, the AIP may make an unnecessary call to the police. Further, there may be misinterpretations around the use of different words, including idioms. If a client tells an AIP, "There are many ways to skin a cat," the AIP might infer concerns about animal abuse. Having risks reported to a social worker or another designated professional could be used to ensure that identified risks are valid and require particular actions.

Although AIPs may be designed to perform certain social work functions, it may be useful to think of AIPs as a supplement to in-person social work services rather than a replacement for them. When social workers refer clients to use AIPs, social workers may continue to provide certain services, including the functions of screening for relevant risks. They may also monitor the clients' use of AIPs and determine whether any information shared with the AIPs may require further action. In addition, social workers can recommend AIPs that help clients deal with specific types of risks. For instance:

- Domestic violence: AIPs can help clients assess risks and connect them with resources such as shelters, attorneys, emergency services, or behavioral health professionals that specialize in domestic violence issues.
- Post-traumatic stress disorder: AIPs can help clients understand the impact of trauma and treatment options. AIPs can also connect them with trauma-informed treatment providers.
- Substance abuse: AIPs can help clients identify problems related to substance abuse and activate motivation to seek services.
    - For some clients, it may be easier to share potentially embarrassing information with an AIP rather than an in-person social worker or other behavioral health professional. The AIP can then provide help that a social worker would not even know was needed. Still, a combination of in-person services and AIPs may be beneficial, giving the client multiple opportunities to share potentially embarrassing information, including information related to child maltreatment, suicidal ideation, and other risks of harm.

Conclusion

When social workers recommend the use of AIPs, some may view the automated clinical process as "therapistless therapy," akin to the concept of a driverless car. In the absence of a human who is facilitating the therapy (or driving the car), it may seem as though nobody is accountable for what happens. When social workers refer clients to use AIPs, however, they continue to owe clients a duty of care. This duty includes the duty to offer clients a choice of interventions, rather than just a single

option (NASW, 2018, Standard 1.03). Social workers should ensure that clients understand whether and to what extent the AIPs has been programmed to ensure the confidentiality of any client information that the AIPs collect (NASW, 2018, Standard 1.07). When AIPs are gathering sensitive health, mental health, or social information, clients may expect a high level of security to maintain their confidentiality. If the AIPs under consideration cannot offer this level of security, then the social worker and client should consider other intervention options. Through the process of informed consent, social workers should also ensure that clients are informed about the limitations of confidentiality when using the AIPs: Under what circumstances will client information be shared, and with whom?

Many AIPs are not specifically programmed to assess for risks such as child or elder maltreatment, suicidal ideation, or serious risk of harm to others. When social workers are considering whether to refer clients to such AIPs, they should consider whether and how they will monitor for risks. They should also consider whether it is safe to refer certain clients to AIPs that do not provide sufficient screening or monitoring. In some instances, social workers may determine that in-person service, without AIPs, is the most appropriate way to proceed. In other instances, it may be useful for the social worker to work with AIP developer to ensure that the AIP is gathering and sharing information related to particular risks.

AIPs offer many potential benefits, particularly in relation to the access, flexibility, and effectiveness of particular types of services. Under some circumstances, AIPs can help prevent harm or ensure appropriate steps are taken to remediate risks of harm. Still, social workers referring AIPs to clients need to maintain oversight and accountability. They should ensure clients are receiving appropriate services. They should also ensure that they have a reasonable opportunity to assess risks and responding in a timely manner when concerns about child maltreatment, suicidal ideation, homicidal ideation, and other serious harm do arise.

References

Barsky, A. E. (2017). *Conflict resolution for the helping professions: Negotiation, mediation, advocacy, facilitation and restorative justice* (3rd ed.). New York, NY: Oxford University Press.

Barsky, A. E. (2019). *Ethics and values in social work: An integrated approach for a comprehensive curriculum* (2nd ed.) New York, NY: Oxford University Press.

Felton, E. M., & Polowy, C. I. (2015). Social workers and elder abuse. Retrieved from: https://www.naswal.org/page/ElderAbuse

Goldkind, L., Wolf, L., & Freddolino, P. (2018). *Digital social work: Tools for practice with individuals, organizations, and communities.* New York, NY: Oxford University Press.

Health Insurance Portability and Accountability Act. (1996). 42 U.S. Code § 299b-22: Privilege and confidentiality protections. Retrieved from: https://www.law.cornell.edu/uscode/text/42/299b-22

Hilty, D., Rabinowitz, T., McCarron, R., Katzelnick, D., Chang, T., Bauer, A., & Fortney, J. (2018). An update on telepsychiatry and how it can leverage collaborative, stepped, and integrated services to primary care. *Psychosomatics*, *59*(3), 227–250.

Kazdin, A. (2015). Technology-based interventions and reducing the burdens of mental illness. Perspectives and comments on the special series. *Cognitive and Behavioral Practice*, *22*(3), 359–366.

Kluge, E. W. (2011). Ethical and legal challenges for health telematics in a global world: Telehealth and the technological imperative. *International Journal of Medical Informatics, 80*, e1-e5.

Kramer, G. M., Kinn, J. T., & Mishkind, M. C. (2015). Legal, regulatory, and risk management issues in the use of technology to deliver mental health care. *Cognitive and Behavioral Practice*, *22*(3), 258–268.

Leff, J., Williams, G., Huckvale, M., Arbuthnot, M., & Leff, A. (2014). Avatar therapy for persecutory auditory hallucinations: What is it and how

does it work? *Psychosis: Psychological, Social and Integrative Approaches*, *6*(2), 166–176.

Maheu, M., Drude, K., Hertlein, K., Lipschutz. R., Wall, K., & Hilty, D. (2018). An interprofessional framework for telebehavioral health competencies. *Journal of Technology in Behavioral Science, 3*,108–14.

Muñoz, R., Bunge, E., Chen, K., Schueller, S., Bravin, J., Shaughnessy, E., & Pérez-Stable, E. (2015). Massive open online interventions: A novel model for delivering behavioral-health services worldwide. *Clinical Psychological Services, 4*(2), 194–205.

National Adult Protective Services Association. (n.d.). What is abuse? Retrieved from https://www.napsa-now.org/get-informed/what-is-abuse

National Association of Social Workers. (2018). *Code of ethics*. Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Possemato, K., Acosta, M., Fuentes, J., Lantinga, L., Marsch, L., Maisto, S., … & Rosenblum, A. (2015). A web-based self-management program for recent combat veterans with PTSD and substance misuse: Program development and veteran feedback. *Cognitive and Behavioral Practice*, *22*(3), 345–358.

Reamer, F. G. (2018). *Social work values and ethics* (5th ed.). New York, NY: Columbia University Press.

Santoni de Sio, F., & van Wynsberghe, A. (2016). When should we use care robots? The nature-of-activities approach. *Science & Engineering Ethics*, 22(6), 1745–1760.

White, H. (2019). Four fundamental principles of evidence-based policy and practice. Campbell Collaboration – Episode #150. Retrieved from https://govinnovator.com/howard-white