

An Overview of Telehealth

Introductory Interview of Dr. Ofer Zur by Nola Nordmarken, M.A.

This transcript is part of an Online Course on [Telehealth: The New Standard](#) for CE Credits (CEUs) for Psychologists, MFTs, Social Workers, Counselors and Nurses.

Welcome to Zur Institute, L.L.C. audio recording on Telehealth. I am your host Nola Nordmarken. I am a Marriage and Family Therapist in Southern California with offices Santa Monica and South Pasadena. I am also a co-author of CEU courses with Dr. Zur, including such topics as Touch in Psychotherapy, The Professional Will, and Home Office Practice.

In this program I will be interviewing Dr. Ofer Zur on his view and understanding on Telehealth or Telementalhealth. This recording is part of an online course on Telehealth by the Zur Institute at www.ZurInstitute.com. Ofer Zur, Ph.D. is a licensed psychologist, Fellow of American Psychological Association, instructor, lecturer, ethics consultant, and expert witness, with a private practice in Sonoma, California. He has been in practice for over 20 years, and is director of the Zur Institute, L.L.C. at again, www.ZurInstitute.com which offers over 130 innovative, and challenging online continuing education courses for psychologists, counselors, social workers nurses, and other mental health practitioners.

Dr. Zur is most known for his effort to humanize the field of psychotherapy and counseling. He is a fierce advocate of appropriate and flexible application of therapeutic boundaries. He has been a visionary in the field, in the 80s warning us about the potential problems with managed care. He has taught many us how to practice outside managed care on a fee for service basis. In 1990 he was a strong advocate of humanizing the field of psychotherapy and counseling. He taught us how to apply therapeutic boundaries with flexibility and care, rather than rigidity and fear, allowing us to tailor boundaries according to the fluctuating clinical needs of each client. In 2002 he saw coming our way ...

These days he has shifted his attention to telehealth, or telementalhealth, which he views as one of the most important developments in our field of psychotherapy and counseling. It is a rapidly expanding field. In this unique audio, or may I say pioneer recording, Dr. Zur will explore the complexities of what we do and do not know regarding telehealth. Because we are pioneers, it is a little bit like the American wild west. The laws and ethics develop in response to what is happening now, and next in very rapid succession.

MS. NORDMARKEN: Is it okay for me to call you Ofer for the rest of this interview?

DR. ZUR: Yes, Nola, absolutely .

MS. NORDMARKEN: This might just be the easiest clarification I have for you today. Can you define for us what is telehealth vs. therapy, or telemedicine?

DR. ZUR: Yes, and thank you for the generous introduction. Telehealth has also been referred to as telemedicine. It refers to the general occurrence of delivery of medicine or mental health services via digital means in a non-in person situation. Another definition of telemedicine is the use of electronic communication in information technology to provide and support clinical care at a distance. Yet, one more definition, the use of telecommunication and information technology to provide access to health intervention, consultation, assessment, supervision, education, and information across distances. When it comes to psychology, counseling, and mental health services, it has been called Telementalhealth, Telepsychology, E-counseling, E-psychotherapy, Telepsychiatry, Internet based psychotherapy, and many other names. It has even been called Telepsychoanalysis for psychoanalytic psychotherapy via telehealth technology. What is important to understand is, telehealth can be delivered in a variety of ways. It can be delivered by phone, email, text, chat, video conferencing, virtual reality, and who knows in other futuristic ways that are probably just waiting around the corner. It can be conducted simultaneously, such as, at the same time by phone and video conferencing. It can be conducted ... simultaneously, meaning sequentially via text, email, or chat.

MS. NORDMARKEN: It is pretty amazing to think if we were to fast forward just five years from now how different the definition might be, or really how different the delivery might be.

DR. ZUR: Absolutely. We didn't think about smart phones a few years ago, or Kindle, or I pads. There is so much new technology around the corner, and they are going to get faster and smaller.

MS. NORDMARKEN: It is really a challenge just to keep up with the rapid changes. I am also aware when I think about this, so much in our profession is limited by state boundaries, and from profession to profession. How would this alter the definition, if at all?

DR. ZUR: That is a good question. The answer is yes, it may vary from state to state, however many states in some organizations, have not attended to the issue of mental health altogether. For example, California is a state that did attend to telehealth, and define it. In this state therapy via the phone is not considered telehealth. This will soon disappear as so much therapy will be happening online, so we won't necessarily need new regulations, but this is something to be seen.

MS. NORDMARKEN: I have heard you use the terms, native and digital immigrant. The natives being those younger people who were born into the digital world. The immigrants are those of us who were born before it, are immigrating into it, and finding out about it. I am wondering as we are talking, what are some of the reasons that telehealth is important? I am guessing ... I just got a book suggestion from Amazon called the New Millennials and How they are Reshaping the World. These are the 20 somethings, and younger who are really the natives that are born in, they are very, very adaptive, and I was surprised to find out that it is a group that is actually larger than the baby boomer generation. I have a hunch that in your response you are going to talk to me about what psychotherapy is going to mean in relation to the

people who are the natives. Why should we, psychotherapists and counselors, become aware or gain knowledge in this arena? What are some reasons?

DR. ZUR: You already answered it in a beautiful way. The future is here with the new millennium, the digital natives that you mention that my daughter and I have been writing about quite a bit. The short answer for your question is that telehealth is probably the most important development in our field. It is the way of the future, and the future is here. With 7 million people on Facebook, people learn to socialize online, to gather information, to communicate, to find future mates, to do sex, and they are going to get their medical needs online as well.

Medicine has been shifting to telemedicine for quite some time. Physicians can do remote check on vital signs, and even do remote surgery. When it comes to mental health there are so many reasons that it is important. The shoulders of therapists in rural areas ... we baby boomers are going to want to be served at home, and many of us digital immigrants like to do things online, to socialize, especially the young ones as I mentioned. Homebound people whether they are at home due to anxiety or disability will need to use telehealth. I am thinking about young LGBT who are ready to come out, and there is no reason in the world they are going to talk to somebody local about coming out with all the homophobia that is so prevalent in the world. Prisons are another place, where instead of moving prisoners, doctors, and therapists around, you do it via telementalhealth. It is already implemented. Needless to say the military, the treatment of post traumatic stress in rural Afghanistan can be done easily via telehealth.

Most importantly, as you started to question, people are getting used to socializing, getting help, shop, do banking, and everything else online. Medicine and psychotherapy are not any different, and this is why every psychotherapist who wants to stay in business will need to learn about this important evolving, and for me, exciting field.

MS. NORDMARKEN: It is so interesting, and none of us really know exactly where it is going to go. I also think about how people are changing their attitudes about commuting from suburban communities to the urban areas for work, and how there is a trend toward local communities, and having that happen on many, many levels, and this might support that as well.

DR. ZUR: Absolutely. People will create a community online, and it will be no different than our little villages, but it is definitely a very powerful community that can change the regime in many countries, and perhaps, hopefully in this country.

MS. NORDMARKEN: I know that this audio recording will be featured in the Zur Institute's continuing education online course on telehealth. Can you tell us what will be included in the course?

DR. ZUR: This probably one of the most comprehensive courses on the topic that is available. There are a few others are also very good. The course includes seven audio interviews with

experts. It will cover some of the hottest issues in the field. Across state lines meaning, when you or I are talking to somebody who does not live in California, and reimbursement issues. Can therapists use Skype in telehealth? There is a huge debate about it, whether Skype is HIPAA compliant or not. Issues of informed consent. Issue of verification of the client. How do we know that we are talking to a 16 year old or a 90 year old? Clinical consideration of what clients are suited for this in kind of work, what condition, what mental disorders, what kind of setting, rural or prison, psychoanalytical practices, and many other clinical, ethical, and legal questions will be covered in the course.

The course will provide probably one of the most comprehensive resource pages with extra long articles, regulations, code of ethics, important organizations, and bibliographies. It is going to be a very comprehensive course. I am very excited about it.

MS. NORDMARKEN: It is very exciting, and for me as a practitioner it feels like we are feeling our way in the dark with a lot of this. Any guidance that we can get is really helpful. Because it is such a new and pioneering field, sometimes there seem to be more questions than answers. It is really wonderful to be able to talk about it, open up communication, and get some information.

DR. ZUR: Beautifully said. What we need to do is to tolerate when we don't know the answer. In our field whenever we don't know something, we are fast to say it is unethical or illegal without any kind of base for that. We need to tolerate not knowing the answer. Personally, as you know, I love not knowing the answer. It gives me juice, it gives me meaning, it gives me incentive to explore. There is very little tolerance among our ranks when people don't know because people feel at ease knowing, is it right, is it wrong, is it ethical, or is it unethical. When it comes to telehealth, so many of the questions, as we will discuss today, are still up in the air. I encourage listeners to dare not to know. Some things are clear, and some things aren't, and we need to know the difference.

MS. NORDMARKEN: I am so glad you are comfortable with the questions Ofer, because a lot of us out here are really wanting answers to make us feel more secure in what we do. This is a course that I think will be really helpful to a lot of us. I have some questions. I have some thoughts. Let's assume that I have seen a client for a long time in California where I am licensed. The client gets a job requiring him to travel extensively throughout the U.S. and abroad. He asks me to continue to do therapy with him via phone and video conferencing technology. Can I legally and ethically provide telehealth to such a client?

DR. ZUR: We'll separate... Let's make sure the parameters of the questions are clear. This is a client who resides in California. He travels throughout the United States or abroad. I have a few clients like that. One is a train engineer. He calls me from the train as he crosses from state to state. Another one is a pilot who may call me from Hawaii, Beijing, Seattle, or Detroit. In both of these situations, the residence of the clients is still in California where I am licensed. If the client's residency has not changed, and he still resides, pays bills, mortgage, PG&E, or whatever, in California, this means he is a resident in California. I can treat him regardless of

where he is on the planet, whether it is on a sailboat, to Hawaii, or while he travels. I have answered the question for somebody who travels, but still resides in California.

MS. NORDMARKEN: Here is another question. I have had this come up several times with adolescents that I have worked with who live in California, and go to college in a different state. They are actually residing in their dorms most of the year in another state, but they come home during holidays, and summer breaks to be with their parents in their parent's homes. How would that affect it.

DR. ZUR: Let me back track a little bit for people who travel for work or for fun. I think your original question was what happens when you get a call from somebody from a different state? Let me answer this one, because this is a very important aspect.

So you get a call from somebody who lives in another state where you and I are not licensed. What do you do? This is a very important question, as we are not licensed in the state where this client resides. We need to know what the licensing laws are in this state. All states within the United States have licensing laws. Most likely we cannot treat this client across state lines if he is permanently residing in another state where we are not licensed. We need to find out what the licensing laws are in the client's state, but most likely this is one thing we cannot do yet. This is very archaic and a very nonsensical law, but it is part of the American structure, and the independence of each state, to make its own laws. What is the big deal about me living one mile away from one state in New Jersey, but not licensed in New York? But I will treat somebody from the other side of the tunnel. We need to be very careful about that.

The question is... Let's say that somebody decides to treat a client anyway. If I treat somebody outside California in a state where I am not licensed, and there is some problem, California licensing board will not do anything about it. We don't have any say about it because the client is not a resident in California. The other state licensing board, I highly doubt, will extradite me to the other state and spend \$20,000, \$30,000, or \$40,000 to extradite me, to take me to court because I treated a client from their state for a panic attack via a phone or Skype. The other concerns are do I know about child abuse reporting in the other state, and many other concerns. We need to be very cautious when we get calls from clients from states where we are not licensed.

MS. NORDMARKEN: How about other countries?

DR. ZUR: Other countries would depend on if they have any licensing laws there. Somebody asked me about Sri Lanka the other day. They don't have licensing laws in Sri Lanka, so you wouldn't break any laws to treat somebody in Sri Lanka. Be sure to understand that California licensing will not get involved if I treat someone in Sri Lanka because this is not where they mandate. They are supposed to mandate to protect people in California, not to deal with people in Sri Lanka.

Let's go back now to the question you asked about the college student. This is where you walk us into the grey area. The question then becomes, is this young college student a resident of the state where he or she goes to college, or are they a resident of California where you and I are licensed? What we need to think about is three aspects. What is the best interest of the client? Continuity of care is very important if the client is suicidal, if the client will not match with another therapist very easily. What is the residency statute, and what are the licensing laws of telehealth in the state where the client goes to college? If the client distrusts another therapist, will not start therapy with somebody else, I can make a point of continuity of care that it could be highly beneficial, at least initially, to continue to work with the client. Then try and help them get local therapy from a college counseling centers that are likely to be more knowledgeable about local resources, including support groups, vocation counseling, psychiatric emergency, etc. The second is what is residency, and this is where the grey area is.

MS. NORDMARKEN: Can we back up just a little bit?

DR. ZUR: Sure.

MS. NORDMARKEN: It sounds as if you are saying that the goal would be transition. So are you saying that it would be not okay to say, "Okay you are going away to college and we will go ahead and continue with our regular sessions as we have had them scheduled. When you come home you will see me at home."

DR. ZUR: We don't know that. No, I am not sure. It can be transition or it cannot be transition. This leads us to the second question. What is the residency of a client who goes to college but comes home to visit. My son just left to college and he already visited two times, and we are not even to Thanksgiving. Every time they come back they may see us in counseling. Some people question what is the residency requirement by the college they are going to? The answer for that is, we really don't know what is permanent residence if we don't have a case law defining it. The answer is that it is one of those grey areas. You need to look at the three components, as I said, what is good for the client clinically, residency status, how you define it, who defines it. What are the licensing laws. One thing to do is check with state licensing board where the client goes to college. They may be able to give you guidance. My sense is that they are probably as much in the dark in some regard because it is such a new area. Hopefully we will get some more clarity in the next few years. You need to think about these three components. As I always say, consult, consult, and consult.

MS. NORDMARKEN: Can you think of any other ways in which doing telehealth across state lines would be relevant?

DR. ZUR: No, I think we covered permanent residence, the college student, and the traveler. I think this is the three main areas. There must be many more, but I think these are the three arc typical area. One is clear that they reside in California even though they travel. The resident of another state is clear. Then we have the middle ground one, where we are not sure yet.

MS. NORDMARKEN: I think a lot about the different forms of telementalhealth, and I wonder about issues of confidentiality. Especially, I like Skype because with Skype I have the ability to see my client, and my client can see me. For me doing special work with body psychotherapy, the physical cues are very important, but I wonder about the confidentiality of that.

DR. ZUR: This is the million dollar question and the debate is raging about whether Skype is HIPAA compliant, whether it is an appropriate means to deliver psychotherapy. There are three areas that we need to look at when we look at the relationship regarding are we allowed to use Skype, and is Skype HIPAA compliant.

- The issue of encryption, and privacy, or we can call this confidentiality.
- The HIPAA notion of business associates, and the HIPAA hitch regulation of 2011.
- The technological issue of interruption of service.

These are the three areas we need look at.

MS. NORDMARKEN: I am not very techie, and I think maybe some of our listeners are not very techie either. Can you say a little bit more about how do we know if Skype uses encryption? How do we know that?

DR. ZUR: Yes, Skype uses Advanced Encryption Standard, AES, what we call encryption. In fact, Skype relies on the same type of encryption used by the United States government to protect secret information. As a matter of fact, Skype to Skype, voice, video, and instant message conversations are likely to be more secure than conventional phone conversations, on a landline or cellular network. That means with all the debate that is raging, bottom line is, Skype is more secure with its encryption system than our phone lines. Skype uses a maximum 256 byte encryption. Skype utilizes technological things that you don't need to remember or do anything with.

MS. NORDMARKEN: That's okay, it helps to hear the words.

DR. ZUR: It uses AES encryption protocol, which means a Federal Information Processing Standard, FIPS for electronic transmission under HIPAA. And then comes the second related question, is Skype encryption accepted by HIPPA standards. HIPAA does not have an encryption standard. They don't have any encryption requirements per se. They mandate issues of protection of PHI, of unauthorized access, issues of confidentiality, and they have a lot of intentionality, but they don't tell us how to do it. HIPAA is technologically neutral.

MS. NORDMARKEN: Will it always be neutral? It surprises me. HIPAA has been around for how many years now, 10?

DR. ZUR: Since 2003.

MS. NORDMARKEN: It surprises me very much that it's not more specific. Is that intentional? Will it always less specific, or is just that it hasn't caught up with what is happening today?

DR. ZUR: No, it was actually intentional of... They decided not to be specific, because they didn't want to favor one technology of protecting information over others. So they are intentionally did not get into the issue of which businesses would become multi-billionaires, because of HIPAA. So they don't mandate specific technologies. Again, I would like to mention several experts noticed that it is harder to hack into Skype than most telephones, and much, much harder to hack into Skype than to hack into your conversation with your client by listening behind the door, which is a non-techie approach to hacking, or by just putting a simple recording device in your office without your knowledge. Again, hacking into Skype requires high expertise and skill. Hacking into Skype is much harder than simpler low tech technology that I just mentioned. This is the answer. HIPAA does not tell us that we must encrypt, it implies that we need to use technology such as encryption.

MS. NORDMARKEN: That is very interesting and very reassuring. I have not personally had this happen to me, but I have talked to colleagues who have occasionally had problems where they are working with a client on Skype, and it is a very critical moment where perhaps the person is paranoid, or they might be suicidal and the call drops...

DR. ZUR: Let me back track a little bit. There is something else I wanted to mention. Sorry to interrupt you. Let me just say a little bit more about Skype and HIPAA. There are venues that will give you a platform of video conferencing, and they say they are HIPAA compliant. Some of the biggest complaints or concerns with Skype are that it doesn't say on their website that they are HIPAA compliant. They also don't say that they are willing to give you a business associate agreement. There are outfits that are willing to give you, and position themselves clearly as different than Skype, and say they will give you a business associate agreement that Skype does not offer. Then one could argue that psychotherapists do not have a HIPAA business agreement with Verizon, AT&T, or phone company, even though they deliver. We talk to our clients on confidential issues everyday and it never occurs to us that we need a business associate agreement with AT&T, Verizon, or whoever is your phone company. Somebody mentioned, we send confidential letters via the mail. It never occurs to us ask the U.S. Postal Service or UPS to sign a business associate agreement under HIPAA. The question is... This is a valid argument about business associate, but also there is a counter argument. This is an incredible grey area. A lot of people, as you say, are already using Skype in telehealth, and the experts are split and feeling heated on both sides. I feel comfortable standing in the middle and asking the right questions. Now back to...

MS. NORDMARKEN: Let me ask you a question Ofer. When you think about this whole issue of telehealth, and confidentiality, and all of the significant questions that are attached to it, what percentage would you say is still grey area?

DR. ZUR: You know, a lot. I am not sure what percentage, but it is a lot, and the grey area will continue to evolve as technologies develop, and new grey areas will come up. This is something we will need to continue to have tolerance to in a field that doesn't tolerate much ambiguity. It is like you and I have been writing about Touch, some touch is essential to

healing, and to calming people, other touch is sexualized and unethical and illegal. People just need to learn the differences, and to apply it right.

MS. NORDMARKEN: I think what is so different though about that is, and I agree with what you are saying, but I think what is so different about that, and especially for those of us who are digital immigrants, is that touch is something that we were born into. It does not seem new, unusual, or unfamiliar, and still, I would agree it is a topic that has a lot of grey area in it. But for those of us who are immigrants, this whole digital age is brand new to us. So it is completely unfamiliar, and it is changing at every moment, every day, and affecting how we do therapy, and how we run our practices. It has that additional challenge of adaptation.

DR. ZUR: That's fair. Welcome to the world of challenges and adaptation.

MS. NORDMARKEN: So, I was asking you about dropped Skype with critical clients.

DR. ZUR: Technology is not perfect. What we need to do about potential dropped calls, is to do two things. Make a clinical judgment. Is it the right client for this technology, which you need to do anyway. Secondly, inform the client that there is a possibility that the call may drop. When cell phones came into the picture, there were a lot of dropped calls with cell phones. The audio video technology will improve. I don't see too much of a big deal about it. You need to do two things, clinical judgment, and inform the client. If the client is very paranoid you talk to them ahead of time. If the call is dropped it is not because I hung up on you. I don't understand why people write articles about it. It seems to be a pretty simple issue for me.

MS. NORDMARKEN: I wonder, is it important, or necessary to have a written and signed informed consent that is different if you are using telementalhealth in any way, other than what you have in your regular office policies and procedures?

DR. ZUR: There are two ways. In California you must have a separate informed consent, this is a mandate, and again, it does not cover phone conversations. I think that informed consent whether you integrate it into your existing one, or create a new one, depends on your organization, professional organization, or the state. But it is a good idea to talk about the vulnerability of the system, issues of confidentiality, issues that we perhaps won't have clear quick access to locally if I treat somebody from San Diego. I may not be as familiar with the local psych hospitals, even though I should know some. We need to talk about issues of availability, how available we are to our clients if we do use chat, or we use text, or we use emails. The office policies and informed consent does not always need to be signed. In some states it is mandated, some ethics code may be mandated, but generally I look at informed consent as a conversation. It is a work in progress. It is not just limited to this one document. It is very important that all my clients sign informed consent before I start treating them. I have 61 clinical forms online that thousands of people have been using over the years. You need to think about informed consent as work in progress, as a dialog, as a conversation. More things will come up, and clients will need to make more informed consent as we move along.

MS. NORDMARKEN: This is a little different topic, but do we know which modality of telementalhealth... Would it be the telephone that people use most frequently?

DR. ZUR: It is really all over the place. People use Skype as you mentioned, people use the phone, and people use email. In increasing numbers are the young ones who prefer text. We see more people using text, and while I cannot think easily how to do psychoanalysis or psychodynamic through a... text. A cognitive therapist can use text. Some people use Apps in conjunction to psychotherapy. It depends, some people will benefit from different format. My sense is text will be the way the young ones move around the world. This will be an increasing accepted modality, even though it is hard for some of us digital immigrants to imagine use of text in psychotherapy. Virtual life is a growing potentiality because there is so much potentiality. We won't get a chance to talk about it, but there is an incredible opportunity in the virtual reality. It has been used in the military very successfully with Post Traumatic Stress Disorder, desensitizing, all kinds of applications for virtual reality. The sky is the limit, and different clients may benefit from different approaches.

MS. NORDMARKEN: It is so exciting, just the possibilities and the potential. This is just a quick question. One of the things about Skype is that you are seeing the person that you are talking to, and you know for example, how old they are. Where I could see on some of the other modalities... and we have different laws and regulations for children, adolescents, and adults. How do I know if I don't see the person that I am actually dealing with an adult, that I am giving therapy to an adult?

DR. ZUR: There is a very good question about verification. How do we verify who we are working with? I think it is important to know if it is a minor, or not minor. That is for sure, because almost all states have laws about who we can treat with or without parental consent. But when it comes to adults, I have never identified any clients. They tell me their name is Joe Smith. He lives in Petaluma. He will fill in the forms in Petaluma. I trust it. I never ask to verify, and I don't know too many people who...

MS. NORDMARKEN: If Joe Smith looked like he could be 17 or 19, what would you do?

DR. ZUR: Exactly. This is when you really need to get verification of age, because you may need to get parental consent. There is potentiality that this client is a child, and you do text, you wouldn't know it unless you find a way to verify it. People scan documents and send them to you, independent verification. It is a field that is really still shifting right now. You need to have it on you map, that you may need to verify...

MS. NORDMARKEN: With what you just said to me, I wouldn't know how to do that.

DR. ZUR: I don't think there is one way to do that. Showing ID in teleconferencing is one way. Getting a signed consent from a parent.

MS. NORDMARKEN: A picture ID?

DR. ZUR: A picture ID that you show in the video conferencing where you put it next to the camera, where I can read it, and see the picture...

MS. NORDMARKEN: And you would have to put your face up right by it because you could be holding anybody's ID up. I am probably getting too stuck on one little...

DR. ZUR: The verification is ... There are many other ways to verify. Get signatures online and all kinds of legal ways to verify. We won't be able to get into that because it can be very technical, but the issue is a very, very important one.

MS. NORDMARKEN: Okay. Then I think to about as an immigrant... I think a lot of us immigrant psychotherapists pay a lot of attention to body language, vocal, visual cue, and my hunch is that the digital generation is less attached to that. Is that true?

DR. ZUR: Because I do so much via text, I find some way to put emotion into the text, and I used to do more with emails, but really primarily right now with text and Facebook. This is how they communicate, so they are not relying on much facial cues. You are absolutely right. My sense is that it is just one modality. I personally do not really focus on facial cues. I sometimes use intuition, sound, music, and other considerations. If visual cue are very important to you, audio visual would be better for you the therapist.

MS. NORDMARKEN: What are the competence and scope of practice considerations that are relevant to telehealth?

DR. ZUR: What we know about competence is that it has to do with experience, supervision or consultation, as well as education. What is important for us to know is that education is not necessarily only formal education in school. It can be a continuing education course such as this course that we are recording, as well as reading books, or going Wikipedia, or going to YouTube to learn about certain modalities. Competence is not necessarily something that is formal in the world, in the university. It is something that you can gain by getting CDs, going online and doing your own searches so you can gain competence, or the education part of competence. It does not need to be formal.

MS. NORDMARKEN: Do we know much about the scientific basis of telehealth practices?

DR. ZUR: We will need 10 more hours to talk about it. We have thousands of research findings about the efficacy of telehealth, including psychoanalysis, the therapeutic alliance, endless treatment modalities to treat endless numbers of DSM disorders and mental conditions. We have tons of research. The resources page in the book will guide you to some bibliographies that exclusively on the efficacy of telehealth. Perhaps we can remind ourselves that we have had a phone crisis line for over 50 years, and saved probably hundreds of thousands of lives, if not millions, and the efficacy has been proven even before the internet was around. Yes, we have the data.

MS. NORDMARKEN: Are there specific guidelines regarding how we as therapists should maintain records of video conferencing, text messages, chats, emails, and other kinds of digital communications with clients?

DR. ZUR: A very, very good question. Emails are easy to document by keeping the email on your computer. You can print it or not, it can be in digital form. When it comes to audio conferencing, or text where you don't keep them, it is like the clinical record, the office session. You record what was treated, what was presented, what was the outcome, was it effective. It is not basically any different. If somebody emails or texts to me an appointment change, that does not have a big clinical significance. If you talk about suicide, or other issues, of course I document it. So basically there is more venues to keep records because texting you can print right now, you have get software that will print it. Voicemail can be transcribed online, but you need to make sure these things are encrypted and protected if you are going to use these technologies.

MS. NORDMARKEN: This is a records question, but it goes back to the prior question. If I, for example, do a self study on a certain topic by finding articles online, etc., is it good to document that in my records?

DR. ZUR: Not necessarily, but if you develop an expertise in a certain area it would be good to rely on some documentation. It is something that if you are ever being asked, or you would be tested... We don't have a standard of care, or how to document that you read all these books. You don't need to be obsessive about noting it. I doesn't hurt of course, to note using a certain kind of therapy, and citing some of the top people in the field in the clinical record. But it is not really necessary to maintain a very high level of compliance with the standard of care. The standard of care is pretty minimum, and we don't have a requirement to document all the books and CDs that you read, but if you are asked, you should be able to answer.

MS. NORDMARKEN: I have talked to some other colleagues who have voiced concerns that opening your clients to working with, specifically email, or text, gives them the unrealistic expectation that they have 24/7 access to you. What are your thoughts on that?

DR. ZUR: It is part of the informed consent. They may have expectations, and is something I talk to my clients about. The young ones do have expectation of immediacy, and speediness of text communication 24/7. I talk to them about my availability or unavailability. My office policies say, "Dr Zur may not be available for weeks at a time for phone, email, text, and any other communication." When I climb Kilimanjaro, or on a glacier in Alaska, or I travel in China, I am not available. It is part of the informed consent that I tell them about my level of availability. Some people are available. Some people text 24/7 to their clients. It is a conversation that will adjust the expectation.

MS. NORDMARKEN: As an ethics expert, would you say that we need a special, additional, or different code of ethics, or guidelines for telehealth? Can it adequately be covered by the existing practice guidelines of the professional code of ethics?

DR. ZUR: This is another great question. There are two approaches. Some, such as the American Counseling Association, and other organizations decided to develop special guidelines and ethics code for telehealth. The American Psychiatric Association, so far, has stated that whatever in the code applies to digital communication as well. I see benefits in downfalls of both approaches. There is no one right way to do that, so either one is really fine. I don't see necessarily a requirement. I think the APA approach is reasonable. The issue of fidelity, confidentiality, loyalty, and do no harm, all apply to our relationship with our clients regardless of whether we practice digital telehealth or online therapy or not.

MS. NORDMARKEN: Ofer it has been such a pleasure to talk to you today. It has been so informative and enlightening. Thank you so much. Before we end can you tell us what are your general recommendations for mental health practitioners who are interested in engaging in telehealth?

DR. ZUR: To recap what we have said today, please get educated regarding the clinical, ethical, legal, and technological aspects of telementalhealth. Attend very carefully to crossing state lines. As we discussed before, tolerate some of the ambiguities. There is a lot that we don't know yet. Consult, consult, and consult. When you consult you may get opposition, opposite opinions, and then you need to make an informed decision. Have a good consent form. Verify the identity of the client. Make an assessment of risk and benefit analysis regarding using telehealth with certain clients, in certain situations, for certain disorders. Telehealth is not for everybody. It is not for all clients, it is not for all therapists. Pay attention to crisis, emergency issues, issues of dangerousness, duty to warn, because it may not be in the community. You may have different laws and regulations where the client resides. Be aware of local resources, again for emergencies. Make sure that your malpractice insurance coverage has liability coverage.

Remain aware of the limitation of online services, and the technology that we discussed before, dropped calls, etc. Evaluate effectiveness of your treatment. You may think it is appropriate for you, or your client, or the situation, but may not be. It is a work in progress of the appropriateness, and the efficacy. Practice within you scope of practice. You asked me about competence, or to become competent if you choose to do that. Attend to the cultural, ethical, language, and other differences that may affect digital communication. Both clinical and technological competence are really, really important. Tolerate not to know, and enjoy these fantastic new opportunities.

MS. NORDMARKEN: Thank you Ofer. It is great to be a pioneer with you. I am looking forward to learning more from you as the knowledge opens up in this field. Thank you so much.

DR. ZUR: Thank you so much, Nola. You are a great interviewer. Bye bye.

MS. NORDMARKEN: Bye, bye.