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the journal of the association of massage therapists ltd 2011

President's Message

By Tamsin Rossiter

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What an exciting time to be a massage therapist. Our profession is positioning itself to develop into a prominent and specialised body.

Since the national release of the consultation draft of AMT's Massage Therapy Code of Practice, we have been receiving informed, critical and constructive feedback from practitioners, educators and government agencies. These wide-ranging views represent concrete evidence of the acceptance of Massage Therapy as a professional vocation.

Feedback on the draft Code peaked on August 3 when Rebecca Barnett and I were invited to meet with Commissioner Beth Wilson and Deputy Commissioner Grant Davies of the Office of Health Services in Victoria. The meeting was collegial, constructive and extremely gratifying. The draft code was warmly received by the Commissioners, who congratulated AMT for producing such a significant document. They advised on the need to include a complaints handling standard and made specific recommendations in connection with a few key points in the Code.

As a result of this meeting, Beth Wilson agreed to speak at our conference in Sydney on 16th October. An open forum covering all aspects of the Code of Practice will afford everyone the opportunity to contribute.

I urge you to give careful consideration to our Code of Practice.

There should be no need to remind you that, as professional massage therapy practitioners, we share equal responsibility for strictly adhering to our rules and regulations. It is not just codes of practice that enhance the professionalism of massage therapy but you - the practitioners - that lay the path for enhanced credibility and mainstream acceptance.

We have revised the launch date for the final Code and we are now looking at an official launch in conjunction with AMT's 2012 Annual General Meeting. So, if you thought it was too late to read and critique the draft Code, it isn't!

We are encouraging member participation via the proposed forum at the annual conference. In addition, our regional AMT executive are organising meetings to encourage dialogue on this critical issue. We welcome any input.

Research is another critical avenue for us to legitimise our profession. It provides evidence of the efficacy of our work to the mainstream and complementary health sectors, educators, government agencies and the wider community. The theme for the AMT Annual Conference this year is how research can enrich our clinical practice. The program highlights the varied approaches to research within our profession and emphasises the importance of increasing our already impressive body of evidence. I look forward to seeing you at the conference, and welcoming our new practitioners and student members.

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ASSOCIATION OF MASSAGE THERAPISTS LTD

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Secretary's Report

by Rebecca Barnett

The Board's focus over the last three months has unashamedly been on the draft Code of Practice document, which was circulated to members in early May. The Draft Code has also been sent to over 50 government agencies and officials, including Federal and State Health Ministers, Health Complaint Entities, WorkCover authorities and the Department of Veterans' Affairs (DVA).

To date, AMT has received 19 formal responses from these government agencies, most of which have been extremely positive and supportive. We have published a few of the responses in the sidebar on page 4.

The response AMT received from the Veteran's Affairs Minister was somewhat inconsistent and equivocal. For the record, we publish it here in full:

> *"Thank you for your letter of 6 June 2011 to the Minister of Veterans' Affairs, the Hon Warren Snowdon MP, concerning the release of the consultation draft of the Massage Therapy Code of Practice. The Minister has asked me to respond on his behalf.*
>
> *As you may be aware, under the Department of Veterans' Affairs (DVA) arrangements, massage may be funded only if it is delivered during a consultation with a physiotherapist, chiropractor or osteopath. These providers will use his or her clinical judgement to determine whether massage techniques, in conjunction with other treatments, are an appropriate form of treatment for the entitled person. The entitled person needs a referral from their Local Medical Officer, and the health provider must be registered with Medicare Australia.*
>
> *As a significant purchaser of healthcare services, the Department is aware of the role of alternative therapies in Australian health care.*
>
> *In 2010, the Department reviewed the policy related to alternative therapies for Gold and White Card holders. The review considered evidence for alternative therapies; the qualifications and regulation of alternative therapy providers; and how veteran agencies overseas deal with alternative therapies. In reviewing the information available on the evidence for the effects of alternative therapy it was concluded there is often not enough evidence to make recommendations about safety or efficacy of a particular therapy.*
>
> *As a result of the review, the Department could not be confident that funding alternative therapies by alternative therapy providers under Gold and White Card arrangements would have significant benefits for patients, be cost effective or be practical to implement at this time. The outcome of the review was that Gold and White Card arrangements will continue to not cover alternative therapies provided by alternative therapy providers. However, DVA is interested in being kept informed of the development of a national agreed code of practice for Massage.*
>
> *I look forward to receiving the final version of the Association of Massage Therapists Ltd Code of Practice.*
>
> *Yours sincerely*
>
> *Judy Daniel*
>
> *Acting General Manager, Services Division"*

Although the DVA's response understandably garners a lot of frustration and angst (I personally thought my head was going to blow off), I think we can thank the DVA for focusing the issues we face, even if their arguments are inconsistently framed.

If nothing else, the DVA has certainly opened the door for further dialogue and clarification!

However, their comments also provide validation for the enormous amount of work that has been invested in drafting a Massage Therapy Code of Practice. The Code allows us to demonstrate in a concrete fashion that massage therapy is not an alternative therapy and that massage therapists have the skills, knowledge, training and awareness to abide by professional standards of practice. It is our message in a bottle: we're here, we're skilled, we're safe and we're professionals. As Tamsin mentioned in her report, it's an exciting time to be a massage therapist!

We sent the following response to the DVA in preparation for making another formal submission to have massage therapists recognised as legitimate providers:

> *"Thank you for your letter dated 21 June 2011 acknowledging receipt of AMT's consultation draft of the Massage Therapy Code of Practice, and outlining the Department's position on the funding of massage therapy services.*
>
> *Over the past 10 years, AMT has received many requests from the veteran community for massage therapy treatments to be funded by the DVA. There is a broad perception that the DVA's policy in this area is out of step with other government bodies such as Commcare and the various WorkCover authorities.*
>
> *AMT sent a major submission to the DVA in 2007 requesting that massage therapy treatments be recognised. This submission contained letters of support from prominent members of the veteran community whose own health conditions had benefited greatly from the care they had received from massage therapists. I have included a copy of our 2007 submission with this letter. To date, AMT has not received a formal response to this submission from the Department.*

AMT intends to make another submission to the DVA, which will incorporate the substantial body of evidence that supports the efficacy of massage therapy as a treatment for a broad range of conditions impacting the veteran community. To assist us in making this submission, I would be pleased if you could clarify the DVA's position in relation to the following:

1. *Does the DVA consider massage therapy to be an alternate therapy?*
2. *Does the DVA consider osteopathy and chiropractic to be mainstream therapies?*
3. *Does the DVA consider massage therapy to be an alternate therapy when a physiotherapist, chiropractor or osteopath provides it?*
4. *Does the DVA consider massage therapy to be an efficacious form of treatment when performed by a physiotherapist, chiropractor or osteopath?*
5. *Is the main barrier to recognition of massage therapists by the DVA efficacy, safety, consistency of qualifications or a combination of all three?*

Thank you for taking the time to acknowledge the work AMT has invested in drafting the Massage Therapy Code of Practice. I look forward to receiving clarification from you on the above issues. "

Yours sincerely

Rebecca Barnett

We'll keep you posted on the response!

On a more positive note, AMT's meeting with the Commissioners from the Victorian Office of Health Services has been the high point thus far in terms of feedback on the Code. It's impossible to overstate the value of the insights given by professionals whose stock in trade is dealing with healthcare complaints. Commissioner Beth Wilson's approach to her role seems to be refreshingly grassroots, driven by the sensible premise that awareness and prevention is far better than having to deal with a complaint from a client. As Tamsin said, both Commissioners commended AMT on the work that has been invested in the draft Code. Their feedback will help us to make the document even more relevant and useable. The harmonica playing was an unexpected bonus ...

National Consultation on options for the regulation of Unregistered Health Practitioners

The national consultation on regulation of unregistered health practitioners that was undertaken by the Australian Health Ministers Advisory Council (AHMAC) was completed in April. AHMAC received 181 submissions from a range of health-related bodies, consumer advocacy groups and private individuals.

The Advisory Council has now completed its research and its report/recommendations are due to go to the Health Workforce Sub-Committee on August 18. Once the Health Workforce Committee has approved the recommendations, they will be tabled at the next AHMAC meeting in October and subsequently at the Health Ministers' meeting in November. AMT should receive notification of the result of the deliberations after the Ministers' meeting.

Although it is not possible for AHMAC to share the contents of their report at this stage, they have informed AMT that the bulk of the submissions supported the implementation of a National Code of Conduct for Unregistered Health Practitioners, suggesting that this is one of the key recommendations of the report. Such a national scheme is likely to be based on the NSW Code of Conduct that operates under the auspices of the NSW Health Care Complaints Commission, which massage therapists practising in the state will already be aware of. This code has been in force since 1 August 2008 and is a form of negative licensing. Essentially, it is a legal instrument that requires practitioners to adhere to standards of professional conduct and provides a mechanism for practitioners to be sanctioned for unacceptable conduct, with penalties ranging from cautions and restrictions on practice to complete prohibition. The HCCC's disciplinary decisions are published on their website.

In its submission to AHMAC, AMT argued in favour of the establishment of a nationally consistent Code of Conduct. Further to that, AMT argued for the establishment of a national Massage Therapy Code of Practice, to be administered under the Australian Health Practitioners' Regulation Agency, to support the goal of identifying Massage Therapy as an Allied Health Profession. AMT's submission to AHMAC is available for download from the AMT website. Just follow the link from the home page **www.amt.org.au**

Follow us on Twitter!

Yes, that's right. AMT has got hip and joined the Twittersphere. Why not watch us get the hang of tweeting as we try to distil all the important stuff from the world of massage therapy into 140 characters or less.

We are using the Twitter feed to disseminate relevant industry news and research. Many researchers now use social media like Twitter to gain wider coverage and publicity for their research, so signing up for a Twitter account has proved to be a surprisingly useful research tool.

You'll find our Twitter feed here:

http://twitter.com/#!/RamblingAMT

But surely that's enough from me now…

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Need CEUs?

Journal question - September edition

How many members were interviewed for AMT's quantitative survey?

Please write your answer in the space provided on your CEU record sheet and retain it until you submit the form with your annual renewal. Blank CEU forms can be downloaded from: http://www.amt.org.au/index.php?Page=Members_CEUs_1.php

Victorian Health Minister's Office

Thank you for your correspondence of 6 June 2011 addressed to the Minister for Health regarding the Association of Massage Therapists (AMT) Massage Therapy Code of Practice. I am responding on behalf of the Minister.

AMT is to be commended for the initiatives it is undertaking to strengthen self-regulation of the massage profession. The draft code of practice appears to be comprehensive and relevant and we look forward to receiving advice on the final adopted version.

Yours sincerely

Rosemary Calder
Chief of Staff

Department of Education and Training

Thank you for your letter dated 6 June 2011 regarding the draft Massage Therapy Code of Practice.

I acknowledge the work the Association of Massage Therapists is doing to promote the safe and ethical practice of massage therapy in Australia. In my view, developing and implementing a code of practice is an important step toward a shared understanding of benchmark standards of practice for self-regulating industries like yours. I also support your opinion that increasing awareness of practitioners and clients about standards of service delivery should improve confidence in the industry and thereby its standing in the broader community.

I would like to thank you for the opportunity to provide comment on the draft code of practice but wish to advise that no formal response will be submitted on behalf of the Department of Education and Training.

Yours sincerely

Julie Grantham
Director General

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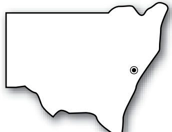
News from the regions



Hunter
by Paul Lindsay

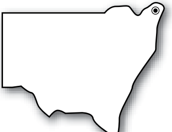
Our March meeting featured Sharon Watson as guest speaker. Sharon is a member of The Reflexology Association of Australia and she presented an overview of Reflexology, covering the theory, personal experiences and a practical demonstration.

Our May meeting was an overview of the Daavid Method of massage presented by therapist Dianne Drelincourt. Regrettably, while the technique seems powerful, Pierre Daavid is no longer teaching and there are no other instructors to perpetuate his teaching, so the method seems likely to die out.

Our branch AGM was held on 17 July and the following committee members were elected:

Chairperson: Kristin Osborn
Secretary: Paul Lindsay
Treasurer: Cherith McInness
Catering Officer: Jean Pearce

The AGM was followed by a workshop on 'Common Muscular Stress Patterns' presented by Philip Latey.



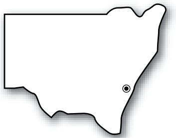
Northern Rivers
by Keryn Rose

The Northern Rivers held a meeting in Lismore on 24 July to discuss the AMT Draft Code Of Practice. All attendees were grateful for the opportunity to discuss the Draft and, in the three hours we had together, we were able to cover the first three standards laid out in the document (Professional Boundaries, Draping and Breast Massage).

We had a discussion on the benefits of having a policies and procedures manual in our clinics that includes a draping policy, and shared some of our own stories of varying draping experiences. Another topic of interest was receiving gifts from clients. Who would have thought massage therapists were such a target for clients baring gifts of the garden variety!

Each individual felt strongly for and against many issues raised by the draft Code and this is sure to be relayed to AMT when they receive our individual feedback on the document. I am pleased to report there were still happy smiles at the end of the meeting, with photographic evidence to prove it!

▲ Northern Rivers region members still smiling after 3 gruelling hours with the AMT Code of Practice!

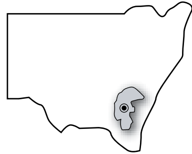


Illawarra
by Malcolm Brown

Our highlight this quarter was the members' day workshop presented by Colin Rossie on the shoulder. Eighteen enthusiastic therapists attended the workshop and Colin's inimitable style of instruction proved to be both educational and entertaining! We look forward to Colin's future return to the Illawarra.

Illawarra branch meetings are held on the last Tuesday of the month at the Corrimal Community Centre (library) Bottlebrush Room, commencing at 7pm. All Illawarra members are encouraged to attend. Aside from gaining CEUs we endeavour to make the meetings informative and enjoyable. The current region executive is:

Chairperson: Malcolm Brown
Secretary: Linda White
Treasurer: Sharon Harley



ACT
by Karin Cavanagh

Hussam Sahib gave an informative presentation on Ortho-Bionomy at our last branch meeting, showing us how using little effort can produce great results. We also discussed the draft Code of Practice in detail and, in response, submitted a substantial feedback document. I strongly urge you to read this document and send your feedback by the deadline of 16 September 2011.

Our next branch event is a combined meeting/workshop on September 11. It will be in a "round robin" format, with each attendee demonstrating a special style or technique that they utilise in their clinic. Please note that we are not expecting anything earth shattering or even mind blowing: sometimes the most profound changes are made with the simplest interventions.

Upcoming branch events are:

Sunday 11 September 2011
Meeting & Workshop

Sunday 6 November
Meeting & Workshop (Presenter TBC)

Wednesday 14 December
Meeting & Christmas Party

Sunday 12 February 2012
Meeting & Workshop (Presenter TBC)

Thursday 5th April
ACT AGM

We hold our meetings in the Weston Club, 1 Liardet Street, Weston. Our meetings during the week commence at 7:30pm and our Sunday meetings commence at 10:30am.

Riverina
by Nicole McKenzie

We were pleased to have a huge turnout and some new faces at our May meeting in Kayuga. Kay Fredericks provided us with another informative workshop, reviewing structural assessment and treatment options for the psoas.

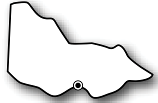
Unfortunately, the Back2Basics Expo held in Kyabram didn't live up to its potential. Local member Siebren de Boer put a lot of time and effort into the event and, although not many potential clients walked through the door, we proudly promoted our profession and Riverina members of AMT.

The branch AGM took place on July 29 and the following executive was elected:

Chairperson: Nicole McKenzie
Secretary: Jodee Shead
Treasurer: Warren Curnick

We thank the outgoing Treasurer, Siebren de Boer, and welcome Warren Curnick to the AMT fold.

The road ahead looks busy with the draft Code Of Practice currently under discussion. Plenty of reading and food for thought for all members since this document will shape our future.



Melbourne
by Kerry Hage

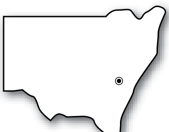
The Melbourne branch is approaching its first anniversary in September when we will hold our AGM. Meeting attendance has been consistent but low since the establishment of the branch. We hope that the survey that was emailed to local members recently will help us ascertain the best times to hold meetings, to ensure maximum attendance and benefit to members.

To date, the main agenda for the group has been raising awareness of the branch and networking within our local membership. We have begun a group library with the purchase of our first book "The Educated Heart", and intend to add to this resource with new book purchases and donations from the personal collections of local members.

Another focus of the group has been to assist members to make the journey to member's days and the annual conference by giving them a platform to share accommodation and travel expenses (and ensure there are familiar faces at gatherings!).

At the July meeting the group made plans to hold a family day in the new year. An email will shortly be sent to members to establish the viability of this endeavour. We hope it will start the year off in a fun, informal way and help raise awareness of the activities within the branch.

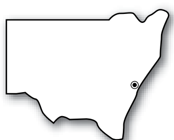
New office bearers will be elected at the upcoming AGM. The group has not had an official Chairperson since its inception and Kerry Hage has indicated that she would like to nominate for the position. This means that the position of branch Secretary will need to be filled to solidify the future of the regional group for the coming year. Gabby Griffiths has indicated that she would be happy to re nominate as Treasurer.



Blue Mountains
by Judi Lambert

Our June meeting was held at Wentworth Falls TAFE with a large group in attendance. Items for discussion included Massage Awareness, new therapist mentoring and how AMT can become more widely known in the Blue Mountains. After concluding the meeting, we enjoyed a relaxing, interactive presentation by our guest, Usha Kumbla, who guided us through a session of yoga.

The next meeting will be held at 7pm on Monday 19 September at Wentworth Falls TAFE, with guest speaker John Bragg. We are looking forward to greeting our local members for another information, packed evening.



Sydney South
by Kelly Walker

Sydney South's AGM was held in June, with a great turnout that included a few new members. The following office bearers were elected:

Chairperson: Rene Goschnik
Treasurer: John Eades
Secretary: Maria Earley
Librarian: Jenny Della Torre

Our guest speaker, Anthony Gould, talked about Achilles Tendinopathy. Anthony is a massage therapist and osteopath with busy clinics in the city, Hunters Hill and Drummoyne.

Rebecca Barnett was guest speaker at our August meeting. Beck discussed AMT's Draft Code of Practice, explaining how AMT plans to use the document to help clearly establish Massage Therapy as a recognised health profession.

We look forward to strong attendances for the rest of the year and welcoming new members to Branch meetings.

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AMT Member Representative

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Enter Michelle McKerron, who is taking up the challenge of a new role as AMT's Member Representative.

Michelle has been a member of AMT since 1996 and manages a small clinic in the south of Sydney. She has been actively engaged with where AMT is heading throughout her whole career as a massage therapist and is now adding to her skill set, participating in AMT Board meetings. She will be acting as the eyes and ears for you - the members!

You can contact Michelle at memberrep@amt.org.au with any questions or feedback you have for the AMT Board.

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Product Review:
Pro Conditioning Exercise Software

by Tyraus Farrelly

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Web: www.proconditioning.com.au
Price: Pro-Rehab. Package $690
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Most massage therapists realise that soft tissue release is often just one step towards a comprehensive treatment plan. A corrective stretching and strengthening program, and core stabilisation are also often needed if you are serious about delivering an effective treatment plan.

So … you give your client an exercise program and watch them run through each exercise, correcting them when needed. Maybe you even draw a few of your famous "stick man" figures to try to reinforce what you have demonstrated. But how much is your client likely to recall when they get home?

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- create exercise programs in 13 different layouts, complete with your branding.

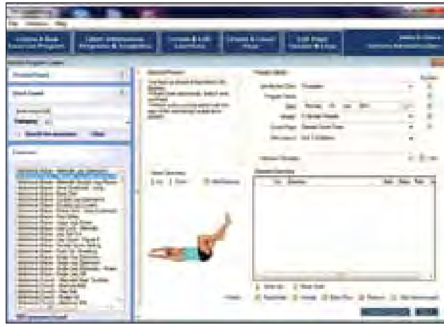
Navigation is via the blue menu along the top of the page. The menu contains the following tabs:

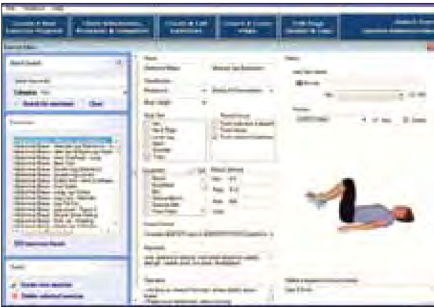
1. Create A New Exercise Program
2. Client Information, Programs & Templates
3. Create & Edit Exercises
4. Create A Cover Page
5. Edit Page Header & Logo.

The software allows you to personalise the cover page, headers and logo to suit your business. You can also create custom exercise lists and templates, import new exercises and modify any existing exercise.

To select from the available 922 exercises you can enter a key word search or choose from the drop down category list. You can also select from a series of pre-defined exercise templates such as "Early Stage Knee Rehab" or "Core - Basic Activation Routine".

When you click on a particular exercise, a preview appears in a pane beside the exercise with pictures and exercise description. Once you have created a list of exercises, you can choose from 13 different layouts to view or print the exercise program.





Options range from a 4-week grid which shows exercise list, reps, sets, rest time etc to a session grid with 4, 6, 8 sessions to choose from or picture grids ranging from 1 picture to 10 pictures per page. The less pictures per page, the more concise the associated printed exercise description. These options give you lots of flexibility to print combinations of layouts according to the specific needs of the client. However, an option for a per session or per week grid with associated thumbnail pictures of the exercise would have been a nice inclusion. I have seen this in other programs and really like this format as it gives a quick visual reference for the more visually-oriented client.

Exercise programs you create are automatically converted to PDF format when you hit the "create program" button. This means you can either print or email your client's exercise program. This is great when you don't have time to create your client's exercise program during their appointment. You also have the option of saving the routine you have created to print later or as a template to use with other clients.

On my new laptop, the PDF takes 4-8 seconds to create. However, my old laptop sometimes took 2 minutes to generate the PDF so be aware if you have an outdated or slow pc!

Pro Conditioning has an update scheduled for September 2011 with extra features and 50 extra exercises. An online subscription version will be rolled out at the same time. At $15 a month, this could be a more feasible option for many therapists than investing over $690 in one go. The online version also contains some extra features that are not included in the desktop version. It could conceivably function as an extended low-cost trial before committing to purchasing the desktop version.

A Final Word

There are many exercise prescription programs out there. Some load onto your PC but have limitations such as no Mac or Android versions. Others are subscription and/or web based, meaning you pay a monthly subscription and access through a login on the provider's website. Others have features that allow clients to click an email link you send them which displays the program you set with pictures and even video of each exercise. There are even systems that can download the exercises onto mobile devices such as the ipad or iphone. It pays to do a bit of research to find what will suit you and your clinic best in terms of features and budget.

Pro Conditioning has the advantage of access from anywhere with any system but the online version does require a fast, reliable broadband service.

Tyraus Farrelly is a senior level 2 AMT member.
He completed the TAFE Associate Diploma of Health Science in 1995. He was the head Massage Therapist for the St George Illawarra Dragons for 4 years & the head consultant Therapist for the Australian National Martial Arts team for the World Karate Championships. He has conducted post graduate workshops privately and for the Illawarra Steelers and delivered workshops on Massage for Pain Relief within a pain management course. He has worked with many Physiotherapists, Musculoskeletal Specialists, Chiropractors, Exercise Scientists and Sports Physicians within a rehabilitation environment and within an elite sports environment. He currently runs a full time clinic in Wollongong, with a focus on sports & occupational injuries.
For comments or suggestions please contact Tyraus at tyraus@triggerpointtherapy.com.au

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Brisbane	12th & 13th Nov 2011	
Tasmania	11th & 12th Feb 2012	
Canberra	25th & 26th Feb 2012	
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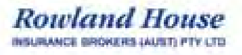

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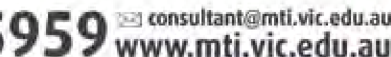

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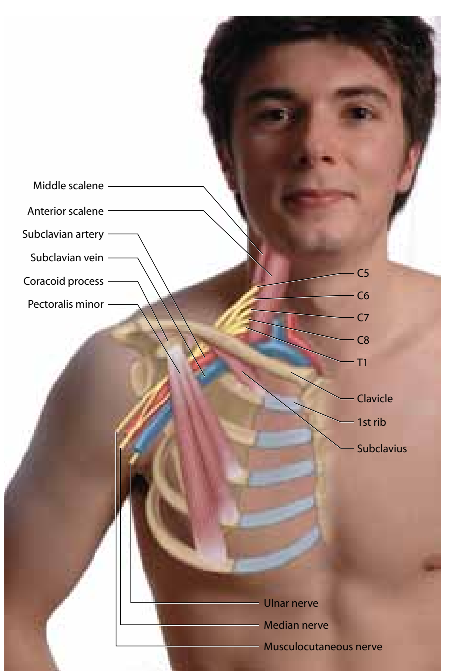
Thoracic Outlet Syndrome

by Joe Muscolino

THORACIC OUTLET SYNDROME

The upper thoracic region is where neurovascular structures exit into or 'outlet' into the upper extremity. These structures are the brachial nerve plexus, the subclavian artery and the subclavian vein. Thoracic outlet syndrome (TOS) is the name given to the group of pathologic conditions in which compression of these neurovascular structures occurs (Figure 1).



▲ **Figure 1:** The three entrapment sites of thoracic outlet syndrome (TOS) are between the anterior and middle scalenes, between the first rib and clavicle, and between the pectoralis minor and rib cage.

There are three major types of TOS, named after the region where the compression occurs:

1. anterior scalene syndrome, which occurs between the anterior and middle scalenes
2. costoclavicular syndrome, which occurs between the first rib and the clavicle
3. pectoralis minor syndrome, which occurs between pectoralis minor and the rib cage.

These conditions are grouped together as TOS because they are all neurovascular compression conditions that can cause the same signs and symptoms into the upper extremity. Further, the same pathologic mechanisms often underlie more than one type of TOS so it is common for a client to present with two or all three forms of TOS.

Anterior scalene syndrome

The brachial nerve plexus and the subclavian artery run between the anterior and middle scalenes. If the scalenes become tight, compression of these structures can occur. Scalenes are commonly tight due to whiplash injuries in which the head and neck are forcefully thrown posteriorly or contralaterally, straining or overstretching them, and triggering a muscle spindle reflex that causes them to spasm. Scalenes can also tighten due to adaptive shortening in response to chronic postural influences, such as typically occurs with a hypolordotic neck. Additionally, they can tighten due to their overuse as assistant muscles of inspiration, presenting in clients who have laboured breathing from chronic respiratory diseases such as asthma, emphysema or chronic bronchitis.

Costoclavicular syndrome

The brachial nerve plexus, subclavian artery and subclavian vein run within the costoclavicular space between the first rib and the clavicle. If this space decreases, these neurovascular structures can become impinged. The costoclavicular space will narrow if the clavicle and first rib approximate each other. This can occur in three ways:

1. The clavicle depresses toward/against the first rib. This can be observed in the common postural condition of rounding and slumping of the shoulders. A tight subclavius can also cause this to occur.
2. The first rib elevates toward/against the clavicle. This often occurs in clients who have laboured breathing. Tight anterior and middle scalenes and subclavius can also cause this to occur.
3. The clavicle depresses and the first rib elevates.

Pectoralis minor syndrome

The brachial nerve plexus, subclavian artery and subclavian vein run between the pectoralis minor and the rib cage. If the pectoralis minor becomes tight, these structures can be impinged. Pectoralis minor syndrome is the most common form of TOS because the pectoralis minor is so often tight. The common postural distortion pattern of rounded shoulders (protracted scapula/clavicle) causes shortening of the pectoralis minor. Then, due to adaptive shortening, the pectoralis minor increases its tone to tighten at this shortened length. However, tightening of the pectoralis minor due to it being overstretched is also fairly common. This occurs if the arm is abducted and then suddenly and forcefully stretched posteriorly behind the body. Also, like the scalenes, the pectoralis minor is often recruited as an accessory muscle of inspiration and may tighten in clients with laboured breathing.

Cervical rib TOS

There is a fourth type of TOS that is often referred to as "true TOS". This condition is caused by the presence of a small, genetically anomalous cervical rib that is attached by fibrous tissue to the transverse process of the seventh cervical vertebra.

The presence of this rib can cause compression of the brachial nerve plexus and/or the subclavian artery.

SIGNS AND SYMPTOMS

If we understand that the pathomechanics of TOS is compression of neurovascular structures, the signs and symptoms can be extrapolated. Compression of the sensory portion of a nerve can cause tingling, numbness, decreased sensation (hypoesthesia), increased sensation (hyperesthesia) or pain. Compression of the motor portion of a nerve can cause weakness or twitching of the associated musculature.

The brachial plexus is composed of five major nerves: the median, radial, ulnar, musculocutaneous, and axillary nerves. Figure 2 shows their sensory innervation distribution in the hand.

Because all three forms of TOS can cause compression of the brachial nerve plexus, all of the aforementioned sensory and motor signs and symptoms can occur. These signs and symptoms could occur anywhere within the upper extremity because the brachial plexus innervates the entire upper extremity (the word brachial refers to the arm).

If the subclavian artery is compressed, the strength of the pulse in the upper extremity will decrease (but the speed of the pulse will not be affected). Most commonly, the radial pulse on the radial side of the distal forearm is the pulse that is assessed to determine whether there is compression. If the subclavian vein is compressed, venous drainage would be compromised, causing swelling in the upper extremity.

Signs and symptoms of neurologic compression with TOS are more common than signs and symptoms of subclavian artery or vein compression. Specifically, tingling and numbness in the hand are the most commonly found symptoms of TOS. However, understanding the mechanics of subclavian artery compression is important when assessing TOS.

ASSESSMENT

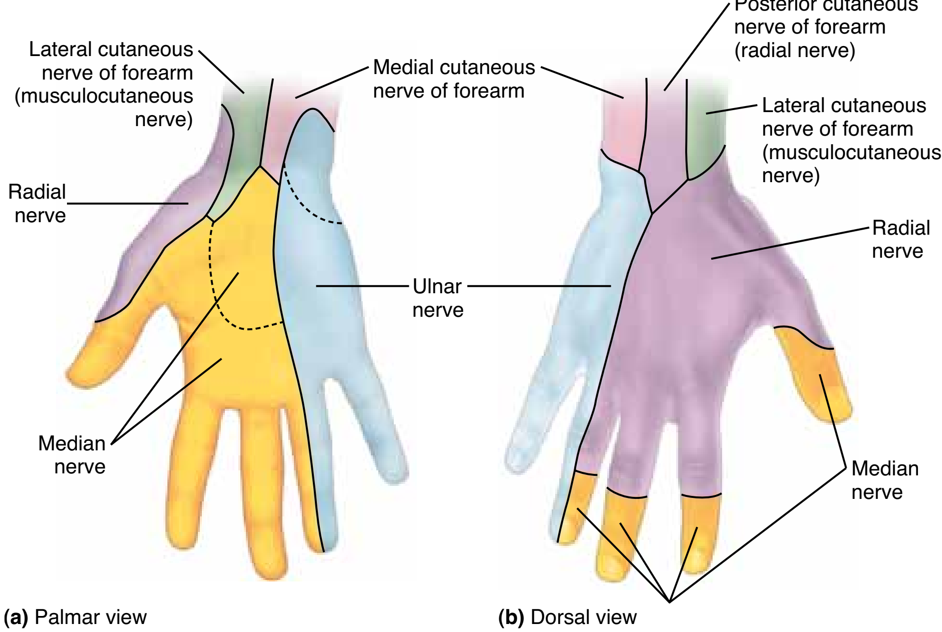
Knowing how to assess TOS is also an extension of our understanding of the underlying pathomechanics of the condition. Even though the effects of neural compression are the most common presenting complaints of TOS, it is the effect of arterial compression that is primarily used to assess this condition.

A different assessment test is used for each of the three forms of TOS. Common to all of them is that the client is moved into a position that increases the neurovascular entrapment of that condition while the strength of the radial pulse is assessed. If the strength of the radial pulse diminishes (showing that the subclavian artery is compressed), then it can be reasoned that any neurologic signs and symptoms that the client is experiencing are coming from the same entrapment site. In this manner, the specific form of TOS can be assessed.

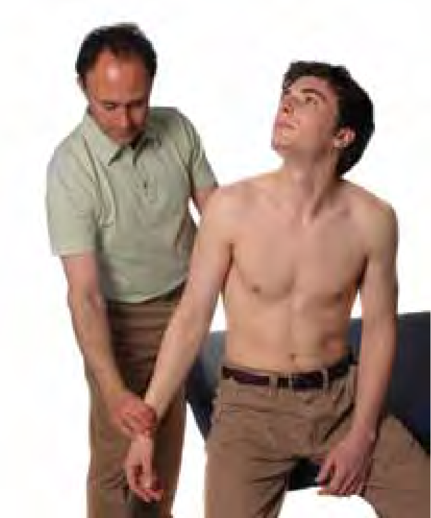
Adson's test (for anterior scalene syndrome)

The assessment test used for anterior scalene syndrome is called Adson's test. It is performed by feeling for the strength of the radial pulse while asking the client to rotate the head and neck to the same (ipsilateral) side, and then extend and laterally flex the head and neck to the opposite (contralateral) side (Figure 3). This position maximally stretches and pulls taut the anterior and middle scalenes on the side being assessed[1]. This may entrap the neurovascular structures as they pass between the two muscles.

The test is positive if the strength of the radial pulse diminishes. It is also positive if the client experiences an increase of neurologic symptoms into the upper extremity on that side.



▲ **Figure 2:** Sensory innervation distribution of the hand.



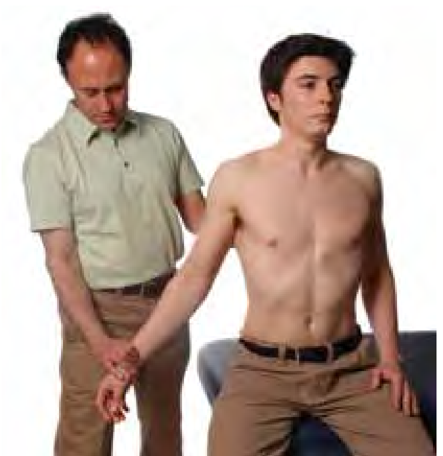
▲ **Figure 3:** Adson's test for anterior scalene syndrome.

[1] Adson's test stretches/elongates the anterior and middle scalenes because the client is asked to perform the actions that are opposite to the actions of these muscles. The anterior and middle scalene flex and do same-side (ipsilateral) lateral flexion; the anterior scalene also does opposite-side (contralateral) rotation.

Adson's test will also likely show as positive if the client has TOS caused by a cervical rib.

Eden's test (for costoclavicular syndrome)

The assessment test used for costoclavicular syndrome is called Eden's test. It is performed by feeling for the strength of the radial pulse while asking the client to stick the chest out and pull the shoulder girdles back, as if standing in a military position of attention (not surprisingly, Eden's test is also known as the military brace test) (Figure 4).



▲ **Figure 4:** Eden's test for costoclavicular syndrome.

This position maximally approximates the clavicle and first rib, decreasing the costoclavicular space and possibly entrapping the neurovascular structures as they pass through this space.

Eden's test is positive if the strength of the radial pulse diminishes. It is also positive if the client experiences an increase of neurologic symptoms into the upper extremity on that side.

Wright's test (for pectoralis minor syndrome)

The assessment test used for pectoralis minor syndrome is called Wright's test. It is performed by feeling for the strength of the radial pulse while passively extending and abducting the client's arm at the glenohumeral joint (Figure 5). This position maximally stretches the pectoralis minor and entraps and compresses the neurovascular structures between the pectoralis minor and the rib cage.

Wright's test is positive if the strength of the radial pulse diminishes. It is also positive if the client experiences an increase of neurologic symptoms into the upper extremity on that side.

▲ **Figure 5:** Wright's test for pectoralis minor syndrome.

There is also an alternative version of Wright's test. It is performed by asking the client to abduct the arm at the glenohumeral joint and flex the forearm at the elbow joint. The forearm can be rested on the head (Figure 6). This tethers the neurovascular structures around the pectoralis minor. If the pectoralis minor is tight, compression will likely occur. The same criteria are used to determine a positive result.

Addendum to Adson's, Eden's and Wright's tests

To intensify the tests described above, ask the client to take in and hold a deep breath. This will increase the possible compression in each condition, specifically:

- it causes the anterior and middle scalenes to contract in an effort to lift their rib cage attachments, thereby intensifying Adson's test for anterior scalene syndrome
- it causes the rib cage to lift, approximating it toward the clavicle, thereby intensifying Eden's test for costoclavicular syndrome

▲ **Figure 6:** Alternative position for Wright's test for pectoralis minor syndrome.

- it causes the pectoralis minor to contract in an effort to lift its rib cage attachment, thereby intensifying Wright's test for pectoralis minor syndrome.

The advantage of adding this component is that it makes each test more sensitive, allowing a milder case of TOS to be detected. However, the disadvantage is that taking in and holding a breath can cloud the discernment of exactly which form of TOS is present (or which forms are present) because any one form of TOS can now possibly show positive to all three tests.

Brachial plexus tension test

If any of the three forms of TOS are found to be present, it is possible to determine which brachial plexus nerve is being impinged. This can be accomplished in two ways.

One approach is to note what region of the client's upper extremity is symptomatic and compare it to a dermatomal map of innervation (see Figure 2). Another approach is to perform the brachial plexus tension test (BPTT). The BPTT is actually a series of three tests, each one designed to assess one of the three major nerves of the brachial plexus that innervate the hand: the median, radial and ulnar nerves.

The concept behind each of the three BPTTs is to place the client into a position that maximally stretches that nerve. The BPTT is considered to be positive if the client experiences increased sensory symptoms in the upper extremity dermatomal distribution region of that nerve.

In all three versions of the BPTT, the client's shoulder girdle is depressed, the arm is abducted at the glenohumeral joint and the neck is laterally flexed to the opposite side, because all three of these nerves travel in the axillary region and side of the neck and would therefore be stretched by these joint motions.

• Median nerve test

The elbow, wrist and finger joints are extended because the median nerve crosses them anteriorly. The forearm is supinated because the median nerve enters the forearm on the medial side. (Figure 7a).

▲ **Figure 7a:** Brachial plexus tension test. Median nerve test.

• Radial nerve test

The elbow joint is extended because the radial nerve crosses it anteriorly. The wrist joint is flexed and ulnar deviated because the radial nerve crosses it on the posterior and radial side. The finger joints are flexed because the radial nerve crosses them on the posterior side. The forearm is pronated because the radial nerve enters the forearm from the lateral side (Figure 7b).

▲ **Figure 7b:** Brachial plexus tension test. Radial nerve test.

• Ulnar nerve test

The elbow joint is flexed because the ulnar nerve crosses it posteriorly. The wrist joint is extended and radially deviated because the ulnar nerve crosses it on the anterior and ulnar side. The finger joints are extended because the ulnar nerve crosses them on the anterior side. The forearm is supinated because the ulnar nerve enters the forearm from the medial side (Figure 7c).

▲ **Figure 7c:** Brachial plexus tension test. Ulnar nerve test.

DIFFERENTIAL ASSESSMENT

TOS can cause neurologic sensory and/or motor symptoms anywhere in the upper extremity so any condition that can do this must be differentially assessed. These conditions include carpal tunnel syndrome, pronator teres syndrome and space occupying lesions in the neck (pathologic disc and bone spurs) that compress the spinal nerves that contribute to brachial plexus nerves (C5-T1 spinal nerves). Muscular trigger points can also refer pain into the upper extremity.

Further, because TOS can compress the subclavian artery and/or vein, vascular conditions should also be differentially assessed by the client's physician. These conditions include Raynaud's disease, diabetes mellitus and vitamin B12 deficiency.

It is critically important that, even if positive findings are found for any one of these conditions, you continue to assess for all of the rest. It is not uncommon for a client to have contributions from more than one underlying pathologic condition.

MANUAL TREATMENT

Manual treatment for TOS is usually very effective. The need to address the client's posture is common to all three types of TOS. Rounded shoulder posture is especially relevant to costoclavicular and pectoralis minor syndromes; forward head posture is especially relevant to anterior scalene syndrome. However, it is extremely common for these two postural distortion patterns to occur together, so addressing both of them for all three forms of TOS is a good idea.

The approach for rounded shoulder posture is to relax and lengthen the client's shoulder girdle protraction and glenohumeral joint medial rotation musculature, and to have the client strengthen the shoulder girdle retraction and glenohumeral joint lateral rotation musculature. The approach for forward head posture is to have the client relax head protraction musculature and strengthen head retraction musculature.

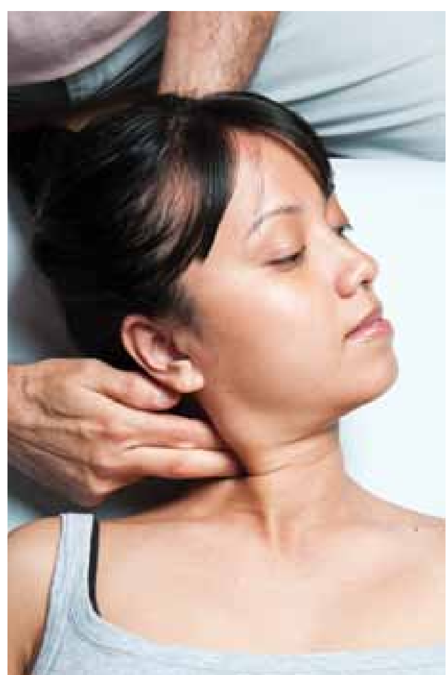
Beyond general postural work, specific work is required for each of the forms of TOS.

Treatment protocols for anterior scalene syndrome

For anterior scalene syndrome, focus needs to be primarily on the anterior and middle scalenes. A good protocol to follow is to apply moist heat to the scalenes, massage and then stretch them. Moist heat can be applied for approximately 5-10 minutes. Massage can be done with both longitudinal strokes and then cross-fibre strokes (Figure 8).

▲ **Figure 8:** Longitudinal and cross-fibre strokes to the anterior and middle scalenes.

To access the transverse process attachments of the scalenes, it is helpful to relax and slacken the sternocleidomastoid (SCM). This is accomplished by passively moving the client into lateral flexion on the side you are working. It is now possible to slip your finger pads deep to the SCM and find the scalenes' transverse process attachments (Figure 9a).

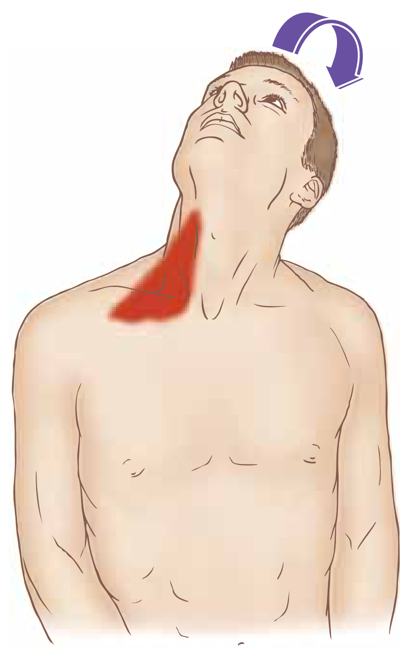


▲ **Figure 9a:** Massaging the scalenes' transverse process attachments deep to the sternocleidomastoid.

To access the rib attachments of the scalenes, it can be helpful to slightly passively flex the client's head and neck to slacken the anterior tissues and then reach deep to the clavicle with your finger pads oriented posteriorly (Figure 9b). Feel for the first rib attachments of the anterior and middle scalenes.

▲ **Figure 9b:** Massaging the scalenes' rib attachments deep to the clavicle.

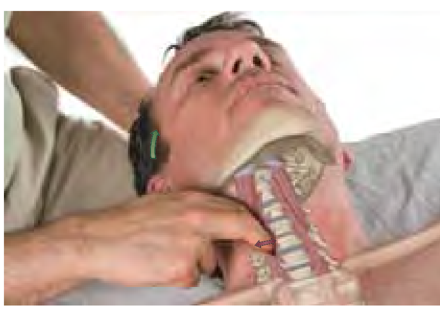
If possible, try to locate the second rib attachment of the posterior scalene. Stretching the scalenes is shown in Figure 10.



▲ **Figure 10:** Stretching the right scalenes.

When working the scalenes, it is important to be aware of the presence of the neurovascular structures running between the anterior and middle scalenes. When stretching the scalenes, caution must be exercised because it requires the client's neck to be extended beyond anatomic position.

Because tight deep neck flexors might also hold the neck in a shortened position of flexion, causing a hypolordotic cervical spine, it is advisable to also work the longus colli and longus capitis (Figure 11).



▲ **Figure 11:** Massaging the longus colli and longus capitis.

Treatment protocols for costoclavicular syndrome

For costoclavicular syndrome, the goal is to open the space between the clavicle and first rib. After placing moist heat on the region for approximately five to ten minutes, begin by working within the costoclavicular space itself (Figure 12).

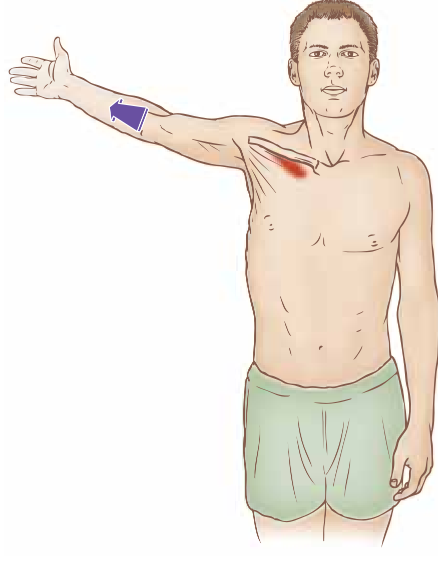
▲ **Figure 12:** Massaging the soft tissues of the costoclavicular space between the first rib and clavicle.

The subclavius muscle is located here and, when tight, can decrease the space by pulling the clavicle and first rib toward each other. In addition to the subclavius, the entire costoclavicular space should be worked in case fascial adhesions are present.

The tissues of the costoclavicular space should now be stretched by passively bringing the client's arm back into extension and up into abduction.

This stretch is easiest to perform with the client seated or standing (Figure 13). It can be done with the supine client if the client is lying at the side of the table.

Finally, any other muscles that can either elevate the first rib into the clavicle or depress the clavicle into the first rib should be worked. These include the scalenes, pectoralis minor and pectoralis major.



▲ **Figure 13:** Stretching the tissues of the costoclavicular space and pectoralis minor.

Treatment protocols for pectoralis minor syndrome

For pectoralis minor syndrome, the primary objective is to loosen the pectoralis minor. This can be accomplished by applying moist heat, and then massaging and stretching it. Massage strokes can be applied longitudinally along the fibres and then across the fibres (Figure 14).

▲ **Figure 14:** Massaging the pectoralis minor - cross-fibre strokes.

If the overlying pectoralis major is tight then it should be slackened by positioning the client's arm slightly in flexion and adduction, so that the pectoralis minor can be worked through it.[2] Pin and stretch while working into the pectoralis minor is also very effective (Figure 15).

▲ **Figure 15:** Pin and stretch technique while working the pectoralis minor.

Agonist contract stretching technique is especially effective and easy to apply to the pectoralis minor when the client is seated. After working the pectoralis minor, it is recommended to work the entirety of the pectoralis major.

Summary of Manual Treatment Protocol for TOS

1. Loosen shoulder girdle protraction and glenohumeral joint medial rotation musculature; and recommend strengthening of shoulder girdle retraction and glenohumeral joint lateral rotation musculature
2. Apply moist heat, massage and stretching
3. For anterior scalene syndrome: work the anterior and middle scalenes
4. For costoclavicular syndrome: work the subclavius and fascial tissues of the costoclavicular space
5. For pectoralis minor syndrome: work the pectoralis minor

PRECAUTIONS/CONTRAINDICATIONS

When working on a client with TOS, it is important to avoid placing excessive pressure directly on the neurovascular structures. However, it may be impossible to completely avoid exerting pressure on them given their proximity to the muscles being worked, so care should be exercised. This is especially true when working the scalenes because the brachial nerve plexus and the subclavian artery are superficial and vulnerable in this region. If you feel a pulse, you are on the subclavian artery. Simply move your finger pads slightly off it and continue working. However, it is difficult to feel if you are on the brachial nerve plexus. If the client feels a sudden shooting pain down the upper extremity, you are most likely on the nerve plexus. Again, simply adjust your location to relieve pressure on the nerve and continue working.

Trigger points in the scalenes may also refer pain or other sensations into the upper extremity but this will not usually be a sudden shooting pain.

Caution also needs to be exercised when stretching the scalenes because this places the client's head and neck into extension beyond anatomic position.

[2] It is often recommended to work the pectoralis minor by reaching in from the armpit and deep to the pectoralis major. This tends to be uncomfortable for the client and is usually not necessary unless the pectoralis major is extremely tight, thereby blocking the ability to penetrate through it to the pectoralis minor. If this approach is employed, caution should be used to avoid pressing too far laterally on the brachial plexus of nerves and subclavian artery and vein.

For some clients, especially elderly ones, this position can be very uncomfortable. Because the stretch involves rotation and extension, it is a good idea to first perform the vertebral artery competency test bilaterally (Figure 16).

▲ **Figure 16:** Position of vertebral artery competency test.

If the client experiences dizziness or lightheadedness in this position, extension of the head and neck are contraindicated, especially when coupled with rotation.

SELF-CARE FOR THE CLIENT

Because poor posture can be a significant contributor to TOS, self-care is an extremely important aspect of the treatment. The client should be advised to avoid offending postures (rounded shoulders and anterior head carriage) as much as possible. Applying moist heat and then stretching the pectoralis minor (shoulder girdle protractor musculature) and scalenes is helpful. Strengthening exercises for the shoulder girdle retractor, glenohumeral joint lateral rotator and head retraction musculature are also extremely important.

Figure credits:

Figures 1-4: Reprinted with kind permission of the massage therapy journal (mtj). Photography by Yanik Chauvin. **Figure 1:** Artwork by Frank Forney. **Figure 2:** Artwork by Lightbox Visuals, Giovanni Rimasti.

Figures 5-7: Reprinted with permission from Muscolino J: Treatment Techniques for the Manual Therapist: Neck. Baltimore, MD: Lippincott Williams & Wilkins. In press. Photography by Yanik Chauvin.

Figures 8 & 10-14: From Muscolino JE: The muscle and bone palpation manual, with trigger points, referral patterns, and stretching. St. Louis, 2009. Elsevier. Photography by Yanik Chauvin.

Figures 9, 15 & 16: Courtesy of Joseph E. Muscolino. Photography by Yanik Chauvin.

Joseph E. Muscolino has been a massage therapy educator for 25 years, and a chiropractor in private practice for 26 years. He is the author of The Muscle and Bone Palpation Manual, With Trigger Points, Referral Patterns, and Stretching; The Muscular System Manual, The Skeletal Muscles of the Human Body, 3ed; and Kinesiology, The Skeletal System and Muscle Function, 2ed; as well as the upcoming Treatment Techniques for the Manual Therapist: Neck. Joe's books are translated into seven foreign languages.

Joe also teaches continuing professional education workshops and will be visiting Australia again in March next year.

For more information, visit his website: www.learnmuscles.com

Profiling the massage therapy industry in Australia: AMT's 2010 Quantitative Survey

by Rebecca Barnett

It's obviously the season for surveys. With the Australian Census not long behind us, I thought it was timely to report on the quantitative survey AMT completed last year.

You may recall that AMT undertook a major telephone survey in late 2010 to gather base line data that has both informed our 2011-2016 Strategic Plan and will allow us to measure progress against the objectives outlined in the Plan.

As I have mentioned previously, it is surprising how little we know about the way massage therapists are working: the number of clients MTs are seeing; the number of hours MTs are employed doing massage; the kind of practices MTs are employed in or running; the number of referrals MTs are getting; the percentage of MTs charging GST on treatments; and the income MTs are earning from massage. Most of the information we had in these areas was either educated guesses or anecdotal. This survey was specifically designed to fill these gaps in our knowledge and the data garnered from it is critical to our key advocacy projects in the years to come.

When you stop to consider it, taking the time to gather this data makes perfect sense from an advocacy point of view. We live in an evidence-based world and evidence-based strategic planning is a part of that - building a plan in a knowledge vacuum just doesn't make sense. It's like trying to walk a tight rope without the rope.

Without up-to-date and relevant industry data, it is virtually impossible to sell our case to government bodies such as the Department of Veterans' Affairs. And it is hard to conceive how we could make an adequate case to Treasury for GST exemption without being able to confidently state just how much this is likely to cost the government in terms of tax revenue.

Some of the results of the survey were surprising and heartening. Contrary to the received wisdom that most massage therapists drop out of the industry within 5 years, nearly 60% of our survey respondents have been working as MTs for at least 6 years. Thirty percent have been working for more than 10 years. Over time, regular follow-up surveys will give us a far more accurate picture of working life spans and retention rates in Australia than the anecdotal evidence or US-based data has been up until now.

It also turns out that we somewhat defy the "third bedroom" stereotype that is often leveled at our profession as a criticism of the way we work. Nearly half the respondents (48%) are working from commercial clinics, with only one third (32%) working from home-based clinics.

We are also quite research literate. Forty percent of respondents regularly access and read research from a variety of sources, including peer reviewed journals.

We plan to circulate a full report on the survey results with our Strategic Plan to all our stakeholders. Make no mistake - this is an intrinsic part of the largest and most consistent drive AMT has made for formal government recognition in the long, proud history of AMT as an advocacy organisation.

Sincere thanks go again to the therapists who generously took part in the survey. They should be proud that they were part of the first project of its kind in Australia. Understandably, not every survey respondent agreed to answer the final question in the survey on income from massage therapy, but an astonishing and impressive 88% did.

So, herewith, a preliminary report on the results.

Methodology

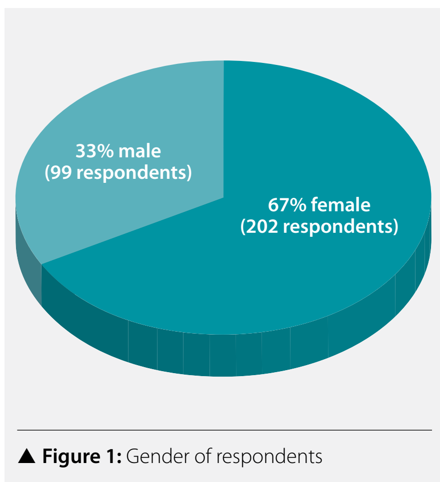
A nationwide telephone survey was undertaken of a random sample of AMT members. Three hundred and one interviews were completed between 21 July and 16 December 2010.

Data was analysed using SPSS software (Statistical Package for the Social Sciences), which allowed us to cross-tabulate responses (for example, we could compare income from massage against participation in continuing professional development. More about this later).

Gender of respondents

Base: all respondents

Sixty-seven percent of survey respondents were female, as Figure 1 below illustrates. This figure corresponds closely with AMT's membership. As at 13 July 2011, membership of AMT was 70% female.



▲ **Figure 1:** Gender of respondents

Question 1:

Professional working life span

"How long have you been working as a massage therapist?"

Base: all respondents

Contrary to the received wisdom that most massage therapists drop out of the industry within 5 years, nearly 60% of those surveyed have been working as massage therapists for more than 6 years. As Figure 2 shows, the greatest concentration of respondents (30%) have been working for 10 years and over. However, a significant percentage of respondents (42%) have been working as a massage therapist for 5 years or less.

At 13 July 2011, 58% of AMT's full practitioner members had held membership for 5 years or less, suggesting that turnover within the profession is indeed very high. However, this result is more likely a reflection of AMT's rapid growth over the same time period, with the association growing by 55% during this time.

Question 2:

Income derived from massage therapy

"Is massage therapy your sole source of income?"

Base: 300

Over half the survey respondents (55%) said that massage therapy was their sole source of income. Forty-five percent of respondents supplemented their income with other activities.

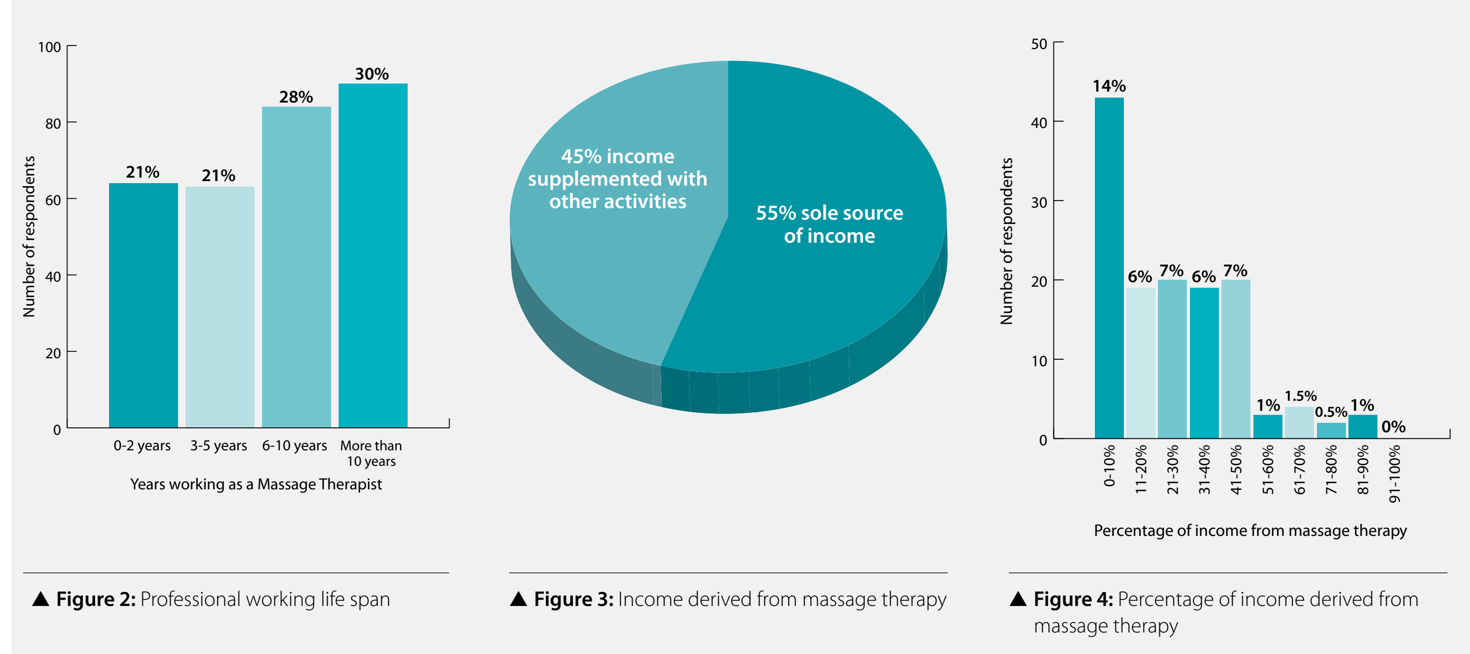
Question 3:

Percentage of income derived from massage therapy

"If massage therapy is not your sole source of income, what percentage of your income is derived from massage therapy?"

Base: 133 respondents (45%)

Figure 4 shows that a significant percentage of total respondents (14%) earned less than 10% of their income from massage therapy. Forty percent of total respondents derived less than 50% of their income from massage.



▲ **Figure 2:** Professional working life span

▲ **Figure 3:** Income derived from massage therapy

▲ **Figure 4:** Percentage of income derived from massage therapy

Examining the data from Figures 3 and 4 together, 60% of survey participants earned at least 50% of their income from massage.

Question 4:

Hours working as a massage therapist each week

"How many hours a week do you work as a massage therapist?"

Base: All respondents

Figure 5 shows the number of hours per week that survey participants work as massage therapists. Nearly one-third of respondents (32%) work over 20 hours per week, with 15% of those working more than 30 hours.

Forty-two percent work as massage therapists for less than 11 hours per week. This figure corresponds closely with the percentage of people who do not derive their sole source of income from massage (45%, see Figure 3).

Question 5:

Number of consultations each week

"How many clients do you treat in an average week?"

Base: All respondents

Figure 6 illustrates that 53% of respondents see at least 11 clients a week. This figure corresponds closely with the percentage of respondents who derive their total income from massage therapy (55%, see Figure 3). Twenty-six percent of respondents see more than 20 clients per week.

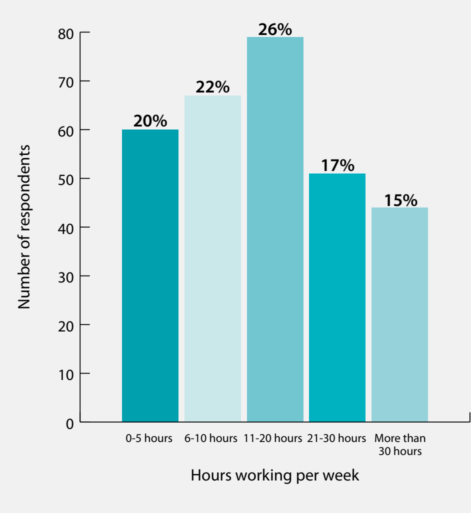
Question 6:

Referrals from allied health professionals

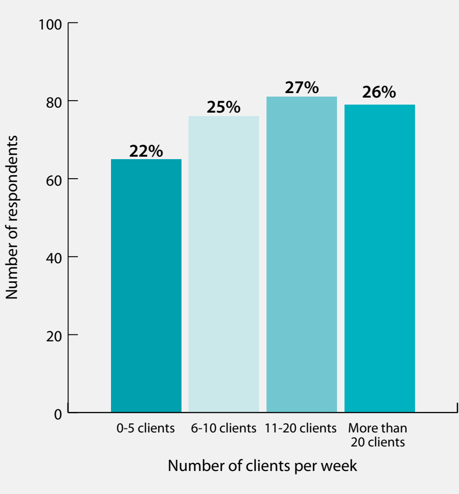
"What percentage of your clientele is referred to you by allied health professionals?"

Base: All respondents

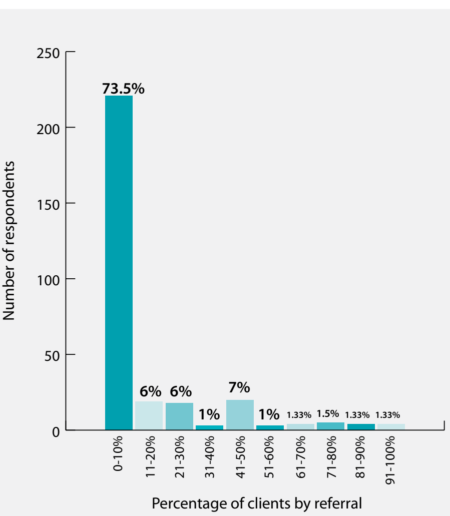
The majority of respondents (73%) ranked in the lowest percentile for referrals from allied health professionals. Only 7% of survey participants have more than half their client base referred to them by doctors, physiotherapists, chiropractors and other allied health practitioners, as Figure 7 illustrates.



▲ **Figure 5:** Hours working as a massage therapist each week



▲ **Figure 6:** Number of consultations each week



▲ **Figure 7:** Referrals from allied health professionals

Question 7: GST

"Do you charge GST on your treatments?"

Base: 300 respondents

Only 18% of respondents charge GST on the treatments, as figure 8 illustrates.

Question 8:

Percentage of clients claiming rebates through a private insurer

"What percentage of your clients claim their treatment through a private health insurer?"

Base: All respondents

As figure 9 shows, the largest band of respondents (22%) have less than 10% of their clients claiming rebates through a private health insurer. At the other end of the chart, 16% of respondents have over 90% of their clients claiming rebates.

More than half the respondents (56.5%) have over half their clients claiming treatments through a private health insurer.

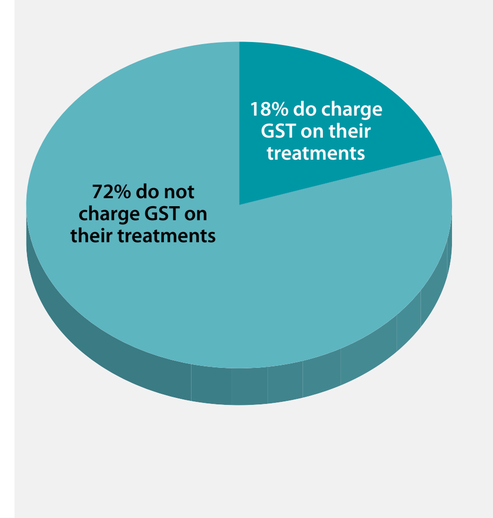
Question 9: Type of employment

"Which of the following statements best describes your current employment:

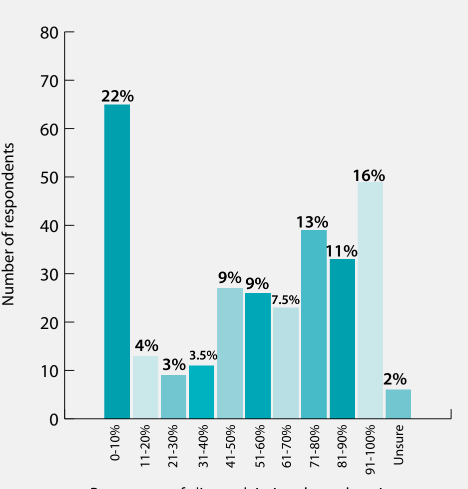
- I am self employed
- I am employed by another massage therapist
- I am employed by an allied health professional (physio, chiro etc)
- I have a practice/business and employ other therapists
- Other"

Table 1 illustrates that a significant majority of respondents (82%) are self-employed. One percent of respondents own a business that employs other massage therapists and 5% work for allied health professionals.

A small percentage of respondents in the "Other" category (4%) indicated that they do massage in either a voluntary capacity or as a hobby.



▲ **Figure 8:** GST



▲ **Figure 9:** Percentage of clients claiming rebates through a private insurer

Type of employment	No.	%
Self employed	246	82
Employed by another massage therapist	25	8
Employed by an allied health professional	14	5
Own a business and employ other therapists	4	1
Other (hobby, volunteer)	12	4
Total	**301**	**100**

▲ **Table 1:** Type of employment

Question 10: Place of employment

"Which of the following best describes your principal place of employment:
- Commercial clinic
- Mobile - home visits
- Mobile - corporate seated
- Home Based clinic
- Other"

Base: All respondents

Almost half the survey respondents (48%) work within a commercial clinic environment (Table 2 below). The next largest group of respondents work from home-based clinics, with nearly one third falling into this category. Mobile practices account for 12% of responses.

The 8% of respondents in the "Other" category work in day spas, gyms, leisure centres and at stadiums/arenas with sporting teams.

Question 11: Qualifications

"Which of the following statements best describes your massage therapy qualification?
- I have an HLT Diploma
- I have pre -HLT (I qualified prior to 2003)
- I am overseas qualified"

Base: All respondents

Fifty-four percent of respondents have an HLT qualification and 44% gained their qualifications prior to the introduction of the health training package. Two percent of respondents hold overseas qualifications.

Question 12: Participation in continuing professional development

"Which of the following statements best describes your participation in AMT's continuing education scheme?
- I do enough to achieve my annual quota of CEUs but no more
- I struggle every year to reach my annual quota of CEUs
- I exceed my annual quota of CEUs every year"

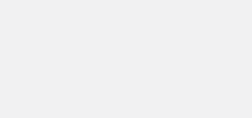
Base: 289 respondents

Forty-three percent of the respondents to this question reported that they exceed their annual requirement for continuing professional development, as Figure 11 shows. Twenty-one percent said that they struggle to achieve their annual quota, while the remaining 36% stating that they achieve their annual requirement but do not exceed it.

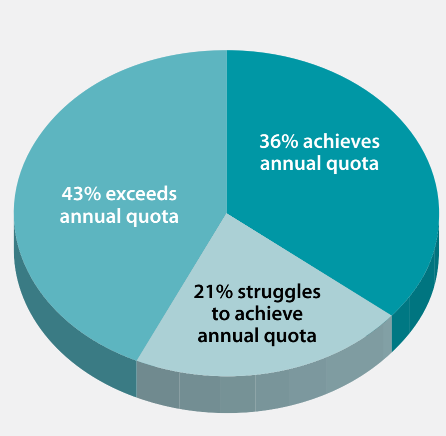
Twelve survey respondents are not currently participating in the continuing education scheme, due to a variety of circumstances.

Principle place of employment	No.	%
Commercial clinic	144	48
Mobile - home visits	30	10
Mobile - corporate seated	5	2
Home-based clinic	97	32
Other (day spa, leisure centre, gym, stadium)	25	8
Total	**301**	**100**

▲ **Table 2:** Place of employment



▲ **Figure 10:** Qualifications



▲ **Figure 11:** Participation in continuing professional development

Question 13: Research Literacy

"Which of the following statements best describes your exposure to massage therapy research:

- I have never read any published research on massage
- I haven't read a research article since I graduated from college
- I read research when it is published by AMT
- I regularly access research articles online and in peer reviewed journals"

Base: 300 respondents

Over half the respondents (56%) rely solely on AMT to access current massage therapy research, as Figure 12 illustrates. Forty percent access research from other sources as well, such as peer-reviewed journals and online. A small percentage of respondents have very limited exposure to research, with 1% stating that they have never read any published research at all.

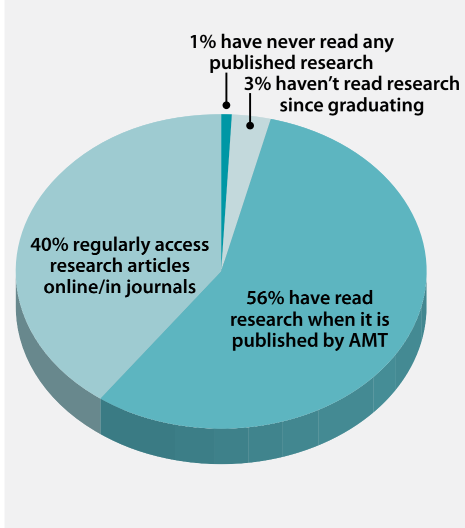
Question 14:

Net income from massage therapy

"What is your net income (after tax and expenses) from massage therapy?"

Base: 265

As Table 3 shows, 41% of respondents to this question earn a net income of less than $10000 a year from massage therapy, with 27% earning less than $5000. Thirty-eight percent of respondents net in the range of $10001 to $30000, and 14.5% fall into the $30001 – 50000 earnings bracket. Just over 10% of respondents earn a net income of greater than $50001 per annum.



▲ **Figure 12:** Research Literacy

Net income ($)	No.	%
0-5000	73	27
5001-10000	37	14
10001-20000	51	19
20001-30000	50	19
30001-40000	28	10.5
40001-50000	11	4
50001-60000	10	4
60001-75000	3	1.5
More than 75001	2	1
Total	**265**	**100**

▲ **Table 3:** Net income from massage therapy

AMT NEW MEMBERS

ACT
Emma Hely, Robert Rider, Xia Wang

NSW
Tony Batterham, Jade Bechaz, Samantha Boland, Andrea Briody, Jesse Bruce, Zoe Butler, Xiaoming Cao, Sarah Clarke, Shelby Craig, Melanie Cupitt, Bronwyn Davies, Carolyn Faill, Volker Fassbender, Veronique Flanagan, Eloise Graf, Jian Xin Guo, William Wen Chang Ho, Nicholas Hood, Kim Hunn, Ivan Jankowski, Yingnan Jin, Elen Kopecka, Morgan Lee, Jun Lin, Jordan Lin, Jianhui Lin, Rong Liu, Xiaojie Liu, Nina Lo Rizzo, Rotsukhon Mathathong, Rachel May, Robyn McKean, Ariana Mesquita Pereira Mckay, Ting Mo, Sally Moss, Michelle O'Leary, Jana Pauliniova, Yu Hong Peng, Hong Qu, Clarita Ruiz de Aufranc, Dionyssia Sklavenitis, Grace Su-Weatherby, Vince Taouk, Simone Unicomb, Ting Wang, Hai Yang Xu, Elle Yevtikevich, Vivienne Young, Chen Yu, Rui Zeng, Lin Zheng

QLD
Jessica Benton, Heather Carfoot, Shao Hua Chen, Fang-Wen Chen, Yu-An Chen, Peter Chen, Lorraine Dalton, Yaqi Fei, Alison Finger, Angela Hollis, Matthew Hunter, Monika Kemp, Chung Hoi Lam, Lucy X S Lu, Theresa Martin, Peter Moore, RaeMing Ong, Chwee Nguan Ong, Xingdong Qu, Liza Ryan, Feiliu Sun, Annette Walters, Si Wang, Lung-Li Wang, Franca White, Tong Xin Xu, Qianting Yin

VIC
Kieran Arnott, Joshua Bjelan, Leia Cirelli, Julie Clifford, Renee Ehmsen, Tamara Gemelli, Melissa Hart, Ashlee Henry, Elaine Stevenson

WA
Leon Musca, Christopher West

The more you learn, the more you earn?

SPSS software allowed us to cross tabulate responses, comparing results across more than one question. One of the most interesting results to emerge from the cross-tabulations was a light correlation between the number of clients seen in an average week and the amount of time invested in continuing professional development.

In other words, in spite of spending more time in clinical practice, busier therapists tended to undertake more continuing education.

There are a number of variables that may inform this trend, but we believe that the correlation is an indicator that a strong commitment to professional development translates directly back into client demand. The data may also support the idea that there are marketing advantages to be leveraged from talking to your clients about what you have been learning.

We plan to publish the results from our other cross-tabulations in the full version of the survey report.

However, by way of preview, Table 4 shows that the greatest concentration of therapists seeing more than 11 clients per week (23.59%) are the group who report exceeding their annual quota of CEUs. Close second comes the group who achieve their annual quota, with 19.27% of these seeing at least 11 clients per week.

Conversely, the group who stated that they struggle to achieve their annual quota of CEUs were over-represented in the 0 to 5 clients per week band (5.98%) and under-represented in the 11+ clients per week band (8.64%), relative to the overall percentage of their representation (20.27% of respondents).

As Table 5 shows, 57% of respondents who said that they exceed their annual CEU quota see more than 11 clients per week. Fifty-six percent (56%) of respondents who said that they achieve their annual CEU quota see more than 11 clients per week. Forty-two percent (42%) of respondents who said that they struggle to achieve their annual CEU quote see more than 11 clients per week.

■**amt**

Continuing education participation	Clients per week			Total
	0-5	6-10	11+	
Not participating	2.33%	0.66%	1.00%	**3.99%**
Struggle to achieve annual quota	5.98%	5.65%	8.64%	**20.27%**
Annual quota only	6.31%	8.64%	19.27%	**34.22%**
Exceed annual quota	7.31%	10.63%	23.59%	**41.53%**

▲ **Table 4**

Continuing education participation	Treats 0-10 clients	Treats 11 + clients	Percentage of total responses
Struggle to achieve annual quota	58%	42%	20.27%
Annual quota only	44%	56%	34.22%
Exceed annual quota	43%	57%	41.53%

▲ **Table 5**

DEADLINE

Deadline for the December 2011 issue of In Good Hands is: 1st November, 2011

Please email contributions to: journal@amt.org.au or phone: 02 9517 9925

The e-Journal club

Congratulations to:

MATTHEW HAWKINS
Winner of our September e-journal club prize.

Thanks to Terra Rosa for donating Matthew's prize.

Health Fund Status

HEALTH FUNDS AND SOCIETIES	CRITERIA
CBHS Health Fund Ltd	This fund recognises all AMT practitioner levels.
A.C.A Health Benefits Fund Cessnock District Health Benefits Fund CUA Health Limited Defence Health GMF Health GMHBA Heath Care Insurance Limited Health Partners HIF WA Latrobe Health Services (Federation Health) Mildura District Hospital Fund Navy Health Fund Onemedifund Peoplecare Health Insurance Phoenix Health Fund Police Health Fund Queensland Country Health Ltd Railway & Transport Health Fund Ltd St. Luke's Health Teachers Federation Health Teachers Union Health Transport Health Westfund	ARHG recognises all AMT practitioner levels. They require you to use their provider number. This number is AW0XXXXM, where the X's are your 4-digit AMT membership number.
Australian Unity GU Health	These funds recognise members with HLT40302/07 and all Senior Level One and Two members.
NIB	This fund will recognise members with HLT50302/07 Diploma of Remedial Massage; HLT50102/07 Diploma of Chinese Remedial Massage; HLT50202/07 Diploma of Shiatsu and Oriental Therapies; Advanced Diploma of Remedial Massage (Myotherapy)
Victorian WorkCover Authority	This fund recognises Senior Level 1 and 2 members.
HCF Manchester Unity	These funds recognise members with HLT50302/HLT50307 Diploma of Remedial Massage Advanced Diploma of Applied Science (Massage) Diploma of Health Science (Massage Therapy) 21511VIC/21920VIC Advanced Diploma in Remedial Therapy (Myotherapy). Existing HCF providers remain eligible. Manchester Unity will recognise HLT50202/07 Diploma of Shiatsu.
ANZ Health Insurance (HBA) Cardmember Health Insurance Plan (HBA) CSR Health Plan (HBA) HBA (formerly AXA) HealthCover Direct (HBA) MBF Mutual Community (HBA) NRMA Overseas Student Health Cover (HBA) SGIC (MBF Alliances) SGIO (MBF Alliances) St George Protect (HBA) VSP Health Scheme (HBA)	BUPA recognises members with HLT5030207 Diploma of Remedial Massage, HLT50102/07 Diploma of Chinese Medicine Remedial Massage, HLT50202/07 Diploma of Shiatsu and Oriental Therapies, 21920VIC or 21511VIC Advanced Diploma of Remedial Massage (Myotherapy).
Australian Health Management Group Medibank Private	These funds recognise Senior Level One & Two members.
HBF	HBF recognises Senior Level 2 members.
The Doctor's Health Fund	Doctors' Fund recognises members with HLT 50302/07 Diploma of Remedial Massage, Advanced Diploma of Applied Science (Remedial Massage), Advanced Diploma of Soft Tissue Therapies, Advanced Diploma of Remedial Massage (Myotherapy) and Bachelor of Health Science (Musculoskeletal Therapy). All Senior Level One and Two members remain eligible. They require you to use their provider number. This number is AMXXXX, where the Xs are your 4-digit AMT membership number.

AMT has negotiated provider status on behalf of members with the Health Funds listed. All funds require a minimum of $1 million insurance, first aid and CEUs.

To be eligible to remain on the above Health Fund lists you must:

1. Be financial and have a commitment to ongoing education (ie: an average of 100 CEUs per year)
2. Provide your clients with a formal receipt, either computer generated, or with rubber stamp or address label clearly indicating practitioner's name, AMT member number (eg: AMT 1-1234), practice address (no PO Box numbers) and phone number. Client's name, date of treatment, nature of treatment (ie: Remedial Massage), and particular health fund provider number may be handwritten.
3. Provide AMT Head Office with a practice address (or business address for mobile practitioners; no PO Boxes) - failure to supply these details to us will result in your name being removed from health fund listings.
4. Notify AMT HO of all relevant practice addresses.

Please check the AMT website for further information on specific Health Fund requirements:

www.amt.org.au

Calendar of Events

Courses accredited by AMT attract 5 CEUs per hour. Courses not accredited by AMT attract 1 CEU per hour.
Please check dates and venues of workshops (using the contact numbers listed below).

September 2011		CEUs
3-4	Somatic CST 3. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105. Part of a 5 day programme, completion date 24/09/11	175
9-11	Infant Massage Training. Presented by IMIS. Sydney. Ph: 1300 558 608	120
10-11	Somatic CST 3. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105. Part of a 5 day programme, completion date 24/09/11	175
11	Small Business Management for Practitioner. Presented by Rosemary Spiteri. Bondi Junction. Ph: 0407 530 272 This a 4 day workshop spread over several weeks starting 31/7/11	140
11	ACT Branch Meeting. Weston. Ph: 0408 238 274	15
17-20	Akupunkt Massage According to Penzel Course A. Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
17-18	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Melbourne. Ph: 03 9532 8144	60
18	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
18	Melbourne Branch Meeting. Langwarrin. Ph: 0401 256 015	15
18	Muscles and Pelvic Alignment. Presented by John Bragg. Katoomba. Ph: 0410 434 092	35
19	Blue Mountains Branch Meeting. Wentworth Falls. Ph: 0416 220 045	15
21-23	Infant Massage Training. Presented by IMIS. Melbourne. Ph: 1300 558 608	120
23-25	Functional Assessments and Corrections of the Lower body (Onsen Vol.2). Presented by Jeff Murray. Ashfield. Ph: 07 5599 2514	105
23	Riverina Branch Meeting. Echuca. Ph: 03 5482 6422	15
24-25	Dorn Spinal Therapy. Presented by Barbara Simon. Sydney. Ph: 0407 946 294	95
24	Somatic CST 3. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105. Part of a 5 day programme, commencement date 03/09/11	175
26-30	Somatic CST 1. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	160
27	Illawarra Branch Meeting. Presentation. Corrimal. Ph: 0417 671 007	15

October 2011		CEUs
5	South Sydney Branch Meeting. Hurstville. Ph: 0411 039 819	15
5-9	Somatic CST 5. Presented by Patricia Farnsworth. Sydney. Ph: 1800 101 105	160
14-16	AMT Annual Conference. Brighton Le Sands, Sydney. Ph: 02 9517 9925	150
14-16	Somatic CST 2. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	100
15-16	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Adelaide. Ph: 03 9532 8144	60
15-17	Master Class in Traditional East-West Cupping. Presented by Bruce Bentley and Shirley Gabriel. Melbourne. Ph: 03 9576 1787	105
15	Mid-North Coast Branch Meeting. Port Macquarie. Ph: 0438 813 994	15
21-23	Infant Massage Training. Presented by IMIS. Melbourne. Ph: 1300 558 608	120
22-24	Advanced Myofascial Techniques. Presented By Larry Koliha and Bethany Ward. Gold Coast. Ph: 02 9517 9925	105
24-28	Somatic CST 3. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105	175
25	Illawarra Branch Meeting. Formal. Corrimal. Ph: 0417 671 007	15
28-30	Structural Assessments and Corrections of the Cervical and Thoracic Spinal Regions (Onsen Vol.3). Presented by Jeff Murray. Ashfield. Ph: 07 5599 2514	105
29-31	Advanced Myofascial Techniques. Presented By Larry Koliha and Bethany Ward. Melbourne. Ph: 02 9517 9925	105
29-31	Infant Massage Training. Presented by IMIS. Cairns. Ph: 1300 137 551	120

November 2011		CEUs
3-5	Practitioner Assessment Skills. Presented by Ron Phelan. Sunshine Coast. Ph: 03 5255 5229	105
4-6	Infant Massage Training. Presented by IMIS. Perth. Ph: 1300 558 608	120
4-6	Infant Massage Training. Presented by IMIS. Gold Coast. Ph: 1300 558 608	120
4-6	Infant Massage Training. Presented by IMIS. Perth. Ph: 1300 558 608	120
5-7	Advanced Myofascial Techniques. Presented By Larry Koliha and Bethany Ward. Sydney. Ph: 02 9517 9925	105
5-11	Neurostructural Integration Technique Introduction. Presented by Marianne Grainger. Perth. Ph: 08 9490 3906	70
5-6	Somatic CST 4. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105. Part of a 5 day programme, completion date 20/11/11	210
6	ACT Branch Meeting. Weston. Ph: 0408 238 274	15
12-13	Certificate of Pregnancy Massage. Presented by Catherine McInerney. Brisbane. Ph: 03 9532 8144	60
12	Shoulder Pain and Scapula Stability. Presented by John Bragg. Sydney. Ph: 0410 434 092	35
12-13	Somatic CST 4. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105. Part of a 5 day programme, completion date 20/11/11	210
13	Arm and Hand Pain. Presented by John Bragg. Sydney. Ph: 0410 434 092	35
18-20	Infant Massage Training. Presented by IMIS. Gold Coast. Ph: 1300 558 608	120
19-20	Chi-Acupressure Massage. Presented by Master Zhang Hao. Strathfield. Ph: 02 9629 1688	75
19-20	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Sydney. Ph: 03 9576 1787	80
19-20	Functional Fascial Taping Upper and Lower Body. Presented by Ron Alexander. Adelaide. Ph: 03 9481 6724	90
20	Hunter Branch Meeting. Adamstown. Ph: 02 4953 2252	15
20	Somatic CST 4. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105 Part of a 5 day programme, commencement date 05/11/11	210
24-28	Neurostructural Integration Technique Basic. Presented by Ron Phelan. Ocean Grove. Ph: 03 5255 5229	175
25-27	Functional Assessments and Corrections of the Upper body (Onsen Vol.4). Presented by Jeff Murray. Ashfield. Ph: 07 5599 2514	105
26-27	Remedial Cupping. Presented by Bruce Bentley and Shirley Gabriel. Melbourne. Ph: 03 9576 1787	80
26-27	Functional Fascial Taping Upper and Lower Body. Presented by Ron Alexander. Melbourne. Ph: 03 9481 6724	90
29	Illawarra Branch Meeting. AGM. Corrimal. Ph: 0417 671 007	15
30	Somatic CST 5. Presented by Patricia Farnsworth. Adelaide. Ph: 1800 101 105 Part of a 5 day programme, completion date 04/12/11	160

Please view the Calendar of Events on the AMT website for the complete 2011 listing: www.amt.org.au

- Follow step by step guidelines
- Improve your skills
- Increase client satisfaction
- Increase clientele
- Increase revenue

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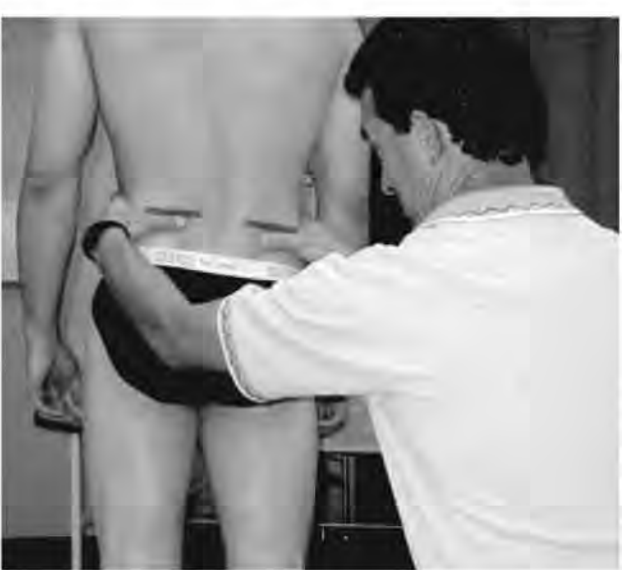

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Vol III Structural Assessment & Correction Cervical & Upper thoracic regions
Vol IV Functional Assessment & Correction of the Upper Body

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