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COUNSELLING AUSTRALIA

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Mental Health needs a further shot in the arm.

A change to the current delivery of Mental Health services is now needed, to minimise the occurrence of mental illness across the Australian community.

Source: Australian Counselling Association

Despite Federal Government making changes to Medicare to provide a rebate for people diagnosed with a mental illness when seeing a Psychologist, much of the Australian population still do not have easy access to general Mental Health Services, because Medicare does not cover Counselling services offered by nationally registered counsellors, Australian Counselling Association manager Philip Armstrong said today.

Mr Armstrong said much of the community's mental health is vulnerable to impacts caused by a wide range of life's difficulties. Counselling services are effective as a preventative vaccination program helping inoculate people from developing a chronic mental illness. Early intervention prevents the majority of minor ailments caused by every day life issues such as relationship, depression, anxiety and grief from becoming chronic issues which impact negatively on quality of life issues and require psychological services.

Mr Armstrong believes the rebate system fails to recognise the vital role played by **nationally registered** counsellors in delivering in-demand services. Mr Armstrong said "the new system had distorted competition and placed current service provision at risk. Opening up Medicare access to general counselling is the best way of maintaining choice and achieving successful early intervention. Surely it is in the public's and health system's interest to support preventative services as opposed to reactive services."

"Many sufferers of mental health issues cannot afford to gain access to on-going counselling services as rebates via Medicare are not yet available," Mr Armstrong said.

Mr Armstrong said access to Medicare rebates for counselling would help people suffering from every day issues find solutions before a crisis developed.

We can already see countries such as the UK obtaining many benefits from providing public funded access to general counselling services through a National Health Scheme, he said.

"Medicare funded counselling rebates for registered counsellors would not only minimise the occurrence of mental illness but would also assist in the prevention of youth suicide, and relationship breakdowns," he said.

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Editorial By Phillip Armstrong

No doubt our readers will have noticed that this edition is over due, my apologies for this. I was waiting for an update from our lobbyists that I was hoping to print in this edition however time has beaten me.

The issue of Medicare rebates is still on the top of our priority list as more and more counsellors and counselling associations contact us with their concerns. I can assure all the readers that ACA is also very concerned and we are in daily contact with our lobbyists. We are going through what I believe is to be the most difficult period of the process and that is the waiting game. Whilst our lobbyists meets with decision makers in Canberra and other cities there is little we can do until they report back to us what the outcomes of the meetings are. It is the outcomes of these meetings that will dictate to ACA what our next moves are, whether we need to adopt an aggressive stance or otherwise.

ACA has recently had success by signing an agreement to supply counsellors for accident victims who carry policies with Lumley's.

There is some positive that have come from this crisis the main one is that counsellors have now been forced to look outside the box to seek further opportunities. There is no point in simply throwing up ones hands in this situation. ACA is dressing the issue as best it can, we are all hoping for a positive outcome. However, worse case scenario is the government simply refuses to expand access or ACA is successful but it takes a lot longer than anticipated. As a practitioner we need to all ensure we seek out ways to continue to earn a living in the mean time. There is also a possibility that simply because we gain access to the rebates that GP's may be slow or even reticent about referring to counsellors when given the first option of referring to a psychologists. Remembering that many GP's will have developed relationships with psychologists over this time and they will possibly prefer to maintain so even if counsellors were to be eligible for Medicare rebates it may take some time to bring back some sort of level playing field.

This challenge has forced many counsellors to seek other forms of income whilst using there counsellor skills. By moving into new corporate and commercial sectors new fertile fields will be found. ACA has recently had success by signing an agreement to supply counsellors for accident victims who carry policies with Lumley's. We have also been able to discuss with a life style program how by using registered counsellors there program will be more attractive to consumers. There some other similar stories by members on how they have now moved beyond traditional practice. There are certainly opportunities out there, we just need to find them or even make them happen. Having said that ACA will continue to work towards having Medicare recognise counsellors as well a having private health organisations recognise our members for provider numbers.

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EXECUTIVE SUMMARY

ACA Medicare Rebate Survey

This survey was distributed to ACA members including their networks. Many non ACA counsellors also completed the survey after being made aware of it through their own networks. The survey was conducted from 18th of May 2007 to 24th of May 2007. This summary does not include surveys received after 24th of May 2007, a further updating of this summary will be made available on 30th of May 2007. To ensure the integrity of the survey it was noted in the survey that the term 'counsellor' referred to a non psychologist or social work counsellor.

Aim: The aim of the survey was to ascertain what impact, if any, have the new Medicare Benefits Schedule (Better Access initiative) had on the counselling industry as a whole. The survey was aimed at gathering information from six areas within the industry:

1. Private Practice
2. Students undertaking counsellor training
3. Non-Government Agencies
4. Training Providers from VET and HE sectors.
5. Employers of Counsellors and employed counsellors
6. Member of the public who is not a counsellor

ACA felt it was important to ensure the survey incorporated all aspects of the industry to capture any general patterns as well as any specific patterns in the responses. The results of the survey do indicate that the introduction of the new legislation opening up NHB exclusively to psychologists and social workers to the exclusion of counsellors has had a negative global impact on the counselling industry.

Not all questions in each category were answered. Some returned surveys showed partial responses in multiple areas. Due to this totals are inconsistent with the number of responses in some cases.

Private Practice: 330 responses were received from Private Practitioners. Of these 313 indicated that they had experienced a decline in referrals since the introduction of the new legislation and 17 indicating no decline. Several of those who indicated 'no' clarified this with notations that they had only just started in practice therefore were not able to identify any patterns. 309 of the 330 respondents who identified a decline indicated that they believed the decline was attributable to potential clients being referred to similar services with Medicare rebates. 255 of the 313 respondents indicated that they had been told directly by clients/GPs that they will no longer use the counsellors service because of a lack of access to Medicare services. 213 respondents indicated that they had lost current clients who stated the reason they were changing services was to access Medicare rebates. 145 respondents indicated that would not be able to continue in practice for more than 6 months unless the current situation changed. Of these 44 were already looking for alternative employment and 3 had already closed their doors. 297 claimed that they believed the down turn in business was directly attributable to the new legislation and 303 stated that their vote at the 2007 Federal election would be influenced by the government's response to this issue. 289 felt this issue was an election issue.

Students undertaking a Graduate or qualification course in counselling: 137 students responded to the survey. 84 indicated they had reconsidered completing there studies as a direct result of exclusion of counsellors to Medicare rebates. 56 indicated they had actually ceased or were seriously considering changing their courses from counselling to social work, 74 indicated they had actually ceased or were seriously considering changing their courses from counselling to psychology and 2 were unsure. 141 believed that exclusion to Medicare rebates would have a direct negative impact on their qualification. 14 respondents had ceased studying as a direct result due to the exclusion of counsellors from Medicare rebates. 12 of the 14 respondents indicated that they had been studying; 1 x PhD, 6 x Masters, 1 x Graduate Diploma, 2 x Advanced Diploma and 2 x Diploma. 123 indicated this was an election issue for them and the outcome would influence how they voted.

Non-Government Agencies: Most respondents disclosed the agency that they worked in, with all the major agencies being named. For confidentiality purposes individual agencies have not been named. 134 surveys were returned from various agencies. 98 of these indicated that they had experienced a significant decrease in client numbers since the introduction of the rebates. 96 of the 98 respondents indicated they attributed the decline to clients being referred to similar private services that offered rebates. 90 respondents indicated that the future of their counselling service was now in danger. 130 of the respondents indicated that the exclusion of counselling services from Medicare rebates was not in the interest of those from low income families.

Training Providers, both VET/HE sectors: 18 providers responded to the survey. 7 indicated that the exclusion of counselling for rebates had a negative impact on enrolments. 15 indicated that they have had students cancel their enrolment as a direct consequence of exclusion from the rebates. 15 indicated that students had shown significant concern about counsellors being excluded from Medicare rebates. All respondents indicated that this was an election issue for them. 12 respondents indicated their training courses would not be commercially viable if counsellors were not given access to rebates. 10 indicated that they believed counsellor training will not be in demand if rebates are not made available to counsellors.

Employed/Employers of Counsellors: 136 responded to this section of the survey. 103 indicated that the introduction of rebates threatened their job security. 110 indicated that it was not viable to hire counsellors because they cannot offer rebates. 105 indicated that there was no future for counselling as an employer/employee without access to Medicare rebates. 102 indicated that there was no future in the counselling industry without immediate access to Medicare rebates.

Members of the public (non counsellors): 303 members of the public responded to this section. 282 indicated they believed that counselling services by counsellors should be made available through Medicare. 300 indicated they would use a counsellor if Medicare rebates were made available.

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The aim of the survey was to ascertain what impact, if any, have the new Medicare Benefits Schedule (Better Access initiative) had on the counselling industry as a whole.

Compulsory Mediation: Commencing 1 July 2007

The Shared Parenting amendments that commenced in July 2006 transformed not only the terminology, and the Parenting Orders the Court makes but also the process for family dispute resolution. With compulsory mediation a pre-requisite for all Court Applications for Parenting Orders from 1 July 2007 it is timely to clarify what the new mediation requirements are all about.

What is happening?

On 1 July 2006 the Family Law Act was amended to introduce the Shared Parenting legislation.

These changes introduced a significant shift in how the *Family Law Act* now deals with the arrangements for children.

In addition to the introduction of the presumption of shared parental responsibility, the new concepts of "equal time" and "substantial and significant" time, Independent Children's Lawyers and the Children's Cases Program the amendments also introduced a number of changes with respect to the family dispute resolution (mediation) provisions of the *Act*.

The amendments have introduced not only new definitions for those doing the mediation but also the commencement of compulsory mediation from 1 July 2007.

I believe an online relationship can unwittingly foster these types of behaviours, as both people are in the position to present the sides of themselves that are complimentary and mask any unattractive traits.

When is mediation compulsory?

From 1 July 2007, if a person wants to apply to the Court for a Parenting Order they will need a certificate from a Registered Family Dispute Resolution Provider which confirms that an attempt at family dispute resolution has been made.

It is contemplated by the Federal Government that sometime in the future the compulsory mediation requirement may be extended to apply to all Court Applications, not just children's matters. At this stage however it is only relevant for parenting Applications.

Who does the mediation?

A Registered Family Dispute Resolution Provider is an individual or organisation who has met the required standards of training and experience for inclusion on the family dispute resolution register.

Registered Family Dispute Resolution Providers can conduct family dispute resolution services (i.e mediation) and if needed, issue a Certificate that can be taken to Court to confirm that an attempt at family dispute resolution has been made.

The Federal Government has funded Family Relationship Centres and a number of other community organisations to provide family dispute resolution services. Individuals working in private practice can apply to be registered as Family Dispute Resolution Providers. The register is accessible at www.familyrelationships.gov.au. The on-line register will provide on-line information about individuals and organisations who meet the requirements of a Family Dispute Resolution Provider under the Act.

Who can be registered?

Approved organisations will be automatically registered and can authorise specific individuals to provide family dispute resolution services on their behalf and this authorisation will continue for the period for which they are authorised.

From 1 July 2009 there will no longer be any approved organisations.

The requirements for registration of an individual Family Dispute Resolution Practitioner are set out in Section 10G of the Family Law Act and provide two pathways for registration prior to 30 June 2009, either pursuant to regulation 83 or under the interim rules.

Registration under regulation 83 must occur before 1 July 2007 and under that there are (2) options. These are:

- (Option 1): Have an appropriate tertiary qualification, have completed 10 hours of dispute resolution and have completed 5 days of training; or
- (Option 2): Complete a tertiary qualification by August 2008 and have provided at least 150 hours of mediation since June 1991 (with at least 50 provided since June 1994).

The alternative option for registration is under the interim rules, however these impose a more stringent requirement, i.e:

- Have an appropriate tertiary qualification, have at least 30 hours of supervised family dispute resolution and have completed 5 days training in mediation.

Final accreditation requirements will be in place after 1 July 2009.

Who has to go?

A Certificate of attendance at mediation is only required if a person wants to apply to the Court for a Parenting Order.

It is hoped that clients will seek legal advice before engaging in any mediation process so as to ensure they are fully advised of their legal position and the options open to them. It may well be the case that mediation is not appropriate for them at that time and that negotiations may be a more appropriate course.

Are there exceptions to the requirement for a certificate?

A Certificate of attendance at mediation is not required where:

- Parties are applying for Consent Orders;
- Where the matter is urgent;
- Family violence has occurred or there is a risk of violence and the mediation would result in a delay;
- It is not practical for either or both of the parties to attend; or
- A person has shown serious disregard in contravening a Court Order in the previous 12 months.

What will the certificate say?

The Certificate will say one of the following, either:

- One of the parties did not attend; or
- Both parties attended and made a genuine effort to resolve the dispute; or
- Both parties attended but one did not make a

genuine effort; or

- The mediator decided that the case was not appropriate for mediation.

A standard form for the Certificate is provided in Schedule 7A of the Act.

Information to clients

Family Dispute Resolution Practitioners must provide parties with a statement about the process, the parties rights and about the qualifications of and fees charged by the practitioner, before family dispute resolution can start.

The practitioner must also give the parties information about Parenting Plans and other services available to help with the preparation of a Parenting Plan. (Readers are referred to the author's previous article entitled "Tips and Traps in Parenting Plans").

Is the process confidential?

Pursuant to Section 10J of the Act 2006 Family Law (Shared Parental Responsibility) Amendment Act 2006, everything said to a Family Dispute Resolution Practitioner is confidential except in special circumstances, such as to prevent a serious threat to someone's life or health or to prevent the commission of a crime.

What is said during family dispute resolution cannot be used as evidence in Court. However, a Family Dispute Resolution must report child abuse, or anything said that indicates a child is at risk of abuse, and this may be used as evidence in some circumstances.

What if one of the parties does not attend?

If one of the parties does not attend or make a genuine effort the Court will take this into account in deciding any Costs Order or the Court may order that that party attend mediation.

Costs

Private providers will set their own fees. Family Relationship Centres provide up to 3 hours of family dispute resolution free but may charge fees if further sessions are needed.

WHERE DO YOU START?

The legal process is complicated and careful consideration of particular circumstances is critical before putting forward proposals or attending a mediation.

Brisbane based Family Law Specialist, Michael Lynch recommends that Specialist Family Law advice should be obtained before doing anything. To assist this process he has recently published a book "A Guide to Family Law – Everyday Answers". Michael says the book is not a substitute for legal advice but will certainly help clarify the changes to the law in an easy to read style. For a free copy of the book telephone (07) 3221 4300 or email law@mlynch.com.au.

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Brandon isn't ashamed to discuss sexual problems and they make him feel, but only when he is typing about it to a woman.

But Was it Really Me? By Angela Lewis (PhD, MaEd)

ONLINE SOCIAL CRUELTY: ANONYMOUS HARASSMENT AND CYBER-BULLYING ON THE INTERNET:

Identity is an essential and accepted aspect of human interaction. Up until the emergence of the world wide web, people were accustomed to interacting with others who they came to know through work, friends or family and it would have been unusual (except for those with overseas pen-pals), for people to have regular contact with strangers they had never met face to face. However the Internet has changed all that and now many people have friendships, relationships and regular contact with people they do not know well in the traditional sense. Those people then interact with others in a similar fashion and before you know it; your life can be an open book for the entire world to read. This free flow of information allows people to make comments, pass judgements and circulate information with impunity. For example, in the process of researching this topic of anonymous email and its consequences, I (along with many others), was sent a stranger's wedding photos in a forwarded email that was making rounds. The wedding photos had been anonymously edited to include comments that were extremely unflattering to the bride and her guests. While it was witty and I did laugh, I know I wouldn't have been sniggering so loud if it my sister's wedding attire that was being ridiculed from Melbourne to Osaka.

The troubling aspect of teenagers being 'authentic,' is that they often revealed personal information such as real name, age, location and other ways of being located such as email addresses, instant messenger addresses or phone numbers.

Online anonymity being what it is, it affords people the opportunity to hide behind their computers while writing whatever, to whomever, whenever they want – with no thought or fear of the consequence of their actions. For the recipients of cruel emails or text messages, this can sometimes turn into online harassment or cyber-bullying. Nancy Willard, Director for the Center for Safe and Responsible Internet Use, describes cyber-bullying as behaviour that is *"defamatory, constitutes bullying, harassment, or discrimination, discloses personal information, or contains offensive, vulgar or derogatory comments"* (Willard, 2003: pp.66). The Internet is able to facilitate these behaviours, precisely because the people that feel the need to behave this way now have an unlimited opportunity to do so from their computer or mobile phone. Psychologists such as the veteran of online behaviour research John Suler, have identified that online communication can manifest in far more disinhibited behaviour than face-to-face communications. He believes this is partly because when people are using technology for communication there is a lack of tangible feedback about their how their actions are affecting others. Willard (2004) also argues that this lack of immediate feedback distances people from any perception of the possible harm their behavior may be causing. Further, the emotional and physical distance that people experience online makes it easy to rationalise any irresponsible or harmful action as being harmless. Pairing that type of disinihibition and disengagement with the perceived guarantee of online anonymity can cause heartache and distress for those on the receiving end of anonymous hate or defamatory email, postings on websites or in the case of younger adults and children, bullying or harassing via anonymous text messages.

The Consequences of Sharing

The Internet has made it possible for anyone with computer access to create and publish online personal journals or diaries (known as blogs) and so share their lives with the world. Unfortunately being so open, blogs can also unwittingly expose people to being cyber-bullied or harassed as the amount and degree of of personal information provided on many blogs gives bullies not only ways of contacting the blogger, but ammunition in the form of personal or candid disclosures made by the writer. As well as being bullied, people of all ages who are online can be exposed to online predators, people who take advantage of the Internet's easy access and availability to create a fictional identity that is enabled by the privacy and secrecy that the Internet affords. Being online offers protagonists the opportunity to develop identities and personas that will lure people into a feeling of 'knowing' the anonymous 'other' who they have never met face to face. People (and young people in particular). will place their trust in the way someone writes, the photographs they post, the language and idioms they use, the music they claim to like and before long they believe and trust in the online presence of a stranger on a social networking site such as 'MySpace' or 'Yahoo' which may well be forged. The reason the most commonly discussed risk group is young children, is unfortunately because of the way online predators target them, spending long periods of time obtaining information about the child, then using this to flatter them, give them compliments and create an ambience of trust and mutual bonding while mostly portraying themselves as being of a similar age (NetSafe Kids Website 2007).

The obvious answer to guarding your privacy is to be totally anonymous. Create a fake name and fake persona, and be tight lipped about yourself and your life when online with strangers. But that isn't why most people go out onto the Internet - most people are genuine in seeking friends, love and relationships and ultimately want to be authentic, while also having an authentic experience. Identity online ("when do I, when don't I"), is the quandary of our times, despite claims that cyberspace should be a democratic global village where information (malicious or otherwise)-should flow freely.

What Can Be Done to Maintain Online Safety?

Short of removing your online presence altogether and only communicating under a pseudonym, there are steps you can take to proactively protect yourself and your children without disappearing completely. Some suggestions might be:

Firstly, try to be selective in what you share with others online. It is easy to feel comfortable when chatting to someone on the screen from the safety of your home and quickly divulge more than you intended to. This often happens when people participate in online communities (e.g. a parenting group, a photography group, youTub.com) and feel they have something in common with the group. It has been found that women more than men seem to provide a rich amount of detail on discussion forums, with some divulging not only names and ages of children, but often linking to photos of them. In some

cases people will also divulge personal information about where they live, shop or work as well as describing their daily activities in the spirit of 'sharing' and getting to know others.

Teenagers and young adults also reveal a lot of personal information on blogs. Given that they are online journals, people sometimes forget that anybody, anywhere can be reading their private thoughts. A recent study of online identity and language among teenagers by Huffaker & Calvert (2005) has found that the vast majority of teenagers stayed close to reality when expressing themselves online. The troubling aspect of teenagers being 'authentic,' is that they often revealed personal information such as real name, age, location and other ways of being located such as email addresses, instant messenger addresses or phone numbers. Parents need to be aware that children and young adults can and do publish private information about themselves and their families which could lead to undesirable contact by other adults who may be sexual predators or even thieves or criminals.

Herring, Scheidt, Bonus & Wright (2004) also found that more than half (54%) of adult blog authors they studied provide explicit demographic information such as age, occupation, or geographic location as well as what some would consider are quite personal details.

As a result, blogs can actually facilitate cyber-bullying, as they provide both a method of contacting the blogger as well as ammunition in the form of the personal or candid disclosures found on the person's blog (Huffaker 2004). A 2005 study by the Media Awareness group found that 60% of students they surveyed pretended to be someone else when online, and a staggering 17% admitted they do so because they want to *"act mean to people and get away with it"*. Willard (2004) makes a good argument for parents to be involved in fostering ethical use and behaviours for young adults and teens in their online behaviours, because adolescence is the time at which the cognitive ability to take on board the perspectives of others emerges. Most teenagers and children are communicating online at a time when their ability to detect or predict how another might feel in response to their communication may not be fully developed. Pairing this to a reduction in social and contextual clues and the absence of social disapproval in an online space means they may engage in unregulated and hostile communication that can manifest itself in cyber-bullying and other forms of social cruelty.

While it shouldn't be necessary to stop making friends and sharing personal bits of information, it is important to take a look at what you are sharing in public online forums and to pay attention to what information your children may be putting online in

For the recipients of cruel emails or text messages, this can sometimes turn into online harassment or cyber-bullying.

But Was it Really Me? (Continued)

terms of compromising the safety of your family. It is easier to be proactive in warding off cyber-bullying or harassment, than dealing with it after the fact.

In terms of posting photos, while it is certainly part of what brings people together online and helps us to 'know' someone we might never meet face to face; it is also prudent to select those photos carefully. Be under no illusions that you cannot control who sees, steals them or alters them or what feelings those photos may bring out in strangers. Aside from that, be careful to crop out any unnecessary background details, because without realising it your photo can be giving away a lot of information about your lifestyle, where you live, how you live and who you do or don't live with.

When dealing with total strangers online use pseudonyms and be very careful about sharing your last name online. People need to be aware of how the internet works. It is not anonymous, because every website you visit leaves information behind about you (what you clicked, how long you read a page for), and every email you send contains information that allows people who know what they are doing to find out further information about you (that is how the authorities go about tracking criminals). While it is easy to get paranoid about this, just remain aware that the feeling of anonymity that comes with browsing the Internet is false and it is easy to think it is just you and your computer sitting there quietly surfing the net in the privacy of your study.

When they are in receipt of a complaint against one of their users, they research the issue fully, which begins by asking for a copy of the messages received in full header settings mode.

The problem some people face is that while they are being harassed or cyber-bullied anonymously, they know or have a fair idea who the perpetrator really is and this behaviour becomes the online version of a poison pen letter - but with further reach. Consider the angst experienced by this middle-aged couple as they describe their experience:

> *We have had a personal profile up on a social website that acts as an introduction facility for people to get to know each other. We have been actively and positively involved with this online community for about two years now. We are well known on this site, have cultivated many good friends and hosted numerous functions. All of a sudden, these devastatingly slanderous emails are appearing to all our listed online friends, some of who are on the board of directors at one of the social clubs we belong to. The email accuses us of having a communicable disease. We don't know who the person is because they have a free generic email account.*

In the following section we will explore what options are available for dealing with these type of situations.

Dealing with Inappropriate Anonymous Email in Practical Terms

Internet service providers (ISPs) are the companies that provide Internet access to consumers. Most ISPs have what are known as Acceptable Use Policies (AUPs) that clearly define privileges and guidelines for those using their services, and the actions that can be taken if those guidelines are violated. Reputable ISPs and mobile phone service providers will respond to reports of cyber-bullying over their networks, or help clients track down the appropriate service provider to contact . As a start, if you receive abusive emails, flame mails or hate mail, you can forward it to abuse@isp where "isp" is the service provider the abuser is using, eg "aol.com" or "yahoo.com". Although Internet service providers may not act on every complaint, the more complaints they receive about a particular individual (with examples of abusive email) the more likely they are to close down the person's account.

Hotmail are one of the largest providers of free and anonymous email accounts. I contacted them to ask about their policies about situations such as the above and they advised that sending objectionable material from a Hotmail account is a violation of their terms of use and as such, is a cause for the termination of that account. When they are in receipt of a complaint against one of their users, they research the issue fully, which begins by asking for a copy of the messages received in full header settings mode. It is up to the owner of the Hotmail account to set it up with full header settings, which then enables Hotmail to verify and track the messages through information known as 'X-Originating-IP', which is included in every mail sent from a valid Hotmail account, but generally not seen by the user. Hotmail use this as evidence that the account has violated the terms of use.

Setting up your email account to show the technical details of the email sender (the X-Originating-IP) is easy to do for Hotmail and I have provided these below. When you do this you reveal the sender's Internet Protocol number (IP), which is somewhat like a phone number for the Internet and enables someone to locate the computer. If you are having problems with another ISP, then contact them and ask them how you can make similar adjustments to reveal details about suspect emails. I have chosen to describe the Hotmail steps as this is one of the most widely used free email services and space does not permit to do this for all providers.

While this article does not pretend to provide legal advice in any form, it is my understanding that under Australian law, defamation applies to email and online communication as it does to any other form of media. (Defamation being written attack on a person's character, while is the spoken attack on a person's character). A good further definition and various other information related to defamation and its definitions can be found on Attorney-General's Department website (www.ag.gov.au 2004). Litigation as a result of defamatory email is far less common though, given the ability of e-mail to transcend geographic boundaries and making the interpretation and subsequent legal action subject to the legal regimes of the countries of the world. However, it appears from reading the government legislation, that defamation/libel action can be taken, and an employer may be liable for the content of emails sent by employees in the course of their employment as well as the individual employees. This is why so many employers print a clause at the end of their emails to cover such matters.

Responding to Cyber-bullying or Harassment

An English website (www.bullyonline.org.au) devoted to all aspects of online harassment advocates that the

number one rule for dealing with this type of behaviour is 'don't respond, don't interact and don't engage'. This is not as easy to do as it sounds, as for most people it is a natural response to want to defend themselves and sort out the situation. Bullyonline maintains:

> *Never argue with a serial bully; it's not a mature adult discussion, but like dealing with a child or immature teenager; whilst the serial bully may be an adult on the outside, on the inside they are like a child who's never grown up - and probably never will. Serial bullies and harassers often have disordered thinking patterns and do not share the same thoughts or values as you.*

The second rule that all professionals in this area advocate is that the person experiencing cyber-bullying ensures they keep all abusive emails (see above). Now this doesn't mean you have to read them, just keep them for future reference. They suggest creating a new folder on the computer, and moving the hate mail and flame mail into this folder. That way when time comes when action can be taken, there is a full trail of evidence that the internet service provider or authorities can pursue. The folk at 'Bullyonline' maintain that bullies, especially cyber-bullies, are obsessive people and if their account is closed down they may simply open a new account and the victim may then start receiving mail from another address, which will then carry all the hallmarks of the previous mail (words, phrases, etc), so giving authorities the opportunity to make links to the perpetrator. These can later be compared to the abusive emails you've already received and work to identify the perpetrator.

Conclusion

The anti-pornography crusade has been reasonably successful in reining in the freefall of online pornography that most of had to grapple with in the early days. Successful intervention measures now being taken by most Internet service providers in the form of firewalls and other control devices manages (to a degree), to shield the young and naive. Now, record companies are appealing to people's ethics in urging parents to help stamp out music pirating. Perhaps next on the agenda should be a concerted effort to stop online social cruelty in all its permutations of cyber-bullying, harassment and stalking.

How to Enable Full Header Settings in Hotmail

1. Open your Hotmail account then click the **Options** link on the upper-right side of the page.
2. Then look on the left side of the screen and click the **Mail** tab.
3. Next click **Mail Display Settings**.
4. Under **Message Headers**, select **Full**, then click OK.
5. After you are done, open the problem email message and you will see a whole lot of data under the email address of the person sending to you.
6. Forward or copy and paste the data onto abuse@hotmail.com

How to Enable Full Header Settings in Outlook

To do this in Outlook Express, just right click on the message you want to see and choose **Properties**. Then choose the **Details** tab and all of the information will come up for you to peruse.

You can do this in all other email programs as well, but they are all a little different. Try looking under the Options menu in your email, and try to locate something about 'headers'.

For some information on how to read routing information in the headers of an email, you can check http://www.stopspam.org/email/headers.html for a good tutorial on the subject.

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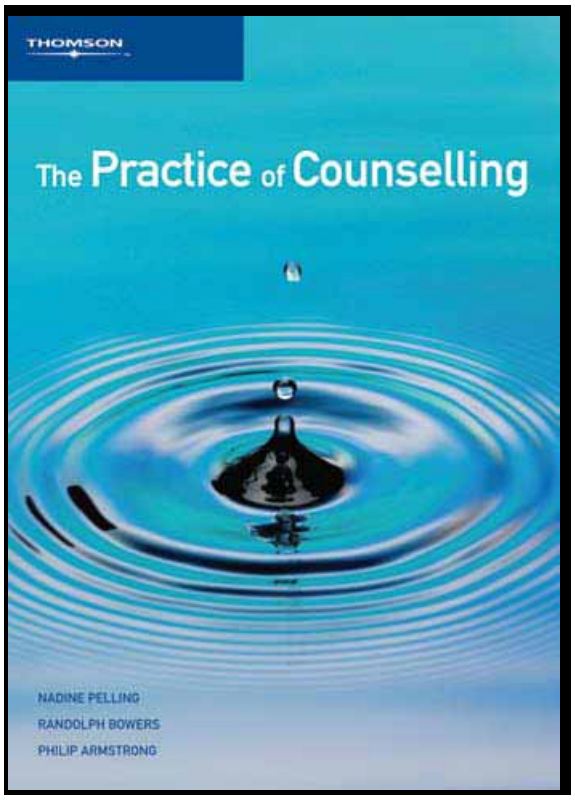
The folk at 'Bullyonline' maintain that bullies, especially cyber-bullies, are obsessive people and if their account is closed down they may simply open a new account and the victim may then start receiving mail from another address, which will then carry all the hallmarks of the previous mail (words, phrases, etc), so giving authorities the opportunity to make links to the perpetrator.

NEW AUSTRALIAN TEXTS



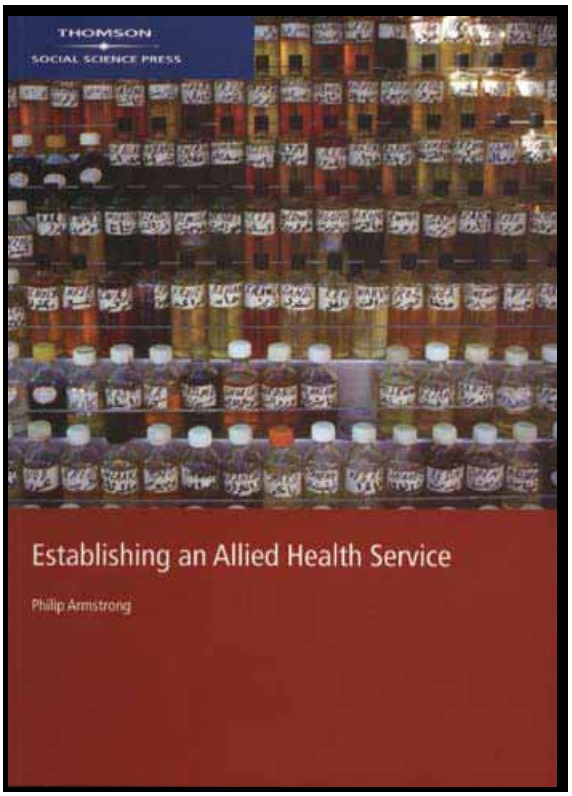
Pelling, Bowers and Armstrong

The Practice of Counselling

The Practice of Counselling is an outstanding Australian text that addresses a wide spectrum of contemporary issues faced by practising counsellors. It is designed to cover a comprehensive range of issues for the practising counsellor and for students of counselling, including integrative approaches to the field, social and political issues, cross-cultural counselling, cultural diversity, Indigenous issues; and counselling in various contexts including grief and loss, crisis work, and issues in supervision.

It is imperative professional counsellors and psychotherapists understand the social and cultural influences that impact clients. This understanding is equally essential for the teaching and learning process. This text explores best practices in the areas of counselling interventions to address some of the most challenging issues facing practitioners today. Offering solid, innovative, state-of-the-art guidance and models, this text helps students to learn and engage in critical thinking much more readily as the literature reflects their own environment and experiences.

An essential text that helps the counsellor understand the client's world-view while assisting the student to explore the transition from theory into practice.



Armstrong

Establishing an Allied Health Service

Establishing an Allied Health Service is designed for anyone planning to set up a professional services business. Whether the business is counselling, massage or physiotherapy, this practical book takes small-business owners through all the primary issues related to running a successful business.

Features include:
- How to put together a business plan
- How to market your business
- How to work through administration issues

Establishing an Allied Health Service is based on the author's thirteen years of experience as a small-business owner and feedback he has received from his nationally acclaimed workshop 'How to Build a Successful Practice'.

THOMSON

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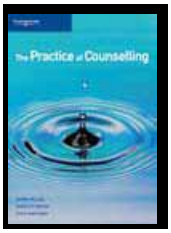

Pelling, Bowers and Armstrong

The Practice of Counselling

Armstrong

Establishing an Allied Health Service

How to Do Self-Awareness By Owen Kessel

Connecting with our selves

One of the ills, a great ill, of Western us, is disconnection. The counselling relationship acts in similar ways to mutual support networks and in finding purpose. In therapy we parallel something of reconnecting; slowing down and connecting both within ourselves and to others.

Therapists wonder about giving of themselves in sessions; opinion, advice, and their internal world of feelings and thoughts. Should we protect clients from ourselves, or are objectivity, boundaries, for example, really just ways of protecting ourselves from our client's pain, the mess and unknowns of life. It is endlessness we fear.

To many clients we are catalysts in their relating better to themselves; with significant others; and among the world in which they live. To other clients we are a significant source of long-term support, with one qualification. Clients borrow us only for as long as they need. Then they let us go.

'Will we connect within us, so clients can go on to connect without us? If we 'keep it all in', then what is the take-home message? And if we let it all hang out, what does that say about managing it all in the first place?

What clients don't know – and what holds them back - is whether we will join them, support them, and manage to get us both through together. Clients want to experience that process of navigation before they may go further. In the same vein, Robert Grant recently work-shopped his experience working with traumatized people. Interestingly, clients when asked about what they found useful in therapy, did *not* rate the skill of the therapist as significant. Rather the question that was critical in clients' minds was, 'Can you manage me?' (Reilly pers comm. 2006a).

What counts to the psyche, deeper down, is how far it feels safe and willing to progress with us. The situation then is that the psyche and particularly the deeper psyche, is sizing us up. Therapists buffer clients from therapeutic bias and power not by avoiding or pretending it's not there but by navigating it. It's up to us to see this coming, and meet and match the need. In therapists handling their own power, clients learn faster to handle their own.

Navigating our way with clients

Lin Reilly is a widely and highly respected practitioner of over 40 years experience and one of a declining group having had direct clinical contact with the salience of Satir and Minuchin. At times a University Lecturer in therapy and family therapy, it is important to honour the oral 'off the record' history such as his that may be all too easily lost.

'Over the last three decades, training has shifted away from spending a lot of time emphasizing and developing self-awareness of one's own vulnerability and intuition in working with clients. Perhaps the earlier ways were seen as too psychoanalytic, too psychodynamic. We have moved instead towards highly developed skills, like solution focused and task-centred therapy… While holding onto these developments, it seems the pendulum has stopped and may be looking back for something more' (Reilly pers comm., 2006b).

The process of giving advice, taking a stance, revealing our thoughts and feelings, carries tensions. Counselling is balance. We juggle 'being involved' with that of 'respecting distance'. Clients will open to the work of therapy according to how well we navigate these tensions together.

To navigate risk, that process of:

— being sensitive to being open
— becoming vulnerable
— holding the space
— maintaining communication
— sitting with uncertainty and/or working through it

is to model something valuable to clients. Clients cannot go there on their own. And when they do, they need time. The teamwork between us, the 'teamwork' within them; they take back to the world.

The question then is, 'Will we connect within us, so clients can go on to connect without us? If we 'keep it all in', then what is the take-home message? And if we let it all hang out, what does that say about managing it all in the first place? Client's come because we have experience in dealing with reality. And the psyche, which underneath it all is nobody's fool, comes with them. Clients give us scope according to how well we navigate the tensions; and the psyche wanting a space that is safe but not too comfortable.

Therapist use of self

At a workshop in Australia, Satir was once asked about how and when why an intervention occurred. "That is a stupid question. You just know", she replied (Reilly pers comm, 2002a). Erickson would have the arrogance to say "I just know" what is happening for clients (Reilly pers comm, 2006c).

Carl Whitaker used spontaneity, absurdity or craziness to shift families stuck at therapeutic impasse (Keith and Whitaker, 1978)[1]. Whitaker would say the first thought or feeling that came to mind! He said therapists should put this information into the interaction, not hide it away. Yet for all his spontaneity, Whitaker would say that therapists must be responsible for:

- relevance
- timing
- and intensity of the intervention

(Reilly pers comm, 2006d).

While we must realize that Whitaker had considerable nous, I think the timing of interventions like this is particularly about clients being at a point where they *trust* themselves rather than the therapeutic relationship per se. We weight our brazenness or reserve accordingly.

Clients carry stereotypes of counsellors: counsellors don't tell you what they really think, counsellors don't give advice, and counsellors act as if they make no judgments. 'Oh, I was worried that you would only just listen.' 'Oh, I was worried that you would just sit there and leave me to work it out myself'. Clients worry we will be so absent of advice that they will feel naked, their imagination running loose to all manner

1 This article of Keith and Whitaker is still highly entertaining and relevant in many ways. Much recommended!

of confusion. The longer the session goes, the more this occurs should we not attend it.

So, if therapy is about being open, are we likewise open? In my work I observe, jink and probe, adjust and check with clients to know well enough what room we have available to work together. Satir said that there is nothing that cannot be talked about (Reilly pers comm, 2002b) and was a passionate advocate for therapist use of self (Baldwin and Satir, 1987). Our intuition and self-awareness is there for a purpose.

Support like being cheeky, rude, 'Oh you didn't!', and 'So you stuffed up, nobody could possibly stuff up like you' may be things you want to sense your timing about but they are often things clients really do think but only faintly say. They carry these inner 'demons', beating themselves up about it. By naming these unnamed fears, therapy avoids reinforcing the inner narratives that clients carry silently. And fear therapy will confirm.

Where vulnerability becomes healing

My University course finished with the memorable words, 'It is through your vulnerability that you will be effective' (North pers comm, 1999). This should not be confused with lack of strength. Being open to the vulnerability of our own self-awareness helps connect us to, and travel with, clients and their deeper being. Clients need us to navigate how connection with self ('to the inside' and 'from the outside') and connection with an 'other' can happen. And this puts something of our selves on the line.

Despite our aversion to vulnerability, can we balance our way back to reclaim it? To do this is to get closer to the deeper part of client psyche; a psyche which persists in weighing us up. Irrespective of how much clients say we are helpful, useful, and glad that they came; such statements are declarative, not comparative. The client won't know whether another therapist might have enabled them to travel further together. It is only as we look back, we can really see how far we were able to take and be taken. This is particularly important if we are to work effectively with complex trauma cases.

One of the disadvantages to being a therapist is having to play catch up to clients. Why do you think Rogers promulgated reflection? Why do you think Freud sat out of view of the client on his couch? It gave time to the therapists in a way they may not otherwise have had. Therapists took their time with clients and modeled something clients had not revisited for some time.

I remember a colleague saying that to really listen comes at a cost (Sabel pers comm, 2001). And by that he meant there are times when we draw from the depths of our being; for what the client needs is nothing less than us as real as we'll ever be.

There is a fine line between hedging or being non-committal, and the therapist pussyfooting under the guise of therapeutic 'integrity', 'staying objective', 'being non-directive'. Pussyfooting is a damaging intervention where we reap what we sow. It looks inert, but it is inert like a black hole is inert, sucking the life out of everything. What went wrong with Roger's followers is that they couldn't duplicate the original him.

Case Study – A turning point intervention[2]

This case study may appear tentative outside of its context. There is an element of significant portent that has been building over the session or sessions. Whilst the client has become comfortable feeling 'heard', the clients has subtly challenged the therapist several times to take things further. The contradiction though is that the client's main feelings and reasoning does not reflect this subtle undercurrent. So to step out, the therapist takes a risk, moving to the brink of a slippery slope.

The exploration with the client can occur in a mutual and open way as I demonstrate in the case study. The key process demonstrated in the case study is that of navigation. In this way, clients don't 'take things personally'. Rather therapist and client and therapist are free to move 'in toward their self' and 'look from outside at their self'. Watch the action as it unfolds.

1 *'Well I know I've let you do a fair bit of talking, can I cut in, maybe I should do a bit of talking here. When you were talking, some thoughts/feelings came to mind. Would it be useful if I put that out there?*

2 *'Okay, look th*is may be useful but it may be it will be not useful. Can you let me know? Would it be okay for you to tell me if it is not useful?

3 *How would you do that?*

4 *'Okay…like I said, take what is useful and leave what's not behind. Okay? When you were talking before about, you know, that stuff, I began to think/feel ……...x y z……(or a part of me thought/felt)*

I don't know whether me saying that was useful. Or not. How did it strike you? Was there a part of that that resonated with you?'

Using the words 'a part of' gives some wiggle room and helps soften statements.

5 *'So, did you find this useful, not useful, what was it like for you?'*

The question seems to be repeating, but clients engage it. I think the 'client' or their deeper psyche continues to need time with it.

6 *'How was it useful?'*

7 *'What are your thoughts now about us starting off on all this. You know, me kind of leaping out there. I know you've already said a bit but just to check in; was it okay for me to just jump out there back then and do that? What do you think?'*

This is a shift in the focus from the dialogue being about the client, and introduces the focus of it being about the therapist. This is followed by the next question:

Perhaps it is something around the edges of those conditions that is really the most important element of therapy - when my self is very clearly, obviously present'

2 The case study uses the word useful many times. My observations is that clients continue to use the time to reflect in further ways.

How to Do Self-Awareness (Continued)

8 *'How was it useful?*

to refocus back from loose, aimless, depleting energy to some 'focused, feel good, pick me up energy' before we head on to the next step.

9 *'You know back there when I talked about talking about xyz… there was a part of me that felt worried you might go 'This is terrible. This might go, aagh, really wrong.' Here I am putting this out there… it's just an idea… an opinion and…'*

Visually I go inward, shifting sight and losing touch with clients, for some moments; all genuinely real for me, and well-bounded.

This invites clients to a deeper process with me. In a way I switch chairs with clients; backtracking, and risking being vulnerable. I can feel the edge, well aware that it gives us both more to work with. This process seen continued in Step 11) I suspect has a hypnotic/trancelike aspect as people are absorbed moving inwards and outwards of their self.

Fundamentally, the notion of these interventions is that vulnerability and strength can co-exist. I think clients sense the safety and openness to 'play' with these notions – a sense of invitation - that happens to effect further change that I'll describe shortly. Play doesn't know the way, it just happens to find a way.

Therapy is of the essence of life…It is only the sad inadequacy of man's (sic) capacity for communication that makes it necessary to run the risk of trying to capture that living experience in words.

10 Clients are quickly reassuring at this point, too reassuring in fact, and as a therapist I soon risk becoming a shadow of my former self should I indulge the client's support too far:

'No, no, that's okay. Thank you. No, I thought it was worth doing, obviously I put it out there, and I thought it was worth it, but there was a part of me that did worry that this could go horribly wrong. I mean, I still did it, and I chose to do it, but I was aware that there was that part of me there. So I thought I would just check in about that.'

I am appreciative but not attached; well-paced but not nervous or rushed; the self-revelation in an 'undeterred by it all' way.

11 *'How was it useful?'*

This question acts to switch the focus back onto clients and something special happens:

1. Clients no longer hold back. A richer dialogue ensues of previous things not said or thought.
2. Clients go inward, shifting sight and losing touch with me, drawing to a silence. And it dawns.
3. Undimmed by fears no longer of therapist left behind; the psyche unleashes its full measure. And it is surprising what resolves.

12 The therapeutic effect is profound. Something special has happened.

'What is happening for you now?'

The client finds their own new voice not reliant on my original input. The client is becoming their own therapist; perhaps they always were.

Revisiting Carl Rogers Client-Centered Therapy

Carl Rogers spoke of a case late in his career where a client broke down into sobs. Rogers said, 'I had responded to his feelings and accepted them but it was when I came to him as a person and expressed my feelings for him, that it really got to him. That interested me, because I am inclined to think that in my writing perhaps I have stressed too much the three basic conditions (congruence, unconditional positive regard and empathic understanding). Perhaps it is something around the edges of those conditions that is really the most important element of therapy - when my self is very clearly, obviously present' (Baldwin and Satir, 1987, 45).

This is relevant to the process of giving advice, taking a stance, revealing our thoughts and feelings because fostering self-awareness through vulnerability connects intuition with essential processes at work in clients. We recede from the pedestal of therapist, demystify our part to the highlight of clients own accomplishments – in case they doubted that, which they usually do - and remove ourselves from pretence.

The brilliance of Carl Rogers's work, so sublime to the naked eye, was his brutal-ness; well tempered, yes, but brutal enough to leave a space the client was forced to face, to confront, and fill if they wished – as they did. Rogers, I believe, knew that we imply all sorts of subtleties, and he carried those tensions ably balanced not because he got rid of them, but because he knew how to work with them, the intrusions still intruding:

— Why this question and not another?
— Why that way of reflecting and not this?
— Why are you silent to what I just said?

In his book Client-Centered Therapy, Roger had the prescience to say 'And if it (the book) suffers the final degradation of becoming 'classroom knowledge' – where the dead words of an author are dissected and poured into the minds of passive students, without even the awareness that they were once living – then better by far the book had never been written. Therapy is of the essence of life…It is only the sad inadequacy of man's (sic) capacity for communication that makes it necessary to run the risk of trying to capture that living experience in words' (Rogers, 1951, x).

Non-directive listening always sold Carl Rogers short. The question then is not whether one does give advice, or something of their self, but rather how we manage the process.

Therapeutic balance in integrating inner and outer healing

Clients come with an 'inner healer', the capacity of the psyche given the right conditions to heal itself (Weinrib 1983, Pearson and Wilson 2001). The role of the therapist is to facilitate that without getting in the way. Therapists also come as 'outer healers'; in bringing energy, power, grasp, direction, and expert status to the process.

But both 'healers' – which can tend to live in separate camps - require skill and the greater balance is knowing how to integrate these two aspects of self. One of the things we may not realize about the great master therapists is that they were psycho-analytically trained. As they moved from the strictures of 'therapist-neutral' psychoanalysis, and moved to greater therapist use of self, they still retained a

considerable attunement to the inner workings of clients. Thus the masters were more blended than their legacies suggest, or words could record, and than those who came after who tried to imitate them. Freud himself said to heal is to love.

When therapy's balance is 'off', therapy creates work for itself that it doesn't need. 'Therapised' clients grown leary, shy and less naïve wall themselves off to further work. They know more about therapists and it is harder to engage them from a clean slate.

Client subroutines of safety kick in like transference / counter-transference. Whitaker's disarming forthrightness could nip things in the bud. This happened before they had the chance to create articles, case studies, and other confused excuses for publishing we have seen and contribute to.

Clients are telling us to get our act together. And connect these two at times disparate concepts of theory and practice to make a difference. The tension between theory and therapist use of self is useful. Theory draws on a body of work that is agreeably beyond 'just us'. Yet the origin of theory is more personal, from the Greek theorus 'spectator' from theoreo 'look at' (Moore 2002, 1390). This validates our presence as self-aware practitioners engaging client-derived need.

Beside each article or book or theory we take to be clients; is an echo calling 'Hey, get over here, give me a hand, let's get among the action.' Every person on the planet has thoughts and opinions, feelings and guesses. Clients give us scope according to how well we navigate the tensions; and the psyche wanting a space that is safe but not too comfortable.

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Short Biography

Owen Kessels is a Counsellor working in private practice. He is a Clinical Member of the Queensland Association for Family Therapy, a member of the AASW, Certified Mental Health Worker. He is highly creative in therapy and works with sandplay and symbol work, as well as traditional verbal approaches. Owen worked in statutory child protection for one year followed by four years with Lifeline - Ipswich and West Moreton counselling abused children, perpetrators and wider generic counselling with people of all ages. He is 43, has 4 kids, 3 dogs, and too many chooks.

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When therapy's balance is 'off', therapy creates work for itself that it doesn't need. 'Therapised' clients grown leary, shy and less naïve wall themselves off to further work. They know more about therapists and it is harder to engage them from a clean slate.

Register of ACA Approved Supervisors

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
NEW SOUTH WALES					
Cate Clark	Albury	02 6041 1913 or 0428 411 906	Grad Dip. Mental Health, Supervisor	$75	Face to Face, Phone, Group
Martin Hunter-Jones	Avalon Beach	02 9973 4997	MA, A d. Ed Ba Psych, Philos	$100	Face to Face, Phone, Group
Jennifer Cieslak	Bathurst	02 6332 4767	Mast. Couns., Grad Dip Couns, Supervisor Trng	$77	Face to Face, Phone, Group
Patricia Newton	Dee Why	02 9982 9988	supervisor Training Certificate	$100	Face to Face & Group
Carol Stuart	Bondi Junction	02 9387 7355	Dip. Prof. Counselling, Supervisor Trng, Workplace Trainer	$88, $70 (conc.)	Face to Face, Phone
Heidi McConkey	Bondi Junction	02 9386 5656	Dip Prof. Couns. Prof. Sup (ACCS)	$99 Ind, $33 Grp	Face to Face, Phone, Group
Gary Green	Brighton Le-Sands	02 9597 7779	MA Couns.(Psych.UWS), Grad Dip Couns.(Spo. Perf. Psych.ACAP), Dip T.A.(ATAA), Cert. IV Assess. Work. Train.(ISA), Cert. IV Ret. Man. (ISA)	$150	Group and Phone by Negotiation
Thomas Kempley	Green Point	0402 265 535	MA Counselling, Supervisor Training	$55	Face to Face, Phone, Group
June Wayne	Haberfield	02 9797 6415	MA. Psych, Clinical APS, MASCH	$70	Face to Face, Phone, Group
Erica Ptiman	Bathurst	02 6332 9498	Supervisor Training Ad Dip Appl Science	$80	Face to Face & Phone
Robert Scherf	Tamworth	(02) 6762 1783 0403 602 094	Registered Psychologist	$120	Face to Face, Group
Samantha Jones	Lindfield	02 9416 6277	Clinical Hypnotherapist, Supervisor Trng	$90 Ind, $40 Grp	Face to Face, Group (2 hrs)
Lidy Seysener	Mona Vale	02 9997 8518	Cet Couns & Psychotherapy Prof Sup (ACCS), Masters NLP	$150	Face to Face, Phone, Group
Sarah McMahon	West Penant Hills	0414 768 575	BA (Psych); PG Dip Psych) COA of Supervision (CCC)	$100	Face to Face, Phone, Group
Irene Colville	North Manly	0439 905 499	BA, Psychology, Hypnotherapy, Supervisor	$90 Ind, $35 Grp	Face to Face, Phone, Group
Brigitte Madeiski	Penrith	02 4727 7499	Dip Prof. Couns. Dip Womens Dev, Dip PSC, Superv. Trg (AIPC)	Neg.	Face to Face, Phone, Group
Sue Edwards	Alexandria	0413 668 759	Dip Prof Couns, Supervisor Trg (ACCS), CMCCA, CPC, Dip Bus Admin, Cert Train & Asses.	$88	Face to Face, Phone, Group
Yildiz Sethi	Roseville	02 9416 6440	B.Ed. Grad Dip Couns, NLP Pract. Prof. Sup. (ACCS)	$80 Ind, $40 Grp	Face to Face, Phone, Group
Elizabeth Lodge	Silverdale	02 4774 2958	Dip. Coun, Dip. Psych, Dip. Hyp	$70	Face to Face, Phone, Group
Grahame Smith	Singleton Heights	0428 218 808	Dip Prof Couns, Supervisor Trg (AIPC)	$66	Face to Face, Phone, Group
Donald Marmara	Sydney	02 9413 9794	Somatic Psych. Cert. Dev. Psych	$120	Face to Face, Phone, Group
Nora Huppert	Sydney	02 9181 3918	Family Therapist	Neg.	Face to Face, Phone, Group
Dr Randolph Bowers	West Armidale	02 6771 2152	PhD., Med Couns. CPNLP,GCHE, BA,CPC, CMACA, RSACA	$80	Face to Face, Phone, Group
Jacqueline Segal	Wisemans Ferry	02 4566 4614	MA Applied Science, Supervisor Trg (AIPC)	$80	Face to Face, Phone, Group
Michelle Dickson	Crows Nest	02 9850 8093 or 0408 230 557	BA.(Hons), PDDip.Ed.(Adult), PGDip.(Child Dev.), Clin.Sup.	$100 Ind $80 Grp Stu. Dis	Face to Face, Phone, Group & Email
Karen Daniel	Turramurra	02 9449 7121	Expressive Therapies & Sandplay Therapy, Supervisor. Traing., (ACCS)	$120 / 2hr Session	Face to Face
Rod McLure	Bondi Junction	02 9387 7752	Supervisor Training (ACCS), Psychotherapist	$110	Face to Face, Phone, Group
Jan Wernej	Caringbah	0411 083 694	M.A., Applied Science, Supervisor	$100	Face to Face, Phone, Group
Brian Edwards	Forresters Beach	0412 912 288	B. Couns UNE, Dip Counselling	$65	Face to Face, Phone, Group
Brian Lamb	Hamilton	02 4940 2000	B Couns, Supervisor Training	$88	Face to Face, Phone, Group
Roy Dorahy	Hamilton	02 4933 4209	Supervisor Training	$88	Face to Face, Group
QUEENSLAND					
Christine Perry	Albany Hills & Beerwah	0412 604 701	Dip. T., B. Ed. MA Couns, Cert IV Ass & Work Trng	$66	Face to Face
Carol Farnell	North Maclean	0410 410 456	B Psych (H), B Bch Sc	$100	Face to Face, Phone, Group
Bruce Lander	Fitzgibbon	(07) 4946 2992 0437 007 950	Bach Theology	$75	Face to Face, Phone
Dr Eunice Ranger	Caboolture	07 5428 6341	Th.o MABA (Hons), Dip Prof Couns, Dip Prof Sup, Govt Trainer, Evaluator, Facilitator	$100	Face to Face, Phone, Group
Myra Cummings	Durack/Inala	0412 537 647	Dip Prof. Couns. Prof. Supervisor Training (AIPC)	$66	Face to Face, Phone
Cameron Covey	Eumundi	07 5442 7107 or 0418 749 849	Grad Dip. (Couns.), BA (Beh.Sci), Prof. Sup (AIPC)	$88 Org $66 Ind	Face to Face, Phone, Group
Judy Boyland	Forest Lake	0413 358 234	Dip Prof Couns., Supervisor Trg (ACCS) Cert. Reality Therapist	$75	Face to Face, Phone
Philip Armstrong	Grange	07 3356 4937	B. Couns., Dip Psych, SOA Supervision (Rel Aust)	$88 Ind $25 Grp	Face to Face, Phone, Group
Bob Pedersen	Hervey Bay	0409 940 764	Dip. Pro.Couns., Dip. Chr. Couns.	Neg.	Face to Face, Phone, Group
Gwenda Logan	Kallangur	0438 448 949	MA Couns., B. Soc Sc., IV Cert Workpl Ass & Trng, JP (C/Dec)	$100	Face to Face, Phone, Group
Boyo Barter	Wynnum & Coorparoo	0421 575 446	MA Mental Health, Post Grad Soc Wk, BA Wk, Gestalt	$80	Face to Face, Phone, Group
Beverely Howarth	Mitchelton	07 3876 2100	Dip Prof. Healing Science, CIL Practitioner	$120	Face to Face, Phone, Group
Kaye Laemmle	Southport, Gold Coast	07 5591 1299	Dip Prof. Couns., SOA Supervision (Re. Aust)	$80	Face to Face, Phone, Group
David Kliese	Sunshine Coast	07 5476 8122	Dip. Prof. Couns. Prof. Sup (AIPC), Dip Clin Hyp.	$75	Face to Face, Phone
Dr John Barletta	Grange	0413 831 946	QLD Psych Board Accreditation, Grad Dip Couns.	$100	Face to Face, Phone, Group
Stacey Lloyd	Brisbane South	07 3420 4127 or 0414 644 650	MA (Couns), BA (Psych), Dip.Bus (Mgnt), Cert IV Trng & Asst	$90	Face to Face, Phone, Group
Lorraine Hagaman	Bridgeman Downs	0413 800 090	M.A., Social Science, B. Bud Comm., Supervisor	$85	Face to Face, Phone, Group
Wendy Campbell	Eumundi	07 5456 7000 or 0437 559 500	Registered Psychologist	$80	Face to Face

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
VICTORIA					
Deborah Cameron	Albert Park	(03) 9893 9422 0438 831 690	M.Couns (Monash), SOA Supervisor Training, M Spec Ed (Spnds) (Deakin) B.A/ (S.Sc) (Deakin)	$99	Face to Face, Phone, Group
Claire Sargent	Canterbury	0409 438 514	BA Hons Psychologist	$110	Face to Face, Phone, Group
Veronika Basa	Chelsea	03 9772 1940	BA Dip Ed., MA Prel Ling., Dip Prof Coun., Supervisor Trng	$80 Ind, $25 Grp	Face to Face, Phone, Group
Miguel Barreiro	Croydon	03 9723 1441	BBSc (Hon) Psychologist	$90	Face to Face, Phone, Group
Sandra Brown	Frankston	03 9783 3222 or 0413 332 675	B. Ed Stud (Mon), Dip Prof. Couns., Dip Clin. Hyp, Prof. Sup (NALAG & ACCS)	$77	Face to Face, Phone, Group
Carol Hardy	Highett	03 9558 3980	Dip App Science (Couns) Grad Cert Bereavement Cert IV Asst & W/place Training & Adv Dip SO Therapy, Prof supervisor	$75	Face to Face, Phone
Michael Woolsey	Seaford	03 9786 8006)	Registered ACA supervisor	$80	Face to Face, Phone
Geoffrey Groube	Heathmont	03 8717 6953	Dip. Prof. Couns., Prof. Supervisor Trg (AIPC)	$75	Face to Face, Phone, Group
Gayle Higgins	Heidelberg	03 9499 9312	Dip Prof Couns., Cert. Dysfun Fam Couns., Prof Super Trg	$70	Face to Face, Phone
Molly Carlile	Inverloch	0419 579 960	RN, B.Ed. Stud., Dip Prof Couns, Supervisor AICD Dip	$100	Phone
Gerard Koe	Keysborough	0403 214 465	Teach Cert., BA Psych, MA Past Couns.	$70	Face to Face
Hans Schmid	Knoxfield	03 9763 8561	Dip. Appl Sc (Couns.) AAI, Prof. Sup HAD	$70	Face to Face, Phone, Group
Sharon Anderson	Nunawading	03 9877 3351	Registered Psychologist	$90	Face to Face, Phone, Group
Sandra Bowden	Rowville	0438 291 874	Dip. Prof. Couns., Prof. Supervisor Trg (ACCS)	$60	Face to Face & Phone
Anita Bentata	Richmond & Montrose,	03 9761 9325 or 0438 590 415	Cert, Prof,Sup (ACCS), Bach. Human Serv (Human Dehav), Psychtherapy & Couns.	$90	Face to Face & Phone
Barbara Matheson	Hallam	03 9703 2920	Dip. Appl Sc (Couns.) AAI, Prof. Sup (ACCS)	$66 Ind, $25 Grp	Face to Face, Phone, Group
SOUTH AUSTRALIA					
Kerry Cavanagh	Adelaide	08 8221 6066	B.A. (Hons), M. App. Psych.	$120	Face to Face, Phone
Adrienne Jeffries	Erindale	0414 390 163	BA Social Work, Dip Psychosynthesis	$85	Face to Face, Phone, Group
Moira Joyce	Frewville	1300 556 892	B. App Sc (Soc Wrk), Cert Mediation, Cert Fam Ther, Cert Couple Ther, Supervisor Trng	$100	Face to Face, Phone, Group
Anne Hamilton	Gladstone	08 8662 2386	Grad Dip Mental Health, Supervisor ACCS	$66	Face to Face, Phone, Group
Yvonne Howlett	Sellicks Beach	0414 432 078	Reg Nurse, Dip Prof. Couns., Supervisor Trng (AIPC)	$100	Face to Face, Phone
Dr Nadine Pelling	Adelaide	0402 598 580	M.A. Ph.D Psychologist & Counsellor	$100	Face to Face, Phone, Group
Maurice Benfredi	Glenelg South	08 8110 1222	Grad Dip Hlth Couns, Dip Counselling and Comm, Advanced Dip Appl Soc Sc	$90	Face to Face, Phone, Group
WESTERN AUSTRALIA					
Christine Ockenfels	Lemming	0438 312 173	MA. Couns., Grad Dip Couns. Dip. C. Couns. Sup Trng (Wasley)	$66	Face to Face, Phone
Dr Kevin Franklin	Mt Lawley	08 9328 6684	PhD (Clin Psych), Trainer, Educator, Practitioner	$100	Face to Face
Carolyn Midwood	Sorrento/Victoria Park	08 9448 3210	MA. Couns. NLP, Sup Trg, Dip Prof. Couns. Cert IV Sm Bus Mgt	$99	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	Dip. Prof. Couns. B. Bus HRD, Prof Supervisor	$99 Ind, $25 Grp	Face to Face, Phone, Group
Eva Lenz	Fremantle	08 9336 3330	Adv. Dip. Edu. Couns., M.A., Religion, Dip Teach	$75	Face to Face, Phone, Group
Lillian Wolfinger	Yokine	08 9345 0387	Professional Supervison	$60	Face to Face, Phone
Deidre Nye	Gosnells	08 9490 2278 0409 901 351	Supervisor Training	$80	Face to Face, Phone, Group
Beverley Abel	Scarborough	08 9341 7981 0402 902 264	Registered Psychologist	$110	Face to Face
John Dallimore	Fremantle	0437 087 119	COA of Supervision (CCC) B. Couns B. Appl. Psych	$90	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip. Prof. Couns. Prof. Sup (AIPC)	$80	Face to Face, Phone, Group
NORTHERN TERRITORY					
Rian Rombouts	Parap	08 8981 8030	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
Margaret Lambert	Brinkin	08 8945 9588 0414 459 585	Grad Dip Psych B Bch Sc (Hons)	$80 ind $120 group	Face to Face, Phone, Group
SINGAPORE					
Hoong Wee Min	Singapore	65 9624 5885	MA Social Science, Supervisor Trng	$100	Face to Face & Group

Private Practice with Ken Warren

Ken Warren runs a successful counselling practice on the Sunshine Coast (Qld). He specialises in mentoring counsellors throughout Australia to succeed in private practice. Download a copy of his free e-book on private practice through www.kenwarren.com.au

TOP 7 LOW-COST MARKETING STRATEGIES

As with most things, there is no return without an investment of some kind. But your investment in marketing your practice does not always have to be financial. It can also be through some smart thinking and consistent effort over time. Here are my top 7 low-cost marketing strategies for private practitioners.

1. **Promote your website on your answering machine message**. This strategy is so easy and gives people, especially those who are reluctant to leave messages, the opportunity to have some of their questions answered and check you out before seeing you. If you think you can't afford a website, check out http://www.myspace.com/ where you can set up your own for free.
2. **Use an email signature to promote your practice**. An email signature is generally your contact details or information about your practice that appears automatically in every email you send. Once set up, an email signature can promote your specialty, direct people to your practice, and build your database providing you give people a compelling enough call to action - more on this later. If you are using Outlook, simply go to Tools / Options / Mail format and then Signatures to set up your own. If you are not computer literate, find a 7 year old to help you.
3. **Start a regular newsletter**. Do you think you could write 4 to 5 paragraphs on topics in which you have expertise or a strong interest? If so, then you have the ability to publish a newsletter. You can send it out weekly if you like, but you might find once per month more manageable. Costs, apart from your internet connection, are nil as long as you send it by email. You can offer it to all of your friends, past clients and coworkers, as well as your new clients. Your newsletter might include an article, an inspirational quote, or details about an upcoming seminar or group you are running. Newsletters are an excellent way to stay in touch as out-of-sight can often mean out-of-mind.
4. **Create a compelling call-to-action**. 'Subscribe to my free newsletter' is a call-to-action, but one that is not-so-compelling. My newsletters all include an offer of something for free, such as, 'Subscribe to my Weekly Newsletter and immediately receive 3 e-books on creating greater happiness in your life'. The beauty of e-books is that once you have one, it costs you nothing to pass it on to others. You might have even noticed the one I am giving away above. You can produce your own e-book or special report by asking yourself what solutions you have for a significant problem your clients experience. The key here is a compelling headline that addresses a key frustration of your ideal clients, as well as quality content. You can also obtain bundles of e-books and e-courses that come with distribution rights through my website. By giving away something for nothing, you can quickly build your database of people who are interested in what you have to offer. You can then stay in touch through your email newsletter which includes details of your services and products. Other compelling calls-to-action include offers of 'Your first session free'. Provided you promote this offer well, it can be an effective way to get busy fast. Although not all clients will re-book for a paid session, clients are more likely to do so than when they are simply offered a discounted session.
5. **Access other people's databases or publications**. Think about who else works with your ideal clients or what publications your clients read. If you specialise in parenting issues for example, then school newsletters or parenting magazines are highly-targeted marketing. Even if you pay for advertising, this tends to be less costly and more targeted than advertising in a newspaper, for example. You might also consider offering to provide such newsletters with a regular article (which also includes your contact details and call-to-action at the end). There is nothing wrong with approaching your community's newspapers and offering to write a regular column for them as well. You can even recycle some of your articles in different publications.
6. **Network with the right people**. By this, I mean either with your ideal clients or those who refer them. You can have the flashiest business cards and website, but unless you are getting out physically meeting with the right people, your business will build slowly. But to do this well, takes some thought about who your ideal clients and referrers are, how you can best meet with them, build good relationships, and speak well about what you do. It is partly also a numbers thing. I advise people I mentor to aim to network with a minimum of 7 people for each day they allocate to networking. Not all will refer to you, but the more people with whom you network, the more who will refer.
7. **Make it easy for clients to give you referrals**. Display quantities of your business cards or practice brochures, perhaps with a sign encouraging clients to take quantities if they know others who may benefit. Encourage people to forward your email newsletter to others. Have on your website or promotional materials a, Why My Clients Refer Their Friends, to not only promote what is special about your work, but also to let clients know that it is OK to refer their friends. Be alert for those times when clients are referring to a friend or family member who needs counselling and do what you can to make it easy for that person to contact you - such as offering your client a business card or brochure to pass on, your phone number if they wish to have a quick chat with you, or your website details for them to check you out.

As with most things, there is no return without an investment of some kind. But your investment in marketing your practice does not always have to be financial. It can also be through some smart thinking and consistent effort over time.

If you are considering private practice or wanting to grow your existing business, then check out my upcoming seminar to be held in Brisbane, Sydney and Melbourne. Details can be gained through http://kenwarren.com.au/workshops-private-practice.html

ACA

Pilot Project for Rebates for Counsellors

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About FPCQ: Federation of Psychotherapists and Counsellors of Queensland Inc (FPCQ) is a full foundation member of Australia's largest peak professional body of counsellors, Australian Counselling Association (ACA). FPCQ was incorporated in 2004, after 4 years operating as a Chapter, and founded on democratic principles with an annually elected management committee. FPCQ adheres to the Code of Ethics and Complaints procedure of ACA, this ensures the associations standards remain parallel with National standards set by its peak body. All FPCQ full members are fully registered with ACA. FPCQ was a co-host of the first International Counselling Conference held in Brisbane, Australia in 2006. The conference was attended by academics, researchers and esteemed professionals from over 15 countries.

FPCQ is also involved in the first Asia Pacific Rim International Conference on Counselling to be held in 2008 in Hong Kong. FPCQ is involved in the delivery of several community services including the regional counselling service and post natal depression support group. FPCQ was also involved in the Back from the Edge youth program in partnership with Pine Rivers City Council in 2005. FPCQ is the most active state based counselling association in Queensland and involves itself in service delivery, advocacy services as well as being a peak state association. Members of FPCQ have an innate belief that professional bodies are not simply about membership and status, they also have a responsibility to contribute to the community in which they operate and promote employment for counsellors. Regional project is a prime example of this as well as FPCQ directing over $150,000 in less than 2 years into the counselling industry in regional Queensland.

Regional Counselling Project

Since 2005 FPCQ has been working with ACA and the Mental Health Association (Qld) to provide for rebates for members of the public seeking counselling services in regional Queensland. FPCQ is the primary driver of this project and administers all data collection, invoicing and policing the project as well as registering counsellors for this project. Regional Queensland has been identified as having an above average incidence of suicide (particularly in mature aged males), depression and family break downs. It has also been identified that regional Queenslanders do not have ready access to mental health and psychological services to address depression and other issues which are triggered through consequences of the drought, down turns in industries such as the sugar cane industry and cyclone affected areas. FPCQ receives $110,000 per year to offer rebates to registered counsellors. This funding has been extended to 2010 by the Queensland government.

FPCQ holds a database of members who are ACA registered counsellors and meet eligibility criteria to access these rebates. Initially funding provided a rebate of $20 per session for a set of 5 sessions with the clients paying $10 per session to make a total of $30.00 per sessions. The rebate was changed in late 2006 to $40 per hourly session (being made up of two 30 minute sessions each attracting a $20 rebate) with a voluntary contribution by the client of a maximum of $20 per hourly session. This gap payment is capped at $20 however many of the counsellors offer the service with no gap payment. This would be equivalent to bulk billing through Medicare. Interestingly enough we are not aware of any psychological services openly offering bulk billing services through the new Medicare Mental Health Care package.

Medicare rebates for mental health services have had no impact on the demand of this service. This makes for some interesting questions and strengthens the argument that the counselling by registered counsellors should be made available on Medicare. The regional project has found that demand has significantly increased since the introduction of the rebates as opposed to a lessoning in demand. This in itself reflects the current policy of ignoring counsellors for Medicare rebates is counter productive. In August 2005 there were 16 members of the public using the service, in July 2006 84 members of the public were using the service. In November 2006 legislation introduced a rebate for psychological services keeping in mind the Mental Health Care package was also operating at this time. FPCQ thought, logically, that there would be a decrease in the demand for the project given Medicare now had two pathways that offered mental health services to the public. Both were well advertised although the government had discriminated against counsellors in regard to access of the new rebate.

FPCQ is the most active state based counselling association in Queensland and involves itself in service delivery, advocacy services as well as being a peak state association.

The demarcation of counsellors within this legislation ignores public demand and confidence in counselling services. A research paper called "Why Go to a Counsellor? Attitudes to, and Knowledge of Counselling in Australia, 2002 by Sharpley, Bond and Agnew reflects the ignorance shown in the discrimination of counsellors in the legislation. The following are excerpts taken directly from the research paper:

- 92.5% of the respondents believed that counselling fees should be covered by Medicare
- 83% of the respondents stated that counsellors should be members of a professional organisation
- Respondents were asked to which of the four health professionals they would recommend to a friend in need of help. A counsellor was the preferred choice of 77.9% of respondents, nearly twice as many as a psychologist (40.3%) and a social worker (39.8%) and three times as many as a psychiatrist (23.5%).
- When asked to select health professionals from a given list of four that they would choose to consult for twenty common presenting problems, participants selected counsellors as the most likely to be consulted.
- Counsellors scored the highest when respondents were asked which profession (counsellor, social worker, psychologist and psychiatrist) they would be

Pilot Project for Rebates for Counsellors (Continued)

able to communicate with in a therapeutical relationship.

- Sixty seven percent of the respondents stated that they considered that counsellors were as professional as their psychological colleagues.
- 79% of the respondents thought there should be more counsellors available in the community.
- Of those who would not pay, being unable to afford the fee was the most common response.
- Overall the data collected here indicated that the profession of counselling is highly regarded by this community…

In spite of the new legislation and access to mental health services against Medicare the demand for services in regional areas through the project have risen by nearly 50% since the inception of the legislation in 2006 with 159 individuals accessing the service in March 2007. Due to the dramatic increase in demand the project has now for the first time introduced caps on how many sessions counsellors can offer and many clients' counsellors can see per month against the project. This is effectively watering down the effectiveness of the project and prohibiting members of the public from accessing the service regardless of the priority of their need.

Medicare. Regional Australians are being prejudiced against, due to counsellors not being able to offer Medicare rebateable services that would be bulk billed.

It is overly obvious the new legislation, in Queensland anyway, is not addressing the needs of the community. By discriminating against counsellors members of the public are denied equity in regard to access and choice. There are far more counsellors in regional areas than psychologists or other mental health workers. Many counsellors live within the communities they service. According to the research undertaken by ACA when profiling counsellors many have a personal investment such as family within the community where they live and practice. Therefore they are not young graduates looking to make significant financial gains by setting up in areas where there are large populations that can afford large gap payments.

There is little financial or professional incentive for psychologists to open private practices in regional and country areas. This brings the burden of delivery of metal services back onto hospitals and government services. With an abundance of counsellors in regional and non regional areas this is necessary and access to Medicare rebates and bulk billing would alleviate this burden on the health system.

It has been suggested that phone counselling services should alleviate demand on current services. Although Lifeline statistics are impressive they are not indicative of preference, region/location or more importantly individuals making multiple calls though out an extended time. This is not to detract from the need of the service or the vital role it plays in the delivery of a much needed confidential service. The point is any argument that the statistics kept by telephone counselling services could be used to suggest they are a valid cost effective replacement for face-to-face services would be nonsense. The majority of telephones counselling services do not offer therapeutic services, nor are the volunteer counsellors in many cases registered or eligible for registration. Also more importantly research has shown that a majority of males would not use telephone counselling services in any case. Effectively alienating a significant portion of the public to counselling services, particularly in regional areas. Research from Advancement of Men's Health (CAHM) taken over a seven period 2000 – 2007 that surveyed 6,500 men with a 65% response rate showed that:

- 62% of the respondents indicated they would not use a telephone counselling service for drought issues with the majority preferring to access a face-to-face counselling service
- 61% of the respondents indicated they would not use telephone counselling services for personal issues
- 79% of these men were married
- 82% of those survey were between 40 to 60 years of age

A detailed research paper on the efficacy of the project by Dr Travis Gee can be read at Appendix 2. Informal results for activities in 2007 from January to March can be seen at Appendix 1.

Future: The future of the Regional Project is positive due to the demand for its services growing significantly. Unfortunately the project is not going to be able to meet the demand which is increasing daily as funding has been set until 2010. Current government and private services cannot meet growing community demand with the provision of current mental health services or access through Medicare. Regional Australians are being prejudiced against, due to counsellors not being able to offer Medicare rebateable services that would be bulk billed. Sadly thousands of counsellors nationally have been denied access to Medicare. Therefore although a proven in demand service is available to help to meet the needs of the public access to these services is being denied by the majority who cannot afford a full fee paying service. Ongoing funding has been supplied by the Queensland government for this project till 2010, unfortunately the demand is far greater than the project is now able to meet although there is no intention of ceasing this service. Growing demand for this service does reflect a significant flaw in the present delivery of mental health services that has not been identified by COAG or the Mental Health Council. Whether this is due more to the Regional Project being administered by professionals working at the coal face and being exposed first hand to the real issues is uncertain. However what is certain is the current legislation is preventing access to much needed services to the public.

The future of the Project is even more guaranteed with the introduction of biased and tunnel vision legislation.

Conclusion: The project administrators expected the project to wind up in short time after the introduction of legislation allowing access to mental health services on Medicare. This has unfortunately not alleviated issues such as access with high gap payments demanded by psychologists in private practice and few services being available in regional areas anyway. There has not been an abundance of new private services made available through the private sector in regional and low income areas to address high needs. Access to current services through Medicare has not addressed equity, access or choice issues as the

rebates are delivered within a biased system that does not allow counselling services to be delivered through it. In light of the outcomes of the FPCQ Pilot Project it would seem that legislation needs to be changed immediately to incorporate services offered by registered counsellors to address these anomalies. One other interesting question that has been raised through the project, if access in regional areas has been negated by biased legislation and demand is increasing because of this, what is the state of mental health services in more densely populated areas?

FPCQ would like to take this opportunity to thank the Queensland Government for its continued support in funding this project.

Philip Armstrong *FACA, AFACHSE*

President (FPCQ)

Appendix 1. Regional Counselling Project Report
Appendix 2. Regional Counselling Projects Results, Dr Travis Gee

Appendix 1.

REGIONAL COUNSELLING PROJECT REPORT FOR JANUARY TO MARCH 2007

Number of Clients

January was a quiet month all round the state. We had a number of enquiries from counsellors about the sudden drop in clients. The client numbers picked up again in the following two months. As the number of counsellors using the project increased we have had to limit the number of clients to the counsellors in order to spread the fund around equitably.

Month	Number of Clients	Number of Sessions	Number of Counsellors
January	76	162	10
February	108	271	11
March	159	555	16

Age Range of Clients

The age range was interesting with few children and no adults in their sixties or eighties. The ninety year old's issue was bereavement. The age range male and female is not shown. A number of clients did not complete details regarding their age or gender.

Children	20	30	40	50	60	70	90	Male	Female
3	14	23	20	20	0	2	1	25	38

Reason for Coming

Depression and anxiety continue to be the most common reasons for requiring assistance. These often were linked to relationship issues.

Anxiety	Depression	Bereavement	PTSD	Relationship	Drug & Alcohol
43	30	7	2	23	4

Outcome of Counselling

Fifteen clients expressed relief at being able to talk about their issue. Other outcomes were:

- assistance with making plans for the future.
- Hope for the future
- Coping strategies for the future
- Childhood issues uncovered and resolved
- Return to work

We have thirty three counsellors who meet the requirements of the project in terms of geographical area and current membership. Of these, ten have used the project since the inception in 2005. We have recently attracted another ten by simplifying the client outcomes form.

The requirement now is to complete the form at the final session. Previously the requirements were two pages for every session. This became impractical as we could not find a volunteer willing to enter the complex data. The statistics expert could no longer volunteer time to prepare a report from the statistics. While we appreciate being a part of this project the increasing time required by volunteers to manage this is an ongoing problem. Our Federation does not have funds available to cover this aspect.

The clients have gained great benefit from this project as otherwise they would not be able to access assistance as they have. The counsellors have also been pleased to be able to offer this service to clients who cannot afford full fees.

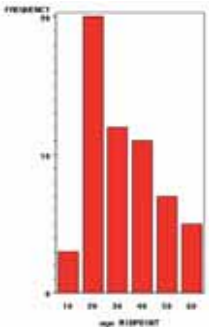
Anne Rickett, MFPCQ; MACA (Clinical)
Individual and Relationship Counsellor
Executive Secretary to FPCQ, RCP Co-ordinator

Clients have gained great benefit from this project as otherwise they would not be able to access assistance as they have.

Appendix 2

REGIONAL COUNSELLING PROJECT RESULTS – PRELIMINARY DATA BY DR TRAVIS GEE — JULY 2006

Eighty-four unique client ID values were assigned in the database. Of these, sixty-eight participants completed at least baseline data of version 2 of the questionnaire or higher, giving scores on both the K10 and the PPSRS. The average number of sessions attended by clients was 4.5 (sd=2.25). On average these sessions occurred over the course of 32.8 days (sd=32.2), ranging from a single session, to 11 sessions over 163 days. Age data were not consistently available, as a small number of counsellors appear to have declined to collect year of birth information, instead writing in "Mature." At baseline only 47 cases had age information, however, some appears to have been collected at a later date for some cases. For the 58 cases on whom such data are available, the mean age was 31.4 years (sd= 13.8). The distribution is shown in Fig. X, and exhibits some positive skewness.



Pilot Project for Rebates for Counsellors (Continued)

Among 70 cases on whom data were available for Session #1, two did not have a primary diagnosis coded, and 38 did not have a secondary issue coded. The breakdown of primary diagnosis is in Table X, and secondary diagnosis is in Table X.

Primary Diagnosis	Freq.	Percent
Anxiety	8	11.76
Depression	31	45.59
Life Skills	3	4.41
Sex Abuse	2	2.94
Marital	17	25.00
PTSD	2	2.94
Anger Mgmt.	1	1.47
Bereavement	3	4.41
Eating Disorder	1	1.47

Secondary Diagnosis	Freq.	Percent
Anxiety	11	34.38
Depression	11	34.38
Life Skills	5	15.63
Marital	2	6.25
PTSD	1	3.13
Bereavement	1	3.13
Rehab.	1	3.13

Perceived sustainability was evaluated via asking clients to rate how confident they were of being able to manage on a direct zero to ten scale for each of the first four goals identified at the outset.

Test Properties and Structure

It should be noted that due to a large number of clients filling out two items of the K10 even when instructed not to do so if they had responded "not at all" to the preceding item, the questionnaire was modified slightly to allow these responses from Version 2 onwards, which includes the present data. Nevertheless, the cross tabulations indicated that individuals who were not apparently nervous did not indicate being excessively nervous (eg., rate the second item as >1), and so with the scoring procedure of assigning a 1 to such cases was moot. The same was true of restlessness.

For the K10, the alpha reliability of the items at baseline was very high (alpha=.90). A similar level was achieved by the five PPSRS variables (alpha=.91) at baseline. Complete test-retest data on the K10 were available for 60 cases. Baseline K10 scores averaged 30.1 (sd=9.12) and changed an average of 11.8 points (sd=9.31; t=-9.8, p< .0001) in the direction of markedly improved scores (effect size=1.29). Age was not significantly correlated with either measure.

The test-retest reliability of the K10 was moderate, with the pre/post correlation being .48 (p<.0001). Test/retest reliability for the PPSRS variables slightly lower (Meaning=.42; Support=.41; Stress=.32; Control=.39; Progress= .36, all p<.01). However, as these were not all taken at the same time (due to highly variable numbers of sessions between pre and post), a variance components method was used to provide another estimate of reliability defined as within-subject homogeneity. For pre/post scores at all points in time, the ratio of Within Subjects to Total variance was .07 for the K10, but between .40 and .49 for all PPS variables. The Shrout-Fleiss reliability of the K10 for a random set of k scores was .63, whereas for the PPSRS variables it ranged between .77 and .84.

The PPSRS and the K10 had correlated total scores at baseline (r=-.70, p<.0001). However, factor analysis of baseline scores (uncontaminated by intervention) of the 10 K10 items and the 5 PPSRS items indicated that there appear to be three fairly distinct constructs measured by them. Initial principal components analysis indicated the presence of three factors with eigenvalues >1, and quartimin rotation produced the factor structure in Table X. The factors were correlated as described in Table X. The first factor appears to be K10 depression, the second K10 anxiety and stress, and the third, the PPSRS variables. The moderate loadings of PPSRS Meaning and Progress on the first K10 factor is the likely reason for the high K10/PPSRS correlation between Factor 1 and 3. This may stabilize as well when more cases have been entered.

Factor Structure (Correlations)						
	Factor1		Factor2		Factor3	
K10 Depressed	94	*	28		44	
K10 Sad	89	*	19		45	
K10 Effort	87	*	27		54	
K10 Worthless	82	*	44		40	
K10 Hopeless	79	*	51		57	
K10 Tired	66	*	34		63	*
K10 Restless	34		95	*	31	
K10 SoNervous	36		94	*	29	
K10 Nervous	33		91	*	22	
K10 SoRestless	18		87	*	29	
PPSRS Stress	55		35		91	*
PPSRS Progress	66	*	25		92	*
PPSRS Control	55		42		89	*
PPSRS Support	23		15		70	*
PPSRS Meaningful	73	*	34		82	*

Printed values are multiplied by 100 and rounded to the nearest integer. Values greater than 0.603098 are flagged by an '*'.

Inter-Factor Correlations			
	Factor1	Factor2	Factor3
Factor1	1.00000	.33	0.51
Factor2	0.33	1.00000	.30
Factor3	0.21	0.30	1.00000

A Goal Attainment scale was also constructed for this study. Respondents were asked to indicate at the end of the sessions the extent to which each of four primary goals had been achieved, on a zero-to-ten scale (zero=not at all, to 10=completely achieved). The items were the first four goals that had been identified at the first session, and naturally varied

widely from client to client. The four items had an alpha reliability of .994.

Perceived sustainability was evaluated via asking clients to rate how confident they were of being able to manage on a direct zero to ten scale for each of the first four goals identified at the outset. Eighteen respondents completed these items, and a 'confidence' score was taken as the mean of their non-missing responses. Each item had a minimum of 13 respondents, and the Cronbach alpha for all cases with complete data was .95.

Changes

Complete pre/post data were available on the K10 and PPSRS variables for 54 cases. As these variables are highly intercorrelated, a repeated-measures MANOVA in multivariate mode (with no assumptions regarding sphericity) was performed on these cases, and revealed statistically significant effects (Wilks' Lambda=.25, F6,48=24.41, p<.0001).

To explore this result further, all available cases were analysed for each outcome measure. For the PPSRS, change scores could be computed for between 71 and 73 cases for each subscale. Meaningfulness scores improved by 2.88 points (sd=2.77; t72=-8.86, p<.0001); Support scores improved by 2.80 points (sd=2.80; t71=-8.80, p<.0001); Stress scores improved by 2.93 points (sd=3.07; t71=-8.04, p<.0001); Control scores improved by 2.45 points (sd=2.97; t72=-7.05, p<.0001) and Progress scores improved by 2.96 points (sd=3.03; t72=-8.34, p<.0001). Taken as a mean across all items, PPS total scores improved by an average of 2.81 (sd=2.72, t72=8.83, p<.0001, effect size=1.36).

Late Starters Excluded

The preceding was an examination that included some 17 cases on whom baseline data from the very beginning of the study had not yet been entered. Thus, their apparent baseline was not the actual beginning of the series of sessions. To understand further the nature of the longitudinal differences across the group, and to account for factor structure, the K10 total score was split into Depression and Anxiety according to the factor structure noted above, and data were analyzed for all cases at all time points up to 10 weeks using a mixed model approach. Times after 10 weeks were excluded as they often involved the 17 cases noted above, which were eliminated because no week 1-5 data have yet been entered for them.

The main effect of session was statistically significant for all seven variables at p<.0001. For this analysis the K10 subscales were reversed and re-scored so they fall on an zero (high distress) to 10 (low distress), to facilitate comparative plotting with the PPSRS variables. These values are plotted in Fig. X, which shows a consistent pattern of improvement up to week 5, followed by a drop at week 6, then continual improvement to week 10.

Comparison of all variable over time

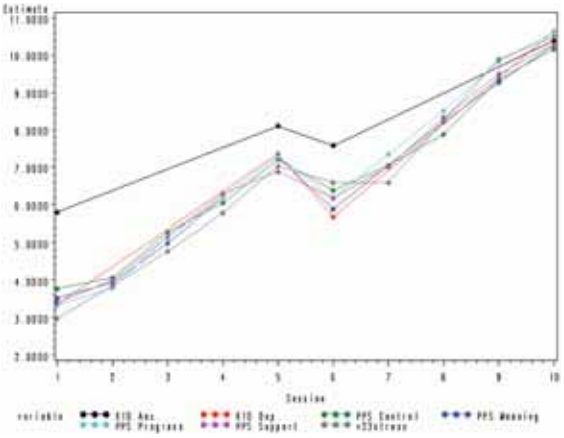


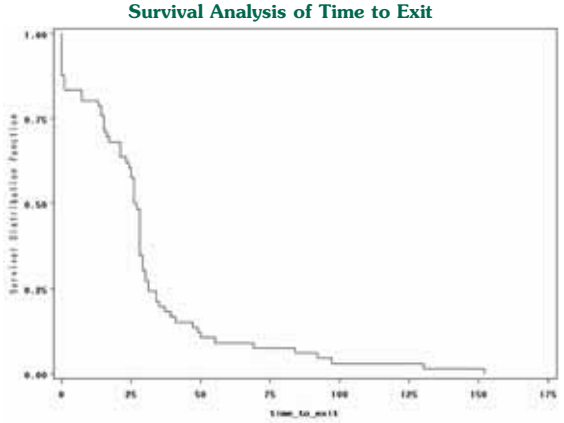
Fig. X: Mixed Model Estimates of Means Over Time (K10 reversed and rescaled).

Predicting Time in Counselling

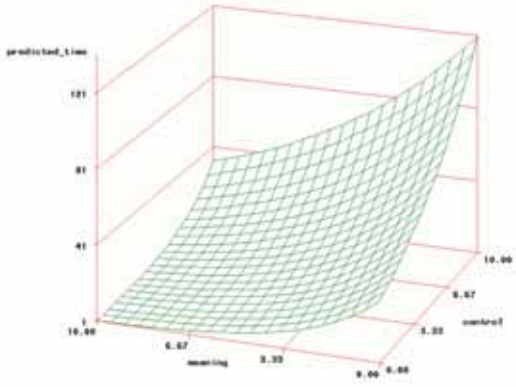
The baseline measures were also shown to be good predictors of length of time spent in counselling. With the 17 cases on whom no baseline (Week 1) data were available dropped, a survival analysis was performed to test the association between the baseline outcome measures and time to final session. A survival curve (ignoring client gender) is plotted in Fig. X, showing the proportion of cases remaining at a given point in time (time being measured in days). As the log of the survival plot was approximately linear through the origin, an exponential model was deemed to be appropriate.

To understand further the nature of the longitudinal differences across the group, and to account for factor structure, the K10 total score was split into Depression and Anxiety according to the factor structure noted above, and data were analyzed for all cases at all time points up to 10 weeks using a mixed model approach.

Survival Analysis of Time to Exit



Meaning, Control and Time in Counselling



Pilot Project for Rebates for Counsellors (Continued)

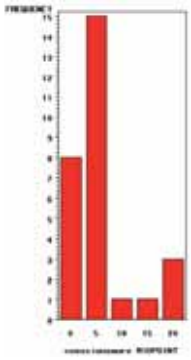
Gender did not predict time in counselling (p=.39, Wilcoxon; p=.50, log rank test). However, with gender included in the model, two of the seven primary baseline outcome measures (K10A, K10D, and PPSRS variables) had significant univariate Wilcoxon tests in a forward stepwise test: PPSRS Meaning (p<.03) and PPSRS Control (p<.0021). Only PPSRS Meaning had a significant univariate relationship with time (p<.0267).

Analysed as a response surface problem, the log of time to exit was predicted from Meaning and Control only. In this instance, of Meaning, Control and the Meaning*Control interaction, Meaning's total contribution was significant (p<.0241) whilst control was marginal (p<.0559). The model accounted for 24% of the variance in time spent in counselling. The full model was statistically significant, however in terms of unique variance, only the linear component was significant (p<.0006). The full response surface of predicted values (a 3-dimensional analog of a regression line) of predicted values of time-in-counselling for the entire range of Meaning and Control is plotted in Fig. X.

This figure indicates that predicted time in counselling is high for those who initially report a great deal of control over relatively meaningless projects, and relatively low for those whose projects are meaningful but relatively out of control.

Those not needing more counselling (expressly or implied) have scores averaging above 7 on the zero-to-ten scale, whereas those explicitly indicating that they need more help average 6 or lower on all measures.

Achievement of Objectives and Need for More Counselling

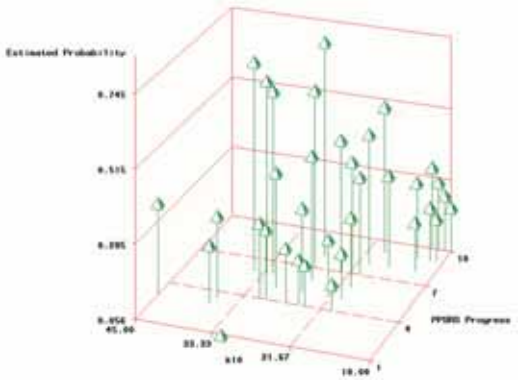


The goal attainment scale noted above was analysed to explore the extent to which clients felt there was still work to do at the last session. Where 3 or more items were available, any missing items were imputed as the mean of the other three, resulting in 42 usable cases that had a mean on the total score scale (range 0-40) of 32.7 (sd=8.5). The total goal attainment score was correlated with the K10 (-.93), Meaning (.95), Progress (.94), Control (.94), Support (.90) and Stress (.95), all r's p<.0001, for N=42 cases.

Twenty-eight cases responded with numeric data to the question of how many more sessions would be needed to achieve their goals. The mean number indicated was 5.8 sessions (sd=5.99). The distribution appears to be Poisson (see Fig. X). Poisson regression analysis to predict this number from the final values of the K10 and PPSRS measures indicated that only PPSRS stress was a predictor of number of sessions that clients felt they needed (chi-squared=35.9, p<.0001). As would be expected intuitively, people with more stress at the end of the sessions felt a need for more sessions.

As it was plausible that many people who had made good progress (as evinced by the PPSRS) towards their goals might not even respond to such a question, cases were categorized according to whether they had somehow indicated needing more counselling. Those clearly indicating in words or a number the need for more sessions were coded 1, and those indicating either zero or not answering the question were coded zero. The cases studied were the last ones recorded for each client, as this variable sometimes occurred more than once, due to a second set of funding being approved after it was initially requested.

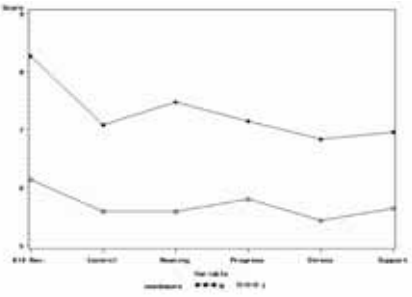
A model was developed using the K10 and PPSRS Progress to predict this variable, using only the interaction term. This was significant (Wald chi-square=4.98, p<.0256) and achieved 72.1% accuracy in classification. In Fig. X, the probability that a person would report needing more sessions, based on this model, is plotted against values of PPSRS Progress and the unreversed K10 scale (where distress is indicated by higher values). These are the predicted values from the logistic regression model for the K10



and Progress scores. From the graph it can be seen that the need for more sessions is highest amongst those who see themselves as having made progress, but who are still experiencing moderate levels of distress.

Profile of Those Wanting More

Sixty-two cases were coded as indicating that they wanted more therapy at the end of their sessions. A MANOVA was run to test the differences on the five PPRSRS variables and the K10 (rescaled here for graphical purposes to a 0-10 scale, with 0 indicating high distress). The overall MANOVA was significant (p<.0005) as were the individual t-tests for each variable (all at p<.0012 or less). The means are plotted in Fig. X. Those not needing more counselling (expressly or implied) have scores averaging above 7 on the zero-to-ten scale, whereas those explicitly indicating that they need more help average 6 or lower on all measures.

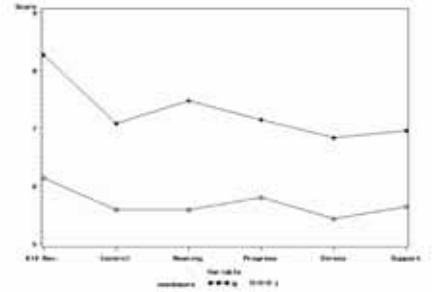


Perceived Sustainability

The overall confidence score on the perceived sustainability scale was 5.9 (sd=2.86), and it was highly correlated with the K10 and PPSRS measures as presented in Table X. Forward stepwise regression indicated that only the K10 contributed significant unique variance (p<.0001).

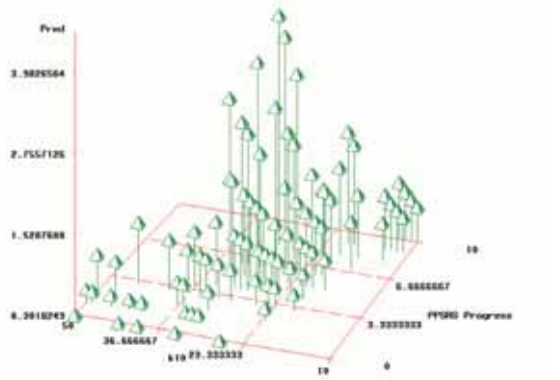
Pearson Correlation Coefficients, N = 18 Prob > |r| under H0: Rho=0							
	Confidence	k10	Meaning	Support	Stress	Control	Progress
confidence	1.00000	-0.78141 0.0001	0.56407 0.0148	0.60112 0.0083	0.74506 0.0004	0.63412 0.0047	0.55357 0.0172
k10	-0.78141 0.0001	1.00000	-0.80594 <.0001	-0.80502 <.0001	-0.74781 0.0004	-0.84283 <.0001	-0.71588 0.0008
V23Meaningful	0.56407 0.0148	-0.80594 <.0001	1.00000	0.80523 <.0001	0.40724 0.0935	0.84932 <.0001	0.87996 <.0001
V23Support	0.60112 0.0083	-0.80502 <.0001	0.80523 <.0001	1.00000	0.39623 0.1036	0.77681 0.0001	0.79235 <.0001
V23Stress	0.74506 0.0004	-0.74781 0.0004	0.40724 0.0935	0.39623 0.1036	1.00000	0.63160 0.0049	0.46581 0.0514
V23Control	0.63412 0.0047	-0.84283 <.0001	0.84932 <.0001	0.77681 0.0001	0.63160 0.0049	1.00000	0.87708 <.0001
V23Progress	0.55357 0.0172	-0.71588 0.0008	0.87996 <.0001	0.79235 <.0001	0.46581 0.0514	0.87708 <.0001	1.00000

Of these cases, only 9 provided usable data on how many more sessions would be needed. Nevertheless, the effect is so strong that only 9 were needed to obtain a Pearson r of -.92 (p<.0004). This relationship is plotted in Fig. X, where it appears that each one-point drop on confidence implies an additional two sessions.



How Much More Counselling? An Imputed-Zero Model

If more sessions are needed, then the question is, how many more? As it appears that people who have progressed well and are not experiencing distress are unlikely even to answer the question, a model was set up that imputed a zero for cases where no additional sessions were indicated as being needed. Following the model involving Progress and K10 Distress was run to predict how many more sessions the client felt they needed. In this instance, those who simply noted "lots more" or words to that effect were excluded as there was no way to impute accurately what they meant. A Poisson regression model above was run to predict number of extra sessions needed from the interaction of Progress and the K10. The interaction term was statistically significant (Chi-square=20.4, p<.0001) and the predicted values are plotted below in Fig. X.



If we assume that no answering the question, or answering with a zero indicates that the problem is resolved, then of 62 cases who had their last session before or on the fifth session, 71% did not indicate further need, and 29% gave a clear indication that they needed more. Of 22 cases that did receive further sessions beyond the 5, only one (4.6%) indicated that additional sessions would be needed beyond the second batch of five.

Discussion

Overall, these results provide supportive evidence for the hypothesis that the RCP was effective in enhancing several key domains of well-being. The reliability of the K10 and PPSRS measures has been demonstrated once again, and the strong, yet discriminable relationship of the PPSRS factor to the two K10 factors points towards their general validity.

The factor structure that emerged from the measures is much as was expected. Depression, anxiety, and general functioning as indexed by the PPSRS variables appear to be distinct, yet related areas that are central features of mental health. That the Progress and Meaning PPSRS items loaded on depression makes perfect sense in view of Little's (personal communication) meaning/manageability tradeoff, in which pursuit of highly meaningful projects can render

Overall, these results provide supportive evidence for the hypothesis that the RCP was effective in enhancing several key domains of well-being.

Pilot Project for Rebates for Counsellors (Continued)

many other activities completely unmanageable, whereas a plethora of manageable projects can come to seem utterly meaningless, with both situations leading to depression. Either tail of the catch-22 implies a sense of either meaningless, lack of self-efficacy, or both. This effect is also captured in the sense of loss of control of meaningful projects as a predictor of time to be spent in counselling, and goes to the tractability of different problems. Those who have meaning, it seems, need gentle nudges to find control, whereas those who lack meaning but have a great deal of control need significant work to relax control in the interest of finding meaning.

From the shape of the two models (logistic and Poisson) of extra time needed, it seems clear that individuals who have attained their goals are unlikely to indicate the need for more sessions, so long as their distress levels are relatively low.

The lack of significant effect for the K10 in predicting time needed suggests that initial distress is not as good a predictor of level of need as are perceptions of how one fits in with one's local social ecology, and one's style of managing one's projects. One the one hand, as an outcome measure it performs on par with the PPSRS, if not perhaps slightly better. On the other hand, however, K10 distress does not predict the level of service needed to alleviate it.

The drop at week 6 across all measures is very likely due to the fact that those cases that completed weeks 1 to 5 successfully then dropped out of the study, and the tougher cases that remained for a second series of sessions naturally had lower scores.

While the lack of a control group means that it is impossible to rule out completely the natural regression to the mean that occurs in untreated cases, it is also notable that there is no rapid improvement from session 1 to session 2 or 3, followed by a plateau, which is the shape of curve that would be expected if the effect were attributable entirely to such regression.

The results relating to time spent in counselling point towards the locus of efficacy of counselling, which seems to be a process that can help quickly in providing some sort of order to people whose problems emerge from chaos, but which has slower effect when there is already a good degree of control present.

It is possible to use our measures to identify with reasonable accuracy those who feel they need more help, and those who do not. Where more help is needed and specified, this too is predictable, and expected values range up to about 4 more sessions beyond that which is funded, at least based on these pilot data. Confidence in ability to sustain results is a direct predictor of number of additional sessions perceived by the client to be needed.

From the shape of the two models (logistic and Poisson) of extra time needed, it seems clear that individuals who have attained their goals are unlikely to indicate the need for more sessions, so long as their distress levels are relatively low. However, the need for more sessions increases rapidly, especially for those who have made good progress but in spite of this are still experiencing distress.

Overall, five sessions is a good start for many people, as the great majority benefited within five sessions, and of the more difficult cases, nearly all of them did not indicate a further need after the second set. It appears that the current system of five sessions, followed by a needs assessment and an additional five sessions where required should be highly effective in providing relief to the designated population.

ACA

Challenging Chicken Little

By Lynn Grodzki, LCSW (Licensed Clinical Social Worker), MCC (Master Certified Coach)

Chicken Little is an old fable about a chicken who believes the sky is falling and that disaster is imminent. Today, given the changes of Medicare rebates in Australia, counsellors may feel that Chicken Little is happening to them right now. But this situation can also be seen as an opportunity: Counsellors can use the current marketplace change as an opportunity for some necessary evaluation to reposition their practices and better secure their professional long-term futures.

The Chicken Little marketplace scenario is a familiar one for me and other mental health therapists in the USA, who have been dealing with another rebate-type program, that of managed care insurance, for the past fifteen years.

In the USA, psychotherapists routinely decide whether to be in or out of the managed care system. Those who originally opted "in" were convinced that being in was crucial to their survival. At first they loved the increased client flow from the doctors who were more prone to refer to therapists who were in the system. But these same therapists came to resent the imposed restrictions, reliance on fees that dropped lower and lower, and the added paperwork required to comply with managed care.

Those who opted "out" were scared initially of going against the tide. They hated losing clients due to not being part of the program, but eventually came to appreciate their independence as an opportunity to become entrepreneurial. They learned to meet the public directly, explore new business models of practice, and the chance to stay in control of their profitability and services.

Here's the thing: In all businesses, markets constantly change. When they do, it's up to the small business owner to become a savvy business person. In my role as both a psychotherapist and a business coach for therapists and other healing professionals, I hear a lot about the state of private practice. I've been a social worker in private practice in the USA for 20 years and have consulted as a business coach for therapists, healers, consultants, and coaches for the past 12.

My practice-building books sit on the shelves of graduate-school libraries and the bedside tables of senior therapists. I write a monthly e-mail newsletter that goes out to 6,000 therapists in 8 countries, many of whom write back telling me about their situations. I

cross the continent giving practice-building workshops and seminars, teach teleclasses to groups of therapists every week, and individually coach a dozen or more therapists at any given time. I have helped thousands of my colleagues learn how to stay independent and profitable by using best business practices, understanding business strategy, and developing themselves into savvy entrepreneurs.

I see all kinds of problems faced by those in private practice. But I also see the creative strategies by which therapists can and do build profitable, satisfying practices. So my belief, unlike Chicken Little, is that we in private practice can ride out the downturns in any marketplace cycle by implementing new business models that help us survive and ultimately thrive. To do this, we must think beyond one-off solutions, be open to making broad, intentional changes, and most importantly, work together to protect our livelihood and, ultimately, our professions.

A Paradigm Shift

In 12-step programs, a story told to motivate newly recovering addicts is about a person who walks down a street absentmindedly and falls into a pothole. If the person is an unrecovered addict, he or she keeps walking down the same street and falling into the pothole, evoking Rita Mae Brown's definition of insanity: "Doing the same thing over and over again, but expecting different results." An addict further along the recovery process sees the pothole and tries to circumvent it, sometimes successfully, sometimes not. The paradigm shift in recovery occurs when the addict decides to walk down a different street.

Given the current situation, can a counselling private practice walk down a different street? The place to start is noticing any of your resistance to altering the traditional methods of finding referrals, billing clients, and positioning yourself with the public. Marketing guru Seth Godin, author of ***Survival Is Not Enough***, offers an improved mind-set for the small business of today: "Change is not a threat, it's an opportunity. Survival is not the goal, transformative success is."

Full recovery for a private practice could mean to stop self-identifying with the medical model and find another way to define oneself, perhaps "necessary human education" or "the prerequisite for wellness." It would mean facing the public squarely, on footing equal to that of other service-oriented professionals, and finding the words to explain who you are, what you really do, and why your unique services have value. You'd seek ways to increase market share, build alliances among colleagues to leverage advertising or PR efforts to help educate the public about the legitimacy and value of counselling.

This process would be akin to reengineering the concept of private practice from a medical model to a consumer model. As a profession evolves, it needs a different approach for each developmental stage. Business ecosystems develop in four stages: birth, expansion, leadership, and self-renewal (or death). If the birth of psychotherapy (and its delivery system of private practice) started with Sigmund Freud, then during the past century we've clearly expanded—in numbers of practitioners and methodology. Today, we're poised at the leadership stage. Taking leadership means captaining our own practices to explore business models that'll give us more access and control in bringing our services to others.

The Foundation for Business Success

To the majority of the public, counselling is a mysterious profession. We therapists bear some responsibility for that, when we speak about our work using jargon and citing psychological theories that the general public often finds confusing. If we want to meet the public, we will be forced to explain, in clear language, what our brand of therapy is, how it really works, and all the benefits it produces. More responsibility will shift to each therapist in private practice to become an educator as well as a clinician.

If you accept the model of a therapy practice as a service business, you will become more businesslike in your approach. You'll learn to articulate who you are and what you do in words that the average person can understand. You'll connect more with your public, finding out what people really want and what they will gladly pay to receive. You'll need to produce tangible results. If your practice competes in the marketplace as a service business, the mystery, taboo, and vagueness of your work may finally be replaced with a broader public understanding of the value, importance and logic of counselling. But you will only see this as good news if you enjoy operating your own business.

Loving the Business of Therapy

Its hard to be successful in private practice if you don't understand how to develop yourself as an entrepreneur. Here are 3 steps to help you on that path:

1. Develop yourself: Begin with a focus on your own personality, your weaknesses and strengths. Shifting who you need to be, not just what you need to do in order to have a successful business.

2. Get educated about business: Learn basic business concepts, including the innovative ideas that are shaping the market today. You may need an adapted form of business information —one that uses metaphors and anecdotes you can relate to, tailored to your specific needs and sensibilities. It's available! (See my website: www.privatepracticesuccess.com for a reading list.) You also need to learn a series of step-by-step marketing, financial and administrative strategies that directly enhance a therapy practice. If knowledge is power, your practice may be severely underpowered.

Bring craftsmanship into your business. Do you know how to polish an ordinary practice and make it shine? You need to know some tricks of the trade, those finishing touches that experienced, successful therapists use to make the business of therapy easier. Its time to network with those who are succeeding despite being in a similar situation to yours, to model their business practices.

The private practice of the future—one that's profitable, relational, consumer driven, independent, and highly marketable—may look quite different from the ones that therapists occupy today. Its time to challenge Chicken Little and ride out this market change to keep your future (and the sky) from falling.

If you accept the model of a therapy practice as a service business, you will become more businesslike in your approach. You'll learn to articulate who you are and what you do in words that the average person can understand. You'll connect more with your public, finding out what people really want and what they will gladly pay to receive

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Lynn Grodzki, LCSW, MCC is a psychotherapist and business coach from Silver Spring, Maryland, USA. She is the author of 4 books, including "Building Your Ideal Private Practice".

ACA

Book Review

The Practice of Counselling

Edited by Nadine Pelling, Randolph Bowers and Philip Armstrong

(2007) Melbourne, Victoria: Thomson. 524pp

ISBN 0170129780 $80

The Practice of Counselling

Edited by Nadine Pelling, Randolph Bowers and Philip Armstrong

With this book the counselling profession in Australia gets what it has needed and requested . . . a quality local comprehensive text which covers the critical issues in ways which our students engage.

It is not often one can honestly say, 'here's on hot off the press", but in this case it is not hyperbole. By the time this journal is published, it is expected/hoped this textbook is available in bookstores. This review, based on a draft publisher's copy of the text, heralds somewhat of a triumph of publishing sorts. *The Practice of Counselling* may lay claim to being Australia's first comprehensive edited textbook aimed squarely at the counselling profession within the academic marketplace.

Pelling, a prolific writer and winner of the 2006 APS Early Career Researcher award, has coupled with the less-known Bowers and Armstrong, to deliver to academics and students a text to fill a void in the Australian counselling literature. Although the three editors have contributed, in various combinations, to almost half of the 20 chapters, they have been diligent about accessing and additional competent 15 authors in Australia to ultimately present a text that reflects our context, time and realities. It is interesting to note that the Foreward is written by esteemed Professor Tom Davis, an American, which bears testimony to the international recognition this text has already gained.

The chapters are sensibly grouped in five parts. Part One, 'The Person as Counsellor', presents a fine introduction to basic skills, the complexity of counsellor competence, and the development of personal qualities for professionals. Part Two, 'Professional Frameworks', gives the reader a solid background in ethics, clinical supervision. and diagnosis and treatment issues. Part Three, 'Culture', explores diversity, religion, indigenous mental health, and Aboriginal approaches to counselling. Part Four, 'Special Issues in Counselling', outlines crisis and trauma, group work, loss and grief, addictions, and ageing and spirituality. Finally, Part Five, 'Professional Issues and Research', examines private practice work, counselling associations and, the often avoided topic, how to read research.

The chapters successfully use subheadings that readers will find very useful, and activities interspersed to enable guided learning via regular reflections. It is obvious this text is aimed squarely at the university market for students in counselling and psychology degrees, but would equally find application in the various vocational sector diplomas offered by private providers and TAFE colleges. This is also a text for practitioners whose education may now be a distant memory!

It is clearly a challenge to produce an edited book of any nature with regards to delivering something that has a somewhat unified voice. The editors of this text unashamedly declare they 'encouraged each author to retain freedom of expression', which is obvious yet not distracting. Insubsequent editions of this text, one can't help predict the varying voices of the 18 authors will be encouraged to be just a little more harmonious in style, structure and delivery. With this book the counselling profession in Australia gets what it has needed and requested . . . a quality local comprehensive text which covers the critical issues in ways which our students engage.

Reviewed by Paul Burnett, Charles Sturt University, New South Wales, Australia.

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Everyone's got a bottom

Author: Tess Rowley.
Illustrator: Jodi Edwards

Publisher: Family Planning Queensland

"Everyone's got a bottom", by Tess Rowley, was published by Family Planning Queensland with the primary aim of keeping children safe from sexual abuse. The book is narrated by a young boy, Ben, who introduces the reader to his family members and speaks in a matter-of-fact way about gender differences and sexuality. Colourful illustrations bring the story to life and assist in capturing the attention of young readers, but the images are neither graphic nor threatening in any sense. A recurring message is presented throughout the book, with the words "from our head to our toes, we can say what goes" appearing at the end of most pages. This message is written in bright colours to stand out from the main text.

In order to gain a child's perspective, I read "Everyone's got a bottom" to our three-year-old daughter. If her response is any indication, the book certainly achieves the goal of educating children about personal safety in a non-threatening manner. Part-way through the first reading of the book, our daughter was predicting the message of the colourful words, chanting "from our head to our toes, we can say what goes" each time she spotted them. Her nightly story time included a request to hear the story on many consecutive evenings. While our daughter was mainly interested in discussing the characters in the story, comments that she made in the days following her initial exposure to the book indicated that she had been absorbing its message without feeling threatened or embarrassed.

It is now some months since our daughter was introduced to the book, so, as is to be expected with young children, its novelty has worn off somewhat. Our daughter's knowledge of the book's messages, however, is still apparent and we re-read the story from time-to-time to reinforce the messages.

"Everyone's got a bottom" is a book that, as a parent and a concerned member of the community, I applaud. It provides an avenue by which parents can introduce their children to vital information without having to search for the "right" words. Subjects that potentially could be uncomfortable for both parents and children to discuss instead become a source of bonding over a bed-time (or daytime) story. The final pages of the book contain information for parents and caregivers about sexual abuse, its indicators, and further strategies to protect children. I sincerely hope that this book is widely embraced by parents and caregivers, so that every child can have the opportunity to absorb its essential messages.

By Alison Armstrong BA (Hon), Grad Dip Rehab Counselling, Grad Dip Psych Studies, MACA (& mum)

Everyone's Got A Bottom

Author:
Tess Rowley.

Illustrator:
Jodi Edwards

Publisher:
Family Planning Queensland

Thank-you to the Medicare Task Force

We would like to thank the following people for their contributions to the Medicare Task Force Levy for 2007. We would also like to thank the anonymous contributors who wish to not be named in the following list:

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PRESS RELEASE

Registered Counsellors face extinction in the "ice" age

Adjunct Assoc Prof Allan Huggins of MensOwn Counselling Clinic stated today that the size of the amphetamine scourge is underestimated by health authorities in Western Australia.

Huggins said "Government figures only reflect public drug and alcohol services, public hospitals and some not-for-profit NGO's. Registered Counsellors in private practice see significant numbers of amphetamines users. Initial counselling attendance may be for relationship, stress or anxiety with no disclosure of a related drug issue. In many cases clients have not disclosed their drug use to GPs or agencies because of the fear that their illicit drug use will be noted on official records and they will be discriminated against. There first disclosure is often to a registered and trained counsellor."

Mr Philip Armstrong of the Australian Counselling Association said "the recent Federal Government initiative of providing Medicare rebates to psychologist potentially undermines professional counselling services in the community because legislation has excluded the many highly trained and experienced and registered counsellors who are not psychologists. In the process they have distorted the playing field and threatened the viability of the many experienced registered counsellors in private practice. This will have an adverse impact on the growing mental health problems in our community.

A recent survey of members of the Australian Counselling Association has shown 302 of 315 responding private practitioners and 95 non government agencies have experienced a significant decline in clients since the introduction of the new legislation. The survey also indicates that many practices and agencies may be forced to close their doors within the next 6 months if they continue to be excluded from the rebates. Figures also revealed that 105 employers surveyed now believe it is unviable to employ counsellors because of the inequity of the rebate system. Claims of an increase of money into Mental Health Services to combat drug and alcohol issues are misleading if it continues to be funnelled into only half the industry at the expense of the other half".

Huggins said "The Premier is to be congratulated on calling a summit on the amphetamine scourge facing Western Australia. High disposable incomes go hand in hand with difficult working arrangements that leave little time for rest and engagement with family and the community. Industries such as mining, construction and hospitality are particularly affected. The price is a crisis for young working people and their family relationships and the ever increasing methamphetamine use and the accompanying mental health problems".

The question that has to be asked is why government that espouses work choices and flexibility has forgotten half the professionals in the mental health field regarding the current Medicare rebate system i.e. registered professional counsellors. If governments are serious about the "ice scourge" they will include all the professional stake-holders including the many highly trained registered counsellors who are already engaged in supporting the casualties of the ice age.

CONTACTS

Mr. Philip Armstrong Australian Counsellors Association 1300784333
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MensOwn Counselling Clinic, Fremantle WA.

Felow member of the ACA,
member of the Board
and ACA research officer,

Dr. Nadine Pelling

has received the
following awards.

We would like to acknowledge
Dr. Pelling's achievements
and congratulate her on
receiving such recognition.

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THE INTERNATIONAL AWARD FOR EXCELLENCE

31 May 2007

Dear Dr Nadine Pelling,

On behalf of the editors and the International Advisory Board I am pleased to announce you were a runner-up for the *International Award for Excellence* in the area of technology, knowledge and society.

Your paper, A Survey of Carers' Interest in Face to Face and Internet Based Counselling: Carers' Interest in Counselling via the Internet, was one of the ten highest-ranked papers emerging from the referee process and according to the selection criteria outlined in the referee guidelines.

Congratulations and thank you for your valued contribution.

Yours Sincerely,

Kathryn Otte
Publishing Manager, International Journal of Technology, Knowledge and Society
www.Technology-Journal.com

Dr Nadine Pelling

is awarded runner-up for the

International Award for Excellence

in the area of technology, knowledge and society.

Your paper

A Survey of Carers' Interest in Face to Face and Internet Based Counselling: Carers' Interest in Counselling via the Internet

was a runner-up for the award as one of the ten highest-ranked papers emerging from the referee process and according to the selection criteria outlined in the referee guidelines.

Congratulations and thank you for your valued contribution.

Kathryn Otte
Publishing Manager, International Journal of Technology, Knowledge and Society
www.Technology-Journal.com

Inaugural 2008 Asia Pacific Rim International Counselling Conference

A Partnership of the Australian Counselling Association, British Association of Counselling and Psychotherapy, Asian Professional Counselling Association, New Zealand Association of Counsellors, Hong Kong Shue Yan University & Polytechnic University (HK) and co-sponsor Hong Kong Professional Counsellors Association present

Counselling in the Asia Pacific Rim: A Coming Together of Neighbours

Thursday 10th to Saturday 12th of July, Hong Kong 2008

Call for Papers – ABSTRACTS

Please ensure that you comply with the following and forward your abstract and details no later than **Monday 27th of August 2007.** Term Counsellor is interchangeable with Psychotherapist. Abstracts/papers will be peer reviewed, presentations can also be submitted for assessing for publishing in the most appropriate partners peer reviewed registered professional journal.

- The abstract should be typed and be **no more** than 1000 words and **no less** than 500 words, providing a brief outline of your proposed paper / workshop.
- Specialty subjects in Supervision, multi-culturalism, guidance and family/relationships therapy are encouraged. Other counselling related subjects welcome. Workshops should be inter-active.
- Abstracts are to be for 90 minute workshops or research presentations. A sequence of up to 3 consecutive workshops can be negotiated.
- Abstracts must be relevant to the counselling and psychotherapy professions.
- Please include:
  - the title of your presentation
  - your qualifications and experience (no more than 100 words)
  - your audio-visual requirements, and
  - your contact details (daytime phone, mobile, fax, email address)
- Please submit your abstract to:
  - mail to **Conference Abstract C/-**
  - **PO Box 88, Grange**
  - **Qld, Australia 4051**
  - fax to + 61 7 3356 4709
  - email to **philip@theaca.net.au** (place 'Conference Abstract' in subject line).
- Accepted papers will need to be provided in electronic and hard copy in Word format.
- For more detailed information please contact Philip Armstrong on email philip@theaca.net.au
- ***Applicants will be notified when the committee has made its selection.***

* ***Please Note:*** *If you submit an abstract you will be placed on the conference mailing list.* *

If you wish to be included in the mailing list to receive the advance program and registration brochure, please complete the following and return via mail, fax or email as listed above.

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