Social Work in Aged Care

Being Resilient in a Challenging and Rewarding Field
This edition focuses on social work in aged care and was prompted by feedback from participants at a workshop in April this year on Developing Resilience in Social Workers in Aged Care. This half-day workshop was organised by the AASW (NSW) Social Workers in Aged Care Practice Group which meets every two months with a speaker on a topic of interest, and provides an opportunity for catching up with colleagues and networking as well as keeping up-to-date with current changes in aged care.

In this edition of SWIFT, Christine asks the question, ‘Who says nobody wants to work in aged care?’, and attempts to debunk the myth while arguing that social workers need to take care of themselves in order to continue to work in such a demanding field. Francis Duffy asks why social work in aged care is so challenging, and suggests that when we undertake this complex work it is important that we articulate it to our teams and not just go humbly about our work. We have included the abstract of Dr Parveen Kalliath’s thought provoking research into When Work and Family are in Conflict on which she based her talk at the recent workshop on resilience. In Knocked Down But Not Out Josephine Chow describes her work in a Transitional aged Care Program and the way she takes care of herself through the creative process of poetry writing. I hope you enjoy her poetry as much as we did.

Elizabeth (Libby) Love describes her role as a social worker in the St Vincent’s hospital Psychogeriatric Mental Health Service, and concludes that it is a rewarding and exciting area of practice. Finally, Pauline Armour from UnitingCare Ageing confirms that Aged Care is undeniably a dynamic sector to work in at present, with the real opportunity now to design the system to deliver better outcomes for older people. We will continue to advocate for older people to be empowered and self determining, and ensure vulnerable and disadvantaged older people are not left behind.

Enjoy this edition of SWIFT. It is important to share and document social work practice and challenges in the field of aged care.

— Christine Sanderson, Leith Cooper
First a vote of gratitude to Leith Cooper and Christine Sanderson for compiling this guest edition of SWIFT, which is devoted to issues around caring for the aged. This is the second time that SWIFT has focused on this important area, and the contribution of these two guest editors is very valued.

There are five vacancies on the Branch Management Committee (BMC), so I encourage any of you who wish to become more involved at the branch level to step up. I am happy to discuss what the role might involve with you. Just give me a call at the branch office. At this point, it is worth mentioning that my term as president expires next year, so if you feel a call to leadership, now would be the time to join the committee.

The branch remains very busy indeed. The Continuing Professional Development (CPD) committee has run an expanded program with all courses full to capacity. CPD is to become the responsibility of the national office and in response to feedback from the report compiled by Jane Britt, it is anticipated that there will be e-learning courses, webinars and online learning rolled out nationwide over the next year. This will give greater access to courses for rural and remote areas and for the smaller branches.

The Brain Injury Practice Group in conjunction with the National secretariat lodged a submission to the NSW Government in response to the proposed changes to the Compulsory Third Party (Green Slip) Insurance scheme. The Group was particularly concerned at the potential negative effect of the changes to children, but there were important issues about the availability of legal representation as well. The submission can be viewed on the AASW website. As a result of the submission, Martine Simons-Coghill from the Practice Group and Stephen Brand from National Office attended the Government Roundtable discussion and have an appointment with the Minister for Finance.

National office has developed some promotional posters for distribution. If any of you would like these, they are available at the branch.

The rental of the practitioner rooms continues at a steady pace and there is still space available, so if you know of anyone who needs a room for their practice pass on the branch details to them. While priority is given to AASW members, these rooms are available to non-members and professionals other than social workers.

We live in interesting times as we await the outcome of the Rudd vs. Abbott election, the results of which will have far-reaching implications for the future of Australia…”

— Annie Crowe, President
AASW NSW Branch
Children’s voices – Children’s future: the key to shifting Parental Conflict

With Bill Hewlett,
Clinical Services Specialist in Family Dispute Resolution, Relationship Australia NSW

This four-day intensive workshop provides skills for working with families in entrenched conflict. The workshop will provide a strong practical focus on the subtle and delicate skills required to bring about a series of transformative shifts in parents, helping them to gain a broader perspective on why they are in conflict, what effect this has had on their children and how they might manage their parental alliance in the future.

Participants will learn:
- To gain an accessible and applicable working knowledge of attachment theory, neurobiology and evolutionary theory
- How to help the parent to have ‘flashes of insight’ into how they are contributing to their conflict with the other parent
- How to interview children and to look for indicators of parents’ conflict
- To formulate these impressions into a narrative that will be persuasive and motivating for the parents.
- ‘Externalising skills’ whereby the parents are helped to become more generous and forgiving towards each other.
- The skill of facilitating parents to actively contribute to how they will positively conduct their alliance in the future

Who should attend
This course is available for participants who wish to work in a child focussed way and for those who wish to practice as a Child Consultant.

About the presenter
Bill Hewlett is a Clinical Services Specialist in Family Dispute Resolution with Relationships Australia NSW, and a lead trainer for the Australian Institute for Relationships Studies. He has extensive experience in child inclusive mediation, having successfully practised as a Child Consultant for the past ten years. This work has led Bill to develop an innovative and effective training model of practice, which responds to the current challenges of the family law system when working with highly conflicted clients. Bill has published articles on family issues and is frequently invited to present at conferences and events throughout Australia.

Workshop Details
When: September 24th -27th 2013
Where: Australian Institute for Relationship Studies
Unit 2 Macquarie Link 277, Lane Cove Road, Macquarie Park (5 min from Macquarie Park Train Station)
Cost: $1299 (excl. GST) for four day Professional Development course *
Enquiries: To register or for more information please contact Tracey Leupen, Academic Administrator 02 8874 8090 or traceyl@ransw.org.au

*Minimum criteria for those wishing to practice as a Child Consultant
- at least 2 years experience in working with children
- Tertiary degree or equivalent in psychology, social work, counselling etc
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If you have any ideas or concerns you’d like to discuss, or if you’re interested in joining one of the branch sub-committees or the NSW Branch Ethics Group, please contact the appropriate convenor.

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REMINDER TO MEMBERS
If you'd like to change any part of your contact details either log in as a member and update this information yourself (your User Name is your member number) or contact the AASW NSW branch office.
I’m sure you have heard it said as often as I have that nobody wants to work in ‘aged care.’ I’m not sure what it means or where it comes from, but it’s a myth of course, and maybe it’s time that those of us who work in something called ‘aged care’ stopped listening to these demoralising rumours and debunked the myth. The reality is that there are many social workers working in aged care because it’s a vast area in which to work and there are a variety of terrific positions available. It’s not about the jobs though, but the way that being in the aged care field is seen by others as being involved in the last and most attractive stage of people’s lives. How wrong they are! As we all know, social work is holistic and contextual and is about social justice and empowering people and advocating for them. What better place to practice what we preach than in an area that is often fraught with emotion, uncertainty and conflict and with the potential for disempowerment. For us, we often work under great pressure, while upholding our social work values and working ethically to empower our clients and their families to make thoughtful decisions based on the best available information and knowledge.

We know that this can be the best of times or the worst of times for our clients and their families, as it involves relationships, and loss and grief and helping people navigate the complexities of the healthcare system and the community services sector. The work can be stimulating, frustrating, energising, administratively overwhelming and the issues seemingly never-ending. But, it’s not boring, and it can make you tired and cranky sometimes. That’s where coping and resilience comes in.

While we can all agree that social work in aged care requires a high level of maturity as well as knowledge and skill,
we may not quite understand the importance that resilience plays in the way that we cope with the pressures of the work. Or for how long we stay working in aged care for that matter. For the other comment which we often hear and which is apparently backed up statistically, is that social workers only stay in aged care for about eight years. What a waste. This is a shocking statistic. By the time you become truly excellent at what you are doing, you may be at risk of becoming ‘burnt out’ or suffer from something called ‘compassion fatigue’ if you believe that it exists. At a time when the population is ageing, it seems to me that it would be economically sensible to help social workers develop their resilience and ability to take care of themselves so that they can stay working with older people and their families. How to do this and care for yourself at the same time: that is the crux of the matter.

Bearing this in mind, the Social Workers in Aged Care Practice Group have contributed to supporting social workers by organising meetings every two months on various aspects of aged care. The aim of the group is to also provide the opportunity to network and generally relax and enjoy good collegial company and morning tea in comfortable surroundings. In April this year we organised a workshop on Developing Resilience in Social Workers in Aged Care. It is a timely topic, as is shown by the amount of literature that is currently available and the great interest being taken by a number of researchers, whether in terms of resilience as a personality trait or a dynamic process. Those of you who are members of the AASW would have read in the Autumn 2013 National Bulletin of the launch in Kathmandu last year of the book, Perspectives on Coping and Resilience edited by Dr Venkat Pulla of Charles Sturt University, which has brought together research examining the interplay of individual, family, community and social factors in the ability of humans to ‘bounce back.’ The editor has gathered together a diverse range of authors, including social workers, who explore the nature of coping and resilience from many different perspectives, both from Australia and internationally.

I also want to draw your attention to another article in the same edition of the National Bulletin in which Lorraine Harrison discusses her research under the title, Feeling the heat: social work and stress. She looked at systems and structures that are causing the work stress in the first place, contrary to the current emphasis which is focusing on the worker and how they need to ‘de-stress’ themselves. Lorraine has kindly made her thesis available for reading online, and I highly recommend it. It is available from the Victoria University Institutional Repository via this link: http://vuir.vu.edu.au/21792/.

In our own small way, the Practice Group has been able to contribute to the discussion about ways to support social workers and help them develop coping strategies to further their resilience. Our workshop in April this year brought together three speakers with diverse knowledge and experience in their different fields of expertise. Two were social workers and Jeannette Harvey, music therapist, concluded the workshop with an exploration of music as a therapeutic means of relaxing and being present in the moment. Fifty social workers, including current students, from many areas of aged care came together in the marvellous auditorium at the education centre at Liverpool Hospital, and were warmly welcomed by A/Professor Anthony Schembri, the General Manager of the hospital, who trained as a social worker and has vast clinical experience.

Enjoy this edition of SWIFT, and you are welcome to attend our meetings which are held at several venues over the year: Montefiore at Hunters Hill and Randwick, War Memorial Hospital and Liverpool Hospital. We have a full program of speakers throughout the year which has included dementia and driving as well as further discussions about coping and resilience, suicidality in older people and loss through the life cycle. If you have any suggestions on topics or wish to join our organising committee please contact me on the email address below and I can put you on the mailing list.

— Christine Sanderson
cfsanderson@optusnet.com
On behalf of the Committee of the AASW Social Workers in Aged Care Practice Group (NSW). July 2013
As many of you probably know, aged care is an area of social work practice avoided by many social workers and also with students going on placement, and is regarded by some as not real social work (Hugman, 2000). Ageism may well contribute to the lack of interest in aged care. Ageism does not just mean having lower regard for the elderly; it can also be driven by fear of growing old, fear of dependency, loneliness and death (Terry, 2008). Another view is that social workers who avoid aged care do not understand what the work entails (McCormack, 2008). The nature of aged care social work is often highly charged and emotionally intense; the pace and pressure is mostly relentless, the nature of the work is complex and the client group are often vulnerable.

Why is aged care challenging? It is well established that there is a lot of pressure in aged care health settings due to the ageing population (Ozanne, 2009). Social work assessments and interventions with the elderly are labour intensive and time consuming for a variety of reasons. A considerable number of the elderly in aged care wards have cognitive impairment and are unable to provide clear information. Client consent is often an issue. The elderly may be slow to process information and provide succinct responses to our questions. Some elderly may have poor hearing, which makes communication and privacy challenging in a four bedded hospital ward. Some elderly may need a substitute decision maker but don’t have one in place. The need for guardianship applications is common and this can be time consuming and stressful for all involved, including social workers. Some elderly may be exposed to various risks, for example risk of falls, self-neglect, or neglect and abuse by others and I certainly encounter financial abuse in my work. A decline in an elderly person can bring families back together, sometimes resulting in family conflict – conversely with therapeutic social work intervention there is a window of opportunity here for good outcomes. Some elderly and their families are facing end-of-life care issues and at St. Vincent’s Hospital aged care is second only to our hospice with having the highest number of deaths, so bereavement work should be a vital part of the social work role. Another major challenge is that often the elderly are adamantly opposed to the recommendations of health care workers or even the views of their own families and carers, for example to accept services, residential or in-home respite, nursing home placement etc. And why wouldn’t they, services can seem intrusive compared to the life the elderly have been used to and if we are motivating them to accept change we can be cutting a fine line between oppressive and anti-oppressive practice.

There is also trauma happening in this work, for social workers and service users. Transition trauma to nursing homes is just one example. Some elderly clients with complex issues are very opposed to staying in hospital and to future care plans and as such aged care wards can sometimes feel like ‘statutory settings’ involving statutory social work practice and this can be quite stressful for the elderly, their families and for staff. Caught in the centre of all this is the client-centred social worker, the promoter of patients’ views, rights, autonomy and the right to self-determination, which may or may not fit with the views within the multidisciplinary team or with the carers or family. The objection that many patients and some families have to the team’s recommendations is worth reflecting on. Recently we had an apology from Julia Gillard, the Prime Minister of Australia to the mothers and families of ‘forced adoptions’ and of course we know this was happening in many countries. A few themes are common with this dark part of history, as with other such events. Human service workers involved often believed they were doing the best thing for the clients, the clients were vulnerable, particularly to the power of the ‘system’; client ‘right to self-determination’ were diluted and workers claim they were under pressure by the system to comply. So from an anti-oppressive social work perspective, a ‘core competency’ may in fact involve having the
We should place limits on how far we are prepared to stretch our resilience or we may start to ‘bear the unbearable’ with serious consequences.

**Workload**

There is a strong link between workload and burnout in the literature (Bourassa, 2009). It goes without saying that it is challenging to deliver a comprehensive and anti-oppressive social work service if we are under-resourced and with a rapidly ageing population we will inevitably find ourselves playing catch-up with resources. If we are seriously under-resourced for too long we will likely pay a price. For example we may be able to sustain a certain level of anxiety for a time if we are under a lot of pressure at work and this will be different for each of us. However if endured for too long this temporary anxiety could turn into a more chronic problem (Hillevi et al, 2011). This is danger territory and we need to be able to read the signs as early as possible. Signs include: emotional distancing from clients and staff, decreased empathy, increased cynicism, decreased self-esteem, loss of sense of humour, sleep disturbance, excessive worry, lethargy, turning against members of your team, physical symptoms such as headaches etc. (Kim, Ji & Kao, 2010). Terms used to describe these negative effects include compassion fatigue and burnout. Unfortunately, I think these pathological terms are sometimes used in a pejorative sense, as if the worker is at fault and lacks resilience, when in fact the issue is one of resources. Comments that the worker is burnt out are neither helpful nor accurate and merely ‘psychologise’ a resources problem. From a ‘critical social work’ perspective, we understand this scenario all too well when it comes to our clients, when they are pathologised as being or having the problem, when in fact the issues are often structural in nature (see for example Mendes, 2009). Of course we are all different in our personal and professional lives and have different protective factors and coping mechanisms. In terms of self care, suggestions include accessing supervision, sharing the load by using a team response to clients’ issues – rather than going alone – having a good social support network, ongoing professional education, spirituality, meditation, exercise, hobbies etc. However it is worth highlighting a 2008 U.S. study of hospice health care professionals, which showed that as compassion fatigue increased, self-care activities decreased (Alkema et al, 2008). We should place limits on how far we are prepared to stretch our resilience or we may start to ‘bear the unbearable’ with serious consequences. We should be able to identify danger symptoms. Adequate resources are central to having the satisfaction of delivering a satisfactory social work service. Delivering a social work service gives us sustenance. Mentors and supervisors who genuinely appreciate and practice according to social work values and principles, provide vital support to enhance our resilience.

**Social Work or Just Work?**

Studies show that ‘role conflict’ is a major source of emotional exhaustion and depersonalization in social work and occurs when our actual work is not congruent with our social work training and what we should be doing (Gauri, 2010). We as social workers need to set professional boundaries and determine the social work role; otherwise we risk others setting these boundaries for us. This can result in us doing work that is not social work and again undermine our job satisfaction. It is of some concern that discharge planning is associated more and more with the role of medical social workers in Australia. Although social workers should be very involved with developing and arranging care plans, approaching an elderly patient or family with discharge planning in mind is a problematic starting point to carry out a social work assessment. It can risk undermining our social work assessment as well as job satisfaction, not to mention compromising...
Service users. We need to remain focused squarely on social work and not just work. From a resilience perspective, it is essential that we have a clear sense of purpose and meaning to our work. We need to be able to readily link our practice to the social work code of ethics, as well as social work theories and research. In the long run, it is this articulation of social work theory to practice and its effectiveness that gives social workers agency and respect from other professionals.

Use of Self and Self-Awareness

Transference and counter-transference is common between workers and clients and can interfere with our work (O’Hara, 2011). We need to have high levels of emotional self-knowledge and an ability to regulate our emotions and not be reactive; otherwise, we may find ourselves emotionally reacting with our clients (Flaskas, 1997). High levels of self-awareness will enhance the therapeutic relationship and give us greater clarity with our work and this is vital as good outcomes for clients and client satisfaction are closely linked to the therapeutic relationship, not just therapy modality (Flaskas, 1997; Bertolino & O’Hanlon, 2002). Social work in aged care can often be messy and the elderly and their families can often change their minds about care plans. This can be because they have had time to rethink their decisions or because geriatric syndromes have been resolved. So we must be comfortable with unpleasant feelings of not being in control.

Nikki Nemerouf (2013), an American speaker on high performance in the workplace explains self-awareness this way: we do not see with our eyes, our eyes merely process light, we do not hear with our ears, they merely process sound. He explains that we see with our brain and we hear with our brain. In other words, the idea that we hear and see objectively is problematic. As social workers, we know what we hear and see is filtered through our own life experiences, our values, and our issues and this influences what drives us and what we focus on in our daily practice. It is interesting to note that social work authors Mark Hughes and Karyn Heycox (2010) cite research which suggests that social workers who have had a close relationship with an elderly person do well in aged care. Of course, they do not say this is a prerequisite. Why is this relevant to resilience? When we are having struggles with families, service providers, and team members—and notwithstanding workload pressures and challenging clients—it is likely our frustrations say a fair bit about us and is a useful inroad to self-examination. Rosalie Pockett from the University of Sydney describes successful social workers as reflective practitioners who examine their own responses to the challenges they face and having tolerance for ambiguity (Pockett, 2003).

So for example, whether or not someone ends up in a nursing home will be influenced by a lot of factors, none more influential than the workers they encounter. This can include workers’ attitudes to risk taking, their attitude toward the elderly in general, their attitude to the pressures within the agency, personal values and knowledge and adherence to social work values, theories, and research. In addition it is important to practice from a strengths perspective as it can be very demoralising for the elderly to focus heavily on their deficits and needs. Child protection services have already moved significantly in the direction of a strengths approach.

Conclusion

To have agency as social workers in aged care, we need to be able to articulate and demonstrate the ability to resolve complex issues and provide good outcomes for service users. Good practice gives us agency and sustenance. If we fall short in this regard, we risk just becoming workers who accept directives to carry out tasks and this approach to our work can be draining. When we undertake complex work, it is important that we articulate this to our teams and perhaps we need to do this more as many of us tend to just humbly go about our work. And we need to do more than advocate for our service users: as social workers we need to advocate for each other.

— Francis Duffy
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References

Bertolino, B. and O’Hanlon, B. 2002, Collaborative and Competency-Based Counselling and Therapy, Chapter 1, Massachusetts, Allyn & Bacon.
Nemerouf, Nikki, Becoming Mentally Prepared for Extraordinary Performance, Date retrieved: http://www.youtube.com/watch?v=dH0ZlyGEbxk
Depression: An Invitation to Engage

Presented by Australian Radix® Body Centered Psychotherapy Association
For Social Workers, Health Practitioners, and those interested in a somatic approach.

Saturday November 9, 2013
The La Perouse Room
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Opening Address by Key Note Speaker Narelle McKenzie
Narelle will present on Depression: A Two Edged Sword

Narelle has a MA in Developmental Psychology from Melbourne University and lectured for many years at Flinders Uni (SA) in Developmental Psychology, Learning & Education. Narelle is a clinician with over 35 years experience in private practice. Narelle is highly valued and recognized in the international Radix community as a leading, innovator and clinician in the field of Radix Body Centered Psychotherapy. She is the Director of Radix Training in Australia, USA and Canada. Narelle is a published author and has presented at a multitude of workshops, and conferences throughout Australia and the USA. Narelle is a Peer Review Committee Member for The International Journal of Body Psychotherapy. Narelle is dedicated to the advancement of Radix theory and practice. Her presentations are rich with depth understanding of the relationship between the body and psyche.

A Somatic Perspective on the Relationship Between Depression & Grief
Robyn will address the journey of grief and loss, exploring how this can support and enhance the life-affirming connection to oneself or, manifest as depression.

About Robyn
Robyn Bull is a Radix Psychotherapist, Corporate Trainer, Success Coach and Time Line Therapist in private practice in Bendigo.

Self Medication: A Journey to Autonomy
Louise will address some of the dilemmas intrinsic in the use of antidepressant medication.

About Louise
Louise is a Radix Somatic Psychotherapist, Counsellor, Mental Health Nurse and Midwife. She has worked in the health industry for over 25 years.

Registration
Early Bird by October 18, $265.00
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Prominent Development People
Knocked Down but Not Out

TACP and Creativity to the Rescue!
—— Josephine W. L. Chow

Josephine W. L. Chow has been a social worker in St Vincent’s Hospital, Sydney for more than 13 years. She started work in the hospital acute ward setting and for the last 6 years she has been working in the community setting with St Vincent’s Hospital Transitional Aged Care Program. She holds a B.A (Hons) in Social Studies, a Bachelor of Social Work, Graduate Diploma in Health Informatics, and Graduate Certificate in Evidence-based Practice.

St Vincent’s Transitional Aged Care Program (TACP), in which I have worked for more than 6 years, provides short-term support and slow-stream restorative therapy (for a maximum of 12 weeks) to older people discharged from hospital. Our Program employs a highly specialized team, consisting of a manager/co-manager, consulting geriatrician, pharmacists, physiotherapists, occupational therapists, dietitian, nurses, social workers, community aides, and a driver. Apart from a wide range of professional expertise to assist our clients, our efficient, diligent, and caring team members are very supportive of one another, helping each and everyone to face the challenges, however big or small, encountered during the course of work.

Aged-care practice is a very challenging field, and the challenges become more complex and demanding due to the increasingly ageing population and shrinking resources. Unresolved, those challenges would further the vulnerability of some older people and gravely depress professional practitioners. While some, sadly, would remain down and out, others would survive. They might be knocked down but certainly not out!

In this article, I discuss the role of creativity in rescuing me as well as TACP’s role in rescuing some of our older clients from the unrelenting challenges of everyday living, especially in light of their numerous declining physical and mental impairments and lack of family and community support and assistance.

I must confess that I have been knocked down several times by frequent punches, demands, and pressure from all directions in aged-care, from, for example, the community, organization, management, clients, their relatives, and my own personal expectations. Nonetheless, having been knocked down, I have fortunately not been knocked out. I manage to survive and thrive in the aged-care sector. How? What is the secret?

There are many ways to maintain a level of resilience and survive. For myself, I have discovered that exploring one’s own creativity is one of the methods in helping to rescue the drowning soul. Whether through art, dance, drama, music, poetry or photography, creative expressions have a therapeutic healing role in building one’s resilience.

The means of my creative expression is through writing poetry. I have a passion for poetry writing. Thus, when challenged with confronting situations, I attempt to stay afloat by incorporating my unsettled or troubled feelings into my passion for poetry writing. During the process of writing a piece of poetry, I channel and express the intense and conflicting emotions generated from work; I externalize the problems, tell my stories, and connect with others in similar situations. I try to do so by tapping into my power of creative expression. I will illustrate my point with some cases.

Social isolation is one of the very difficult phenomena in ageing. Many older people will find that they are becoming socially isolated because they have lost their spouses, loved ones, and close friends. Due to their age, many have outlived their close supportive social networks. It is not easy for them to establish new close social relations, especially when they have declining physical health and mental impairments. They may feel knocked down by their afflictions or impairments, making it very difficult for them to remain living at home without sufficient family or community support and assistance. They are terrified to be ‘kicked out’ from their own homes into residential aged-care facilities.

Their difficulties evoke a huge range of emotions not only in them but also in me. Having witnessed and thus been touched by the intense emotions of older people crippled by their declining physical health, family loss, and psychological anxiety, apprehension and fear, I pen these emotions down in poetic creations to echo these emotions. This media of poetry writing enables me to give voice to the emotions of these older people, and also serves as an outlet for me to unleash in words my trapped feelings.

One heart-wrenching case I had dealt with involved an elderly man with declining mobility and cognition returning home to an empty house. It was formerly his cosy home but now an empty shell because his wife had passed away. He had no children, close relatives or friends. Entering his house, he felt isolated and lonely. There was no one else there but him alone, confronted by the deafening silence.

My poem below reflects his loneliness and grief.

The Deafening Silence

I return home broken hearted
Reluctantly open the door
No voice I hear
But my own long forlorn sigh
And be greeted by the deafening silence.

Entering into an abode of emptiness
Previously a happy home
When once there was another presence
Radiating life and bliss
Now it is just me
Enveloped by the deafening silence.

No one greets me
No one in for me to greet
I just have to turn on the television
My sole companion.

Sitting alone
Staring blankly at the screen
Just to hear human voices
To drown the deafening silence!
The very sad, frail, old man, who had just lost his wife, was knocked down by his immense loss. However, the emptiness in his home was soon dissipated or dispersed to some extent when he came into our TACP. He was visited very frequently by various members of our Team, and they helped him regain his optimum functional abilities and independence. The visits also provided him the social support that he had recently lost. Prior to his discharge from our Program, he was linked up with other community services which would provide him the ongoing assistance and support that he required. When he lost his wife, he felt that he had also lost his main social interaction. But he subsequently gained much from the social interactions with our Team members when he was on our Program. Needless to say, he would further gain from the ongoing social interactions provided by the other community service providers after his discharge from our Program.

For those frail, older people who are afraid to be ‘kicked out’ from hospital into residential aged care facilities, TACP is sometimes their last saving grace. The Program comes to their rescue! They are given their last chance to trial living at home before heading off to institutional living in residential aged care facilities. While on our Program, these clients are provided with a wide range of assistance tailored to their needs to help them to regain their optimum levels of functions and, where needed, some are linked up with community resources to enable them to remain living in their own home.

To remain living independently in one’s own home is an ideal; for no matter how good or bad the home condition may be it is one’s castle. But sometimes entering into aged-care facility is no longer an option; it is a necessity. But for the older person, it conjures very strong negative images; it is a nightmare to be avoided. In the acute hospital setting where beds are in shortage, those feelings of anxiety, apprehension, and fear of being forced into residential care placement may often be ignored.

I feel that I have learned many priceless life lessons from our older clients and such sentiments are depicted in this poem, Advancing Age.

Advancing Age
I have felt...
The agonizing longing of an old man
Starting fortuitously at the photo of his daughter
Silently wept and screamed
‘Why haven’t you called?
I don’t have many years left
To wait anymore!’
I have seen...
The controlled tears of a dignified matron
Desperately anxious and feared
The fading away of her ageing husband.
I have heard...
The soft obliging answers
Of a sweet pleasant old lady
Saying ‘Yes’ to all questions
But totally forgotten
What was just said before.
I have sensed...
The despair of a previously active carer
Crippled overnight from a hip fracture
Housebound now with pain
With nothing much to gain.
I have felt, seen, heard and sensed.....
The agencies of advancing age
But I am honoured
To be taken in and partake
The experiences of the older persons
Making me a wiser and kinder person!

Knocked down but not out: creativity in poetry writing has not only rescued me many times but also added passion into my professional life. The poems listed above, as well as some others, are treasured and revisited many times for reflection upon practice and may also relate and connect with other social workers who have had similar experiences.

My poem Nursing Home epitomizes the anxiety and apprehension of older people entering into care; it gives voice to their often ignored feelings and fully acknowledges their strong sentiments.

Nursing Home Placement
I walked alongside
A frail old lady
Encouraged to consider permanent care
Because she has no family who cares.

Passing down the corridor
Bedrooms on both sides
Ageing faces everywhere
Vacant eyes staring nowhere.
Deep sense of alienation
Tyranny of the authority
Loss of individuality
Total dependency
Swamped the air.
I sensed her deep fear
Gripping her heart
Vision of being one of the residents
In such institutions.
Would she rather die alone
In her own home
A place she could claim
Her very own?

Despite our assistance, not all of our older clients are able to regain the level of functional abilities to remain living at home. For these clients, our Program assists them to explore long term options. Sometimes, admission to residential facilities is inevitable. Having been back in their own homes and facing the stark reality of being unable to cope, some of them may be more accepting of residential placement.

Poetic creations not only give vent to my emotions, but they also allow me to reflect on my practices. Reflecting on the cases I have worked on, I am very thankful for all the lessons learned. It has been a great honour and privilege to have worked in the aged care area, especially in St Vincent’s Transitional Aged Care Program, where our committed team members work tirelessly to provide the best care for our older clients and bring some sparks of sunshine into their twilight years.
I have been asked to write about my role as a social worker in the Psychogeriatric Mental Health Service at St Vincent’s Hospital. My work history commenced in 2002 after having completed a Bachelor of Social Work degree and Bachelor of Arts degree (majoring in Psychology and Sociology) at the University of Sydney. I have worked as a social worker in both Australia and the United Kingdom and I am currently completing a Master of Mental Health (Older Person) at the NSW Institute of Psychiatry.

After graduating from university, I worked at St Vincent’s Hospital primarily in a counselling role for four years. Then, in 2006 I travelled to London and worked in aged care for four years at Guys and St Thomas Hospitals. I gained experience in both inpatient and community work, completing protection assessments for vulnerable adults, assessing for care packages, nursing and residential placements, rehabilitation and mental capacity assessments.

I have been working in the St Vincent’s Hospital Psychogeriatric Mental Health Service for nearly 3 years. The service is delivered by a specialised, multidisciplinary team of dedicated, highly trained clinicians. The service was created in 2003 with the appointment of Dr. David Burke (Psychiatry) as a part time specialist. Since then, the team has expanded to include two part time staff specialists, one senior registrar, two clinical nurse specialists, four part time clinical psychologists, a full time social worker and a part time occupational therapist. I work closely with all members of the multidisciplinary team and each profession provides recommendations for patient care.

The social work position in psychogeriatrics was created in 2010. It was challenging to join an already established team in a new social work position. The team had some uncertainty regarding the role of a social worker and what social work could bring to the service. To counter this, I provided education and clarification about my role. The most successful way of clarifying the social work role was by demonstrating through my work with clients, core social work skills and values resulting in positive outcomes for clients.

The aim of the service is to provide assessment and treatment of psychiatric presentations in older adults within an inner city catchment area. The age group is over 65 for the general population and over 55 for Aboriginal and Torres Strait Islander and homeless people. The presentations range from acute psychotic presentations, anxiety and depression, behavioral and psychological symptoms related to dementia (BPSD), schizophrenia, dementia, mild cognitive impairment and personality disorders.

The psychogeriatric team has strong professional relationships with geriatric medicine, community dementia nurses, the adult mental health service at St Vincent’s Hospital and with GPs in the inner city, with whom the team operates a collaborative, shared-care model of patient management. This is a unique model of care that focuses on actively involving the patient, their carers and GP in the management of their psychogeriatric mental health problems through advice, education and supervision. The model works by providing support to those most directly affected and involved, empowering the patient’s primary carers, enhancing continuity of care and maximising patient outcomes.

The psychogeriatric team is involved in a wide variety of educational activities. We deliver lectures, seminars and workshops on psychogeriatrics for the general public, GPs, mental health professionals, hospital staff, aged care residential staff and patients. For example, the team has delivered a number of community forums on healthy brain ageing, memory and depression.

My role includes working with issues such as adjustment to illness, grief and bereavement, counselling, provision of services, facilitating moving into residential aged care, guardianship applications, family and carer support, advocating for patients within a medical model and ensuring that all least restrictive options have been explored, before considering permanent residential care. Grief and loss for older people is not restricted to bereavement. Older people can experience a variety of feelings relating to loss. These include: loss of control, independence, accommodation, health and function, social interaction and sense of self.

I have been involved in a number of interesting cases:

- Setting up a safety plan in collaboration with Waverley Aged Care Assessment Team (ACAT) for an older person experiencing elder abuse
- Assisting a nursing home resident to return home after two years in high level care
- Liaising with the public trustee and the public guardian on behalf of a resident of an aged care facility to facilitate the sale of her properties and arrange daily private services to improve her quality of life in residential aged care.
- Being the advocate for the dismissal of a guardianship application rather than the applicant.

Self-determination and respect for autonomy guide my clinical practice; however I understand that as a health professional, I have a duty of care when a client lacks capacity. There can be tension when working in aged care between self-determination versus beneficence. In particular, with clients who lack capacity wanting something that is not in their best interest (e.g. declining services, accommodation, and healthcare).

In my opinion, aged care is an underestimated area of health for social work practitioners. There are many myths and preconceptions about working in aged care, some of these stemming from ageist attitudes and assertions about what it means to be ‘old’.

There are also beliefs that being a social worker in aged care is a practical role focusing on referrals and setting up services. This is certainly part of the role, however there is also much more depth to explore as a social work practitioner. The benefits of working in aged care include complex and challenging presentations. These include having the opportunity for skills building through family work and working therapeutically with complex family dynamics, legal issues, elder abuse and safeguarding adults, advocacy, issues around capacity and consent, guardianship, grief and loss, counselling around adjustment to illness and changes in accommodation or other circumstances.

It has been extremely interesting and rewarding working as a social worker in the ever-growing area of psychogeriatrics. I recommend aged care as an exciting and rewarding area of practice for the social work profession.

— Elizabeth (Libby) Love
Social Workers are well represented within the Aged Care sector. Many of their roles are included in the following: in not-for-profit aged care leadership positions, as service and case managers, in aged care assessment teams, in social work roles within hospital and health care settings, in government policy and consultancy, research and education and in private practice. Titles and roles may vary, but the fundamental focus on human rights, social justice, empowerment and self determination, are commonly shared by all social workers.

We have seen changes in demographic and industry responses over the past decade and participated in research to improve service provision. We have also developed an understanding of the range of drivers for policy change, which include:

• Growing numbers, longevity and diversity of older people who wish to continue to live in their local community
• Need to effectively respond to the health and care needs for older people with chronic and complex health conditions, including dementia and mental health issues
• Need to improve social participation and social connectedness, especially of older people living in poverty, and those living alone
• Changing consumer preferences and expectations
• Decreasing availability of family carers
• Workforce shortages and changing patterns of volunteering
• Advances in technology and assistive technology.

Aged care is currently undergoing a paradigm shift, a once in a generation change. Social workers have been active to bring about this change. It has been an exciting time in the sector and still is. We have recently participated in the Aged Care Legislation Senate Inquiry, watched the legislation pass through the Legislative Assembly and move to the Senate, with a countdown of available Parliamentary sitting days as we head to the next Federal election.

It is important to understand the work done, which has brought us to this point:

Advocacy for systemic change, which involves legislation and administrative changes to enable older Australians to exercise choice and control in how they live their life, when needing to access health and support services in later life. In particular, supporting vulnerable and disadvantaged older people has been a focus of the aged care sector for over a decade. Coalitions of providers, consumers, researchers, unions and industry peak bodies have formed to progress this agenda, including improving general community support for political change.

The National Aged Care Alliance (NACA http://www.naca.asn.au/) has become the major industry representative forum to develop agreed policy and advocacy positions, community campaigns and to consult and work with the Commonwealth Government and the Department of Health and Ageing on Aged Care reforms. The Productivity Commission Inquiry ‘Caring for Older Australians’ Report which was released in August 2011 (http://www.pc.gov.au/projects/inquiry/aged-care) developed options for structural reform of the aged care system to address the challenges of supporting a growing number of older Australians. Some key points of the inquiry:

• examined the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector
• addressed the interests of special needs groups
• developed regulatory and funding options for residential and community aged care including the Home and Community Care program (HACC)
• examined the future workforce requirements of the aged care sector
• recommended a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust
• examined whether the regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector

assessed the fiscal implications of any change in aged care roles and responsibilities

The Inquiry was extensive with industry organisations and individuals contributing 925 submissions, attending roundtable discussions on key issues, presenting at public hearings and hosting visits by Commissioners to aged care services.

The Commonwealth Minister for Mental Health and Ageing, Mark Butler, then undertook a nationwide consultation, with 3,400 people attending 31 ‘Conversations on Ageing’ forums, which were organised by COTA (http://www.cota.org.au) across Australia for older people, to hear their views and have a dialogue on the recommendations of the Inquiry. Most views expressed by older people were that they wanted to live in their own homes until ‘the very end’, if possible, and that they wanted support to stay mentally and physically fit, keep learning and maintain independence. Concerns were also expressed about the current aged care system’s capacity to support the needs and expectations of older people in the coming decades.

On the specifics of the Productivity Commission report, forum participants generally supported the proposal that services be accessed through a single aged care ‘Gateway agency’, although some were sceptical that it would be delivered as described in the report. Consumers agreed with the Commissioners, that aged care services should not be rationed by limiting bed licenses and community care packages. Despite preferring to stay at home, older Australians did want to see improvements in the quality of residential aged care, supported by trained staff that were effectively remunerated and maintained by a robust accreditation and complaints system.

Following these consultations the Commonwealth government responded

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Aged Care Reforms – A Paradigm Shift

with the Living Longer Living Better aged care reforms, announced in April 2012. (http://www.livinglongerliving-better.gov.au/). For Community Care this included:

- growing community care services including 84,538 new home care packages nationally over the next 10 years
- increasing from 27 to 45 home care packages per 1000 people aged over 70 yrs
- developing 4 levels of home care packages with a focus on offering a consumer directed care approach
- developing a Home Support Program (HSP) from a range of existing funded programs (including HACC, Assistance in Care and Housing for the Aged (ACHA), National Respite for Carers(NRCP), and Day Therapy Centres (DTC) with a focus on prevention and enablement,
- providing a dementia behavioural supplement for home care packages across all 4 levels
- strengthening the interface to Home Care packages from a range of current funding programs
- introducing means tested care fees for part pensioners and self-funded retirees with a lifetime cap of $60,000 for Home Care packages and residential aged care

As part of the Health Reforms, the HACC Program transition took effect with the Commonwealth HACC Program commencing on 1 July 2012. Under the new program, the Commonwealth Government has full funding, policy and operational responsibility for HACC services for older people in states and territories, except Victoria and Western Australia. The NSW Government funds and administers HACC services for people under the age of 65, or under 50 for Aboriginal and Torres Strait Islander people, which has now been renamed the NSW Community Care Supports Program (CCSP). Previously the HACC program was jointly funded by the Commonwealth, State and Territory governments and administered by the States and Territories.

The National Strategies on (Culturally and Linguistically Diverse) CALD and the first National LGBTI Ageing and Aged Care Strategy, were developed with working group and sector consultation and announced in December 2012, to support the implementation of ‘Living Longer Living Better’ reforms.

Currently there is broad sector consultation and consultants. NACA working groups are working with the Department of Health and Ageing, developing and designing the new arrangements for assessment, service provision and linkages in the developing Commonwealth, end-to-end aged care system. The Aged Care Contact Centre commences on 1 July this year and Consumer Directed Care Home Care Packages are to be delivered from July. Also, expected soon are the next Aged Care Approvals Round announcement.

There are concerns about the impact of some proposed changes in legislation and administrative arrangements on specific groups of older people. These include the impact of income tested fees on part pensioners, due to take effect from July 2014 under the current legislation being considered by the Senate. There will be challenges as the design pieces of the new arrangements need to be connected and commissioned progressively over the next few years. Challenges of an election year and tight deadlines also impact on the reform agenda.

Aged Care is undeniably a dynamic sector to work in at present, with the real opportunity now, to design a system which delivers better outcomes for older people.

We will continue to advocate for older people to be empowered and self determining, and we will ensure that vulnerable and disadvantaged older people are not left behind.

— Pauline Armour
Director Community Care
UnitingCare Aged NSW ACT

Social Workers are human beings too. Work and family are integrated parts of our lives.

Dr Parveen Kalliath spoke at the workshop Building Resilience in Social Workers in Aged Care and based her presentation on her research. This research was published in Australian Social Work, 65:3, 355-371, Parveen Kalliath, Mark Hughes & Peter Newcombe (2012): When Work and Family are in Conflict: Impact on Psychological Strain Experienced by Social Workers in Australia.

ABSTRACT

The impact of workplace stress and the need for work-life balance are increasingly recognised within social work. Recent theorising on work-family interface suggests that work-related stress cannot be contained within the workplace without it impacting on other life domains such as the family. Similarly, it is claimed that family-related issues also affect what happens at work. The present study examined the impact of different forms of work-to-family conflict (WFC) and family-to-work conflict (FWC) on social workers’ psychological strain. An online survey of Australian Association of Social Workers members yielded a final sample of 439 responses. Hierarchical multiple regression analyses examining the direct effects of work-family conflict on psychological strain showed that respondents experienced all three forms of WFC (time, behaviour, strain) and two forms of FWC (strain and behaviour), and these were significantly associated with psychological strain. These findings may be useful in developing strategies that aim to reduce conflict, thereby enabling social workers to make meaningful contributions in their work and family lives.

To link to this article go to: http://dx.doi.org/10.1080/0312407X.2011.625035
This workshop aims to introduce clinicians working with children and adolescents to the range of common anxiety disorders and their impact on psychosocial development. The workshop examines differences in rates of anxiety and other emotional problems between the genders with a view to understanding possible aetiologies. Early warning signs of anxiety disorders as well as presentations of phobic disorders, separation anxiety disorder, social phobia, generalised anxiety disorder, panic disorder and obsessive compulsive disorders in children and adolescents are discussed during the workshop. The final topic in the workshop deals with the management of anxiety disorders in children and adolescents with a special focus on the impact of the school environment on anxiety disorders.

After the workshop, participants will:

- Understand the symptoms, causes and treatments for anxiety disorders in children and adolescents
- Become aware of specific strategies that can ameliorate anxiety in children and adolescents

Jodie Wassner is a child and adolescent psychologist. She completed her Bachelor of Science (Psychology) with Honours at UNSW and then went on to complete her Master of Psychology (Educational and Developmental) degree at Monash University. She has developed and presented many workshops including mental health and well-being programs for young people and parenting programs. Jodie has worked as a school psychologist for fifteen years across schools in Melbourne and Sydney. She also ran a Melbourne-based private practice specialising in young people and their families Jodie is currently the Youth Series Facilitator for the Black Dog Institute's Mental Health Workshops. Jodie’s main areas of interest are anxiety in children, family-related anxiety, depression in adolescence and Asperger’s syndrome.
The Cognitive Therapy (CT) model developed by Aaron T. Beck and supplemented by the work of Albert Ellis (REBT), Donald Meichenbaum, Christine Padesky, Art Freeman, Martin Seligman and others provides a clear, systematic and well-tested basis for working with clients who experience one or more of a wide range of clinical disorders. CT is a versatile skill-building model with a solid reputation for relapse prevention and client empowerment.

This workshop will provide comprehensive coverage of the Cognitive Therapy model, its principles and clinical relevance. Further, it will also offer participants the opportunity to explore:

- Tasks in the practice of CT
- The main theoretical constructs
- A significant number of key techniques commonly used in CT.

This workshop will include a review of training DVDs and audios, practice skills, clinical applications and case studies, substantial notes and references.

GREG SORRELL B.A., M.A., M.Psych. is a clinical psychologist with over thirty years’ experience. Initially, Greg worked with the Department of Youth and Community Services, followed by fourteen years with the Cumberland Hospital drug and alcohol unit. While working in that unit, he developed a cognitive restructuring course (the precursor of his Cognitive Therapy training) for patients and for staff training. During the last ten years, Greg has been conducting Cognitive Therapy training for individual mental health workers on behalf of government and private organisations. His main professional interest is the application of Cognitive Therapy principles to a range of clinical areas, and keeping up-to-date with the latest developments in Cognitive Therapy.
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Comments from previous participants: ‘Excellent course, very informative, practical and well delivered.’ ‘Presenters were professional, experienced and tailored the training to suit the groups needs.’ ‘Thanks for your passion and inspiring me to want to learn more.’ ‘I would highly recommend this to my peers.’

Geraldine McKay BSW, MSW, AMHSW. Geraldine is a Social Worker and trained Couple and Family Therapist. She conducts training courses for the Centre for Community Welfare and Training and has extensive experience as a clinical social worker who has worked with individuals, couples, families and communities both in the public sector and in private practice.

Pamela Seraskeris BSW, MA (CFT), AMHSW. Pamela is a Social Worker and a Couple and Family Therapist. She has worked in a variety of settings primarily in the areas of counselling and adult education. She is a skilled facilitator and provides training, consultation and supervision to individuals and organisations. Pamela currently works in the public sector and in private practice.

CLOSING DATE FOR APPLICATIONS: FRIDAY, 18 OCTOBER 2013.

Enquiries: AASW NSW Branch, tel. 02 8394 9850, fax. 02 8394 9895, email info@aaswnsw.com.au

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