the journal of the association of massage therapists ltd

december 2008

President's Report

By Alan Ford

Association of
Massage Therapists Ltd

Office hours:
Monday-Friday 10.00am - 4.00pm

Level 1 Suite B,
304 King Street
Newtown NSW 2042

Postal address:
PO Box 792, Newtown NSW 2042

T: 02 9517 9925
F: 02 9517 9952

massage@amt-ltd.org.au

www.amt-ltd.org.au

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Our Annual Conference was a resounding success with an enthusiastic swag of delegates in attendance, 14 exhibitors, 12 presenters, and numerous volunteers and staff making sure the event went off smoothly. I thank you one and all for being part of our very first Melbourne conference and a special acknowledgement to all our interstate members who made the journey south.

Congratulations to our 2008 Award recipients. Student Therapist of the Year was awarded to 3 outstanding nominees - Sebnem Giner from Gracegrove College, Emma Campbell from Hunter TAFE and Damian Spadaro from North Melbourne Institute of TAFE in Preston, Victoria.

Our Massage Therapist of the Year is Noreen Davern. Noreen inspired and deeply moved us with a presentation of her work in South Africa where she volunteers with HIV and AIDS-affected families, including children orphaned by the disease who are unable to receive assistance from government institutions or charities. These are communities living on the margins, in conditions that are almost impossible for us to imagine. Many of the images in Noreen's slide presentation were confronting.

Congratulations Noreen. You are, without doubt, a most worthy recipient of this Award.

Since this is my last report for the year, I'd like to feature again some of the projects currently being undertaken by the AMT Board.

Work continues on formalising our subcommittee structures in the areas of Strategic Planning & Marketing, Ethics, Finance, Discipline, Education and Research. The work of these subcommittees will be crucial to our strategic advocacy plan – it will form the foundation of our case for mainstream recognition of Massage Therapy by the Australian Government. If you believe that you have skills to bring to any of these committees and you are interested in being a part of the future of our profession, please contact AMT Head Office.

One of the other major tasks scheduled for 2009 is a program of surveys and data collection. In order to make a convincing advocacy case, we need to profile the industry so we can tell government clearly and coherently who we are. Obviously, the larger our pool of collected data is, the more accurate and reliable our resulting profile will be. As such, we will be relying on information from within the AMT membership and, ideally, broadening our data pool to include Massage Therapists in other associations.

I cannot overemphasise how important your involvement in this process is. We need you to complete these surveys when they are circulated so we have a representative pool of data. Without this information, we will not have the ammo we need to lobby for improvements within the profession. Please, help us to help you.

On the governance and public accountability front, AMT's Formal Complaints Policy has been ratified by the Board and is now publicly available in the Find a Therapist section of the AMT website.

Additionally, the Board will soon ratify a Code of Conduct for Directors that was submitted for comment at our recent face-to-face meeting in Melbourne. Governance reform has been a key feature of our program of work in 2008. We believe this work is crucial to the continued prosperity and longevity of our Association.

One piece of unfortunate news since my last report is the resignation of our Vice- President, Keryn Rose, due to family and work commitments. Keryn was an inspiration to all of us with her exceptional work ethic and determination to see AMT reclaim its position as the leading professional Massage Therapy organisation in Australia.

Keryn took particular interest in her home turf, Northern Rivers, where she promoted AMT to Gold Coast, Coolangatta and Kingscliff TAFEs, as well as ACE Mullumbimby and Massage Schools of Queensland. Under the mentorship of our ever-reliable Secretary, Keryn quickly became expert at presenting the benefits of AMT and fostering student membership in the region.

Since 2006, membership in the region has grown by a staggering 31%, in no small part due to Keryn's efforts and perseverance. Thank you Keryn for your wonderful contribution to the association. I look forward to catching up with you at the AGM in Sydney next March!

Tamsin Rossiter has stepped into the vacant Vice-President position until elections are held again in 2009.

This issue of our Journal also marks the passing of an era for In Good Hands. Journal Editor, Rebecca Barnett, will be handing over the reins to a new editor in 2009.

Many thanks for putting this publication together for the past 9 years OB 1. I don't know how you managed it, on top of all of your other volunteer duties within the association.

Many thanks to my fellow Board members for their contributions throughout the year - without your efforts AMT would not be in such a stable position. Our membership numbers continue to grow at a steady rate, our finances are sound and we are leading the way once again within the Massage Therapy industry.

To the members I say a big thank you for supporting your association. We are now on the threshold of some serious and exciting changes in the industry.

Last but no means least, thank you to Linda and Katie from Head Office for keeping up with the ever-increasing workload created by an active Board and a growing membership. We salute you.

Happy holidays to all

■**amt**

Need CEUs?

Journal question - December edition

In Upper Crossed Syndrome, which muscles become hypotonic?

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

DEADLINE

Deadline for the March 2009 issue of In Good Hands is:

1ST FEBRUARY, 2009

Please email contributions to: newsletter@amt-ltd.org.au or phone: 02 9517 9925

MEMBERSHIP FEES

FOR 2009

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Secretary's Report

By Rebecca Barnett

Recently, I had the privilege of addressing delegates at the AMT conference on the subject of advocacy and leadership in the Massage Therapy industry. This was a rare opportunity to speak directly to AMT members about the strategic directions being taken by the AMT Board and the reasoning behind them.

Much of my presentation revolved around the issue of identity, something that I believe forms the crucial subtext for any advocacy work that the Association undertakes on behalf of the membership and the industry at large. Forming a coherent identity will underscore our rite of passage from being labelled just an 'industry' to becoming a fully-fledged profession.

In order for us to make this transition, there is an enormous amount of work to be done, both at an Association level and at the level of individual responsibility. The transition must occur at both ends of the advocacy spectrum. If we expect to be taken seriously as a profession, every single person working within our professional community must commit to thinking and working like a professional: regardless of whether our client base consists of 10 people or 10,000 people, we are all advocates.

The regulatory agenda is gaining enormous momentum in Australia. This is in no small part due to our success as a community in reinventing our image and promoting Massage Therapy as a health intervention rather than an indulgence or luxury item.

Thus far, however, the process has been largely consumer driven and somewhat ad hoc. Mainstream government recognition has eluded us.

Obviously, AMT has had enormous historical success in its advocacy work with third party payers like WorkCover and the private health insurers. (Our submission to the Department of Veterans' Affairs is still being considered by the Commission, 20 months after the original approach was made!)

There is no doubt that these sorts of hard-won, 3rd party payment arrangements have helped significantly in repositioning Massage Therapy as a health service rather than a leisure service. The establishment of the Health Training Package and National Competency Standards in 2002 was another gigantic leap.

But until we have conquered the hurdle of formal, government recognition as a health service, we are still only part way along the path to professionalism.

Which is precisely why mainstream government recognition is the centrepiece of AMT's strategic plan.

The four pillars that will form the foundations of our approach to government are where the serious work will be done over the next few years. We'll be relying on you to get engaged with the activities of the AMT Board and play your part in the glorious evolution of our chrysalis industry into a mature profession. We really can't get there without you.

So what are the 4 pillars of our advocacy plan?

THE 1ST PILLAR - OUR CLINICAL EVIDENCE BASE

Evidence-based practice is firmly entrenched as the primary rationale behind health policy-making. It would be nice to think that this was purely driven by an admirable and noble desire to ensure optimal health outcomes but it is also largely driven by economic rationalism - when there are limited dollars to disburse, governments need an evidence base to justify their health spending.

If we ignore this bottom line, we'll fail at the first hurdle. Our research base is our greatest ally in the advocacy universe. Synthesising our research base and presenting it in a digestible form will be critical to the task of convincing government to treat Massage Therapy as a health service. Whether government policy-making is motivated by economic imperatives or health outcomes is largely irrelevant to us as long as our own professional motivations are clear and unequivocal.

So, if any of you still believe that the research agenda is irrelevant, please think again. The outcomes we achieve in our clinic should be based on sound, clinical reasoning and research is an inseparable piece of the equation. Research should support our clinical experience, instincts and insights.

How can you help to support your industry's research agenda? Walk outside your comfort zone! Next time you see an item on our conference program relating to research, don't reflexively assume it will be boring and irrelevant. Don't assume that research negates your ability to respond dynamically and instinctively to your clients. Assume, instead, that you may discover the answers to the great mystery of why an approach you took with a client worked. Assume that your confidence as a practitioner will be enhanced, not compromised. Know that you are helping your community to make the transition from industry status to professional status. Research literacy and basic engagement with the research agenda is crucial to that process.

THE 2ND PILLAR A NATIONAL CODE OF PRACTICE FOR MASSAGE THERAPISTS

A Code of Practice is a set of written guidelines issued by an official body or professional association to its members to help them comply with ethical and professional standards.

From an advocacy perspective, a Code of Practice signals to government that a profession has reached a sufficient level of maturity and self-determination to define, set, promote and monitor specific policies and standards.

As an industry, we really don't want a bunch of government bureaucrats doing this job on our behalf. We are the obvious experts here so we are best positioned to set the standards for our own work practices. If we don't, we run too great a risk of having standards imposed on us by people who have scant or no understanding of what we do and how we do it.

Establishment of a National Code of Practice for Massage Therapists not only signals to government that we are serious about our professionalism, it also provides a framework for both the public and other health professionals to better understand our professional scope, skills and boundaries. It will help us promote a clear and coherent distinction between professional / ethical treatment and the many suspect or even marginal practices that continue to attach themselves like barnacles to the bow of the good ship Massage Therapy.

How can you support the establishment of a National Code of Practice for Massage Therapists? Visit the AMT wiki and read the introductory pages on the current state of regulation. Ask yourself if you can name the Federal Minister for Health. If we want to play a more mainstream role in healthcare delivery in this country, each and every one of us needs to take some responsibility and develop at least a rudimentary understanding of the regulatory environment in which we operate.

www.amt-ltd.org.au/wiki

THE 3RD PILLAR A NATIONAL CODE OF CONDUCT FOR MASSAGE THERAPISTS

A Code of Conduct is a set of rules outlining the values and standards of behaviour expected of an individual or an organisation.

Establishment of a nationally-endorsed Code of Conduct for Massage Therapists would enable us to promote our profession as safe and ethical to government, allied health professionals, the general public and other key stakeholders such as the private health insurers. The principles enshrined in a code of conduct should contribute to the welfare of all stakeholders and respect the rights of all parties affected by its operation.

Formulating a National Code of Conduct is a key advocacy task for our profession, especially in light of the work program of the Australian Commission on Quality and Safety in Health Care. The Commission has been charged with a government mandate to lead and coordinate the establishment of national accreditation schemes across the health care sector. An endorsed Code of Conduct sends a clear signal to government that we are serious about setting and monitoring ethical and professional standards of behaviour and we are ready to take our rightful place in the mainstream healthcare sector.

How can you help support the establishment of a National Code of Conduct for Massage Therapists? One of the key ways you can support AMT's work in this area is by supporting our continuing education program and philosophy. Ongoing education is a key part of our ethical framework, as it gives us a precious opportunity to continually reassess our strengths and weaknesses as practitioners and feel 'safer' within our scope of practice. A practitioner who has stopped learning and interacting with his/her peers at workshops and meetings is a practitioner at risk. Benchmarking our performance against other practitioners is one way we can regularly flex our ethical muscles, as well as demonstrating our commitment to professional excellence.

THE 4TH PILLAR - INDUSTRY PROFILING

We need to be able to tell government who we are and how we work. To do this, we need survey data. How many of us work full time? Part time? How many of us charge GST? How many of us earn more than the GST threshold of $75,000?

Many of us would like to see massage become GST exempt. But the first thing that Treasury will need to assess is how much revenue would be lost. We cannot answer that question without collecting the necessary data. We cannot advocate effectively until we have compiled our own industry evidence base.

How can you assist us in the task of compiling an industry profile? When we start surveying you next year, please respond. Your data is immensely valuable to your professional community.

AND NOW FOR SOMETHING COMPLETELY DIFFERENT

In this edition of *In Good Hands* you will find a registration form for our 2009 AGM/Members' Day, which is scheduled for March 8, 2009. There is a preview of the workshop content on page 17.

The Agenda, notice of any Special Resolutions and Board nomination forms will be sent out early next year. Under the terms of the Corporations Act, we are entitled to send this information via email so please keep an eye out for it in your inbox. Members without email addresses will be sent this information in hard copy. You can also request a hard copy by calling Head Office on 02 9517 9925.

I'M JUST A SOUL WHOSE INTENTIONS ARE GOOD …

As Alan mentioned, this will be my last outing as Editor of *In Good Hands*. After 9 ½ years and 37 issues, I am really quite tired you know.

Thank you to all the members who have contributed over the last decade. Special thanks to Paul Doney, John Pollard and Colin Rossie – their regular articles were the high watermark of my career as AMT Journal Editor and I am proud to have been associated with publishing them.

My tenure hasn't been without detractors … but I'd still like to acknowledge those of you who may have found my early pieces a little too edgy. At least I knew you were reading and critiquing the Journal!

In the words of the immortal Oscar Hammerstein:
"So long, farewell, Auf Wiedersehen, adieu Adieu, adieu, to yieu and yieu and yieu."

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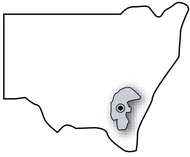
News from the regions



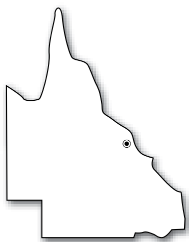
ACT
by Robert Brown

The new ACT regional executive is now bedded in and enjoying the task of co-ordinating regional activities.

Once again, we had good numbers for our August and October meetings. Anthony Swan presented a session on Ortho-Bionomy at our October meeting, a form of structural bodywork that utilises the body's inherit self-corrective capacity. The work is gentle on both the client and the practitioner, enhancing the practitioner's palpation/tracking skills through different tissue and structural aspects of the body.

Our next meeting is scheduled for Tuesday 16 December. We are hoping for a large turnout so we can turn the evening into a Christmas celebration!

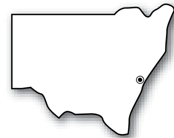
We have already locked in meeting dates for 2009. These have been published in the Calendar of Events online and will also appear in the Journal calendar in 3-month increments. I look forward to seeing you at an upcoming meeting.



Mackay
by Annie Caruana-Kirchner

Our August meeting was well attended, with those present enjoying a talk by Chiropractor Daniel Bank. Daniel combines Chiropractic and Kinesiology in his practice with favourable results. He demonstrated muscle testing, outlining the theory by the kinesiology model of treatment.

Due to poor attendance in the past, we will be holding our AGM and Christmas party separately for the first time this year. We hope that this will attract more members to both events. I look forward to seeing you all there!



Sydney South
by Rene Goschnik

Michelle McKerron has stepped down as region Secretary due to family commitments. Her cool, calm efficiency will be sorely missed. Thanks for the work you invested in helping to get this branch up and running.

Michelle's resignation has created an opening still waiting to be filled.

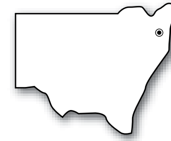
Our new treasurer, John Eades, made his first official appearance in a decidedly glamorous fashion. He arrived at the meeting with his laptop to show us an educational video, not realising that we had a speaker planned. However, with his sixth sense he saved the evening - our guest speaker could not attend due to an unexpected family illness.

The second year of our branch is coming to an end with good attendances throughout the year. Our last meeting will be on December 3 at Hurstville library, where John Eades and Jenny Della Torre will present an information hour on the AMT Annual Conference in Melbourne. We will conclude the evening with dinner at a local restaurant.

Coming together every two months has been a great opportunity for networking, discussion and ongoing education. Best of all, our meetings always start with a short massage! I encourage all local members to attend and I hope to see you at our next meeting.

For further information please call Rene on 9547 0158.

Merry Christmas and a Happy New Year to you all!



Mid North Coast
by Jan Crombie

During Massage Therapy Awareness Week, I was invited to present on seated massage to a large group of doctors, practice nurses and practice managers at the Annual Conference of the local Division of General Practice. I commenced with a demonstration and then invited participants to take part in a hands-on session. The presentation was extremely well received and I had a huge number of questions to field.

I would like thank Head Office for copying/supplying all the supporting educational and promotional information that helped to make the session so popular. All of this info was handed out in last year's conference satchels, with the rather apt title of 'Physician Heal Thyself'! This certainly helped get AMT's name across to the medical profession.

At our October meeting, AMT member Rachel Martin gave an interesting presentation on MET. Thanks and well done, Rachel.

As I write this report, we are gearing up for the Port Macquarie Half Ironman Triathlon in November. This is only a small event compared to the Australian Ironman, with only 750 entrants. Yet again, our efforts will be supported by volunteers from the local area and students from Port Macquarie TAFE. I would like to express my thanks to the local therapists and TAFE students who have done a fantastic job over the last six years and still keep returning to volunteer their hands! The organising committee of the triathlon refers to massage as "the icing on the cake" that completes a very successful event.

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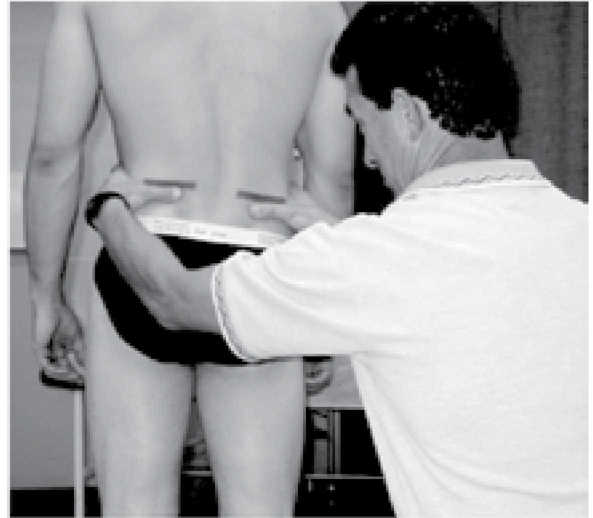

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Letter to the Editor

I read with disappointment an article in the June 2008 journal titled "Competency Based Education - Spot the Difference". It is an article that I am astounded the Association felt necessary to print, however, the older adage "never let the facts get in the way of a good story" may be relevant here.

Stewart Condie's opinion of competency-based training is an unfair appraisal of the many massage colleges that produce professional therapists utilising all the requirements of competency-based training. There are certain points and allegations that are misrepresenting the great work that private colleges and funded TAFEs are achieving in benchmarking massage education.

A student reading this article would unnecessarily doubt his current schooling based on Stewart's comments, which do not present all the facts.

I would like to address these particular quotes and clarify to the reader (and student) that educational institutions are bound by a rigid set of standards (the Australian Qualification Training Framework – AQTF) that are required to be met in order to deliver competency based training courses.

Stewart states:

"I do not think that many colleges have actually embraced the competency model at all"

- The fact is that all registered training organisations (RTOs) **have to** embrace the competency model as they are audited by their relevant state training board to ensure that all the learning outcomes of the training package are being presented and that the student is being assessed as required by the package.

"Many still deliver the same program that they did 6 years ago but call it competency-based training"

- This is an irrelevant statement as many RTOs may keep the same unit name but amend the outcomes of the unit to meet the requirements of the training package. One of the key features of the AQTF is that it focuses on the quality of services and outcomes being achieved for clients rather than the inputs to get there. This means RTOs have more *flexibility* in demonstrating how their individual approaches provide quality training outcomes for their clients.

Further, RTOs can focus on providing quality training and assessment in the way that **best suits their business**.

"If you are sitting a vast number of written examinations then, chances are, you are stuck in the curriculum model"

- There is **absolutely nothing wrong** with sitting an examination. Part of competency-based training is assessing over three different methods and written assessments are an accepted form of assessment.

"The mere fact that students still enrol in discrete anatomy and physiology at 99% of the educational institutions teaching massage therapy means that it's highly likely these institutions are still delivering the way they delivered 6 years ago"

- It is highly **unlikely** that institutions are still delivering the way they did 6 years ago. As stated previously RTOs can present the course in whatever format suits their needs provided all the outcomes of the training package are achieved. One of the great things is that massage schools in Victoria meet regularly through the Massage Network. The attending Colleges often validate their assessment tools with other colleges (their commercial opposition) to ensure that they all have consistent outcomes achieved for all students. This is one of the benchmarks of competency based training. The Victorian Massage Network is represented by private and public RTOs.

  So, while the name of a module might not have changed, the outcomes still certainly reflect the requirements of the Health Training Package.

In regards to Stewart's reflection on forklift driving and standardisation in training, it just is not as easy as that and will never be. Look at your driving licence test – when you got your licence were you tested on a nice clear day? Does that mean then you are not competent to drive at night or in the rain? There are just too many variables.

Lastly, in the final paragraph Stewart mentions colleges inventing qualifications and I **agree with him**. However, the fact is that we live in a great country where entrepreneurial entities are allowed to flourish.

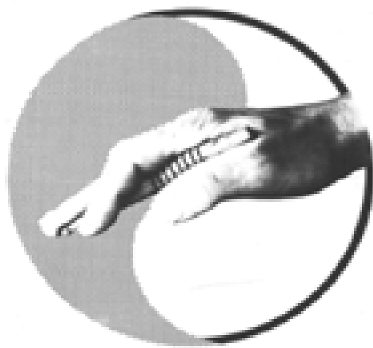
I should point out that I have contacted Stewart directly about this article.

Competency-based training (CBT) was something that was supported by many associations – it is still in its infancy – but I believe that the industry is moving ahead in leaps and bounds and I am personally proud to be an educator (and therapist) in this fantastic industry. Please don't say you printed this article to create a debate … debate about what …CBT? We all had this debate 7 years ago when it was introduced – we should now be embracing it.

CBT should be getting full support of the association. As with any change "great spirits will always encounter violent opposition from mediocre minds".

Let's give credit to the schools for managing this exciting industry the best way they can.

Graeme Di Goldi
Melbourne Institute of Massage Therapy



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AMT Annual Conference Diary

by Nicole McKenzie

leading the way 2010

Nicole McKenzie qualified as a Remedial Massage Therapist in 2007 and has been an AMT member for just over a year. She is also a member of AMT's Riverina branch. Curiosity and proximity led her to check out the conference in Melbourne and to get a taste of ongoing education.

Here is a brief overview of her conference journey.

Friday 24th October

As I set off at 4.45am for the drive to Melbourne, I watched my 6-year-old in tears, neatly framed by the window of my house. So, now on top of the Melbourne trip, I had a guilt trip!

I picked up fellow Riverina member, Roz Keech, and we were safely at The Rydges by 8.15am.

Today is the much anticipated full–day workshop 'Tricks of the Trade'. A fellow therapist raved to me about how brilliant Jeff Murray's workshops are and I am not disappointed. The day seemed to fly by. Roz and I thought we would be a little weary but we were engaged by Jeff's wonderful tricks throughout the whole day.

Saturday 25th October

Rebecca made my mind boggle with her 'Mission Possible' keynote address. A historical overview of our industry brought us through to today and beyond, challenging everyone to consider where our profession should be heading and by which path.

Dr Gordon Waddington, Physiotherapist and Exercise Physiologist, spoke about the importance of physical activity and conducting research in this area to achieve a holistic approach to health improvement, injury prevention and rehabilitation.

Ron Alexander presented the results so far of his research into Functional Fascial Taping, bringing to light how complex and involved it is to conduct quality research.

Afternoon sessions switched from plenary to break out workshops. I attended another Jeff Murray workshop, 'Secrets of the Sacrum'. This hands-on session was packed with lots of great assessment tools.

Then, there was the gala dinner! Fun was had by all. It was a great night and a late night for some, with several local establishments receiving extra business in the wee hours of Sunday morning courtesy of a few conference delegates keen to party on!

Sunday 26th October

The eyes were a little weary and the body a little tender after a big night on the dance floor. Just the right time to get on some Swiss balls with Dr Paul Hermann in his 'Dealing with Arthritis, Osteoporosis and Diabetes' workshop! This was a great workshop as it complemented the rest of the things I had learnt during the weekend. A day in the hands of Dr Hermann proved to be a day well spent.

After the closing address and copious amounts of chocolate fondue, Roz and I set off tired but happy. I arrived home at 7pm and there was no-one to greet me! What do you know - the kids were out having a great weekend without me …

In closing, I feel compelled to introduce some special conference awards with a distinctly Victorian flavour. My congratulations to the winners of the inaugural ***'Down-low Awards'***.

3 votes awarded to Jeff Murray for his 4-quarter performance on Saturday night and Sunday morning. Although one of the older players in the team, he showed his experience and stamina, playing hard all night.

He managed to bring it home in the final quarter without the aid of a GPS or much in the way of sleep.

Jeff Murray on the dance floor! ▲

2 votes awarded to Echuca members for showing that, although we missed out on hosting this year's conference, we can still work well together as a team (particularly at leading Jeff astray!). Boy did we carve up the dance floor!

1 vote awarded to Ron Alexander for his efforts in the first quarter when he accidentally thanked AAMT instead of AMT. Whoops! This certainly brought a few friendly jeers from the crowd!

Thank you to the AMT Board and everyone involved in organising the 2008 Conference. I thoroughly enjoyed my first conference experience and will definitely be back for more.

■**amt**

Conference Postscript: Sacroiliac Joint (SIJ) Closure

by Jeff Murray

Having reviewed the feedback and comments from my presentations in Melbourne, I would like to clarify some salient points.

If your client exhibits a positive Trendelenburg - where they have insufficient stability of their SIJ region - it may be due to Sensory Motor Amnesia (SMA) of the Gluteus Minimus/Medius and Tensor Fascia Latae complex. Research conducted by Paul Hodges (Queensland University) has demonstrated that insufficient activation of these muscles can greatly affect the closure of the SIJ. Hodges also found that forced closure of the SIJ improved the activation of multifidus and transverse abdominus, and enhanced diaphragmatic breathing.

If there is Sensory Motor Amnesia of these gluteal muscles, we may also find that our client has recruited other muscle/s to assist in the stabilisation of the SIJ. We must tread cautiously here because we could easily misinterpret our client's pattern of muscle spasm - do not be in a hurry to release the very muscles that are providing the only stabilisation of the area. If you do release them, your client will probably get worse, not better.

Where there is sensory motor amnesia of the stabiliser muscles, we may find that muscles such as piriformis or gemellus have been recruited in an attempt to provide some stability to the sacrum (Wisbey-Roth).

Another potential area of concern is the anterior and posterior sling complex. If your client is complaining of adductor longus problems, you may find that the contralateral external oblique is not strong enough to assist the adductor in stabilising the hip, thus the adductor has to compensate and take on a bigger stabilisation role. Attempting to release the adductor longus when the external oblique is underactive will only serve to exacerbate the problem.

If we look at the posterior sling, we often find that our clients will have a non-firing gluteus maximus and, as a result, the contralateral latissimus dorsi is called on to take up the extra load. According to Professor Vladimir Janda (1983), T4 syndrome is a major issue when gluteus maximus is not stabilising. Clients with T4 syndrome will experience referred neural symptoms to the shoulders and arms as a result of hypomobility at T4 and the close proximity of the autonomic and sympathetic nerve branches. However, it is contraindicated to release the latissimus dorsi without addressing the underactivity of the contralaterial gluteus maximus.

POINTS TO REMEMBER

- Check for Trendelenburg (non-firing glute min/med and TFL on the standing leg)
- Determine which muscles are providing stabilisation If positive Trendelenburg
- Piriformis syndrome may be caused by non-firing stabilisers. Do not release piriformis – strengthen glutes!
- Check contralateral external obliques if client presents with non-specific adductor longus strain or tension. Do not release adductor longus – strengthen obliques!
- Non-firing gluteus maximus - check contralateral latissimus dorsi and strengthen gluteus maximus
- Non-specific, mid-thoracic pain around T4 (Check gluteus maximus for pyramidal firing pattern -T4 Syndrome)

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WorkCover
Schedule of Fees for 2009

Payment Code	Type of Treatment	Maximum Amount
RMA001	Consultation & treatment (1 hour)	$63.00
RMA002	Consultation & treatment (45 mins)	$47.00
RMA003	Consultation & treatment (30 mins)	$31.00

What the delegates said:

"The knowledge of this presenter was amazing. It's a credit to AMT to get such a quality presenter to the Conference"
(Dealing with Diabetes, Arthritis and Osteoporosis)

"Most valuable/useful workshop of the conference for me."
(Massage for Asthma and Breathing Problems)

"Vertebral artery testing is an essential tool which I will use from now on"
(Myofascial and Structural Considerations in Cervicogenic Pain)

"Jeff was inspiring, smart, experienced and entertaining. Frightening to discover what I don't know!"
(Secrets of the Sacrum)

Jeff Murray is a top presenter, articulate, informative and entertaining. I've never nodded off in any of his presentations!
(Tricks of the Trade)

"Enthralling and inspiring"
(Mission Possible Keynote Address)

"We needed longer … about 3 weeks!"
(Body Reading Beyond the Plumbline)

"I got some great information from this workshop"
(Practice Management)

"Loved it!"
(20/10 Ethics Summit)

"Engaging presentation by both Michelle and Karen"
(20/10 Research Summit)

For more photos from the conference, why not check out AMT's Facebook page:

www.facebook.com/group.php?gid=15414711439

Congratulations to our Award Recipients

MASSAGE THERAPIST OF THE YEAR
Noreen Davern

STUDENT THERAPIST OF THE YEAR
Damian Spadaro

STUDENT THERAPIST OF THE YEAR
Sebnem Giner

STUDENT THERAPIST OF THE YEAR
Emma Campbell

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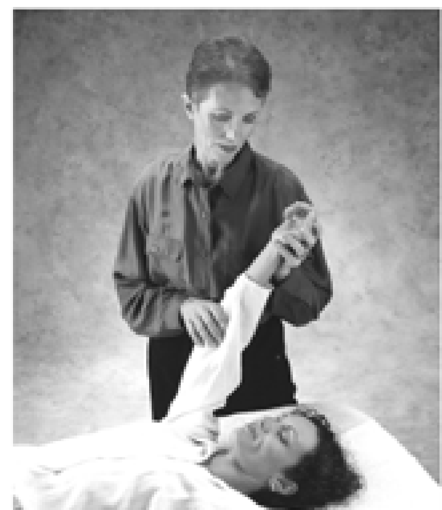

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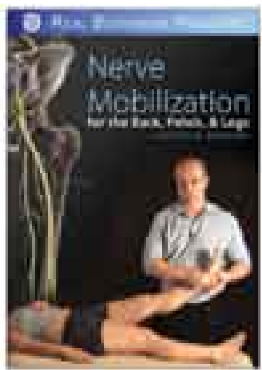
DVD Reviews

By Tyraus Farrelly

NERVE MOBILIZATION FOR THE BACK, PELVIS & LEGS with Doug Alexander (Sciatic, Tibial, Peroneal and Sural Nerves)



Supplier: Terra Rosa
Presenter: Doug Alexander
Format: DVD - All regions, PAL/NTSC - Widescreen
Duration: 4 Hours 5 Mins
Price: $69.00 + P&H
Contact: www.terrarosa.com.au or 0402 059 570

Doug Alexander is the founder of 'The Journal of Soft Tissue Manipulation and an instructor at Algonquin College in Canada. He has published over 30 papers in the massage literature and has been a practising Massage Therapist for over 20 years.

This DVD covers the assessment and treatment of the Sciatic Nerve, including the Tibial, Peroneal and Sural branches. It is one of the best bodywork DVDs I have had the pleasure of watching. The 3D still and animated anatomy graphics are simply awesome and it is jam packed with over 4 hours of assessment and treatment techniques covering the lower back, hip and pelvis and the sciatic nerve along its entire course. At $69 for over 4 hours of high quality video instruction, this represents extremely good value for money.

The DVD shows 21 assessment techniques for the nerves and surrounding structures of the lumbar spine, pelvis and legs.

The advanced nerve tension tests include the Sciatic Nerve and its Tibial, Peroneal and Sural nerve branches.

There are 32 treatment techniques covering Acute, Sub-Acute and Chronic conditions. These are designed to free restrictions along the entire path of each nerve and normalise function from the hip to the foot.

The DVD concludes with Mr. Alexander demonstrating 12 home-care exercises to help support post-treatment recovery.

Many of the techniques demonstrated by Mr Alexander are designed to have a direct effect on the nerves and any surrounding structures that may inhibit or compress the nerves. Mr Alexander shows the anatomical regions where the nerves becomes more superficial and accessible and provides a range of techniques for treating these areas. These are precise techniques focused on precise outcomes. However, they are adaptable to just about any clinic and, thanks to the great 3D animations and knowledgeable instruction, are easy to understand and apply.

I particularly liked the neural stretching techniques, which isolated specific local restrictions along the nerve by using differing degrees of joint ROM between the hip, knee and ankle. These, combined with the nerve gliding and fluid lymphatic techniques used to reduce adhesions and inflammation within the nerve tissue, were worth the price of the DVD alone!

I previously reviewed Mr. Alexander's 'Nerve Mobilization for the upper extremities' DVD in the March 2007 edition of In Good Hands. Although this is also a very good DVD, I was a little critical about the fact that it didn't include adequate precautions against possible vascular complications during certain techniques. To Doug's credit, he actually contacted me concerning the review and acknowledged that there could have been more focus on precautions and contraindications. I am very happy to say he has corrected that omission within this DVD and devotes an entire chapter to precautions and contraindications.

What didn't I like about this DVD?

As I said from the outset, this is one of the best bodywork DVDs I've had the pleasure of watching so finding fault seems a little chary. If I had a wish list, though, I would ask for the inclusion of sensory, motor and reflex tests for the specific nerves covered and possibly a section on segmental distribution.

I do realise that some of the advanced neural tension testing that is covered may already establish any neural involvement and, in some cases, its precise location. However, it would still be advantageous, in this age of evidence-based assessment requirements, to demonstrate quantifiable results from the treatment. Having said that, I don't know where Mr Alexander could possibly fit this in, with a DVD that is already crammed with over 4 hours of invaluable instruction and information. He could easily have spanned this information over 3 DVDs at $60.00 each and it would still represent very good value for money!

Who would benefit from this DVD? Any therapist who treats lower back pain within their clinic and, in particular, clients who present with sciatic-type symptoms. Which, I guess, probably means all of us! :-)

At a glance:

☑ Excellent quality
☑ Excellent value for money
☑ Invaluable learning resource
☑ Awesome Animated Graphics
☑ Best nerve treatment DVD I have ever seen

Overall Rating

★★★★★

A must see, highly recommended!

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

For comments or suggestions please contact Tyraus at tyraus@hotmail.com

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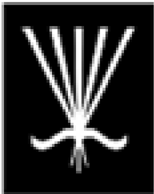

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Members' Day/AGM preview
Lumbopelvic pain: Breaking the pain cycle

Our 2009 Members' Day/AGM will be held on Sunday March 8 at Ryde-Eastwood Leagues Club, Sydney. We are extremely fortunate to have secured two brilliant presenters for the day. Trish Wisbey-Roth, renowned Sports Physiotherapist, will start the day with a one-hour lecture on lumbopelvic pain. The rest of the day will be devoted to practical demonstrations from Trish and Jeff Murray.

We'll round off the day with AMT's Annual General Meeting.

Below we preview Trish Wisbey-Roth's presentations.

LECTURE: WHEN LUMBOPELVIC PAIN KEEPS RECURRING - HOW TO BREAK THE PAIN CYCLE

Dynamic motor control of the lumbopelvic/hip region involves complex movement patterns and interrelated kinematics of many joints. Not only must key muscles have endurance and contraction-specific strength but the Central Nervous System must consider input form the periphery and adjust its pre-programmed responses accordingly.

An explosion of research into muscle and proprioceptive requirements in the region and changes that occur due to pain gives us insight into the many aspects of rehabilitation that must be considered to maximise dynamic function.

This presentation will discuss the current research detailing the many changes that occur with pain and dysfunction in the lumbopelvic/hip complex. Such changes include local muscle changes; function specific recruitment patterns; degradation of proprioceptive, balance and motor planning systems, all combined with faulty virtual body engrams within the motor cortex itself.

The aim of this presentation is not only to outline these changes but also to present practical strategies that can be used both within the clinic and with rehabilitation and maintenance training programs for athletes.

A multidisciplinary approach to optimising biomechanics in the lumbopelvic/hip complex will also be discussed.

If motor control retraining is too uni-dimensional and does not address retraining the complex proprioceptive and motor planning components of dynamics movement, then dysfunctional movement patterns can continue well after the initial pain has settled.

An important question to consider when rehabilitating athletes is - Are the motor patterns we are retraining actually reinforcing dysfunctional dynamic movement and/or shifting an abnormal load to another part of the kinetic chain."

WORKSHOP: DESIGNING A LUMBOPELVIC STABILITY PROGRAM TO BREAK THE RECURRENT PAIN CYCLE

Lumbopelvic stability encompasses much more than simply the lumbar spine and pelvic joint structures. It is a complex interplay of the proprioceptive input from joints and muscles of the spine, pelvis, hips and limbs. Optimal dynamic low back and pelvic function is the end result of muscle control, muscle recruitment patterns, joint stability and effective balance strategies.

If the aim of treatment is to restore dynamic lumbopelvic muscle control and improve proprioception, retraining of optimal muscle recruitment patterns in the lumbopelvic complex is vital. Optimising proprioceptive input from the pelvis can prove vital in breaking down dysfunctional muscle recruitment patterns in both the lumbar spine and hip regions.

The Wisbey-Roth functional assessment protocol described in this workshop is a graded and function-specific assessment used to establish the level of lumbopelvic motor control presented by the patient. The important principles of the functional grading assessment will be presented to workshop participants so the concept can be adjusted to suit a wide variety of individuals from the athlete to the elderly.

The principles of the 5-level grading system can also be incorporated into a functional muscle retraining program to improve the specificity of exercise intervention. They can also be utilised to gauge improvement in dynamic lumbopelvic function. Examples of grade specific rehabilitation exercises to optimise dynamic function will be presented along with the underlying key principles.

ABOUT TRISH WISBEY-ROTH

Trish Wisbey-Roth is known for her expertise in the management and treatment of musculoskeletal problems with emphasis on spinal stabilisation (cervical and low-back) and functional progression of core stability. A Physiotherapist with over 20 years' experience, Trish has completed both a Sports Physiotherapy Masters at the AIS Canberra and post-graduate Manipulative Therapy training in the Kaltenborn/Evjenth system. She has been an Olympic Physiotherapist since 1996, having been involved in both the Commonwealth Games and Olympics.

Trish is a leader in designing and progressing functional stability programs both for the upper body and the lower-back, pelvis/hip area. She has pioneered the design of simple and effective, repeatable treatments to optimise the three-dimensional biomechanics of the spine. Trish created the BOUNCE Back system of active rehabilitation to enable a simple and effective method of enabling other trained physiotherapists to utilise this approach to active rehabilitation with their patients. She is currently the Director of both Bounce Back Active Rehabilitation Systems and The Take Control Active Rehabilitation Clinic in Sydney.

■**amt**

An interview with Noreen Davern

"No man is an island, entire of itself; every man is a piece of the continent, a part of the main: any man's death diminishes me, because I am involved in mankind." John Donne

Noreen Davern graduated from Blue Mountains TAFE in 2003 and quickly established herself in clinical practice. Now a much sought-after practitioner, Noreen works in a multidisciplinary practice with 2 Osteopaths, 2 Naturopaths and a Counsellor. She employs two Massage Therapists in the practice but still has a month long waiting list.

Noreen's commitment to voluntary work and her passion for Massage Therapy make her an extraordinary ambassador for the profession.

She has trained in Oncology Massage through the Quest for Life Centre and has a long list of clients from the Blue Mountains Cancer Care.

In 2007, Noreen volunteered with the AIDS Hospice Organisation, spending 6 weeks in South Africa in a community stricken by AIDS. She massaged people living with the disease and taught basic massage skills to 38 Zulu, home-based carers, many of whom are HIV positive themselves.

In 2009 Noreen plans to return to South Africa for three months to continue her work there. She will be volunteering in an HIV orphanage, teaching massage skills to carers and massaging traumatised children.

Noreen's speech at the Conference Dinner garnered a strong, emotional reaction. In this interview, we invite Noreen to talk about her challenging work in South Africa.

You have a thriving practice in the Blue Mountains, where there are many practising Massage Therapists competing for business. What do you attribute your success to?

I have been very passionate about my work from the start of my career. I try to reach out to people through my profession with an attitude of sincerity, genuine caring and respect for life. My business has expanded mainly from word of mouth.

How did you first get involved in your volunteer work in South Africa?

A client of mine went over to South Africa for 6 months as a volunteer. When she returned, I was very moved by the experiences she described. She told me about how the children with cerebral palsy were neglected so I decided to go over and teach basic massage techniques to carers for pain relief.

Is it possible to describe a typical working day in South Africa?

Not really. Nothing ever goes to plan. Each day brings a different crisis. It is a matter of dealing with whatever comes your way in the moment.

You shared a few moving, individual stories during your presentation at the Conference Dinner. Can you share one for readers of this Journal?

We treated a 54-year-old man who was sick. He was struggling to swallow and hadn't eaten in a week. The room he was in reeked of urine and he lay curled up with his knees bent up under his chin, spasming from time to time. We found an open bed sore on his knee, which was covered in maggots. We undressed him to clean his wounds and we turned him over to find enormous bedsores all over his back, some of them back to the bone. The whole bed was a sea of maggots.

We went to a local church and got him some clean clothes and blankets.

We dressed his wounds, changed his clothes and lay him on clean blankets. We sat with him and I held him until he fell asleep. On that day, that man felt love from three strangers for a few hours. We felt humility. He died the following morning, clean and with some dignity.

The working conditions are obviously immensely challenging. What kind of adaptations do you need to make?
Sometimes, because of the smell in the huts, it was difficult to work. When people could be moved out of the hut, I massaged them on the clay ground or on the grass if there was any.
Working with a table was not really an option - many people were in too much pain to even try to move them, let alone get them on a massage table. I did take a table with me but it was mostly just used for teaching demonstrations.
We were donated towels but didn't always have facilities to wash them. I took over sarongs that were easier to wash. Unfortunately, at times we had to reuse the same sarongs or not use any covering at all. We always had to carry water to wash our hands as most huts did not have running water.
The language barrier was difficult when you didn't have an interpreter. Another volunteer and I went to huts to pick up sick people to take them to hospital and we didn't get one 19-year-old girl because of a communication barrier.

The girl died two days later and we both felt very guilty.

Tell us a bit about the self-care dimensions of the work. How do you cope in the face of so much hardship?
My saving grace at the time was my diary, however, I still have not been able to open it since I returned to Australia.
Sometimes, when we were involved in very sad situations, we just sat in the car in silence, fighting back the tears. I cried a lot at night in bed. That helped.
There were times in the hut when we would just look at each other and think "how are we going to deal with this?". But somehow we always did. You have no choice. In the villages, you just put one foot in front of the other and deal with situations as they arise. There was always at least one other volunteer with me, which is great moral support.
Mostly, you are totally absorbed in trying to help people who are immeasurably less fortunate than us.

You put yourself and your own needs last. When I felt really flat I used to call friends back home and would get the words of encouragement I needed to keep going. It was actually much harder for me when I came home – having to deal with the guilt of leaving these people behind in their squalor. I hated my house and all my clutter. It was so strange having electricity and water. I had to cancel my clients for a couple of weeks until I regained some focus.

Clearly, an experience like this is going to have a profound impact on your psyche. Has it changed the way you look at the world?
We take so much for granted in this country. Because we are so removed from hardship, we tend to absorb ourselves in trivialities and cut ourselves off from the suffering of fellow human beings. Working in South Africa taught me that we are all connected: our tendency to isolate ourselves from the mass suffering in disadvantaged countries is a peculiarly first world fantasy.

Can AMT members get involved in the project?
Most definitely. Sofi Cogley, the hospice coordinator, always needs help, both hands on and financial. A lot of volunteers don't have any particular skills, just a willingness to assist those in need.
AMT members who are interested in being involved can contact me on 0421 841864 or email: noreen_davern@hotmail.com

Structural and Myofascial Considerations in Cervicogenic Pain

by Colin Rossie

Cervicogenic pain is pain that has its genesis in the neck. Soft tissue pain in this region can be local, referred, somatic, autonomic, visceral or neurogenic. In addition to local visceral structures, pain can also refer from viscera in the torso. The main considerations of this article will be somatic pain from soft tissue structures, primarily the myofascia. Aside from direct trauma to the region, such as whiplash, myofascial dysfunction in the cervical region is generally secondary to structural imbalances below the level of the neck.

Many structures and tissues in the neck can be responsible for pain. Autonomic manifestations would include perturbation of the cervical sympathetic ganglia (just anterior to the vertebral bodies) such as could occur as a result of whiplash or prolonged forward head posture, where vertebral instability creates a cluster of symptoms, e.g. Barré-Lieou Syndrome. Somatic pain could originate either in bony tissue (e.g facet joint referral) or soft tissue.

STRUCTURAL CONSIDERATIONS

1. Gravity

"Posture is the distribution of body mass in relation to gravity over a base of support. The base of support includes all structures from the feet to the base of the skull." (Kuchera and Kuchera, 1997)

The first thing to consider structurally is our response to gravity. All posture can be viewed as a response to gravity. Humans are unique in the animal kingdom in that we have evolved to stand and operate upright in gravity. This places unique stresses on our bodies. A snake, a quadruped (like the horse or dog) and another possible biped like the kangaroo respond to gravity differently from humans.

Form follows function: our structure has evolved to meet the demands of uprightness in gravity with maximum efficiency of energy expenditure. To maintain our upright posture we need to be aligned around our centre of gravity (COG) over 2 bases of support (the feet) and, from that place, move in and relate to the 3-dimensional space around us. While each of us is unique and our postural pattern can vary slightly from one individual to another, we all conform to major, common patterns that are determined by our form as a species and the relentlessness of gravity operating upon us.

2. Tensegrity

Twentieth century architect, inventor and philosopher R. Buckminster- Fuller coined the term 'tensegrity' as a contraction of 'tensional integrity'. He used the term to encapsulate the concept of a lightweight, integrated structure that gives great stability with the use of minimal material. A tensegrity structure thus maintains a synergy between balanced tension and compression forces. This means that any applied force can be met evenly by the structure, yielding without disturbing its internal equilibrium.

Tensegrity structures are composed of two different materials with specific, different properties:

- One that is strong when compressed (a compressive property), such as posts, poles, struts or columns.
- One that is strong when stretched (a tensile property), such as cables, wires, ropes, sheets.

There are some notable architectural examples - Centrepoint Tower is a tensegrity structure. A cantilever bridge or an old-fashioned airplane with struts and guy wires is a tensegrity structure. A tent is another basic example.

To be dynamic, animal bodies need to operate effectively in gravity by minimising the effect of their weight. Tensegrity is one part of achieving this: animals embody the characteristic unison of compressed and tensioned parts that defines a tensegrity structure. The skeleton is the compressive component, while the soft tissue, myo-fascial / tendinous and ligamentous structures are the tensile component.

3. The functional anatomy of the spine

The human spine is a tensegrity structure. It consists of a series of rigid bones (compressive structures) interposed between deformable, fibro-cartilaginous intervertebral discs (tensile structures). The soft tissue muscles, fascia and ligaments connecting the bones are also tensile structures.

In dysfunction, the tensile soft tissue can respond by tightening to counter other weak/ looser soft tissue, which either affects or is affected by the position of the compressive, bony structures. Think in terms of an unstable tent: if the poles are skewiff, some of the tent ropes are tensioned, others are slack. The lines of pull of the neck muscles are like the ropes, the cervical vertebrae are like the poles

The spine has curves anterior (lordoses) or posterior (kyphoses) in the sagittal plane. Where there are kyphoses, there are bony structures such as the ribs and pelvis enclosing and protecting vital organs. There is also less mobility. Where there are lordoses, there are no bony enclosures and therefore greater mobility. In these more mobile, lordotic regions the fascia has greater significance as it takes on increased stabilising and load transmitting functions.

These spinal curves have a definite relationship to our COG, sometimes passing behind it, sometimes slightly anterior to it.

Together with the tensegrity relationship within the spine, they allow the spine resilience in movement and stance.

The lordotic, cervical spine has the greatest mobility within the vertebral column. All mobility comes at the cost of stability and thus this region has a greater propensity for damage and soft tissue adaption / maladaption.

4. The head as a level platform for the senses

The head is the platform for the senses. Because of the Ocular Righting Reflex, the eyes will always seek to look at a level horizon. So any initial damage, shortening or habitual pattern will be allowed and further compensated for by involving other structures, as long as the eyes can look at a level horizon. With the head in a different position due to dysfunction, the vestibular system will make accommodations and the sense of balance and proprioception will alter.

MYOFASCIAL CONSIDERATIONS

The myofascial and connective tissue network can be viewed as a tensegrity arrangement within the body. Much like the mast of a sailing ship, the soft tissue from the shoulder girdle, ribs, lower vertebrae and manubrium that goes into the cervical spine, hyoid, mandible and cranium is like a tensegrity mast.

1. Fascia and connective tissue are highly plastic

Fascia is composed of about 30% collagen, 1% elastin and some reticulin fibres in a matrix of water-loving cells. Collagen is the netting that gives fascia its form - it is stronger than steel fibres of the same size. Fascia encloses every structure in the body and is the substance that is responsible for the form of the body.

It is also highly innervated with sensory nerves and can respond to neural inputs by contracting, relaxing, remodelling and changing its chemical makeup and ratios. When damaged, collagen frays and reconnects wherever it can. This is the basis of scar formation.

Fascia/connective tissue responds to chronic postural change by:

1. Thickening
2. Shortening
3. Calcifying
4. Eroding

Like bone, fascia is subject to Wolf's Law: it changes and remodels in response to the forces placed on it. Muscle fibres can contract and relax, unless in spasm. Fascia, on the other hand, can't relax as readily and responds to poor usage by remodelling negatively. This can be quite rapid - it doesn't take much to change its length. However, this plasticity is also a blessing because it doesn't take much to remodel it positively either.

The fascia is throughout what is commonly thought of as muscle. A piece of red meat trimmed of all its connective tissue (the white stuff) is approximately 50-60% muscle fibre and 40-50% fascia.

The high mobility of the neck and consequent greater propensity for damage means that the plasticity of the fascia is clinically significant in working with cervicogenic pain.

2. Neuro-Fascial Considerations

As mentioned above, fascia is a heavily innervated material. For example, Golgi Tendon Organs only occur in fascia. As such, they can be found not only in the tendon but also throughout the fascia within the muscle belly. There are huge numbers of proprioceptors, chemoreceptors, mechanoreceptors and thermoreceptors in fascia. Once I would have added nociceptors here as well but recent reading has made me doubt the specific existence of nociceptors - nociception and pain may just be the response to threat or damage. What I will say is that fascial, neural structures are sensory and capable of involvement in pain symptoms.

Proprioceptive feedback alters our cortical response which, in turn, alters our motor patterns … which will then alter structure and biomechanics. If this is prolonged, the fascia responds by changing its internal environment, creating thickenings and adhesions and increasing myofibroblast activity, which will further increase the contractile property of fascia.

Sympathetic nervous system activity (fight or flight responses) can shorten fascia. It is not just prolonged physical overload that creates compromise but also constant low-level, psycho-emotional input: stress from the job/partner/children/bully/tax department/recent injury/that old pain that won't go away etc. Fear and insecurity can lead to Autonomic Nervous System sympathetic involvement and can easily lead to protective behaviour patterns, be they emotional in origin or physical, such as muscle guarding around immediate physical pain.

Golgi Tendon Organs, Golgi receptors, Pacinian and Ruffini Corpuscles - all present in the fascia – will respond to appropriate manual therapy and can act to inhibit sympathetic activity.

3. Cervical Fascial Anatomy

There are 4 major layers of deep fascia in the neck:

1. An outer, extrinsic, superficial layer around the sleeve musculature
2. An Inner, intrinsic, deeper layer around the core musculature
3. A visceral layer around the oesophagus and the thyroid/parathyroids.
4. A meningeal layer around the spinal cord.

The Superficial Cervical Fascia is partly fascia and adipose tissue and is immediately under the dermis. It contains the platysma muscle. After the superficial fascia but before the epimysium of individual muscles lies the deep fascia. There are several layers in the neck:

- Deep Cervical Fascia around the whole neck, with an Investing Layer enclosing interiorly the trapezius and sternocleidomastoid.
- Prevertebral Fascia, superficial to longus colli and scalenes, it continues deep to the Investing Layer to enclose the deep posterior neck muscles.
- A Middle Layer that encloses the infra hyoids anteriorly.

• Visceral fascia that consists of:

1. The Pre Tracheal Fascia enclosing the cervical viscera anteriorly as well as the infra hyoids posteriorly, and
2. Retrovisceral Fascia, enclosing the viscera posteriorly.

The meninges can be viewed as neural fascia enclosing the spinal cord.

Individual muscles are covered with epimysium; perimysium encloses fascicles and endomysium surrounds muscle fibres. These are morphologically no different to fascia. In other words, fascia is distributed throughout the entire structure.

Fascia is the most pervasive substance in the body. In the cervical region its functions of stabilising and force transmission and properties of neural responsiveness and structural plasticity are highly significant in the treatment of cervicogenic pain, especially given the role of the neck in providing the dynamic platform for the senses.

4. Postural and phasic muscles

Myofascial structures throughout the body can be divided into tonic or phasic, depending on muscle type and function. Both respond to stress in different ways. In dysfunction muscles can change their morphologic properties; sometimes the functional demands can alter but not the morphology so the demands placed on the muscle can lead to further dysfunction. Phasic muscles try to do the role of postural muscles. An altered relationship to gravity can lead to structural modification which, depending on muscle type, can manifest as hypertonicity, hypotonicity or muscle wasting.

Tonic or postural muscles are the anti-gravity muscles, working constantly to maintain upright stance. Postural muscles are Type 1 fibres and are fatigue resistant. They will tend to shorten but can either tighten or weaken in dysfunction.

Phasic muscles tend to be recruited only for specific movement, then rest and restore their energy levels. Phasic muscles are Type 2 fibres and fatigue easily. Most type II fibres will tend to weaken without shortening and dysfunction.

I have taken the following list from Robert Schleip's website www.somatics.de, a wonderful source of articles on structure and bodywork.

TONIC/POSTURAL MUSCLES	PHASIC/MOBILISER MUSCLES
Hamstrings	Tibialis Anterior
Iliopsoas	Vastus Medialis and Lateralis
Rectus femoris	Gluteus (Maximus and Minimus)
Tensor Fascia Latae	Rhomboids
Triceps surae	Trapezius (ascending & horizontal fibres)
Pectoralis Major (sternal; clavicular?)	Serratus Anterior
Trapezius (ascending fibres)	Long adductors
Levator Scapulae	Short hand and foot muscles
Erector Spinae (lumbar and cervical)	Longus Colli and Capitus
(thoracic?)	Omohyoid (?)
Erector Spinae (lumbar and cervical)	Gluteus Minimus
Quadratus Lumborum	Pectoralis Major (Costal attachments)
Sartorius	Gluteus Minumus
Piriformis	Triceps Brachii
Short Adductors (Magnus and Brevis)	
Sternocleidomastoid	
B. Brachii (?)	
Flexors of hand (?)	
Scalenii	Scalenii

For example. note that the scalenes appear in both lists. They are phasic muscles which, if put under the chronic stress of altered posture, adapt their fibre type (itself a dysfunction). This is a very common pattern in both Forward Head Posture (see below) and in respiratory dysfunction.

The following list defines the features of the different fibre types (again from www.somatics.de):

TYPE I MUSCLE FIBRES

- Slow twitch
- Contract slowly
- Low stores of glycogen
- High concentrations of myoglobulin and mitochondria
- Fatigue slowly
- Mainly involved in postural and stabilising tasks
- Tonic or postural muscles
- Stress or dysfunction will lead to shortening
- When short/tight, may test either strong or weak

TYPE II MUSCLE FIBRES

- Fast twitch
- Rapid contraction
- Depending on sub-type, mitochondria and myoglobulin concentrations vary
- Generally fatigue rapidly
- Mainly involved in phasic activity
- Also referred to as phasic or mover muscles
- Stress or dysfunction will lead to weakening over their whole length
- Will always test as weak and without shortening

There are 3 subtypes of Type II muscles fibres:

TYPE IIa FIBRES

- "Fast twitch" or "fast white" fibres
- Contract more rapidly than type 1
- Are moderately resistant to fatigue
- High concentrations of mitochondria and myoglobulin compared to other type II fibres

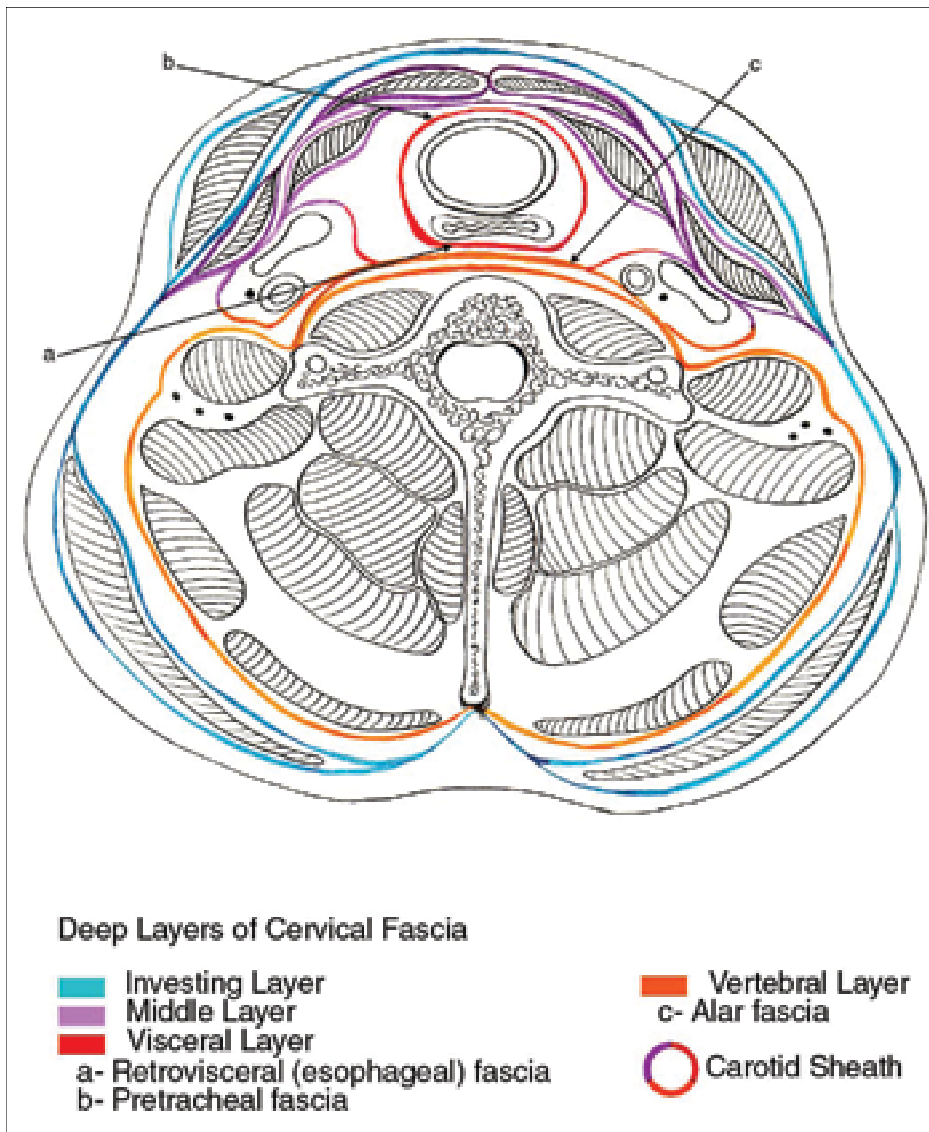

Image Source: Tufts University Department of Anatomy and Cellular Biology Medical and Dental Gross Anatomy Web Server

TYPE IIb FIBRES

- "Fast twitch glycolytic" or "fast white"
- Less fatigue resistant
- Depend more on glycolytic sources of energy
- Low levels of mitochondria and myoglobulin

TYPE IIM FIBRES

- "Super fast" fibres
- Found mainly in the jaw muscles
- Depend on a unique myosin
- High glycogen content
- These last two properties differentiate it from other type II muscle fibres

OTHER CONSIDERATIONS

Upper Crossed Syndrome

Vladimir Janda's 'Crossed Syndromes' are worth considering in treating the cervical region, specifically the Upper Crossed Syndrome. The following muscular patterns constitute an Upper Crossed pattern of postural (mal)adaption to gravity:

- Hypertonic trapezius and levator scapula posteriorly, hypertonic pectoralis major anteriorly
- Hypotonic anterior deep neck flexors and rhomboids and serratus anterior

An appropriate treatment protocol could be to lengthen the upper trapezius, levator scapulae and pec major, accompanied by strengthening exercises and resisted movement for the anterior cervical musculature and rhomboid/serratus sling.

Forward head posture

Forward head posture is a common presentation, with myofascial compensations that are quite similar to upper crossed syndrome.

In forward head posture, we can expect the following:

- The upper traps and levator scap are shortened. This creates an increased cervical lordosis.
- Moro (Startle) Reflex. Increased Autonomic Nervous System activity (fight or flight response) – cervical ganglions involved.
- TMJ involvement - retraction of mandible
- Jaw clenched or mouth open, possibly bruxism (grinding)

In forward head posture, the head doubles in weight for every 2.5cm forward, increasing the load on tonic musculature and possibly leading to the recruitment of phasic muscles, such as the scalenes. Additionally, the suboccipitals, which should be used to fine-tune the head's position as the senses respond, become postural in function. Many cervical structures will respond to the altered biomechanics with dysfunction and pain.

Conclusion

In this article, I have discussed the possible sources of cervicogenic pain primarily in terms of being a local phenomena. However, nothing occurs in isolation in the body. A more global perspective would take into account that the neck is near the top of a chain that commences with the feet. Any other dysfunction in this chain will manifest sooner or later in the neck. Viewing neck pain as a purely local phenomenon may mean overlooking the genesis of that pain elsewhere in the body. Trigger point pain is very much a local manifestation of a more global pattern. Many trigger points and acupoints correspond to where nerves pass through the fascia.

These are very real to the client and offer fairly immediate pain relief when they are deactivated but are only a part of the problem. The trick is to make the client aware of what else is contributing and work to prevent recurrence.

By way of a closing example, let's consider Tom Myers' 'Anatomy Trains' concept of the body. Perhaps we could view the involvement of the myofascial meridian or locomotor sling of the Superficial Back Line. The local manifestation of the global pattern could be neck pain or headache. But there will also be tight plantar fascia, perhaps with collapsed arches, genu recurvatum (knee hyperextension), anterior pelvic tilt, either hypo- or hyperlordosis of the lumbar spine and definitely cervical hyperlordosis and forward head posture.

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A.C.A Health Benefits Fund Cessnock District Health Benefits Fund CUA Health Limited Defence Health GMHBA Heath Care Insurance Limited Health Partners HIF WA Latrobe Health Services (Federation Health) Mildura District Hospital Fund Navy Health Fund Onemedifund Peoplecare Health Insurance Phoenix Health Fund Police Health Fund Queensland Country Health Ltd Reserve Bank Health Society Railway & Transport Health Fund Ltd St. Luke's Health Teachers Federation Health Teachers Union Health Transport Health United Ancient Order of Druids Friendly Society Westfund	ARHG recognises all AMT practitioner levels. They require you to use their provider number. This number is AW0XXXXM, where the X's are your 4-digit AMT membership number.
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Calendar of Events

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

December 2008		CEUs
3	South Sydney Branch Meeting. Hurstville. Ph: 0410 604 510	15
4-8	Neurostructural Integration. Presented by Ron Phelan. Sydney. Ph: 0419 380 443	175
6-7	Manual Lymphatic Drainage. Presented by Michelle Yaffe. Brisbane. Ph: 03 9481 6724	70
6-7	Muscle Energy Technique. Presented by Paula Nutting. Melbourne. Ph: 03 9481 6724	70
16	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
20	Mid North Coast Branch Meeting. Port Macquarie. Ph: 02 6584 6661	15

January 2009		CEUs
31-1	Traditional Cupping- Western Tradition. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	80

February		CEUs
6-10	Neurostructural Integration. Presented by Ron Phelan. Black Rock Melbourne. Ph: 0419 380 443	175
8	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
14-15	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	80
21	Mid North Coast Meeting. Port Macquarie. Ph: 02 6584 6661	15
21-25	Akupunkt-Massage according to Penzel (Course A). Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
21-22	Manual Lymphatic Drainage. Presented by Michelle Yaffe. Melbourne. Ph: 03 9481 6724	70
24	Illawarra Branch Meeting. Corrimal. Ph: 0417 671 007	15
28-1	Contemporary Cupping Concepts. Presented by Bruce Bentley. Adelaide. Ph: 03 9576 1787	80
28-1	Treatment of Pain (Onsen Technique) Vol I. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
28-1	Myofascial Cupping. Presented by David Sheehan. Brisbane. Ph: 03 9481 6724	70

March		CEUs
1-2	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	80
5-9	Neurostructural Integration. Presented by Ron Phelan. Perth. Ph: 0419 380 443	175
8	Members' Day/Annual General Meeting. Lumbopelvic Pain Workshop. Presented by Trish Wisbey-Roth and Jeff Murray. Ryde-Eastwood Leagues Club Sydney. Ph: 02 9517 9925	40
14-15	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Brisbane. Ph: 03 9576 1787	80
21-22	Contemporary Cupping Concepts. Presented by Bruce Bentley. Melbourne. Ph: 03 9576 1787	80
25	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
27-29	Treatment of Pain (Onsen Technique) Vol II. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
28-29	Myofascial Cupping. Presented by David Sheehan. Melbourne. Ph: 03 9481 6724	70
31	Illawarra Branch Meeting. Corrimal. Ph: 0417 671 007	15

April		CEUs
18	Mid North Coast Meeting. Port Macquarie. Ph: 02 6584 6661	15
28	Illawarra Branch Meeting. Corrimal. Ph: 0417 671 007	15

May		CEUs
2-3	Manual Lymphatic Drainage. Presented by Michelle Yaffe. Perth. Ph: 03 9481 6724	70
9-13	Akupunkt-Massage according to Penzel (Course A). Presented by Rene Goschnik. Sydney. Ph: 02 9547 0158	200
16-17	Chi Acupressure Workshop. Presented by Master Zhang Hao. Strathfield Ph: 02 96299 1688	70
16-17	MET. Presented by Steve Jones. Brisbane. Ph: 03 9481 6724	70
17	ACT Branch Meeting. Fyshwick. Ph: 0480 238 274	15
26	Illawarra Branch Meeting. Corrimal. Ph: 0417 671 007	15
29-31	Treatment of Pain (Onsen Technique) Vol III. Presented by Jeff Murray. Sydney. Ph: 07 5599 5214	105
30-31	Traditional Cupping- Eastern Tradition. Presented by Bruce Bentley. Sydney. Ph: 03 9576 1787	80

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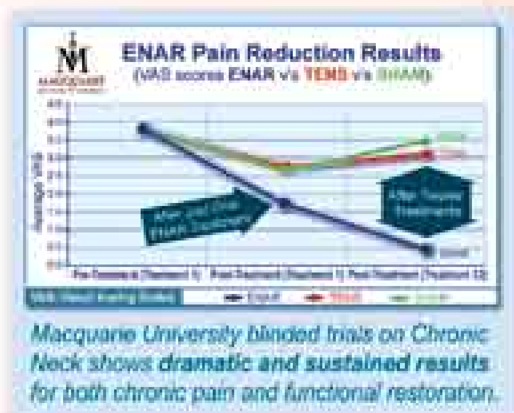

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TIME:	10.00am to 4.30pm (Registration 9.45am)	**COST:**	$80 AMT members $110.00 non-AMT members Morning, Tea, Lunch and Afternoon Tea will be provided
WHERE:	Ryde-Eastwood Leagues Club 117 Ryedale Road West Ryde, Sydney	**PLEASE BRING:**	an inflated MediBall and/or massage table if possible

MEMBERS' DAY – LUMBOPELVIC PAIN

10.00am "Breaking the Recurrent Pain Cycle" Presented by Trish Wisbey-Roth

Trish is known for her expertise in the management and treatment of musculoskeletal problems with emphasis on spinal stabilisation and functional progression of core stability. A Physiotherapist with over 20 years' experience, Trish has completed both a Sports Physiotherapy Masters at the AIS Canberra and post-graduate Manipulative Therapy training. She has been an Olympic Physiotherapist since 1996, having been involved in both the Commonwealth Games and Olympics. She is a leader in designing and progressing functional stability programs both for the upper body and the lower-back, pelvis/hip area.

In this lecture, Trish will discuss the current research detailing the many changes that occur with pain and dysfunction in the lumbopelvic/hip complex and present practical strategies that can be used both within the clinic and with rehabilitation and maintenance training programs for athletes.

11.30am Designing a lumbopelvic stability program Presented by Trish Wisbey-Roth

In this workshop, Trish outlines the Wisbey-Roth functional assessment protocol, a graded and function-specific assessment used to establish the level of lumbopelvic motor control presented by the client/patient.

1.30pm Clearing the Hip Presented by Jeff Murray

During this session, Jeff will address orthopaedic range of motion of lower limb muscles affecting hip flexion, popliteal extension, internal and external hip rotation, adduction and abduction of the hip, ITB, hip flexors and knee extensors. Participants will be taken through a step-by-step assessment to identify which muscles are short and tight and which muscles are long and weak. Identifying these muscle imbalances will allow a better understanding of the effects they can have on the structures of the lumbopelvic complex and provide clarity to the question of stability in the region.

3.15pm 2009 Annual General Meeting

4.00pm Afternoon tea

Members who do not wish to attend the whole day are warmly invited to attend the AGM and afternoon tea. There is no fee to attend this portion of the program but we do need you to RSVP so we can cater appropriately. Please return the registration form overleaf to AMT Head Office.

ABN 32 001 859 285

AMT Members' Day and Annual General Meeting

Please find enclosed:
- ☐ $ 80.00 AMT members
- ☐ $110.00 non-members

TOTAL $

Cheque or Money Order (made out to AMT) ☐
EFT (see payment details below) ☐
Or please debit my visa/mastercard ☐

AMT Membership number:

Please indicate if you can bring a MediBall: Yes / No
Please indicate if you can bring a massage table: Yes / No
I will only be attending the Annual General Meeting and Afternoon Tea ☐

*** NON-MEMBERS, PLEASE SUPPLY ADDRESS & PHONE CONTACT DETAILS**

First name: Surname:

Address:

Phone number:

Cardholder's Name:

Card Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Cardholder's Signature: Expiry Date: /

AMT REFUND POLICY
- Cancellation up to 4 weeks prior – **full refund**
- Cancellation less than 4 weeks but more than 2 weeks – **less 15%**
- Cancellation less than 2 weeks but more than 1 week – **less 25%**
- Cancellation less than 1 week – **less 50%**
- No refund will be given after the event

EFT PAYMENT DETAILS
PLEASE USE YOUR NAME UNDER THE TRANSACTION DESCRIPTION SO WE CAN IDENTIFY THE PAYMENT AND SEND THIS FORM BACK TO AMT
Account Name: Association of Massage Therapists Ltd
BSB: 062-212
Account Number: 1034-0221

Please return to:
AMT Ltd, PO Box 792
Newtown NSW 2042
or fax 02 9517 9952