

# Kidney Disease

## Education Pathway

### Guideline 2014



This ESKD pathway guideline document was inspired and developed by HOME Network members in the Early Patient Education Working Group:

- Debbie Fortnum (Kidney Health Australia)
- Bridget Brown (Launceston Hospital)
- Anne Maguire (Canberra Hospital),
- Tanya Smolonogov (Westmead Hospital)
- Josephine Chow (South Western Sydney Renal Service)
- Janine Jeffries (Princess Alexandra Hospital)

A special thank you to Dr. Jane Nearhos (Princess Alexandra Hospital) for her contribution.

The report is available for download from:

<http://thehomenetwork.weebly.com/>

[www.homedialysis.org.au/healthprofessionals](http://www.homedialysis.org.au/healthprofessionals)

Citation:

Fortnum, D, Brown, B., Maguire, A., Smolonogov, T., Chow, J. & Jeffries, J. (2015). Kidney Disease Education Pathway Guidelines 2014. Available at <http://thehomenetwork.weebly.com>

## Contents

Scope of document .....	4
Introduction and Background .....	4
Rationale for Comprehensive Education and Shared Decision Making .....	5
Overview of education (diagram 1) .....	5
Models for delivery of education .....	7
Timing of education about treatment options .....	7
Changing treatment options (including withdrawal) – revisiting options .....	7
Education about healthy living .....	8
Individualised education .....	9
Place of education .....	9
Psychological needs (detail Appendix 3) .....	9
Strategies to improve and enhance education uptake .....	10
Use of technology to enhance education .....	11
Use of resources to support education .....	11
Use of shared decision making strategies .....	11
Informed Consent/Informed decision making .....	12
Consumers rights to choose conservative/supportive care .....	12
Cultural considerations .....	13
Involvement of family .....	14
Special needs for parents and children .....	14
Workforce .....	14
Health professional self-education and skills to be educators .....	15
Key Performance indicators .....	16
The need for research .....	16
The advantages of home dialysis .....	16
Appendix 1 .....	17
Appendix 2 .....	21
Appendix 3 .....	22

## Scope of document

The scope of this document is to provide an overview of the education needs of those with chronic kidney disease throughout the continuum from initial diagnosis to end of life. This document can be used to inform local pathway development and review of models of care. It outlines important information and models with supporting evidence. The goal for patient education is to support timely and effective renal replacement therapy, dialysis starts with functional access and a timely and smooth transition between modalities.

The underpinning principles include comprehensive patient education and decision-making that incorporates shared decision-making for all aspects of care.

## Introduction and Background

It is estimated that approximately 1.7 million Australians over the age of 25 years have at least one clinical sign of existing Chronic Kidney Disease (CKD)<sup>1</sup>. CKD may further deteriorate into end-stage kidney disease (ESKD), when renal replacement therapy (RRT) - dialysis or transplantation - is required to stay alive. Without kidney function death will occur in a matter of days. Dietary needs, medications, managing symptoms and general health care are all aspects that can be improved by education when living with CKD.

At the end of 2012 a total of 11,466 Australians were on dialysis of which 2534 had started dialysis that year.<sup>2</sup> According to the Australian Institute of Health and Welfare this figure is expected to increase 80 per cent by 2020.<sup>3</sup> Dialysis options include home dialysis; either peritoneal dialysis (PD) or home haemodialysis (HHD) and centre-based haemodialysis. 21% are using PD with the majority choosing the overnight automated peritoneal dialysis machine (APD) and the others using continuous ambulatory peritoneal dialysis (CAPD); the manual bags. 10% of dialysis patients perform haemodialysis at home.<sup>2</sup> Transplantation is offered to those who are able to undergo the transplant surgery safely and in 2012, 845 persons received a kidney transplant.

It is known that for every person that chooses to have dialysis or a transplant there are equal numbers who decide to have supportive or conservative care, an option that offers support to relieve symptoms but does not artificially prolong life. It is also known that not all patients are offered all appropriate options.<sup>4</sup> Advance care planning is an important part of the process as the CKD journey continues.

---

1 Study GFR estimating equations: The AusDiab (Australian Diabetes, Obesity and Lifestyle) Study. *Am J Kidney diseases* 2010;55(4):660-70.

2 ANZDATA report – Data to Dec 2012 (2013) [www.anzdata.org.au](http://www.anzdata.org.au).

3 White SL, Polkinghorne KR, Atkins RC, Chadban SJ. Comparison of the prevalence and mortality risk of CKD in Australia using the CKD Epidemiology Collaboration (CKD-EPI) and Modification of Diet in Renal Disease (MDRD).

4 Ludlow, M., Lauder, L., Mathew, T., Hawley, C. & Fortnum, D. (2012). Australian consumer perspectives on dialysis: First national census. *Nephrology* 17, 703-709.

## Rationale for Comprehensive Education and Shared Decision Making

At all stages of the CKD/ESKD journey there is a need for education regarding living with kidney disease, maximising health and choosing the right treatment options. Golper suggest there are many decisions made by a patient ordered as RRT vs. conservative, pre-emptive transplant vs. dialysis, home vs. in-centre, then PD vs. HD.<sup>5</sup>

Education about treatment options and decision-making practice are important steps in the patient journey as they come to terms with a disease that has a huge treatment burden. Education is not only required at the beginning of the treatment journey, but will need to be revisited as life determines that it is time to change treatment option, either by choice or because of a medical change in condition.

Shared decision making is considered to be the pinnacle of patient-centred care<sup>6</sup> and evidence suggests many advantages if this is done with the support of a decision aid.<sup>7</sup> Shared decision making must be supported by education from the clinical expert. It must also involve the input of the patient as the lifestyle expert.<sup>5</sup>

The education journey often takes place over extended periods of time. It is recommended that every unit utilises a schematic diagram (pathway) that outlines when, what and by whom education will be completed. This can be complemented by an 'activity completed' form for the patient when they have completed each stage.

### Overview of education (diagram 1)

This diagram provides a snapshot of the education needs of each individual.

When is education required?

Education is required at diagnosis, progression from stages 4-5, when selecting treatments, during treatments and at any stage when a change of treatment is required including withdrawal from dialysis.

What education is required?

There are multiple topics, many of which require repeating or revisiting as the kidney disease journey progresses. Appendix 1 provides more detail about the content of the education at different stages.

Who delivers education?

The entire multidisciplinary team have a role to play. At specific times roles such as the nurse educator may be more prominent. It is important that the entire team have a consistent approach to education.

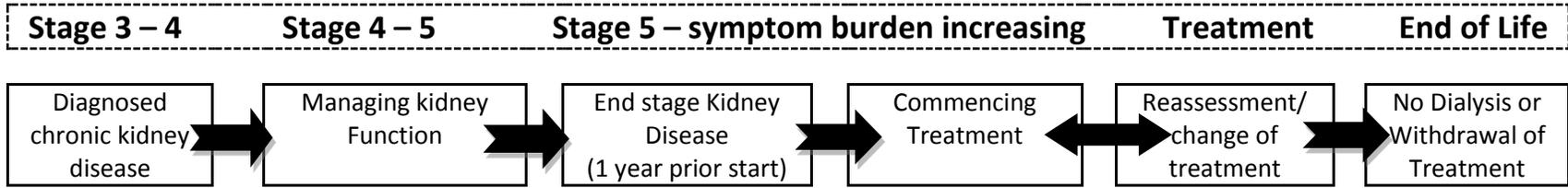
---

5 Young, B., Chan, C., Blagg, C., Lockridge, R., Golper, T., Finkelstein, F., Schaffer, R., Mehrotra, R., (2012) "How to Overcome Barriers and Establish a Successful Home HD Program" Clinical Journal of the American Society of Nephrology (p.1-10).

6 Barry, M. & Edgeman-Levitan, S. (2012). Shared decision making – pinnacle of patient centred care. The New England Journal of Medicine 366(9), 780-781.

7 Stacey D, Bennett CL, Barry MJ, Col NF, Eden KB, Holmes-Rovner M. et al. (2014) Decision aids for people facing health treatment or screening decision. Cochrane Review.

Diagram 1. Chronic Kidney Disease Education: Pathway Key stages\*



**Person and significant others to be involved in all levels of education**

**TOPICS\***

<p>What is CKD? Risks with CKD Heart Disease Tests for CKD</p>	<p>Healthy Lifestyle Living with CKD Medications Monitoring function Psychological state</p>	<p>Healthy lifestyle Managing symptoms Understanding treatment options** Decision making Access/Surgery</p>	<p>Healthy lifestyle Care of Access Healthy kidney Tx Training for dialysis/support Trouble shooting Symptom assess &amp; management</p>	<p>Healthy lifestyle Symptom control Treatment Options** Decision Making Advance care planning</p>	<p>Decision Making Advance care planning Dying process</p>
--	--	---	--	--	--

**Renal Dietary advice and Renal Social Worker Support to be offered at every stage \***

**TEAM\***

<p>Community i.e. GP/health clinic</p>	<p>Community i.e. GP/health clinic Nephrologist CKD Nurse Educator</p>	<p>Nephrologist Nurse educator Vascular access Nurse</p>	<p>Dialysis team Psychologist</p>	<p>Dialysis team Nephrologist Nurse Educator Psychologist</p>	<p>Dialysis team Nephrologist Palliative team</p>
--	--	--	---------------------------------------	---	---

\* Additional detail in Appendix 1

\*\*Treatment options hierarchy: transplant (living or cadaveric), home PD - CAPD/APD, home HD, satellite HD and supportive care

## Models for delivery of education

Models for patient education vary widely across Australia.<sup>8</sup> Each model for education should include the service philosophy rather than individual doctor or nurse preference and bias. The education model will however be strongly dictated by existing resources, past practice and the preferences of the team members. There are many options for delivery of education which include:

- One-on-one education (with or without family members)
- Group education by health professionals and sometimes patients
- Small group problem solving activities
- Self-education

Multidisciplinary team approach is recommended from the pre-treatment stage as it allows the person to identify all key support people in their team. Group education has been found to support home dialysis selection and can be time-effective for those delivering the information.<sup>7</sup>

Education should be considered an ongoing part of treatment and the care-plan of all patients should reflect an ongoing education pathway as they transition through the different stages of CKD and ESKD. It is useful to discuss broad options early i.e. transplant, treatment or maximum conservative management (MCM).

## Timing of education about treatment options

Timing of education for treatment options can be difficult but it is widely accepted that the workup prior to transplant or dialysis (access insertions/creation) will average 6 months to one year. This should be tailored to the waitlists at each service. Therefore education needs to be started at least 6 months before a first treatment is anticipated. Effective education can only occur once the patient as an adult learner is willing to be educated.

It can be difficult to predict the point at which dialysis will need to start or whether dialysis will ever need to start. Monitoring of deterioration of renal function is critical and erring on the safe side is practical. There are predictors such as using albumin /creatinine ratio to predict future dialysis requirements in addition to a declining eGFR<sup>9</sup>. Factors such as age and comorbidities are also a consideration as to whether the person will actually survive to treatment.

The advantage of earlier education is that patients can then make decisions such as economic, work and personal lifestyle. It also overcomes the risk of advancing ESKD when uremia causes decreased mental acuity and concentration difficulty. Early education during CKD is also an opportunity to develop a self-management philosophy that will direct future care towards home dialysis options and enhanced self-care.

## Changing treatment options (including withdrawal) – revisiting options

The current treatment option may fail for a number of reasons including technique failure, death or voluntary change of modality. 1 in 5 PD patients end that treatment each year and 44% who cease PD are for social reasons. 2.5% of patients who had a transplant need to recommence dialysis.<sup>10</sup>

---

<sup>8</sup> Fortnum, D. Ludlow, M. & Morton, R. (2014). Renal unit characteristics and patient education practices that predict a high prevalence of home-based dialysis in Australia *Nephrology* 19, 587-593.

<sup>9</sup> Maziarz, M., Hall, Y., et al. (2014) Evaluating the risk of ESRD in the Urban Poor. *JASN* Dec 10 ANZDATA report (2013) [www.anzdata.org.au](http://www.anzdata.org.au).

At this point if a person is using PD or HHD ideally they should feel empowered when approaching treatment or changing treatments to choose the treatment that best suits their circumstances<sup>11</sup> which preferably is home based. Patients at the discussion stage should have an “ESRD life plan” that is changeable but includes the possibility of transitioning from one treatment to another and should have all therapies discussed and included. Sometimes the changes may be planned and sometimes clinically required.<sup>12</sup>

To achieve this there must be monitoring to determine risk of failure and timely planning for a smooth transition to the other home modality. Promote elective transfer from peritoneal dialysis to home haemodialysis by early identification of at risk patients and planned transition. Transition could occur when PD dialysis dose changes with decline in renal function by doing twice weekly HD in a home training unit to allow smooth transition between treatments.<sup>12</sup>

Those who are established on satellite dialysis may also wish to change modality and it is important to review whether current modality remains the best modality on a regular basis. It should be recognised that many people with in centre dialysis become dependent on the nurses and enter a state of “learned helplessness”<sup>13</sup> The KHA consumer perspectives survey found that 37% of patients are also willing to change modality if appropriate supports are available and these patients all wanted to transfer to home.<sup>14</sup> Formal transitions processes are not well documented or researched. Likewise a person with a failing transplant should enter the PD or HHD programme.<sup>15</sup>

Timely withdrawal from dialysis is important and planning for this with advance care planning and family involvement will reduce the stress and anxiety when the decision needs to be made. It is important that patients and families understand the prognosis of those with kidney failure. If the surprise question ‘would I be surprised if this person died within a year’ elicits a ‘no’ then it is time to discuss end of life planning. Classification of transition from PD to HD as a failure is better considered as survival time on therapy should be considered a positive outcome.<sup>12</sup>

## Education about healthy living

The focus for education in CKD and ESKD is often on treatment options. There are opportunities for patients to delay progression to ESKD and to remain healthier during CKD/ESKD, reducing the risk of heart disease. This includes exercise, dietary intake, correct use of prescribed medications, understanding depression, symptom management, prevention of infection and bacterial illnesses and even how to maximize life such as how to travel or work with CKD/ESKD.

Many of these topics should be addressed at minimum annually with a structured programme available as well as ongoing written information, DVDs, phone apps and possible group sessions available for those who engage with this strategy.

---

11 Improving Choice for Kidney Patients: Home Haemodialysis (February 2010) NHS Kidney Care

12 Burkart, J., (2007) “Transitions from PD are expected. Why not continue at home?” Peritoneal Dialysis International, vol.27, pp645-646.

13 Young, B., Chan, C., Blagg, C., Lockridge, R., Golper, T., Finkelstein, F., Schaffer, R., Mehrotra, R., (2012) “How to Overcome Barriers and Establish a Successful Home HD Program” Clinical Journal of the American Society of Nephrology (p.1-10).

14 Ludlow, M., Lauder, L., Mathew, T., Hawley, C. & Fortnum, D. (2012). Australian consumer perspectives on dialysis: First national census. Nephrology 17, 703-709.

15 Renal Health Network (September 2011) Framework to Improve Home Dialysis Therapy in Western Australia Department of Health, State of Western Australia (2011).

## Individualised education

It is important to recognize stages and the fact that each client journey is different. A positive way of engagement may be to introduce a “life planning” approach and keep revisiting this wherever education is required. It is important that the capacity of the learner to retain information is considered. It is estimated that it takes an average of five encounters to have individuals understand the message. CKD affects people of all different levels of educational ability who may be further impaired by the presence of kidney disease. Therefore a cognitive assessment and physiological assessment of the individual play an important part in understanding them in order to individualise their education. The Montreal Cognitive Assessment tool is one example of a tool that may complement this process.<sup>16</sup>

The principles of adult learning are important and allow for determining motivation and engagement, evaluation of learning styles and opportunities for self-directed learning.<sup>17</sup> Nosology is the science of understanding learning in those with chronic disease.<sup>18</sup>

## Place of education

Traditionally education is delivered in the hospital setting during clinic appointments or at a special education session(s)<sup>19</sup>. Once on dialysis education is usually delivered during treatment. Rural locations and those with mobility or transport issues present additional hurdles. Therefore it is important to reduce the rigidity of service design and be flexible to meet the needs of those receiving education. For example (but not exclusively):

- Use a skype education session to overcome the tyranny of distance
- Set up of a choice room, where individuals have access to equipment and can discuss their therapy choices (Lister Hospital education service)
- Educate at home and simultaneously complete an assessment of family support and home for home dialysis or family support for conservative care (Launceston education service)
- Provide education in the home dialysis unit (Hobart education service)
- Send out an education pack (with DVDs/weblinks/written materials) and provide phone guidance to the contents
- Connect patients by phone to peers (Teleconnect KHA)
- Provide education sessions about healthy living ‘on-line’ for existing dialysis patients when they are off dialysis

## Psychological needs (detail Appendix 3)

ESKD has a significant impact on the person’s psychological health, and their subjective well-being. It intrudes onto most aspects of the person’s life and carries a high risk of co-morbidity. The substantial life changes require the person to make adjustments in their behaviour, affecting their physical and emotional states. Managing emotions, managing interpersonal interactions, and riding the uncertainty of the illness make demands on the person’s psychological resources. Coping behaviours that worked in other settings are no longer available or effective, and the person needs to find the best way to manage.

---

16 Nasreddine, Z., Philips, N. & Chertkow, H. (2011). Montreal Cognitive Assessment (MoCA). Available at [www.mocatest.org](http://www.mocatest.org).

17 Principles of adult learning. (2014) <http://www.qotfc.edu.au/resource>.

18 Kehler, B. (2014). Teaching for those with chronic disease. Presentation at ISPD conference Madrid.

19 Fortnum, D. Ludlow, M. & Morton, R. (2014). Renal unit characteristics and patient education practices that predict a high prevalence of home-based dialysis in Australia *Nephrology* 19, 587-593.

This can often include maladaptive or self-defeating strategies such as substance abuse, overdependence, denial, avoidance and disengagement which limit the effectiveness of education.

CKD is also associated with anxiety, cognitive decline and depression, further barrier to education and healthy behaviours. These may also be enhanced by denial or anger. There are some simple strategies to manage psychological needs.

- Engage each individual and understand their priorities and current feelings
- If depression is suspected perform a formal assessment for depression and refer
- Social worker consultation (often first line referral)
- Psychology consult
- Be aware of and teach about the impact of treatment i.e. side-effects transplant drugs
- Honesty about future life
- Curriculum for education needs to include psychosocial aspects and coping skills
- Ensure clients are not depressed when making decisions. Major depression is linked to learned helplessness. Depression leads to information bias, i.e. negative info is retrieved more readily
- Anxiety reduces effectiveness of processing new info. Frequent reviews necessary

There are also strategies that require trained health professional intervention<sup>20</sup> (detailed in Appendix 3) and these include:

- Motivational interviewing techniques
- Cognitive behavior therapy
- Interpersonal therapy
- Mindfulness based cognition therapy
- Behavior therapy
- Problem solving therapy

### Strategies to improve and enhance education uptake

Beyond professional referral as above all health professionals need to identify stages of behaviour change and provide education in line with this. Other strategies include:

- Physician's influence- patient's perceptions of statements and behavior of the attending physician influence the patient's decision regarding education. The discussion regarding the need for education needs to begin with the nephrologists.
- Ensure the patient understands the importance of education and implications of not learning about their condition/treatment options
- Utilise spare time i.e. time spent in waitrooms, time on dialysis
- Offer multiple ways to receive education and allow patient to choose (including technological advances)
- Educate in small amounts regularly; building block principle
- Determine ways to engage those who are not English speaking
- Specialist educator nurse to have close contact and influence patients to seek out education
- Use of appointment reminders by mobile phone/letter
- Pre dialysis CNC/NP to post out individual invitations

---

<sup>20</sup> Asay, T. P.; Lambert, M.J. in Hubble, M.A. (Ed); Duncan, B.L. (Ed); Miller, S.D. (Ed), (1999). The heart and soul of change: What works in therapy (pp. 23-55). Washington, DC, US: American Psychological Association.

- Make attendance compulsory as part of the pre dialysis education pathway/education programme.
- Check for learning regularly and aim to fill gaps

### Use of technology to enhance education

Technology includes educational programmes that are produced on electronic media and may be interactive. It also includes methods for delivering education such as video and skype. For education that requires regular input such as chronic disease management mobile phone messaging has been proven as effective. Units in Northern Queensland are amongst a number using computers to deliver education during dialysis.

Translation of resources is important and although they are limited it is possible to obtain limited resources in alternate languages but another option is to utilize Google translator on website pages.<sup>21</sup>

Local policy related to privacy and confidentiality may restrict the technology that can be utilized but legislation is not yet clearly defined for this area.

### Use of resources to support education

Resources need to be tailored to the needs of the individuals. Examples that complement standard written materials are pictures, videos, websites, translated resources and phone apps. To determine the most relevant resources it is important to get to know the individual and determine how they would like to learn. It is also important to know their ability to read and write. Use of resources varies widely in Australia.<sup>22</sup>

In Australia two independent and reputable sources of resources are available; Kidney Health Australia and the Renal Resource Centre.<sup>23,24</sup> In addition private dialysis and/or pharmaceutical companies also produce written and video materials. As technology advances the use of interactive learning materials will become more prominent.

It is also important that education tools focus on the priorities of the patient. For example patients likely to choose a home therapy if patients see “freedom and lifestyle” of home dialysis.<sup>25</sup>

### Use of shared decision making strategies

Shared decision making is the accepted practice for determining the best treatment option for any individual<sup>26</sup>. The health professional is the clinical expert whilst the patient is the life expert. Shared decision-making involves a structured process that follows accepted decision-making practice; deliberation (acknowledging a decision to be made), options talk (identifying options), choices talk (exploring options and weighing up consequences), and finally decision-making.<sup>27</sup> This is about

---

21 Google translator (2014) [www.translate.google.com](http://www.translate.google.com).

22 Fortnum, D. Ludlow, M. & Morton, R. (2014). Renal unit characteristics and patient education practices that predict a high prevalence of home-based dialysis in Australia *Nephrology* 19, 587-593.

23 Kidney Health Australia [www.homedialysis.org.au](http://www.homedialysis.org.au) [www.kidney.org.au](http://www.kidney.org.au).

24 Renal Resource Centre. [www.renalresourcecentre.com.au](http://www.renalresourcecentre.com.au).

25 McLaughlin, K., Jones, H., VanderStraeten, C., Mills, C., Visser, M., Taub, K., Manns, B., (2008) “Why do patients choose self-care dialysis” *Nephrology Dialysis Transplantation*.

(<http://ndt.oxfordjournals.org/content/23/12/3972.long>) accessed 26/8/14

26 Fortnum, D. Smolonogov, T., Walker, R., Kairaitis, L., & Pugh, D.. (2014). My Kidneys My Choice decision aid. Supporting shared decision making. *Journal of Renal Care*. Dec 2014.

27 Barry, M. & Edgman-Levitan, S. (2012). Shared decision making – pinnacle of patient-centred care. *NEJM*1(366(9) 780-781.

determining which modality best fits with lifestyle (individual decision), which can enhance compliance and quality of life<sup>28</sup>.

In Australia the 'My Kidneys, My Choice' decision aid is designed to support the education process by guiding shared decision-making<sup>29</sup>. This is available both as a written booklet and a digital version<sup>30</sup>. Health professional guidance regarding this practice is available in the 'My Kidneys My Choice' health professional guide.<sup>31</sup>

To support shared decision making staff must have training to utilize appropriate techniques that enhance this practice.<sup>32</sup>

## Informed Consent/Informed decision making

Education supports the principles of informed consent or informed decision-making. Some states have developed clear policy on such practices and Queensland provides a comprehensive document.<sup>33</sup> Consent does not have to be written but the nature of dialysis means it could incur harm and therefore written consent is recommended. Implicit consent is considered appropriate for minor procedures where harm is not likely to occur.

For a patient to consent they must understand the condition and all potential procedures, potential benefits and risks of harm of each and this should be in relation to themselves. If they lack the capacity to give consent it should be provided by their medical power of attorney.

## Consumers rights to choose conservative/supportive care

Often decisions are made when the patient is acutely unwell.<sup>34</sup> Ideally discussions regarding treatment and end of life decisions should be made before the patient becomes unwell.<sup>14</sup>

The Renal Physicians Association and the American Society of Nephrology provide clinical practice guidelines "Shared decision – making in the appropriate initiation of and withdrawal from dialysis" (Washington DC: Renal Physicians Association, Feb 2000).<sup>35</sup> The nine recommendations are;

- **Shared decision making:** at least between patient and physician
- **Informed consent or refusal:** including dialysis modalities, conservative management, time limited trial, stopping dialysis.
- **Estimating prognosis:** these discussions should continue as the renal disease progresses, with reassessment of treatment goals
- **Conflict resolution:** with possible areas of conflict being; miscommunication/misunderstanding, interpersonal/intrapersonal issues, values.

## Recommendations

28 O'Connor, A., Bennett, C., Stacey, D., Barry, M., Col, N., Eden, K. B., Rovner, D. (2009). Decision aids for people facing health treatment or screening decisions (Review). *The Cochrane Database systems review*; 3.

29 My Kidneys My Choice Decision Aid, 2013. Available from [www.homedialysis.org.au](http://www.homedialysis.org.au).

30 Digital version of My Kidneys My Choice decision aid (2014) Available from [www.homedialysis.org.au/health\\_professionals](http://www.homedialysis.org.au/health_professionals).

31 Kidney Health Australia – health professional guide to using the decision aid. [www.homedialysis.org.au](http://www.homedialysis.org.au)

32 Staff and training for shared decision-making.

33 Queensland health (2012). Guide to informed decision making in healthcare. Viewed at: <http://www.health.qld.gov.au/consent/>.

34 Thorsteinsdottir, B., Swetz, K. M., Feely, M. A., Mueller, P. S., Williams, A. W., (2012) "Are There Alternatives to Hemodialysis for the Elderly Patient With End-Stage Renal Failure?" *Mayo Clin Proc.* \_ June 2012;87(6):514-516

35 Chambers, J.E., Brown, E.A., Germain, M.J. (2010) *Supportive Care For the Dying Renal Patient* 2nd ed. Oxford University Press, New York, USA.

- Expand nephrologists training and multidisciplinary team to include “communication, prognostication, and end-of-life care may help bridge that gap”<sup>23</sup>
- Multidisciplinary approach to care through renal supportive care clinics to maintain “ongoing discussions about medical management, disease progression, psychological care, social issues, palliative care treatment options and personal goals/objectives”<sup>24</sup>
- Incorporation of advance care planning<sup>36</sup> in patient care.
- Use of predictor models; e.g. surprise question<sup>37</sup>
- End of life tools The Gold Standards Framework, Preferred Priorities for Care, Liverpool Care Pathway.<sup>38</sup>
- Increased referrals to palliative care at an earlier stage of symptom control need.<sup>39</sup>

Consent forms may outline specific aspects of the condition as well as offer space for both doctors and patients to sign a statement regarding their participation in education and understanding of options. If an interpreter’s is used they may also need to sign a statement.

There are no clear guidelines regarding how long a consent form remains current. Ongoing implicit consent by cooperation and attendance should be acceptable. Each state should determine the consent requirements based on local guidelines.<sup>40</sup>

Every state has advance care planning, directive forms and guidelines.<sup>41</sup>

## Cultural considerations

Each culture has its’ own language and communication nuances. It is important to understand the key cultures that present to the organisation. Being culturally sensitive involves respecting rules about touching, eye contact and taboo subjects. There are many tools to support Indigenous terminology/visual educational tools that are culturally sensitive and appropriate.

- Informed consent- information must be communicated in a way that patients can understand, even if it requires the use of an interpreter. Patients can then make a decision about how to proceed with treatment.
- Advance care planning which can be formalized into advance care directives allow individuals to influence their course of treatment when incapacitated and unable to express their wishes directly- It is important to be aware of cultural opinion on this practice.
- Asian and Pacific Islanders (this encompasses 30 distinct cultural and linguistic groups). There is growing literature that suggests that this cultural group is more collectivist than individualist (that is these cultures tend to downplay the goals of individuals in favor of those of the group). In collectivist societies many decisions are not made by individuals but by families and groups.
- Filial Piety refers to the obligation of family members to care for each other, with a particular obligation for the younger generation to care for the older generation and family ancestors.

---

36 Yeun-Sim Jeong, S., Higgins, I., McMillan, M., “The essentials of Advance Care Planning for end-of-life care for older people” *Journal of Clinical Nursing* (389-397).

37 Brown, M.A., Crail, S.M., (2013) *Renal Supportive Care Guidelines 2013* The often difficult decision of which patients will benefit from dialysis *Nephrology* 18 401–454.  
<http://onlinelibrary.wiley.com/doi/10.1111/nep.12065/full> accessed 14/5/14.

38 Chambers, J.E., Brown, E.A., Germain, M.J. (2010) *Supportive Care For the Dying Renal Patient* 2nd ed. Oxford University Press, New York, USA.

39 *Kidney Health Australia & Palliative care Australia* (2014). *Palliative care for chronic and end-stage kidney disease position statement*. [www.kidney.org.au](http://www.kidney.org.au).

40 NSW guidelines for consent.(2014) Viewed at: <http://clinicaethics.info/consent/requirement-to-inform-and-obtain-consent>.

41 *Advance care planning Australia* (2014) *Advance care planning*. Viewed at <http://advancecareplanning.org.au/>

- Silent communication-is a collectivist style that relies on an implied understanding between people of that culture. However these implicit concerns cannot be verbalised. Unless the health care worker understands the culture in order to address the unspoken this valuable information is lost and can lead to a misunderstanding about family-patient dynamics and an agreement with a plan of care. Cultural training or employment of culturally aware individuals can overcome this issue.
- Preservation of harmony affects health care decision making in several ways. People from collectivist societies may less likely to share bad news within the group. They may also be less likely to question the decisions made by family, feeling that the decision was made for the overall good of the family. This also applies to questioning health care providers who have the harmony of the health system to maintain.

The primary recommendation for cross-cultural practice is for increased sensitivity by health care workers. This begins at a tertiary level and through the health care sector where there needs to be education regarding understanding and appreciation of diverse cultures.

### **Involvement of family**

The diagnosis of a serious medical condition may create a state of crisis for the patient and family characterized by fear, shock, anger, sadness, anxiety, grief, shame and self-blame. A feeling of loss may be experienced due to a decline in health and energy affecting previously enjoyed activities. Both education and support interventions for patients and family that are informed by good relationships including social worker assessment can facilitate and empower psychosocial adaption and coping behavior. In turn this will promote independence and a sense of control over the course of the disease. Education provides the basis to match personal and family needs to existing renal replacement therapies.<sup>42</sup>

### **Special needs for parents and children**

Education for parents and children needs to encompass both parties. Parents of children with CKD need to recognize that their children may need additional guidance and understanding. Parents can help children with CKD fit in at school, deal with low self-esteem, make friends, be physically active, and follow their treatment regimen.

It is important to have policy that follows legislation related to consent and decision-making. Children should be involved in making decisions when they demonstrate the maturity to participate.

Adolescents with CKD have special needs as they approach adulthood. They may need help with preparing to enter the workforce and managing their own treatment choices. Teenagers are particularly resistant to managing chronic disease in their quest to be 'normal' and may require psychological support rather than education.

### **Workforce**

For a successful education pathway proactive clinical leaders or clinical champions are important. The culture of the unit should include education at every part of the journey. Responsibility of organisation: Support needed from management/organization to attend education and to pay any associated fees.

---

42 Curtis, C., Rothstein, M., & Hong, B. (2009). Stage-specific educational interventions for patients with end-stage renal disease: psychological and psychiatric considerations. *Progress in Transplantation*, 19 (1), 18-24.

Many units have educators specifically employed to manage the decisions in the pre-treatment journey or living healthy in the CKD space. The ratio of treatment options educator to patients is variable by jurisdiction with ratios varying from two to thirty one patients per employed hour per week.<sup>43</sup>

**The role of social workers.** This specialist position provides supportive counseling and information to patients and their families about the psychosocial impact of ESKD and its various treatment options. The Renal Social Worker works across all stages of kidney disease from prevention and disease management, through to supportive therapy<sup>44</sup>. For many services social workers play a critical role during the education process within ESKD. The 'Standards of Practice for nephrology social workers' – National Kidney Foundation provide a benchmark for the scope and practice of this role.

Health professional involvement by role and topic is included as part of Appendix 2.

## Health professional self-education and skills to be educators

All renal staff should be able to provide basic renal education to patients (especially all treatment options and healthy living). Focused education teams need to be skilled in presentation and how to communicate interactively; delivery of messages vitally important and staff should not be didactic but should be able to facilitate shared decision making, adult learning and understand motivational interviewing type techniques. Workforce require training to focus on education once treatments to maximise opportunities for timely transition or withdrawal. The entire renal workforce also require training to deliver healthy living and withdrawal from treatment education.

Health professional training should incorporate the following elements:

- Mandatory Skills based
- Hands on, train the trainer
- Use of technology such as online learning packages
- Other options such as conferences, workshops, department or unit specific education, formal lecture with interactive question time
- Standardised with competency based assessments
- Include key concepts in facilitating shared decision making

Remote and rural: Education capacity can be maximised by having a central "hub" hospital that facilitates renal education for rural and remote areas to have education (possibly a key person/people) and use the "hub" hospital

---

43 Fortnum, D. Ludlow, M. & Morton, R. (2014). Renal unit characteristics and patient education practices that predict a high prevalence of home-based dialysis in Australia *Nephrology* 19, 587-593.

44 Murrumbidgee Local Health District (2014). MLHD Renal Service Plan – personal communication.

## Key Performance indicators

These are key performance indicators for consideration related to education about treatment options and decision-making.

- Percentage of patients starting treatment who have received education regarding all options of renal replacement treatment
- Percentage of patients who participate in decision making about RRT options
- Percentage of dialysis patients on home dialysis (prevalent and incident)
- Percentage of patents with an advance care plan

Victoria, South Australia and Western Australia all have established KPIs (Appendix 2). Other states are currently determining their KPIs.

There are no KPIs that measure how well informed renal patients are about how to live healthily with CKD/ESKD.

## The need for research

There is lack of understanding and evidence about how those with CKD/ESKD learn best and what is important to them. Formal evaluation of effectiveness of teaching strategies and how well information is learnt by official research could help to breach this gap.

## The advantages of home dialysis

A number of studies show benefit of home dialysis. Benefits include reduced medications better BP control, and the "ability to live a more normal life"<sup>45</sup> It is associated with greater employment in a comparison between PD and in centre HD. There is a greater ability to travel which is improving with more portable HD machines.<sup>46</sup> Satellite HD patients who were on the transplant waiting list were compared with HHD patient admission to hospital.<sup>47</sup> The mean length of stay for HHD was 5.9 days v 6.7 for SHD. The mean potassium and phosphate were improved for HHD compared to the satellite group.

WA "Framework to Improve Home Dialysis Therapy in Western Australia"<sup>48</sup> have seven benefits listed for home dialysis including more autonomy, improved quality of life, rural residents are able to stay in own homes, more likely to work, lower mortality rates, less hospitalisations, less complications, access to enhanced dialysis hours. HHD is a cheaper form of HD due to less Health Professional interventions and reduced infrastructure.<sup>49</sup>

---

45 Improving Choice for Kidney Patients: Home Haemodialysis (February 2010) NHS Kidney Care

46 Young, B., Chan, C., Blagg, C., Lockridge, R., Golper, T., Finkelstein, F., Schaffer, R., Mehrotra, R., (2012) "How to Overcome Barriers and Establish a Successful Home HD Program" Clinical Journal of the American Society of Nephrology (p.1-10).

47 Zimbudzi, E., Samlero, R. (2014) "How do hospitalization patterns of home hemodialysis patients compare with a reasonably well dialysis patient cohort?" International Journal of Nephrology and Renovascular Disease (7) 203–207

48 Renal Health Network (September 2011) Framework to Improve Home Dialysis Therapy in Western Australia Department of Health, State of Western Australia.

49 Agar, J., Hawley, C., George, C., Mathew, T., McDonald, S., and Kerr, P., (2010) "Home haemodialysis in Australia-is the wheel turning full circle?" The Medical Journal of Australia, vol 192, no.7.

## Appendix 1

Existing resources do include indigenous specific and translated resources from other sources. The Kidney Health Australia websites provide links to all known and reputable resources in Australia.

Education needs: Diagnosis	Detail	Who should be involved?	Existing Resources
What is CKD?	What do healthy kidneys do? Risk factors that damage kidneys What CKD will mean to you – possible prognosis	General practice (Drs or nurses)	KHA fact sheets Living with Kidney failure book (KHA) KHA website <a href="http://www.kidney.org.au">www.kidney.org.au</a> Managing Kidney disease for general practitioners
Monitoring CKD	What is a Kidney Health Check Understanding eGFR and proteinuria (know your numbers) Frequency of monitoring		
Healthy lifestyle	Risk factors that can be modified Importance of exercise, diet and avoiding smoking		SNAPS or similar healthy living tools

Education needs: Managing Kidney Function	Detail	Who should be involved?	Existing Resources
Healthy Lifestyle (as per diagnosis)	Risk factors that can be modified Importance of exercise, diet and avoiding smoking, limiting alcohol	General practice (Drs or nurses) Dietitian for special needs re diet	Living with chronic kidney disease book Written leaflets (KHA) Website referral (KHA) DVD Phone apps
Living with CKD	Avoiding further damage i.e. x-ray dyes, infections Brief introduction to ESKD treatments How to self-manage Understanding how kidney damage is linked with other symptoms Understanding how blood pressure, diabetes and kidney disease are linked	General practice (Drs or nurses)	
Medications	Diabetes medications Blood pressure medications	General practitioner Pharmacy for medications	

	All prescribed medications Analgesics and kidney failure		
Monitoring function	What is a Kidney Health Check Understanding eGFR and proteinuria (know your numbers) Frequency of monitoring Self-monitoring BP	General practice early Nephrologist or specialist nurses as disease progresses	
Psychological state	Awareness of depression & CKD Assessment for depression Understanding reduced cognitive function	GP initial review Referral to Renal Social Worker Referral to a psychologist if depression suspected	Websites (sane, beyond blue and lifeline, headspace) Written brochures KHA fact sheet - depression

<b>Education needs: ESKD (stage 5)</b>	<b>Detail</b>	<b>Who should be involved?</b>	<b>Existing Resources</b>
Managing symptoms (What to expect and how to cope)	Anaemia – ESA administration Bone disease – Vit D & phosphate management Gastrointestinal symptoms Uraemic symptoms Fluid control	Nephrologist doctor or specialist nurse via clinics Written information for back-up  DVD/websites	Fact sheets (KHA) Pharmacy information
Understanding treatment options (up to 1 year prior to treatment needed)	Transplant (living or cadaveric donor) Home dialysis – PD and HHD Centre based dialysis Supportive care	Nephrologist or specialist nurse. In rural may be dialysis nurse Personalised: One-on-one, group, unit visits, patient contact etc	Fact sheets & photo information sheets (KHA) Renal resource centre DVDs and websites (KHA and homedialysis)
Decision making	Support to make decisions Use of a decision aid Importance of family	Nephrologist or nurse	My kidneys my choice decision aid (KHA)
Access/Surgery	Peritoneal dialysis catheter Vascular access for HD How will surgery affect me? Caring for access	Nephrologist and surgeon Vascular access nurse	Fact sheets (KHA) Local hospital leaflets
Healthy lifestyle	Maintaining usual activities Altered dietary and fluid needs Social supports Sexual intimacy Healthy bowels	Dietitian Renal Social worker Specialist nurses	Living with kidney failure (KHA) Fact sheets (KHA) SNAP website

	Vaccines		
Psychological state	Awareness of depression & CKD Assessment for depression Understanding reduced cognitive function Coping strategies	Social worker Psychologist Nurse/nephrologist	Websites (sane, beyond blue and lifeline, headspace) Written brochures KHA fact sheet - depression
When to start treatment	Understanding the life-threatening symptoms Process when starting treatment (surgery)	Nephrologist/specialist nurse	

<b>Education needs: Starting treatment</b>	<b>Detail</b>	<b>Who should be involved?</b>	<b>Existing Resources</b>
Care of Access	Preventing infections Maintaining patency Preventing damage	Nurses Written back-up	Local leaflets
Healthy kidney transplant	Monitoring Importance of Medications Dietary needs Healthy lifestyle	Surgeon/doctor Transplant nurse Dietitian	
Training for dialysis	Understanding dialysis Self-care for dialysis (as able) Trouble-shooting and support	Dialysis nurses Social workers	Local training packages Company product training materials
Healthy lifestyle	Work/leisure activities and dialysis Dietary needs Exercise and dialysis Sexuality and dialysis Maintaining healthy bowel habits	Social worker Dietitian Dialysis nurses	Living with kidney failure (KHA) Fact sheets (KHA) SNAP website Renal resource centre
Remaining safe and well	Access issues Managing dialysis (if home) Recognising fluid overload	Dialysis nurses	Local resources
Support	Financial and personal support available	Social worker Aboriginal support team	KHA website support pages

<b>Education needs during treatment including supportive</b>	<b>Detail</b>	<b>Who should be involved?</b>	<b>Existing Resources</b>
Healthy lifestyle	Work/leisure activities and dialysis Dietary needs Exercise and dialysis Sexuality and dialysis	Social worker Dietitian Dialysis nurses	Living with kidney failure (KHA) Fact sheets (KHA) SNAP website

	Maintaining healthy bowels Vaccines		Renal resource centre
Symptom assessment & management	What symptoms to expect How to manage those symptoms Role of palliative care for symptom management Understanding medications	Dialysis nurses Nephrologist Palliative care team Pharmacist	POS(S) renal symptom assessment tool
Support	Available financial and personal support available Psychological support	Social worker Aboriginal support team Psychologist	KHA main website and home dialysis website support pages
Treatment Options (if treatment not suitable or failing)	All options with a decision aid	Nurse educator/dialysis nurses/nephrologist	My kidneys my choice decision aid (KHA)
Advance care planning	The importance of advance care planning How to complete advance care planning Choosing a power of attorney – health/financial Wills	Nurses Renal Social Worker General practitioner	Advance care planning materials – state specific
Travel with ESKD	Planning travel (with dialysis) Travelling safe Insurance limitations Medications and travel	Dialysis nurses Booklets available KHA/companies	Websites (KHA, home-dialysis, dialysis abroad) Booklets and leaflets – dialysis companies and KHA
<b>Education needs end of life</b>	<b>Detail</b>	<b>Who should be involved?</b>	<b>Existing Resources</b>
Decision Making to withdraw	Understanding the outcomes of no treatment Support by decision aid Importance of family involvement	Nephrologist/Nurse Religious support Palliative care team	Renal resource centre booklet Decision aids
Symptom assessment & management	What symptoms to expect How to manage those symptoms Referral to palliative care Medication management	Dialysis nurses Nephrologist Palliative care team	POS(S) renal symptom assessment tool
Advance care planning	The importance of advance care planning How to complete advance care planning Involving the family Choosing a power of attorney – health/financial Wills	Nurses General practitioner Social worker	Advance care planning materials – state specific
Dying process	Family support What to expect for the final days of life	Palliative care team Social worker Dialysis nurses	

**Appendix 2****Existing Key Performance Indicators – (related to education only)**

<b>State</b>	<b>Key Performance indicator</b>	<b>Target</b>
Victoria	Proportion of new planned patients who have received CKD education before starting dialysis.	80% of planned patients (>3 months referral) have received education
	Percentage of patients dialyzing at home	Prevalent 35% Incident 35%
Western Australia	Proportion of new patients who have received education before starting dialysis	70% of patients (>3 months referral) have received education
	Percentage of patients dialyzing at home	Prevalent 35%
South Australia	Proportion of new, planned (i.e. early referral) patients that have received Chronic Kidney Disease (CKD) education before starting dialysis.	90% of patients (>3 months referral) have received education
	Percentage of patients dialyzing at home	Prevalent and incident as a trend

## Appendix 3

### End stage kidney disease – Psychological needs

#### Jane Nearhos. Psychologist Princess Alexandra Hospital QLD

It should not be surprising that ESKD has a significant impact on the person's psychological health, and their subjective well-being. It intrudes onto most aspects of the person's life and carries a high risk of co-morbidity. The substantial life changes require the person to make adjustments in their behaviour, affecting their physical and emotional states. Managing emotions, managing interpersonal interactions, and riding the uncertainty of the illness make demands on the person's psychological resources. Coping behaviours that worked in other settings are no longer available or effective, and the person needs to find the best way to manage. This can often include maladaptive or self-defeating strategies such as substance abuse, overdependence, denial, avoidance and disengagement.

#### Quality of Life

Losses in usual activities and changes in relationships affect the person's ability to gain the rewards of an active and meaningful life. While the aim of medical care is to prolong life and limit co-morbidity, the person with ESKD may need a higher emphasis on gaining (or regaining) a life that is worth living. Costs and benefits of treatments can include the potential to allow the person to fulfil life roles that they value such as worker, parent, carer, spouse.

The person's values and lifestyle are central to determining their treatment options and choices. This in turn can inform the goals of their health care and education.

#### Relationships

One of the challenges in caring for the person with ESKD is to provide care in ways that do not damage existing or potential relationships. The amount of time the person devotes to their treatment (time in waiting rooms, undergoing procedures, travelling to treatment locations) is time taken from the people and activities they value. Hence the frequent comment "I just want to have a normal life". Any treatment options need to consider the impact on the person's relationships.

#### Cognitive decline

Cognitive impairment has been observed in ESKD, particularly in the pre-dialysis patient (Nikhil, 2010). With adequate dialysis, this may not be a barrier (Griva, 2003). An assessment of cognitive function can assist in identifying learning strengths and deficits, but it cannot determine treatment options.

Functional status (*ie-i.e.* Ability to manage important tasks) is more relevant than results of formal cognitive assessment.

#### Depression

While depression is assumed to be a high risk in this population, prevalence rates vary and symptoms can be very similar to symptoms of uraemia. Diagnosis of depression relies on a mental state assessment

Normal variation in emotional states needs to be considered. It is normal and appropriate to feel grief and sadness when confronted with losses from chronic illness or disability.

Depressed mood, crying, negative expectations of the future can be related to the person's realistic appraisal of their situation rather than symptoms of a mood disorder.

However, untreated mood disturbance can limit the person's ability to consider information and make informed decisions. Depression can be life threatening and it may be necessary to refer to specialist mental health team for risk assessment and management.

### **Anxiety**

Anxiety is a normal human response to novelty, change, danger, or trauma. It is related to the sympathetic nervous system that activates the person's response to a fearful situation and is not in conscious control. The fight/flight/freeze response is part of the normal human operating system and is essential for our survival. However, it is also a response that limits the person's ability to use rational or thoughtful decision making. The anxious person is not usually able to reason or think clearly. They need to feel safe in order to recover.

The level of anxiety can vary from low level of feeling wary or cautious, to a high level of panic or desire to escape.

The person with ESKD is likely to feel anxious during education sessions.

Anxiety can interfere with a person's ability to take in information. They are likely to be more aware of body language and non-verbal signals than verbal communication.

The experience of chronic illness often includes facing additional diagnoses, co-morbidities, physiological changes, and traumatic medical situations. Every medical procedure, even if it is a simple blood test, is another challenge to the person's sympathetic nervous system. Repeated trauma or chronic stress can exhaust the person's ability to respond, and can be linked to the symptoms of acute stress disorder or post-traumatic stress disorder.

### **Adjustment to illness**

Any change in physical well-being requires person to adapt, even if only a small amount. Adjustment or adaptation is similar to a grief response – any change includes losses as well as gains.

Adjustment is the ability to make the most of the gains and accepting losses. It includes adaptive coping responses such as problem solving, planning for the future, learning new skills, and re-interpreting change as a growth opportunity.

Psychological flexibility is a key quality to assist in process of adjustment and this is the goal of most psychotherapies.

### **Chronic disease factors**

Our physiology is designed to respond to acute stressors and seek to return to balance.

Righting reflex – seeking to return to previous situation, an unconscious and automatic response to change.

However, with a chronic condition, these attempts to return to "normal" function can interfere with adjusting to the illness or learning new skills. Instead, we often find ourselves repeating unhelpful

behaviours because they are familiar and allow us to escape or avoid the discomfort of our current problem. The

Over time, the person's coping resources can be overwhelmed by the series of losses and stresses (i.e. Comorbidities, loss of function, loss of work, missing out on social activities, loneliness, medical traumas and hospitalisation). The grief and sadness associated with these changes are often not acknowledged or understood by the person, or by other people in their life. The person's response to chronic illness can fluctuate from anger to passivity, with their family bearing the worst of the emotional storms. Learned helplessness and poor treatment adherence can be the result.

Chronic disease needs a different model of care from acute illness. Rather than seeking cure, the goal needs to be to manage symptoms and improve quality of life. Searching for quick fixes or new treatments can distract from the more mundane tasks of self-monitoring and self-care.

The treatment plan also needs to prioritise the person's ability to manage and control their treatment choices, rather than being driven by their health care practitioner.

### **Adherence**

No-one likes to follow the intrusive and humiliating regimes of ESKD treatments.

Knowledge does not guarantee adherence. The causes of non-adherence are not usually about lack of knowledge and for this reason it is unlikely that more patient education will help.

It is unlikely that the person with ESKD is as concerned about adherence as their health practitioner. The person with ESKD is probably more interested in having a normal life.

Improving treatment adherence is achieved by aligning the person's goals with their treatment and developing a collaborative approach to the person's medical care.

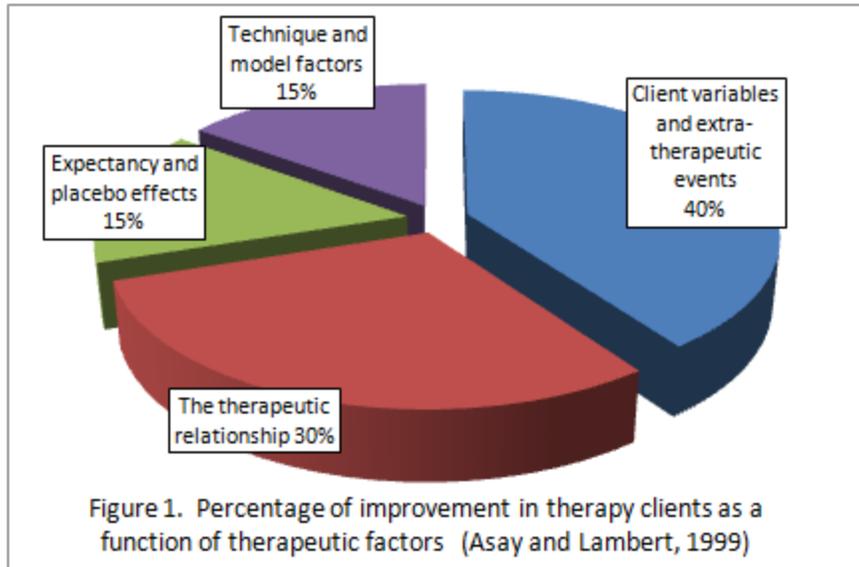
Using an approach like motivational interviewing is more beneficial as this promotes more effective communication between the person and their treating practitioner.

### **Interventions**

Psychologists have a range of therapy techniques that can assist the person with ESKD. Find more information about treatment options at [www.beyondblue.org.au](http://www.beyondblue.org.au) or [www.mindhealthconnect.org.au](http://www.mindhealthconnect.org.au) . See below for some descriptions of treatment techniques.

It is important to note that all psychological interventions are most effective when there is a therapeutic alliance between the client and the therapist. Research on what works in psychotherapy has demonstrated that the quality of the client-therapist relationship contributes 30% to the client improvement, while the specific therapy technique contributes 15% (Asay & Lambert, 1999). Finding a therapist that can fit with the client is more important than the specific therapy technique.

Find a psychologist through Australian Psychological Society (APS) [www.psychology.org.au](http://www.psychology.org.au) .



### **Cognitive behaviour therapy (CBT)**

CBT is a structured psychological treatment which recognises that a person's way of thinking (cognition) and acting (behaviour) affects the way they feel. CBT is one of the most effective treatments for depression, and has been found to be useful for a wide range of people, including children, adolescents, adults and older people.

In CBT, a person works with a professional (therapist) to identify the patterns of thought and behaviour that are either making them more likely to become depressed, or stopping them from improving once they become depressed.

CBT has an emphasis on changing thoughts and behaviour by teaching people to think rationally about common difficulties, helping them to shift their negative or unhelpful thought patterns and reactions to a more realistic, positive and problem-solving approach.

CBT is also well-suited to being delivered electronically (often called [e-therapies](#)).

### **Interpersonal therapy (IPT)**

IPT is a structured psychological therapy that focuses on problems in personal relationships and the skills required to deal with these problems. IPT is based on the idea that relationship problems can have a significant impact on a person experiencing depression, and can even contribute to the cause.

IPT is thought to work by helping people to recognise patterns in their relationships that make them more vulnerable to depression. Identifying these patterns means they can focus on improving relationships, coping with grief and finding new ways to get along with others.

### **Behaviour therapy**

Behaviour therapy is a major component of cognitive behaviour therapy (CBT), but behaviour therapy focuses exclusively on increasing a person's level of activity and pleasure in their life. Unlike CBT, it does not focus on changing the person's beliefs and attitudes. Instead it focuses on encouraging people to undertake activities that are rewarding, pleasant or give a sense of satisfaction, in an effort to reverse the patterns of avoidance, withdrawal and inactivity that make depression worse.

### **Mindfulness based cognitive therapy (MBCT)**

MBCT is generally delivered in groups and involves learning a type of meditation called 'mindfulness meditation'. This meditation teaches people to focus on the very present moment, just noticing whatever they are experiencing, be it pleasant or unpleasant, without trying to change it. At first, this approach is used to focus on physical sensations (like breathing), but later it is used to focus on feelings and thoughts.

MBCT helps people to stop their mind wandering off into thoughts about the future or the past, or trying to avoid unpleasant thoughts and feelings. This is thought to be helpful in preventing depression from returning because it allows people to notice feelings of sadness and negative thinking patterns early on, before they have become fixed. It therefore helps the person to deal with these early warning signs better.

### **Acceptance and Commitment Therapy (ACT)**

This is a technique that uses cognitive and behavioural strategies that are aimed at increasing psychological flexibility.

### **Dialectical behavioural therapy (DBT)**

A treatment specifically developed for borderline personality disorder and includes individual and group therapy. Techniques such as mindfulness are used to help manage intense and difficult feelings.

### **Psychodynamic therapy**

A long-term individual therapy that helps you understand your behaviours, moods and disruptive thoughts through a therapeutic relationship with a single therapist. These insights can help you find ways to respond to the environment and better manage your symptoms.

### **Schema-focused therapy**

A technique that helps change the way people view themselves (reframing schemas) to improve self-image.

### **Motivational Interviewing**

Motivational interviewing (MI) is a person-centered, goal-oriented style of counseling, which aims to elicit and strengthen an individual's own motivation and commitment towards behaviour change by attending closely to the client's language of change, exploring ambivalence and evoking their reasons for change. MI has been shown to be helpful in the treatment and management of a range of health conditions and problem behaviours, however it has received its strongest support in the area of substance abuse. Numerous meta-analyses have shown that MI interventions which are directed at reducing alcohol and other drug use result in better client outcomes (e.g. abstinence) compared to no-treatment controls and are equivalent to (and in some cases better than) other treatments such as CBT.

While there is limited research investigating the efficacy of MI for problems other than substance abuse, MI has been found to be effective for a number of health behaviours, including smoking cessation, treatment adherence, and increased physical activity and improved dietary habits.

### **Acceptance and Commitment Therapy**

This therapy style uses acceptance and mindfulness strategies, together with commitment and behaviour change strategies, to increase psychological flexibility. Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behaviour in the service of chosen values.

Based on Relational Frame Theory, ACT illuminates the ways that language entangles clients into futile attempts to wage war against their own inner lives. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to recontextualise and accept these private events, develop greater clarity about personal values, and commit to needed behaviour change.

### **Problem-solving therapy (PST)**

This is a form of cognitive-behavioural therapy that promotes the application of functional and effective problem-solving skills to difficult situations. The overall aim of PST is to help individuals cope more effectively with the problems they encounter in their daily lives and, in turn, maximise their psychological and behavioural well-being and functioning.

PST is adaptable to a wide range of real-life problems including relationship difficulties, financial troubles, and health concerns. Its application has also led to positive outcomes for individuals with a range of mental health problems, being an effective treatment for depression and anxiety and significantly improving functioning in individuals with schizophrenia and personality disorders.

### **Mindfulness**

Mindfulness techniques can be used to redirect an individual's attention from negative thinking. In using these techniques, psychologists help individuals focus on present moment experiences without worrying about the future or making any type of judgments about their current thoughts, physical sensations, or environment. It has been used successfully in stress reduction, managing chronic pain, and improving quality of life.

### References

- Asay, T.P.; Lambert, M.J. in Hubble, M.A. (Ed); Duncan, B.L. (Ed); Miller, S.D. (Ed), (1999). The heart and soul of change: What works in therapy, (pp. 23-55). Washington, DC, US: American Psychological Association.
- Griva, K., Newman, S. P., Harrison, M. J., Hankins, M., Davenport, A., Hansraj, S., et al. (2003). Acute neuropsychological changes in hemodialysis and peritoneal dialysis patients. *Health Psychology, 22*, 570–578.
- Holman, H. & Lorig, K. (2004) Patient self-management: a key to effectiveness and efficiency in care of chronic disease. *Public Health Reports, 119*, 239-43.
- Nikhil, S., Koushik, F., Steven, F., McArthur, B., & Baird. A (2010). Adult Chronic Kidney Disease: Neurocognition in Chronic Renal Failure. *Neuropsychological Review, 20*, 33–51.
- Williams, M. & Penman, D. (2011) *Mindfulness: a practical guide to finding peace in a frantic world*. London: Piatkus.