Mental Health Care Pathway for Adults Receiving Dialysis

April 2026

OBJECTIVE: To provide evidence-based, clinical direction, and resources for the person-centred mental health care of adults receiving long-term dialysis.

- See additional pathway details here and overview in Appendix 1.
- See also the patient-facing version of the pathway on MyHealth.Alberta.ca

APPLICABILITY:
The pathway is intended to be used in all dialysis settings, with all dialysis modalities, to address mental health care for adults receiving long-term dialysis care. The pathway specifically addresses depression and anxiety, as well as coping with and adjusting to dialysis. (The pathway does not focus on pre-dialysis, pediatrics, transplant, family caregivers, or Indigenous ways of healing.)

INTERVENTIONAL GUIDELINES: Do not replace individualized care and clinical expertise.

1. **Initial conversation:**
   Either a healthcare provider or patient may initiate a conversation about mental health. Tools outlined below are used to **support** this conversation.
   Note: Depression and anxiety are two symptoms on the Edmonton Symptom Assessment System revised for renal (ESAS-r:Renal). When needed, use translated versions or Interpretation Services.
   a. As per AKC-N Patient Care Activities and AKC-S Patient Care Activities practice direction documents (PDD) (link forthcoming), the healthcare provider will invite the patient to complete the ESAS-r:Renal as part of the Supportive Care Assessment. (in Connect Care, ESAS-r:Renal is found in the Screenings tab and in Flowsheets)
      i. If ESAS-r: Renal recently done (within the last two weeks), or there are concerns about depression or anxiety, skip to #2.

   Notes:
   - When inviting a patient to complete the ESAS-r: Renal, the conversation may be started with the following question: **"May I ask about what symptoms you may be experiencing and how you are adjusting to or coping with dialysis?"**
   - All scores cannot be used at face value: different scores have different meanings for different people; conversation is key.
   - The Initial Conversation will be done by a nurse or another member of the multidisciplinary kidney team.

2. **Screen:**
   a. Look at ESAS-r:Renal responses for depression and anxiety, invite the patient to interpret the score(s), and discuss. For addressing the scores for the other symptoms, follow usual unit practices.
   b. If the patient doesn't express concerns about depression, anxiety, coping with and adjusting to dialysis, **and** there are no clinical concerns, provide usual care and reassess with their next Supportive Care Assessment.
   c. If the patient expresses concern about coping with and adjusting to dialysis, refer to #6 for resource list. Continue to monitor and reassess with their next Supportive Care Assessment.

   Note: Steps "a-c" will be done by a nurse or another member of the multidisciplinary kidney team.

d. If the patient or health care provider has concerns about depression / anxiety, two options are available. If patient consents and social worker is available, they continue with next steps. If no social worker applicable / available, the nurse or another member of the multidisciplinary kidney team continues with next steps.
Invite the patient to complete the appropriate screening tool:
   i. **Anxiety:** Generalized Anxiety Disorder (GAD-7; in Connect Care under Flowsheets)
   ii. **Depression:** Patient Health Questionnaire (PHQ-9; in Connect Care under Flowsheets)

Note: The conversation may be started with the following question: **"I would like to learn a little more about your symptoms that look like depression or anxiety. Please answer these questions and we will discuss them together."** It is the person's choice to do so or not.

3. **Follow-up:**
Although there are guidelines for interpreting the GAD-7 and PHQ-9 scores (see table below), the severity of symptoms must be determined in discussion with the patient.
Note: Follow-up will be done by applicable/available social worker, nurse, or spiritual care.

Tool	Minimal	Mild	Moderate	Moderately severe	Severe
PHQ-9	Score of 0-4	Score of 5-9	Score of 10-14	Score of 15-19	Score of 20-27
GAD-7	Score of 0-4	Score of 5-9	Score of 10-14	n/a	Score of 15-21

a. Minimal / Mild scores
   i. Discuss scores and severity of symptoms with the patient
   ii. Continue to monitor and reassess with next Supportive Care Assessment
   iii. Offer and provide relevant resources (refer to #6 for resource list)

b. Moderate – Severe scores
   i. Discuss scores and severity of symptoms with the patient
   ii. If the patient **has** a Primary Care Provider (PCP):
      1. Ask patient if they will follow-up with their PCP or if they want the healthcare provider (on behalf of the most responsible health practitioner (MRHP)) to send a referral / letter to the PCP. If sending a letter, include the GAD-7 and/or PHQ-9 score and ask PCP to let MRHP know of their assessment and initial plan.
   iii. If the patient **does not have** a PCP:
      1. Ask the patient if they will call the Mental Health Helpline (toll free: 1-877-303-2642) or if they want the kidney healthcare provider to call.
      2. Notify the MRHP.
   iv. With patient consent, refer to unit social worker, spiritual care, or psychologist requesting follow-up, if applicable / available.
   v. Continue to monitor and reassess with next Supportive Care Assessment. Ask patient about their follow-up with PCP or Mental health helpline.
   vi. Offer and provide relevant resources (refer to #6 for resource list).

4. **Follow-up on suicidal risk:**
If the patient expresses a plan for suicide, or on the PHQ-9, the patient answers question #9 ("thoughts that you would be better off dead or of hurting yourself in some way") with "several days", "more than half the days", or "nearly every day":
   a. Ask patient to complete the Columbia Suicide Severity Rating Scale (C-SSRS). (In Connect Care, the C-SSRS (Screen Version) is found in Flowsheets.)

b. On the C-SSRS, if the patient is **not at high risk**:
   i. Talk with the patient about their supports and safety. Refer to the Personal Safety Plan form
   ii. With patient consent, refer to unit social worker or a psychologist, if applicable / available

Note: Follow-up on suicidal risk will be done by applicable/available social worker, or nurse, or spiritual healthcare provider.

Note: There is an AHS policy on Suicide Risk Program Management.

5. **Urgent referral:**
   a. On the C-SSRS, if the patient is at **high risk**:
      i. Ask the patient: **"Are you willing to go to the Emergency Department for assistance?"**
      ii. If YES:
         1. Notify the MRHP.
         2. Either arrange for the patient to get to the nearest Emergency Department (if applicable), or refer them for an emergency psychiatry consult (if available) or call the Mental health helpline (toll free: 1-877-303-2642).
      iii. If NO:
         1. Notify the MRHP.
         2. MHRP completes Form 1.
         3. Call 911.

Note: Urgent referral will be done by applicable/available social worker and/or nurse.

6. **Management:**

Non-pharmacological intervention options:

- Patient handouts are available for depression (AKC South and AKC North) and anxiety (AKC South).
- Patient resources for coping with and adjusting to dialysis.
- Online wellness program (see posters in AKC-S dialysis units).

Pharmacologic interventions (for MRHP):

- See this paper, or this prescription guide written by AB Kidney Care pharmacists

7. **Document:**

For the applicable steps above, the healthcare provider shall document in the patient's health record (e.g., noting outcome of discussions with the patient, interventions, resources provided). The healthcare provider shall also document any patient refusals.

Appendix 1

Mental Health Care Pathway for Adults Receiving Dialysis

1. Initial conversation

Adult receiving chronic (ongoing) dialysis or health care provider initiates a conversation about mental health.

Or

Health care provider invites patient to complete the ESAS-r: Renal.
Tip: start the conversation with *"May I ask you about how you are adjusting to or coping with dialysis?"*

2. Screen

Look at responses on the ESAS-r:Renal for depression and anxiety and invite patient to interpret the score(s)

Concerns are expressed or clinical judgment reveals concerns

No → Usual care. Reassess with next Supportive Care Assessment

Yes - Concerns regarding symptoms of depression → Invite patient to do the PHQ-9

Yes - Concerns regarding symptoms of anxiety → Invite patient to do the GAD-7

Yes – Concerns about coping with & adjusting to dialysis → Provide resources. Reassess with next Supportive Care Assessment

Tip: start the conversation with "I would like to learn a little more about your symptoms that look like depression / anxiety. Please answer these questions and we will discuss them together."

Review the score(s) of PHQ-9 and / or GAD-7 and invite the patient to interpret the score(s); it is the person's choice to do so or not.

3. Follow-up

The patient and the health care provider discuss symptoms of **depression** and PHQ-9 score **OR anxiety** and GAD-7 score:

- **Minimal / mild** → Monitor and reassess with next Supportive Care Assessment → Provide Resources
- **Moderate** → Ask patient if they will follow-up with their PCP or if they want the health care provider to send a referral / letter to the PCP.
- **Severe** → Ask patient if they will follow-up with their PCP or if they want the health care provider to send a referral / letter to the PCP.

With patient consent, refer to unit social worker, spiritual care, or psychologist requesting follow-up, if applicable / available (include PHQ-9/GAD-7 score and this pathway).

If they do not have a primary care provider:
- Patient or health care provider call Mental health helpline or
- Notify MRHP

Monitor and reassess; discuss follow-up

4. Follow-up on suicidal risk

If patient expresses a plan for suicide or answers PHQ-9 question 9: ***"thoughts that you would be better off dead or of hurting yourself in some way"*** *with "several days," "more than half the days," or "nearly every day"*:

Ask to complete Columbia Suicide Severity Rating Scale

- **Low Risk**
  - Talk about their supports
  - Personal Safety Plan Form
  - With consent, send referral to a dialysis social worker or psychologist
- **Medium Risk**
  - Talk about their supports
  - Personal Safety Plan Form
  - With consent, send referral to a dialysis social worker or psychologist
- **High Risk** → If they plan to end their life or have means to enact this plan, ask: *"Are you willing to go to the Emergency Department for assistance?"*

Yes → Notify MRHP; Arrange for Patient to get to Emergency Department or refer to emergency psychiatry consult

No → Notify MRHP; MRHP completes form 1; Call 911

5. Urgent referral

Notify MRHP; Arrange for Patient to get to Emergency Department or refer to emergency psychiatry consult

Notify MRHP; MRHP completes form 1; Call 911

6. Management

- Provide suggestions regarding non-pharmacological interventions.
- For MRHP to consider: Pharmacologic treatment is one option.

7. Document

- Document in the patient's health record (e.g. note outcome of discussion, resources provided, interventions).

See the original pathway and its details here.
See the AHS policy on Suicide Program Management here:
https://publicshare.albertahealthservices.ca/teams/policydocuments/1/clp-ahs-suicide-risk-program-mgmt-ps-114.pdf