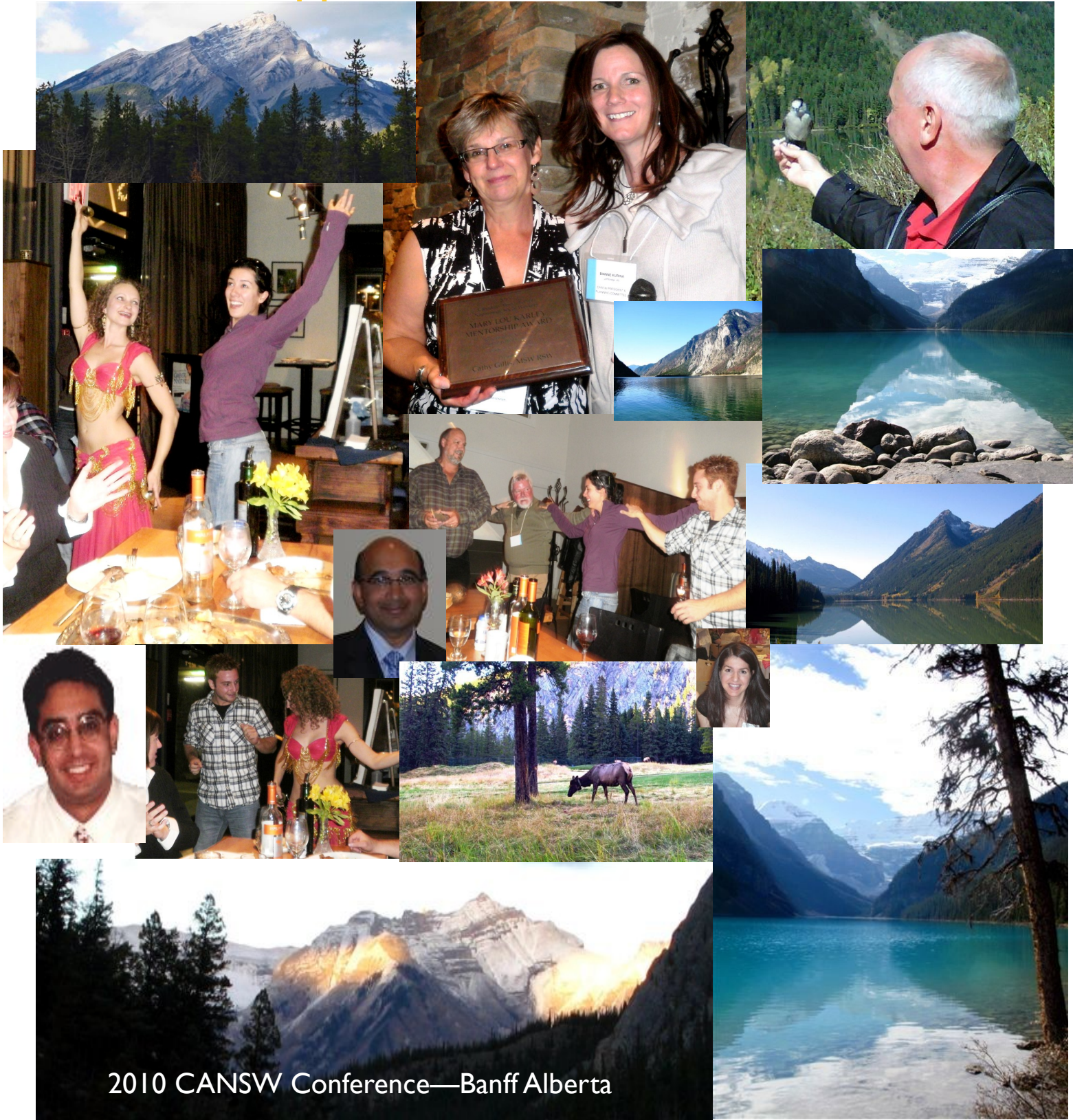




CANSW VOICE

Volume 2010 Issue 3



2010 CANSW Conference—Banff Alberta

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The Editor



Lyle Stockwell MSW, RSW

Your feedback is welcome.

Contact me at:

**Istockwell@lakeridgehealth.on.ca
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Yikes!

Let's all take a deep cleansing breath... now shut the hell up

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SocialJerk

Because writing about social work can be funny, too! (Sorry Precious)

Once again, it's confession time: I don't like Enya. I haven't used incense since high school. I don't know what chakras are, and I'm OK with that. I don't really even believe that people are sincerely good at heart. I am a bit cynical and sarcastic. I'll give you all a moment to let that news sink in.

Sometimes, it makes me feel a little out of place in this profession. Back in Dr. Horrible's ...sorry, social work school, I got tired of learning how closed minded I was. Well-meaning suggestions that I introduce my elderly clients to the healing power of crystals or repetitive chanting just didn't do it for me. I didn't mean to laugh *at* people, I genuinely thought we were joking. I started to feel like the Grinch Who Stole New Age.

I've worked on improving, really I have. I've opened up the old mind a bit. Meditating isn't for me, but that, combined with breathing exercises, has helped a lot of my anxious clients with the scary life stuff they can't control. I'm willing to incorporate that with some of what I've been told are more traditional, "Western" methods. (Apparently, "Western" in this case does not mean that lassoes will be used. Boo.)

I'm even co-leading a teen girls' self-esteem group that combines movement with shouted affirmations.

Does anyone need another minute? OK.

Once a week, a group work intern and I lead a group of 13-17 year old young women in stretching, punching the air, jumping invisible ropes, and other moves designed for the sole purpose of making me

Followed by snacks and discussion time. (Both of which bring me right back into my comfort zone.)

I was rather skeptical at first. I did not become less skeptical when my co-leading intern brought out electric mini-candles and a silk scarf, to place in the center of our circle to "calm the environment." But you know what? The girls love it. And this jerk over here is having a great time.

Meditation, breathing, and scented candles help some workers to cope with the stressful, upsetting situations we deal with. I cope through obnoxious sarcasm ...sorry, humor. I'm willing to make a deal with the tantric (I don't know what that word means) social workers out there.

Accept my methods, and I'll accept yours.

Turn on those electric tea lights, pretzel your legs, and imagine a glowing ball of warm energy illuminating your face.

But when I am venting after my fourth unsuccessful home visit attempt that week, saying, "The woman has two babies and no money, where the hell is she going, to a day spa?" the correct response is just to let it go. Not to say, "Wow, she must really be experiencing a lot of isolation. Maybe she's identified some new supports."

We can coexist. I firmly believe this.

2010 Jane Dicks Award

Re: Jane Dicks Award 2010

I would like to nominate Corinne MacNab for the Jane Dicks award. I have known Corinne for the last four and a half years. I was new to the renal field when I started working at OSMH. ... Corinne has been patient as I negotiated my new learning curve.

Over the years Corinne has participated in different pursuits in the kidney field. A few years ago she was the lead person from our area (Simcoe and Muskoka) who helped to organize a kidney symposium in partnership with the kidney foundation. The symposium would not have been a success if it were not for the hard work Corinne put in.

Corinne is well liked by the dialysis patients that she works with. ... One of her greatest strengths is always considering the patients first. All of her pursuits in the field lead her to always consider the patients needs first.

She has been there for different staff such as some of the nurses to be a listening ear to help them with any ethical challenges they face.



Corinne MacNab
2010 Jane Dicks
Award Winner

Monthly Corinne facilitates a session with nurses to discuss any ethical issues that they have been presented with over the month. It gives them an opportunity to discuss challenges they have about specific patients.

Corinne also collects the names of dialysis patients who have passed away and annually organizes a small memorial type service to read over these names and to reflect on their lives and our interactions with them.

Corinne has taken on social work students over the years. She is willing to do this and work in an environment that provides little physical working space. She has had some student experiences that have not worked out so well. She has now started a committee with other hospital social workers to plan for students who will do their placements at OSMH and to brainstorm about how the process can run as smooth as possible. ...

Corinne has been involved with different CANSW committees. I know that she was part of the transportation committee. Corinne has focussed a lot of attention on transportation for patients to get to dialysis. ...

always goes above and beyond her regular duties as a renal social worker. She stands firm in her social work values and is not afraid to stand up to other professionals in order to advocate for her clients. Sometimes other professionals are not happy with Corinne, but she does not mind again her only goal is to put dialysis patient's needs first.

Sincerely,

Deanne Graham, BSW, RSW

Orillia Soldiers' Memorial Hospital

Building an Implantable Artificial Kidney

A prototype uses kidney cells to help it perform vital functions.

By Lauren Gravitz

Reprinted with permission from MIT Technology Review.

Nearly 400,000 people in the United States--and as many as two million worldwide--rely on dialysis machines to filter toxins from their blood because of chronic kidney failure. Patients must be tethered to machines at least three times a week for three to five hours at a stretch. Even then, a dialysis machine is only about 13 percent as effective as a functional kidney, and the five-year survival rate of patients on dialysis is just 33 to 35 percent. To restore health, patients need a kidney transplant, and there just aren't enough donor organs to go around. In August, there were 85,000 patients on the U.S. waiting list for a kidney in the U.S., while only 17,000 kidney transplants took place last year.

A collaborative, multidisciplinary group of labs is working to create the first implantable artificial kidney. The prototype, revealed last week, is compact, no larger than a soup can. It not only filters toxins out of the bloodstream but also uses human kidney cells to perform other vital functions, such as regulating blood pressure and producing vitamin D.

"Dialysis is not only time-consuming, but it's also debilitating. Many patients don't feel good, because it's not doing all the functions of a normal, healthy kidney," says bioengineer [Shuvo Roy](#), whose lab at the University of California, San Francisco produced the new device and is already testing it in animals. "The kidney doesn't just filter toxins. It also has metabolic functions and hormonal functions, and dialysis doesn't capture these abilities."

Making an artificial kidney small enough to fit inside the body is, however, a big challenge. A healthy kidney filters 90 liters of water each day. Current dialysis machines are the size of a small refrigerator, and require substantial pressure to pump enough water through the machine's porous membranes to allow contaminants to be filtered out of the blood.



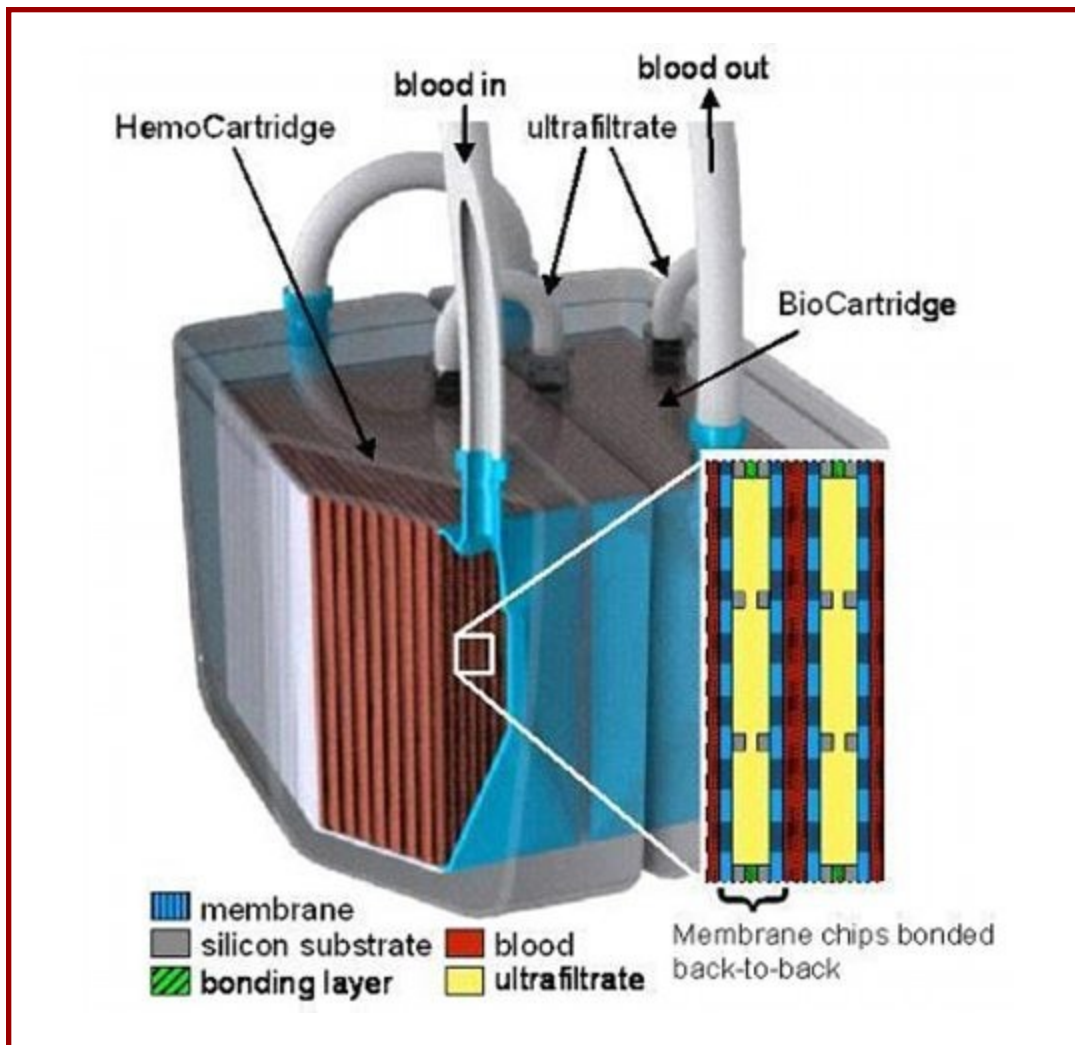
H. David Humes

The new implant is a fusion of multiple lines of research, and takes advantage of two recent advances in the field. University of Michigan nephrologist [David Humes](#) has shown that [human kidney cells could be used in a room-sized filtration machine](#) to greatly improve the health of patients whose kidneys have stopped functioning. Meanwhile, Roy and [William Fissell](#), a nephrologist at the Cleveland Clinic, have [produced a nano-pore silicon membrane](#) that--with its dense and precise pore-structure--could help miniaturize dialysis machines.

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The clean blood and watery filtrate are both shunted into the other half of the system: a separate cartridge. Here, they flow over more silicon membranes, these ones coated with a single type of human kidney cell, which helps the device reabsorb some of the water, sugars, and salts, as well as produce vitamin D and help prevent blood pressure from sinking too low--normal kidney functions that are not offered by dialysis. The waste that's not reabsorbed is shunted to a tube attached to the bladder and removed as waste in the urine--just like a normal kidney would do.



It's far from a complete system, and the researchers note that they don't ever expect it to replace kidney transplants. "Your kidney has 20 to 30 cell types in it, all of which accomplish different functions. But we'd like to overcome a critical issue that's emerged in renal failure," says Fissell. "If you're listed for a kidney transplant, you're far more likely to die on the waitlist than you are to get a kidney." He says the device could act as a bridge for patients awaiting transplant.

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"From a general perspective, any implantable device would sharply reduce the burden that patients now experience," says [Glenn Chertow](#), the chief of nephrology at the Stanford University School of Medicine. "And if some of the additional magic that a native kidney provides could be added to an implantable device, we could come closer to a restoration of good health."

The researchers have already worked out some of the more difficult issues: Humes has worked out how to culture kidney cells on the necessary scale (he can culture enough cells for 100,000 devices from a single kidney). He's also determined the best way to freeze them for future use. And Roy, [a TR35 winner in 2003](#), has tested the implant in a dozen rats and a handful of pigs. They still have to scale up the implant's efficiency to something that could work effectively in humans, but they hope to start human trials in five-to-seven years. Right now the biocartridge can filter between 30 to 35 liters of water per day, and it needs to be able to filter at least 43. They also have to find ways to ensure that the devices don't cause blood clots or immune reactions.

Other groups are also working toward alternatives to thrice-weekly dialysis appointments, although most are concentrating on wearable dialysis devices--a difficult proposition in itself, given the challenge of constant filtration at such large volumes without an external pump. One such device is already in the second stage of clinical trials. But even constant dialysis can't take the place of the kidney's other functions. Allen Nissenson, CMO of [DaVita](#), one of the country's largest dialysis provider, says the implantable concept holds appeal. "It's a bioreactor kidney, an incredibly innovative concept, and really exciting if it proves to be workable on a larger scale," he says.



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Multidisciplinary care improves outcome of patients with Stage 5 Chronic Kidney Disease

Dasgupta, I, Fenton, A, Sayer, Z, Dodds, A Heartlands Hospital, Birmingham

<https://registrations-online.com/Renal2008/docs/.../P83%20Dasgupta.doc>

Abstract:

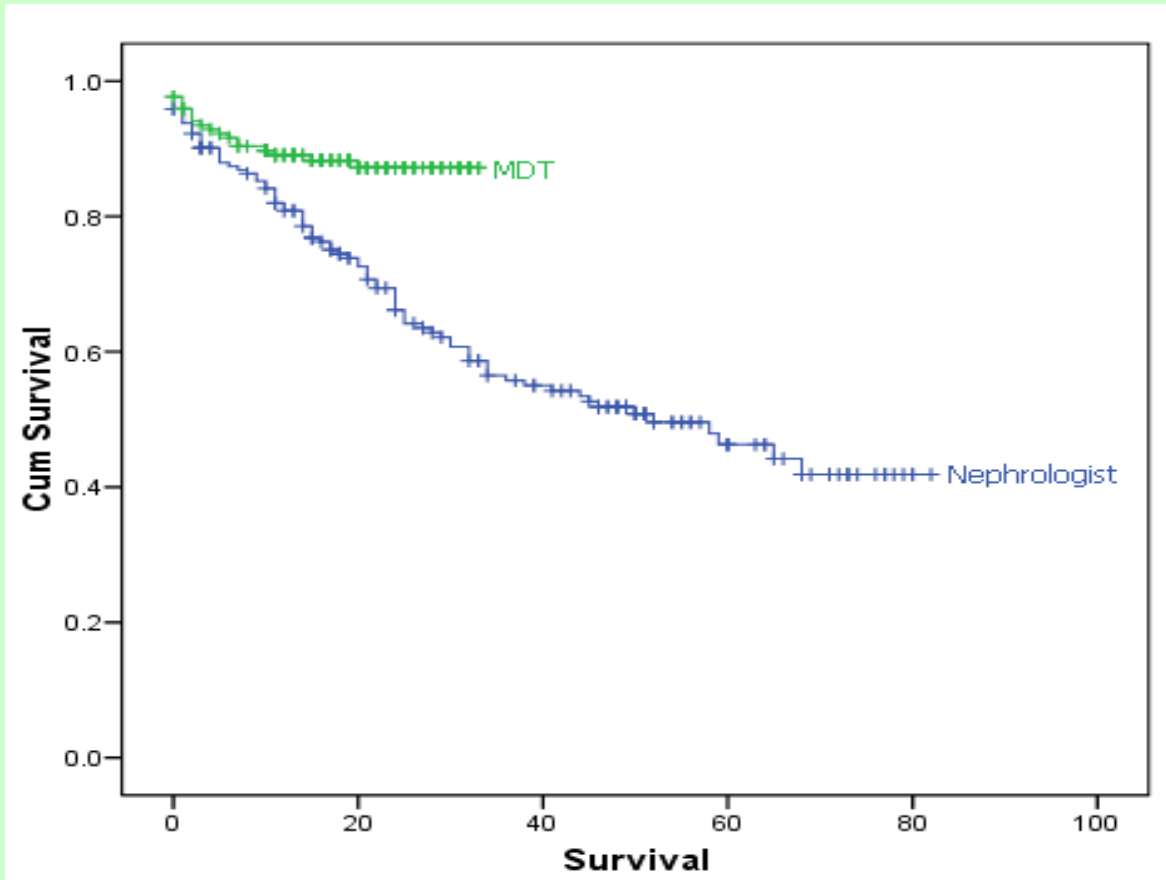
Multidisciplinary care (MDC) is known to improve chronic disease management. In nephrological setting, MDC has been shown to improve short and long term outcomes of patients starting dialysis. In our centre, a nurse-led predialysis clinic was set up in 2003. The team comprises of 3 predialysis nurses, 2 anaemia specialist nurses, a vascular access specialist nurse, a dietitian, a social worker, an occupational therapist and 2 nephrologists. Previous to 2003, pre-dialysis patients were cared for in the general nephrology clinic with the help of a predialysis nurse. In this retrospective case control study we have compared the outcomes at the point of starting dialysis and beyond between a cohort of MDC patients (n = 171) and a cohort of nephrology patients (n = 194). The groups were closely matched in terms of age, sex, primary renal disease, diabetes status and the chosen mode of dialysis. The table below shows the main outcome data.

Outcome	Nephrogy patients (n=194)	MDC patients (n=171)	P value
Hospital admissions (per patient per year)	2.52	1.42	0.005
Starting dialysis with permanent access (%)	57.7	67.3	0.04
BP at 1 st dialysis	154±29/ 77±15	150±24/ 77±14	ns
eGFR at start of dialysis	9.51±4.41	9.39±4.09	ns
Hb levels	9.81±1.76	10.28±1.86	0.02
Serum Calcium	2.27±0.23	2.27±0.26	ns
Serum phosphate	1.93±0.52	1.94±0.54	ns
Albumin	35.76±5.10	36.68±6.38	ns

The Kaplan-Meier survival curve below shows significantly better patient survival in the MDC group
(log rank p < 0.0001)

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This retrospective cohort study shows that patients attending a multidisciplinary predialysis clinic are better prepared for dialysis treatment, have fewer hospital admissions after start of dialysis and have a higher patient survival compared to those attending a traditional nephrology clinic.

Convicted murderer moving forward

By [Scott Rothschild](#)
September 26, 2010

Reprinted from LJWorld.com with permission.

The 30-year-old front page headline asks the question: “Murder or suicide?”



Today, the subject of that article, Kathleen Cobb, wants to focus on the present and the future, not the past. But Cobb, 53, says she knows the past will always be with her even though she says, “I’m not the same person.”

Cobb, who grew up in Lawrence, served 16 years in prison after being convicted of first-degree murder in the shooting death of Henry Davis, a Lawrence resident.

It was a sensational case in 1980 — one that focused on drugs and friendship and drew national attention over the question of assisted suicide.

Cobb maintained that she was helping in Davis’ wish to kill himself. A jury, however, said it was murder.

Changing in prison

Fast-forward to the present, and Cobb has recently returned to her hometown and is working as a case manager with the Lawrence-Douglas County Housing Authority, where she helps people get to their doctor’s appointments, receive financial assistance and, in general, manage their lives.

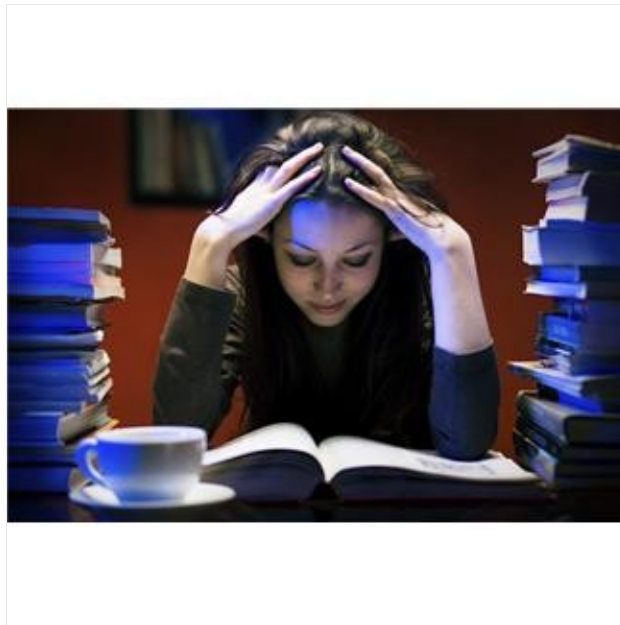
While in prison, she said, she took advantage of every opportunity she could to get more education, counseling and work.

“I knew I needed to change,” she said.

She earned an associate’s degree behind bars, and after being paroled in 1996, she moved to Colorado and enrolled in Metropolitan State College of Denver.

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Van Voorhis nominated Cobb for an outstanding student award, which Cobb won. “She overcame a lot of obstacles,” Van Voorhis said.

After getting her bachelor’s degree in social work, Cobb got a master’s in the same subject at Colorado State University.

She then moved to Wyoming where she worked at a small community mental health center as a licensed social worker.

Cobb returned to Lawrence this year, saying she wanted to be near her aging parents; her father, Robert Cobb, is a former executive vice chancellor at Kansas University.

Clashing opinions on licensure

This summer, the state Behavioral Sciences Regulatory Board heard her request for a masters social worker license in Kansas.

State law says the board can refuse to issue a license if the person has been convicted of a felony and the board feels the person “has not been sufficiently rehabilitated to merit the public trust.”

The board was divided. In that meeting, Cobb told board members she has thought extensively about what happened 30 years ago.

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“I’m not blaming drugs and alcohol, but that was part of it,” she said. “I know now that that was the most severe and biggest mistake I could ever make, and from that time until now I have tried to atone for that,” she said.

The social worker committee of the board recommended against granting the license.

Board member Ron McNish, a psychologist, agreed with that recommendation. “This was first-degree murder,” he said. McNish said he wouldn’t expect the state to license a doctor or nurse who had been convicted of murder, and because social work can be a “life-saving” occupation, the same rules should apply to social workers.

But Richard Maxfield, another psychologist on the board, said,

“It seems to me that Miss Cobb made a terrible mistake many years ago, for which she has paid a very big price, and she has tried to rehabilitate herself, and from what I can tell has done so, successfully. She’s an asset to society at this point.”

The board voted 5-3 to grant her a masters social worker license, once she passes the required exam, but attached a number of conditions that filled nearly four pages. She must be supervised in her work, she must be evaluated to see if she needs further mental health services, she must submit to random drug tests, and she cannot work with clients who are severely depressed or suicidal.

Cobb says she has no problem with the conditions.

“I’ll do what I have to do, to do what I want to do,” she said.

A troubled youth

When Cobb was younger, she was heading for trouble. In 1977, she was convicted of various theft and burglary charges and was incarcerated for nearly a year. Today, she describes her former self as a know-it-all, angry youth who should have listened to her parents.

In 1980, Davis and Cobb were close friends, both 22-year-olds and both heavy drug users, according to reports. Cobb said she thought of Davis like a brother.

But according to testimony at the time, Davis had a suicidal side. Davis told Cobb he wanted to kill himself because he had had a premonition that he would be in a car crash that would result in a long and painful death. His premonitions had a way of coming true, Cobb said. He was also in debt to some dangerous people, she said. His plan was to overdose on cocaine and if that didn’t work, the backup was to use a gun. He wrote a suicide note. He wanted Cobb to help him commit suicide.

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On the night of Feb. 27, 1980, Davis and Cobb pulled off the side of a country road southwest of Topeka.

Cobb administered two doses of cocaine to Davis, but Davis didn't die. He went into convulsions.

Cobb panicked. She said she hoped Davis would die without suffering further. She tried to suffocate him. He quieted down. Then she screamed, "God, please forgive me," and shot him in the back of the head. A coroner later testified that Davis was probably still alive when he was shot.

After Davis' death, Cobb gave herself up to police and confessed what happened.

At her trial, Cobb said she helped Davis overdose and shot him "because he had asked me to do it and I was only trying to do what he wanted." But the jury found her guilty of murder and she was sentenced to life in prison with the first possibility of parole after 15 years.

Cobb appealed her conviction, saying the jury should have been allowed to find her guilty of assisting a suicide, which carried a maximum five-year sentence.

But the Kansas Supreme Court rejected her appeal, saying "Davis did not destroy himself. It is possible Davis may have assisted Cobb in destroying himself, but the actual destruction was performed by Kathleen Cobb."

Today, Cobb sounds like many people who return to Lawrence to live after a long absence. She complains about the humidity and traffic congestion.

But unlike others, she said she knows she will be attached to one event that happened a long time ago. He turned to social work, she said, because she has had a lot of help in her life and wanted to give back and help others. She said her past drug problems have helped her relate and counsel people who are struggling with addictions. "I believe that everyone can change.

They just need a little help," she said.

Adherence Program for Kidney Recipients and Caregivers



Transplant
Adherence
Program[®]

Le Programme
d'adhésion
en transplantation^{MD}

A kidney transplant is a life-changing experience that allows the recipient to enjoy newfound health and a new lease on life.

Despite this, some kidney recipients find the adjustment to post-transplant life a difficult one. The adjustment requires “adherence”, which means taking prescribed medications at the same time every day for life, keeping clinic appointments for regular blood work and recognizing the early signs of rejection. Incorporating adherence into one’s daily routine can be challenging, but it is crucial to long-term post-transplant health.

Launched in 2009, the **Transplant Adherence Program** is a free, national and bilingual adherence program designed to help post-transplant kidney patients start off on the right foot, with tools and information to help them develop or maintain good habits when it comes to their post-transplant treatment and overall care.

This Program was developed for adult kidney recipients and can be used regardless of when the transplant took place or the medication regimen. Developed in consultation with nephrologists and renal transplant recipients, the Program includes newsletters, an information booklet for recipients and caregivers, self-evaluation tools, a website and reminder tools such as an alarm pill box, and a collapsible cup and pill box.

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Information available to Program members emphasizes the importance of following medical advice, keeping clinic appointments, and using reminders to help with medication adherence. For more information or to become a member of the Transplant Adherence Program visit www.transplantadherence.ca or call 1-877-691-7455.

The Transplant Adherence Program is one of several community based initiatives supported by grants from Astellas Pharma Canada, Inc., an industry leader in immunology. With a focus on life *after* transplantation, this is Astellas' second program to support the Canadian transplant community. Its sister program, Transplant Companions, launched in 2002, is aimed at pre-transplant kidney patients and is based on an interactive, small-group learning model. The Program is now offered at 14 Canadian transplant and care centres, seven of which have made attendance compulsory for their pre-transplant patients. For more information, visit www.transplantcompanions.ca.

Renal Social Worker looking to give voice to the experience of mothers caring for a child who has had a kidney transplant

Research has often neglected the voices of mothers and caregivers when a child has undergone a kidney transplant. We don't know about what it is like for mothers to provide care on a day to day basis. We understand the medical process of the days, weeks, months following transplant for a child but understand little from a mother's point of view. We do not know if mothers have to make any changes in how they went about your daily life throughout the experience of transplant for their child.

Andrew Mantulak, Pediatric Nephrology social worker at The Children's Hospital, London, Ontario, is undertaking a research study examining the experience of mothers whose children have undergone kidney transplantation. Andrew is hoping to better understand from the mother's themselves what this experience was like for them.

Andrew's research is supported by an Allied Health Doctoral Fellowship through the National Office of the Kidney Foundation as well he is a past recipient of an Allied Health Scholarship on two occasions throughout the course of his academic advancement. Mantulak is quick to credit the Foundation for supporting this project and research for all renal professionals, "without the support of the Kidney Foundation I would not be afforded the opportunity to pursue my PhD and to contribute to the knowledge base in pediatric Nephrology."

If you are a mother of a child whose has had a kidney transplant and would be interested in participating in this study please contact email kidneymoms@gmail.com or (519) 433-3491 ext. 5445.



Andrew Mantulak

Hospital Readmission Studies: Influencing factors studied

Blog entry by BJS Oct. 12, 2010 from Science Blog

(see disclaimer at the end of the article)



In two studies published today in the *Journal of Hospital Medicine*, the risk factors for readmission to the hospital are examined based upon general medicine inpatients and those with at least two admissions in a six-month period. Alongside clinical factors such as having cancer, chronic diseases such as heart failure or lung disease, or being on high-risk medications, the studies identified other factors which increase the likelihood of a patient being readmitted which could help hospitalists focus in on these groups.

In the first study, Nazima Allaudeen, MD, and colleagues at the University of California San Francisco (UCSF), looked at the factors behind unplanned hospital readmission within 30 days — which occurs in nearly one in five Medicare patients in the US. The study involved patients admitted to UCSF hospitals between June 2006 and May 2008; 6,805 unique patients for a total of 10,359 admissions. 17% of admissions were readmitted within thirty days, with almost half of these (49.7%) occurring within 10 days.

Of the sociodemographic factors, African-American race and Medicaid as payer status were associated with readmission, with a 43% and 15% increased risk of readmission respectively after adjustment for other variables. Of the clinical factors, high-risk medications and six comorbidities (congestive heart failure, renal disease, cancer (with and without metastasis), weight loss, and iron deficiency anemia) were associated with readmission.

The study also examined operational factors, such as weekend discharge or admission source, but none were significantly associated with readmission.

“The US spends over \$15 billion in Medicare on readmissions to hospital within 30 days and readmissions are also distressing to patients and their caregivers,” said Allaudeen, now based at the VA Palo Alto Health Care System, California. “Many healthcare systems are now making efforts to improve the transition from hospital to home or nursing facility to try to reduce preventable readmissions but they need to know which patients to focus on to have the biggest impact. Studies like ours should give practitioners direction to non-clinical factors to identify.”

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Recognizing the limitations in the choice of data variables available in studies using administrative data, the second smaller study used detailed clinical assessments to examine a range of readmissions risk factors in a recognized high risk patient group, those with two or more recent admissions. Dr Alison Mudge FRACP and colleagues at the Royal Brisbane and Women's Hospital, Australia, undertook detailed assessment of 142 patients aged over 50 admitted between February 2006 and February 2007 who had two or more hospitalizations in the preceding six months, studying factors such as depression, nutritional status, and functional status as well as demographic and disease variables.

After six months, 55 participants (38.7%) had had a total of 102 unplanned admissions to the hospital. As the researchers expected, the strongest predictor of readmission was the presence of a chronic disease diagnosis, but alongside this, they found that BMI had a non-linear relationship with readmission, with a higher risk in those underweight and obese; 72% and 50% of each category respectively were readmitted compared to 27% of those with normal weight and 37% of those classed as overweight. Depressive symptoms were also associated with a higher risk of readmission (47% readmitted). Age, sex, number of previous admissions, and discharge support were not significantly influential.

“Patients with multiple recent readmissions may have a unique risk factor profile, and may be a group which may particularly benefit from complex interventions, but no previous study has specifically examined risk factors in this high risk group,” said Mudge. “We sought to look specifically at health factors which we know are under-recognized in hospitals and primary care, and this showed that poor nutrition and depression are associated with higher health care use in this vulnerable subgroup.

“We hope this study might increase awareness of poor nutrition and depression as importance concurrent factors in medical illness, and encourage research into improving nutritional and depression management in medically ill patients.”

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Cumulative Impact of Shortening Hemodialysis Time

Patients who shorten their time by 30 minutes per treatment, will lose total time equal to 8 treatment weeks - 24 four hour treatments

Your patient may not realize the cumulative time they lose by cutting short their hemodialysis:

REDUCING TREATMENT BY (4 Hours, 3 Days/Week)	MEANS LOST TIME BY WEEK	AND LOST TIME BY MONTH	AND LOST TIME BY YEAR	IT ALL ADDS UP TO WEEKS OF DIALYSIS LOST PER YEAR
5 Minutes	15 Minutes	65 Minutes	780 Minutes	1 Week
10 Minutes	30 Minutes	130 Minutes	1560 Minutes	2 Weeks
15 Minutes	45 Minutes	195 Minutes	2,340 Minutes	3 Weeks
20 Minutes	60 Minutes	260 Minutes	3,120 Minutes	4 Weeks
25 Minutes	75 Minutes	325 Minutes	3,900 Minutes	7 Weeks
30 Minutes	90 Minutes	390 Minutes	4,680 Minutes	8 Weeks

Reprinted with permission from The Renal Network, Inc. www.therenalnetwork.org (see Adherence Tools)



Dianne Kurina
President



Message from the President

I am just back from our 32nd Annual CANSW Conference in Banff! It was such a pleasure to meet so many colleagues in such a beautiful location. Very special thanks again to our conference planning committee chairperson (Shirley Pulkkinen) and committee members (Neil Thompson, Gordon Smith, and Lee Woytkiw) for all of their hard work and dedication in bringing this event to life.

Our 33rd CANSW National Conference will be held in Halifax, Nova Scotia in the Fall of 2011. This promises to be another amazing destination!

We are sincerely hoping that you will consider bringing the 2012 CANSW National Conference to your area. We would love to hear from you if you might be interested in helping to plan one of these events in your special region of Canada. Please remember that these events can not take place without the support of our membership. Promise to give it some thought as it is a tremendous opportunity to work together with your CANSW colleagues!

Speaking of tremendous opportunities, I had the experience of a lifetime participating in the 2010 Kidney March this past September 10th – 12th, 2010 in the beautiful Kanaskis region of Southern Alberta! For those of you who attended the Banff National Conference, the Kidney March took place on some of the very roads you traveled on your way into Banff National Park. You can imagine how beautiful it was to walk there!

This event raised over \$900 000.00 towards kidney disease research and organ donation awareness across Canada! Please visit www.kidneymarch.ca to scroll through some inspirational photos from the 2010 Kidney March.

Given its tremendous success, the 2nd Kidney March is already in the works for 2011! If you are looking for a very special way to make a difference while challenging yourself at the same time, you want to participate in this event! Stay posted for more information.

You will also want to watch the CANSW listserver in the weeks and months ahead for opportunities to participate in CANSW webinar opportunities (we will be looking for both presenters and participants) as well as to work together with our very important partner, The Kidney Foundation of Canada, on collaborative committees to continue improving the lives of individuals living with kidney disease and their families.

We have an exciting year ahead!

Best wishes for a very happy holiday season,

Dianne Kurina President

**2010 Mary Lou Karley Mentorship Award
Winner — Cathy Gillis — Halifax**

Congratulations to Cathy Gillis, the 2010 winner of the Mary Lou Karley Mentorship Award. Over the past 26 years, she has gained invaluable expertise and experience in all areas of the nephrology program at the QEII.

Cathy has demonstrated tremendous leadership throughout her career and has been a mentor to her colleagues and students over the years, as well as to all the nephrology social workers at the QEII and to many others practicing throughout Nova Scotia.

She is member of the Canadian and Nova Scotia Associations of Social Workers and is a dedicated member of long-standing in the Canadian Association of Nephrology Social Workers.

Cathy Gillis is a passionate advocate for kidney patients and their families. This passion informs both her practice and her service to the Nephrology program, CANSW and the Kidney Foundation.

She continues to be an active member of the Kidney Foundation and has served extensively at both the national and branch levels.

Cathy is past president of both CANSW (1997-2000) and the Nova Scotia branch of the Kidney Foundation.

**2010 Winner of the Mary Lou Karley
2011 Mentorship Award
Cathy Gillis with CANSW President
Dianna Kurina (right)**



***This award was initiated in 2009
in the memory of the late
Mary Lou Karley.***

***It recognizes CANSW members
who have made outstanding
contributions in the field of Cana-
dian Nephrology through
Mentorship.***

Effect of Pathological Use of the Internet on Adolescent Mental Health

Abstract:

A Prospective Study Lawrence T. Lam, PhD; Zi-Wen Peng, MSc

Arch Pediatr Adolesc Med. 2010;164(10):901-906. doi:10.1001/archpediatrics.2010.159

Objective To examine the effect of pathological use of the Internet on the mental health, including anxiety and depression, of adolescents in China. It is hypothesized that pathological use of the Internet is detrimental to adolescents' mental health.

Design A prospective study with a randomly generated cohort from the population.

Setting High schools in Guangzhou, China.

Participants Adolescents aged between 13 and 18 years.

Main Exposure Pathological use of the Internet was assessed using the Pathological Use of the Internet Test.

Outcome Measures Depression and anxiety were assessed by the Zung Depression and Anxiety Scales.

Results After adjusting for potential confounding factors, the relative risk of depression for those who used the Internet pathologically was about 2 ^{4/2} times (incidence rate ratio, 2.5; 95% confidence interval, 1.3-4.3) that of those who did not exhibit the targeted pathological internet use behaviors. No significant relationship between pathological use of the Internet and anxiety at follow-up was observed.

Conclusions Results suggested that young people who are initially free of mental health problems but use the Internet pathologically could develop depression as a consequence. These results have direct implications for the prevention of mental illness in young people, particularly in developing countries.

Author Affiliations: School of Medicine, Sydney, and the University of Notre Dame, Fremantle, Australia (Dr Lam); and Department of Psychological Education of Elementary School and Secondary School, Ministry of Education, and the School of Public Health, SunYat-Sen University, Guangzhou, Guangdong Province, China (Mr Peng).

Different Dialysis Modalities Can Provide Different Outcomes And Quality of Life

By Rebecca Zumoff

A nocturnal in-center hemodialysis pilot program: logistic issues and improved clinical outcomes



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www.nephronline.com/blogs

Sheila Doss, Brigitte Schiller, Donna Lemus Satellite Healthcare, Mountain View, CA

Modality: Nocturnal in-center hemodialysis

This small study sought to evaluate the patient outcomes and clinic operational issues of offering a pilot program of extended nocturnal hours at a hemodialysis clinic.

Methods: Thrice weekly 8 hour overnight hemodialysis was offered to clinic patients who were already on conventional hemodialysis Twenty-one patients enrolled in the study.

Results: Clinical outcome measures improved during twelve months of nocturnal hemodialysis, with 97% albumin greater than 3.5 g/dL compared to 86% in the previous 12 months.

62% of phosphate values less than 5.5 mg/dL were reached on nocturnal compared to 46% prior on conventional HD.

Mean std Kt/V during the 12 months prior to starting nocturnal was 2.5 and increased to 2.8 on nocturnal HD.

While maintaining Hgb levels ESA use decreased over time and reached 62% lower Epopen dose per treatment by month 12.

Patients on in-center nocturnal hemodialysis reported significant improvement in quality of life. The major operational issue was recruiting and retaining the RN staff for nocturnal schedule.

Conclusion: The study authors said challenges in implementation of nocturnal programs as part of routine ESRD care are outweighed by improved outcomes including decreased drug utilization.

10 Things Learnt in 10 Years as a Social Worker

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Victoria Hart, the author.

I qualified as a social worker in 2000. I don't remember the exact date I started my first 'qualified' post. It was sometime in the early summer I think - in those days before registration was required and all I needed to prove I was qualified was a letter from the university stating I had passed the course - of course, the certificate would take a few more months to arrive.

We were eagerly snapped up by employers with open arms. As an HR guy told me a few years later

'Those were the days when all you had to do was stand on a street corner with your social work qualification and someone would come and employ you'

And I could see his point. Employers - agencies and local authorities came to our university in our last month in a battle to employ us. We never realized we had it so good.

I had gained in confidence exponentially throughout the course but when I look back on my first days, weeks, months and years in practice, I realize how the initial Masters was just a starting point rather than an end in itself as far as my learning has been.

I wanted to reflect on some of the most important lessons I've learnt since qualification.

1. Theories matter.

It was always a little hard on placement to draw out some of the theoretical models I felt. They could seem so distant - or sometimes it felt as if we were superimposing the 'most convenient' theory onto the 'common sense' approach.

That is over-simplifying but putting theory into practice was always something I struggled with initially because the pace of work seemed to see me exist from day to day patching up and making do. When I was on placement I had a gentle introduction of an uncomplicated caseload of six people. I was able to spend time with all of them and gain an understanding. In practice, I had a standard caseload between 30-40. I came down to earth with a 'bump'

But, as I have developed ways of time management and workload management, I increasingly returned back to the theoretical bases that I learnt about at university. I have read about more as they have developed over the years.

I retained a subscription to the 'British Journal of Social Work' and learnt that we have to have a grounding of why we do the work we do - the history of social policy and the ways to develop relationships, work within systems and organizations even though it can feel like banging our head against a collective wall at times.

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Back in the day, we joked as students about our preferred 'eclectic' approaches.

Eclectic does have value though. You just have to know which bits to pick – and we do develop favoured theoretical approaches. I've been just about consistent in that. I sometimes feel that there needs to be some more research in practice about developing more complex theoretical bases as the nature of the work that we do changes but that's something for me to ponder in retirement, I suspect.

2. Confidence matters.

This is the biggest change I've seen in my own practice. Some days I feel like a bit of a fraud and wonder if I know what I'm doing. I don't think that will ever go away – but more and more I am able to trust the judgments I make as I refer to experience and different situations I have been in. I remember when I was first asked to do the ASW (Approved Social Worker – now changed to Approved Mental Health Professional) training. I hadn't particularly wanted to but the service needs required more ASWs. I was reluctant due to the authoritative, control aspect of the role and I'm really a rather woolly liberal at heart.

I wanted to study though. I really wanted to know more about mental health work in general and the Mental Health Act in particular. I like learning and having the opportunity to learn, understand and study at a higher level was too appealing. I tried not to think about the actual assessments too much as I didn't really like the idea of making decisions about detaining people compulsorily.

Then, during the course, I realized. My power was

as much about preventing inappropriate detentions as making applications when they are necessary. I can stop a detention when I have two medical recommendations in my hand but I can't apply when I don't. The quality of the increased knowledge base built my confidence. Often it comes with knowledge both formally taught/read/discussed and informal experiential 'knowledge'.

I have more confidence in my own judgment now. That makes practice more straightforward. I also know my own fallibility and go back to study and learn more independently.

3. Power matters.

Again, reaching into my fluffy liberal side, I talk about 'strengths models' and working in a 'person-centred' way but there's no escaping the power role I have as an agent of the state. We like to talk about 'working together' but my statutory role and my role as 'expert' in the way the organization (being the local authority) works put me in a powerful position vis-à-vis service users and sometimes other professionals.

I tended to shirk the idea of power. It doesn't naturally sit comfortably with me. But I have become more aware of it and I think that makes me a better practitioner.

As much as we try to pretend there is an equality, we can potentially do a disservice to those for whom we work. Power doesn't have to be bad, but we have to be aware of it. ...continued next page

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4. *Advocacy matters.*

This is an extension of the ‘power’ issue. We are placed within an organization that has many pulls on its time and money.

Sometimes it is not easy to give a voice to those for whom we work – especially if we ‘go native’ within the large organization or have difficulties personally with particular managers but it is important that our voices are not lost, even if it feels sometimes that we are shouting into the wind.

We need to best represent those for whom we are guided to work with and sometimes that means challenging systems we work with, especially if they are discriminatory – institutional oppression is alive and well and is best combated ‘from the inside’.

We also need to advocate for ourselves, our profession and people who may need to use our services. Against inadequate management procedures, against chipping away of professional roles.

It’s one of the reasons that union membership is important.

5. *Honesty matters.*

Honesty to an extent at any rate. When I was in my first placement I learnt a lesson from my practice teacher who told me never to promise what I couldn’t guarantee that I would be able to deliver. If anything, under-promise. I have extended that a little to being as honest as I can with service users and with other professionals and colleagues.

I don’t assume I know what the organizational response will be to a proposed care package until it has been agreed by those with funding responsibility. I can take a good guess, knowing my managers and the eligibility criteria pretty well but sometimes they can change or someone can challenge.

When I go to do a community care assessment or, as happens now, validate a Self-Assessment Questionnaire, I don’t promise anything at all initially. I will probably discuss options but until I have a guaranteed budget in my hand or a guaranteed service promised, I will try to talk very vaguely about potential options, making it clear that the decisions often lie outside my power to grant. Which is true. I hold no budget myself. I can only make recommendations and advocate strongly. Which I do. Which I try to do.

Trust requires honesty.

Phoning when you say you will.

Turning up when you say you will.

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6. Punctuality matters.

It is one of the very basic courtesies we are often judged on. When I first qualified I was appalled by how lackadaisical some of my new colleagues were about time-keeping and keeping to appointments. I think it often sets up a relationship. Of course, I am far from perfect. I am also on a couple of duty rotas including AMHP (Approved Mental Health Professional) and BIA (Best Interests Advisor) work as well as holding a full caseload.

More often than not when I cancel or postpone, it is because I have to carry out a Mental Health Act Assessment or deal with some kind of crisis in my own caseload. I am not able to clear my diary for the week that I am on the AMHP rota just because I am on the rota very frequently.

I still hate cancelling. I hate being late but I do always phone when I am running more than about 5 minutes late.

I'm far from perfect. The nature of the role is that sometimes I have to be in two or three places at once but I do try to pay attention to the timings because I feel it denoted an element of respect and can be important in minimizing some of the power differential.

Lateness sends signals that can be hard to explain away.

7. Limits matter.

This was a big one for me. You come into the job all fresh and excited about the difference you are going to make in peoples' lives.

You are going to change the world. Make a difference. Help people to understand and come to terms with challenges.

Sometimes though, you can't help.

You try and you go through the processes necessary but there is just nothing there that you can do. It might be about so-called 'unwise decisions' made by capacious adults – it might be that the criteria and/or budgets don't allow for it.

Sometimes the decisions you have to make are grounded in organizational policy rather than your own professional judgment. Sometimes I wish I had a budget I could spend.

An ex-manager once told me (when I was having a particularly stressful time of it) to think logically about separating 'the things you can change' from 'the things you cannot change' and not to worry about the second category as long as you do your absolute best with the first category – sometimes there is nothing you can do. That's a big challenge.

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It didn't stop me having difficulty sleeping a couple of months ago when I was concerned about one particular individual and their 'unwise decision' but it helps me to rationalize my own role in the troubling situations and circumstances that I do see.

8. *Discrimination matters.*

I work with a wide range of people of different backgrounds and social classes. I enjoy that aspect of my work. As I hear and understand the backgrounds and life histories, I can see the effects of different attitudes and the way that people are regarded and the ways that has shaped lives.

The impact of poverty is one of the underlying issues that hits me from time to time and the utter inequity of the way we live in this country. I have advantages of birth that were not enjoyed by a lot of the people I work with. I can try and discount that but it doesn't go away.

People do not 'deserve' poverty. Society creates enormous inequalities. It is hard to distance yourself sometimes but it's about boundaries.

I wonder if I have become a bit hardened to some of the situations I see but I try to use fresh eyes with each file that (virtually at least) lands on my

desk. Sometimes though, what we see and the way we see people and the lives that they have created through enormous difficulties gives me a sense of pride in this country and this city that I don't think I would ever have if I had joined a different kind of profession.

I see the effects of poverty pretty much on a day by day basis. It makes me so grateful for what I have. It isn't just poverty of course that divides but race, class, disability, gender and any number of less obvious forms of discrimination.

The learning on paper is very different from the learning in practice but no less important. We cannot remove the glasses through which we see society but we can be aware of the particular tint and hue that they have and through which we see our realities.

My experiences of practice have changed some of the hues and tints but they have not removed them.

9. *Humility matters.*

I have previously stated that one of my power bases is that I am an 'expert' in the ways some of the local authority criteria and organization functions.

I can never be an 'expert' in someone else's life though. I absolutely need to remember that accordingly.

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Sometimes I tell people what to do. That is a part of my statutory role. I don't particularly enjoy it but I can't pretend it doesn't happen and that all the work I do is consensual. It isn't.

But it is important to listen and not just to a person but to the important people in their networks – family, friends, neighbours and remember that I will be flitting in and out of this persons' life but others will remain.

10. Reflection matters.

One of the old staples from my course has almost come back to haunt me but I think it is an absolute vital part of my practice and my professional development.

I feel that if I stopped the reflection, I would stop learning about myself and the ways that I work and there would be nothing more dangerous to me as a practitioner. I need to learn continually about why I work in the way I do.

What made me choose or avoid a particular piece of work?

What are the things I most enjoy and dislike about the work I do?

How have my experiences informed my practice and what makes me feel that I am better able to practice now than I was 10 years ago?

Am I better now?

Have I lost any of the exuberance and freshness?

When is the best time to move on to another job?

It helps me to write things down which is how I came upon writing this blog for the first time in November 2007. Just writing this post has helped me learn, develop, quantify and appreciate the experience. That is reflection. And so to the next 10 years of practice. I expect social work will be a very different profession in 10 years time, if it still exists in its current form. I think that is the next battle to be had.

I don't intend giving up on it quite yet.

*About me: I'm a social worker in an over 65s community mental health team in England. Previously, I've worked in Over 65s Community Care Teams, Physical Disabilities Teams and Learning Disabilities settings. I am also an AMHP (Approved Mental Health Professional) and a BIA (Best Interests Assessor). I also worked, for many years, and prior to qualifying, in residential care as a support worker – the hands-on care work that has informed a massive amount of my future practice and which I see as an exceptionally important part of my professional development. In retrospect at least. I am also a foster carer but I don't really write about that at all except possibly may do in the context of interactions with professionals but it remains something more 'private' for reasons of confidentiality. Some things I write about are based on the work I practice but I change enough of the details to prevent identification.. this is intentional! If you are wondering about the title of the blog it comes from the following quotation: **'Be careful when you fight the monsters, lest you become one'** (Nietzsche). I think some of the distinctions that we work with are very arbitrary at times as can be the distinction between professional and patient. The monsters I am referring to in the title is mental disorder and illness itself.* Victoria Hart.