Clinical Resource Guide:
Depression Management in Hospice

INTRODUCTION TO DEPRESSION

Depression is a significant emotional challenge that can affect patients at the end of life, especially in hospice care. It is essential for the hospice team to recognize and address depression as a part of comprehensive patient care. Depression at the end of life may arise from a combination of factors, including the patient's medical condition, psychological distress, and existential concerns. Addressing depression is crucial not only for improving quality of life but also for supporting their families during the challenging time.

Pharmacist Corner Objectives

1.) Understand assessment of depression in the hospice setting
2.) Develop a treatment plan to address symptoms of depression, considering both nonpharmacologic and pharmacologic treatment options
3.) Recommend a monitoring plan and determine when to adjust therapy as indicated

CAUSES OF DEPRESSION

Depression in hospice patients can stem from various causes. These include the psychological impact of impending mortality, physical discomfort and pain, social isolation, unresolved emotional distress, and medication side effects. Additionally, the loss of independence, changes in body image and decreased sense of purpose can contribute to depressive symptoms. Understanding these causes can help the hospice team provide targeted interventions that address the specific contributors to the patient's depression.

COMMON CAUSES CONTRIBUTING TO DEPRESSION				
Psychiatric				
▪ Adjustment disorder	▪ Anxiety or panic disorder	▪ Chemical imbalance		
Medical				
▪ Infection	▪ Parkinson's	▪ CNS tumor	▪ Metabolic	▪ Opioids
▪ Anemia, B12 or folate deficiency	▪ Uncontrolled symptoms	▪ Hypothyroidism		
Physiological/Social/Spiritual				
▪ Grief	▪ Financial worry	▪ Existential distress	▪ Guilt	▪ Family Concerns

ASSESSMENT OF DEPRESSION

Accurate assessment of depression is the foundation of effective management. Hospice clinicians should use a validated assessment tool, such as the PHQ-2 or PHQ-9.

DEPRESSION ASSESSMENT TOOLS

PHQ-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

1-4: Minimal; 5-9: Mild; 10-14: Moderate; 15-19: Moderately Severe; 20-27:Severe

These tools can help evaluate the severity of the patient's depression and determine the significance of impact on quality of life. Additionally, considering the patient's medical history, psychosocial factors and family dynamics can offer a comprehensive understanding of the patient's condition. Regular assessments allow for ongoing monitoring of depressive symptoms and the impact of interventions trialed to support the patient.

COMMON SYMPTOMS OF DEPRESSION IN THE HOSPICE SETTING		
Feelings of worthlessness	**Excessive feelings of guilt**	**Hopelessness**
Fatigue	**Suicidal Ideation**	**Involuntarily waking early**

NONPHARMACOLOGIC MANAGEMENT OF DEPRESSION

Following the comprehensive assessment and considering the identification of reversible contributing causes, the following steps should be followed when developing a patient-specific treatment plan:

1. Address underlying common factors contributing to depression in the setting of a life-limiting illness
2. Consider appropriate nonpharmacologic treatment approaches based on identified patient needs
3. Consider patient-specific pharmacologic treatment for persisting symptoms

Nonpharmacologic interventions play a vial role in managing depression in hospice care. The goal of these interventions is to provide emotional support, facilitate expression of feelings and emotions, and help patients find meaning and acceptance. The table below can help guide hospice clinicians in tailoring approaches to the patient's needs, fostering a holistic approach to care.

NONPHARMACOLOGIC TREATMENT STRATEGIES FOR DEPRESSION IN THE HOSPICE SETTING	
Intervention	**Brief Description**
Supportive Psychotherapy	Focused on empathetic, compassionate, nonjudgmental listening
Cognitive Behavioral Therapy	Based on modifying dysfunctional thoughts, feelings and behaviors
Interpersonal Therapy	Therapy focused on the improvement of relationships
Dignity Therapy	Life reflection interview and creation of subsequent legacy document
Meaning-Centered Therapy	Enhancement of sense of purpose in life through meaning, vales, humor
Music Therapy	Recorded or performed music provided at patient bedside
Relaxation Training	Successive muscle relaxation or guided imagery with patient and family
Aromatherapy	Therapeutic use of plant-derived aromatic essential oils for comfort
Art Therapy	Encouragement of self-expression and creativity through painting, drawing

PHARMACOLOGIC MANAGEMENT OF DEPRESSION

In cases when reversible causes are not identified or able to be addressed and nonpharmacologic interventions do not result in symptom improvement, pharmacologic interventions may be considered. However, careful consideration should be given to medication choices, as the most commonly used medications prescribed for management of depression often take at least several weeks to take effect.

PHARMACOLOGIC TREATMENT STRATEGIES FOR DEPRESSION IN THE HOSPICE SETTING		
Medication	**Dosing**	**Notes**
Methylphenidate	5mg daily Or 5mg twice daily (AM and early afternoon)	Stimulant often used for improving energy and mood **Time to effect**: 1-3 days Can result in sleep disturbance if taken too late in the day Can result in decreased appetite
Mirtazapine	15mg daily	Can be helpful when addressing depression, insomnia & decreased appetite **Time to effect**: 1-4 weeks Improvement in sleep results from lower doses (7.5-15mg)
Sertraline	25-50mg daily	From the class of SSRIs, most commonly used medications for depression **Time to effect**: 6-8 weeks Time to effect is a significant barrier to use in the palliative care setting SSRIs use can result in insomnia, decrease libido, increased suicidal ideation
Diazepam	2mg – 10mg PO/SL/IV/PR Two to Four times/day	Peak serum level achieved in 15-45 minutes, active metabolite ½ life: 50hrs+ Elevated risk for accumulation and oversedation with multiple doses
Haloperidol	0.5mg – 5mg PO/SL/PR/SC/IV Every 2 to 12 hours	Peak serum level achieved in approximately 2-6 hours; duration **4-12 hours** May be considered in patients with behavioral issues from depression In addition to depression, may have additional benefit for anxiety, nausea and insomnia

SUMMARY

Managing depression at the end of life within the hospice setting requires a multifaceted approach. Hospice clinicians should be attentive to the causes of depression, utilize validated assessment tools, and tailor interventions to address both psychological and physical symptoms of depression. Nonpharmacologic interventions offer pathways for emotional expression and support, while pharmacologic options can be considered for severe cases. Regular monitoring and adjustments help evaluate tolerability and effectiveness of trialed interventions. Addressing depression effectively can significantly improve overall well-being, quality of life and comfort of hospice patients and their families.

