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Prevalence and Management of Depression, Anxiety, and Spiritual Distress in Palliative Care Patients in Primary Care Settings: Systematic Review

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ABSTRACT:

Background: Emotional and existential suffering in serious illness is frequently managed outside hospital settings, yet evidence on its frequency and management in primary care is fragmented and highly dependent on clinical setting and measurement.

Objective: To synthesise evidence on depression, anxiety and spiritual distress among adults receiving palliative care through general practice, community and home-based services, and to describe how these problems are recognised and managed.

Methods: A structured review of original observational, qualitative and intervention reports published through 9 November 2026 was undertaken using bibliographic and publisher records. Reports were classified by the closeness of the service to general practice and by outcome; findings were synthesised narratively without meta-analysis because populations, instruments, denominators and delivery models varied. Twelve traceable empirical reports describing 11 distinct participant populations were analysed.

Results: In a general-practice sample of 30 patients, depression and spiritual distress were each identified in 7/30 (23.3%). A Canadian home-care cohort (n = 5,144) reported depressive symptoms in 9.8%, while a rural Malawian service cohort (n = 151) reported positive depression and anxiety screens in 72% and 70%, respectively. Home-hospice proxy reports were higher near death. In home-based palliative care (n = 658), 319 patients or proxies reported at least some spiritual distress, including 181 with moderate-to-severe distress. Psychological, narrative spiritual and remote-monitoring interventions showed feasibility and within-group improvements, but causal evidence specifically from general practice was sparse.

Conclusion: Depression, anxiety and spiritual distress merit routine, differentiated assessment within community palliative care. Reported prevalence is not directly

transferable across service models and tools. Coordinated psychological and spiritual responses are feasible, while stronger primary-care-based comparative evaluations are needed to establish effectiveness.

BACKGROUND

Palliative care aims to prevent and relieve suffering across physical, psychological, social and spiritual domains. The World Health Organization places early identification, assessment and treatment of distress at the centre of this approach; it also recognises that palliative care must extend beyond hospital teams to services accessible to patients and families in their own communities. This broad remit is especially relevant to primary care, where clinicians may know the patient over years rather than during a single admission. [1]

The burden of psychological symptoms depends greatly on who is assessed, how and when. In a study comparing palliative patients at home and in hospital, Austin and colleagues assessed 46 participants in each setting and found that approximately one in five patients screened positive for depression or anxiety on the Hospital Anxiety and Depression Scale (HADS). They found no clear setting-related difference after accounting for important characteristics. [2] A much larger Ontario home-care study by Fisher and colleagues (5,144 patients) reported depressive symptoms in 9.8% using a different instrument, the interRAI Depression Rating Scale. [3]

Symptoms are not equivalent to a psychiatric diagnosis. In a Portuguese primary-care practice, Velosa and colleagues recruited 30 palliative patients through general practitioners and used clinical interviews, HADS and the Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being instrument. Seven patients met criteria for depression and seven for spiritual distress; four fulfilled both sets of criteria. Their study illustrates the clinical overlap between low mood and loss of meaning, alongside the need to avoid diagnosing one solely from a score intended to measure the other. [4]

An important clinical distinction is the difference between a symptom score and a sustained mood disorder. People with advanced illness may describe loss of energy, insomnia, reduced appetite and impaired concentration for reasons that overlap with their underlying disease or its treatment. A depression scale that places heavy weight on these somatic experiences can therefore perform differently from an instrument intended to minimise that overlap. The Hospital Anxiety and Depression Scale (HADS), for example, captures a particular symptom construct, whereas the interRAI Depression Rating Scale (DRS) is used within a multidomain care assessment. Neither scale alone determines whether a person has major depressive disorder, adjustment difficulties or distress linked principally to uncontrolled physical symptoms. Decisions about further assessment must also take into account cognition, language, the ability to communicate and the patient's own interpretation of suffering. These distinctions explain why prevalence estimates obtained with different instruments should not be averaged as though they measure the same diagnostic event. [2,3]

The setting of care also influences the likelihood that distress is recorded. A general practitioner may recognise a long trajectory of functional decline, family conflict or social isolation, but the consultation is often constrained by time and competing physical problems. In contrast, a home hospice team may assess symptoms repeatedly near death, when fatigue, delirium, dependency and caregiver strain have become more prominent. Patients attending a community-linked specialist service may represent a more selected group than those managed principally by family physicians. Consequently, the location of care is more than a descriptive label: it affects referral pathways, the measurement window and the population for whom any estimated prevalence may be applicable. The contrast between the general-practice cohort of Velosa and colleagues and home-hospice proxy assessments illustrates these structural differences without establishing which service has a greater underlying psychiatric burden. [4,6]

Recognition and referral also depend on the organisation of care. A Dutch mixed-methods study of 31 spiritual caregivers by Koper and colleagues identified existential, relational and religious needs, together with practical barriers to collaboration with general practitioners and district nurses. [5] Conversely, a study of home-hospice patients based on 351 bereaved-caregiver interviews described substantially greater symptoms at the end of life than were reported in some earlier-stage palliative cohorts, underlining the influence of proximity to death and proxy reporting. [6]

Management can be delivered outside a hospital, but evaluation must distinguish treatment outcomes from the willingness or ability to complete treatment. A home-palliative-care pilot trial of meaning-centred psychotherapy recruited 51 patients with advanced cancer and analysed 32 who completed all three sessions. Improvements in distress were reported, although completion and the small size limit generalisation. [7] In a different model, Cipta and colleagues studied 658 patients at entry to home-based palliative care and identified spiritual distress by a brief numerical screening question. [8]

A general-practice interview study by Busser and colleagues showed that existential conversations were often managed intuitively, with uncertainty about vocabulary and referral pathways. [9] Meanwhile, an intervention study by Liefbroer and colleagues investigated 75 patients receiving six structured home chaplaincy sessions and found improvements in several domains of spiritual well-being; a companion qualitative study by Foppen and colleagues explored the experiences of the same 75 clients and 33 chaplains. These reports provide complementary perspectives, not independent populations. [10][11]

More recently, a Hong Kong community palliative-care programme used an electronic symptom-reporting application and nurse follow-up; depressive symptom scores improved during follow-up among completers, without a control group. [12] In rural Malawi, a 2026 study across nine health facilities found high positive screening rates for depression and anxiety in a mixed-diagnosis palliative-care population, reminding clinicians that context and resource access may alter detection and burden. [13] Taken together, these reports justify examining prevalence and management as linked but distinct questions, while separating general practice from broader community services rather than treating the terms as interchangeable.

Spiritual care presents a complementary challenge because the relevant concerns are frequently expressed without clinical labels. Patients may speak about unfinished responsibilities, uncertainty about what their illness means, loss of dignity or the wish to reconnect with someone rather than identifying a formal spiritual need. General practitioners who know the family over many years can recognise these themes, but professional familiarity does not guarantee a shared vocabulary or a reliable pathway for referral. The Dutch professional interviews described both the potential of ordinary conversation and the difficulties of defining specialist spiritual-care responsibilities. These findings suggest that a service model should make room for open questions and continuity of contact while also allowing escalation to a trained chaplain or other appropriately qualified professional when existential suffering is persistent or complex. Such an approach does not require an assumption that every patient is religious. [5,9]

OBJECTIVES

This review sought to determine how commonly depression, anxiety and spiritual distress are identified among adults with palliative-care needs in primary-care and community-linked settings, paying particular attention to the instrument, threshold, clinical stage and care pathway used. It also evaluated documented approaches to recognition, referral, psychological intervention, spiritual care, symptom monitoring and follow-up. Differences between directly general-practice-based evidence and broader home or community services were examined throughout.

LITERATURE REVIEW

In palliative practice, sadness can reflect an understandable response to loss, a syndrome meeting criteria for depression, or a feature of existential suffering. A screening tool is useful for opening a conversation, but its score does not establish all the clinical features of a depressive disorder. Velosa and colleagues deliberately combined clinical interviews with rating scales; this multimethod approach recognised overlap but prevented spiritual distress and depression from being assigned the same meaning. [4]

The contrast between Fisher and Austin illustrates measurement heterogeneity. Fisher used the clinician-administered interRAI Depression Rating Scale in a broad Canadian home-care population and identified a relatively modest proportion above the depressive-symptom threshold. In contrast, Austin used self-report HADS in a smaller palliative cohort with a hospital comparison group. A simple difference in prevalence cannot be attributed to country or quality of care because case mix, cognitive eligibility, timing and instrument varied simultaneously. [2][3]

The broader Canadian data provide a useful illustration of associated factors rather than a universal probability of depressive illness. Fisher and colleagues studied 5,144 palliative home-care recipients and reported an elevated DRS-defined symptom proportion of 9.8%. Their adjusted analyses associated depressive symptoms with low life satisfaction (odds ratio [OR] 3.01, 95% confidence interval [CI] 2.37–3.82), moderate or severe sleep disturbance and daily pain. Caregiver distress was also

associated with the outcome (OR 2.01, 95% CI 1.62–2.51). These observations strengthen the rationale for integrated assessment: mood, sleep, physical symptoms and family burden cannot be considered in isolation. However, a cross-sectional association cannot show whether poor sleep causes depressed mood, depression aggravates sleep disturbance, or both reflect advancing illness. The estimates describe patterns within a defined home-care population; they should not be applied as risk predictions to an individual patient without external validation. [3]

A further contrast emerges at the very end of life. Kozlov and colleagues asked bereaved caregivers to reconstruct patients' symptoms during their final week of home-hospice care. They reported moderate-to-severe anxiety in 46.4% and depression in 43%, but considerable psychological-symptom data were missing and assessments were made by proxies after death. These estimates describe a specific phase and reporting method; they are not equivalent to routine HADS screening among community-dwelling patients who can self-report. [6]

Spiritual distress extends beyond formal religious concerns. For a patient, an inability to find meaning, loss of connection, unresolved relationships, fear or guilt may be central to suffering despite the absence of religious affiliation. In the large home-based cohort studied by Cipta and colleagues, spiritual distress correlated with greater physical and emotional symptom burden and poorer mental well-being. It was not associated with increased subsequent hospital-based utilisation in adjusted analyses, illustrating why clinical importance cannot be judged by admission rates alone. [8]

A further conceptual distinction concerns spiritual wellbeing, spiritual distress and demoralisation. Positive spiritual wellbeing may involve purpose, connectedness, acceptance or a meaningful relationship with others; distress involves difficulty sustaining these experiences and may exist without psychiatric disorder. Demoralisation can include helplessness, loss of meaning and perceived inability to cope. These constructs overlap, but they are not synonymous, and their respective scales do not have interchangeable thresholds. A patient may remain anxious while also experiencing greater peace after a supportive conversation, or may feel spiritually unsettled without endorsing the anhedonia and other symptoms typical of depression. In the Portuguese primary-care cohort, the partial overlap of depression and spiritual distress demonstrates why the two outcomes require separate enquiry and interpretation. Subsequent intervention studies that measure spiritual wellbeing and HADS symptoms in parallel further show the value of maintaining distinct outcome domains. [4,10]

The delivery literature points to different levels of responsibility. General practitioners can ask about meaning and relationships during ongoing consultations, but referral to trained spiritual caregivers may be needed when existential suffering is substantial or persistent. Koper's respondents emphasised inadequate awareness, communication and funding, whereas Busser's general practitioners identified uncertainty about how to discuss spiritual concerns and where to refer. The convergence between professional groups strengthens the case for clear local pathways without implying that spiritual needs can be resolved by a single checklist. [5][9]

The term community care covers several service arrangements. Some programmes deliver specialist palliative input to a home under the coordination of a hospital, while others rely mainly on the general practitioner, district nurse and local social services. The Hong Kong SUPPORT+ programme recruited people with advanced cancer from a university-hospital outpatient service for community-based follow-up, and its feasibility findings cannot be equated directly with outcomes in an ordinary rural primary-care clinic. Similarly, the Dutch life-story intervention was delivered by chaplains to home-based palliative clients rather than being an intervention provided solely by a general practitioner. A systematic synthesis should therefore preserve service ownership and clinical referral context, especially when comparing access to psychological care or discussing implementation in settings with fewer specialist professionals. Interventions may be transferable in principle, but the resources required to deliver them are part of the evidence. [10,12]

The treatment literature is promising but design-limited. Fraguell-Hernando and colleagues compared meaning-centred psychotherapy with counselling in a randomised feasibility study; the principal findings concerned within-group improvement among completers. Liefbroer and colleagues documented trajectories during structured spiritual conversations and follow-up, while Foppen and colleagues characterised plausible working processes in the same cohort. Neither uncontrolled time trends nor qualitative accounts alone establish causal treatment effects, although both contribute to practical care design. [7][10][11]

Evidence about management also needs careful separation of feasibility, acceptability and effectiveness. Recruiting patients to an intervention demonstrates interest and access; completion of several sessions demonstrates that some participants can sustain treatment; improvement among those who complete questionnaires is an outcome description. A credible causal

comparison additionally requires an appropriate control condition, protection against allocation bias and accounting for participants who deteriorate or die before follow-up. In the home-based meaning-centred psychotherapy pilot, 51 patients were recruited but only 32 completed treatment and the required assessments. This difference matters because patients able to complete therapy may be less unwell than those not represented in the analysed endpoint. The study provides useful support for the practicality of home-delivered sessions, while the strength of any efficacy claim remains limited by the sample and attrition. [7]

Technology-assisted services offer another route for patients who cannot attend repeated clinic visits. The SUPPORT+ study used weekly symptom reports over 16 weeks and rapid nurse contact for marked symptoms, with improvements in depression measures among those retained. Its feasibility design demonstrates an operational model rather than a controlled effect estimate. The need to own and use a smartphone also restricts applicability to frailer and more socially disadvantaged populations. [12]

Finally, the Malawian health-facility cohort highlights the danger of importing a prevalence estimate from high-resource home services into rural primary palliative care. Standard PHQ-9 and GAD-7 screening suggested high symptom burden in the 151 respondents, but screening positivity should not be relabelled as a confirmed psychiatric diagnosis. Interpretation also depends on service mix, disease patterns, socioeconomic context and clinical thresholds. [13]

Different health systems may also offer quite different responses to a positive psychological screen. In a well-resourced home-care programme, a nurse may discuss symptoms with a specialist team and arrange a psychologist or chaplain review. In a rural district programme, the same screen may be administered during a general clinic visit with limited specialist availability. The Malawian findings, with 109 of 151 patients screening positive for depression and 105 of 151 for anxiety, show that substantial symptom burden can be identified in a non-tertiary care pathway, but the recorded percentages are screening classifications rather than verified psychiatric diagnoses. Interpretation also depends on translated instruments and appropriate threshold validation. For service planning, it is therefore necessary to distinguish the proportion exceeding a score cut-off from the proportion who actually receives an assessment, an offered treatment and follow-up care. [13]

METHODS

Design, information sources and eligibility

A structured systematic evidence synthesis was prepared for publications available through 9 November 2026. Original empirical reports were located through targeted PubMed and publisher/academic-repository searches, using combinations of “palliative care”, “primary care”, “general practice”, “community”, “home care”, “depression”, “anxiety”, “spiritual distress”, “spiritual well-being”, “psychotherapy”, “chaplaincy”, “screening” and “intervention”. Reference linking was used to resolve bibliographic details. Retrieval focused on verifiable patient- or care-delivery-level primary reports rather than pooled estimates from previous reviews. Figure 1 describes the report-level selection and classification of eligible empirical publications; database-level record and deduplication totals were not reconstructed. Reporting was informed by PRISMA 2020 and the SWiM principles for narrative synthesis. [14][15]

The clinical question was structured around a defined patient population and two complementary types of outcome. The population comprised adults with palliative-care needs managed in general practice, primary care, home-care or closely linked community pathways. The prevalence component sought report-specific proportions of depression, anxiety or spiritual distress, with explicit recording of the assessment instrument and threshold. The management component examined recognition, referrals, psychological or spiritual interventions, symptom monitoring and changes in reported outcomes. Provider-only qualitative studies were retained for service-delivery interpretation but did not contribute to any patient-level prevalence denominator. Inpatient or specialist-centre evidence was retained only when its relationship to community services was clear and was described as indirect to exclusively primary-care practice. The approach favoured clinically interpretable grouping over an unqualified aggregate percentage.

Eligible reports involved adults receiving palliative care from a general practitioner or an explicitly community, home or mixed health-facility pathway, or professionals directly providing care in those settings. They had to report at least one of the three specified symptom domains, its measurement, assessment or management. Home hospice and specialist-supported community programmes were retained as an adjacent evidence stratum rather than silently treated as ordinary GP care.

Hospital-only cohorts without community delivery, purely caregiver outcome trials and secondary reviews were not used to estimate patient prevalence. Each study was assigned to a prevalence, intervention or service-delivery stream; reports covering more than one stream were not counted as separate populations.

Extraction, outcome definitions and synthesis

For each empirical report, the extracted fields were publication year, country, setting, design, participant count, source and threshold of symptom measurement, reported burden, intervention or professional practice and key limitations. An observed positive screen was distinguished from a diagnostic interview. Patient, professional and proxy denominators remained separate. Attributable outcomes from interventions were interpreted according to the presence or absence of a control group, completion rate and reported comparison. The complementary Liefbroer and Foppen publications were explicitly linked to the same client population. As studies differed markedly in diagnosis mix, care model, observation period, symptom tool and unit of analysis, no overall prevalence estimate, pooled effect size or statistical significance test across reports was calculated. [15]

Quantitative findings were interpreted with the denominator used by each original report. A proportion of patients crossing a validated symptom-screening threshold is not a rate of new psychiatric diagnoses; a caregiver-proxy estimate of symptoms during the final week is not the prevalence observed at admission to palliative care. For intervention studies, the numbers recruited, beginning treatment and completing assessments were differentiated wherever reported. Change scores and statistical significance from uncontrolled cohorts were not converted into comparative treatment effects. Where the same participants appeared in a quantitative study and a subsequent qualitative analysis, their contributions were described in two evidence categories without creating a second independent participant sample. This preserved the unit of analysis and avoided double counting when reviewing outcomes from the Dutch spiritual-care programme. [10,11]

Critical appraisal

Published methods and available numerical descriptions were critically appraised across sampling, outcome ascertainment, confounding, missingness and appropriateness of causal interpretation. The JBI prevalence and other design-specific appraisal frameworks informed the structure of judgements. For qualitative work, credibility of setting, sampling, data collection and interpretation was considered; for uncontrolled interventions, selection, dropout and regression-to-the-mean were treated as material concerns. Assessments are descriptive and source-based rather than artificially precise summary scores. [16]

Assessment of methodological limitations was tailored to each design. For prevalence reports, particular attention was paid to sampling frame, representativeness, measurement validity, handling of non-response and whether the outcome referred to diagnosed illness or symptoms. Provider interviews were considered in relation to recruitment, reflexivity, analytic transparency and whether interview findings were supported by adequate quotations or triangulation. For intervention evidence, allocation, comparator suitability, attrition and timing of follow-up were especially important. Because the designs and endpoints differed, qualitative domain judgements were more informative than a numerical total quality score. The appraisal was used to qualify claims in the synthesis rather than to assign arbitrary statistical weights to incommensurable studies. [16]

RESULTS

Study identification and care settings

Twelve verified primary reports were synthesised. Two articles concerned the same Dutch life-story intervention participants, leaving 11 independent empirical populations. Three reports directly studied general practice or GP-linked spiritual care (Velosa, Koper and Busser); the remaining reports concerned community, home, hospice, ambulatory or mixed facility pathways. The settings differed in whether a specialist palliative team, community nursing service, oncology clinic or general practitioner coordinated care. This distinction was retained in all comparisons.

The included literature therefore forms an evidence map rather than a single homogeneous cohort. Reports on directly GP-managed patients contributed to the most specific estimates for primary care. Larger home-care and hospice studies offered richer epidemiological descriptions but often reflected different eligibility criteria or stages of disease. Provider-interview studies explained how distress might be recognised and responded to, while home psychotherapy, chaplaincy and digital

monitoring studies provided intervention and implementation evidence. In the two Dutch reports, the same 75 clients and 33 chaplains generated complementary quantitative and qualitative data. Counting these publications as separate observations is appropriate, but treating their participants as independent in a numerical total would be misleading. The 12 reports are thus presented as 11 distinct empirical populations, with their differences retained in the study table. [10,11]

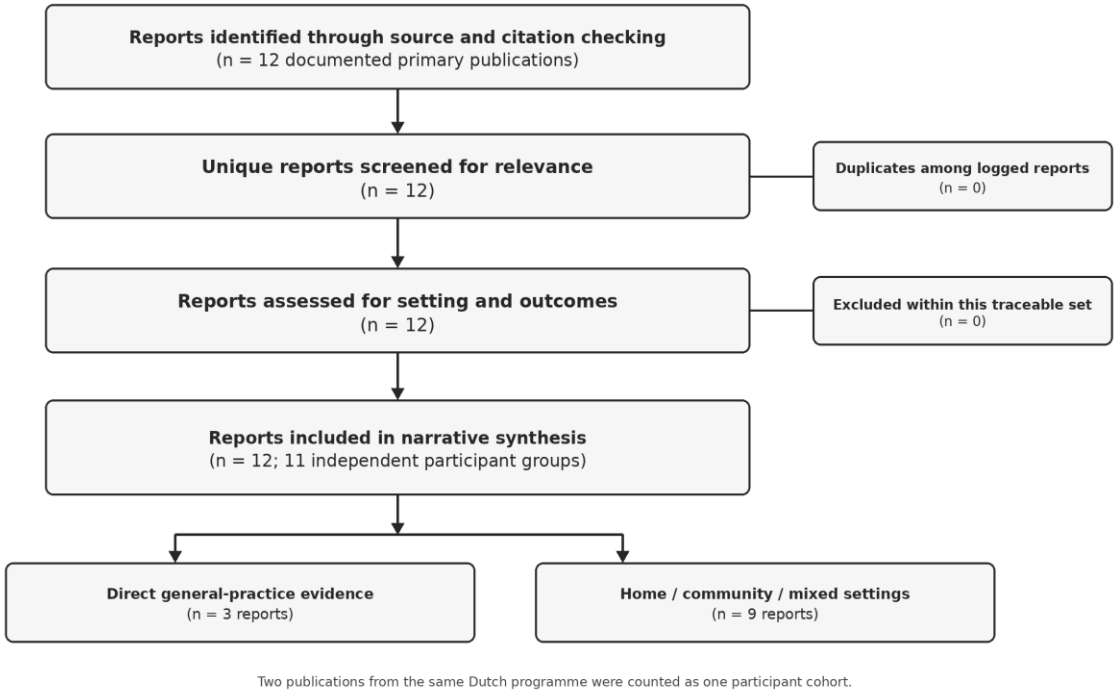

Figure (1): PRISMA 2020-informed selection pathway for individually traced primary reports

The pathway distinguishes 12 eligible reports from 11 independent empirical populations and separates directly general-practice-based evidence from broader community and home-care services.

Table (1): Overview of the evidence structure and units of analysis

Characteristic	**Observed evidence**
Primary empirical reports	12 publications, representing 11 independent empirical participant populations
Direct general practice/GP-linked delivery	3 reports (Velosa 2017; Koper 2019; Busser 2022)
Broader community/home/mixed delivery	9 reports, including 2 reports from one Dutch intervention cohort
Patient burden outcomes	Clinical interview, HADS, DRS, PHQ-9, GAD-7, ESAS symptom item, numerical spiritual screening
Management evidence	Practice descriptions; meaning-centred psychotherapy; chaplaincy life review; digital symptom monitoring
Quantitative synthesis	Narrative presentation only; no pooled prevalence or treatment effect

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Characteristics of included reports

The chronological evidence table records the denominator and clinical interpretation appropriate to each report, rather than reducing all palliative-care studies to a single set of interchangeable percentages. The table separates direct general-practice evidence from other community pathways and explicitly identifies a shared cohort.

Table (2): Chronological evidence table of empirical reports on psychological and spiritual distress

Study	Setting	Design and denominator	Relevant numerical or management finding	Key interpretive boundary
Austin et al. 2011 [2]	Australia; home vs ward	Cross-sectional HADS; 46 home + 46 inpatient	~20% met HADS depression/anxiety thresholds across both groups; no adjusted setting difference	Mixed setting; small sample
Fisher et al. 2014 [3]	Canada; palliative home care	InterRAI cross-sectional; 5,144 patients	Depressive symptoms 9.8% (reported estimate); reduced life satisfaction and sleep disturbance associated	DRS screening, not diagnosis
Velosa et al. 2017 [4]	Portugal; GP primary-care practice	Cross-sectional interviews; 30 patients	Depression 7/30; spiritual distress 7/30; overlap 4/30	Small direct primary-care cohort
Koper et al. 2019 [5]	Netherlands; GP-linked spiritual care	Mixed methods; 31 chaplains, focus group 9	Existential, relational and religious care; referral and funding barriers	Provider evidence, not prevalence
Kozlov et al. 2019 [6]	USA; home hospice	Retrospective proxy interviews; 351 caregivers	Moderate/severe anxiety 46.4%; depression 43% in final week	Proxy and missing symptom data
Fraguell-Hernando et al. 2020 [7]	Spain; home palliative cancer care	Randomised feasibility; 51 recruited, 32 completed	Meaning-centred arm improved anxiety, depression and demoralisation within group	Small completer analysis
Cipta et al. 2021 [8]	USA; home-based palliative care	Cohort; 658 patient/proxy assessments	Any spiritual distress 319/658; moderate/severe 181/658; poorer mental wellbeing	Screening item; proxy component
Busser et al. 2022 [9]	Netherlands; general practices	Qualitative interviews; 17 GPs	Existential needs addressed intuitively; inconsistent referral knowledge	GP perspectives, not patient outcomes
Liefbroer et al. 2025 [10]	Netherlands; home chaplaincy	Single-arm longitudinal; 75 clients, 33 chaplains	Spiritual wellbeing increased; anxiety decreased; depressive symptoms did not change significantly	Non-controlled selected sample
Foppen et al. 2025 [11]	Netherlands; same client cohort	Qualitative interviews/workbooks; 75 clients, 33 chaplains	Meaning, connectedness and calm described as intervention mechanisms	Same cohort as Liefbroer
Chan et al. 2025 [12]	Hong Kong; community-linked clinic	Single-arm prospective; 109 recruited, 84 completed	HADS-D mean 8.4 to 6.7; positive threshold 64.3% to 45.2%	No comparator; smartphone selection

Phiri et al. 2026 [13]	Malawi; nine health facilities	Cross-sectional; 151 respondents	Positive PHQ-9 screen 109/151 (72%); GAD-7 screen 105/151 (70%)	Mixed district facilities; screening

HADS = Hospital Anxiety and Depression Scale; DRS = Depression Rating Scale; ESAS = Edmonton Symptom Assessment System; GP = general practitioner. Two 2025 Dutch publications share the same client cohort and must not be summed.

Prevalence and overlap of symptoms

The clearest direct general-practice estimate came from Velosa et al.: 7/30 (23.3%) for depression and 7/30 (23.3%) for spiritual distress, with four patients (13.3%) meeting both sets of clinical criteria. Fisher et al. identified depressive symptoms in 9.8% of a much larger Canadian palliative home-care cohort using the interRAI DRS, whereas Austin et al. reported approximately 20% depression and anxiety in a mixed home/inpatient HADS study. The variation reflects different patient populations and ascertainment methods as well as plausible differences in burden. [2][3][4]

At the other end of the illness trajectory, caregivers of home-hospice patients in the study by Kozlov et al. reported moderate-to-severe anxiety in 46.4% and depression in 43% during the last week of life. Missing proxy symptom data were substantial, and these figures should not be interpreted as the proportion of all palliative-care patients with diagnosed mental disorders. In a different district-level population, Phiri et al. found 109/151 positive depression screens and 105/151 positive anxiety screens; the service covered nine Malawian facilities, and the scores represent instrument-defined screening burden rather than diagnostic interview prevalence. [6][13]

Spiritual burden was similarly measurement-sensitive. At admission to home-based palliative care, Cipta et al. found 319/658 (48.5%) with at least mild distress and 181/658 (27.5%) with moderate-to-severe distress on a global 0–10 question. Their adjusted analyses associated increasing spiritual distress with greater overall symptoms and lower mental well-being, while finding no corresponding increase in later hospital-based utilisation. These numerical screening categories should not be equated with the structured clinical criteria for spiritual distress used by Velosa et al. [4][8]

Numerically, the extremes in reported symptom burden are informative primarily because they demonstrate different definitions and populations. The 9.8% DRS-defined depression figure from Canadian home care is an estimate from a broadly assessed care population, whereas the 43% depression and 46.4% anxiety figures from US home hospice describe bereaved caregivers' reports of symptoms during the final week of life. The 72% and 70% screening results from Malawi reflect still another service setting and measurement approach. None of these percentages has a common diagnostic threshold, time origin and patient-selection process. Even when two reports use HADS, different cut-offs, timing or availability of complete questionnaires may invalidate a direct numerical comparison. The evidence therefore establishes substantial clinical relevance and measurement dependence, not a defensible pooled prevalence. [3,6,13]

Table (3): Published prevalence estimates retained with their original denominators and meanings

Report and group	Domain / measure	Reported result	Interpretation
Austin 2011; 92 total, 46 at home	HADS anxiety/depression	Approximately 20% across both settings	Not home-only rate
Fisher 2014; 5,144	DRS depressive symptoms	9.8%	Palliative home-care assessments
Velosa 2017; 30	Clinical criteria: depression	7/30 = 23.3%	Direct primary-care practice

Velosa 2017; 30	Clinical criteria: spiritual distress	7/30 = 23.3%	Four participants had both
Kozlov 2019; 351 proxies	ESAS anxiety ≥4 in last week	46.4%	Proxy report; missing data
Kozlov 2019; 351 proxies	ESAS depression ≥4 in last week	43.0%	Proxy report; missing data
Cipta 2021; 658	Any spiritual distress (>0/10)	319/658 = 48.5%	Patient or proxy screening
Cipta 2021; 658	Spiritual distress ≥5/10	181/658 = 27.5%	Moderate to severe screening
Phiri 2026; 151	PHQ-9 positive depression screen	109/151 = 72.2%	Rural mixed-facility cohort
Phiri 2026; 151	GAD-7 positive anxiety screen	105/151 = 69.5%	Rural mixed-facility cohort

Proportions calculated from numerators are shown to one decimal; published rounded percentages (72% and 70% for Phiri) are substantively equivalent. No pooled prevalence is calculated.

Recognition and management strategies

The service-delivery studies reveal a continuum from ordinary clinical recognition to specialist support. Koper et al. described spiritual caregivers undertaking conversations about meaning, reconciliation, relatives and end-of-life choices, but also documented limited professional familiarity, referral uncertainty and financing difficulties. Busser et al. found that general practitioners often recognised the need for existential conversations but used intuitive rather than standardised language. In both studies, collaboration and education were practical themes, not patient-level proof of symptom reduction. [5][9]

Home-delivered psychological interventions were feasible. Fraguell-Hernando et al. recruited 51 patients to a feasibility trial; the analysed group comprised 16 completers per intervention arm. Meaning-centred psychotherapy participants showed within-group reductions in depression, anxiety and demoralisation, but selective completion and the small sample constrain comparisons. In the Netherlands, Liefbroer et al. observed improved spiritual well-being and reduced anxiety during six chaplaincy sessions in 75 participants, without significant improvement in depression. The accompanying qualitative analysis of the same participants described reflection, trust, connection and calm as potentially relevant mechanisms. [7][10][11]

Among psychological intervention studies, the distinction between completion and improvement is especially salient. Fraguell-Hernando and colleagues analysed outcome change in the 32 participants who finished the allocated three-session programme and assessments, from 51 initially recruited. The larger recruitment number describes feasibility of engagement, while the smaller group supplies the reported post-treatment outcomes. By contrast, the SUPPORT+ programme recruited 109 participants and obtained follow-up from 84; its depression score fell from a mean of 8.4 to 6.7 among assessed participants. Neither result alone establishes that the same improvement would occur in everyone offered treatment, because deterioration, symptom burden and access to technology may influence retention. These differences are shown alongside the intervention descriptions without treating the observed changes as directly comparable treatment effects. [7,12]

Chan et al. followed 84 of 109 recruited patients using a 16-week symptom-reporting programme. Mean HADS depression scores declined from 8.4 to 6.7, with the proportion at or above a HADS-D score of eight decreasing from 64.3% to 45.2%; anxiety showed no corresponding improvement. Because the study had no untreated comparison group and recruited smartphone-owning patients from an oncology-affiliated clinic, findings support feasibility and possible benefits rather than a causal effect for general practice. [12]

The longitudinal Dutch spiritual-care programme produced another distinct outcome pattern. In the 75-client cohort, several domains of spiritual wellbeing increased over time, and anxiety symptoms decreased, whereas depressive symptoms did not show a statistically significant change. Its companion qualitative analysis described mechanisms such as being heard, revisiting personal narratives and developing new perspectives. These complementary observations are clinically meaningful, but the absence of an untreated comparison limits claims that the observed changes were caused by the intervention rather than concurrent support or the passage of time. The findings also argue against a simplistic assumption that an intervention designed for spiritual wellbeing must improve every psychiatric symptom domain. [10,11]

Table (4): Community management evidence and implications for clinical implementation

Approach	Evidence	Practical implication	Limitation
GP conversations and referral	Koper 2019; Busser 2022	Ask about meaning, connection, fears; build named referral pathways	Professional reports, no controlled outcomes
Meaning-centred psychotherapy	Fraguell-Hernando 2020	Short home sessions may suit immobile patients	Small feasibility trial, attrition
Narrative spiritual care	Liefbroer and Foppen 2025	Structured life review and follow-up may support wellbeing	Single cohort without control
Remote symptom monitoring	Chan 2025	Weekly patient reports plus nurse callbacks can identify worsening symptoms	Single-arm, digitally selected patients
Whole-person symptom assessment	Fisher 2014; Cipta 2021	Attend to sleep, pain, life satisfaction and distress together	Observational associations, not treatment effects

Risk of bias and confidence in interpretation

Interpretive confidence varied by design. Large observational samples improved precision within their own instruments but did not remove confounding or make tools comparable. Small direct-primary-care samples, retrospective proxies and uncontrolled interventions contributed more uncertainty. Table 5 records the most consequential limitations of each report; no numerical quality score is assigned where the source or study design does not support such precision.

Table (5): Domain-focused critical appraisal of the included empirical reports

Study	Selection	Measurement	Key bias consideration	Overall
Austin 2011	Small convenience groups	Self-reported HADS; adequate domain coverage	Residual confounding	Some concerns
Fisher 2014	Large home-care sample; cognitive exclusions	DRS; screening rather than diagnosis	Cross-sectional; setting mix	Some concerns
Velosa 2017	30 patients from one practice	Interview and validated instruments	Imprecision; selection	High

Koper 2019	31 spiritual caregivers, focus group 9	Mixed methods, professional perspective	Non-representative case descriptions	Some concerns
Kozlov 2019	Bereaved-caregiver sample	Proxy ESAS; missing 13–21%	Recall and non-response bias	High
Fraguell-Hernando 2020	51 recruited, 32 completers	Validated symptoms, small comparison	Attrition and weak precision	High
Cipta 2021	658 entering home-based service	Single-item SD; proxy contribution	Observational associations	Some concerns
Busser 2022	17 purposively selected GPs	Detailed qualitative interviews	Self-selection/social desirability	Some concerns
Liefbroer 2025	75 voluntary intervention clients	Repeated scales, follow-up	No control; differential attrition	High
Foppen 2025	Same 75 clients and 33 chaplains	Qualitative triangulation	Shared cohort; subjectivity	Some concerns
Chan 2025	84/109 completed; smartphones	HADS and app logs	No control; dropout/selection	High
Phiri 2026	151 patients, one rural district	PHQ-9 and GAD-7 screens	Generalisability and case mix	Some concerns

The overall label represents a qualitative judgement about the main evidence contribution; it is not an automatically calculated JBI total. "High" indicates a material threat to a prevalence generalisation or causal interpretation.

Conceptual synthesis

Interpretation of the risk-of-bias table follows the measurement and design problems evident in the included reports. Small direct primary-care samples give an unusually clear view of care location but are imprecise and susceptible to local referral patterns. Large secondary-care datasets may be more precise numerically but less able to distinguish clinical depression from elevated screening scores. Provider qualitative work is strong for understanding language and access barriers, not for estimating prevalence. Uncontrolled intervention cohorts may demonstrate feasibility or patient-perceived benefit, yet changes between baseline and follow-up are vulnerable to selection, regression to the mean and concomitant care. These design-specific distinctions explain why the evidence cannot sensibly be reduced to a uniform quality score or a single numerical effect. [3,5,10,12]

The evidence supports a four-stage community response: recognise distress, differentiate its likely nature, offer a preference-sensitive response and reassess with referral when needed. This is a synthesis of reported care activities rather than a tested single treatment package. Figure 2 illustrates the distinct tasks so that repeated screening does not replace clinical judgement or access to suitable care.

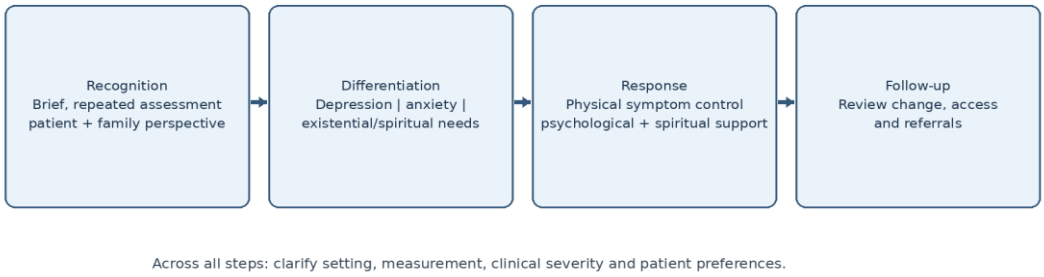

Figure (2): Conceptual pathway for differentiated psychological and spiritual care in community palliative services.

DISCUSSION

The evidence indicates that depression, anxiety and spiritual distress are clinically important in community palliative care, but it does not support a single prevalence figure applicable to every primary-care patient. A Portuguese general-practice study identified depression and spiritual distress in a notable minority of participants [4], whereas a much larger Canadian home-care study recorded a lower prevalence of depressive symptoms [3]. These findings should not be ranked as indicators of better or worse care without considering who entered each service, how symptoms were defined and when the assessments took place.

The most direct general-practice evidence is valuable but limited in scale. Velosa and colleagues combined clinical interviews with assessment instruments, providing a more differentiated clinical picture than a questionnaire alone [4]. However, thirty participants from one practice cannot represent all adults with serious illness who receive primary care. A rural Malawian palliative programme sampled 151 people across nine health facilities and reported much higher positive screening rates [13]. Those results suggest considerable unmet need in a different service context, but positive PHQ-9 and GAD-7 screens must not be equated with diagnosed depressive or anxiety disorders.

Different thresholds can create apparent disagreement between studies even when the underlying burden is similar. The interRAI Depression Rating Scale used in Ontario is not interchangeable with HADS in the Australian home-versus-ward comparison, or with the 0–10 symptom questions completed by proxies during the final week of hospice. Furthermore, some palliative-care instruments deliberately avoid somatic questions that overlap with cancer and advanced organ disease, while others retain symptoms such as sleep disturbance and fatigue. A comparative review must therefore retain the original outcome definition next to every reported percentage. [2][3][6]

For clinical practice, the key difficulty is translating heterogeneous prevalence evidence into a practical assessment process without overdiagnosing or overlooking suffering. An elevated screening score should prompt a conversation about duration, severity, functional impact, safety and the patient's own priorities. Some patients will benefit most from treatment of uncontrolled pain or sleep disturbance; others may need a structured assessment for major depression or a specialist response to debilitating anxiety. Spiritual questions may require time, trust and reflective listening rather than a psychiatric label. The studies in this review support the importance of each domain, but they do not demonstrate that a single questionnaire or threshold provides the same predictive value in cancer, organ failure, dementia and mixed chronic disease populations. [3,4]

Timing is equally consequential. Patients entering palliative home care may be clinically stable enough to complete interviews, whereas relatives recalling the final week of life describe people whose consciousness, communication and independence may have deteriorated. The particularly high burden reported by Kozlov and colleagues needs to be interpreted in that final-week context. Missing proxy responses complicate the denominator further, and neither a clinician nor a family member can always distinguish depressive cognitions from reduced communication late in life. Early and repeated conversations may be more informative than one last-minute attempt to diagnose a complex syndrome. [6]

Spiritual distress emerges as a distinct but overlapping clinical domain. In the Portuguese study, four of seven people with spiritual distress also met the depression criteria, yet the conditions were not identical. In the US home-based cohort, almost

half of patient or proxy respondents reported some spiritual distress, and increasing scores tracked worse symptom burden and mental wellbeing. The absence of an association with subsequent hospital use does not diminish the patient-centred importance of those concerns. Indeed, whether a person finds peace, reconciliation or meaning is not adequately captured by emergency department visits. [4][8]

The prevalence of spiritual distress also depends on its operational definition. Velosa required multiple clinical indicators and a threshold on a spiritual well-being instrument, whereas Cipta used a single numeric screening question and defined both any and moderate-to-severe distress. The two methods address different decisions: one concerns a more stringent clinical classification, the other a rapid signal that further discussion may be useful. A brief question may be appropriate at a busy consultation, but it should lead to assessment rather than be treated as a complete spiritual diagnosis. [4][8]

The capacity to communicate affects both measurement and equity of access. A patient who is severely fatigued, cognitively impaired or close to death may be unable to complete a written questionnaire, while a family caregiver may give a valuable but not identical account of distress. The home-hospice proxy study captures an important phase of illness that patient self-report studies can miss, but proxy responses remain an estimate of perceived symptoms rather than direct testimony. Likewise, digital monitoring programmes may exclude those without compatible devices, connectivity or the capacity to interact with an application. A service that relies on one assessment channel risks preferentially representing people who are relatively well and technologically equipped. Flexible patient interviews, supported communication and carefully distinguished proxy assessments are therefore relevant both to care and to future research design. [6,12]

Available primary-care service studies provide a practical explanation for why distress may remain unidentified. Koper's spiritual caregivers described care that reached beyond religion into relationships, fear, loss and decisions about dying; however, practitioners could be difficult to contact and their services inadequately integrated with medical teams. Busser's general practitioners considered existential issues legitimate clinical work but often lacked standard language and knowledge of referral options. This convergence argues for local training, a trusted contact pathway and regular multidisciplinary case discussion, rather than expecting family doctors to resolve every form of spiritual suffering alone. [5][9]

Psychological and spiritual care should not be collapsed into the same referral route. A patient with persistent major depressive symptoms, suicidal thoughts or disabling anxiety may need formal psychiatric assessment and treatment alongside control of pain, sleeplessness or breathlessness. Someone whose central concern is guilt, separation, unfinished relationships or loss of purpose may prefer sensitive conversation, a social worker, a spiritual caregiver or a personally chosen faith or community resource. These possibilities can coexist, and the correct response is shaped by patient preference and severity rather than a rigid sequence of referrals. The WHO model of palliative care supports such multidimensional assessment. [1]

The intervention findings are encouraging without being definitive. The home psychotherapy feasibility trial suggests that patients who cannot travel can complete meaningful sessions and may experience relief; nevertheless, only 32 of 51 recruited patients contributed complete treatment data. Apparent within-group improvement must not substitute for an adequately powered and intention-to-treat comparison. The Dutch life-story intervention also showed improving spiritual wellbeing and anxiety over time, but lacked a control arm, so attention, expectancy and disease-related changes cannot be excluded. Importantly, that study did not report a significant improvement in depressive symptoms, which argues against presenting spiritual interventions as a universal treatment for depression. [7][10]

Treatment delivery also demands a realistic account of workforce and continuity. A general practitioner can begin the conversation, review physical contributors, assess urgent mental-health risks and make a first care plan, but sustained psychotherapy or complex spiritual counselling may require additional trained professionals. Formal referral is only useful when the patient can reach that service and feedback returns to the primary-care team. The professional studies from the Netherlands describe how uncertainty about language, role boundaries and referral can interrupt this process. These observations suggest the practical value of defined interprofessional responsibilities, a shared approach to documentation and follow-up that is adjusted to prognosis and patient preferences. They are organisational implications drawn from provider evidence, rather than demonstrated effects of a tested service redesign. [5,9]

The companion Dutch qualitative publication enriched the interpretation of the quantitative changes by describing mechanisms such as new perspectives on one's life story, being heard, and an increased sense of connection or calm. However, it used the same underlying participants as the longitudinal report. Treating the two publications as independent

replication would artificially enlarge the evidence base and overstate confidence. Together they offer process and outcome information from one programme, not two independent trials. [10][11]

Technology can extend the reach of a community team, but only if it improves clinical response rather than merely adding a measurement burden. In SUPPORT+, regular symptom reporting and the possibility of rapid nurse contact were feasible for participants with adequate digital access. Depression scores fell over follow-up, while anxiety did not show a parallel reduction; the absence of a control group means that causality is uncertain. The requirement for smartphone ownership and preserved functional status also means that the people most isolated or close to death may be the least well represented in an apparently successful digital programme. [12]

Interpretation of management effectiveness needs attention to the proper comparator. Professional interviews tell us what care staff perceive and the barriers they experience; they do not measure patient-level recovery. Single-arm longitudinal studies show change over time; they cannot separate treatment response from natural fluctuation, response shift, selection or regression to the mean. A pilot trial with completer outcomes may help establish feasibility but provides an imprecise estimate of clinical benefit. This hierarchy is especially important when translating promising specialist-home or chaplaincy programmes into routine general practice. [5][7][9][10][12]

There is also a distinction between measuring improvement in an outcome and improving the experience of the whole patient. A reduction in HADS depression scores may be desirable, but patients may also prioritise relief from guilt, reconciliation with family, less fear of dying or confidence that their preferences will be respected. The Dutch narrative intervention appears to work partly through meaning, connection and dialogue, while technology-assisted monitoring may enable quicker symptom response and advance-care-planning conversations. Different approaches could therefore produce benefit through different mechanisms and on different timescales. Evaluations that measure only depression may miss gains in spiritual wellbeing, whereas those that measure only satisfaction may fail to detect untreated clinically significant anxiety. A multidomain outcome framework is more appropriate than a single generic measure of success. [10–12]

Context may help explain extreme differences. Primary-care services differ in whether they treat advanced malignancy, dementia, heart failure, HIV-related illness or mixed severe chronic disease; they also vary by resources for symptom control, home visits and mental-health support. Social isolation, food insecurity, caregiver strain and barriers to transport can influence both distress and the chances of being assessed. These factors are particularly salient when interpreting rural district services alongside better resourced metropolitan home-care cohorts, but no single observed cross-country comparison in this evidence set isolates their independent effects. [3][13]

The results suggest a practical minimum standard for the next consultation: ask directly, in understandable language, about low mood, fear and the person's sense of peace or meaning; check physical contributors and immediate safety; and document what the patient wishes to discuss or address. Where a short instrument is used, its cut-off and purpose should be documented, and a positive screen should be followed by clinical evaluation. Plans should be revisited because needs change as function, treatment and family circumstances evolve. Such a model complements rather than displaces established management of pain, dyspnoea and other symptoms. [1][4][8]

The evidence base has substantial limitations. Only a small subset of reports specifically describes general-practice-managed palliative patients; several others concern specialised home or hospice services or community programmes connected to hospitals. Selection mechanisms, illness stage and diagnosis differ widely. Study size ranges from 17 professionals to more than 5,000 patient assessments, but large sample size does not make differently defined outcomes interchangeable. Some reports rely on proxy rating, selective participation or single sites; the controlled treatment evidence is sparse; and two spiritual-care publications reuse one cohort. These limitations preclude a defensible pooled prevalence or a quantified overall treatment effect.

A further interpretive limitation is that the apparent international range of prevalence may be shaped by more than differences in clinical need. Inclusion criteria, the proportion of patients near death, access to palliative services, language validation and whether professionals or caregivers provide the ratings are not held constant. For example, the Canadian DRS estimate, the Portuguese clinical assessment and the Malawian PHQ-9/GAD-7 screens answer different questions. It would therefore be misleading to portray them as points on a comparable geographical league table. More informative future work

would enrol prospectively identified primary-care palliative populations, state the precise clinical screening threshold and report the number receiving a diagnostic follow-up and an appropriate response. [3,4,13]

Future work would benefit from multicentre primary-care cohorts that identify patients by explicit palliative need, measure psychological and spiritual outcomes consistently, report language and threshold validation, and distinguish clinical diagnosis from screen positivity. Comparative service trials should allocate and analyse patients appropriately, report uptake and drop-out, and record meaningful outcomes such as patient-defined relief, function, quality of life and continuity of support. Research in low-resource settings should be sufficiently represented, and qualitative patient perspectives should be included alongside staff reports so that a culturally responsive approach can be evaluated rather than assumed.

CONCLUSION

Depression, anxiety and spiritual distress are substantial, overlapping but distinct concerns among people receiving palliative care in primary and community settings. The strongest direct general-practice evidence identifies both depression and spiritual distress in a notable minority of patients, while larger home-care, hospice and mixed health-facility studies demonstrate a broad range of symptom prevalence. Much of this variation is attributable to differences in care setting, illness stage, measurement instrument and reporting source. A positive symptom score should therefore be regarded as a prompt for further assessment rather than a diagnosis, and percentages should not be pooled without clinical and methodological compatibility.

Practical management is best understood as an integrated and evolving response: repeated recognition of emotional and existential concerns, differentiation of mental disorder from spiritual or adjustment-related distress, attention to physical and social contributors, access to psychological and spiritual expertise, and follow-up in line with patient wishes. Home psychotherapy, structured chaplaincy dialogue and remote symptom monitoring provide feasible models, but their present evidence is not strong enough to establish a single superior intervention for routine general practice. Clear collaboration between general practitioners, nurses, mental-health services and spiritual caregivers, supported by better comparative research and culturally sensitive measurement, offers the most credible route towards effective and person-centred care.

The most useful direction for primary care is consequently not an attempt to adopt a single universal prevalence figure, but to develop a repeatable and person-centred response to changing needs. Recognition should be sensitive to physical illness, treatment burden, communication ability and local cultural expressions of distress. Clear links between general practitioners, home nursing teams, mental-health professionals and spiritual caregivers can help ensure that problems detected in an assessment lead to meaningful action. Better comparative studies, with validated outcomes and follow-up that includes patients who discontinue intervention, are needed to establish which approaches produce durable improvements. Until then, available evidence supports attentive multidomain assessment and coordinated response while leaving substantial uncertainty about the comparative effectiveness of specific community delivery models. [5,7,10,12]

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APPENDIX A. SEARCH CONCEPTS AND STUDY CLASSIFICATION

The search was structured around three intersecting concepts: palliative or serious illness; primary, general practice, community or home-based care; and emotional or spiritual distress or its assessment/management. Source-level retrieval was supplemented by identifying linked publications and checking original articles for setting and denominator detail. The following syntax is a reproducible MEDLINE/PubMed strategy; equivalent terminology can be adapted to other bibliographic platforms.

(("Palliative Care"[Mesh] OR palliative[tiab] OR "serious illness"[tiab] OR "end of life"[tiab]) AND ("Primary Health Care"[Mesh] OR "Family Practice"[Mesh] OR "Home Care Services"[Mesh] OR "primary care"[tiab] OR "general practice"[tiab] OR community[tiab] OR "home based"[tiab]) AND (depression[tiab] OR depressive[tiab] OR anxiety[tiab] OR "spiritual distress"[tiab] OR "spiritual wellbeing"[tiab] OR "spiritual well-being"[tiab] OR chaplain*[tiab] OR psychotherap*[tiab] OR screening[tiab]))

Prevalence, professional-practice and intervention evidence were retained in separate interpretive groups. Home-hospice and specialist-supported community studies were not relabelled as pure general practice. A longitudinal report and companion qualitative report on the same 75 Dutch clients were linked to avoid double-counting.

APPENDIX B. CLINICAL INTERPRETATION OF INSTRUMENTS

Table (6): Why the psychological and spiritual instruments cannot be pooled indiscriminately

Measure	What it represents in this evidence set	Interpretation safeguard
HADS	Self-reported anxiety/depression symptom subscales	Cut-offs identify elevated symptoms, not diagnosis
interRAI DRS	Clinician-rated depressive symptom algorithm	Depends on home-care data definitions
PHQ-9 / GAD-7	Nine- and seven-item positive screens	Severity and cut-off matter; confirm clinically
ESAS item	0–10 symptom item, sometimes proxy reported	Time near death and missingness change meaning
FACIT-Sp / clinical criteria	Spiritual well-being and structured clinical indicators	Low spiritual well-being is not identical to depression
Global spiritual-distress item	Single 0–10 distress assessment	Prompt for dialogue; not comprehensive diagnosis

Interpretation of the measures

The instrument selected for a clinical consultation should match the question being asked. HADS can identify elevated anxiety or depressive symptoms while reducing emphasis on some somatic features, but its cut-offs still require clinical interpretation in a person living with advanced illness. A PHQ-9 score captures a broader set of depressive symptoms, including physical symptoms that may be influenced by the disease itself. In contrast, an interRAI DRS score is embedded within a more comprehensive assessment and need not map directly onto the threshold of an independent questionnaire. Reported proportions above a cut-off should be labelled as screening results unless the study established a diagnostic interview. [3,12,13]

For spiritual assessment, the global distress score used in a home-based cohort offers a brief opening for discussion but does not describe which dimension of meaning, connection or faith is most affected. More detailed wellbeing instruments may distinguish relationships with self, others or a transcendent source and can detect change within those domains following supportive conversation. Such changes are not necessarily accompanied by reductions in anxiety or depression; the Dutch longitudinal intervention demonstrated improvement in several spiritual-wellbeing domains and anxiety symptoms without a significant change in depressive symptoms. A clinician should consequently select measures that reflect the intended outcome and interpret them together with the patient's account rather than treating every tool as a substitute for another. [8,10]