

# **Follow-up care after screening for postpartum depression**

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**Barriers and facilitators from health care workers' perspective**

**C.J.M. Gabriels, University of Utrecht**

**A.I. van den Berg, University of Twente**

**H. van Os-Medendorp, University of Utrecht**

**M.M. Boere-Boonekamp, University of Twente**

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**Mw. C.J.M. Gabriels      4015886**

Master:                      Clinical health sciences – Nursing science  
University:                  University of Utrecht, Utrecht – University of Twente, Enschede  
Supervisor:                Dr. M.M. Boere-Boonekamp  
Lecturer:                    Dr. H. van Os-Medendorp  
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## **LIST OF ABBREVIATIONS AND RELEVANT DEFINITIONS**

EPDS	Edinburgh Postnatal Depression Scale
Ic	Informed consent
PPD	Postpartum depression
HCW	Healthcare workers
WHO	World Health Organization

## ABSTRACT

**Title:** Follow-up care after screening for postpartum depression.

**Background:** Postpartum depression (PPD) is a common and under-diagnosed complication after childbirth. Therefore, youth health care centers in the east of the Netherlands implemented routinely screening for PPD using the Edingburgh Postnatal Depression Scale. However, it is important to not only implement routinely screening but also make sure that an adequate follow-up process is provided. Therefore, factors influencing participation, execution and realization of a successful process of screening and follow-up need to be identified before a strategy can be designed for implementation throughout The Netherlands.

**Aim:** To identify barriers, facilitators and suggestions for improvement of the follow-up process of PPD from the perspective of all involved health care workers (HCW).

**Method:** A qualitative deductive design was used. The study population was a purposeful, heterogeneous sample consisting of seventeen HCW from different professions. Data was collected using individual, face-to-face, semi-structured interviews.

**Results:** Stigma, support and lack of knowledge about PPD are the main barriers for patients concerning help seeking and treatment. Barriers on provider level were lack of knowledge, indistinctness about involved health care workers, treatment options and responsibilities and lack of communication and consultation between health care workers. Finances were a barrier across all levels. Main facilitators on patient and provider level were education, support and home visits.

**Conclusion:** HCW identified barriers on patient- provider and system level. Most importantly, Stigma is of great concern. The multidisciplinary collaboration as it is now is not working optimally and the referral process is unstructured and decentralized.

**Recommendations:** Patients' and providers' perspective should be combined into an implementation strategy for improving the multidisciplinary follow-up process for PPD in the Netherlands.

## KEY-WORDS

Screening, Follow-up, Postpartum depression, Youth health care, Health care workers

## INTRODUCTION

Postpartum depression (PPD) is a very common complication after childbirth<sup>(1,2)</sup> and is of serious concern since it affects the health of mothers and their child negatively. Mothers who suffer from this condition exhibit less affective behavior and are less responsive towards their infant<sup>(3,4,5)</sup>. PPD can have a negative effect on breastfeeding<sup>(6,7)</sup> and is associated with mental, cognitive and behavioral disorders in the infant<sup>(2,5,8)</sup>. However, many cases of PPD stay unnoticed and routine screening worldwide is not common<sup>(2,9)</sup>.

A widely utilized self-rating instrument for the identification of PPD is the Edinburgh postnatal depression scale (EPDS)<sup>(10)</sup>. This instrument is specifically developed to fit in the routine work of community health workers in a primary care setting. The study of Glavin<sup>(11)</sup> showed that screening for PPD using the EPDS provides better possibilities for professionals to help mothers with PPD in municipality settings.

In the Netherlands, the Youth health care center offers a consistent health care contact encountered routinely by almost all new mothers (95%) during the first year after giving birth. At this moment, screening for PPD is not a routine part of Youth Health Care. However, it might be a unique and very suitable setting for signaling PPD and recommend further treatment. In 2008, the centers for Youth Health Care in the east of the Netherlands started routinely screening on postpartum depression as a pilot. Every mother who visits a center is asked to complete the Dutch validated version of the EPDS questionnaire<sup>(12)</sup> at one, three and six months after childbirth. The results are discussed with the mothers and depending on the score, options for further help are offered.

At the moment, a study is evaluating the (cost) effectiveness and negative effects of the intervention in this specific setting. However, screening for PPD can only be effective if adequate cooperation between involved health care workers (HCW) and follow-up of screening results is provided<sup>(2,13)</sup>. Previous studies show that in practice, only very few women with PPD actually use the offered referral and treatment options<sup>(14,15,16,17)</sup>. Also, a questionnaire among HCW in the region of Twente shows that very few women actually receive follow-up care. This means it is important to not only implement routinely screening but also make sure that an adequate follow-up process is provided. Therefore, factors influencing participation, execution and realization of a successful process of screening and follow-up need to be distinguished before further implementation can take place throughout The Netherlands. It is important to identify the enhancing and impeding factors to be able to optimize the process and contribute to better follow-up care. The aim of this study is to identify barriers, facilitators and suggestions for improvement of the follow-up process of PPD from the perspective of all involved HCW.

## **METHODS**

### **Design**

A deductive qualitative approach was chosen. This design has the advantage of using existing theory and research as a focus for this study. It helps answering the research question and gives the opportunity of quickly focus on and get to the point of interest. Therewith the study can refine and deepen what is already known and transfer the information into the specific Dutch setting.

### *Conceptual framework*

A social-ecological framework for health care utilization was used<sup>(18)</sup> in combination with relevant literature. The framework is based on the idea that health care utilization is influenced by several personal and situational factors and by delivery of programs and services. These factors overlap and influence each other and therewith influence the health care utilization.

### *Sensitizing concepts*

The sensitizing concepts for this study are based on the conceptual framework and derived from a thorough review of the literature<sup>(15,17,19,20,21)</sup>. Twelve concepts could be identified: (1) Stigma, (2) Support, (3) Information, (4) Education, (5) Communication, (6) Resources, (7) Skills, (8) accessibility, (9) Finances, (10) Practical issues, (11) Cultural issues and (12) Multidisciplinary collaboration.

### **Population and recruitment**

The target population consists of HCW involved in the process of screening and follow-up for PPD in The Netherlands. The study population was a purposeful, heterogeneous sample consisting of seventeen HCW from different professions. To be eligible for participation, HCW needed to: (1) be involved in the process of screening, treatment, referral and/or follow-up for PPD, (2) read and speak Dutch fluently and (3) be eighteen years or older. For recruitment, maximum variation sampling was used. Participants were selected purposefully based on profession and work location. A few HCW were identified through snowball sampling, after which they were also approached. Potential participants were approached by telephone and email. If interested in participating, the information letter was sent and an appointment for the interview was made.

### **Data collection**

Data was collected using semi-structured interviews. Semi-structured interviews fit the deductive approach and were chosen to ensure similar types of data were collected from participants, based on the conceptual framework. An interview guide based on the social-ecological framework and the 12 sensitizing concepts was used to guide the interview (Appendix 1). When new themes and categories emerged, they were added to the interview

guide. Although semi-structured, questions were formulated open-ended to ensure that participants had the opportunity to answer from their own perspective.

### **Data analysis**

Data was analyzed using the software package ATLAS.ti 7 for windows. To ensure consistency of coding, a coding scheme (Appendix 2) was developed and tested on a sample of data. The coding scheme was based on the social-ecological framework and sensitizing concepts, and consists of four parts: The HCW (A-H), Barriers/facilitators/suggestions(-/+/=), Patient/provider/system level(a/b/c) and the twelve sensitizing concepts(1-12). A separate code, MAP, was used to code parts of the data describing involved health care workers and organizations. Coding was done by the first author (CG), and the codes from a sample of transcribed interviews were checked by the second author(MB) after which inter-coding agreement was achieved. The coding scheme was constantly checked against the data through a constant comparative method. When new themes or categories emerged, they were added to the coding scheme.

### **Procedures**

A total of seventeen individual, face-to-face interviews were conducted between February and May, 2015. The interviews had an average length of 39 minutes (range 23-55 minutes). The interviews were conducted by the first author (CG), who was unknown to participants. Interviews were tape-recorded, transcribed verbatim and anonymized immediately afterwards. Recordings were deleted after transcribing. Theoretical data saturation was reached after thirteen interviews, but four more interviews were conducted with HCW with different professions to verify this finding. Data analysis started after ten interviews and continued until all data was analysed.

### **Ethical issues**

The study was conducted according to the principles of the Declaration of Helsinki. All participants received an information letter outlining the purpose of the study, risks, benefits, privacy, consequences of participating and the option of withdrawal from participation at any time and without consequences during the research. All participants signed an informed consent form before the interview.

## **RESULTS**

The results are presented below, using six subheadings: Participant characteristics (Table 1), care network (Figure 1), patient- provider- and system level barriers and facilitators (Table 2) and participants' suggestions for optimizing the care process for postpartum depression. Table 3 provides an overview of relevant quotes of participants.



**Participant characteristics**

Participants were a diverse and representative sample of HCW involved in the care process of postpartum depression (Table 1).

(Insert Table 1)

**Care network**

HCW and referral lines were identified during the interviews (Figure 1). It turns out that Youth healthcare is the only organization that refers to other HCW, but is not referred to by others. For all other HCW applies that there is no logical referral-path they follow, it differs per patient. The circle "Others" includes additional activities HCW refer to like baby massage, mamacafe, mindfulness courses etc.

(Insert Figure 1)

**Patient level barriers and facilitators**

Several barriers on patient level were identified by HCW. One of the most mentioned barriers was the stigma parents express to HCW that they experience regarding mental health issues, especially when there is a healthy baby. There is a lot of pressure from society on being a good, happy parent. Parents feel ashamed and the topic cannot really be discussed. As a result, mothers do not talk about their problems until they really get out of hand and cannot be ignored any more. Only then, they admit having a problem and seek help. In addition to this, HCW feel that there seems to be lack of information and knowledge about PPD among parents. HCW expressed that it is very important that parents know what PPD is, what causes it, that it is common and that it can be treated. If so, the stigma reduces, women seek help earlier and work on their recovery. Another barrier perceived by HCW is social support. Support can encourage mothers to seek help, and helps when working on recovery. However, lack of support keeps mothers from seeking help. This applies not only to support from partners, also from family, friends, other mothers and HCW. They can talk about and share problems. A social network can also help with practical things, so mothers can focus on recovery.

Several other barriers were identified by HCW. HCW feel that it is important for parents that health care is easily accessible. Regarding this accessibility, participants said that mothers expressed that male HCW act as barriers when talking about PPD, because they cannot empathize as much as women. Also, participants expressed that a waiting list can act as barrier for starting treatment, while accessible HCW and care that is tailored to the needs of parents work facilitating. Participants perceived that finances are always a barrier. If care is not insured, parents sometimes choose not to utilize treatment options. Further, cultural differences can be difficult for parents to overcome or work with. However, using an assistant

for culture and language helps overcome any cultural barriers. Parents expressed to HCW that they like the use of home visits from HCW during treatment and coordination of care. They feel like it is a very approachable and practical way of care.

Some practical issues like distance and the need to use a babysitter can also act as barriers. However, participants expressed that if parents made that first step in admitting there is a problem and they need help, they go for it, no matter what practical barriers they encounter.

### **Provider level barriers and facilitators**

HCW also identified several provider level barriers and facilitators. One barrier participants perceived was difficulty discussing PPD, because of the taboo on mental health issues. However, using a screening instrument and announcing this screening already during the first home visit two weeks after birth, helps normalizing PPD and provides an entry for discussing the topic. Subsequent to this, it works facilitating for HCW if parents have knowledge about PPD and the treatment process. The topic is easier to discuss and treatment is more effective. Also enabling support from partners and family helps a lot while treating PPD.

Participants mainly identified barriers regarding the multidisciplinary collaboration. Most participants expressed indistinctness about what HCW are involved in the process of screening, referral and treatment for PPD, what their role is, where to find them, how to contact them and who is responsible for what part of the care process. There is no written care network reference available.

Participants expressed that knowing the other HCW you work with in person and having short communication lines work facilitating. However, there is hardly any consultation between involved HCW, unless really necessary. After referral, there is not much feedback and no transfer about provided care. All participants expressed that it would be helpful if other HCW let them know if and when they start or finish treatment, and what this treatment comprised.

Another expressed barrier is that participants felt like they lack knowledge and skills for recognizing and treating PPD. They also feel there is too little information available and almost no education or training options. Participants feel like available knowledge and new insight do not find their way to daily practice. Also, knowledge and ideas about treatment should be more on a par between HCW.

A few other barriers were perceived. There were no protocols or guidelines available for HCW. Everything they do is from experience and daily practice. Participants expressed that this can be a challenge. Also, cultural differences can be an issue. There often is a language barrier and taboo on the topic, making it difficult to treat PPD. However, using a translator and having knowledge about things that are typical for a specific culture, act as facilitators.

Participants experienced home visits as a very pleasant and effective way of treating PPD. Much more insight is gained in someone's specific situation and problems and therewith it is easier to tune the treatment to the needs of this situation. They also experience home visits as very practical.

### **System level barriers and facilitators**

A few barriers and facilitators on system level were identified. Waiting lists, work pressure in organizations and too little time for consultations can act as barriers. However, flexibility in scheduling work hours and consultations work facilitating in getting done what should be done.

One of the biggest identified system level barriers were finances. Sometimes specific care cannot be offered because it is too expensive or not reimbursed by insurance companies. In The Netherlands, the municipality is responsible for organizing mental health care since January 2015. This is perceived as a barrier so far. The municipality lacks knowledge about mental health problems and therefore restrict care when they should not. They want to help as much people as possible with the budget they have, making it impossible to offer important individual care and interventions.

### **Suggestions for optimizing the care process**

Participants feel there is much to be gained when it comes to reducing stigma and increasing knowledge. There should be prevention programs about PPD, using flyers, posters and one-liners on television screens in waiting rooms. This information should be given way earlier in the care process, before and during pregnancy, by midwives and gynecologists. Participants expressed that mothers should be reached before they get problems. All participants feel that with more information sooner in the process, the stigma reduces, parents will seek help earlier and recovery of PPD will go quicker.

Participants also expressed there should be more information about HCW involved in signaling and treating PPD. Every organization should have a clear website with information about PPD and about the treatment they provide. They also expressed that websites should contain up-to-date research articles and news about PPD. There should be more education and training possibilities for HCW, like symposia, conferences and refresher courses.

Furthermore, participants suggested that there should be regular meetings between HCW from different professions. They want direct contact and communication and really want to know each other.

(Insert Tables 2 and 3)

## DISCUSSION

This study identified involved HCW, barriers and facilitators of the screening, referral and treatment process of PPD, from HCW perspective. The barriers and facilitators were divided in patient- provider and system level. Most important, barriers on patient level mainly concerned encouraging or hindering help seeking behavior of mothers. Barriers on provider level mainly concerned difficulties in the multidisciplinary collaboration process. Barriers on system level mainly concerned finances, work pressure and waiting lists.

Other research confirms stigma and shame as a barrier for help seeking and treating PPD<sup>(17,19,20)</sup>. Also, several studies emphasized the importance of social support. Not having social support is associated with higher risk for PPD and higher levels of social support is associated with less depressive symptoms and works facilitating for mothers when it comes to help seeking<sup>(17,19,22,23,24)</sup>.

Besides lack of support, lack of knowledge may magnify stigma and help seeking problems<sup>(15,19)</sup>. In this study, HCW expressed lack of knowledge and education as a barrier on both patient and provider level and suggested informational and educational interventions. Recent literature endorses this suggestion. Higher levels of information and education to parents and training of HCW was shown to be effective in preventing PPD and increased the use of the EPDS<sup>(25,26,27,28,29)</sup>. Also, educating mothers resulted in better depression awareness, better ability to judge their own emotional state and more selected use of postpartum services<sup>(30)</sup>. This last point is specifically interesting since HCW in this study identified barriers on system level regarding work pressure and lack of time for treating women with PPD. Educational interventions might reduce this work pressure due to the more selected service use, which may result in more time available for treating women that do need help.

As stated in the introduction, screening can only be effective if systems are in place to provide adequate follow up<sup>(2,13)</sup>. This study identified lots of barriers concerning the multidisciplinary collaboration, resulting in an inadequate, unstructured and decentralized follow-up process at this moment. This is not a very surprising result when it comes to multidisciplinary working and is confirmed in lots of other research. Like the results of this study, other studies found indistinctness about other HCW and their roles and responsibilities, lack of resources (time, facilities, finances), not knowing other HCW and lack of communication and leadership as barriers for multidisciplinary collaborations<sup>(31,32,33,34,35,36)</sup>. Participants in this study specifically expressed the need of someone main responsible for the mothers' follow-up process. Darlington et al. (2004) expressed the importance of a specific leader in someone's care process. The danger of indistinctness about roles and responsibilities is that everyone thinks someone is doing the job, but in the end no one is doing it. This can have far reaching consequences for the mother and child<sup>(37)</sup>. Of course this

raises the question of who this leader should be. Participants in this study expressed preferring the general practitioner or practitioner assistant as coordinators of and responsible for the follow-up process of mothers. It is unclear if the general practitioners and practitioner assistants also think they are the designated persons and it is also unclear how this leadership should be designed.

The positive effects of collaborating were demonstrated repeatedly<sup>(33,38,39)</sup>. But the question is what makes collaboration effective. Several studies identified important factors for designing effective collaborations. To start with, there should be a need for collaboration, relevant organizations must be identified and preconditions need to be established<sup>(35,36,40,41)</sup>. After this, it is important to set joint and realistic goals to guide the collaboration<sup>(33,34,40)</sup>. Roles, expertise, expectations and responsibilities should be clearly defined<sup>(31,32,33,34,42)</sup>. Also, joint trainings and multidisciplinary meetings help getting to know other involved HCW. This contributes to identifying gaps in services, increasing trust, improving communication, forming new alliances and gaining new perspectives on service delivery, which in turn contributes to good referrals<sup>(31,32,35,41,43,44)</sup>. This complements suggestions made by participants for improving the multidisciplinary collaboration.

Multidisciplinary working can be combined with extensive home-visits<sup>(44,45)</sup>. In a review of Dennis et al. (2003), several studies showed the effectiveness of home-visits in treating mental issues post partum<sup>(24)</sup>. Other studies showed that home-visits contribute to reduced psychological distress, improved experienced social support and increased mother-child interaction<sup>(45,46,47)</sup>. This is interesting, because participants in this study expressed that they perceived home-visits as a facilitating factor in treating mothers with postpartum depression. In addition, participants said that parents also expressed their satisfaction with home-visits. The study of Aston et al. (2015) explored why home-visits are so effective and satisfying. The results of this study showed the importance of building a trusting, supportive, power-relationship. The home-environment seems to greatly facilitate the establishment of this relationship and the presence of such a relationship leads to increased self-confidence and mothers regaining control over their lives<sup>(48)</sup>, which is associated with lower depressive symptoms<sup>(49,50)</sup>.

However, it cannot be said that home-visits are the ideal way of treating PPD. The study of Flynn et al. (2010) found that Mothers preferred multiple and varying kind of treatment options. They stated that tailored care might influence if mothers follow through with referral options<sup>(51)</sup>. The study of Dennis et al. (2006) found that mothers did prefer the same kinds of treatment, but that preferences of treatment especially differed per country and culture<sup>(52)</sup>. Since the youth healthcare setting in the Netherlands is a very unique and different setting compared to well-child visits in other countries, treatment preferences may also differ from women in other countries. Therefore it seems important to tailor treatment

and referral options to the needs of mothers in The Netherlands. The World Health Care Organization (WHO) promotes patient-centered care as a way to balance capacities and responsibilities of organizations with the needs of patients<sup>(53)</sup>. Patient-centeredness leads to an improved patient-satisfaction<sup>(54,55,56,57)</sup>, which often is an indicator for healthcare quality.

Strengths and limitations of this study need to be addressed. The maximum variation sample gave the opportunity to explore differences in professions and experiences. It ensures a representative sample, which contributes to the generalization of the findings. However, the sample was not fully complete because a psychiatrist and social worker could not be persuaded for participation. The original area was expanded due to not enough participants available and participants were included conveniently based on who first indicated they wanted to participate. This might also influence representativeness of the sample. The deductive qualitative design had the advantage of comparing results across multiple studies, because roughly the same framework was used. Conducting the research in a research-group and constantly asking feedback challenged the sensitivity of the researchers on the topic and took multiple perspectives into account. The first author conducted interviews for the first time, after only little interview training. This might influence the depth of the collected data. Patient barriers were identified through HCW views, not from patients with PPD. This might have influenced the content and depth of the identified barriers. Last, data was coded systematically using a software package and coding scheme, making the analyzing process transparent, more complete and rigorous. However, coding was not done independently. Only a sample of the coded data was discussed, and other authors gave feedback after which agreement on final codes was achieved.

Further research is needed to identify experienced barriers and treatment preferences of mothers in the follow-up process for PPD in The Netherlands. After this, further research is needed how the multidisciplinary follow-up process can be designed in the specific Dutch setting, taking all facilitating factors and patients' view into account.

## **CONCLUSIONS**

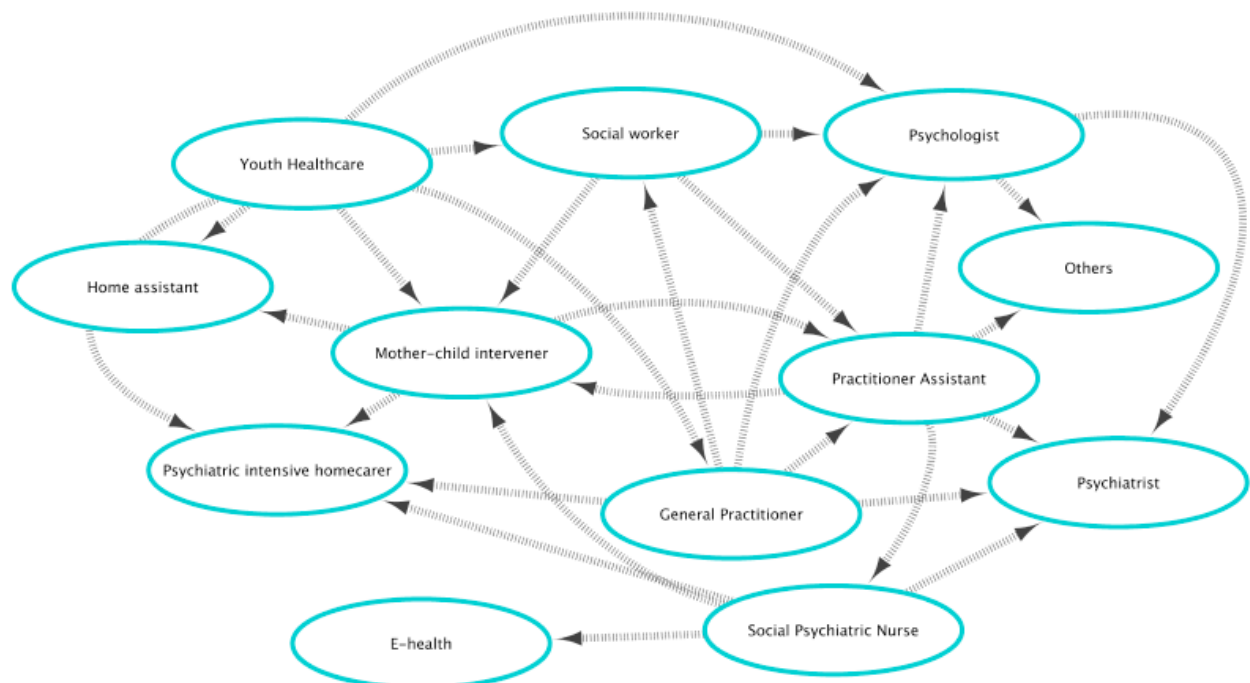
Overall, this study was successful in providing insight in the current follow-up process of PPD screening in The Netherlands. HCW identified barriers on patient-, provider- and system level. Most important barriers concerned Stigma, lack of knowledge and support at patient level, and on provider level, barriers concerning the multidisciplinary collaboration: indistinctness about involved HCW, referral lines, responsibilities, treatment options and lack of communication and consultation between HCW.

**RECOMMENDATIONS**

It is recommended that patients' and providers' perspective will be combined into an implementation strategy for improving the follow-up process for PPD. This implementation strategy should focus on reducing stigma by facilitating information and support for parents, and on designing an effective multidisciplinary collaboration process for all HCW involved in the treatment of PPD in The Netherlands.

**Table 1. Participant characteristics**

	N=17	%
<b>Gender</b>		
Female	15	88
Male	2	12
<b>Occupation</b>		
Youth health care doctor	3	18
Youth health care nurse	3	18
General practitioner	2	12
Practitioner assistant	4	22
Psychologist	2	12
Intensive psychiatric homecare nurse	1	6
Mother-child intervention nurse	1	6
Social psychiatric nurse	1	6
	<b>Mean</b>	<b>Range</b>
<b>Age (years)</b>	50	35-63
<b>Work experience with PPD (years)</b>	15	6-29
<b>Working hours per week</b>	26	8-40



**Figure 1. Care and referral network. Circles: Involved HCW. Arrows: Referral lines.**



**Table 2. Patient- provider and system level barriers and facilitators.**

Barriers	Facilitators
<b>Patient Level</b>	
<ul style="list-style-type: none"> <li>• Difficulty admitting all is not well</li> <li>• Fear of being judged as an unfit parent</li> <li>• Stigma from society</li> <li>• Shame</li> <li>• Lack of support</li> <li>• Lack of knowledge and information</li> <li>• Waiting lists</li> <li>• Financial problems/care not insured</li> <li>• Male health care workers</li> <li>• Practical issues</li> <li>• Cultural differences</li> </ul>	<ul style="list-style-type: none"> <li>• Realizing and acknowledging need of help</li> <li>• Notice that the topic can be discussed</li> <li>• Normalizing PPD</li> <li>• Knowledge and information about PPD</li> <li>• Support</li> <li>• Tailoring care to the needs of the parents</li> <li>• Easily accessible health care</li> <li>• Ensure continuity of the care process</li> <li>• Reimbursement of treatment costs</li> <li>• Home visits of health care workers</li> <li>• Using assistant for language and culture</li> </ul>
<b>Provider Level</b>	
<ul style="list-style-type: none"> <li>• Taboo of the topic</li> <li>• Lack of communication and consultation between HCW</li> <li>• Indistinctness about responsibilities</li> <li>• Indistinctness about involved health care workers and treatment options</li> <li>• Lack of knowledge and skills about mental health problems/PPD</li> <li>• Lack of protocols and guideline for treatment and referral of PPD</li> <li>• Practical issues</li> <li>• Cultural differences</li> </ul>	<ul style="list-style-type: none"> <li>• EPDS screening instrument</li> <li>• Option to activate social network</li> <li>• Knowledge of parents about PPD</li> <li>• Education and training for diagnosis, treatment and referral of PPD</li> <li>• Knowing other health care workers</li> <li>• Short communication lines</li> <li>• Regular communication and consultation between HCW</li> <li>• Multidisciplinary meetings</li> <li>• Being able to make home visits</li> <li>• Using assistants for language and culture</li> </ul>
<b>System level</b>	
<ul style="list-style-type: none"> <li>• Finances and cuts</li> <li>• Time</li> <li>• Lack of knowledge about mental health problems at municipality</li> <li>• Work pressure Top down</li> <li>• Waiting lists</li> </ul>	<ul style="list-style-type: none"> <li>• Time and space for consultations and home visits</li> <li>• Flexibility in scheduling work hours</li> </ul>

**Table 3. Patient- provider and system level quotes of health care workers.**

Patient level
<ul style="list-style-type: none"> <li>• <i>“Parents do say: Everything has to go right. I can never just say that it’s not, or it’s heavy. It’s just not accepted”</i></li> <li>• <i>“How society talks about it...And family and friends. It’s being dismissed, like it’s not important and should not be there”</i></li> <li>• <i>“If you explain, It occurs in a lot of women, what causes it, that a baby is very stressful. That helps getting mothers to seek help. Some information”</i></li> <li>• <i>“Fathers struggle with it to. They don’t know what is happening and what to do. They know nothing about PPD. They worry about their wife but have no idea were to go for help”</i></li> <li>• <i>“Like a mamacafe. Places were other mothers go to. Share experiences, find support, get tips. Not only if you are depressed, but just about normal things young parents encounter. And they go somewhere to.”</i></li> <li>• <i>“I try to adapt the care process to parents’ needs. What do they want and like. This helps tracing and solving problems in the care process. They have to feel like they’re being helped. Otherwise, the interventions won’t work, no matter how hard we try. The parents like that we really work together in this process, to ensure tailored care”</i></li> <li>• <i>“Especially with postpartum depression. Women don’t want to go places. So it is very helpful and practical that we come to them. Parents express they really like that”</i></li> <li>• <i>“Finances can act as a real barrier. Some patients do not utilize care, because they just don’t have the money. And that is a real problem, with big consequences for the mother and babies health”</i></li> </ul>
Provider level
<ul style="list-style-type: none"> <li>• <i>“If you mention it already at the first postnatal home visit, it is more normal. You’ll have an entry for discussing the topic, say it is more common. And then people will open up.”</i></li> <li>• <i>“Like a social network or something. Now I had to search by myself, I just googled. But some sort of overview, so that you can pick what care is needed in different situations. But that you know what is out there and what other HCW do. I really missed that.”</i></li> <li>• <i>“It’s important to get to know each other. Not only sending information, but actually meeting other HCW. Knowing what you can do for each other. You really need some sort of consultation every once in a while, where you can meet everyone and share experiences and news.”</i></li> <li>• <i>“I find it difficult to get a grip on PPD. What is it exactly? Where can you pay attention to and where can you anticipate on during treatment. Specific knowledge would be nice, and training options”</i></li> <li>• <i>“That is a real advantage of my work, the home visits. I can spot a lot. You gain insight in the daily program and how parents handle things. I have much interest in this way of treating. I think it is our power, we get closer to the core.”</i></li> </ul>
System level
<ul style="list-style-type: none"> <li>• <i>“The time we have for consultations, 10-20 minutes, is very short if you want to give mothers some attention. A double consult would be better. I indicated that to the manager. But it’s difficult with work load and finances.”</i></li> <li>• <i>“Finances in the organization act as big barriers. If something doesn’t fit in the care pathway of a different department, it gives a lot of hassle and discussion”</i></li> <li>• <i>“You must argue what intervention is needed. Only then insurance pays for it. The municipality have no idea what they are talking about, no knowledge about mental health problems. That is a real barrier. It costs a lot of time and gives a lot of hassle. And in the end, the patient is screwed and stuck with the wrong care. So they stop utilizing health care.”</i></li> </ul>

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**Appendix 1. Interview guide**

Beroep:.....  
Leeftijd:.....  
Werkervaring in het veld:.....  
Aantal uren per week:.....

(Introductie/uitleg over de studie en het doel)

1. Kunt u me iets vertellen over uw ervaringen met het proces van screening, verwijzen, behandelen en follow-up m.b.t. postpartum depressie?
2. Kunt u enkele belemmerende of bevorderende factoren benoemen op patienten niveau die u ervaart in dit proces?
3. Kunt u enkele belemmerende of bevorderende factoren benoemen op zorgverlener niveau die u ervaart in dit proces?
4. Kunt u enkele belemmerende of bevorderende factoren benoemen op systeem niveau die u ervaart in dit proces?
5. Heeft u het gevoel dat uw kennis voor het herkennen, behandelen en verwijzen van vrouwen met PPD toereikend is?
6. Heeft u het gevoel dat uw communicatie vaardigheden toereikend zijn voor een dergelijk gevoelig onderwerp?
7. Zijn er ook professionals of plekken waar makkelijker of minder makkelijk naar te verwijzen is dan naar anderen?
8. Zou een protocol of richtlijn voor het screenen, verwijzen en behandelen van vrouwen met PPD behulpzaam zijn?
9. Heeft u het gevoel dat screenen bijdraagt/dan wel niet bijdraagt aan het verwijs en behandel traject?
10. Is de jeugd gezondheidszorg toegerust voor het signaleren en behandelen van vrouwen met psychische klachten?
11. Hoe ervaart u de samenwerking met andere professionals?
12. Wat mist er naar uw idee nog in het proces van screening, verwijzen, behandelen en follow-up van PPD?
13. Wat zou u aanraden om te veanderen/verbeteren in dit proces?
14. Is er nog iets wat u graag wilt bespreken/toevoegen aan dit gesprek?



**Appendix 2. Coding scheme**

