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Research on the Construction of a Screening and Intervention Service System for Postpartum Depression

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Abstract

Postpartum depression is a common but easily overlooked mental health problem in maternal care. Many women do not actively describe themselves as depressed, and their symptoms may be hidden behind sleep loss, childcare pressure, breastfeeding difficulties, irritability, guilt, or fatigue after delivery. At present, postpartum health services still tend to focus more on physical recovery and infant health, while psychological screening, referral, intervention, and follow-up are not always well connected. This paper discusses the construction of a screening and intervention service system for postpartum depression. It analyzes the service needs of postpartum women, the current gaps in screening and intervention, the design of a screening pathway, the construction of an intervention service pathway, coordination among maternal care, community health, and mental health services, and the supporting mechanisms needed for implementation. The paper argues that postpartum depression care should not stop at one-time screening or general advice. A more effective service system should combine routine screening, risk classification, graded intervention, referral collaboration, family support, privacy protection, and continuous follow-up, so that women at risk can receive timely and appropriate help within the maternal and child health service process.

Keywords: postpartum depression, screening, intervention service system

1. Introduction

Postpartum depression is one of the mental health problems that can easily be overlooked in maternal care. The World Health Organization has estimated that about 13% of women who have just given birth experience a mental disorder, primarily depression, and the proportion may be higher in developing countries. A global review also reported that postpartum depression affected about 17.22% of postpartum women, although prevalence varies across regions and assessment methods. These figures suggest that postpartum depression is not a rare or marginal condition, but a common maternal health issue that requires regular attention in postpartum care.

After childbirth, many women experience changes in sleep, physical strength, family roles, feeding pressure, and emotional regulation. Some emotional fluctuations may be temporary, but when persistent low mood, anxiety, irritability, guilt, loss of interest, or feelings of helplessness continue, they may indicate a more serious depressive state. The difficulty is that these symptoms are often hidden behind the ordinary language of “being tired after delivery” or “not yet adapting to motherhood,” so they may not receive timely attention.

The influence of postpartum depression is not limited to the mother’s emotional state. It may affect breastfeeding, mother-infant bonding, infant care, marital communication, and the wider family atmosphere. In more serious situations, it can also be associated with self-harm risk or thoughts of harming the infant. For this reason, postpartum depression should not be treated as a private emotional problem that women must endure by themselves. It is a maternal and child health issue that requires early identification and appropriate service support.

At present, maternal health services still tend to pay more attention to physical recovery after childbirth. Uterine involution, wound healing, lactation, contraception, and infant growth are usually easier to observe and manage. Psychological symptoms, by contrast, are less visible and may not be actively reported by women. Some mothers worry that admitting emotional distress will make them seem weak or unqualified as mothers. Family members may also misread depressive symptoms as bad temper, lack of patience, or normal postpartum fatigue. These misunderstandings can delay screening and intervention.

A screening and intervention service system is therefore needed. Screening alone is not enough. If a woman is identified as being at risk but no one explains the result, follows up her condition, offers basic psychological support, or refers her to professional services when necessary, the screening process loses much of its value. In the same way, intervention cannot depend only on specialist hospitals, because many women first appear in obstetric clinics, maternal and child health institutions, community health services, or child health visits. These service points need to be connected.

This paper discusses the construction of a screening and intervention service system for postpartum depression. The focus is not on evaluating a single scale or proving the effect of one intervention method. Instead, it considers how postpartum depression can be identified earlier, how risk can be classified, how different levels of intervention can be arranged, and how maternal care, community health services, mental health professionals, and families can work within the same care pathway. A more useful system should make psychological care a regular part of postpartum health services, rather than an emergency response after symptoms have already become severe.

2. Service Needs of Women with Postpartum Depression

Women with postpartum depression often need more than a diagnosis. What they face is usually mixed with emotional distress, physical exhaustion, childcare pressure, and changes in family relationships. Some mothers may not describe themselves as “depressed” at first. They may only say that they cannot sleep even when the baby is asleep, that they cry more easily than before, that they feel guilty for not being a good mother, or that they have lost interest in things they used to care about. These expressions may sound ordinary in postpartum life, but they can also indicate that the woman is already under considerable psychological strain.

In routine maternal care, emotional distress can be difficult to notice. A postpartum visit may confirm that the wound is healing well, lactation is normal, and the baby is growing as expected, while the mother’s mood is still unstable. She may look calm during the consultation, especially when family members are present. She may also avoid speaking directly about sadness, fear, anger, or hopelessness because she worries that these feelings will be judged. For this reason, postpartum care needs to leave room for emotional expression, not only physical examination.

Many women at this stage need practical psychological support rather than immediate specialist treatment. Timely listening, reassurance, and basic guidance may help them understand that emotional difficulty after childbirth is not a personal failure. Some women need advice on sleep, feeding pressure, role adaptation, and communication with family members. Some need short-term counseling. Others may need more structured psychological intervention. If early distress is simply dismissed as normal postpartum fatigue, symptoms may become harder to manage later.

Family support is closely tied to these service needs. After childbirth, the mother’s mental state is often affected by how childcare responsibilities are shared at home. Lack of sleep, pressure around breastfeeding, disagreement over infant care, conflict with elders, or limited support from the spouse can all worsen emotional distress. In some families, the mother is expected to recover quickly and take care of the baby as a matter of course. Such expectations leave little space for her fatigue and vulnerability. A service system for postpartum depression therefore needs to involve family members, helping them understand what kind of support is actually useful.

For women with more serious symptoms, accessible referral and treatment are essential. Comfort and encouragement are not enough when there is persistent depression, obvious functional impairment, self-harm thoughts, or possible risk to the infant. These women may need professional assessment by mental health specialists, psychotherapy, medication evaluation, or crisis intervention. The difficulty is that many mothers do not know where to seek help, or they hesitate because of stigma, cost, time, and concern about breastfeeding or medication. If the referral channel is unclear, they may move between obstetric care, community services, and mental health departments without receiving continuous support.

Postpartum depression also requires follow-up over time. It does not always appear immediately after delivery, and it does not necessarily end after the routine postpartum check-up. Some women develop symptoms gradually as childcare pressure accumulates. Others experience repeated emotional fluctuations over several months. A single screening or one brief consultation cannot fully capture these changes. Follow-up should pay attention not only to mood, but also to sleep, family support, parenting stress, and whether the woman has

actually received the help she was advised to seek.

The service needs of women with postpartum depression are therefore broader than symptom identification. They include being heard, receiving practical psychological help, gaining family support, finding professional care when necessary, and being followed up after the first contact with health services. This is why postpartum depression care is better organized as a continuous service process rather than a single clinical encounter.

3. Current Gaps in Postpartum Depression Screening and Intervention

Postpartum depression has received more attention in recent years, but the service response is still not very stable. A recent review reported that the prevalence of postpartum depression in China was about 21.4%, suggesting that this is not a marginal problem in maternal health care. Even so, postpartum services often remain centered on physical recovery and infant health. During a postpartum visit, medical workers may ask carefully about breastfeeding, lochia, wound healing, contraception, and the baby's growth, while the mother's emotional state is touched on only briefly. If she does not say directly that she feels depressed or anxious, her condition may be missed.

Part of the difficulty comes from the way postpartum distress is understood. Some women do not recognize their own symptoms as something that needs help. Crying often, sleeping poorly, losing interest, feeling guilty, or becoming unusually irritable may be explained as the normal cost of becoming a mother. Family members may use similar explanations, seeing these changes as tiredness, bad temper, or lack of patience. In this kind of atmosphere, a mother may learn to hide her feelings, or give safer answers when asked about her mood. The problem is not only that screening is absent, but that women may not feel able to speak honestly when screening does occur.

The use of screening tools is also uneven. The Edinburgh Postnatal Depression Scale can help health workers identify women who may be at risk, but it is not used consistently across hospitals, maternal and child health institutions, and community services. Some institutions screen regularly, while others depend more on clinical impression or the mother's own complaint. Even when the scale is used, the process can become too procedural. A woman may fill in the form, receive a score, and leave without being told clearly what the result means or what she should do next. Under these conditions, screening finds a risk on paper, but does not necessarily lead to care.

The link between screening and intervention is still weak. Some institutions can identify possible depressive symptoms, yet lack a clear referral or follow-up pathway. Mild symptoms may be put aside because they do not look urgent. Moderate symptoms may be left to the woman and her family to "adjust slowly." More serious symptoms may also be referred late if obstetric, community, and mental health services are not connected. One study of 429 postpartum women in China reported a postpartum depression prevalence of 22.14%, which again suggests that a noticeable proportion of mothers may need more than a single score or a brief reminder.

Professional support is limited in many frontline settings. Obstetricians, midwives, nurses, and community health workers are often the first to meet postpartum women, but not all of them have enough training in mental health assessment or psychological communication. They may know that postpartum depression exists, yet still feel unsure about how to ask sensitive questions, how to respond when a woman cries during consultation, or when referral should be made. Without training and backup from mental health professionals, some frontline workers may avoid going deeper, not because they are indifferent, but because they do not know how to manage what may come next.

Family participation is another weak part of current services. Screening and intervention are often directed at the mother alone, while the family environment around her is left outside the process. This is a problem because postpartum women rely heavily on family members for rest, childcare, medical visits, and emotional support. If the spouse or other caregivers do not understand postpartum depression, they may increase pressure without realizing it. They may tell the mother to "think less," criticize her feeding choices, or treat her symptoms as a bad attitude. These responses can make her less willing to talk about her condition the next time she meets a health worker.

Privacy and stigma also affect whether women accept screening and follow-up. Some mothers worry that a depression label will be written into their record, judged by relatives, or interpreted as evidence that they are unable to care for the baby. Others fear that psychiatric treatment may affect breastfeeding, work, or family reputation. These concerns are not always expressed openly. They may appear as refusal to complete a scale, denial of symptoms, vague answers, or failure to return after a positive screening result.

4. Design of the Screening Pathway

The screening pathway for postpartum depression should be embedded in the ordinary contacts between postpartum women and the health service system. Many women will not go directly to a psychiatric clinic, even

when they are already distressed. They are more likely to appear in antenatal care, delivery hospitalization, postpartum visits, the 42-day postpartum review, vaccination appointments, or child health clinics. These routine contacts are often the first chance to notice emotional changes. If screening is left only to mental health departments, a large number of women with early symptoms may never enter the service pathway.

Screening also needs to follow the actual course of postpartum psychological changes. Some women begin to show anxiety or depressive symptoms before delivery, especially when there is a history of mental disorder, poor family support, pregnancy complications, or a difficult childbirth experience. For these women, risk identification can start in late pregnancy. After delivery, the first few weeks are often unstable. Pain, feeding problems, sleep loss, and the sudden change of family roles may all affect mood. A woman who seems calm before discharge may feel much worse after returning home. The 42-day postpartum visit and later community follow-up should therefore not be treated as routine physical checks only; they are also useful points for mental health screening.

Screening tools can help, but they should not dominate the whole process. The Edinburgh Postnatal Depression Scale is widely used and is suitable for initial screening in maternal care settings. Still, a scale score is not the same as a diagnosis. A high score needs further conversation and, when necessary, professional assessment. A low score should not automatically end concern if the woman is crying repeatedly, sleeping very little, expressing strong guilt, or saying that she cannot cope. In real clinical work, the scale is only one part of judgment. The health worker's observation and the woman's own description are just as important.

The way screening is carried out will affect whether women are willing to speak honestly. Some mothers may avoid telling the truth if their spouse, parents, or parents-in-law are sitting beside them. This is especially likely when the distress is related to family conflict, childcare burden, or lack of support. Screening should, as far as possible, give the woman a short private space. The language used by health workers also matters. If the questions sound like criticism, the woman may protect herself by denying symptoms. If screening is explained as a normal part of postpartum care, it is easier for her to talk about sadness, anxiety, anger, or exhaustion without feeling that she is being judged.

After screening, the result needs to lead somewhere. Women with no obvious depressive symptoms can still receive brief mental health education, because mood problems may appear later. Women with mild symptoms may need advice on rest, feeding pressure, family communication, and a planned follow-up. Those with more persistent or moderate symptoms should be linked with psychological counseling or community follow-up. For women who express self-harm thoughts, thoughts of harming the infant, psychotic symptoms, or severe functional impairment, referral to mental health professionals should be immediate rather than delayed until the next routine visit.

Records are also necessary, but they should serve care rather than paperwork. A useful record should show when the woman was screened, what level of risk was identified, whether referral was advised, and whether follow-up has taken place. This is important because postpartum women may move between obstetric clinics, maternal and child health institutions, community health services, and child health clinics. Without a shared or at least continuous record, each setting may see only one fragment of the problem. The woman may then be screened repeatedly, but not actually helped.

A workable screening pathway does not have to be complicated. It should make use of the service contacts that already exist, protect the woman's privacy, combine scale results with clinical judgment, classify risk in a practical way, and connect positive screening results with follow-up or referral. Otherwise, screening may remain a form filled out during postpartum care, rather than the beginning of real support.

5. Construction of the Intervention Service Pathway

After screening, the real question is whether the woman can receive help that matches her situation. A high score or a suspected risk is only a signal. If the service ends with "pay more attention to your mood" or "go to a specialist hospital if necessary," the mother may still be left to handle the problem by herself. For many women, especially those who are tired, ashamed, or unsure whether their symptoms are serious, this kind of vague advice is not enough.

For women with mild symptoms, intervention does not have to begin with specialist treatment. Some mothers mainly need someone to explain that emotional distress after childbirth is not a personal failure. They may also need practical advice on sleep, feeding pressure, physical recovery, and how to ask family members for help. A short conversation can be useful if it is specific. For example, telling a mother to "relax" is not very helpful, but discussing who can take one night feeding shift, how to arrange rest after breastfeeding, or when to return for another mood check is much more concrete.

When symptoms last longer or begin to affect daily function, the service response should become more active. A mother who keeps crying, feels hopeless, loses interest in caring for herself, or cannot manage basic childcare

should not simply be told to adjust slowly. At this point, follow-up needs to be planned, not left to chance. Community health workers, maternal health staff, or psychological counselors can keep contact with her, check whether symptoms are improving, and decide whether professional mental health care is needed. The pathway should allow the level of support to rise when the woman's condition does not improve.

High-risk cases need a much clearer route. If a woman mentions self-harm, thoughts of harming the infant, severe insomnia, psychotic symptoms, or obvious inability to care for herself or the baby, referral should not wait until the next routine visit. Obstetric and community services should know whom to contact and how to respond. In these cases, the aim is not only emotional comfort. Safety assessment, family notification when appropriate, urgent specialist care, and crisis management may all be necessary.

Family involvement should be part of the pathway, but it should not be treated as a simple instruction to "give more care." Some families do not know what care means in practice. They may offer advice, criticism, or pressure while believing that they are helping. Health workers can explain to family members that postpartum depression may appear as sadness, irritability, withdrawal, guilt, or loss of confidence. More importantly, they can tell the family what to do: reduce blame, share childcare, protect the mother's sleep, accompany her to medical visits, and avoid treating her symptoms as laziness or bad temper.

Follow-up is what keeps the intervention from breaking off after one contact. A woman referred for counseling may not go. A woman advised to rest may still have no one to help at home. A woman who seemed better at the first visit may worsen after several weeks of poor sleep. For this reason, the intervention pathway should include a return point. Health workers need to know whether the mother received the suggested service, whether her mood changed, whether family support improved, and whether risk signs appeared later.

The pathway does not need to be overly complicated. Mild distress can be supported through explanation, listening, practical guidance, and planned observation. More persistent symptoms need counseling and closer follow-up. Severe symptoms require urgent referral and safety management. What matters is that screening should lead to a response, and that response should not depend entirely on whether the mother has the energy and courage to seek help on her own.

6. Coordination Among Maternal Care, Community Health, and Mental Health Services

Postpartum depression care cannot be handled by one service setting alone. Many women first appear in obstetric clinics, maternal and child health institutions, or community health services, not in psychiatric departments. This means that the first opportunity for identification often belongs to workers who are not mental health specialists. If these services are not connected, a woman may be screened in one place, advised to seek help in another, and then lost before any real intervention begins.

Maternal care services should take the first step in recognition. Obstetricians, midwives, and nurses are familiar with the woman's pregnancy, delivery process, physical recovery, and breastfeeding problems. These details are often related to her emotional state. A difficult delivery, poor lactation, wound pain, or repeated concern about the baby may all increase psychological pressure. Maternal care workers do not need to provide full psychiatric treatment, but they should be able to notice risk signs, ask basic questions about mood and sleep, and explain why further support may be necessary.

Community health services are important because postpartum life mostly happens after the woman leaves the hospital. Emotional symptoms may become clearer at home, when sleep loss, childcare pressure, and family conflict begin to accumulate. Community health workers can provide follow-up during home visits, postpartum reviews, vaccination appointments, or child health services. Their advantage is continuity. They may see the mother more than once and may understand something about her family situation. This makes them suitable for checking whether symptoms are improving, whether referral advice has been followed, and whether the family is giving enough support.

Mental health services should provide professional assessment and intervention for women whose symptoms go beyond basic support. This includes women with persistent depressive symptoms, serious anxiety, self-harm thoughts, psychotic symptoms, or obvious impairment in daily functioning. The problem is that referral to mental health services is often not easy for postpartum women. Some are afraid of being labeled. Some worry about medication and breastfeeding. Some do not know which department to visit. If referral only means telling the woman to "go to psychiatry when you have time," many cases will not be followed through.

A more workable model is to create a clear connection between these services. Maternal care workers can identify risk and explain the need for help. Community health workers can keep contact after discharge and support follow-up. Mental health professionals can provide diagnosis, counseling, medication assessment, or crisis management when needed. The connection does not have to be complicated, but it should be specific. For example, a positive screening result should indicate who informs the mother, who contacts the family, who arranges referral, and who checks whether the referral was completed.

Information sharing is also part of coordination, but it has to be handled carefully. Postpartum depression involves privacy, and some women may be sensitive about who can see their mental health information. A basic record system can help different service points understand the woman's risk level and follow-up needs, but access should be limited to relevant health workers. The aim is not to circulate private information widely. It is to avoid the situation in which the woman has to repeat her distress at every visit while no one takes continuous responsibility.

Family members can also be included in coordination when the woman agrees and when safety allows. In many cases, the family decides whether the mother can rest, attend follow-up, receive counseling, or seek specialist care. If the family does not understand the seriousness of postpartum depression, referral advice may not be carried out. Health workers can explain the situation in practical terms: what symptoms need attention, what kind of support is useful, and when urgent help is needed. This is more useful than simply telling the family to be considerate.

The coordination among maternal care, community health, and mental health services should finally make the care pathway less dependent on the woman's own initiative. A mother with postpartum depression may not have the energy to find the right department, explain her condition repeatedly, and insist on getting help. The service system should reduce this burden. Once risk is identified, the next contact point should already be clear. This is the basic meaning of coordination in postpartum depression care.

7. Supporting Mechanisms for System Implementation

A screening and intervention system for postpartum depression will not work only because a pathway has been written down. It needs several forms of support in daily practice. The first is training. Obstetricians, midwives, nurses, maternal and child health workers, and community health workers are often close to postpartum women, but many of them have not received enough training in mental health communication. They may know the name of postpartum depression, yet feel unsure about how to ask about sadness, anxiety, guilt, self-harm thoughts, or family conflict. Training should therefore be practical. It should help frontline workers recognize warning signs, use screening tools properly, respond to emotional disclosure, and decide when referral is needed.

Another support is a clear working procedure. If a woman screens positive, health workers should know what to do next. Who explains the result to her? Who contacts the family if family support is needed? Which department receives referral? Who follows up if she does not attend the referral appointment? These details may look small, but they decide whether the system can really operate. Without a procedure, screening may depend too much on individual responsibility. Some health workers may handle the case carefully, while others may simply record the score and move on to the next patient.

Privacy protection is also important. Postpartum depression is still surrounded by misunderstanding and stigma. Some women are afraid that their emotional problems will be known by relatives, employers, or people outside the clinic. If they do not trust the service, they may refuse screening or hide their symptoms. Health institutions should make it clear that mental health information will be used only for care and follow-up. Conversations about mood should be arranged as privately as possible, especially when family conflict or self-harm thoughts may be involved.

Family education is another necessary mechanism. The family is often the place where postpartum depression becomes better or worse. A mother may receive good advice from a doctor, but if she returns home to constant criticism, poor sleep, and little childcare support, the advice may not help much. Health services can provide simple guidance to spouses and other caregivers: postpartum depression is not laziness or weakness; the mother needs rest, emotional support, and help with infant care; blame and pressure usually make symptoms worse. These messages do not need to be complicated, but they need to be repeated in different service contacts.

Digital tools can support the system, but they should be used carefully. Electronic health records, online follow-up, appointment reminders, psychological hotlines, and internet hospital services may make postpartum care more continuous. They can help health workers track screening results and remind women to attend follow-up. Still, digital follow-up cannot replace face-to-face assessment when symptoms are serious. It also cannot solve the problem of stigma or family pressure by itself. Its value lies in making contact easier, not in replacing professional judgment.

The system also needs evaluation, but evaluation should not become empty paperwork. It is useful to know whether women at risk are actually followed up, whether referrals are completed, whether health workers receive training, and whether families understand basic warning signs. These indicators are more meaningful than simply counting how many screening forms were collected. A service system should be judged by whether it helps women receive care after risk is identified, not only by whether screening has been performed.

8. Conclusion

Postpartum depression care should not depend only on whether a mother has the courage to ask for help. Many women may not recognize their symptoms at first, or they may hide their distress because they fear being judged. This makes active screening and a clear intervention pathway necessary in postpartum health services.

The construction of a screening and intervention service system should begin with routine maternal and child health contacts. Screening can be placed in antenatal care, postpartum visits, the 42-day review, community follow-up, and child health services. The result should not stop at a score. It should lead to risk classification, explanation, follow-up, psychological support, family involvement, or referral when needed.

A workable system also depends on coordination. Maternal care services can identify early risk, community health services can provide continuing contact, and mental health professionals can take over more serious cases. Families should also be included, because the mother's recovery is closely related to sleep, childcare support, communication, and the emotional atmosphere at home.

The main purpose of this system is not to make postpartum care more complicated. It is to prevent women with depressive symptoms from being seen once and then forgotten. When screening, intervention, referral, and follow-up are connected, postpartum mental health can become a regular part of maternal care rather than a problem addressed only after symptoms become severe.

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