Response to

"Detection and management of perinatal depression by midwives"

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Response to Letter to Editor titled:

"*Detection and Management of Perinatal Depression by Midwives*"

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Response to Letter to Editor titled:

"*Detection and Management of Perinatal Depression by Midwives*"

Thank you for the opportunity to respond to comments received by the Journal. In response to the Letter to the Editor titled "*Detection and Management of Perinatal Depression by Midwives*", we will address the following points. Our original conclusion stating "*further training is required to ensure midwives' competency in psychosocial assessment and management of women experiencing antenatal and postpartum depression*" is not based solely on the 17.6% of surveyed midwives' inability to recognise that further mental health assistance was needed for the fictitious test case. Instead, the conclusion is based on the pattern of results reported in the paper:

- There was a 16% decrease in scores by surveyed midwives identifying depression in the fictitious test case compared with 79.3% in the Buist et al. (2006) study.
- Mean positive and negative depression awareness scores of 5.0 (*SD* = 1.8) and 1.8 (*SD* = 1.4) respectively reflected a moderate level of ability by surveyed midwives to 1) recognise depression; 2) identify the need for help; and 3) identify appropriate treatments.
- A higher proportion of midwives in our study advocated the use of antidepressants and identified it as being useful during pregnancy and postpartum in comparison to midwives participating in the Buist et al. (2006) study. However, there is presently insufficient evidence to demonstrate the efficacy of antidepressant medication in preventing or treating women experiencing perinatal depression.

We agree it is encouraging that (a) around three quarters of surveyed midwives reported working with (*but did not identify*) women with antenatal and postpartum mood disturbance; and (b) 69.1% of participants have screened women for depressive symptoms during pregnancy and/or postpartum. However, these findings are not indicative of midwives as being knowledgeable or skilled in this area of work. Importantly, as discussed in the paper, we are cautious about an over reliance on the Edinburgh Postnatal Depression Scale (EPDS) as a stand alone screening instrument, which was reportedly used by 54.0% of surveyed midwives. Furthermore, the paper also raised the possibility of an erroneous belief by midwives that the EPDS can be used to fully assess symptoms of psychotic depression.

Our conclusion focuses on education for competency in psychosocial assessment, not limited to the use of screening tools, and management of women experiencing perinatal depression in part because self-reported behaviour of a self-selecting group on a fictitious test has limitations which are acknowledged in the paper. Furthermore, we are cautious in our conclusions because the survey was designed to elicit minimum knowledge requirements for midwives yet a sizable proportion was not able to identify appropriate responses on a number of items. While acknowledging the excellent work of our colleagues in promoting awareness and knowledge of perinatal mental health issues, the results of this survey suggest that more work in this area is required.