Briefing local government about PRISM: details of the briefing sessions conducted with all areas expressing interest in participation in the trial

A brief overview of the content areas covered at each of the briefing sessions held with municipalities interested in participating in PRISM is given in Table 1 (p4).

All briefings were held in local communities, mostly at municipal offices, involving in excess of 4,500 kilometres of travel by the research team across the state of Victoria. Local government participants numbered 103 in total (range of participants from 2-11,with a median of 3) and included a municipal chief executive officer, community service directors and managers, maternal and child health or family support co-ordinators, and in five instances, the whole team of maternal and child health nurses participated. At one briefing session, local government had also invited both a local paediatrician and a representative of the local general practice division[1] to attend. Two members of the PRISM research team (two of RS, SB, WD, JL) attended all briefings. The briefings were interactive sessions which enabled not only the presentation of more detailed information about the trial, but also provided an opportunity for local government participants to ask questions and for the research team to develop further understanding of service provision and local issues in each municipality.

Topics raised specifically by local participants at the briefing sessions are summarised in Table 2 (p5). The two members of the research team who attended each briefing session both made notes of the discussion and these were used in compiling the information in the table.

In general, responses to PRISM at the briefings were very positive. For twenty of the 25 communities briefed, explicit statements indicating enthusiasm to take part in PRISM were recorded in the briefing notes. Three raised issues that might prove problematic for participation, with direct statements about issues to be resolved/negotiated before proceeding made by two; and the notes for a third area indicated a range of queries over participation although no overall response about participation was recorded. Two areas appeared on balance of the comments recorded, to be mostly positive about participation, although no overall view was articulated at the briefing and recorded in the notes.

Specific topics raised in discussion by local participants totalled 169 and fell into four areas: logistics of participation (70); particular aspects of the PRISM intervention program as proposed (31); specific information provided about the local community (17); and issues in relation to the research design (26). Topics raised were coded as indicating a positive or 'non-problematic' comment about the topic in relation to potential participation in PRISM, or coded to indicate that the topic was mentioned by a local participant wanting clarification or raising possible problems for participation in PRISM. In 104 instances (61.5%) positive comments were made and in 64 (38.5%) the topics were raised for clarification or because they were seen as potentially problematic by local participants.

[1] General practice divisions are groupings of GPs within defined areas, with a local secretariat, to facilitate collaboration, participation in research and continuing education.

Given overall positive responses to the project as proposed, it is perhaps not surprising that the most frequently raised topics related to the actual logistics of local participation. Our stipulation that maternal and child health nurses not use the Edinburgh Postnatal Depression Scale (18) as a screening or diagnostic tool during the project[2] was commented on as unproblematic for 13 of the 21 where it was mentioned, but for eight areas this was an issue requiring further clarification from us at the briefing, discussion at a nurses' meeting or potentially as a major factor in deciding not to participate (3 areas). Queries were also raised about whether involvement in PRISM would prove to be a burden (rather than a support) for already over-worked maternal and child health nurses, an issue we agreed to address in the nurses' training program.

As outcome data measurement would rely on birth notification data, systems for recording birth notifications (ranged from handwritten ledgers to computerised databases, and from centralised systems for the whole local government area to MCH centre-based records) were frequent topics for discussion and highlighted the extent of support work that would be required from the research team in assisting some areas to develop systems that would incur least burden on local government staff. The infrastructure support requested from local government authorities allocated intervention status for a community development officer was mostly raised as non-problematic (ie provision of office space, computer access, costs of local travel), though this was raised in five areas as posing possible issues (availability of council cars, current over-crowding in council offices, whether available funds would stretch to cover some or all of the costs that would be incurred). Mostly, where these issues were raised it seemed likely that solutions could be found, and in two instances it was possible to agree immediately to some swapping of project supported costs (postage for outcome questionnaires) for local costs (covering travel costs of the community development officer). A number of areas mentioned the status of their MCH service contracts (whether these were in-house or contracted out, and when they might next be reviewed), but in no case was this seen to pose problems for participation in PRISM.

Around one in five of all topics raised related to specific aspects of the proposed intervention program, with our proposal for MCH training (particularly the active listening component) and the focus on strategies to reduce isolation and increase supportive social connections for mothers ('befriending') viewed particularly positively. The aspect of the program which received most questioning comment was our proposal for a continuing education program with general practitioners, where all 6 comments essentially shared the same question: "How will you get GPs to attend?", followed by stories of their own about trying to involve GPs in continuing education activities. At two briefings questions were raised about sustainability of the strategies (production of mothers' information kits, maintaining the intervention *in toto*) once the trial had concluded.

[2] Our reasons included: the lack of evidence for population screening for maternal depression; the testing of an alternative approach in PRISM to reducing depression; and the potential problems arising from prior completion by women of the depression outcome measure to be used in the study.

At a number of briefing sessions, local participants described particular features of their community – the mobility or diversity of the population, particular local initiatives around support for mothers, the existence of one or several 'centres' of population or activity (especially in rural areas) – all of which were seen as important in thinking about the implementation of PRISM, and some of which were posed as challenges for the intervention program. As PRISM was proposed as a universal program of support for all mothers, something received positively in most areas, a few had queries in relation to its potential relevance for particular population groups (fathers, teenage mothers, mothers of non-English speaking backgrounds, mothers with intellectual disabilities).

Twenty-five comments about research issues were noted. At six briefings specific positive comment was made about the proposed research design, either in terms of its rigor, the amount of detail provided or clarity of what was proposed. One remote area was also particularly pleased about the use of random selection of the final set of communities and then randomisation to intervention /comparison status, due to their experiences of often being 'left out' because they were so far from the capital city. Four areas raised the question of obtaining informed consent to participation by individual women, something discussed in terms of our seeking approval for a process that included different levels of consent. (19,20: p46) These different levels included approvals for the conduct of the trial from funding bodies and from university human ethics committees, local government consent to community participation and individual consent from women to participation in outcome assessment.

There was some interest in discussing aspects of the process and outcome evaluation proposed and one area was concerned that communities not be individually identified in dissemination of the findings – something we were able to confirm would not happen. Queries about the role of comparison areas, how we intended to prevent the intervention 'leaking' from intervention into comparison areas and the nature of restrictions on service developments in comparison areas were also raised at some briefings. These queries enabled immediate discussion and clarification which emphasised the important role of control communities in randomized trials in determining the effectiveness (or not) of the intervention program; the fact that selection of participating areas would take into account contiguous boundaries to reduce 'leakage' (contamination); and acknowledgment that comparison areas would not be restricted from developing their services during the trial, beyond not implementing the specific intervention strategies being tested in PRISM. Given the climate of fiscal restraint and cuts to local government services it seemed unlikely that any municipality would implement PRISM without specific additional funding. This was common ground across the research team and local participants at the briefings. After discussion, this range of issues did not seem to present barriers to participation.

Finally, a few 'informal' comments were made at briefings that underscored the importance of making the processes for participation clear and transparent from the outset. At one briefing, it was suggested, for example, that local political influence could be brought to bear to ensure participation of their area, if necessary. What is more, our own personal responses to the people we met and discussed the project with could also have been influential, consciously or otherwise, in selecting areas identified as 'easy to work with,' or in our view 'best able to implement PRISM', were the whole process not bound by a clear and public commitment to randomisation.

TABLES

Table 1: Overview of the content covered in research team presentations about the trial at local government briefing sessions

Background to PRISM: research evidence about maternal depression and physical ill health after childbirth

Description of the key elements of the planned intervention program:

Forms of evaluation proposed in PRISM:
- Health outcome evaluation
- Process and impact evaluation
- Ecological and economic evaluation

Design of the trial

Selection of participating areas:
- Areas to be matched in pairs
- Random selection of matched pairs from all areas signing a Memorandum of Understanding
- Public randomisation of final set of matched pairs to intervention or comparison status

Progress to date: funding secured, expressions of interest from local government

Costs and contributions to be met by the project

Outline of the contributions requested from local government: for both intervention and comparison areas

Acceptance of randomisation: discussion of the importance of acceptance of randomisation outcome and conditions of participation in the project

Project implementation timelines: establishment through to reporting of trial findings

Memorandum of Understanding: draft presented and discussed

Questions and discussion

Table 2: Topics specifically raised by local participants at the 25 PRISM briefing sessions

TOPICS	Frequency that a topic was raised in discussion by local participants	Frequency that a topic was raised when seen as positive/ non problematic	Frequency that a topic was raised because it required clarification or was seen as problematic
Overall relevance to the local community of PRISM as proposed	**25#**	**21**	**4**
Logistics of participation			
Non-use of the EPDS as a clinical tool during the project	21	13	8
MCH issues (workloads, timing & back-fill for training)	7	2	5
Data collection process and systems	15	7	8
Locally provided CDO support infrastructure	12	7	5
Involvement in other projects	6	4	2
Amendments to the MOU	2	2	0
MCH contract issues	7	7	0
SUB-TOTAL	**70**	**42**	**28**
Aspects of the PRISM program			
MCH training	9	9	0
GP training	6	0	6
Kits	1	0	1
Vouchers	2	2	0
Befriending	7	6	1
CDO	2	0	2
Steering Committee	2	2	0
Sustainability of program	2	0	2
SUB-TOTAL	**31**	**19**	**12**
Nature of the local community			
Community profile: special issues	7	5	3
Particular population groups	9	3	6*
SUB-TOTAL	**17**	**8**	**9**
Research design			
Rigor/detail/clarity	6	6	0
Randomisation	1	1	0
Ethical issues	4	0	4**
Evaluation (methods and outcomes)	6	3	3
Identification of LGAs in outcomes	1	0	1
Comparison areas (role, restrictions)	8	3	5
SUB-TOTAL	**25**	**12**	**13**
TOTALS	**169**	**104**	**65**

For 5/25 briefings, the code here was determined on balance (ratio of 'positive' comments to problems raised) from the notes of the discussion, rather than a specific comment made and recorded in the briefing notes.

*"What about… fathers (1), teenage mothers (2), mothers of non-English speaking backgrounds (2), mothers with intellectual disabilities (1)?"

**Queries and concerns about the process of obtaining consent from individual women