PRISM Information Package for Local Government

On June 1, 1997, the Centre for the Study of Mothers' and Children's Health began an exciting new project which aims to improve the physical health and emotional well-being of mothers, via an integrated program of community based and primary care strategies.

The program, called PRISM (Program of Resources, Information and Support for Mothers), is designed to take place in local communities involving primary care providers (maternal and child health nurses and general practitioners), community agencies, community mental health services and local government.

Invitations to take part in PRISM are being extended to 33 local government areas across Victoria. The 33 eligible local government areas are those which had 300 to 1500 births in 1996.

We are seeking to involve a total of 14 local government areas, with seven participating in the PRISM intervention program and seven acting as comparison communities. Each local government area will be matched with another community taking into account socio-demographic factors, numbers of births, geographic size and levels of community activity. Within each matched pair, only one community will receive the intervention program. Randomisation to intervention or comparison community status will occur at the official launch of PRISM in June 1998.

This information package contains:

A letter of invitation to participate in PRISM, and an 'expression of interest' form to be returned by Friday 20th March, 1998.

A detailed outline of the rationale and benefits of the project, and what would be involved for local government areas interested in taking part.

Contents

1. PRISM: Program of Resources, Information and Support for Mothers

1.1 Project Summary

PRISM is an innovative program of community based and primary care strategies which aims to build on the existing services and capacities of local communities in order to provide a more responsive and supportive local environment for women with young children.

The project, being conducted by the **Centre for the Study of Mothers' and Children's Health**, La Trobe University, will evaluate a range of strategies designed to improve:

recognition and treatment of depression and common postnatal physical health problems in primary care,

listening skills and offers of 'time to talk' by GPs and MCHNs,

local availability of social support and time-out for women with young children.

It is intended to involve 14 local government areas, seven participating in the intervention program and seven acting as comparison communities. Communities will be matched in pairs and then randomised, with one in each pair receiving the intervention program.

Evaluation will assess major health outcomes and wider community benefits (flow-on effects) of the program. Process and impact evaluation will also be undertaken to document and assess different program elements and enhance the reproducibility of the program if successful.

The project develops a model for community capacity building and intersectoral collaboration in community health, which if successful, will have highly significant implications for future municipal planning of health and human services.

1.2 Major objectives

The four major objectives of PRISM are:

1. ***Improved health outcomes*:**

To reduce the prevalence of depression and of physical health problems in mothers 6-9 months after birth and to reduce the proportion of women still depressed 18-21 months after birth in communities randomised to receive an intervention program.

To improve family well-being by acknowledging the important social role encompassed in parenting, and by mobilising community support for families following the birth of a baby.

2. ***Community capacity building*:**

To utilise and build on the existing strengths of local communities in an innovative health promotion program designed to address an issue of major public health significance with scope for significant local input and thus greater potential for sustainability.

3. ***Intersectoral collaboration in community health*:**

To develop and test a model for intersectoral collaboration on a public health issue at the local level involving primary care (maternal and child health nurses and general practitioners), mental health services, local government and community organisations.

4. ***Rigorous evaluation***:

To determine the effectiveness of the proposed intervention including detailed process, impact and health outcome evaluation, as well as a comprehensive economic evaluation.

1.3 Benefits of PRISM for the local and wider community

Potential community benefits of PRISM include:

immediate benefits for the well-being and health of women, children and families, and thus for the community at large;

the development of a model for intersectoral collaboration to improve health outcomes that has potential benefits and flow-on effects to other health and human service program areas;

the potential to incorporate the lessons and successes of the program into ongoing health and community service provision without major injections of new funding;

the capacity to answer crucial questions about the intervention program:

Has the intervention worked?
Have the benefits to the community been worth the costs?

Immediate benefits for participating local government areas include:

the significant contribution made by the project to the costs involved in implemention of local health promotion activities, including training for maternal and child health nurses in an area of identified need;

the opportunity to take a lead role in a project consistent with the frameworks being developed in Municipal Public Health Plans.

1.4 Background and rationale

PRISM is the culmination of eight years of descriptive research conducted by the Centre for the Study of Mothers' and Children's Health mapping the experiences of Victorian women as they become mothers:

1989 Survey of Recent Mothers: a population based statewide postal survey exploring women's views of maternity care and assessing the prevalence of depression after birth.

Follow-up Study of Women's Emotional Well-being and Experiences of Motherhood: in-depth personal interviews with 90 women who had taken part in the 1989 Survey, half of whom had been depressed 8-9 months after the birth, exploring factors contributing to depression, and strategies found to be helpful.

1993 Survey of Recent Mothers: a second statewide postal survey with additional emphasis on physical health problems after birth.

Life as a Mother Project (LAMP): in-depth telephone interviews with women concerning the first nine months of life with a new baby, focusing on factors affecting maternal health and recovery.

Mothers in a New Country (MINC) Study: a cross cultural interview study with Vietnamese, Turkish and Filipino women assessing their views of maternity care and exploring physical and emotional health issues after birth.

This series of projects was complemented by an analysis of Medicare data on claims for medical services made by a random sample of Victorian women and their babies in the six months following birth; by a survey of Victorian general practitioners on their beliefs, attitudes and practice in the provision of postnatal care; and results of a randomised trial investigating the effect of changing the timing of the postnatal check-up.

The results of these studies demonstrate that depression and physical health problems after childbirth are significant public health issues for Victorian women and families:

> 8,000-12,000 Victorian women a year (around 17% of those who have recently had a baby) experience depression in the year after childbirth

> 94% of women experience one or more physical health problems in the first six months after childbirth; the most common problems being exhaustion (69%), backache (43%), perineal pain (21%), sexual problems (26%) and urinary incontinence (11%)
>
> scores on all domains of the health status measure, the SF-36, were significantly lower for women three months after childbirth, than the comparative mean scores in Australian population-based data for women of childbearing age.

Maternal health problems often go undetected, despite frequent contact with primary health care services:

> Fewer than one in three women depressed at 8-9 months postpartum had sought help from health professionals. When they did so, it was generally from maternal and child health nurses or a local GP. It was extremely rare for women to have had contact with mental health services. Half had turned to family members or friends, but half had talked to no-one about how they felt.
>
> Two out of five women had not talked to their maternal and child health nurse about their own health and recovery since the birth. This included many women experiencing problems such as incontinence, persisting perineal pain and exhaustion. Fewer than ten percent of women experiencing these problems 6-9 months after the birth had sought help from their maternal and child health nurse or local general practitioner.

A number of factors contribute to the under-recognition of maternal health problems in primary care:

> A consistent finding of the Centre's research is that discussion of maternal health problems is quite unlikely to be initiated by women themselves.
>
> Most mothers perceive maternal and child health services as primarily providing advice and support in relation to infant health and development, a finding confirmed in the recent *Maternal and Child Health Consumer Survey* conducted by the Victorian Department of Human Services.
>
> According to a recent Victorian survey of general practitioners, discussion of depression and physical health problems is not generally seen by GPs as a standard aspect of postnatal care.

Women perceived a range of factors as contributing to poorer emotional well-being. These included:

lack of practical and emotional support
isolation
poor physical health
exhaustion.

Reflecting back on the experience of being depressed, the 'advice' women had for other mothers was:

"find someone you feel able to talk to"
" try to get some time-out".

Forty-nine percent of women who took part in the 1993 Survey would have liked more advice and support in relation to their own health and recovery after the birth. The issues that came up most frequently were: emotional well-being, general health and recovery, tiredness, and breast-feeding. Other issues women wanted more advice about included: sexual issues, weight loss and weight gain, perineal pain, bleeding, backache and relationship issues.

Addressing the health of women after childbirth
What needs to happen?

Re-orientation of universal primary health care services to provide a greater emphasis on maternal health issues.

Local strategies for support and time-out for mothers.

Better information about local services, with greater encouragement and incentives to use them.

Evaluation: of health outcomes, and wider community benefits.

PRISM follows on from the Centre's extensive research with recent mothers, and primary care in Victoria. Since work on the design for PRISM began in 1995, we have also closely monitored developments in research conducted overseas.

In the United Kingdom, three studies are currently evaluating different strategies for re-orienting postnatal care to give greater emphasis to maternal health and recovery in the first six months after childbirth. Two other studies already completed have demonstrated the success of offering 'time to talk' as an intervention for postnatal depression.

Like the studies currently underway in the UK, the aim of PRISM is *to re-orient existing services to give greater priority to maternal health*. It is *not* intended to add an extra workload to the already busy schedules of primary care and community based services.

The World Health Organisation recently identified depression as likely to be the second highest contributor to the global burden of disease by the year 2020. Evaluation of primary and secondary prevention strategies for this major public health problem must therefore be regarded as an urgent priority.

1.5 Major elements of the intervention program

PRISM: Minimum or 'key elements' of the intervention

A developmental training program for primary health care providers (maternal and child health nurses and general practitioners) to enhance recognition and treatment of depression and physical health problems occurring in the year after birth, and promote 'listening skills' and offers of 'time to talk' in primary care.

A Mothers' Information Kit providing information about common experiences of early motherhood (chronic fatigue, low emotional well-being, physical health problems), and about local support services.

A Voucher Scheme offering incentives to recent mothers to take up locally available support services, via the distribution of free vouchers or discounts for services to be incorporated in the Mothers' Information Kits.

Social Network Development informed by focus groups and individual interviews in each community.

The developmental work necessary in intervention communities will begin with the setting up of a small **steering committee of key stakeholders** (local government, maternal and child health nurses, GPs, community and consumer organisations) in each intervention community.

A **community development officer**, employed by the Centre, will work full-time for two years in each intervention community to facilitate the establishment of the intervention by:

liaising with local government and non-government agencies, GPs, maternal and child health nurses and local psychiatric services;

providing support to the local steering committee in overseeing the intervention program in each local area;

assessing levels of community service provision and compiling information on services for mothers, soliciting voucher contributions from relevant bodies, and producing the package of information for mothers;

assisting in the establishment of social support networks (eg. peer befriending schemes) through local government or a community agency as appropriate;

assisting with the economic evaluation, and the process and impact evaluation phases of the project.

It is important to note that the 'key elements' of the intervention are prespecified in the protocol for the project (See boxed section, p10).

Beyond the minimum elements of the intervention program, each steering committee will be invited to make decisions about other supportive interventions, as well as the appropriate implementation of different elements of the intervention in their local community. For example, some steering committees may feel that organising a community forum to raise awareness about maternal health issues is appropriate, others may want to publicise the program in the local papers. Strategies for social network development are also likely to vary according to the assessment of local needs and the range of existing services.

1.6 Why is PRISM being conducted as a randomised trial?

PRISM is designed as a randomised trial so that health outcomes (depression and physical ill-health) can be assessed and compared in the seven communities receiving the intervention, and in the comparison communities not receiving the intervention.

The reason for designing PRISM as a randomised trial is that randomisation offers the best chance in evaluation research that *like is being compared with like*.

In other research designs (e.g. cross-sectional surveys) it is difficult to sort out the contribution of any single factor to an effect or outcome, because of associations between factors which may either mask or exaggerate effects. For example, in assessing differences in health outcomes for recent mothers in a particular local community, it is important to take into account obstetric factors such as the number of women in that locality who have had caesarean sections or births assisted with forceps. Social differences such as the number of younger women and sole parents may also be important. Another factor, rarely considered in evaluation research, is differences that may exist at the local area level in relation to types of community activity and social network development. These differences are potentially important because they may affect the implementation and effectiveness of social and health care interventions.

In considering intervention programs conducted in local communities, it is crucial to build into the evaluation, methods for taking into account the sorts of variables described above. Randomisation provides the best chance that potential confounders will be evenly distributed between intervention and comparison communities, enabling us to attribute differences in outcome between the intervention and comparison communities to the intervention program.

The reason for randomising 14 communities - with seven receiving the intervention and seven acting as comparison communities - is that this is the minimum number of communities required to provide adequate statistical power for assessing the effectiveness of the intervention program.

1.7 Evaluation

Evaluation will involve both process and impact assessment, and measurement of health outcomes:

Process and impact evaluation will be undertaken to document and assess the different program elements, and to enhance the reproducibility of the program if successful.

Evaluation of health outcomes will occur in the intervention and comparison communities via a postal survey including the Edinburgh Postnatal Depression Scale, and the SF-36 self report health questionnaire.

The benefits of PRISM, if it is effective, have the potential to be sustained over time and to extend beyond the immediate target of the intervention. Successful development of professional networks and competencies would have positive implications for the full range of maternal and child health and mental health services. The development of social networks is also likely to have wider benefits for the community generally. Given the costs involved it is important that the economic evaluation captures this full range of outcomes.

The wider community benefits of the program - cost-benefits and flow-on effects of strengthening provider networks and building supportive social networks - will be evaluated as a separate very important component of the evaluation (ECO-PRISM). Alan Shiell and Penny Hawe, of the Department of Public Health and Community Medicine, University of Sydney, will be working on this aspect of the project.

2 Roles and responsibilities

2.1 Research team

Professor Judith Lumley
Ms Rhonda Small, Research Fellow
Ms Stephanie Brown, Research Fellow
Ms Wendy Dawson, Research Administrator
Ms Lyn Watson, Statistician
Dr Jane Gunn, General Practitioner, Research Fellow
Mr Alan Shiell, Health Economist
Dr Penny Hawe, Community Intervention/Program Evaluation

The research team has overall responsibility for:

study design
conduct of research
recruitment and supervision of staff
analysis and writing up of results
dissemination of findings.

2.2 Local Steering Committees

key stakeholders in each intervention community (local government, maternal and child health nurses, general practitioners, community and consumer organisations).

Terms of reference:

Although the major elements of the community intervention are defined, some flexibility will be maintained providing scope for each local steering committee to make decisions about other supportive interventions, as well as the appropriate implementation of key elements of the intervention within their local community.

Working within this framework, the terms of reference for the local steering committees are:

to oversee the establishment and implementation of the intervention program in their community;

to facilitate integration of the community service program in each local community once it is established.

2.3 Community Development Officers

Major responsibilities:

liaise with local government and non-government agencies, GPs, maternal and child health nurses, local mental health services

compile local service information and solicit voucher contributions for the information kits

assist in social network development

provide support to the local steering committee

assist in process evaluation and aspects of the economic evaluation.

The community development officers will be employed as staff of the Centre to facilitate:

clear lines of responsibility to the research team
uniform conditions of employment
training opportunities in program evaluation.

Initially the community development officers will be located at the Centre to facilitate training. An appropriate community auspice for the duration of the intervention program will be negotiated with each local council.

2.4 Reference Group

Ms Christina Bryant, clinical psychologist

Dr Regina Clarke, general practitioner, Bendigo Community Health Service

Ms Crissene Fawcett, consumer advocate, mother of three children, background in community development

Assoc Prof Michael Hamel-Green, Co-ordinator BA (Community Development), Department of Social Inquiry and Community Studies, Victoria University

Ms Clare Hargreaves, Municipal Association of Victoria

Prof Helen Herrman, Director of Psychiatry, St Vincent's Hospital, and Professor of Psychiatry, University of Melbourne

Ms Lesley Hubble, Manager, Family and Neighbourhood Services, Department of Human Services Victoria, responsible for the Maternal and Child Health Program.

Dr David Legge, Senior Lecturer, School of Public Health, La Trobe University

Ms Reay Presser, Maternal and Child Health Co-ordinator, City of Yarra

Dr Andrew Stocky, Director, Mother and Baby Unit, Monash Medical Centre; and Director, Mother Baby Program, Melbourne Clinic

Prof Roger Strasser, Director, Centre for Rural Health, Monash University

Terms of reference:

to provide advice and assistance to the research team in relation to planning and implementation of the intervention program, and analysis of the findings

to provide advice and assistance in facilitating discussion of the project findings.

The roles and responsibilities of the research team, local steering committees, community development officers and the reference group will be covered in a Memorandum of Understanding to be signed as a condition of participation in PRISM (See Section 4).

3. Funding Issues

3.1 Funding support for PRISM

Source	Purpose	$
NH&MRC	Research funding Economic evaluation	$311,000 $143,000
La Trobe University (Collaborative Industry Grant)	Project development	$10,000
Department of Human Services Victoria (Youth and Family Services and Public Health Divisions)	Project development Program implementation	$10,000 $240,000
VicHealth	Program implementation	$97,000

Further funding to support the project is being sought from a range of sources.

3.2 Implementation costs provided by the project

Training for maternal and child health nurses in an area of identified need

Salary for full-time community development officer in each intervention community

Initial costs for the Mothers' Information Kits

All evaluation costs: health outcome evaluation, process evaluation, flow-on benefits and economic evaluation

Expenses for each local steering committee ($500/year for 4 years)

Travel for community development officers in rural areas to attend 4 project meetings in Melbourne ($1,500)

Costs of stationery, newsletters

Production of reports and presentations

3.3 Contributions requested from local government

1. For the community development officers:

office space
computer access
use of telephone, and cost of local calls
travel within local area

2. In relation to maternal and child health services:

time release and back-fill to participate in training (2.5 days per nurse)

3. For the purposes of data collection:

The process of data collection involves mailing out surveys and a reminder postcard to all mothers in both the intervention and control communities 6 months after birth on a rolling basis over 12 months, and then to send out questionnaires to a sub-group of mothers two years after the birth, again on a rolling basis.

To ensure confidentiality mail-outs will need to occur from city or shire offices using birth registration information.

All participating local government areas (i.e. those receiving the intervention program, and comparison communities) will be asked to assist the project team to establish an appropriate data system drawing on local computerised systems in each local government area (The costs of data collection will be covered by the project).

4. Proposed Memorandum of Understanding with each participating Local Government Area

It is important that there is a clear understanding between the research team and each participating local government area in relation to all major aspects of the project. As noted above, the key elements of the intervention program are pre-specified. It is important that these minimum aspects of the intervention program are implemented in all intervention communities, although the precise details of how they are implemented may vary according to local community needs and the range of existing services. Beyond the minimum elements of the intervention program, each steering committee will be able to make decisions about further action they may wish to take. These and other aspects of what it means to be involved in PRISM will be clearly defined in a Memorandum of Understanding to be negotiated with Local Government Areas after an initial expression of interest in participation has been lodged with the research team.

The Memorandum of Understanding will cover:

the roles and responsibilities of the research team, local steering committees, community development officers and the project reference group

the key elements of the intervention program

what it means to be involved in PRISM for both intervention and comparison communities

the process for randomisation

implementation costs provided by the project

infrastructure support to be provided by local government

details of the evaluation program, including processes for data collection in both intervention and comparison communities.

5. Process for Local Government Expressions of Interest

1. **Return the enclosed form by Friday 20th March, 1998.**

2. **PRISM Briefings**: The research team have scheduled time from late March to early May to visit each local government area interested in taking part in PRISM to provide further information and answer questions about the project.

   The enclosed form for expressions of interest asks for a contact person to be nominated. A member of the research team will contact the nominated person within a week of receiving your expression of interest to discuss the next steps in the process.

3. **Signing the Memorandum of Understanding**: This will be the next formal step in the process. Agreement regarding the details of the Memorandum of Understanding needs to be reached and signed prior to the randomisation of local government areas in June.

4. **Launch of PRISM/randomisation of local government areas on Tuesday June 16, 1998.**