



Memorandum of Understanding

This is an agreement between _____ and La Trobe University (on behalf of the Centre for the Study of Mothers' and Children's Health), regarding participation in *PRISM - Program of Resources, Information and Support for Mothers*, a community intervention trial to improve the physical and psychological health of women following childbirth.

The memorandum covers the following areas in turn:

1. PRISM: the project
2. Roles and responsibilities of project participants
3. The intervention program
4. The process for randomisation
5. Implications of allocation to intervention community or comparison community
6. Implementation costs to be provided by the project
7. Project evaluation
8. Project timelines
9. Mechanism for communication between the research team and local government

1 PRISM: The Project

1.1 Summary

1.1.1 PRISM is a 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.

1.1.2 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 general practitioners and maternal and child health nurses
- local availability of social support and time-out for women with young children.

1.1.3 PRISM is designed as a randomised trial involving 14¹ local government areas, seven participating in the intervention program and seven acting as comparison communities. Communities are to be matched in pairs and then randomised, with one in each pair receiving the intervention program.

1.1.4 Evaluation will assess major health outcomes and wider community benefits 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.

1.2 Objectives

1.2.1 The four major objectives of PRISM are:

1.2.2 *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 2 years 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.

1.2.3 *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.

1.2.4 *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.

1.2.5 *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 Subsequently this was increased to 16 participating local government areas.

2. Roles and Responsibilities of Project Participants

2.1 The 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, Senior Lecturer, Public Health

2.1.1 The research team has overall responsibility for: project design; conduct of the research; recruitment and supervision of staff; and analysis, writing up and dissemination of the findings.

2.1.2 Professor Judith Lumley, the Chief Investigator, is accountable to the National Health and Medical Research Council, the Department of Human Services and VicHealth for the conduct of the research within ethics requirements and as approved by the above funding bodies.

2.1.3 The research team is responsible for overseeing, on behalf of the University, the deployment of funds granted to the project, as outlined in Section 6.

2.1.4 The research team agrees to brief all participating local government areas on the findings of the project before publication of the results.

2.1.5 The research team is free, with due acknowledgment, to publish the results of their work on the project.

2.1.6 The research team retains copyright, on behalf of the University, of all materials produced for the project.

2.2 Local Steering Committees

2.2.1 Local steering committees will be established in each intervention community and will comprise key stakeholders: local government, maternal and child health nurses, general practitioners, community and consumer organisations.

2.2.2 The Terms of Reference for local steering committees are:

- to oversee the establishment and implementation of the key elements of the intervention program in their community;
- to implement other activities consistent with the aims of PRISM if feasible;
- to facilitate integration of the community service program in each local community once it is established.

2.3 Community Development Officers

2.3.1 A community development officer employed by La Trobe University, will be appointed 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.

2.3.2 A representative from each local government area allocated to intervention community status will be invited to join selection panels for the appointment of community development officers.

2.3.3 The community development officer will be accountable to the research team at the Centre and will work according to the protocols developed for the intervention program.

2.4 Local Government

2.4.1 Local government has responsibility for agreeing to participate in the project and is acknowledged as the lead agency in facilitating the establishment and implementation of the project in each participating area:

- in intervention communities, via nomination of relevant officers to the local steering committee, chairing steering committee meetings and providing infrastructure support for the community development officer;
- in comparison communities, via nomination of the appropriate contact officers for facilitation of data collection processes involving mailout of questionnaires using birth registration data for 12 months of births².

2.4.2 In agreeing to participate in the project, each local government area agrees (itself or via a delegated agency) to provide the project with such infrastructure and other support as is outlined in Section 5.

² This was subsequently increased to 18 months of births with written agreement from all participating areas.

2.5 Project Reference Group

2.5.1 A project reference group has been established comprising people with a wide range of experience and expertise, with the following 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.

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

3. The intervention program

3.1 Key elements

3.1.1 It is agreed that the key and minimum elements of the PRISM intervention program to be established in each intervention community will include:

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 to establish a locally appropriate befriending scheme for mothers.

3.2 Other activities

3.1.2 Steering committees will be free to initiate other activities consistent with the objectives of PRISM *in addition* to the above elements, should they wish to do so.

3.2.2 Funding for such activities is not able to be provided by the University, apart from that provided to employ the community development officers.

4. The process for randomisation

4.2 Stage 1

4.2.1 It is understood that once all eligible local government areas wishing to participate have signed this Memorandum of Understanding, these areas will be:

- matched in potential pairs taking into account sociodemographic factors, numbers of births, geographic size/location and levels of community activity
- allocated to potential sets of seven pairs, if more than one set is possible
- subject to a process of random selection of a final set of seven pairs from the potential sets available.

4.2 Stage 2

4.2.1 At the Launch of PRISM scheduled for June 1998, the selected fourteen areas will be randomised within pairs, one area in each pair allocated to be an intervention community and one a comparison community.

4.2.2 The outcome of this randomisation process will be final.

5. Implications of allocation to intervention or comparison community

5.1 Acceptance of randomisation

5.1.1 Withdrawal from participation in the project following the outcome of randomisation threatens the design of the study and the capacity to test whether the intervention is effective.

5.1.2 It is thus crucial to the success of the project that the outcome of randomisation is accepted by each participating area whether it results in allocation to intervention community status or comparison community status.

5.1.3 The signing of this memorandum of understanding is an acceptance of the processes as outlined in Section 4 above and of the responsibilities outlined for intervention and comparison communities in Sections 5.2 and 5.3 below.

5.2 Responsibilities for intervention communities

5.2.1 Each local government area allocated to be an intervention community accepts the following responsibilities:

- provision of support for the community development officer in the form of office space, computer access, use of telephone and cost of local calls; costs of travel within the local government area
- time release and back-fill (where necessary) for all maternal and child health nurses to participate in training (2.5 days per nurse in total, undertaken in blocks of time to be negotiated, most likely in half day sessions)
- provision of assistance to the research team to establish an appropriate data system drawing on local computerised systems for birth registrations to enable the mailing out of surveys and a reminder postcard to all mothers six 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.
- participation of key people (eg maternal and child health nurses and community services managers) in brief process evaluation interviews once the intervention is established to obtain feedback about program implementation.
- agreement for the period of the study, not to use the health status measures to be utilised in PRISM (Edinburgh Postnatal Depression Scale and the Short Form 36)

5.3 Responsibilities for comparison communities

5.3.1 Local government areas allocated to be comparison communities accept the following responsibilities:

- provision of assistance to the research team to establish an appropriate data system drawing on local computerised systems for birth registrations to enable the mailing out of surveys and a reminder

postcard to all mothers six 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.

- agreement not to implement the key elements of the PRISM intervention program during the period of the project.
- agreement for the period of the study, not to use the health status measures to be utilised in PRISM (Edinburgh Postnatal Depression Scale and the Short Form 36).

5.4 Benefits

5.4.1 The benefits for local government areas participating as comparison communities will be the availability of data on maternal psychological and physical health outcomes for their communities, important in planning future service delivery. As well, should the intervention program prove to be effective in improving maternal psychological and physical health, the comparison communities will have first access to materials developed by the project and a detailed implementation report to enable them to implement the PRISM strategies, if they wish.

5.4.2 The benefits for local government areas participating as intervention communities include: the opportunity to participate in an innovative health promotion program to improve maternal psychological and physical health, with significant funding support available; and to receive a detailed and rigorous evaluation of their efforts in order to make informed decision about program delivery in the future.

6. Project costs to be provided by the University

6.1 PRISM Funding

6.1.1 The Centre for the Study of Mothers' and Children's Health at the University has received funding for PRISM from the National Health and Medical Research Council, the Department of Human Services and VicHealth.

6.1.2 The costs of the following elements of PRISM will be provided from funding obtained by the Centre:

- Training and ongoing support for the community development officers
- Training programs and resource materials for maternal and child health nurses and general practitioners
- Salary for a full-time community development officer in each intervention community for a period of two years
- Initial costs of production for the Mothers' Information Kits

- Small amount for 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
- Costs of project stationery and newsletters
- Evaluation costs: health outcome evaluation, process evaluation, flow-on benefits and economic evaluation (including questionnaires and postage)
- Production of reports and presentations

7 Project evaluation

Evaluation will involve both process and impact assessment, and measurement of health outcomes, to be instituted as indicated on the project timelines (see 8 below).

7.1 Process and impact evaluation

7.1.1 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.

7.2 Evaluation of health outcomes

7.2.1 Once the intervention program has been satisfactorily established in each intervention community (by the end of 1999) and all key elements are in place, data collection on health outcomes for mothers will begin.

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

7.2.3 All mothers who give birth in a twelve month period will be surveyed six months after the birth, and then a sub-sample of mothers surveyed again at two years after the birth of their babies.

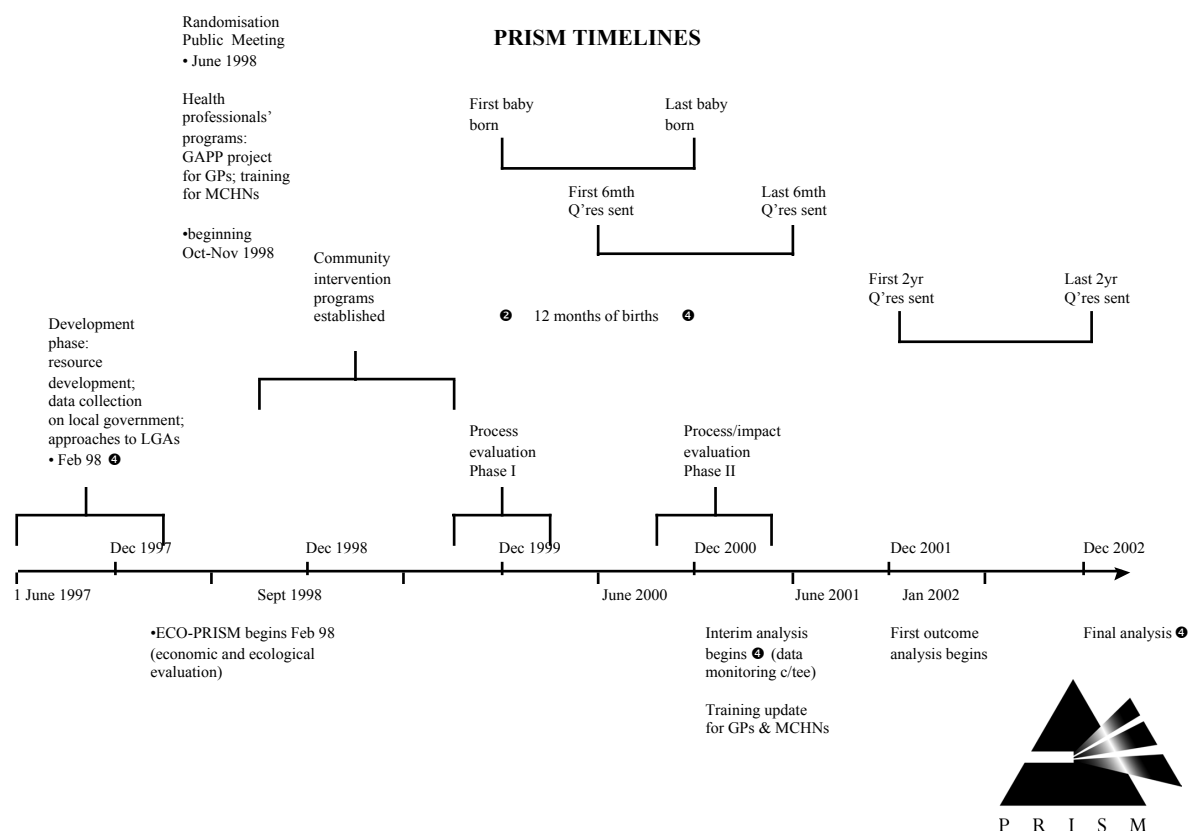
Economic evaluation and wider community benefits

7.3.1 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.

7.3.2 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 component of the evaluation.

8 Project timelines

8.1 A schematic view of the project timelines is as follows:



Key dates in the timeline:

- Randomisation of local government areas - June 1998
- Appointment of community development officers (for two years) and setting up of Steering committees - August-October 1998
- Development of local material for the Mothers' Information Kits (local services information and voucher scheme) - October-December 1998
- Training of maternal and child health nurses - November-December 1998
- Training of general practitioners - March 1999 onwards
- Mothers' Information Kits available for distribution to mothers - mid 1999
- Establishment of social network development model (befriending scheme) for mothers - first half of 1999
- Process evaluation - are all the elements of the program up and running smoothly? - September 1999 - March 2000
- Births to mothers participating in trial : December 1999 - November 2000³
- Data collection six months after birth: beginning June 2000 for 12 months⁴
- Data collection two years after birth: beginning December 2001 for 12 months⁵
- Outcome analysis: begins mid 2001 and final analysis: begins late 2002⁶

9 Mechanisms for communication between the research team and local government

9.1 General

9.1.1 The nominated contact people from the research team for discussion of any project related issues are, in the first instance, the two project co-ordinators (Rhonda Small and Stephanie Brown).

9.1.2 Each participating local government area agrees to nominate their own contact person to be responsible for general communication about project related issues.

³ These dates subsequently became: February 2000 to August 2001

⁴ Data collection was increased to 18 months beginning August 2000 (to February 2002)

⁵ The date of beginning the two year follow-up data collection subsequently became: February 2002

⁶ Outcome analysis began mid 2002 for the main data collection and follow-up data analysis will begin late 2003.

9.1.3 Both parties to the memorandum undertake to facilitate good communication about implementation and progress with the project, via regular telephone contact and face to face meetings where appropriate.

9.1.4 The research team undertakes to produce a regular newsletter informing participating local government areas of progress with the project.

9.2 Dispute resolution

9.2.1 Should there be a dispute about any matter relating to the project, the two parties undertake to raise any such matter in a timely manner and to utilise this memorandum of understanding as a basis for discussion and for reaching agreement on a satisfactory resolution of the issues underlying any dispute.

Signed

on behalf of
City/Shire of _____

Date: _____ May 1998

Professor Stephen Duckett
Dean of Health Sciences
on behalf of
La Trobe University

Date: _____ May 1998