THE ADVISORY AND DATA MONITORING COMMITTEE CHARTER[1]

The CORE Study: a stepped wedge cluster randomised controlled trial to test a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness in the community mental health setting

PROTOCOL NUMBER: Version 2

SPONSOR OF PROTOCOL: The University of Melbourne

DATE: 13 February 2015

[1] This Charter has been prepared using Ellenberg et al's 2002 Template for the DMC Charter, the DAMOCLES Study Group (DAta, MOnitoring COmmittees: Lessons, Ethics, Statistics guidance. DAMOCLES 'A Proposed charter for clinical trial data monitoring: helping them to do their job well' Lancet 2005; 365; 711-22 and Chan et al's 'SPIRIT 2013 explanation and elaboration: guidance for protocols of clinical trials' BMJ Research Methods and Reporting 2013; 346: e7586.

Introduction

This Charter is for the Advisory and Data Monitoring Committee (ADMC) for **CORE Protocol Version 2.** CORE is registered with the Australia and New Zealand Clinical Trials Registry (ACTRN 12614000457640) and has received ethics approval from The University of Melbourne Health Sciences Ethics Sub-Committee No: (1340299.3).

CORE is a stepped wedge cluster randomised controlled trial (SWCRCT) to test a co-design technique to optimise psychosocial recovery outcomes for people affected by mental illness. It is a world first trial of a structured Experience Based Co-design (EBCD) method to improve recovery orientation in the community mental health setting and test for individual improvements in recovery outcomes (see Study Protocol for full explanation). The stepped wedge design means that the intervention will be rolled out sequentially to participating mental health community support service teams (11 clusters). Clusters are randomised by time to one of three start dates (waves) to receive the intervention. By the end of the trial all clusters (and participants) will have received the intervention. Figure 1 shows the trial design for the **CORE** study.

Scope of this Charter

This Charter details the aim and terms of reference of the ADMC for **CORE**. It describes roles and responsibilities, membership and size, the frequency and format meetings, methods of providing information to and reporting from the ADMC in the context of the **CORE** trial.

Trial Design

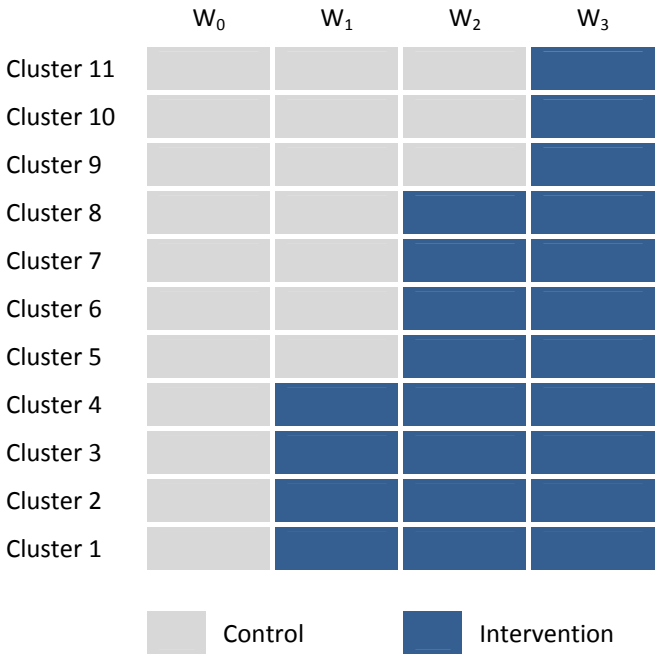


Figure 1 Design of a stepped wedge cluster randomised controlled trial in the community mental health setting.

Funding and Sponsor

CORE (2013-2017) is funded by the Victorian State Government's Mental Illness Research Fund (MIRF) and the Psychiatric Illness & Intellectual Disability Donations Trust Fund (PIIDDTF). The University of Melbourne, Australia is the sponsor organisation and the study is coordinated by the Primary Care Research Unit located in the Department of General Practice, Melbourne Medical School, The University of Melbourne.

Aims and Terms of Reference

The aim of the **CORE** ADMC is to:

1) advise investigators regarding the implementation, maintenance and monitoring of overall conduct of the trial;

2) safeguard the interests of trial participants, assess the safety of the interventions during the trial and address any adverse events (particularly the reporting of harms for the duration of the trial);

3) provide advice and feedback on qualitative elements and the nested process evaluation for the trial.

Responsibility of ADMC

The ADMC is responsible for safeguarding the interests of trial participants by assessing the safety of the intervention and monitoring the overall conduct of the trial. The ADMC will provide advice to enhance trial integrity, recruitment and retention, procedures for data management and quality control, and give feedback on qualitative aspects and the process evaluation. The ADMC is advisory to the investigator and trial implementation group and entails the following functions.

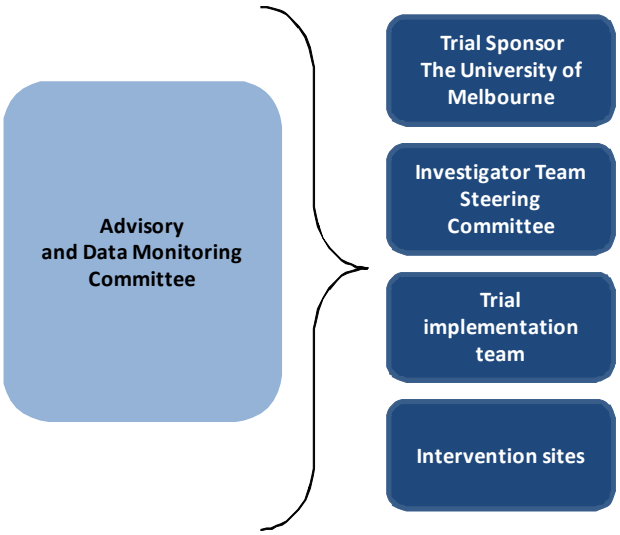
Roles of the ADMC

- monitor implementation of trial protocol;
- advise on protocol modifications suggested by investigators (e.g. to inclusion criteria, trial endpoints or sample size);
- advise on recruitment, retention and follow up issues;
- monitor sample size assumptions;
- advise on statistical analysis plan;
- advise on qualitative data collection and analysis plan;
- advise and feedback on the nested process evaluation framework, data collection and analysis;
- consider adverse events and possible harms to study participants[2].

[2] *A note on "stopping rules" in CORE – in clinical trials interim statistical analyses of the primary outcome are conducted to determine the effectiveness of a therapeutic intervention, if harm is determined a stopping rule may apply. CORE does not employ the stopping rule in the same way as a clinical trial because (a) the intervention is not therapeutic and (b) the stepped wedge design does not allow for interim analysis since all clusters will not*

Governance of CORE

The following diagram shows the relationship between the ADMC and other functional areas involved in the CORE trial.



Membership, Composition and Size

There are nine committee members for the ADMC (member details are provided in Appendix 1 of this Charter). Members represent a multidisciplinary mix of research expertise across the study disciplines: psychosocial recovery, randomized controlled trials and complex interventions, experience based co-design, biostatistics and clinical psychiatry, consumer and carer representation. The ADMC is chaired by the Principal Investigator (Victoria Palmer) to enable a summary of the trial developments in the context of the ADMC report, facilitate discussion and encourage consensus. It may be best for the Chair to provide their opinion last.

Confidentiality and Conflicts of Interest

Members of the ADMC have been identified and selected because they do not have financial, scientific or regulatory conflicts. Members should declare any consulting agreements or financial interests they may have with the funder or sponsor organisation or trial sites. ADMC members will declare any competing interests; members agree that if this changes they will notify the Chair. If significant conflicts of interest emerge during the course of the trial the member should consider resignation from the ADMC and the investigator team will reappoint a replacement.

Relationship with investigator team

The ADMC functions in an advisory capacity to provide expert input into design and implementation issues and be an independent safeguard for trial participants. Members are independent of the sponsor, funding body and investigators.

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have received the intervention. It is expected that the ADMC will monitor the trial for any serious adverse events related to the intervention and make recommendations to the team on actions related to these.

Frequency, location and duration of meetings

The CORE ADMC will meet bi-annually (circa February and November) for up to two hours on each occasion via teleconference.

Organisation of the ADMC meetings

Each meeting will be an open session that other investigators can attend if they wish. No closed sessions for the ADMC are likely to be required as there is unlikely to be any confidential data and results that should not be reviewed by investigators presented to the ADMC, particularly since no interim analysis will occur. Open sessions will be audio recorded and summaries presented back to the Committee and investigator team.

The first meeting of the ADMC for 2014 members will be introduced to the study protocol[3] and discuss the Terms of Reference as stipulated within this Charter. The first session provides an opportunity for ADMC members to give feedback and advice on the study protocol to ensure trial integrity. The second meeting for 2014 will involve discussion and feedback on protocol implementation and recruitment and overall study progress.

Meetings for 2015 and 2016 will focus on updates about recruitment, intervention implementation and maintenance, follow up, retention and attrition. 2017 meetings will examine progress in the context of outcomes. All meetings will consider any qualitative data collection and process evaluation issues that are relevant including the need to report any adverse or harmful events.

Reports to the ADMC - trial documentation and procedures to ensure confidentiality and proper communication

At least 2 weeks before each meeting, the trial implementation team will send ADMC members a report for the open meetings with details on the trial progress, including recruitment, baseline characteristics of participants, available pooled data, eligibility violations, withdrawals, completeness of follow up, and compliance.

The trial coordinator is responsible for preparing these reports and open reports will be overseen by Principal Investigator (PI) Palmer. The trial biostatistician will attend open sessions in conjunction with the statistical advisory member.

All reports will include any reporting of adverse events or "harmful events that occurring during a trial" including any relevant data analyses. Table 1 documents the definitions of adverse events and harms as they apply to the CORE intervention and a form for documentation of adverse events is available on request.

[3] DAMOCLES guidance outlines that the committee members should be in agreement with the trial protocol so an early meeting to introduce members and consider the protocol in more detail is important. Following this first meeting, CORE ADMC members have the opportunity to withdraw their membership if they do not agree with trial protocol.

Table 1 Definitions of adverse and harmful events in the CORE trial

Adverse Event Adverse events may be serious (resulting in death, hospitalization, a persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions) with the causal link with the intervention difficult to determine.	Serious adverse events as a result of the experience based co-design method intervention are unlikely but given the population group there is a small risk that hospitalization may occur and coincide with the intervention. For example for some participants group participation causes extreme distress and while unlikely, it is possible that a group event may trigger anxiety or panic for this group and result in substantial disruption of the ability to conduct normative life activities.
Harms The total opposite of adverse consequences of an intervention or therapy; they are the direct opposite of benefits, against which they must be compared.	An individual participating in the focus groups or face to face meetings for the co-design phase of the intervention may experience heightened anxiety, reduced functioning and harm may result instead of the anticipated improvements to recovery. An individual who completes an in-depth interview to collect their story about service experience may re-experience negative emotions and experiences and feel distressed as a result of re-telling negative aspects of service experiences.

Effectiveness and safety data by study group will especially be made available where appropriate. The ADMC will be blinded to the intervention allocation; blinding can be removed at the request of the Committee.

The ADMC members do not have the right to share confidential information with anyone outside the ADMC. The PI/trial implementation team will be responsible for circulating any external evidence from other trials/systematic reviews to the ADMC members that assist in the interpretation of the report or data within the report.

Decision-making

The ADMC is independent to the investigator group and functions in an advisory capacity. The ADMC is asked to make decisions about the ethical, practical, statistical and financial implications of reports for the trial and make recommendations to the investigators. ADMC members will provide advice on the actions taken regarding adverse and harmful events and review the procedures followed by the trial implementation team. There should be a minimum number of five attendees at each ADMC for decision-making. An odd number is preferred if a decision must be voted on. If at short notice someone cannot attend, then the

meeting should go ahead once the Chair, one clinician representative and the trial statistician are present. Comments on reports circulated prior to committee meetings for those who cannot attend should be passed to the Chair.

Reporting from ADMC

The ADMC will make its recommendations verbally to the PI and other investigators at the end of every open meeting. Minutes of the open sessions will be recorded and circulated to the ADMC and investigators.

After the trial

ADMC members' names and affiliations will be listed in the protocol and main report and outcomes paper, unless they explicitly request otherwise. A brief summary of the timing and conclusions of ADMC meetings will be included in the body of the outcomes paper. The ADMC will be given the opportunity to read and comment on any publications prior to submission, any feedback provided will be acknowledged within the acknowledgements section of published works. To maintain independence from the trial, ADMC members external to the investigator group will not participate as authors in the above listed publications arising directly from the trial data.

Appendix 1

Membership of the ADMC for the CORE Trial

Professor Judith Cook (Randomised Controlled Trials and Recovery) Director, Center on Mental Health Services Research and Policy Department of Psychiatry University of Illinois at Chicago, USA Email: cook@ripco.com
Hilary Boyd (Experience Based Co-design) Performance Improvement Specialist | Concord Team Auckland District Health Board, New Zealand Email: hboyd@adhb.govt.nz
Karen Fairhurst (Carer / quality and safety representative) Victorian Mental Health Carers Network, Australia Email: karen.fairhurst@carersnetwork.org.au
Professor Sally Wyke (Complex interventions and Health Services Research) Deputy Director Institute of Health and Wellbeing University of Glasgow, Scotland Email: Sally.Wyke@glasgow.ac.uk
Professor John Carlin (Biostatistics) Director, Clinical Epidemiology & Biostatistics Unit Murdoch Children's Research Institute Royal Children's Hospital, Australia Professor, Department of Paediatrics, and Centre for Molecular, Environmental Genetic & Analytic (MEGA) Epidemiology School of Population Health University of Melbourne Email: john.carlin@mcri.edu.au
Dr Lynne Maher (Expertise in Experience Based Co-design) Director for Innovation Ko Awatea, the Centre for Health System Innovation and Improvement for Counties Manukau Health Auckland, New Zealand Email: lynne.maher@middlemore.co.nz
Jane Gray (Expertise in Experience Based Co-design) Director of Innovation for Hunter New England Health District, Australia Email: jane.gray@hnehealth.nsw.gov.au
Professor Glenn Robert (Expertise in Experience Based Co-design) Chair in Healthcare Quality and Innovation King's College London, UK E-mail: glenn.robert@kcl.ac.uk

Assistant Professor Robert Whitely (Expertise in psychosocial recovery)

Social Science Researcher

Douglas Hospital Research Centre
Assistant Professor, Department of Psychiatry

McGill University, Canada

Email: robert.whitley@mcgill.ca