ALTER for Home Safety in Brief: A Process Evaluation to Examine the Feasibility and
Acceptability of an Adapted Intervention Program for a Vulnerable Population

by

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ABSTRACT

ALTER FOR HOME SAFETY IN BRIEF: A PROCESS EVALUATION TO EXAMINE THE FEASIBILITY AND ACCEPTABILITY OF AN ADAPTED INTERVENTION PROGRAM FOR A VULNERABLE POPULATION

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Unintentional injury is the leading cause of death in children 1-19 years of age, and rates of injury are even higher in children of vulnerable parent populations. The previously validated Supervising for Home Safety program was adapted to fit the needs of a vulnerable parenting population within the context of pre-existing community programming. This process evaluation sought to explore parent acceptability, feasibility of facilitator implementation, and to determine practicality of a PRE/POST questionnaire as a future method to evaluate efficacy of the newly adapted program. Results suggest that overall parents and Facilitators rated the program positively. Major themes identified by Facilitators suggest that the questionnaire should be shortened and simplified to account for low literacy and reading level in this population specifically, and to address the limits of existing session length. Moving forward, changes will be made accordingly based on feedback, and alternatives to a questionnaire format will be explored.

Keywords: unintentional injury, parenting intervention, supervision, vulnerable population
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INTRODUCTION

Parent Populations Designated as “High Risk”

In the parenting literature, the term High-risk is a fairly imprecise and yet widely used term that has been applied to define parents of children who are at risk for adverse developmental outcomes. Despite its extensive use, the term has no consistent definition and its strong intuitive meaning can be viewed as stigmatizing certain groups (Moore, 2006). While this term has been widely accepted in the past, the current trend is to describe these parents more generally as vulnerable to indicate that they require more support in parenting because their children are at risk of attaining less than optimal developmental outcomes. Research suggests that those most at risk often possess a number of socio-demographic and individual characteristics. Some of the factors that have been identified include maternal age (Baldwin, & Cain, 1980), socioeconomic status (McLoyd, 1998), parental level of education (Davis-Kean, 2005), poverty (Brooks-Gunn & Duncan, 1997), family instability (Fomby & Cherlin, 2007), family structure (Brown, Manning, & Stykes, 2015), and parental characteristics such as mental health status (Grace, Evindar & Stewart, 2003; Murray, Fiori-Cowley, Hooper & Cooper, 1996; Petterson & Albers, 2001), and substance abuse (Osborne & Berger, 2008). It may be the interaction of these factors that yield distinct research results among vulnerable populations in particular, and subsequently require that greater sensitivity is employed in intervention efforts. In consideration of these differences, the research areas of child unintentional injury and parent interventions are explored within the context of vulnerable populations below.

Injuries in Vulnerable Populations

In most developed countries, unintentional injuries are the leading cause of death among children 1-19 years of age (Center for Disease Control, 2013). For young children under 6 years
unintentional injuries occur most often in the home (McDonald et al., 2003; Shanon, Bashaw, Lewis & Feldman, 1992). Although injuries of this nature are a concern for all children, those from vulnerable families are at heightened risk of experiencing unintentional injuries and visits to emergency room departments as a result. Socioeconomic status has been frequently cited in the literature as leading to an increased risk for unintentional injury in children (Birken, Parkin, To, & Macarthur, 2006; Durkin, Davidson, Kuhn et al. 1994; Faelker, Pickett & Brison, 2000; Jolly, Moller & Volkmer, 1993; Laflamme, Hasselberg, & Burrows, 2010). Specifically, children under the age of one from families of lower socioeconomic status are 17 times more likely to die from unintentional injury (Mooney, 2010). Similarly, risk for death and hospitalization due to unintentional injury has been found higher among children of parents with lower levels of education (Beiki, Karimi & Mohammadi, 2014; Laursen & Nielsen, 2008), and those with higher rates of unemployment (Pomerantz, Dowd & Buncher, 2001). The same can be said for younger maternal age, which is associated with increased rate of injury in both infants (Siegel et al., 1996), and pre-school children (Ekeus, Christensson & Hjern, 2004; Readinga, Langfordb, Haynesb & Lovettb, 1999). Not surprisingly, having multiple risk factors further increases children’s risk of injuries (Hjern, Ringback-Weitoff & Andersson, 2001; Readinga, Langfordb, Haynesb & Lovettb, 1999; Scholer, Mitchel & Ray, 1997).

With respect to individual parent characteristics, higher injury rates for children have been documented in parents who struggled with mental health challenges, such as depression (Phelan, Khoury, Atherton & Kahn, 2007; Schwebel & Brezausek, 2008). Additionally, these higher injury rates are seen in children of parents who have experienced a higher number of negative life events (e.g., separation from their partner, recent bereavement, or moving the household) (O’Connor et al., 2000).
Home safety knowledge, practices and beliefs about injury

Although many studies document increased injury risk for children of vulnerable parent groups, relatively little is known about these parents’ knowledge of home safety, and beliefs about injury and children’s need for supervision. This makes it difficult to draw conclusions as to why higher rates of injury are seen specifically in these populations. The extent of this research is discussed below.

Maternal knowledge. Maternal knowledge of child development will undoubtedly affect a parent’s ability to anticipate their child’s needs and risk for injury (Rivara & Howard, 1982). Many parents who fall into demographic groups deemed vulnerable have specifically been shown to have decreased knowledge about child development. Teenage or young mothers have been found to be less knowledgeable about developmental milestones of young children than older mothers (Hammond-Ratzlaff & Fulton, 2001). Similarly, lower socioeconomic status and lower level of maternal education have been associated with lower levels of maternal knowledge of child development (Benasich & Brooks-Gunn, 1996), child safety (Eichelberger, Gotschall, Feely et al., 1990) and safety practices (Rivara & Howard, 1982). Mothers who report higher depressive symptoms have also been found to have less accurate knowledge of child development (Veddovi, Kenny, Gibson, Bowen & Starte, 2001).

Concern related to lower levels of child development knowledge suggest that parents may not be able to accurately predict what their child can do and when. A study of maternal knowledge by Huang, Caughey, Genevro, & Miller (2005) found that mothers who were younger, not married, and of lower socioeconomic status tended to overestimate their child’s abilities, and mothers having lower education and who reported higher depressive symptoms tended to underestimate their child’s ability. Both overestimating or underestimating a child’s
developmental ability has the potential for greater risk of injury given that parents may leave their children in an environment presuming the risk is low, or they don’t anticipate motor milestones that could leave the child moving around without adequate supervision. Injuries are found to occur more often when parents are not able to predict their child’s ability to perform tasks (e.g., climbing or opening locks), or when parents expect children to understand and remember instructions aimed at keeping them safe from injury (Smithson, Garside & Pearson, 2010).

**Maternal beliefs.** Maternal beliefs about locus of control regarding their child’s health has been shown to influence children’s risk for injury and maternal supervision (Morrongiello & House, 2004). It has also been found that the younger the age at which mother’s believe they can leave their child alone without constant supervision the greater the frequency of injuries experienced (Morrongiello, Odejko & Littlejohn, 2004a), and the less frequently mother’s believe they have to check on their child the greater number of injuries to a child (Morrongiello & Hogg, 2004). Less understood is the connection between maternal beliefs and risk for injury in a vulnerable population.

Murphy (2001) conducted a focus group with adolescent mothers and asked them about important aspects of parenting. Not one parent mentioned keeping their child safe or injury prevention. Rather, the discussion’s main focus revolved around child misbehaviour (Murphy, 2001). Adolescent mothers also have been found to identify risky scenarios as often as older mothers, but to be significantly less likely to intervene in the situation (McClure-Martinez, 1996). While information about their beliefs was not obtained it could be that beliefs about locus of control might lead to their reduced likelihood to intervene. Additionally, Azar and colleagues (2016) found that a “high-risk” group of mothers (i.e., those identified as previously being
involved with Children’s Aid Society for neglect) endorsed significantly greater beliefs in fate as the cause of injuries and showed a trend indicating stronger beliefs that injuries are beneficial because they toughen children. They also had significantly higher scores on a factor measure of maladaptive beliefs (Azar, Miller, Stevenson, & Johnson, 2016). More research is needed in this area to elaborate the complexities of how varying factors may impact the beliefs of vulnerable parenting populations.

**Safety practices.** Younger mothers (under 25) have been found more likely to store cleaners/medication unsafely (Jaques, Weaver, Weaver & Willoughby, 2018). Depressed mothers have also been found less likely to engage in safety practices such as using a child car seat or electric socket covers (McLennan & Kotelchuck, 2000). Socioeconomic status also relates to an increased number of observed household safety hazards (Greaves, Glik, Kronenfeld, & Jackson, 1994; Mulvaney & Kendrick, 2004). Fewer safety practices in low income families may in part be due to barriers in their living environment. Implementing safety equipment or child proofing a home is more difficult if one is not able to modify rented space, living or staying with extended family. Additionally, the cost of the equipment itself can be a barrier to implementation (Smithson, Garside & Pearson, 2010).

**Supervision & Supervisory Neglect**

Parents of young children implement three strategies, to varying degrees, to reduce risk in the home: 1) Environmental Modification 2) Child-based (teaching rules) and 3) Parent-based (supervision). Of concern is that parents who use strategies inappropriately do not keep their children safe. The use of child-based strategies, such as teaching rules, has actually been found to increase risk if they are implemented at too young an age in early childhood (Morrongiello, Ondejko & Littlejohn, 2004). Additionally, using environmental strategies, such as eliminating
hazards, also elevates risk if parents use this instead of supervising. Actively supervising children (attentive, within reach, continuity in the latter) is the most effective strategy to promote young children’s safety and prevent injuries; however, it is also a taxing strategy to implement (Morrongiello, 2004a, 2004b). A pattern of increased hospital admission in vulnerable populations suggests that the supervision strategies being used by these groups of parents to promote their child’s safety are inadequate. Similarly, lower levels of child development knowledge in vulnerable parents may result in greater difficulty knowing how to most effectively supervise their children and moderate these patterns as children acquire new motor development skills (Huang, Caughy, Genevro, & Miller, 2005).

While no specific research has documented supervision behaviours of vulnerable parent groups, rates of neglect and supervisory neglect have been identified as being higher among these groups. Young mothers have been found more likely to neglect their children than older mothers (Brown et al., 1998; Zuravin 1988), and both lower socioeconomic status (Herrenkohl & Herrenkohl, 2007) and lower levels of education (Euser, van Ijzendoorn, Prinzie & Bakermans-Kranenburg, 2010) have been identified as relating to higher levels of neglect. In particular, supervisory neglect is a risk factor for child injury (Ruiz-Casares, Trocme & Fallon, 2012). In Canada, supervisory neglect occurs more often and is investigated more frequently than any other type of neglect, and additionally has the highest rate of substantiation of all maltreatment investigations (Ruiz-Casares, Trocme, & Fallon 2012; Public Health Agency of Canada, 2008). Almost half of all child maltreatment deaths have been found related to supervisory neglect (Damashek, Drass, & Bonner, 2014), and inadequate supervision has been found to predict injuries and fatalities more than any other form of maltreatment (Chahine & Sanders, 2013; Coohney, 2003ab; Pears, Kim, & Fisher, 2008). Younger children are at greater risk of child
neglect victimization than older children, and child fatalities from neglect are also most common among this age group (U.S. Department of Health and Human Services, Administration for Children and Families, 2010). Unfortunately, questions regarding adequacy of supervision often only arise after a child suffers an unintentional injury and is brought for medical care (Anderst & Dowd, 2010).

**Parenting Interventions**

Given the significant rates of supervisory neglect and unintentional injuries and/or hospital admissions for children of vulnerable parent groups, a variety of parenting intervention programmes have been developed and evaluated. A number of studies have cited the efficacy of home-visitation programs in reducing risk for injury within the first six months of birth (McDonald, Culp, Blankemeyer & Passmark, 1998), the first two years (Koniak-Griffen et al., 2003) and from birth up until 5 years of age (Gershater-Molko, Lutzker & Wesch, 2003). In addition, a review by Kendrick et al. (2013) found support among 10 studies for home-visiting interventions in reducing the number of injuries to young children that are sustained in the home.

Despite home intervention programs being effective ways of reducing unintentional injuries in the home, they are often resource and time intensive to deliver (Prinz, 2007). In considering alternatives to home-visitation some less intensive programs that focus on parent education and provision of information have proven successful. Infants of adolescent mothers at 3 months postpartum had a significantly lower risk of injury at follow up when mothers were given home safety information from family or community sources compared to those who did not receive the information, and as the number of sources increased the injury rate decreased (Jordan, Duggan & Hardy, 1993). Similarly, a home safety intervention in an emergency department setting found that providing home safety education and free safety devices showed
significant improvement in self-report safety scores (Posner, Hawkins, Garcia-Espana & Durbin, 2004), and an increase in safety practices used by parents (Watson et al., 2005). Reviews have suggested that providing injury prevention education alone have not shown reductions in injury occurrence (Kendrick et al., 2007). However, combing injury prevention education with parenting support more generally can be effective in reducing injuries (Kendrick et al. 2008); this was the approach applied herein. Group-based parenting interventions might be effective because strategies are introduced and then there is discussion and problem solving about these. In essence, there is the chance for many instructors (parents) to help communicate key points. The support that parents experience from one another also matters (Muzik et al., 2013). Having other parents in the group has also been identified as increasing potential for sharing in the generation of solutions, and such partnership in problem solving is fundamental to success with group interventions (Puckering et al., 1994).

Home visiting programs have been effective in improving factors such as positive parenting, maternal psychosocial health, and child behavioural problems that have been identified as having a positive effect in reducing injury rates (Kendrick et al., 2000; Schwebel, 2004; Soubhi, Raina, & Kohen 2004). Additionally, a systematic review identified outcome variables of interventions to include injury rates, reported safety practices (e.g., lowering bath water temperature, use of safety gates), and parent’s ability to identify hazards in the home (Kendrick et al., 2013). Yet none of these studies obtained measures of parents’ supervision habits or practices, beliefs about supervision, and the efficacy of these factors in keeping their child safe. It is clear that no current intervention targeted at reducing injury risk focuses on parent supervision or has included parent supervision habits as an outcome variable.
Supervising for Home Safety Intervention. The Supervising for Home Safety (SHS) intervention program is the only known program that is focused specifically on improving caregiver supervision practices. Its efficacy has been demonstrated both when delivered one on one (Morrongiello, Zdzieborski, Sandomierski, & Munroe, 2013) and in a group format in a community setting (Morrongiello et al., 2016). The SHS program applies a psychological approach to prevention and targets not only supervision behaviours, but also caregivers’ beliefs about injury (child’s vulnerability to injury, severity of injury, preventability) and their ability to prevent injury (self-efficacy). All of these factors have been shown to influence caregivers use of safety strategies (Morrongiello & Kiriakou, 2004), and the SHS program targets these beliefs specifically.

First, the program involves presenting a video to caregivers about four common types of injury in the home that could affect young children (drowning, falls, burns, poisoning). This video was developed through research evaluating parents’ opinions of the content, design and production aspects and the effect they had on everyone (Morrongiello, Zdzieborski, Sandomierski, & Lasenby-Lessard, 2009). Following this SHS introduces caregivers to a flexible approach to reducing injury risk based on a mnemonic: ALTER (see Appendix A). This approach is flexible in that it allows caregivers to tailor their prevention approach to meet their own individual needs and preferences, avoiding prescriptive messages (e.g., ”caregivers should”) which are not always willingly accepted by caregivers (Morrongiello, Corbett, & Falls-Prevention Team). The importance of tailoring an intervention program is important and has previously shown to improve effectiveness of interventions (McDonald et al., 2005; Nansel et al., 2002; Weaver et al., 2008).
CURRENT STUDY

While the SHS program has been implemented with parents for research purposes in a community setting, it has yet to be applied within existing community agency programming. Recently, the Child Development Research Unit was approached by professionals at Halton Public Health who expressed an interest in aspects of the SHS program. Halton Public Health nurses implement a number of different parenting programs, many of which are offered in geographical locations that have been identified as having low SES populations, and may also include parents identified as potentially benefiting from more support or newcomer families to Canada. Consultation with a group of these professionals indicated that there is a lack of resources to address home safety and injury prevention within their programming. These parenting programs have limited time to devote to specific topics given the range of information they need to cover, therefore they specified the need for resources to implement a one-hour long session dedicated to home safety and planned to use the ALTER pneumonic as a strategy for parents. The previously validated SHS program involves 9 1-hour long sessions that cover individual types of injury and the use of ALTER in great depth, and while this program was proven efficacious in a RCT (Morrongiello et al., 2016), it is not necessarily generalized to other contexts, such as this one, as easily. The SHS program’s length (9 sessions) is not feasible or realistic in the context of programming developed through Public Health and therefore an adaptation of the current SHS program was needed to meet their needs. In consultation with Halton Public Health professionals, the previously validated SHS program was adapted to meet the needs of this specific population of families and to provide a shorter one-hour version of the program entitled ALTER for Home Safety in Brief.
**Process Evaluation**

As part of the development of a one-session version of the SHS program it was imperative to conduct a process evaluation to investigate the feasibility and acceptability of the program. Addressing this aim, the current study was initiated as a process evaluation to determine the perception of the program from both Facilitator and Parent perspective, and to understand the ease with which a questionnaire to evaluate the efficacy of the program could be implemented with these vulnerable populations. It is important to know from the Facilitator how easy the program is to implement, including clarity of materials, as well as their perception of the parents’ engagement. In addition, it is essential to evaluate parent appraisal, and know if they felt as though the session was of use to them, and if they would use the ALTER strategy at home. Conducting research with a diverse and vulnerable population, and within an existing program structure, poses its own challenges and therefore to address the practicality of a PRE/POST questionnaire as a method to evaluate the efficacy of the program in future, Facilitators’ impressions of reading level and ease of completion are required. This process evaluation will focus on these subjective experiences of the Facilitator and parent.

The current study sought to evaluate:

1) The **feasibility** of program implementation
2) The **acceptability** of the program by parents from the Facilitator’s perspective
3) Parents’ perception of the program **utility** and what they gained from the program
4) The Facilitators’ perception of the PRE/POST Questionnaire and **ease** with which parents’ could complete it; the actual data from this questionnaire are not a focus herein because it is still in development.
METHOD

Participants

Participants in this study included both nurse practitioners who acted as facilitators of the ALTER for Home Safety in Brief program \((N = 6)\) and parents who attended an ALTER for Home Safety in Brief program as a registered participant in one of the Halton Public Health parenting programs \((N = 23)\). Halton Public Health operates a number of different parenting programs including Nobody’s Perfect, Parenting with Love, and the Halton Prenatal Nutrition Program— all of which cover home safety at some point in time. Additionally, as part of the current study an ALTER for Home Safety in Brief program was implemented at the Halton Women’s Place (a women’s shelter in the area), which is another location Halton Public Health may want to implement the session in future. Parents attended the program in one of a number of locations where programs were being offered (Oakville, Burlington, Acton, Milton). Halton Public Health does not obtain any demographic information from participants in their groups; however professionals informed us that these groups often include immigrant families, those of low SES or level of education, and some who have been referred through the Children’s Aid Society. Participants did not receive compensation for taking part in the current study.

Materials

ALTER for Home Safety in Brief Program. A manual was developed for the one-hour program with the understanding that delivery could be extended longer, depending on the nature of discussion within the group. The program includes a brief overview of home safety and injury risk through the use of a PowerPoint. This PowerPoint was designed to cover the same topics presented previously in the SHS program’s video, with the aim of increasing parents safety knowledge while allowing for discussion around parents’ supervision practices and challenges they might face in supervising their children. The session includes the introduction of the
ALTER mnemonic, and session facilitators receive a link to a Dropbox with a variety of video clips to use in introducing the ALTER strategy. Videos span different locations, types of injury and include children of varying ages and siblings. A video reference guide (see Appendix B) was developed to make selecting a video easy according to what safety issues may be of particular concern or interest to parents (e.g., if none have more than one child then videos showing sibling risk factors would not be relevant). Facilitators receive a Program Delivery Manual that guides them through implementing the program and addresses a number of important discussion points. During the session, each parent received an ALTER strategy sheet which includes potential strategies for parents to think about using when supervising their children, and an ALTER activity sheet for them to practice using ALTER and generate solutions to challenges they face at home. Each parent also received a laminated ALTER magnet for them to put on their fridge and keep in view.

**Facilitator Evaluation Feedback Sheet.** The Facilitator Evaluation Feedback Sheet addresses both feasibility in terms of implementation but also perception of parent acceptability and engagement (See Appendix C for list of items). This feedback sheet includes 11 items, all of which include a five point Likert scale of how true the statement was, ranging from ‘Not at all true’ to ‘Very true’. Facilitators indicate the ease of implementation and clarity of the materials. They also address whether the PRE and POST questionnaire is an appropriate length and if the parents understand the questions being asked. Facilitators were asked to indicate how parents presented during the session, if they seemed engaged with the material, understood, and endorsed the ALTER strategy. Facilitators also had an opportunity to write things they liked about the program, as well as suggestions for improvement. In addition to this, Facilitators wrote a short
description of what their session looked like and how many video clips they used and what types of injury/location were covered.

**Parent Evaluation Feedback Sheet.** The Parent Evaluation Feedback Sheet aims to address parent satisfaction with the program and to identify if they perceived an increase in their knowledge about home safety or awareness of supervision practices. Questions also asked parents to rate how useful the program was and if the video examples of how to use ALTER were helpful or not. Parents also indicate the likelihood that they will use ALTER at home, and how likely they would be to recommend the session to a friend. This feedback sheet includes 7 items (See Appendix D for list of items) and features a 5-point Likert scale asking parents to rate how true each statement is ranging from ‘Not at all’ to ‘Very much’.

**Procedure**

The *ALTER for Home Safety in Brief* program was implemented by Halton Public Health nurse practitioners during one week of their programming dedicated to home safety. The nurse practitioners attended a training session which provided an overview of the *ALTER for Home Safety in Brief* program and main messaging for parents, and additionally were sent the materials ahead of time to allow for ample time to go through the manual and the opportunity to contact the researchers if they had any questions. The current study was not reviewed by the Research Ethics Board (REB) due to consultation with an REB professional who informed researchers it was not required. Nurse practitioners acted as the Facilitators of the program, implementing all aspects of the program, and collecting data in the form of a questionnaire and evaluation feedback sheet. Parent participants were those attending the parenting program run by Halton Public Health, and as a result took part in the *ALTER for Home Safety in Brief* program during the week dedicated to home safety. Prior to the program parents were informed that the
PRE/POST questionnaire was for research purposes and would remain anonymous, however they did not sign a consent form due to no such requirements of REB. Parents were given an information sheet to take home explaining the research purposes, and with contact information should they have questions or concerns. If parents agreed to take part in the research they completed the PRE questionnaire, and then following the program they completed the POST questionnaire on another day when they returned to the parenting program. Parents were also asked at that time to complete the Parent Evaluation Feedback Sheet to determine their appraisal of the program. Researchers were not privy to the setting in which parents completed the questionnaire but it is assumed this was in the shared room where sessions took place. Following the implementation of the session each facilitator also completed the Facilitator Evaluation Feedback Sheet to comment on the feasibility of program delivery from their perspective.

RESULTS

Of the 46 parents who were documented as attending the program 42 attempted the PRE questionnaire, however only 26 also completed the POST questionnaire. Similarly, only 23 parents completed the evaluation of the program and were included in the current study. Information with respect to parent age or number of children they had was not collected. Parents reported the age of their child (\( M = 2.8 \) years old), which included infants as young as three months old to children seven years of age.

Parent Evaluation Feedback

There were 23 parents who provided data. Approximately 70% of parents rated the usefulness of the program as ‘A fair amount’ or ‘Very’ useful. With respect to how their knowledge of home safety had improved, 47% indicated it increased ‘A fair amount’ or ‘Very
much’. When asked to rate how much their awareness of how to keep their child safe improved, 56% indicated ‘A fair amount’ or ‘Very much’. 95% of parents rated their confidence in keeping their child safe at home as ‘A fair amount’ or ‘Very much’. Parents were also asked to rate how helpful they found the video clips that were used in the session, and 70% indicated ‘A fair amount’ or ‘Very much’. When asked how likely they would be to use ALTER in their home 80% of parents said ‘Fairly’ or ‘Very’ likely, while the remaining 20% indicated ‘Somewhat’. Lastly, when asked if they would recommend the ALTER session to a friend 43.5% said they would ‘Highly recommend’ and the remaining 56.5% said they would ‘Recommend’ the session.

A table including frequency and means for each item on the parent evaluation feedback can be found in Table 1.

**Facilitator Evaluation Feedback**

There were 6 facilitators who provided data. All facilitators rated ‘Mostly true’ or ‘Very true’ when asked if the instructions in the manual were easy to follow, and whether they understood what they were supposed to do for the session. When asked if the questionnaire was at an appropriate reading level for parents, 4 of the 6 facilitators rated this as only ‘A little’ true. Similarly, 4 of the 6 facilitators rated the ease of filling out the questionnaire for parents as only ‘A little’ true and 1 facilitator rated this as ‘Not true at all’. A table including frequency and means for each item on the facilitator evaluation feedback can be found in Table 2.

When asked what they liked about the program, facilitators provided written feedback which was reviewed and amalgamated, whereby main themes were identified and presented as follows. Only positive comments were stated about the program. Facilitators indicated that they liked the content of the program, and that messaging and the language used was non-judgemental, helpful and supportive (n = 3). They also thought the videos were clear (n = 3),
facilitated good discussion \((n = 4)\), and were a helpful way to explain risky situations to parents \((n = 1)\). Facilitators stated that the materials provided for the program was something they liked \((n = 5)\), particularly the handout sheets and ALTER magnet for parents to take home with them. Lastly, facilitators liked using and practicing the ALTER model while integrating the videos and work sheet for parents to fill out.

In terms of suggestions for improvements, facilitators all suggested that the Pre/Post questionnaire be “shortened” and “simplified”. Facilitators also reported that some participants included those designated as English as a Second Language (ESL) and had difficulty understanding the wording used \((n = 4)\). Additionally, Facilitators stated that many parents had babies in their arms which made it difficult to complete a lengthy number of pages \((n = 4)\). Lastly it was also suggested that completing the POST questionnaire a week later was challenging given that many participants show inconsistent attendance or they do not return an additional week because they “graduate” from the program (their infant reaches 6 months of age). Facilitators reported that due to time constraints they did not have time to allow for both the PRE and POST to be completed on the same day as the program.

Some facilitators also reported that the program was more of a challenge to use with pre-natal parents because they had to anticipate how they would care for their child using hypotheticals \((n = 2)\). Additionally, one facilitator sought suggestions for what to include if the program had to be reduced in length. Lower literacy and reading level, with fewer words on the PowerPoint, were requested and one facilitator asked that speaker notes be added into the PowerPoint slides as opposed to the manual.
DISCUSSION AND IMPLICATIONS

The *Supervising for Home Safety* program (SHS) is a previously validated group-based intervention program aimed at increasing active supervision practices in parents as a means to reduce unintentional injury in the home for young children (Morrongiello, Hou, Bell, Walton & Haines, 2016). The program’s 9-session format, while effective, is not easily generalized to contexts with existing program structure constraints, especially those involving extremely heterogeneous populations. Responding to a need for resources on home safety in Halton Public Health’s current parenting programs, the SHS program was modified to a one-hour long program entitled *ALTER for Home Safety in Brief*. This process evaluation’s aim was to evaluate both feasibility of implementing the program from a facilitator perspective and the acceptability and usefulness of the program based on parent impressions. Results of both the parent and facilitator feedback suggest that overall the *ALTER for Home Safety in Brief* program is both feasible to implement by facilitators and well accepted by parents. This suggests that formal evaluation of the efficacy of the program content should proceed once the pre/post questionnaire is finalized.

Overall parents rated the usefulness of the program highly. All parents said they would recommend the program, with 43.5% specifically stating they would highly recommend it. These positive ratings of satisfaction are consistent with those of when the SHS program was previously implemented in a community setting (Morrongiello et al., 2016). Most importantly, 80% of parents rated that they were either ‘Fairly’ or ‘Very much’ likely to use the ALTER mnemonic in their home. This is important because it suggests that parents recognize the ALTER model as a tool they would apply to their everyday lives.

Overall facilitators also gave positive ratings in response to the feasibility of implementing the program, and their perception of parent’s engagement in discussion. In contrast, facilitators rated the use of the PRE and POST questionnaire poorly, emphasizing that
the evaluation instrument needs further refinement. Four of the 6 facilitators rated whether items on the questionnaire were at the appropriate reading level for parents as only ‘a little bit’ true. Items are at a grade 6 reading level but ESL is an issue in some groups of parents where the program was delivered. Hence, there may need to be a simplified or different version of the questionnaire for those parents in particular. Consistent with reading level, five of the 6 facilitators rated the ease of completing the questionnaire as low. Facilitators expressed that most importantly the questionnaire needed to be shortened and simplified to account for not only reading level or literacy level of participants, but also the time the facilitators can allow for completing the questionnaire within their programming schedule; pilot tests indicated the questionnaire took 15 minutes to complete but the facilitator comments suggest these parents sometimes take longer. These ratings and overall feedback imply that while the program itself is positively rated, the outcome measure to be used in evaluating the program’s efficacy requires further action. Despite a number of changes previously made to the questionnaire during a pilot study phase, the length and reading level of the questionnaire continue to be the main barriers in hindering the completion rate of this evaluation instrument.

With respect to the reading level of the PRE/POST questionnaire, it is important to consider that demographic characteristics of participants in these parenting groups are extremely heterogeneous and both reading level and literacy level is substantially variable. In Canada, census data have indicated that 43% of immigrants whose mother tongue is different from the testing language fall in the lowest level on the prose literacy scale (International Adult Literacy and Skills Survey, 2003). With the possibility of the parent groups including many immigrant families in future the reading level of the PRE/POST questionnaire needs to be appreciably reduced to account for a lower reading level, or perhaps a simplified alternate version of the
evaluation instrument needs to be developed using more images or easier response formats than currently in place. Conducting research with individuals with low literacy, or who require a lower reading level, poses a problem for evaluation by not only frustrating the participant but also reducing the likelihood that the data will be reliable and valid. Participants may not understand the intricacies of what is being asked of them, and misinterpretations can easily occur and lead to inaccurate responses and conclusions. Additionally, if the reading level is not appropriate it could lead to exclusion of ESL, or similarly individuals with low literacy or who require a lower reading level if they cannot complete the questionnaire, which could lead to systematic bias in the evaluation of the program (Beaton, Bombardier, Guillemin & Ferraz, 2000). Additionally, some research has implied that using Likert scales may pose its own challenges in immigrants with low literacy or lower reading level, particularly that the graded response format is poorly understood and that questions containing double negatives are a challenge as well (Bernal, Wooley & Schensul, 1997). These are all considerations in revising the evaluation instrument.

The unique setting within which this program is implemented requires that adaptations are made not only to the reading level of the questionnaire but also the content and length. Given constraints in timing based on greater programming needs, the evaluation of the program needs to be completed within a short time frame. This speaks to the challenge researchers often have to face: striving to obtain quality data for research purposes while meeting the needs of the community setting within which the research functions. Facilitators reported that the PRE questionnaire took most participants around 20 minutes to complete, and due to the program being only an hour and a half in length often times the PRE or POST questionnaire had to be completed as part of a different week’s session. This not only takes up session time of another
week’s topic, but also reduces the completion rate of the evaluation because some participants did not return to the following week’s session. Additionally, with more time required to fill out the questionnaire, this reduces the time facilitators have for the actual program implementation, which could lead to less time for meaningful discussion with parents or to complete the worksheet activities aimed at solidifying their skills in using ALTER to reduce injury risks.

Conducting research within a community setting and existing program structure poses various challenges as a researcher. With the length of session out of one’s control this requires that the method of evaluation works around the program’s needs and results in more strenuous data collection. While typically the session length for program implementation would be extended to account for ample time to complete the necessary measures for evaluation, in this case, solutions need to be developed for how to address research with more constraints than usual. The above challenges in evaluating the efficacy of the program require that a number of alternatives or options are considered moving forward. To address low literacy and reading levels, Cremers and colleagues (Cremers, Welbie, Kranenborg, & Wittink, 2017) suggest providing alternatives to text such as an audio playback or having someone read aloud, or including visuals such as pictures. Given that the graded response format of a Likert Scale is likely to be poorly understood by immigrants with low literacy (Bernal et al., 1997), fewer response options or an alternative format may be more beneficial for use in this situation. Another alternative may involve moving away from a questionnaire format all together, however doing so would likely have to involve research assistants and would no longer be able to be administered by the Facilitators themselves as the questionnaire is now. Alternative methods could additionally include tasks such as a photo card sorting task, which has been previously
used by Morrongiello and colleagues (Morrongiello, Schmidt, & Schell, 2010) to assess parents’ recognition of injury hazards and risky behaviors.

Another challenge worth noting, aside from the method of evaluation, is to consider the extremely heterogeneous population with which Halton Public Health would like to use the ALTER for Home Safety in Brief program. For example, feedback from Facilitators indicated that it was more difficult for pre-natal mothers to identify how they would care for their children and, therefore, conversations were more hypothetical. This demonstrates how challenging it can be to create a program that is easily generalizable to a context where the population is so variable. Undoubtedly some adjustments need to be made to allow for the messaging and purpose of the session to be flexible and applicable to such a heterogeneous population. Programs for a pre-natal group may require a greater emphasis on targeting the beliefs and values of these parents and less focus on the actual ALTER model and how to use it at home. By getting parents to buy into the fact that children are not only highly vulnerable to injuries but that injuries can be severe, they may be more likely to use the ALTER strategy at home once their children are at an age where they are mobile.

LIMITATIONS

The small sample size needs to be acknowledged. Data collection depended solely on the number of programs being run by Halton Public Health during a certain period of time, and this was not under this researcher’s control; programs were cancelled sometimes due to low enrollment. Additionally, because the Facilitators of the program were responsible for collecting the data some did not have the parents complete the Evaluation Feedback Sheet because there was push back and frustration with the PRE and POST questionnaire; one of the challenges of having non-researchers deliver the program and evaluation is they may not appreciate the importance of the evaluation component. Because of this, fewer parents than expected were
included in the study. Similarly, some Facilitators had the parents complete the *Evaluation Feedback Sheet* during a following week’s session and many parents did not return to complete it. Additionally, the current study was unable to include feedback from the entire variety of parenting groups that Halton Public Health hopes to run the program with and it is possible that feedback may change based on a particular group’s needs. Furthermore, the parents’ feedback on the program was limited to graded responses on 7 items and did not include any qualitative feedback. Similarly, parents were not asked about their experience of completing the questionnaire. Parent evaluations were kept short due to the length of the existing PRE/POST questionnaire; however, this resulted in limited information from parents. Additionally, data collection was administered strictly by the Facilitators themselves, and this may have affected the parent data. Specifically, social desirability bias may be a greater issue than if research assistants had collected the data, given that parents are aware the Facilitator would see their evaluation of the program. Similarly, in having Facilitators collect the data researchers had no control over what the session looked like or how strictly Facilitators followed the program manual.

**CONCLUSION**

In conclusion, results from the current study suggest that the *ALTER for Home Safety in Brief* program was accepted by parents and seen as feasible to implement by facilitators. While the program itself received positive ratings of satisfaction, practicality and ease of completing the PRE/POST questionnaire (a method of evaluation to be used in future) was identified as a concern. Facilitators reported that the PRE/POST questionnaire most notably needs to be “shortened and simplified” due to low literacy levels within the population and time constraints of session length. Moving forward, steps will need to be taken to either develop a questionnaire that is significantly shorter with a reduced reading level or find another way to obtain data, such
as a photo card sorting task. The current study served as a means to confirm that the ALTER for Home Safety in Brief program is both accepted by parents and feasible for Facilitators to implement, and that before a formal evaluation of the program’s efficacy is put in place changes need to be made to the questionnaire or method of evaluation.
**TABLE 1**

*Parent responses on the Parent Evaluation Feedback Sheet.*

<table>
<thead>
<tr>
<th>Item</th>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how useful was today’s session?</td>
<td>Somewhat</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td>How much has your knowledge of home safety improved?</td>
<td>Not at all</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td>How much has your awareness of how to keep your child safe improved?</td>
<td>Not at all</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>4</td>
<td>17.4</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>7</td>
<td>30.4</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>6</td>
<td>26.1</td>
</tr>
<tr>
<td>How confident are you about knowing what to do to keep your child safe at home?</td>
<td>Somewhat</td>
<td>1</td>
<td>4.3</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>10</td>
<td>43.5</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>12</td>
<td>52.2</td>
</tr>
<tr>
<td>How helpful were the videotaped examples that were used to communicate about home safety?</td>
<td>A little</td>
<td>2</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>8</td>
<td>34.8</td>
</tr>
<tr>
<td>How likely is it that you will use ALTER to try and keep your child safer at home?</td>
<td>Somewhat</td>
<td>5</td>
<td>21.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>9</td>
<td>39.1</td>
</tr>
<tr>
<td>Overall, would you recommend the ALTER Home Safety Session to a friend?</td>
<td>Recommend</td>
<td>13</td>
<td>56.5</td>
</tr>
<tr>
<td></td>
<td>Highly recommend</td>
<td>10</td>
<td>43.5</td>
</tr>
<tr>
<td>Item</td>
<td>Response</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>The instructions provided in the manual were generally easy to follow.</td>
<td>A fair amount</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td>I understood what I was supposed to do for the session.</td>
<td>A fair amount</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Very much</td>
<td>5</td>
<td>83.3</td>
</tr>
<tr>
<td>The session was generally easy to implement.</td>
<td>A little</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>It did not take a lot of extra time out of my schedule to familiarize myself with the program.</td>
<td>A little</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td>The questionnaire was at an appropriate reading level for most parents.</td>
<td>A little</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td>The questionnaire was generally easy for the parents to fill out.</td>
<td>Not at all</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>A little</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td>Most parents seemed to enjoy the session.</td>
<td>A little</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>3</td>
<td>50.0</td>
</tr>
<tr>
<td>Most parents seemed engaged in discussion or listening closely.</td>
<td>A little</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>1</td>
<td>16.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td>Most of the parents seemed to gain some new knowledge over the session.</td>
<td>Somewhat</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Most parents seemed to find ALTER helpful.</td>
<td>Somewhat</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>4</td>
<td>66.7</td>
</tr>
<tr>
<td>I would implement this session again for another parenting group and/or recommend it to other professionals.</td>
<td>A little</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>A fair amount</td>
<td>2</td>
<td>33.3</td>
</tr>
</tbody>
</table>
REFERENCES


Human Resources and Skills Development Canada and Statistics Canada. 2003. *Building on Our Competencies: Canadian Results of the International Adult Literacy and Skills Survey.* Statistics Canada Catalogue number 89-617-XWE.


Mooney, H. (2010). Less advantaged children are 17 times more at risk of unintentional or violent death than more advantaged peers. *BMJ: British Medical Journal (Online), 341*.


APPENDICES
Appendix A

ALTER Mnemonic

<table>
<thead>
<tr>
<th>Activities</th>
<th>Location</th>
<th>Timing</th>
<th>Environment</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change what you</td>
<td>Move to where you can better</td>
<td>Ask yourself, “Do I need to be</td>
<td>Make changes around your home that can</td>
<td>Ask for help and use what you have</td>
</tr>
<tr>
<td>or your child is</td>
<td>see your child or bring your</td>
<td>doing this right now?”</td>
<td>prevent a fall.</td>
<td>learned.</td>
</tr>
<tr>
<td>doing.</td>
<td>child to where you are.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


## Appendix B

### Video Reference Guide

<table>
<thead>
<tr>
<th>ALTER Videos – Master Reference List</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Injury</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Burn</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Cooking and Suffocation</td>
</tr>
</tbody>
</table>
Appendix C

Facilitator Evaluation Feedback Sheet

Facilitator Session Evaluation

Thank you very much for your time and commitment to this important project. We could not do this without wonderful professionals like yourself!

We would greatly appreciate your feedback as well as any suggestions on how to make the program better.

Parenting Program Name: ____________________________

Your Name (PRINT): ____________________________ City Location: ____________________________

Number of attendees: _________ Date of Session Delivery (dd/mm/yy): ____________________________

This is my _______ time implementing this program. (Ex. 3rd)

I showed _______ ALTER video clips to my group (Ex. 5)

Please check the boxes below of which types of videos you included:

☐ Choking/Suffocation  ☐ Drownings  ☐ Poisonings  ☐ Falls  ☐ Burns

☐ Kitchen  ☐ Living Room  ☐ Bathroom  ☐ Bedroom  ☐ Staircase

☐ Toddler  ☐ Toddler and School Age

Describe briefly what your session looked like including any particular characteristics of the group worth noting, how you integrated the manual and videos, or parents’ response to the session.

1. The instructions provided in the manual were generally easy to follow.
1. **I understood what I was supposed to do for the session.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

2. **The session was generally easy to implement.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

3. **It did not take a lot of extra time out of my schedule to familiarize myself with the program.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

4. **The questionnaire was at an appropriate reading level for most parents.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

5. **The questionnaire was generally easy for the parents to fill out.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

6. **Most of the parents seemed to enjoy the session.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

7. **Most of the parents seemed engaged in discussion or listening closely.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

8. **Most of the parents seemed to gain some new knowledge over the session.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

9. **Most parents seemed to find ALTER helpful.**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

10. **I would implement this session again for another parenting group and/or recommend it to**
other professionals.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true</td>
<td>A little</td>
<td>Somewhat</td>
<td>Mostly</td>
<td>Very</td>
</tr>
</tbody>
</table>

Anything you especially liked about the program?

Any suggestions for improvement?

Any strategies that parents suggested that were not already on the Strategy Sheet and should be added.
Appendix D

Parent Evaluation Feedback Sheet

Please mark the answer that best describes how you feel about the ALTER Home Safety Session that you received.

*Your answers will be kept private. When you are finished, fold the paper in half and put it in the box please.*

1. Overall, how **useful** was today’s session?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very

2. How much has your **knowledge** of home safety improved?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very much

3. How much has your awareness of **how to keep your child safe** improved?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very much

4. **How confident** are you about knowing what to do to keep your child safe at home?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very much

5. How **helpful** were the videotaped examples that were used to communicate about home safety?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very much

6. How likely is it that you will use ALTER to try and keep your child safer at home?
   - [ ] Not at all
   - [ ] A little
   - [ ] Somewhat
   - [ ] A fair amount
   - [ ] Very much

7. Overall, would you **recommend** the ALTER Home Safety Session to a friend?
   - [ ] Would not recommend
   - [ ] Recommend
   - [ ] Highly recommend

Thank you for your time!