Preventing Product-related Injuries

A Randomized Controlled Trial of Poster Alerts

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ABSTRACT

Background: The Product Safety Programme (PSP) of Health Canada is responsible for preventing product-related injuries. If PSP decides a product is dangerous, it can publicize its dangers, prohibit, or control its distribution; but for child products, the preferred option is to publicize its concerns. In the past, this included sending posters to paediatricians' offices and, more recently, placing alerts on the PSP website. This study examines the effectiveness of this process.

Methods: 15 Montreal paediatricians participated in a modified crossover randomized trial. During a randomly chosen intervention week, two product-related notices were posted in the paediatricians' waiting area. In the following or preceding week, these notices did not appear. Parents were interviewed by telephone to determine if they saw the posters and acted on the information received.

Results: We interviewed 808 parents (86%) of the 940 who agreed to participate. Of these, only 16% of the intervention and less than 1% of the control group reported seeing the posters. There were no differences in reported changes in behaviours related to the notices. These findings are unchanged after taking account of socio-economic status. No parents cited the posters, websites, or paediatricians as their main source of information about dangerous products.

Conclusion: Product safety notices, whether sent to paediatricians' practices or posted on a website, cannot be relied upon to reach parents of preschool age children. Other approaches require consideration, such as increasing the power of PSP to regulate product safety.

Mesh terms: Health promotion; public health; safety management; promotion of health; knowledge/attitudes/practices

La traduction du résumé se trouve à la fin de l'article.

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Injuries from consumer products are common, especially among children.¹ In Canada, protection from these injuries is the responsibility of the Product Safety Programme (PSP) of Health Canada. Unlike the system to ensure the safety of drugs,² PSP does not often use regulatory powers to protect the public from dangerous products.³ Instead, PSP relies on communicating its concerns to the public.

PSP's preference for education may reflect the limited resources currently available to it. For example, even after design modifications to baby walkers were agreed upon, injuries continued^{4,6} and it was only in 2004 that they were banned.⁷ Similar concerns regarding clothing drawstrings prompted us to examine the effectiveness of PSP's preferred alternative to regulation – public notification.

Until recently, warnings were sent to physicians' offices (chiefly paediatricians) or to the media. They are now posted on Health Canada's website.⁸ This study examined whether providing safety information through notices intended to be posted in paediatricians' offices reaches parents and changes their behaviour. Specifically, our goal was to determine how well posters alert parents to the dangers associated with clothing drawstrings and blind-cords (i.e., strangulation, entrapment, respectively) and, if alerted, whether reported changes in behaviour occur in the intended direction. Our secondary goals were to examine parents' awareness of the Health Canada website and to document other sources of safety information.

METHODS

As shown in Figure 1, all 115 'private' paediatricians on the Island of Montreal were contacted by mail and asked to return a postcard indicating their willingness to participate. After one follow-up phone call, 23 agreed, 64 failed to respond, and 28 refused. Participating physicians were stratified by socio-economic status (SES) based on census tract characteristics of the areas where their practices were situated. We used a random number table to select 5 practices in each high, medium, and low SES area, with cut-offs based on average income, divided into tertiles.

A research assistant asked each practice secretary to distribute consent forms

approved by the Montreal Children's Hospital Research Ethics Board to parents of children under six years of age. The consent form solicited parents' agreement to be contacted and those agreeing provided contact information.

At each practice, we randomly selected one week for the intervention and another for the control. Thus each office served as its own control. During the intervention week, our research assistant posted two bulletins in the waiting rooms – one pertaining to the dangers of venetian blinds^{9,10} and the other to the risk of strangulation from clothing drawstrings.¹¹⁻¹³ Both posters were originally issued in the 1990s and reprinted for this study. Paediatricians were asked not to change their behaviour with respect to safety counselling.

Within two weeks after posting the notices, the research assistant telephoned to interview the parent, making up to 5 attempts to establish contact. The interview included closed and open questions with structured probes, and was conducted in French or English. The questions asked were based on those shown to be reliable and valid by other investigators.¹⁴⁻¹⁶ Questions focused on blinds and drawstrings but were supplemented by others related to baby walkers,^{5,6} bunk beds,^{17,18} toy boxes,¹⁹ and balloons.²⁰

A typical question was "Does your child use (specified product)?" If "yes," "Are you aware of safety issues associated with this product?" and "where or from whom did you receive (this) safety information?" All parents, regardless of the child's age, were asked general questions about sources of information and awareness of dangers associated with each product.

If parents stated they had blinds or curtain cords, a question pertaining to behaviour change was asked: "Did you cut them off or take them out? Or, have you bought specially designed safety blinds?" A similarly worded question was used for clothing drawstrings.

A change in reported behaviour of 10% was considered clinically important. We estimated that the baseline rate of the desired behaviour would be 60% and assumed most paediatricians see about 40 patients under age 6 each week. After taking account of refusals and non-responses, we estimated the 15 practices would yield 360 parents in each arm.

Figure 1. Selection of practices and parents: Randomization to intervention and control weeks

Legend: * Pediatricians not in hospital or clinics (sent consents)
R = randomization to intervention or control week

TABLE I

Respondents to Parent Consent Requests and to Telephone Interviews: Control vs. Intervention

	Control N=900 (%)	Intervention N=900 (%)	Total N=1800 (%)
Not distributed consents	356	256	612
Total distributed	544 (100)	644 (100)	1188 (100)
Not returned	47 (9)	45 (7)	92 (8)
Refused	73 (13)	83 (13)	156 (13)
Consented	424 (78)	516 (80)	940 (79)
Interviews attempted	424 (100)	516 (100)	940 (100)
5 incomplete calls	42 (10)	64 (12)	106 (11)
Wrong number	3 (1)	4 (1)	7 (1)
Not eligible	10 (2)	9 (2)	19 (2)
Completed	369 (87)	439 (85)	808 (86)

TABLE II

Demographic Characteristics of Interviewees: Control vs. Intervention

Completed Interviews	Control N=369 (%)	Intervention N=439 (%)	Total N=808 (%)
Respondent			
Father	40 (11)	32 (7)	72 (9)
Mother	329 (89)	407 (93)	736 (91)
Age of youngest child (months)			
0-24	240 (65)	308 (70)	548 (68)
25-48	96 (26)	95 (22)	191 (24)
49-72	33 (9)	36 (8)	69 (8)
Number of children in family			
1	249 (67)	281 (64)	530 (65)
2-3	117 (32)	156 (35)	273 (34)
≥4	3 (1)	2 (1)	5 (1)

A sample of this size is able to detect a change from 60% to 70%, with alpha set at 0.05, with 90% power.²¹

We used chi-square tests with Yates correction to compare the proportions of parents who stated they saw posters and whether they reported having done or intending to do what was recommended and the proportion who knew about the website or other sources of safety informa-

tion. All those interviewed were included in the denominator for these calculations.

RESULTS

As shown in Figure 1, we stratified the 23 practices by SES, such that 202 parents visited practices in high SES areas, 323 in medium, and 283 in lower SES areas. In each practice, parents were designated as

TABLE III

Percent of Parents Who Had Specified Hazards in the Home and Percent Who Were Aware of Related Safety Issues: Control vs. Intervention

Hazards	Hazard Present (%)			Aware Safety Issues (%)		
	Control Week N=369	Intervention Week N=439	p-value	Control Week N=369	Intervention Week N=439	p-value
Loose blinds or curtain cords in the home*	312 (85)	348 (79)	0.06	341 (92)	403 (92)	0.85
Long cords or drawstrings on clothing*	146 (40)	155 (35)	0.24	274 (74)	364 (83)	0.003
A baby walker with wheels	161 (44)	184 (42)	0.67	329 (89)	372 (85)	0.08
Unsafe bunk bed	46 (12)	47 (11)	0.50	38 (10)	23 (5)	0.01
A toy box with a heavy lid and no ventilation	259 (70)	310 (71)	0.96	231 (63)	262 (60)	0.44
Balloons at home	155 (42)	177 (40)	0.68	297 (80)	341 (78)	0.37

* Posters used during intervention week

TABLE IV

Parents Reporting Having Taken Recommended Safety Measures for Clothing Drawstrings and Blind Cords, by Socio-economic Status: Control vs. Intervention

	Safety Measures for Clothing Drawstrings		Safety Measures for Blind Cords	
	Intervention	Control	Intervention	Control
High SES	N=117 (%)	N=85 (%)	N=117 (%)	N=85 (%)
Yes	13 (11)	13 (15)	75 (64)	61 (72)
No	26 (22)	26 (31)	18 (15)	16 (19)
NA	78 (67)	46 (54)	24 (21)	8 (9)
Medium SES	N=162 (%)	N=161 (%)	N=162 (%)	N=161 (%)
Yes	20 (13)	16 (10)	95 (59)	97 (60)
No	44 (27)	43 (27)	29 (18)	35 (22)
NA	98 (60)	102 (63)	38 (23)	29 (18)
Low SES	N=160 (%)	N=123 (%)	N=160 (%)	N=123 (%)
Yes	15 (9)	18 (15)	106 (66)	80 (65)
No	38 (24)	31 (25)	25 (16)	23 (19)
NA	107 (67)	74 (60)	29 (18)	20 (16)
Total	N=439 (%)	N=369 (%)	N=439 (%)	N=369 (%)
Yes	48 (11)	47 (13)	276 (63)	238 (64)
No	108 (25)	100 (27)	72 (16)	74 (20)
NA	283 (64)	222 (60)	91 (21)	57 (15)

NA = not applicable

TABLE V

Parents Who Were Aware of Website and Had Access to Internet at Home, by Socio-economic Status: Control vs. Intervention

	Aware of PSP Website		Access to Internet	
	Intervention	Control	Intervention	Control
High SES	N=117 (%)	N=85 (%)	N=117 (%)	N=85 (%)
Yes	6 (5)	8 (9)	103 (88)	73 (86)
No	111 (95)	77 (91)	14 (12)	12 (14)
Medium SES	N=162 (%)	N=161 (%)	N=162 (%)	N=161 (%)
Yes	5 (3)	8 (5)	129 (80)	131 (81)
No	157 (97)	153 (95)	33 (20)	30 (19)
Low SES	N=160 (%)	N=123 (%)	N=160 (%)	N=123 (%)
Yes	5 (3)	7 (6)	122 (76)	96 (78)
No	155 (97)	116 (94)	38 (24)	27 (22)
Total	N=439 (%)	N=369 (%)	N=439 (%)	N=369 (%)
Yes	16 (4)	23 (6)	354 (81)	300 (81)
No	423 (96)	346 (94)	85 (19)	69 (19)

intervention or control depending on the week they attended.

Table I shows that of the 1,188 parents who received questionnaires, 940 (79%) consented. Of these, 808 were interviewed (86%) and the distribution of responses was similar for intervention and control parents. Table II shows that there were no differences between the groups on the characteristics compared.

We found that 85% and 79% in the control and intervention groups respective-

ly reported having loose blinds or curtain cords, and 40% and 35% respectively reported having clothing cords or drawstring (Table III).

As noted in Table IV, the same percent of parents in both groups reported changing behaviour in the direction recommended with respect to blind cords and drawstrings.

It is noteworthy, as shown in Table V, that regardless of SES, less than 10% of parents report being aware of the PSP web-

site, although about 80% have access to the internet.

The results in Table VI indicate that most information about dangerous products comes from the media. Only 3.3% of parents chose paediatricians and 8.4% chose websites and, notably, it is to manufacturers (34.7%), not Health Canada (4.6%), to whom parents said they would report product-related concerns.

DISCUSSION

About one quarter of all injuries involving children receiving emergency room care at the Montreal Children's Hospital between June 1, 2003 and May 31, 2004 were product-related. (Personal Communication, Keays, G. CHIRPP Coordinator, 2005). This likely reflects the pattern at other Children's hospitals in Canada, although the frequency of these injuries among adults is not known.

Although Health Canada has much of the responsibility for the prevention of injuries, this study suggests that its strategies aimed at reaching parents are ineffective. We found virtually no differences between reported behavioural changes of parents exposed to posters during the intervention week and those not exposed during the control week. This is consistent with other findings noting the severe limitations of exclusively relying on education to achieve preventive goals.^{6,22-24} Using websites is equally discouraging,^{25,26} especially in light of a study of 55 online resources addressing child safety. The authors judged that 41 (74.5%) of these websites failed to provide reliable and/or credible sources of safety information.²⁷

Public education, or the use of mass communications to notify the public of product-related dangers, is part of an extensive literature. Unfortunately, it

TABLE VI
Sources of Information and Choice of Contact Regarding Dangerous Product

	N=808	%
Sources		
Books/magazines	238	29.5
Other media	191	23.6
Notices	86	10.6
Internet	68	8.4
Word of mouth	68	8.4
Paediatrician	27	3.4
CLSC	26	3.2
Other	81	10.0
No information received	23	2.9
Contact		
Manufacturers	280	34.7
Health professionals	110	13.6
Consumer Safety	78	9.7
Health Canada	37	4.6
Media	5	0.6
No one	70	8.7
Other	44	5.5
Don't know	184	22.8

appears that only a few of these approaches have been formally evaluated.^{22,23,28-31} Although the topic is complex, it appears that for communication to be effective, it must elicit a chain of responses. Our study was not influenced by this literature, however, because our goal was to replicate and then evaluate actions taken by PSP, not to improve on them. We do not know whether those actions were based on an awareness of the relevant literature,³²⁻³⁴ but for the purposes of this study there was no reason to change PSP's approach.

Our results need to be viewed in light of several limitations. The choice of paediatricians alone is questionable because family doctors treat most Canadian children. However, there is no reason to believe that parents attending paediatricians' offices would differ in their responses to the posters from those attending family doctors. The response rate by physicians appears low but there were few outright refusals and most of the non-responders were physicians who did not return the contact card, which we assume reflects ineligibility or lack of interest, but is not a systematic bias. The effect of any apparent differential response by SES is diminished by our design in which practices were stratified by SES before randomization and served as their own controls.

A related concern is the proportion of parents who did not sign consent forms and who could not be contacted. As noted previously, this reflects difficulties the office staff had in handing out the forms to all parents. The pattern of non-response is, however, virtually identical for control and

intervention groups. Thus although generalizability may be affected if parents not offered consent forms differed from those who were, this would not affect internal validity given the similar pattern in both weeks. Hence any within-practice comparisons, our main focus, should be valid.

There are other more minor concerns. The unit of analysis in a study such as this should be the practice, not the parent. Given, however, that there were no statistically or clinically significant differences between intervention and control weeks, we reasoned that a cluster analysis was not required. Although this is post hoc reasoning and we should have planned the study to take clustering into account, we did not do so because 1) it is exceptionally difficult to estimate how large the clustering effect might be in the absence of any studies indicating, for example, how homogeneous patients in a paediatric practice are, and 2) a cluster analysis would have required a larger sample and we did not have the funding to include many more practices.

It is also possible that parents' responses may be biased by social desirability but in light of the findings, this seems not to be an issue. Inability to blind the reviewer is another limitation that could have prompted differential, e.g., more intense probing following the intervention, but this was minimized by the use of structured probes.

CONCLUSION

Product safety notices, whether sent to physicians' offices or posted on a website, cannot be relied upon to reach those at risk or to change their behaviour. What alternatives are there to protect children and others?

At present, PSP cannot recall products; it can only prohibit, restrict or control products proven to be dangerous.³⁵ As prohibition is time-consuming, manufacturers are instead asked to voluntarily ban or modify hazardous products. Inspectors are empowered to enforce any agreed restrictions, but there are too few to do so effectively.^{8,13} Consequently, one promising option that remains is the proposed reform of the legislation under which PSP operates that would make it "illegal for anyone to manufacture, promote or market a product that may present an undue risk to health, under reasonably foreseeable condi-

tions of use".^{36,37} This reflects the 'precautionary principle' which "shifts the burden of proof ... to requiring proof of absence of negative consequences in order to allow an action".³⁸⁻⁴⁰ If this were to come about – and the findings of this study indicate that it may be the only alternative to currently unsuccessful strategies – Canadians of all ages would be better protected against numerous and often serious product-related injuries.

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RÉSUMÉ

Contexte : Le Programme de la sécurité des produits (PSP) de Santé Canada est chargé de prévenir les risques de blessures associés aux produits. Si le PSP détermine qu'un produit est dangereux, il peut soit en faire connaître les dangers, soit l'interdire, soit en restreindre la distribution, mais en ce qui concerne les produits destinés aux enfants, c'est la première de ces trois approches qui est la plus utilisée. On envoie d'habitude des affiches aux cabinets des pédiatres; depuis peu, on publie aussi des alertes sur le site Web du PSP. Notre étude porte sur l'efficacité de tels procédés.

Méthode : Quinze pédiatres montréalais ont pris part à un essai aléatoire croisé modifié. Au cours d'une semaine d'intervention sélectionnée au hasard, ils ont affiché dans leur salle d'attente deux avis concernant des produits destinés aux enfants. Ces avis n'ont été affichés ni la semaine suivante, ni la semaine précédente. Nous avons interviewé des parents au téléphone pour leur demander s'ils avaient vu les affiches et s'ils en avaient pris acte.

Résultats : Sur les 940 parents ayant accepté de participer, 808 (86 %) ont été interviewés. De ce nombre, 16 % seulement du groupe de la semaine d'intervention et moins de 1 % du groupe témoin ont dit avoir vu les affiches. Les répondants n'ont mentionné aucun changement dans leurs comportements après avoir pris connaissance des avis. Ces constatations demeurent inchangées même après la prise en compte du statut socioéconomique des répondants. Aucun parent n'a mentionné une affiche, un site Web ou un pédiatre comme étant sa principale source de renseignements sur les produits dangereux.

Conclusion : Pour informer les parents d'enfants d'âge préscolaire des risques que posent certains produits, on ne peut se fier aux avis affichés dans les cabinets des pédiatres ou publiés sur un site Web. D'autres méthodes doivent être envisagées, comme d'accroître les pouvoirs conférés au PSP pour réglementer la sécurité des produits.