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Sample Assessment Material

Level 3 Cambridge Technical Health and Social Care

05871

Unit 25: Research methods in health, social care and childcare

Pre-release material

First Name		Last Name	

Centre Number						Candidate Number				

Date of Birth								

GUIDANCE NOTES

- This pre-release material contains three research articles on three different themes.
- The question paper will require learners to respond to questions about research they have completed and questions which are associated with general research principles.
- Learners need to conduct research linked to the pre-release material in the five weeks they have access to the document.

INSTRUCTIONS FOR TEACHERS

- This material must be issued 6 weeks prior to the published examination date.
- This material must be printed on A4 only.
- Learners are permitted to summarise their research findings and record results/evidence/data gathered **in the notes pages at the back of this document only** (not in the margins or around the pre-release material itself or on additional sheets) and **must not exceed the 2 pages provided**.
- The notes section must **not** be used to produce a formal write-up of the research conducted.
- Teachers must collect in each learner's pre-release material and notes **one calendar week** prior to the exam date.
- Teachers must check that the notes made are appropriate and are the learners' own work in advance of the examination taking place.
- The pre-release and notes must then be returned to learners **immediately before the exam commences**.
- The pre-release and notes **must** be submitted along with the learners' Question Paper at the end of the examination.

Ofqual Reference number A/615/1576
Turn over

INFORMATION FOR LEARNERS

- You **must** choose **one** of the research articles (source **A**, **B** or **C**).
- You **must** identify a specific focus from the article for further secondary research.
- You **must** then complete further secondary research related to your focus, using **at least two** sources.
- Your notes on the research **must not** exceed the pages provided in this document; no additional sheets may be taken into the examination.
- Your secondary sources **must be** recorded on page 8 of this document.
- Notes are **only** permitted on pages 9 and 10, not elsewhere within the pre-release material such as in the margins or around the sources themselves.
- You **must** hand in your pre-release material and notes with your question paper at the end of the examination.

SOURCE A

Extracts from and summary of:

Peters, J., Parletta, N., Campbell, K. and Lynch, J. (2014) 'Parental influences on the diets of 2- to 5-year old children: Systematic review of qualitative research' Journal of Early Childhood Research Vol. 12 (1) 3-19.

Introduction

Parents have a major influence on young children's diets, food choices and habit formation but research concerning parental influence on children's diets is limited. This paper reviewed nine qualitative research studies to build a picture of 'what works' to inform the design of intervention programmes and good practice.

Worldwide rates of obesity have more than doubled since 1980, including approximately 43 million preschool children. A healthy diet is best developed at a young age as habits and practices are difficult to change once established. In a child's early years, parents are the primary educators and care givers and have a major influence on children's diets. In order for parents to encourage their children to make healthy food choices they need to be well informed about healthy and unhealthy foods

Methodology

Academic databases were searched for relevant research using key terms. 663 articles were first identified. By refining the search criteria, this number was reduced to 133. The authors then read the abstracts of these to decide on the nine to include in their review. Seven of these are summarised below.

The research studies

1. **Haerens et al. (2009)**

Focus group research was conducted in eight European countries. Three groups were involved: children aged 6-8 years (n = 155), parents of children aged 2-4 years (n=106), and parents of children aged 6-8 years (n=83). Results included recognition that young children find it difficult to prepare fruit provided for snacks outside of home and parental concern that the child could be stigmatised for being the only one with a healthy snack. Parents identified barriers to healthy feeding practices as: healthy food taking longer to prepare, children's unhealthy food preferences, high cost of healthy food, high availability of unhealthy food and difficulty reading food labels. Helping with healthy habits included parents modelling healthy eating, offering healthy snacks that appeal to children, not having unhealthy foods in the home.

2. **Horodynski et al. (2009)**

Participants included 27 African American low-income mothers of children aged 1-3 years. Findings were that the mothers' perception of a healthy child was one who ate well. Healthy food was sometimes not offered due to perception of child's preferences. Concerns included fear that children who were picky eaters were at risk of malnutrition. One mother explained her choice between buying a smaller quantity of healthy fresh food and a larger quantity of unhealthy food for the same cost. This research identified the important challenges faced by lower income families such as cost, convenience and quality versus quantity.

3. **McGarvey et al. (2006)**

This study aimed to identify cross-cultural differences. 25 mothers were allocated to one of four focus groups. There was one focus group per ethnic group: White (n=8), African American (n=6), Hispanic (n=6) and Vietnamese (n=5). White and Hispanic women were concerned about overweight once a child started school due to stigmatisation and health issues; however, African American and Vietnamese women were more concerned with underweight. A common perception was that if a child experienced overweight at 3 or 4 years of age they would outgrow it. All groups reported using food as rewards and many parents believed children's eating problems mostly originated outside the home environment (e.g. child care, preschool, grandparents).

4. **Crawford et al. (2004)**

Semi-structured focus groups were carried out at 5 obesity prevention programmes in California. Discussions were for two hours and 43 mothers attended. They were asked about their beliefs in relation to children's weight. Heavier children were perceived as healthier than thinner children. Mothers predominantly believed that childhood overweight was a result of genetics or a condition their child would outgrow. They believed modelling to be a key strategy in child behaviour change.

5. **Sherry et al. (2004)**

A total of 12 diverse groups of mothers were recruited to examine the impact of culture and socio-economic status on attitudes and practices with child feeding and perceptions of child weight. Of the 12 groups, 9 groups were of low SES and 3 consisted of middle-income earners (n=28). The 9 low SES groups included 3 White American groups (n=22), 3 African American groups(n=24) and 3 Hispanic groups(n=27). Six themes were identified: goals and beliefs about what was good nutrition; cost of food; mealtime environment and encouraging children to eat; strategies to persuade children to eat; reactions to children claiming to be full and concerns and beliefs about child weight. This research identified the need to be aware of cultural and income differences in concerns, attitudes and practices in relation to child feeding and perceptions of child weight.

6. **Adams et al. (2008)**

Three American Indian communities participated in focus group research about parental perspectives regarding child health, diet and physical activity. Participants were parents (n=42) of 5-8 year old children. A total of 10-12 interviews and observations were conducted at each community. The research highlighted that some parents did not want to control their children or dictate food choices, particularly if the parent had been controlled as a child. Parents wanted their child to eat healthier foods but did not provide the right environment to facilitate this. There was a focus on the here and now rather than the longer term future.

7. **Bolling et al. (2009)**

Parents of children aged 2-6 years were recruited from private paediatric practices in suburban, rural and urban areas. Focus groups ranged from 3 to 7 participants per groups and lasted approximately 90 minutes. Many of these parents shared the common misconception that fruit juice consumption was the equivalent of whole fruit consumption. Another common barrier to providing a healthy diet was increasing fruit and vegetables to five portions per day. Children reported not liking vegetables and refusing to eat them. This often resulted in struggles between parents and children and child tantrums.

Conclusion

Findings highlight the need to promote culturally tailored programmes to combat specific cultural differences such as attitudes, perceptions and concerns. There are some common barriers to providing healthy foods and challenges faced by lower income families. Food is often used by parents to shape children's behaviour. Commonly held beliefs include: that children will grow out of excess weight, heavier children are healthier and that not meeting a child's request for food could result in starvation. There is a need for further research into parents' understanding of healthy diets and feeding practices.

SOURCE B

Extracts from and summary of:

Coyle, D. (2011) 'Impact of person-centred thinking and personal budgets in mental health services: reporting a UK pilot study' Journal of Psychiatric and Mental Health Nursing, 18, 796-803

Summary

- This paper reports the use of personal budgets in three early intervention teams in England.
- Person-centred thinking tools were helpful to staff and helped them gain new insights about what is important to and for the service user.
- The research demonstrated how personal budgets enhanced recovery for service users.
- Challenges for mental health nurses and the services they work for were highlighted by the research.
- Mental health practitioners need to work with service users creatively in partnership in ways that may not fit traditional service responses.

Introduction

Mental health services are being challenged to provide recovery-focused and inclusive ways to provide services. They may be able to transform their approach, by learning from other services who have embraced personalized support. Person-centred planning and tools have been used within learning disabilities for many years, providing a foundation for good practice.

Method

In 2007 a pilot was carried out by an NHS Trust in England to explore how early intervention teams (EITs) could deliver highly personalized interventions to promote recovery for people with serious mental health disorder. Service users accessed Individual Recovery Budgets (IRBs) and EITs used a process of person-centred thinking tools and support planning.

The EITs were selected because they already had a history of supporting individuals within their communities. The EITs were given expert help with support planning and using person-centred thinking tools to develop outcome-focused support plans. They were also given two days of training in person-centred thinking and tools. There was an initial target of 100 individuals who were provided with an individual recovery budget (IRB) to take part in the study.

Seven individuals who received an IRB were interviewed individually on two occasions between October 2008 and February 2009. Additionally two focus groups were held with EIT members involved in the pilot. Data was transcribed and analysed to identify themes. Data also included information from support plans.

Ethical considerations

The evaluation was subject to local ethical scrutiny and the Trust Governance Office was satisfied with the ethical processes that were in place. Participants were provided with information about the research. Consent was obtained and data was stored and used in accordance with ethical guidelines.

Narrative accounts of individuals prior to receiving an IRB

Here participants describe their life before commencing with the EIT and with an IRB.

> *When I was unwell I was really unwell. Things were really bad for me. I was very isolated. Very alone. I felt like I was dealing with my problems all alone. I had no-one to speak to, no-one to turn to, no-one to offload on …. Er so, things were very bad for me.*
>
> (Te)

Jn was failing in college. Unable to complete his course-work, Jn was absenting himself and withdrawing socially. Here he describes his strategy for managing failure before the IRB.

> *And what I've done over the last couple of years is rather than risk failing with full effort in anything I've aimed to fail and then failure is a success.*
>
> (Jn)

Narrative accounts of individuals after receiving an IRB

Self-directed support enabled service users to obtain otherwise unavailable items or services. Both individuals receiving IRBs and those working in EITs reported positive effects from the process. The evaluation showed self-directed care mechanisms and support recovery processes led to hope and a positive self-direction.

Te had used the IRB to fund a continuing education course.

> *It's given me some sort of goal to head towards. It's also allowing me to meet other people er… Er… so again it's given me something to aim for in life er… hopefully er… it will give me a lot more security when I go into the job market and try and look for employment*
>
> (Te)

Jn accessed the IRB to buy a laptop which allowed him to complete his college coursework more easily.

> *I mean you'd only have to ask - and – [EIT workers] to see the improvement that's been made. Maybe not all because of the laptop but because that started a change of events of me going in and … it's just helped a lot of things come together really and stopped a lot of things from going downhill.*
>
> (Je)

Staff experiences of Individual Recovery Budgets: change in professional roles

Self-directed support should better reflect what individuals want which changes the role of professionals. Their role is to facilitate co-production of support plans, manage medication and organise therapy. Support planning provided them with richer information than usual assessment processes. Professionals reported a sense of job satisfaction in facilitating change for individuals.

Staff experience of using Individual Recovery Budgets (IRBs)

Positive aspects of IRBs	Challenges for IRBs
New and helpful tool	Fitting in with regulatory forms
Different way of approaching the person	Parity and equity
Unanticipated positive outcomes	Making it work
Modesty of request	Not for everyone

Conclusion

New directions in mental health services better reflecting choice have been demanded for many years (Crossley 1999). This small study demonstrates the impact of this way of working and the potential benefits for users and providers.

However there were challenges. The feeling that the recipients of IRBs in this pilot were advantaged over existing service users was problematic. The association between parity and equity is a common feature in the public sector. Services responding flexibly to individuals' needs challenges commonly held ideas of fairness.

SOURCE C

Extracts from and summary of:

Sidhu, M.S., Daley, A. and Jolly, K. (2016) 'Evaluation of a text supported weight maintenance programme 'Lighten Up Plus' following a weight reduction programme: randomised control trial' International Journal of Behavioural Nutrition and Physical Activity, 13:19

Background: Many overweight people find it difficult to maintain weight loss after attending a weight reduction programme. Self-weighing and telephone support are known to be useful methods for self-monitoring for weight loss. We examined the effectiveness of an SMS-text messaging based weight maintenance programme to encourage regular self-weighing in adults who had completed a 12 week commercial weight loss programme.

Methods: Randomised controlled trial of 380 obese or overweight men and women. The intervention group (N = 190) received a single maintenance support phone call and SMS-text based weight maintenance messages over 12 weeks to encourage regular self-weighing after completing their weight loss programme. The control group (N=190) received a brief maintenance support phone call but no text messages. Participants were randomly allocated to either the intervention or the control group. Participants were eligible to take part if they were over aged 18 years, had their final weight recorded at the end of the weight loss programme, had access to scales to weigh themselves and owned a telephone. The primary outcome was whether there was a change in weight after 9 months.

Ethics: Ethical approval was obtained for the study from the NHS Research Ethics Committee. The research team had no relationship with the commercial weight loss programme organisers and they were not involved with the research. The research only began when the commercial programme had ended. Participants were sent a letter of invitation and an information sheet. Written informed consent was obtained.

Results: Our sample (N = 380) had a mean age of 47.4 years, mean baseline weight of 93.1 kg (16.1)and BMI of 34.4 kg/m2. The majority were female (87.3 %) and White British (80.0 %).
Both groups regained weight at 9 months follow up; the intervention group regained an average of 1.36 kg while the control group regained 1.81 kg.

Conclusions: We found no evidence that an SMS based weight maintenance intervention significantly reduced weight at 3 and 9 months after completing a 12 week commercial weight loss programme. However the change in direction favoured the intervention group. Participants in both study groups showed resistance to weight regain in the short term, but the effects were not maintained in the longer term. The text messaging did encourage greater self-weighing and recording of weight, but there is no evidence that it promoted behaviour change.

Please record your secondary sources below:

Notes Page

Notes Page

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