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For issue on or after: Monday 16 November 2026

Level 3 Cambridge Technical in Health and Social Care

05871 Unit 25: Research methods in health, social care and childcare

Pre-release material

To prepare candidates for the examination taken on Friday 15 January 2027 – Afternoon

C446/2701

05871-25

Please write clearly in black ink. **Do not write in the barcodes.**

Centre number | | | | | | Candidate number | | | | |

First name(s) _____

Last name _____

Date of birth | D | D | M | M | Y | Y | Y | Y |

INSTRUCTIONS

- Choose **one** research article and identify a specific focus for further secondary research.
- Undertake further secondary research related to your specific focus. Use **at least two** secondary sources.
- Record your secondary sources on page **8** of this booklet.
- You can summarise your findings on pages **9** and **10** of this booklet to use in the exam.
- Do **not** produce a formal write-up of your research.
- **Seven** days before the exam, hand in this booklet to your teacher. This booklet will be given back to you at the start of the exam.
- Do **not** take any other notes into the exam.
- At the end of the exam, hand in this booklet with your exam paper.

INFORMATION

- You have **five** weeks to undertake your research.
- This document has **12** pages.

ADVICE

- Keep a clear record of your findings as you work through the task.

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Research Article A

A UK national cross-sectional survey of stroke support groups: exploring the role of social identification and group processes in reducing loneliness

Extracts from:

Hollands, L., Calitri, R., Haslam, C. *et al.* A UK national cross-sectional survey of stroke support groups: exploring the role of social identification and group processes in reducing loneliness. *BMC Public Health* **24**, 2992 (2024).

DOI: https://doi.org/10.1186/s12889-024-20432-w

Background

Loneliness is a common experience following stroke. Stroke support groups may protect against loneliness, but little is known about how these groups exert their influence. This research drew upon current theorising on the role of groups for health and explored (i) social identification as a potential mechanism for overcoming loneliness, and (ii) psychological group resources (support, control, self-esteem), and functional group processes (clear goals, group autonomy, member continuity) which might structure social identification.

Study design

This cross-sectional study comprised a national survey of the UK Stroke Association's network of peer-led support groups. Data were collected between November 2019 and March 2020. The survey was initially designed for a longitudinal study of stroke support group members. However, due to the COVID-19 pandemic the follow-up survey was adjusted to reflect the context of stroke group membership at that time. Findings from that survey are reported elsewhere. Our stroke advisory group, which comprised stroke survivors, stroke group leaders and an aphasiologist, advised on acceptability of survey content, study materials (information sheets, consent forms) and recruitment processes.

Methods

Five hundred seventy-nine stroke survivors from 84 Stroke Association support groups across the UK completed a cross-sectional survey measuring: support group identification; psychological resources (given and received social support, control, self-esteem, identity centrality); functional processes (goal clarity, group autonomy, member continuity); and loneliness (3-item UCLA Loneliness Scale).

Study population

The Stroke Association peer support groups are led by volunteer members who may themselves be stroke survivors. A convenience sampling approach was taken to data collection, where all groups in the Stroke Association network were invited to take part (N = 214). Each group leader was contacted and asked to share information about the study with their groups. At least one week later, the group leaders distributed the consent form and a questionnaire during one of the group's regular meetings, which participants completed themselves. The group leader returned the questionnaires to the study team by post. Aphasia-friendly versions of the questionnaire and study documents were available for participants that required these. As the Stroke Association does not maintain official membership numbers for each group, we requested group leaders to estimate the number of questionnaires needed. Consequently, the exact number of stroke survivors approached could not be accurately recorded. Group members were eligible to take part if they were (i) a stroke survivor, (ii) a member of a Stroke Association peer support group, and (iii) over 18 years of age.

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Conclusions

Stroke support group identification may play an important role in reducing loneliness for stroke survivors that attend stroke support groups. A range of group resources (given and received social support) and functions (goal clarity, and group member continuity) were particularly strongly associated with greater support group identification. These findings contribute to the body of knowledge illustrating how support groups exert their effects. Theoretical alignment with the Social Identity Approach to Health means these findings can be compared to and inform interventions that might be designed following that approach. Future research using longitudinal methods may help further disentangle the directionality and temporal effects of these processes and outcomes.

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Research Article B

Universal mental health support in the early years in the context of the UK: early years professionals' views

Extracts from: Bakopoulou, I., & Sheppard, J. (2024). Universal mental health support in the early years in the context of the UK: early years professionals' views. *Early Years*, 1–16.

DOI: https://doi.org/10.1080/09575146.2024.2378065

Introduction

Recent years have seen the topic of mental health propelled into the limelight, receiving extensive media coverage and featuring at the forefront of numerous campaigns and government initiatives, particularly within the UK education sector. With teachers undertaking specific training in 'Mental Health First Aid', the assignment of designated Mental Health Specialists in every school (Department for Health and Department for Education), and the appointment of Emotional Literacy Support Assistants in local authorities there is markedly a strong drive to improve children and young people's mental health. However, in recent years, these initiatives were aimed towards primary and secondary schools, thereby excluding the nation's youngest children, 5.5% of whom were found to hold a mental health diagnosis. This figure was based on a nation-wide survey carried out in 2017, including oppositional defiant disorder, autism spectrum disorder and sleeping and feeding disorders. These figures are likely to have been amplified by COVID-19.

Research design

An online questionnaire survey was used to examine the capability and preparedness of the early years workforce to support children's mental health needs, as well as to explore practice in promoting SEL. The design selected provided us with rich and in-depth data in order to address the research questions.

Participants

Practitioners working within the UK early education sector were the target participants for this study, who were accessed via a large Facebook support group dedicated to early years practitioners. A total of 123 participants were reached in this way, comprising 39 participants who were employed in private day nurseries, 6 from local authority children's centres, 12 from maintained nursery schools, 55 from the early years departments in schools, 2 childminders and 5 who specified 'other'. Of these participants, 34 held Qualified Teacher Status qualification, while the remaining participants were qualified to Level 3 and above (from the 9 levels of qualification that exist in the UK, with Level 1 being the lowest and Level 9 the highest level of qualifications). The participant sample appears to be largely representative of the wider UK early years workforce in terms of the proportion and number of childcare providers and their overall qualifications (DfE, 2021).

Data collection

An online questionnaire survey was used to examine the capability and preparedness of the early years workforce to support children's mental health needs, and to explore practice in promoting SEL. Aside from standard information-gathering questions (e.g. qualification status, type of setting, etc.), questions were predominantly open and explored practitioner preparedness to support mental health, availability and accessibility of CPD, as well as their suggestions for further training. The second part of the questionnaire asked practitioners to describe the strategies and approaches they use in their everyday practice to support mental health and encourage children's SEL.

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Procedures

A link to the online questionnaire survey was shared on social media, specifically a large Facebook group dedicated to early years practitioners. Participants were given a three-week time frame in which to complete the questionnaire, after which, the data was collated and analysed.

Data analysis

For the quantitative questions of the survey, descriptive statistics were used. Due to the relatively small sample size, the results from the quantitative questions of the survey should be treated with a degree of caution, as the margins of error on small sample sizes are typically wide. For this reason, responses are given as numbers as well as percentages. All percentages have been rounded to the nearest integer and so may not sum to exactly 100%.

For the qualitative, open questions of the questionnaire, we followed the five key stages of the 'Framework' approach: 'familiarisation' with the data, creating a 'thematic framework', 'indexing' the data in relation to the framework; 'charting' or collating the data under each theme and sub-theme, and finally 'mapping and interpretation' of the data. Where words are quoted, the participant is identified only by a randomly assigned unique code, e.g. Participant 4.

Conclusion

This research has highlighted concerns raised by early years practitioners that essentially, in the context of the UK, early years training, including CPD, is insufficient in preparing practitioners to support children's mental health needs. Whilst there is an evident national push to improve this, with increased opportunities for professional development and learning and recommendations for upgraded teacher training, there is extensive room for improvement, with a significant portion of survey participants reporting feeling ill-equipped in the field of childhood mental health. The variety of strategies and techniques reported by participants to be used in their everyday practice emphasises the importance of a highly skilled workforce, reinforcing the argument for increased mental health training for all early years professionals in the UK.

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Research Article C

Real-world treatment trajectories of adults with newly diagnosed asthma or COPD

Extracts from:

Markus AF, Rijnbeek PR, Kors JA, Burn E, Duarte-Salles T, Haug M, Kim C, Kolde R, Lee Y, Park HS, Park RW, Prieto-Alhambra D, Reyes C, Krishnan JA, Brusselle GG, Verhamme KM. Real-world treatment trajectories of adults with newly diagnosed asthma or COPD. BMJ Open Respir Res. 2024 Feb 27;11(1):e002127.

DOI: https://doi.org/10.1136/bmjresp-2023-002127

Introduction

Asthma and chronic obstructive pulmonary disease (COPD) are prevalent chronic respiratory conditions with a large global health burden (21.6 and 74.4 million disability-adjusted life-years, respectively). Both diseases have a negative impact on all aspects of life when not properly controlled and are responsible for (preventable) deaths, often as a result of acute exacerbations. Treatment is mainly organised via primary care and is aimed to minimise symptoms and prevent acute exacerbations. To support clinicians in the management of patients with asthma or COPD, several national and international guidelines have been developed which are frequently updated based on the latest research and insights. These guidelines suggest a stepwise treatment approach where treatment is initiated and tailored on the needs (i.e. symptoms, severity, disease control and future risk) of the individual patient.

There is a lack of global knowledge on how patients with asthma or COPD are treated in the real world, especially with regard to the initial pharmacological treatment of newly diagnosed patients and the different treatment trajectories (encompassing both treatment step-up and treatment step-down strategies). Therefore, the purpose of this global characterisation study was to shed light on real-world treatment trajectories of newly diagnosed adults with asthma and COPD across different countries and continents. This descriptive study provides high-level insight into real-world treatment practices and helps to generate hypotheses for follow-up studies to address current gaps in clinical practice.

Study population

For this study, four claims databases and four electronic health record (EHR) databases from six countries were used: the USA, the UK, Spain, South Korea, the Netherlands and Estonia. Within the databases, we identified two mutually exclusive cohorts: (1) a cohort of adults newly diagnosed with asthma (and no prior history of COPD) and (2) a cohort of adults newly diagnosed with COPD (and no prior history of asthma). For each cohort, we included patients available in the database with a first diagnosis from 1 January 2010 to 31 December 2019, having at least 1 year of database observation time prior to the first occurrence of a diagnosis record and at least 3 years of follow-up time since first diagnosis. This was required not only to have sufficient information on treatment history, but also to allow sufficient time following diagnosis to study treatment trajectories. Furthermore, we restricted the asthma cohort to patients aged 18 years or older and the COPD cohort to patients aged 40 years or older. Patients entered the cohort on the date of first diagnosis (i.e. index date) and contributed to the follow-up time until they were transferred out of the database, death or the end of data collection, whichever occurred first.

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Respiratory drug classes

We studied treatment trajectories at drug class level and investigated the following types of respiratory drug classes: inhaled corticosteroids (ICS), short-acting ß2 agonists (SABA), long-acting ß2 agonists (LABA), short-acting muscarinic antagonists (SAMA), long-acting muscarinic antagonists (LAMA), leukotriene receptor antagonists (LTRA), xanthines, oral systemic glucocorticoids, phosphodiesterase-4 (PDE4), and biologics (including anti-IL4Rα, anti-IL5(R) and anti-IgE). Furthermore, we included four classes of fixed combinations of inhaled drugs: SABA-SAMA, LABA-LAMA, LABA-ICS and LABA-LAMA-ICS. With regard to systemic steroids, use of <30 days was considered a steroid burst whereas use of ≥30 days was considered maintenance therapy.

Treatment trajectories

For all patients we investigated whether or not they received treatment during follow-up. For those who did, we studied the treatment trajectory, which is defined as the sequence of the respective respiratory drug classes over time. We first defined drug eras as continuous sequences of exposure records from the same class with a maximum gap of 30 days between exposures. Only drug eras of at least 5 days were included in the analysis.

Discussion

Sunburst plots for the treatment trajectories of newly diagnosed adults with asthma and of newly diagnosed adults with COPD are presented.

We found large differences in the proportion of patients with asthma or COPD receiving treatment across databases. Medicaid and Medicare (both US claims databases) had the largest percentage of untreated patients (33.2% and 21.0% for asthma; 52.2% and 32.9% for COPD), while European primary care EHR databases had the smallest percentage of patients not receiving any treatment (6.9%–15.2% for asthma; 4.4%–17.5% for COPD). With regard to first-line treatment, we found that in four countries (USA, UK, Spain and the Netherlands) most adults with asthma initiated treatment with SABA monotherapy (20.8%–47.4% of first-line treatments). Other frequent first-line treatments were (LABA-)ICS in Europe and systemic steroid bursts in the USA. In EHIF (Estonia), LABA-ICS and ICS monotherapy were frequently used first treatments, whereas in AUSOM (South Korea) LTRA monotherapy was the most common. With regard to COPD, LAMA monotherapy was the most frequent first-line treatment in IPCI (the Netherlands) and EHIF (Estonia), whereas in the UK (CPRD) and Spain (SIDIAP) this was monotherapy with a short-acting bronchodilator (SABA and SAMA, respectively). In the US databases, steroid bursts were frequently prescribed as first treatment. Systemic steroid bursts were rarely observed in combination with inhalation therapy for both asthma and COPD. Treatments for asthma COPD overlap (ACO) are different than the treatments observed for asthma or COPD alone. Patients with both diagnoses are more often treated and the variation in initial treatments is even larger.

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