



Oxford Cambridge and RSA

For issue on or after: 23 November 2020

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
Wednesday 20 January 2021 – Afternoon**

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Centre number

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Candidate number

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First name(s)

Last name

Date of birth

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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** sources.
- Record your sources on page **9** of this booklet.
- You can summarise your findings on page **10** and **11** 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 booklet has **12** pages.

ADVICE

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

SOURCE A

Daily touchscreen use in infants and toddlers is associated with reduced sleep and delayed sleep onset.

Extracts from:

Cheung, Celeste and Bedford, R. and Saez De Urabain, Irati R. and Karmiloff-Smith, Annette and Smith, Tim J. (2017). Daily touchscreen use in infants and toddlers is associated with reduced sleep and delayed sleep onset. *Scientific Reports* 7, p. 46104. ISSN 2045-2322.

Aims

This study aims to examine whether frequency of touchscreen use is associated with sleep in infants and toddlers between 6 and 36 months of age.

Introduction

Traditional screen time (e.g. TV and videogaming) has been linked to sleep problems and poorer developmental outcomes in children. With the advent of portable touchscreen devices, this association may be extending down in age to disrupt the sleep of infants and toddlers, an age when sleep is essential for cognitive development. However, this association has not been demonstrated empirically.

Participants

In total, 715 UK-based parents of 6- to 36-month-old children completed an online questionnaire asking questions about demographic information, their child's media usage and retrospectively reported developmental milestones. The questionnaire was administered between June 2015 and March 2016. Specifically, we were interested in the impact on developmental milestones, sleep and temperament. We encouraged all kinds of users, including babies that had never used a touchscreen. Parents completed the questionnaires, on a voluntary basis, which took on average 15 minutes. An online survey was chosen in order to allow maximum response from a range of socioeconomic groups, varying degrees of touchscreen use and to reach families across the UK. Information was collected about the child's age and sex, as well as mother's educational level. Parents were also asked about child illnesses, but no sleep-related disorders were reported.

Discussion

Data from 715 UK infants and toddlers aged 6–36 months indicated a significant association between the frequency of touchscreen use and sleep quantity (reduced total duration, with reduced duration of night-time and increased daytime sleep), and longer sleep onset (time taken to fall asleep). Every additional hour of tablet use was associated with 15.6 minutes less total sleep (on average, 26.4 minutes less of night-time sleep and 10.8 minutes more of daytime sleep). However, we found no association between touchscreen use and the number of night awakenings. To our knowledge, this is the first study to investigate the association between touchscreen use and infant/toddler sleep. Our results are consistent with a recent meta-review in older children and adolescents illustrating the negative effects of touchscreen use on sleep quality and quantity, extending the findings to younger children under the age of 3. Our results also extend existing reports on the negative effects of TV exposure on sleep in this age group. We show that, independent of other known factors related to sleep and touchscreen use (age, sex, maternal education and TV exposure), touchscreen use was robustly associated with many sleep attributes.

In this study, we included a range of specific sleep outcomes encompassing quality, quantity and onset of sleep. Our findings extend the limited knowledge at present on media use and sleep in toddlers beyond TV exposure. Yet, a few limitations should be noted.

Firstly, our findings are based on cross-sectional data, therefore a directional relationship between touchscreen use and sleep cannot be established. It is possible that infants and toddlers who use touchscreen devices more frequently also require less sleep. Future longitudinal or intervention studies will be needed to examine the direction of causality. Secondly, we did not include specific records of the timing, content and location of use. Such information would be crucial in future studies to elucidate the mechanisms by which touchscreen usage impacts sleep patterns. Previous studies in older children do suggest, however, that it is not the exposure to a media device per se that impacts sleep, but the modifiable aspects of media such as content, timing and environment that may have a damaging effect on sleep. Third, the current study only investigated the association between touchscreen use and sleep, it will be important for future studies to establish whether this reduced sleep indirectly impacts cognitive functioning.

It is worth noting that touchscreen use may also have positive effect on some aspects of development. In our recent study of the same sample of infants and toddlers, increased active touchscreen use was associated with earlier achievement in fine motor milestones. Thus, total restriction of touchscreen use may limit young children in terms of the potential benefits of these devices. Together, our findings emphasize the need for a more in-depth understanding of how to maximize benefits and minimize negative consequences of this modern technology.

SOURCE B

Homelessness and social control: a typology

Extracts from:

Sarah Johnsen, Suzanne Fitzpatrick & Beth Watts (2018) Homelessness and social control: a typology, *Housing Studies*, 33:7, 1106-1126, DOI: 10.1080/02673037.2017.1421912

Abstract

The use of 'social control' interventions in housing and welfare policy often courts intense controversy, and never more so than when attempts are made to bring about change in the conduct of street homeless people. To date, academic scrutiny has focused on the so-called 'regulation' or 'criminalisation' of rough sleepers occupying public space, but a range of 'softer' control mechanisms are also now in evidence within homelessness support services. This paper explicates the relationship between the distinct forms of social control that have been used in this field – force, coercion, bargaining, influence and tolerance – and compares the perspectives of policy makers, frontline practitioners and homeless people regarding the appropriateness of their deployment in England. It emphasizes that the use of every one of these modes of social control, and indeed the absence of such controls, raises moral and practical dilemmas, the nuance of which is often unacknowledged in academic accounts.

Data Source

The analysis presented draws upon a major UK-based five year programme of research, entitled *Welfare Conditionality: Sanctions, Support and Behaviour Change*, funded by the Economic and Social Research Council, to create an interdisciplinary focal point for research on the efficacy and ethicality of conditionality across a range of social policy fields. Fieldwork included national-level key informant interviews, focus groups with frontline welfare practitioners, and qualitative longitudinal research with 480 welfare service users interviewed over three waves of fieldwork. The latter were recruited in nine case study areas across England and Scotland, these being urban centres with significant numbers of welfare recipients located in a range of geographically diverse contexts. This paper focuses on data from the main English case study sites (London, Bristol, Sheffield and Peterborough), as the social control interventions discussed above were seldom employed in Scotland.

The specific data sources utilized here include: interviews with national level stakeholders including government policy-makers, umbrella bodies and campaigning/service provider agencies (n = 9); focus groups with frontline practitioners involved in street outreach, emergency accommodation and community safety (n = 6, involving a total of n = 27 individuals); and the wave one interviews with (current or former) homeless people (n = 55). The latter were purposively sampled on grounds of having recent experience of relevant social control interventions and were recruited via specialist support agencies including hostels, day centres, soup kitchens and street outreach services. The sample was deliberately weighted towards London where half of (n = 28) participants were recruited, given the capital's status as the epicentre of rough sleeping in the UK (Fitzpatrick et al., 2017) and track record of policy responses containing 'hard' forms of social control (Johnsen & Fitzpatrick, 2007). Note, however, that this paper focuses on the broad-based conceptual lessons that emerged from across all four of these sites rather than seeking to describe in detail variations in practice between them.

Homeless interviewees included 40 men and 15 women, the majority (n = 39) of whom were aged 25–49 years, with three aged 18–24, 12 aged 50–64, and one over 65 (n = 1 no age specified). At the point of wave one interview, more than one quarter (n = 16) were sleeping rough, nearly half (n = 24) were living in homeless hostel accommodation, four were staying with friends or relatives ('sofa surfing'), and 10 had recently moved into a rental tenancy. All had experience of sleeping, begging and/or drinking on the streets and are thus sometimes referred to below as members of the 'street population', a term widely used in English policy circles (e.g. St Mungos, 2017). Practitioner focus groups were held in a subset (n = 6) of the agencies from which the homeless interviewees were recruited. Verbatim transcripts were analysed thematically with the aid of qualitative data analysis software.

Concluding reflections

In short, the deployment of every one of these modes of social control, and indeed the absence of such controls, raise moral and practical dilemmas, the nuance of which is often unacknowledged in current academic accounts.

By examining service provider and homeless people's perspectives on these varying means of exercising social control, we have been able to shine a light not only on their nature and diversity, but also on their interrelationship and the 'permeability' of particular boundaries within our proposed typology. Defensive architecture, for instance, may be considered a force-based mechanism or an example of influencing via nudge, depending on whether the option to bed down is removed or simply made (much) more difficult. Moreover, in practice, particular programmes of interventions may contain elements of more than one of the modes of social control mapped above. The 'RS205' initiative developed in London in 2009 for example – so-called because it targeted the 205 (known) most 'difficult to reach' rough sleepers in the capital – included elements of *persuasion* (assertive outreach), *bargaining* (personalized budgets) and, if/when these techniques did not elicit the desired response, *force* (arrest or ASBO) (Teixeira, 2010). Similarly, Housing First projects which provide rapid access to independent housing with wraparound support to homeless people with complex needs (Homeless Link, 2016; Pleace, 2016; Tsemberis, 2010) arguably represent a meld of: *persuasion*, wherein staff proactively motivate clients to progress through the stages of recovery from addiction; *bargaining*, this being the 'immediate' offer of an independent tenancy direct from the street thereby negating the need for a prolonged hostel stay; and *tolerance*, that is, provision of long-term support which is not conditional on engagement with treatment plans (Tsemberis, 2010).

Previous research has also demonstrated that frontline workers may oscillate between 'therapeutic' and 'disciplining' methods given the challenges they are faced with in the course of their day-to-day work (Dobson, 2011). These complexities do not, to our mind, negate the relevance of a clear conceptual framework within which to consider the meaning, impact and ethical implications of these distinctive mechanisms of control. On the contrary, they reinforce the need for a durable tool that can provide a consistent starting point for deconstructing and making sense of these subtleties.

SOURCE C

Web-Based Activity Within a Sexual Health Economy: Observational Study

Extracts from:

Turner KM, Zienkiewicz AK, Syred J, et al. Web-Based Activity Within a Sexual Health Economy: Observational Study. *J Med Internet Res*. 2018;20(3):e74. Published 2018 Mar 7. doi:10.2196/jmir.8101

Background

Regular testing for sexually transmitted infections (STIs) is important to maintain sexual health. Self-sampling kits ordered online and delivered in the post may increase access, convenience, and cost-effectiveness. Sexual health economies may target limited resources more effectively by signposting users toward Web-based or face-to-face services according to clinical need.

Objective

The aim of this paper was to investigate the impact of two interventions on testing activity across a whole sexual health economy: (1) the introduction of open access Web-based STI testing services and (2) a clinic policy of *triage and signpost* online where users without symptoms who attended clinics for STI testing were supported to access the Web-based service instead.

Methods

Data on attendances at all specialist public sexual health providers in an inner-London area were collated into a single database. Each record included information on user demographics, service type accessed, and clinical activity provided, including test results. Clinical activity was categorized as a simple STI test (could be done in a clinic or online), a complex visit (requiring face-to-face consultation), or other.

Results

Introduction of Web-based services increased total testing activity across the whole sexual health economy by 18.47% (from 36,373 to 43,091 in the same 6-month period—2014-2015 and 2015-2016), suggesting unmet need for testing in the area. Triage and signposting shifted activity out of the clinic onto the Web-based service, with simple STI testing in the clinic decreasing from 16.90% (920/5443) to 12.25% (511/4172) of total activity, $P<.001$, and complex activity in the clinic increasing from 69.15% (3764/5443) to 74.86% (3123/4172) of total activity, $P<.001$.

This intervention created a new population of online users with different demographic and clinical profiles from those who use Web-based services spontaneously. Some triage and signposted users (29.62%, 375/1266) did not complete the Web-based testing process, suggesting the potential for missed diagnoses.

Conclusions

This evaluation shows that users can effectively be transitioned from face-to-face to Web-based services and that this introduces a new population to Web-based service use and changes the focus of clinic-based activity. Further development is underway to optimize the triage and signposting process to support test completion.

Implications

This paper reports on an innovative service evaluated in a timely way to inform service development. The use of routinely collected data collected offers consistent information on all attendances at all services in the area.

This paper evaluates a clinic-led service improvement in a complex and changing environment rather than a planned research intervention. Some important questions such as the subsequent STI testing behaviour of those who did or did not transition to Web-based services could not be answered with routinely collected data. We were unable to compare rates of treatment and partner notification with the routine data; however, positive patients were managed in the same way following diagnosis according to relevant clinical guidelines. Some assumptions such as the use of microscopy as a proxy for symptoms among clinic users are not substantiated. Additionally, some variables were self-reported in clinic data and could be missing where online users were required to select gender and sexual orientation to determine which test kits to send out.

Further research is required to investigate the long-term changes in service use behaviours, for example, the choice of service for subsequent STI testing, the reasons that those signposted online do not make the transition, improved strategies for triage and signposting so that those signposted are more likely to shift online, and the cost effectiveness of the shift in activity for sexual health economies.

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Notes Page

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