Different Cultures, Different Ethics? Research Governance and Social Care

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This article focuses on the governance and ethical conduct of research within the domain of social work and social care. Globally, research in this domain appears less well regulated than those in the domains of health care. Within the United Kingdom, the Westminster government is implementing a Research Governance Framework for Social Care in England (RGF Social Care). This article locates this development in a broader global context and uses as an example a regionally based implementation to explore some potential issues that arise from the governance and ethical framework in social work and social care. The proposed system is located with English local authorities. Various models are emerging: single department; corporate; dual or multi-council collaborations; cross-sector collaborations. Whatever the merits of the organizational form adopted, the influence of different cultures upon the form of governance and ethical regulation adopted is significant.

Keywords Social Work; Social Care; Research Ethics; Research Governance; Health Ethics and Governance; Organizational Culture

Introduction

The proper conduct of research is a matter of concern for all who are involved with the research process either as research subject, research sponsor, or investigator—to say nothing of the general public who need to have confidence that reasonable controls exist to ensure acceptable standards in the conduct of research. There are variations in the way in which different countries regulate and govern the domain of social work and social care research (for country-by-country details see Privireal 2005). Robust structures exist in many countries that provide for institutional review of proposed research and enforceable protocols for the governance of research, and for the regulation of research that concerns human subjects in respect of health (for example, Canada has Local and

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Multi-centre Research Ethics Committees;[1] the United Kingdom has Research Ethics Committees (LRECs and COREC);[2] and the United States has Institutional Review Boards (IRBs)).[3] The situation in respect of social work and social care is somewhat different. For example, in the Netherlands no formal governance structures exist in this domain. Hence, a PhD student in the Netherlands or Hong Kong SAR, for example, wishing to conduct research involving direct data collection from service users is free to do so without accountability or reference to any other body. In the Netherlands there is neither a research governance structure located within universities nor in social work delivery agencies. This is not so in England where a national structure for the regulation and governance of social work and social work research is currently under development by the Department of Health (England). It should also be noted that in some countries, like Australia, the Human Research Ethics Committees already cover both health and social work research (Melville 2005).

There are many definitions of 'research governance'; a useful and pragmatic definition is given by Walsh *et al*.:

> Research governance is a framework through which institutions are accountable for the scientific quality, ethical acceptability and safety of the research they sponsor or permit. (Walsh *et al*. 2005, p. 468)

Broadly, there are two approaches to the regulation of research: (i) self-regulatory mechanisms and (ii) formalized research governance frameworks. Self-regulatory mechanisms typically depend on the ethical judgement of the investigator to conduct research appropriately. This expectation may be reinforced by an additional expectation that researchers conform to a code of practice that specifies how research should be conducted (see, for example, International Sociological Association 2001). Since, the Second World War there have been many research projects that have aroused modest or major concern about whether they have been ethical or implemented in a socially acceptable fashion. Notable examples of unethical or dubious research, often quoted in textbooks, include: the non-treatment of syphilis in the Tuskegee Syphilis study (Brandt 1978); the non-treatment of a pre-cancer symptomatic group of women in New Zealand (Smith 1999); the public funding by the United States in Asian, African and Caribbean countries to test AZT, an antiviral HIV drug, against placebos (Plomer 2005); and more recently in the United Kingdom the retention of babies' organs at Alder Hey hospital for research purposes without the parents' consent (Redfern 2001). The medical profession has always had particular need to regulate its research activity owing to the intrusive nature of clinical medicine and its potential for life-threatening outcomes. Hence, in the United Kingdom in the immediate post-Second World War period a framework for governing research developed that rested on three legs: 'international

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1. or more details see <http://www.ncehr.medical.org/>.
2. or more details see <http://www.nres.npsa.nhs.uk/>.
3. or more details see <http://www.hhs.gov/ohrp/>.

convention law, international codes of conduct for the medical profession, and legal regulation of the pharmaceutical industry' (Kerrison *et al*. 2003). In 1991, a centralized system of Local Research Ethics Committees (LRECs) was set up within the National Health Service (NHS) to govern the effective conduct of research. These are co-ordinated nationally by the Department of Health (England). Whilst regulation of medical research in England has become ever more rigorous and robust (some may say overbearing!), social care research has been left relatively ungoverned by social work and social care delivery organizations. At the same time, university research governance and ethical frameworks have become increasingly common. This means that research conducted into social work and social care, where the principal investigator is based within a university, is likely to have been subject to university governance and ethical scrutiny. This will not have been the case where the researcher is a member of staff in a local authority or is from a private research organization. In 2001, the Department of Health (England) introduced proposals for the development of a research governance framework that, although not uniform in form or structure across health and social care, sought to provide a comprehensive and inclusive approach across both sectors (Department of Health 2001a). This article identifies and explores some of the key emergent issues as this research governance framework is introduced. These reveal a considerable difference in the influence of the managerial and cultural context within English local authorities and how it impacts upon the way in which the framework is developing. The revealed character of the developing framework poses questions about how the framework for social care will interface with other pre-existing governance frameworks—including both university and health research governance frameworks.

Research Governance Framework (RGF) Social Care (England)

In the foreword to the draft *Research Governance Framework: Resource Pack for Social Care* (Department of Health 2008) the Department of Health (England) noted that the Research Governance Framework (RGF) (Department of Health 2001b, 2004) aimed to cover both health and social care but owing to the 'diverse nature and fragile research infrastructure' of social care a separate strategy was required. This strategy applies only to those service users, carers and staff populations that are the responsibility of the Secretary of State for Health as administered through the Department of Health in England. In essence the strategy only covers adult services and does not include services for children even though the resource pack is endorsed by the Department for Children, Schools and Families (DCSF) who are currently seeking to develop their own approach. It is noticeable too that it is not endorsed by the Directors of Children's Services although it is by their sister organization for adults. It is therefore ironic that the areas where risks of abuse are often seen as the highest and where public scandals have driven practice (Butler & Drakeford 2003) there is

currently no compulsory RGF process in operation. It should also be noted that the published document is still a draft so there still remain opportunities for revision or for councils not to implement on the grounds that it is not the final version.

Currently, the National Research Ethics Service (NRES) covers only health-related research. With the introduction of the new research governance framework the Department of Health has also established a Social Care Research Ethics Committee under the auspices of the Social Care Institute for Excellence (SCIE) which will operate as part of the NRES. This new committee will cover multi-site applications (more than four sites), high-risk applications, and proposals which require ethical approval for the involvement of participants who lack capacity or who lose their capacity to make decisions during a research project as defined by the Mental Capacity Act (2005). The SCIE has also been tasked with responsibility to develop and maintain a register for social care research approved by local councils.

RGF Definition and Key Areas

The RGF defines research broadly as:

> The systematic application of established research methods and techniques to gather information on human participants in an explicitly planned way. (Department of Health 2008, p. 10)

This broad definition potentially includes all manner of management data collections using questionnaires or interviews. In addition, the definition specifically identifies 'established research methods', which begs the question as to what is to happen to non-established research methods and innovative approaches. It is not clear what this would mean for the developing field of service-user-controlled research (Turner & Beresford 2005).

In order to assess a research proposal five key areas are identified within the RGF for consideration. These are:

(i) ethics;
(ii) science;
(iii) information;
(iv) health and safety;
(v) finance (and value for money).

'Ethics' concerns the moral conduct of research and is informed by principles of autonomy, beneficence, non-malfeasance and justice both singly and in combination. This is very much in keeping with Butler's (2002) articulation of an ethical code for social work research. 'Science', according to the RGF, involves ensuring that there are good reasons for undertaking the research; an

appropriate research method with appropriately competent researchers and a planned approach to reporting and dissemination. The use of the term 'science' within the RGF does not appear to privilege quantitative or qualitative research but is more concerned with the fit between the research question and its method as opposed to any particular ontological or epistemological position. Similarly, the use of the term 'science' within this article should not be assumed to privilege any particular position, but merely to reflect the use of the term in the RGF. The importance of 'information' acknowledges that social care research is conducted to benefit social care users, social care professionals and the public generally, and thus it is important to ensure that research findings are made accessible to the respective stakeholders. The RGF requires that the 'health and safety' of research participants and researchers is paramount. 'Finance' in research implies that research budgets should provide value for money and reasonably cover staffing and non-staffing resource requirements.

These five elements are not given equivalent treatment within the RGF. There are six pages related to ethics, three pages to science and just half a page each to information, health and safety, and finance. This imbalance is also reflected within the balance of different questions included in the paperwork for 'Greater Mill Town's' research governance application form. These differences in the extent of consideration are suggestive that the five areas cannot be considered of equal value. Within the same section (Section 5) of the resource pack (Department of Health 2008) the benefits of involving service users and carers are strongly championed, although the guidance stops short of insisting on their involvement. Whilst the recognition of the importance of the involvement of service users is to be welcomed, the failure to be more prescriptive about service user involvement has authorized councils to view service user involvement as aspirational rather than a current requirement—perversely giving permission for local authorities to avoid engaging with this difficult issue.

Models for Implementing RGF Social Care in England

Across England several different models to implement RGF Social Care have emerged, and can be characterized as follows:

(1) Single department: the governance framework is developed by one department, the department that has responsibility for services to Children and Adults and is applied to that department only within the local authority.

(2) Corporate: the governance framework applies to two or more departments with the council; it may have been developed jointly or developed by a single department and then the reach extended.

(3) Multi-council: the same governance framework applies across two or more local authorities (a minimum of one department in each authority must be involved but several departments may also be involved, as in the corporate

approach indicated above) and the same procedures and documents are used.

(4) Multi-agency: where several different types of agency, including at least one council have adapted the same iteration of RGF Social Care.

'Greater Mill Town', an example of one of these types, the multi-council, is used to highlight some of the key issues involved in the introduction of the RGF to social care. Following the publication of the research governance framework in 2005, the Department of Health provided funds of £2,500 per local council to bid in partnership with other local councils to implement the RGF. At this stage both children's and adult services were under the control of the Department of Health. Under the auspices of Making Research Count[4] the authors applied for funds on behalf of local councils to develop a pan-Greater Mill Town approach.

This bid proposed to support a project to develop a shared approach to research governance as opposed to each individual council having to develop its own individual and therefore slightly different version to other councils in the region. Just as the time for the announcement of the outcome for bids approached, the Department of Health suffered a financial squeeze on research and the money was frozen without a timescale for its release. The next contact the authors had with the Department of Health was when it contacted the university to ask why we had not claimed any of the money and where we were up to in delivering the outcomes! Following discussion with the 10 councils, although some had now changed their RGF leads and champions, a revised but similar project was agreed which comprised the following elements: an audit of current practice, the development of a single application process for Greater Mill Town, and RGF training for those administering the process and developing ways of involving service users in the process.

Findings

When the project began the most notable feature of the participating councils was the diversity of approaches to the RGF. At one end of the continuum a few councils had developed a comprehensive and wide-ranging package of supporting documentation, including supplementary forms and guidance (produced in response to queries) as well as a core application form. Some other councils had a minimalist response to the documentation, whilst others were still

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4. Making Research Count is a national collaborative research dissemination initiative, currently run by 10 regional centres based in the Universities of Bedfordshire, Brighton, East Anglia, Keele, Kings College London, Salford (Greater Manchester), Central Lancashire, York and the Open University. This consortium of universities has a proven track record in social work and social care research as well as providing social work education at qualifying and post-qualifying levels. The main aims of the national initiative are to: improve the dissemination and implementation of research findings; increase mutual understanding between researchers and practitioners; and to influence the shape of evidence-based practice through its contribution to the debates about appropriate research methodologies for the field of social care.

developing it. In addition, on close examination the documentation produced by one council did not meet RGF requirements. Apart from this variation amongst councils, characterized as the extensive to minimalist spectrum, there were a number of other key dimensions of variation:

(1) The range of applicability governance procedures: in all the councils the RGF covered adult services. Services for children and families were covered in a few, and one council had expanded its provisions to include other local council functions but none was fully corporate. Where the RGF covered both adults and services for children and families this was realized either through a single system or separate directorate structures. The original RGF funding had provided an extra £1,000 incentive for councils to develop and implement a corporate approach. None of the councils involved in this project wanted to apply for this extra funding.

(2) Individual or team-based approaches: to administer and assess the application forms some councils had developed procedures that incorporated a *team* approach whilst others had adopted an approach where a single person was responsible for both tasks—an *individual* approach. In one case a council had aligned its procedures with the local university, which would consider its complex proposals.

(3) Processes for the RGF: the processes for RGF operation were quite different in different councils. This was reflected in the degree of involvement of the RGF co-ordinator within the approval process and the degree to which they would intervene to help researchers complete the applications and/or develop acceptable 'science' or ethically sound research. There was also a difference in what was included as research in the different authorities. Whilst all external research could be seen as requiring RGF approval this situation began to be less clear in respect of management information, consultations and internal staff projects.

   One other aspect of process is worthy of consideration: the position of external research formally approved by the NHS or universities. The guidance suggests that there should be 'mutual respect' between the differing systems of research governance and evidence of formal approval should be given 'due weight' to avoid unnecessary delays (Department of Health 2008). Councils, however, are expected to ensure that research teams understand the particular needs of *their* service users and staff. Councils have the right to refuse permission even if it has been externally approved. Last year the councils making up Greater Mill Town reported that there were significant numbers of requests for research with learning disability communities, leading one council to consider whether it should refuse any more requests in its area. One council took a more proactive position; it identified the areas in which it would welcome research applications. These differing management strategies could potentially have a major impact upon the nature and type of research undertaken in councils and what research is not

undertaken at all. Not only are councils being asked to decide whether research meets the relevant standards in the five key areas of ethics, science, information, health and safety, and finance but also whether such research should be undertaken in their area. At the level of staff or service user protection this is to be welcomed. However, this may this begins to shape and potentially distort the research agenda to one that is instrumental to the needs of the council, which would clearly not be desirable in the development of an agenda the meets the needs of social care research at national level. This has also led to critics such as Furedi (2002) to view such committees as bureaucratic gatekeepers overly concerned with protective paternalism and using ethics as the new managerial ideology for controlling which types of research methodologies get approved and in which research areas.

All the councils within Greater Mill Town have, or intend to place, their RGF process on their intranet for staff applications, and the local council website for external applications. This means that external researchers will be able to electronically access and complete the form online. Whilst electronic research applications may be the norm for external university researchers it will present access difficulties for those without access to the Internet and, potentially, research proposals by service user groups

(4) Extent of assistance provided: in particular councils the RGF co-ordinator would also provide support not only for completion of the paperwork but also advice on the quality of the 'science'. The location of responsibility for the RGF varied across the councils. One other council had located its service within the service user participation section and this co-ordinator, perhaps unsurprisingly, spent much of their time with researchers improving this aspect of applications.

(5) The scope of governance: there was also a significant difference in the numbers of applications received by the different councils, which was incommensurate with the size of the council. One of the largest councils was yet to reach double figures for its applications in spite of councils half the size having four times the number of applications. This raised the question as to the nature of projects that were for consideration within the RGF across different councils; the range of material that is considered as suitable for the RGF in one council is not the same as in other councils. We are not able to explain why this is the case, although one explanation may be the power and perspectives of who champions the RGF within the council, different levels of engagement with the RGF by different councils and different councils views of research and its benefits.

All councils made a distinction between internal and external research in accordance with the guidance provided by the Department of Health (2008), affording internal applications a 'lighter touch'. All the co-ordinators of the RGF system acknowledged that there was research taking place in their authorities that did not have RGF approval. This was compounded by the fact

that in individual cases researchers, having found out about the RGF process, had said they would go to another council which would not require the submission of an application under the RGF guidance.

(6) Service user involvement: one area of the process was consistent throughout: none of the councils have yet developed service user involvement in the process. Council representatives expressed concern about the 'representativeness' of those recruited and expressed concerns about many service users' research competence. It is accepted that it is nigh impossible to achieve 'representativeness', and what may be required is to select a number of service users who could provide differing perspectives. In accordance with the guide developed by INVOLVE (2006), involving service users in the research process has to begin somewhere and if one decides to wait for the ideal circumstances then service user involvement will never happen. Within Greater Mill Town the issue of competence will be resolved by involving service users in the training being developed for the RGF co-ordinators and assessors. Any service user assessor would not be approved to undertake the assessment of an RGF proposal until they had successfully completed a training programme.

It is also clear that as councils retain their decision-making powers in relation to research access of both staff and service users a university researcher wanting to look at mental health services will require university ethics committee approval, Local Research Ethics Committee (LREC—NHS), and council RGF approval. This can cause delays and runs the danger whereby all three gatekeepers may request changes that are contradictory. Also, LRECs have been viewed as unsympathetic to social care researchers and qualitative approaches. In a Department of Health update on the implementation of the research governance framework it noted that:

> Some experienced researchers working in the field of social care reported that the process of approval by NHS Research Ethics Committees was often frustrating and time-consuming (Tinker 2001). Common complaints about the NHS RECs include their focus on research methods rather than ethical issues, the lack of expertise in social science methods, the burden of paperwork in making applications, and lengthy delays which can be catastrophic for short term projects. (Department of Health 2007, 4.7)

Discussion

Drawing upon the experience of seeking to develop RGF Social Care (England) in Greater Mill Town and the literature it is possible to make some guarded observations about emergent issues, given the current stage of implementation of RGF Social Care (England):

(1) What constitutes research: it may seem rather obvious but it is important to identify what is and what is not included as research within the RGF. Guidance drawn from the resource pack is equivocal: this specifies that areas such as consultations and non-financial audit are domains that may potentially require RGF approval. However, where these types of activities are undertaken internally (i.e. within an authority where the principal investigator or equivalent is an employee of the authority) they may not require it. It is worthy of note that at a regional implementation event sponsored by the Department of Health there was considerable debate around the notion of 'consultations' as a form of activity that may or may not constitute research. Different positions were adopted by the authorities: some had decided that all consultations should be considered within the RGF processes, and some that none should be.

Whilst this distinction between internal research and external research may be helpful for the council to manage its data and knowledge requirements it does not protect service users or ensure that such consultations or audits are undertaken ethically or with sound science. The notion of an internal 'lighter touch' is embedded within the resource pack and is potentially flawed. Research either is or is not ethically sound, methodologically competent and meets the standards of information, health and safety, and financial probity. Differing thresholds for internal and external applications potentially expose service users and staff to unacceptable and harmful research practices. This suggestion of a 'lighter touch' is dangerous and potentially opens the way to decisions being made about the suitability of a research proposal being based on what is known of the applicant rather than whether they are seeking to undertake research that is ethical according to prescribed and known criteria.

(2) Comprehensive coverage? Currently, the coverage provided by the RGF is ad hoc—only adult services are comprehensively covered, with patchy coverage across children's services and even less consistent coverage across the voluntary and private sectors. The RGF does make allowances for research within the voluntary and private sectors, where this is in relation to services contracted by a local council, and it is suggested such a provision should be introduced in future contracts. It does not, however, cover independent social care providers whose services are not contracted to the local councils and whose referrals do not come from those working in social services or the NHS. Research in these categories is not subject to the RGF. At one level this may be understandable in the sense of not seeking to overburden local council processes. Yet at another level it is quite dangerous in so far as this approach fails to provide a safeguard that prevents exploitative and ill-designed research. In addition, the approach structurally entrenches different ethical thresholds to ensure the well-being of service users and social care staff and safeguard the integrity of research and its scientific quality. Whilst it is welcomed that a research governance framework for

social care has now been introduced, the lack of comprehensive coverage is a major concern. There is a danger of providing a false sense of assurance for service users or social care staff that any research they become involved in will have been subject to a quality scrutiny process.

The original vision of the RGF (Department of Health 2001a) was for an ethical governance framework which covered not merely social care services but all council services. This original vision has been stymied by the fragmentation of council social service departments as exemplified by the DCSF's endorsement of the draft guidance but failure to make it mandatory across social work with children and families. It is difficult to see how comprehensive coverage can be achieved without the DCSF making compliance a requirement. If its intention is to develop separate guidance for social work with children and families this then raises the spectre of lead researchers from universities being required to gain four differing research approvals from four different ethical and governance frameworks. Consider the following example: if a project sought to investigate the emotional impact on children living with parents who had a chronic mental illness. Such a study would require approval from the university system, the health system—it concerns parents with a mental illness—social care RGF if the parents are in receipt of social care services, and the proposed children's ethical framework to identify the children's emotional needs.

(3) Ownership: ownership is important and authorities that do not own or champion the RGF will be failing in their duty to:

- ensure the dignity, rights, safety and well-being of researchers and service users, carers and staff participating in research;
- help to safeguard the integrity of research, and upholding standards for ethical review and scientific quality;
- establish transparent systems to approve, record and monitor all research activity (Department of Health 2008).

Those authorities that had developed the most comprehensive approach to research ethics and governance had RGF co-ordinators who were not only 'research friendly' but also had the support of senior managers. Where this was not the case progress was slow, with other priorities always seeming to take precedence. One issue of ownership that was not in dispute was the need for each council to develop and 'own' its own forms. Research ethics and governance is particularly suited to joint working; however, local authorities in Greater Mill Town have yet to exploit the benefits by rationalizing the use of resources that appear to have been developed by the South and South East Authorities Research and Information Group (SSERIG) or in some parts of the Midlands. For example, there is uncertainty at present as to whether each council would accept a neighbour's RGF scrutiny; however, this remains an aspiration for many councils for the

future. This state of affairs is perhaps not surprising given the nature of litigation, when it is recognized that none of the councils was willing to accept a prior health or university ethical approval. The draft guidance (Department of Health 2008) also notes that councils may decide to reject a previously ethically approved research project if the project does not demonstrate a satisfactory awareness of their service users or staff participants. However, none of the authorities involved had yet developed service user involvement in the process. The current processes are only owned by a minority within the separate councils and for many this has to be overcome before service users are introduced into the system. It will be very interesting to evaluate the impact and outcomes of service user involvement in the RGF process when there is experience in a significant number of councils of such involvement.

(4) Different cultures, different ethics: the world of research governance is potentially one of increased fragmentation for social work researchers. A principal investigator, employed within a university, in England who wished to undertake a comparative study comprising interviews with health care professionals and social workers (irrespective of the sample size or nature of inquiry) would be expected to submit application papers to seek the agreement of at least three research governance bodies: one based at the university, one at the service delivery organization for social care, and one for the health service.

Ideally, from the perspective of the principal investigator, decisions made by the competent body in respect of one governance framework should be accepted by each of the others. In other words, ideally there would be mutual recognition for decisions made by other competent governance frameworks. However, existing experience suggests that in current circumstances this is unlikely to be the case, as there is no such mutuality between the currently existing LREC system and the
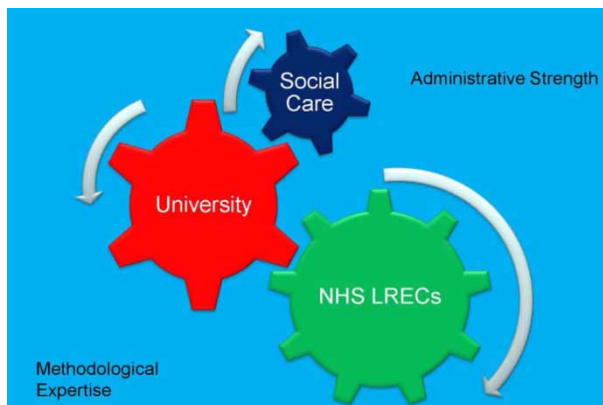

Figure 1   Working together? The world of research governance.

university-based research governance system. These two systems have been in operation for several years. Hence, if mutual recognition of decisions does not currently exist between these two systems then there can be little reason to assume that the introduction of a further governance framework will lead to increased mutuality and simplification. Indeed, within the present structures multi-site research can lead to considerable complexity, with requirements to submit applications to the competent governance body for each site (in practice this may imply submission to several universities or LRECs). While it may desirable that the various research governance bodies act as indicated in Figure 1, i.e. that they interact and help 'oil each other's wheels', the reality is very different. They tend to act independently of each other. This trend is in complete opposition to the stated intent of the recently published draft guidance which states that:

> In trying to reduce the risks from poor quality research, the Department of Health does not wish to encourage the growth of cumbersome and overly bureaucratic procedures at local level. (Department of Health 2008, p. 73)

The tendency towards autonomy for each governance framework is strengthened by the culture and character of the organization in which each governance framework is located. Each type of organization involved in the process will, by virtue of the skill mix of the workforce and the organization mechanisms that develop for the governance of research, develop a characteristic approach. Hence, for example, the majority of councils that provide services for adults do not have a workforce that is used to carrying out research. They may have a strong commitment to research usage through the need to develop evidence-based practice. This lack of familiarity with the conduct of research, combined with a tendency to proceduralize, generates an approach to research governance where all risks are managed through ever more detailed and precise procedural requirements. This is grounded in the belief that if the procedure is carried out then *risk* will be minimized. This is evident in other aspect of social work provision in the United Kingdom, for example the procedural complexity that has developed over 40 years for the safeguarding of children from abuse. This culture is less evident in the university research and governance framework where there is a partial reliance upon the researcher to draw the attention of the governance and ethics committee to potential difficult areas for consideration. This difference is illustrated in Figure 1. Whatever the governance framework, there will always be some degree of risk attached to research.

It would be interesting to have comparative data, from a substantial number of countries, that detail the approach taken to the governance and ethical conduct of research in the domain of social work and social care. This would provide the opportunity to explore the cultural and political reasons why this type of research is strongly or weakly regulated around the globe. The evolving systems in England may be better or worse than those in force elsewhere. Whatever the comparative strengths and weaknesses of the English system, its

implementation is not yet complete and there is a very real probability that human subjects are not adequately protected in social work and social care research.

References

Brandt, A. M. (1978) *Racism, Research and the Tuskagee Syphilis Study*, Report no. 8, Hastings Center, New York.

Butler, I. (2002) 'A Code of Ethics for Social Work and Social Work Research', *British Journal of Social Work,* Vol. 32, no. 2, pp. 239–48.

Butler, I. & Drakeford, M. (2003) *Scandal, Social Policy and Social Welfare*, Palgrave Macmillan, Basingstoke.

Department of Health (2001a) *Research Governance Framework for Health and Social Care*, Department of Health, London.

Department of Health (2001b) *Research Governance Framework for Health and Social Care*, Department of Health, London.

Department of Health (2004) *The Research Governance Framework for Health and Social Care*, Department of Health, London.

Department of Health (2007) *Progress with the Implementation of the Research Governance Framework in Social Care*, Department of Health, London.

Department of Health (2008) *Research Governance Framework: Resource Pack for Social Care (Draft)*, Department of Health, London.

Furedi, F. (2002) 'Don't Rock the Research Boat', *Times Higher Education Supplement*, 11 January, p. 20.

International Sociological Association (2001) *Code of Ethics*, International Sociological Association, Madrid.

INVOLVE (2006) *Peer Reviewing Research Proposals: Guidelines for Members of the Public P2*, INVOLVE, Eastleigh.

Kerrison, S., McNally, N. & Pollock, A. M. (2003) 'United Kingdom Research Governance Strategy', *British Medical Journal*, Vol. 327, no. 7414, pp. 553–56.

Melville, R. (2005) 'Human Research Ethics Committees and Ethical Review: The Changing Research Culture for Social Workers', *Australian Social Work*, Vol. 58, no. 4, pp. 370–83.

Plomer, A. (2005) *The Law and Ethics of Medical Research: International Bioethics and Human Rights*, Cavendish, London.

Privireal (2005) *Research Ethics Committees: Bibliography by Country*, Privacy in Research Ethics and Law, Sheffield.

Redfern, M. (2001) *The Royal Liverpool Children's Inquiry*, The Royal Liverpool Children's Inquiry, Liverpool.

Smith, L. T. (1999) *Decolonising Methodologies: Research and Indigenous People*, Zed Books, London.

Tinker, A. (2001) 'Ethics Committees—Help or Hindrance? The Experience of the ESRC Growing Older Researchers', *Journal of the British Society of Gerontology,* Vol. 11, no. 3, pp. 16–18.

Turner, M. & Beresford, P. (2005) *What User Controlled Research Means, and What it can Do*, INVOLVE, Eastleigh.

Walsh, M. K., McNeil, J. J. & Breen, K. J. (2005) 'Improving the Governance of Health Research', *Medical Journal of Australia,* Vol. 182, pp. 468–71.