Ethical approval and being a virtuous social work researcher. The experience of multi-site research in health and social care: an Approved Mental Health Professional case study.

Abstract:
Seeking ethical approval and conducting research in an ethical manner are necessary components of research with human participants. Using the experiences of four individual studies undertaken separately into the same role, that of the Approved Mental Health Professional (AMHP), this article critically examines the challenges encountered in seeking ethical approval for multi-site research in health and social care settings. Issues arising from the experience of doing so are discussed: These are systemic and procedural, or the barriers encountered using the integrated approach of the National Research Ethics Service. We discuss the lessons learned and argue that seeking ethical approval in multi-site research is currently a static construct involving the satisfying of what are in effect closed systemic and procedural requirements. We suggest that being a virtuous social work researcher, which we explore in the context of contemporary debates in social sciences to turn towards common principles in social science research, should instead afford open-ended integrity whereby the 'permission' granted is constantly revisited by the researcher or, in other words, that the integrated approach should allow being a virtuous researcher. We suggest that this cyclical activity has particular resonance for those researchers who are, simultaneously, health and social care practitioners. The article adds to the literature on ethics, conduct and integrity in health and social care.

Key Word: Ethics, AMHP, Approved Mental Health Professional, governance, multi-site.

Introduction

Using the experiences of four individual studies undertaken at different times into the same role, that of the Approved Mental Health Professional (AMHP), this article recounts the challenges that were experienced when seeking approval for multi-site research in health and social care settings. Systemic and procedural issues arising from these experiences are discussed and concern the barriers encountered using the current integrated approach as it exists in the England, the National Research Ethics Service (NRES). In theory, NRES reviews any request for ethical approval in all health and social care settings in a consistent manner regardless of setting and encompasses all research designs. We discuss the lessons learned and argue that**,** being a virtuous social work researcher (Barsky, 2010), a concept explored in the light

of contemporary debates in social sciences to turn towards common principles of research conduct in social science research (Iphofen, 2017), is preferred. The authors found that seeking ethical approval for AMHP related studies is not a straightforward linear process as the concept of integration might belie. Rather, it is an inconsistently experienced process that simultaneously gives rise to procedural and methodological challenges which, in its present iteration as it is applied in the United Kingdom, does not easily afford open-ended integrity. We suggest that ethical conduct in research is not a static construct involving the satisfying of what are in effect closed systemic or procedural requirements but that instead the process needs to be adapted to allow researcher integrity. In other words, that the researcher constantly revisits ethical 'permission' considering ongoing developments, or is afforded being a virtuous researcher (Macfarlane, 2009, 2010). We suggest that the need for this cyclical activity has resonance for those researchers who are, simultaneously, health and social care practitioners and operating in complex organisational arrangements. The article adds to the literature on ethics, conduct and integrity in health and social care and to the existing view that the current systems that govern ethical approval in the United Kingdom are not wholly fit for purpose, specifically, in this instance, for research studies where participants are from a multi-professional, multi-site setting. We hope to stimulate further debate about the concerns and barriers which have arisen and add to the current dialogue about ethical efficacy in research governance in health and social care and of the turn towards being a virtuous researcher.

Ethical governance and being ethical

Ethical governance is concerned with the conduct of research, its use and the integrity of it in practice (Walter et al., 2004). in the United Kingdom the process and regulation

of seeking ethical approval for any research that involves human participants is currently a formal procedural one, acquired at a point in time and arguably therefore a closed or static construct. Much research is based in Higher Education Institutions where a principle-based Concordat has been developed with the aim of providing a comprehensive framework in the United Kingdom for good governance and research conduct (QAA 2018). The Concordat is committed to the idea that research conduct is undertaken and aligned within ethical, legal and professional frameworks, obligations and standards (UK 2012, 2016). To this end ethical approval must be sought from the relevant university ethics research committee before research can be undertaken in the field (QAA 2018).

What also exists outside of the university is a parallel, national integrated research approval system known as NRES), locally administered by research ethics committees, or research development teams within health trusts and local authorities. This integrated system is driven by health and has developed in the United Kingdom because of earlier medical scandals which revealed poor conduct in relation to subjects of experimentation using human body parts without express permission (such as the Alder Hey Scandal which came to light during the late 1980s in England and involved the unauthorised removal, retention and disposal of human tissue including children's organs). This same integrated system, as the name implies, also determines ethical approval in social research which takes place in social care environments, typically within the jurisdiction of local authorities through the Social Care Research Ethics Committee (SCREC, 2018). Sometimes, alongside this integrated approach, research undertaken in local authority social care and social work settings is also required to seek approval from the Association of Directors for either Adult Services (ADASS) or Children's Services (ADCSS), but adherence to this process and the

requirement to do this can vary. Therefore, an inconsistent approach across and between local authorities, is experienced, with no apparent benefit.

The efficacy of the integrated governance system attracts criticism. Some, even in the medical professions from which it emerged, query whether the cure that is now in place is worse than the disease (Flynn, 2000) and it is suggested that the process is an administrative and constraining burden (Jamrozik, 2004). Social scientists also view the current structure as a form of restriction and of disempowerment which results, they argue, in shifting the responsibility for ethical decision-making away from the researcher to those who sit on committees (Dingwall, 2006). In recognition of this, some commentators are also recommending different practice for research committees (Carpenter, 2015) building on the case for virtuous research and the virtuous researcher (Macfarlane, 2009, 2010). Ironically, researchers in social care settings can also in effective bypass the integrated system, as it is a somewhat anecdotal belief based on their own understanding or the advice of potential research sites themselves that where their research does not involve medical or other health procedures there is no need to pursue this requirement for approval.

Running parallel to procedural systems are also Research Ethics Frameworks, developed to guide good ethical conduct for Associations whose members wish to undertake research. For example, social scientists are regulated by a framework introduced in 2000 by the Economic and Social Research Council (ESRC) and updated in 2015 (ESRC, 2015). However, these frameworks have also been criticised: for extending regulation in significant ways (Hammersley, 2010); for introducing ethics creep (Stanley and Wise, 2010) and for being an exercise in fatuity (Dingwall, 2006). Other means governing ethical research exist in legislation. In the United Kingdom the implementation of capacity legislation has included guidance for research where the

subjects may lack capacity to provide valid consent. The first of the Acts was introduced in Scotland by the enactment of the Adults with Incapacity (Scotland) Act, 2000, followed five years later by the Mental Capacity Act 2005 (Sections 30 - 34) which covers England and Wales and, most recently, by the Mental Capacity Act Northern Ireland. Each of these Acts provides a statutory requirement to ensure that participants who lack or have fluctuating capacity are not harmed during any research study.

There have also been attempts to construct Codes of Practice, born of a desire to have a suitable framework in place for research undertaken by health and social care practitioners, evaluated as usually small scale and undertaken by lone individuals (Shaw, 2005). For social work, the professional background of the four authors of this article, the development of a Code of Practice began in the late 1990s (Butler 2002) and remains an ongoing activity; the Joint Universities Councils for Social Work Education has recently published a new Code (Joint University Council Social Work Education, 2018). The correlation between social work as an activity and qualitative social work research has been a matter of discussion in the literature with some viewing the skills, knowledge and value base as parallel or, to borrow a phrase, “like sliding a hand into a well-made glove” (Gilgun, 1994 p.115). Gilgun argues, for example, that both activities undertake individual assessment with attention to detail of the individual and moreover, that social workers examine information from a variety of sources before deciding on a course of action, thereby being in parallel with the researcher’s approach to data collection and analysis. Gilgun and Abrams (2002) later repeat the assertion that there is a match between qualitative approaches and the complexities of social work practice. In addition, Atkinson contends that practitioner research often emulates social work (Atkinson, 2005). Others disagree and suggest

that, whilst there are parallels, the purpose of each differs (Padgett, 1998). The relationship between being a practitioner and at the same time a researcher, additionally researching one's own peers, undoubtedly brings challenges not only in operationalizing the research to address criticisms associated with reflexivity, but also within the process of gaining ethical approval in the first place. It is the relationship between being a practitioner and a practitioner researcher that is the third element under consideration in this article, the turn to the virtuous researcher after Macfarlane (2010).

Ethical practice in to research that involves human participants is currently characterised by a tension between what is in effect an abstract independent framework and the actual experience faced once the researcher engages with participants (Oates, 2018). As we have seen, current models governing research approval are imbued with protection of the person evolving from medical ethics. However, it is now suggested that the ethical governance framework in the United Kingdom is not wholly fit for purpose because it focusses upon the study of ethical duties, behaviour and the consequences thereof, with less emphasis on ethical character or of encompassing good values, morals and ideals in all elements of research (Barsky, 2010). Seeking ethical approval or 'permission' at a set point in time, albeit a complex and arguably thorough procedural process, would therefore seem in contrast to be limited in its efficacy. Moves are now afoot to find common principles for conducting social science research beyond formal approval (Iphofen, 2017).

This article will discuss, through the lens of our individual experiences of seeking ethical approval to conduct research into the same professional role. We aim to provide insight into the challenges encountered and to use this experience to muse

upon what we feel are its shortcomings in relation to research into multi-professional roles in multi-sites.

Gaining ethical approval: four examples

Created in 2007 through an amendment of the Mental Health Act 1983 in England and Wales, the AMHP role which since 1983 had been exclusive to social work as the Approved Social Worker (ASW), was opened up to mental health and learning difficulties nurses (‘thereafter nurses’), occupational therapists and chartered psychologists. Broadening out the eligibility of professions who could train and practice as AMHPs came about in the light of research which suggested that the numbers of Approved Social Workers, as they were previously known, were decreasing at the same time as the work was increasing (Huxley and Kerfoot, 1994 and Huxley et al., 2005 Evans et al, 2005, Evans et al, 2006). The change also took place in the policy driven context that any role in mental health services could be fulfilled regardless of professional background, education or identity (CSIP/NIMHE 2007). The primary function of the AMHP is to be the applicant for admission to hospital or guardianship should they agree with medical recommendation(s) that a person is suffering a mental disorder and requires assessment or treatment in hospital under compulsion.

At the time of writing, no single registering body can provide information about the numbers of AMHPs nationally or where they geographically located. Nor is there a reliable breakdown of professional background. This practical matter affects the ability to establish a sampling frame, consequently affecting the recruitment and in turn the ethical issues that must be considered. The best attempt to date is that conducted by ADASS (2018) which offers a more up-to-date indication than offered previously through the AMHP leads network (Bogg, 2011). However, the ADASS study is still

incomplete due to the overall response rate. There is a possible change afoot as it is being suggested that Social Work England, the forthcoming regulator (December, 2019) for social work which is to come into being in 2019 might also maintain a register where a social worker (and other professions) also undertakes AMHP duties (Department of Education, 2018).

Each of the four examples provided are taken from qualitative research studies into different aspects of the AMHP role (two completed, and two underway), undertaken at different times and in different geographical locations as doctoral studies. Each study sought initial approval from a University Research Ethics Committees and later through the various health and social care research governance processes. What follows is a precis of the process as experienced individually using an aspect from each. The first two studies recruited AMHP professionals only as participants, whilst the third and fourth also recruited more widely (the person being assessed, the AMHP, doctors and other attendees). Undertaken as doctoral studies, the guidance provided by university supervisors although paramount, differed and illustrates more broadly the variation in understanding and application of ethical governance processes for research into multi-professional areas.

Example one *"Seeking ethics approval through the local authority"*

The research upon which this first example is based aimed to explore whether there are differences in the decision outcomes between social workers and nurses when assessing for hospital admission under the Mental Health Act 1983 as an AMHP (author's own, 2018). The process for gaining ethical approval commenced with the University Research Ethics Committee sponsored by Research and Enterprise

Development within the University. It involved submitting the standard University ethics approval form and, once approved, sponsorship from the University. Having gained this approval, the researcher next needed to gain the same from each of the proposed research sites but was at first unable to easily access a sample; as we have seen, no centralised database exists. Consequently, access was sought through information collected by the AMHP Leads Network (Bogg 2011) into locations that had been early adopters of nurse AMHPs after the broadening out of the role beyond social work. The researcher approached each site in turn to establish which ethical governance processes needed to be followed as these were often not in the public domain. What quickly became apparent was that each site had a different approach and requirement, and that they were not, in the main, following either an integrated or centralised approach (despite this being suggested by the researcher as a possible method).

To begin, the researcher approached local authorities since it is these that have vicarious responsibility for AMHP services, although more usually employ AMHPs from a social work background. However, the study also wished to access AMHPs who were not social workers by professional background and the researcher next approached health research and development sites. The diversity in the structure of contemporary mental health service created a range of difficulties, encapsulated by the various processes experienced; each site required their own ethical governance requirements to be met. There were other practical difficulties; at least two local authorities did not know who their research governance officer was or were unclear as to how to give ethical approval. Ironically, this required prompting and guidance from the researcher. Consequently, to gain ethical approval to access and recruit twenty

participants, eleven separate ethical governance applications were required. Requiring, in turn, several versions of participant information sheets and consent forms to be developed and agreed. Only one site asked specifically for Association of Directors of Adult Social Services (ADASS) screening. In addition, where there was an integrated local authority and mental health trust and a local health research and development ethics committees had to be approached through IRAS, even though it had been determined at the initial ethical approval stage of the study that IRAS would not be required.

Participant interviews were undertaken at the discretion of the participant, but this created further complexity were the participant to request an interview on health property. It had to be explained that conducting the interview on NHS property was not possible due to the ethical governance process that had been followed since this specific NHS ethics approval had not been gained. This unexpected barrier was overcome by using shared local authority and health spaces or neutral spaces, such as libraries. However, for the researcher it raised an interesting issue as to when a nurse might be available to be an AMHP research participant, as when on duty as an AMHP they could well be on local authority property but would be engaged in undertaking assessments and therefore not free to be a research participant.

Example two: "Seeking approval through NRES: same but different*"*

Example two is based on a research study which aimed to explore whether the professional background of AMHPs influenced the way in which the role was fulfilled and experienced. The researcher accessed and interviewed participants where possible from each of the eligible professions (author's own, 2017). Ethical approval

was sought through three separate routes: from a University's Research Ethics Committee; from the Association of Directors of Adult Social Services in respect of social work participants; and from each of three separate health trusts that employed either the nurse or occupational therapist participants. However, despite having successfully achieved permission through the first two separate governance routes the need to seek permission via the third was not initially indicated nor, as it transpires did the third route did not 'trust' the decision making of the first two routes and involved a protracted undertaking not aligned to the first two.

The process for obtaining ethical permission varied for all: for the University it involved the completion of standard forms, compilation of Participant Information Sheets and consent forms and attendance, in person, at the University Research Committee to answer any queries. Questions were asked about the choice of method and timing of interview in relation to accessing the participant. Ethical approval was granted. The process for the Association of Directors of Adult Social Services also involved the completion of a set forms in addition to submission of the same Participant Information Sheet and consent form used previously, but attendance at their research committee in person was not required. No additional queries were raised, and again ethical approval was granted.

The process for obtaining permission from the health trusts arose later. Despite having sought and obtained permission from the University and ADASS the researcher was also obliged to approval through IRAS. It transpired that neither the University nor ADASS approval was accepted by health settings when seeking to access potential participants in that setting. IRAS is an electronic system which requires completion

and submission both of a generic form and one specific to each individual health trust research site. Since case study two straddled three health trusts this involved three similar processes but also different requirements. For two trusts the site-specific process also required undertaking, separately, different online training courses concerning matters such as the safe and secure handling and storage of data, confidentiality and issues relating to avoidance of harm to participants and self. The researcher was required to achieve a successful pass on both occasions. No additional queries were raised once this process was complete. Approval was obtained in each case and a Research Passport specific to the researcher enabled access to the sample and allowed data generation to proceed. The third trust required different evidence of ethical competence and a requirement that once written up the research would be made available to them. The same Participant Information Sheet and consent form was accepted by each albeit a change of logo was required.

Example Three "Gaining approval through NRES and Social Care Research Ethics Committee"

The third example sought ethical approval to carry out observations of AMHPs whilst carrying out statutory duties under the Mental Health Act. Research ethics committee approval and sponsorship by the university was gained but was a lengthy and complex process because of the observational methods being proposed. The process was lengthy due to the consideration that was required to gain informed consent from all those present during the assessment, which included the person being assessed, the AMHP, potentially family or friends of this individual plus a range of workers such as doctors, the police, nursing staff and ambulance crew (amongst other attendees).

Gaining sponsorship approval led to the first hurdle; the form did not lend itself to describing the AMHP participant as a local authority employee but often working within an NHS site. This led to confusion about accountability and a lengthy process before the university confirmed sponsorship of the study. Ethical review was sought via NRES and a decision taken early on to submit to the Social Care Research Ethics Committee (SCREC) as the research involved people who may not be able to give valid consent to participate. The researcher attended in person the Ethics Committee meeting to talk through the application and, further to two rounds of amendments to Participant Information Sheets and the process of gaining consent, a favourable opinion was received. Interestingly the approach the committee took was less paternalistic than the researcher had anticipated and was helpful in finding ways to manage the issues of gaining consent for example, advising that use of provisions within The Mental Capacity Act 2005 were not necessary as informed consent could be gained after the event of the Mental Health Act assessment taking place. There was an acknowledgement from the committee that this area of practice lacked research evidence and a will to support the researcher in navigating an ethically challenging path to enable the study to take place. Alongside IRAS, permissions were also sought from the NHS Trust Research Governance department and the local authority for each site.

In this study the AMHP participants were all employed by the local authority, but the fieldwork was taking place in National Health Service (NHS) sites and with patients. In terms of access, it was necessary to obtain an NHS Research passport which involved gaining clearance from the University's Occupational Health department, undergoing

blood tests and a Disclosure and Barring Service check. The NHS Research Governance process required the researcher to submit site specific applications and to liaise with a 'collaborator' from within the organisation to authorize both the NRES form and the local Research Governance documentation. Once completed these were also reviewed by a service user group and further amendments made to the some of the Participant Information Sheets. In total the ethical review process led to 26 accompanying documents including 6 different participant information sheets and 4 consent forms. All of these steps took time, around one year in total.

Example Four "Gaining ethical approval through the appeal process"

This fourth example is seeking ethical approval to carry out a study exploring the operation of power within assessments under the Mental Health Act, 1983. The research is to consider assessments as individual systems and as such, seeks to interview all those who participate and attend in one, starting with the person being assessed and working outwards to include both family, friends, carers and professionals. Data will be comprised of these interviews and documents written at the time of the assessment, including the referral, any medical recommendations, the AMHP report and the electronic notes summary. The researcher set out to examine up to 10 assessments, with interviews taking place within 6 months of the original. Data will be analysed using both narrative analysis and discourse analysis.

The process of gaining ethical approval was akin to playing a game of snakes and ladders. The researcher had previously undertaken research that involved interviewing AMHPs about decision-making in MHA assessments, which involved

gaining University and Local Authority approval before data collection started. At the beginning of the process for this later research therefore the researcher anticipated undertaking similar processes, with an additional layer of NHS ethical approval, given that access was also being sought to patients and NHS medical records. The researcher knew that this would be a lengthy process but was surprised by how obtuse. It began with the completion of the universities ethical governance paperwork, supported by the development of a comprehensive research protocol and the collation of indemnity and insurance documents provided by the University. This then permitted the researcher to gain university sponsorship. This was followed by completion of the IRAS process within the NHS and submitting various evidence such as participant recruitment posters, Participant Information Sheets, consent forms and General Practitioner letters. Within the research these are slightly different forms people assessed under the Mental Health Act, for professionals and for carer, relatives and friends. Throughout, a network of helpful people built up to assist the researcher in navigating these processes and who could anticipate the sorts of issues that may arise and how best to address them.

Once all the university sponsorship processes had been achieved the researcher was then permitted to book an NHS Research Ethics Committee panel date. This panel, which is convened locally between once a month to once every two months, comprised fifteen medics from various disciplines, who asked assorted questions about the research and the documents produced. A few weeks later the researcher was asked to make various amendments to the research plans and documents. This iterative process of refining this aspect of research design continued for a while. At the same time, the researcher was constantly in touch with the Research and Development team

within the Trust in which they planned to undertake the research, navigating access and completing further spreadsheets and forms about anticipated financial costs to the Trust. Once this was all completed the researcher also contacted ADASS for ethical approval. Although likely not essential, given that the researcher would be interviewing AMHPs, they nonetheless hoped that ADASS approval would help recruitment. The researcher been in touch with ADASS earlier on and had been told to re-submit once the NHS processes were completed. The study finally gained ethical approval after the researcher attended a further ethics committee on appeal. Interestingly, this is a similar study in design to case study 3 above which did get ethical approval, demonstrating further inconsistency.

Lessons learned

Whilst it is agreed that seeking objective ethical approval is a necessary part of the research process, the process as it has been experienced separately by the researchers in the examples above has demonstrated challenges beyond what could reasonably be expected. These experiences are further exacerbated given that AMHPs are situated across professional and organisational boundaries: the structure of mental health services (which includes AMHPs) has been in a state of flux for some years; either they are integrated, co-located or they operate as discrete entities sometimes, but not always, in cooperation. This mixed picture leads to varied approaches to ethical governance, complicated further by the multi-professional nature of the current AMHP workforce. The processes for seeking ethical approval varied according to site and local understandings of research processes, a variety highlighted in several ways. For example, some local authorities would not recognise

alone the ethical approval authorisation of the University, nor was it always possible, in turn, for health trusts to rely on the authorisation of local authorities. It is not clear why this apparent lack of transferability is not afforded. Although, speculation is likely to be a combination of the local need for accountability, whether that is in health or social care settings, and, perhaps underpinning this, a fear of litigation.

Lack of transferability or integration aside, even within the same type of setting, processes were not standard. In separate health trusts, one researcher had to undertake two different online modules to demonstrate their understanding of ethical issues. A second had to complete eleven different applications. Others have argued that such processes are overly burdensome and have the effect of stultifying the ethical approval with the danger of a tick box effect (Flynn, 2000, Jamrozik, 2004) and so it would seem to be borne out with our experiences here. One possible impact therefore is that this makes undertaking research in multi-site roles such as the AMHP role less attractive due to the high level and inconsistent bureaucratic barriers of gaining approval. It is undoubtedly the case that determination needed to navigate the complex procedural process. The result is that the role of the AMHP will continue to be an under investigated one, with little possibility of gaining an overview across the different professional perspectives. Given the powers that the AMHP has, and that the majority of their work occurs behind closed doors away from public scrutiny (mental health assessments often take place in people's homes) this further limits, ironically, the opportunity to examine its integrity in depth. Therefore, there is a disincentive to undertake multisite research on AMHPs due to the procedural ethics burden and the accompanying variations in documentation need to get ethical approval through for each site. Particularly when studies of this nature may not gain research funding.

As also highlighted, AMHPs also now hail from up to four professional backgrounds and to all intents and purposes can, because of this, appear an integrated workforce. However, from the perspective of ethical approval, matters are not unified. It is a statutory requirement that each local authority must approve sufficient AMHPs (Department of Health 2015). However, the information available about numbers, type and employment situation of AMHPs is not captured centrally either through government requirement or regulation. Data captured by Bogg (2011) and more recently by ADASS (2018) to rectify this, has relied entirely upon voluntary reporting by those people employed as AMHP leads, and others. The outcome is at best partial and may not always be accurate. It is also not clear if the forthcoming social work regulator (December, 2019) will address this matter, as no confirmation of this has yet been made. It has been suggested, that Social Work England will regulate AMHP and Best Interest Assessors under the Mental Capacity Act, 2005 (or their equivalents as might be determined by on the newly announced Mental Capacity (Amendment) Bill) centrally. The regulator would then, in principle, have a sampling frame for future AMHP related studies. To date, the impact of a lack of centralised database is that appropriate access to participants proves problematic and, in turn, a sampling frame difficult to achieve, again limiting the possibility of quantitative research studies into this role. Whilst access issues are not peculiar to research studies, including those concerning AMHPs, this matter suggests in this case that researchers are not able to determine whether any local social service authority employs AMHPs who are not social workers. As no contact can be established with individual participants until ethical approval had been ratified, this is an additional practical barrier and may also apply to research into other multi-professional roles. This issue is also compounded by lack of understanding of gatekeepers; in the examples here, the researcher would

be directed to a health and social care referral point where professionals make requests for mental health act assessments and not to the 'real' gatekeeper such as the AMHP leads or managers. It was also difficult to differentiate between those professionals approved to undertake the AMHP role and currently practising and those who whilst remaining approved are no longer practicing. when using inclusion and exclusion criteria, the researcher in this instance had to rely on self-reporting by the participant. The impact of this experience proved frustrating to the individual researcher and highlighted the weaknesses in navigating a rigid procedural system with seemingly little consistency of approach between those who are responsible locally for processes governing ethical approval.

Other systemic or procedural matters concerned the lack of standardisation of the required paperwork including what was expected in terms of participant information sheets, consent forms and any guidance for debriefing between the different bodies. A single process for standardised research paperwork might assist multi-site research governance but may not be possible. As stated, perhaps some improvements will be seen in this respect with the introduction of a new regulator for social work. The key issue here is that the current multisite procedural ethical governance processes can act as disincentive to designing and undertaking a study that focuses upon the AMHP profession. AMHP work happens away from public scrutiny as the assessment which are undertaken occur in people homes or institutional settings. Although arguments for privacy and upholding dignity are convincing as to why this should be the case, research offers the opportunity to illuminate AMHP practice and provide some form of evaluation where otherwise none would exist. Recent UK governmental statements have expressed concern over the over use of the mental health legislative powers being used to remove

people liberty who are experiencing mental disorder and at risk, but the opportunity to offer evidence is diminished through problematic procedural ethical arrangements.

The AMHP regardless of their professional background (social worker, nurse, occupational therapist or psychologist) is working on behalf of the local authority when undertaking AMHP duties such as mental health act assessments. Therefore, we would recommend applying for national ADASS research approval in the first instance. Although, local authorities may still require you to complete their own ethics processes applying for ADASS approval offers some degree of consistency to the multi-site application process. We would also advise seeking out a researcher who has undertaken an AMHP related study who can offer advice and guidance through the @AMHPResearch twitter network. We would also recommend using established research information sheet, consent forms and debrief templates to also add consistency.

Within the examples provided, individual researcher used various research designs including methodological approaches such as Interpretative Phenomenological Analysis and methods such as semi-structured interviews, vignettes, rich pictures and observation to elicit qualitative data. It may well be that the tradition within social work and AMHP practice has largely been towards this qualitative paradigm as a natural fit since what is sought is a depth of data and an account of participants experiences (Gilgun1994). However, a move towards quantitative data collection would also be supported if there was a central data set of AMHP demographics that could be accessed and analysed in the future, a development that may also assist with

recruitment of non-social work AMHPs and overcome the challenges of recruiting AMHP participants from across the profession.

It is interesting to note that the two studies which had the most protracted difficulties in accessing ethical permission were those undertaking observational studies. It can be suggested that studies such as these offer a counter-balance to the daily occurrence of mental health act assessments occurring behind closed doors away from public scrutiny (Shepard 1993). Whilst the lack of public scrutiny can be seen as protecting dignity and upholding confidentiality, observational studies can strike a balance to illuminate what occurs behind closed doors and perhaps add to our argument that ethical governance processes that allow for the virtuous researcher should be developed beyond the procedural.

Regulation will not stop observational work, but simply ensure that it is done by people outside its regulatory jurisdiction, such as by journalists who won't be seeking ethical permission from an ethics committee governing research into human participants, and unconstrained by the standards of scientific rigour expected of academic researchers' (Murphy and Dingwall 2007). This also suggests that there are differing thresholds that are at play as to when and how data can be collected, who decides that this is acceptable to put in the public domain, by what means and when it is established that distributor is acting in the public interest to make it available, or their own (Canella and Lincoln 2007)

Spending time gaining access to research populations and developing appropriate informed consent procedures through the development of appropriate information

sheets and consent forms are vital parts of ethical research practices. This required the investment of time by the researchers in each of the case study, and was not unexpected. Whilst the requirement evidence and develop appropriate consensual processes are essential, what was not anticipated perhaps was the varied nature of how these forms might need to be laid out differently according to the committee giving approval. This was not unexpected or seen as an attempt at inconvenience researchers, however a disjointed ethics application process for AMHP research led to unnecessary delays. Which is not seen for nurses for example due to process embedded in NHS ethics procedures.

The incentive to undertake the research is the rich data that can be gathered and in turn to shed light on a process which some have suggested is in any case entirely behind closed doors and away from public scrutiny (Sheppard 1993) and an area of practice that is little explored. However, this needs to be balanced against the disincentives which manifest themselves.

Confidentiality and anonymity are key components of appropriate ethical conduct and this can be particularly challenging when the overall national picture is that the number of non-social work AMHPs are relatively few, a circumstance that makes identification a greater risk, whilst at the same time wishing to ensure participant voices are heard. To this end researchers have been required to ensure that ready identification could not occur thereby limiting what can be reported in academic outputs, either in writing or verbally. This concern might have been lessened had the researchers had a clear idea of the demographics of the overall AMHP workforce.

Each of the examples would suggest that the role of NRES needs to be examined further in relation to multi-professional and multi-site roles such as AMHPs, a role that straddles health and local authority settings and has varying contractual arrangements for their substantive and local authority function. NRES was either discounted or not initially considered in some of the examples, only to be engaged later when it became apparent that health some sites required this. We suggest a number of reasons for this: broadening out the AMHP role, has also increased the complexity of undertaking research in this area as there is now a wider professional pool of participants spanning social care, health and allied fields. Moreover, AMHPs can also be physically located in a variety of health and social care settings, with differing employers. For instance, an AMHP from a nursing background could be a ward manager four days a week and a duty AMHP on the fifth. Although the AMHP remains vicariously responsible to the local authority when on duty as an AMHP and accountable to them, when not they could be the employee of the National Health Service, potentially requiring two different ethical governance processes. It is incumbent on any researcher in this area therefore to establish in what role participants are acting when being interviewed. Consequently, an additional judgement must be made as to whether ethical approval falls within the jurisdiction of the local authority governance framework alone, or whether there is also a need to use those governed by health.

Furthermore, It may be that it is primarily the belief of those seeking or providing ethical permission that AMHPs as professionals need less ethical ‘protection’ than patients or their carers. Therefore, in some of the examples where permission was being sought for AMHPs alone this was initially deemed unnecessary. However, this is an interesting issue; reflective practice for AMHPs is now well established, therefore participation in research could be seen a form of reflective therapy and is often deemed

a possible harm and therefore contained within research risk assessments. Moreover, the advice on this, and other matters, was inconsistent and the understanding provided of one process did not marry with one another, leading to retrospective permission being sought.

Guillemin & Gillam (2004) suggest there are two dimensions to ethics, 'procedural ethics' and 'ethics in practice'. Procedural ethics was a key restraint for the studies reported in this AMHP paper, due to non-centralised ethical approval processes, which saw ethics as a procedure that must be adhered to regardless of the risk of the study and lacked transferability between sites. Also ethics in practice links well with the idea of a vitreous researcher as it concerns the day-to-day ethical issues as they arise which practitioners and professional are familiar with responding to on a daily basis and therefore should suggest greater trust could be afforded for qualitative social research undertaken by professionals

One way forward?

Suffice to say, we agree that a formal approval should be sought but we also suggest that failing to take into account the skills and value base of the researcher or at least treating these as secondary is a flaw in the current system andcould be detrimental rather than beneficial. At the present time, once approved a researcher could in theory, put to one-side ethical considerations, since there are no further external ethical checks built into the current process. For most researchers we would contend that this does not happen, but the danger is that the overly burdensome nature of the initial process could mean that this particular box has been ticked and any later ethical considerations that arise could be trivialised at best and ignored at worst. One

suggestion might be that researchers subscribe to an ethical code, which is widely recognised, and which allows researchers to nominate an ethics committee to review their work and demonstrate virtuosity.

For us, the current system for gaining ethical approval detracts from the way in which researchers should behave. This turn to being a virtuous researcher and of negotiating the complexity of undertaking research at all its stages is of current debate in the social sciences (Dingwall et al., 2017) and challenge the notion of an abstract independent framework (Oates, 2018). Our examples show that even in seeking ethical approval the researchers came up against unexpected issues, the chance of this happening beyond approval stage is also high. To what end does the current system afford researcher agency? It is suggested that the review process stands in need of development (Dingwall et al., 2017) and we would support this from our experiences of seeking ethical approval alone. As we have seen, precise frameworks are not consistently understood nor does the one size fit all. Moreover, the system, based as it is on a protectionist model tend to suggest that researchers might avoid the difficult. Instead, Dingwall et al., (2017) recommend that the researcher does not just tick the approval box (however intense the current process is) but it is also about being sensitive to the presence of ethical issues throughout.

The four examples illustrate the disproportionate challenges and inconsistency faced by the researchers following the bureaucratic ethics approval process into one professional role. Arguably, the agency of the researcher was secondary to this bureaucratic process. For example, the researcher in case study four needed to convince the ethics panel through a process of appeal that the study was ethical, even

though they were a member of a professional bound by an ethical code. Whilst in case study three, the process almost appears not to have been as onerous as they had initially perceived. Arguably, if the researcher in case study one researcher virtuosity had been accepted, there would not have been the requirement overall to replicate so many ethical applications, including, in one instance, the researcher themselves supporting the process in critiquing the very ethical application form that was submitted.

Although in this article the AMHP role has been used to highlight the difficulties of gaining ethical approval across professional and organisational boundaries, this could easily apply to other professional roles within nursing and allied professionals. To gain greater insights the need for what are seemingly unnecessary barriers should be to challenged, and greater emphasis placed upon the virtuosity of the researcher. The portability of ethics approval to multiple sites should also be considered. Lessons can certainly be learnt from the experiences of these four case studies to the study of occupational therapy and nursing for instance, as they can be found in variety of settings working across NHS and local authority boundaries.

Conclusion

In this article we have discussed gaining ethical approval for research as experienced separately but into the same multi-professional role undertaken in mutli-site settings. Using these individual experiences, we discuss issues that have arisen; systemic, methodological and virtuousness as a researcher. To all intents and purposes, an integrated approval system or NRES, seems straight forward and neat. However, unified it was not. There is undoubtedly a commitment from the researchers (and

supervisors) as highlighted in the case studies above to achieve sound research governance (UUK 2012, 2016). Apart from the methodological differences underpinning the research design of each and the implications of these, difficulties arose when moving beyond the research governance of the universities to that which is required for multi-site research in the field. We suggest that a single process is needed, one that can minimise excessive time in navigating the differing bureaucratic structures that currently exist and instead maximises the time and resources that are required to achieve a satisfactory aim of gaining and applying sound research. Moreover, we contend that gaining ethical approval is an inconsistently experienced process that not only gives rise to practical and methodological challenges in its present iteration but does not easily afford open-ended integrity. Seeking ethical approval is not the sole element of ethical conduct in research nor is it a static construct involving the satisfying of what are in effect closed systemic requirements. Instead the process needs to be adapted to allow researcher integrity or, that as part of approval that the researcher constantly revisits ethical 'permission' considering ongoing developments. In other words ethical approval and being a virtuous researcher should interweave and in turn just as one governance should trust another so too should the agency of the researcher form part of and be trusted in the process.

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