18th January 2022

Mr William Wragg, MP
Chair of the Public Administration & Constitutional Affairs Committee (PACAC)

Dear Mr Wragg

Re: **Ethical concerns arising from the Government's use of covert psychological 'nudges' in their COVID-19 communications strategy**

We are writing to you as a group of psychological specialists and health professionals to highlight our major ethical concerns about the deployment of covert behavioural-science techniques (commonly referred to as 'nudges') in the Government's COVID-19 communications strategy. Our view is that the use of these behavioural strategies - which often operate below people's conscious awareness and frequently rely on inflating emotional distress to change behaviour - raises profound moral questions. In light of these pressing concerns we respectfully request that, in your role as chair of the Public Administration & Constitutional Affairs Committee (PACAC), you instigate a comprehensive inquiry into the acceptability of using these strategies on the British people as a means of promoting compliance with public health directives.

Background

The appetite for using covert psychological strategies as a means of changing people's behaviour was boosted by the emergence of the 'Behavioural Insights Team' (BIT) in 2010 as 'the world's first government institution dedicated to the application of behavioural science to policy' (1). The membership of BIT rapidly expanded (2) from a seven-person unit embedded in the UK Government to a 'social purpose company' operating in many countries across the world. A comprehensive account of the psychological techniques recommended by the BIT is provided in the Institute of Government document, *MINDSPACE: Influencing behaviour through public policy* (3), where the authors claim that their strategies can achieve 'low cost, low pain ways of nudging citizens … into new ways of acting by going with the grain of how we think and act'.

Since its inception in 2010, the BIT has been led by Professor David Halpern who is currently the team's chief executive. Professor Halpern and two other members of the BIT also currently sit on the Scientific Pandemic Insights Group on Behaviours (SPI-B) (4), a subgroup of SAGE that advises the Government on its COVID-19 communications strategy. Most of the other members of the SPI-B are prominent British psychologists who have expertise in the deployment of behavioural-science 'nudge' techniques.

It is important to emphasise that the use of behavioural science in this way represents a radical departure from the traditional methods – legislation, information provision, rational argument – used by governments to influence the behaviour of their citizens. By contrast, many of the 'nudges' delivered by the BIT are – to various degrees – acting upon us automatically, below the level of conscious thought and reason.

The ‘nudges’ of concern

The BIT and the SPI-B have encouraged the deployment of many techniques from behavioural science within the Government’s COVID-19 communications. However, there are three ‘nudges’ which have evoked most of our alarm: the exploitation of fear (inflating perceived threat levels), shame (conflating compliance with virtue) and peer pressure (portraying non-compliers as a deviant minority) – or “affect”, “ego” and “norms”, to use the language of the *MINDSPACE* document.

AFFECT/FEAR

Aware that a frightened population is a compliant one, a strategic decision was made to inflate the fear levels of all the British people. The minutes of the SPI-B meeting (5) dated the 22nd March 2020 stated, ‘*The perceived level of personal threat needs to be increased among those who are complacent*' by ‘*using hard-hitting emotional messaging*’. Subsequently, in tandem with a subservient mainstream media, the collective efforts of the BIT and the SPI-B have inflicted a prolonged and concerted scare campaign upon the British public. The methods used have included:

- *Daily statistics displayed without context*: the macabre mono focus on showing the number of COVID-19 deaths without mention of mortality from other causes or the fact that, under normal circumstances, around 1600 people die each day in the UK.
- *Recurrent footage of dying patients*: images of the acutely unwell in Intensive Care Units.
- *Scary slogans*: for example, ‘IF YOU GO OUT YOU CAN SPREAD IT, PEOPLE WILL DIE’, typically accompanied by frightening images of emergency personnel in masks and visors.

EGO/SHAME

We all strive to maintain a positive view of ourselves. Utilising this human tendency, behavioural scientists have recommended messaging that equates virtue with adherence to the Covid-19 restrictions and subsequent vaccination campaign. Consequently, following the rules preserves the integrity of our egos while any deviation evokes shame. Examples of these nudges in action include:

- *Slogans that shame the non-compliant*: for example, ‘STAY HOME, PROTECT THE NHS, SAVE LIVES’.
- *TV advertisements*: actors tell us, ‘I wear a face covering to protect my mates’ and ‘I make space to protect you’.
- *Clap for Carers*: the pre-orchestrated weekly ritual, purportedly to show appreciation for NHS staff.
- *Ministers telling students not to ‘kill your gran’*.
- *Shame-evoking adverts*: close-up images of acutely unwell hospital patients with the voice-over, ‘Can you look them in the eyes and tell them you’re doing all you can to stop the spread of coronavirus?’

NORMS/PEER PRESSURE

Awareness of the prevalent views and behaviour of our fellow citizens can pressurise us to conform and knowledge of being in a deviant minority is a source of discomfort. The

Government has repeatedly encouraged peer pressure throughout the COVID-19 crisis to gain the public's compliance with their escalating restrictions, an approach that – at higher levels of intensity – can morph into scapegoating. The most straightforward example is how, during interviews with the media, ministers have often resorted to telling us that the vast majority of people are 'obeying the rules' or that almost all of us are conforming. However, in order to enhance and sustain normative pressure, people need to be able to instantly distinguish the rule breakers from the rule followers; the visibility of face coverings provides this immediate differentiation. The switch to the mandating of masks in community settings in summer 2020, without the emergence of new and robust evidence that they reduce viral transmission, strongly suggests that the mask requirement was introduced primarily as a compliance device to harness normative pressure.

Ethical questions

Compared to a government's typical tools of persuasion, the covert psychological strategies (outlined above) differ in both their nature and subconscious mode of action. Consequently, we believe there are three main areas of ethical concern associated with their use: problems with the *methods* per se; problems with the lack of *consent*; and problems with the *goals* to which they are applied.

First, it is highly questionable whether a civilised society should knowingly increase the emotional discomfort of its citizens as a means of gaining their compliance. Government scientists deploying fear, shame and scapegoating to change minds is an ethically dubious practice that in some respects resembles the tactics used by totalitarian regimes such as China, where the state inflicts pain on a subset of its population in an attempt to eliminate beliefs and behaviour they perceive to be deviant.

Another ethical issue associated with these covert psychological techniques relates to their unintended consequences. Shaming and scapegoating have emboldened some people to harass those unable or unwilling to wear a face covering. More disturbingly, the inflated fear levels will have significantly contributed to the many thousands of excess non-COVID deaths (6) that have occurred in people's homes, the strategically-increased anxieties discouraging many from seeking help for other illnesses. Furthermore, a lot of older people, rendered housebound by fear, may have died prematurely from loneliness (7). Those already suffering with obsessive-compulsive problems about contamination, and patients with severe health anxieties, will have had their anguish exacerbated by the campaign of fear. Even now, when all the vulnerable groups have been offered vaccination, many of our citizens remain tormented by 'COVID-19 Anxiety Syndrome' (8), characterised by a disabling combination of fear and maladaptive coping strategies.

Second, a recipient's consent prior to the delivery of a medical or psychological intervention is a fundamental requirement of a civilised society. Professor David Halpern (the BIT Chief Executive and prominent member of SPI-B) explicitly recognised the significant ethical dilemmas arising from the use of influencing strategies that impact subconsciously on the country's citizens. The *MINDSPACE* document (3) – of which Professor Halpern is a co-author - states that, 'Policymakers wishing to use these tools … need the approval of the public to do so' (p74). More recently, in Professor Halpern's book, *Inside the Nudge Unit,* he

is even more emphatic about the importance of consent: ‘If Governments … wish to use behavioural insights, they must seek and maintain the permission of the public. Ultimately, you – the public, the citizen – need to decide what the objectives, and limits, of nudging and empirical testing should be’ (p375).

As far as we are aware, no attempt has yet been made to obtain the public’s permission to use covert psychological strategies.

Third, the perceived legitimacy of using subconscious ‘nudges’ to influence people may also depend upon the behavioural goals that are being pursued. It may be that a higher proportion of the general public would be comfortable with the government resorting to subconscious nudges to reduce violent crime as compared to the purpose of imposing unprecedented and non-evidenced public-health restrictions. Would British citizens have agreed to the furtive deployment of fear, shame and peer pressure as a way of levering compliance with lockdowns, mask mandates and vaccination? Maybe they should be asked before the Government considers any future imposition of these techniques.

The position of the British Psychological Society

The British Psychological Society (BPS) is the leading professional body for psychologists in the UK. According to their website (9), a central role of the BPS is, ‘To promote excellence and **ethical** practice in the science, education and application of the discipline’. [*Our emphasis*]. Mindful of their important position as the guardian of ethical psychological practice, on the 6th January 2021 46 psychologists and therapists (including many of the signatories of the present letter) wrote to the BPS (10) raising the ethical questions outlined above.

A month later, on the 5th February 2021, a reply (11) was received from Dr Debra Malpass (Director of Knowledge and Insight at the BPS) which failed to directly address our ethical concerns and was, in our view, evasive and disingenuous. Dr Malpass’s response included questioning whether the strategies deployed by Government psychologists were actually covert, stating that the role of specific psychologists had not been evidenced, and expressing how ‘incredibly proud’ the BPS was about the ‘fantastic work done by psychologists throughout the pandemic’.

Dissatisfied with this initial reaction, we contacted the BPS again to question whether our expressed concerns had actually been considered by their ethics committee. We received a brief reply from Dr Malpass on the 16th February 2021 informing us that our initial letter would be considered at their next BPS Ethics Committee on the 1st March; we understood this to be an admission that the covert psychological strategies recommended by psychologists had yet to be scrutinised in regards to their ethical acceptability.

By 12th March, and not having received any further communication from the BPS, we prompted them again. On the 23rd March a message was received from Dr Roger Paxton (Chair of the BPS Ethics Committee) apologising that ‘owing to a very full agenda and an oversight’ no discussion about our concerns had taken place but that they would be included on the agenda of their June meeting.

On the 30th June, and not having received any further communication from the BPS, we prompted them again. On the 1st July we received a response (12) from Dr Paxton, comprising three paragraphs, informing us that the issues we raised had been considered and that their ethics committee had endorsed all previous BPS responses. In this communication, Dr Paxton acknowledged that he had received a large number of recent emails raising the same issues, but rejected our ethical concerns arguing that the strategies referred to were 'indirect' rather than covert, the application of psychology in this instance fell outside the realm of individual health decisions (so informed consent was not an issue), levels of fear within the general population were proportionate to the objective risk posed by the virus, and the psychologists' role in the pandemic response demonstrated 'social responsibility and the competent and responsible employment of psychological expertise'.

We believe the BPS responses to our ethical concerns about the deployment of covert psychological strategies throughout the COVID-19 pandemic have been defensive and disingenuous. Also we believe the BPS is impeded by a major conflict of interest on this issue in that several members of the SPI-B are also influential figures within the BPS. As such, the impartiality of the BPS in addressing the ethical issues we raised is highly questionable.

Finally, it is worth noting that serious concerns about the Government's use of behavioural science have previously been raised in relation to other spheres of government activity. An All Parliamentary Group Report (APGR) (13) analysing the recommendations of the Morse Report (14) (a Treasury-commissioned review into the Loan Charge, published in December 2019) found that the distress evoked in those people targeted by behavioural insights may, in some instances, have led to victims taking their own lives. In the words of the APGR:

'*HMRC continue to apply pressure to taxpayers by using 30 behavioural insights in communications, something that has been cited in one of the seven known suicides of people facing the Loan Charge*'.

In further recognition of the suffering and anguish associated with these 'nudge' techniques, the APGR recommends:

'*An independent assessment and suspension of HMRC's use of behavioural psychology/behavioural insights in light of the ongoing suicide risk to those impacted by the Loan Charge*'.

Clearly, a truly independent and comprehensive evaluation of the ethics of deploying psychological 'nudges' on the British people - during public health campaigns and in other areas of government - is now urgently required. We respectfully ask the PACAC to consider performing this important role.

Co-signatories

Psychology/therapy/mental health

Dr Gary Sidley (M.Sc., ClinPsy, PhD) Retired Consultant Clinical Psychologist

Ms Jen Ayling (UKCP registered counsellor) Psychotherapeutic Counsellor

Dr Faye Bellanca (DClinPsy) Clinical Psychologist

Dr Christian Buckland ((PsychD) Psychotherapist

Alison Burnard (Dip Gestalt Therapy) Gestalt Psychotherapist

Daran Campbell (PG Dip Counselling) Substance Misuse Practitioner

Dr Tom Carnwath (FRCPsych, FRCGP) Consultant Psychiatrist

Dr Maria Castro Romero (DClinPsy) Senior Lecturer in Clinical Psychology

Gillian England (PG Dip Cognitive Behavioural Psychotherapy) Cognitive Behavioural Therapist

Dr Elizabeth English (M.Phil, DPhil) Mindfulness Teacher & Trauma Therapist

Mr Patrick Fagan (M.Sc.) Chief Scientific Officer, Capuchin Behavioural Science

Dr Tracey Grant Lee (DClinPsy) Chartered Clinical Psychologist

Andy Halewood (Advanced M.Sc. in Counselling Psychology) Chartered Psychologist

Sue Parker Hall (CTA, MSc, PGCE) Psychotherapist

Andrew D Harry (RPP PTP) NLP Master Practitioner

Mrs Nicole Harvey (B.Sc, Pg Dip) Mental Health Practitioner/CBT Therapist

Ms Julie A Horsley (Advanced Diploma in Counselling) Counsellor/Therapist

Dr Richard House (MA, Ph.D, C.Psych. AFBPsS) former Senior Lecturer in Psychology

Emma Kenny (MA Counselling, Advanced Diploma Counselling) Media Psychologist & Psychological Therapist

Rachel Maisey (MA, PGCE, PgDip Counselling) Integrative Counsellor

Jane Margerison (PG Dip Integrative Psychotherapy, RMN) Psychotherapist

Kate Morrissey (Advanced Diploma in Counselling, MA Social Work) Counsellor

Lucy Padina (Diploma in Psychology, Advanced Diploma in the Management of Psychological Trauma) Independent Consultant & Registered Social Worker

Carolyn Polunin (M.Sc.) Integrative Psychotherapist

Dr Livia Pontes (DClinPsy) Clinical Psychologist

Dr Kate Porter (DClinPsy) Clinical Psychologist

Ian Price (M.Sc. Organisational Behaviour) Business Psychologist

Dr Bruce Scott (B.Sc., PhD) Psychoanalyst

Professor David Seedhouse (PhD) Honorary Professor of Deliberative Practice

Deborah Short (MA Gestalt Psychotherapy) Psychotherapist

Ms Deborah Sharples (B.A. [Hons] Social Work) Mental Health Social Worker

Susan Sidley (RMN) Retired Psychiatric Nurse

Dr Angela Smith (DClinPsy, PhD) Psychology Lead

Dr Helen Startup (DClinPsy, PhD) Consultant Clinical Psychologist

Dr Dov Stein (MA, MB, BCh, BAO DCH Dobs) Consultant Psychiatrist & Psychotherapist

Dr Zenobia Storah (DClinPsy) Child & Adolescent Clinical Psychologist

Professor Ellen Townsend (PhD) Professor of Psychology

Sarah Waters (BA, Dip Counselling & Therapy) Psychotherapist

Dr Alice Welham (MA, DClinPsy, PhD) Clinical Psychologist

Dr Damian Wilde (DClinPsy) Highly Specialist Clinical Psychologist

Other health professionals

Mr John Collis (PGCert in Advanced Practice, BSc[Hons] Nursing, BA [Hons]
Retired Nurse Practitioner

James Cook (Bachelor of Nursing [Hons], Master of Public Health [MPH]) Registered Nurse

Dr Clare Craig (BM, BCh, FRCPath) Consultant Pathologist

Dr David Critchley (BSc, PhD) Clinical Pharmacologist

Roisin Dargan-Peel (MA) Former Registered General Nurse, Midwife & Health Visitor

Mr Paul Goss (MCSP, HCPC, KCMT) Clinical Director & Chartered Physiotherapist

Dr Ros Jones (MD, FRCPCH) Retired Consultant Paediatrician

Mrs Alison Langthorne (RGN) Staff Nurse

Jenna Leith (RGN) Advanced Nurse Practitioner

Dr Sam McBride (MB, BCh, MRCP, FRCP, FRCEM) Clinical Gerontologist

Mrs Julie Noble (M.Sc, RN) Senior Forensic Nurse Examiner & Advanced Practitioner

Mrs Christine Mary Proctor (RGN) Former Registered General Nurse

Dr Annabel Smart (MBBS, BSc, DFSRH) Retired General Practitioner

Nat Stephenson (B.Sc Audiology) Paediatric Audiologist

Dr Helen Westwood (MBChB, MRCGP, DCH, DRCOG) General Practitioner