

More concerns about the current UK Welfare Reform

Margaret Williams 22nd January 2012

Attention is drawn to a letter recently sent to two high-profile members of The House of Lords by Douglas Fraser, a former professional violinist but now severely affected by ME/CFS (<http://www.meactionuk.org.uk/FraserToTGTandMM.htm>).

In it, Fraser sets out his concerns about a paper circulated by Lord (David) Freud, Parliamentary Under Secretary of State (Minister for Welfare Reform) to certain members of the House of Lords (this being "Models of Sickness and Disability" by Waddell G and Aylward M, whose track record on the alleged deviance of sick people -- those with ME/CFS being specifically targeted -- is documented in "Magical Medicine: how to make a disease disappear" by Professor Malcolm Hooper available at www.meactionuk.org.uk/magical-medicine.htm).

David Freud's history is interesting: he previously worked as a journalist for the Financial Times and then joined a leading UK investment bank (UBS investment banking), where he was on record as saying to his deputy: *"If the rest of the country knew what we were being paid, there would be tumbrels on the streets and heads carried round on pikes"*. In his city career he frequently got things seriously wrong. As one reviewer of his book put it, Freud *"will be remembered in the City as one of the key players in several of the most embarrassing and badly managed deals in investment banking"*. His revenue forecasts were, in his own words: *"completely potty"*; according to the Daily Telegraph, his financial plans for Euro Disney *"went so goofy they almost wrecked his career"* and on the Channel Tunnel Rail Link he got his sums wrong by £1.2 billion and had to be bailed out by the Government (www.variant.org.uk/events/Doc7Poverty/BankerBankies.pdf).

Nonetheless, as the "To Banker from Bankies" 2009 report (which was supported and funded by Oxfam) states, in 2007 Freud was appointed as the key Government advisor on welfare reform by Labour's John Hutton, having been commissioned to produce a report *"Reducing Dependency, Increasing Opportunity"* on the "Welfare to Work" programme. This was despite the fact that, in his own words, Freud *"didn't know anything about welfare at all"* (Daily Telegraph, 4th February 2008). Despite the great complexity of the welfare system, Freud researched and wrote his welfare "shake-up" plan in just three weeks. It recommended that the existing role of private firms (such as the French company Atos) in the Government's "Welfare to Work" programme be dramatically increased; he acknowledged that there was no evidence to suggest that private contractors were any better than the Department for Work and Pensions, but he still concluded that it would be *"economically rational"* to pay them tens of thousands of pounds for every person they removed from benefits.

The Daily Telegraph subsequently reported that Freud himself had severed all ties with Labour Ministers and was joining the Conservatives' Work and Pensions team *"after being put forward for a peerage"*.

In May 2010 the Coalition Prime Minister (David Cameron) appointed him to his current post as Minister for Welfare Reform.

On 17th January 2012 Hansard recorded that Lord Freud referred to the "Models of Sickness and Disability" document that he had handed round to some members of the House of Lords (<http://www.publications.parliament.uk/pa/ld201212/ldhansrd/text/120117-0001.htm>), this being the document which will apparently underpin the transition from Disabled Living Allowance (DLA) to the Personal Independence Payment (PIP) and from which document it is clear that the biopsychosocial construct now permeates medical assessments for state benefits (so it may come as no surprise that Professor Peter White is acknowledged as an advisor).

Lord Freud explained: *"I am hopeful that PIP will do a better job than DLA....I shall now turn to the more technical aspects of this issue – that is, looking at what we are doing with the PIP and its assessment. Is it a medical assessment...? It absolutely is not.*

"...Our approach is – and this is rather a mouthful – akin to the biopsychosocial model...

"I sent round a rather interesting piece of analysis to many noble Lords in the Committee, called Models of Sickness and Disability, which showed the differences between the models, explaining the medical model, the reaction of the social model against the pure medical model and the synthesis of the biopsychosocial model. The summary of the biopsychosocial model in the analysis is that: 'Sickness and disability are best overcome by an appropriate combination of healthcare, rehabilitation, personal effort and social/work adjustments'. There is a coherent theory behind this assessment".

There are about 170 references to "models" scattered throughout the 40 page document and Fraser points out that readers may get the impression when it comes to the "biopsychosocial model" that a rigorous and scientific approach has been taken, yet it may be argued that there is no coherent theory whatsoever behind that "model".

Fraser draws attention to the authors' footnotes, which are rife with selective referencing and contain misquotations from and misrepresentations of the (not easily available) cited source.

In one instance the authors seem to infer (from their cited source) that it has been shown to be perfectly legitimate to proceed directly from biopsychosocial theory (or the "conceptual model") to biopsychosocial practice and policy, when the cited author in fact concluded that the biopsychosocial model is *"hardly a theory"* and *"certainly not a model"*.

The central arguments surrounding issues of bias and confounding in relation to the biopsychosocial model that are exposed within the cited source are not -- as they should have been -- made known by Waddell and Aylward.

Notably, the impression from the footnotes is that it was Professor Peter White who provided "classic" examples on *"how the biopsychosocial model is not an aetiological model of disease, and (how) arguments about whether the cause of a particular disease is biological or psychosocial obscure the main issue"*, when in reality it was George Davey-Smith, Professor of Clinical Epidemiology at the University of Bristol who urged caution and who carried the torch for intellectual integrity: it was he who showed that bias can generate spurious findings and that when interventional studies to examine the efficacy of a psychosocial approach have been used, the results have been disappointing, and he who pointed out that cholera was attributed to "moral" factors and that peptic ulcer was attributed to stress before the appliance of science (Proof Positive? Eileen Marshall & Margaret Williams, 30th August 2005 http://www.meactionuk.org.uk/PROOF_POSITIVE.htm).

According to Waddell and Aylward (and White), both these examples are of *"specific diseases of doubtful relevance to common health problems"* and they are dismissed because they appear to threaten the biopsychosocial philosophy, which Waddell and Aylward claim applies to *"any illness"*.

However, when one examines Waddell and Aylward's claim of supporting evidence for the biopsychosocial model in the management of low back pain (*"extensive scientific evidence that the biopsychosocial model provides the best framework for the modern management of low back pain"*), one finds from the latest Cochrane meta-analysis examining the results of behavioural interventions for low back pain that: *"the risk of bias of the trials included in this review was generally high"* and, in relation to the addition of behavioural therapy to in-patient rehabilitation over the longer term, that: *"there was only low or very low quality evidence, which was based on the results of only two or three small trials"* (Behavioural treatment for chronic low-back pain; 7 JUL 2010. The Cochrane Collaboration. <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD002014.pub3/full>).

Such seeming sleight of hand by Waddell and Aylward in seriously misleading a Government Minister and members of the House of Lords is to be deplored.

When it comes to ME/CFS, over 20 renowned international experts on ME/CFS have provided written statements of concern effectively stating that cognitive behavioural therapy and graded exercise therapy used to support the alleged existence of the “biopsychosocial model” do not work for people with ME/CFS (Magical Medicine pp 88-92).

Furthermore, numerous trials have shown that not only is the “biopsychosocial model” unsuccessful in the management of ME/CFS but that the model itself is not evidence-based and it may be actively harmful:

- (i) the evidence that behavioural modification techniques have no role in the management of ME/CFS is already significant and has been confirmed by a study in Spain, which found that in ME/CFS patients, the two interventions used to justify the biopsychosocial model (CBT and GET) did not improve HRQL (health-related quality of life) scores at 12 months post-intervention and in fact resulted in worse physical function and bodily pain scores in the intervention group (Nunez M et al; Health-related quality of life in patients with chronic fatigue syndrome: group cognitive behavioural therapy and graded exercise versus usual treatment. A randomised controlled trial with 1 year follow-up. Clin Rheumatol 2011, Jan 15: Epub ahead of print)
- (ii) *“Notwithstanding the medical pathogenesis of ME/CFS, the (bio)psychosocial model is adopted by many governmental organizations and medical professionals to legitimize the combination of Cognitive Behavioral Therapy (CBT) and Graded Exercise Therapy (GET) for ME/CFS.... Justified by this model CBT and GET aim at eliminating presumed psychogenic and socially induced maintaining factors and reversing deconditioning, respectively. In this review we invalidate the (bio)psychosocial model for ME/CFS and demonstrate that the success claim for CBT/GET to treat ME/CFS is unjust. CBT/ GET is not only hardly more effective than non-interventions or standard medical care, but many patients report that the therapy had affected them adversely, the majority of them even reporting substantial deterioration.... We conclude that it is unethical to treat patients with ME/CFS with ineffective, non-evidence-based and potentially harmful ‘rehabilitation therapies’ such as CBT/GET”* (A Review on Cognitive Behavioural Therapy (CBT) and Graded Exercise Therapy (GET) in Myalgic Encephalomyelitis (ME) / Chronic Fatigue Syndrome (CFS). Neuroendocrinol Lett 2009;30(3):284-299)
- (iii) The Wessely School’s much-vaunted FINE (Fatigue Intervention by Nurses Evaluation) Trial could not by any standards be judged to have been successful: the results showed that “pragmatic rehabilitation” (PR, based on CBT/GET) was minimally effective in reducing fatigue and improving sleep only whilst participants were engaged in the programme and that there was no statistically significant effect at follow-up. Furthermore, pragmatic rehabilitation had no statistically significant effect on physical functioning; equally, its effect on depression had diminished at follow-up. Moreover the other intervention being tested (“supportive listening” or SL) had no effect in reducing fatigue, improving physical functioning, sleep or depression (AJ Wearden et al; BMC Medicine 2006, 4:9 doi:10.1186/1741-7015-4-9)
- (iv) Equally, the widely acclaimed but statistically unsustainable PACE Trial cannot be said to have been successful since, uniquely, ratings that would qualify a potential participant as sufficiently impaired to enter the trial were considered “within the normal range” when recorded on completion of the trial and no recovery statistics have been published by the Chief Principal Investigator, Professor Peter White (Comparison of adaptive pacing therapy, cognitive behaviour therapy, graded exercise therapy, and specialist medical care for chronic fatigue syndrome (PACE): a randomised trial. PD White et al. Lancet 2011 Mar 5;377(9768):823-36).

It has not been possible to determine Lord Freud’s awareness of the need to distinguish biomedical science from biopsychosocial ideology before he formulates Government policies that will have a

profoundly detrimental impact on sick and frightened people whose means of survival is threatened if their state support is withdrawn.

The term “biopsychosocial model” is used almost exclusively by Wessely School psychiatrists to refer to disorders that they continue to regard as psychosomatic (especially ME/CFS) and it is not used by other disciplines. For example, cardiologists do not refer to patients as having a “biopsychosocial” disorder and oncologists do not refer to cancer as a “biopsychosocial” disorder, nor do they claim that their patients must be coerced back to work by the withdrawal of their state benefits because it is patients’ aberrant belief that they are physically sick which maintains their disease.

The use of such a term can be seen as a linguistic misdirection by these psychiatrists, allowing them to conceal their belief that ME/CFS is not a physical disease but an aberrant state of mind maintained by psychological and behavioural factors (ie. the psychosocial components of “biopsychosocial”). The only “bio” in their “biopsychosocial model” is their reluctant concession that ME/CFS is sometimes preceded by a self-limiting viral infection (and, despite the overwhelming international evidence to the contrary, they insist it is maintained by psychosocial elements that do not result from any organic pathology).

As Fraser states: *“As the tortured arguments continue, one suspects that the authors (Waddell and Aylward) are keenly trying to ensure something is kept out of public view....Had Lord Freud said ‘We have not gone for the medical model; we have gone for the psychosomatic model’, I do not think that members of the House would have been impressed for a moment”.*

Informed readers of “Models of Sickness and Disability” might wonder why something that has been repeatedly shown not to be a successful model is being promoted by a UK Government.

As Fraser points out, an explanation may be found from a 2005 issue of “Decision Makers’ Exchange” (DME), the monthly newsletter for DLA and Attendance Allowance decision makers: *“Confirmation that Medical Services (ie. the DWP) have adopted the Biopsychosocial Model for assessing not just claims based on incapacity for work but also DLA and AA came in the July edition of Decision Makers’ Exchange...An item explained that Medical Services have recently introduced a change in the way that they assess a customer’s disabilities and the effect it has on their lives. The Biopsychosocial Model aims to address how a person’s disability has an effect on that individual’s life”.* The newsletter features an article by Mansel Aylward, former Chief Scientist at the DWP, entitled *“Professor Aylward endorses the Biopsychosocial Model of Disability....Conditions for which there is limited or no recognised pathological basis, such as chronic fatigue, fibromyalgia...feature regularly in disability assessments for state benefits....The Biopsychosocial Model is the answer to the disability analyst’s plight”.*

Fraser then quotes from an Atos Origin Medical Services meeting in 2004 which sets out just how the dogma that underpins the “biopsychosocial model” is being authoritatively promulgated, and he notes *“the convenient fictions and lack of logic those responsible would...refuse to tolerate if applied to their own family and friends”.*

The Atos Origin 2004 Conference report is explicit: *“Psychosocial factors...are at least as important as physical factors in the onset and maintenance of these conditions. Patients can make a number of ‘secondary gains’ with these unexplained illnesses, such as...turning a socially unacceptable disability into a more acceptable ‘organic’ disability caused by injury or disease beyond their control. They can blame their failures on the illness; elicit care, sympathy and concern from family and friends; avoid work or even sex; and there are financial rewards associated with disability.*

“...if a patient believes their illness was caused by a virus and there’s nothing they can do about it, their prognosis is not likely to be positive. But if the patient believes...that the symptoms won’t last long and they have control over them, then the prognosis will be better.... We need patients to understand their situation, so they are more likely to go back to work” (<http://www.meactionuk.org.uk/AtosConference2004.pdf>).

Fraser concludes in his letter: *“Given the combined forces of what appears as an unseen (and) corporate-generated self-serving attitude (tacitly approved by “Models of Sickness and Disability” authors as perfectly moral) in the guise of the...psychosomatic model...promoting the prejudice of...pop-psychology directed at vulnerable and relatively powerless others...and a profit-driven foreign company...it is unsurprising that so many of the bad decisions they help facilitate are overturned on closer examination at costly appeals. It would of course, be much cheaper in the long run to adopt some of the higher standards of appeal tribunals in the first place”.*

This non-evidence-based but pervasive biopsychosocial ideology is now being foisted on the unsuspecting people of Australia and New Zealand, because in May 2010 Aylward wrote a report for the Australasian Faculty of Occupational and Environmental Health (Realising the Health Benefits of Work: A Position Paper. Professor Sir Mansel Aylward CB; Director: Centre for Psychosocial Research and Disability Research, Cardiff University (the Centre being funded by the health insurance company UNUM Provident). In it, Aylward asserts:

“Fundamental Precepts:

- *Main determinants of health and illness depend more upon lifestyle, socio-cultural environment and psychological (personal) factors than they do on biological status and conventional healthcare*
- *Work: most effective means to improve well-being of individuals, their families and their communities*
- *Objective: rigorously tackling an individual’s obstacles to a life in work.*

“Making the distinction: definitions and usage:

- *Disease: objective, medically diagnosed pathology*
- *Illness: subjective feeling of being unwell*
- *Sickness: social status accorded to the ill person by society*

In that report Aylward claims that largely subjective complaints (such as ME/CFS) are often associated with psychosocial issues, not with pathology, and that “bio-psycho-social factors” may aggravate and perpetuate disability and that they may also act as obstacles to recovery and barriers to return to work. He refers to the UK Government’s “Pathways to Work” initiative, with its mandatory work-focused interviews for sick people and the use of CBT to change people’s alleged misperceptions about their health; his message is: *“Barriers to recovery and return to (retention in) work are primarily personal, psychological and social rather than health-related ‘medical problems’ and that “Perceptions lie at the ‘heart’ of the problem”.*

His report provides guidance on *“Engaging and Exploiting Stakeholders”*, which he says must include changing the beliefs and attitudes of politicians, civil servants, health professionals, employers etc and changing the present culture about health and well-being in order to deliver *“visible hard outcomes”*.

Even more disturbingly, Aylward’s report asserts that there must be new roles for health professionals, who must no longer permit their patients to believe that they are incapable of work if they have a disease but must instead propel them back into work even if they do have a legitimate medical disease. In the UK, there are recorded accounts of people with cancer being forced back to work and of a cancer sufferer dying whilst awaiting an appeal against a refusal of benefits by Atos.

Unsurprisingly, since he has invested so much into the promulgation of it, despite the accumulating evidence to the contrary, Aylward claims that the biopsychosocial principles of management are evidence-based, when the “biopsychosocial model” can be readily shown to have no empirical foundation, particularly in relation to ME/CFS.

It has nevertheless been used to justify beliefs and policies, for example, in his letter to the two members of the House of Lords, Douglas Fraser quotes the following:

"Benefits and Work has seen one recent medical report in which a DWP doctor explicitly stated that he had used the Biopsychosocial model. The claimant has Chronic Fatigue Syndrome and was seeking renewal of an award of the middle rate of the care component and the higher rate of the mobility component. His condition had deteriorated since his last award over two and a half years ago. The doctor who visited him recorded that: 'There are few significant findings other than subjective tenderness and stiffness. But the customer is clearly living the life of a disabled person and I have applied the Biopsychosocial model'. The doctor then stated, without explaining how the conclusion had been reached, that the claimant's condition was just 40% physical and '60% psychosocial'.... This allowed the decision maker to conclude that the claimant's award of higher rate mobility was no longer appropriate as the primary reason for his virtual inability to walk was psychosocial rather than physical".

The specific numbers given (40/60 split) provided a superficial appearance of scientific objectivity to cover what was in fact no more than a highly-prejudiced guess, because such things cannot be measured or quantified, but they achieved the required outcome (which was to strip this person of his benefits and for which the company to which the DWP has delegated its medical assessments would receive a handsome financial reward).

It is, of course, imperative to seek out and remove from state benefits the cheats and idle lead-swingers, but it is even more imperative to take appropriate medical care of the sick, yet what underpins current Government welfare reform is the un-evidenced conviction that work is always good for people, no matter how ill they may be.

Commenting on a response to her article *"Illness as Deviance, Work as Glittering Salvation and the 'Psyching-up' of the Medical Model: Strategies for Getting the Sick 'Back to Work' "* (http://www.democraticgreensocialist.org/wordpress/?page_id=1716), Gill Thorburn says: *"I was appalled to discover what they have been doing to the ME community for so many years. Its nothing short of legitimised abuse. The one discouraging thing I've experienced in all my research so far has been discovering for how many years how much authentic evidence has been simply disregarded by those in power in favour of this spurious psychological approach. Some of the accounts on the net are simply heartbreaking, and it beggars belief that these people should have been allowed to continue with their 'methods' and 'theories'. As someone pointed out recently, they 'intervene' in peoples' lives with impunity, disregarding their negative effects, for which they are never held to account".*

A UK Government is democratically elected to look after the best interests of the nation and of its citizens, not to abuse and persecute the sick in favour of foreign corporate profits by imposing the "biopsychosocial model" that is promoted by UK psychiatrists who have vested financial interests in such a "model" because they work for the health insurance industry, whose profits benefit from its use.