

WARNING: UK Prime Minister's Strategy Unit on Mental Health

Eileen Marshall Margaret Williams 26th May 2005

On 24th May 2005 Tom Kindlon posted an item on Co-Cure from “spiked Online: Workers behaving sadly” by David Wainwright. That article ought to ring deafening warning bells throughout the ME community, as it sets out the planned implementation of the chilling policy about which previous warnings have been given: see for example “The Strasbourg Convention on Biomedicine and the Reform of the UK Mental Health Act” (<http://www.meactionuk.org.uk/strasbourg.html>) and “The Mental Health Movement: Persecution of Patients? (75 page document available at http://www.meactionuk.org.uk/SELECT_CTTEE_FINAL_VERSION.htm), to name just two of many attempts to draw public attention to the proposals to give far greater powers to psychiatrists to enforce compulsory psychiatric treatment upon both adults and children.

Put simply, people need to be aware of the relentless march of the Mental Health movement, because those proposals included provision for psychiatrists to be able to drug people, including children against the wishes of their parents, if they have “any disability of the mind **or brain**, whether permanent or temporary, which results in impairment of mental functioning” (“Mind control drug threat for children”. Anthony Browne, Health Editor, The Observer, 27th February 2000).

Currently, Myalgic Encephalomyelitis (ME) is a classified disorder of the brain, so could it fall into that category? It almost certainly will if, as anticipated, ME becomes subsumed into the heterogeneous label “CFS/ME” and becomes reclassified in the next revision of the International Classification of Diseases (ICD-11) as a “Functional Somatic Syndrome” as psychiatrists of the “Wessely School” intend.

As noted in “Time for a Reality Check at the UK Department of Health?” (see Co-Cure, 3rd April 2004), ME was recognised as an organic disorder on 27th November 1987 and this was documented in Hansard. On 15th March 1992, the Parliamentary Under Secretary of State for Health (Stephen Dorrell) confirmed in writing that (quote) “a physical cause for ME is recognised”, a confirmation that Mr Dorrell repeated on 16th August 1992 when he addressed a meeting of the Leicestershire ME Group at which, in his official capacity as a Minister of Her Majesty’s Government, he asserted that “ME is established as a medical condition”.

Seemingly official confirmation now counts for nothing, because in today’s climate of dictatorship in place of democracy, people with what are said to be mental illnesses must, as Wainwright says, “surrender a degree of sovereignty over (their) mental life”. Why this should be required only of those with ME and not of those with multiple sclerosis or other neurological disorders is not explained.

To quote Wainwright:

“The UK is mobilising an army of psychotherapists to get people off Incapacity Benefit. The therapeutic apparatus of the British state is poised to undergo a rapid and far-reaching expansion. At a recent meeting of the Prime Minister’s Strategy

Unit, the following were proposed: **five thousand extra psychotherapists to be trained in Cognitive Behavioural Therapy; a doubling of the number of psychiatrists, and all new GPs to receive training in psychiatry focusing on treatment of depression and anxiety in the community**".

(The recent promise by the British Government to create 7,500 new consultant psychiatrist posts is already on record -- see the blueleaf.net website of European Doctors: Psychiatry in the National Health Service: www.europeandoctors.co.uk).

It seems that people who were previously accepted as being physically sick but who are now deemed to be "mentally" sick are not to be tolerated because they are draining the country by being on Incapacity Benefit when, with a bit of brain-washing, they could return to work: those who are likely to be especially targeted are those who suffer from **"the creation of 'diseases' like chronic fatigue syndrome and fibromyalgia for which no evidence of physical pathology can be found"**.

It remains beyond comprehension how any "Strategy Unit", especially one at Prime Ministerial level, feels able to ignore the published evidence about the organic basis of ME/ICD-CFS that has been repeatedly put before the Prime Minister, Ministers of State, the Chief Medical Officer, the Chief Executive Officer of the Medical Research Council and the Lord Chief Justice, to name but a few to whom convincing evidence has been sent. That evidence includes proof of an organic pathoaetiology causing disruption of virtually all the major systems of the body, most notably the neurological, immunological, cardiovascular, respiratory, musculoskeletal and gastrointestinal systems, yet the State officials (and the psychiatrists who advise them) who determine what is or is not a "mental health" disorder seem determined to lump together all states of so-called medically unexplained "chronic fatigue" without differentiation and to impose the same management regime of graded exercise upon one and all.

Patronising promises that this regime will be "gentle" and will let the patient set the pace and that they can withdraw at any time are only for the gullible, because if patients do withdraw, they will automatically lose their right to state benefit and there is already evidence that in an existing clinic, CBT is being used to convince patients that their pain, insomnia, gut problems and allergies are simply somatisation and that these symptoms will resolve once a correct mode of thinking is achieved. There is also a worrying obsession with the patients' sex lives. Patients are told that using a support group is a retrograde step and are advised against it, and there is a refusal to refer people to a pain clinic or to offer any care other than anti-depressants. Is this is just what the Prime Minister's Strategy Unit hoped for?

It could be argued that no competent decision maker (and certainly no competent clinician) can rationally ignore the pressing need for sub-grouping as summarised in the document "Vilified but Vindicated" released on 29th April 2005 by Hooper et al (available online at [http://www.meactionuk.org.uk/Vilified but Vindicated.htm](http://www.meactionuk.org.uk/Vilified_but_Vindicated.htm)).

It is surely remarkable that it was in **1981** that Professor CS Goodwin of Perth, Australia, described ME so admirably (see Lancet 3rd January 1981 pp 37-38):

“In 1969, it was suggested that ME should only be diagnosed if neurological and muscle signs were found (Adamson JR. N Eng J Med:1969:281:798). Firstly, symptoms and signs in relation to muscles, such as recurrent episodes of profound weakness and exhaustion, easy fatigability, and marked muscle tenderness. Second, neurological symptoms or signs – pyramidal or cranial nerve lesions, especially affecting the eyes; or weakness of the peripheral muscles, as demonstrated by the voluntary muscle test; or some loss of peripheral sensation; or involvement of the autonomic nervous system (orthostatic tachycardia, abnormal coldness of the extremities, episodes of sweating or pallor, constipation and bladder disturbances). Thirdly, biochemical abnormalities such as raised urinary creatine, low serum pyruvate, or raised serum myoglobin, or an abnormal electrophoresis pattern with raised IgM”.

For the record, the Adamson 1969 reference to which Goodwin referred is unequivocal about ME: “Almost every conceivable neurologic sign has been described under the heading of (ME). It is clear that no progress can be made on defining the nature, cause or method of transmission of this disease until more exact criteria are set forth for the diagnosis”, but this cannot be achieved without properly focused research that, thirty-six years later, is being denied in the UK because it does not accord with Government “policy”.

How arrogant has medicine become that it now dismisses as irrelevant such clinical expertise and wisdom? It is to be noted that at the time, a response to Goodwin was published from May et al, who argued that epidemics of ME “are more than aggregates of cases, not least because ‘altered medical perception’ causes a variety of disorders to be lumped together”. This concept of the existence of ME being due only to ‘altered medical perception’ was formulated in 1970 by two psychiatrists (McEvedy CP, Beard AW: Concept of benign myalgic encephalomyelitis. BMJ 1970;1:11-15) and has been used not infrequently by Simon Wessely (for example: The chronic fatigue syndrome -- myalgic encephalomyelitis or postviral fatigue. Wessely S, Thomas PK. In: Recent Advances in Clinical Neurology No 6. Ed: C Kennard; pub: Churchill Livingstone, 1990: pp 85-132) to support his own belief that “ME is simply a belief, the belief that one has an illness called ME” (Microbes, Mental illness, the Media and ME: the Construction of Disease. 9th Eliot Slater Memorial Lecture, 12th May 1994: see

http://www.meactionuk.org.uk/wessely_speech_120594.htm).

It may be recalled that it was in the same lecture that Wessely asserted: “From the time of the Royal Free epidemic in 1955, the possibility that (ME) represented transmitted emotional distress was always present” and that ME “will be listed in the new revision of ICD-10 twice, once under neurology and once under psychiatry”. It took much effort (by people who chose not to claim the credit that was subsequently claimed by a UK patient association) before the UK Government was convinced that this was not permitted under the WHO rubrics.

It is indeed true that “altered medical perception” surrounds and dogs ME, but those who display this altered medical perception are in reality Wessely School psychiatrists themselves: they perceive only what they choose to perceive and insist

on lumping together all manifestations of “chronic fatigue” as one single entity that they claim is a functional somatic syndrome.

How is it that these psychiatrists insist on what they call “evidence-based” medicine for all medical disciplines apart from their own speciality of psychiatry, a branch of medicine in which double-blind, placebo-controlled trials are almost impossible to achieve and in which laboratory markers are notable for their absence and in which the diagnosis depends for the most part on the subjective opinions of the psychiatrists themselves?

Illogically it is these psychiatrists who, when presented with evidence of biomarkers that indicate that ME is an organic disorder, ignore these biomarkers in favour of emphasis and reliance upon non-organic factors such as “illness beliefs” and “personality” as “perpetuating factors”.

The importance of creatine excretion in the urine of patients is a case in point. Creatine is a sensitive marker of muscle inflammation and the knowledge that it is excreted by ME patients has existed in the literature since at least 1969, yet it took another thirty-two years for Wessely School psychiatrist Anthony Cleare to “discover” that patients with “CFS” were excreting significant levels of creatine in their urine, as well as other muscle related metabolites (choline and glycine). Cleare et al concluded that this might well represent ongoing muscle damage (382. Muscle metabolites detected in urine in fibromyalgia and chronic fatigue syndrome may suggest ongoing muscle damage. SCM Richards, A Cleare et al. Conference Proceedings of the British Society of Rheumatologists, Edinburgh, April 2001). Is it not therefore remarkable that, having themselves demonstrated this organic abnormality, it is the same psychiatrists who are promoting graded exercise as a blanket “therapy” for those with evidence of muscle inflammation?

Because of the stated intention of the MRC to use a set of criteria allegedly known as the “London” criteria, there is much current discussion about the various versions of the “London” criteria for ME/ICD-CFS, but it was twenty years ago in 1985 that Dr RW Gorringer from Cambridge, New Zealand produced his excellent “Diagnostic Criteria and Tests for ME”. These are descriptive and informative and of immense value, so why have they been largely ignored? They were available via ANZMES (Australia and New Zealand ME Society). They list the key concepts of easy fatigability, aching muscles, the tendency to a relapsing course, as well as the plethora of symptoms involving multiple organ systems, including ones that are rarely mentioned today but which do still occur in true ME, such as moist chest alternating with a cough, a tight chest, sore shoulder and neck muscles, oesophageal reflux, oesophageal spasm, oesophageal tenderness, chest pain that may be severe enough for hospital admission, forceful beating of the heart, shaky and tremulous muscles, jerkiness of limbs, shooting nerve pains, distended abdomen with pain, blurred vision, retinal inflammation and intermittent nasal congestion. Dr Gorringer also listed essential laboratory tests including immunological tests as markers of immune activity.

Excellent and accurate though they are, Dr Gorringer’s 1985 Diagnostic Criteria were not included in the Report of the UK National Task Force (Westcare, 1994) and are not mentioned in the current “CFS/ME” literature.

Yet again, this wealth of valuable information has been disregarded by “evidence-based medicine” and ME sufferers are relentlessly bullied into accepting the unproven psychiatric paradigm. How has medicine reached such an abysmal state in which patients are dismissed, derided, ridiculed and abused by the very people charged with helping and supporting them, and when signs such as liver involvement, hair loss, mouth ulcers, demyelination and cerebral oedema are either not looked for or dismissed as “aberrant beliefs” on the part of the patient? How much longer will it be before Wessely School psychiatrists will be compelled to accept that the disorder they are studying and which they patronisingly call “CFS/ME” is not ME? How much more evidence will these psychiatrists ignore because they are permitted to continue in their belief (welcomed by Government) that ME/ICD-CFS is a somatoform disorder?

What has happened to our country? Why is evidence dismissed or ignored? Where has integrity gone? Why are civil servants protected from accountability? Why has medicine sold out to industry? What now underpins our once-respected judicial system, because apparently the concept and practice of justice no longer does so? Why are people deemed to have no value unless they are contributing to the commercial prosperity of the State and its servants? Why is it apparently official policy of the General Medical Council that it is acceptable for doctors to deliberately withhold food and water from people regarded as “bed-blockers” in NHS hospitals in order to hasten their death? State control seems set to exert an ever-tightening grip to the point of strangulation on increasingly defenceless human beings.

To quote Wainwright again: “Layard estimates that mental illness costs £25 billion per annum. The cost of expanding mental health services may be high, but Layard calculates that every £1,000 spent on treatment will yield a return of £3,000. Others are also lobbying for expansion. The Sainsbury Centre for Mental Health has recently published a report that also calls for a widening of mental health services to see through the ‘unfinished revolution’ in mental health services begun in 1985 (Beyond the Water Towers: the unfinished revolution in mental health services 1985-2005)”.

It will be recalled that Lord Sainsbury has made financial donations in excess of £13.5 million to Prime Minister Blair’s New Labour Party, for which he was rewarded by being granted a title and the post of Minister of Science, a position that affords control of the Medical Research Council. Lord Sainsbury is currently Minister for Industry and, as noted in “The Mental Health Movement: Persecution of Patients?”, is on record as citing that British universities spun off 199 companies in 2000, up from an annual average of 67 in the previous five years. The UK’s ratio of companies to research spending is now more than six times higher than the US. Lord Sainsbury is quoted as saying: “It’s a dazzling record”. This involvement of vested commercial interests with medicine is a cause for concern, as noted by Professor Stephen Rose of the Open University Biology Department: “The whole climate of what might be open and independent scientific research has disappeared”.

Wainwright says: “There is an assumption that the speed of modern life has outstripped the human capacity to cope, both mentally and physically. The question for the government is how to defray the ballooning rates of Incapacity Benefit claims without derailing productivity and growth. The New Labour response to this dilemma

is not to stamp on the brakes but to make us better drivers. That is why Lord Layard's proposals for a radical extension of the therapeutic state apparatus have been so warmly received in Downing Street....the new army of psychotherapists will use techniques like Cognitive Behavioural Therapy (because) CBT recognises that it is not the speed of modern life that disables the worker, but his subjective response to it – a response that is highly malleable”.

The key word there would seem to be “malleable”: it will be recalled that in the Chief Medical Officer's Working Group Report of January 2002, CBT is described as “a tool for modifying attitude and behaviour”, so are we now entering Huxley's Brave New World in which the “rulers” exert mind control?

To reduce a complex multi-system organic disorder that is ME to mere fatigue, aberrant illness beliefs and a defective personality not only conveniently creates a pool of people who can be “controlled”, but degrades them by removing the idea that they have any free will.

That would seem to be a secondary consideration in the world of Brave New Labour, the main consideration being the return of a million Incapacity Benefit claimants to gainful employment: without doubt, those who are not genuine claimants should be identified and removed from benefit, but to target those with ME/ICD-CFS on the basis that they suffer from a mental disorder seems sinister indeed. Wainwright notes that CBT “might ameliorate symptoms, but it also gives rise to a new sense of selfhood; **one in which notions of autonomy may be fundamentally diminished**”.

Does this not constitute infringement of civil liberties and human rights?

It seems that for those who must somehow cope with the devastating neuro-immune illness ME (and the abuse by the ignorant that it still evokes), the Brave New World has arrived.

See Also:

Conflicting Concepts?

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http://www.meactionuk.org.uk/Conflicting_Concepts.htm
