Professor Wessely's presentation made several points.

1. The evidence for inequity in the funding of mental health services was overwhelming (see http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf).

2. There are several reasons for this, none of which are new. Stigma and discrimination remain at the forefront, linked with the poor "PR" image of mental health. Perhaps we will know we have finally turned a corner when the next Danny Boyle at the next Olympics salutes the Maudsley instead of Great Ormond St! He also pointed out that if we are to really engage with the public we need to acknowledge that stigma is not always totally irrational, and that also as a profession we had a duty not to create "over stretch" by extending the boundaries of disorder too far. The recent backlash against the proposed changes in DSM V was a warning in that respect. Sometimes "bookish" children are just that, and not Asperger's, and sometimes shyness is just shyness, and not social phobia.

3. Instead he chose to highlight the way in which the artificial distinctions that the way we organize the health service impact on inequalities in access, services, treatments and outcomes.

4. The increasing separation of physical and mental services that has been institutionalized in our system of acute versus community/mental health trusts has had some positive effects, for example in protecting resources for those with severe mental illness (SMI), but also some unintended consequences. The lack of integrated physical and mental health care does not reflect the reality of the comorbidity of physical and mental disorder and the reciprocal interactions between them. Those with chronic long term physical conditions have an increased risk of many mental health problems, which adversely impact prognosis. For example after an acute myocardial infarction depression has the same adverse impact as continuing to smoke. Patients with diabetes have worse mental health, and indeed improving that mental health not only improves quality of life, it also improves diabetic control. And it is a two way street. We also know that those with serious mental illness have on average a 15 year reduction in lifespan, largely caused by physical comorbidities.

5. This effect is seen most of all in the area of what we currently call medically unexplained symptoms and syndromes. Terminology is always tricky in this area, but what we mean are disorders associated with physical symptoms, impaired quality of life and disability, but no clear cut biomedical pathology as we currently understand it. At the same time there are also close links with both depression and anxiety.

6. These presentations continue to make up a considerable proportion of the work of primary care, and also are the commonest group of those attending new patient appointments in a wide variety of medical outpatient clinics. Yet at present management largely consists of excluding conventional diagnoses and little else. There are often perverse incentives within the structure of health care systems and payments that actively mitigate against, or alternatively provide no reward for, detecting for example common mental disorders.

7. We also know that this is an area in which there is good evidence that certain interventions, for example various forms of CBT and graded exercise programmes, are of proven and cost effective benefit. However, very few people even have the opportunity to receive such treatments.

8. The situation is different for severe mental illness, in which we know that the majority of sufferers are in contact with secondary care services, albeit of varying standards. There the problem is that so far the great advances that have been made in the neuroscientific understanding of disorder have not as yet been reflected in similar advances in treatments. However, in the area of many common mental disorders and the area of the unexplained symptoms/syndromes, there have been genuine gains in treatment over the last 30 years, but these have not been reflected in clinical practice.

9. Improving access to psychological treatment (IAPTS) is a policy initiative to address these gaps. However, it is unfortunately true that although the policy is sound, it is not always been implemented at local level. Furthermore IAPTS as currently configured will not address the problems of either long term conditions or unexplained symptoms/syndromes, because to do that, care will need to be delivered in tandem with, and in close proximity to, physical care. One optimal time would be when a patient is referred by a GP for a secondary care opinion in order to exclude for example ischaemic heart disease as a cause of chest pain, or Crohn's disease as a cause of change in bowel habit.

10. And for once just saying "improve GP recognition" may not be an answer. GPs have very little difficulty in recognizing chronic fatigue or chronic pain syndromes. What they do have difficulty is finding a service that both has an evidence based cost effective treatment to offer, and is situated in a setting that is acceptable to patients (ie not in a formal mental health setting but integrated alongside general medical care). The most common situation is that you either get no service, or a good service in the wrong place (not integrated), or you get a service (more often an individual) that is in the right place but offers the wrong treatment.

Finally Professor Wessely addressed the issue of the declining numbers of medical students opting for a career in psychiatry. There are many reasons for this, some long standing, others less so. However, in the context of the current talk he chose to emphasise the dangers of decoupling psychiatry from medicine, a situation which if allowed to continue would be a loss to medicine, and also a loss to patients. He concluded that it was for psychiatry to reinforce its medical origins, to relish the opportunities that will come from increased neuroscientific insights into the nature of mental disorders, and to oppose efforts to distance it from medical practice at primary and secondary care level, which is where so many of our patients are and expect us to be too