problems (CMHP) in the workforce [2] and the general population [4] has remained fairly stable over the past 20 years. Thus—without being alarmist—there is a continuing and costly problem which employers find difficult to manage. What can occupational health (OH) professionals do to help?

First, OH professionals are in a uniquely authoritative position to explain what CMHP are and what they are not. To do so, they will need to put their medical expertise into perspective. Perhaps a good starting point would be to eschew the terms 'mild' or 'moderate' when describing significant levels of mental distress. No one who is sufficiently distressed to seek medical help would describe themselves as having a mild depression. Henceforth, we should use the term CMHP which makes no presumptions about their severity or potential for becoming disabling. OH professionals can also explain that CMHP are not a life sentence, they are amenable to treatment and that most people recover and return to work after a comparatively short while. There is of course the need to be alert to the issue of 'presenteeism', when people insist on remaining at work until the situation has become so intolerable that it is hard to retrieve, but good communications between OH professionals and line managers can often pick this up.

Most important of all the OH professional is in the best position to explain that although medication is effective in managing crises and taking the edge off mood swings, mental ill-health leading to long-term absence from work or risk of job loss is not solely or even mainly a medical issue. Once the absence has reached 4–6 weeks, alarm bells should be ringing that the person is not recovering as expected [5]. The question the employer and the OH professional should therefore be asking is: what are the barriers to recovery and return to work that this person is experiencing [6]?

It is important at this stage to make no assumptions. It may be that the distress has been triggered directly by a situation in the workplace that must be remedied, for instance bullying or being in the wrong job. However, in most cases it is probably safest to assume that barriers to recovery are multiple and individual to the person concerned and located within their entire network of relationships. It follows therefore that the remedy will be found within the individual and his/her relationships. The focus of the rest of this editorial will be on how OH professionals can help the individual and the employer manage deteriorating relationships in the workplace and restore trust and confidence.

The emphasis on relationship problems is vividly expressed in interviews with users of a job retention case management service in Bristol [7]. The initial distress can become the trigger for a vicious circle of depression, anxiety, despair, loss of mastery and loss of self-confidence. This is often reinforced by breakdown in key relationships including but not exclusively those at work. The

Common mental health problems in the workplace: how can occupational physicians help?

Depression and anxiety are common and part of the human condition. Up to one in four of us will experience significant levels of mental distress in any 1 year [1]. However, despite rising levels of sickness absence [2] and incapacity benefit claims [3] attributed to mental ill-health, the prevalence of common mental health

longer the process of disintegration goes on the harder it is to retrieve the situation.

The first key point for intervention is therefore the point when it becomes clear that the person is not recovering as expected and doubts have started to creep into relationships with colleagues, managers and the company. We have already indicated that this point can be reached in as little as 4–6 weeks. It is possible to screen for risk of long-term absence [5], but most employers will have to rely on informal assessment. The important thing at this stage is to ensure that the employer keeps in touch on a regular basis and at least once in every 2 weeks [8]. OH professionals can facilitate this process and offer guidance on what to say.

The next thing is to ensure that everyone involved is working together—especially the treating physician (usually the general physician), the line manager and the human resource department. Working together in this instance means, *inter alia*, giving out the same messages of reassurance and expectation of recovery. This requires an element of case management [9]. Occupational physicians and especially occupational therapists are often at least partially prepared by their training to fulfil this role [7]. For many people, a phased return will be necessary [7] and it is often helpful if this is supported by medical authority. It is especially helpful to have a clinician available to talk to the treating physician and to negotiate a joint approach.

However, simply keeping in touch with the individual and waiting for the treatment to work may prolong absence unnecessarily. Indeed, there is some evidence that raising GP awareness of untreated depression can actually reduce labour market participation [10]. Once a person has accepted the patient role, they may need help in refocusing their thoughts on becoming the active, coping person they were before the bout of depression. There is strong evidence that a short course—up to eight sessions—of cognitive behavioural therapy (CBT) can help enhance confidence and coping skills and reduce negative thinking [11].

However, CBT is not a magic bullet. It is not necessarily suitable for everyone or for all types of employment situation. It will not work if the workplace situation and relationships remain toxic. It will not help someone if they are in the wrong job. It seems to be more effective for people in high control occupations. A recent review of workplace interventions for people with CMHP [11] found good evidence in favour of CBT but also limitations in the evidence base which suggest that more attention should be paid to developing and evaluating a range of prevention strategies and cognitive educational tools which enable the interventions to be matched with the particular needs of the individual and the job.

What can OH professionals do to prepare themselves for managing these issues more successfully? Not everyone can or wants to become a cognitive behavioural therapist, but everyone can learn the principles of case management and everyone can learn simple techniques for talking confidently and therapeutically to people suffering depression or anxiety. Usefully the same principles apply to more serious mental health problems; the barriers are much the same, it is just that the stigma is greater. Motivational interviewing [12] and solution-focused approaches [13] have been found to be very helpful and can be safely learned by everyone who has contact with people who need to change self-defeating thoughts and behaviour.

Perhaps the most important thing of all however is to learn (and to help others to learn) how to normalize mental distress. This may sound paradoxical—normalizing the abnormal—but top of the list of barriers to returning to work cited by people with mental ill-health is fear of stigma and discrimination [14,15] which is unfortunately often well justified. To overcome this, it is necessary for those who know about the nature of mental ill-health to be able to speak about it as something which is known, normal and manageable. Health professionals sometimes tend to reify and pathologize mental distress and to shy away from dealing with the mess of strained or broken relationships it leaves in its wake. We must all now learn to use clinical skills, knowledge and authority to demystify CMHP and engage with those who experience it in ways that reduce fear and stigma and help them rebuild their relationships and their lives.

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