



Healthy Brains at Work.

Creating the Conditions for Healthy Brains in the Workplace

At a Glance

- Early diagnosis provides significant opportunity for recovery among Canadians living with a mental illness.
- Emerging and innovative practices suggest some employers are exploring ways to innovate in the programs and benefits they offer.
- An incremental improvement in functionality for those living with depression and/or anxiety produces significant improvements for Canada's economy.
- Effective mental health strategies must be accessible at an early age, provide effective supports and address gaps for those in precarious employment.

Executive Summary

Although mental health and well-being are a priority issue in Canada, reducing the significant individual, business, and societal burden of mental illness is challenging and the conditions to address this burden need to be in place. As significant benefits for both employers and employees can be realized by addressing mental health and illness among the working population, the Healthy Brains at Work research series focuses on the role of the employer in addressing mental health and mental illness in the workplace.

The first three briefings explored data on mental health conditions in the employed population, discussed survey findings of mental health supports currently offered, and estimated the potential impact of optimizing effective mental health benefits and workplace programs. This final briefing in the series investigates the conditions that support mental health in the workplace and presents scenarios where mental health supports are optimized among working Canadians. It builds upon the results of the third briefing by looking at the functionality and economic cost of depression and anxiety for specific age cohorts over time and quantifies the effects of optimal and incremental improvement.

Finding the optimal treatment for an individual is challenging, but an early, optimized approach (early diagnosis with rapid, personalized treatment) is reported to provide significant opportunity for symptom and functional recovery. To be fair, many factors influence the treatments being used, including clinical effectiveness, individual preference and response, provider practices, accessibility, and financial considerations. Emerging practices in areas such as enhanced paramedical services, personalized approaches to treatment, and targeted supports for select populations are innovative programs being offered by employers.

Canada's mental health agenda should include focused actions to address mental health in its working population and youth.

Addressing some of the gaps in access to workplace supports and benefits has led to efforts involving government programs in some jurisdictions.

With that in mind, if all employed Canadians living with depression received optimal treatment, over 1.2 million Canadians living with depression could be working full time and fully functional. Higher productivity would contribute an additional \$32.3 billion annually to Canada's economy—\$2.6 billion from those aged 15–24, \$13.2 billion from those aged 25–44, and \$12.6 billion from those aged 45–64. Meanwhile, if all employees living with anxiety received optimal treatment, an additional 545,000 Canadians would be fully functional at work and a significant number who were previously unable to work would be able to enter the workforce. At a higher productivity level, Canada's economy would gain approximately \$17.3 billion a year—\$837 million from those aged 15–24, \$7 billion from those aged 25–44, and \$8.3 billion from those aged 45–64.

These two scenarios present a world where each Canadian living with depression/anxiety achieves the highest level of functionality due to optimal treatment. However, a more realistic scenario of incremental improvement in functionality would also lead to significant gains. A 10 per cent improvement would lead to over \$1.2 billion in economic impact—\$109 million for those aged 15 to 24, \$563 million for those aged 25 to 44, and \$534 million for those aged 45 to 64. Similarly, a 10 per cent improvement in functionality for those experiencing anxiety would lead to a GDP increase of \$681 million—or \$35 million, \$295 million, and \$351 million for the respective age groups.

Reduced functionality has a significant impact on workers experiencing depression and/or anxiety, and the negative impacts could persist over an individual's entire working life if left untreated. In particular, substantial benefits can be gained by addressing mental illness in youth, as they have a longer work life and early interventions will hopefully prevent future relapses. Canada's mental health agenda should include focused actions to address mental health in its working population and youth.

Key elements of an effective mental health strategy include accessing mental health supports at an early age, providing supports during key transition points, addressing gaps for those in precarious employment, and ensuring supports are effective.

The Healthy Brains at Work research series has added to the overall body of research showing the significant individual and economic impacts if the conditions to support employee mental health are in place. Canada must ensure its mental health agenda includes focused actions to address the mental health of its current working population, including its youth, who will be the workforce of tomorrow.

Introduction and Background

Mental health and well-being are a priority issue in Canada. High-profile public awareness campaigns, along with efforts of the Mental Health Commission of Canada and other key stakeholders, have helped bring attention to mental health and mental illness. Despite these efforts, progress in addressing the significant individual, business, and societal burden of mental illness remains a challenge.¹ It is critical that the conditions to address this burden are in place and good mental health and well-being are fostered among Canadians.

The Healthy Brains at Work research series explores the employer role in addressing mental health and mental illness in the workplace. The sector, occupation, and demographic analysis presented throughout the series has created a compelling case for action and provided insights on a targeted role among Canadian employers.

Significant benefits for employees and employers can be realized by addressing mental health and illness among working Canadians. This final briefing builds on previous findings and insights shared through the project's advisory committee.² It explores the conditions that support this objective and presents a scenario where mental health supports are optimized among working Canadians.

¹ Jorm and others, "Has Increased Provision."

² See the acknowledgements section for the project advisory committee membership.

The Healthy Brains at Work Series

The Healthy Brains at Work research series explores the importance of addressing mental health and mental illnesses³ in Canadian workplaces. Its objectives are to:

- explore what is known, and not known, about the profile of mental health and mental illness among working Canadians (including by industry/occupation).
- understand what is being done in the workplace to address mental health and mental illness and how this compares with evidence-based guidelines, recommendations, and standards.
- estimate the potential impacts from greater uptake of effective workplace programs and benefits as they relate to mental illness—particularly depression.

The series comprises four briefings:

Briefing 1: *The Footprint of Mental Health Conditions.* This first briefing explored data on mental health conditions in the employed population. The prevalence of mental health disorders is significant among employed Canadians, with workers in the services industries experiencing the highest occurrence of mental illness over their lifetime.

Briefing 2: *Healthy Brains at Work: Employer-Sponsored Mental Health Benefits and Programs.* The second briefing explored findings from the Conference Board's survey of Canadian employers on the mental health supports currently offered in the workplace. It also highlighted leading workplace mental health strategies, programs, and benefits through employer case studies.

Briefing 3: *Estimating the Impact of Workplace Mental Health Benefits and Programs.* The third briefing of the series builds on the Conference Board's economic modelling expertise to estimate the potential impact if the use of effective mental health benefits and workplace programs were optimized in Canada. Insights from the results for businesses, health, and policy stakeholders are included.

Briefing 4: *Creating Conditions That Support Healthy Brains at Work.* The final briefing synthesizes findings from the series and discusses existing and emerging workplace programs practices, therapies, and treatments. The briefing

3 Refers to the DSM-IV classification of mental illnesses.

presents results from a scenario exercise that considers the potential impact of optimizing supports and implementing innovative programs and treatments through these supports.

The objectives of this briefing are to:

- highlight key findings from the research series to date;
- explore the conditions that support healthy brains in the workplace and the opportunities and challenges in creating these conditions;
- consider the potential economic impacts by age cohorts, and whether modest progress toward these conditions is achieved;
- discuss the implications of these findings for key stakeholders.

Creating the Conditions for Healthy Brains in the Workplace

Briefing 1 of the series showed that mental illness can affect anyone, regardless of age. However, there is a significant burden among youth, with the prevalence of mood disorders highest among those 15–24 years of age, compared with all the other age cohorts.⁴ Roughly 7.1 per cent of those between ages 15 and 24 have lived with a depressive episode within the last year.⁵

Furthermore, in some industries, more than 15 per cent of the workforce has lived with either a mood disorder or generalized anxiety disorder in their lifetime.⁶ Certain industries, such as accommodation and food services, are notable for both the higher prevalence of mood disorders among the workforce and the high number of younger workers employed in those workplaces. Young workers may experience more precarious employment (such as part-time and temporary work)⁷ where they may not have access to workplace benefits that support their health and wellness.

4 Statistics Canada, Canadian Community Health Survey.

5 Statistics Canada, CANSIM table 105-1101.

6 Statistics Canada, Canadian Community Health Survey.

7 Statistics Canada, “Perspectives on the Youth.”

While many employers are placing increased attention on the mental health of their employees, briefings 1 to 3 of the series revealed significant opportunity and benefits for individuals, workplaces, and society in ensuring the availability and uptake of effective and evidence-based approaches. Many approaches and treatments exist, but research suggests that implementation should also receive greater attention.⁸ Thus, innovation in workplace programs, and benefits, and mechanisms for implementation are critical. Integrated strategies across business, governments, and public health are also needed to address mental health and mental illness among younger people.

Workplace Mental Health Strategies, Policies, and Programs

Briefing 2 of the series explored some of the hallmarks of good practice among employers along with insights, by industry, into the actions some employers are taking to address mental health and mental illness in their workplace. (See “Hallmarks of Good Practice Among Employers.”)

Hallmarks of Good Practice Among Employers

- a comprehensive mental health strategy;
- a mental health policy;
- benefits, including coverage for evidence-based medications and paramedical services;
- employee assistance programs (EAPs) for short-term help;
- leave options;
- supportive programs, such as modified work schedules or flexible work arrangements to attend medical appointments, peer support programs, mental health training, and education.

Source: *Chénier and Boyer*.

As highlighted in that briefing, the adoption of a comprehensive mental health strategy (a detailed and integrated plan of action) and a

8 Jorm and others, “Has Increased Provision.”

Employers in the public sector were more likely to have implemented a mental health strategy compared to those in the private sector.

mental health policy is an important part of creating the conditions that support mental health and address mental illness in a workplace. A comprehensive approach integrates programs, practices, benefits, and policies into an overall mental health strategy. By adopting this approach employers demonstrate commitment to workplace mental health, understand employee needs through risk analysis, and provide targeted, measurable programming based on these needs.

Survey results from the briefing found that only 39 per cent of employers had implemented a mental health strategy and 42 per cent had a policy to address mental health in the workplace.⁹ Barriers for those that hadn't implemented a strategy include lack of financial and human resources or time.

The survey also showed that those in the health, education, finance, insurance and real estate, public administration, and utilities sectors were more likely to have implemented a mental health strategy. Employers in historically male-dominated industries like transportation and warehousing, manufacturing, construction, and natural resources were less likely to have implemented a mental health strategy. Moreover, employers in the public sector were significantly more likely to have implemented a mental health strategy compared to those in the private sector.

For employers that had implemented a mental health strategy, guidelines and tools were part of their efforts in ensuring that workplace conditions support mental health and address mental illness. One tool organizations can use is the Mental Health Commission of Canada's (MHCC) National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard)—a set of resources to help employers adopt a more strategic approach to promoting psychological health at work and to prevent psychological harm due to workplace factors.

Over the time frame of the Healthy Brains project, some employers have moved ahead with implementation of the Standard and shared their experiences. For example, the MHCC sponsored a three-year case study research project on workplaces that have implemented

9 Survey respondents were largely medium-sized and large organizations.

the Standard. A new report presents the results based on the 40 participating organizations.¹⁰ Organizations were followed to report on their implementation journey on all five elements of the Standard:

- Commitment and Policy
- Planning
- Implementation
- Evaluation and Corrective Action
- Management Review

Results showed that significant progress was achieved, particularly with the last two elements. Commitment, leadership, communication, adequate resources, measurement of results, and a strong business case were among the promising practices. Barriers to implementation included data, definition, and reporting challenges, and inconsistency with leadership support. Organizations must dedicate time and funding for those responsible for implementing the Standard. Some organizations had sufficient capacity, others added capacity, and others were challenged to provide this. All organizations took some action such as enhancing mental health knowledge throughout the workplace and ensuring that managers have appropriate training and skills.

As the first major evaluation of Canadian organizational experience with the Standard, these results provide important insights for other employers as they promote psychological health in their workplace. It will be important to continue learning as others implement the Standard. The challenges and opportunities that small businesses encounter will also be critical to understand.

Other tools and resources are available and accessible for all employers regardless of the size of the organization. For example, Ottawa Public Health and the MHCC collaborated to create a series of videos accessible for all employers to facilitate talking about the key factors in the MHCC Standard.¹¹ The Conference Board has seen tremendous uptake in its workshop series *Managers Leading Mentally Healthy Workplaces*, with interest in areas such as coping and resilience

¹⁰ Mental Health Commission of Canada, *Case Study*.

¹¹ Ottawa Public Health, "Have That Talk."

training, supporting managers and training leaders, and ways to have conversations about mental health in the workplace.¹² Collectively, these developments help employers build knowledge and expertise to provide optimal employee mental health supports.

Mental Health Treatments and Employer-Sponsored Benefits

Treatments for mental illnesses are variable and can range from pharmacotherapy and/or psychotherapy to other approaches.¹³ Evidence-based clinical guidelines from the Canadian Network for Mood and Anxiety Treatments (CANMAT) are available for health professionals as they develop treatment plans for individuals diagnosed with mood and anxiety disorders.^{14,15} In some cases, these treatments can lead to recovery from a mental illness. (See “Recovery Is Possible.”)

Recovery Is Possible

The Mental Health Strategy for Canada defines recovery as living a satisfying, hopeful, and meaningful life, even when there may be ongoing limitations related to mental health issues. Recovery starts with the fundamental belief that recovery is not only possible for people living with mental health problems and illnesses, but should be expected regardless of diagnosis or situation.

With the right combination of services and supports, many people who are living with even the most severe mental illnesses can experience significant improvements in their quality of life. But recovery does not imply a “cure”—it is a process marked by both achievements and setbacks, ending with individuals taking charge of their mental health and well-being. Each person’s journey of recovery is unique, but they are not alone. Their journey takes place within the social, family, political, economic, cultural, and spiritual context that affects their mental health and well-being.

12 Charles Boyer (Research Associate, CBoC), e-mail communication to Greg Sutherland, April 25, 2017.

13 O’Donnell and others, “Use of Medication.”

14 Lam and others, “CANMAT 2016 Clinical Guidelines.”

15 Kennedy and others, “Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines.”

New ways of delivering treatment are among the emerging opportunities on the horizon.

Analysis by the Public Health Agency of Canada (PHAC) provides insights on treatments that Canadians (not just those employed) access for mental illness.¹⁶ According to 2014 survey data, the majority (81.8 per cent) of Canadian adults with a mood and/or generalized anxiety disorder had taken prescription medications and/or received psychological counselling in the past 12 months.¹⁷ Nearly half of them reported taking medications only, compared to 6.9 per cent who received counselling only; 27.3 per cent received both forms of treatment; and 18.2 per cent reported receiving neither. Those who reported having neither treatment were more likely to be younger.

Even with the range of effective treatments available, finding the optimal treatment for an individual can be challenging.¹⁸ There is no one-size-fits-all treatment, but an early, optimized approach (early diagnosis with rapid, personalized treatment) is reported to provide the greatest opportunity for symptom and functional recovery in the case of major depressive disorder.¹⁹ In practice, many factors influence the type of treatment(s) used, including clinical effectiveness, individual preference and response, provider practices, accessibility, and financial considerations.²⁰

New ways of delivering treatment, such as using technology for psychological supports,²¹ and personalized treatments are among the emerging opportunities on the horizon. (See “Targeted Treatment for Major Depressive Disorder.”)

Targeted Treatment for Major Depressive Disorder

The phrase “one size doesn’t fit all” is increasingly seen as key to the treatment and supports for individuals experiencing a mental illness—particularly

16 O’Donnell and others, “Use of Medication.”

17 Ibid.

18 Felix, “The Promises and Perils.”

19 Habert and others, “Functional Recovery.”

20 O’Donnell and others, “Use of Medication.”

21 Sun Life Financial, “Sun Life Financial to Launch Online Therapy.”

depression. In fact, patients with major depressive disorder (MDD) may have only a few symptoms, or even just one symptom, in common.²² As a result, the differences in how individuals respond to and/or tolerate antidepressant treatments, together with research pointing toward the genetic association in antidepressant response, has led researchers to search for more personalized approaches to treatment (known as pharmacogenetics).²³

A large collaborative research network is working to better understand the potential of a personalized approach to treatment. The Canadian Biomarker Integration Network in Depression (CAN-BIND) research program is searching for clinical and biological markers of an individual's response to treatment for major depressive disorder.²⁴ Identifying these biomarkers could help care providers develop a personalized approach to treatment for individuals, and ultimately improve outcomes.²⁵ The first phase of CAN-BIND is focused on medication therapy, with additional work to consider other evidence-based therapies, including cognitive behavioural therapy, cognitive remediation, and transcranial magnetic stimulation.²⁶ Results are not yet available from this program, but as they emerge, it will be critical for employers to understand the recommendations from this research.

Insurers have started to explore pharmacogenetics as a possible way to help foster more effective treatment earlier in the course of an individual's illness, achieve better outcomes, and allow the individual to return to work earlier.²⁷ For example, Sun Life has announced that plan members on leave for depression and anxiety will be offered an opportunity to take part in a study on the impact of pharmacogenetic testing.²⁸ Sun Life has partnered with Assurex Health and the Centre for Addiction and Mental Health on the IMPACT study evaluating the potential benefits of finding a more effective medication sooner for those individuals, where it is part of their treatment plan. The findings will help Sun Life, and others in the industry, better understand the potential of pharmacogenetics in benefits programs.²⁹

22 Van Loo and others, "Data-Driven Subtypes of Major Depressive Disorder."

23 Rosenblat, Lee, and McIntyre, "Does Pharmacogenomic Testing."

24 Canadian Biomarker Integration Network in Depression, "CAN-BIND."

25 Lam and others, "Discovering Biomarkers."

26 Ibid.

27 Lee, "Sun Life to Look."

28 Sun Life Financial, "Pharmacogenetics."

29 Lee, "Sun Life to Look."

About 11 per cent of Canadians have no drug coverage, and 20 per cent report being uninsured or underinsured.

However, it must be noted that a recent systematic review found that initial, promising findings in pharmacogenetics are tempered by the need for additional, replicable evidence demonstrating improved clinical outcomes and cost-effectiveness.³⁰

Benefits provided through an employer, including prescription drug coverage, employee assistance programs, and paramedical services (e.g., psychotherapy or counselling), can facilitate access to the evidence-based services and treatments detailed in the CANMAT guidelines and reduce the financial barriers that individuals may experience in seeking support. Findings from Briefing 2 indicate that most employers who responded to the survey offer these benefits to their full-time permanent employees.³¹

What is more, the Conference Board's *Benefits Benchmarking 2015* report found that the average reimbursement level for prescription drug plans (for those with one set reimbursement level) was 89 per cent.³² A minority reported having a plan maximum (annual or lifetime amount they will reimburse) for prescription drugs. Benefit plan parameters (such as generic substitution, step therapy, caps, or prior authorization) can vary depending on the offerings of insurers and choices made by employers for the plans they offer. Employers must balance providing broad access to evidence-based treatments that optimize outcomes and health with costs and sustainability of the benefits they offer.³³

The Healthy Brains series has focused on the working population and employer supports. However, except for Quebec, private plans are voluntary.³⁴ About 11 per cent of Canadians have no drug coverage, and 20 per cent report being uninsured or underinsured, with the latter more likely to work in small and medium-sized organizations; be employed part-time and in a non-union environment; and earn low wages.³⁵ The

30 Rosenblat, J. and others, Does Pharmacogenomic Testing.

31 Survey respondents were mainly medium-sized and large.

32 Stewart, *Benefits Benchmarking 2015*, 25.

33 Herbert and Po, *Express Scripts Canada*, 13.

34 Morgan and Boothe, "Universal Prescription."

35 *Ibid.*, 248.

extent to which employers that do not provide benefits or limited benefits can be encouraged to address this shortfall is unclear.

A recent, and promising, initiative is the Government of Ontario's OHIP+, which will, as of January 2018, provide free prescription medications with no upfront costs for children and youth 24 years or younger.³⁶ Considering the earlier figures showing the higher prevalence of certain mental illnesses among youth, reducing financial barriers to pharmaceutical treatment for young working Canadians, who may not otherwise have coverage through work, is important.

As noted in Briefing 2, the average reimbursement level for paramedical services (e.g., psychotherapy or counselling) was 92 per cent of all services per year. Most employers that provide paramedical services, including coverage for psychotherapy, have maximum reimbursement amounts (median of \$1,000), usually as a combined maximum covering all types of paramedical services (such as massage therapy or acupuncture). This means that even for employees with benefits, the coverage may be inadequate for their mental health needs.

Some employers have redesigned their benefit offerings to include a more targeted focus on mental health paramedical supports. Sun Life, for example, removed the psychological benefit from the combined maximum for paramedical benefits for their employees, expanded the type of mental health professionals reimbursed for, and increased the amount to up to \$12,500 (including family members), with the goal of removing as many barriers as possible for the use of a psychological benefit.^{37,38} Similarly, Manulife has separated its coverage for mental health providers for its own employees and increased the amount to \$10,000 (which includes services for family members).³⁹ Starbucks, an employer whose average workforce age is 24 years, has undertaken a similar initiative, boosting its coverage for therapy to \$5,000 annually.⁴⁰

36 Government of Ontario, "Free Prescription Medications."

37 Chénier and Boyer, *Healthy Brains at Work*.

38 Sun Life Financial, "Walking the Talk."

39 Lee, "Manulife Boosts."

40 Andressen, "Why Starbucks."

Early access to optimal mental health supports and treatment is important for increasing the likelihood of recovery.

These changes are promising developments in ensuring those requiring treatment and support can access the care they need. Recent international efforts to provide publicly funded psychotherapy are also noteworthy for helping to reduce barriers, particularly for those without access to private coverage.

England, for example, has committed to improving access to psychological therapies for people with anxiety and depression.⁴¹ The government's National Health Service offers evidenced-based, no-cost talk therapy at clinics across the country.⁴² The significant data and analysis generated through the initiative are said to provide an immense opportunity to understand the real-world effectiveness of the program. The program has become so popular that wait-lists have emerged, prompting the exploration of new forms of online therapy programs—said to be especially attractive for younger men who may otherwise not seek out face-to-face therapy.

Collectively, these innovative approaches in expanding access to paramedical services provide important insights for Canada, for both employer-sponsored benefits and the role of publicly funded mental health supports.

Employee assistance programs (EAPs) or employee and family assistance programs (EFAPs) are a central component of many employer benefit packages. These programs have been found to improve the symptoms, function, and productivity of individuals with depression or other mental health conditions.⁴³ Supports offered through EAP can provide critical health promotion and early intervention for those who access the services.

The MHCC case study research project described earlier found that a key action undertaken by organizations to address psychological health and safety is the provision of EAP services tailored toward mental health promotion.⁴⁴ (See “Mental Health Promotion and Prevention.”) Early

41 NHS England, “Adult Improving Access.”

42 Carey, “England’s Mental Health Experiment.”

43 Chénier and Boyer, *Healthy Brains at Work*, 27.

44 Mental Health Commission of Canada, *Case Study*.

access to optimal mental health supports and treatment is important for increasing the likelihood of symptomatic and functional recovery.⁴⁵

Mental Health Promotion and Prevention: The BroMatters Project

The BroMatters: Healthy Minds for Working Men research project is targeting innovative ways to prevent major depression among working men. Men are not as likely as women to seek help for symptoms relating to depression and may delay seeking help until symptoms become severe.⁴⁶ This project is focused on early identification and prevention and targets working men who do not have depression but are at high risk. It aims to increase knowledge and awareness of depression and reduce stigma in accessing supports.

Through an interdisciplinary partnership, the research explores strategies and self-management tools effective in reducing the impact of mental health issues for working men. The ultimate aim is to create and disseminate a web-based e-mental health program, mobile, and resources (personalized online and telephone coaching supports) to facilitate self-management, self-care, and self-help.

An additional emerging practice, noted in the MHCC case study research project, is organizations increasingly using data to gain a better understanding of employee mental health.⁴⁷ These data include EAP utilization rates, return-to-work and accommodation data, and long- and short-term disability rates.⁴⁸ As employers gain improved insights into the supports that employees require and use, they will be able to make more informed decisions about future benefits, programs, and policies.

In summary, emerging practices in areas such as enhanced paramedical services, personalized approaches to treatment, and targeted supports for select populations suggest some employers are exploring ways to

45 Habert and others, "Functional Recovery."

46 BroMatters, "The Project."

47 Mental Health Commission of Canada, *Case Study*.

48 Ibid.

innovate in the programs and benefits they offer. The Healthy Brains at Work series has highlighted the importance of addressing mental health in industries where the prevalence of mental illness is higher, as well as targeting mental illness in youth. Addressing gaps in access to workplace supports and benefits is also key, and efforts have been taken in some jurisdictions to close these gaps through government programs.

Optimizing Mental Health Supports and Treatment in the Workplace: A Scenario Analysis

In the third briefing of the series, we presented estimates of the potential impact on the economy if the use of effective mental health benefits and workplace programs was optimized in Canada. Our simulation exercise concluded that improved treatment of depression among employed Canadians could boost Canada's economy by up to \$32.3 billion a year. Improved treatment of anxiety among Canadians could boost Canada's economy by up to \$17.3 billion a year. These estimates illustrate the significant benefits to be realized for individuals, businesses, society, and the economy by addressing mental health and illness among working Canadians. This fourth briefing dissects these results further, pinpointing the segments of the working population that could benefit the most from the improved treatment of mental illness.

Approach and Methodology

Replicating the methodology from the third briefing, the Conference Board outlines the extent to which people with mental illness are unable to work; able to work part time; able to work, but with reduced functioning; or fully able to function at work with their symptoms. Accessing data from the 2012 Canadian Community Health Survey (CCHS), specifically the Mental Health Profile, which includes data on mood disorders (with a specific breakdown for major depressive episodes and bipolar disorders) and generalized anxiety disorders, enables us to apply weights to each functional category.

This approach allows the Conference Board to estimate the impact of mental illness on the economy while considering the different levels of functioning that are evident among the population of Canadians living

with poor mental health. These levels of functioning are independent of the treatment needed—some individuals currently on medication can exhibit functional limitations for an extended period.^{49,50} Thus, for the purposes of this briefing there are several limitations to the methodology. (See “Methodological Limitations.”)

Methodological Limitations

Despite our best efforts, it is difficult to take into account every nuance at play with mental disorders. Therefore, we outline possible shortcomings with our classification of mental illness.

For instance, our methodology does not factor co-occurrence. Each mental illness is not necessarily independent of the others. Any person living with major depressive disorder, for example, may also possess symptoms of dysthymia (or persistent depressive disorder). Some sources even say that the co-occurrence of depression and anxiety is around 50 per cent.^{51,52} Therefore, it is difficult to separate the effects of each condition. Multiple diagnoses were more likely to result in patients being unable to work or not returning to full-time work.

Optimal treatment is defined as any pharmaceutical or therapeutic treatment, or a combination of both, that enables someone with depression/anxiety to work full time and be fully functional while at work.

For the purposes of our study, *full-time work with reduced functioning* includes those who are working full-time hours, but with accommodation or in a different role/job description. This is presumed to include those who have just recently returned to work from a disability leave. It also includes those affected by presenteeism. By the same token, *fully functional* equates with returning to the same or similar pre-illness position and hours.

Our methodology supposes that there is no comorbidity with physical illness. Depression is common for those with a chronic physical illness.^{53,54,55} As well,

49 Nil, Lütolf, and Seifritz, “Residual Symptoms and Functionality.”

50 IsHak and others, “Patient-Reported Functioning.”

51 Hirschfeld, “The Comorbidity of Major Depression.”

52 Cameron, “Understanding Comorbid Depression and Anxiety.”

53 Ruttley and Reid, “Depression in Physical Illness.”

54 Olver and Hopwood, “Depression and Physical Illness.”

55 Smyth, “Depression in Physical Illness.”

reduced functioning due to physical illness could also be related to a mental illness, contributing to depression's growing economic impact.⁵⁶

Our methodology also presumes that there is no comorbidity with substance use, which is common in individuals with co-occurring mental disorders.

Research shows that mental illness is the most important risk factor for suicide and that more than 90 per cent of people who commit suicide have a mental or addictive disorder.⁵⁷ Despite this, the direct economic costs of premature mortality due to suicide are not measured.

The data included in this briefing suggest that mental illnesses are more common in women. Although women are treated more often, it is not clear if they suffer more than men. Indeed, the rate of suicide is much higher in men.

Although our methodology considers the age of individual living with a mental illness, with prevalence on the rise among young people, many are living with symptoms even before they enter the workforce. In fact, bipolar, social anxiety, and panic disorders are more common in youth and can even prevent people from working in the first place.⁵⁸

The next step calculates the economic activity that could be gained if the functional limitations of poor mental health on working Canadians were fully mitigated. The analysis in this briefing takes an existing “base case” scenario and compares it with a simulated scenario that increases both employment and workplace functionality resulting from the successful implementation of effective workplace benefits and programs dealing with mental illness. The difference between the “base case” scenario and the simulation becomes an estimate of the benefit of addressing mental illness in the workplace. To estimate the economic impact of mental illness in the workplace, The Conference Board of Canada combines its own economic data with the CCHS data.

By taking a closer look at the breakdown by age, we can estimate how each age group (i.e., 15–24 years, 25–44 years, 45–64 years)

56 Rubin, “Mental Disorders Linked With Chronic Disease.”

57 Navaneelan, *Suicide Rates*.

58 Wilkerson, *Mental Health in the Workplace*; Bill Wilkerson (Executive Chairman, Mental Health International), in-person interview by Greg Sutherland, January 6, 2016.

contributes to the economic impact of mental illness. The contribution of each age group to the impact of mental illness is determined by estimating an average level of productivity for each age category. Unfortunately, Statistics Canada does not publish GDP data by age group. Therefore, the Conference Board must estimate this contribution by age using the difference in average employment income across age groups.⁵⁹

Once an average level of productivity is estimated for each age group, the contribution of each age category to the impact of Canadians living with a mental illness is determined over the working life of each of these age groups. Briefing 3 estimated the impact of depression on the Canadian economy at about \$32.3 billion (\$17.3 billion for anxiety) in one year. But over the working life of Canadians, the cost is significantly higher. For instance, in the 15–24 age group, the average remaining working life is 45 years. In the 25–44 age group, the average remaining working life is 30 years. In the 45–64 age group, the average remaining working life is 10 years. Therefore, the impact over the working lives of Canadians is determined by calculating the present value of the impact of depression and/or anxiety over the remaining years of working life.⁶⁰ The present value of the impact is inflated at a rate of 1 per cent per year (the average productivity growth in Canada from 1996 to 2012), and discounted at a rate of 3 per cent (the approximate average prime rate over the past five years).⁶¹

Scenario Results

Working Life Estimates

Mental illness can have a significant impact on workplace performance. Mental illness can contribute to absenteeism (absence from work) and presenteeism (coming to work while sick, and consequently, working under suboptimal conditions). In 2011, The Conference Board of Canada released *Building Mentally Healthy Workplaces*, based on a survey of more than 1,000 employees nationwide. Of the survey respondents,

59 Statistics Canada, CANSIM table 206-0052.

60 This analysis presumes that depression or anxiety persists over the entire lifetime of the individual.

61 Conference Board of Canada, The, Canadian Forecast Database.

Much more needs to be done to ensure that Canadians with mental illness are supported by workplace policies, programs, and benefits.

12 per cent said they were currently experiencing a mental health issue, while 32 per cent reported that they had experienced one in the past. Taken together, almost half the employees surveyed reported experiencing a mental health issue at some point in their life.⁶²

The third briefing in this series indicated that the improved treatment of depression/anxiety among employed Canadians could boost Canada's economy. What is more, if all employees living with depression and/or generalized anxiety disorder had access to treatments allowing them to be fully functional at work, Canada's economy could gain somewhere between 228,000 and 352,000 jobs per year until 2035. These estimates illustrate the significant benefits to be realized for individuals, businesses, society, and the economy by addressing mental health and illness among working Canadians. While there have been considerable efforts in recent years, much more needs to be done to ensure that Canadians with mental illness are supported by workplace policies, programs, and benefits that help improve their health and productivity.

Considering this, we take the results presented in the third briefing and extend the analysis to look at the functionality of Canadians within three age categories (i.e., 15–24, 24–44, and 45–64) and the economic cost of each cohort over time. We also present a scenario analysis that improves functionality by 10 per cent and the effects of this improvement in the three age categories outlined above. The underlying theme and objective is to measure the gap that could be closed and stress the importance of a policy addressing mental health in youth.

It must be remembered that the economic gains associated with improved functionality are twofold. The first is a result of improved productivity for those who are working at reduced functionality because of their symptoms. In this case, boosting the productivity of these workers will have an impact on GDP but no impact on the size of the workforce. The second gain is a result of those who were unable to work because of their symptoms entering the workforce. In this case, boosting the productivity of these workers will have an impact on both GDP and employment.

62 Thorpe and Chénier, *Building Mentally Healthy Workplaces*.

As well, it can be a long time before the economic gains are fully realized. When discussing the steps that need to be taken to make Canadians fully functional at work, the scenarios presume that those living with depression and/or anxiety have full access to available treatments, which is not the case. For this to happen, it will take a strong commitment from governments and businesses to ensure that all employees have full access. As mentioned earlier, benefit plan parameters can vary depending on the offerings of insurers and choices made by employers. Not all workers (especially part-time and non-permanent employees) have access to benefits coverage, and employees in precarious work arrangements (who are usually younger) can be very vulnerable. But promising initiatives such as Ontario's free prescription medications for children and youth 24 years or younger and England's no-cost talk therapy are positive steps to provide assistance to those who otherwise may not have access to benefits. Unfortunately, it is challenging to measure the return on this large investment.

Indeed, as Briefing 3 noted, the economic costs of mental illness normally far exceed the health care costs. Therefore, most of the benefit will be felt by the Canadian economy through the increased level of productivity among employees. The Canadian health care system, while benefiting from expected declines in hospitalizations and lower future drug costs, may not observe a noticeable impact.

Depression

According to the Canadian Community Health Survey, about 1.3 million Canadians lived with a depressive episode in the past year. Our methodology suggests that around 1 million of this total are employed in the base case scenario, sometimes experiencing depressive symptoms while at work. Indeed, only 222,000 of the 1 million employed Canadians living with depression are working full time and are functioning at full capacity while at work. The others are either functioning below full capacity or unable to work full time because of their symptoms. On top of that, roughly 310,000 are unable to work at all because of their symptoms. (See Table 1.)

Table 1

Depression and Workplace Performance, Base Case Scenario, 2012

(employed population with a major depressive episode; number; past 12 months)

Unable to work	310,009
Work part time	266,102
Work full time, but with reduced functioning	532,204
Work full time, fully functioning	222,195
Total employed with depression	1,020,501
Total population with depression	1,330,510

Sources: Statistics Canada; The Conference Board of Canada.

If all Canadians living with depression received the optimal treatment to be fully functional at work (which includes treatment to remission without residual symptoms), scenario A implies that more than 1.2 million Canadians living with depression would be working full time and be fully functioning at their job. This number includes those who used to work at reduced functioning or work part time. It would also mean that a portion of the 310,000 who were unable to work would now enter the workforce. At the 2012 participation rate of 66.5 per cent, more than 207,000 Canadians who were unable to work could potentially enter the workforce.

Thus, each employed Canadian living with depression would now be fully functional while at work. This has a significant impact on the Canadian economy. For instance, average productivity for the Canadian worker would have risen from \$66,100 to \$67,200. (See Table 2.) With this higher level of productivity, Canada’s gross domestic product (GDP) would have been \$32.3 billion higher, a gain of 1.8 per cent. Extending the analysis over the forecast period reveals that GDP in scenario A would be more than \$50 billion higher in 2035 than in the base case scenario.

Table 2

Economic Impact of Depression, 2012

(employed population)

	Base case	Scenario A—All employees receive proper treatment
GDP (\$ billions)	1,672.1	1,704.4
Employment (millions)	17.4	17.7
Productivity (\$)	66,139	67,196

Sources: Statistics Canada; The Conference Board of Canada.

Breaking down the data by age reveals that a little more than 1 million employed Canadians aged 15 to 64 are either unable to work or work at below full capacity because of their symptoms of depression. If workers received the optimal treatment to be fully functional at work, another 195,000 employed Canadians would now be part of the workforce. This includes 49,100 in the 15–24 age group, 78,200 in the 25–44 age group, and 67,300 in the 45–64 age group. (See Table 3.) Since workers in the 65-and-over age group make up only 3 per cent of the workforce, they were not included in this case. (See “Working Life Benefits for Seniors” following the Anxiety section for a discussion of the impact for those 65 years of age and older.)

Table 3
Depression, Breakdown by Age, 2012

(employed population 15–64 years of age with depression; number)

	Age range	Base case	Scenario A—All employees receive proper treatment
Unable to work	15–24	73,611	24,513
	25–44	117,202	39,028
	45–64	100,940	33,613
Work part time	15–24	63,186	
	25–44	100,602	
	45–64	86,644	
Work full time, but with reduced functioning	15–24	126,371	
	25–44	201,204	
	45–64	173,288	
Work full time, fully functioning	15–24	52,760	291,415
	25–44	84,003	463,983
	45–64	72,348	399,608
Total employed with depression	15–24	242,317	291,415
	25–44	385,809	463,983
	45–64	332,281	399,608

Sources: Statistics Canada; The Conference Board of Canada.

The reduced level of productivity for youth will persist if they have not recovered from their mental health issue.

However, there is more to the story than simply separating the numbers, mostly because each age category contributes to GDP differently.

Normally, the average level of productivity is a function of the wages/salary of the worker. As workers gain more experience, income rises, as does the level of productivity. Average productivity (gross domestic product per worker) is highest in the 45–64 age group (\$79,440), is only slightly lower in the 25–44 age group (\$71,910), and is significantly lower in the 15–24 age group (\$21,450). Consequently, the direct economic costs by age category depend on two things: the number of Canadians in each age group and the average productivity of the same age group.

And so, the \$32.3-billion cost of depression can be separated into \$2.6 billion for the 15–24 age group, \$13.2 billion for the 25–44 age group, and \$12.6 billion for the 45–64 age group (the remainder being for those over 65 years of age). (See Exhibit 1.) But keep in mind that these are the economic costs for one year. If we follow these age groups over time, it becomes apparent that the youngest age group will see the highest costs. Indeed, the average worker in the 15–24 age group is just beginning their working life and has approximately 40 to 45 years of potentially working at reduced levels of functionality. Meanwhile, the average worker in the 25–44 age group and the 45–64 age group has roughly 30 years and 10 years, respectively, of work life remaining.

All in all, the reduced level of productivity for youth will persist for a much longer period if they have not recovered from their mental health issue. Thus, the present value of economic costs is much higher. On a per capita basis, the productivity of an employed individual aged 15 to 24 would be about \$29,000 higher over their entire working life. This compares to \$23,500 for the 25–44 age group and \$9,500 for the 45–64 age group. (See Table 4.)

Exhibit 1
Cost of Depression, by Age Group

The **\$32.3-billion cost of depression** can be separated into:



Over their entire working life, **productivity of an employed individual** at full functionality would be an additional:



Source: The Conference Board of Canada.

Table 4**Depression, Working Life Estimates by Age, 2012**

(employed population 15–64 years of age with depression)

	15–24	25–44	45–64
Productivity (\$)	21,450	71,910	79,440
Cost of depression in 2012 (GDP \$ billions)	2.6	13.2	12.6
Present value of cost over entire working life (GDP \$ billions)	350.9	293.5	115.3
Present value of cost over entire working life of individual (GDP \$)	29,091	23,466	9,509

Sources: Statistics Canada; The Conference Board of Canada.

Anxiety

According to the Canadian Community Health Survey, nearly 722,000 Canadians lived with generalized anxiety disorder in the past year. Approximately 170,000 were unable to work because of their symptoms, while 433,000 worked either part time or full time at reduced capacity due to their anxiety symptoms. Only 121,000 of the 722,000 employed Canadians with anxiety functioned at full capacity while at work. (See Table 5.)

Table 5**Anxiety and Workplace Performance, Base Case Scenario, 2012**

(employed population with generalized anxiety disorder; number; past 12 months)

Unable to work	168,149
Work part time	144,334
Work full time, but with reduced functioning	288,667
Work full time, fully functioning	120,519
Total employed with anxiety	553,519
Total population with anxiety	721,668

Sources: Statistics Canada; The Conference Board of Canada.

If all employees living with anxiety received the optimal treatment, it would mean that an additional 545,000 Canadians would be fully functioning at their job. It would also mean that a significant number of Canadians with anxiety who were previously unable to work would be able to enter the workforce. This would have a significant impact on the Canadian economy, as average productivity for the Canadian

worker would rise to \$66,700. (See tables 6 and 7.) At this higher level of productivity, Canada's GDP would be \$17.3 billion higher, a gain of 1 per cent. Extending the analysis over the forecast period reveals that GDP would be more than \$27 billion higher in 2035 than in the base case scenario.

Table 6
Economic Impact of Anxiety, 2012
(employed population)

	Base case	Scenario A—All employees receive proper treatment
GDP (\$ billions)	1,672.1	1,689.3
Employment (millions)	17.4	17.6
Productivity (\$)	66,139	66,700

Sources: Statistics Canada; The Conference Board of Canada.

Table 7
Anxiety, Breakdown by Age, 2012
(employed population 15–64 years of age with anxiety; number)

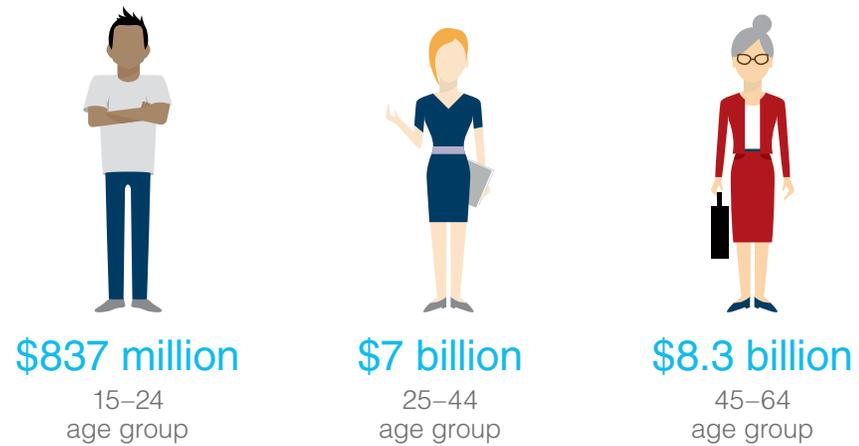
	Age range	Base case	Scenario A—All employees receive proper treatment
Unable to work	15–24	25,084	8,353
	25–44	62,488	20,809
	45–64	67,193	22,375
Work part time	15–24	21,531	
	25–44	53,638	
	45–64	57,676	
Work full time, but with reduced functioning	15–24	43,063	
	25–44	107,276	
	45–64	115,353	
Work full time, fully functioning	15–24	17,979	99,304
	25–44	44,788	247,381
	45–64	48,160	266,007
Total employed with anxiety	15–24	82,573	99,304
	25–44	205,702	247,381
	45–64	221,189	266,007

Sources: Statistics Canada; The Conference Board of Canada.

Like depression, the \$17.3-billion cost of anxiety can be separated into \$837 million for the 15–24 age group, \$7 billion for the 25–44 age group, and \$8.3 billion for the 45–64 age group (the remainder would be for those over 65 years of age). (See Exhibit 2.) Following these groups over time shows that the reduced level of productivity for youth will follow them for a much longer period. Thus, the present value of economic

Exhibit 2
Cost of Anxiety, by Age Group

Like depression, the **\$17.3-billion cost of anxiety** can be separated into:



Over their entire working life, **productivity of an employed individual** at full functionality would be an additional:



Source: The Conference Board of Canada.

costs is much higher. On a per capita basis, the productivity of an employed individual aged 15–24 would be about \$16,200 higher over their entire working life. This compares to \$14,200 for the 25–44 age group and \$6,200 for the 45–64 age group. (See Table 8.)

Table 8
Anxiety, Working Life Estimates by Age, 2012
 (employed population 15–64 years of age with anxiety)

	15–24	25–44	45–64
Productivity (\$)	21,450	71,910	79,440
Cost of anxiety in 2012 (GDP \$ billions)	836.7	6,960.8	8,272.3
Present value of cost over entire working life (GDP \$ billions)	200,590.9	178,527.5	75,856.7
Present value of cost over entire working life of individual (GDP \$)	16,209	14,245	6,217

Sources: Statistics Canada; The Conference Board of Canada.

Working Life Benefits for Seniors

Although the analysis focuses on working life estimates of those not yet at retirement age, it ignores the benefits of addressing depression and/or anxiety in Canada's seniors. In our estimates, seniors account for approximately \$4 billion of the \$32.3-billion gap due to depression (\$1.2 billion of the \$17.3-billion gap for anxiety). In a single year, this is greater than the gap among those between 15 and 24 years of age. However, given that those over the age of 65 have few years of working life remaining, the present value of economic costs is low.

Nevertheless, roughly 78,350 seniors have experienced a depressive episode in the past year. Similarly, about 57,440 seniors have lived through generalized anxiety disorder. For seniors, these episodes can come about from declining physical health, social isolation, or even the adjustment to retiring from working life.⁶³ Addressing mental issues in the final years of seniors' work lives will not lead to the economic benefits outlined in this briefing, but can lead to better quality of life during retirement years.

63 World Health Organization, *Mental Health and Older Adults*.

Incremental Improvement

While the results presented above imagine a world where each Canadian living with depression/anxiety receives optimal treatment enabling them to achieve the highest level of functionality, we understand that may be an overly optimistic scenario. A more realistic picture would be to look at incremental improvement and see which age group benefits the most. Indeed, approximately 42.5 per cent of Canadians with depression seek treatment for their symptoms, which represents approximately 565,200 Canadians.⁶⁴ Only about 53 per cent of this total receives the minimally adequate treatment,⁶⁵ which generally works for only 70 per cent of patients.⁶⁶ All in all, it means that just over 10 per cent of Canadians (139,000) are receiving the proper treatment. This shows how difficult it would be to ensure the entire population receives optimal treatment.

With that in mind, even a 10 per cent improvement in functionality from depression leads to significant gains. For instance, if we focus only on the workplace, an increase in optimal treatment that generates a 10 per cent improvement for workers at the part-time and the full-time with reduced functioning levels indicates that the number of Canadians (in each age group) at each functional level would change. (See Table 9.) As a result, more Canadians in the 25–44 age group will become fully functional compared with the other two age groups.

Table 9

Mental Illness and Workplace Performance, With a 10 Per Cent Improvement in Functionality, 2012

(employed population with a mental illness; number; past 12 months)

	Depression	Anxiety
Unable to work	310,009	168,149
Work part time	239,492	129,900
Work full time, but with reduced functioning	505,594	274,234
Work full time, fully functioning	275,416	149,385
Total employed with mental illness	1,020,501	553,519
Total population with a mental illness	1,330,510	721,668

Sources: Statistics Canada; The Conference Board of Canada.

64 Figures calculated by The Conference Board of Canada based on results from Dewa, Thompson, and Jacobs, “The Association of Treatment of Depressive Episodes and Work Productivity.”

65 Puyat and others, “How Often Do Individuals With Major Depression.”

66 Greden, “Workplace Depression.”

For Canadians with depression, it comes as no surprise that in a given year, the economic impact of this change will be \$109 million in the 15–24 age group, \$563 million in the 25–44 age group, and \$534 million in the 45–64 age group. But over time, it will become apparent that the youngest age group will be impacted the most. Indeed, the present value of the increased productivity is highest in the youngest age category. On a per capita basis, the productivity of an employed individual aged 15 to 24 would be about \$2,200 higher over their entire working life. This compares to \$1,750 for the 25–44 age group and \$700 for the 45–64 age group. (See Table 10.)

Table 10
Depression, Incremental Improvement Estimates by Age, 2012
 (employed population 15–64 years of age with depression)

	15–24	25–44	45–64
Productivity (\$)	21,450	71,910	79,440
Cost of depression in 2012 (GDP \$ billions)	109.3	562.8	534.2
Present value of cost over entire working life (GDP \$ billions)	14,918	12,473	4,899
Present value of cost over entire working life of individual (GDP \$)	2,169	1,747	706

Sources: Statistics Canada The Conference Board of Canada.

Similar results can be expected for Canadians living with anxiety. An increase in optimal treatment that generates a 10 per cent improvement in functionality will lead to a \$35-million GDP gain in the 15–24 age group, a \$295-million jump in the 25–44 age group, and a \$351-million boost in the 45–64 age group. But over time, the present value of the increased productivity is highest in the youngest age category. On a per capita basis, the productivity of an employed individual aged 15 to 24 would be about \$1,200 higher over their entire working life. This compares to \$1,100 for the 25–44 age group and \$500 for the 45–64 age group. (See Table 11.) All in all, the economic gains stemming from an incremental 10 per cent improvement in workplace functionality for Canadians with depression and/or anxiety are sizable. (See Chart 1.)

Table 11

Anxiety, Incremental Improvement Estimates by Age, 2012

(employed population 15–64 years of age with anxiety)

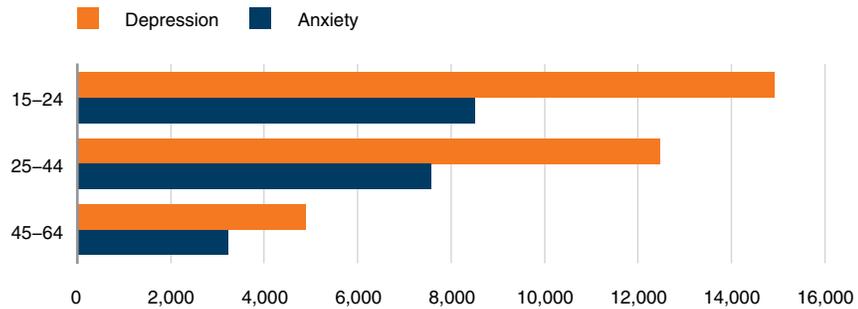
	15–24	25–44	45–64
Productivity (\$)	21,450	71,910	79,440
Cost of anxiety in 2012 (GDP \$ billions)	35.5	294.9	350.5
Present value of cost over entire working life (GDP \$ billions)	8,499	7,565	3,214
Present value of cost over entire working life of individual (GDP \$)	1,214	1,068	468

Sources: Statistics Canada; The Conference Board of Canada.

Chart 1

Present Value of Productivity Gains, by Age Group

(\$ millions)



Sources: Statistics Canada; The Conference Board of Canada.

Benefits by Industry

With the focus of this briefing on mental illness in Canadian workplaces, it would be interesting to get a sense of the impact of reducing the number of Canadians with depression and/or anxiety in industries where prevalence is the highest. Earlier briefings in the Healthy Brains research series indicated that for Canadians experiencing a mental illness in the past 12 months, the sectors with the highest prevalence are wholesale and retail trade, health care and social assistance, and accommodation and food services. In fact, a special focus of the first briefing was how employees in the accommodation and food services sector work for smaller employers who often do not provide benefits, and the rates of turnover in these sectors are high relative to other sectors.

Briefing 3 outlined how the economy would improve if all Canadians received the proper treatment that allows them to be fully functional while at work. Indeed, these three sectors account for approximately one-third of the Canadian workforce (5.9 million employees in 2012), so the benefits would be substantial. But on a smaller scale, it is interesting to see the direct economic gains if prevalence in these three sectors matched the national average.

Table 12 displays the results for both depression and anxiety. As expected, if prevalence in these three sectors matched the Canadian average, there would be significant gains. But considering that benefits are not as available to employees in these industries, innovative ways to implement the programs and interventions described in this brief are needed.

Table 12
Economic Gain of Lowering Prevalence, by Condition—Canada
 (by selected industry)

	Wholesale and retail trade	Health care and social assistance	Accommodation and food services
Employees with depression (number)	133,320	108,970	73,310
Employees with depression (Canadian average)	124,326	97,369	51,813
Economic gain (\$ millions)	762.1	264.7	263.5
Employees with anxiety (number)	94,110	64,050	31,590
Employees with anxiety (Canadian average)	68,926	55,326	28,718
Economic gain (\$ millions)	656.8	195.7	34.5

Sources: Statistics Canada; The Conference Board of Canada.

Implications From the Scenario Analysis and Briefings

The scenario analysis shows the importance of addressing mental illness in the workplace. For workers experiencing depression and/or anxiety, reduced functionality has a significant economic impact. If left untreated, this impact could potentially persist over an individual's entire working life.

Properly addressing depression and/or anxiety in the workplace so all Canadians are fully functional at work is extremely optimistic. With that

When youth experience mental illness, barriers to early and optimized treatment can have long-term consequences.

in mind, the scenario analysis demonstrates that small improvements can make a big difference. Tackling mental illness in sectors with the highest prevalence may be a logical first step. An approach to bring the prevalence more in line with the Canadian average can potentially help roughly 42,000 working Canadians (out of approximately 2 million working Canadians experiencing depression/anxiety in the past year). Finding solutions that include targeted, effective workplace programs and benefits for these sectors, and ways to address gaps in access, is essential. Findings from this and the other briefings in the series have provided insights on the activities some employers and governments have adopted. Solutions for small and mid-sized employers are required.

While the intent of this briefing and the series is not to focus on one segment of the workforce, the analysis reveals that targeting mental illness in youth will produce substantial benefits. The reason for this is twofold: younger Canadians have a much longer work life; and addressing mental illness at younger ages will hopefully prevent relapses in the future.

As youth transition to adulthood and enter the workforce, there are many touchpoints where mental health can be addressed. While the focus of the Healthy Brains at Work series has been on employers, many stakeholder groups, including governments; clinicians; educators; researchers; insurers; industry; and relevant mental health organizations, have a role to play in optimizing the supports needed for youth and through these transitions. Considerations include the following.

Access to Mental Health Supports at an Early Age Is Critical

Across the lifespan, mental health and well-being go together with physical health. Mental health promotion at home, at school, and in communities is essential. When youth experience mental illness, barriers to early and optimized treatment and supports can have significant and long-term consequences. Effective and accessible supports are central. This requires evidence-based services and programs, sufficient funding to support these services, and research and evaluation to determine the effectiveness of current and emerging treatments and services.

More often than not, youth rely on their parents' benefits and access to treatment and supports, making it both a public and private sector issue.

Supports During Key Transition Points Are Needed

Life transitions, such as moving from high school to college or university, can be points of vulnerability in mental health. Proactive supports to address mental health and provide early access to appropriate treatment is essential. Since many student plans offer only limited support, treatment as recommended by the CANMAT guidelines is vital. Post-secondary institutions are starting to provide these supports.⁶⁷ These efforts should be accelerated and offered broadly. Strong integration of mental health services provided for children and youth and those for young adults should also be present.

Address Gaps for Those in Precarious Employment

As young adults move into the workplace, they can face precarious employment and a lack of benefits. Providing barrier-free access to mental health supports is especially critical and has been the focus of efforts in several jurisdictions. These efforts require multi-stakeholder involvement, including employers and governments. Broader uptake of initiatives such as these is needed to address the barriers some young adults face as they seek treatment and support.

Ensure the Supports Provided Are Effective

Understanding the needs, preferences, and effectiveness of supports for youth is essential, as those may differ from other age cohorts.⁶⁸ Research is needed on the effectiveness of new and innovative approaches to providing mental health services (e.g., e-mental health applications), new programs that target mental health promotion among youth, and new treatments and therapies. Industries and organizations that tend to have a younger workforce should consider the extent to which their workplace programs and benefits are effective and support the needs and preferences of their workforce.

67 For example, see Centre for Innovation in Campus Mental Health at <http://campusmentalhealth.ca/about/news/>.

68 O'Donnell and others, "Use of Medication."

The Healthy Brains at Work research series has added to the overall body of research showing the significant individual and economic impacts if the conditions to support employee mental health are in place. Canada must ensure its mental health agenda includes focused actions to address the mental health of its current working population, including its youth, who will be the workforce of tomorrow.

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Acknowledgements

This briefing was researched and written by Greg Sutherland, Principal Economist, Health Economics and Policy, and Carole Stonebridge, Principal Research Associate, Health Economics and Policy, The Conference Board of Canada.

The briefing was made possible through the financial support of Lundbeck Canada Inc., Sun Life Financial, Cira Health Solutions, the Mental Health Commission of Canada, the Canadian Depression Research and Intervention Network, the Mood Disorders Society of Canada, and The Conference Board of Canada's Canadian Alliance for Sustainable Health Care (CASHC). We are extremely grateful for their generous support.

The authors would like to thank a number of individuals who provided advisory support for the briefing:



- Laurie Down, Director, Disability Policy, Canadian Life and Health Insurance Association Inc.
- Beth Dunton, Senior Market Access Manager, Lundbeck Canada Inc.
- Daniel McCarthy, Senior Director, Public Affairs and Market Access, Lundbeck Canada Inc.
- Dr. Marie-Hélène Pelletier, Assistant Vice-President, Workplace Health, Sun Life Financial
- Karen Cohen, Chief Executive Officer, Canadian Psychological Association
- Dr. Raymond Lam, Professor and Associate Head for Research, Department of Psychiatry, University of British Columbia
- Dr. Zul Merali, President and Chief Executive Officer, The Royal's Institute of Mental Health Research, affiliated with the University of Ottawa
- Phil Upshall, Mood Disorders Society of Canada and Canadian Depression Research and Intervention Network
- Joseph Ricciuti, President and Chief Executive Officer, SEB Benefits and HR Consulting Inc. and Mental Health International
- Susanne Cookson, President and Co-Founder, BestLifeRewarded Innovations.
- Nitika Rewari, Manager, Workplace Mental Health, Mental Health Commission of Canada
- Bill Wilkerson, Executive Chairman, Mental Health International

The authors would also like to thank our internal reviewers, Nicole Stewart and Charles Boyer, from The Conference Board of Canada. Our appreciation also goes to Sandra Koppert, Manager, Prevention and Promotion—Workplace, and Karla Thorpe, Director, Prevention and Promotion Initiatives, from the Mental Health Commission of Canada; and David Walker, President, West-Can Consultants Ltd., for reviewing the document and sharing their expertise and insights.

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To cite this briefing: Sutherland, Greg, and Carole Stonebridge. *Healthy Brains at Work: Creating the Conditions for Healthy Brains in the Workplace*. Ottawa: The Conference Board of Canada, 2017.

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PUBLICATION 9187 | 9208

PRICE: Complimentary