

Productivity and Access to Psychotherapy: Lessons for Canada from the United Kingdom

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Abstract

This paper examines lessons for Canada from the United Kingdom's (UK) efforts to improve productivity by increasing public funding for psychotherapy. Improving workforce productivity has been a core element of the original business case, subsequent program design, and on-going performance measurement for the Improving Access to Psychological Therapies (IAPT) program) launched in England in 2008. The original business case for IAPT was presented by economist Lord Richard Layard and psychologist David Clark, with a cost-benefit analysis showing that the costs of expanded psychotherapy services would be fully recouped within two years through the increased tax revenue and reduced disability benefits projected to result from more people being able to work. The IAPT proposal was successful and IAPT is now offered in every district of England, with targets set by the UK government and program implementation led by NHS England. The focus on productivity was carried through into the IAPT program design, with employment support as one of the core elements of the program alongside of cognitive behavioural therapy and other evidence-based psychotherapies. Productivity outcomes are analyzed drawing on publicly-available IAPT data and reports, with reference to the original business case. Productivity impacts are recognized as leading contributors to the estimated \$50B annual impact of mental ill-health on the Canadian economy, and formed part of the policy rationale for the new \$5B federal transfer to improve access to mental health services over the next ten years. This paper analyses how lessons learned from the UK need to be adapted to differences in the Canadian context, including: the role of employment-based insurance in providing access to psychotherapy, federal/provincial dynamics in a more decentralized government structure, and Canada's mental health system.

Productivity and Access to Psychotherapy: Lessons for Canada from the United Kingdom

The impact of mental ill-health on employment and productivity are well known. According to the OECD (2012), employment rates are 10-15 percentage points lower for people with moderate mental disorders and 30 percentage points lower for people with severe mental disorders. Disability claims attributed to mental ill-health have been rising over the past two decades and were up to 1 out of 3 disability claims in 2009. Mental ill-health is also associated with higher rates of presenteeism and absenteeism. For example, 69% of people with moderate mental disorders report reduced productivity at work because of emotional or physical health problems, compared to 26% of people with no mental disorder. These economic impacts are compounded by the prevalence and chronicity of mental ill-health. The OECD (2012) reports lifetime prevalence rates of 40-50% and 12-month prevalence rates of 25% (1 in 4), as well as a lower likelihood of moving off of disability benefits for mental disorders than for other disabilities.

In the United Kingdom (UK), this relationship formed the core of a successful case for increased public investment in psychotherapy¹ for depression and anxiety. Depression and anxiety tend to be moderate relative to more severe disorders such as schizophrenia but much more common, and with lower rates of treatment (OECD, 2012). Based on strong evidence from the National Institute for Healthcare and Excellence (NICE, 2011) regarding the efficacy of psychotherapy, the proponents argued that the cost of increased services would be more than recouped through reduced disability claims and increased tax revenue as improvements in mental health status boost employment and productivity (Layard, Clark, Knapp, & Mayraz, 2007). The

¹ In this paper, the term *psychotherapy* refers to evidence-based psychological therapies, psychotherapies, and counselling, in keeping with the approach taken by the recent programs announced by Ontario and Quebec (Ontario, 2017a, Quebec, 2017).

Improving Access to Psychological Therapies (IAPT) program was launched in 2008 and is now offered in every district of England, with targets set by the UK government and program implementation led by NHS England.

In Canada, interest in the relationship between mental ill-health and productivity is very strong, as evidenced by the return-on-investment arguments underpinning the 2013 National Standard of Canada for Psychological Health and Safety in the Workplace (CSA Group et al., 2014), increases employment-based psychotherapy benefits by ground-breaking employers such as Starbucks and Manulife (Ramsey, 2016; Ramsay, 2017), and the ten-year \$5B federal transfer to improve access to mental health services introduced in 2017 (Finance Canada, 2017). With both the private and public sector in Canada poised to expand access to psychotherapy with a view to improving productivity, it is timely to ask: what are the lessons for Canada from the UK's efforts to improve productivity by increasing public funding for psychotherapy?

This paper first explores the lessons learned from IAPT in England, including an analysis of results against the original business case and a consideration of the context for reform. Data is drawn from the publicly-available IAPT data collected and housed by NHS Digital (NHS Digital, 2018). This paper then considers how these lessons can be adapted to differences in the Canadian context, including: the greater role of employment-based benefits, federal/provincial dynamics in a more decentralized government structure, and gaps in public insurance for psychotherapy in Canada's two-tier mental health system.

Lessons Learned from IAPT in England

Improving workforce productivity has been a core element of the original business case, subsequent program design, and on-going performance measurement for the UK's Improving Access to Psychological Therapies (IAPT) program) launched in 2008. The original business

case for IAPT was presented by economist Lord Richard Layard and psychologist David Clark and colleagues (Layard et al., 2007). Their cost-benefit analysis (see Table 1) showed that the government's costs for expanded psychotherapy services would be more recouped within two years through the increased tax revenue and reduced disability benefits that would result from more people being able to work, with additional benefits to society from increased output (from wages), foregone medical costs, and improvements in quality of life (QALYs).

Table 1

<u>Average costs and benefits per person treated (£) (includes only benefits for first two years)</u>	
<u>Cost</u>	750
<u>Benefits to Society</u>	
Extra output (wages earned)	1100
Medical costs saved	300
Quality of life (extra QALYs)	3300
Total	4700
<u>Benefits to Exchequer</u>	
Benefits and Taxes	900
Medical costs saved	300
Total	1200

Source: Layard, Clark, Knapp and Mayraz, 2007

These findings rest on several evidence-based assumptions made by Layard and colleagues (2007). The first assumption is that 32% of people with anxiety and depression who receive Cognitive Behavioural Therapy will recover², with an average increase in 6.5 months of health in the first two years. The second assumption is that the probability of employment among people who recover will increase by 14 percentage points, taking into account that some improvements in employment status would have happened without treatment and that some

² IAPT defines recovery as people who met diagnostic criteria for depression and anxiety at the start of treatment no longer meeting these criteria at the end of treatment.

people will move into unemployment even if they recover. Further, the probability of being on disability benefits is assumed to decrease by 18 percentage points. In this way, two thirds of the employment and disability benefit gaps between people with mood and anxiety disorders and those with no mental disorders are assumed to close following treatment. By combining these two assumptions, Layard and colleagues (2007) calculated one extra month of employment on average in the first two years following treatment for an increased employment rate of 4 percentage points (1 month/24 months), and further calculated an average of 1.17 fewer months on disability benefits. The resulting in benefits to the Exchequer were £900 (1.17 x £750/month in disability claims and foregone tax revenue).

The focus on productivity has weakened somewhat in the implementation phase of IAPT. While the original service design and funding envelop included one employment advisor for every eight therapists, the actual ratio has been 1:50 after the mandate for this component of the program was shifted from the Department of Health to the Department for Work and Pensions (Layard and Clark, 2014). As will be seen below, the approach to employment outcome measurement has also been rather muddled, with shifts between a narrow focus on sickness pay and/or disability benefits and a broader range of employment metrics, and with less transparency in public reporting than is true for IAPT as a whole. Nevertheless, it is possible to conduct a partial analysis of outcomes related to the original business case.

Rates of recovery have steadily increased over the course of IAPT implementation, with the most recent data from 2017-18 showing more than a 50% recovery rate for people who complete IAPT treatment³ (Community and Mental Health Team, 2017). This rate of recovery surpasses the 32% assumption for the 2007 business case by a wide margin, suggesting that

³ IAPT defines treatment completion as anyone who has completed at least two IAPT sessions.

employment outcomes should exceed the original projections. When looked at as a single metric, reductions in the number of people on sick pay and/or disability benefits has also seemed to be promising (see Figure 1). By March 2012, more than 45,000 IAPT clients moved “off of sick-pay or ill-health related benefits” (Mullins, 2012). Between 2012-13 and 2015-16, a further 50,000 IAPT clients who were “long term sick or disabled, or in receipt of benefits” before treatment were no longer receiving benefits after treatment (NHS Digital, 2018). From 2016-17 to February 2018 (the most recent data available), another 55,207 IAPT clients moved “off sick pay”, leading IAPT to tout that “well over 100,000 people [have been] supported to move off sick pay and benefits, [and] currently, around 25,000 people per year” (NHS Digital, 2018; Jarman, 2017).

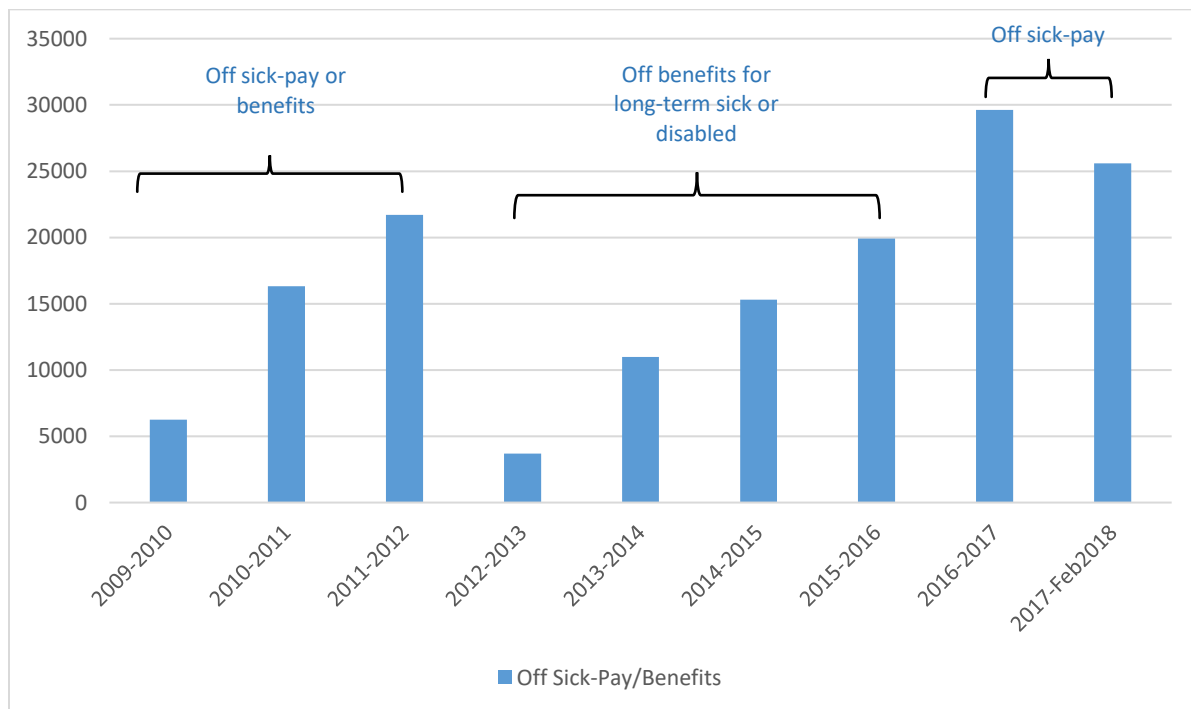


Figure 1. IAPT clients moving off of sick-pay and/or benefits, 2009-10 to 2017-18 (Source: NHS Digital).

While the methodology for measuring recovery outcomes has been consistent, rigorous and transparent from the outset of IAPT, the same can not be said about benefit outcomes and broader employment outcomes. In addition to the changes in how the number of people who moved off of sick pay and/or disability benefits have been measured, between 2012-13 and 2015-16 IAPT also collected a wider range of pre- and post-treatment data on employment status (NHS Digital, 2018). This categorical employment status variable measured not just the raw numbers of clients who had moved *off of* benefits but also the numbers who had moved *onto* benefits, movement in and out of employment, education, home-making, volunteer work, retirement, and so forth. When the fuller employment picture is considered, the impact of treatment on employment status and benefits is far from clear.

To take just a few illustrative examples from 2014-15 (see Table 2), it is apparent that fewer IAPT clients overall were employed and more were on benefits at the end of treatment than at the start (Health and Social Care Information Centre, 2015). Further, just looking at the number of people who were employed at both the start and end of treatment gives the appearance of more desired outcome (-32,042) than the net change (-11394). Similarly, the number of people on benefits at both the start and end of treatment decreased (-15312) but the net change is actually a small increase (+570). Several considerations should be kept in mind when interpreting these results. First, the movement of clients between various states of employment is multi-directional and complex in ways that may or may not have to do with the effects of any improvements to mental health status resulting from treatment. People lose their jobs, land a job, start school, retire, stay home to care for a child or elderly parent, qualify for benefits, lose their benefits for any number of reasons. Second, the number of employment status values for IAPT clients at the end of treatment is much higher than at the start of treatment. This increase in

missing values contributes to lower post-treatment numbers across the board. Moreover, according to an analysis of the impact of missing values in the original IAPT pilots, the post-treatment results are likely to be biased in a positive direction as missing IAPT values are more likely to come from people with poor outcomes (Clark et al., 2009).

Table 2

<u>IAPT clients completing treatment by employment status[*], illustrative examples, 2014-15</u>	
Employed, start of treatment	237,986
Employed, start and end of treatment	205,944
Employed, end of treatment, any status at start	226,592
Benefits, start of treatment	37,479
Benefits, start and end of treatment	22,167
Benefits, end of treatment, any status at start	38,049
Missing employment status values, start of treatment	23,964
Missing employment status values, end of treatment	53,870

^{*}The full suite of employment status outcomes included: employed; unemployed and seeking work, students who were not working or actively seeking work; long terms sick or disabled or in receipt of benefit payments; home makers who are not working or actively seeking work; not receiving benefits and not working or actively seeking work; unpaid voluntary work and not working or actively seeking work; retired.
Source: Health and Social Care Information Centre, 2015

While the original IAPT business case recognized that the impact of treatment on employment status would need to be tracked by measuring net changes in both employment status and benefit outcomes (Layard et al., 2007), the actual monitoring of employment status impacts has been less straightforward. In 2012-13 employment outcomes of any sort stopped being reported in IAPT's annual and quarterly reports, and in 2016-17 IAPT reverted to measuring only whether clients had moved "off sick pay" (NHS Digital, 2018). There are some signs that IAPT is actively working to strengthen its employment status monitoring. In 2014 a major report on mental health and work commissioned by the UK government recommended that IAPT strengthen its employment supports (Van Stolk, Hofman, Hafner & Janta, 2014). In

2017, IAPT secured funding for a large pilot project to first and foremost bring the ratio of employment advisors to therapists up from 1:50 to 1:8 (as original planned), but also to improve performance monitoring regarding various dimensions of employment status (Community and Mental Health Team, 2018). Data from these pilots will become available shortly.

Attributing changes in employment status to IAPT is complicated enough with the ebbing and flowing of work, health, caregiving, school and so forth. However, it is also important to consider changes in the wider social and economic context. IAPT was launched in 2008 at the height of an economic downturn and on the heels of decades of welfare retrenchment designed to “make work pay” (Glyn & Wood, 2001). According to the OECD (2012), disability claims went up as other income costs went down over this time period, which also saw unprecedented increases in the proportion of disability benefit recipients with mental health problems. Meanwhile, 2008 was also the year of a significant reform to disability benefits in the UK, which changed from Incapacity Benefits to the more work-focused Employment Support Allowance (Department for Work and Pensions, 2008). The impact of psychotherapy on employment status could easily be swamped by such sweeping social and economic changes.

Before moving on to a consideration of productivity and psychotherapy in the Canadian context, several lessons learned can be summarized from this analysis of IAPT in England. First, the productivity-focused case for investment in psychotherapy that clearly identifies the costs and benefits to the *funder* (in this case, the UK government’s Exchequer) is compelling for policy-makers. Second, measuring changes in employment status is complex and requires careful attention to ebb and flow across various forms of occupation. Third, transparency and rigour in reporting employment status outcomes is needed to prevent over-enthusiastic accounts that are based on oversimplified metrics. Fourth, broader economic and social changes need to be

considered when attributing changes in employment status to psychotherapy. Last but not least, improving access to evidence-based psychotherapy can improve mental health status, which is known to have an impact of employment status (including disability benefits) in addition to improving quality of life. Given all of the complexities for attributing changes in employment status to one factor, this result may be the most compelling of all.

Adapting Lessons Learned from IAPT to the Canadian Context

There are many similarities in the Canadian context, but also many differences with important implications for adapting the lessons learned from IAPT regarding psychotherapy and productivity. Just as in the UK and other OECD countries, Canadians living with mental ill-health have high rates of unemployment, disability benefits, absenteeism and presenteeism. These high rates have led to similar interests from policy-makers in the relationship between productivity and mental health. However, relative to the UK and specifically England, the role of employment-based benefits is much greater in Canada, federal/provincial dynamics in a Canada's more decentralized government structure are more complex, and the gaps in public insurance for psychotherapy in Canada's two-tier mental health system are both more striking and more inequitable. Moreover, Canadian innovations with Guaranteed Basic Income have the potential to open up a non-clinical pathway to improved mental health and employment.

The private sector has a far greater role in health and disability insurance coverage in Canada than in the UK. Whereas only 1 in 10 people in the UK have private health and disability insurance, 1 in 3 Canadians have private disability insurance and 2 out of 3 have some form of private extended health insurance (Canadian Life and Health Insurance Association, 2017; Commission on the Future of Health and Social Care in England, 2014). Canadian private

insurance is split between employment-based insurance and individually-purchased insurance, and often includes psychotherapy coverage.

This sharing of costs across the public and private sector has implications for the case for investment in mental health. Various studies of mental ill-health in Canada have estimated the economic impact to be in excess of \$50B annually, from health and social service costs and productivity losses (Mental Health Commission of Canada, 2017). As can be seen in Figure 2, income supports (such as disability benefits) and productivity losses from absenteeism and presenteeism account for 40% of the economic impact, with health services and other social services such as housing supports making up the other 60%.

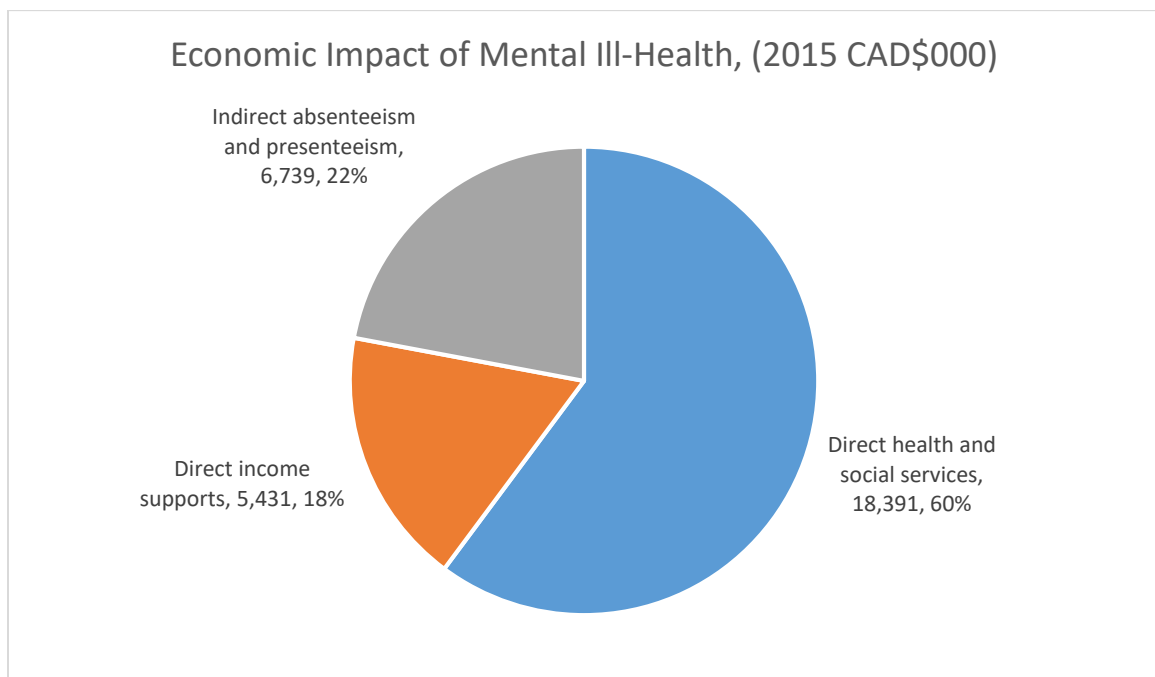


Figure 2. Economic impact of mental ill-health in 2015 CAD\$000 (Source: Mental Health Commission of Canada, 2017)

Making a clear business case becomes more complicated when it is harder to point to the costs and benefits for the public versus the private sector in the Canadian context. While indirect costs are generally borne by the private sector (other than through the public sector's role as an

employer), the private sector also pays \$2B for more than half of health services costs for prescription medications, and another \$2B for more than a third of income support costs (Mental Health Commission of Canada, 2017). The clear lines of return on investment are further blurred in Canada's highly decentralized federal structure. IAPT's return on investment for the UK Exchequer can be clearly articulated in England's unitary government structure. In Canada, however, the federal, provincial and territorial levels of government all play a role in funding healthcare services and income supports, including disability benefits (Jacobs, 2010).

In keeping with this diffuse funding structure, the productivity-related case for investment in mental health has as much influence on private sector employers and insurance companies in Canada as it has on the public sector, and the focus of reforms has been divided between improving workplace mental health and expanding access to psychotherapy. The *National Standard of Canada for Psychological Health and Safety in the Workplace* was launched in 2013 (CSA Group et al., 2014), with a primary focus on improving mental health outcomes (and reducing disability benefit costs) by improving the work environment. While voluntary, the interest in this standard has been high from both public and private sector employers. More recently, reforms to improve productivity by expanding access to psychotherapy have gained ground, with a ten-year \$5B federal transfer to improve access to mental health services launched in 2017, new psychotherapy services being launched by provincial governments such as Ontario and Quebec, and policy analysis from the Mental Health Commission of Canada (Chodos, 2017; Finance Canada, 2017; Ontario, 2017a; Quebec, 2017). A few private sector employers such as Starbucks and Manulife have also expanded employee psychotherapy benefits (Ramsay, 2016; Ramsay, 2017).

The reforms to improve access to psychotherapy seem to have been influenced by the recovery and productivity messages from IAPT. During the 2016 Health Accord negotiations between federal, provincial and territorial governments, the federal Minister of Finance Bill Morneau stated that: “Mental health investments help people get back to work faster... But we need to show that investments really result in that outcome” (Hall and Morneau, 2016). However, in the Canadian context policy-makers also emphasized the importance of addressing gaps and inequities in funding for psychotherapy. In the lead up to the same negotiations, federal Minister of Health Jane Philpott argued that under the current two-tier system, “most [patients who require counselling] have to pay out-of-pocket, or try to manage without” (Canada, 2016). While Canada’s Medicare system guarantees first-dollar coverage of physician and hospital services, the services of psychotherapy providers such as psychologists and clinical social workers are not covered. Further, a third of the population does not have access to employment-based extended health benefits (Canadian Life and Health Insurance Association, 2017).

Strong performance monitoring for any health reforms have long been a challenge in Canada’s decentralized context, where shared responsibility for healthcare financing make it difficult to hold any one level of government to account. At the pan-Canadian level, it seems unlikely that recovery outcomes will be measured directly. Rather, new pan-Canadian indicators for the new \$5B federal transfer seem likely to focus on indirect measures of access such as hospital readmission rates for mental disorders (Canadian Institutes for Health Information, 2018). At the provincial level, it remains to be seen whether new psychotherapy programs will include fully transparent session-by-session outcome measures in keeping with the IAPT model, and whether employment status will be closely monitored.

The risk of cost-shifting between the private and public sector creates a further complication for monitoring the return on investment in the Canadian context. In Australia, where rates of private insurance are analogous to those in Canada, claims for psychotherapy fell sharply after the introduction of Medicare coverage for psychologists, social workers and occupational therapists (Diminic & Bartram, in press). Unless private insurance claims for psychotherapy are reported far more publicly than they currently are by the Canadian insurance industry, similar cost-shifting could result in a shifting of costs onto the public purse with little by way of either recovery or productivity gains.

What about the broader economic and social context surrounding the relationship between mental health and productivity? Decades of welfare retrenchment and the 2008 economic downturn have also had an effect in Canada. In 2017, the Ontario government launched several Basic Income Pilots that are tracking a range of outcome relevant to the focus of this paper, such as mental health, stress, healthcare utilization and labour market participation (Ontario, 2017b). While a full-scale national roll-out is far from certain, this pilot could open up a different approach for transforming the relationship between mental health and productivity to that extent that improved income security is associated with reduced stress, improved mental health status, and/or improved employment status. Depending on the strength of these associations, basic income could out-perform the productivity gains of psychotherapy without invoking the stigma of mental health treatment.

Summary and conclusion

Each of the lessons learned through IAPT in the UK regarding the relationship between mental health and productivity need to be adapted to the Canadian context. First, it is more challenging to clearly identify the costs and benefits of improving access to psychotherapy to the

funder in the Canadian context than in the UK. Not only are there more governments involved in Canada's decentralized federation, but the private sector also plays a far greater role in both mental health service delivery and disability insurance under Canada's two-tier mental health system. Second, while transparent and rigorous reporting of employment outcomes was challenging in the UK, in Canada it may prove challenging to even get direct measures of recovery outcomes let alone employment outcomes. Without a single point of accountability and with the risk of cost shifting from the private to the public sector, the incentives for rigorous performance monitoring are weak. Third, the impact of psychotherapy needs to be considered in the broader social and economic context in Canada just as in England. If basic income continues to gain momentum in Canada, it has the potential to either complement or overtake the impact of psychotherapy on mental health status and employment. Finally, IAPT has been able to sustain and grow its funding largely on the basis of its 50% recovery rates, with the return on investment implied but only weakly demonstrated. Reducing depression and anxiety in Canada would be an equally significant achievement in and of itself, even if employment outcomes are not measured directly. However, in the context of Canada's two-tier system, the more modest objective of reducing financial barriers to accessing psychotherapy also carries considerable weight.

References

- Canada. (2016). Remarks from the Honourable Jane Philpott, Minister of Health, to the Canada 2020 Health Summit: A new Health Accord for all Canadians [speech posted on the website]. Retrieved from <https://www.canada.ca/en/health-canada/news/2016/10/remarks-honourable-jane-philpott-minister-health-canada-2020-health-summit-new-health-accord-canadians.html?=&wbdisable=true>
- Canadian Institute for Health Information. (2018). Selecting pan-Canadian indicators for access to mental health and addiction services, and to home and community care: Progress report. Ottawa, ON: Author.
- Canadian Life and Health Insurance Association. (2017). Canadian life and health insurance facts [website]. Toronto: Author. Retrieved from: <http://clhia.uberflip.com/i/878840-canadian-life-and-health-insurance-facts-2017/7>
- Chodos, H. (2017). Options for improving access to counselling, psychotherapy and psychological services for mental health problems and illnesses. Ottawa, ON: Mental Health Commission of Canada.
- Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11), 910–920.
- Commission on the Future of Health and Social Care in England. (2014). The UK Private Health Market. London, UK: The King's Fund. Retrieved from <https://www.kingsfund.org.uk/sites/default/files/media/commission-appendix-uk-private-health-market.pdf>
- Community and Mental Health Team. (2017). Psychological therapies: Annual report on the use of IAPT services, England 2016-17. Leeds, UK: Health and Social Care Information Centre. Retrieved from <https://digital.nhs.uk/catalogue/PUB30157>
- Community and Mental Health Team. (2018). IAPT: Report on Employment Advisors in IAPT pilot. Leeds, UK: Health and Social Care Information Centre. Retrieved from <https://files.digital.nhs.uk/publication/3/o/iapt-ea-rep-nov-2017-exec-sum.pdf>
- CSA Group, Bureau de normalisation du Québec, Standards Council of Canada, & Mental Health Commission of Canada. (2014). *Psychological health and safety in the workplace: prevention, promotion, and guidance to staged implementation*. Retrieved from <http://www.deslibris.ca/ID/241415>
- Department for Work and Pensions. (2008). Raising expectations and increasing support: Reforming welfare for the future. London, UK: Author. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/238683/7506.pdf
- Diminic, S., & Bartram, M. (in press). Does introducing public funding for allied health psychotherapy lead to reductions in private insurance claims? Lessons for Canada from the Australian experience. *Canadian Journal of Psychiatry*.

- Finance Canada. (2017). Building a strong middle class. Ottawa, ON: Author.
- Glyn, A., & Wood, S. (2001). Economic policy under New Labour: How social democratic is the Blair government? *The Political Quarterly*, 72(1), 50–66. <https://doi.org/10.1111/1467-923X.00343>
- Hall, C., & Morneau, B. (2016). The House with Chris Hall: Bill Morneau discusses health care funding [Audio, 9:33 min.]. Ottawa: CBC Player. Retrieved from <http://www.cbc.ca/player/play/835118659826>
- Health and Social Care Information Centre. (2015). Psychological therapies, annual report on the use of IAPT services, England 2014/15. Leeds, UK: Author.
- Jacobs, P., Dewa, C., Lesage, A., Vasiliadis, H.-M., Escobar, C., Mulvale, G. & Yim, R. (2010). The cost of mental health and substance abuse services in Canada. Edmonton, AB: Institute of Health Economics.
- Jarman, K. (2017). Employment Advisers in IAPT – providing integrated IAPT and employment support. Presentation to the New Savoy Partnership Conference. Retrieved from <https://www.newsavoypartnership.org/2017presentations/kevin-jarman.pdf>
- Layard, P. R. G., & Clark, D. M. (2014). Thrive: The power of evidence-based psychological therapies. London, UK: Lane.
- Layard, R., Clark, D., Knapp, M., & Mayraz, G. (2007). Cost-benefit analysis of psychological therapy. *National Institute Economic Review*, 202(1), 90–98.
- Mental Health Commission of Canada. (2017). Strengthening the case for investing in Canada’s mental health system: Economic considerations. Ottawa, ON: Author.
- Mullins, K. (2012). Improving access to psychological therapies & employment support in England [presentation]. NHS. Retrieved from <http://www.oecd.org/els/emp/3%20UK%20-%20presentation.pdf>
- NHS Digital. (2018). Improving Access to Psychological Therapies (IAPT) reports [website]. Leeds, UK: Author. Retrieved from <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set-reports/monthly-improving-access-to-psychological-therapies-iapt-reports>
- NICE. (2011). Common Mental Health Problems: Identification and Pathways to Care. London: Author. Retrieved from <https://www.nice.org.uk/guidance/CG123/chapter/1-Guidance#improving-access-to-services>
- OECD. (2012). *Sick on the job? myths and realities about mental health and work*. Paris: Author.
- Ontario. (2017a). Ontario Providing Faster Access to Mental Health Services for Thousands of People: news release [website]. Retrieved from <https://news.ontario.ca/mohlrc/en/2017/02/ontario-providing-faster-access-to-mental-health-services-for-thousands-of-people.html>

- Ontario. (2017b). Ontario's basic income pilot [website]. Toronto, ON: Author. Retrieved from https://files.ontario.ca/170508_bi_brochure_eng_pg_by_pg_proof.pdf
- Quebec. (2017). Santé mentale - Le Gouvernement du Québec annonce la création d'un programme public de psychothérapie : fil d'information [website]. Retrieved from <http://www.fil-information.gouv.qc.ca/Pages/Article.aspx?idArticle=2512031288>
- Ramsay C. (2016). Starbucks Canada boosts mental health benefits to \$5K per year. Global News [website]. Retrieved from <https://globalnews.ca/news/2988902/starbucks-canada-boosts-mental-health-benefits-to-5k-per-year/>
- Ramsay, C. (2017). Manulife increases mental health coverage for employees to \$10K per year. Global News [website]. Retrieved from <https://globalnews.ca/news/3175067/manulife-increases-mental-health-coverage-for-employees-to-10k-per-year/>
- Van Stolk, C., Hofman, J., Hafner, M., & Janta, B. (2014). Psychological Wellbeing and Work: Improving Service Provision and Outcomes. OECD disability mental illness and work <https://www.oecd.org/els/45008308.pdf>