

The Economic Cost of Mental Health in Canada

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Executive Summary

This report estimates the economic cost of poor mental health in Canada at **$180 billion** annually. This high cost is driven largely by reactive and downstream spending, meaning only after serious mental health challenges have escalated and spilled into systems never designed to manage them. These include housing supports, police services, correctional services, and emergency departments.

Decades of policy choices, including chronic underinvestment in prevention, narrow interpretations of medically necessary care and persistent transinstitutionalization have shifted mental health costs to the most expensive and least effective parts of the public sector. This report estimates that if Canada continues on its current trajectory, the annual cost of poor mental health is expected to rise to **$600 billion by 2050**, driven by worsening prevalence, increasing pressure on public systems, and continued reliance on crisis-based responses.

This growing burden will further strain productivity and limit Canada's potential for long-term economic growth. It will also deepen the impact on employers, who already absorb roughly $110 billion of the current $180 billion burden, and are the single largest payer for poor mental health in the country.

To reverse this trajectory, the report identifies two essential reforms:

1. Achieving mental health parity so that mental health receives funding, coverage and accountability equal to physical health
2. Reorienting the system toward prevention by shifting resources upstream to reduce incidence, and expanding meaningful mental health support into the places where people spend most of their time—schools, workplaces, primary care and community settings

Although these reforms will require substantive changes to the healthcare system and to how mental health is managed, they represent the most necessary and effective path to containing the escalating financial burden and addressing the human suffering behind the numbers.



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Canada's Mental Health Crisis

The term *mental health crisis*[1] captures not only the growing number of Canadians experiencing mental illness, but also the persistent barriers that delay access to care, worsening symptoms over time and compounding the effects of neglected and fragmented services.

Its consequences are visible across the country—in the tent encampments that occupy major city centers,[2] and in the overdoses that have closed small-town parks and triggered states of emergency.[3]

This crisis is also seen in workplaces where mental health sick leave and psychological injury claims undermine productivity, and in overcrowded emergency rooms, where nearly half of "first contact" psychiatric visits are due to inadequate outpatient care access.[4] It's evident in classrooms—from elementary to post-secondary—where Canadian youth struggle to learn while managing anxiety and depression.[5]

What the data tells us

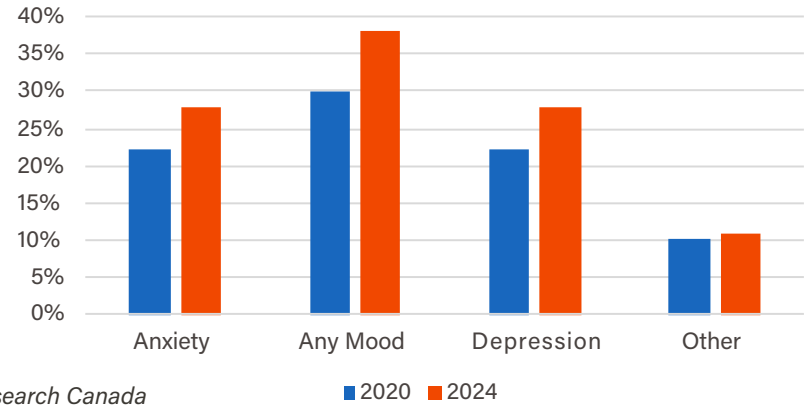
Data on mental health prevalence confirm what these daily realities reveal. Nearly one in three Canadians reports that mental health challenges significantly affect their work or studies.[6] By age 40, about half of the Canadian population will have had a mental illness.[7] National surveys show a growing prevalence of anxiety, mood disorders and depression, with several indicators now five to eight percentage points higher than since the start of the pandemic.[8]

The onset of mental illness and deviations in mental health can occur throughout the life course, with certain age periods associated with higher vulnerability. Many mental disorders—such as mood, anxiety, externalizing and substance use disorders—often begin to manifest during young adulthood (18 to 24 years old) or in the early 30s,[9] but may appear as early as childhood or adolescence.[10] As many mental illnesses begin in adolescence or early adulthood, their long-term course can have lasting implications for employment trajectories and income stability.

Although many mental illness conditions manifest in young adulthood, the prime working years (25 to 64) are a period when many adults experience mental health challenges. Given the cumulative effects of chronic stressors, caregiving responsibilities, workplace pressures and emerging physical health challenges, many mental illnesses such as major depressive disorder, anxiety disorders, post-traumatic stress disorder and substance use disorders are common during this time of life. Consequently, mid-adulthood is a critical period in which mental health challenges are both common and consequential, shaping individual well-being and broader economic outcomes.

In later life, neurocognitive disorders—including dementia and Alzheimer's disease—represent the predominant mental-health-related concern in older adulthood (65 years and older).[11] The age-standardized prevalence of dementia in Canada is approximately 5.2% among men and 6.1% among women over the age of 65.[12] While these conditions are not commonly thought of as mental health disorders in the traditional sense, they are often included in mental health life-course models due to their impact on cognition, mood and daily functioning. As a result, neurocognitive disorders constitute a major source of economic impact in later life, reflecting both the intensive care resources required and the broader ripple effects on families, caregivers and health systems.

Prevalence of Mental Health Conditions (2020 vs. 2024)



Source: Mental Health Research Canada



A lack of action

Despite growing evidence of worsening mental health prevalence across the population, policy responses at all levels of government remain slow and fragmented.[13] As a result, the burden is growing and becoming more visible, more widespread and profoundly more expensive.

This report makes that burden explicit. It quantifies the economic costs of poor mental health, examines the historical and policy choices that have shaped Canada's current trajectory, and outlines the systemic reforms required to build a more sustainable system.

It calls for two fundamental shifts—establishing mental health parity within the healthcare system and reorienting toward prevention—before the economic costs become unsustainable.

Together, these reforms confront a landscape dominated by reactive spending, a national productivity crisis impacted by mental ill health, and employers absorbing the majority of its costs. Addressing the mental health crisis is therefore not only a public health imperative, but also a national economic strategy.

What is Mental Health?

Mental health is a state of well-being that enables people to manage stress, work productively, sustain relationships and make decisions that allow full participation in life. Like physical health, it exists on a continuum that can shift over time—from periods of resilience and adaptive coping to distress, to impairment and clinical mental illness.

The term *mental illness* is used here to describe a diagnosable condition that affects mood, thinking and behaviour. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists more than 450 such conditions, including anxiety and mood disorders, substance-related and addictive disorders, and schizophrenia spectrum disorders.

While not every diagnosis carries the same economic impact, costs rise sharply as conditions become more severe, escalating from reduced productivity to long-term disability, emergency care, justice involvement, homelessness and incarceration.

The economic cost of poor mental health

Our report estimates the annual economic cost of poor mental health at $180 billion—an amount that is almost certainly underestimated, given gaps in available data and several cost components that cannot yet be reliably quantified.

The previous national estimate, published in 2011, placed the cost at $50 billion,[14] equivalent to about $67 billion in today's dollars. Taken at face value, these figures suggest an increase in the estimated economic burden of mental illness in Canada over the past 14 years. However, the two estimates are not directly comparable, as each report used different methodological approaches.[15] As a result, the apparent difference reflects both real changes in the burden of mental illness and the distinct methods used to measure it.



Methodological differences

In August 2012, the Mental Health Commission of Canada (MHCC) published a report titled *Life and Economic Impact of Hypothetical Intervention Scenarios on Major Mental Illness in Canada: 2011 to 2041*.

Prepared by Risk Analytica, it costed mental health at $50 billion annually, using a "life at risk" simulation model projecting prevalence and costs to 2041. The report focused primarily on health-system spending and productivity losses, excluding social service, justice and caregiver costs. It explicitly noted results likely underestimated the true burden.

This 2026 CSA study applies a prevalence-based, bottom-up approach grounded in recent Canadian data. It integrates medical, non-medical, employer and individual costs, as well as costs related to productivity. With careful safeguards to avoid double-counting, this report provides a picture of the system-wide impact of the mental health crisis.

Part of the difference in cost over the past 14 years may be attributable to different methodologies used in estimating cost. However, since 2011, Canada has experienced an increasing prevalence of mental health challenges across many different groups of Canadians, presenting a social, health, and economic burden that is more visible today.

The new CSA model captures a broader and more contemporary reality—revealing just how much the economic burden of mental illness has grown.

Projected Fiscal & Social Risks

If current patterns of unmet need, rising prevalence and constrained service capacity persist, these costs are projected to rise to **nearly $600 billion by 2050**, an amount approaching one-fifth of Canada's projected GDP.[16] This trajectory raises serious concerns about fiscal sustainability, crowding out other priorities and constraining the healthcare system's capacity to deliver essential services.

Without significant reform, poor mental health will not only remain a leading driver of human suffering but may evolve into a significant structural threat to Canada's long-term economic prosperity and social stability.

Methodology

In this report, we aimed to answer the following questions:

- What is the current cost of poor mental health and mental illness in Canada?
- What are the most prominent costs?
- Who is paying these costs?
- How are these costs impacting Canadian workers, employers and the economy?
- How did we get to these costs?

We answered these questions with a focus on the working-age population of Canada. The first three questions were answered by developing a model of the direct and indirect costs of mental illness in Canada. The latter two questions were answered through a narrative review of academic and grey literature.

The **$180 billion** annual cost of poor mental health in Canada reflects two primary categories of expenditure.

1. **Direct costs:** Visible expenditures that can be tracked in budgets and accounts. These include spending within the healthcare system, as well as non-medical costs such as disability programs, employer benefits, justice, policing and homelessness services.
2. **Indirect costs:** Economic losses that do not appear directly in budgets, but that arise when mental health conditions reduce participation and productivity in the labour force. These costs are most commonly measured through presenteeism, absenteeism, unemployment and premature mortality.[17]

Direct costs were estimated using a mix of bottom-up, prevalence-based methods, drawing on the most current Canadian data on medical, non-medical, employer and out-of-pocket mental health expenditures. Indirect costs were estimated using a bottom-up, prevalence-based, cost-of-illness approach, capturing the impact of unemployment, premature mortality, absenteeism and presenteeism. Costs are primarily estimated for Canadians of working age.

A third type of cost that contributes to the economic burden of mental health challenges is intangible costs, which capture the non-monetary burden of illness, including pain, suffering and changes in quality of life.[18] While these costs are important, they were not included in this report as they are difficult to quantify in the Canadian context and can introduce substantial uncertainty into the total cost estimate, including the risk of double counting that may inflate overall estimates. Excluding these costs likely results in an underestimate of the annual cost of mental illness presented here.

As with all cost-of-illness models, these estimates rest on a set of assumptions. Multiple iterations were conducted with different inputs across cost categories to test robustness. Full details on data sources, assumptions and calculations are provided in the Appendix.

Breakdown of costs

The resulting estimates, disaggregated below, provide a high-level view of where the $180 billion burden falls across sectors and types of cost.

Total Costs: $180 billion (2024 CAD)[19]		
Direct Costs: $164 billion		
Medical	Expenditures within the public healthcare system, including hospital admissions, physician services, psychiatric medications and other insured treatments directly related to mental illness.	**$23 billion**
Non-medical	Government spending outside the health system, such as homelessness supports, policing and crisis response, court processes and correctional services linked to mental illness.	**$28 billion**
Employer	Costs borne by workplaces, including disability claims, group benefits, wage replacement, accommodations and insurance premiums.	**$110 billion**
Out-of-pocket	Out-of-pocket expenses for mental healthcare not covered by public or employer insurance, including psychotherapy, medications and related supports. Individuals also face other hard-to-capture costs (e.g., family strain, loss of social connections and reduced participation in community life) that fall outside the scope of this and other costing models.	**$3 billion**
Indirect Costs: $17.09 billion		
Presenteeism	The total value of lost productivity when people living with mental illness go to work but are less productive due to their condition.	**$12.5 billion**
Absenteeism	The total value of income lost to society when people living with mental illness miss workdays due to their condition.	**$2.88 billion**
Unemployment	The total value of income lost to society when people living with mental illness are unable to work due to their condition	**$1.70 billion**
Premature Mortality	The total value of income lost to society when people die early due to mental illness, before reaching retirement age.	**$0.01 billion**

Key implications

Although the methodology measures the total economic burden, a closer look at how those costs are allocated reveals the systemic failures that drive these disparities.

Understanding where mental health costs are concentrated—and who ultimately pays for them—is critical to shaping effective policy reform. Based on our national cost model, three key insights emerge.

1. **Reactive spending drives unsustainable costs**
   Although the annual economic burden of poor mental health in Canada is estimated at $180 billion, only $23 billion—about 7% of Canada's $372 billion[20] total health spending in 2024—is directed toward mental health. This level of investment falls short of the Organisation for Economic Co-operation and Development (OECD) benchmarks, where many countries dedicate 10% to 15% of health spending to mental health.[21]

   Our analysis finds that provincial and federal governments currently spend more than $28 billion annually on reactive responses to mental illness, including homelessness services, incarceration, and repeated ambulance and police interventions. This exceeds the $23 billion allocated to direct mental healthcare, underscoring that more is spent managing the outputs of the crisis than treating mental illness itself.

   Given that municipalities and provinces fund healthcare, emergency response, and workers' compensation through public revenues, increases in system costs place additional pressure on these systems.[22] At the municipal level, rising workers' compensation costs and service expansion, driven by increasing exposure to psychological hazards at work, along with limited prevention and early intervention, contribute to higher property tax requirements.[23] Across the health system, repeated emergency visits and psychiatric hospitalizations increase overall system expenditures and demand on public resources. Evidence shows that prevention and early intervention are far more cost-effective, yet the system remains structured around crisis response rather than addressing root causes.[24]

2. **Presenteeism undermines economic potential**
   Our analysis finds that presenteeism accounts for $12 billion annually, nearly 90% of all indirect costs and one of the largest components of the $180 billion national burden of mental illness. It occurs when employees remain at work but perform below capacity due to mental illness symptoms.

   The implications for productivity are significant. Canada has long struggled to match peer countries in output per worker, trailing the United States, the United Kingdom, Australia and several other OECD nations.[25] While the relationship is complex, mental health challenges are one of several factors that may contribute to workforce performance as nearly one in three Canadian workers report that their performance is directly affected by mental health challenges.[26] At scale, this erosion of workforce effectiveness may be connected to Canada's broader productivity problem and warrants closer examination.

   Left unaddressed, the costs associated with presenteeism may continue to strain productivity and limit Canada's capacity for growth.[27] Targeted investment in prevention and early intervention represents both a public health priority and a potentially important lever for strengthening business performance over time.

3. **Employers shoulder the greatest burden**
   Employers currently absorb more than $100 billion annually—more than half of the total costs of poor mental health—through direct costs, including disability claims, benefits and rising insurance premiums. They are also impacted by productivity losses, facing the dual challenge of high expenditures and reduced output. Gaps in the public health system shift many of the costs of untreated or poorly treated mental health conditions onto workplaces, making employers one of the largest payers in Canada's mental health landscape, according to our modelling. While labour costs, competitiveness and workforce stability are shaped by many factors, workplace conditions and exposure to psychosocial hazards can influence both mental health outcomes and organizational performance.

Analytic focus for this report

This study primarily focuses on Canadians aged 15 to 64 years, reflecting both the epidemiological distribution of most mental disorders and their substantial economic implications within the working-age population.

Given this focus, neurocognitive disorders such as dementia were not included in the cost estimates presented in this report. While dementia represents a major Canadian public health concern, it primarily affects older adults beyond the traditional working age and thus has a more limited direct effect on labour market productivity.

This exclusion ensures that cost estimates reflect conditions most pertinent to economic output and workforce well-being. However, we acknowledge that the economic burden of dementia is substantial and, if included, would likely significantly drive the overall cost estimate, with recent analyses estimating annual costs of approximately $40 billion.[28]



How Did We Get Here?

Canada's high mental health costs reflect the cumulative impact of historical choices, entrenched stigma, and legislative and federal government leadership gaps. These forces have left mental health at the margins of the healthcare system—structurally underfunded and inconsistently protected compared to physical health.

Using a narrative review framework, this section provides a brief historical context and outlines the main drivers of this imbalance.

The shift in mental healthcare

Deinstitutionalization

Until the mid-20th century, psychiatric hospitals and asylums formed the core of Canada's mental health system.[29] These institutions were often overcrowded and underfunded, and care was largely custodial rather than therapeutic.[30] Yet, these institutions did receive dedicated government funding for treatment.

In the 1950s and 1960s, governments began closing these facilities, spurred by the rise of new psychiatric medications and growing criticism of institutional conditions.[31] This process of deinstitutionalization shifted mental healthcare into general medical practice and community-based settings, with family physicians becoming the primary point of contact. Establishing a comprehensive community-based system proved challenging, and financial and logistical constraints meant that services did not expand at the scale originally planned. This left a major gap in care.[32]

At the same time, Canada was building Medicare—a system of publicly financed health insurance guaranteeing universal access to physician and hospital services.[33] The 1984 *Canada Health Act* (CHA) consolidated this model by setting national rules for federal funding and prohibiting user fees for insured services.[34] By then, most psychiatric hospitals had closed, community mental health was never brought under Medicare's mandate, and the impact was clear—dedicated funding for place-based mental health treatment disappeared.[35]

Transinstitutionalization

With psychiatric hospitals and asylums no longer the primary site of care, and community services underdeveloped, people experiencing severe mental health challenges have increasingly been absorbed into other public institutions. This shift, known as *transinstitutionalization*, has turned public safety and emergency systems into default points of response for mental illness.[36]

As a result, prisons are said to be functioning as Canada's "largest psychiatric facilities."[37] Correctional Service Canada estimates that up to 70% of federally incarcerated individuals have a mental health issue, with nearly one-third living with a diagnosed disorder. [38]

Housing one inmate costs roughly $114,000 per year, bringing the direct cost of incarcerating people with mental illness to an estimated $2 billion annually.[39] The justice system also absorbs significant costs to prosecute these cases—costing an estimated half a billion dollars each year.[40]

The same pressures are visible in hospitals. Between 2016 and 2024, Canada recorded nearly 200,000 emergency department visits for substance related harms, with nearly half (46%) in 2024 involving fentanyl and its analogues, which is a 130% increase from 2018.[41] At an average cost of roughly $300 per visit, this represents a rapidly escalating financial and clinical burden.[42]

Transinstitionalization has resulted in Canada spending billions of dollars managing mental illness through prisons, courts and emergency rooms. These systems were never designed to manage mental health conditions. This shift has moved the burden of mental illness onto the most expensive parts of the public sector, driving costs upward, while leaving prevention, early intervention and recovery chronically underfunded. It is one of the central forces fuelling Canada's current mental health crisis.

Medicare's narrow definition of "medically necessary"

The trend of transinstitutionalization has been driven in part by the CHA.[43] While the Act commits to protecting the "physical and mental well-being of residents," it does not define what is "medically necessary."[44] This omission has left important gaps in mental health coverage across Canada and has shaped the system's evolution.[45]

Services delivered by medical practitioners, such as family physicians, nurses and psychiatrists, are routinely covered under public healthcare.[46] These professionals play an important role—they can screen for mental health conditions, prescribe medication, provide initial treatment and coordinate referrals. As many as 80% of Canadians rely on family physicians as their main entry point for mental health support, yet nearly one in four Canadians report having no regular family doctor, leaving many without access to this limited pathway.[47] Even when referrals to mental health professionals are made, long wait times exist for access to care.[48]

By contrast, services provided by psychologists, psychotherapists, social workers and peer support workers—the providers who deliver much of the frontline mental healthcare to Canadians—are largely excluded from the publicly funded system.[49] While some government programs include limited coverage, this varies by province and territory. For example, in most parts of Canada, evidence-based therapies for post-traumatic stress disorder (PTSD), eating disorders and substance use are insured only when delivered in hospitals.[50]

Outside hospital and outpatient medical settings, Canadians must rely on private insurance or pay out-of-pocket for therapy and prescription medications, unless those medications are covered under a provincial or territorial drug plan. This has forced individuals and businesses to subsidize recovery costs, with Canadians spending an estimated $1 billion annually on private counselling and psychotherapy alone, and an additional $2 billion on psychiatric medications.[51]

The result of this coverage gap is a two-tier model—hospital and psychiatric care are covered under public insurance, while counselling and therapy depend on private coverage or the ability to pay. In practice, this creates deficits in healthcare access across both the public and private systems.

It has also reinforced the trend of transinstitutionalization —where those unable to access timely, community-based supports are more likely to cycle into hospitals, correctional facilities or workers' compensation systems. The CHA's narrow definition of coverage has thus not only left gaps in care but has contributed to shifting the burden of untreated mental illness into other costly institutions.



Issues of funding and leadership

Chronic underfunding and short-term programs at the provincial level

Because most mental health services are not considered medically necessary under the CHA, funding does not automatically flow to them. Mental health is forced to compete with acute care and other visible priorities—and consistently loses.

On average, only 5% to 7% of provincial and territorial health budgets are directed to mental health, well below the OECD benchmark of 10% to 11%.[52] By comparison, peer countries invest considerably more—15% in France, 11% in Germany and 10% in the United Kingdom.[53] Without benchmarks or dedicated mental health funding, Canada continues to lag, with wide disparities across provinces. Some allocate modest sums to community services, while others provide little beyond hospital-based psychiatry.[54]

Federal initiatives have been similarly inconsistent. Bilateral agreements in 2017 and 2023 provided roughly $900 million per year, alongside targeted programs such as the 9-8-8 crisis line, substance use initiatives and wellness funds.[55] Yet these investments remain short-term, fragmented and program-specific, falling far short of the structural funding needed for a comprehensive mental health system.

Program / Fund	Federal Commitment
Substance Use and Addictions Program	$144 million
Youth Substance Use Prevention Program	$20 million
Wellness Together Canada	$240 million
9-8-8 Crisis Helpline	$158 million
Mental Health Promotion Fund	$46.3 million
Youth Mental Health Fund	$500 million
Emergency Treatment Fund	$150 million

A more permanent solution was proposed in 2021, when the federal government committed to creating a Canada Mental Health Transfer, a dedicated and sustained fund. That commitment was abandoned, with resources redirected to the national dental plan—leaving Canada with a patchwork approach that cannot meet the scale of need.[56]

Limited federal prioritization and accountability

The failure to establish sustained provincial funding reflects the lack of federal prioritization of mental health. In 2021, the federal government created a Minister of Mental Health and Addictions, signalling recognition of the issue, but the portfolio was dissolved in 2025 and folded back into the Ministry of Health.[57]

A federal Minister of Mental Health and Addictions can act as a champion—a role that is pivotal for creating and sustaining change.[58] Without a national champion, mental health policy has relied heavily on fragmented bilateral agreements and short-term programs, reinforcing the stop-start pattern of investment.

Elsewhere, mental health is integrated into broader provincial health ministries, where it competes with acute care and other urgent priorities. Only British Columbia has maintained a dedicated ministerial portfolio since 2017. The lack of consistent federal direction has reinforced the perception of mental health as peripheral to Canada's health system, leaving reforms dependent on provincial priorities and vulnerable to shifting political agendas.

Fragmented provincial and territorial approaches

Because the CHA never defined what counts as medically necessary, provinces and territories set their own priorities. The result is a patchwork of access and quality. Data from the Canadian Institute for Health Information (CIHI) show stark contrasts—the median wait for counselling is eight days in Saskatchewan, but 62 days in New Brunswick. Geography, not need, often determines whether someone receives timely care.[59]

For Canadians unable to access public services, the options are limited—pay privately or forgo care altogether. Delayed or insufficient care does not eliminate costs but rather shifts them elsewhere. According to our model, the largest indirect cost drivers are presenteeism ($12 billion annually) and mental health disability claims (about $13 billion), which drain employers, governments and the wider economy.

Without federal benchmarks or a framework for mental health parity, provinces continue to move in different directions, leaving Canadians with uneven care and shifting a financial burden onto households and employers that varies across the country.



Social, economic and system pressures

A shortage of specialists

Canada's patchwork of access to mental health services is compounded by a shortage of mental health specialists. Even where coverage exists, timely care is often out of reach because the workforce simply does not exist to meet the current demand for mental healthcare services. Canada ranks near the bottom of peer nations in psychiatrists per capita, with just 0.18 per 1,000 people, compared to 0.28 in Germany and 0.52 in Switzerland. Wait times for psychiatric care can stretch to six months, even in major centres.[60]

This national shortage is intensified by uneven distribution. CIHI data show that per-population rates of mental-health and substance-use health providers vary widely across provinces and territories, with some jurisdictions like Nova Scotia and Newfoundland exceeding 2,200 providers per 100,000 people, while Nunavut falls below 700 per 100,000.[61] In many regions, particularly rural, northern and Indigenous communities, the workforce gap is especially large.[62]

Nursing shortages further strain access.[63] Psychiatric nurses play a central role across hospital, community, and crisis services, but their numbers remain far below need.[64] In 2023, Canada had only 6,725 registered psychiatric nurses, which is a modest 3% increase that does not keep pace with rising demand.[65] Chronic understaffing in community settings has led to heavier workloads, rising burnout and higher acuity patients.

The shortage of experts is particularly acute in Indigenous communities, where intergenerational trauma and jurisdictional gaps compound barriers.[66] Access to culturally safe, Indigenous-led services remains limited, with relatively few Indigenous providers and chronic underfunding of community-driven programs.[67]

The full scale of the problem remains difficult to quantify because Canada lacks reliable workforce data. Information on the number, distribution and competencies of mental health providers is limited, and there is no systematic data on uninsured non-physician services such as psychotherapy or community-based supports. Until these gaps are addressed, workforce planning will remain reactive and insufficient to meet current or future needs.

The COVID-19 pandemic

The COVID-19 pandemic both exposed and intensified existing shortages in mental healthcare. For example, in Ontario, it was estimated that 3% of family physicians stopped practicing at the beginning of the pandemic, likely due to premature retirement, revenue loss and burnout, reducing one of the main entry points to mental-health support for Canadians.[68]

At the same time, more than one-quarter of Canadian psychologists reported probable burnout, along with symptoms of depression, anxiety and emotional exhaustion. These factors have pushed many out of the workforce.[69] Layered onto longstanding shortages, this attrition has left a system struggling to meet rising demand.[70]

Even as the mental health workforce shrank, rates of anxiety, depression and other mood disorders climbed sharply, as shown above. Studies also show steep increases in the prevalence of eating disorders[71] and substance use mortality[72] since the start of the pandemic.[73]

Canada is still recovering from this increase in prevalence in mental illness and healthcare system use. A 2025 national survey of physicians found that 46% suffer from high levels of burnout, further limiting the entry point for mental healthcare.[74] The result is a widening gap—with a shrinking pool of experts on one side and sustained, elevated demand on the other.[75] The pandemic did not create the crisis in mental-healthcare. Rather, it accelerated it, leaving a system that remains overstretched, reactive, and in urgent need of long-term workforce and policy renewal.



The introduction of social media

A growing body of research points to the rising mental health burden associated with social media use, particularly among adolescents and young adults. For example, systematic reviews show consistent associations between heavy or problematic social media use and increased symptoms of anxiety, depression, disordered eating and sleep disruption.[76]

These effects are not uniform, and research indicates that the risks are significantly higher among individuals who spend large amounts of time online, use multiple platforms intensively, or engage in passive scrolling rather than active interaction.[77] Studies also highlight that heavy users are more likely to experience social comparison, cyberbullying, disrupted sleep patterns and heightened stress reactivity, all of which contribute to poorer mental health outcomes.[78]

Economic and public health research also indicate a population-level impact—exposure to algorithm-driven platforms has been associated with declines in adolescent well-being and increases in self-harm and suicidality after the mid-2010s.[79] Major health authorities have echoed these concerns, with the U.S. Surgeon General identifying youth social media exposure as a growing public health risk.[80] Canada's public health agencies have raised similar alarms.[81] The Canadian Paediatric Society has reported increasing associations between social media use, cyberbullying, sleep disruption, and rising anxiety and depressive symptoms among youth.[82]

While causality remains debated, the consistency of findings across disciplines underscores that digital environments have become a meaningful contributor to the rising prevalence and severity of mental health challenges in Canada.

Neglect of social determinants of mental health

The pandemic also magnified vulnerabilities rooted in Canada's social and economic landscape. Rising rates of mental illness are not only the product of limited clinical capacity, but also of poverty, housing insecurity and unstable employment, which make people more susceptible to mental illness and less able to recover.

For example, 16% of Canadians with poor mental health live in inadequate housing compared to 10% with good mental health, with the highest rates in provinces facing affordability crises—British Columbia (19%), Ontario (18%) and Alberta (17%).[83] Studies also estimate that between 23% and 67% of people experiencing homelessness live with a mental illness.[84] Income gradients are equally striking. Those in the lowest income group are three to four times more likely to report poor or fair mental health.[85]

Canada's response to the mental health crisis remains largely medical, centred on physicians and hospitals, while the social determinants of health, such as housing, income, education and employment, receive far less attention.[86]

Yet their exclusion from health budgets does not eliminate costs—it simply shifts them elsewhere. An estimated $13 billion in homelessness expenditures are directly linked to mental illness according to our model. By neglecting these structural drivers, Canada sustains a cycle in which mental illness both stems from and reinforces broader inequities.



Rising costs for employers

According to our modelling, employers spend around $110 billion annually in mental-health-related expenses, making them one of the largest groups carrying this burden in Canada.

The surge has been driven particularly by disability and psychological injury claims. According to Sun Life Financial, mental health disability claims more than doubled between 2019 and 2022, with the steepest increases among younger workers.[87] Other insurance providers are seeing similar increases.[88]

Workers' compensation boards show a similar pattern—accepted psychological injury claims[89] are rising by an average of 10% each year, and these cases are markedly more complex to resolve. In WorkSafeBC, for example, psychological-injury-only claims reported grew from 4,437 in 2020 to 7,258 in 2024, yet only 46% were accepted in 2024. This statistic shows that a large proportion of workers seeking support still do not meet the strict diagnostic and legislative criteria for approval.[90]

Among those that do proceed, accepted mental-health-related claims can be extremely costly.[91] Some literature suggests that the average duration and cost of a psychological injury claim are 61 days and $15,667,[92] respectively, while other sources have estimated an average cost of about $50,000[93] and wage-replacement durations can exceed 400 days[94]—more than five times longer and more expensive than the average physical-injury claim.[95] Since the onset of the pandemic, the total cost of these claims has climbed by more than 90%.[96]

This increase also aligns with the expansion of presumptive legislation for psychological injuries, particularly post traumatic stress disorder (PTSD), across Canadian jurisdictions beginning in the early to mid-2010s and expanding to additional occupations over time.[97] These policies have lowered the evidentiary burden for certain workers and contributed to increased claim recognition and acceptance.

In response, many employers have expanded benefit coverage, introduced mental health training and launched wellness initiatives. Yet these preventive investments remain modest relative to the scale of the problem. Our model shows that of the $106 billion employers spend annually, only about $15 billion—roughly 14%—is directed toward prevention, including mental-health benefits ($14 billion) and training ($1 billion). The remaining $91 billion (86%) is spent after harm occurs, covering disability leaves, accommodations, overtime backfill, turnover, and legal or compliance costs.

In other words, most employer spending still flows downstream into crisis response and recovery, the most expensive stages, rather than upstream into prevention and early risk reduction. This imbalance keeps organizations focused on managing the consequences of poor mental health rather than addressing its causes.

Recommendations

Any recommendations on how to reduce these costs must be set against the reality of a public healthcare system that is currently under significant strain.[98]

Hospitals are operating beyond capacity,[99] emergency rooms face record volumes and closures,[100] and wait times for many procedures continue to grow.[101] Meanwhile, healthcare workers face high burnout rates and the sector has difficulty attracting new staff.[102] Millions of Canadians lack a family doctor, cutting off the most common entry point for care.[103]

In this environment, the call to expand services—particularly in mental health—can feel daunting. Policymakers and practitioners may question how new responsibilities can be layered onto a system that is already in crisis.

This fragility is what makes reform urgent. Without upstream investment, unmet mental health needs will only deepen pressures on an already overextended system, driving more patients into emergency rooms and further straining primary care.

As such, Canada now faces two pathways. The first is to continue on the current trajectory, managing mental health primarily through downstream, reactive spending, which will continue to increase over time. Our analysis projects that maintaining the status quo can push the economic burden to $600 billion annually by 2050, reflecting sustained growth in disability claims, hospitalizations and productivity losses.

The second option is to achieve mental health parity and reorient the system toward prevention by shifting resources upstream to reduce the incidence, severity and progression of mental health problems. Though more difficult to implement, prevention offers the most credible path to long-term cost containment and improved outcomes. Although the entire health system would benefit from this shift, our focus here is on mental health.

The recommendations that follow provide a pathway to achieve this shift.

1. Mental health parity

The fragility of Canada's health system underscores the need to treat mental health as integral to healthcare as physical health. Establishing parity between mental and physical health means treating mental health services as equally essential, with access determined by clinical need rather than geographic location or ability to pay.

At present, the exclusion of most community-based mental health services—and the lack of coverage for practitioners such as psychotherapists, psychologists, social workers and peer mentors—has produced a fragmented system where untreated needs spill into emergency rooms or are displaced into other parts of the public sector. Parity is therefore not only an equity issue, but also a matter of cost containment.

By increasing investments through health budgets, Canada could have the ability to deliver timely, evidence-based care before people reach crisis. This would not only improve access, but also generate savings elsewhere by reducing the costly spillover of untreated mental illness into homelessness services, corrections and the judiciary. The United Kingdom's Mental Health Investment Standard demonstrates how such reforms can be embedded into funding rules to drive sustained, system-wide change.



Case study: Mental health parity in the United Kingdom

In 2011, the UK National Health Service (NHS) embraced the notion of parity of esteem, mandating that mental health be regarded on equal footing with physical health. The Improving Access to Psychological Therapies (IAPT) program facilitated the provision of prompt, evidence-based treatment, predominantly cognitive behavioural therapy, for prevalent illnesses like depression and anxiety.

The justification was both economic and clinical. Unaddressed mental illness was contributing to elevated expenses in poverty, incapacity and diminished productivity. The NHS redirected resources upstream by enacting access rules and financing therapy on a large scale. Assessments indicate that each £1 allocated to IAPT yields almost £4 in savings due to diminished welfare reliance, decreased health-system usage, and heightened tax income from individuals re-entering the workforce. Recovery rates are near 50% and psychiatric hospitalizations have decreased by one-third.

Achieving parity does not require overhauling Medicare, but rather introducing structural reforms that build on its foundations through steps such as the following.

- **Redefine "medically necessary" services:** Establish a national expert panel to expand publicly insured care to include evidence-based treatments such as counselling, psychotherapy and community support. These services, where most mental healthcare occurs, remain outside the CHA, forcing Canadians to pay privately or go without. Including them would close one of the system's largest gaps.
- **Use federal spending levers to drive measurable mental health outcomes:** Tie federal mental health funding to clear, outcomes-based benchmarks, such as maximum wait-time targets, minimum service availability, provider-to-population ratios, and standardized public reporting on access and workforce capacity. This would reduce interprovincial fragmentation, relieve pressure on workplaces, emergency departments, and correctional systems, and establish a national performance floor for access and quality across the country.
- **Dedicate leadership**: Establishing a dedicated federal minister for mental health and addictions would provide the visibility, accountability and authority required to implement a coherent national strategy, manage budgets and ensure compliance with national standards. Complementing this, each province should establish its own dedicated ministerial portfolio, embedding leadership across all levels of government. This proposed mental health governance structure would reduce fragmentation, promote consistency and enable coordinated implementation of reforms nationwide.



2. A preventative approach

A preventative approach requires system architectures that reduce exposure to psychosocial risks, strengthen protective factors, and support early identification of emerging concerns before they progress into clinical illness or disability. Recent global mental health frameworks highlight several policy directions relevant to Canada's context.[104]

First, prevention must be embedded across the institutional systems that shape daily life, rather than confined to specialized mental-health services. A whole-of-society model expands responsibility for early detection and early support to workplaces, schools, primary care and community settings.[105] This reorientation treats early psychological distress and adverse psychosocial conditions as health risks requiring timely response, not issues addressed only once they reach diagnosable thresholds.

Second, investments need to be made in psychosocial and community-based responses that address the social and structural determinants of mental health.[106] Evidence demonstrates that outcomes are influenced by environments such as educational settings, working conditions, housing stability, social supports and economic security.[107]

Finally, strengthening the capacity of frontline systems, educators, primary-care providers, community agencies and employers to recognize and respond to early concerns can reduce escalation and reliance on downstream emergency or institutional services.[108]

Canada currently lacks the system design and cross-sector coordination needed to operationalize prevention at scale.[109] A national prevention mandate can set overarching direction, but effective implementation must occur across the institutional settings where early risk emerges and the opportunities for timely intervention are greatest.

3. Dedicated budgets

Achieving parity between mental and physical health will not be possible without dedicated, stable and long-term funding. At present, the absence of such funding is a central barrier to sustainable reform and a key driver of escalating cost pressures across the economy. This underinvestment leaves governments managing crises downstream rather than preventing them upstream.

One approach could be to introduce a dedicated mental health transfer—an annual allocation to provinces and territories delivered alongside the existing health transfer. The size of the allocation should be grounded in evidence—a business case that maps provincial cost pressures, identifies where needs are most acute, and directs resources where they will have the greatest impact on outcomes and fiscal sustainability.

To ensure consistent access and quality of mental healthcare across Canada, the proposed transfer should be tied to national mental health standards mentioned above. This would help reduce disparities in wait times and out-of-pocket costs, while promoting equitable service delivery. To guarantee long-term sustainability, the funding mechanism should also include a growth clause that ensures mental health spending increases in line with overall health expenditures, as was done in the United Kingdom.



Case study: The UK's Mental Health Investment Standard (MHIS)

The United Kingdom offers a useful model through its Mental Health Investment Standard (MHIS), introduced in 2015. The policy requires each regional NHS body to increase mental health funding at least in line with overall NHS spending, ensuring that mental health budgets are not left behind during broader health system growth.

Compliance is enforced through clear accountability measures. Regions that fail to meet the standard face financial penalties and the loss of performance-based incentives. By embedding this requirement into funding rules, the MHIS has helped to entrench mental health parity within the U.K. system, reducing the risk of short-term cuts and promoting a more predictable, sustained trajectory of investment.



4. Employer relief

While dedicated public funding is essential, it must be complemented by measures that address both the disproportionate burden currently borne by employers, and the significant role workplaces play in generating psychosocial risks. Workplaces are not merely sites where the costs of mental illness become visible—they are also contributors to mental health problems through factors such as excessive workload, poor leadership, bullying, low job control and exposure to trauma.[110]

Employers currently account for more than $106 billion annually in mental-health-related costs that could be prevented, yet less than 10% of this spending is directed toward prevention. The overwhelming majority flows downstream into disability claims, turnover, accommodations and benefit premiums, reflecting a system that responds to harm rather than reducing the conditions that produce it.

To shift this trajectory, employers should be incentivized to invest earlier through preventive initiatives aimed at supporting mental health, and government policy can play a catalytic role. One potential solution is the use of tax credits and grants. For example, in Germany, employers can allocate up to €600 per employee (CAD $880) on stress management or mental well-being programs on a tax-free basis.[111] In Australia, some states provide grants ranging from AUD $50,000 (CAD $45,000) to AUD $175,000 (CAD $155,000) to employers piloting preventive workplace initiatives.[112] These mechanisms lower barriers to adoption and create incentives for sustained investment in prevention.

It is equally critical to offset employer costs when workers are already experiencing mental illness and cannot work—a stage that accounts for nearly 50% of total employer mental health costs. Other countries address this through return-to-work subsidies. In Japan, employers implementing accommodations such as flexible hours or coordinated medical leave can receive up to JPY 200,000 (CAD $2,400) per employee.[113] Sweden provides wage subsidies covering part of salary costs for up to four years when employers reintegrate workers with reduced capacity, including those with mental illness. These supports reduce the financial barriers to retention and reintegration, easing one of the most significant drivers of employer costs.

A final critical lever is accelerating the integration of psychological health and safety (PHS) into existing occupational health and safety legislation.[114] PHS refers to the policies, practices and conditions that protect and promote workers' psychological well-being by identifying, assessing and controlling psychosocial hazards in the workplace.[115] Unlike disability claims or wage subsidies that respond after illness occurs, PHS focuses on prevention. It would require employers to identify and manage psychosocial hazards—including bullying, excessive work demands and poor leadership—that can erode mental health and lead to illness, and to address them with the same urgency as physical hazards.

As mentioned above, Australia has already taken this step by embedding psychosocial risk controls into its worker health and safety regulations and creating a National Code of Practice related to managing psychosocial risks in the workplace, with funding set aside to help small businesses comply.[116] Canada is starting to move in a similar direction with most provinces starting to update their occupational health and safety (OHS) legislation to protect not just physical but also psychological safety. However, that move should be accelerated to ease costs and normalize prevention, as well as to harmonize approaches to the prevention and management of work-related mental health conditions across different Canadian jurisdictions.[117]



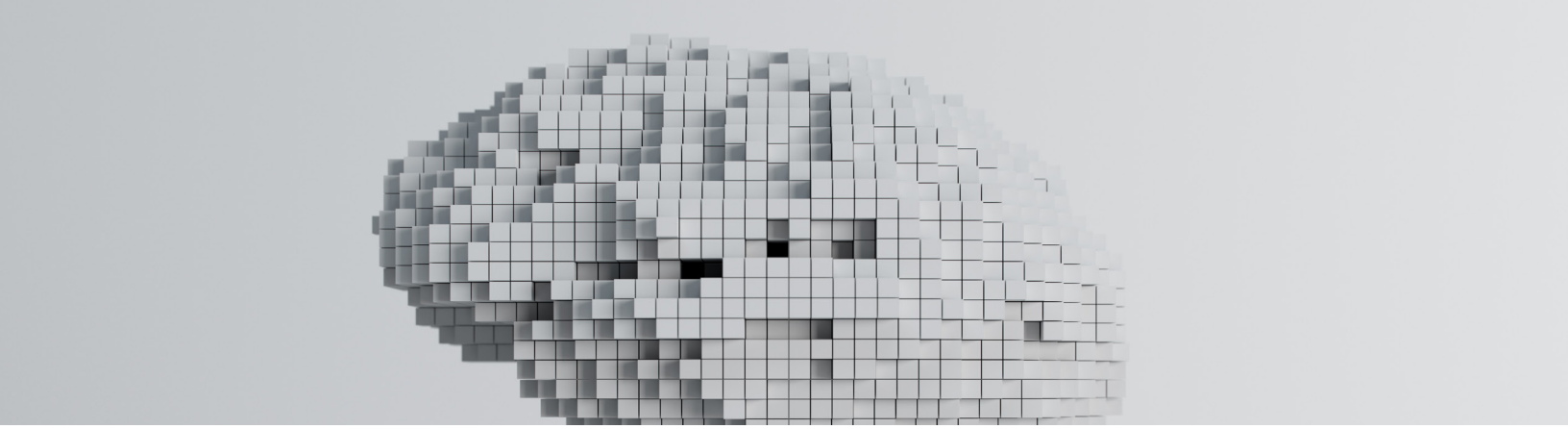
5. Mental health workforce strategy

Reducing costs and improving outcomes depends not only on shifting investment toward prevention, but also on strengthening and better utilizing the mental health workforce.[118] At present, Canada lacks reliable data on the composition and distribution of its mental health workforce.[119] A standardized national surveillance system is needed to capture providers across jurisdictions and sectors, identify which professions are under-represented relative to need, and map geographic disparities. Without this foundation, workforce planning will remain fragmented and reactive.

With accurate data, recruitment can be targeted to address specific gaps by provider type. International experience demonstrates the value of explicit targets. In the United Kingdom, the NHS Mental Health Implementation Plan set out clear numbers for expansion by practitioner type (e.g., 600 psychiatrists, 600 social workers, 4,000 nurses, 5,000 peer support workers).[120] Such precision strengthened accountability and clarified the scale of investment needed for workforce development.

Canada should adopt a similar approach by co-designing recruitment pathways and service models with people with lived and living experience, alongside clinicians and system planners. It should also expand team-based care within primary care settings, co-locating and funding mental health services within medical clinics. Integrating psychiatric nurses, nurse practitioners, social workers, counsellors and peer-support workers alongside family physicians would broaden access, facilitate early identification and enable more flexible distribution of tasks across the workforce. This approach would ensure decisions are made that reflect existing gaps, and which services can be safely and effectively delivered by providers outside psychiatry and psychology.

Beyond recruitment, retention is also critical. High rates of burnout, poor working conditions, and other psychosocial factors continue to drive practitioners and healthcare support professions out of the field, further constraining capacity. Evidence from other jurisdictions underscores the importance of workforce development strategies that embed supervision supports, provide career progression, ensure manageable caseloads and offer competitive compensation.[121] Without such measures, gains in recruitment will be offset by losses in retention and undermine Canada's ability to reduce wait times, expand access and contain escalating costs.



6. Acknowledging the social determinants of mental health

Even with a productive workforce, Canada will continue to face escalating costs if the broader social conditions that shape mental health are neglected. The approach to mental health remains heavily clinical, while poverty, housing insecurity and unstable employment—factors that both drive the onset of illness and impede recovery—are largely left outside the health budget.

The OECD has emphasized that durable mental health reform requires cross-cutting governance structures that align health policy with housing, employment and income supports, alongside equity-focused investment in marginalized populations.[122]

International practice shows the potential of such approaches. Finland's National Mental Health Strategy 2020–2030, for example, explicitly defines mental health as a right linked to housing, education, employment and social inclusion, creating a framework for multi-sector accountability.[123]

For Canada, advancing a comparable model would mean embedding interministerial mechanisms that link funding and accountability across portfolios, while directing sustained resources to Indigenous-led and community-driven programs that address trauma, poverty and housing insecurity. Integrating these principles into policy and financing frameworks would bring Canada closer to OECD best practice and tackle one of the most significant structural drivers of its escalating mental health costs.

7. Investing in mental health data

Measurement is a prerequisite for meaningful action and for assessing progress. Currently, in-depth national estimates of mental health prevalence are produced only once every 10 years.[124] Provinces and territories report on service use in different ways, sometimes leading to difficulty in quantifying national service use trends. Additionally, information on private practice trends remains limited at both provincial and federal levels.

Therefore, we suggest that Canada:

1. Conduct more frequent national surveillance of poor mental health and illness prevalence to capture emerging trends.
2. Establish capacity to evaluate innovative treatments, early-intervention models and pilot programs. Publicly funded programs, whether clinical or community-based, should be expected to demonstrate measurable improvements in outcomes, equity and cost-effectiveness.
3. Expand data collection to better capture how psychosocial factors and workplace conditions interact with mental health. This includes impacts on productivity, the proportion of workers who are effectively accommodated, employer confidence in providing accommodations, and levels of workplace stigma.
4. Invest in robust data linkages across administrative, clinical and employment datasets to support a more integrated understanding of mental health and work.

Together, these actions would generate a more timely and comprehensive picture of needs, service use and workforce outcomes, allowing policymakers to respond proactively rather than reactively.

A call for action

The costs of untreated mental illness are ultimately borne by the public. Citizens face higher tax pressures as municipalities, provinces and the federal government allocate substantial resources to emergency response, homelessness services, policing and the judicial system. Businesses absorb these costs through disability claims, lost productivity and accommodations. Together, these expenditures reflect a system that finances the consequences of mental illness.

This reactive approach has produced a paradox—substantial public resources are already allocated to mental health as our model has shown, yet the benefits to society on these investments are limited. Because investments are made only after an illness has advanced to a diagnosable stage, costs escalate and ancillary consequences, such as homelessness, incarceration or workplace disability, accumulate.

Clinical evidence demonstrates that early effective intervention can prevent many mental health challenges from progressing to more severe, diagnosable illnesses.[125] For reform to be sustainable, citizens must articulate the expectation that prevention and long-term planning guide policy.

Establishing this societal mandate would allow governments to reorient spending away from costly crisis management and toward upstream interventions that improve outcomes and reduce overall systemic cost pressures.



Conclusion

This is not the first report to document the immense economic toll of mental health in Canada. The question that remains is whether a burden approaching $180 billion annually—projected to surpass $600 billion by 2050—will finally be enough to drive meaningful reform.

The costs are already unsustainable, spilling beyond the health system into sectors that were never designed to absorb them. Employers face escalating disability claims, lost productivity and rising turnover. Justice and homelessness systems, under-resourced and overextended, are forced into crisis response rather than recovery.

If the fiscal argument is not persuasive, the productivity one should be. Over the past five years, business productivity in Canada has declined, leaving the country behind not only the United States, but also many advanced economies in Northern and Western Europe and Australia.[126] Our analysis shows that mental health conditions are a significant contributor to this decline, affecting workforce participation and performance.

Presenteeism, absenteeism and the premature exit of workers due to psychological injury are now among the most significant drivers of productivity loss and the largest sources of indirect costs. When nearly one in three Canadians are not fully present or performing at their potential because of mental health challenges, the productivity gap will only widen.[127] Addressing mental health is therefore not ancillary to economic growth, but central to it.

If the productivity case isn't convincing, the human one must be. Mental health challenges touch every Canadian. It is not a distant abstraction, but a daily reality that people live, feel and, as this report shows, increasingly pay for.

Costing the burden sharpens the economic imperative for reform and makes change needed more urgent. But the deeper imperative is moral—to relieve suffering, restore potential, and enable every Canadian to participate in society to their full potential.

Achieving that outcome requires two fundamental shifts—mental-health parity and prevention. Parity places mental health on equal footing with physical health, supported by comparable funding, coverage and accountability.

Prevention moves resources upstream to address risks before they become costly crises. Together, these shifts offer the clearest path to a healthier population, a stronger economy and a sustainable public healthcare system.

Appendix A: Costing Summaries

Table A. Definition of Costs Included in the Analysis

Cost Type	Specific Cost	Definition
Direct, Medical	Medical Costs	Expenditures within the public healthcare system, including hospital admissions, physician services, psychiatric medications and other insured treatments directly related to mental illness
Direct, Non-medical	Income Support	Federal and provincial disability payments provided to individuals unable to work due to mental illness, as mapped through program expenditures and psychiatric caseload proportions
Direct, Non-medical	Homelessness	Public spending on shelters, housing and related services for individuals without stable housing who live with mental illness
Direct, Non-medical	Crisis Response and Public Safety	Costs of police, ambulance and emergency services responding to mental-health-related incidents
Direct, Non-medical	Justice System	Costs related to policing, courts, corrections and forensic psychiatry for individuals with mental illness involved in the legal system
Direct, Employer Costs	Mental Health Premiums	Employer spending on benefits covering counselling, therapy, medications and other mental-health-related services
Direct, Employer Costs	Mental Health Training	Employer-funded programs that build awareness, prevention, and management skills for psychological health in the workplace
Direct, Employer Costs	Manager Time	The portion of managerial work hours spent addressing employee mental health issues, support and related administrative tasks
Direct, Employer Costs	Disability Leave	Employer costs for short- and long-term absences due to mental-health-related conditions
Direct, Employer Costs	Overtime to Cover Disability	Additional wage costs incurred when employees work extra hours to replace absent colleagues on mental-health-related leave

Appendix A: Costing Summaries

Cost Type	Specific Cost	Definition
Direct, Employer Costs	Accommodations and Return to Work	Employer costs for modifying duties, scheduling and coordination to support employees returning from mental-health-related leave
Direct, Employer Costs	Voluntary Turnover	Employer costs of replacing employees who leave jobs due to mental-health-related stress or mental illness
Direct, Employer Costs	Legal and Compliance Costs	Employer expenses for meeting psychological health regulations, conducting investigations and managing legal claims related to mental health
Direct, Employer Costs	Safety and Incident Related Costs	Expenses from workplace injuries, errors and investigations linked to psychological strain, fatigue and burnout
Direct, Out-of-Pocket Costs	Psychologists and Private Counselling	Out-of-pocket spending on therapy and psychological services not covered by public or employer insurance
Direct, Out-of-Pocket Costs	Private Share of Psychiatric Medications	Out-of-pocket and privately insured spending on prescription drugs used to treat mental illness
Indirect Costs	Unemployment	The value of lost income due to individuals being unable to obtain or maintain employment as a result of mental illness
Indirect Costs	Premature Mortality	The value of forgone future income and lost workforce impact due to individuals dying earlier than expected from mental illness
Indirect Costs	Absenteeism Costs	The cost of missed workdays due to mental illness
Indirect Costs	Presenteeism Costs	The cost of reduced productivity while at work due to mental illness

Appendix A: Costing Summaries

Table B. Age Range Costs are Based On, and Whether Costs Account for Mental Illness and Mental Health

Cost Type	Specific Cost	Age Range Cost is Based On	Mental Illness Accounted for in Cost	Mental Health Accounted for in Cost
Direct, Medical	Medical Costs	All age groups	Yes	No
Direct, Non-medical	Income Support	18+	Yes	No
Direct, Non-medical	Homelessness	Not stated	Yes	Yes
Direct, Non-medical	Crisis Response and Public Safety	Not stated	Yes	Yes
Direct, Non-medical	Justice System	Not stated	Yes	Yes
Direct, Employer Costs	Mental Health Premiums	18+	Yes	Yes
Direct, Employer Costs	Mental Health Training	18+	Yes	Yes
Direct, Employer Costs	Manager Time	Not stated	Yes	Yes
Direct, Employer Costs	Disability Leave	18+	Yes	Yes

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Cost Type	Specific Cost	Age Range Cost is Based On	Mental Illness Accounted for in Cost	Mental Health Accounted for in Cost
Direct, Employer Costs	Overtime to Cover Disability	18+	Yes	Yes
Direct, Employer Costs	Accommodations and Return to Work	18+	Yes	Yes
Direct, Employer Costs	Voluntary Turnover	18+	Yes	Yes
Direct, Employer Costs	Legal and Compliance Costs	18+	Yes	Yes
Direct, Employer Costs	Safety and Incident-related Costs	18+	Yes	Yes
Direct, Out-of-Pocket Costs	Psychologists and Private Counselling	Not stated	Yes	Yes
Direct, Out-of-Pocket Costs	Private Share of Psychiatric Medications	Not stated	Yes	No
Indirect Costs	Unemployment	15 to 64	Yes	No
Indirect Costs	Premature Mortality	15 to 64	Yes	No
Indirect Costs	Absenteeism Costs	15 to 64	Yes	No
Indirect Costs	Presenteeism Costs	15 to 64	Yes	No

Appendix A: Costing Summaries

Table C. Analytic Cost Estimation Technique

Cost Type	Specific Cost	Cost Estimation Technique	Overview of Estimation Method
Direct, Medical	Medical Costs	Top-down, prevalence-based	Used total national public health expenditure ($372 billion) and applied a 7% mental health share to estimate total mental-health-related medical costs
Direct, Non-medical	Income Support	Top-down, prevalence-based	Took aggregate federal and provincial disability program spending and applied the estimated 40% psychiatric caseload share to calculate the mental-health-related portion
Direct, Non-medical	Homelessness	Bottom-up, prevalence-based	Estimated by multiplying the annual number of people experiencing homelessness (235,000 × 40% with mental illness) by per-person service cost ($134,000), producing a macro-level, bottom-up estimate using published aggregate data
Direct, Non-medical	Crisis Response and Public Safety	Bottom-up, prevalence-based	Estimated number of police and ambulance calls attributable to mental health (31% and 10% shares, respectively) × cost per call ($200–$500) to derive national totals (~$1 billion)
Direct, Non-medical	Justice System	Top-down, prevalence-based	Applied prevalence shares (70% in corrections, 40% in legal aid) to total correctional and court system budgets to estimate total mental-health-related costs (~$3 billion)
Direct, Employer Costs	Mental Health Premiums	Bottom-up, prevalence-based	Used average employer benefit costs per employee ($1,000 for mental health services) × total covered workforce ($13.65 million)
Direct, Employer Costs	Mental Health Training	Bottom-up, prevalence-based	Applied average per-employee training cost ($100) × proportion of employers offering training (55%) × total workforce
Direct, Employer Costs	Manager Time	Bottom-up, prevalence-based	Estimated average manager time spent on mental health support (2.5 hrs/week or ~5% of time) × average manager wage, scaled across workforce

Appendix A: Costing Summaries

Cost Type	Specific Cost	Cost Estimation Technique	Overview of Estimation Method
Direct, Employer Costs	Disability Leave	Bottom-up, prevalence-based	Used per-employee disability cost estimates (from incidence and cost per STD/LTD[1] claim) × prevalence of mental health–related claims (40%) × workforce
Direct, Employer Costs	Overtime to Cover Disability	Bottom-up, prevalence-based	Applied overtime wage premiums (1.5 × wage) to proportion of absences requiring coverage (~80–100%) across the workforce
Direct, Employer Costs	Accommodations and Return to Work	Bottom-up, prevalence-based	Estimated by applying average HR and supervisory time per mental-health-related case (15 hours × $60/hour) × prevalence of mental-health-related disability claims (40%) × total workforce ($13.65 million)
Direct, Employer Costs	Voluntary Turnover	Bottom-up, prevalence-based	Estimated mental-health-related turnover (25% of 11.9% annual turnover) × replacement cost per exit (75% of salary), applied to national workforce
Direct, Employer Costs	Legal and Compliance Costs	Bottom-up, prevalence-based	Estimated by applying per-employee compliance ($200–$250), investigation, and litigation costs (~$510 total per employee) × total workforce (13.65M).
Direct, Employer Costs	Safety and Incident-related Costs	Bottom-up, prevalence-based	Estimated by applying a 1–2% share of total workplace safety expenditures ($100–$120 billion) to reflect the portion attributable to mental-health-related strain and fatigue
Direct, Out-of-Pocket Costs	Psychologists and Private Counselling	Top-down, expenditure-based	Derived from national mental health expenditure data, assuming ~6% of mental health spending is for psychologists/private therapy, mostly out-of-pocket

[1] STD stands for short-term disability, LTD for long-term disability.

Appendix A: Costing Summaries

Cost Type	Specific Cost	Cost Estimation Technique	Overview of Estimation Method
Direct, Out-of-Pocket Costs	Private Share of Psychiatric Medications	Top-down, prevalence-based	Total psychiatric drug expenditure ($4.3 billion) × private financing share (40%) to estimate individual out-of-pocket and privately insured costs
Indirect Costs	Unemployment	Prevalence-based, bottom-up (friction cost)	From MHACS survey microdata: number of unemployed individuals with mental illness × median earnings × friction period (1–6 months)
Indirect Costs	Premature Mortality	Prevalence-based, bottom-up (friction cost)	Number of deaths among persons with mental illness × probability of paid employment × productivity weights × median earnings × friction period
Indirect Costs	Absenteeism Costs	Prevalence-based, bottom-up	Number of employed individuals with each mental illness × average mental-health-related sick days × median daily wage
Indirect Costs	Presenteeism Costs	Prevalence-based, bottom-up	Number of employed individuals with each disorder × number of lost productivity days (from TELUS Mental Health Index) × median daily wage x productivity adjustment

Appendix A: Costing Summaries

Table D. Total Cost Summary

Cost Type	Specific Cost	Initial Cost Amount	Year of Initial Currency	Initial Currency	Year CPI Value	Value in 2024 CAD Dollars	Total Cost (2024 CAD)
Direct, Medical	Medical Costs	$23 billion	2024	CAD Dollars	160.9	$23,000,000,000	**$181,390,963,814**
Direct, Non-medical	Income Support	$11 billion	2024	CAD Dollars	160.9	$11,000,000,000	
Direct, Non-medical	Homelessness	$13 billion	2023	CAD Dollars	157.1	$13,314,449,395	
Direct, Non-medical	Crisis Response and Public Safety	$1 billion	2024	CAD Dollars	160.9	$1,000,000,000	
Direct, Non-medical	Justice System	$3 billion	2024	CAD Dollars	160.9	$3,000,000,000	
Direct, Employer Costs	Mental Health Premiums	$14 billion	2024	CAD Dollars	160.9	$14,000,000,000	
Direct, Employer Costs	Mental Health Training	$1 billion	2024	CAD Dollars	160.9	$1,000,000,000	
Direct, Employer Costs	Manager Time	$7 billion	2024	CAD Dollars	160.9	$7,000,000,000	
Direct, Employer Costs	Disability Leave	$40 billion	2024	CAD Dollars	160.9	$40,000,000,000	
Direct, Employer Costs	Overtime to Cover Disability	$15 billion	2022	CAD Dollars	151.2	$15,962,301,587	
Direct, Employer Costs	Accommodations and Return to Work	$4 billion	2024	CAD Dollars	160.9	$4,000,000,000	

Appendix A: Costing Summaries

Cost Type	Specific Cost	Initial Cost Amount	Year of Initial Currency	Initial Currency	Year CPI Value	Value in 2024 CAD Dollars	Total Cost (2024 CAD)
Direct, Employer Costs	Voluntary Turnover	$19 billion	2024	AD Dollars	160.9	$19,000,000,000	
Direct, Employer Costs	Legal and Compliance Costs	$7 billion	2024	CAD Dollars	160.9	$7,000,000,000	
Direct, Employer Costs	Safety and Incident-related Costs	$2 billion	2023	CAD Dollars	157.1	$2,048,376,830	
Direct, Out-of-Pocket Costs	Psychologists and Private Counselling	$1 billion	2024	CAD Dollars	160.9	$1,000,000,000	
Direct, Out-of-Pocket Costs	Private Share of Psychiatric Medications	$2 billion	2024	CAD Dollars	160.9	$2,000,000,000	
Indirect Costs	Unemployment	$1.66 billion	2023	CAD Dollars	157.1	$1,697,514,150	
Indirect Costs	Premature Mortality	$0.01 billion	2023	CAD Dollars	157.1	$10,827,308	
Indirect Costs	Absenteeism Costs	$2.81 billion	2023	CAD Dollars	157.1	$2,878,925,715	
Indirect Costs	Presenteeism Costs	$12.18 billion	2023	CAD Dollars	157.1	$12,478,568,829	

Appendix A: Costing Summaries

Table E. Potential Biases in Cost Burden Estimates

Cost Type	Specific Cost	Data Sources Used	Potential Biases in Cost Estimate
Direct, Medical	Medical Costs	Canadian Institute for Health Information and Canadian Mental Health Association (CMHA)	Medical costs include Canadians of all ages and not just working-aged Canadians. Given the population of interest were working-aged Canadians, this cost is likely overestimated in analyses.
Direct, Non-medical	Income Support	Peer-reviewed literature: de Oliveira, C., et al. (2024). Government of Canada, Public Accounts of Canada (2023)	Income supports may account for supports provided to Canadians outside of prime working age (> 64 years old). This can potentially overestimate costs.
Direct, Non-medical	Homelessness	Peer-reviewed literature: Dionne et al., Statistics Canada (2023). Grey literature: Canadian Observatory on Homelessness.	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Direct, Non-medical	Crisis Response and Public Safety	Statistics Canada and grey literature: Vancouver and York Region Police.	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Direct, Non-medical	Justice System	Government of Canada data.	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Direct, Employer Costs	Mental Health Premiums	Statistics Canada and grey literature: Canada Life, Deloitte, Benefits by Design.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.

Appendix A: Costing Summaries

Cost Type	Specific Cost	Data Sources Used	Potential Biases in Cost Estimate
Direct, Employer Costs	Mental Health Training	Grey literature: Benefits by Design.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct, Employer Costs	Manager Time	Grey literature: Deloitte.	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Direct, Employer Costs	Disability Leave	Grey literature: Sunlife and Deloitte.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct, Employer Costs	Overtime to cover disability	Government of Ontario and grey literature: Deloitte.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct, Employer Costs	Accommodations and return to work	Grey literature: Mental Health Commission of Canada.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct, Employer Costs	Voluntary Turnover	Grey literature: Conference Board of Canada	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct, Employer Costs	Legal and Compliance Costs	Grey literature: Ponemon Institute, Rubin Thomlinson LLP.	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.

Appendix A: Costing Summaries

Cost Type	Specific Cost	Data Sources Used	Potential Biases in Cost Estimate
Direct, Employer Costs	Safety and Incident-related Costs	Grey literature: Osler, Canadian Centre for Occupational Health and Safety (CCOHS), WorkSafeBC, International Social Security Association (ISSA), and the UK Health and Safety Executive (HSE).	An upper age range was not provided for this cost estimate. While this can potentially overestimate cost, the potential bias is minimal.
Direct - Individual Costs	Psychologists and Private Counselling	Peer-reviewed literature: Milliken, O. et al. (2024)	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Direct - Individual Costs	Private Share of Psychiatric Medications	Health Canada, CIHI	An age range was not provided for this cost estimate. This can potentially overestimate cost.
Indirect Costs	Unemployment	Statistics Canada data sources: MHACS and data table 11-10-0239-01	Some disorder-sex-age strata in the MHACS contained a small number of observations. This may impact the reliability of indirect cost estimates for these strata. Using a survey estimate of mental illness prevalence, as compared to a clinical diagnosis, may under- or over-estimate the prevalence of mental illness, which in turn could under- or over-estimate cost estimates.
Indirect Costs	Premature Mortality	Statistics Canada data sources: MHACS, data table 11-10-0239-01, Canadian Vital Statistics Survey. Peer-reviewed literature: Adhikari et al. (2020)	The completeness and accuracy of the Canadian Vital Statistics database for deaths attributable to mental disorders and/or suicide may affect the precision of these estimates.

Appendix A: Costing Summaries

Cost Type	Specific Cost	Data Sources Used	Potential Biases in Cost Estimate
Indirect Costs	Absenteeism Costs	Statistics Canada data sources: MHACS and data table 11-10-0239-01. Peer-reviewed literature: Evans-Lacko & Knapp (2016). Grey literature estimates.	Absenteeism costs were estimated using a single value for the number of absenteeism days across all disorders, although this value likely varies by disorder. The absenteeism estimates were drawn from grey literature sources. However, the selected estimate was more conservative than those reported in peer-reviewed studies. As a result, any bias introduced is likely minimal.
Indirect Costs	Presenteeism Costs	Statistics Canada data sources: MHACS and data table 11-10-0239-01. Grey literature: Telus Mental Health Index 2023 survey. Peer-reviewed literature: Maestas et al. (2021).	Presenteeism estimates were based on grey literature sources, which may overestimate costs. This bias is partly mitigated by incorporating a productivity-loss metric, which applies a more conservative estimate of productivity for individuals with mental health conditions.

Appendix B: Direct Costing Methodology

This analysis draws on more than 150 sources, with a clear priority placed on peer-reviewed academic literature. Where peer-reviewed evidence was unavailable for specific data points, high-quality grey literature was used, such as national surveys, government statistics and reports from reputable research organizations. To strengthen validity, we preferentially relied on studies with larger sample sizes, robust methodologies and transparent assumptions. Given that top-down and bottom-up costing approaches each have advantages and limitations, estimates were cross-checked across multiple sources and methodological approaches to increase confidence in the findings and reduce susceptibility to bias.

Limitations are noted where they exist, and care was taken to avoid double counting by clearly distinguishing between direct and indirect costs. The result is a conservative estimate that likely understates the true economic burden of mental health in Canada.

Appendix B: Direct Costing Methodology

Medical costs: $23 billion

This cost category includes expenditures within the public healthcare system, including hospital admissions, physician services, psychiatric medications and other insured treatments directly related to mental illness. Importantly, this estimate includes only services explicitly classified as mental-health-related (e.g., psychiatric hospitalizations, physician billings and psychiatric medications). It does not capture the wider range of general medical services that individuals with mental health challenges often use.

- Total baseline spending: In 2024, total healthcare spending in Canada was $372 billion.[128]
- Why total expenditure, not the Canada Health Transfer (CHT): The CHT reflects only the federal contribution to provincial and territorial health budgets. It does not capture the full scope of spending, most of which comes directly from provinces and territories. Studies of mental-health expenditures use total health expenditure as the denominator to calculate the mental health share, and this approach provides a more accurate measure of system-wide costs.
- Share attributable to mental health: National estimates put mental-health spending at 7% of public health expenditures.[129]
- Apply to 2024 dollars: 7% of $372 billion equals $26 billion in mental-health-related medical spending (public and private combined).
- Allocate to public versus private: About 88% of the $26 billion is attributed to public financing ($23 billion), with the balance ($3 billion) private or out-of-pocket.[130] This is calculated using expenditure breakdowns (hospitals 32%, drugs 25%, community care 21%, physicians 16%, psychologists 6%) and Canadian financing patterns (hospital, physician and community care are largely public, psychologists are mostly private, and drugs are both).
- Rationale: Hospitals and physician services (together 48%) are almost entirely public. Community services (21%) are largely public, while psychologists (6%) are mostly private and drugs (25%) are both.[131]
- Limitations: Sources differ in methods and time frames. Private spending (especially counselling/psychology) is under-reported. CIHI classifications sometimes overlap (e.g., physician or drug costs within hospital budgets). The $23 billion estimate is conservative and likely understates the full cost.

Appendix B: Direct Costing Methodology

Non-medical costs: $28 billion

Government expenditures outside health budgets that are attributable to mental illness include income support (transfer payments), homelessness system costs (shelters and housing programs), crisis response and public safety (policing and mobile interventions), and justice system costs (courts, corrections, forensic psychiatry). Health system use such as emergency room visits is captured under medical costs, not here.

One important category not included in this section is education-related mental health spending, as national data are highly fragmented and our 15–64 age focus means school-based costs cannot be reliably isolated or attributed to mental illness.

Income support: $11 billion

- Program outlays: Federal CPP Disability paid $4.6 billion in 2022–23, trending toward $5 billion in 2023–24.[132] Provincial programs total about $18.7 billion (Ontario $7.7 billion, Alberta $2.9 billion, BC $3.5 billion, others proportional).[133]
- Attribution: Studies indicate close to 40% of disability caseloads are psychiatric in nature.[134] Applying this range to the combined envelope yields $11 billion.

Homelessness: $13 billion

- Population: About 235,000 people experience homelessness in Canada each year.[135]
- Prevalence of mental illness: Cohort studies, including At Home/ Chez Soi, estimate 25–50% of the homeless population has a diagnosable mental illness.[136]
- Per-person cost: Canadian studies report service costs ranging from $30,000 to over $134,000 annually, with chronically homeless individuals with mental illness incurring the highest expenditures.[137]
- Computation: Using a prevalence of 40% (around 94,000 people) and applying the cost level reported ($134,000 per person per year) produces $ 12.7 billion, rounding to $13 billion. Used higher per person cost estimate as much of the homeless data is under-reported.

Appendix B: Direct Costing Methodology

Crisis response and public safety: $1 billion

Note: This area had the largest gap in terms of national data. As such, we had to triangulate data and make assumptions on overall cost.

- Evidence: Police. Police services devote substantial resources to mental-health-related calls. York Regional Police spend about $4 million annually. Extrapolated province-wide, based on population size, this comes to around $48 million. Ontario Mobile Crisis Teams and diversion initiatives cost nearly $4.8 million annually.[138] Estimated nationwide, that would equal around $25 million. The Vancouver Police Department's Lost in Transition report found that up to 31% of calls had a mental-health component, costing the service an estimated $9 million annually.[139]
- National perspective: Police. Nationally, there are about 12 million calls annually to police and around 31% are due to mental health.[140] At an estimated average cost of $200 per call (covering officer time, transport and administrative overhead), this equates to approximately $744 million annually.[141]
- National perspective: Ambulance. Canada records an estimated 1.4 million ambulance transports per year. Applying a conservative 10% share for mental-health-related incidents gives roughly 140,000 calls.[142] At an estimated average cost of $500 per call, this equates to about $70 million annually.[143]
- Total estimate: The annual cost of mental-health-related emergency response in Canada is in the range of $1 billion. Police data indicate approximately 3.7 million mental-health-related calls annually, at an average of $200 per call, for a total of $744 million. Ambulance data suggest around 1.3–1.4 million transports per year, of which an estimated 10% (140,000 calls) are mental health–related; at $500 per call, this adds $70 million. Together, these direct response costs already exceed $800 million annually. When diversion programs, paramedic overtime, officer wellness impacts, and downstream health and justice system burdens are considered, a system-wide estimate of $1 billion is a reasonable and defensible figure.

Appendix B: Direct Costing Methodology

Justice system: $3 billion

- Corrections: Correctional Service Canada (CSC) reports that about 70% of federally incarcerated individuals present with a mental health issue, and about 30% live with a serious disorder.[144] Of the approximately $2 billion CSC budget, between $1.5 billion to $2.0 billion is allocated to programs and supports directly related to mental health.[145]
- While it is true that a portion of these costs would exist regardless of mental health status (e.g., basic incarceration and security expenses), the estimate presented here reflects the incremental burden associated with mental illness, namely the additional costs of specialized care, behavioural management, forensic psychiatry and longer average lengths of stay. This approach aligns with standard cost-of-illness methodology, which attributes a share of system costs proportional to the prevalence and resource intensity of mental-health-related cases, rather than assuming that all affected individuals would otherwise not be in the system.
- Courts and legal aid: In Ontario, about 40% of criminal legal aid certificates are linked to defendants with mental health issues, implying a national estimate of $0.5 billion to $0.8 billion.[146]
- Computation: Combined costs total around $3 billion.

How double counting is minimized

- Distinct streams: Income support, homelessness services, crisis response and justice are defined as separate categories, ensuring expenditures appear in one stream only.
- Health versus non-health: Medical encounters are assigned to the medical category. Non-health categories exclude those expenditures.
- Prevalence-based attribution: Percentages are applied to caseloads/populations rather than individuals to reduce overlap.
- Residual overlap: Some individuals use multiple systems, but the overall model remains conservative, as it omits costs such as comorbidities, caregiver burden and long-term liabilities.

Appendix B: Direct Costing Methodology

Employer costs: $106 billion

These are costs borne by workplaces, including disability claims, group benefits, wage replacement, accommodations and insurance premiums. This section deliberately excludes absenteeism-related overtime for short-term sick leave and presenteeism productivity losses as those are already captured in the indirect cost model. This ensures the two models complement each other without overlapping.

Although this seems high, other estimates are even higher. The Conference Board of Canada reported that mental health problems cost employers more than $11,000 per employee each year in a 2012 report.[147] Applied nationally to Canada's 13.65 million covered workers, that equates to roughly $150 billion annually. Therefore, the estimate we present is likely conservative.

Overall methodology in this section

The estimate of $106 billion in annual employer costs was derived using a bottom-up, prevalence-based approach. Per-employee costs were calculated for major drivers—benefit premiums, training, manager time, disability leaves, overtime coverage and turnover, among others—using recent Canadian data on wages, benefits, disability incidence and turnover rates.

These per-employee figures were then multiplied by the covered workforce (13.65 million employees) to produce national totals. To avoid double counting, productivity losses from presenteeism and short-term sick leave were excluded here, as they are captured separately in the indirect cost model. Conservative assumptions were applied throughout, meaning the $106 billion figure likely understates the true employer burden.

Mental health premiums: $14 billion

- Employers spend around 23% of payroll on benefits, averaging $14,318 per employee. Mental health services (paramedical, EAP, drugs) represent 7% of benefits, or roughly $1,000 per employee.[148] With 13.65 million covered employees, the national total is $13.7 billion, which we rounded to $14 billion.

Appendix B: Direct Costing Methodology

Mental health training: $1 billion

- About 55% of employers offer mental health training at an average of $100 per employee. This equals $55 population-averaged. At 13.65 million employees, this equates to $0.75 billion.[149]
- An estimate of $1 billion is used here to reflect both existing expenditures and the steady growth in employer adoption, as mental health training is rapidly expanding across sectors through compliance requirements and prevention programs. The $1 billion estimate represents a realistic national average in lieu of a strict lower-bound snapshot of current coverage.

Manager time: $14 billion

- While Canadian data on managerial time spent supporting employee mental health are limited, global surveys offer clearer benchmarks. A 2024 international study of 1,000 managers found that managers spend over five hours per week—about 12% of their working time—providing emotional or mental-health-related support to their team members.[150]
- Similarly, Deloitte's 2023 Human Capital Trends report found that roughly 40% of managers' time is consumed by people-related issues and "putting out fires," much of which involves stress, burnout or psychological health matters.[151]
- Using an estimate of five hours per week (approximately 12% of managerial time), and assuming a manager's average salary of $85,000 with nine direct reports, the time cost equals roughly $1,050 per employee per year. Applied to 13.65 million employees, this results in an estimated $14 billion annually.

Disability leave: $30 billion

- Mental health accounts for approximately 40% of disability claims.[152] With six STD and one LTD cases per 100 employees, and average costs of $30,000 for STD and $40,000 for LTD, the baseline is $2,200 per employee.[153] Applied to 13.65 million employees, this equals approximately $30 billion.

Appendix B: Direct Costing Methodology

Overtime to cover disability: $15 billion

- In sectors that require continuous operations, 80% to 100% of disability absences are typically backfilled, most often through overtime pay at 1.5 times the regular wage rate. Assuming an average salary of $62,000[154] and that 4% of employees are on disability leave at any given time, the incremental wage cost is approximately $1,100 per employee. Applied to 13.65 million employees, this equals about $15 billion in annual backfill costs.[155]

Accommodations and return to work: $4 billion

- Mental-health-related disability cases require significant coordination between HR, supervisors, and medical and legal professionals to manage accommodations and gradual return-to-work (RTW) plans. This involves case management, documentation, modified-duty scheduling, and coordination with unions or WSIB/WCB representatives.
- Although no study quantifies the administrative hours per case, guidance from the Canadian Centre for Occupational Health and Safety,[156] the Mental Health Commission of Canada,[157] and the Government of Canada[158] all emphasize the multi-party, time-intensive nature of RTW planning and make clear the extensive steps in this process.
- After an analysis of these steps, we estimated an average of 15 hours of HR and supervisory time per case at $60/hour. Applying this to the 40% of disability claims linked to mental health, the per-employee cost is $252—or roughly $4 billion annually across 13.65 million employees.
- Including this component is essential. Even without precise measurement, RTW coordination represents a real and recurring employer cost that captures the unseen labour behind every mental-health-related leave.

Turnover: $19 billion

- Voluntary turnover averages 11.9%, with 25% linked to mental health. Replacement cost per exit is 75% of salary ($46,350), or $1,400 per employee. Applied nationally, this equals around $19 billion.[159]

Appendix B: Direct Costing Methodology

Legal and compliance costs: $7 billion

- Employers face growing legal and compliance costs tied to psychological health, including harassment and violence prevention (Bill C-65), investigations into psychological injury or bullying, and legal defence or settlements arising from such cases. These obligations now represent a recurring and measurable cost of doing business. Based on employer data and international benchmarks:
  - Compliance: Activities (policy reviews, training, documentation) cost about $200–$250 per employee annually.[160]
  - Investigations: Industry data show roughly 1.5 to 1.6 workplace issues per 100 employees annually.[161] To reflect the higher sensitivity and reporting of mental-health and harassment issues, this model rounds to two investigations per 100 employees, each costing an average of $12,000.[162]
  - Litigation: Serious cases occasionally progress to legal action, with defence and settlement costs averaging $150,000–$300 000.[163] Using a conservative rate of 0.07 cases per 100 employees, the expected annual cost is about $140 per employee.
- Together, these compliance, investigation and litigation costs equal roughly $510 per employee, or $7 billion annually across 13.65 million employees.
- Including this category is critical. It captures the hidden cost of compliance and legal exposure, from required prevention and training to the financial consequences when things go wrong.

Appendix B: Direct Costing Methodology

Safety and incident-related costs: $2 billion

- Psychological strain and fatigue increase risk of workplace incidents, near-misses and safety violations. These events trigger investigations, modified-duty assignments, retraining and, in some cases, workers' compensation claims, all of which carry measurable costs.
- Research consistently links mental stress, burnout and fatigue to higher injury and error rates across safety-sensitive sectors such as construction, transportation, manufacturing and healthcare.[164]
- Across Canadian employers, total workplace safety expenditures (training, PPE, inspections and claims management) are estimated at $100 billion to $120 billion annually, combining direct and indirect OHS costs.[165]
- Mental-health-related strain is conservatively assumed to contribute 1–2% of these safety costs, according to a UK study, based on evidence that psychological stress and fatigue increase incident likelihood by roughly 25–40%, but affect only part of the workforce at any given time.[166]
- Applying this range yields an estimated $1–$2 billion annually. For modeling purposes, $2 billion is used as a conservative upper-bound estimate, reflecting the likelihood that incident-related costs linked to psychological strain are systematically underreported.
- Including this component recognizes that psychological-health issues not only cause absences, but also drive safety-critical errors and claims, particularly in high-risk occupations.

Appendix B: Direct Costing Methodology

Out-of-pocket costs: $3 billion

Out-of-pocket expenses for mental healthcare are those not covered by public or employer insurance, including private counselling, psychotherapy, medications and related supports. For clarity, this category captures only costs directly attributable to mental health conditions, not all health or social costs incurred by people who happen to have a mental disorder. The model focuses specifically on expenditures where mental health challenges or mental illness is the primary driver of service use or spending, rather than the full range of costs individuals that fall into this category may experience.

Psychologists and private counselling: $1 billion

- Roughly 6% of total mental health expenditures in Canada are for psychologists and private practice therapy.[167]
- These services are rarely insured under provincial plans and are only partially reimbursed through employer benefits.
- Estimated total direct out-of-pocket spending by individuals is $1 billion annually (conservative).[168]

Psychiatric medications (private share): $2 billion

- Total psychiatric drug expenditure in Canada was around $4.3 billion. [169]
- Private financing accounts for about 40% of all prescription drug spending in Canada (mix of out-of-pocket and private insurance).[170]
- Applying this proportion to psychiatric drugs produces $1.7 billion in individual spending annually, rounding this number to $2 billion.

Appendix C: Indirect Costing Methodology

We conducted an indirect cost of illness analysis focused on estimating the indirect costs associated with four different mental illnesses—depression, bipolar disorder, anxiety disorders and substance use disorders. These disorders were selected because they are among the most prevalent in Canada and have sufficient Canadian data to support accurate cost estimation. These mental illnesses represent only a subset of the broader spectrum of mental health conditions that contribute to the economic burden and, as such, our estimates likely understate the true indirect costs.

Indirect costs capture the economic losses arising from illness, disability, and death.[171] These are typically estimated as productivity-related costs, such as absenteeism (missing work due to illness) and presenteeism (working while unwell).[172] The scope of the analysis included estimating four types of indirect costs:

1. **Unemployment costs**: The value of lost income due to individuals being unable to obtain or maintain employment as a result of mental illness.
2. **Premature mortality costs**: The value of forgone future income and lost workforce impact due to individuals dying earlier than expected from mental illness.
3. **Absenteeism costs**: The cost of missed workdays due to mental illness.
4. **Presenteeism costs**: The cost of reduced productivity while at work due to mental illness.

Total costs are the sum of these four costs.

Our analysis used a prevalence-based, bottom-up framework and incorporated data inputs from a variety of sources. Specifically, we ascertained data on:

- Mental illness prevalence
- Labour force participation
- Employment income
- Mortality
- Absenteeism
- Presenteeism

Appendix C: Indirect Costing Methodology

Data inputs were selected according to the following criteria:

- All data sources were required to be Canadian.
- Data sources were required to be as recent as possible, with most selected data inputs published within the past decade.
- When Canadian data were not available for analysis, we prioritized Canadian estimates from the peer-reviewed literature. If no peer-reviewed sources existed, we consulted grey literature in the Canadian context. When neither Canadian peer-reviewed nor grey literature was available, we used estimates from peer-reviewed studies conducted in other countries.

Mental illness prevalence data

We ascertained prevalence data for the four mental illnesses using the publicly available Mental Health Access and Care Survey (MHACS).[173] Conducted in 2022, the MHACS was designed to measure the prevalence of mental health conditions, behaviours and healthcare use among the Canadian population. The MHACS was a national survey of Canadians 15 years or older, living in the 10 Canadian provinces.[174]

The sampling frame for the MHACS was based on the 2021 long-form census.[175] Less than 3% of the Canadian population was excluded from the MHACS sampling frame. This included persons living on Aboriginal settlements or reserves (as defined in the MHACS target population), full-time members of the Canadian Armed Forces and individuals living in collective dwellings (e.g., institutional residences).[176] The overall response rate was 25% and the total sample size was 9,861.

Defining mental illnesses and estimating prevalence

Mental illnesses were assessed in the MHACS using the World Health Composite International Diagnostic Interview (WHO-CIDI), a lay-administered psychiatric interview that generates disorder profiles aligning to the DSM-IV.[177] The following table shows how specific mental illnesses were defined in the MHACS.

Appendix C: Indirect Costing Methodology

Table 1. Definitions of Mental Illnesses

Mental Illness Assessed in Cost of Illness Report	Mental Illness Assessed in the 2022 MHACS
Depression	Major depressive episode
Bipolar disorder	Bipolar I, Bipolar II
Anxiety disorders	Generalized anxiety disorder, social phobia
Substance use disorders	Alcohol, cannabis or other substance use dependence or abuse

For each mental illness, we estimated annual prevalence rates by sex/gender (men, women) and by age (15 to 24 years old, and 25 to 64 years old). We estimated prevalence rates using population survey weights.[178] We estimated confidence intervals for prevalence rates using bootstrap estimation.

Table 2. 2022 Mental Illness Prevalence Estimates

Disorder Group	Age Group	Weighted Number of Participants Meeting WHO-CIDI Criteria	Weighted Prevalence (%)	Lower 95% CI[2]	Upper 95% CI
Men					
Anxiety Disorder	15 to 24	259,497	11.7	10.9	12.5
Anxiety Disorder	25 to 64	722,442	7.6	7.2	8.1
Bipolar Disorder	15 to 24	83,123	3.7	3.3	4.1
Bipolar Disorder	25 to 64	217,621	2.2	2.0	2.5
Major Depressive Episode	15 to 24	198,496	8.9	8.2	9.6

[2] Confidence interval (CI)

Appendix C: Indirect Costing Methodology

Disorder Group	Age Group	Weighted Number of Participants Meeting WHO-CIDI Criteria	Weighted Prevalence (%)	Lower 95% CI_2	Upper 95% CI
Major Depressive Episode	25 to 64	621,989	6.4	6.0	6.8
Substance Use Disorder	15 to 24	218,399	10.2	9.4	11.0
Substance Use Disorder	25 to 64	397,284	4.3	4.0	4.7
Women					
Anxiety Disorder	15 to 24	604,613	29.1	27.9	30.3
Anxiety Disorder	25 to 64	1,260,353	12.8	12.3	13.3
Bipolar Disorder	15 to 24	169,321	8.1	7.3	8.8
Bipolar Disorder	25 to 64	177,218	1.7	1.5	2.0
Major Depressive Episode	15 to 24	385,089	18.4	17.4	19.4
Major Depressive Episode	25 to 64	990,004	9.8	9.3	10.3
Substance Use Disorder	15 to 24	135,490	6.7	6.0	7.4

Appendix C: Indirect Costing Methodology

Labour force participation data

To estimate labour force participation, we used self-reported information from the MHACS.

Defining labour force participation rates

In the MHACS, participants were asked the following questions about their labour force participation.

Table 3. MHACS Labour Force Questions

Variable Name	Variable Question	Variable Response Options
GEN_08	All participants were directly asked if they worked at a job or business at any time in the past 12 months.	▪ Yes ▪ No ▪ Missing (valid skip, don't know, refusal or not stated)
LBSDWSS	For respondents aged 15 to 75, this derived variable defines their working status in the past week. This is based off the questions "Last week, did you work at a job or business?" and "Last week, did you have a job or business from which you were absent?"	▪ Worked at a job or business ▪ Had a job but did not work (absent) ▪ Did not have a job ▪ Missing (valid skip or not stated)
LMAMG03	For participants who were absent from their job in the past week, participants were asked what the reason for their absence was.	▪ Vacation ▪ Own illness or disability ▪ Maternity or parental leave ▪ Other ▪ Missing (valid skip or not stated)

From these variables, we defined four labour force states—employed, unemployed, out of the labour force and unknown. We derived these variables by adapting an established methodology to categorize labour force participation in Canadian national health surveys.[179]

Appendix C: Indirect Costing Methodology

Table 4. Labour Force Classification in MHACS

Have you worked at a job or business at any time in the past 12 months?	Working status in the past seek	Reason for missing work	Labour force category
Yes	Had a job	Reason other than parental leave[3]	Employed
No	Had a job	Reason other than parental leave	Employed
Yes	Had a job	Missing	Employed
No	Had a job	Missing	Employed
Missing	Had a job	Missing	Employed
Yes	Had a job	Maternity or parental leave	Not in labour force
No	Had a job	Maternity or parental leave	Not in labour force
No	Did not have a job	Missing	Not in labour force
Yes	Did not have a job	Missing	Unemployed
Missing	Missing	Reason other than parental leave	Unknown
Missing	Did not have a job	Missing	Unknown
Yes	Missing	Missing	Unknown
No	Missing	Missing	Unknown
Missing	Missing	Missing	Unknown

Estimating labour force participation rates in the MHACS

We calculated the weighted proportion of participants within each mental disorder, age, and sex/gender group who were classified into each of the four labour-force categories.

[3] Vacation, own illness or disability, or other

Appendix C: Indirect Costing Methodology

Table 5. 2022 Male Labour Force Participation Rates, by Disorder and Age

Disorder Group	Age	Labour Force Status	Weighted %	Weighted 95% CI	
Anxiety Disorder	15 to 24	Employed	57.1	53.4	60.7
Anxiety Disorder	15 to 24	Not in labour force	21.0	18.2	24.2
Anxiety Disorder	15 to 24	Unemployed	21.9	18.9	25.1
Anxiety Disorder	25 to 64	Employed	72.0	69.1	74.8
Anxiety Disorder	25 to 64	Not in labour force	23.1	20.5	26.0
Anxiety Disorder	25 to 64	Unemployed[1]	4.8	3.7	6.3
Bipolar Disorder	15 to 24	Employed	50.9	44.1	57.6
Bipolar Disorder	15 to 24	Not in labour force[1]	32.1	25.7	39.3
Bipolar Disorder	15 to 24	Unemployed[1]	17.0	13.4	21.3
Bipolar Disorder	25 to 64	Employed	67.1	61.4	72.4
Bipolar Disorder	25 to 64	Not in labour force[4]	18.2	14.0	23.3
Bipolar Disorder	25 to 64	Unemployed[4]	14.7	10.9	19.5
Major Depressive Episode	15 to 24	Employed	59.2	55.1	63.2
Major Depressive Episode	15 to 24	Not in labour force[4]	16.0	13.2	19.4
Major Depressive Episode	15 to 24	Unemployed	24.8	21.3	28.7
Major Depressive Episode	25 to 64	Employed	63.9	60.4	67.2

Appendix C: Indirect Costing Methodology

Disorder Group	Age	Labour Force Status	Weighted %	Weighted 95% CI	
Major Depressive Episode	25 to 64	Not in labour force	29.8	26.6	33.3
Major Depressive Episode	25 to 64	Unemployed[4]	6.3	4.8	8.3
Substance Use Disorder	15 to 24	Employed	72.3	68.3	75.9
Substance Use Disorder	15 to 24	Not in labour force[4]	5.7	4.1	8.0
Substance Use Disorder	15 to 24	Unemployed	22.0	18.7	25.7
Substance Use Disorder	25 to 64	Employed	84.6	81.5	87.3
Substance Use Disorder	25 to 64	Not in labour force[4]	7.6	5.8	9.8
Substance Use Disorder	25 to 64	Unemployed[4]	7.8	5.9	10.3

[4] Unweighted cell size less than 15 observations

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Table 6. 2022 Female Labour Force Participation Rates, by Disorder and Age

Disorder Group	Age	Labour Force Status	Weighted %	Weighted 95% CI	
Anxiety Disorder	15 to 24	Employed	63.3	60.8	65.7
Anxiety Disorder	15 to 24	Not in labour force	20.7	18.6	22.9
Anxiety Disorder	15 to 24	Unemployed	16.0	14.3	17.9
Anxiety Disorder	25 to 64	Employed	70.9	68.8	72.9
Anxiety Disorder	25 to 64	Not in labour force	24.4	22.5	26.4
Anxiety Disorder	25 to 64	Unemployed[5]	4.7	3.9	5.7
Bipolar Disorder	15 to 24	Employed	67.6	62.5	72.3
Bipolar Disorder	15 to 24	Not in labour force	7.6	5.7	10.0
Bipolar Disorder	15 to 24	Unemployed	24.9	20.5	29.8
Bipolar Disorder	25 to 64	Employed	63.1	56.4	69.2
Bipolar Disorder	25 to 64	Not in labour force[5]	31.1	25.1	37.9
Bipolar Disorder	25 to 64	Unemployed[5]	5.8	3.8	8.8
Major Depressive Episode	15 to 24	Employed	62.9	59.7	66.0
Major Depressive Episode	15 to 24	Not in labour force	18.6	16.2	21.3
Major Depressive Episode	15 to 24	Unemployed	18.4	16.0	21.1
Major Depressive Episode	25 to 64	Employed	69.2	66.8	71.5
Major Depressive Episode	25 to 64	Not in labour force	26.6	24.3	29.0
Major Depressive Episode	25 to 64	Unemployed[5]	4.3	3.3	5.4

Appendix C: Indirect Costing Methodology

Disorder Group	Age	Labour Force Status	Weighted %	Weighted 95% CI	
Substance Use Disorder	15 to 24	Employed	69.0	63.2	74.3
Substance Use Disorder	15 to 24	Not in labour force[5]	6.9	3.8	12.0
Substance Use Disorder	15 to 24	Unemployed*	24.1	19.7	29.2
Substance Use Disorder	25 to 64	Employed	73.3	68.7	77.5
Substance Use Disorder	25 to 64	Not in labour force[5]	21.1	17.2	25.5
Substance Use Disorder	25 to 64	Unemployed[1]	5.6	3.9	8.1

[5] Unweighted cell size less than 15 observations

Employment income data

Employment income is defined as income ascertained from wages, salaries, commissions or self-employment.[180] We ascertained employment income data from Statistics Canada Table 11-10-0239-01. This data table defines income sources of individuals by age group, sex/gender and income source.[181] When estimating costs for the year 2022, we used 2022 employment income estimates that were expressed in 2023 real dollars. Estimating unemployment- and mortality-related costs required an estimate of median annual earnings, whereas absentee- and presenteeism-related costs required an estimate of daily wages.

Median annual employment income

Statistics Canada Table 11-10-0239-01 provided information on median annual employment income for age groups 15 to 24, 25 to 54, and 55 to 64.[182] To align with the age groups of 15 to 24, and 25 to 64, used to estimate mental illness prevalence, we estimated weighted averages of median employment income for each sex/gender.

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Table 7. Weighted Average Median Employment Income

Sex/Gender	Age Group	Weighted Average 2022 Median Income (Reported in 2023 dollars)
Women	15 to 24	$11,900.00
Women	25 to 64	$47,250.27
Men	15 to 24	$13,800.00
Men	25 to 64	$65,045.96

Daily wages

From the weighted average median income values, we estimated daily wage by dividing the weighted average median income for each sex/gender and age group by 260.88.[183] The value of 260.88 arises by multiplying 52.177 average weeks in a year by five workdays.

Productivity weight

To estimate indirect costs related to premature mortality, a productivity weight—a measure of the proportion of earnings of the general population for persons with a specific mental illness—was required.[184] For depression, anxiety and bipolar disorder, we used earning difference estimates from the study conducted by Dobson et al. (2021).[185]

For substance use disorders, we used the difference in household income estimates written by Diotte (2016) for the Canadian Human Rights Commission.[186] Productivity weight estimates are shown in the table below. A value of 1.0 suggests there is no difference in the earnings of those with versus without a specific disorder. The value of 0.914 suggests that the annual earnings for women with depression, anxiety or bipolar disorder is 91.4% of the earnings for women without these disorders.

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Table 8. Productivity Weights

Disorder	Men	Women
Depression	0.934	0.914
Anxiety Disorder	0.934	0.914
Bipolar Disorder	0.934	0.914
Substance Use Disorder	1.000	0.855

Mortality data

We ascertained mortality rates from publicly available data tables derived from the Canadian Vital Statistics Survey (CVS). The CVS is an administrative survey that collects monthly and annual demographic and medical information from all provincial and territorial vital statistics registries on all deaths in Canada.[187] To estimate mortality rates specific to age, sex/gender and disorder in 2022 and 2012, we combined data on mortality attributable to mental illness and suicide-related mortality.

Death due to mental illness

To estimate mortality due to mental illness, we used data from Statistics Canada Table 13-10-0143-01 (*Deaths, by cause, Chapter V: Mental and behavioural disorders (F00 to F99),* formerly CANSIM 102-0525).[188] For each age group (15 to 24, and 25 to 64) and sex/gender, we defined the number of deaths due to the following.

Disorder	Cause of Death
Depression	Mood [affective] disorders [ICD-10 codes F30-F39]
Bipolar Disorder	Mood [affective] disorders [ICD-10 codes F30-F39]
Anxiety Disorders	Neurotic, stress-related and somatoform disorders [ICD-10 codes F40-F48]
Substance Use Disorders	Mental and behavioural disorders due to psychoactive substance use [ICD-10 codes F10-F19]

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Death attributable to suicide

To estimate mortality due to suicide, we used data from Statistics Canada Table 13-10-0392-01 (*Deaths and age-specific mortality rates, by selected grouped cause,* formerly CANSIM 102-0551).[189] For each age group and sex/gender, we defined deaths due to suicide as intentional self-harm (suicide, ICD-10 codes X60-X84, Y87.0). This includes the following.

- Intentional self-poisoning by and exposure to chemicals and noxious substances [X60-X69]
- Intentional self-harm (suicide) by discharge of firearms [X72-X74]
- Intentional self-harm (suicide) by other and unspecified means and their sequelae [X70-X71, X75-X84, Y87.0]

Estimating mortality rates

We first estimated age- and sex-specific crude mortality counts and rates (per 100,000 population) for causes of death related to mental illness. Mortality data were linked with Canadian population denominators (ascertained from Statistics Canada data table 17-10-0005-01, formerly CANSIM 051-0001)[190] and restructured to ensure a common format. Age groups were collapsed into two broader age categories of 15 to 24, and 25 to 64, years old. Deaths were then aggregated by cause, sex and age group. Age-specific mortality rates were calculated separately for males, females and the total population for each disorder.

We then used the same procedure to estimate age- and sex-specific crude mortality counts and rates (per 100,000 population) for deaths attributable to suicide. Following estimates from Adhikari et al. (2020),[191] we assigned fixed proportions of these deaths to depression (15.58%), bipolar disorder (14.47%), anxiety disorders (27.40%) and substance use disorders (15.58%), thereby partitioning suicide mortality into disorder-specific counts and rate per 100,000 by sex and age group.

We then combined (summed) counts and rates from each two sources to create overall age- and sex-specific mortality rates per each disorder.

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Table 9. 2022 Mortality Rate Estimates for Various Mental Health Disorders

Age Group	Disorder	Number of deaths, male	Number of deaths, female	Number of deaths, total	Mortality rate, male (per 100,000)	Mortality rate, female (per 100,000)	Mortality rate, total (per 100,000)
15 to 24	Anxiety	86.58	46.03	132.62	3.64	2.07	2.88
15 to 24	Bipolar Disorder	45.73	24.31	70.03	1.92	1.09	1.52
15 to 24	Depression	49.23	26.17	75.41	2.07	1.18	1.64
15 to 24	Substance Use Disorders	55.23	29.17	84.41	2.32	1.31	1.83
25 to 64	Anxiety	607.27	202.38	809.64	5.78	1.94	3.87
25 to 64	Bipolar Disorder	324.64	114.76	439.41	3.09	1.10	2.10
25 to 64	Depression	349.16	122.8	471.96	3.32	1.18	2.26
25 to 64	Substance Use Disorders	928.16	317.8	1,245.96	8.84	3.05	5.96

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Absenteeism and presenteeism data

We gathered estimates of absenteeism (the number of days missing work due to illness) and presenteeism (the number of days going to work while unwell) from academic and grey literature.

Absenteeism data

We consulted two sources for absenteeism data. The first source was the study *Global patterns of workplace productivity for people with depression: absenteeism and presenteeism costs across eight diverse countries*, conducted by Evans-Lacko and Knapp (2016). In this study, the authors performed a secondary analysis of the Global IDEA (Impact of Depression in the Workplace in Europe Audit) data source.[192] This cross-sectional data source included data on worker productivity attributable to depression.[193] Participants were recruited through an online market research panel.[194] Those who worked in advertising or market research, or were younger than 16 years old, were excluded from the survey.[195] In the sample recruitment, quotes were set to include equal distributions of age and gender, and designed to be geographically representative of each country. The Canadian sample size was 1,000 participants.[196]

In their study, they present a frequency table for the number of days taken off during an episode of depression. Using this data, we estimated a weighted average of 8.75 days.

Table 10. Estimating Weighted Mean of Number of Absenteeism Days for Depression

Number of days taken off during episode of depression	Number of individuals	Percent of individuals	Midpoint of number of days	Percent * midpoint[+]
0	421	52.1%	0	0.00
1 to 5	126	15.6%	3	0.47
6 to 10	21	2.6%	8	0.21
11 to 15	28	3.5%	13	0.45
16 to 20	17	2.1%	18	0.38
21+	195	24.1%	30	7.24
			Mean	**8.75**

[+] *Because the data are grouped, the mean number of absenteeism days was estimated as a weighted mean, by multiplying each category's midpoint by the proportion of respondents in that category.*

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The second source of absenteeism data was a prior estimate from Heal-3, which estimated an average of 3.7625 sick days due to mental illness:

Mental health share of sick days

- Studies estimate that 25% to 35% of all sick days are related to mental health concerns.[197]
- We used the high end (35%) to reflect research showing that many employees do not disclose mental health issues to their managers.

Average sick days per employee per year

- According to Statistics Canada, sick day averages vary by sector:[198]
  - Public sector: 16 days
  - Private sector: 9 days
- We used a weighted average of these two values to represent a mid-range estimate, incorporating the proportion of employees working in the private and public sectors:[199]
  - (16*0.25) + (9*0.75) = 10.75 sick days per employee per year

Mental-health–related sick days

- Applying the 35% mental health attribution rate to the average sick days:
  - 35% * 10.75 days = 3.7625 absenteeism days per employee per year due to mental health issues

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Presenteeism data

To estimate presenteeism, we consulted data from the Mental Health Index Report series.[200] First conducted in April 2020 by Morneau Shepell, the purpose of the Mental Health Index was to provide monthly measures of the current mental health status of employed adults.[201] In April 2021, the Mental Health Index Report was published by LifeWorks, who published reports until December 2022.[202] Starting in January 2023, reports were published by TELUS Health (formerly LifeWorks).[203]

The Mental Health Index Report is a series of cross-sectional online surveys of 3,000 adults in Canada who are either currently employed or were employed at some time in the past six months.[204] Participants are selected to be representative of the age, gender, industry and geographic distribution in Canada.[205] The Mental Health Index scores are based on participants' recollection of their mental health two weeks prior to when they were surveyed. Responses are typically collected over a period of one week.[206] Each report discusses mental health risk, various mental health conditions (e.g., anxiety and depression), work productivity and mental health by employment status.

To estimate presenteeism, we applied rates from the Telus Mental Health Index 2023 survey. In their survey, "productivity losses" were estimated as the amount of effort put into work while feeling unwell, and the frequency of working when feeling unwell. It is reported in terms of number of days per year (out of a maximum 240 days). The survey reports the following statistics:

Mental Illness	Number of Days Lost Due to Productivity Losses
Depression	55.5 working days/year
Anxiety	52.8 working days/year
Mental health condition other than depression or anxiety	52.7 working days/year
Undiagnosed mental health conditions other than anxiety or depression	61.3 working days/year

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Based on these estimates, for our indirect cost analysis, we specified the number of presenteeism days attributable to each mental disorder as follows.

Mental Illness	Number of Presenteeism Days
Depression	55.5
Anxiety	52.8
Bipolar Disorder	61.3
Substance Use Disorder	52.7

Productivity loss and presenteeism

Even when a worker is experiencing presenteeism—attending work despite being unwell—they may still retain some level of productivity. To reflect this, we incorporated an estimate of productivity loss into our calculation of presenteeism. Based on research by Maestas and colleagues (2021), American workers with depression were more likely to experience high productivity loss (PL), defined as productivity loss greater than 30%.[207] Thus, in our analysis, we estimated productivity loss, PL, to be 30%.

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Statistical analysis

The total indirect cost of mental illness was estimated as the sum of the indirect cost of each mental illness (MI) studied.

$$Total\ Indirect\ Cost\ of\ Mental\ Illness\ = \sum_{MI} Indirect\ Cost_{MI}$$
$$= \sum_{MI} (Mortality\ Cost_{MI} + Unemployment\ Cost_{MI} + Absenteeism\ Cost_{MI} + Presenteeism\ Cost_{MI})$$

We estimated mortality and unemployment costs using both human capital and friction cost methods. The human capital method estimates the value of *potentially* lost production (or *potentially* lost income) as a consequence of disease.[208] The value of costs related to permanent disability or premature death is counted from a specific age until the age of retirement. This typically provides an upper-bound estimate of indirect costs.[209]

The friction cost method estimates the value of lost production (lost income) due to disease only for the limited time it takes to replace a worker, "the friction period".[210] This method assumes that absent workers are eventually substituted from the pool of unemployed individuals, and thus only short-term losses are counted. As a result, it typically provides a lower-bound (i.e., more conservative) estimate of indirect costs.

In our analyses, we used one-, three-, and six-month friction period estimates to model labour force scenarios where the unemployment rate is high (i.e., a longer friction period, where it may take longer to find a job) and is low (i.e., a shorter friction period, where it may be easier to find a job).

After estimating the total indirect cost, we express it as a function of gross domestic product (GDP) using the following equation:

$$Indirect\ Cost\ as\ a\ Proportion\ of\ GDP = \left(\frac{Total\ Indirect\ Cost\ of\ Mental\ Illness}{Gross\ Domestic\ Product}\right) * 100\%$$

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Unemployment cost estimation

To estimate costs related to unemployment, among each age- and sex/gender- strata, the number of individuals with a mental illness who are unemployed was multiplied by the median earnings of that group and a friction period estimate.[211]

$$Unemployment\ Cost\ = \sum_i \sum_j N_{ij}^{MI} \times \frac{Y(E)_{ij}}{12} \times F$$

Where:

- N_{ij}^{MI} : The number of people with a specific mental illness (MI) of the ij^{th} population group (age and sex/gender) who are unemployed
- $Y(E)_{ij}$: The median annual earnings of employed persons in the ij^{th} population group (age and sex/gender), divided by 12 to convert to a monthly estimate of earnings
- F : The friction period, in months

Premature mortality cost estimation

To estimate premature mortality costs, we used the methodology of Goeree and colleagues (1999).[212] Under this methodology, mortality loss is estimated as the sum of the lost productivity due to premature death among persons with a specific mental illness, across all sex/gender and age groups.

We estimated premature mortality costs as:

$$Mortality\ Cost\ = \sum_i \sum_j D_{ij}^{MI} \left[p(E)_{ij}^{MI} \times \frac{Y(E)_{ij} \times PW_{ij}^{MI}}{12} \times F \right]$$

Where:

- D_{ij}^{MI} : The number of deaths among persons with a specific mental illness (MI) of the ij^{th} population group
- $p(E)_{ij}^{MI}$: The probability that a person with a specific mental illness (MI) in the ij^{th} population group is in paid employment
- $Y(E)_{ij}$: The median annual earnings of employed persons in the ij^{th} population group (age and sex-gender), divided by 12 to convert to a monthly estimate of earnings
- PW_{ij}^{MI} : Productivity weights (percent earnings of the general population for persons with a specific mental illness) in the ij^{th} population group
- F : the Friction period, in months

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Absenteeism cost estimation

To estimate absenteeism costs for each mental illness, the number of days of work missed due to the specific mental illness was multiplied by the number of employed individuals in each age- and sex/gender-strata and the average or median daily earnings of employed adults.[213]

$$Absenteeism\ Cost\ = \sum_i \sum_j (N_{ij}^{MI} \times DA \times W_{ij})$$

Where:

- N_{ij}^{MI} : The number of people with a specific mental illness (MI) of the ij^{th} population group (age and sex-gender) who are employed
- DA : Average number of absenteeism days
- W_{ij} : Median daily earnings from employed individuals in the ij^{th} population group

Presenteeism cost estimation

A similar approach to absenteeism costs was used to estimate presenteeism costs,[214] where:

$$Presenteeism\ Cost\ = \sum_i \sum_j (N_{ij}^{MI} \times (DP^{MI} \times PL) \times W_{ij})$$

Where:

- N_{ij}^{MI} : The number of people with a specific mental illness (MI) of the ij^{th} population group (age and sex-gender) who are employed
- DP^{MI} : Average number of presenteeism days for people with a specific mental illness
- PL : Productivity loss, namely the impairment in work productivity due to presenteeism
- W_{ij} : Median daily earnings from employed individuals in the ij^{th} population group

We estimated productivity loss, PL, to be 30%. Based on literature by Maestas and colleagues (2021), American workers with depression were more likely to experience high productivity loss, defined as greater than 30%.[215]

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Indirect cost analysis results

Table 11 presents the most conservative total indirect costs of mental health disorders in 2022 in terms of unemployment, premature mortality, absenteeism and presenteeism. Across all disorders, the combined cost amounts to approximately **$16.7 billion (2023 CAD),** which reflects an economic burden equivalent to 0.5% of Canada's GDP (Table 12). This estimate accounts for unemployment, mortality, absenteeism and presenteeism costs attributable to depression, anxiety, bipolar disorder and substance use disorders.

Table 11. Indirect Cost of Mental Illnesses in 2022, Reported in 2023 CAD Dollars

	All Disorders	Anxiety Disorders	Bipolar Disorders	Major Depressive Episodes	Substance Use Disorders
	($)	($)	($)	($)	($)
A. Model for Both Men and Women					
Total indirect cost	**16,662,789,533**	**6,717,722,672**	**1,676,866,061**	**5,333,897,647**	**2,934,303,153**
Unemployment[1]	1,657,423,698	576,991,304	267,820,307	496,580,794	316,031,293
Premature mortality[1]	10,571,598	2,810,980	1,403,736	1,481,318	4,875,564
Absenteeism[2]	2,810,933,684	1,178,111,234	239,081,507	891,357,315	502,383,628
Presenteeism[3]	12,183,860,553	4,959,809,154	1,168,560,511	3,944,478,220	2,111,012,668
B. Model for Men Only					
Total indirect cost	8,328,008,297	2,913,121,679	1,037,369,288	2,384,697,328	1,992,820,002
Unemployment[1]	921,162,821	250,164,923	187,458,528	264,527,546	219,011,824
Premature mortality[1]	8,575,265	2,267,939	1,128,376	1,160,584	4,018,366
Absenteeism[2]	1,385,650,476	510,692,089	144,161,775	390,582,834	340,213,778
Presenteeism[3]	6,012,619,735	2,149,996,728	704,620,609	1,728,426,364	1,429,576,034

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	All Disorders	Anxiety Disorders	Bipolar Disorders	Major Depressive Episodes	Substance Use Disorders
C. Model for Women Only					
Total indirect cost	8,334,781,235	3,804,600,992	639,496,774	2,949,200,319	941,483,150
Unemployment[1]	736,260,877	326,826,381	80,361,779	232,053,248	97,019,469
Premature mortality[1]	1,996,331	543,040	275,360	320,734	857,197
Absenteeism[2]	1,425,283,209	667,419,145	94,919,733	500,774,481	162,169,850
Presenteeism[3]	6,171,240,818	2,809,812,426	463,939,902	2,216,051,856	681,436,634

[1] Estimates based on the assumption of a one-month friction period.

[2] Estimates based on an average of 3.725 absenteeism days.

[3] Estimates assume that workers with these conditions experience a 30% productivity loss per presenteeism day.

Table 12. Total Indirect Cost as a Proportion of Canada's GDP

Total Indirect Cost	GDP, Q4 2022	GDP, Q1 2025	Indirect Cost as a Proportion of 2022 GDP	Indirect Cost as a Proportion of 2025 GDP
$16,662,789,533	$2,866,460,000,000	$3,174,264,000,000	0.58%	0.52%

Among these, depression and anxiety disorders have the highest indirect costs (over $5.3 billion and $6.7 billion, respectively), while bipolar disorder contributes around $1.7 billion and substance use disorders approximately $2.9 billion. Across all disorders, the majority of indirect costs were attributed to presenteeism.

When comparing men and women, the distribution of cost shows that both groups bear similar total burdens, at about $8.3 billion. Premature mortality costs were often higher for men than women. Presenteeism costs were higher for women with anxiety and depressive disorders compared to men, likely due to the higher prevalence among women.

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Limitations of the indirect cost analysis

Results from this analysis should be interpreted with the following limitations in mind.

- Indirect costs for all mental illnesses were not quantified. This likely underestimates the true total indirect cost.
- There are many ways to define and measure indirect costs (e.g., work loss, worker replacement, productivity loss, and costs related to short- and long-term disability).[216] In our analysis, some costs could not be measured or quantified. As such, the true total indirect cost is likely higher than what we have presented.
- Each cost-of-illness study uses different inputs and methodologies. As such, comparison to prior studies is not appropriate.
- Using a survey estimate of mental illness, as compared to a clinical diagnosis, may under- or over-estimate the prevalence of mental illness, which in turn could under- or over-estimate costs.
- When estimating 2022 indirect costs, certain disorder-sex-age strata contained a small number of observations. This may impact the reliability of indirect cost estimates for these strata.
- Absenteeism costs across disorders are based on the same value for the number of absenteeism days. It is likely that this value varies by disorder.

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