Mental Health Commission of Canada

Commission de la santé mentale du Canada

Examining Two Psychosocial Factors in Long-Term Care During the COVID-19 Pandemic

Policy Brief

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Contents

Summary of Recommendations

1. Address the long-standing economic, social, intersectional, and organizational structural issues brought to light during the COVID-19 pandemic that require immediate attention.
2. Support staff through continuing education and training to increase their capacity for both psychological self-care and protection from moral distress.
3. Invest in leadership development to foster improved team functioning.
4. Rectify all safety issues to ensure safe working conditions for staff.
5. Develop or improve human resource policies that build equity, increase benefits, address burnout, and acknowledge the value of support workers.

Introduction

Purpose

Since its publication in 2013, organizations have been using the National Standard of Canada for Psychological Health and Safety in the Workplace (the Standard) as a guide for promoting mental health and preventing psychological harm at work. The Standard outlines 13 psychosocial factors in a workplace that should be assessed for risk and opportunities for improvement. Recently, these were supplemented by two additional factors that are specific to the health-care sector: (1) support for psychological self-care and (2) protection from moral distress.[1]

Support for psychological self-care is a factor that reflects the emergent focus on support for staff members' capacity for psychological self-care when dealing with occupational stress. Health-care organizations support such self-care when they encourage staff to care for their own psychological health and safety in their workplace. This can include paid sick leave, protected break times, designated break spaces, paid education and learning opportunities, or replacement staff to enable self-care.

Protection from Moral Distress is a factor that reflects the well-documented concern in healthcare with the psychological stress experienced by staff caused by moral quandaries. Organizations that protect workers from moral distress create an environment that enables them to do their work with a sense of integrity while being supported by their professional bodies, employer, and peers.[2] Such protection can include dedicated staff and resources for wellness, opportunities for de-briefing sessions following significant events, and clearly defined and consistently followed policies and protocols.

With these two factors in mind, this report presents considerations for policy changes that can better support the psychological well-being of health-care professionals in Canada's long-term care sector.

Two questions guided this study:

1. What are the barriers and facilitators for long-term care workers, their teams, and long-term care organizations to providing support for psychological self-care and protection from moral distress?
2. In relation to the barriers and facilitators identified, how has the COVID-19 pandemic impacted long-term care workers, their teams, and the organizations they work in?

Methods

This project included two types of exploration: (1) a review of academic and peer-reviewed literature and (2) semi-structured interviews with seven professionals in the long-term care sector. We searched a database of recent empirical international medical literature, focusing on nursing, allied health, and health care, and analyzed all relevant articles published in English. The interviews (also conducted in English) were audio recorded and transcribed verbatim, then analyzed thematically. Participants included personal support workers, nurses, physicians, and administrators.

This project supplements a larger, national exploration that included all health-care workers and various types of health-care workplaces, entitled *Exploring Two Psychosocial Factors in Health-Care: Support for Psychological Self-Care and Protection From Moral Distress in the Workplace: Facilitators and Barriers*. Both studies were conducted between November 2021 and February 2022.

Ethical compliance was approved by the Queen's University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Background

Even before the pandemic, it was well-known that health-care workers were more likely to experience chronic stress and burnout, compared to workers in other sectors.[3] By late 2020, a Statistics Canada survey found that health-care workers' exposure to COVID-19 at work was exacerbating their situation, with 77 per cent reporting worsening mental health.[4] In December 2020, long-term care was the sector most strongly affected, with a disproportionately high number of COVID-19-related deaths, among both residents and staff.[5] Yet the facilitators and barriers tied to the psychological health and safety of its workers, particularly in connection with COVID-19, are not well understood — despite the fact that failing to understand them poses a significant threat to the sector's sustainability.

A diverse sector with diverse approaches

Long-term care is often referred to through a variety of terms (e.g., nursing home, continuing care, skilled-nursing facility) to reflect the types and extent of care the sector provides. In our

literature review, we not only found that different countries understand and approach long-term care in distinct ways,[6] the jurisdictions, regulations, legislation, funding, staff, and care models it falls under can also vary significantly.[7] For instance, Canada's long-term care sector is under provincial or territorial jurisdiction, unlike some parts of the United States, Europe, and Asia, which shows that different approaches can exist in the same country.[8] So, while our own sector faces similar challenges to other parts of the world, policy changes must consider local, provincial-territorial, and national differences to ensure that these issues are addressed.

Key Considerations and Results

A historically under-resourced sector

The allocation of resources is an enduring challenge for long-term care in many countries, and it remains a key reason that health-care professionals in this sector experience moral distress.[9] Prior to the pandemic, the sector was already being constrained by a lack of funding for medical equipment, patient beds, and training.[10,11] Yet resource constraints have also led to poor organizational decisions, such as onboarding unqualified staff, tolerating ineffective care practices, and failing to prevent rapid turnover in management. Since these factors heighten moral distress, long-term care workers have been faced with having to make ethically complex decisions that are incongruent with patient care standards.[12]

While distress is evident at the management level, with leaders reporting that they feel powerless to effect positive change in the face of these constraints,[13] mental health resources to support psychological self-care are said to be scarce, inaccessible, unreliable, and in certain cases, completely unavailable. In some organizations, no dedicated physical spaces (e.g., staff rooms) exist to allow staff to engage in self-care or take breaks during difficult situations.

The pandemic has only exacerbated these struggles with resource allocation. Over 50 per cent of long-term care workers reported having no access to proper personal protective equipment (PPE) such as N95 masks, face shields, and eyewear while working.[14]

Chronic understaffing, staff retention difficulties, heavy overwork culture

In an effort to meet mounting demands, the sector generally expects its staff members to work overtime.[15–17] Yet climbing death rates and increasing patient loads throughout the pandemic have led to high turnover rates among front-line staff and management. Despite the fact that long-term care workers often take on high patient loads with little assistance, they have little time for psychological self-care. Not only is skipping breaks and meals common, when workers do opt to take mandated break times or sick days, many feel guilty.[18]

Among peers, the expectation to overwork is reinforced through bullying and gossip.[19] Although the sector has a prevalence of moral distress, efforts to practise psychological self-care are often dismissed as "excuses" not to work. Such pressure further heightens worker distress and

deters them from seeking out psychological self-care. Bullying also inhibits teamwork and encourages individuals to work independently with little to no support to help them deal with challenging situations.[20-22]

Physical distancing measures related to COVID-19 have largely limited staff's ability to socialize with one another, while reducing opportunities for debriefing, knowledge sharing, community building, and peer or leadership support. These measures have also prevented informal caretakers (e.g., family, friends, hired companions) from entering long-term care homes. Not only has this put front-line workers on the receiving end of hostility from patients and families dissatisfied with the care or restrictions in place, it has forced them to make the tasks usually performed by informal caretakers part of their workload. The observed retention issues at the management level further decreases the capacity to support staff when needed.[23] In light of these challenges, workers report being "caught in the middle," something that exacerbates their already difficult working conditions and puts patient care at greater risk.

Precarious workforce

Around 530,000 staff are employed at nursing and long-term care settings in Canada, with racialized, immigrant women overrepresented in the sector.[24,25] On average, 16.4 per cent of employees hold casual positions and about four percent have contract positions (though some provinces report a much higher number of contract workers).[26,27] Unregulated health-care providers, such as personal support workers, comprise a large part of the workforce. Yet, part-time, casual, or unregulated workers experiencing systemic discrimination and undervaluing, are not provided access to the same benefits or educational programs.[28,29] So not all staff members are provided equal opportunity to psychological self-care, and some are not given access to any supports. Support staff report more symptoms of burnout, compared to other professionals in the sector.[30]

Interviews: Voices of workers in the long-term care sector

"The hospital has proper masks, and there is a differentiation between the hospital mask and the nursing home masks. So, I asked myself, are we not both nurses? But they have a different mask than us."

"Lots of new rules. We didn't have the space in the beginning. We didn't have enough dumpsters outside, and so the hallways were lined with bags and bags of garbage."

"Especially for the leaders. There is a lot of moral distress. You look at how many of us have not taken our vacation this past year and a half and it's a problem. We are all burning out, and we are all really tired."

"So, people feel guilty taking time off. There is an expectation that a lot of people work overtime, which is really tough."

"You have families who are angry because the restrictions were in place for so long, and we have families who are angry because you are lifting the restrictions. And this workforce has often been caught in the middle."

"A lot of our employees left to go to other jobs because the conditions are better and the pay is better and they were treated better."

"There wasn't really any support. I lived in a hotel room for two months during COVID because I couldn't come home."

"So, in other words, we don't help each other anymore and there is no teamwork. There is no communication. These are the boss's rules, and this is how it is going to be."

Calls to Action

Address emerging and longstanding structural issues in the long-term care sector

Recent investigations by non-profit, media, and governmental organizations into the growing number of COVID-19-related deaths in long-term care raises an alarm about the lack of support being provided to the sector in Canada. This report supports the need to address these emerging and longstanding economic, social, and organizational issues.[31]

Provide funding to make continuing education and training accessible to all staff

Chronic underfunding and understaffing[32,33] alongside limited health and human resources[34-39] over long periods of time have wrung workers and management dry — a situation connected to larger systemic and organizational factors that seem to be prevalent in long-term care practices across the country. Even though exhaustion is widespread among all staff, the sector "keeps on taking" and is bursting at the seams with the demand. At the same time, any admissions of distress appear to signal greater workloads for peers while fostering a culture of bullying and distrust.

Despite these conditions, an opportunity exists to strengthen community and capacity building among the long-term care workforce through continuing education, training, and transformative leadership. The significant improvements in mental health outcomes that result from provding mental health resources, continuing education, and training sessions are well documented.[40-43] Should physical distancing be required, virtual forums can be used for peer-to-peer learning, community building, and moral support[44] (yet resources are only effective if staff are informed about how and when to access them).

Support leadership and organizational staff

Supportive management personnel are significant conduits to the psychological well-being of staff.[45-50] Organizational leaders play a key role in creating strong and inclusive teams which contribute to a work culture that supports psychological self-care.[51-53] But underfunding and resource constraints make it difficult to provide meaningful and accessible supports. These constraints also contribute to organizational decisions that reduce workers' ability to protect themselves against moral distress in the workplace. It is therefore imperative that resources (e.g., mental health supports for staff) are made available at the management level as well.

Eliminate unsafe working conditions brought on by COVID-19

The pandemic has exacerbated the challenges the long-term care workforce has experienced through constantly changing regulations, which have thrown this chronically underfunded health-care sector into disarray. The need to secure proper PPE, rectify unsafe working conditions, provide supports, and revise safety protocols is hampered by underfunding and understaffing that place workers in increasingly vulnerable situations with limited options to practise physical and psychological self-care. Enforcing safe working conditions is crucial for reducing the rapid turnover caused by the uncontrolled exposure to COVID-19 in the workplace. Doing so would also be a way to illustrate the sector's commitment to ensuring the well-being of its staff. First steps could include providing them with proper PPE, updating safety protocols, and providing appropriate training on infectious diseases and hazards.

Implement significant improvements to existing workplace human resource policies

Beyond these steps, the sector must acknowledge and reconcile the personal, physical, and psychological toll the workforce bears — not only due to the pandemic, but also because of the decades of structural inequity in the sector that has made low pay and unstable working conditions acceptable. It must also implement significant improvements to workplace human resource policies around pay, benefits, and sick leave to address the precarious nature of its employment and the underrecognition of its workforce.

Conclusion

Psychological health and safety in the workplace are critical for enabling a workforce to use its training, skills, and expertise to contribute to society as valued and respected employees. The significant stressors health-care staff have faced throughout the pandemic — particularly by those in long-term care — have emphasized the need for increased attention to the provision of support for psychological self-care and protection from moral distress. Policy makers and

health-care leaders must not turn away from the issues that will continue to impact the long-term sector's recruitment and retention of staff, their health and safety and, most critically, their ability to continually provide quality care to some of our most vulnerable citizens. Much more work is needed if the sector is to strengthen its health-care workers, teams, and organizations. The recommendations contained in this report should only be considered the starting point of that process.

References

[1] Mental Health Commission of Canada. (2022). *Advancing psychological health and safety within healthcare settings.* https://mentalhealthcommission.ca/what-we-do/workplace/workplace-healthcare/

[2] Mental Health Commission of Canada. (2022). *Advancing psychological health and safety within healthcare settings.*

[3] Kitts, J. (2013). Psychological health and safety in Canadian healthcare settings. *Healthcare Quarterly*, 16, 6-9. https://doi.org/10.12927/hcq.2014.23643

[4] Statistics Canada. (2021, February 2). Mental health among health care workers in Canada during the COVID-19 pandemic. *The Daily*. https://www150.statcan.gc.ca/n1/daily-quotidien/210202/dq210202a-eng.htm

[5] Canadian Institute for Health Information. (2021). *COVID-19's impact on long-term care.* https://tinyurl.com/2p8wuxab

[6] Sanford, A. M., Orrell, M., Tolson, D., Abbatecola, A. M., Arai, H., Bauer, J. M., Cruz-Jentoff, A. J., Dong, B., Ga, H., Goel, A., Hajjar, R., Holmerova, I., Katz, P. R., Koopmans, R. T. C. M., Rolland, Y., Visvanathan, R., Woo, J., Morley, J. E., & Vellas, B. (2015). An international definition for "nursing home." *Journal of the American Medical Directors Association*, 16, 181-184. https://doi.org/0.1016/j.jamda.2014.12.013

[7] Ågotnes, G., McGregor, M. J., Doupe, M. B., Müller, B., & Harrington, C. (2019). An international mapping of medical care in nursing homes. *Health Services Insights*, 12. https://doi.org/10.1177/11786329188250 83

[8] Tolson, D., Rolland, Y., Katz, P. R., Woo, J., Morley, J. E., & Vellas, B. (2013). An international survey of nursing homes. *Journal of the American Medical Directors Association*, 14, 459-462. https://doi.org/10.1016/j.jamda.2013.04.005

[9] Green, A. E., & Jeffers, B. R. (2006). Exploring moral distress in the long-term care setting. *Perspectives: The Journal of the Gerontological Nursing Association*, 30, 5-9. https://pubmed.ncbi.nlm.nih.gov/17518034/

[10] Burston, A. S., & Tuckett, A. G. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. *Nursing Ethics* 20, 312-324. https://doi.org/10.1177/0969733012462049

[11] Brassolotto, J., Daly, T., Armstrong, P., & Naidoo, V. (2017). Experiences of moral distress by privately hired companions in Ontario's long-term care facilities. *Quality in Ageing and Older Adults*, 18, 58-68. https://doi.org/10.1108/QAOA-12-2015-0054

[12] Caspar, S., Brassolotto, J. M., & Cooke, H. A. (2021). Consistent assignment in long-term care homes: Avoiding the pitfalls to capitalise on the promises. *International Journal of Older People Nursing*, 16, 1-10. https://doi.org/10.1111/opn.12345

[13] Spenceley, S., Witcher, C. S. G., Hagen, B., Hall, B., & Kardolus-Wilson, A. (2017). Sources of moral distress for nursing staff providing care to residents with dementia. *Dementia*, 16(7), 815-834. https://doi.org/10.1177/1471301215618108

[14] Canadian Institute for Health Information. (2021). *The impact of COVID-19 on Canada's long-term care workers.* https://tinyurl.com/2bu22ytc

[15] Burston & Tuckett. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions.

[16] Spenceley, S., Caspar, S., & Pijl, E. (2017). Mitigating moral distress in dementia care: Implications for leaders in the residential care sector. *Nursing Leadership*, 30, 45-59. https://doi.org/10.12927/cjnl.2017.25449

[17] Pijl-Zieber, E. M., Awosoga, O., Spenceley, S., Hagen, B., Hall, B., & Lapins, J. (2018). Caring in the wake of the rising tide: Moral distress in residential nursing care of people living with dementia. *Dementia*, 17(3), 315-336. https://doi.org/ 10.1177/1471301216645214

[18] Moon, Y., & Shin, S. Y. (2018). Moderating effects of resilience on the relationship between emotional labor and burnout in care workers. *Journal of Gerontological Nursing*, 44, 30-39. https://doi.org/10.3928/00989134-20180815-01

[19] Burston & Tuckett. (2013).

[20] Brassolotto, et al. (2017). Experiences of moral distress by privately hired companions in Ontario's long-term care facilities.

[21] Spenceley, Witcher, et al. (2017). Sources of moral distress for nursing staff providing care to residents with dementia.

[22] Pijl-Zieber, et al. (2018). Caring in the wake of the rising tide: Moral distress in residential nursing care of people living with dementia.

[23] Spenceley, et al. (2017).

[24] Luna, K. C. (2021). *Racialized women and COVID-19: Challenges in Canada* [Fact sheet]. Canadian Research Institute for the Advancement of Women. https://tinyurl.com/ymx5ts6m

[25] Marrocco, F. N., Coke, A., & Kitts., J. (2021). *Ontario's long-term care COVID-19 commission: Final report*. https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf

[26] Canadian Institute for Health Information. (2021). *The impact of COVID-19 on Canada's long-term care workers.*

[27] Statistics Canada. (2021, September). A profile of nursing and residential care facilities, 2019. *The Daily.* https://www150.statcan.gc.ca/n1/daily-quotidien/210916/dq210916c-eng.htm

[28] Brassolotto, et al. (2017).

[29] Spenceley, Caspar, et al. (2017). Mitigating moral distress in dementia care: Implications for leaders in the residential care sector.

[30] Hunter, P. V., McCleary, L., Akhtar-Danesh, N., Goodridge, D., Hadjistavropoulos, T., Kaasalainen, S., Sussman, T., Thompson, G., Venturato, L., & Wickson-Griffiths, A. (2019). Mind the gap: Is the Canadian long-term care workforce ready for a palliative care mandate? *Ageing and Society*, 40, 1223-1243. https://doi.org/10.1017/S0144686X18001629

[31] Mapira, L., Kelly, G., & Geffen, L. N. (2019). A qualitative examination of policy and structural factors driving care workers' adverse experiences in long-term residential care facilities for older adults in Cape Town. *BMC Geriatrics*, 19, Article 97. https://doi.org/10.1186/s12877-019-1105-3

[32] Burston & Tuckett. (2013).

[33] Brassolotto, et al. (2017).

[34] Green, A. E., & Jeffers, B. R. (2006). Exploring moral distress in the long-term care setting.

[35] Burston & Tuckett. (2013).

[36] Brassolotto, et al. (2017).

[37] Lev, S., & Ayalon, L. (2018). A typology of social workers in long-term care facilities in Israel. *Social Work*, 63(2), 171-178. https://doi.org/10.1093/sw/swy002

[38] Dunn, L. A., Rout, U., Carson, J., & Ritter, S. A. (1994). Occupational stress amongst care staff working in nursing homes: An empirical investigation. *Journal of Clinical Nursing*, 3(3), 177-183. https://doi.org/10.1111/j.1365-2702.1994.tb00383.x

[39] Islam, M. S., Baker, C., Huxley, P., Russell, I. T., & Dennis, M. S. (2017). The nature, characteristics and associations of care home staff stress and wellbeing: A national survey. *BMC Nursing*, 16, Article 22. https://doi.org/10.1186/S12912-017-0216-4

[40] Rivett, E., Hammond, L., & West, J. (2019). What influences self-perceived competence and confidence in dementia care home staff? A systematic review. *Psychogeriatrics*, 19(5), 440-456. https://doi.org/10.1111/psyg.12422

[41] Bluth, K., Lathren, C., Silbersack Hickey, J. V. T., Zimmerman, S., Wretman, C. J., & Sloane, P. D. (2021). Self-compassion training for certified nurse assistants in nursing homes. *Journal of the American Geriatrics Society*, 69(7), 1896-1905. https://doi.org/10.1111/jgs.17155

[42] Franzosa, E., Tsui, E. K., & Baron, S. (2019). "Who's caring for us?": Understanding and addressing the effects of emotional labor on home health aides' well-being. *Gerontologist*, 59(6), 1055-1064. https://doi.org/10.1093/geront/gny099

[43] O'Brien, W. H., Singh, R.(S), Moeller, M. T., Wasson, R., & Jex, S. M. (2019). Group-based acceptance and commitment therapy for nurses and nurse aides working in long-term care residential settings. *Journal of Alternative and Complementary Medicine*, 25(7), 753-761. https://doi.org/10.1089/acm.2019.0087

[44] Baughman, A. W., Renton, M., Wehbi, N. K., Sheehan, E. J., Gregorio, T. M., Yurkofsky, M., Levine, S., Jackson, V., Pu, C., T., & Lipsitz, L. A. (2021). Building community and resilience in Massachusetts nursing homes during the COVID-19 pandemic. *Journal of the American Geriatrics Society*, 69(10), 2716-2721. https://doi.org/10.1111/jgs.17389

[45] Burston & Tuckett. (2013).

[46] Spenceley, Caspar, et al. (2017).

[47] Franzosa, et al. (2019). "Who's caring for us?": Understanding and addressing the effects of emotional labor on home health aides' well-being.

[48] Nielsen, K., Randall, R., Yarker, J., & Brenner, S-O. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study. *Work and Stress*, 22(1), 16-32. https://doi.org/10.1080/02678370801979430

[49] Zhang, Y., Punnett, L., & Gore, R. (2014). Relationships among employees' working conditions, mental health, and intention to leave in nursing homes. *Journal of Applied Gerontology*, 33(1), 6-23. https://doi.org/10.1177/0733464812443085

[50] Pijl-Zieber, E., Hagen, B., Armstrong-Esther, C., Hall, B., Akins, L., & Stingl, M. (2008). Moral distress: An emerging problem for nurses in long-term care? *Quality in Ageing and Older Adults*, 9(2), 39-48. https://doi.org/10.1108/14717794200800013

[51] Moon & Shin. (2018). Moderating effects of resilience on the relationship between emotional labor and burnout in care workers.

[52] Nielsen, et al. (2008). The effects of transformational leadership on followers' perceived work characteristics and psychological well-being: A longitudinal study.

[53] Barry, T., Longacre, M., O'Shea-Carney, K., & Patterson, S. (2019). Team inclusion and empowerment among nursing staff in long-term care. *Geriatric Nursing*, 40(5), 487-493. https://doi.org/10.1016/j.gerinurse.2019.03.014

Appendix

Case scenarios

The purpose of the following scenarios, drawn from major insights in this study, is to inform capacity-building strategies to advance psychological health and safety for health-care workers, teams, and organizations in the long-term care sector.

Case scenario A: Group debrief sessions

When one long-term care home experienced a high number of deaths or a substantial loss, leaders brought in a professional counsellor to lead group debriefing sessions. The facility provided private therapy services to full-time staff as part of their benefits package, but the group sessions seemed to remind staff about the availability and helpfulness of these services. Leaders also felt that these sessions allowed some staff to take part who might not otherwise have sought a counselling session following a time of high stress in the organization.

Case scenario B: The bereavement process

Due to the high death rate in long-term care during COVID-19, allowing time for staff and families to grieve became more challenging. One organization provided protection from the moral distress this created by making a bereavement counsellor available for both groups. The ability to honour residents who died at a memorial service each month also enabled staff to talk to one another, take time to grieve, and prevent the hectic nature of the pandemic from dismissing death so easily.

Case scenario C: Continuing education

One private long-term care organization prioritized the use of continuing education for all staff, something uncommon in this sector. Leadership recognized that providing paid time for training (specifically for management and front-line personal support workers) pays dividends for the organizational culture while supporting professionals that work in isolation at separate locations who rarely get the chance to connect with their peers to share knowledge. An annual two-day learning event has also benefited leaders and other workers, leading to an energized workplace and potentially increased staff loyalty in the organization.

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