Unpaid Family Caregiving

for People Who Use Drugs in Rural Western Canada

RESEARCH FINDINGS

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This work was primarily conducted on the territory of the Néhiyaw (Cree), Niitsitapi (Blackfoot), Métis, Nakoda (Stoney), Dene, Haudenosaunee (Iroquois) and Anishinaabe (Ojibway/Saulteaux), lands that are now known as part of Treaties 6, 7 and 8 and homeland of the Métis. We respect the sovereignty, lands, histories, languages, knowledge systems and cultures of all First Nations, Métis and Inuit nations.

We acknowledge that Indigenous peoples are disproportionately impacted by the unregulated drug crisis due to colonialism, racism, and systemic discrimination. These structural challenges must be addressed as part of reconciliation.

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Background

UNREGULATED TOXIC DRUG CRISIS

Since 2016, nearly 54,000 Canadians have died from drug poisoning (sometimes referred to as "overdose").[1] Thousands more have experienced other health and social harms, including risks of HIV, hepatitis C, other infectious diseases, acquired brain injury, and criminalization.[2-5]

Some populations have experienced disproportionate impacts of the unregulated toxic drug crisis. For example, Indigenous people are disproportionately affected due to colonialism, systemic racism and discrimination.[6] In 2020, the drug poisoning death rate was 7 times higher among First Nations people than non-First Nations people in Alberta.[7] Research also indicates that people living in rural Canada may be more likely to experience a drug poisoning death than people living in cities.[8]

The highly toxic and unpredictable unregulated drug supply is the primary driver of this urgent public health issue. This supply contains various powerful synthetic drugs, including fentanyl, benzodiazepines, and xylazines.[9,10] Social and structural factors, such as poverty, trauma, and drug and social policies, also shape how people experience this issue.[11]

Evidence-informed programs can prevent drug poisoning and support the wellbeing of people who use drugs (PWUD). These programs span prevention (e.g., school-based programming), harm reduction (e.g., supervised consumption sites, naloxone), and treatment (e.g., opioid agonist treatment, such as methadone and buprenorphine/naloxone).[12] However, access to these services can be hard in some rural and remote areas of Canada. Key access barriers include the limited availability of services, transportation and weather challenges, stigma, perceived lack of privacy, and limited digital infrastructure for virtual health options.[13-17]

UNPAID FAMILY CAREGIVING IN CANADA

When services are hard to access, families and friends often fill the gap by providing unpaid support (also known as "caregiving"). Currently, about 25% of Canadians are unpaid caregivers and 50% of the population is expected to provide unpaid care in their lifetime.[18] Caregiving is critical to the functioning of the healthcare system and provides an estimated $98 billion in annual savings.[18] Caregiving is even more prevalent in rural communities where access to formal health care can be limited.[19]

Most caregivers in Canada are women, who frequently balance these responsibilities with work and other family commitments.[20] Although caregivers want to support their loved ones, this work comes with considerable challenges. Caregivers report diminished physical and mental health (e.g., trouble sleeping, anxiety, depression), social isolation (e.g., time away from friends and hobbies), and financial stress (e.g., increased expenses, time away from work).[18,20,21] Despite the all-consuming nature of caregiving, existing caregiver supports remain minimal.

RESEARCH QUESTION

The unregulated toxic drug crisis and unpaid family caregiving are two important health and social issues in Canada, particularly in rural communities. However, we do not know much about the relationship between the two issues. We asked "**What are the experiences of unpaid family caregivers of people who use drugs in rural Canada?**"

> “There’s always that element that people think there’s a choice in [addiction], you know? It’s just so barbaric. We would never do that with cancer or anything else like that. … There’s trauma. There’s racism. … We need people that understand that. We need politicians that understand that.”
>
> (P12, ALBERTA, MOTHER)

The Research

SETTING

This research was conducted in rural communities across the three Prairie provinces: Alberta, Saskatchewan, and Manitoba. This region of Canada has a significant rural population compared to other regions of Canada and has been impacted by the unregulated toxic drug crisis. Approximately, 14,300 people across the Prairies have died from a drug-related death since 2016.[1]

WHAT DID WE DO?

This research is a community-based qualitative study. In Fall 2021, we convened a working group to design and lead the research. The 16-person working group is composed of individuals across the Prairies, including academics, family members of PWUD, people with lived experience of substance use, and community-based organization staff.

Participants were recruited through community organizations, social media, and word of mouth. To be eligible for the study, participants had to be:

a) At least 18 years of age

b) Providing unpaid care for an adult who uses drugs other than alcohol, tobacco and cannabis (e.g., family, friend, neighbour, other loved one)

c) Providing care that was not compensated through paid employment

d) Living in rural Alberta, Manitoba, or Saskatchewan

e) Able to complete an interview in English

In Fall 2024, we interviewed 31 unpaid family caregivers of people who use drugs in rural communities across the Prairies. Interviews took place over the phone or on Zoom after informed consent was collected. Participants received $50 CAD as a thank you for their time and expertise. Interviews were audio-recorded and transcribed verbatim. The interview transcripts were analyzed for key themes using reflexive thematic analysis.

Research approval was received from the University of Alberta Health Research Ethics Board 1.

WHO DID WE HEAR FROM?

We interviewed 31 family members from across the Prairie provinces. Key sociodemographic information includes:

100%
identified as women

48%
lived in rural Alberta

39%
lived in rural Manitoba

62%
identified as a mother of someone who uses drugs

71%
identified as white

58%
were between the ages of 40-59

> “We’re built for connection and so when people are sobering up, they have nobody. Like their friend list is all gone. That’s actually something my partner has mentioned. Like he has no friends, you know? So not having that part of his life is huge. We need community.”
>
> (P13, MANITOBA, PARTNER)

What Did We Hear?

THE BEGINNINGS OF CARE: SUPPORTING LOVED ONES IN UNDER RESOURCED SETTINGS

Many caregivers shared that their loved one's substance use started as a way to cope with trauma and mental health issues. Since few communities had the appropriate health and social services available, substance use became the primary coping mechanism.

> "He didn't start using drugs in grade seven, but, you know, as time went on from grade seven, eight, nine, ten, his anxiety in school and just for handling things got a lot worse. And so then I think his coping was to self-medicate."
>
> (P1, SASKATCHEWAN, MOTHER)

Caregivers began providing care because their communities lacked critical formal services and supports. These gaps spanned crucial areas including early childhood development, trauma-informed mental health and substance use care, harm reduction services, social services, and housing supports.

Even when formal services were available, they were sometimes inaccessible or did not meet the needs of PWUD. Participants identified several barriers including:

- **Logistical Challenges:** Service location, hours of operation, long wait lists, staff shortages, and the cost of programs
- **Program Design and Appropriateness:** Strict program practices, complicated intake criteria and processes (e.g., needing to be sober to start treatment), and lack of specialized services (e.g., supports for pregnant PWUD)
- **Transitional and Follow-Up Gaps:** An absence of supports for those leaving treatment or jail or "aging" out of youth-centered systems.
- **Community Barriers:** Stigma, systemic racism and discrimination, perceived lack of privacy, and transportation challenges (e.g., no public transportation, weather conditions)
- **Personal Barriers:** Anxiety about accessing formal services, not having ID (e.g., health card), knowledge of existing services, limited access to technology and poor digital literacy.

> "I think our housing crisis gets exponentially worse every year. It seems like more and more people are unhoused. There are just not enough treatment beds available. Wait lists are really, really long. And there's a lot of stigma and shame in all communities,but especially in rural communities around substance use."
>
> (P18, MANITOBA, SISTER)

THE CAREGIVING EXPERIENCE

Faced with little to no help from formal supports and services, families often stepped in to provide a comprehensive range of support. Examples of their care activities include:

- **Providing basic necessities:** Food (e.g., home cooked meals, groceries, food gift cards), housing (e.g., paying for rent, providing a room, buying furniture), and clothing;
- **Emotional support**;
- **Financial support:** Paying for transportation, medical expenses (e.g., private treatment, dental care), necessities, phone, fines and legal fees;
- **Medical support:** Advocacy within and outside the healthcare system, providing transportation to appointments, detoxing loved ones at home, reversing drug poisoning, providing harm reduction support (e.g., distributing naloxone), service navigation, and direct medical care (e.g., wound care)
- **Social support:** Access to social assistance and other social programs, supporting getting ID (e.g., health card), job search and education support, and facilitating leisure activities
- **Broader family support:** Providing support to a loved one's partner, assuming permanent or temporary custody of loved one's children, and providing necessities for children in the home (e.g., clothing, school supplies)

> "Like with my daughter, right? I support her financially with everything. She lives at home with me. I have guardianship of her daughter. So, my five year old granddaughter that lives with us. So it's like all the emotional support, the mental support, the physical support, giving her housing, and then making sure that she has food ..."
>
> (P9, ALBERTA, MOTHER)

In addition to providing care to fill gaps in formal services, many caregivers provided care because of existing gender and family roles.

> "When she comes home here, and she's detoxing, as a mom, I immediately go into that mode of nurturing her."
>
> (P3, ALBERTA, MOTHER)

The dedication of caregivers often extended beyond their families. Their personal experiences and desire to help others motivated many caregivers to support PWUD in the wider community, including through mutual aid, creating non-profit organizations, and entering care-centered careers (e.g., nursing, social work).

> "I lost my son who aged out of the system and ended up at the homeless shelter and passed away from a fentanyl overdose. Because of that, I started a grassroots nonprofit organization to help bridge the gap ..."
>
> (P10, ALBERTA, PARTNER/MOTHER)

Many caregivers were told they should stop providing care by others who viewed their help as "enabling" drug use. However, caregivers were determined to provide care to the best of their ability. Recognizing the complexity of substance use, many caregivers pursued training and professional development by reading books, contacting experts, and attending workshops. Some caregivers shared that their approaches to providing care were always evolving as they learned more about substance use and connected with other families in similar situations.

IMPACT OF CARE: ON THE CAREGIVER AND BEYOND

Caregiving was a challenging role that affected nearly every aspect of caregivers' lives, as well as the lives of their family members. Caregivers identified key challenges, including:

- **Emotional and Mental Strain:** Constant worry, stress, and feeling overwhelmed, dealing with loss and worrying about their loved one dying in the future (anticipatory grief), feelings of anger, and experiences of trauma and symptoms related to post-traumatic stress
- **Physical Toll:** Suffering from chronic headaches, lack of sleep and loss of appetite, worsened existing health issues (e.g., heart disease, autoimmune disorder), or development of new health issues due to chronic stress
- **Financial Hardship:** Loss of income related to increased expenses and a need to reduce working hours or take unpaid leave, taking on new debt (e.g., remortgaging home), and loss of savings
- **Work Conflicts:** Feeling distracted while on the job, facing stigma and micromanagement in the workplace, and losing their job
- **Social Challenges:** Self-isolation and the loss of friends and close personal relationships, being unable to pursue hobbies, and missing out on important family events (e.g., weddings)

These challenges were at times amplified by the stigmatization and criminalization of substance use, as well as the few supports available to them in rural settings.

> "Mentally, it was really hard. There were lots of days at work that I wasn't there 100% totally. How can you be? There's this chaos happening. And, you know, he's running from the police and he's getting arrested and he's been thrown in jail or you haven't heard from him. He hasn't called you in three or four or five days. And you think, 'Okay, this will be the time I get, you know, that knock at the door. Right? Or like our house in town now is on a corner and if I see a police car go by, my heart is like …"
>
> (P15, ALBERTA, MOTHER)

> "I took all my RRSPs out first. I had to pay for that $30,000 [treatment]. I paid for that, took a loan out for that, you know. Then he had like $6,000 worth of fines because we had to get his license back. It was all stupid red light tickets but you know, we had to get that back and then just the money, right? Like I paid for his medication a lot."
>
> (P16, ALBERTA, MOTHER)

CARING FOR THE CAREGIVER

There were very few supports available to caregivers of PWUD in rural settings.

Caregivers shared that few support groups for families existed in these communities and they mostly focused on families impacted by alcohol or cannabis. The extra stigma of caring for someone who uses illegal drugs, amplified by the tight knit nature of rural communities, prevented caregivers from attending these groups. Instead, some participants accessed private mental health services, but acknowledged that cost was sometimes prohibitive.

> "A friend wanted me to go to Al-anon in town with her and I didn't really want to because I was worried who might be there."
>
> (P15, ALBERTA, MOTHER)

Those who did access formal services found that virtual supports were helpful due to their geographic location and ability to remain relatively private (e.g., ability to leave their cameras off). Caregivers also shared that peer support groups targeted to illegal substance use were helpful because there was a shared sense of understanding.

Caregivers also relied on informal support; however, they noted that this support did not always come from their families. Family members sometimes disagreed with caregivers' decision to provide care or the level of support being given (e.g., extensive financial support). These conflicting points of views created significant tension between family members and sometimes led to the loss of close family relationships. This also left caregivers as often the only people providing care to their loved one.

> "I would say that there are conflicting views about whether we should have been providing support, and what that should look like. I think there are a few people in the family who are real proponents of tough love and no contact."
>
> (P18, MANITOBA, SISTER)

Caregivers felt very supported by informal peer networks that they built over time. Important members of their support network included supportive family members, other families supporting PWUD, and understanding members of the community. These networks were especially helpful for caregivers because of their non-judgmental nature, ability to provide privacy, and understanding of the person's family situation.

> "I have a close group of friends and also my boyfriend is really helpful. They listen and kind of check in in case you're not okay. They're pretty non-judgmental and they kind of give me a base I need."
>
> (P17, MANITOBA, DAUGHTER)

WHAT WOULD MAKE LIFE EASIER?

When asked what would make their lives easier, caregivers emphasized the need for large-scale system changes rather than individual-level programs and policies. While they suggested small improvements that might support individual families, like more psychosocial and financial support for caregivers of PWUD, they viewed community-level support as most important. Many suggested education and stigma reduction campaigns as good starting points.

> "Stigma trickles down, right? Like if people are stigmatizing the user, then they're stigmatizing the person who raised the user or who's giving that user a hamburger."
>
> (P2, ALBERTA, MOTHER)

Caregivers believed that governments should reinvest in public health and social services in rural communities. Beyond mental health and addiction services, caregivers emphasized the importance of strengthening broader services, like primary care, that could benefit the entire community and help prevent substance use. They stressed that adding "more" services were not enough. Services also needed to be "better". They called for family-centered treatment, the integration of traditional Indigenous knowledge and practices, the expansion of publicly-funded services (e.g., dental care), and a shift away from carceral approaches. While some virtual services may help certain PWUD, caregivers highlighted the importance of maintaining in-person services for those without reliable technology or who prefer the in-person connection.

> "I think one thing we're lacking is, for my adopted sister who still has her kids, more family-oriented rehabs because I feel like if they had more family things that more parents would come forward and say, 'I do have an addiction, but I don't want to lose my kids. So help me help myself so I can help my kids.' I know that's her biggest barrier."
>
> (P23, ALBERTA, SISTER)

Participants also emphasized the need to address root causes of substance use, such as housing insecurity and poverty. They wanted more safe and affordable housing options, including housing supports for PWUD leaving treatment or jail. A basic income program was also seen as a potential way to lift PWUD out of poverty.

> "If people could be housed, that would be such a helpful thing. And not just like housed but also housed in a way that is safe and secure. If people could have their housing and very basic needs met, that would be what a huge start because how are people supposed to address things like a substance use disorder when you can't even have your daily needs met?"
>
> (P18, MANITOBA, SISTER)

> “Stigma stops our society and our politicians from providing [support] because we don’t think that the mentally ill and people who suffer from some problematic substance use are worthy. That’s the bottom line. And until we see that they are worthy and that they are people that contribute, we just need to change everything”
>
> (P12, ALBERTA, MOTHER)

Highlights and Recommendations

- **Families provide extensive care for PWUD, often filling critical gaps left by limited formal services in rural communities.**

  Recommendation: Additional publicly-funded formal health and social services are needed across rural Prairie communities. New services should be flexible and responsive to the needs of PWUD and the broader community. Accessible early intervention for child mental health is also essential. Strengthening these services would not only support PWUD but also ease the care burden placed on families.

- **The unique geographic and sociocultural characteristics of rural communities can limit access to services, especially due to transportation. Many communities lack public transportation and PWUD often do not have a vehicle or driver's license. In addition, weather conditions can also make travel to appointments unpredictable or impossible.**

  Recommendation: Service providers should recognize the distinct barriers to care in rural communities and adapt accordingly. This may include offering virtual care, avoiding penalties for missed appointments due to travel or weather issues, or providing subsidized transportation (e.g., taxi chits).

- **Caregiving is an all-consuming endeavour with significant health, social and financial strain. However, supports for caregivers of PWUD are almost non-existent in rural spaces.**

  Recommendation: Accessible and adequate formal psychosocial and financial caregivers supports are needed. These may entail expanded publicly-funded services that address grief and trauma, and enhanced employment leaves and financial supports. Supports targeted to caregivers of PWUD should be provided given the extent of the unregulated toxic drug crisis.

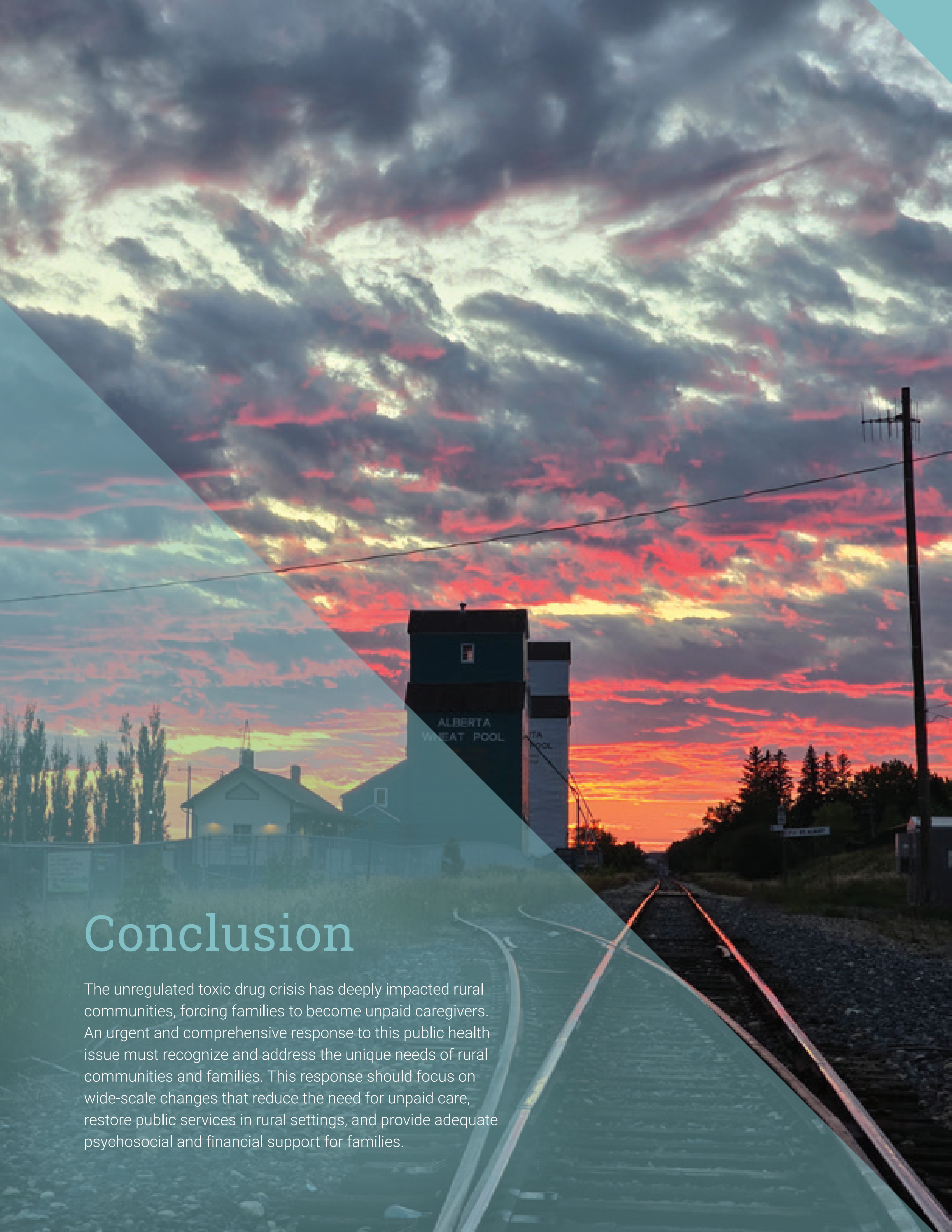
- **Caregivers recognize the complexity of substance use and the structural factors that shape service access and substance use. They emphasized that the root causes must be addressed to effectively support PWUD.**

  Recommendation: The upstream factors of substance use must be addressed to ideally prevent substance use and the conditions that create the need for unpaid care. This means addressing systemic racism and discrimination within the healthcare system, stigma, housing insecurity, and poverty.

- **Modern caregiving requires acknowledging diverse and evolving family structures. Traditional definitions of family do not always adequately reflect who is providing care for PWUD.**

  Recommendation: Eligibility for caregiving supports must be expanded to recognize all kinships providing care. This is crucial to ensure some caregivers do not fall within the cracks. For example, many grandparents currently provide care for a child with a parent who uses drugs, but may not be eligible for supports. Broader definitions of family will also support different cultural understandings of family and kin, such as within Indigenous communities.

> "Never give up on your loved one. I never will. Hang in there. Stay strong. Don't be afraid to talk to people about it. It's okay. ... Take one day at a time. Just do the best you can. And do what you feel is best in your heart, no matter what people say."
>
> (P1, SASKATCHEWAN, MOTHER)



Conclusion

The unregulated toxic drug crisis has deeply impacted rural communities, forcing families to become unpaid caregivers. An urgent and comprehensive response to this public health issue must recognize and address the unique needs of rural communities and families. This response should focus on wide-scale changes that reduce the need for unpaid care, restore public services in rural settings, and provide adequate psychosocial and financial support for families.

REFERENCES

[1] Substance-related Overdose and Mortality Surveillance Task Group on behalf of the Council of Chief Medical Officers of Health. Opioid- and stimulant-related harms in Canada. Ottawa: Public Health Agency of Canada; 2025. Available from: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

[2] Health Canada. Opioid-related poisoning and anoxic brain injury in Canada: a descriptive analysis of hospitalization data. Ottawa: Government of Canada; 2021. Available from: https://www.canada.ca/en/health-canada/services/opioids/opioid-related-hospitalizations-anoxic-brain-injury.html

[3] Saeed S, Thomas T, Dinh DA, Moodie E, Cox J, Cooper C, Gill J, Martel-Laferriere V, Panagiotoglou D, Walmsley S, Wong A, Klein MB. Frequent disengagement and subsequent mortality among people with HIV and Hepatitis C in Canada: a prospective cohort study. Open Forum Infect Dis. 2024;11(5):ofae239. Available from: https://doi.org/10.1093/ofid/ofae239

[4] Scher BD, Neufeld SD, Butler A, Bonn M, Zakimi N, Farrell J, Greer A. “Criminalization causes the stigma”: perspectives from people who use drugs. Contemp Drug Probl. 2023;50(3):402-425. Available from: https://doi.org/10.1177/00914509231179226

[5] Xavier, C.G., Kuo, M., Desai, R., Palis, H., Regan, G., Zhao, B., Moe, J., Scheuermeyer, F.X., Qi Gan, W., Sabeti, S., Meilleur, L., Buxton, J.A., & Slaunwhite, A.K. (2023). Association between toxic drug events and encephalopathy in British Columbia, Canada: A cross-sectional analysis. Substance Abuse Treatment, Prevention and Policy, 18(42). https://doi.org/10.1186/s13011-023-00544-z

[6] Lavalley J, Steinhauer L, Bundy DB, Kerr T, McNeil R. “They talk about it like it’s an overdose crisis when in fact it’s basically genocide”: the experiences of Indigenous peoples who use illicit drugs in Vancouver’s Downtown Eastside neighbourhood. Int J Drug Policy. 2024;134:104631. Available from: https://doi.org/10.1016/j.drugpo.2024.104631

[7] Government of Alberta. Alberta opioid response surveillance report: First Nations peoples in Alberta. Edmonton: Government of Alberta; 2024. Available from: https://open.alberta.ca/dataset/dda35281-eeb4-42d6-a146-6f34d408ac92/resource/8ee1addc-8496-4709-b40f-7cb1063b0d36/download/mha-alberta-opioid-response-surveillance-report-first-nations-peoples-2024.pdf

[8] Hu K, Klinkenberg B, Gan WQ, Slaunwhite AK. Spatial-temporal trends in the risk of illicit drug toxicity death in British Columbia. BMC Public Health. 2022;22(1):2121. Available from: https://doi.org/10.1186/s12889-022-14586-8

[9] Health Canada. Canada’s overdose crisis and the toxic illegal drug supply. Ottawa: Government of Canada; 2024. Available from: https://www.canada.ca/en/health-canada/services/opioids/overdose-crisis-toxic-illegal-drug-supply.html#a3

[10] Wu PE, Austin E. Xylazine in the illicit opioid supply. CMAJ. 2024;196(4):E133. Available from: https://doi.org/10.1503/cmaj.231603

[11] Lin C, Cousins SJ, Zhu Y, Clingan SE, Mooney LJ, Kan E et al. A scoping review of social determinants of health’s impact on substance use disorders over the life course. Journal of Substance Use and Addiction Treatment. 2024;166.

[12] Health Canada. Canadian Drugs and Substances Strategy: Substance use services and supports. Ottawa: Government of Canada; 2024. Available from: https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/substance-use-services-supports.html

[13] Bardwell G, Bowles JM, Mansoor M, Werb D, Kerr T. Access to tablet injectable opioid agonist therapy in rural and smaller urban settings in British Columbia, Canada: a qualitative study. Subst Abuse Treat Prev Policy. 2023;18(1):14. Available from: https://doi.org/10.1186/s13011-023-00525-2

[14] Jackson LA, Mathias H, Martin F, Buxton JA, Dubé A, Kiepek N, MacDonald J, Strike C. Accessing drug treatment programs in Atlantic Canada: the experiences of people who use substances. Drugs Educ Prev Policy. 2023;30(6):550–62. Available from: https://doi.org/10.1080/09687637.2022.2102461

[15] Mathias H, Jackson LA, Buxton JA, Dubé A, Kiepek N, Martin F, Martin P. What features of drug treatment programs help, or not, with access? A qualitative study of the perspectives of family members and community-based organization staff in Atlantic Canada. Subst Abuse Treat Prev Policy. 2024;19(1):20. Available from: https://doi.org/10.1186/s13011-024-00602-0

[16] Pijl EM, Alraja A, Duff E, Cooke C, Dash S, Nayak N, Lamoureux J, Poulin G, Knight E, Fry B. Barriers and facilitators to opioid agonist therapy in rural and remote communities in Canada: an integrative review. Subst Abuse Treat Prev Policy. 2022;17(1):62. Available from: https://doi.org/10.1186/s13011-022-00463-5

[17] Mema SC, Sage C, Popoff S, Bridgeman J, Taylor D, Corneil T. Expanding harm reduction to include fentanyl urine testing: results from a pilot in rural British Columbia. Harm Reduct J. 2018;15(1):19. Available from: https://doi.org/10.1186/s12954-018-0224-z

[18] Canadian Centre for Caregiving Excellence. Giving care: An approach to a better caregiving landscape in Canada. Toronto: Canadian Centre for Caregiving Excellence; 2022. Available from: https://canadiancaregiving.org/wp-content/uploads/2022/11/CCCE_Giving-Care.pdf

[19] Crosato KE, Leipert B. Rural women caregivers in Canada. Rural and Remote Health. 2006;6:520.

[20] Canadian Centre for Caregiving Excellence. (2024). Caring in Canada: Survey insights from caregivers and care providers across Canada. Canadian Centre for Caregiving Excellence. https://canadiancaregiving.org/wp-content/uploads/2024/06/CCCE_Caring-in-Canada.pdf

[21] Kayaalp, A., Page, K. J., & Rospenda, K. M. (2021). Caregiver burden, work-family conflict, family-work conflict, and mental health of caregivers: A mediational longitudinal study. Work and stress, 35(3), 217–240. https://doi.org/10.1080/02678373.2020.1832609

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