

Addiction Medicine in BC

PRA-BC Orientation

Fall 2025

Dr. Steven Yau

Land Acknowledgement

We are on the unceded homelands of the Indigenous People of Canada, and here in Vancouver, we are on the traditional territories of the Coast Salish People, including the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Səlilwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.



Source: Beadwork by Amanda Laliberte, Ashley Copage, Ashley McKenzie-Dion, Didi Grandjambe, Jennelle Doyle, Joelle Charlie, Kyla Woodward, Lenore Augustine, Marissa Magneson, Mellz Compton, Monique Jolly, and Rena Laboucan. Graphic design by Justin Romero. (Koo teen Creations/Facebook)

Disclosure and Conflict of Interests

- No relationship to any commercial interests
- Professional roles:
 - Prescriber: opioid use disorder and chronic pain when it is appropriate
 - Preceptor: for BCCSU opioid agonist treatment program
 - Reviewer: Risk Mitigation Prescribing Guidelines in the Context of Dual Public Health Emergencies. 2020
- Views and opinions are not representative for the organizations I work for.

Learning Objectives

By the end of the session participants should be able to:

1. Recognize the ongoing toxic drug deaths in BC/Canada since 2016
2. Recognize the historic and current trends in opioid prescribing in Canada.
3. Identify indications for prescription opioids.
4. Apply safe prescribing parameters to minimize the risk of harm to the patient and wider community
5. Identify aberrant behaviours that could suggest opioid use disorder
6. Explain current opioid use disorder pharmacological options in BC
7. Understand the roles and responsibilities for PRA-BC candidates in the context of opioid prescribing
8. Identify appropriate consultation options and community resources for patients who are suffering from substance use disorder

What we don't have time to discuss today:

- Other substances use disorders: alcohol, tobacco, stimulants, sedatives, hypnotics, etc
- Non-substance use addiction: sex, food, gambling, etc
- Clinical assessment to diagnose opioid use disorder (OUD)
- Opioid agonist treatment details (initiation, titration, cessation)
- Treatment of acute/chronic pain in either acute vs community settings
- Solving the toxic drug supply problem
- History of drug prohibition and “War On Drugs”

Preamble

- You will encounter patients in your assessment and future practice with substance misuse, abuse or use disorder
- You will be presented with some statistics that may challenge your current clinical understanding, assumptions and judgements about substance use disorder, particularly opioids.
- You are encouraged to consider your own views, values, beliefs, assumptions and judgements to people who use substances.

Scenario 1

45yoF came in for medication refill near the end of the day. You noticed that patient was getting loud in the waiting room because you are running behind schedule. You have not met this patient before.

- She had suffered an obvious ankle injury yesterday but there is no fracture based on your exam.
- She is asking for pain medications and said she has a “high pain tolerance” and had already tried Acetaminophen and NSAID and they did not work. She is asking for “something stronger”
- On Pharmanet review, you noticed she is on Methadone daily.

Q: What goes through your mind and what would you do?

Scenario 2

You are working in the ER and a 55yoM came was brought by EHS after he was found overdosing from using fentanyl. Naloxone was administered 3 times in total on the scene and enroute.

- His vitals were reassuring, and you noticed he's no longer sedated and in fact displaying signs of opioid withdrawals.
- You found several other ER visits for the same reason.

Q: What goes through your mind and what would you do?

Scenario 3

You inherited a practice and your next appointment is a 65yoF for “refills”.

- Her medications include: Paroxetine 20mg daily, Clonazepam 1mg BID, Hydromorphone 4mg 1-2 tabs QID PRN, metformin 1000mg BID, Zopiclone 7.5mg HS
- This is your second time meeting this person, she suffers from anxiety/depression, chronic pain (known bilateral moderate/severe knee OA), obesity, diabetes. You noticed her A1c is relatively controlled, vitals were acceptable but her BMI is 40.
- She seems to be coming in a little earlier than you think she should based on her last refill amount.

Q: What goes through your mind and what would you do?

I) Opioids and Stimulants-related Harms in Canada

Key updates

Reported in 2024 in Canada

OPIOIDS

STIMULANTS

7,146

Apparent opioid toxicity deaths [1](#) [2](#) [3](#)
(17% lower than the same period in 2023)

20

Deaths per day on average

5,514

Opioid-related poisoning hospitalizations [8](#)
(15% lower than the same period in 2023)

15

Hospitalizations per day on average

24,587

Opioid-related poisoning Emergency
Department (ED) visits [9](#)
(14% lower than the same period in 2023)

67

ED visits per day on average

36,266

Emergency Medical Services (EMS) responses
to suspected opioid-related overdoses [11](#)
(15% lower than the same period in 2023)

99

EMS responses per day on average

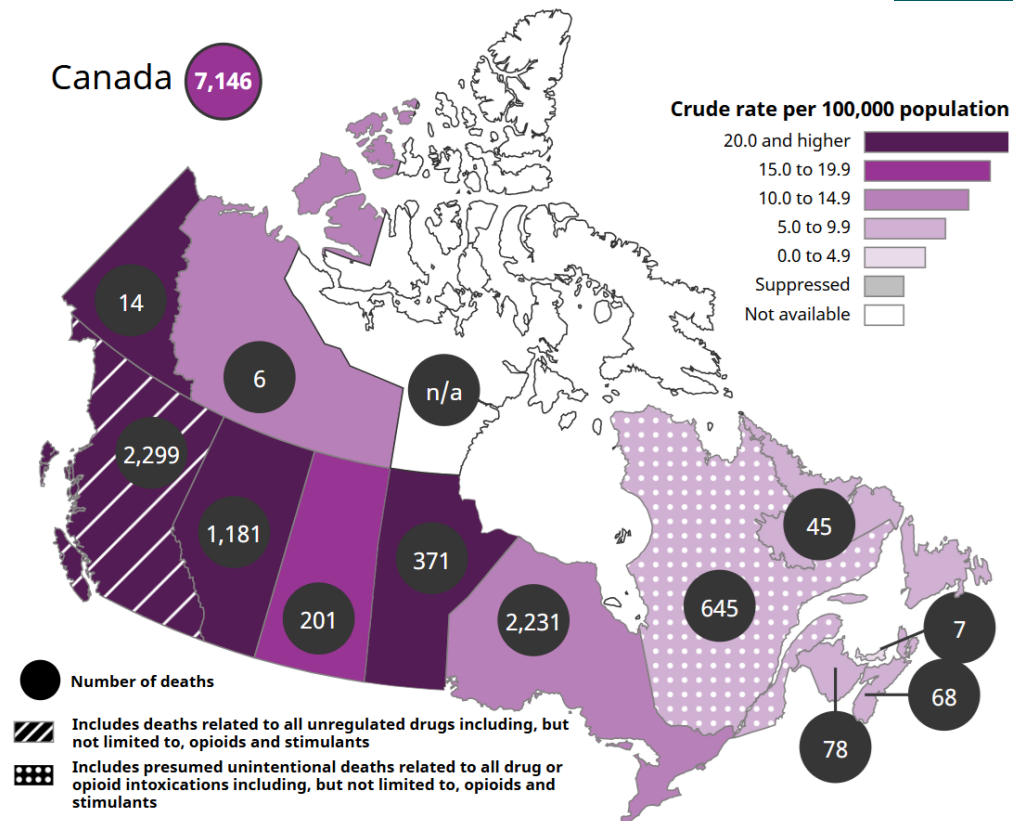
I) Opioids and Stimulants-related Harms in Canada

Health Canada

In 2024. of all apparent opioid toxicity deaths:

- 80% occurred in B.C., Alberta and Ontario
- 71% were males
- 28% age 30-39
- 84% involved **non-pharmaceutical** opioids
- 74% involved fentanyl
- 70% involved a stimulant

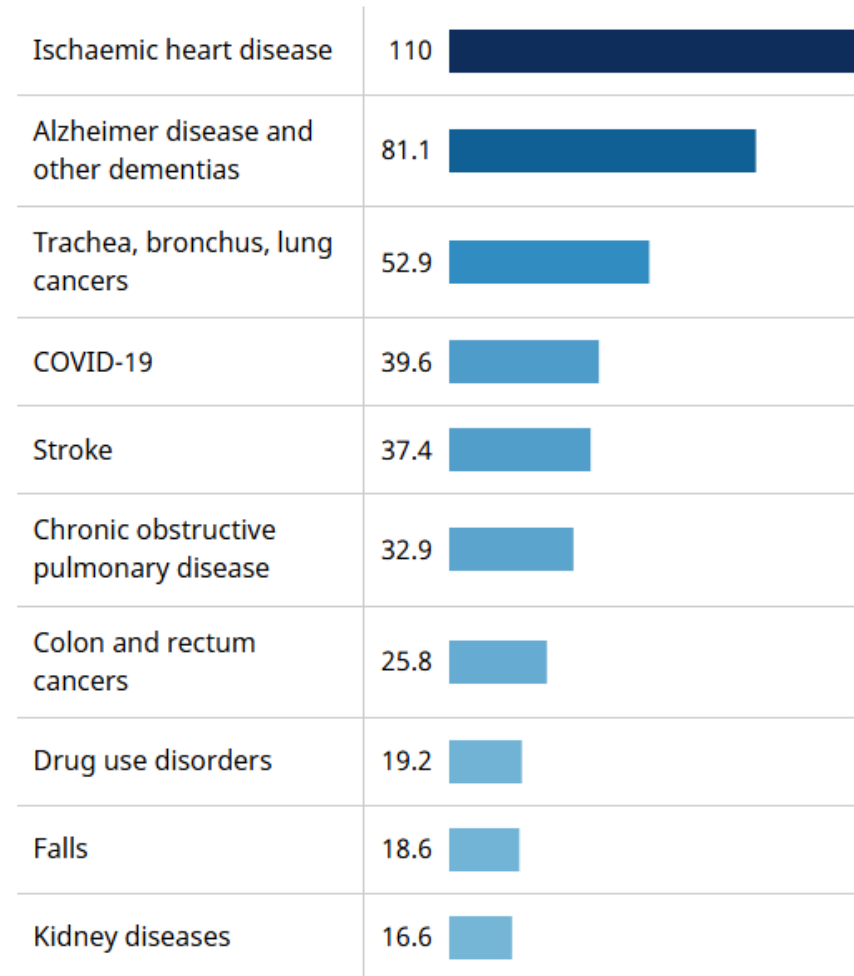
Last Updated: 2025-06-25





Top causes of death

Deaths per 100 000 population. Canada, 2021



[Source: WHO – Health data overview for Canada](#)

Unregulated Drug Deaths – BC Summary

In BC:

- Public health emergency declared on BC April 14, 2016 under Public Health Act
- Primarily caused by imported synthetic opioids such as **fentanyl and its derivatives**, but also other contaminants.
- 17,401 illicit drug toxicity deaths in BC from 2014 – Jan 2025

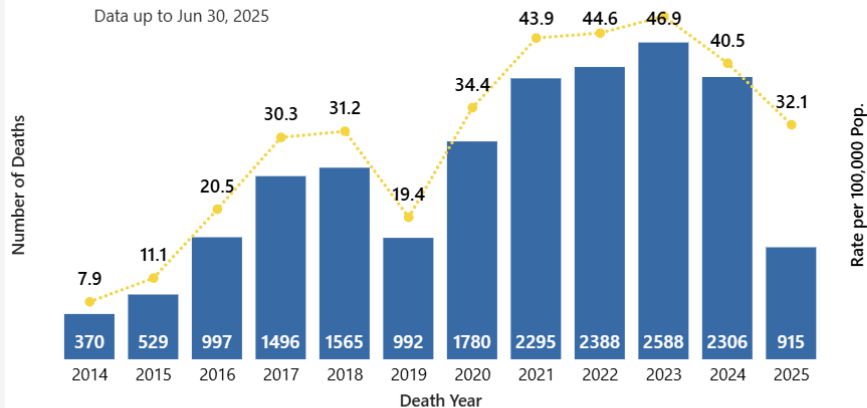
So far in 2025:

- 147 deaths in June 2025, **27% decrease** vs June 2024 (201);
- Common mode of consumption: smoking (64%); then nasal insufflation (12%), injection (10%), oral (5%); unknown (9%)
- 81% occurred indoor (47% private residence, 32% supported housing, SRO, shelters, etc); only 21% outdoor (street, parks, vehicles, sidewalks)
- Two most common occupation industry of past and present:
 - Trades, transport and equipment operators
 - Sales and service

Unregulated Drug Deaths - BC

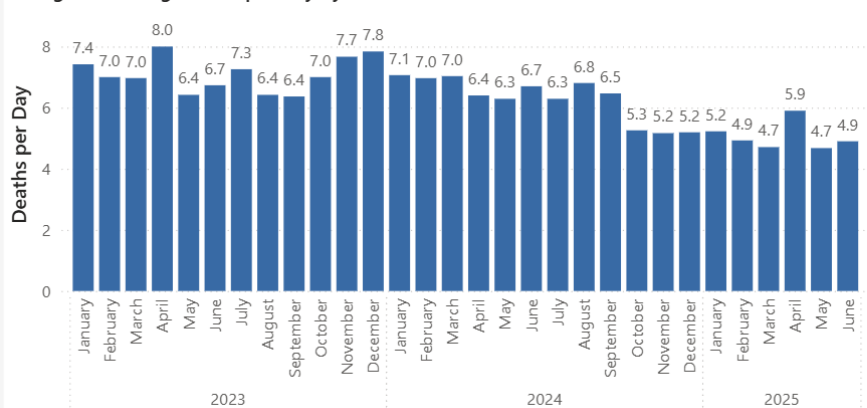
Unregulated Drug Deaths and Death Rate per 100,000 Population, 2014-2025

Data up to Jun 30, 2025



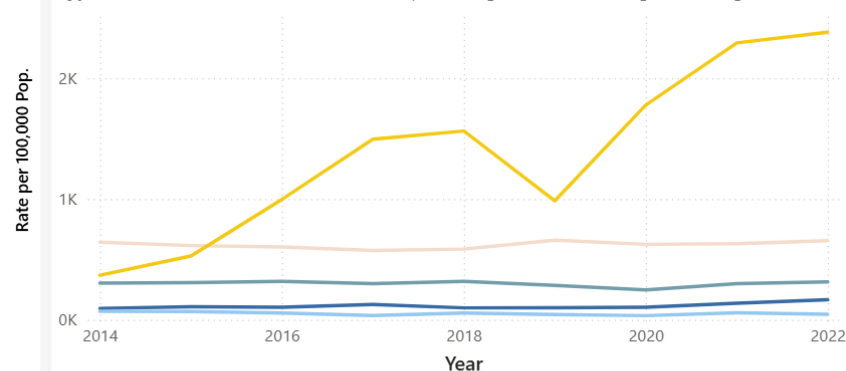
Note: 2025 rate is annualized for the year.

Unregulated Drug Deaths per Day by Month



Causes of Unnatural Deaths in BC

Type of Death ● Homicide ● MVI ● Prescription drug ● Suicide ● Unregulated drug

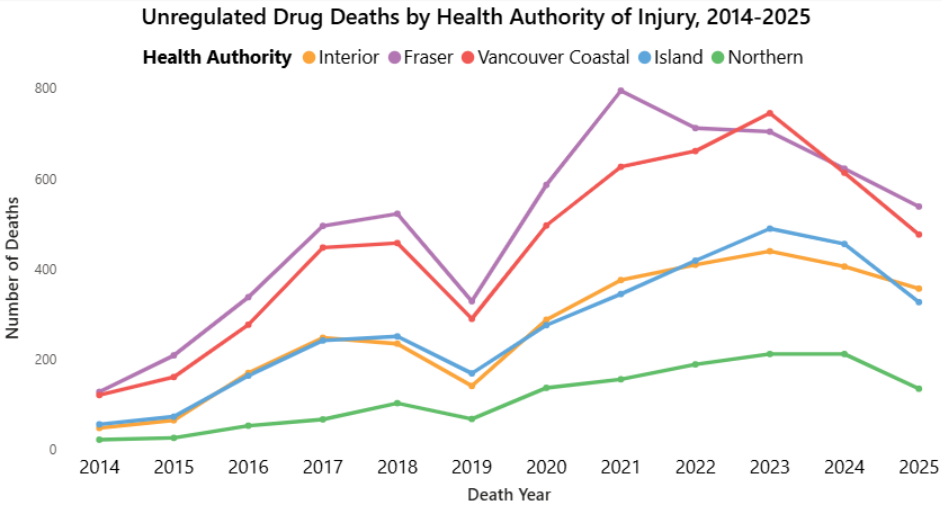


Note: Numbers are preliminary and subject to change as investigations are completed.

Unregulated Drug Deaths by Month, 2014-2025

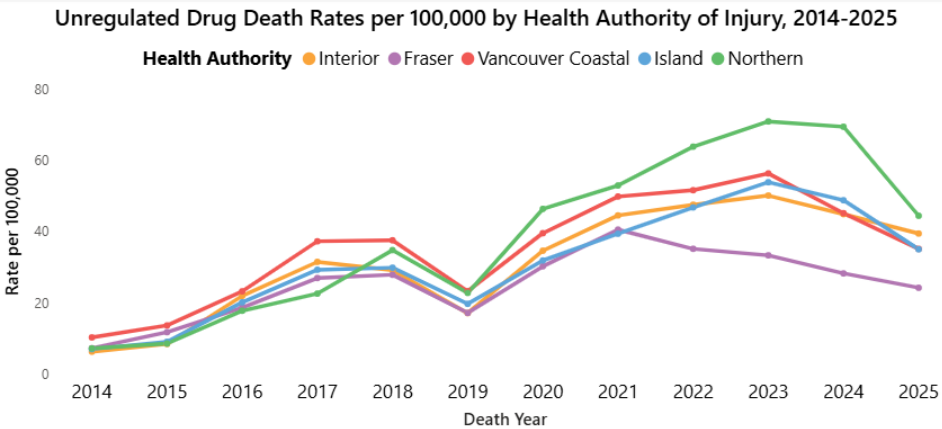
Month	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
January	23	43	86	148	134	94	80	188	217	230	219	162
February	38	31	58	125	108	87	79	177	204	196	202	138
March	28	32	76	129	158	122	120	173	185	216	218	146
April	29	34	73	156	137	81	130	188	175	240	192	177
May	40	41	51	149	119	93	176	174	214	199	195	145
June	29	34	72	130	117	73	189	178	158	202	201	147
July	26	40	74	122	150	72	187	199	202	225	195	
August	37	53	65	127	126	83	163	202	192	199	211	
September	32	50	63	97	139	63	143	161	193	191	194	
October	35	53	77	98	119	79	176	212	211	217	163	
November	28	52	140	111	131	81	170	215	203	230	155	
December	25	66	162	104	127	64	167	228	234	243	161	
Total	370	529	997	1496	1565	992	1780	2295	2388	2588	2306	915

Unregulated Drug Deaths - Health Authority of Injury (Year)



Unregulated Drug Deaths by Health Authority of Injury, 2014-2025

HA_Name	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Interior	47	64	169	247	234	140	287	375	409	439	405	178
Fraser	127	208	337	495	522	328	586	795	712	704	622	269
Vancouver Coastal	120	160	276	447	457	289	496	626	661	745	613	238
Island	55	72	163	241	250	168	275	344	418	489	455	163
Northern	21	25	52	66	102	67	136	155	188	211	211	67
British Columbia	370	529	997	1496	1565	992	1780	2295	2388	2588	2306	915



Unregulated Drug Death Rates per 100,000 by Health Authority of Injury, 2014-2025

Health Authority	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Interior	6.3	8.5	22.0	31.5	29.2	17.2	34.6	44.5	47.5	50.1	44.9	39.4
Fraser	7.3	11.8	18.7	27.0	27.9	17.2	30.3	40.5	35.2	33.3	28.3	24.2
Vancouver Coastal	10.3	13.7	23.2	37.3	37.5	23.3	39.5	49.8	51.6	56.3	45.1	35.1
Island	7.1	9.1	20.2	29.3	29.9	19.7	31.9	39.4	46.8	53.8	48.8	35.0
Northern	7.3	8.6	17.8	22.6	34.8	22.8	46.3	52.9	63.8	70.9	69.4	44.4
British Columbia	7.9	11.1	20.5	30.3	31.2	19.4	34.4	43.9	44.6	46.9	40.5	32.1

Note: In the figures, 2025 numbers and rates are annualized for the year.

Unregulated Drug Deaths - Sex

Yearly

Monthly

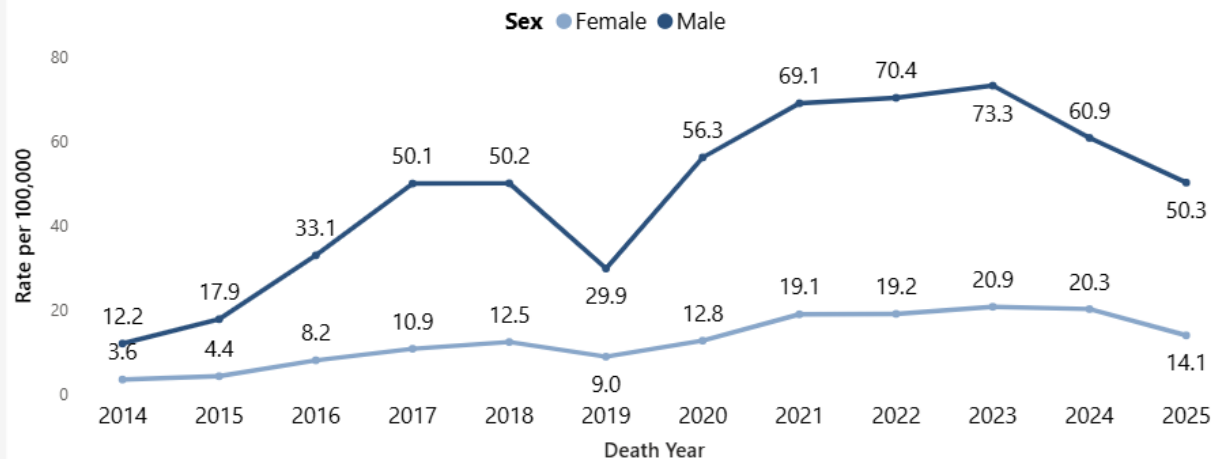
British Columbia

Interior

Unregulated Drug Deaths by Sex, 2014-2025

Sex	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Female	86	106	201	272	317	233	335	503	519	581	584	203
Male	284	423	796	1224	1248	759	1445	1792	1869	2007	1722	712
Total	370	529	997	1496	1565	992	1780	2295	2388	2588	2306	915

Sex-Specific Unregulated Drug Death Rates per 100,000, 2014-2025



Note: In the table and figure, 2025 rates are annualized for the year.

Unregulated Drug Deaths - Drugs Involved

Click to filter by health authority (HA) or ctrl + click to filter by multiple HAs. Click again on a highlighted HA to remove it from the selection.

Select all	Interior	Fraser	Vancouver Coastal	Island	Northern
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Unregulated Drug Deaths by Drug Types Relevant to Death

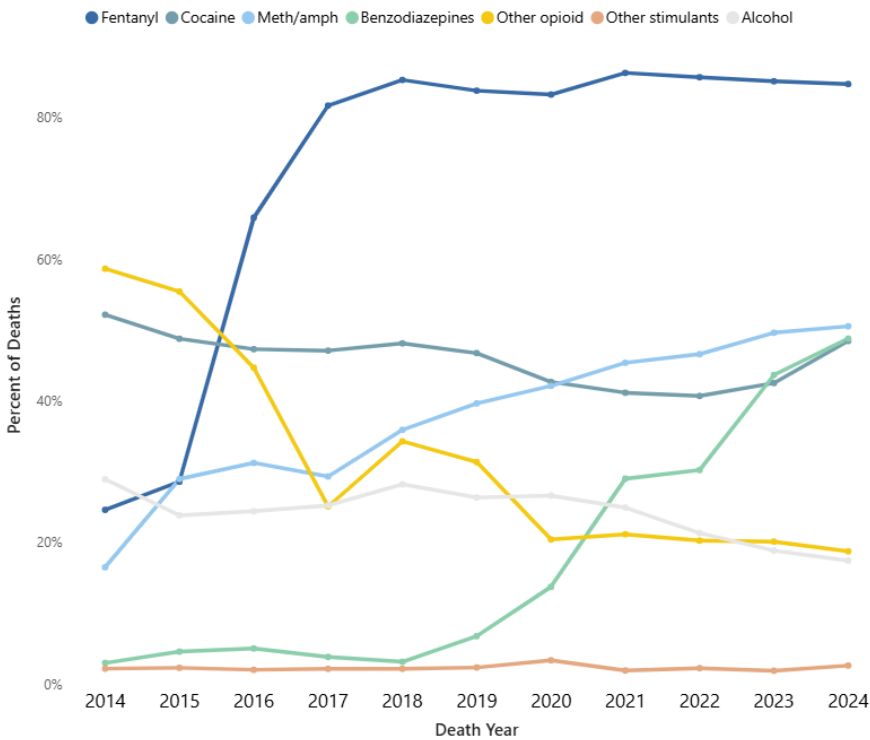
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Fentanyl	24.6%	28.6%	65.9%	81.7%	85.3%	83.8%	83.2%	86.3%	85.7%	85.1%	84.7%
Cocaine	52.2%	48.8%	47.3%	47.1%	48.1%	46.7%	42.7%	41.1%	40.7%	42.5%	48.5%
Meth/amph	16.5%	29.0%	31.2%	29.3%	35.9%	39.6%	42.1%	45.4%	46.6%	49.6%	50.5%
Benzodiazepines	3.0%	4.6%	5.0%	3.8%	3.1%	6.8%	13.7%	29.0%	30.2%	43.6%	48.8%
Other opioid	58.6%	55.4%	44.7%	25.1%	34.3%	31.4%	20.4%	21.1%	20.3%	20.1%	18.7%
Other stimulants	2.2%	2.3%	2.0%	2.1%	2.2%	2.3%	3.4%	1.9%	2.2%	1.9%	2.6%
Alcohol	28.9%	23.8%	24.4%	25.2%	28.2%	26.3%	26.6%	24.9%	21.3%	18.8%	17.4%

Notes:

This data is only available for completed unregulated drug toxicity death investigations. Drugs involved are noted by the coroner as being relevant to the death. Data does not indicate when a substance was taken.

- **Fentanyl & analogues** includes fentanyl, acetylfentanyl, 3-methylfentanyl, furanylfentanyl, carfentanil, cyclopropyl fentanyl, methoxyacetylfentanyl, 4-fluoroisobutryl fentanyl, and norfentanyl.
- **Meth/amph** includes methamphetamine and amphetamine.
- **Other opioids** include heroin, codeine, oxycodone, morphine, hydromorphone, methadone, etc but excludes fentanyl and analogues.
- **Other stimulants** include MDMA, MDA, paramethoxymethamphetamine, paramethoxyamphetamine, pseudophedrine, methylbenzodioxylbutamine, methylone, methylphenidate, caffeine, and ephedrine.

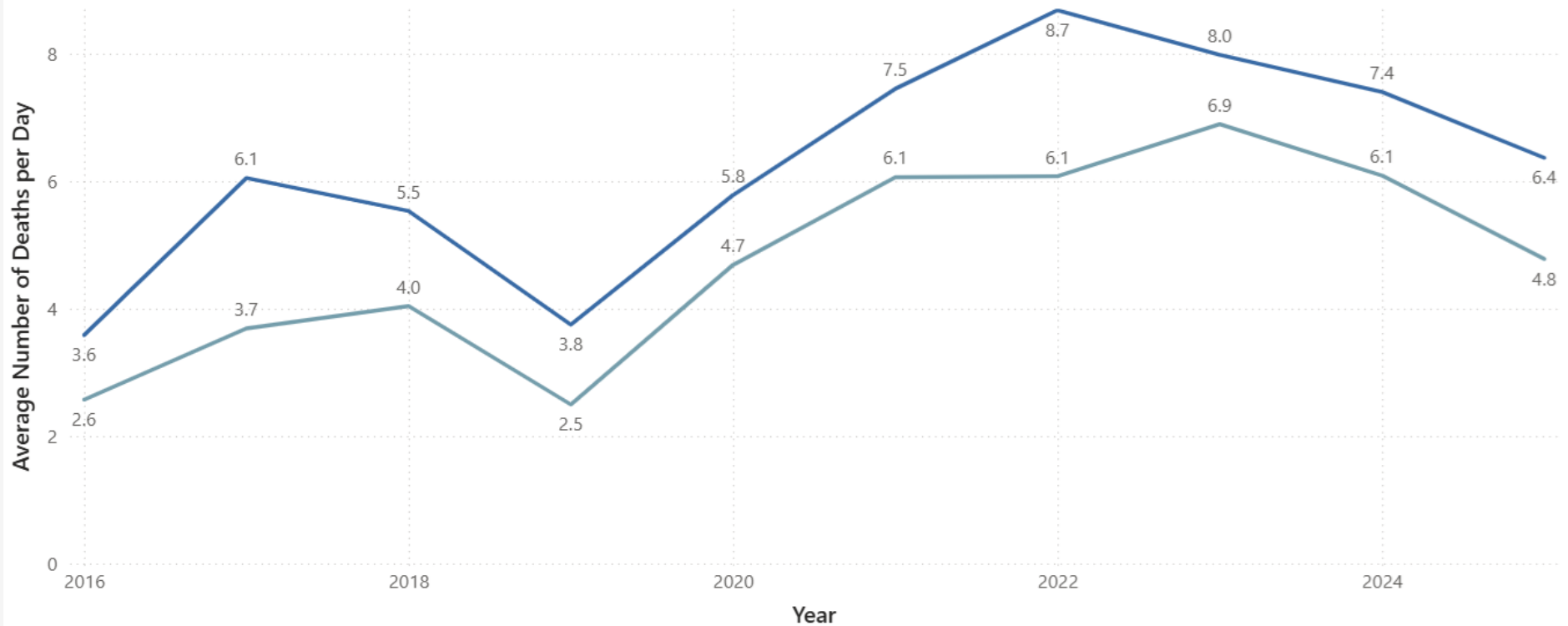
Unregulated Drug Deaths by Drug Types Relevant to Death



Unregulated Drug Deaths - Income Assistance Day

Average Number of Unregulated Drug Toxicity Deaths per Day Following Income Assistance Payment Day

● Days Following Income Assistance ● Other Days of the Year



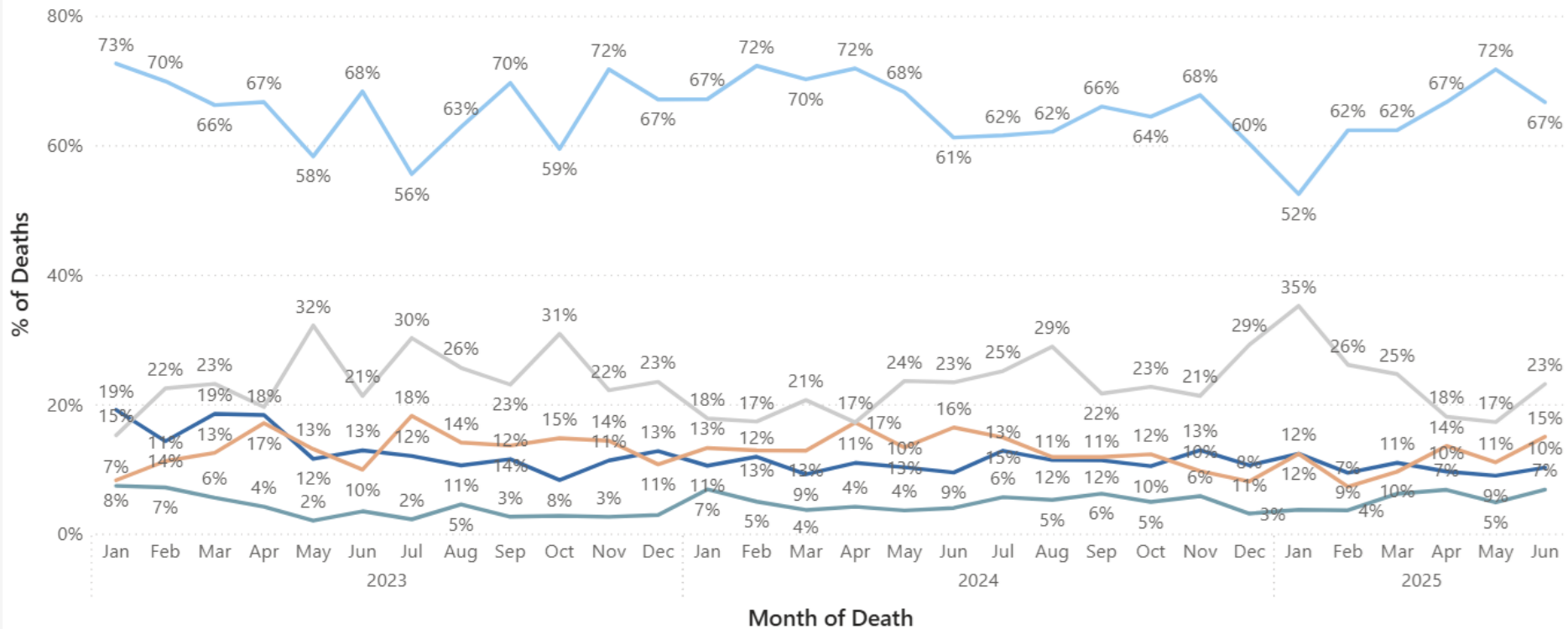
Notes:

The days following income assistance payment day include the payment day (Wednesday) to the Sunday. Income assistance payment dates can be found at <https://www2.gov.bc.ca/gov/content/family-social-supports/income-assistance/payment-dates>.

Unregulated Drug Deaths - Mode of Consumption

Mode of Consumption Among Unregulated Drug Deaths

Mode of Consumption ● Injection ● Nasal insufflation/snorting ● Oral ● Smoking ● Unknown/Unavailable



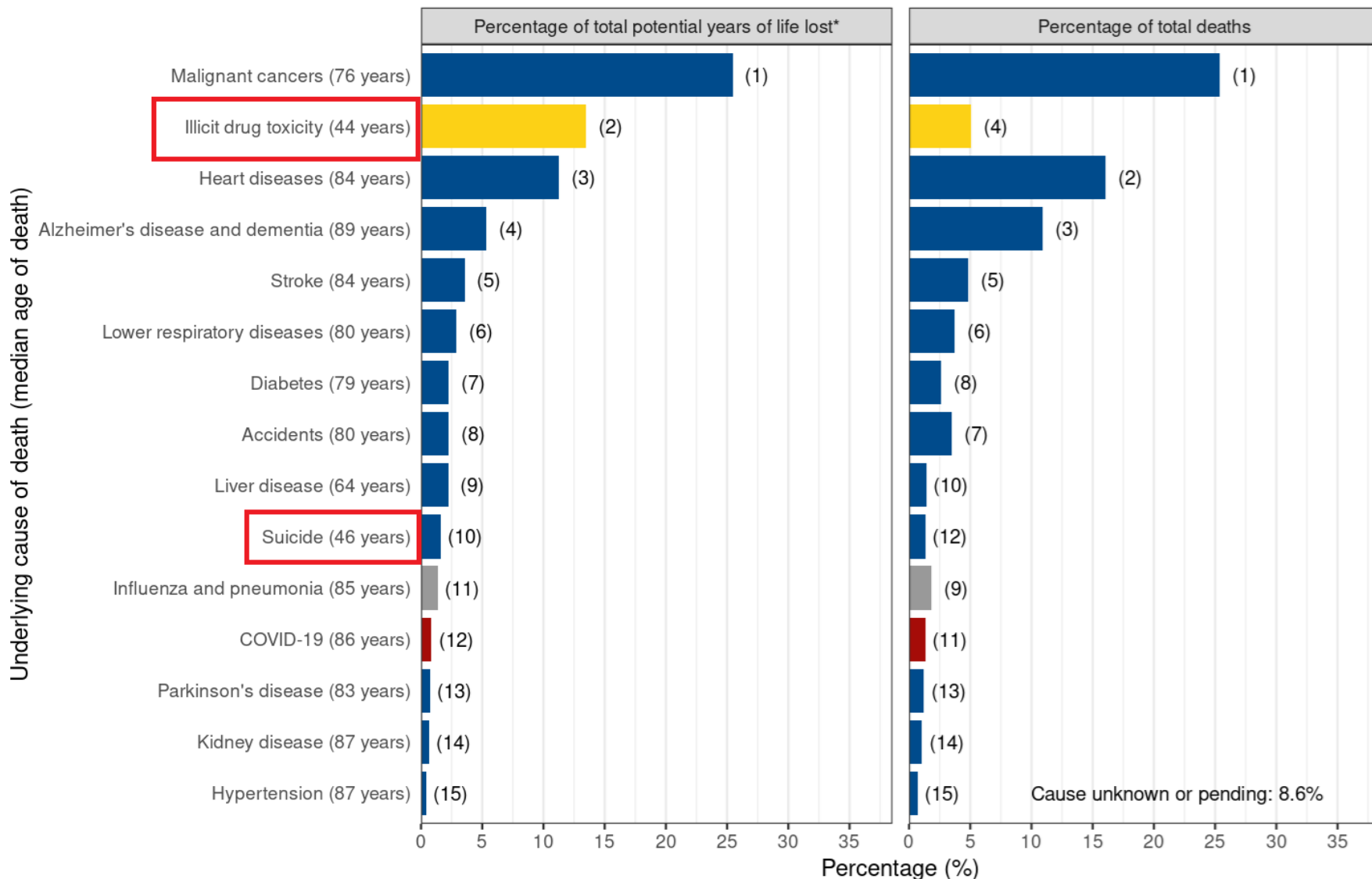
Notes:

Percentages can add up to more than 100% as individuals could have had multiple modes of consumption. Data is based on information gathered by the coroner which may include scene investigation, witness interviews, or a review of circumstances. Data is preliminary and subject to change.

BCCDC Mortality Context App

[Introduction](#)[Top 15 causes of death](#)[All-cause mortality rates](#)[Disclaimer](#)

Top 15 causes of death (ranking) in BC for January 2024 to December 2024

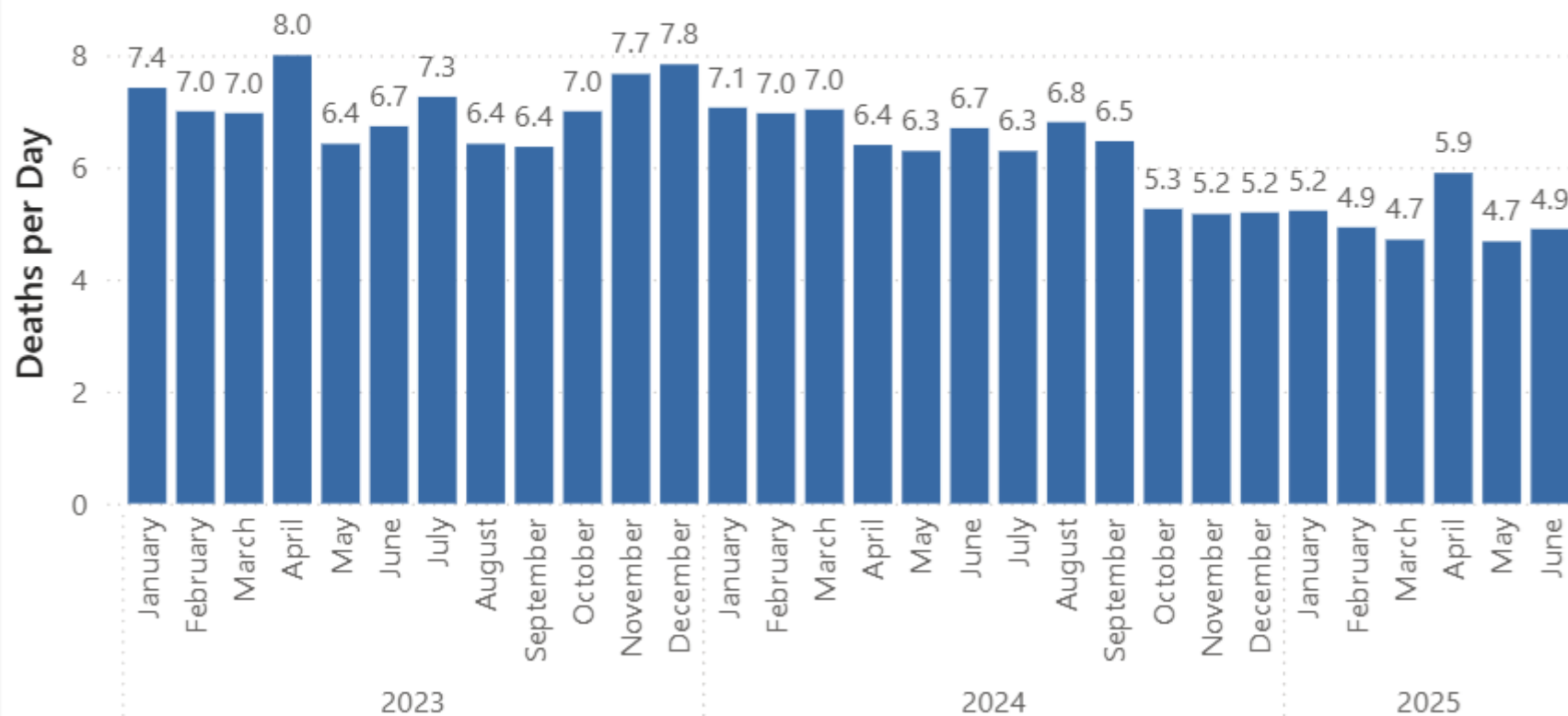


*Potential years of life lost due to accidents and suicide are incomplete due to reporting delay and the ranking by this measure may change as data become complete.

But...finally trending in the right direction?

Unregulated Drug Deaths - BC

Unregulated Drug Deaths per Day by Month



How does this resonate with you?



- As a physician?
- As a new Canadian?
- As a person?

What are your thoughts?

- What conclusion(s) can you draw from these data?
 - What about the people who use drugs?
 - Who do you think they are?
 - Why do you think they use drugs?
 - What should they do?
 - What should we (as physicians) do?
 - What should society do?
-
- What assumptions did you think you made?
 - Did/do you think you have a bias opinion?



When you hear about this...what do you think of?

Health officials advise people not to panic if they've accidentally stepped on a needle

CBC News · Posted: Jan 11, 2018 12:45 PM PT | Last Updated: January 11, 2018



A three-year-old child was pricked by an uncapped syringe at a park on Vancouver Island earlier this year (CBC)

The
Economist

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Weekly edition

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Vancouver wants to decriminalise possession of many hard drugs

But how to supervise such a policy?



Jul 24th 2021

24

Share

Drug overdose among the top 10 causes of death in B.C.



By Leslie Young

Senior National Online Journalist, Health Global News

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A man walks past a mural by street artist Smokey D. about the fentanyl and opioid overdose

Opioid-related deaths soar in British Columbia, Alberta

CARLY WEEKS

PUBLISHED JUNE 19, 2018



An anti-fentanyl advertisement is seen in Vancouver in 2017. In British Columbia, there were 523 deaths attributed to illegal-drug overdoses in 2015. A year later, the number rose to 974 and increased further to 1,399 in 2017.

JONATHAN HAYWARD/THE CANADIAN PRESS

The number of opioid deaths is accelerating in the hardest-hit provinces of British Columbia and Alberta, with Canada's top doctor describing the growing crisis across the country as "devastating."

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2020 was B.C.'s deadliest year ever for drug overdoses, coroner says



1,716 people died due to illicit drug use last year, equating to 4.7 deaths a day — a 74% increase over 2019

Andrea Ross · CBC News · Posted: Feb 11, 2021 10:04 AM PT | Last Updated: February 11



VANCOUVER NEWS BUSINESS SPORTS ARTS & LIFE HOMES TRAVEL CURRENTS DRUGS CLASSIFIED

B.C. to ban pill presses in fight against drug overdose deaths

ROB SHAW Updated: April 25, 2018



The B.C. government is moving to ban pill presses in the province with new legislation. THE ASSOCIATED PRESS



VICTORIA — B.C. is moving to ban the use of pill presses as it continues to try and curb the province's fentanyl overdose crisis. Solicitor General Mike Farnworth introduced legislation Wednesday that would forbid the sale and use of pill presses.

Not just a “big city”/BC problem

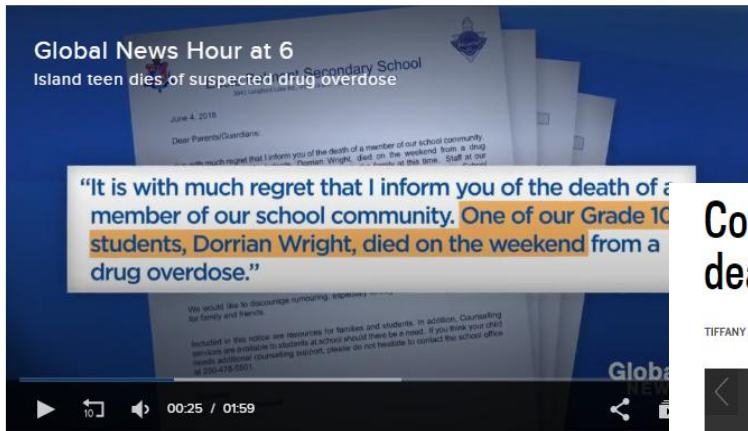
Grade 10 student from Metchosin dies of suspected overdose



By Richard Zussman

Online Journalist based at B.C. Legislature Global News

Comments 1 Facebook 87 Twitter Email Print ...



WATCH: For the second time in as many months, a teenager has died of a suspected drug overdose on Vancouver Island, leaving behind devastated family and friends. Kylie Stanton reports.

Zussman R. Grade 10 student from Metchosin dies of suspected overdose. Global News June 7, 2018. <https://globalnews.ca/news/4259989/grade-10-student-from-metchosin-dies-of-suspected-overdose/>. Accessed August 14, 2018.

Thompson Rivers University executive Christopher Seguin's fatal drug overdose ruled accidental, result of fentanyl

by Travis Lupick on June 21st, 2018 at 8:46 AM



Victoria hospital

Coroner confirms fentanyl linked to deaths of young North Vancouver couple

TIFFANY CRAWFORD, VANCOUVER SUN 07.31.2015 |



The B.C. Coroners Service has confirmed the deaths of a North Vancouver couple earlier this month are linked to fentanyl, a powerful but deadly synthetic opiate. Hardy and Amelia Leighton, both in their early 30s, were found dead in their North Vancouver home on July 20. The coroner said investigators believed at the time that the deaths may be linked to the use of drugs. [YOU CARE.COM](http://youcare.com/) / .

Lupik T. Thompson Rivers University executive Christopher Seguin's fatal drug overdose ruled accidental, result of fentanyl. The Georgia Straight. June 21, 2018. <https://www.straight.com/news/1093116/thompson-rivers-university-executive-christopher-seguins-fatal-drug-overdose-ruled>. Accessed August 14, 2018.

Crawford T. Coroner confirms fentanyl linked to deaths of young North Vancouver couple. Vancouver Sun. July 31, 2015. <http://www.vancouversun.com/Coroner-confirms-fentanyl-linked-deaths-young-North-Vancouver-couple/11254498/story.html>

Overdose in Indigenous Population

FIRST NATIONS AND THE TOXIC DRUG POISONING CRISIS IN BC

JANUARY – DECEMBER 2024



TOXIC DRUG POISONING DEATHS

Toxic Drug Poisoning Deaths
of First Nations People

427

↓ 6.8%
Decrease from 2023

FIRST NATIONS PEOPLE DIED FROM TOXIC DRUG
POISONINGS IN 2024.

This is a 6.8% decrease from the 458 deaths in 2023.

Rate of Toxic Drug Poisoning Deaths
Involving First Nations People

6.7 x First Nations people died at 6.7 times the rate of
other BC residents in 2024. **This number was
6.1 in 2023.**

11.6 x First Nations females died at **11.6 times** the rate
of other female BC residents in 2024.

5.2 x First Nations males died at **5.2 times** the rate
of other male BC residents in 2024.

Deaths of
First Nations People
BY SEX

♂ 259
Males 60.7%

♀ 168
Females 39.3%

Deaths of
First Nations People
BY AGE

49.9%
40 Years and Older

50.1%
Younger than 40

First Nations Females Experience
Very High Rates of Toxic Drug
Poisoning Deaths

22.4% 39.3%

22.4% of other BC residents
who died in 2024 were
female.

39.3% of First Nations
people who died in 2024
were female.

First Nations People are
Disproportionately Represented in
Toxic Drug Poisoning Deaths

3.4% 19.0%

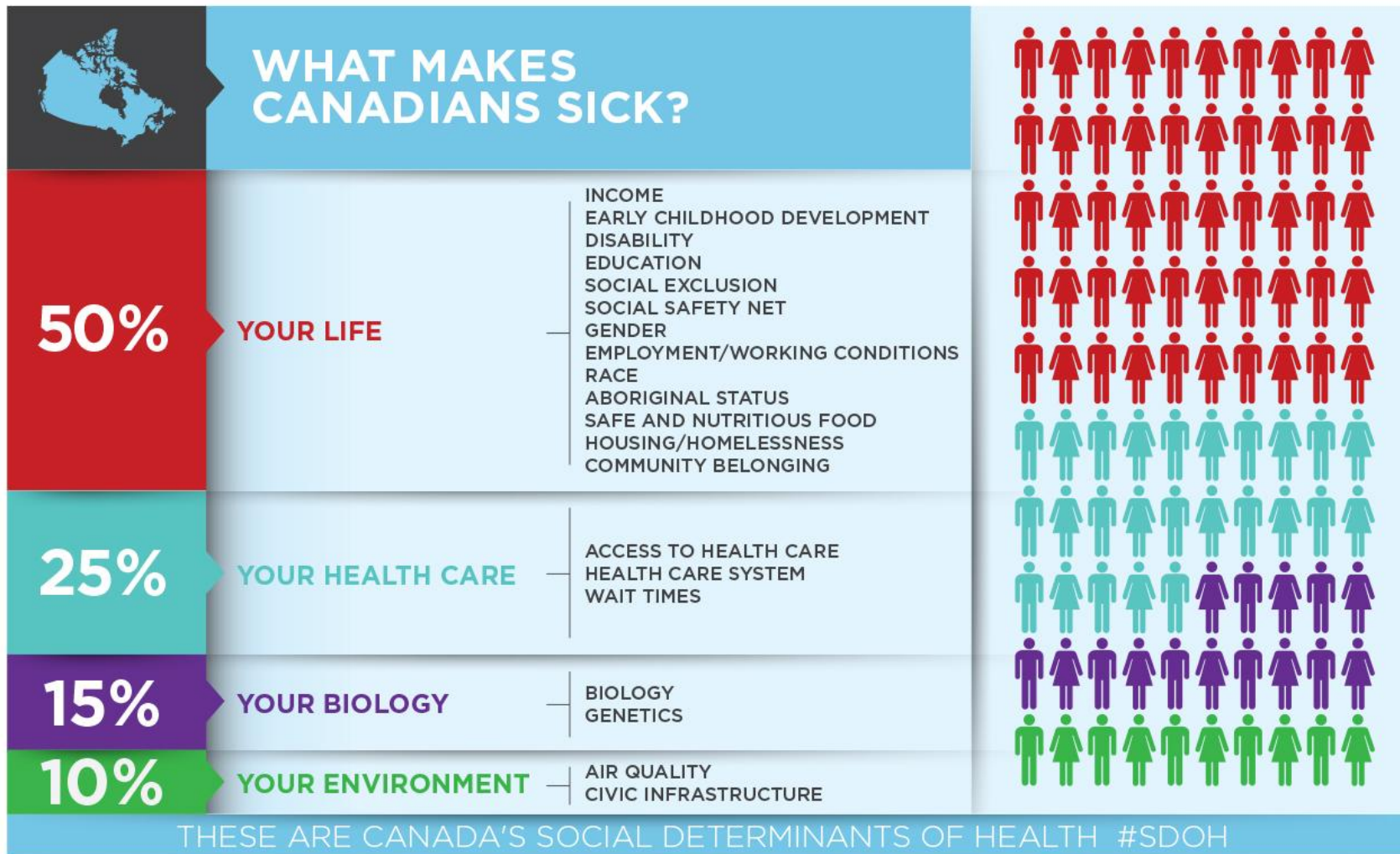
First Nations people make
up 3.4% of BC's population.

19.0% of toxic drug
poisoning deaths in 2024
were First Nations people.

So what do all these info tell us?

- It is a serious and complex problem
- But some patients are dis-proportionally affected:
 - Indigenous
 - Male
 - Young(er) Age
 - Lower socioeconomic statuses
- Stigma associated with substance use disorder and those who died from
 - It is an urban AND rural problem
 - It is not just associated with IVDU

Canadian Medical Association (2013) Healthcare in Canada: What makes us sick?



What do you think the responds would (should) be if this happens month after month...



2) A Brief History of Prescriptions Opioids

- 1914 US Harrison Narcotic Control ACT
- Reports of “under-treatment” of pain in late 1980s and early 1990s
- 1986 – WHO Cancer Pain Monograph re: under-treatment of post-op and cancer pain
- 1995 – pain as “5th vital sign” campaign by American Pain Society
- 2000 – standards for pain management based on recommendations by Institute of Medicine
 - Regulators promised less scrutiny
- Physicians are mandated/expected to provide adequate pain control → heavy reliance on opioid
- Fear of losing federal funding due to not meeting pain treatment standards and dis-satisfied patients
- Prescriptions of pharmaceutical opioids increased in the last 2-3 decades until 2012 in Canada
- 90% in “advanced” markets such as Canada and U.S.

The History of Opioid Crisis in the U.S.

Hippocrates

Opioid usefulness acknowledged by Hippocrates, a Greek physician.

460 B.C.

01

1803

02

Morphine

Morphine is isolated and Merck & Co. sell 22 years later getting many hooked on the drug.

Heroin

From morphine, heroin was made and sold as a cough suppressant; heroin would become illegal in 1924.

1874

03

04

1939-1945

World War II

Nerve block clinics open and doctors administer injections to treat pain without surgery.

Gerald Ford

With a growing addicted population, focus shifts from marijuana and cocaine, to task forces aimed at the heroin epidemic.

1970's

05

1990's

06

Painkillers

Prescriptions for painkillers began increasing by 2 to 3 million per year, with a staggering 8 million in 1996.

OxyContin

Purdue Pharma launches OxyContin, prescriptions of all opioid painkillers increases to 11 million.

1996

07

2000

08

Purdue Book

Joint Commission releases a book citing no addiction evidence of opioid use; the book was sponsored by Purdue Pharma.

Guilty Plea

Purdue Pharma settles for \$635 million after three executives plead guilty to misbranding and misleading OxyContin's addiction potential.

2007

09

2010

10

New Formula

Purdue Pharma introduces a new formula containing an abuse deterrent; nearly 1/4th of all abusers find a way around the taper resistant measures.

2016

11

FDA Steps In

The Food and Drug Administration, along with the Centers for Disease Control, begin addressing the opioid crisis.

2018

12

Suits Filed

Several states, in addition to a number of cities, file lawsuits against pharmaceutical companies for their role in the epidemic.

There is reliable evidence of opium use stretching as far back as 3,400 B.C. Since then, opioid use has steadily grown into the epidemic it is today.

Prescriptions Opioids Marketing in the 80/90's

When you know NSAIDs or acetaminophen will not be enough...

OxyContin[®] q12h
Controlled release oxycodone tablets

© 2007 Janssen-Cilag, Inc. All rights reserved. OXYCONTIN is a registered trademark of Janssen-Cilag, Inc. in the United States and other countries. OXYCONTIN is a registered trademark of Janssen-Cilag, Inc. in the United States and other countries. OXYCONTIN is a registered trademark of Janssen-Cilag, Inc. in the United States and other countries.

Radio personality Rush Limbaugh for

OxyContin[®]

**"OxyContin® helped me
deal with the pain of
living in a world that**

The New York Times

Purdue Pharma Pleads Guilty to Criminal Charges for Opioid Sales

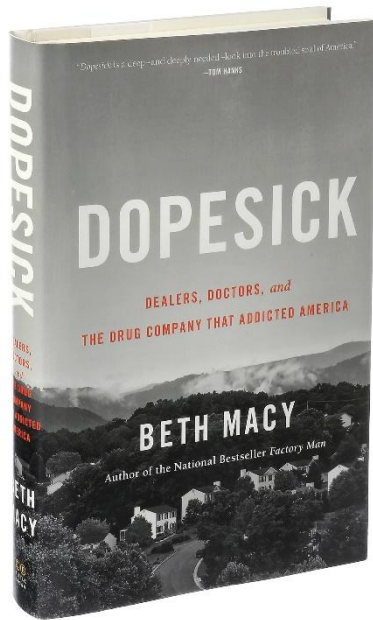
The Justice Department announced an \$8 billion settlement with the company. Members of the Sackler family will pay \$225 million in civil penalties but criminal investigations continue.

[illegible]

Small print at the bottom of the ad states 'Drug abuse is not a problem in patients with pain for whom the opioid is appropriately indicated. (Source: [CBC NEWS](#))'

prescribe an opioid medication.

Less than 1% of patients become addicted.



Apr 2018

The harm reduction model of drug addiction treatment

Mark Tyndall



Nov 2014

Why we need to end the War on Drugs

Ethan Nadelmann

CNN health Life, But Better Fitness Food Sleep More Audio Live TV Q Log In

America's opioid epidemic

CNN Exclusive: The more opioids doctors prescribe, the more money they make

ER visits for opioid overdose up 30%, CDC study finds

Drug addiction: There is help

KRATOM

Can the kratom plant help fix the opioid crisis?

This is fentanyl: A visual guide

Fentanyl: The new heroin, but deadlier



Opioid Prescribing in Canada

2019 Canadian Institute for Health Information

- Key findings:
 - Fewer people being prescribed opioids
 - Fewer people have started opioids
 - Dose/duration remained stable
 - Fewer people are prescribed on long-term basis
 - People on long-term therapy being prescribed smaller doses
 - More people are stopping long-term opioid therapy



Opioid Prescribing in Canada

How Are Practices Changing?

Source: [Canadian Institute for Health Information](#)

In 2018 – BC/Ont/Man/Sask

How many people are prescribed opioids?

1 in **8** **people**^{*} were prescribed
opioids in 2018



Note

* Reflects people who filled prescriptions at community pharmacies in Ontario, Manitoba, Saskatchewan and British Columbia.

In 2018 – BC, Ontario and Saskatchewan

How many people are starting opioids?

Fewer people are starting new prescribed opioid therapy*




Note

* Reflects people who filled prescriptions at community pharmacies in Ontario, Saskatchewan and British Columbia.

About 3 in 4 people starting opioid therapy began on a weak opioid, while 1 in 4 started on a strong opioid. This finding was consistent over the study period. Of the weak opioids, codeine was prescribed to over half of those who started opioid therapy (55.1%), followed by tramadol (12.3%) and hydrocodone (7.8%). Hydromorphone (11.7%) was the most commonly prescribed strong opioid, followed by oxycodone (10.1%) and morphine (4.1%).

In 2018 – BC, Manitoba and Saskatchewan

In 2018, **1 out of 4*** **people** had a previous non-opioid prescription for pain relief prior to starting opioid therapy

An infographic showing four stylized human figures in a row. The first figure on the left is teal, representing the '1' in '1 out of 4'. The remaining three figures are light beige, representing the '4'. They are positioned below the text '1 out of 4'.

Note

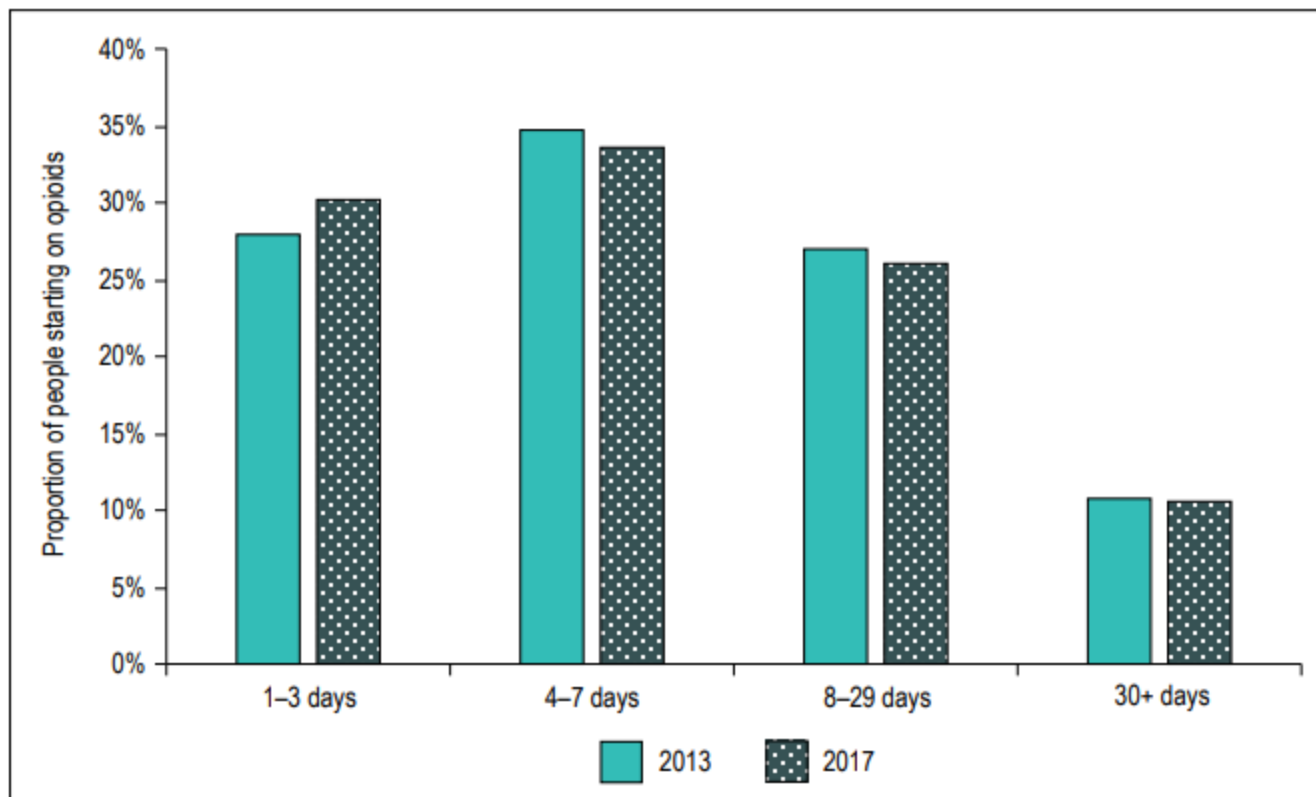
* Reflects people who filled prescriptions at community pharmacies in Manitoba, Saskatchewan and British Columbia. This excludes Ontario because the Narcotics Monitoring System data does not include all non-opioid pain medications.

NSAIDs were the most common type of non-opioid pain medication prescribed to people prior to starting opioids. Of those who were prescribed a non-opioid pain medication, 82.5% were prescribed an NSAID within the 6 months before starting opioids. This finding was consistent over the study period.

It is important to note that the data sources used for this analysis did not include information on over-the-counter pain relievers obtained without a prescription, such as acetaminophen or ibuprofen, or non-pharmacological treatments, such as physiotherapy. Therefore, it was not possible to examine other treatments for pain, which may have been tried prior to starting opioids. For information on additional limitations, see [Appendix B](#).

In 2017 – BC, Ontario and Saskatchewan

Figure 4 Duration of use for people starting opioids (in days),* 2013 and 2017



Note

* Includes data from Ontario, Saskatchewan and British Columbia. Manitoba is excluded from trends because data prior to March 2015 is unavailable.

Sources

National Prescription Drug Utilization Information System, Canadian Institute for Health Information; Ontario Narcotics Monitoring System.

In 2018 – BC, Ontario, Manitoba and Saskatchewan

1 out of **5**^{*} **people** were prescribed opioids
on a **long-term basis** in 2018



Note

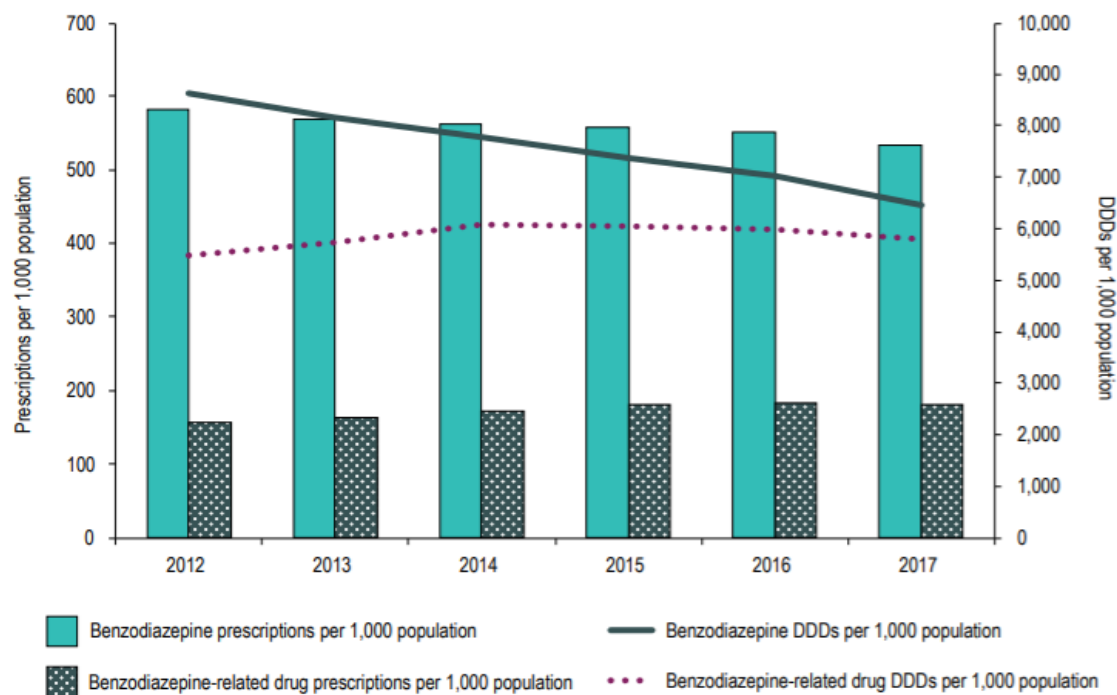
* Reflects people who filled prescriptions at community pharmacies in Ontario, Manitoba, Saskatchewan and British Columbia.

In 2018, 17.6% of people prescribed opioids were using them long term, a decrease from 19.8% in 2013. About two-thirds of people on long-term therapy (62.8%) were prescribed strong opioids.^{vii} The most common strong opioids prescribed to the study population on long-term therapy in 2018 were oxycodone (32.7%), hydromorphone (25.6%), morphine (9.4%) and fentanyl (3.7%). There was some variation by province (Figure 7).

Benzodiazepines prescribing also reduced

Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines, 2012 to 2017

Figure 4 Benzodiazepines and benzodiazepine-related drugs, prescribing trends, Canada,* 2012 to 2017



Both the number of prescriptions and the amount of benzodiazepines and benzodiazepine-related drugs prescribed per 1,000 population decreased between 2016 and 2017.

Individual/public harms - Opioids

- **Individual**

- **Short-term:** nausea/vomiting, constipation, loss of appetite, sweating, sleep apnea, insomnia, mood disorder, premature delivery, NAS, HIV/HepC, drowsiness, respiratory depression, coma, death
- **Long-term:** dependence, tolerance, withdrawal symptoms, **addiction**; sexual dysfunction, abnormal menstruation/amenorrhea

- **Public/System**

- Increased ER visits – withdrawals, intoxications, psychosis, complications from drug use
- Increases neonatal abstinence syndrome – tripled between 2003-2014 (1.8-5.4/1000births)
- Increased accidental deaths
- Increase in crime associated w/ activities to secure drugs
- Pressure on system and institutional resources
- Loss of human potential

- <https://www.ccsa.ca/sites/default/files/2020-07/CCSA-Canadian-Drug-Summary-Prescription-Opioids-2020-en.pdf>

News / Local News

UBC study finds drivers on prescription drugs like benzodiazepines have higher risk of crashing

The study found people on commonly prescribed benzodiazepines like Valium or Xanax increase their risk of crashing by 25 to 30 per cent.

Tiffany Crawford

Apr 22, 2021 • 6 days ago • 2 minute read • [Join the conversation](#)

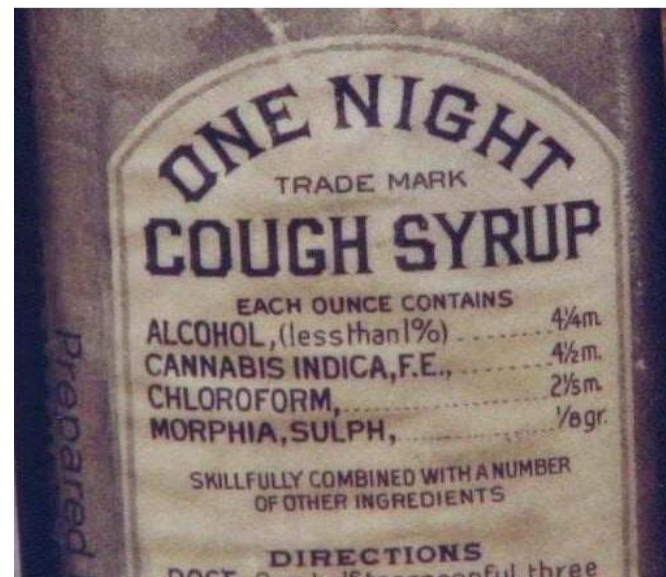
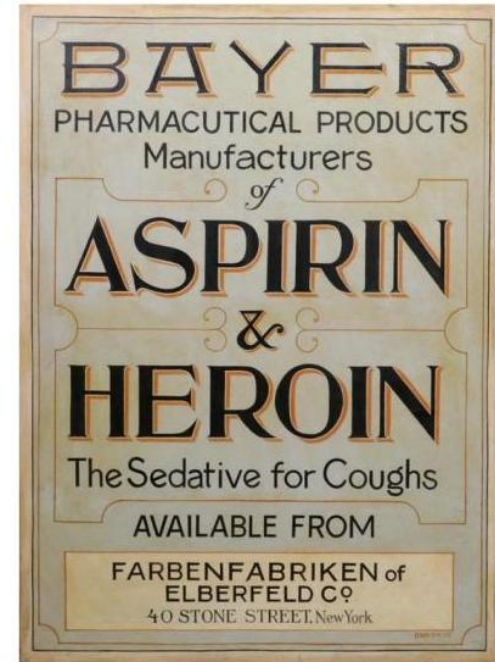
Back up....so why are we prescribing **ANY** opioids?



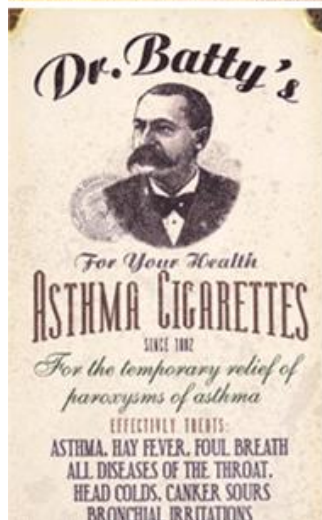
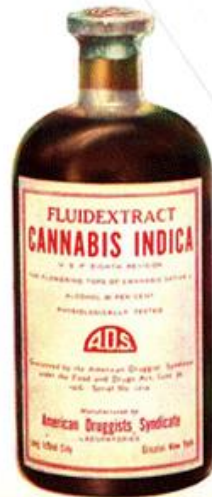
Better yet, let's just not prescribe any opioids?!

- Are opioids ever indicated, or even required?
- When is it appropriate?
- How long should you keep someone on opioids?
- When should patients be tapered off opioids?
- When it is time, how do you help patients come off/stop using opioids?
 - Prescribed
 - Illicit
- When should you be concerned for substance use disorder (SUD), or specifically opioid use disorder (OUD)?

46



It's not just opioids...



now
she can
cope...

thanks to
Butisol
(SODIUM BUTYRIBUTAL)

"daytime sedative" for
everyday situational stress

When stress is situational and occasional, Butisol offers relief for an acute and temporary stress, which has a primary and secondary relaxing effect on the body and mind. Butisol is a powerful sedative and tranquilizer, and it is recommended for the treatment of nervous tension, nervous exhaustion, nervous headache, nervous insomnia, and nervous depression.

After 30 years of clinical use, it is still a first choice among many physicians for depression and nervous tension in mild to moderate cases. Contraindications: Pregnancy or sensitivity to butyrate.

Precautions: Excessive reaction to moderate to severe hypotension. Butisol is a depressant and patients may react with marked excitement or depression. Adverse Reactions: Disturbances of vision including double vision, blurred vision, "hangover" and extreme drowsiness are seldom seen.

Warnings: May be habit forming. Usual Adult Dosage: At a dinner interval, 10 mg. (1/4) and at 35 mg. (3/4) and at 10 mg. (1/4). Available for dosage between 10 mg. (1/4) and 35 mg. (3/4). Butisol is a first choice for the treatment of nervous tension, nervous exhaustion, nervous headache, nervous insomnia, and nervous depression.

McNEIL
McNeil Laboratories, Inc., New York, N. Y.



if chronic fatigue
and mild depression
make simple tasks
seem this big...



Ritalin (methylphenidate CIBA)
relieves chronic fatigue
that depresses and mild
depression that fatigues

Roles of opioids in medicine

- Long established as effective analgesics for:
 - Acute vs Chronic
 - Malignant vs non-malignant
 - Pre-/Post-op
- Use for dyspnea/coughing
- Palliative/End of Life symptoms management
- Opioid use disorder
- Other conditions?

4) Steps for safe(r) Opioid Prescribing

1. Evaluate the role of opioids used in pain management
2. Recognize the risks of long-term opioid use
3. Recognize factors that increase unintentional overdose (OD) risks
4. Incorporate pharmacovigilance during patient assessment.
5. Safety at forefront of any treatment planning
6. Strategy for patients with chronic pain who have challenges w/ using prescribed opioid safely
7. Mitigate harms to patient, their families and the community.

Risk factors for OD:

- >65yo
- Respiratory disease
- Depression
- Renal/liver dysfunction
- Increase BMI
- Sleep-related breathing disorder
- Hx of OUD and other illicit substance use

*** Acknowledgement to Dr. Rashmi Chadha for sharing her previous slides for this session. They were adapted and updated for this presentation.**

Some good practice tips

1. Before you start prescribing, ensure you have exhausted other non-opioid options and has enough evidence to support its use.
2. Discuss with patients rationale, how/when to reassess, what is the ultimate goal(s)
3. Monitoring compliance/adherence
 - **Pharmanet** checks with every visit that requires *any* prescription
4. Discuss how to taper/stop, when? Who? Why?
5. Holidays/missed doses strategies?
6. Patient travel plans?
7. Carries?
8. Documentation
 - What about “opioid contract”?

5) Patient behaviours that may raise concerns

- Running out of medications early
- Not following agreed-upon prescribing instructions: taking more and/or more frequently
- Lost/stolen medications
- Opposition to requested urine drug screen (UDS)/random pill-count
- Prefers immediate release (IR) opioids rather than long-acting
- Multi-doctoring
- Evidence of borrowing/sharing of medications
- Current use of other substances including alcohol
- Requesting other psychotropic medication
- Seems to focus on medications and not the illness

* These signs alone are not diagnostic for Substance Use Disorder, but rather should serve as opportunities to discuss with patients of behaviours observed.

Reference: James J. Dealing with drug-seeking behaviour. Australian prescriber. 2016;39:96-100

Legacy patients

- If patient has good biopsychosocial functioning and on opioid dose <90 MME (mg Morphine Equivalent)
 - Continue current regiment but make prescribing contingent on ongoing re-evaluation and risk mitigation, pharmacovigilance
- If patient is on >90 MME
 - Consider to continue current regiment in the short-term, but inform patients that thorough longitudinal evaluations needed and taper maybe considered/required.
- It is unethical to “fire” or “screen out” patients who have a substance use disorder in your practice.
- Do not “abandon” patient, unsafe rapid taper or “cut off”.
 - Refer to CPSBC Professional Standard on Safe Prescribing of Opioids and Sedatives

DSM-V Criteria for Opioid Use Disorder

Summarized DSM-5 diagnostic categories and criteria for opioid use disorder: (≥ 2 or more to fit criteria)

This can be applied to those who use illicit opioids and those who use pharmaceutical opioids that are prescribed.

Note: “Criminality” is no longer a criteria for substance use disorder.

DSM-5 recognizes “substance use disorder”, and does not use the term “drug addiction” or “drug abuse”.

Category	Criteria
Impaired Control	<ul style="list-style-type: none">• Opioids used in larger amounts or for longer than intended• Unsuccessful efforts to or desire to cut back or control opioid use• Excessive amount of time spent obtaining, using, or recovering from opioids• Craving to use opioids
Social Impairment	<ul style="list-style-type: none">• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued opioids despite these problems• Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky Use	<ul style="list-style-type: none">• Opioid use in physically hazardous situations• Continued opioid use despite knowledge of persistent physical or psychosocial problem that is likely caused by opioid use
Pharmacological Properties	<ul style="list-style-type: none">• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

6) Current OUD Treatment Options in BC

- Access to resources maybe challenging for many rural, or even urban, communities

Many evidence-based treatment options:

1. Harm reduction strategies:

- Naloxone Kits
- Safer Consumption Site
- Harm reduction supplies
- Drug testing kits
- Hydromorphone – Risk Mitigation during COVID-19 pandemic

2. Oral opioid agonist treatment (OAT)

- Methadone; Slow-Release Oral Morphine (SROM); Buprenorphine/Naloxone

3. Others:

- Injectable (diacetylmorphine, fentanyl, Buprenorphine), fentanyl patch, fentanyl tablets, antagonist (Naltrexone)

4. **Withdrawal management “detox” – no longer recommended as only treatment due to high relapse and mortality rate**

5. Non-pharmacological treatment: counselling, in-patient/residential treatment, addressing social determinants of health

Key Skills/Tips

- Do not avoid uncomfortable or “difficult” conversations but do not become confrontational
- Remain neutral and avoid judgmental statements
- Focus on patient safety and functional capacity
- Self-reflection and recognize conscious and unconscious biases
- Role as physician is to help patients and “do no harm”
- Definitely possible to be collaborative and empathetic while maintaining a rational treatment plan with patients
- Be the change to destigmatize:
 - Avoid terms: “addicts” (person who use drugs), “dirty urine” (urine with ____ present), “high” (intoxicated); “drug seeking”, etc
- If you are stuck – talk to another colleague, call R.A.C.E, BCCSU, CPSBC, CMPA

7) Addiction Medicine for PRA-BC Candidates

- You **WILL** encounter patients who have a substance use problem at some point during your CFA and ROS
- During your 12-week CFA, all prescriptions, including opioids, sedatives and other psychoactive medications, will be signed off by your assessors.
- However, screening, assessment and treatment for patients presenting with substance use disorders are part of your assessments but likely opportunistic
- The DSM 5 recognizes substance-related disorders resulting from the use of 10 separate classes of drugs: **alcohol**; caffeine; **cannabis**; hallucinogens (phencyclidine or similarly acting arylcyclohexylamines, and other hallucinogens, such as LSD); **inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants** (including amphetamine-type substances, cocaine, and other stimulants); **tobacco**; and other or unknown substances

****Focus on the patient assessment, ultimate prescribing decision from assessor**

8) Further training and education

Online learning

- BCCSU Opioid Use Disorder
 - Provide and support education and training in addiction care for opioid use disorder
 - Online modules, OAT preceptorship

<https://www.bccsu.ca/education-training/>

Guidelines

- A Guideline for the Clinical Management of Opioid Use Disorder. 2023 Update
https://www.bccsu.ca/wp-content/uploads/2025/09/BC-OUD-Treatment-Guideline_2023-Update2.pdf
- 2017 Canadian Guideline for Opioids for Chronic Non-cancer Pain. (Full)
https://files.magicapp.org/guideline/dc12d4fe-5df9-46ce-9eae-4b266c70e89a/published_guideline_2849-4_10.pdf
- 2024 Canadian Opioid Prescribing Guideline for Chronic non-Cancer Pain (Summary)
[2024-Opioid-Prescribing-Guideline-Web.pdf](https://www.bccsu.ca/wp-content/uploads/2024/09/2024-Opioid-Prescribing-Guideline-Web.pdf)

Professional Standards

- Practice Standards – Safe Prescribing of Opioids and Sedatives. College of Physicians and Surgeons of BC. <https://www.cpsbc.ca/files/pdf/PSG-Safe-Prescribing.pdf>

Rural Providers

- BCCSU - Rural Education Action Plan (REAP)
- <https://www.bccsu.ca/rural-education-action-plan/>

Resources: PathwaysBC.ca

- You will get have a session on Pathways this week.
- Access will be granted for you.
- You should try it during CFA

The screenshot displays the PathwaysBC.ca website interface. At the top, there is a navigation bar with links for Home, Resources, Forms, Favourites, and a user profile. A search bar is also present. Below the navigation bar, a dropdown menu for 'SELECT SPECIALTY OR SERVICE' is set to 'ADDICTION MEDICINE'. A row of tabs includes Specialists, Clinics & Pooled Referrals, Community & Health Authority Services, Physician Resources, Patient Info, Pearls, RACE, and Forms. The main content area features a table of services with columns for Programs/Services, Service Area, and Ways to Access. A sidebar on the right titled 'Filter Programs/Services' allows users to filter by Service Types, including Access / Intake for Health Authority Addiction Services, Clinician Consultative Advice, Emergency / Rapid Access, Health Authority Addiction Services, Helpline / Crisis Line for Public, Navigation Support, Opioid Treatment (OAT), and various treatment and support programs.

Programs/Services	Service Area	Ways to Access
Access & Assessment Centre - Intake for Mental Health and/or Substance Use Services [Vancouver Coastal Health]	Vancouver	📍 📞 🏠
Access Central - Detox Referral Line [Vancouver Coastal Health]	Vancouver Coastal Health Area	📞
Addiction Services - Vancouver [Vancouver Coastal Health]	Vancouver	📞 🏠 🏠 🏠
Clinician Telephone Consultation Service - 24/7 Addiction Medicine Advice to Providers [BC Centre on Substance Use (BCCSU)]	Province-wide	📞 🕒
Older Adult Mental Health & Addiction Services Central Intake - Non-emergency support phone line [Vancouver Coastal Health]	Richmond, Vancouver	📞
Peer Navigator and Peer Support Programs - For individuals with mental illness and/or addictions [Canadian Mental Health Association (CMHA) - Vancouver Fraser Branch]	Vancouver	📍 🏠
Rapid Access Addiction Clinic (RAAC) - Opioid Agonist Treatment (OAT Clinic) - St. Paul's Hospital [Providence Health Care]	Vancouver Coastal Health Area	📍 🏠
START - Substance Use Treatment and Response Team [Vancouver Coastal Health]	Vancouver Coastal Health Area	🏠 🏠 🏠
Youth Central Addiction Intake Team (CAIT) - Vancouver CYMH and Substance Use Services [Vancouver Coastal Health]	Vancouver Coastal Health Area	🏠 🏠

Filter Programs/Services

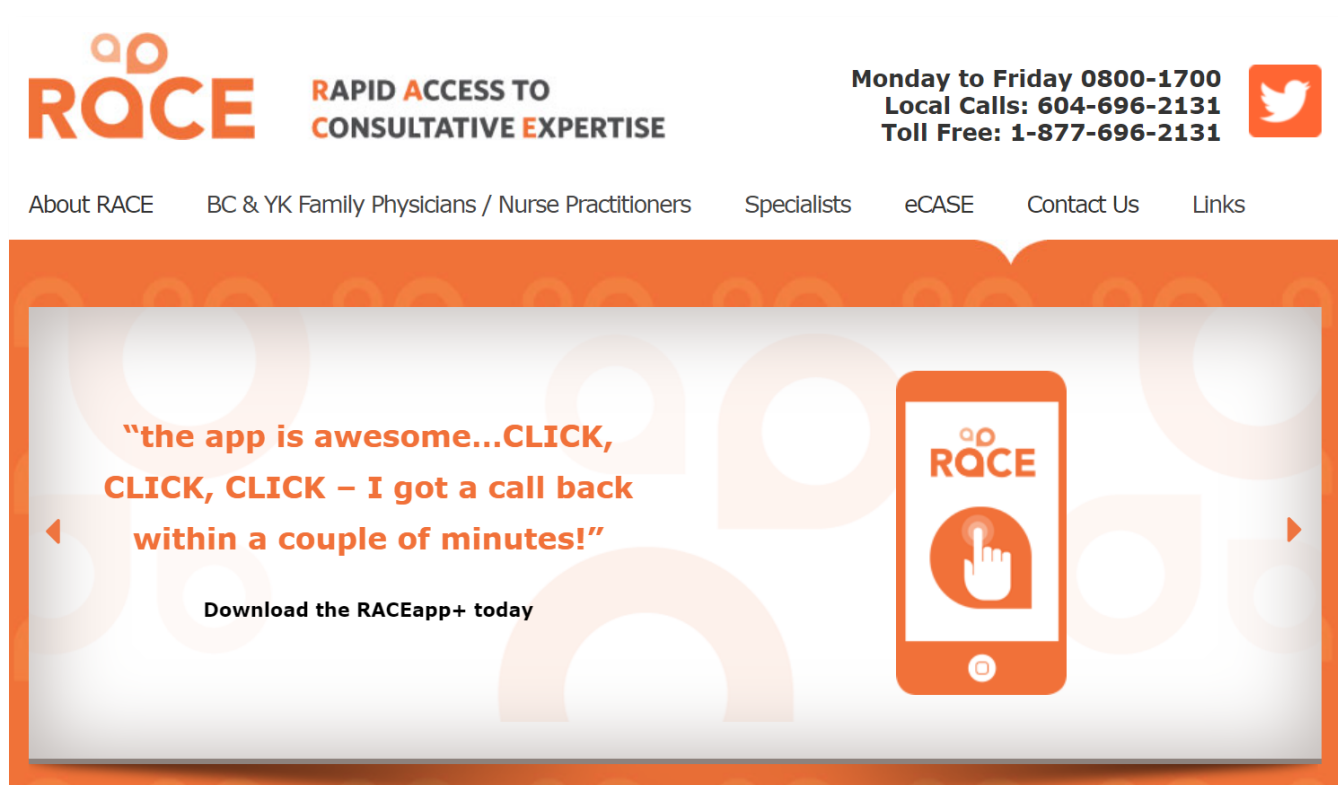
Service Types

- ☐ Access / Intake for Health Authority Addiction Services
- ☐ Clinician Consultative Advice
- ☐ Emergency / Rapid Access
- ☐ Health Authority Addiction Services
- ☐ Helpline / Crisis Line for Public
- ☐ Navigation Support
- ☐ Opioid Treatment (OAT)
- ☐ Addiction Counselling
- ☐ Addiction Treatment: Day Programs
- ☐ Addiction Treatment: Residential
- ☐ Addiction: Support for Recovery
- ☐ Addiction: Supports for Families & Friends
- ☐ Alcohol Use Disorder (AUD)
- ☐ Concurrent Disorders
- ☐ Detox / Withdrawal
- ☐ Early Intervention: Addictions
- ☐ Fatal Alcohol Poisoning

Consultation – Addiction Specialists

Rapid Access to Consultative Expertise (RACE) – Addiction Medicine and Perinatal Addiction

- **Online request** via www.raceapp.ca (or mobile app “RACEApp+” [iOS](#) and [Android](#)). The Specialist will call you back on the direct line listed in your profile.
- Note that not all specialties are available via the direct telephone request method.
- For MDs and NPs



The screenshot shows the RACE website homepage. At the top left is the RACE logo, consisting of two orange circles above the word "RACE" in orange. To the right of the logo is the text "RAPID ACCESS TO CONSULTATIVE EXPERTISE" in orange and black. Further right, contact information is listed: "Monday to Friday 0800-1700", "Local Calls: 604-696-2131", and "Toll Free: 1-877-696-2131". A Twitter icon is to the right of this text. Below the header is a navigation bar with links: "About RACE", "BC & YK Family Physicians / Nurse Practitioners", "Specialists", "eCASE", "Contact Us", and "Links". The main content area has an orange border and a light gray background with a pattern of large, faint orange circles. On the left, a quote in orange text reads: "the app is awesome...CLICK, CLICK, CLICK – I got a call back within a couple of minutes!". Below the quote is the text "Download the RACEapp+ today". On the right is an illustration of a smartphone with the RACE logo and a hand icon pointing at the screen.

Consultation – Addiction Specialists

- To call the 24/7 Addiction Medicine Clinician Support Line and speak to an Addiction Medicine Specialist, call 778-945-7619.
- For MDs, NPs, nurses, midwives, pharmacists



The screenshot shows the website of the British Columbia Centre on Substance Use (BCCSU). The header includes the BCCSU logo and navigation links: ABOUT, RESEARCH, EDUCATION, CARE GUIDANCE, PUBLICATIONS, and NEWS. A prominent banner reads "24/7 Addiction Medicine Clinician Support Line". Below this, a breadcrumb trail indicates "BCCSU > 24/7 Addiction Medicine Clinician Support Line". The main content area features a large graphic with the "24/7 ADDICTION MEDICINE CLINICIAN SUPPORT LINE" logo, which includes a telephone handset icon. To the right is the logo of the First Nations Health Authority, with the tagline "Health through wellness". Below these logos, the text "Call to speak with an Addiction Medicine Specialist" is displayed, followed by the phone number "778-945-7619" in a large, bold font.

BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE
Networking researchers, educators & care providers

ABOUT ▾ RESEARCH ▾ EDUCATION ▾ CARE GUIDANCE ▾ PUBLICATIONS ▾ NEWS ▾

24/7 Addiction Medicine Clinician Support Line

BCCSU > 24/7 Addiction Medicine Clinician Support Line

24/7 ADDICTION MEDICINE CLINICIAN SUPPORT LINE

First Nations Health Authority
Health through wellness

Call to speak with an Addiction Medicine Specialist
778-945-7619

Referral – Ministry of Health

Help lines - Alcohol & Drug Information Referral Service

- Call toll-free at 1 800 663-1441,
- Call 604-660-9382 (Lower Mainland)
- Free, multilingual telephone assistance is available 24 hours a day, 7 days a week.

 **Public Health Alerts:** [Overdose advisory: Prince George](#)



HealthLinkBC

Living well ▾

Health library ▾

Mental health and ▾
substance use

Find care ▾

 Call 8-1-1

 Search

Substance use

[Home](#) / [Mental health and substance use](#) / Substance use

Last updated: **August 28, 2024**



Overview

The term "substance use" refers to the use of drugs or alcohol, and includes substances such as cannabis, vapes, tobacco or cigarettes, illegal drugs, prescription drugs, inhalants and solvents. Substance use can be viewed on [a spectrum](#) with varying stages of benefit and harm. There can be risks associated with using substances and any type of substance use can cause harm. Substance use can also lead to addiction.

<https://www.healthlinkbc.ca/mental-health-and-substance-use/substance-use>

Resources – Regional Health Authorities

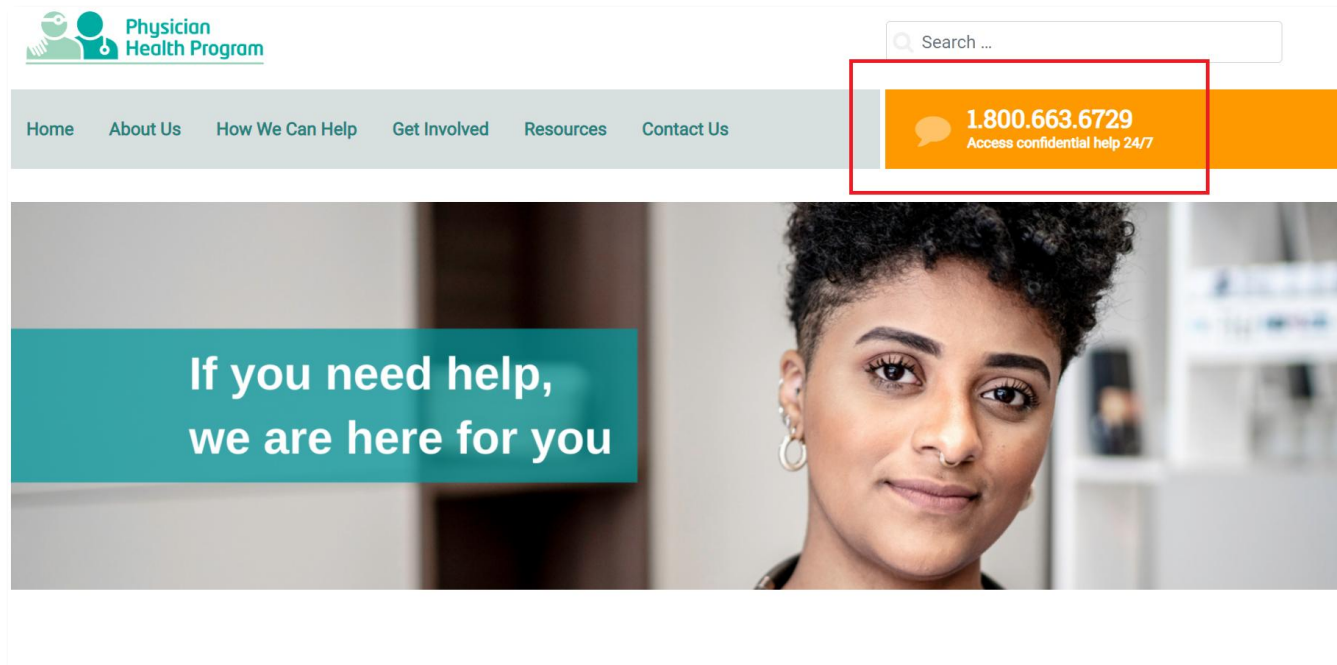
- Vancouver Coastal Health: <http://www.vch.ca/your-care/mental-health-substance-use/substance-use-services>
- Fraser Health: <https://www.fraserhealth.ca/Service-Directory/Services/mental-health-and-substance-use/mental-health-centres/community-substance-use-services-clinics#.YIYFUdJKiUk>
- Island Health: <https://www.islandhealth.ca/our-services/mental-health-substance-use-services/access-referrals-mental-health-substance-use-services>
- Interior Health: <https://www.interiorhealth.ca/YourCare/MentalHealthSubstanceUse/Pages/default.aspx>
- Northern Health: <https://www.northernhealth.ca/services/mental-health-substance-use>



Resources – Physicians who need help

Physician Health Program (PHP) is primarily funded by the Ministry of Health and governed by a steering committee composed of Ministry of Health and Doctors of BC representatives. PHP services are managed and delivered by a caring and diverse clinical team at Doctors of BC.

1-800-663-6729



Learning Objectives

By the end of the session participants should be able to:

1. Recognize the ongoing toxic drug deaths in BC/Canada since 2016
2. Recognize the historic and current trends in opioid prescribing in Canada.
3. Identify indications for prescription opioids.
4. Apply safe prescribing parameters to minimize the risk of harm to the patient and wider community
5. Identify aberrant behaviours that could suggest opioid use disorder
6. Explain current opioid use disorder pharmacological options in BC
7. Understand the roles and responsibilities for PRA-BC candidates in the context of opioid prescribing
8. Identify appropriate consultation options and community resources for patients who are suffering from substance use disorder

Additional Resources and References

Patients and Families

- HelpStartsHere.ca: <https://helpstartshere.gov.bc.ca/substance-use/types-substance-use>

Harm Reduction

- Toward the Heart: <http://www.towardtheheart.com>
- Lifeguard app: [Lifeguard App | HelpStartsHere](#)

Education/Training/Guidelines

- BC Centre on Substance Use: <http://www.bccsu.ca>
- UBC CPD Opioid Prescribing Online Module: <https://ubccpd.ca/learn/learning-activities/course?eventtemplate=45-safe-prescribing>. Updated 2025

References

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<https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/statistical-reports>
- Health Canada Infobase: Key findings The most recent available data on overdoses and deaths involving opioids and/or stimulants from January 2016 to December 2024 in Canada, where available. Last updated: 2025-06-25 <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/>
- First Nation and the Toxic Drug Poisoning Crisis in BC <https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-Dec-2024.pdf> Accessed September 21, 2025
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- Canadian Institute for Health Information. Opioid Prescribing in Canada: How Are Practices Changing?. Ottawa, ON: CIHI; 2019g-term opioid therapy
<https://www.cihi.ca/sites/default/files/document/opioid-prescribing-canada-trends-en-web.pdf>
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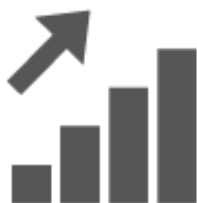
Dual emergencies: COVID-19 and Fentanyl

Dual Public Health Emergencies

Overdose in BC during COVID-19



BC Centre for Disease Control
Provincial Health Services Authority



The overdose public health emergency, declared on April 14 2016, has claimed the lives of almost 7,000 British Columbians. Since the declaration of the COVID-19 public health emergency on March 17, 2020, the rate of **overdose events and illicit drug toxicity deaths have increased** and surpassed historic highs.

Illicit drug toxicity deaths exceeded the combined deaths from motor vehicle, suicide, and homicide in 2020

Overdose Events

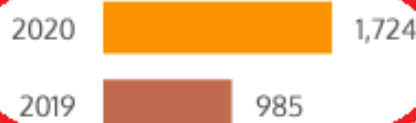
There were 17,159 paramedic attended* overdose events** in 2020 compared to 13,486 in 2019

*some overdoses go unreported
**fatal and non-fatal overdoses



Illicit Drug Toxicity Deaths

1,724 people died from overdose in 2020 compared to 985 people in 2019



Drug Toxicity

Fentanyl and analogues‡ were relevant to over **8 in 10** illicit drug toxicity deaths in 2020, followed by methamphetamine

‡Fentanyl increases the risk of overdose due to the variable potency within the illicit drug supply



Increased number of **high fentanyl concentrations**