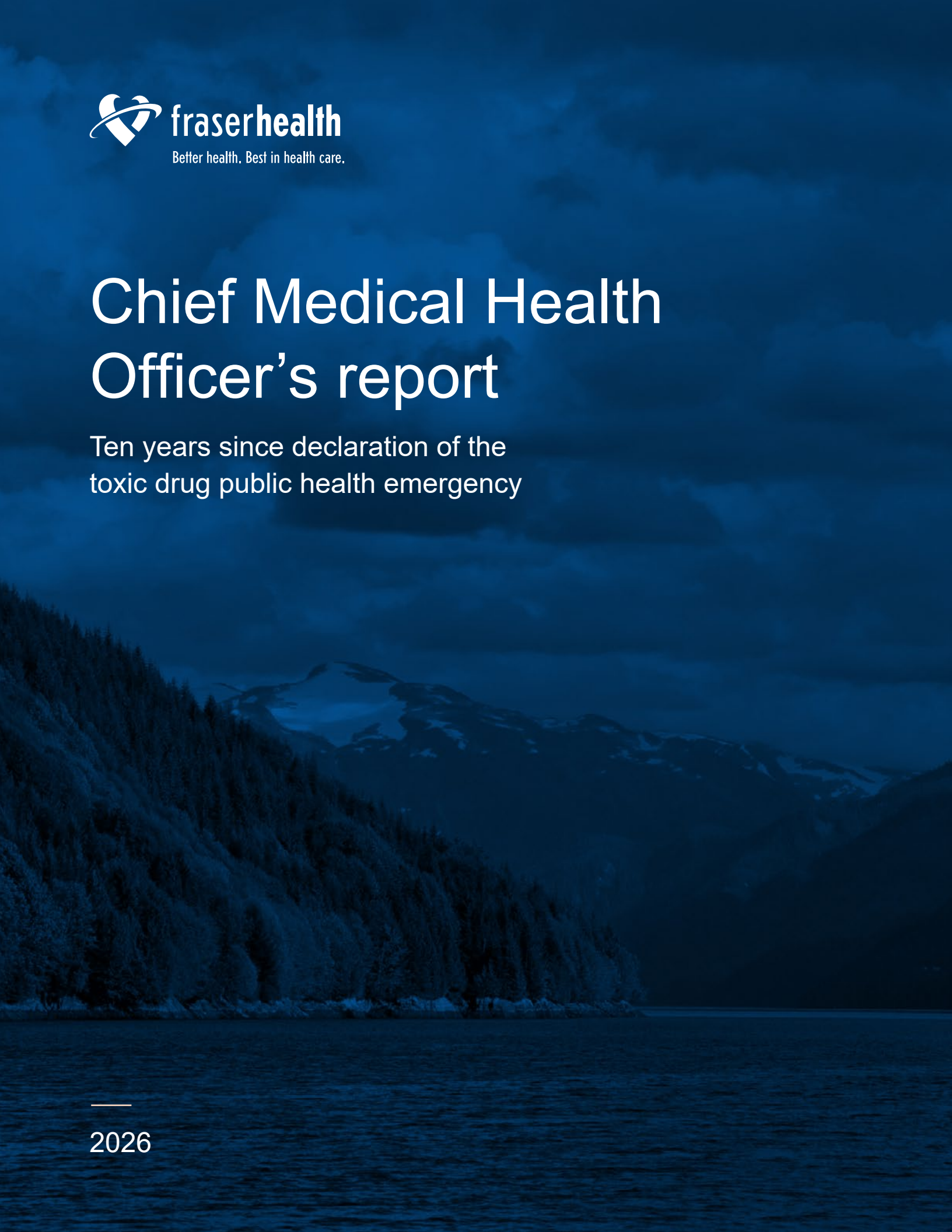


fraserhealth

Better health. Best in health care.

Chief Medical Health Officer's report

Ten years since declaration of the toxic drug public health emergency

2026

Letter from the Chief Medical Health Officer

Over the past decade, toxic drug poisonings have profoundly affected individuals, families and communities throughout the Fraser Health region. This report marks ten years since the declaration of British Columbia's public health emergency and provides an opportunity to reflect on the human, community and system level impacts of this emergency as well as the health, policy and social system opportunities that lie ahead.

The purposes of this report are threefold. First, it seeks to acknowledge the deep and enduring impacts of the toxic drug emergency over the past decade—impacts felt by individuals, families, communities and the health system itself. Second, it describes ten years of Fraser Health's evolving response across prevention, treatment, harm reduction and recovery-oriented supports. Third, it is intended to inform ongoing response by identifying key learnings, persistent gaps and opportunities for continued improvement.

As Chief Medical Health Officer, I am deeply grateful to the many partners, staff, clinicians, peer workers and community members who have contributed to this work and to the development of this report. Their commitment, expertise and care continue to save lives and strengthen our collective response. For many health care workers and staff, this crisis has also been deeply personal. Alongside their professional roles, they have experienced the loss of clients, friends, family and others. The cumulative impact of these losses and the distress of working within systems that cannot always meet the scale or complexity of need must be acknowledged as part of the ongoing toll of this emergency.

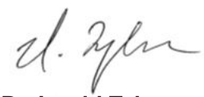
The drug supply itself is a critical factor shaping this emergency. Over the past decade, we have seen many shifts in the unregulated drug supply, with recent changes including the emergence of potent veterinary sedatives such as medetomidine. These shifts have continued to alter toxic drug poisoning presentations and subsequent response, most recently contributing to more complex and prolonged medical emergencies. While toxic drug poisoning deaths are decreasing throughout the province, health systems are experiencing increased acuity and demand within emergency departments and intensive care units, underscoring new and evolving challenges.

This report is intentionally focused on essential and evidence-based health services and health system interventions. While the contributions of partners across housing, social services, enforcement, municipalities and community organizations are recognized throughout, these areas are addressed primarily where they intersect directly with health. This reflects both the mandate of the health system and the reality that effective responses depend on coordinated action across sectors. It also recognizes that the toxic drug crisis is shaped by broader policy and system contexts, including intersecting social, economic and structural factors, including housing instability, poverty, systemic racism, stigma and the criminalization of substance use. These dynamics influence both substance use and toxic drug poisoning risk as well as our collective capacity to deliver evidence-based care. Public narratives that frame responses as binary such as treatment versus harm reduction, abstinence versus ongoing use or housing versus health care can undermine support for low barrier, person-centred approaches and limit the effectiveness of interventions.

At the same time, communities are experiencing very real and visible impacts related to substance use, including concerns about personal safety, encounters with people in distress or toxic drug poisoning, discarded drug paraphernalia and effects on neighbourhoods and local businesses. These concerns are legitimate and deserve thoughtful response; however, they become life-threatening when they limit the ability to deliver health care services to those that need them. Addressing these concerns effectively requires coordinated, cooperative approaches that bring together public health, housing, community services, education and enforcement, supported by sustained investment and shared accountability. As this report outlines, continued progress depends not only on health service innovation and refinement but also on cross sector coordination and a willingness to reduce longstanding structural barriers that perpetuate risk and inequity.

At its core, this work is about people—about dignity, connection and creating the conditions for wellness. Numbers and data are essential but they cannot fully capture the human realities behind this crisis. Throughout this report, we share the experiences of clients and staff to illustrate the real world impact of services. These voices ground the work in compassion and help ensure that planning and decision making remain connected to lived and living experience. This includes an ongoing commitment to advancing cultural safety and humility, particularly in partnership with Indigenous communities, and to addressing the legacy and ongoing impacts of colonialism within health systems.

This ten year review is not an endpoint. It is a call to deepen relationships, strengthen cultural safety and humility and continue working across systems to reduce preventable harms and improve outcomes for those most affected. By listening carefully, learning continuously and acting collaboratively, we can honour those we have lost and build a more compassionate, effective and equitable response moving forward.



Dr. Ingrid Tyler
Chief Medical Health Officer
Fraser Health Authority

Territory acknowledgement and partnership commitment

We recognize that Fraser Health provides care on the traditional, ancestral and unceded lands of the Coast Salish and Nlaka'pamux Nations and is home to 32 First Nations within the Fraser Salish region. We are grateful for the care that First Nations have taken of the land and of their communities' health since time immemorial.

We are dedicated to serving all Indigenous people and honour the unique cultures of the First Nations, Métis and Inuit living within the Fraser Salish region. We commit to working together with Indigenous partners to build a more equitable system of care that supports the health and well-being of Indigenous people across the Fraser Salish region.

Content advisory

This report includes information related to toxic drug deaths. We recognize that this content and subject matter may activate trauma or distress for readers. Before you proceed, please find the right time and space where you are ready to engage with the material and please care for your safety and wellbeing. We recognize that the impacts of toxic drug poisoning are deeply personal for many and that these impacts disproportionately affect Indigenous communities and other equity-deserving groups. We encourage readers to access culturally grounded supports if needed.

Fraser Health Crisis Line

604-951-8855 or toll-free 1-877-820-7444

Trained volunteers provide toll-free telephone support and crisis intervention counselling, 24 hours a day, seven days a week. You can also call for information on local services or if you just need someone to talk to.

Culturally sensitive crisis lines for Indigenous people

1-800-KUU-US17 (1-800-588-8717)

KUU-US Crisis Response Services provides culturally sensitive support and counselling to First Nations, Inuit and Métis peoples 24 hours a day, seven days a week.

1-833-MÉTISBC (1-833-638-4722)

The Métis Crisis Line in B.C. is available for immediate crisis intervention but also a variety of other issues like relationship troubles, depression and anxiety, financial issues and bullying and peer pressure support.

Fraser Health Access Line

Mental Health and Substance Use (Home of Access Central for Substance Use Services)

1-833-866-6478

Callers receive support to get connected with the mental health and/or substance use service that best fits their needs. The service is available seven days a week from 8:30 a.m. to 8:30 p.m., including statutory holidays.

Acknowledgements

Fraser Health gratefully acknowledges the many dedicated individuals who contributed to this report, including those who provided content and data, reviewed drafts and offered input at various stages of development. While it is not possible to name everyone, sincere appreciation is extended to all who contributed in ways both big and small.

Core project team

Dr. John Harding
Public Health Physician

Scally Chu
Epidemiologist
Population Health Observatory

Sonya Ishiguro
Project Leader
Population and Public Health

Additional contributors

Alyssa Pelletier
Harm Reduction Lead Toxic Drug Response

Anosha Afaq
Leader
South Asian Health Institute

Cheryl Prescott
Director, Clinical Operations
Toxic Drug Response

Corinne Stone
Leader
Indigenous Health

Dr. Sharon Vipler
Program Medical Director/Regional Department Head, Addiction Medicine and Substance Use Services

Erin Gibson
Manager, Clinical Operations
Toxic Drug Response

Erin Senior
Regional Director (interim)
Mental Health and Substance Use Services

Gwenyth Dwyn
Project Lead, Healthy Schools (interim)
Population and Public Health

Kyleia Gallagher
Lead
Indigenous Health

Margo Pearce
Leader, Monitoring and Evaluation
Indigenous Health

Marika Sandrelli
Strategic Leader
Mental Health and Substance Use Services

Tracy Hoskin
Project Lead, Wellness Promotion
Population and Public Health

Additional thanks to those who provided review and feedback during the report development process, including:

Aileen Murphy
Social Planner
City of Surrey

Dr. Alexis Crabtree
Public Health Physician
BC Centre for Disease Control

Dr. Ariella Zbar
Executive Medical Director and Medical Health Officer
Fraser Health Authority

Dr. Bonnie Henry
Provincial Health Officer

Donnie Rosa
Chief Administrative Officer
City of New Westminster

Dr. Elizabeth Brodkin
Deputy Provincial Health Officer

Dr. Esther de Vos
Executive Director, Research
BC Housing

Geneva Healey
Director, Child and Youth, Young Adult Mental Health and Substance Use Services Fraser Health Authority

Jennifer Derinzy
Coordinator, Substance Use and Addiction Programs
Fraser Health Authority

Jessica Bridgeman
Manager, Harm Reduction, Population and Public Health
Interior Health Authority

Judi Mussenden
Director, Clinical Operations, Population and Public Health
Fraser Health Authority

Mara Billings
Probation Officer
BC Corrections

Penny Trites
Director, Indigenous Health and Cultural Safety and Humility and Indigenous Recruitment and Retention
Fraser Health Authority

Rahul Chhokar
Director, Public Health Epidemiology and Informatics
Fraser Health Authority

Dr. Silvina Mema
Deputy Chief Medical Health Officer
Interior Health Authority

Tammy Theis
Senior Consultant, Communications and Public Affairs
Fraser Health Authority

Executive summary

Ten years after the declaration of a public health emergency in British Columbia, toxic drug poisoning continues to exert profound health, social and system-level impacts throughout the Fraser Health region. Since 2016, and as of February 28, 2026, more than 5,600 people in the region have died from toxic drug poisonings, driven primarily by exposure to an increasingly toxic and unpredictable unregulated drug supply. Toxic drugs are now the leading cause of death for people aged 19–59 years in the province and have contributed to declining life expectancy. While Fraser Health has maintained the lowest toxic drug death rate among B.C. health authorities, the absolute burden of mortality, morbidity and trauma experienced by individuals, families, communities and service providers remains substantial.

This Chief Medical Health Officer report provides a ten-year overview of the toxic drug poisoning emergency in the Fraser Health region. Drawing on surveillance data, program evidence and lived and living experience, the report examines evolving patterns of substance use; the health and societal impacts of toxic drug poisonings; and the individual, social and structural risk and protective factors that shape vulnerability across the lifespan. The report highlights persistent and disproportionate harms among Indigenous people, people of South Asian descent, people experiencing homelessness or housing instability, youth and young adults, pregnant and parenting people, men aged 30–59 years and people working in the trades and transport industries. It also identifies significant data limitations that constrain the ability to fully measure inequities affecting many equity-deserving populations.

Over the past decade, Fraser Health has developed and expanded a comprehensive continuum of prevention, harm reduction, treatment and recovery supports in response to the evolving emergency.

Fraser Health has also prioritized culturally grounded and population-specific approaches and the expansion of peer roles throughout the system. Trauma and Resiliency Informed Practice has supported more person-centred, culturally safe care while addressing stigma, implicit bias and workforce burnout. In response to the increasing unpredictability of the unregulated drug supply, innovative safety measures have been implemented, including expanded drug checking, real-time drug alerts and virtual observed consumption options.

The learnings and opportunities identified in this report point to priority areas for strengthening the response. These include the need to further strengthen drug checking, real-time alerts and peer witnessing to mitigate risk from an unpredictable drug supply; to scaling flexible, low barrier, person-centred care that is responsive to diverse needs and contexts; to continuing to advance workforce capability through Trauma and Resiliency Informed Practice; to more fully embedding equity, cultural safety and peer leadership across services; to optimizing multisector collaboration with housing, education, municipalities, policing and community partners; and to advancing supports for protective factors such as housing stability, mental wellness, social connection and community belonging.

While this report focuses on the health system response, it reinforces that preventing further loss of life requires coordinated action beyond the health sector. Addressing the toxic drug poisoning emergency demands sustained leadership, strong partnerships with Indigenous communities, meaningful involvement of people with lived and living experience and long-term investment in the social and structural conditions that support health, resilience and wellness throughout the Fraser Health region.

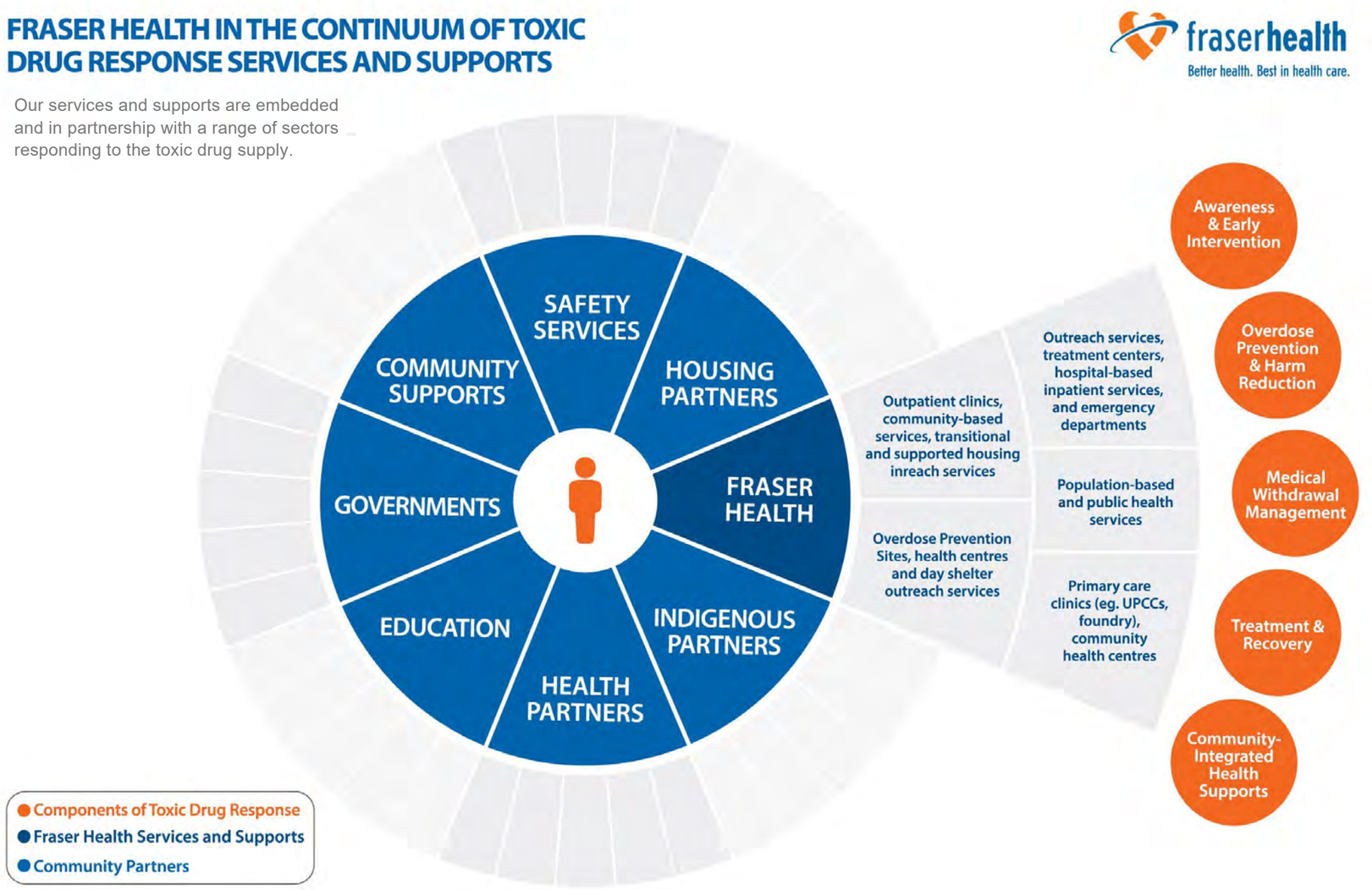
Introduction

The toxic drug emergency has broad impacts throughout Fraser Health, which serves more than 2.2 million people in urban, suburban and rural communities from Burnaby to Boston Bar. About 62,000 Indigenous people live in the region, including members of 32 First Nations and six Métis Chartered Communities.

Ten years after the declaration of a public health emergency, this Chief Medical Health Officer report recognizes the breadth of health system responses mobilized within Fraser Health to address the crisis. Grounded in evidence, surveillance data and the lived and living experience of those most affected, this report reflects on what has evolved over the last decade, what has worked and where significant challenges persist.

In this report we focus on health system services and supports to meet the diverse range of needs at various points in an individual's substance use and wellness journey. Fraser Health's response spans the full continuum of care including harm reduction, rapid access to addiction care and substance use treatment, medical withdrawal management, bed-based and community-based recovery supports, hospital-based addiction medicine services and prevention and health promotion activities. This report and our continuum (Figure 1) recognize the significant intersectoral supports and partnerships that exist across our services to help those with mental health and addiction or related risk factors.

Figure 1: Fraser Health's Toxic Drug Response Continuum



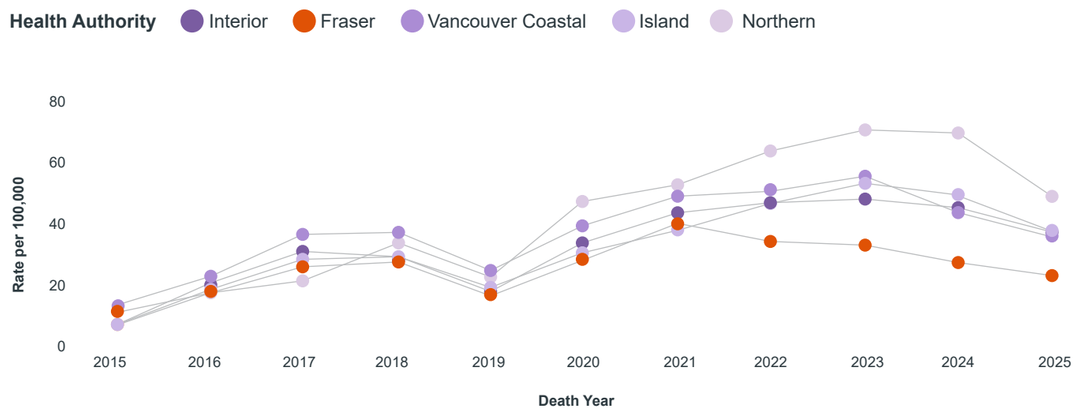
10-year overview of toxic drug poisonings in the Fraser Health region

In April 2016, British Columbia's Provincial Health Officer declared a public health emergency in response to a rise in toxic drug poisoning deaths driven by the increasing presence of illicit fentanyl in the unregulated drug supply.(1) Early responses included improving data sharing to guide the health response, expanding access to overdose prevention services and other rapid-response supports and collaborating with the federal government and law enforcement to reduce the distribution of illicit fentanyl.(2–4) Over the first decade of the emergency, the toxic drug crisis has continued to evolve as the drug supply and how substances are consumed continue to reshape patterns of harm throughout communities.(5,6)

Between January 1, 2016 and December 31, 2025, over 18,200 people in British Columbia died from toxic drug poisonings, including more than 5,600 people in the Fraser Health region.(7) Today, toxic drugs are the leading cause of death for people aged 19–59 in British Columbia, surpassing deaths from homicides, suicides, accidents and natural causes in this age group.(7) These deaths affecting younger demographics have also contributed to a decline in life expectancy in the province.(8)

The Fraser Health region has had the highest number of toxic drug poisoning deaths compared to other B.C. health authorities. However, because of our large population, Fraser Health has seen the lowest rate of toxic drug deaths per 100,000 population among B.C.'s health authorities (Figure 2).

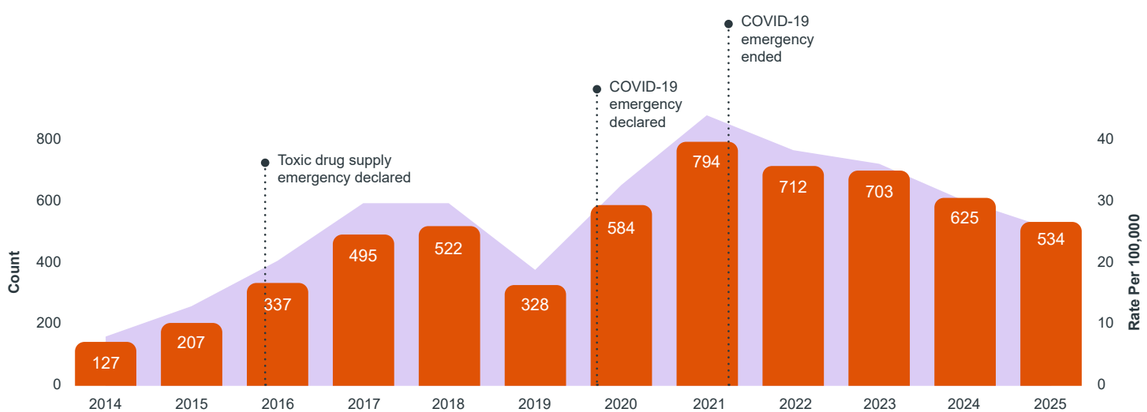
Figure 2: Unregulated drug death rates per 100,000 population by health authority of injury, 2015-2025



Data source: BC Coroners Service, February 2026. Preliminary data, numbers are subject to change.

As seen in Figures 2 and 3, deaths increased from 2014, with a brief decline in 2019 followed by a sharp increase associated with the COVID 19 pandemic. Since 2021 toxic drug poisoning deaths have been declining in our region.

Figure 3: Number and rate of unregulated drug deaths in the Fraser Health region, 2014-2025



Data source: BC Coroners Service, February 2026. Preliminary data, numbers are subject to change.

Clinical Insight

Why did toxic drug events peak during the COVID-19 pandemic?

Several factors are likely to have influenced the rise in toxic drug deaths during the COVID-19 pandemic. The COVID-19 pandemic increased social isolation, stress and anxiety and loss of employment.(9) Response measures affected peoples' access to some health services and disrupted illegal drug supply routes, which made the contents of unregulated drugs more toxic and less predictable.(9–14) In addition, guidance intended to limit the transmission of COVID-19 (e.g., social distancing) directly contradicted response guidance to the ongoing toxic drug crisis (e.g., never use drugs alone), exacerbating harms among people reliant on the toxic, unregulated drug supply.(9)

The pandemic also reinforced existing social inequities.(9) First Nations people were disproportionately impacted, with drug poisoning deaths increasing 93 per cent between January and May 2020.(15) Many Indigenous people experienced additional vulnerabilities to both the toxic drug emergency and the impacts of COVID-19.(9) Public health restrictions were layered onto the cumulative stresses of intergenerational trauma, systemic poverty and pervasive racism and discrimination.(9)

The 2022-2025 decrease in toxic drug-related deaths seen in Fraser Health is likely influenced by a reduced presence of fentanyl in the unregulated drug supply, increased awareness and availability of naloxone (used to restore breathing in the event of an opioid toxic drug poisoning) and a reduced number of individuals at highest risk, in part due to the cumulative loss of life in previous years.(16) Emerging evidence suggests that regions where these factors are more pronounced (e.g. areas that have higher naloxone distribution, higher historical death counts and/or higher historical presence of fentanyl in the supply) tend to now be experiencing greater reductions in toxic drug mortality.(16)

However, the reasons for decline in deaths remain uncertain and should not be interpreted as showing cause and effect because of the inability to distinguish between multiple simultaneous interventions, plus other data limitations.(16)

Furthermore, any decline in toxic drug deaths must be interpreted in the context of other ongoing impacts and does not signal resolution of the emergency.(16) For example, recent changes in the drug supply indicate that medetomidine and newer adulterants may be leading fewer deaths, however the number of non-fatal toxic drug poisonings and subsequent hospitalization and associated disability may be increasing.

Part 2

Substance use and health

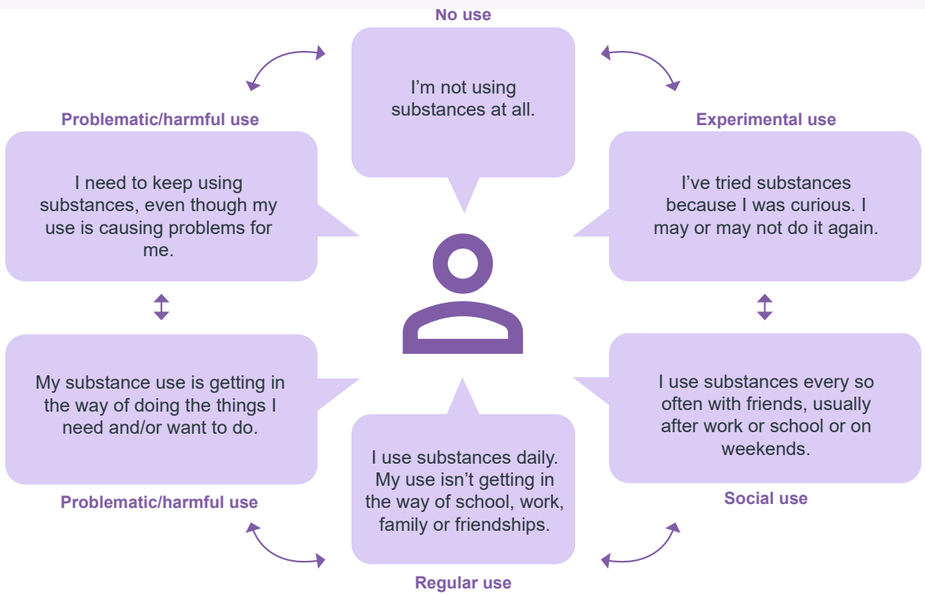
To better understand the evolution of and response to the toxic drug public health emergency, it is important to understand substance use patterns, policy and societal views more generally. This section also introduces risk and protective factors for substance use, which highlight the need for intersectoral partnership and responses in substance use prevention and recovery.

Patterns of substance use

Substance use is a global phenomenon. Worldwide in 2023, an estimated 2.3 billion people consumed alcohol, 1.3 billion people used tobacco and 316 million people used unregulated drugs.(17) People use substances for many reasons, including ceremony, enjoyment or coping with stress, trauma or pain.(18,19) The reasons people use a substance influences their pattern of use and risk of harmful consequences.(19) Patterns of use are also influenced by social, cultural and personal factors such as genetics or personality (e.g. tendency towards sensation-seeking).(19) Characteristics of different substances, such as absorption, duration of action, clearance, as well as mode of use, influence patterns of use as well as the degree of risk and potential harm.

Substance use exists on a spectrum of use from not using at all, to occasional or more frequent use, to substance use disorder (Figure 4).(18,19) People may move between these patterns over time depending on context, environment and available supports.(18,19) Most people who use substances do not develop a substance use disorder,(18,20) defined as dependent or harmful use. The likelihood of developing a substance use disorder is influenced by a combination of biological (e.g. genetic), psychological (e.g. trauma), social and structural factors (e.g. poverty, racism and housing instability).(18–20) Despite this, substance use disorder is often framed as a moral failing rather than a health condition, which may deter and/or limit access to care.(20,21)

Figure 4: Adapted from: mindyourmind (mindyourmind.ca)



Clinical Insight

Recovery in the context of substance use disorders

Substance use disorder is a chronic health condition that can include psychological and/or physical dependence resulting in health and social harms.

While rates of substance use-related morbidity and mortality are high, sustained long-term remission is possible.(20,22) Recovery does not mean abstinence for everyone; it can instead focus on improved quality of life, reduced harm, enhanced wellbeing and progress toward personally meaningful goals.(18)

It is important to note that substance use disorder recovery and wellness are defined differently across individuals and cultures.(20,22) Some people may benefit from non-use, while others may benefit more from other supports, including medication, counselling, withdrawal management and wrap-around services such as culturally grounded, community-led supports that address needs like employment and housing to promote longer-term wellness.(20,22)

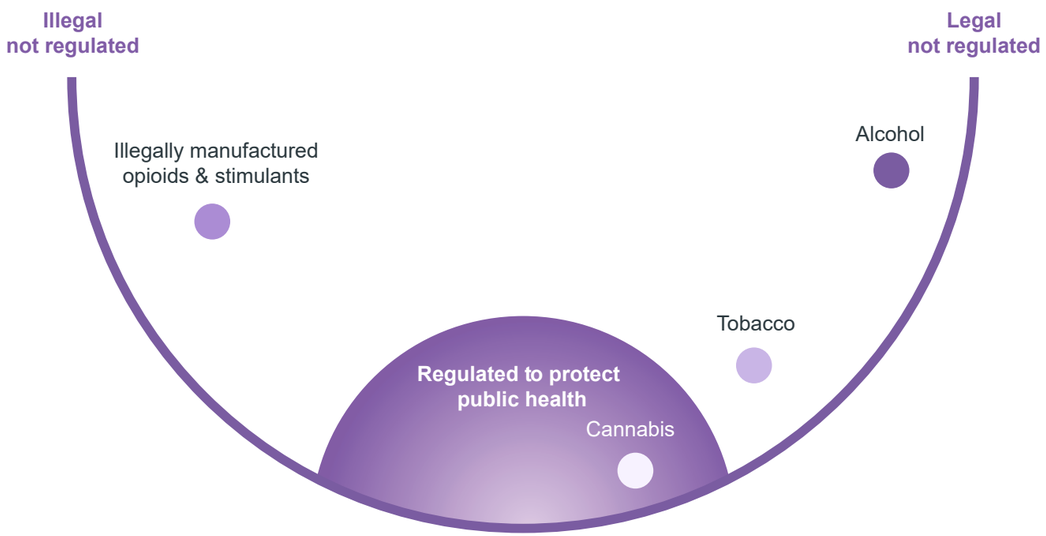
Regulated and unregulated substances in Canada

Regulatory approaches to psychoactive substances exist along a continuum (Figure 5). For more details on the history of substance use policy in British Columbia and its impacts, see pages 19-23 of Island Health's 2024 Chief Medical Health Officer Report. (23)

Tobacco, alcohol and cannabis are legal substances with varying levels of regulation in Canada. Policies that reduce consumption of regulated substances vary but can include pricing controls, minimum age requirements, limits on sales locations and hours, bans on advertising and promotion, health labelling and public education. Effective regulation of production of the supply ensures substances have known and consistent composition. A relatively significant combination of regulations, as currently seen in cannabis regulation, most consistently and effectively minimizes health and social harms associated with a substance.

Illegal substances are prohibited and therefore cannot be effectively regulated, monitored or researched. Their production and distribution most often occur through organized crime, contributing to significant health and social harms.

Figure 5: The drug policy continuum: From: Island Health's 2024 Chief Medical Health Officer Report adapted from the original work of Dr J Marks (Marks, J. (1989). The Paradox of Prohibition).

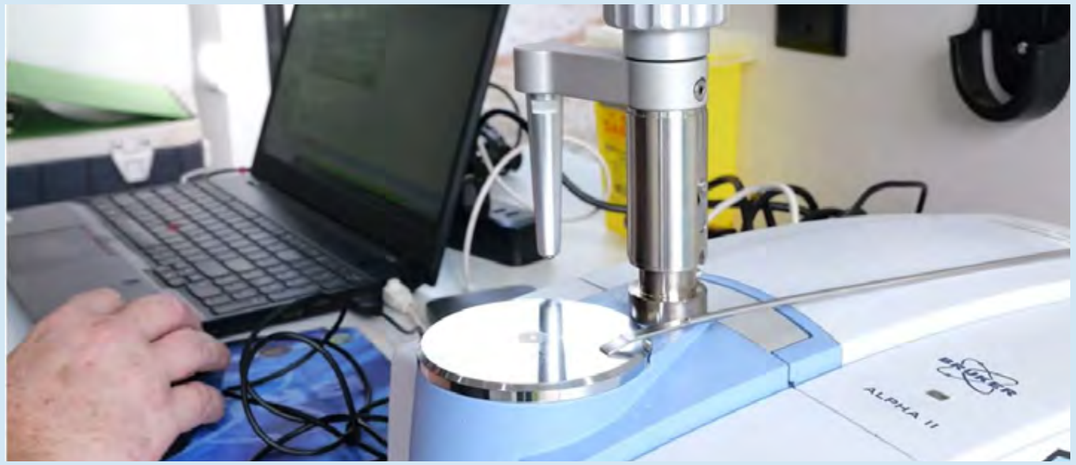


Regulatory and enforcement approaches should be complementary. During the period covered by this report, British Columbia implemented a time-limited decriminalization pilot that removed criminal penalties for possession of small amounts of certain substances for personal use.(24) While this policy was intended to reduce harms associated with criminalization, it did not regulate the production or distribution of substances and therefore did not address the underlying toxicity and unpredictability of the unregulated drug supply. Experience with prescribed safer supply as a harm reduction intervention has also reinforced that policy intent and implementation context matter. While safer supply aims to reduce exposure to a toxic, unregulated market for a small subset of people at highest risk, implementation has highlighted some challenges, including diversion (sharing, trading or selling prescribed medications).

Clinical Insight

Unpredictability of the unregulated drug supply

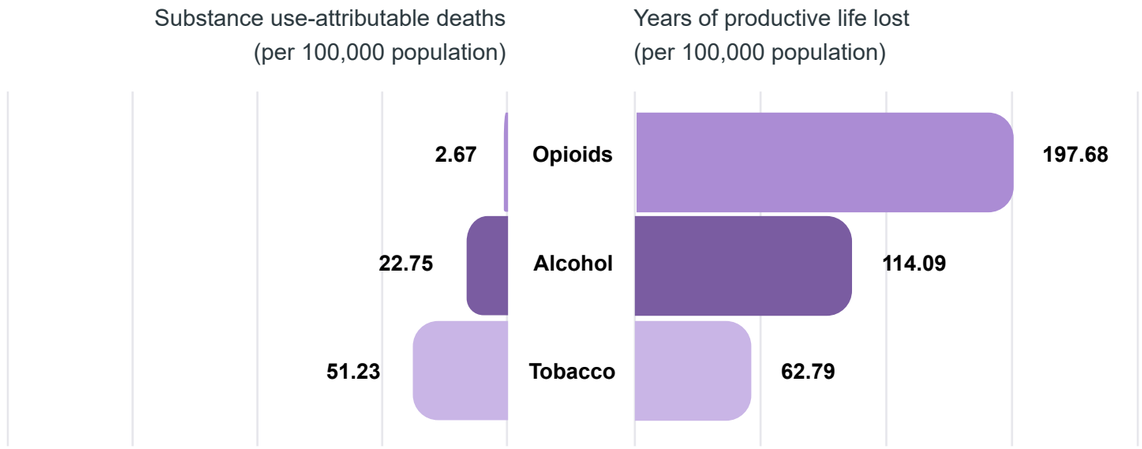
Between 2016 and 2026, data shows that the unregulated drug supply in B.C. has become increasingly unpredictable, containing highly variable and medically risky substances.(7,25,26) Monitoring of the unregulated drug supply (i.e. drug checking) demonstrates continual shifts in unregulated substance composition, including the emergence of new additives and adulterants. In the Fraser Health region, fentanyl was detected in over two-thirds of opioid samples checked in 2025.(25) Benzodiazepine-type drugs such as etizolam were identified in roughly 40 per cent of opioid samples, complicating toxic drug poisoning management and diminishing the effectiveness of naloxone.(25,27) More recently, medetomidine, a veterinary sedative that does not respond to naloxone, has emerged as a concerning new adulterant, detected in 38 per cent of opioid samples tested in November 2025.(28,29)



Impact of substance use on health and society

All substances contribute substantially to health, social and economic harms. In B.C., the use of widely-accepted substances such as alcohol and tobacco remains the leading cause of preventable illness and death in Canada (Figure 6).(30) In contrast, unregulated substances such as opioids found in illegal substances and stimulants carry higher acute risks. This is in part because of unknown potency (the effect of the drug), contamination or adulteration (the contents of the drug) and lack of dosing information (the amount of the drug), causing tragic potential years of productive life lost despite comparatively low death rates relative to regulated substances like alcohol and tobacco (Figure 6).

Figure 6: Standardized rates of substance use attributed deaths and potential years of productive life lost for alcohol, opioids and tobacco, British Columbia, 2020



Source: Canadian Centre on Substance Use and Addiction and Canadian Institute for Substance Use Research, 2023, Canadian substance use costs and harms (CSUCH) visualization tool (23)

In 2020, the health costs attributable to tobacco and alcohol were more than five times higher than those associated with opioids (Figure 7).(30) Alcohol and tobacco contribute heavily to chronic disease, cancers, cardiovascular conditions and other long-term health impacts, which drives their per capita health cost burden higher (Figure 7).(30)

Criminal justice costs linked to alcohol were almost three times greater than those for opioids (Figure 7).(30) Alcohol has especially high criminal justice impacts because of its broad availability and high rates of involvement in violence, impaired driving, public disorder and other offences (Figure 7).(30)

Lost productivity includes potential years of productive life lost due to premature death and long- and short-term disability, including that associated with brain injury.(30) Although opioids contribute heavily here due to deaths and disability affecting younger demographics, because tobacco and alcohol are used by much larger segments of the population, they also result in significant productivity losses from chronic illness, disability and early death (Figure 7).(30)

Figure 7: Substance use attributable costs per capita, British Columbia, 2020

	Health	Lost Productivity	Criminal Justice	Total cost per capita
Opioids	$	$ $ $ $ $ $ $ $ $ $ $ $	$ $	$315.32
Alcohol	$ $ $ $ $ $ $ $ $ $	$ $ $ $ $ $ $ $ $ $ $ $	$ $ $ $ $	$521.23
Tobacco	$ $ $ $ $ $ $	$ $ $ $ $ $ $		$260.36

$ = 20 dollars per capita

Source: Canadian Centre on Substance Use and Addiction and Canadian Institute for Substance Use Research, 2023, Canadian substance use costs and harms (CSUCH) visualization tool (23)

Spotlight

Public substance use and community concerns

The visible impacts of substance use can significantly affect communities. These impacts may include concerns about personal safety, witnessing intoxication or toxic drug poisoning, substance related litter (e.g., used drug equipment, packaging and alcohol containers) and effects on local businesses and neighbourhood reputation. These experiences fuel opposition to substance use and to harm reduction services in some communities. Visible substance use, however, often reflects a lack of housing, private space and access to supports—rather than individual preference. Many evidence-based services, including Overdose Prevention Sites, are intended to reduce the risk of toxic drug poisoning and death while also decreasing substance use in public spaces by providing observed consumption services.

Paradoxically, while many of these services are designed to bring people indoors, their presence can also contribute to congregation in surrounding areas, including before or after accessing services. Also, not all observed consumption sites are able to provide observed inhalation in indoor space. As a result, some community impacts may remain visible and are not always fully contained within service settings.

These impacts are unlikely to be eliminated entirely. When they disproportionately affect nearby residents or businesses, effective responses require coordinated, cooperative approaches that bring together public health, housing, community services, education, enforcement and sustained funding. This report acknowledges that continued progress depends not only on health service innovation and refinement, but also cross-sector coordination and a willingness to reduce long-standing structural barriers that perpetuate risk and inequity.

Risk and protective factors for substance use and substance use disorders

The risk and protective factors on the following page (Table 1) have been validated across substances including alcohol, tobacco, cannabis and opioids.(31) Individuals may experience more than one risk or protective factor. This is related to intersectionality, a concept acknowledging how overlapping identities such as race, gender, age, disability, housing status and mental health shape people's health, including exposure to substance-related harms and access to health and social supports. Intersectionality helps us understand how multiple forms of marginalization can compound stress, trauma, discrimination and stigma.

Protective factors include strong family and community connections, positive mental health and safe, stable environments.(31–38) These supports help build resilience and reduce the likelihood that individuals will engage in substance use as a way of coping. In contrast, risk factors such as trauma, social isolation, poverty and exposure to substance use can increase vulnerability to problematic substance use.(31–38)

These protective and risk factors operate across multiple levels, including individual characteristics (e.g., coping skills, mental health), family dynamics (e.g., parental monitoring, household substance use), peer influences, school environments, community context and broader societal conditions.(31) Many of these same factors also influence whether someone may develop a substance use disorder, as discussed earlier in the report.

These risk and protective factors inform population prevention frameworks and are reflected in Fraser Health's toxic drug continuum (Figure 1). Housing, culture as medicine, prevention of adverse childhood experiences (ACES) and comprehensive school health are explored further in the report materials. Addressing both individual supports and the broader social and structural determinants of health, such income security, access to education and community safety, supports prevention and recovery efforts, reduces the likelihood of problematic substance use and supports healthier, more resilient communities.(31–38) These upstream factors also play a role in supporting recovery from substance use disorder.

Table 1: Risk and protective factors for problematic substance use across the lifespan (31–38)

Level	Protective Factors	Risk Factors
Cultural/ Societal	• Cultural identity and pride • Connection to heritage and traditions • Health equity and culturally safe services • Inclusive, youth-centred and community-informed policies • Culture as medicine	• Systemic issues (e.g., poverty, housing insecurity, food instability) • Stigma and discrimination (e.g., based on race, gender, sexual orientation, disability) • Policy gaps (e.g., inadequate prevention funding, limited access to services)
Community	• Safe neighbourhoods • Accessible recreational spaces • Strong community partnerships, including coalitions integrating health, education and social services	• High crime rates and unsafe environments • Lack of recreational or engagement opportunities • Weak community cohesion • Limited access to community services and supports
School/ Workplace	• Positive school or workplace climate • Engagement in academic or professional activities • Access to health promotion and wellness programs • Sense of belonging, connectedness and purpose	• Negative or unsafe school/work environments • Academic failure or disengagement • Professional burnout or job insecurity • Limited access to health education or support services
Peers/ Friends	• Supportive peer relationships • Inclusive social environments • Peer groups that discourage substance use • Community engagement and social connectedness	• Peer pressure to use substances • Social isolation or exclusion • Association with substance-using peers • Lack of positive role models or mentors
Family	• Supportive home environment • Caregiver involvement and open communication • Stable housing • Positive family relationships	• Family conflict or dysfunction • Housing instability • Exposure to substance use within the family
Individual	• Emotional regulation and stress management skills • Healthy coping mechanisms • Positive mental health (e.g., self-esteem, resilience, sense of purpose) • Engagement in structured activities (e.g., hobbies, sports, volunteering)	• Poor emotional regulation/coping skills • Mental health challenges (e.g., depression, anxiety) • Lack of purpose or direction, creating feelings of emptiness, boredom or uncertainty • Early initiation of substance use

Practice highlight

Working together for community impact

Established in most Fraser Health communities in 2018, Community Action Teams (CATs) bring together municipalities, Indigenous leadership, people with lived and living experience, service providers and local organizations to co-design tailored responses to harms from the toxic, unregulated drug supply. Supported by provincial funding and coordinated through the Community Action Initiative, Community Action Teams advance priorities such as expanding harm reduction access, increasing public awareness and reducing stigma.

Research shows that when health, education, social services, municipalities and community partners work together, communities build more protective environments that help to reduce stigma and other risks for harmful substance use.(39,40) This integrated, upstream approach also strengthens social connections and improves timely access to prevention supports and expanded harm reduction while promoting pathways to recovery and wellness.

Tara Jeeves, outreach support worker

Stigma and implicit bias

Stigma, in the context of substance use, refers to the negative labels, assumptions and judgments that society attaches to people who use substances, shaping how they are treated and how they see themselves. Stigma can be a barrier across the care continuum, affecting quality of care, help-seeking and health outcomes for people who use substances.(41) These impacts are even more severe for people who experience additional marginalization based on race, culture, gender identity or socioeconomic status.(21) For example, the *In Plain Sight* report documents cases where Indigenous patients seeking pain relief were commonly labelled "drug seeking" and denied appropriate assessment or medication, illustrating how substance use stigma can intersect with racism to produce inequitable, unsafe care.(42)

Stigma surrounding substance use is widespread, but it is not experienced equally across all substances or populations. People who use unregulated (illegal) substances, including those who only use occasionally, experience greater negative impacts from stigma than people who use regulated substances (e.g., alcohol, tobacco, cannabis).(43) In British Columbia, tobacco use is increasingly discouraged through public health messaging, smokefree policies and social norms that frame smoking as undesirable. Alcohol, by contrast, remains normalized and woven into social life.

> "One person I was speaking to about their substance and alcohol use said "I would have no qualms walking into liquor stores and I would have no qualms walking into bars but, for some reason, I don't want to walk into Surrey Substance Use Services because I'm scared people will see me.That's how prevalent the stigma of substance use disorder is.""
>
> **Substance Use Service Access Team clinician**

> "I used to blame them (clients) for their problems and not wanting to get the help we provide... We have to create safe and engaging relationships to reduce social trauma before they (clients) are able to connect with us."
>
> **Medical Office Assistant**

Implicit bias refers to the unconscious attitudes, stereotypes or associations that influence our understanding, actions and decisions without our deliberate awareness. In society and within the health care system, implicit biases shape how substance use is interpreted and who is viewed as deserving of care.(44) Implicit bias often leads people to see legal substance use as normal, while viewing illegal or unregulated use as a sign of danger or moral failure.(44) Education, like Fraser Health's Trauma and Resiliency Informed Practice training that combines evidence-informed anti-stigma content with skills-based training, structured reflection and feedback can help mitigate implicit bias and support more equitable, culturally safe and person-centred practices.(44–47) Inclusion of peer roles and peer-based programs in substance use services also contributes to decreased stigma.(48)

Practice highlight

Trauma and Resiliency Informed Practice

In 2017, Fraser Health developed an innovative mental wellness and resiliency education program for direct service providers designed to address the important connection between trauma, distress and stigma. Trauma and Resiliency Informed Practice (TRIP) education seeks to improve care by enhancing knowledge and skills related to trauma awareness, self-compassion and compassion satisfaction — the positive emotions that a person feels while helping or caring for someone else — in contrast to compassion fatigue, which refers to the profound emotional and physical erosion that takes place when helpers are unable to refuel and regenerate — through a shared humanity lens. Evaluation results show significant improvements in provider resiliency when responding to distress and the effects of trauma in clients. These results directly correlated to decreases in substance use-related stigma and burnout scores.

Part 3

Impacts of the toxic drug poisoning emergency

Toxic drug poisonings in the region impact people across ages and sexes and can occur even with infrequent or occasional use, with the primary risk factor being exposure to the unregulated drug supply.(8) Part 3 looks at impacts of the toxic drug poisoning emergency in various subpopulations; however, our best data does not consistently or comprehensively capture key identity characteristics. Where this data exists, it shows clear and persistent patterns in toxic drug outcomes, including increased risk and impact in many equity-seeking populations. Part 4 outlines Fraser Health's support services including how programs have been adapted to serve key populations in response to the increasingly unpredictable and toxic drug supply.

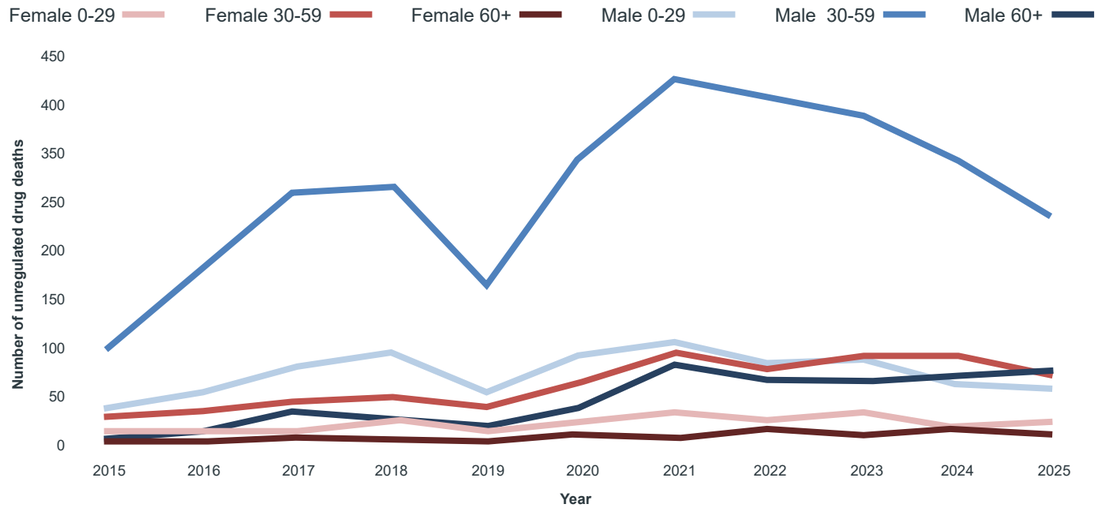
Men aged 30-59 years

The majority of toxic drug deaths are among men aged 30–59 (Figure 8). According to the 2023 Canadian Alcohol and Drugs Survey, men are more likely to have reported use of an illegal drug in the past year compared to females (8.7 per cent compared to 6.4 per cent).(50) There is still an unclear understanding of why men represent most toxic drug poisoning deaths and the precise mechanisms through which masculinity shapes toxic drug poisoning risk.(49) Stigma, criminalization and poverty reinforce solitary use and these pressures may interact with masculine gender expectations to create conditions where men are especially likely to use drugs alone.(49)

Those working in trades and transport

Workers in the trades and transport industries (including construction) experience disproportionately high rates of toxic drug poisonings. Among deaths where occupation industry is known, the majority worked in the trades and transport sector, accounting for nearly 30 per cent of all toxic drug deaths in the Fraser Health region in 2025.(7) Contributing factors include workplace culture, the physical nature of the work leading to chronic pain and the use of substances to manage both physical and emotional stress.(51) Related to this report's discussion of stigma, a national survey found that 60 per cent of trades workers reported they would not want anyone to know they needed support with substance use, limiting their access to care.(52)

Figure 8: Number of unregulated drug deaths by year, stratified by sex and age category



Data source: BC Coroners Service, February 2026. Preliminary data, numbers are subject to change.

Evidence in focus

Why people use substances alone

Private residences are the most common location of death, followed by shelters and public spaces (Figure 9).(7) In contrast, 911-attended toxic drug poisonings tend to occur in public spaces or communal settings, where events are more likely to be witnessed (Figure 10). As a result, toxic drug poisonings in more public settings have higher survival rates, while those in private residences where drug use is often solitary carry a higher risk of death.

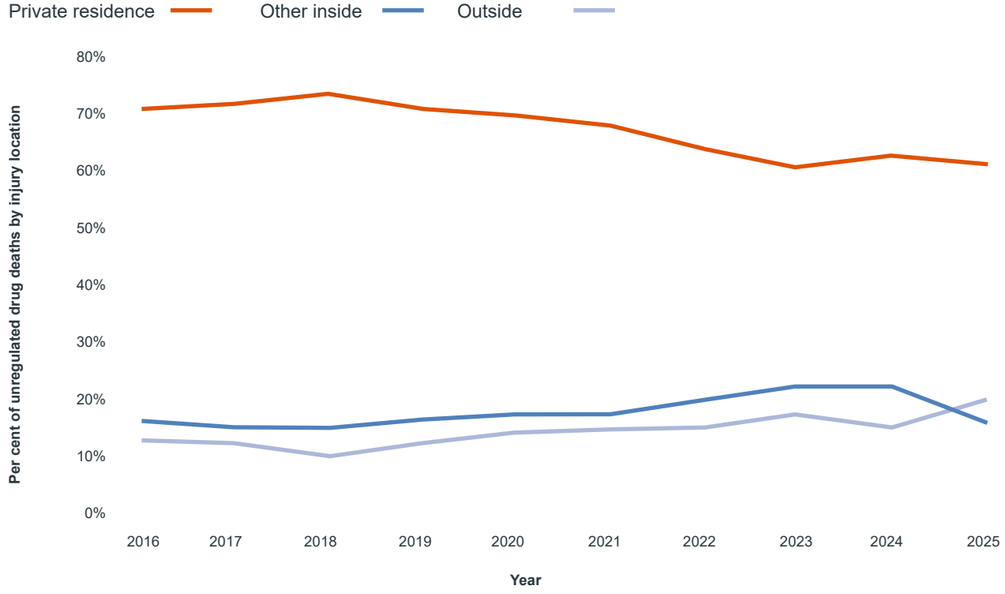
A desire for autonomy and comfort is the most frequently reported reason among people who use substances and have accessed harm reduction services in B.C., who often describe home use as easier, calmer and less socially demanding.(53,54) Cost pressures and limited access to drugs further reinforce solitary use, as people may avoid social settings where sharing is expected.(53) Fear of arrest or other legal consequences can push people who use drugs to consume alone or in private residences, increasing the risk of fatal toxic drug poisoning.(55,56)

Stigma also plays a role. People may hide their drug use due to shame, fear of judgment or the risk of being recognized by family, coworkers or community members. Stigma can lead individuals to isolate themselves and avoid harm reduction or health services even when they understand the risks of using alone.(54,55)

The need to protect privacy extends to emotional vulnerability as well; people often report not wanting others to witness them coping with grief, trauma, withdrawal or the physical act of drug use itself.(55)

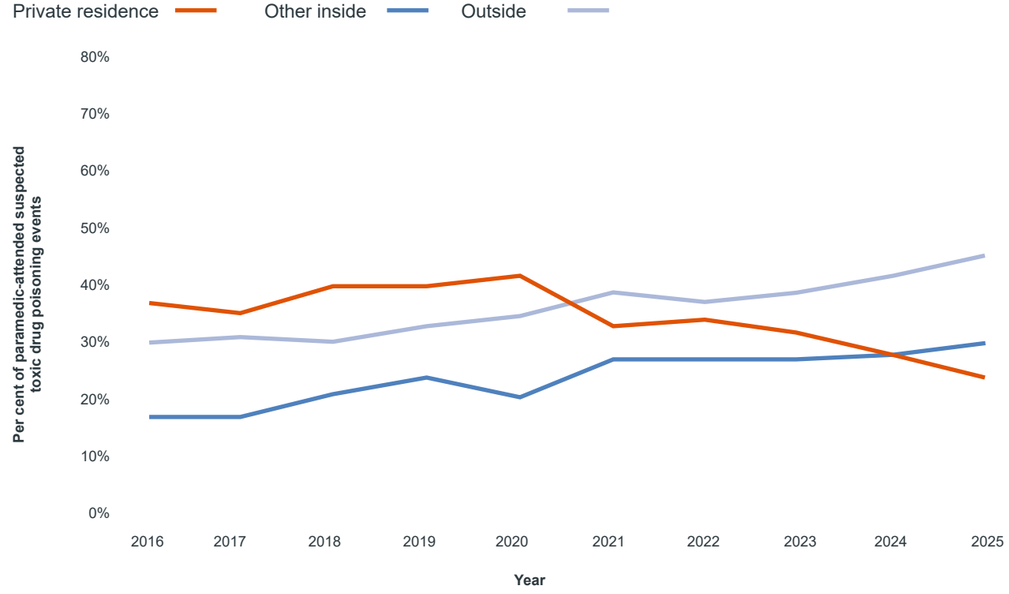
Safety concerns influence solitary use as well, though in a paradoxical way. While using alone increases the risk of fatal drug poisoning, experiences of theft, assault, predatory behaviour or mistrust of peers cause people to perceive private spaces as safer, despite the medical risk.(55) Others use alone due to episode-specific factors such as the urgency to use immediately after obtaining drugs to avoid withdrawal or the absence of a trusted person being available to use with at that moment. Mental health issues further reinforce isolation, making solitary use both a coping mechanism and a risk factor.(55)

Figure 9: Per cent of unregulated drug deaths by injury location



Data source: BC Coroners Service, February 2026. Preliminary data, numbers are subject to change.

Figure 10: Per cent of paramedic-attended suspected toxic drug poisoning events by location



Data source: BC Emergency Health Services, February 2026. Preliminary data, numbers are subject to change.

Indigenous people

Data from First Nations Health Authority (46) alongside research papers (58–60) show that the toxic drug crisis disproportionately impacts First Nations peoples (specific data on Inuit and Métis peoples is not available) as a direct result of the harms caused by colonialism, including systemic racism, intergenerational trauma and structural inequities. Generations of systemic inequity continue to shape Indigenous peoples' health and wellbeing, including increased harms caused by toxic drug poisoning.

In the Fraser Health region from January to June 2025, First Nations people were more than six times more likely to experience a toxic drug poisoning. (57) Provincially in 2025 (January to June), a higher proportion of toxic drug poisoning events were experienced by First Nations women (37.9 per cent of toxic drug events in First Nations) compared to other residents of B.C. (27.4 per cent of toxic drug poisoning events among other residents of B.C.).(61) First Nations youth aged 15-29 are also disproportionately affected.(62) In 2022 the rate of toxic drug events among First Nations female youth in B.C. was nine times higher than for non-First Nations female youth and the rate of toxic drug events among First Nations male youth was 11 times higher than for non-First Nations male youth.

Significant gaps remain in our ability to fully quantify the impact of the crisis on Indigenous people. Current datasets do not consistently capture the experiences of non-status First Nations people or Métis and Inuit populations, highlighting the need for distinctions-based data and Metis and Inuit-specific approaches. New data development and analyses are underway to enable Métis-specific reporting, but comprehensive, distinctions-based data remains limited. This includes the need to ensure that all data related to Indigenous people in British Columbia is gathered, governed and used in accordance with Indigenous data sovereignty principles while upholding appropriate Indigenous led data governance frameworks to guide collection, access, use, reporting and stewardship. By aligning with these frameworks and ensuring First Nations' authority over their own data, we help prevent further harm, avoid misinterpretation or misuse of data and support self determination, cultural safety and ethical decision making.

Spotlight

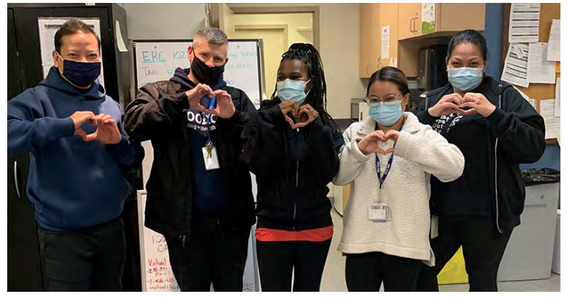
Partnership Accord

Fraser Health's commitment to creating culturally safe and equitable health care environments for Indigenous people is grounded in formal agreements that articulate shared values, responsibilities and mechanisms for accountability. The Partnership Accord, originally signed in 2011 and renewed in 2024, now includes Métis Nation British Columbia (MNBC) alongside the Fraser Salish Regional Caucus and the First Nations Health Authority (FNHA). This Accord serves as a living framework for shared decision-making, resource allocation and service delivery, reflecting a collective commitment to reconciliation, health equity and the implementation of the United Nations Declaration on the Rights of Indigenous people (UNDRIP). Together, these agreements have helped formalize and strengthen partnerships, ensuring that Indigenous voices are central in shaping health services and systems transformation.

South Asian populations

The Fraser Health region is home to approximately 75 per cent of people of South Asian descent living in B.C., with high concentrations living in Surrey (37.8 per cent of residents), Abbotsford (30.2 per cent of residents) and Delta (26.1 per cent of residents).(63) An earlier Fraser Health Chief Medical Health Officer (CMHO) Report (2019) explored toxic drug poisoning deaths in people of South Asian descent through medical chart reviews of decedents and coroners data.(64) Based on these estimates, people of South Asian descent were found to be more likely to die from a toxic drug poisoning (rate of 159.5 fatal toxic drug poisonings per 1,000 toxic drug poisonings) compared to people who are not of South Asian descent (84.9 fatal toxic drug poisonings per 1,000 toxic drug poisonings).(64)

Overall, the impact of the toxic drug crisis on people of South Asian descent is under-researched.(65) Cultural factors like collectivism, which emphasizes group harmony and family expectations, heightened stigma, and the 'model minority' stereotype, which pressures individuals to appear high-achieving and self-reliant, may influence risk behaviour, help-seeking and attitudes towards substance use.(65) For some, psychosocial stress associated with acculturation may lead to unregulated drug use as a coping mechanism.(65) Additionally, intergenerational trauma stemming from colonialization and genocide continues to shape mental health and substance use within many South Asian communities.(66) Language barriers such as limited Punjabi or Hindi recovery resources and differing substance use terminology can make it harder for clients to access or engage in services delivered primarily in English.(67) Recognizing the existence of diverse perspectives and experiences within the South Asian community is essential for developing targeted interventions that address the unique needs of each South Asian community in the region.



Integrated Homelessness Action Response Team

Those experiencing housing instability or homelessness

People experiencing homelessness face extreme vulnerability. Toxic drug poisoning is the leading cause of death in this population, associated with 86 per cent of all deaths in 2023.(68)

National hospitalization data indicates that people experiencing homelessness are significantly overrepresented in toxic drug poisoning statistics, experience longer inpatient stays and are more likely to leave hospital care against medical advice. This reflects both the severity of their health needs and the systemic barriers they face in accessing appropriate treatment and supports.(69)

Without a safe and stable home, risks of chronic disease, mental illness, substance-related harms and premature death rise sharply, and the longer people remain unhoused, the more severe these harms become.(70) While there is a common belief that substance use causes homelessness, the relationship is bidirectional.(69) While substance use can precipitate housing loss for some, the trauma, instability and exposure to street environments during homelessness can also initiate or intensify substance use as a coping or adaptive response to distress and trauma.(69)

Evidence in focus

Housing First approaches

Housing First approaches treat housing as the starting point for prevention and recovery, recognizing that stability, dignity and a sense of belonging are foundational to wellness. They offer immediate, permanent housing without requiring sobriety or completion of a treatment program, paired with person-centred, wrap-around supports grounded in harm reduction. The approach centers on stabilizing living conditions to promote earlier, more effective engagement with health and social services.(71) Housing First approaches can reduce emergency department visits and hospitalizations without increasing problematic substance use.(71) In B.C., the Housing First philosophy aligns with Belonging in B.C., the provincial plan to make homelessness rare, brief and a one-time occurrence, supported by coordinated health and social supports through the Integrated Support Framework.(72)

Fraser Health's Intensive Case Management (ICM) and Assertive Community Treatment (ACT) teams are examples of Housing First service models that support people to remain stably housed while addressing complex health and social needs. Both teams support clients with complex needs, with ICM serving individuals with significant substance use issues and ACT supporting clients with serious mental illness. Both programs embody Housing First principles by prioritizing immediate access to permanent housing without preconditions, centring client choice and recovery, and providing individualized, voluntary supports to help people maintain housing and improve quality of life.

> "Three years later, [my client] has continued to achieve his goals of remaining free of illicit substances, strengthened his social relationships and reconnected with family. They now live in community and continue to enjoy a very active social life."
>
> **Assertive Community Treatment staff**

Pregnant people and parents

In 2023/2024 in the Fraser Health region 2.7 per cent of pregnant people reported using a substance other than tobacco or alcohol.(73) These numbers are likely an underestimate. Many pregnant people choose not to tell their maternity care provider about their substance use (e.g. alcohol, cannabis, opioids) due to fear of discrimination and being reported to child protection services.(74,75) Stigma and fear of child apprehension may also stop pregnant people from seeking prenatal care, harm reduction supports and substance use services.(75)

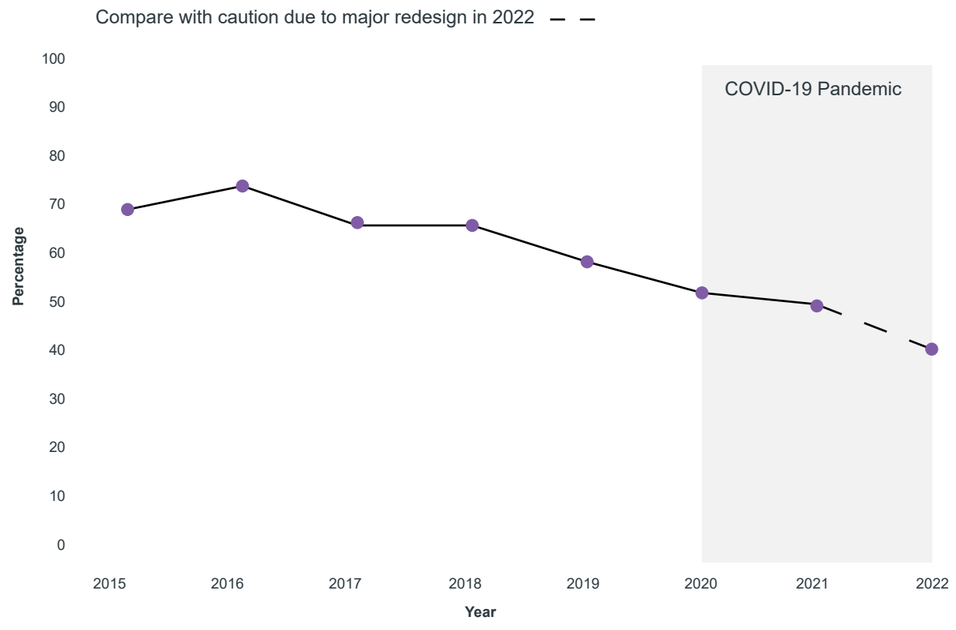
It is important to identify and support pregnant people with a substance use disorder as they can experience serious health problems, with rates of harm and death for birthing parents and newborns nearly twice as high as those seen in the general population.(76) Beyond these immediate health concerns, toxic drug poisonings involving opioids are a leading cause of death for birthing parents in their first year after giving birth.(76)

Youth and young adults

While the number of toxic drug deaths is low among youth, toxic drug poisoning is the leading cause of unnatural death among young people under the age of 19.(77) As described in part 2 of this report, development of problematic substance use is heavily influenced by social and structural determinants of health. A national chart review of young adults aged 18 to 24 who died of toxic drug poisoning found they were disproportionately unemployed, unhoused or unstably housed.(78) Youth receiving services from the Ministry of Children and Family Development are also at increased risk.(77) Stigma also increases risk of toxic drug poisoning, reducing the willingness of youth to seek help and engage in open dialogue about substance use.(79,80)

A significant individual risk factor for problematic substance use is the presence of mental health issues. Since 2018, the self-reported mental health of youth aged 12 to 25 in British Columbia and the Fraser Health region has declined (Figure 11), with youth reporting more stress, less sleep, declining hope and lower community/school connectedness.(81)

Figure 11: Percentage of B.C. population 12-25 who report their mental health is "very good" or "excellent", 2015-2022



Source: Canadian Community Health Survey, 2015-2022

Another concerning trend is that between 2018 and 2023, youth aged 12 to 19 years old who used alcohol, cannabis and tobacco tended to start at younger age, despite an overall decline in youth use rates over the same time period.(81)

2SLGBTQIA+

Routine toxic drug poisoning data in B.C. does not capture information on sexual orientation or gender identity, making it impossible to measure toxic drug poisoning deaths among 2SLGBTQIA + people. However, a growing body of research from B.C. and Canada shows that 2SLGBTQIA+ communities face higher exposure to substance-related harms and greater risk factors for toxic drug poisoning than cisgender, heterosexual populations.(82–84) These inequities are shaped by intersecting factors such as stigma, discrimination, social exclusion and difficulties accessing gender-affirming health care.(85,86)

In response to this research, 2SLGBTQIA+ specific substance use and harm reduction initiatives are emerging, with a particular emphasis on peer-led, culturally safe and gender affirming approaches. These approaches are reflected in the BC Centre for Disease Control's Harm Reduction Manual which identifies 2SLGBTQIA+ people as an equity-deserving population and underscores the importance of inclusive, stigma free and gender affirming service delivery.(87)

Grief and loss

The toxic drug poisoning emergency in the Fraser Health region has profoundly affected individuals, families, communities and the systems that support them. Alongside deep and often repeated loss, the crisis has also revealed significant resilience, compassion and advocacy. Many people and communities have mobilized to support one another, share knowledge and push for change despite stigma, inequities and the ongoing pressures of the emergency. Understanding both the challenges and the strengths within these networks is essential for recognizing the experiences of those most affected and identifying the supports they need.

Children and youth who have lost parents

Children and youth who lose a parent, sibling or caregiver to toxic drug poisoning experience a sudden and often unrecognized form of grief.(88) This type of loss is an example of an Adverse Childhood Experience (ACE) which can have long-term impacts on physical, emotional and social wellbeing as described above in the risk and protective factor section. However, these harms can be significantly mitigated when children and youth have access to trauma informed counselling, consistent and caring adult relationships and culturally grounded supports that help build resilience and restore a sense of safety and belonging. While Canadian data is limited, recent American estimates show that over 320,000 children lost parents to toxic drug poisonings between 2011 and 2021, highlighting the importance of this issue and underscoring the need for better local data and targeted support.(89)

People who use substances

For people who use substances, the deaths of peers and community members are frequent and deeply destabilizing.(90–92) Many navigate grief while also managing their own health, treatment goals or survival needs. This repeated exposure to loss can erode hope, heighten isolation and sometimes lead to re-engagement with substance use.(90–92) Peer-led grief supports, culturally safe counselling and accessible visible spaces to honour those who have died are critical components of care that acknowledges both loss and community strength.(90–92)

Family, friends and loved ones

For many families, partners and friends, the impact of this crisis is both deeply personal and shaped by social stigma.(93–96) Peoples' grief is often complicated by judgment related to substance use, which can silence open mourning and leave people feeling isolated.(93–96) Loved ones frequently describe their loss as intertwined with a sense of injustice, knowing that timely access to safer supply, treatment and harm reduction services might have prevented a death.(93–96) Support groups such as Moms Stop the Harm and Parents Forever provide vital spaces where people can share their stories, find validation and advocate for change.(93–96)

Indigenous communities and compounded grief

For Indigenous communities, grief from the toxic drug crisis cannot be separated from the ongoing impacts of the harms caused by colonialism, creating a profound burden that threatens cultural continuity, community wellbeing and family systems. For this reason, Indigenous-led healing approaches rooted in ceremony, land-based practices, language and self-determination are essential for immediate and long-term recovery from grief.(97,98)

Service providers

Health care workers, emergency responders and community service providers are also significantly affected by the crisis both personally and professionally as they navigate repeated exposure to trauma and loss among clients, community members and colleagues.(99,100) This sustained exposure to trauma can lead to distress fatigue, burnout, moral distress and cumulative trauma especially when systemic barriers limit their ability to provide the care they know is needed.(99,100) Organizational supports such as Trauma and Resiliency Informed Practice training, regular debriefing, culturally safe mental health services, access to cultural supports such as Elders and ceremony and peer networks are crucial for sustaining the workforce and supporting high quality, compassionate care.(99,100)

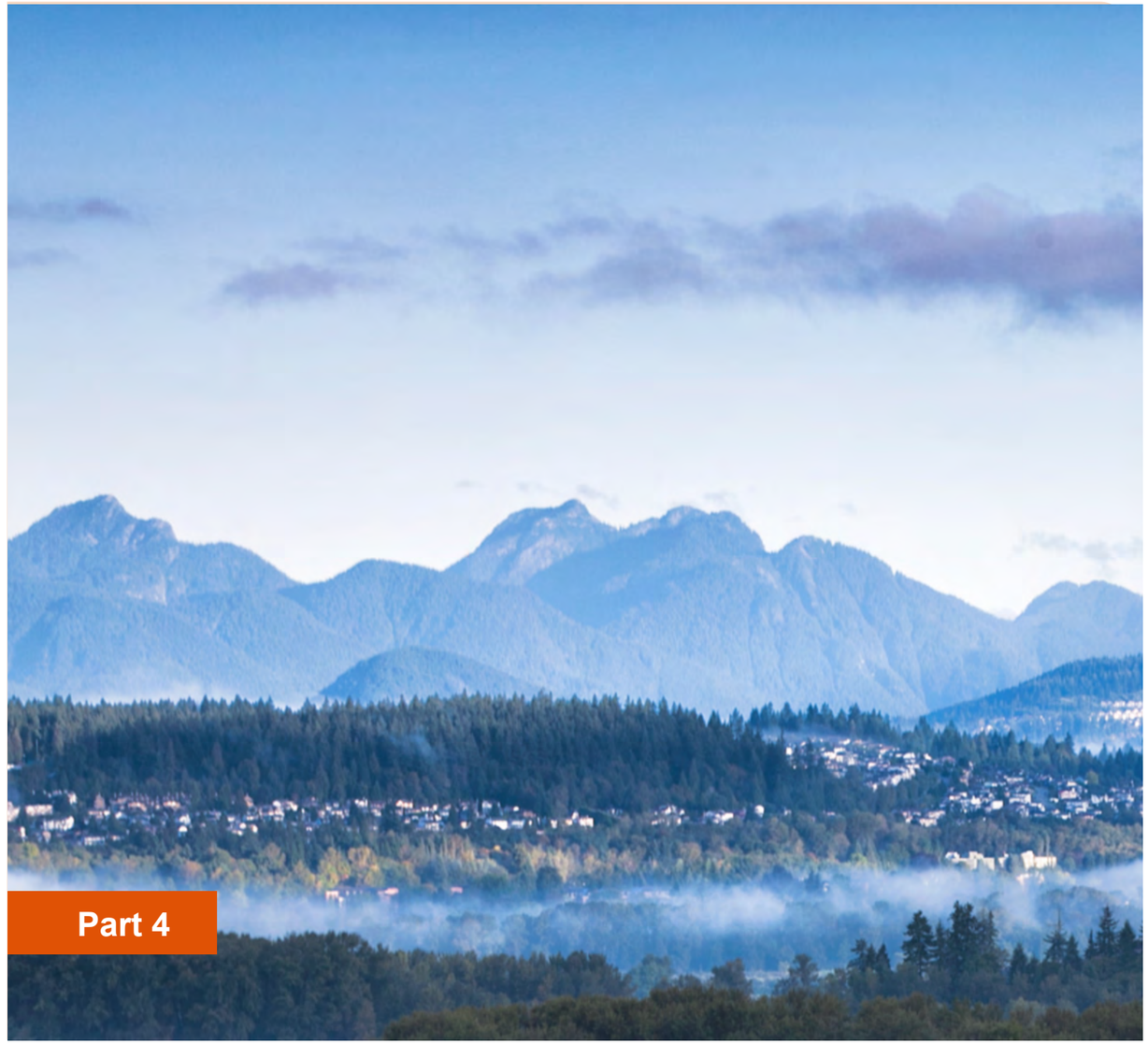
Spotlight

International Overdose Awareness Day

Every year on August 31, global communities come together to recognize International Overdose Awareness Day (IOAD). This campaign is the world's largest annual movement to end toxic drug deaths, remember those we have lost, acknowledge the grief of the family and friends left behind and renew the commitment to end toxic drug deaths and related harms across the world.

Throughout the Fraser Health region, communities come together to mark International Overdose Awareness Day through a variety of meaningful events on and around August 31. Fraser Health participates in and supports events including the "Purple Chair Campaign" which symbolizes the seat at the table that lost loved ones would have occupied and provides a place to reflect and remember.

More information on International Overdose Awareness Day including a listing of events can be found here: overdoseday.com



Part 4

Fraser Health's evolving toxic drug response

2016

- Take Home Naloxone distributed by all Fraser Health Emergency Departments
- The first Overdose Prevention Sites open

2017

- Take Home Naloxone distribution expands to community pharmacies
- Friendship Centres trained to distribute Take Home Naloxone kits, reaching urban Indigenous and Métis populations
- First Rapid Access to Addictions Care (RAAC) clinic opens
- First Supervised Consumption Site opens
- Formalized process for email distribution of community drug alerts begins

2018

- Opioid Stewardship Program established
- Two new Opioid Agonist Treatment (OAT) clinics opened
- Injectable Opioid Agonist Treatment (iOAT) clinic begins service
- Drug checking with Fentanyl Test Strips and Fourier transform infrared spectroscopy (FTIR) begins
- Substance Use Services Access Team (SUSAT) launches
- Chief Medical Health Officer Report released

2019

- 1 new Opioid Agonist Treatment clinic opens
- Community Action Teams launched in Fraser Health communities
- Chief Medical Health Officer Report released

2020

- Virtual Health Addictions Clinic begins service
- New Rapid Access to Addictions Care (RAAC) opens
- Lifeguard App launches
- Addiction Assessment Nurse program initiated at 2 sites

2021

- New Rapid Access to Addictions Care (RAAC) opens

2022

- Overdose Outreach Team launches
- Real-time toxic drug alert system launches

2023

- 2 new Opioid Agonist Treatment (OAT) clinics open
- Implementation of Substance Use Services Access Team Aftercare program
- Peer Support Worker pilot at Chilliwack General Hospital starts
- Episodic Overdose Prevention Service (eOPS) launches at Surrey Memorial Hospital
- Harm reduction online launches

2024

- Addiction Assessment Nurse program launched at additional sites
- Substance Use Clinicians in all Fraser Health Mental Health Centres to address concurrent concerns
- Virtual Health Addictions Clinic expands
- Access Central launches

2025

- Abbotsford and Hope Junctions (Recovery Community Centres) open
- Day Evening Weekend program expands to include 2SLGBTQIA+ and Indigenous specific options
- Creekside Withdrawal Management expands

This timeline outlines key service milestones of the toxic drug response in Fraser Health, many of which were accomplished and delivered in partnership with community providers and guided by direction from the Ministry of Health.

Theme 1

Expanding person-centred and flexible supports

With support from communities and the Ministry of Health we have significantly expanded the number and variety of services offered. This means individuals can choose care that aligns with their goals whether that is abstinence, safer substance use or improving overall health and wellbeing. While this report highlights successes, we also recognize ongoing challenges in addressing toxic drug poisoning risks across the broad spectrum of substance use from occasional use through to substance use disorders. There are also challenges in addressing the diverse risk and protective factors that shape substance use patterns and related toxic drug death prevention needs.

Prevention of toxic drug deaths and events

The impact of the toxic drug emergency is often measured in terms of drug poisoning deaths. Health services have shown to decrease risk of toxic drug poisoning events and deaths include Opioid Agonist Treatment (OAT), harm reduction services (e.g. Take Home Naloxone, observed consumption and drug checking). Over the last 10 years, these low-barrier entry points into substance use services have been significantly expanded.

Naloxone kits and toxic drug poisoning response education

In Fraser Health we have grown from 26 (2016) to 667 (2026) Take Home Naloxone (THN) sites, a part of the program administered by the B.C. Centre for Disease Control (BCCDC) and launched in 2012. Kits containing injectable naloxone, a life-saving medication that reverses opioid overdoses, are provided at no cost to community members at risk of experiencing or witnessing a toxic drug poisoning.

Nasal naloxone is now being introduced. Education on how to recognize and respond to a toxic drug poisoning is also provided.

Observed consumption services

We have grown from zero (2016) to 13 (2026) observed consumption service sites that include Supervised Consumption Sites (SCS) and Overdose Prevention Sites (OPS). These provide safe environments for substance use, reducing risk of toxic drug deaths and connecting individuals to health and social services. In addition to observing consumption of substances, these locations provide access to harm reduction supplies, referrals to health care and social services and low-barrier health care support. Staff play a vital role in building trusting relationships with clients through consistent, non-judgmental support. These relationships often serve as a bridge to the broader substance use system of care, with staff offering referrals to additional services such as treatment, counselling or housing supports when clients express interest. Inhalation services have been added to these sites as consumption patterns have changed over the last decade.

Spotlight

"Little Doug" Nickerson

Known across Surrey's 135A Street as "Little Doug," Doug Nickerson was a quiet, steady presence whose compassion reshaped an entire community. Having survived multiple toxic drug poisonings himself, he carried a naloxone kit everywhere he went, usually on his bicycle, determined to ensure others had the same chance he'd been given. Over the years, he reversed close to 150 toxic drug events, racing toward anyone in distress and staying until he knew they were safe.

For his tireless efforts, the City of Surrey honoured him with the Heart of the City Award in 2018, recognizing how his everyday acts of care had saved lives and built trust.

Although Doug Nickerson passed away in 2017, his legacy of courage, compassion and community-led harm reduction continues to highlight the vital role of Take Home Naloxone in the ongoing toxic drug poisoning crisis.

"That's what it's all about, is preventing death."

Doug Nickerson

Evidence in focus

Lives saved by interventions

Even though toxic drug poisoning deaths remain high, this does not mean services are ineffective. In fact, implementation of Opioid Agonist Treatment (OAT), Take Home Naloxone (THN) and supervised consumption/overdose prevention sites (SCS/OPS) have saved thousands of lives in the Fraser Health region. Using statistical modeling, it is estimated that between January 2019 and October 2025, roughly 13,700 death events were prevented, compared to the 4,158 deaths that occurred.(101) Of these interventions, Take Home Naloxone (THN) is estimated to have prevented about 11,160 deaths, Opioid Agonist Treatment (OAT) has prevented about 6,260 deaths and Supervised Consumption/Overdose Prevention Sites (SCS/OPS) have prevented about 600 deaths by responding to toxic drug events on site.(101) More information on the methodology used can be found in these peer reviewed journal articles.(101,102)

"I really want to go back to work. I used to be a chef and now want to go back to culinary school. It seemed so overwhelming, but now with being connected to this clinic, I have hope… they even helped me get an appointment with Vancouver Community College to check out their program."

Virtual Health Addiction Clinic client, September 2020

"It's the only place that I feel understood and heard with no judgment, no shame and no stigma. That is the main reason it worked for me. Now, I have proper information and medication to improve my health and I am back at school and even signing a lease this week for my own place to live."

Virtual Health Addiction Clinic client, March 2022

Opioid Agonist Treatment

We have grown from 1 (2016) to 15 (2026) Opioid Agonist Treatment (OAT) or injectable Opioid Agonist Treatment (iOAT) service sites. At these sites people who have been diagnosed with an opioid use disorder receive treatment using medications that stabilize their substance use disorder and includes specialized services for people who are pregnant.

Fraser Health's Opioid Agonist Treatment services provide longitudinal, comprehensive care and facilitate connections to other health care services and community supports (e.g. primary care, harm reduction, cultural supports, counselling). Opioid Agonist Treatment is strongly associated with positive outcomes, including reduced toxic drug deaths, decreased unregulated opioid use and improved engagement in treatment and other supports.(22)

Bed-based substance use treatment

Bed-based treatment for substance use disorder is one part of a broad continuum of treatment options that includes outpatient programs, community-based supports and harm reduction strategies. For some, this level of care aligns with their defined wellness journey. Intensive Residential Treatment services (IRT) offer an intensive program experience within a bed-based setting, supported by qualified and trained health care providers. Stabilization and Transitional Living Residences offer programs for individuals post-withdrawal management that vary in length depending upon client needs. These residences do not provide intensive long-term care services and supports but provide support and safety through peer counselling, group work and structured activities. Short-term Transitional Access to Recovery programs

offer a safe, structured short stay for individuals who lack safe housing to help improve access to and engagement with health care and support services following a withdrawal management program.

Recovery supports

Fraser Health's Aftercare Team is the first regional program of its kind, providing longitudinal, recovery-focused support for individuals transitioning out of substance use treatment. The program strengthens continuity of care by offering ongoing clinical followup, proactive relapse prevention supports and tailored connections to community-based resources. In addition, Junction Recovery Centres opened in Abbotsford and Hope in September 2025. These recovery-oriented hubs provide spaces where people seeking or maintaining wellness from substance use can build connection, resilience and practical skills. Through peer support, cultural guidance, recreational activities and wellness groups, the centre offers a welcoming, low barrier environment that strengthens social networks and supports recovery goals. Services range from drop-in community gatherings and mutual support groups to one-on-one navigation, advocacy, peer support and vocational or referral support.

Enhancing access through flexible service options

Fraser Health has intentionally diversified access points to substance use services to meet people where they are, through virtual platforms, walk-in services, telephone and outreach. This approach recognizes that individuals engage with services in different ways depending on their needs, preferences and circumstances and helps ensure that support is available when and how people need it.

Harm reduction online

Harm Reduction Online is a low-barrier digital access point that connects people to substance use information, service directories and free, confidential mail-based delivery of safer sex supplies, naloxone and fentanyl test strips. In a survey of clients, 30 per cent who responded said they would not have been able to acquire harm reduction supplies elsewhere. This aligns with evaluations of established mail order programs in the United States which demonstrate that confidential, mail-delivered harm reduction supplies effectively reach individuals who might not engage with in-person services.(103–108)

While not currently available from Fraser Health, evidence from similar initiatives shows that confidential delivery of sterile substance use supplies can mitigate a wide range of substance use-related risks including blood-borne infections and toxic drug poisonings, particularly for people who use substances alone, have concerns about being seen by others and judged negatively or live in rural or under-resourced regions.(103–108)

> "I found the marketplace very helpful to share with my patients as it often aided with my harm reduction discussions… [many] patients don't necessarily know where and how to access supplies and they also don't feel comfortable doing so in person, so the marketplace was something that they showed a lot of interest in accessing."
>
> **Rapid Access to Addictions Care clinic Physician**

Phone-based and virtual services

Phone-based and virtual access to care expands the reach of substance use services, enabling clients who might otherwise struggle to engage consistently to remain involved in their recovery. For example, the Integrated Homelessness Action Response Team (IHART) has an established partnership with the Virtual Health Addictions Clinic (VHAC) to bring addiction medicine supports to clients living in encampments or shelters that avoids them having to go to a clinic. Positive feedback has included that VHAC has been able to accommodate on-demand appointments for clients that otherwise might not be able to start on Opioid Agonist Treatment (OAT) due to intermittent contact with the IHART team.

The Fraser Health Access Line: Mental Health and Substance Use (Home of Access Central for Substance Use Services) offers support to help people get connected to the mental health and/or substance use service that best fits their needs.

> "There is no longer a room full of people waiting for one doctor and experiencing long waits. I never have to worry if I will run into someone that I am trying to avoid because they have hurt me in the past. The virtual service is safer for me and I get more quality time with my doctor. I am finding I listen more and follow through more now as well."
>
> **Virtual Health Addictions Clinic client**

Flexible outpatient services

Group therapy options are offered during the day, evenings and weekends so that people can access care at times that work for their lives and responsibilities. Specific supports have recently been developed for Indigenous people and people who identify as LGBT2Q+ that are foundational to a responsive, inclusive and effective substance use treatment system. The expansion of virtual offerings further enhances accessibility of these services.

Walk-in services

Rapid Access to Addiction Care (RAAC) clinics offer low-barrier, same-day walk-in support without referral at six locations in our region. Services include assessment, initial stabilization and transition to community-based clinics and services.

Fraser Health Opioid Agonist Treatment (OAT) services welcome walk-in clients for both initiation and stabilization of Opioid Agonist Treatment (OAT) as needed.

Overdose Prevention Sites, harm reduction distribution sites and Take Home Naloxone (THN) distribution sites operate exclusively on a walk-in basis, ensuring that individuals can receive critical supports without delay or referral.

Strengthening integration

Recognizing that substance use intersects with many areas of health care, Fraser Health has embedded specialized supports within Emergency Departments, hospitals, mental health centres and other clinical settings. These integrated approaches ensure that individuals with substance use concerns can access timely, compassionate and coordinated care regardless of where they first enter the system.

Perinatal supports

The Enhanced Family Visiting program strengthens integration across perinatal, primary care and substance use services by engaging clients during a pivotal period, before and after the birth of a baby. By maintaining consistent, relationship-based contact, the program provides non-judgmental information, fosters trust and strengthens connections for people throughout different parts of the health care system.

Hospital-based supports

Addiction Medicine Consult Teams (ACMT) and Addiction Assessment Nurses (AANs) play a key role in Emergency Departments. They provide quick substance use assessments, education, crisis support and coordinated discharge planning. By connecting patients with addiction medicine, hospital services and community resources, they help people move smoothly into ongoing care.

The Substance Use Services Access Team (SUSAT) receives referrals from Emergency Departments and provides information, harm reduction education, referrals, brief interventions and supports to clients transitioning between services. The team provides in-reach into hospitals as well as bringing services to clients in the community. Their crucial work involves ensuring that individuals who visit Emergency Departments due to risk of toxic drug poisoning or substance use concerns receive coordinated follow-up care within their communities.

> "I don't know if I would have the courage to tell [my wife] about my overdoses without [SUSAT] being there as well. We are working it out and she has a kit in case it happens at home. That was a huge relief and even though I still feel guilty and ashamed, I don't feel so alone. I guess they came along at a good time. I am on OAT now but still in a lot of pain from this injury a few years ago. I am worried about my work finding out and my counsellor is helping me stay on course to see this through."
>
> **Substance Use Services Access Team (SUSAT) client**

Kim Wood, peer support worker

Mental health services

Concurrent disorders, where individuals experience both mental health and substance use challenges, are increasingly recognized as a significant concern across all age groups, yet individuals often face fragmented services that delay timely support. Substance use clinicians are now embedded in all mental health centres, while the Youth Concurrent Disorders Program, developed with the Ministry for Children and Family Development and later joined by the First Nations Health Authority, provides a wide range of supports including consultation, assessment, treatment planning, therapy, navigation and education. The Short-Term Assessment, Response and Treatment Team (START), which provides timely support to youth under 19 with significant mental health and/or substance use concerns, became concurrent capable (able to support clients with both mental health and substance use concerns) in 2020.

Improving safety through innovation

Many of the clinical services above were newly created or delivered in innovative ways to adapt to the toxic drug poisoning crisis. They provide timely information and help individuals navigate substance use safely and with the information they need to make choices that enhance their wellbeing.

Remote witnessing options

These resources offer virtual, discreet options that promote safety, autonomy and rapid access to help during a toxic drug poisoning.(109,110)

The Lifeguard App is a free virtual witnessing service that helps prevent toxic drug poisoning deaths among people who use substances alone.

Practice highlight

Fraser Health's opioid stewardship program

Fraser Health's Opioid Stewardship Program was Canada's first regional opioid stewardship initiative. Led by clinical pharmacy specialists, the opioid stewardship program prioritizes prevention through safer prescribing, optimized pain management and clinician education.

Since its establishment in 2018, the Fraser Health Pain and Opioid Stewardship on-line App has become a nationally recognized resource, accessed by thousands of clinicians for evidence-based prescribing guidance. The team has supported over 5,000 patients at Fraser Health hospitals, reducing unnecessary opioid use and promoting non-opioid alternatives

This model continues to bridge clinical practice, education and policy. Future priorities include expanding digital tools, leveraging health data for system-wide monitoring and driving innovation to strengthen Fraser Health's preventive response to the toxic drug crisis.

The app is activated before drug use and triggers an escalating alarm if the person becomes unresponsive. If the alarm is not shut off, it automatically initiates a call to 9-1-1 with the person's location.

Recent updates provide extended alarm times, step-by-step CPR guidance and direct links to health and crisis supports. Versions have also been developed specifically for Métis communities and for people working in the trades and the app has been translated into French and Punjabi.

Alternatively, individuals can access the National Overdose Response Service (NORS). This multimodal harm reduction service is available throughout Canada and provides virtual witnessing services through text and phone where trained peers provide virtual supervision and emergency support for people using substances alone.(109,110)

Drug checking

Drug checking helps community members check their drugs for fentanyl and other contaminants. Fraser Health offers two different ways to check drugs—fentanyl test strips and Fourier transform infrared (FTIR) spectrometers.

By providing objective, timely information that helps people make better-informed decisions, drug checking services also generate valuable data for public health about emerging trends, contaminants and adulterants in the local drug supply. These insights inform clinical responses to new substances such as medetomidine and enable timely community alerts when concerning changes are detected.

Real-time drug alerts

The real-time drug alert system is designed to quickly inform the public and service providers about toxic substances circulating in the region. Alerts are issued through multiple channels including email notifications and a text-based alert system managed in partnership with the BC Centre for Disease Control. Anyone can subscribe by texting JOIN to 253787 and alerts are anonymous and free of charge.

By sharing real-time data and observations from community, local law enforcement and many community organizations help inform the alert system, enabling Fraser Health to issue warnings that are localized, evidence-based and timely. This collaborative model not only enhances safety but also builds trust with people who use substances, ensuring that alerts are grounded in lived experience and community knowledge.

Jana Baller, drug checking lead

Theme 2

Designing responsive and equitable services

Fraser Health's response to the toxic drug crisis is guided by a strong focus on equity. This involves looking closely at who is not accessing services, listening to community feedback and identifying and partnering with groups most affected by the crisis. This understanding directly shapes how services are developed and expanded to better meet community needs. Fraser Health works to ensure services are not only available but designed to reduce stigma, acknowledge historical and ongoing inequities and reflect the lived realities of those most impacted.

Indigenous supports

As shown above, the toxic drug crisis disproportionately impacts Indigenous people as a direct result of the harms caused by colonialism. To improve culturally safe care, Indigenous-specific clinicians and peer support workers have been added to multiple services within Fraser Health's addiction medicine and substance use continuum, informed by insights shared from Indigenous partners. These roles provide culturally-informed support to clients as they transition through various stages of care.

Spotlight

Culture as healing

Embedding Indigenous worldviews, practices and values into health care spaces strengthens trust, supports culturally safe access to services and advances Fraser Health's commitment to reconciliation, equity and the delivery of care that meets the needs of a highly impacted population. The creation of welcoming, culturally grounded spaces supports healing for Indigenous people by ensuring Indigenous voices are meaningfully integrated into facilities design, redevelopment and service planning, creating environments where Indigenous clients and families feel safe, welcomed and respected. This approach recognizes that culture itself is healing.

Fraser Health's Restoring Balance initiative offers a wholistic, culture-based response to substance use and mental health challenges, placing Indigenous voices, practices and healing at the centre of care. Indigenous community members engage, through weekly healing circles, in ceremony, storytelling, wellness planning, drum and rattle making and teachings led by Elders. These circles are grounded in trauma-informed, wrap-around care, with staff from Fraser Health's Indigenous Health and Mental Health and Substance Use programs, First Nations Health Authority (FNHA) and Métis Nation B.C. (MNBC) walking alongside participants on their healing journeys. The program has supported individuals in achieving abstinence, securing stable housing, reconnecting with family and reclaiming cultural identity and belonging.

The Rapid Access to Addiction Care (RAAC) Indigenous Outreach Team provides comprehensive, culturally safe services to Indigenous people throughout the Fraser East region. A mobile health van also supports referrals and episodic Overdose Prevention Services throughout Indigenous communities in the East. There are also bed-based programs for Indigenous people including A:yelexw Women's Home and A:yelexw Men's Home in partnership with the Seabird Island Band.

South Asian supports

As noted above, people of South Asian descent have an elevated risk of dying from a toxic drug poisoning. The South Asian Health Institute (SAHI) has been pivotal in Fraser Health's response to the toxic drug crisis by delivering culturally and linguistically-tailored campaigns and resources in Punjabi, Hindi and Urdu. Through community engagement, SAHI works to reduce stigma and foster open conversations about substance use, strengthening community resilience and improving access to life-saving resources.

Launched in 2017 as the first of its kind in British Columbia, the Surrey-based Roshni Clinic serves people from South Asian communities who are struggling with the challenges associated with substance use. Culturally responsive service delivery has been further strengthened by adding South Asian-specific clinicians at both the Substance Use Services Access Team (SUSAT) South (Surrey) and East (Abbotsford) hubs. Providing substance use services in Punjabi and Hindi reduces language-related barriers, ensuring clients remain meaningfully engaged throughout their care.

Family and youth supports

Fraser Health works with families, schools and other community partners to support the healthy development of children and youth. Our approach spans universal prevention, early intervention, rapid response and specialized treatment so that young people receive the level of support that matches their needs.

Children who experience multiple adverse childhood experiences have a higher chance of developing health issues including substance use disorder. In contrast, positive childhood experiences and relationships increase children's ability to cope with these challenges. The more positive experiences a child has, the more likely they are to experience good health throughout their life. Preventing adverse childhood experiences and increasing positive childhood experiences can reduce the risk of future toxic drug poisonings by decreasing the risk of substance use disorder. To promote positive childhood experiences, Fraser Health is working with partners to build connected and inclusive communities, provide opportunities for social emotional development, promote reproductive health and rights and offer culturally responsive care and supports.

Fraser Health's Enhanced Family Visiting Program focuses on strengthening self-efficacy for clients and building their own capacity to maintain or improve their health and wellbeing. This includes skill-building and connection to resources but ultimately seeks to make a long-term difference by increasing clients' capacity to meet their own needs and build their circle of support to thrive even when they are not in direct contact with a public health nurse. Family home visiting is an effective, evidence-based strategyfor improving outcomes for children through parental support and early intervention.(111)

Public health nurses work with school districts to enhance physical, mental, social and emotional wellbeing through a comprehensive school health approach. In addition, child and youth substance use prevention and health promotion program facilitators provide presentations, group work, mentoring and recreational engagement for youth in both schools and community settings. Fraser Health further supports school districts by offering guidance on naloxone and Automated External Defibrillators as they work to ensure these life saving tools are accessible in all schools.

More individualized support is available for youth aged 10 to 19 who may benefit from building resiliency and strengthening their decision making around wellness, particularly in relation to substance use. Through school and community-based services, trained facilitators work with students to prevent or delay substance use, reduce related harms and promote healthy lifestyles. The program offers awareness presentations, group sessions, individual mentoring and recreational activities designed to foster supportive environments, encourage positive choices and build self esteem. By creating trusting relationships and engaging youth in open, respectful dialogue, the program aims to enhance their skills and resiliency and increase their knowledge of the health and social impacts of substance use.

When mental health and/or substance use concerns begin to emerge, Fraser Health's Integrated Child and Youth teams provide early intervention and wrap-around support in partnership with school districts, Child and Youth Mental Health, and FamilySmart. Services are for children and youth aged 0 to 19 and are offered in schools, homes, First Nations-operated schools, alternative programs and community environments. Referrals come from schools, Foundry centres, primary care, early years programs, Indigenous-led organizations and other partners and self-referral is available when capacity allows. In addition, at Foundry centres, multiple service providers and organizations work together to provide a variety of services to youth ages 12-24 and their families, including mental health and substance use supports.

For youth experiencing significant and rapid changes in functioning related to mental health or substance use, Short-Term Assessment, Response and Treatment (START) teams offer urgent support. Services include crisis response, safety planning, brief interventions, psychiatric consultation, caregiver education and outreach for families facing barriers to attending in-person appointments.

The Youth Concurrent Disorders (YCD) program provides therapeutic outreach services to young people aged 13 to 24, as well as their families, who are experiencing co-occurring substance use and mental health challenges. YCD clinicians deliver specialized assessment, individual and group counselling, co-therapy, psychiatric consultation and coordinated system navigation supports. The program gives priority to youth presenting with severe or cyclical patterns of substance use, persistent difficulty engaging with services, destabilization associated with reduced substance use or a history of toxic drug events.

Clinical Insight

How to talk to your kids about drugs

Parents often report feeling a lot of pressure to 'get it right,' which can turn conversations into lectures. Conversations with youth about substance use are most effective when they reflect what young people say they need: honesty, understanding and space to explore their own experiences.(112)

Young people want adults to move beyond fear-based messages and focus instead on why youth use substances, the full spectrum of impacts on their lives and how to support healthier decisions.(112) Approaching these discussions with openness, evidence-based information and a recognition of youths' lived realities helps build trust, making it more likely that they'll turn to you when they have questions or need support.(112)

7 tips for talking to your kids about drugs

1. Avoid blaming, shaming, and lecturing
2. Speak with care and concern, not suspicion and blame
3. Acknowledge their autonomy
4. Invite them to share their experience
5. Share your concerns in concrete and non-blaming terms
6. Commit to understanding their perspectives and supporting their wellbeing
7. Explore what would or would not be welcome now

People working in the trades and transport industries

Fraser Health laid important groundwork by convening industry roundtables to build collaborative relationships with key partners in the building trades, including construction industry leaders, trade associations, unions, employers, health and safety programs, first responders and the Construction Industry Rehabilitation Plan. These partnerships helped inform education and outreach strategies aimed at supporting construction workers who may be at risk of toxic drug poisoning.

Fraser Health also conducted a province-wide review of Return to Work practices, identified as both a critical component of long term recovery and a period of heightened toxic drug poisoning risk. The resulting report highlighted promising practices to better support individuals with mental health and/or substance use concerns as they reintegrate into the workplace.

These efforts strengthened relationships across the construction sector and created a shared foundation for addressing toxic drug poisoning risks among trades workers. The work has since transitioned to WorkSafeBC and other provincial partners, such as the BC Construction Association, as part of broader provincial strategies to enhance engagement with people working in the trades. Local outreach and engagement with this population continues through several of our Community Action Teams.

Theme 3

Respecting and centering lived and living experience

Throughout the health care system, meaningful involvement of patients and communities in service and support design is a core quality and equity strategy that makes services more relevant, trusted and effective.(113,114) With substance use services specifically, this approach is not just beneficial, it is necessary to counter the long history of inequity, stigma and discrimination that has sidelined the voices of people with substance use disorder and limited their influence on decisions about their own health and care.(115,116) Peer reviewed studies show that when people with lived and living experience co-create harm reduction and hospital-based services, trust improves, stigma decreases and access and uptake of care increase.

"I was able to get into [shelter], the [PSW] helped me get into a shelter as I had nowhere to go. She helped me with breakfast and coffee and a way there. I am really thankful."

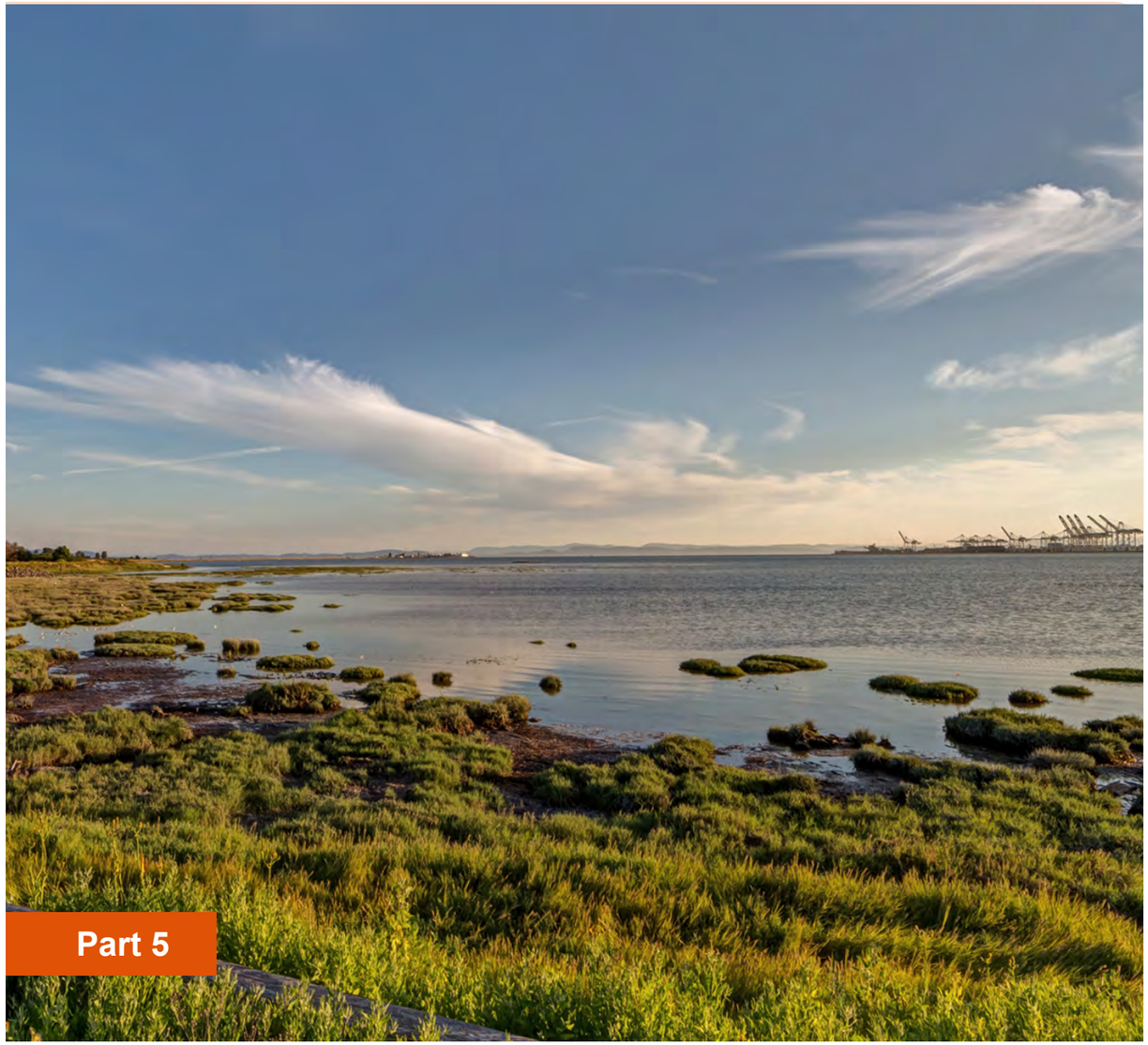
Peer support worker client

"The PSW pilot program has been an amazing addition to the Chilliwack Emergency Department. Their knowledge is invaluable and the ability to build connections has drastically improved the overall emotional well-being of the people we assist."

Chilliwack General Hospital staff member

Peer Support Workers (PSWs), individuals who have personally navigated substance use, recovery or harm reduction, play a unique role by offering emotional, social and practical support grounded in shared experience.(115–117) Inclusion of peer support worker roles in harm reduction and substance use services is associated with better engagement and retention of clients in these services by reducing stigma, building trust and creating safer points of connection for individuals accessing care.(115–117) Specifically, peer involvement has been linked to decreased substance related harms—including toxic drug poisoning—and reduced hospitalizations, as well as improvements in quality of life, stability and social functioning for people who use substances.(116,117) Peer workers also play a critical bridging role between clinical care and community-based supports by providing advocacy, navigation assistance and culturally relevant engagement.(115–117)

Fraser Health has significantly expanded Peer Support Work initiatives throughout substance use service programs to ensure services are culturally safe, contextually relevant and responsive to those most affected by the toxic drug crisis, including Indigenous people, people working in the trades and members of the South Asian community. Given the evidence supporting retention and recovery outcomes, targeting peers towards populations that are disproportionately impacted by the toxic drug public health emergency is key. Sustaining these emerging peer support initiatives will benefit from ongoing attention to the refinement and formalization of peer roles, guided by people with lived and living experience.(118)



Part 5

Learnings and opportunities

The preceding sections of this report document the scale, complexity and persistence of this crisis throughout the Fraser Health region, drawing on surveillance data, emerging evidence, program experience and the lived realities of clients, families, communities and staff. Together, they demonstrate that while important progress has been made, the conditions driving toxic drug deaths remain complex, rooted in the toxicity and unpredictability of the unregulated drug supply, the ongoing impacts of colonialism, racism, stigma, poverty and housing instability and the need for access to evidence-based health interventions including harm reduction, treatment and recovery oriented supports, particularly those that are flexible, low barrier, culturally grounded and peer-informed.

Fraser Health is committed to acting on what has been learned over the past decade—from data, emerging evidence and lived experience—and to continuing to strengthen the health system response within its mandate. This includes recognizing where health services have been effective, where gaps remain and where system-level constraints continue to limit impact. It also includes clarifying the boundaries of health system authority and the necessity of shared responsibility. Progress in reducing preventable deaths requires alignment across health, housing, income supports, child and family services, education, justice and municipal systems, supported by coherent policy direction and sustained investment.

The learnings and opportunities that follow are therefore intentionally structured to reflect varying levels of accountability and influence. They identify actions within Fraser Health's direct control, actions requiring collaboration across the broader health system and actions that address upstream drivers beyond the health sector.

Further embed equity and cultural safety, leveraging peer leadership

Learning

Indigenous people, people of South Asian descent and people who are unhoused face disproportionate harms from toxic drug poisoning. Indigenous led and culturally-specific services have been effective in addressing some of these inequities, while peer workers have improved engagement, trust and the relevance of services across a range of Fraser Health programs and settings.

Opportunity

Deeper integration of equity, cultural safety and peer leadership across all aspects of service planning and delivery.

Key opportunities include:

- Expanding Indigenous specific roles across the substance use service continuum.
- Strengthening culturally tailored substance use services.
- Refining models of care for priority populations, including family centred approaches
- Working with drug user groups and networks serving specialized populations such as people who are unhoused to support equity focused engagement.
- Formalizing peer roles in service co design, communications, evaluation and governance.

Scale up flexible, low barrier, person-centred and partnership-oriented care

Learning

Over the past decade, flexible models of care — including rapid access clinics, outreach teams, virtual care and phone-based access — have consistently demonstrated success in engaging people who face stigma, geographic barriers, unpredictable schedules, or episodic readiness for treatment.

Opportunity

Further strengthen these approaches throughout the system by improving accessibility, continuity and responsiveness throughout the substance use service continuum.

Key areas for continued focus include:

- Optimizing accessible hours, geographic reach and care modalities, including technology-enabled options.
- Strengthening transitions across prevention, treatment, harm reduction and recovery supports.
- Prioritizing flexible, same day and walk in options where feasible.

> "Some of the most impactful work in this crisis has come from the partnerships we cultivate across the health care continuum."
>
> **Jennifer Conway-Brown, harm reduction lead**

Strengthen drug checking, real time alerts and peer witnessing

Learning

The toxic, unpredictable drug supply remains the driver of unregulated drug deaths. Drug checking services and real time alerts reduce risk for both regular and occasional substance use. Technology-enabled approaches have reached individuals who use substances alone, live in rural or remote communities or face barriers to in-person services.

Opportunity

Expanding the reach and integration of drug checking and peer-witnessing to reach people who are not accessing in-person services.

Key opportunities include:

- Expanding access throughout communities and service types, with a focus on populations not currently accessing existing locations.
- Increasing uptake of remote witnessing supports (e.g., Lifeguard App, National Overdose Response Service).
- Expanding harm reduction and education services available through online platforms.

Advance workforce capability through Trauma and Resiliency Informed Practice

Learning

Evaluation demonstrates that Trauma and Resiliency Informed Practice (TRIP), developed by Fraser Health for health care providers, consistently improves client experience and engagement. TRIP has also been shown to reduce stigma within care environments and supports staff wellbeing by strengthening trauma aware, compassionate and relational approaches to care.

Opportunity

Further embedding TRIP across the health system can strengthen service quality, workforce resilience and organizational culture. Continued emphasis on TRIP supports more consistent, stigma reducing practice across diverse settings and disciplines.

Key opportunities include:

- Integrating TRIP principles more fully into orientation and onboarding for new staff
- Expanding access to TRIP education and training across services, roles and disciplines.
- Supporting team and organization-level TRIP development to reinforce shared language, practice and leadership alignment.

> "I was going to retire because I was so burned out and now I have found new hope in learning about mindful self-compassion [through Trauma and Resiliency Informed Practice training]."
>
> **Emergency Department nurse**

Advance support for protective factors

Learning

Protective factors such as strong family and caregiver supports and supportive social environments play a critical role in reducing vulnerability to substance-related harms. These are shaped both by programs and services and by broader social and policy conditions that influence access to supports, opportunities for early intervention and the environments in which children, families and communities develop and thrive.

Opportunity

Strengthening prevention and early support requires sustained attention to both service delivery and the policy environments that shape health and risk over time. Policy decisions play a critical role in enabling early intervention, reducing stigma and improving access to supports across the life course.

Key opportunities include:

- Expanding early childhood supports for parents and caregivers to promote stability, attachment and resilience.
- Supporting programs that increase positive childhood experiences and address adverse childhood experiences.
- Expanding culturally relevant prevention and early intervention programming in diverse and rural communities.
- Improving access to tailored supports for eligible pregnant and parenting people.
- Advancing provincial and federal shifts toward evidence informed policy approaches, including appropriate regulation.

Optimize multi-sector collaboration

Learning

Toxic drug poisoning risk is shaped by factors that extend well beyond the health system. It intersects with social and structural determinants of health such as housing, poverty, policing, education, employment, and emergency response systems. Among these, housing instability stands out as one of the strongest and most consistent risk factors for toxic drug death.

Opportunity

Reducing preventable harm requires strengthened and sustained collaboration across sectors, with a shared focus on addressing both immediate risks and underlying drivers of vulnerability.

Key opportunities include:

- Improving coordination of strategies, shared data and aligned communication across health, social, housing and community systems.
- Supporting low barrier, supportive and Housing First models that integrate health, mental health and substance use supports.
- Strengthening school-based health promotion to support protective factors and trauma informed educational approaches that promote early identification and coordinated care.
- Strengthening collaboration with local policing partners to support shared objectives related to safety, enforcement and access to health and social services, including approaches that minimize harms and reduce barriers to care for people who use substances.

References

1. Government of British Columbia. Provincial health officer declares public health emergency [Internet]. BC Government News. 2016 [cited 2025 Dec 8]. Available from: https://news.gov.bc.ca/releases/2016hlth0026-000568

2. BC Minister of Health. Ministerial Order No M488 [Internet]. Emergency Health Services Act Dec 9, 2016. Available from: https://www.bclaws.gov.bc.ca/civix/document/id/mo/hmo/m0488_2016

3. Joint Task Force on Overdose Prevention and Response. B.C.'s Opioid Overdose Response: One-Year Update [Internet]. Victoria, BC: Government of BC; 2017 Apr [cited 2025 Dec 8] p. 6. Available from: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-response-one-year-update-april2017.pdf

4. Premier O of the. Joint task force mobilized to scale up overdose response. BC Gov News [Internet]. 2016 Jul 27 [cited 2026 Jan 22]; Available from: https://news.gov.bc.ca/releases/2016PREM0082-001361

5. Tobias S, Angelucci J, Wood E, Buxton JA, Ti L. Novel adulterants in unregulated opioids and their associations with adverse events. Can J Public Health. 2025 Jun 1;116(3):356–63.

6. Russell C, Law J, Bonn M, Rehm J, Ali F. The increase in benzodiazepine-laced drugs and related risks in Canada: The urgent need for effective and sustainable solutions. Int J Drug Policy. 2023 Jan 1;111:103933.

7. BC Coroners Service. Unregulated Drug Toxicity Deaths [Internet]. Unregulated Drug Deaths Dashboard. [cited 2025 Dec 8]. Available from: https://app.powerbi.com view?r=eyJrIjoiYjlkYTNmZjEtNzVjYi00NTMzLWE5NmEtMjU4NjEzYTMyNjVjIiwidCI6IjZmZGI1MjAwLTNkMGQtNGE4YS1iMDM2LWQzNjg1ZTM1OWFkYyJ9

8. BC Coroners Service. BC Coroners Death Review Panel: A Review of Illicit Drug Toxicity Deaths [Internet]. 2022 Mar. Available from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/review_of_illicit_drug_toxicity_deaths_2022.pdf

9. BC's Provincial Health Officer. Examining the Societal Consequences of the COVID-19 Pandemic [Internet]. Victoria, 2024 Dec [cited 2025 Dec 8] p. 296. Available from: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/pho-annual-report-examining-societal-consequences-of-covid-19.pdf

10. Mathew N, Wong JSH, Krausz RM. An inside look at BC's illicit drug market during the COVID-19 pandemic. Br Columbia Med J. 2021 Feb;63(1):9–13.

11. United Nations Office on Drugs and Crime. COVID-19 and the Drug Supply Chain: From Production and Trafficking to Use [Internet]. Vienna; 2020 May [cited 2025 Dec 9] p. 45. Available from: https://www.unodc.org/documents/data-and-analysis/covid/Covid-19-and-drug-supply-chain-Mai2020.pdf

12. Palis H, Bélair M, Hu K, Tu A, Buxton J, Slaunwhite A. Overdose deaths and the COVID □19 pandemic in British Columbia, Canada. Drug Alcohol Rev. 2022 May;41(4):912–7.

13. Public Health Ontario. Substance Use-Related Harms and Risk Factors during Periods of Disruption [Internet]. 2020 Jul [cited 2025 Dec 11]. Available from: https://www.publichealthontario.ca/-/media/documents/ncov/main/2020/08/substance-use-related-harms-disruption.pdf

14. Tobias S, Grant CJ, Laing R, Lysyshyn M, Buxton JA, Tupper KW, et al. What impact did the COVID-19 pandemic have on the variability of fentanyl concentrations in the Vancouver, Canada illicit drug supply? An interrupted time-series analysis. BMJ Public Health. 2023 Oct;1(1):e000197.

15. First Nations Health Authority. First Nations Illicit Drug Deaths Rise during COVID-19 Pandemic [Internet]. 2020 Jun. (First Nations in BC and the Overdose Crisis). Available from: https://www.fnha.ca/Documents/FNHA-First-Nations-in-BC-and-the-Overdose-Crisis-Infographic.pdf

16. Canada PHA of. Decline in opioid-related deaths in Canada [Internet]. 2025 Dec [cited 2025 Dec 31]. Available from: https://health-infobase.canada.ca/substances/harms/decline-opioid-related-deaths/

17. United Nations Office on Drugs and Crime. World Drug Report 2025 [Internet]. Available from: https://www.unodc.org/documents/data-and-analysis/WDR_2025/WDR25_B1_Key_findings.pdf

18. Health Canada. Substance Use Spectrum [Internet]. 2022 [cited 2026 Jan 22]. Available from: https://www.canada.ca/content/dam/hc-sc/documents/services/publications/substance-use-spectrum-infographic/pub-eng.pdf

19. Norman, Trudy, Reist, Dan. Understanding substance use a health promotion perspective [Internet]. Canadian Mental Health Association; 2013 [cited 2026 Jan 22]. Available from: https://www.heretohelp.bc.ca/sites/default/files/understanding-substance-use-a-health-promotion-perspective.pdf

20. BC Ministry of Mental Health and Addictions. Adult Substance Use System of Care Framework [Internet]. 2022 [cited 2026 Jan 22]. Available from: https://www2.gov.bc.ca/assets/gov/health/managing-your-health/mental-health-substance-use/substance-use-framework/mmha_substanceuseframework_dec2022.pdf

21. Tam, Theresa. Addressing Stigma Towards a More Inclusive Health System [Internet]. Public Health Agency of Canada; 2019 Dec [cited 2026 Jan 21]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf

22. British Columbia Centre on Substance Use, BC Ministry of Health, BC Ministry of Mental Health and Addictions. A Guideline for the Clinical Management of Opioid Use Disorder [Internet]. BC Centre on Substance Use; 2023 [cited 2026 Jan 22]. Available from: https://www.bccsu.ca/wp-content/uploads/2023/12/BC-OUD-Treatment-Guideline_2023-Update.pdf

23. Gustafson R. Island Health CMHO Report 2024 [Internet]. 2024. Available from: https://cdn.prod.website-files.com/66a14d58ed088fe4de1ccda3/688ba6121256bb4dcaef6122_2024_cmho_report.pdf

24. Ministry of Mental Health and Addictions. Decriminalization of People Who Use Drugs in BC [Internet]. Government of BC; 2024 [cited 2026 Apr 7]. Available from: https://www2.gov.bc.ca/assets/gov/overdose-awareness/factsheet_on_decrim.pdf

25. BC Centre on Substance Use. DrugSense Dashboard [Internet]. [cited 2026 Jan 29]. Available from: https://drugsense.bccsu.ubc.ca/

26. Government of Canada. (2025). Health Canada Drug Analysis Service. In Focus: The Emergence of Opioids in Canada. Longueuil (QC), 2025. Retrieved from https://www.canada.ca/en/health-canada/services/publications/healthy-living/emergence-opioids-canada.html

27. BC Centre for Disease Control. BC Centre for Disease Control Fact Sheet: Etizolam in British Columbia's Illicit Drug Market [Internet]. 2021 [cited 2026 Mar 10]. Available from: https://towardtheheart.com/assets/uploads/1620768097sIdcTgyTPH64oIUECbSHJYRMklJdFBZngLCwls5.pdf

28. BC Centre for Disease Control. BC warns of increase in drug poisonings, shifts in unregulated supply [Internet]. [cited 2026 Jan 29]. Available from: https://www.bccdc.ca:443/about/news-stories/stories/2026/bc-drug-poisonings

29. BC Centre for Disease Control. Unregulated drug supply substance information sheet: Medetomidine [Internet]. 2024 [cited 2026 Mar 10]. Available from: https://www.bccdc.ca/resource-gallery/Documents/Harm%20Reduction/Medetomidine%20Substance%20Info%20Sheet.pdf

30. Canadian Centre on Substance Use. Canadian Substance Use Costs and Harms 2007–2020 [Internet]. Ottawa, ON: Canadian Centre on Substance Use and Addiction; 2023. Available from: https://csuch.ca/assets/documents/reports/english/Canadian-Substance-Use-Costs-and-Harms-Report-2007-2020-en.pdf

31. Tam, Theresa. Preventing Problematic Substance Use in Youth [Internet]. Ottawa, ON: Public Heal; 2018 Oct [cited 2026 Jan 28]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth/2018-preventing-problematic-substance-use-youth.pdf

32. Afuseh E, Pike CA, Oruche UM. Individualized approach to primary prevention of substance use disorder: age-related risks. Subst Abuse Treat Prev Policy. 2020 Dec;15(1):58.

33. Cleveland MJ, Feinberg ME, Bontempo DE, Greenberg MT. The Role of Risk and Protective Factors in Substance Use Across Adolescence. J Adolesc Health. 2008 Aug;43(2):157–64.

34. Brumback T, Thompson W, Cummins K, Brown S, Tapert S. Psychosocial predictors of substance use in adolescents and young adults: Longitudinal risk and protective factors. Addict Behav. 2021 Oct;121:106985.

35. Stewart SA, Copeland AL, Cherry KE. Risk Factors for Substance Use across the Lifespan. J Genet Psychol. 2023 Mar 4;184(2):145–62.

36. Sloboda Z, Glantz MD, Tarter RE. Revisiting the Concepts of Risk and Protective Factors for Understanding the Etiology and Development of Substance Use and Substance Use Disorders: Implications for Prevention. Subst Use Misuse. 2012 Jun 10;47(8–9):944–62.

37. Nawi AM, Ismail R, Ibrahim F, Hassan MR, Manaf MRA, Amit N, et al. Risk and protective factors of drug abuse among adolescents: a systematic review. BMC Public Health. 2021 Dec;21(1):2088.

38. Kristjansson AL, Mann MJ, Sigfusson J, Thorisdottir IE, Allegrante JP, Sigfusdottir ID. Development and Guiding Principles of the Icelandic Model for Preventing Adolescent Substance Use. Health Promot Pract. 2020 Jan;21(1):62–9.

39. Public Health Agency of Canada. A primer to reduce substance use stigma in the Canadian health system [Internet]. Ottawa, ON: Government of Canada; 2020 Jan [cited 2026 Mar 10]. Available from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/primer-reduce-substance-use-stigma-health-system/stigma-primer-eng.pdf

40. Corbin JH, Jones J, Barry MM. What makes intersectoral partnerships for health promotion work? A review of the international literature. Health Promot Int. 2016 Aug 9;daw061.

41. Tsai AC, Kiang MV, Barnett ML, Beletsky L, Keyes KM, McGinty EE, et al. Stigma as a fundamental hindrance to the United States opioid overdose crisis response. PLoS Med. 2019 Nov 26;16(11):e1002969.

42. Turpel-Lafond ME. In plain sight. Addressing Indigenous-specific racism and discrimination in B.C. health care. [Internet]. 2020 Nov [cited 2026 Mar 10]. Available from: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

43. Scher BD, Neufeld SD, Butler A, Bonn M, Zakimi N, Farrell J, et al. "Criminalization Causes the Stigma": Perspectives From People Who Use Drugs. Contemp Drug Probl. 2023 Sep 1;50(3):402–25.

44. Ginther, J, McNally, G. Reducing Bias Against People with Substance Use Disorders. Am J Nurs [Internet]. 2024 Jan [cited 2026 Jan 28];124(1). Available from: https://learning.lww.com/files/ReducingBiasAgainstPeoplewithSubstanceUseDisorders-1706613822530.pdf

45. Cooper LA, Saha S, van Ryn M. Mandated Implicit Bias Training for Health Professionals—A Step Toward Equity in Health Care. JAMA Health Forum. 2022 Aug 11;3(8):e223250.

46. FitzGerald C, Martin A, Berner D, Hurst S. Interventions designed to reduce implicit prejudices and implicit stereotypes in real world contexts: a systematic review. BMC Psychol. 2019 May 16;7(1):29.

47. Vela MB, Erondu AI, Smith NA, Peek ME, Woodruff JN, Chin MH. Eliminating Explicit and Implicit Biases in Health Care: Evidence and Research Needs. Annu Rev Public Health. 2022 Apr 5;43(Volume 43, 2022):477–501.

48. Public Health Ontario. Evidence for Strategies that Address Substance-Use Related Stigma [Internet]. 2024 Apr. (Rapid Review). Available from: https://www.publichealthontario.ca/-/media/Documents/E/2024/evidence-strategies-substance-use-related-stigma.pdf?rev=33766e9437904100a3de0622979ae28d&sc_lang=en

49. Bardwell G, Kerr T, McNeil R. The Opioid Overdose Epidemic and the Urgent Need for Effective Public Health Interventions That Address Men Who Use Drugs Alone. Am J Mens Health. 2019 May 1;13(3):1557988319859113.

50. Health Canada. Drug and alcohol use in Canada: General populations (ages 15+) [Internet]. Health Infobase. 2025 [cited 2026 Mar 10]. Available from: https://health-infobase.canada.ca/substance-use/csus/

51. Bharmal A. Supporting recovery through Return to Work [Internet]. 2020 [cited 2026 Feb 5]. Available from: https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/MHO-updates/FH_RTWReport_September11.pdf

52. Canadian Apprenticeship Forum. Understanding Substance Use Among Apprentices in the Skilled Trades [Internet]. Ottawa, ON: Canadian Apprenticeship Forum; 2023 Aug [cited 2026 Apr 8]. Available from: https://cupe.on.ca/wp-content/uploads/2024/01/Understanding-Substance-Use-Among-Apprentices-in-the-Skilled-Trades.pdf

53. Papamihali K, Yoon M, Graham B, Karamouzian M, Slaunwhite AK, Tsang V, et al. Convenience and comfort: reasons reported for using drugs alone among clients of harm reduction sites in British Columbia, Canada. Harm Reduct J. 2020 Nov 23;17(1):90.

54. Government of BC. Beyond the Numbers Initiative [Internet]. 2018 Aug [cited 2025 Dec 11]. Available from: https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/services-policies-for-government/service-experience-digital-delivery/service-design/journey_map_-_aug_2018.pdf

55. Fernando S, Hawkins J, Kniseley M, Sikora M, Robson J, Snyder D, et al. The Overdose Crisis and Using Alone: Perspectives of People Who Use Drugs in Rural and Semi-Urban Areas of British Columbia. Subst Use Misuse. 2022 Oct 15;57(12):1864–72.

56. Boyd J, Maher L, Austin T, Lavalley J, Kerr T, McNeil R. Mothers Who Use Drugs: Closing the Gaps in Harm Reduction Response Amidst the Dual Epidemics of Overdose and Violence in a Canadian Urban Setting. Am J Public Health. 2022 Apr;112(S2):S191–8.

57. First Nations Health Authority. First Nations and the toxic drug poisoning crisis in BC Jan-Jun 2025 [Internet]. 2025. Available from: https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-June-2025.pdf

58. Lavalley J, Steinhauer L, Bundy D (Boomer), 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 people who use illicit drugs in Vancouver's Downtown Eastside neighbourhood. Int J Drug Policy. 2024 Dec;134:104631.

59. Public Health Ontario. Substance Use Services with, and for, Indigenous Communities [Internet]. 2023 Sep. Available from: https://www.publichealthontario.ca/-/media/Documents/S/2023/substance-use-services-indigenous-communities.pdf?rev=c50da5f26fea491caf6bfc937a0d9060&sc_lang=en

60. Lavalley J, Kastor S, Valleriani J, McNeil R. Reconciliation and Canada's overdose crisis: responding to the needs of Indigenous people. Can Med Assoc J. 2018 Dec 17;190(50):E1466–7.

61. First Nations Health Authority. Toxic Drug Poisonings-Community Situation Report-August 2025 [Internet]. 2025 [cited 2026 Jan 28]. Available from: https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-August-2025.pdf

62. First Nations Health Authority. Toxic Drug Poisoning Trends Among First Nations Youth-Fraser Salish Region [Internet]. 2025 [cited 2026 Jan 28]. Available from: https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisoning-Trends-Among-First-Nations-Youth-Fraser-Salish-Region.pdf

63. Statistics Canada. 2021 Census of Population [Internet]. Ottawa: Statistics Canada; 2023 Nov [cited 2026 Mar 19]. Report No.: Statistics Canada Catalogue number 98-316-X2021001. Available from: https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=E

64. Fraser Health Authority. Chief Medical Health Officer's report 2019 [Internet]. 2019. Available from: https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Professionals/MHO-updates/2020_0618_FHA_CMHOReport.pdf

65. Mirza N, Singh M, Hyshka E. Responding to drug-related harm among South Asian populations in Canada. Can J Public Health. 2025 Aug 1;116(4):573–6.

66. Thandi G. Addressing Trauma Through an Intergenerational, Systems Lens. Vis J [Internet]. 2023 [cited 2026 Mar 10];18(2). Available from: https://www.heretohelp.bc.ca/visions/intergenerational-trauma-vol18/addressing-trauma-through-an-intergenerational-systems-lens

67. Kaur K. 'Reputation, reputation, reputation! Oh, I have lost my reputation!'; A literature review on alcohol addiction in the British Sikh and/or Punjabi community and the barriers to accessing support. Alcohol. 2024 Jan 17;59(2):agad080.

68. BC Coroners Service. Deaths of Individuals Experiencing Homelessness in British Columbia, 2016-2023 [Internet]. 2025 Feb [cited 2026 Jan 21]. Available from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/250212_homeless_web_report_2016-2023.pdf

69. Plouffe R, White R, Orpana H, Grywacheski V. Substance-related poisoning hospitalizations and homelessness in Canada: a descriptive study. Health Promot Chronic Dis Prev Can Res Policy Pract. 2024 May;44(5):208.

70. Hwang, Stephen W. Homelessness and health. Can Med Assoc J. 2001 Jan 23;164(2):229–33.

71. Baxter AJ, Tweed EJ, Katikireddi SV, Thomson H. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health. 2019 May;73(5):379–87.

72. Government of BC. Belonging in BC [Internet]. 2022 [cited 2026 Jan 21]. Available from: https://news.gov.bc.ca/files/BelongingStrategy.pdf

73. Perinatal Services BC. Perinatal Health Report - Fraser Health 2023/24 [Internet]. Provincial Health Services Authority; 2025 Mar [cited 2026 Mar 10]. Available from: https://www.perinatalservicesbc.ca/Documents/Data-Surveillance/Reports/PHR/Perinatal%20Health%20Report%20Facility%20Fraser%20202324.pdf

74. Wolfson L, Schmidt RA, Stinson J, Poole N. Examining barriers to harm reduction and child welfare services for pregnant women and mothers who use substances using a stigma action framework. Health Soc Care Community. 2021 May;29(3):589–601.

75. Weber A, Miskle B, Lynch A, Arndt S, Acion L. Substance Use in Pregnancy: Identifying Stigma and Improving Care. Subst Abuse Rehabil. 2021 Nov;Volume 12:105–21.

76. Piske M, Yan Y, Homayra F, Joyce S, Barker B, Meilleur L, et al. Perinatal Substance Use and Factors Associated With Maternal and Neonatal Morbidity and Mortality. Pediatrics. 2025 Jul 10;156(2):e2024070352.

77. BC Coroners Service. Youth Unregulated Drug Toxicity Deaths in BC 2019-2023 [Internet]. 2024 [cited 2026 Jan 28]. Available from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/youth_unregulated_drug_toxicity_deaths_in_bc_2019-2023.pdf

78. Chang GYS, VanSteelandt A, McKenzie K, Kouyoumdjian F. Accidental substance-related acute toxicity deaths among youth in Canada: a descriptive analysis of a national chart review study of coroner and medical examiner data. Health Promot Chronic Dis Prev Can. 2024 Mar;44(3):77–88.

79. Beck K, Pallot K, Amri M. A scoping review on barriers and facilitators to harm reduction care among youth in British Columbia, Canada. Harm Reduct J. 2024 Oct 23;21(1):189.

80. BC Representative for Children and Youth. Representative's Statement on the Toxic Drug Crisis [Internet]. August 25, 20233. Available from: https://rcybc.ca/wp-content/uploads/2022/08/Representatives-Statement-on-Toxic-Drug-Crisis_25_Aug_22_FINAL.pdf

81. McCreary Centre Society. 2023 BC Adolescent Health Survey results for the Fraser Region [Internet]. Vancouver, BC; 2024 [cited 2025 Dec 16]. Available from: https://www.mcs.bc.ca/pdf/2023_bcahs_fraser_health.pdf

82. Varatharajan T, Patte KA, de Groh M, Jiang Y, Leatherdale ST. Exploring differences in substance use behaviours among gender minority and non-gender minority youth: a cross-sectional analysis of the COMPASS study. Health Promot Chronic Dis Prev Can. 2024 Apr;44(4):179–90.

83. Chow C, Vallance K, Stockwell T, Macdonald S, Martin G, Ivsins A, et al. Sexual identity and drug use harm among high-risk, active substance users. Cult Health Sex. 2013 Mar 1;15(3):311–26.

84. Bellows Z, Kim C, Bai Y, Cao P, Chum A. Disparities in self-reported mental health, physical health, and substance use across sexual orientations in Canada. PLOS ONE. 2025 Mar 17;20(3):e0305019.

85. Xin Y, Schwarting CM, Wasef MR, Davis AK. Exploring the intersectionality of stigma and substance use help-seeking behaviours among lesbian, gay, bisexual, transgender, queer, questioning or otherwise gender or sexuality minority (LGBTQ+) individuals in the United States: A scoping review. Glob Public Health. 2023 Jan 2;18(1):2277854.

86. Hillyard M. LGBTQ+ drug and alcohol use: discrimination breeds disparity. Br J Gen Pract. 2024 Jul 26;74(745):344.

87. BC Centre for Disease Control, First Nations Health Authority. Harm Reduction Manual [Internet]. BC Centre for Disease Control; 2025 [cited 2026 Apr 8]. Available from: https://www.bccdc.ca/Health-Info-Site/Documents/Section%204%20-%20Harm%20Reduction.pdf

88. BC Representative for Children and Youth. Representative's Statement on the Toxic Drug Crisis [Internet]. August 25, 20233. Available from: https://rcybc.ca/wp-content/uploads/2022/08/Representatives-Statement-on-Toxic-Drug-Crisis_25_Aug_22_FINAL.pdf

89. Jones CM, Zhang K, Han B, Guy GP, Losby J, Einstein EB, et al. Estimated Number of Children Who Lost a Parent to Drug Overdose in the US From 2011 to 2021. JAMA Psychiatry. 2024 Aug 1;81(8):789–96.

90. Selseng LB, Reime MA, Lindeman SK. Help and support for bereaved persons who use drugs: a qualitative study. Eur J Soc Work. 2024 Mar 3;27(2):427–39.

91. O'Callaghan D, Lambert S. The Internalization of Stigma and the Shaping of the Grief Experience for Peers Bereaved by a Drug-Related Death. OMEGA - J Death Dying. 2024 Aug 19;00302228241275728.

92. Selseng LB, Lindeman SK, Reime MA. Bereavement and support in the conduct of everyday life: Insights from dual experiences of loss and drug use. Nord Stud Alcohol Drugs. 2025 Dec 1;42(5–6):532–50.

93. Coady A, Johnston C, Koersen B, Piercy J. Stopping the Harm: Psychosocial Outcomes of Families Affected by Drug Use. Can J Addict. 2022 Dec;13(4):44–52.

94. Morris H, Hyshka E, Schulz P, Jenkins E, Haines-Saah RJ. "It's a Bit of a Double-Edged Sword": Motivation and Personal Impact of Bereaved Mothers' Advocacy for Drug Policy Reform. Qual Health Res. 2021 Aug 1;31(10):1812–22.

95. Feigelman W, Jordan JR, Gorman BS. Parental Grief after a Child'S Drug Death Compared to other Death Causes: Investigating a Greatly Neglected Bereavement Population. OMEGA - J Death Dying. 2011 Dec 1;63(4):291–316.

96. Shaw A. Grief on the margins: The death of a family member to substance use [Internet] [Masters of Social Work]. Wilfred Laurier University; 2025. Available from: https://scholars.wlu.ca/etd/2755?utm_source=scholars.wlu.ca%2Fetd%2F2755&utm_medium=PDF&utm_campaign=PDFCoverPages

97. First Nations Health Authority. Healing Indigenous Hearts [Internet]. 2023 Jan [cited 2025 Dec 15]. Available from: https://www.fnha.ca/Documents/Healing-Indigenous-Hearts.pdf

98. Aboriginal Healing Foundation. Final Report of the Aboriginal Healing Foundation Volume III Promising Healing Practices in Aboriginal Communities [Internet]. Ottawa, ON: Aboriginal Healing Foundation; 2006. Available from: https://nctr.ca/wp-content/uploads/2021/01/final-report-vol-3.pdf

99. O'Callaghan D, Lambert S. The experience of drug-related client loss for healthcare professionals who support people in addiction. J Subst Use Addict Treat. 2024 Mar;158:209236.

100. Kolla G, Khorasheh T, Dodd Z, Greig S, Altenberg J, Perreault Y, et al. "Everybody is impacted. Everybody's hurting": Grief, loss and the emotional impacts of overdose on harm reduction workers. Int J Drug Policy. 2024 May;127:104419.

101. Irvine MA, Bardwell S, Williams S, Liu L, Ge W, Kinniburgh B, et al. Estimating the total utilization of take home naloxone during an unregulated drug toxicity crisis: A Bayesian modeling approach. Int J Drug Policy. 2024 Jun 1;128:104454.

102. Irvine MA, Kuo M, Buxton J, Balshaw R, Otterstatter M, Macdougall L, et al. Modelling the combined impact of interventions in averting deaths during a synthetic-opioid overdose epidemic. Addict Abingdon Engl. 2019 Jun 28;114(9):1602.

103. Pacheco M, Ologunowa A, Jacobson A. Analysis of different populations accessing online overdose response training and harm reduction supplies (ADORES). Harm Reduct J. 2024 Nov 20;21(1):202.

104. Barnett BS, Wakeman SE, Davis CS, Favaro J, Rich JD. Expanding Mail-Based Distribution of Drug-Related Harm Reduction Supplies Amid COVID-19 and Beyond. Am J Public Health. 2021 Jun;111(6):1013.

105. Hoopsick RA, Campbell BM, Yockey RA. Harm reduction self-efficacy and motivations for contactless supply access among a sample of syringe services program participants. Harm Reduct J. 2025 Jul 28;22(1):130.

106. Hayes BT, Favaro J, Davis CS, Gonsalves GS, Beletsky L, Vlahov D, et al. Harm Reduction, By Mail: the Next Step in Promoting the Health of People Who Use Drugs. J Urban Health Bull N Y Acad Med. 2021 Mar 12;98(4):532.

107. Hayes BT, Favaro J, Coello D, Behrends CN, Jakubowski A, Fox AD. Participants of a mail delivery syringe services program are underserved by other safe sources for sterile injection supplies. Int J Drug Policy. 2021 Oct 5;99:103474.

108. Yang C, Favaro J, Meacham MC. NEXT Harm Reduction: An Online, Mail-Based Naloxone Distribution and Harm-Reduction Program. Am J Public Health. 2021 Apr;111(4):667.

109. Rioux W, Viste D, Orr T, Rider N, Ghosh SM. Predictors of overdose response hotline use for mental health and fatal overdose prevention. Can J Public Health. 2025 Jun 1;116(3):364–75.

110. Rioux W, Enns B, Ghosh SM. Virtual overdose monitoring services/mobile overdose response services: estimated number of potentially averted drug poisoning fatality events by various telephone and digital-based overdose prevention/harm reduction services in North America. Front Public Health [Internet]. 2023 [cited 2025 Dec 11];Volume 11-2023. Available from: https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1242795

111. Casillas KL, Fauchier A, Derkash BT, Garrido EF. Implementation of evidence-based home visiting programs aimed at reducing child maltreatment: A meta-analytic review. Child Abuse Negl. 2016 Mar 1;53:64–80.

112. Canadian Centre on Substance Use and Addiction. How to Prevent and Reduce Substance Use Harms for Youth: What Youth Say Works.[Internet]. Available from: https://ccsa.ca/sites/default/files/2025-05/Youth-SU-Prevention-What-We-Heard-en.pdf

113. Sharma AE, Knox M, Mleczko VL, Olayiwola JN. The impact of patient advisors on healthcare outcomes: a systematic review. BMC Health Serv Res. 2017 Dec;17(1):693.

114. Improving Health Quality Together - Health Quality BC [Internet]. [cited 2026 Jan 28]. Available from: https://healthqualitybc.ca/improving-health-quality-together/

115. Stanojlović M, Davidson L. Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support. Subst Abuse Res Treat. 2021 Jan 1;15:1178221820976988.

116. Eddie D, Hoffman L, Vilsaint C, Abry A, Bergman B, Hoeppner B, et al. Lived Experience in New Models of Care for Substance Use Disorder: A Systematic Review of Peer Recovery Support Services and Recovery Coaching. Front Psychol [Internet]. 2019 [cited 2025 Dec 18];Volume 10-2019. Available from: https://www.frontiersin.org/journals/psychology/articles/10.3389/fpsyg.2019.01052

117. Eddie D, O'Connor JB, George SS, Klein MR, Lam TCS, Abry A, et al. Peer Recovery Support Services and Recovery Coaching for Substance Use Disorder: A Systematic Review. Curr Addict Rep. 2025 Apr 22;12(1):40.

118. Miller SJ, Frary SG, Wu E, Chu W, Moskal M, Bodalski E, et al. A Qualitative Analysis of Organizational Practices to Support Peer Support Workers in The Substance Use Disorder Recovery Field. J Behav Health Serv Res [Internet]. 2025 Nov 4 [cited 2026 Apr 8]; Available from: https://doi.org/10.1007/s11414-025-09980-0