Living Well, Drinking Less

Reducing Alcohol-related Harms in BC

Provincial Health Officer's Annual Report

BRITISH COLUMBIA
Office of the Provincial Health Officer

Office of the Provincial Health Officer

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Location of cycling photo on cover: xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) traditional territory, Vancouver BC.

Ministry of Health
lək̓ʷəŋən Territories
Victoria, BC

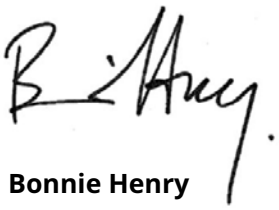
May 2026

The Honourable Josie Osborne
Minister of Health

Dear Honourable Josie Osborne:

I am submitting this report to you in accordance with Section 66 of the *Public Health Act*, and my duty to inform and advise on public health issues in BC.

Sincerely,



Bonnie Henry
OC OBC MD MPH FRCPC
Provincial Health Officer

Land and Rights Acknowledgements

We acknowledge with great respect the territories of the lək̓ʷəŋən Peoples on which the Office of the Provincial Health Officer stands, and the Songhees, Esquimalt (Xwsepsum), and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day. We recognize and express our gratitude for the medicines within these territories.

We acknowledge with respect the inherent rights of the First Nations whose ancestral territories cover every inch of the province now known as British Columbia, including their unextinguished land rights and rights to self-determination, health, and wellness within these territories. Laws and governance systems rooted in the land have upheld the sovereignty of these diverse Nations for thousands of years. The rights and responsibilities of First Nations to their ancestral territories have never been ceded or surrendered, and are upheld in provincial, national, and international law.

We also acknowledge that many Indigenous Peoples (First Nations, Métis, and Inuit) from elsewhere in what is now known as Canada also call these lands and waters home, and we have obligations to uphold their rights to self-determination, health, and wellness. This includes Métis Nation British Columbia and the 39 Chartered Communities across BC, as well as those whose ancestral territories are outside of BC.

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Executive Oversight

Dr. Bonnie Henry
Provincial Health Officer

Fifth-generation Canadian settler, Scottish Highland and Welsh ancestry. Born and raised on Mi'kmaq territory, Prince Edward Island, and New Brunswick.

Dr. Danièle Behn Smith
Deputy Provincial Health Officer, Indigenous Health

Eh Cho Dene, Fort Nelson First Nation. Métis/French Canadian, Red River Valley, Manitoba. Born in Fort Nelson, BC, on her paternal Eh Cho Dene territory. Raised in the territories of the Cree, Anishinaabe, Dene, Dakota, and Anisininew Nations, and her maternal Métis territory in Winnipeg, Manitoba.

Dr. Martin Lavoie
Deputy Provincial Health Officer

Multi-generation French Canadian settler with French ancestry. Born and raised on Atikamekw territory, in the Lanaudière region of the province of Québec.

Dr. Silvina Mema
(former) Acting Deputy Provincial Health Officer

Armenian descent, born and raised in Argentina. Currently living and working on the traditional and unceded territory of the Syilx Okanagan people in British Columbia.

Dr. Brian Emerson
(former) Deputy Provincial Health Officer

French and Irish heritage, born and raised on Treaty 7 territory, which includes the Siksika Nation, Piikani Nation, Kainai Nation, the Îethka Stoney Nakoda, Nah-koh-duh Nation—consisting of the Chiniki Bearspaw and Good Stoney Bands, the people of the Tsuut'ina Nation, and the people of the Métis Nation of Alberta, Region 3 within the historical Northwest Métis homeland.

We extend our sincere gratitude to the many people who contributed to the development of this report.

Thank you to reviewers of our draft report. Your time and thoughtful comments are deeply appreciated.

Disclosures

Dr. Henry has owned a share in a BC winery since 2006. This potential conflict of interest was formally declared in 2018 when she was appointed as BC's Provincial Health Officer and she has recused herself from any discussion or decisions directly affecting wineries, including in this report.

Truth, Rights, and Reconciliation

The Office of the Provincial Health Officer (OPHO) is committed to upholding inherent Aboriginal and treaty rights, as well as anti-racist approaches, and truth and reconciliation. The office is also committed to seeing the ways that Indigenous-specific racism and white supremacy* show up in the office's day-to-day work (i.e., policies, practices, processes), and deliberately taking anti-racist approaches to arrest white supremacy and racism. This commitment also includes paying particular attention to the rights and needs of First Nations, Métis, and Inuit Elders; women; Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (2SLGBTQQIA+) people; youth; children; and people with disAbilities.[a] This section describes some of this work as it relates to this report— *Living Well, Drinking Less: Reducing Alcohol-related Harms in BC*.

Distinctions-based Approaches

Through the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA),[1] the Province of BC has adopted a distinctions-based approach to advancing reconciliation and implementing the *United Nations Declaration on the Rights of Indigenous Peoples*. A distinctions-based approach means that work with First Nations, Métis, and Inuit Peoples will be conducted in a manner that acknowledges the specific rights, interests, priorities, and concerns of each, while respecting and acknowledging these distinct Peoples with unique cultures, histories, rights, laws, and governments.[2] In this report, the term "Indigenous" encompasses First Nations, Métis, and Inuit Peoples. The term Indigenous can unintentionally homogenize the distinct rights, histories, and experiences of First Nations, Métis, and Inuit Peoples. Specific Peoples or Nations are referred to wherever possible. The term Indigenous is used when the source being cited uses the term, and when referring to shared realities of colonialism.

Foundational Obligations

For settler-colonial institutions, including the OPHO, actively upholding inherent Aboriginal and treaty rights must involve taking action on specific foundational obligations to Indigenous Peoples and individuals. The *United Nations Declaration on the Rights of Indigenous Peoples*[3] provides a framework for reconciliation. It has also been established as BC's guide for reconciliation through DRIPA.[1] Additional foundational documents outline detailed instructions provided by Indigenous Peoples on how to move forward with this work.

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* In this context, the term "white supremacy" is not meant to evoke the types of racism enacted by white nationalist groups. The term is increasingly used in public health contexts to describe oppression that is entrenched into societal systems and that grants power and privilege to whiteness, including with political, social, cultural, educational, and economic systems, institutions, and spaces. For more information, see https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/unlearning-undoing-project.

a The Office of the Provincial Health Officer recognizes that people living with disAbilities are diverse and identify in various ways. The "A" in disability has been capitalized to focus on the abilities of people who live with disAbilities and to help remove deficit undertones of the word.

Foundational Obligations Relevant to This Report and the Work of the Office of the Provincial Health Officer

United Nations Declaration on the Rights of Indigenous Peoples[3]

Article 21

(1): Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.

(2): States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

(2): Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Truth and Reconciliation Commission of Canada: Calls to Action[4]

Call to Action 18

We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

Call to Action 22

We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care[5]

Recommendation 2

That the B.C. government, in collaboration and cooperation with Indigenous peoples in B.C., develop appropriate policy foundations and implement legislative changes to require anti-racism and "hard-wire" cultural safety, including an *Anti-Racism Act* and other critical changes in existing laws, policies, regulations and practices, ensuring that this effort aligns with the *UN Declaration* as required by *DRIPA*.

Recommendation 17

That the B.C. government and FNHA demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.

BC's Declaration on the Rights of Indigenous Peoples Act Action Plan[6]

Action 1.2

Shift from short-term transactional arrangements to the co-development of long-term agreements that recognize and support reconciliation, self-determination, decision-making and economic independence. (Ministry of Indigenous Relations and Reconciliation)

Action 1.4

Co-develop with Indigenous Peoples a new distinctions-based fiscal relationship and framework that supports the operation of Indigenous governments, whether through modern treaties, self-government agreements or advancing the right to self-government through other mechanisms. This work will include collaboration with the Government of Canada. (Ministry of Finance, Ministry of Indigenous Relations and Reconciliation)

Action 1.5

Co-develop and implement new distinctions-based policy frameworks for resource revenue-sharing and other fiscal mechanisms with Indigenous Peoples. (Ministry of Finance, Ministry of Indigenous Relations and Reconciliation)

Action 3.9

Identify and implement multi-modal transportation solutions that provide support and enable the development of sustainable, safe, reliable and affordable transportation options for First Nations communities. (Ministry of Transportation and Infrastructure)

Action 4.11

Increase the availability, accessibility and the continuum of Indigenous-led and community-based social services and supports that are trauma-informed, culturally safe and relevant, and address a range of holistic wellness needs for those who are in crisis, at-risk or have experienced violence, trauma and/or significant loss. (Ministry of Public Safety and Solicitor General, Ministry of Health, Ministry of Mental Health and Addictions)

Action 4.13

Increase the availability and accessibility of culturally safe substance use services, including through the renovation and construction of Indigenous-run treatment centres and the integration of land-based and traditional approaches to healing. (Ministry of Health, Ministry of Mental Health and Addictions)

Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ People: Calls for Justice[7]

Call for Justice 1.3

We call upon all governments, in meeting human and Indigenous rights obligations, to pursue prioritization and resourcing of the measures required to eliminate the social, economic, cultural, and political marginalization of Indigenous women, girls, and 2SLGBTQQIA people when developing budgets and determining government activities and priorities.

Call for Justice 1.5

We call upon all governments to immediately take all necessary measures to prevent, investigate, punish, and compensate for violence against Indigenous women, girls, and 2SLGBTQQIA people.

Call for Justice 1.9

We call upon all governments to develop laws, policies, and public education campaigns to challenge the acceptance and normalization of violence.

Call for Justice 3.4

We call upon all governments to ensure that all Indigenous communities receive immediate and necessary resources, including funding and support, for the establishment of sustainable, permanent, no-barrier, preventative, accessible, holistic, wraparound services, including mobile trauma and addictions recovery teams. We further direct that trauma and addictions treatment programs be paired with other essential services such as mental health services and sexual exploitation and trafficking services as they relate to each individual case of First Nations, Inuit, and Métis women, girls, and 2SLGBTQQIA people.

Call for Justice 18.28

We call upon all governments to fund and support, and service providers to deliver, expanded, dedicated health services for 2SLGBTQQIA individuals including health centres, substance use treatment programs, and mental health services and resources.

Resolutions of the BC Assembly of First Nations and Union of BC Indian Chiefs

In addition to the above, in 2023, the British Columbia Assembly of First Nations (BCAFN) and the Union of British Columbia Indian Chiefs (UBCIC) passed resolutions on alcohol regulation, funding, and jurisdiction that include calls to action for all levels of governments.[8,9] The First Nations Leadership Council, comprised of the political executives of the BCAFN, the First Nations Summit, and the UBCIC, has raised these resolutions with the BC provincial government.

The resolutions outlined, among other points, that First Nations people face disproportionate harms related to alcohol; federal and provincial governments continue to promote access to alcohol; more resources are needed for education, treatment, and cultural safety in health-care settings; and First Nations have jurisdiction in alcohol laws.

The BCAFN Chiefs-in-Assembly resolved that:

1. The BCAFN Chiefs-in-Assembly fully supports First Nations exercise of their jurisdiction in alcohol laws, controls and initiatives and calls upon all levels of governments to work in partnership with them, as mandated by the *United Nations Declaration on the Rights of Indigenous Peoples*;

2. The BCAFN Chiefs-in-Assembly calls on the governments of British Columbia and Canada to take a holistic, culturally-appropriate approach to alcohol regulation that respects title and rights and reflects the unique needs of First Nations, and to provide increased funding for both First Nations-specific and culturally-safe mainstream alcohol prevention and treatment services and supports;

3. The BCAFN Chiefs-in-Assembly demands that BC's future engagements and consultations related to alcohol are completed in accordance with the *United Nations Declaration on the Rights of Indigenous Peoples* and ensure engagement with all First Nations regardless of whether or not they are involved in the BC Treaty Commission process; and

4. The BCAFN Chiefs-in-Assembly directs the BCAFN Regional Chief and BCAFN staff to work with federal, provincial and municipal governments and liaise with the First Nations Health Authority and other like-minded organizations, on alcohol regulations and funding to reduce alcohol-related harms, increase Indigenous-specific supports, ensure cultural-safety in mainstream services, and recognize and support First Nations jurisdiction and initiatives.

The UBCIC Chiefs Council resolved that:

- The UBCIC Chiefs Council fully supports First Nations exercise of their jurisdiction in alcohol laws, controls and initiatives, and calls upon all levels of governments to work in partnership with them;

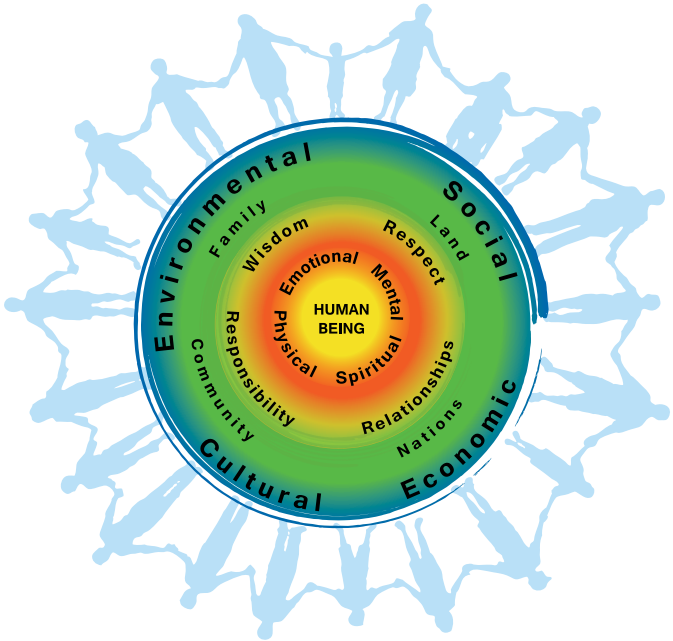
- The UBCIC Chiefs Council calls on the governments of British Columbia and Canada to take a holistic, culturally-appropriate approach to alcohol regulation that respects title and rights, and reflects the unique needs of First Nations, and to provide increased funding for both First Nations-specific and culturally-safe mainstream services and supports;

- The UBCIC Chiefs Council demands that BC's future engagements and consultations related to alcohol are completed in accordance with the *United Nations Declaration on the Rights of Indigenous Peoples* and ensure engagement with all First Nations regardless of whether or not they are involved in the BC Treaty Commission process; and

- The UBCIC Chiefs Council directs the UBCIC Executive and staff to work with federal, provincial and municipal governments and liaise with the First Nations Health Authority and other like-minded organizations, on alcohol regulations and funding to reduce alcohol related harms, increase Indigenous-specific supports, ensure cultural-safety in mainstream services, and recognize and support First Nations jurisdiction and initiatives.

First Nations Perspective on Healing, Health, and Wellness

The BC First Nations Perspective on Health and Wellness offers a visualization of the relationship between the elements that cultivate health for First Nations individuals, families, communities, and Nations.[10] At the centre of the circle is the individual human being, with several rings expanding outwards to represent the full social, environmental, cultural, and economic context in which people live. Each ring represents a different area of life, with four areas or elements within each. The rings refer to the overarching values that uphold and support wellness—*Respect, Wisdom, Responsibility,* and *Relationships*, and to the people and land that provide support—*Land, Community, Family*, and *Nations*. These concepts are reflected in traditional and cultural perspectives shared by First Nations people, such as the Stó:lō Peoples,



Source: First Nations Perspective on Health and Wellness.[10] Reproduced with permission from the First Nations Health Authority.

for whom the term "Letsemot" expresses the togetherness and interconnectedness of all things—land, human, and non-human relatives—and ways of living that support traditional health and wellness.[11]

Métis Perspectives on Cultural Wellness

For Métis people in BC, there is a strong connection between culture and wellness. Métis Nation British Columbia (MNBC) has developed the following description of what cultural wellness means to Métis people. This statement was based on input from more than one hundred Métis Elders and youth.

> *Cultural wellness is a sense of belonging and pride we feel when we are connected to our Métis families, communities, traditions and the land. It feels like home.*
>
> *We express cultural wellness by honouring the strength, determination, and traditions of our ancestors. We do this by telling stories, using the Michif language, being on the land, and practicing and passing on traditions such as our music, jigging, and art.*
>
> *Métis culture is a beautiful continuation of the strength and resiliency of our ancestors, the joy of family connection and the passing on of the teachings and traditions of our Elders to future generations.*
>
> *Cultural wellness fosters balance in physical, emotional, mental and spiritual health for our Métis individuals, families and Communities.*
>
> *Embracing Métis heritage and culture honours each Métis person's unique story and our distinct identify as Métis people in B.C. today.*[12 (p.10)]

Photo credit: Métis Nation British Columbia

The MNBC Ministry of Health and Wellness: Mental Health and Harm Reduction Mission and Vision also highlights the connection between culture and health for Métis people:

Mission: We promote lifestyle as medicine, provide wholistic health and cultural wellness programs and resources, and advocate for the removal of all systemic gaps and barriers, ensuring Métis health governance is driven by the community voice to influence policy, legislation, and health outcomes.

The Ministry of Mental Health and Harm Reduction is working towards fully realized mental health and wellness for Métis people in BC. Through our Ministry, we advocate for culturally appropriate mental health and harm reduction programs and services at the national, provincial, and regional levels. We continue to highlight and address the gaps in existing services and advocate for changes needed to better foster the health, wellness, and resilience of Métis individuals and communities. Additionally, the mental health and harm reduction team provides support, education, and advocacy for Métis people and Métis Chartered Communities across BC. As a growing Ministry, the Ministry of Mental Health and Harm Reduction strives to create whole-life, wraparound mental wellness initiatives – centered in community wisdom, and rooted in the idea of "culture as medicine." Utilizing a whole-life approach to foster mental health and wellness for Métis individuals and Communities across all stages of life – from prenatal to end-of-life. We seek to develop and implement mental wellness programming that is grounded in Métis culture and Métis ways-of-knowing. In understanding and recognizing intersectionality, we honour the diversity of the Métis population across BC; a population that is inclusive of all age groups, gender identities, sexual orientations, and diverse abilities. As such, our work seeks to be inclusive and representative of Métis youth, adult, Elder, GBA+, diverse abilities, and 2SLGBTQQIA+ lenses.[13]

First Nations, Métis, and Inuit Representation in This Report

The First Nations Health Authority (FNHA) and MNBC hold important roles in the stewardship of First Nations and Métis health data respectively. The FNHA and MNBC have directed OPHO to not present disaggregated data by First Nations or Métis identity in this report. The OPHO is grateful to experts and knowledge keepers from the FNHA and MNBC who took the time to review the content of this report, and for the permission to include Métis perspectives as detailed below. The OPHO is partnering with these organizations on other projects that include health outcomes related to alcohol:

- For information on First Nations population health, see the First Nations Population Health and Wellness Agenda series of reports.[14]
- For information on Métis population health, see the Métis Public Health Surveillance Project series of reports.[15]

The OPHO recognizes that Inuit living in BC hold inherent rights to health and wellness but remain largely invisible within the health-care system and reporting. In May 2023, the Inuit Collective Society of BC (BCmiut) was founded to provide a collective voice for Inuit living in BC and to advance Inuit data governance in the province.[16] The OPHO has begun working with BCmiut to ensure Inuit perspectives are reflected in future reports.

Métis Perspectives

Métis people have a distinct history and culture. The MNBC permitted the OPHO to include its Mental Wellness and Harm Reduction Sash in this report. This sash represents the wisdom shared by Métis participants of MNBC's Alcohol and Community Health Dialogue sessions. A more detailed description of the sash, its development, and its meaning is available in Chapter 3.

The OPHO was also permitted to use quotes from MNBC's *Resilient Roots: Métis Mental Health and Wellness Magazine*, which are featured throughout the report. The OPHO is grateful to be trusted with these cultural components for inclusion in this report.

Conclusion

There is still much work to be done to meaningfully advance truth and reconciliation in Canada and BC as it relates to alcohol and other issues. The foundational obligations highlighted in this report represent just one piece of an important step forward. The OPHO urges those reading this report to learn, understand, and act on the pieces relevant to work in their institutions and to continue taking action to dismantle systemic white supremacy and Indigenous-specific racism.

Executive Summary

Many people drink alcohol to relax, celebrate, and connect. But the impacts of drinking extend beyond these moments of enjoyment. Alcohol use continues to be a major public health concern in BC, contributing to death, disease, injury, and social harm. This report provides the latest data on provincial alcohol consumption and explores ways to reduce harm and support well-being for everyone in the province.

While people can lower their health risks by drinking less, reducing alcohol-related harm is not solely a personal responsibility. Alcohol policies are key to shaping and reducing alcohol consumption. They can help governments balance the social and economic considerations of alcohol with the harms it can cause. In BC, there are significant opportunities to strengthen existing policies and introduce new ones that support healthier communities. This report provides government with practical, actionable recommendations to move forward.

Key Findings

Alcohol is a leading cause of preventable death, injury, and disAbility in Canada and globally. Health experts agree that it is better for one's health to drink less alcohol. No matter how much a person is currently drinking, less is best.

Alcohol consumption is at a 20-year low in BC, but is still above national and recommended levels

BC residents are drinking less alcohol than in recent years, yet still consume an average of 8.8 standard drinks per week—higher than the national average of 8.2 and well above the recommended one to two drinks per week to avoid most alcohol-related risks to health. Compared to previous generations, youth are beginning to drink at an older age and they are consuming less alcohol overall. There is still work to be done to lower consumption rates.

Male residents in the province are consuming more alcohol than female residents, and a higher proportion of male residents are drinking heavily (five or more standard

drinks per occasion) than female residents. Consumption is highest among male seniors (who consume 15 standard drinks per week on average) and those living in the Interior, Northern, and Island health regions.

Alcohol consumption causes health and social harms

Alcohol causes harm. In 2023, an estimated 6 per cent of all deaths in BC were caused by alcohol use. Hospitalization and death rates related to alcohol are highest in regions that have greater alcohol consumption levels. Male seniors are more likely to die or be hospitalized for reasons attributable to alcohol than female seniors and BC residents of other ages.

Settler-colonial policies and practices introduced alcohol to Indigenous societies, and alongside Indigenous-specific racism, continue to be the main drivers of the disproportionate harms from alcohol experienced by Indigenous people in BC.

People living in remote and rural areas, people of lower socio-economic status, women, men age 65 and older, and members of the 2SLGBTQQIA+ community also experience disproportionate harm from alcohol use. Systemic factors such as racism and discrimination, classism, sexism, and anti-2SLGBTQQIA+ discrimination contribute to these disparities.

> Each death represents a person who was loved and cared for and who is missed by their family and community.

The costs of alcohol to the Province outweigh the revenue

The BC Government spends more to address the direct health and social harms of alcohol use than it makes in net revenue from alcohol sales, licensing, and taxes, with an estimated deficit of $768 million in 2020. Taking action to reduce alcohol-related harms in BC would not only improve health outcomes but also help close this financial gap by lowering the costs of health care, enforcement, and other impacts.

People in BC want to know more about alcohol use and risks

Many people are unaware of the full health risks associated with alcohol use. Public awareness of these risks is essential to support informed decision-making and reduce preventable harm. The majority of people surveyed in BC agree that the government has a role to play in making people more aware of the health risks of alcohol. Knowledge about the health risks of alcohol is low in Canada, particularly when it comes to cancer and heart disease. While other jurisdictions (e.g., the United States) require warning labels on alcoholic beverages, BC and other Canadian provinces do not.

There is no safe level of alcohol consumption, and no amount of alcohol use is without risk for people who are pregnant. Drinking alcohol increases the risk of developing chronic diseases as well as cancers of the breast, colon, rectum, mouth and throat, liver, esophagus, and larynx.

In BC, 3.8 per cent of people are at high risk of having or developing alcohol use disorder. While treatment is available, including through primary care, medications that treat alcohol use disorder are underused in BC.

Stigma and lack of awareness hinder access to care, particularly for pregnant people and marginalized groups, which may prevent those who need help from seeking support.

The Province can use policy tools to improve health and well-being related to alcohol

Provinces and territories have broad scope to shape the environment in which alcohol is consumed. Changes to alcohol policy that prioritize health can lower the burden of injuries, diseases, and deaths from alcohol.

There are proven ways to reduce the harms associated with alcohol use, including pricing based on alcohol content rather than volume, warning labels, and awareness campaigns. All approaches must align with the BC *Declaration on the Rights of Indigenous Peoples Act* and centre First Nations, Métis, and Inuit rights and perspectives, following guidance from resolutions of the Chiefs-in-Assembly of the BC Assembly of First Nations and the Chiefs Council of the Union of BC Indian Chiefs.

Recommendations

1. **Uphold the foundational obligations to First Nations, Métis, and Inuit Peoples.** Uphold the foundational obligations to First Nations, Métis, and Inuit Peoples—including those related to rights to health and wellness—to ensure that First Nations, Métis, and Inuit Peoples are safe from Indigenous-specific racism and discrimination, and have access to Indigenous-led, holistic, and culturally safe alcohol prevention and treatment services and supports.

2. **Develop a provincial alcohol strategy.** Develop and implement a cross-government alcohol strategy—co-led by the Ministry of Health, Ministry of Agriculture and Food, and Ministry of Public Safety and Solicitor General—and developed in partnership with First Nations and Métis Nation British Columbia. This strategy should

   - prioritize reducing health harms from alcohol;
   - balance government revenues from alcohol with their associated health and social costs to lower BC's alcohol deficit;
   - articulate a clear vision, goals, objectives, and measures to guide coordinated action across ministries and sectors to reduce alcohol harms and costs; and
   - exclude industry from strategy development. Industry representatives should be engaged with only as needed to advise on the implementation of aspects of the strategy that rely on industry action. Industry representatives should not be involved in setting or influencing vision, goals, objectives, or measures included in a strategy to reduce alcohol harms and costs.

3. **Shift to minimum unit pricing.** Shift alcohol minimum pricing from the current volume-based approach to one based on alcohol content (minimum unit pricing). Implement this shift in full partnership with First Nations, Métis, and Inuit Peoples, as required under BC's *Declaration on the Rights of Indigenous Peoples Act* and as emphasized by First Nations leadership in the province. Ensure that those who have difficulty scaling back their alcohol use are supported during this policy shift. Index minimum unit pricing to inflation to maintain effectiveness over time.

4. **Require warning labels on packaging.** Require evidence-based warning labels and health information on alcohol packaging, including cancer risk, risks to pregnant people, fetal alcohol spectrum disorder risks, and advice from the Canadian Centre on Substance Use and Addiction's guidance on alcohol and health.

5. **Launch an awareness campaign.** Develop and disseminate an ongoing, permanent awareness campaign about alcohol use and risks. This campaign should be free from industry involvement and reflect up-to-date evidence on alcohol use and risk, particularly relating to cancer, as people in BC want to know more about this topic.

6. **Strengthen the health system response.** Monitor and improve implementation of alcohol use disorder screening, brief intervention, and referral to treatment in primary care settings. Improve the capacity of the health-care system to

   - provide culturally safe care to First Nations, Métis, and Inuit patients;
   - recognize and diagnose alcohol use disorder;
   - deliver more comprehensive, evidence-based care for people experiencing alcohol use disorder, including psychosocial and pharmacological treatments; and
   - retain more people in care and treatment.

Chapter 1
Introduction

In BC and across Canada, any meaningful conversation about health-related topics, including **alcohol**,[b] must begin with a recognition of the inherent rights to self-determination held by First Nations, Métis, and Inuit Peoples.

In 2019, BC passed the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA), establishing the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) as the province's framework for reconciliation.[1,2] This legislation acknowledges the rights of **Indigenous** Peoples (First Nations, Métis, and Inuit) to self-determination, also affirmed in the Canadian Charter of Rights and Freedoms.[3] DRIPA requires the BC Government to ensure that its laws, policies, and practices are consistent with UNDRIP.

Rights to self-determination and self-government include the realm of alcohol regulation and policy.

As outlined in the preceding section on Truth, Rights, and Reconciliation, First Nations leadership in BC has clearly articulated the need for jurisdictional authority, culturally safe services, and meaningful engagement in all aspects of alcohol regulation. Alcohol regulation and policy in BC and Canada have long been shaped by colonial systems that impose external control over Indigenous Peoples, often with lasting, harmful consequences. As this report aims to highlight, the path forward must be different and centre the inherent rights to self-determination held by First Nations, Métis, and Inuit Peoples in the province.

Alcohol has been produced and consumed for thousands of years across many cultures and societies.[4] Today, many people drink alcohol to relax, celebrate, and socialize, as well as to cope with challenges such as stress, pain, and trauma.[5] In 2023, more than three-quarters of adults living in Canada's provinces reported

b Terms bolded in the body of this report are defined in the glossary. See Appendix A.

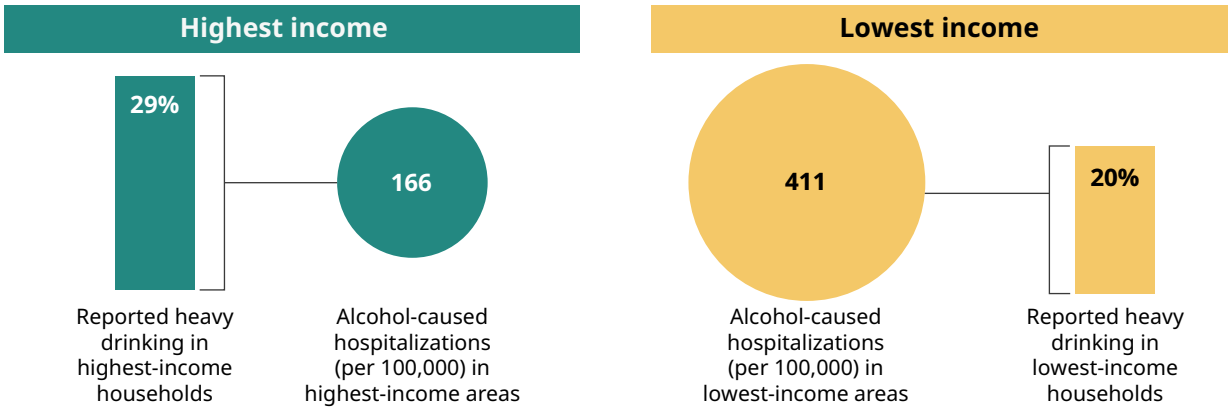
drinking at least one **alcoholic beverage** in the past 12 months,[6,7] and alcohol sales in Canada for 2022/23 totalled over $26 billion.[8]

Despite its place in society and the economy, alcohol remains one of the leading causes of preventable death, injury, and **disAbility**[c] in Canada and globally.[9-11] It also contributes to a wide range of chronic diseases that can persist for years and negatively impact health and well-being. Alcohol causes cancer[12] and contributes to roughly 7,000 new cancer cases each year in Canada, primarily breast and colon cancer, as well as cancers of the rectum, mouth, throat, liver, esophagus, and larynx.[13] Alcohol use increases the risk of several other health conditions including cirrhosis of the liver, stroke, hypertension, heart disease, and **alcohol use disorder**.[14,15] It is estimated that more than 3,000 children are born with **fetal alcohol spectrum disorder** per year in Canada due to alcohol use during pregnancy.[16] Alcohol intoxication is linked to incidents of violence[17-20] as well as **impaired driving** deaths,[21] and impaired driving remains one of the leading causes of criminal death in Canada.[21] In 2020, the cost of these harms in Canada reached an estimated $19.7 billion.[22]

Harms from alcohol are not experienced equally. In Canada, although people with the lowest incomes report less heavy drinking than people with the highest incomes, they are more than twice as likely to be hospitalized for conditions entirely caused by alcohol.[24]

BC First Nations leaders have highlighted the disproportionate alcohol-related harms that impact their communities,[25] and Métis people in Canada are at greater risk of dying from alcohol-related causes than non-Indigenous people.[26] These inequities stem from deeply embedded systems and ideologies of **settler colonialism** and **racism** that impact access to health care,[27] access to alcohol prevention and treatment programs (particularly in remote First Nations communities),[25] and socio-economic conditions[25,28] for Indigenous populations. Alcohol was not a prominent part of First Nations cultures and societies in BC before European contact, and the alcohol-related harms experienced by Indigenous people are a product of settler colonialism.

People with the lowest incomes report less heavy drinking but are more than twice as likely to be hospitalized for conditions caused by alcohol



Source: Canadian Institute for Health Information.[23,24]

c The Office of the Provincial Health Officer recognizes that people living with disAbilities are diverse and identify in various ways. The "A" in disability has been capitalized to focus on the abilities of people who live with disAbilities and to help remove deficit undertones of the word.

In Canada, all levels of government have considerable control when it comes to alcohol, as alcohol is a regulated, legal substance. Government policies can reduce the harms people experience from alcohol use. For example, changes to where and how alcohol is allowed to be sold can save lives.[29,30] Funding for alcohol treatment programs is typically administered at a provincial and territorial level.[25] Large-scale public awareness campaigns can also provide information to individuals about the risks of alcohol use and how to drink less.[31,32]

The purpose of this report is to provide updated information on alcohol use and its related health, social, and public safety harms experienced at a population level and by people in BC. It describes the province's current **alcohol policy** landscape and offers recommendations to improve health and well-being for everyone in the province.

Source: PEI Chief Public Health Office.[33]

A *Less Is Best* Approach

Health experts in Canada and elsewhere have determined that drinking less alcohol results in a lower risk of harm.[11,34,35] In other words, when it comes to avoiding the health risks of alcohol, less is best. Even small amounts of alcohol—such as one to two drinks per week—can pose risks to individuals, regardless of age, sex, gender, tolerance for alcohol, or lifestyle.[31] Whereas previous guidance in Canada defined low-risk drinking as 10 **standard drinks** per week for women and 15 for men,[36] updated guidance now considers low-risk drinking as one to two standard drinks per week regardless of gender.[31,d]

Alcohol use and patterns of drinking are shifting. Today's **youth** are trying their first alcohol at a later age and consuming less overall than youth in previous years. This

Inspiration for this report's key message of "less is best" comes from **Prince Edward Island's *Less Is Best* campaign**.[33]

d A standard drink is 17.05 millilitres or 13.45 grams of ethanol. See Chapter 2 for more information.

coincides with a growing interest in alcohol-free or "sober curious" lifestyles.[37-39] Based on sales data, alcohol consumption in BC peaked in 2020/21, during the COVID-19 pandemic, and as of 2023/24 has declined to its lowest levels in more than 20 years. Still, BC's per capita alcohol consumption remains higher than the Canadian average. It is also at levels that can cause health harms.

Over the past decade, alcohol policy in BC has also undergone its own shifts—ones that have made alcohol more physically and economically available to people in the province. These policies have often run counter to previous Provincial Health Officer's and other health experts' recommendations on alcohol.[40,41] As such, alcohol policies could be more closely aligned with public health priorities.

Previous Provincial Health Officer Reports on Alcohol

In 2008, then BC Provincial Health Officer Dr. Perry Kendall published a report titled *Public Health Approach to Alcohol Policy*[40] that updated and expanded upon a 2002 report of the same title. Where the 2002 report warned of upcoming provincial policy changes that were likely to increase the availability of alcohol in BC (e.g., the continued privatization of retail alcohol stores),[41] the 2008 report assessed the impacts of these changes. It showed that the physical and economic availability of alcohol, alcohol consumption, alcohol-related hospital stays, chronic disease deaths from alcohol, and impaired driving all increased in BC under these policies.[40] That report put forward 27 recommendations to mitigate these harms, 13 of which have been fully or partially implemented (see section Uptake of Recommendations From *Public Health Approach to Alcohol Policy* (2008) for more details).[42-51]

The Province made progress on recommendations related to alcohol-impaired driving, specifically with the introduction of its **Immediate Roadside Prohibition** program in 2010.[52] At the time, this made BC a leader in Canada in impaired driving countermeasures. Impaired driving deaths have decreased in the province since the introduction of Immediate Roadside Prohibition, demonstrating the powerful role policy can play in reducing alcohol-related harms.

The 2008 recommendations related to restricting the economic and physical availability of alcohol, which have the most potential to reduce alcohol consumption at the population level, remain largely unimplemented. Opportunities remain to implement recommendations to index the minimum price of alcohol to inflation, create surtaxes and harm reduction levies on high alcohol content drinks, and bring in measures such as **minimum unit pricing**—which encourage consumption of beverages with lower alcohol content.

Uptake of Recommendations From *Public Health Approach to Alcohol Policy* (2008)

Economic Availability

- ✗ Implement minimum unit pricing, indexed to inflation
- ✗ Encourage lower-alcohol products
- ~ Surtax on high-alcohol drinks

Physical Availability

- ✓ Keep moratorium on private liquor licences
- ✗ Review and adjust liquor outlet density in areas with vulnerable populations
- ✓ Increase minimum distance between licensed private liquor stores
- ✗ Monitor violence and road trauma associated with licensed venues
- ~ Restrict sales at bars/clubs to 2 a.m.

Other Policies

- ~ Resource enforcement/training to raise age verification compliance rates
- ✓ More random checks for impaired driving
- ✓ Ignition interlocks for people convicted of impaired driving
- ✓ Improve administrative licence suspensions
- ✓ Re-invigorate impaired driving enforcement
- ~ Increase screening and brief interventions for risky alcohol use
- ? Evaluate effectiveness of advertising restrictions/youth exposure
- ? Discuss controlling quantity of advertising
- ✓ Support BC Alcohol and Other Drug monitoring project
- ? Allocate resources to BC Vital Statistics Agency to improve data collection on alcohol morbidity and mortality
- ✗ Create harm reduction levy on specific alcohol products
- ✗ Meaningfully involve public health and addictions experts in all alcohol decision-making
- ~ Support local government decision-making
- ✓ Consider implementing the Municipal Alcohol Policy program

Reduce Violence Near Establishments

- ✗ Implement a violence prevention program
- ? Encourage local collaboration to reduce violence
- ? Implement compliance checks for service to intoxicated patrons and overcrowding
- ✗ Collect "last drink" information at alcohol-involved crime incidents
- ~ Require Serving it Right training every five years; do compliance checks

Legend

- ✓ Completed
- ✗ Not completed
- ~ Partially completed
- ? Unclear

Alcohol Policy in BC: Current Landscape

Indigenous Governments

Indigenous governments across Canada exercise their rights to self-govern in matters related to alcohol. Several First Nations in BC have implemented restrictions on alcohol sales, transportation, possession, and use that exceed federal and provincial/territorial restrictions. Some of these restrictions have led to what are known as "dry communities"—that is, communities that choose to be alcohol- and drug-free.[53] In BC, the Esk'etemc First Nation has been a dry community since 1972. The Nation's efforts are focused not on **prohibition** but on providing support to community members choosing sobriety.[54,55] The Nation runs a recovery house that provides "cultural components, safe housing and programs to strengthen wellness, recovery and reintegration into the community."[56] The snpink'tn Indian Band became a dry community in 2018.[57] The band supports this mission from a foundation of healing for its members that centres on treatment, recovery, and healing through ceremony.[58] In 2022, the Ahousaht First Nation petitioned provincial and municipal governments to limit sales at a nearby BC Liquor Store. The Nation's goal is to prevent alcohol being bootlegged in their community, which prohibits alcohol. In 2024, the Ministry of Public Safety and Solicitor General limited sales at the specific store to a maximum of four bottles of spirits per customer of any type packaged in plastic bottles of any size.[59-61]

Provincial Government

The BC Government is the main wholesale distributor of alcohol in BC, with some **liquor stores** owned and operated by the provincial government and others by the private sector. The BC Government is also responsible for the licensing and control of liquor-serving establishments (e.g., restaurants, bars, stadiums, manufacturers, special events).

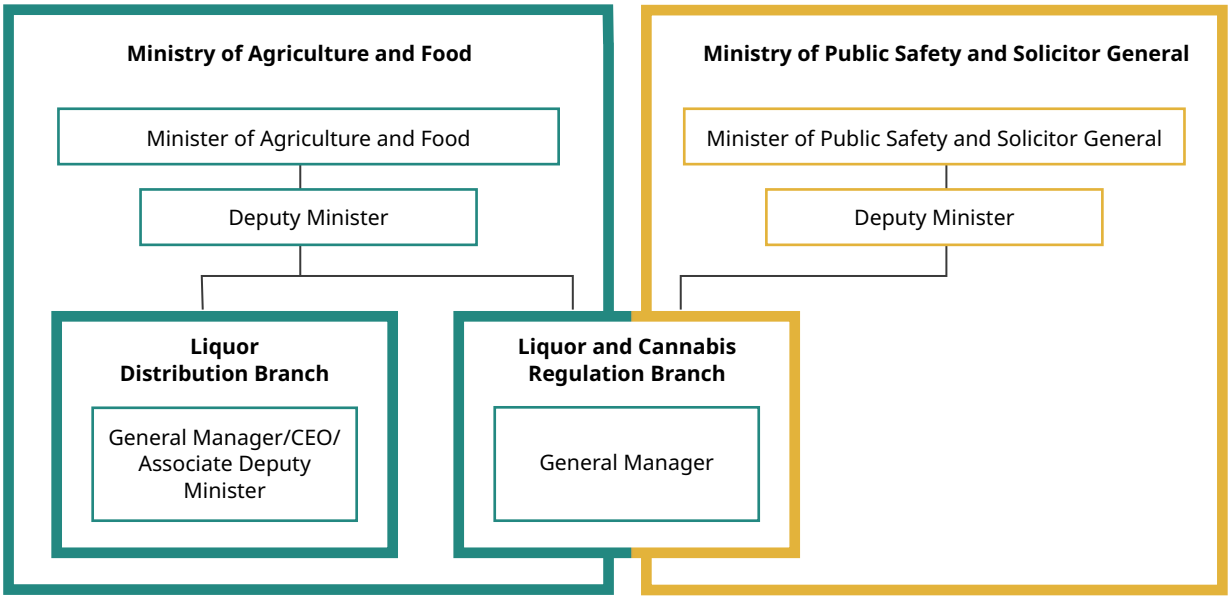
Two main government agencies are responsible for the sale, distribution, and regulation of alcohol in the province: the **Liquor Distribution Branch** (LDB) and the **Liquor and Cannabis Regulation Branch** (LCRB). Their roles and responsibilities are described in the following sections.

Liquor Distribution Branch

The LDB is responsible for the wholesale distribution of alcohol and cannabis to both private and government-run retailers. The LDB has been located in several ministries[e] over the years and in 2025 was moved from the Ministry of Public Safety and Solicitor General to the Ministry of Agriculture and Food.[62,63] Under the *Liquor Distribution Act*, the general manager, associate deputy minister, and chief executive officer of the LDB are authorized to establish **government liquor stores** and to set prices at which alcohol must be sold at these stores. As presented in Chapter 5, government liquor stores are the largest chain of liquor retail stores in the province, accounting for 34 per cent of alcohol sales in 2023/24. The LDB's goals include sustaining net returns to the province, improving the customer service experience, and creating positive social impact.[62]

e Liquor Distribution Branch service plans and mandate letters indicate that between 2009 and 2025 the Liquor Distribution Branch has been located in the following ministries: Housing and Social Development, Public Safety and Solicitor General, Energy and Mines, Justice and Attorney General, Finance, and Agriculture and Food.

BC Provincial Government Structures Responsible for Alcohol Distribution and Regulation



Liquor and Cannabis Regulation Branch

The LCRB administers legislation governing liquor and cannabis. The branch is located within two ministries: the Ministry of Agriculture and Food and the Ministry of Public Safety and Solicitor General.[63,64] Its general manager administers the *Liquor Control and Licensing Act* and the act's related regulations, subject to policy direction from the ministers.[65] The LCRB's mission is to "through sound policy and regulation, enable vibrant liquor and cannabis industries, while ensuring public health and safety."[66] The LCRB and the LDB have a shared mandate of encouraging "the responsible consumption of beverage alcohol and cannabis."[62]

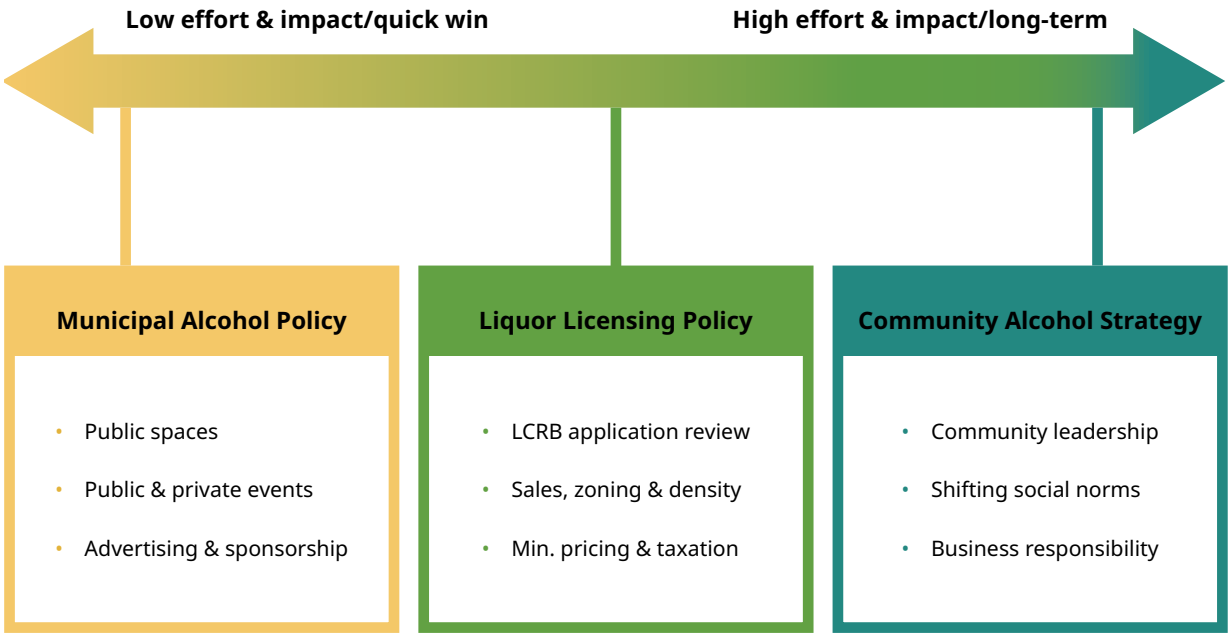
How the Provincial Government Engages With Industry

In 2018, the BC Government convened the Business Technical Advisory Panel (BTAP), a forum that formalized relationships with representatives from BC's alcohol and hospitality industries. BTAP was established as a time-limited panel to provide recommendations to government on liquor policy from an industry perspective.[67] BTAP has transitioned to be an ongoing avenue for government engagement with industry.[68,69]

Municipal and Local Governments

Municipal and local governments in BC have several tools at their disposal to control alcohol availability in their jurisdictions. The Municipal Alcohol Policy Continuum depicts this set of tools, which range from "quick-win" strategies to more comprehensive,

The Municipal Alcohol Policy Continuum



Source: Adapted from Island Health. *Alcohol Control Policies for Local Government.*[70]

long-term approaches to reduce alcohol consumption.[70] These include zoning bylaws that limit outlet density and proximity to sensitive locations (e.g., schools), noise and nuisance bylaws that regulate hours of sale and licensed outdoor patios, and policies that restrict alcohol advertising and sponsorship on municipal property.

There are recent examples of BC municipalities exercising their authority when it comes to liquor policy. In 2020 and 2021, several municipalities launched pilot projects to allow drinking in parks, and many of these pilot projects have since become permanent.[71] In 2025, despite opposition from public health experts,[72] Vancouver City Council amended its business hours bylaw to permit extended liquor service in certain areas, allowing bars in the downtown core to remain open until 4 a.m. and others until 3 a.m.[73]

Local governments have also acted to reduce alcohol-related harms. The District of Tofino implemented a municipal alcohol policy for events that is based on the principles of community health and safety, engagement and support, and inclusivity.[74] This policy sets out several conditions under which alcohol cannot be served at events held on municipal property, such as events intended for families and children.[74]

Alcohol Policy Changes Since the 2008 Provincial Health Officer Report on Alcohol

Since 2008, the provincial government has introduced a range of legislative and policy changes related to alcohol. Some of these changes are aligned with public health goals, such as the Immediate Roadside Prohibition program.[75] Additionally, legislative changes in 2014 created the Mandatory Display Program, which requires liquor-selling establishments to display educational material about "liquor, responsible consumption of liquor and liquor-related issues."[76] Other changes have made alcohol more readily available in BC.[77,78] The BC Government's 2014 Liquor Policy Review, a public consultation, resulted in 73 recommendations to government—nearly all of which were subsequently implemented.[78,79] These included allowing the sale of lower-priced alcohol at specific times ("happy hour"), relaxing restrictions to allow restaurants to operate as de facto bars, eliminating beer gardens (which removed the need for separate fenced areas in which to drink alcohol at events), and authorizing alcohol sales at farmers markets.[78,79]

Since BTAP's creation in 2018, further policy changes have also increased the availability of alcohol in BC. The LCRB extended liquor retail hours[80] and approved the sale and delivery of packaged alcohol from restaurants with the sale of a meal,[81] as well as wholesale pricing for restaurants and bars.[82] Alcohol industry representatives who sit on BTAP have taken credit for influencing some of these policy changes.[83-85]

Overview of the Alcohol Legislative and Policy Landscape in BC, 2008 to Present

2008

The Provincial Health Officer releases the updated report *Public Health Approach to Alcohol Policy*.[40]

2010

BC introduces the Immediate Roadside Prohibition program.[52,86]

2014 January

The *BC Liquor Policy Review Final Report* is released by the BC Ministry of Justice.[78]

Amendments are made to the *Liquor Control and Licensing Act* to allow for swifter implementation of the BC Liquor Policy Review recommendations.[87]

2014 April

Beverage garden and fencing requirements at events such as festivals are eliminated.[79,87]

2014 June

Minors can now enter approved bars for the purposes of family dining.[79,87]

Manufacturers (e.g., breweries, wineries, distilleries) are permitted to sell liquor at farmers markets.[79,87]

UVin/UBrew allowed to be served at special events (e.g., weddings, family reunions).[79,88]

Happy hour is permitted at restaurants, bars, clubs, lounges, and special events.[79,87]

2015 April

Grocery stores may sell liquor (using a store-within-a-store model or selling only BC-made wine).[79,87]

Private liquor store licence moratorium is maintained.[89]

Social responsibility public education materials on alcohol use are required to be displayed at all licensed establishments and private liquor stores. This program is called the Mandatory Display Program, or "Alcohol Sense."[76,79]

2015 November

Food primary licence restrictions are relaxed and patrons can now have a drink anywhere in an establishment (not just in a lounge) as long as the overall focus is still food.[79,90]

2016 February

BC implements new penalties for alcohol-impaired driving. Drivers issued a 90-day immediate roadside prohibition or who accumulate points on their licence related to repeat impaired driving are required to participate in the Responsible Driver Program and/or the Ignition Interlock Program.[91]

2016 May

New minimum liquor prices (by volume) established for off-premise sales.[92]

2016 October

Online alcohol orders and delivery from stores and certain manufacturers are permitted.[93]

2017 January

Patrons in a hotel with a licensed restaurant or bar can take an unfinished drink to their room, and hotels can offer a free drink during check-in.[79,88]

Restaurants with approval can operate as a bar or nightclub after a certain hour.[79,88]

Any business can be licensed to serve alcohol (e.g., bookstores, art galleries).[79,88]

2017 December

People can access alcohol samples at any time during a guided tour of a winery, brewery, distillery, etc. [88,94]

2018

The Business Technical Advisory Panel is established to provide recommendations.[67,83]

2018 July

Imported wine is allowed on grocery store shelves (prior to this, only BC wine was allowed).[95]

2019 November

BC passes the *Declaration on the Rights of Indigenous Peoples Act* into law mandating the provincial government to bring provincial laws into alignment with UNDRIP.[1]

2020 March

The World Health Organization officially declares COVID-19 a pandemic.[96]

Restaurants and bars are temporarily permitted to sell and deliver packaged liquor for off-site consumption with the purchase of a meal.[97]

2020 April

Liquor store retail hours are temporarily extended from 9 a.m.–11 p.m. to 7 a.m.–11 p.m.[98]

2020 May

Restaurants and bars are temporarily permitted to expand their alcohol service areas to comply with physical distancing.[98]

2021 February

Restaurants and bars are permanently permitted to purchase liquor at the wholesale price set by the Liquor Distribution Branch.[82]

2021 March

Licensed restaurants and bars are permanently allowed to sell and deliver packaged liquor for off-site consumption with the purchase of a meal.[81]

2021 July

Liquor store retail hours are permanently extended from 9 a.m. – 11 p.m. to 7 a.m. – 11 p.m.[80,84]

Restaurants and bars can now sell and deliver mixed drinks (e.g., cocktails) with the purchase of food.[84,99]

2021 October

The moratorium on new Licensee Retail Store licences is extended from July 1, 2022, to July 1, 2032.[100]

2022 April

Managed alcohol programs are authorized under the *Liquor Control and Licensing Act* if approved by a health authority.[101]

2023 February

The Chiefs Council of the Union of BC Indian Chiefs adopts resolutions on alcohol regulation, funding, and jurisdiction.[102]

2023 March

The Chiefs-in-Assembly of the BC Assembly of First Nations adopt resolutions on alcohol regulation, funding, and jurisdiction.[25]

2023 December

Licensees who hold multiple licences can now purchase and sell (transfer) up to $100,000 of liquor between their own licences annually.[103,104]

2024 January

The Health Officers Council of BC publishes a position paper on alcohol that includes 29 recommendations to government.[105]

2024 April

Liquor manufacturers (e.g., wineries, breweries, distilleries) with an on-site store endorsement are now permitted to sell packaged liquor almost anywhere on the manufacturing site and are allowed to sell and serve liquor by the glass (with restrictions) in a picnic sale area.[106,107]

2025 March

The Liquor Distribution Branch pauses the importation of U.S.-made liquor products, and BC Liquor Stores halt retail sales of U.S.-made liquor products. Both measures are responses to the Canada-U.S. tariff crisis.[108]

2025 July

Oversight of LDB and LCRB is transferred from the Ministry of Public Safety and Solicitor General to the Ministry of Agriculture and Food, with the Ministry of Public Safety and Solicitor General retaining the compliance and enforcement functions.[63,64]

Note: If a policy was announced on one date but took effect later, the effective date is used. If the effective date is not clear in the sources, or when implementation was immediate, the announcement date is used.

Organization of This Report

This report summarizes the most recent data available on alcohol consumption and its impacts on the health and well-being of individuals and the population as a whole in the province. Chapter 2 reviews alcohol consumption across the province by health region, age, and sex to identify trends. Chapter 3 presents the population-level harms of alcohol use, including deaths and hospitalizations, **alcohol-impaired driving**, and economic costs associated with health and social harms of alcohol use. Chapter 4 provides information on how reducing alcohol use can lower risks for conditions like cancer and heart disease and highlights available tools people can use to reduce drinking. Chapter 5 reviews alcohol policy in BC—from pricing and physical availability to impaired driving countermeasures and health and safety messaging—and outlines how various policy levers can be used to decrease the risks of alcohol-related harms. Finally, Chapter 6 offers recommendations to the BC Government for alcohol policy and legislation. These recommendations aim to strike a better balance between the social and economic considerations of alcohol use and the harm caused by alcohol consumption while also highlighting existing direction on alcohol regulation given to the Province by the Chiefs-in-Assembly of the BC Assembly of First Nations and the Chiefs Council of the Union of BC Indian Chiefs.

Data in This Report

A large portion of the data for this report comes from the BC Alcohol and Other Drug monitoring project, run by the Canadian Institute for Substance Use Research at the University of Victoria, which uses alcohol sales data from Statistics Canada and from the LDB and the LCRB. Data related to self-reported alcohol use come from the following sources: the Canadian Substance Use Survey, the Canadian Community Health Survey, and the BC Survey on Population Experiences, Action, and Knowledge. Youth-specific data on alcohol use come from the BC Adolescent Health Survey. Throughout this report, the time frames and age ranges included in charts vary. Where possible, time frames extend back to the publication of the previous Provincial Health Officer report on alcohol in 2008. If this was not feasible, the longest available time frames were selected that maintained consistent data collection and analysis methods. Age ranges in charts were mainly determined by the source data and may vary across data sources. Most of the data reflect only binary sex categories (male/female), and not a full spectrum of sex and gender identities. When most of these data were collected, data collection instruments did not differentiate between an individual's biological sex and their gender (how a person self-identifies). Greater inclusion of sex and gender categories is a goal for future Provincial Health Officer reports.

This report presents estimates of alcohol consumed in BC using annual alcohol sales data. Annual alcohol sales data do not take into consideration homemade alcohol or **non-beverage alcohol** (e.g., rubbing alcohol, mouthwash, hand sanitizer) that can sometimes be consumed by people with alcohol use disorder. People in the province may also purchase alcohol and not drink it right away, particularly when it comes to specialty products. A portion of annual alcohol sales data includes alcohol sold to tourists, who are not BC residents. Alcohol

sales data therefore both underestimate and overestimate consumption in the province. However, sales data are still the most reliable snapshot of how much people drink in BC and provide valuable insight into an important factor influencing the health and wellness of the BC population.

Conclusion

Alcohol has long played a role in people's lives, but its consumption remains the leading cause of preventable death, injury, and disAbility in Canada and contributes to chronic disease. Many of these harms are disproportionately experienced by certain segments of the population. While people can lower their health risks by drinking less, reducing alcohol-related harm requires collaborative, system-wide efforts. All levels of government have a role to play in shaping alcohol policy in BC, and Indigenous rights to self-determination include the realm of alcohol regulation and policy. Together, governments have an opportunity to balance the social and economic aspects of alcohol with the goal of protecting health and well-being for all.

Key Messages

- Indigenous rights to self determination are affirmed in BC under the *Declaration on the Rights of Indigenous Peoples Act* and these rights extend to alcohol regulation.
- The Chiefs-in-Assembly of the BC Assembly of First Nations and the Chiefs Council of the Union of BC Indian Chiefs have called on the BC Government for greater jurisdictional control of alcohol and involvement in provincial alcohol regulation via meaningful engagement and consultation.
- Drinking less alcohol is best for overall health, as has been confirmed by recent research and updates to alcohol guidance in Canada.
- Changes to alcohol policy in recent decades have made it easier for people to buy and drink alcohol.
- This report provides updated information on alcohol use and its related health, social, and public safety harms in BC, and provides recommendations to reduce those harms.

Chapter 2
Alcohol Use in BC

Alcohol is one of the most widely used **psychoactive substances**. More than 60 per cent of people in BC report drinking alcohol on a regular basis (at least once a month in the last 12 months).[1,2] By comparison, 38 per cent had used cannabis, and 12 per cent had used **unregulated drugs** such as cocaine, heroin, hallucinogens, or methamphetamines.[3] About 10 per cent of the population in BC smoke cigarettes.[3] Monitoring alcohol use at a population level is crucial for public health leaders, government officials, and other decision makers. It sheds light on changes in drinking habits over time, across demographics, and in different geographic regions. Sometimes, data broken down to these levels can reveal **health inequities** within a population.

This chapter examines drinking levels (how much people consume) and drinking patterns (how much people consume per occasion) in BC and in Canada.

Why Do People Drink Alcohol?

People drink alcohol at ceremonies and celebrations, to mark life events, and to relax and socialize. Alcohol is also used to cope with personal challenges, including stress, depression and anxiety,[4] grief,[5] and trauma.[6] At various points in history, alcohol was even used medicinally,[7] and misinformation persists that small amounts are therapeutic or beneficial to health.[8,9] Although evidence now shows that alcohol offers no overall physical health benefits,[10-12] some people may continue to drink based on this outdated information.

The reasons for alcohol consumption go far beyond personal choice, however. Alcohol is a commercial product, and the environment in which it is sold and promoted can greatly influence consumption at both an individual and a population level.[13,14] Weak controls on advertising,[15] outlet density,[16,17] hours of sale,[18] and pricing[19-21] all contribute to increased consumption.

Globally and in BC, the alcohol industry often influences this environment as well.[13,22,23]

Through tactics such as lobbying, gaining access to political decision makers, and corporate messaging, industry actors often protect and expand their market interests in ways that normalize drinking and obscure its harms.[13] This influence is an example of the **commercial determinants of health**, where industry interests directly impact population-level health outcomes.[13,22] Recognizing this influence creates opportunities for governments, health-care leaders, and others to raise public awareness about alcohol use and risks, enact evidence-based policies to reduce consumption, and create a healthier balance between public interests and industry practices.

Structural factors also play a role in alcohol use. Research shows a link between higher socio-economic status and regular drinking,[24] but alcohol use is also common among people experiencing poverty,[25] homelessness,[26] and other forms of marginalization.[27] And because **ethanol** is an addictive substance, some people continue drinking simply because stopping is difficult or seems impossible.[28] Access—or lack thereof—to alcohol use disorder treatment and support also impacts how and why people may continue to drink.

What is a Standard Drink?

A standard drink is a common measure in public health and clinical research to identify and standardize what is meant by a single drink of alcohol. This standardization is needed because the percentage of ethanol (consumable pure alcohol) contained in a single drink can vary across beverage types.

For example, a single beer could contain a lower or higher percentage of ethanol (e.g., a 3 per cent "light" beer compared with a 10 per cent stout), yet both are commonly referred to as "a drink." Standard drinks account for this difference. In Canada, a standard drink is defined as 17.05 millilitres or 13.45 grams of ethanol.[29]

A STANDARD DRINK MEANS:

BEER
341 mL (12 oz), 5% alcohol

COOLER/CIDER/ HARD SELTZER
341 mL (12 oz), 5% alcohol

WINE
142 mL (5 oz), 12% alcohol

SPIRITS (WHISKY, VODKA, GIN, ETC.)
43 mL (1.5 oz) 40% alcohol

Source: Adapted from Health Canada. *Low-Risk Alcohol Drinking Guidelines.*[29]

Alcohol Use by Geography

Consuming seven or more standard drinks per week puts individuals at increasingly high risk for health harms, according to the **Canadian Centre on Substance Use and Addiction's guidance on alcohol and health**.[11] Data from alcohol sales show that the average per-person consumption of alcohol in BC is above this threshold and higher than the Canadian average. In 2023/24, averaged across the population age 15 and older, people in BC bought the equivalent of 8.8 standard drinks per person per week, compared to 8.2 standard drinks per person per week in Canada.[30,f] While average sales in BC have decreased from a high of 10.1 standard drinks per week in 2020/21 (years coinciding with the height of the COVID-19 pandemic), they remain above levels associated with elevated health risks.[11,30]

Average Standard Drinks per Person, per Week, BC and Canada, 2023

CANADA

standard drinks per person per week

BRITISH COLUMBIA

standard drinks per person per week

Note: Standard drinks per week calculated from litres per year.
Source: Statistics Canada.[30]

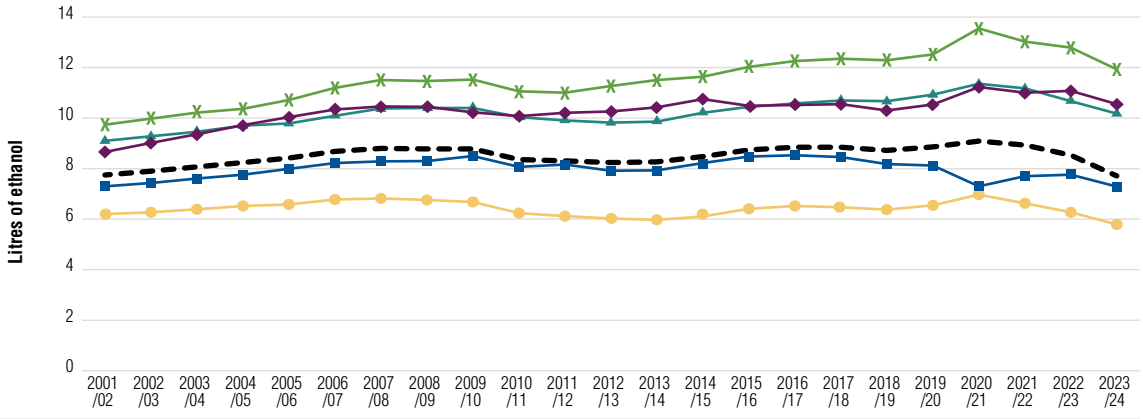
f This report draws on two sources of data for total alcohol consumption in BC: the BC Alcohol and Other Drug monitoring project (which provides estimates by health region within BC) and Statistics Canada's Control and Sale of Alcoholic Beverages and Cannabis program (which allows comparisons between BC and Canada). Each produce slightly different estimates due to different approaches and inclusion criteria. See Appendix B for further information about these data sources.

Average alcohol consumption figures do not capture individual patterns of alcohol use. Not everyone age 15 and older in BC drinks alcohol, and among those who do, consumption varies widely. While some people have one or two drinks per week, others consume much more.

Estimates suggest that just 10 per cent of the population buys and consumes nearly half of all alcohol sold in Canada.[31] However, the majority of alcohol-related deaths happen among the other 90 per cent—the people who buy and drink much less.[31] This is because even small risks from alcohol, when spread across millions of people, add up to a large amount of harm. While interventions are needed for people who drink large amounts or who have alcohol use disorder, policies to reduce or prevent consumption must also be targeted at everyone so that they can have the widest and most meaningful impact on the overall health of the population.[31]

Alcohol use also varies in different regions of BC. People living in the Island, Interior, and Northern health regions consistently consume higher levels of alcohol than the provincial average (Figure 2.1 and Table 2.1). In 2020/21, alcohol consumption in the Interior health region peaked at an annual average of 13.6 litres of pure ethanol per person (equivalent to 15 standard drinks per week)—well above the provincial average that year of 9.1 litres (equivalent to 10 standard drinks per week). This is consistent with other reports of high consumption rates in the Interior health region.[32]

FIGURE 2.1 **Per Capita Average Alcohol Consumption by Regional Health Authority, BC, 2001/02 to 2023/24**



	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Interior	9.7	10.0	10.2	10.4	10.7	11.2	11.5	11.5	11.5	11.1	11.0	11.3	11.5	11.6	12.0	12.3	12.4	12.3	12.5	13.6	13.0	12.8	11.9
Fraser	6.2	6.3	6.4	6.5	6.6	6.8	6.8	6.8	6.7	6.2	6.1	6.0	6.0	6.1	6.4	6.5	6.5	6.4	6.6	7.0	6.6	6.3	5.8
Vancouver Coastal	7.3	7.4	7.6	7.8	8.0	8.2	8.3	8.3	8.5	8.1	8.2	7.9	7.9	8.2	8.5	8.5	8.5	8.2	8.1	7.3	7.7	7.8	7.3
Island	9.1	9.3	9.5	9.7	9.8	10.1	10.4	10.4	10.4	10.0	9.9	9.8	9.9	10.2	10.5	10.6	10.7	10.7	10.9	11.4	11.2	10.7	10.2
Northern	8.7	9.0	9.4	9.7	10.0	10.3	10.5	10.5	10.2	10.1	10.2	10.3	10.4	10.8	10.5	10.5	10.6	10.3	10.5	11.2	11.0	11.1	10.6
BC	7.8	7.9	8.1	8.2	8.4	8.7	8.8	8.8	8.8	8.4	8.3	8.2	8.3	8.5	8.7	8.9	8.9	8.7	8.9	9.1	8.9	8.5	7.7

Notes: The quantities displayed represent estimated litres of pure ethanol consumed per person age 15 and older, derived from alcohol sales data. Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Tourism is potentially driving up alcohol sales in the Interior health region, which is where most of BC's wineries are located. However, as discussed in the next chapter, data show that people in BC experience higher rates of deaths, hospitalizations, and injuries from alcohol in regions where alcohol sales are higher. This includes the Interior, which suggests that the high alcohol sales in this region stem not solely from tourism but also from people in the area purchasing—and drinking—more.

Nearly all health regions saw an increase in alcohol consumption in 2020/21, which corresponds with the start of the COVID-19 pandemic. The decline seen in Vancouver Coastal during this period may have been due to reduced sales at bars and restaurants that likely impacted metro areas of Vancouver more than other regions of the province. Overall, people in BC are drinking less since the pandemic. However, some local health areas such as Revelstoke, Howe Sound, and Fort Nelson are still seeing increases in consumption over 2020/21 levels.[33]

TABLE 2.1 **Average Standard Drinks per Person, per Week, by Regional Health Authority, BC, 2023/24**

Health Region	Average Standard Drinks per Person, per Week
Interior	**13.4**
Northern	**11.9**
Island	**11.5**
Vancouver Coastal	8.2
Fraser	6.5
BC	8.8

Note: Standard drinks per week is calculated from litres per person, per year, where a standard drink is 17.05mL of ethanol and a year is 52.1429 weeks. Please see Appendix B for more information. Bold and highlighted text indicates levels of consumption above provincial average.
Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

People in the **Interior, Northern, and Island health** regions **drink more** than the provincial average.

Alcohol Use by Age and Sex

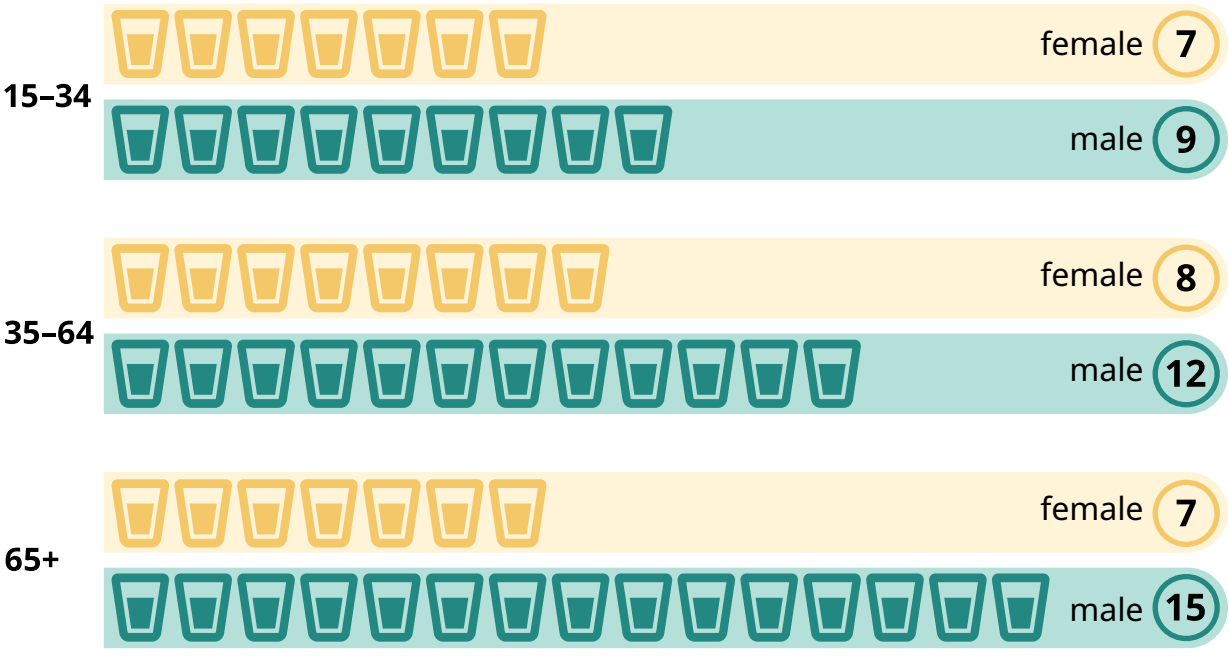
In BC, male residents across all age groups drink more alcohol than female residents (Table 2.2). In 2023, male **seniors** (those age 65 and older) consumed the most in the province at an estimated 13.4 litres of pure ethanol per person annually, or an average of 15 standard drinks per week. This amount is more than double that consumed by female seniors and by female residents age 15–34. Nearly all age groups in BC are consuming more alcohol than their peers in the rest of Canada, except for male residents age 35–64, who drink slightly less.

TABLE 2.2 Average Litres of Pure Ethanol per Person, per Year, by Age and Sex, BC and Canada, 2023

	Female, 15–34	Male,15–34
BC	**6.6**	**7.7**
Canada	5.5	7.4
	Female, 35–64	**Male, 35–64**
BC	**7.3**	**10.2**
Canada	6.5	10.6
	Female, 65+	**Male, 65+**
BC	**6.6**	**13.4**
Canada	6.0	10.5

Note: Estimates are derived from self-reported alcohol use survey data and alcohol sales data. Please see Appendix B for more information.
Source: Canadian Substance Use Survey, Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

Average Standard Drinks per Person, per Week, by Age and Sex, BC, 2023



Notes: Litres per year from Table 2.2 are converted to standard drinks per week.
Source: See Table 2.2.

Alcohol Use: Stereotypes, Discrimination, and Racism in BC's Health-care System, and Identified Ways Forward

In BC and across Canada, there is widespread and ongoing stereotyping and discrimination towards Indigenous people, particularly relating to alcohol use.[34] In 2020, the Province commissioned the report *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C*. Led by an independent review team, the report uncovered and sought to address **Indigenous-specific racism** in BC's health-care system.[34] Specific to alcohol, Indigenous survey respondents described how health-care providers routinely presumed them to be drunk when their presentation was due to other causes. This led to their medical needs going unassessed or untreated.[34]

Since the 2020 report, other studies have documented how Indigenous patients' medical symptoms are often dismissed or misattributed to intoxication or withdrawal, sometimes with fatal consequences for the patient.[34,35] A higher proportion of visits to emergency departments and urgent care centres by First Nations patients result in the patient leaving without being seen compared with visits by non-First Nations patients.[36,37]

These outcomes are not the result of Indigenous people being heavy drinkers but are the result of ongoing Indigenous-specific racism in BC and within health-care settings. In fact, First Nations people and Inuit are more likely to abstain from alcohol than the general population. National survey results showed that 31 per cent of off-reserve First Nations people and 38 per cent of Inuit were non-drinkers compared with 24 per cent of the non-Indigenous population.[38] Indigenous people experience discrimination, stereotyping, and racism related to alcohol as a result of settler colonialism—and this contributes to poorer health outcomes. It also perpetuates distrust in provincial institutions and compounds intergenerational traumas by preventing Indigenous people from receiving the culturally safe care in health-care settings that they are entitled to.

Recommendations from the *In Plain Sight* report:

Recommendation 1: That the B.C. government apologize for Indigenous-specific racism in the health care system, setting the tone for similar apologies throughout the health system, and affirm its responsibility to direct and implement a comprehensive, system-wide approach to addressing the problem, including standardized language and definitions, and clear roles and responsibilities for health authorities, regulatory bodies, associations and unions, and educational institutions.

Recommendation 2: That the B.C. government, in collaboration and cooperation with Indigenous peoples in B.C., develop appropriate policy foundations and implement legislative changes to require anti-racism and "hard-wire" cultural safety, including an *Anti-Racism Act* and other critical changes in existing laws, policies, regulations and practices, ensuring that this effort aligns with the *UN Declaration* as required by *DRIPA*.

Heavy Episodic Drinking

Drinking a large amount of alcohol in one sitting—five or more drinks for male individuals, or four or more for female individuals—is referred to as **heavy episodic drinking** or "binge drinking."[39] The percentage of people drinking heavily on a single occasion at least once a month in BC is relatively consistent across different regions of the province, with some slight variations.

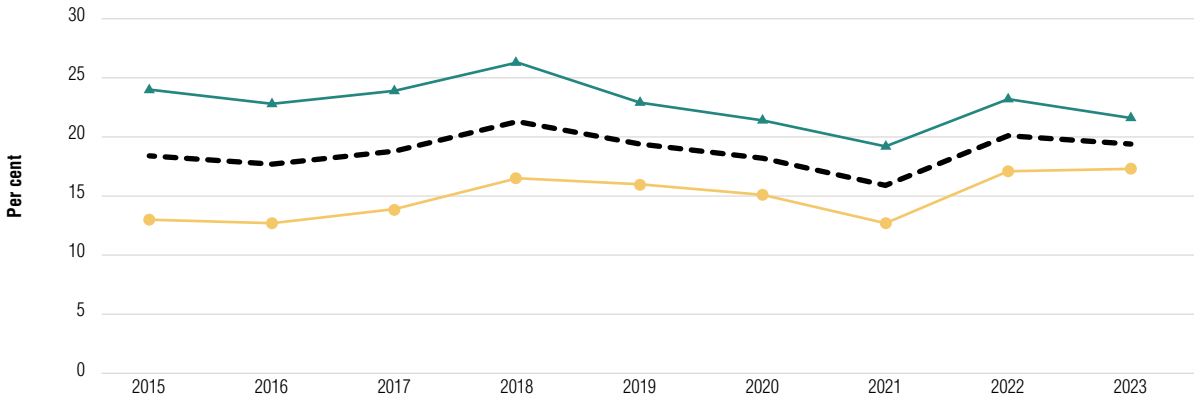
In 2021, the Interior health region had the highest percentage of people reporting this drinking pattern (29 per cent) and Fraser had the lowest (25.3 per cent) (see Table 2.3). These percentages reflect only those who drank alcohol in the past year, not the total provincial population. While data show relatively lower alcohol sales in Vancouver Coastal, self-reported rates of heavy episodic drinking in this region are similar to those seen elsewhere in the province.

TABLE 2.3 Percentage of People Reporting Drinking Heavily at Least Once per Month in the Past Year, by Regional Health Authority, BC, 2021

Interior	Fraser	Vancouver Coastal	Island	Northern	BC Total
29.0%	25.3%	28.0%	27.8%	27.0%	27.1%

Notes: Heavy episodic drinking is called "binge drinking" in the survey. Binge drinking is defined as five or more drinks on one occasion for male respondents, and four or more drinks on one occasion for female respondents, at least once a month, in the last 12 months. The results reflect percentages among people who drank alcohol. People who did not drink alcohol in the last 12 months were not included in the calculation.
Source: BC COVID-19 Survey on Population Experiences, Action, and Knowledge, Round 2 Results. BC Centre for Disease Control. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

FIGURE 2.2 Heavy Episodic Drinking, by Sex, BC, 2015 to 2023



	2015	2016	2017	2018	2019	2020	2021	2022	2023
Male	24.0	22.8	23.9	26.3	22.9	21.4	19.2	23.2	21.6
Female	13.0	12.7	13.9	16.5	16.0	15.1	12.7	17.1	17.3
Total	18.4	17.7	18.8	21.3	19.4	18.2	15.9	20.1	19.4

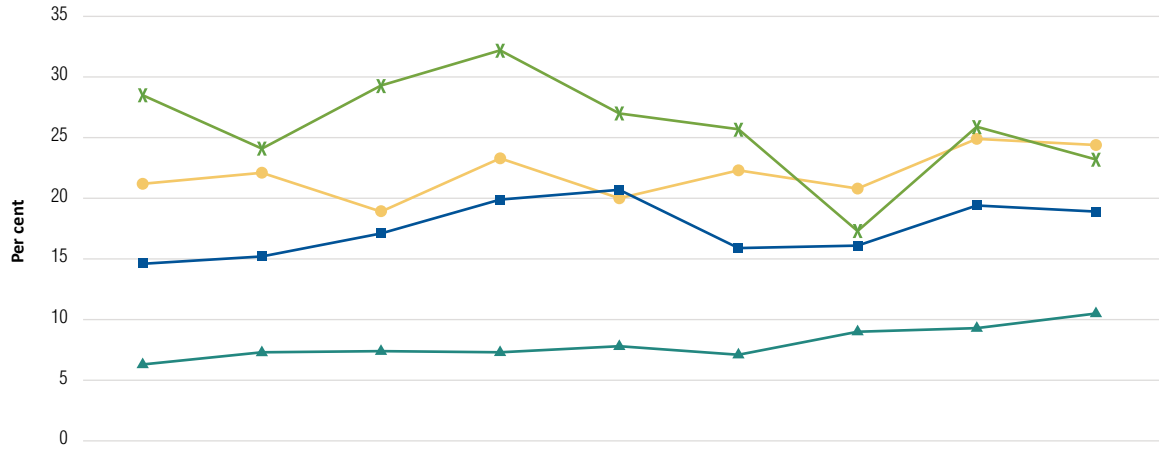
Notes: Heavy episodic drinking refers to male respondents who reported having five or more drinks, or female respondents who reported having four or more drinks, on one occasion, at least once a month in the past year. Data reported as percentage of population age 18 and older. Please see Appendix B for more information.

Source: Canadian Community Health Survey. Retrieved from Statistics Canada Table 13-10-0905-01 Health indicator statistics, annual estimates. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Figure 2.2 presents the percentage of people age 18 and older in BC who reported drinking heavily on a single occasion at least once per month in the past year. While the gap has been narrowing over time, male residents are overall more likely to engage in this pattern of drinking than female residents. In 2023, around one in five people in BC reported drinking heavily on a single occasion at least once per month.

Although overall alcohol consumption in BC has declined in recent years, this does not necessarily mean that all drinking behaviours are decreasing. Patterns of drinking, including heavy episodic drinking, can change or stay the same independently of overall consumption. From 2015 to 2023, younger age groups (18–34, 35–49, and 50–64) in BC were more likely to engage in heavy drinking on a single occasion than those age 65 and older (Figure 2.3). The fluctuations over time in Figure 2.3 are generally not statistically significant (see Appendix B for more information). Overall, trends of heavy episodic drinking in BC are on par with Canada's national average.[40]

FIGURE 2.3 **Heavy Episodic Drinking, by Age, BC, 2015 to 2023**



	2015	2016	2017	2018	2019	2020	2021	2022	2023
18–34	28.5	24.1	29.3	32.2	27.0	25.7	17.3	25.9	23.2
35–49	21.2	22.1	18.9	23.3	20.0	22.3	20.8	24.9	24.4
50–64	14.6	15.2	17.1	19.9	20.7	15.9	16.1	19.4	18.9
65 and over	6.3	7.3	7.4	7.3	7.8	7.1	9.0	9.3	10.5

Notes: Heavy episodic drinking refers to male respondents who reported having five or more drinks, or female respondents who reported having four or more drinks, on one occasion, at least once a month in the past year. Data reported as percentage of population age 18 and older. Please see Appendix B for more information.

Source: Canadian Community Health Survey. Retrieved from Statistics Canada Table 13-10-0905-01 Health indicator statistics, annual estimates. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

People **age 64 and younger** in BC are more likely to **engage in heavy episodic drinking** than BC seniors.

Youth drinking has reached a **20-year low** in the province.
There is more to be done: **38% of youth age 12–19 have tried alcohol**.

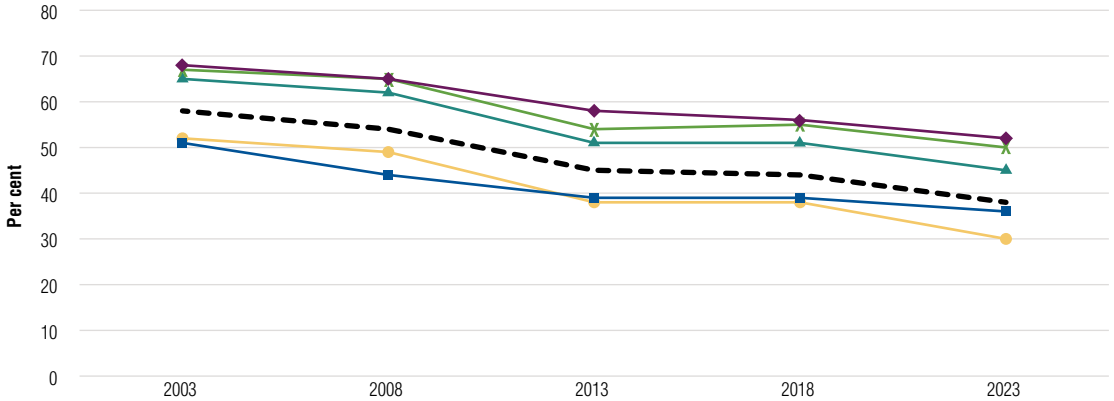
Youth Experiences With Alcohol

There are many reasons youth choose to drink. In BC, youth have reported using alcohol and other substances to experiment, to have fun, and "because their friends were doing it."[41] At the same time, the harms youth experience when consuming alcohol are greater than those for adults.[39] These include adverse effects on brain development and functioning,[42,43] unintended or unsafe sexual behaviour,[44,45] violence,[46] injuries,[47] and alcohol overdose.[48] Heavy episodic drinking in youth increases risks of injury,[47] aggression and violence,[46] dating violence,[49] and worsening academic performance.[39,50] The Canadian Centre on Substance Use and Addiction's guidance on alcohol and health recommends youth under the legal drinking age (age 19 in BC) delay their introduction to drinking as long as possible.[51]

Fewer young people in BC are choosing to drink alcohol than ever before. The percentage of youth who have tried alcohol beyond a few sips is on the decline overall and across all health regions—and reached its lowest point in 2023 (see Figure 2.4). The percentage of youth who have tried alcohol beyond

FIGURE 2.4

Alcohol Use Among Youth, by Regional Health Authority, BC, 2003 to 2023



	2003	2008	2013	2018	2023
Interior	67	65	54	55	50
Fraser	52	49	38	38	30
Vancouver Coastal	51	44	39	39	36
Island	65	62	51	51	45
Northern	68	65	58	56	52
BC	58	54	45	44	38

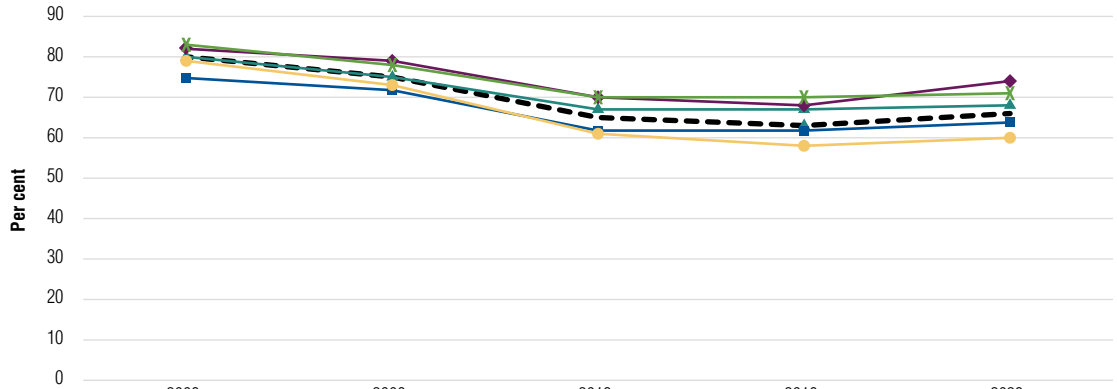
Notes: Percentage of youth age 12–19 in public schools who reported having ever tried alcohol, beyond a few sips. Please see Appendix B for more information.
Source: BC Adolescent Health Survey, McCreary Centre Society. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

a few sips is the highest in the Northern (52 per cent), Interior (50 per cent), and Island (45 per cent) health regions, which aligns with patterns of adult alcohol use in the province described earlier.

Youth in BC are also delaying the age at which they start drinking. From 2003 to 2013, the percentage of youth who had tried alcohol beyond a few sips before the age of 15 decreased across all health regions (Figure 2.5). Rates remained stable from 2013 through 2023, aside from slight increases in Northern and Fraser health regions between 2018 and 2023. For other regions, changes between 2018 and 2023 likely reflect small random variations in results over survey cycles rather than true changes in youth behaviour.[52] While these data show a long-term decline in early alcohol use among youth, 38 per cent of youth age 12–19 in public schools have tried alcohol (Figure 2.4), highlighting opportunities for the province to further strengthen efforts that support healthy choices and reduce alcohol-related risks for youth.

FIGURE 2.5

Alcohol Use Before Age 15, by Regional Health Authority, BC, 2003 to 2023



	2003	2008	2013	2018	2023
Interior	83	78	70	70	71
Fraser	79	73	61	58	60
Vancouver Coastal	75	72	62	62	64
Island	80	75	67	67	68
Northern	82	79	70	68	74
BC	80	75	65	63	66

Notes: Among youth age 12–19 in public schools who had ever tried alcohol beyond a few sips, percentage who first tried it before the age of 15. Please see Appendix B for more information.

Source: BC Adolescent Health Survey, McCreary Centre Society. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

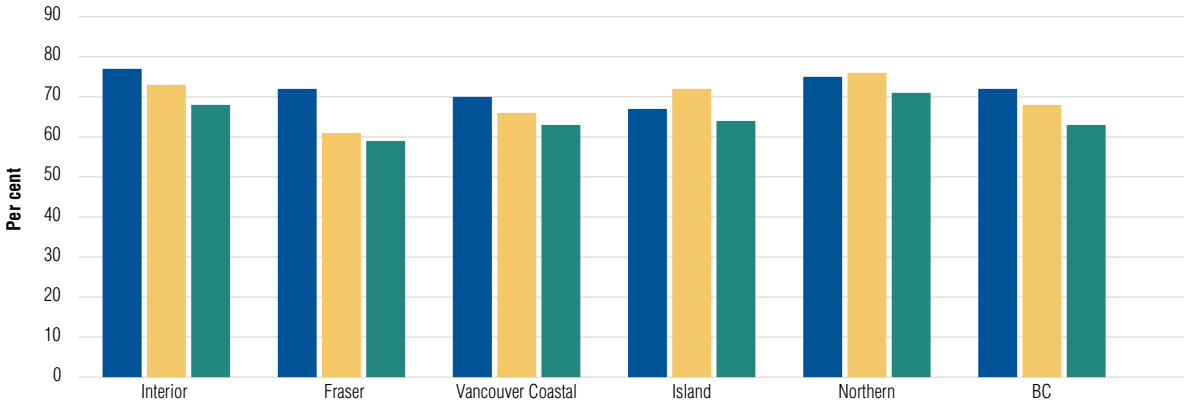
Affirming education and **anti-bullying policies** strengthen health-protective factors for non-binary youth.

Overall, the trend towards reduced alcohol consumption is likely contributing to overall health and well-being among youth. However, not all youth are benefiting equally. Non-binary youth in BC—those who do not identify as male or female or who are not yet sure of their gender identity[g]—are more likely to start drinking at a younger age (Figure 2.6). While 68 per cent of female youth and 63 per cent of male youth who have ever consumed alcohol started drinking before the age of 15, this number rises to 72 per cent for non-binary youth.

This finding aligns with broader research showing that **2SLGBTQQIA+** youth—including those who identify as non-binary—face higher rates of discrimination, stigma, and social exclusion, which can contribute to increased mental health challenges.[53-55] These experiences, in turn, can be linked to higher rates of hazardous substance use, including alcohol, compared to their peers.[54,56] Anti-bullying policies and improved classroom education on sexual orientation and gender identity are upstream factors that can help address and prevent the discrimination and harassment that may lead to substance use among 2SLGBTQQIA+ youth.[57,58]

FIGURE 2.6

Alcohol Use Before Age 15, by Gender Identity, Regional Health Authority, BC, 2023



	Interior	Fraser	Vancouver Coastal	Island	Northern	BC
Non-binary	77	72	70	67	75	72
Female	73	61	66	72	76	68
Male	68	59	63	64	71	63

Notes: Among youth age 12–19 in public schools who had ever tried alcohol beyond a few sips, percentage who first tried it before the age of 15.The survey question asked youth to identify as male, female, or non-binary. Usually "female" and "male" are terms for sex, not gender. However, this survey used the terms as gender categories. Please see Appendix B for more information.

Source: BC Adolescent Health Survey, McCreary Centre Society. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

g The survey question asked youth to identify as male, female, or non-binary. Usually "female" and "male" are terms for sex, not gender. However, this survey used the terms as gender categories.

Conclusion

Although alcohol use in BC is at a 20-year low, many people are consuming alcohol in ways that put them at increased risk. As has been the case for two decades, people living in the Interior, Northern, and Island health regions are drinking more alcohol than those in the rest of the province. Male residents age 65 and older drink more than any other age-sex group in BC, and male residents of all ages are more likely to drink heavily per occasion compared to female residents. The percentage of youth who have tried alcohol beyond a few sips is on the decline overall and across all health regions—and while this is a positive trend, many youth are still drinking; more can be done to empower them to delay their use of alcohol.

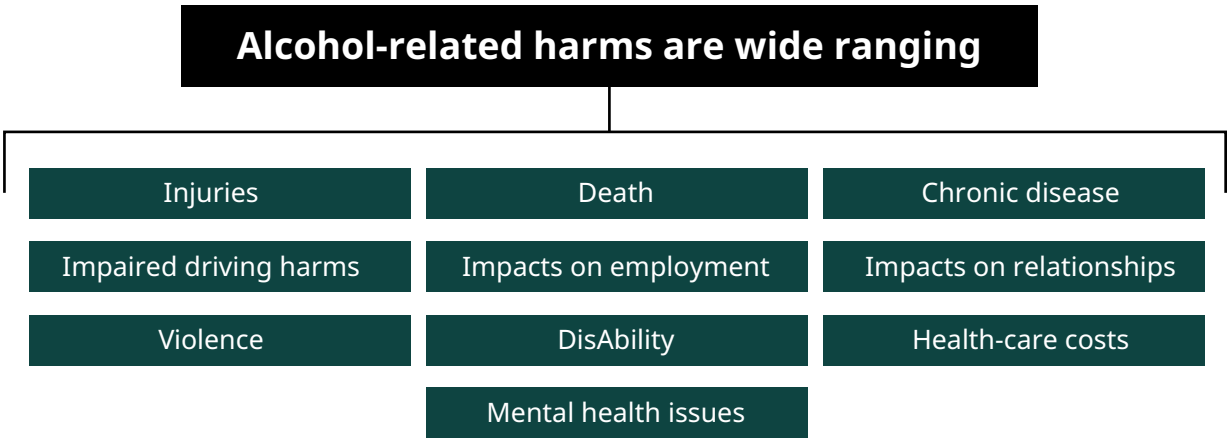
Key Messages

- Although people in BC are drinking less, they still consume alcohol at levels above the national average and in ways that put them at risk of health harms.
- Stereotypes related to alcohol use persist and negatively impact quality of care, particularly for Indigenous people.
- The Interior, Northern, and Island health regions have the highest levels of drinking per person.
- Alcohol use varies among populations. Male seniors are drinking the most, while youth are not drinking as much as they have historically.

Chapter 3

Population-level Harms of Alcohol Use in BC

Alcohol-related harms are wide ranging and experienced across the entire population—not just by those who drink. Long-term alcohol use is linked to a variety of chronic health conditions (e.g., cancer, liver cirrhosis, and cardiovascular disease)[1-3] and mental health issues (e.g., depression, anxiety, and alcohol use disorder).[1,4] Alcohol impairment is responsible for falls,[5,6] drownings,[7,8] and motor vehicle crashes[7,9]—all of which can result in injury, disAbility, or death. Increases in crime and violence, including **gender-based violence**, are also associated with alcohol use.[10-12] Many harms from alcohol are more difficult to measure but no less considerable. These include breakdowns in families and relationships, loss of employment, and loneliness.[4] **Alcohol-attributable** harms are harms that would not have occurred in the absence of alcohol use.



This chapter focuses on the burden of deaths, disease, and injuries using data on deaths, hospitalizations, and impaired driving.

At a population level, health harms from alcohol are often measured through mortality (deaths) and morbidity (disease and injury burdens). This chapter presents BC data for both through rates of deaths and in-patient hospitalizations that are attributable to alcohol use. It also provides rates of deaths and injuries from motor vehicle crashes in BC that involved alcohol. A large portion of the data come from the BC Alcohol and Other Drug monitoring project, led by the Canadian Institute for Substance Use Research at the University of Victoria. The project generates estimates of alcohol-attributable deaths and hospitalizations in the province using a method called alcohol attributable fractions.[13] Data for alcohol-impaired driving deaths and injuries come from the Insurance Corporation of BC (ICBC). See Appendix B for more information on these data and methods.

Alcohol-attributable Deaths

Causes of Alcohol-attributable Deaths

Cardiovascular conditions and cancer have been the top causes of alcohol-attributable deaths in BC over the past two decades (Table 3.1).[14] In 2023, cardiovascular conditions were the leading cause of alcohol-attributable deaths in the province, followed closely by cancer. Unintentional injury is the third leading cause of death attributable to alcohol; the equivalent of 570 people in the province died from this cause in 2023. Other leading causes of death from alcohol in BC include digestive and neuropsychiatric conditions. Digestive conditions include alcoholic gastritis, liver cirrhosis, and acute and chronic pancreatitis. Neuropsychiatric conditions include alcoholic psychoses, alcohol use disorder, degeneration of the nervous system due to alcohol, and epilepsy.

TABLE 3.1 **Leading Causes of Deaths Attributable to Alcohol, BC, 2023**

	Cause of Death	Estimated Number of Deaths
	Cardiovascular conditions	705
	Cancer	634
	Unintentional injuries	570
	Digestive conditions	443
	Neuropsychiatric conditions	242

Notes: The estimated number of deaths is rounded to whole numbers. Data are for age 15 and older. Unintentional injuries, neuropsychiatric conditions, and digestive conditions are the top three causes of deaths across most age and sex categories. Please see Appendix B for more information.
Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

Number of Alcohol-attributable Deaths

Over the past 16 years, alcohol has increasingly contributed to deaths that occur across the province (Table 3.2). In 2023, 6 per cent of all deaths in BC were caused by alcohol use. This represents 2,681 people who lost their lives that year from alcohol. Deaths from alcohol in BC peaked in 2021 with 6.1 per cent of all deaths in the province caused by alcohol. That year the alcohol-attributable death rate reached a 17-year high of 52 deaths per 100,000 population (Figure 3.1).

TABLE 3.2 **Deaths Attributable to Alcohol, BC, 2007 to 2023**

Year	Alcohol-attributable Deaths	Total Deaths in BC	Per cent Attributable to Alcohol
2007	1,594	31,308	5.1
2008	1,581	32,095	4.9
2009	1,558	31,440	5.0
2010	1,526	31,324	4.9
2011	1,585	31,966	5.0
2012	1,584	32,524	4.9
2013	1,770	33,200	5.3
2014	1,828	33,791	5.4
2015	1,990	35,246	5.6
2016	2,145	36,627	5.9
2017	2,274	38,498	5.9
2018	2,252	38,479	5.9
2019	2,134	38,565	5.5
2020	2,453	41,339	5.9
2021	2,741	44,601	6.1
2022	2,720	45,829	5.9
2023	**2,681**	**44,746**	**6.0**

Notes: Alcohol-attributable deaths are estimates of deaths partially or wholly attributable to alcohol. Please see Appendix B for more information.
Sources: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research; and Statistics Canada Table 13-10-0708-01, Deaths by month. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

Each death included in this chapter represents a person who was loved and cared for and who is missed by their family and community.

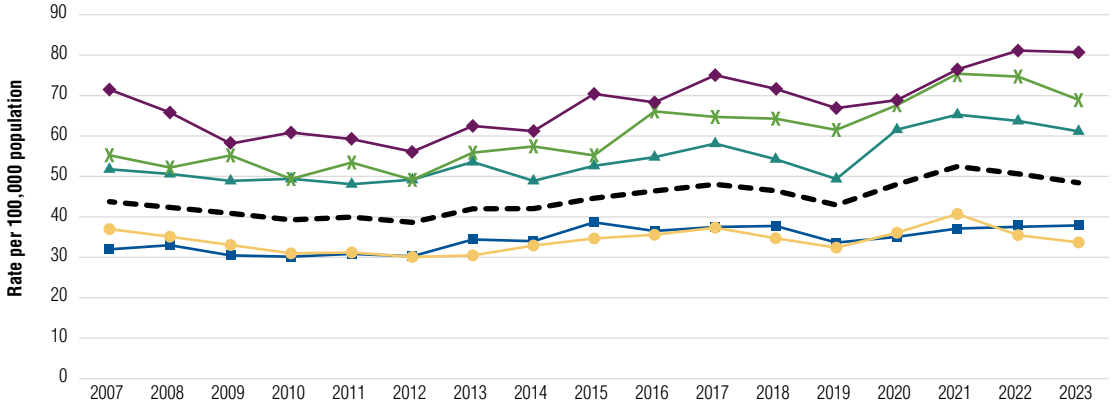
Alcohol-attributable Deaths by Health Region

As has been the case from 2007 to 2023, people living in the Northern, Interior, and Island health regions are more likely to die from alcohol-attributable causes than those living elsewhere in the province (Figure 3.1). The Northern health region has consistently had the highest rate of alcohol-attributable deaths. In 2023, this rate was 81 deaths per 100,000 population—well above BC's average of 48 deaths per 100,000 population. As outlined in Chapter 2, these three regions also have the highest rates of alcohol consumption.

The rate of alcohol-attributable deaths increased across the province from 2019 to 2020 and again in 2021—the years coinciding with the COVID-19 pandemic and a rise in alcohol consumption in BC (see Chapter 2). The Island health region had the largest increase, from a rate of 49 deaths per 100,000 population in 2019 to 65 deaths per 100,000 population in 2021, an increase of more than 30 per cent. Since 2021, the death rate has declined slightly across most health regions, except for the Northern health region, where it remains at a 16-year high. Because many of the health harms associated with alcohol use develop gradually, the full extent of the impacts of the increases from 2019 to 2021 may not become apparent for some time.

FIGURE 3.1

Deaths Attributable to Alcohol, by Regional Health Authority, BC, 2007 to 2023



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Interior	55	52	55	49	53	49	56	57	55	66	65	64	62	68	75	75	69
Fraser	37	35	33	31	31	30	30	33	35	36	37	35	32	36	41	35	34
Vancouver Coastal	32	33	30	30	31	30	34	34	39	36	37	38	34	35	37	38	38
Island	52	51	49	49	48	49	54	49	53	55	58	54	49	62	65	64	61
Northern	71	66	58	61	59	56	63	61	70	68	75	72	67	69	76	81	81
BC	44	42	41	39	40	39	42	42	45	46	48	46	43	48	52	51	48

Notes: Alcohol-attributable deaths are estimates of deaths partially or wholly attributable to alcohol. Rates are standardized. Data are for residents age 15 and older. Please see Appendix B for more information.

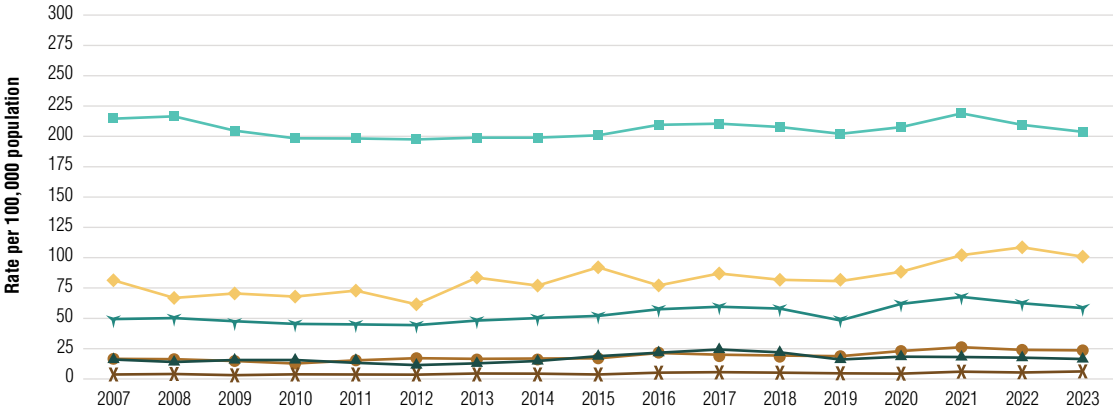
Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Alcohol-attributable Deaths by Sex and Age

The alcohol-attributable death rate in BC has remained relatively stable across most ages and sexes over time. The rate for female seniors (age 65 and older) increased between 2019 and 2022. As of 2023, the rate for female seniors remained higher than it was before 2019 (Figure 3.2).

Male seniors (age 65 and older) in BC experience a much higher rate of death attributable to alcohol than other BC residents. This has been consistent from 2007 to 2023. In 2023, the death rate from alcohol for male residents age 65 and older was 204 deaths per 100,000 population, which was more than double that of female residents in the same age group. This is consistent with the findings shown in Chapter 2, in which male residents in BC—and in particular male seniors—have higher rates of alcohol consumption compared with other population groups.

FIGURE 3.2 Deaths Attributable to Alcohol, by Age and Sex, BC, 2007 to 2023



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
15–34 Male	16	14	16	16	13	11	13	15	19	22	24	22	16	18	18	18	16
35–64 Male	49	50	48	45	45	44	48	50	52	57	60	58	48	62	68	62	59
65+ Male	215	216	205	198	198	198	199	199	201	210	210	208	202	208	219	210	204
15–34 Female	4	4	3	4	4	4	4	4	4	5	6	5	5	4	6	5	6
35–64 Female	17	16	15	13	15	17	17	17	17	21	20	19	19	23	26	24	24
65+ Female	81	67	71	68	73	62	84	77	92	77	87	82	81	88	102	109	101

Notes: Alcohol-attributable deaths are estimates of deaths partially or wholly attributable to alcohol. Data are for residents age 15 and older. Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Male seniors in BC are more likely to **die from alcohol** than female seniors and BC residents of other ages.

Although female residents age 65 and older consume the least compared to other population groups (Chapter 2), they experience the second-highest rate of alcohol-related deaths among age-sex categories (Figure 3.2). This means that despite drinking less than other demographic groups, female seniors in BC face disproportionately more harm compared to other demographic groups for the amount consumed.

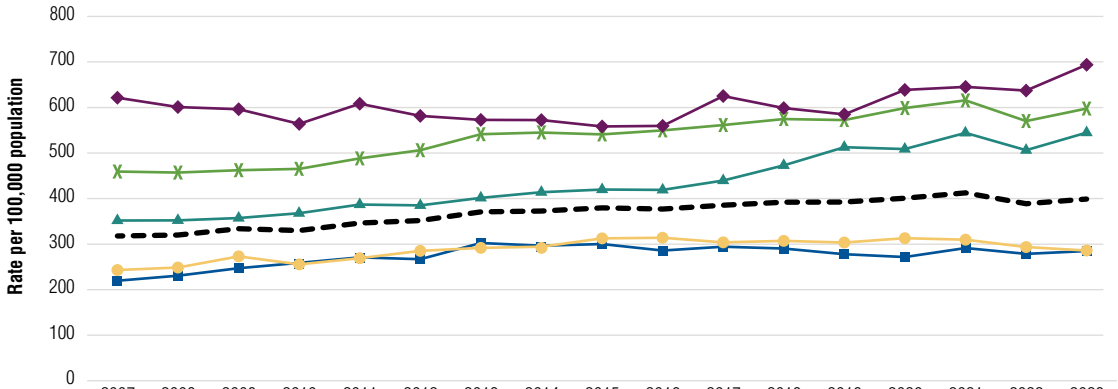
The data presented in Figure 3.2 do not speak to the reasons why female seniors experience disproportionate harm. Based on other research, some contributing factors could be that the health harms of alcohol accumulate over a lifespan[1] and that alcohol-related organ and bodily damage impacts women more than men.[15]

Alcohol-attributable Hospitalizations

People living in the Northern, Interior, and Island health regions are more likely to be hospitalized as a result of harms caused by alcohol than people in the rest of the province (Figure 3.3). This has been the case from 2007 to 2023 and is consistent with higher consumption rates for these regions (Chapter 2). The Northern health region has consistently had the highest rate of alcohol-attributable hospitalizations. In 2023, this rate was 598 hospitalizations per 100,000 population, well above the provincial average of 399. The Island health region had the largest increase over time in the rate of alcohol-attributable hospitalizations—a 55 per cent increase from 2007 to 2023. Although the Fraser and Vancouver Coastal health regions have experienced slight increases, they have both remained below BC's average.

FIGURE 3.3

Hospitalizations Attributable to Alcohol, by Regional Health Authority, BC, 2007 to 2023



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Interior	459	457	462	465	488	506	541	545	541	550	562	575	572	599	616	570	598
Fraser	243	249	273	256	269	285	292	294	313	314	304	307	304	313	310	294	286
Vancouver Coastal	220	231	247	259	271	267	302	297	300	286	294	290	278	272	291	279	285
Island	352	352	357	368	387	385	401	414	420	419	440	473	513	509	544	506	545
Northern	621	601	596	564	608	582	573	572	558	560	625	599	585	639	645	637	694
BC	318	320	334	330	346	352	371	373	379	377	385	392	392	401	413	389	399

Notes: Alcohol-attributable hospitalizations are estimates of hospitalizations partially or wholly attributable to alcohol. Rates are standardized. Data are for residents age 15 and older. Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

People in the **Northern, Interior, and Island health** regions experience **higher rates of deaths and hospitalizations** from alcohol than those in other regions of the province.

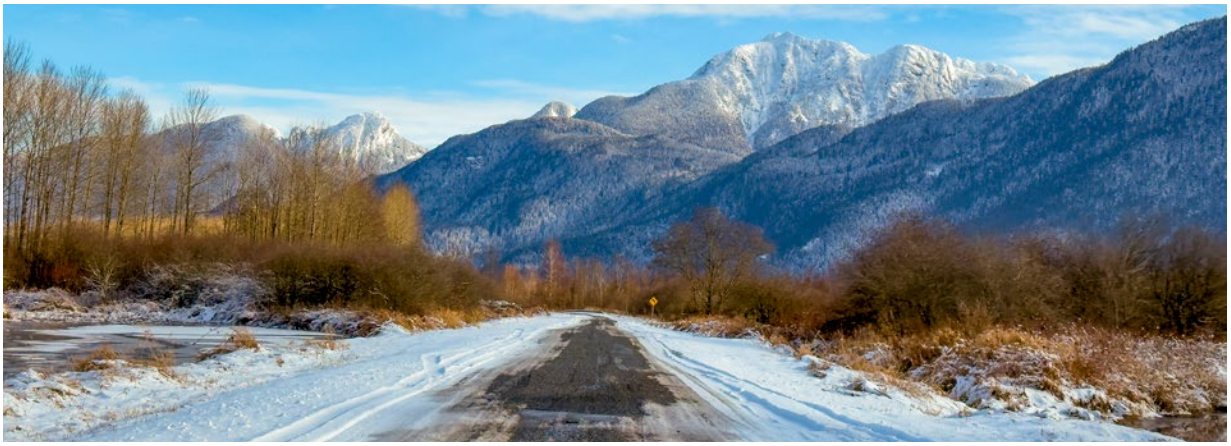


Photo location: q̓íc̓ə́y̓ (Katzie) traditional territory, Pitt Meadows.

Health-care access may also play a role in the distribution of alcohol-attributable hospitalizations across BC. A 2015 study found that physicians in rural areas have difficulty referring patients for health issues related to alcohol use due to long waitlists, limited services, and barriers related to transportation and leaving the community for treatment.[16] Difficulty accessing complex health-care services could be one factor that contributes to higher rates of alcohol-attributable hospitalizations—and ultimately deaths—in more rural areas of the province.

Emergency Department Visits: An Area for Improvement of Data Collection in BC

Hospitalization data in this report refer to injuries and health problems that required in-patient care. People experiencing alcohol-related injuries and health problems also go to emergency departments. This report does not include data on alcohol-attributable emergency department visits because these data are not consistently available throughout the province through the National Ambulatory Care Reporting System, with some health regions having a third or fewer of their emergency department visits included in the reporting system. Other data limitations in one or more health regions include uneven reporting over the years and not reporting diagnostic codes that would permit the identification of alcohol-attributable visits.[17] The Canadian Substance Use Costs and Harms study estimates alcohol-attributable emergency department visits based on published research and available data in Canada.[18] In 2020, an estimated 127,983 alcohol-attributable emergency department visits occurred in BC.[19]

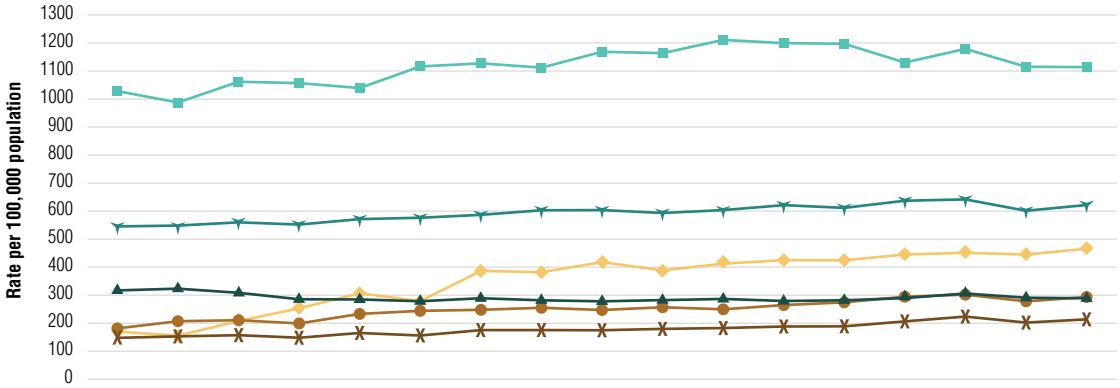
Male seniors are **twice as likely** as female seniors to be **hospitalized** due to alcohol.

Alcohol-attributable Hospitalizations by Sex and Age

Male seniors have the highest rate of hospitalizations attributable to alcohol among all sexes and ages in BC (Figure 3.4). In 2023, this rate was more than double that of female seniors. Male residents age 35–64 have consistently had the second highest rate of hospitalizations from alcohol over time. As described in Chapter 2, both groups also have the highest consumption rates in the province. Hospitalizations from alcohol for most groups have been relatively stable over time and have decreased for male residents age 15–34. However, the rate for female seniors has nearly tripled—from 170 hospitalizations per 100,000 population in 2007 to 466 per 100,000 population in 2023.

FIGURE 3.4

Hospitalizations Attributable to Alcohol, by Age and Sex, BC, 2007 to 2023



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
15–34 Male	317	323	309	285	285	279	289	282	279	282	287	280	282	290	306	291	289
35–64 Male	545	548	560	552	571	576	587	603	604	594	604	621	612	637	642	601	622
65+ Male	1,028	988	1,062	1,057	1,039	1,116	1,127	1,112	1,169	1,164	1,211	1,200	1,197	1,130	1,179	1,115	1,114
15–34 Female	148	153	157	148	165	156	175	175	175	180	183	188	189	207	224	202	214
35–64 Female	182	207	211	200	233	244	248	255	247	257	249	265	275	295	302	278	293
65+ Female	170	156	208	253	307	279	387	382	418	389	412	425	425	445	451	445	466

Notes: Alcohol-attributable hospitalizations are estimates of hospitalizations partially or wholly attributable to alcohol. Data are for residents age 15 and older. Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Causes of Alcohol-attributable Hospitalizations

Unintentional injuries, neuropsychiatric conditions (e.g., alcoholic psychoses, alcohol use disorder, degeneration of the nervous system due to alcohol, epilepsy), and digestive conditions (e.g., alcoholic gastritis, liver cirrhosis, acute or chronic pancreatitis) are regularly the leading causes of hospitalizations from alcohol in BC. Among seniors, hospitalizations due to unintentional injuries are roughly three times higher than other causes of hospitalization for alcohol (Table 3.3). Alcohol use in older adults can worsen existing balance problems and lead to falls or other unintentional injuries. In general, injuries due to falls are a considerable public health issue for the aging population in Canada.[5,20,21]

TABLE 3.3 **Rate of Hospitalizations Attributable to Alcohol, Age 15 and Older, BC, 2023**

	Unintentional Injuries	Neuropsychiatric Conditions	Digestive Conditions
Male (all ages)	214	178	47
Female (all ages)	135	94	31
Male, 65+	657	131	69
Female, 65+	390	54	43

Notes: Rates are per 100,000 population age 15 and older ("all ages"), and age 65 and older ("65+"). Rates are rounded to whole numbers. Unintentional injuries, neuropsychiatric conditions, and digestive conditions are the top three causes of hospitalizations across most age and sex categories. Please see Appendix B for more information.
Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

The leading cause of hospitalizations due to alcohol for **BC seniors** is **unintentional injury**.

We promote and support Indigenous cultural practices and activities in our programmes and services, as we believe that they are integral to the self-care and health of Indigenous peoples and are "good medicine." In fact, common sayings among Indigenous peoples include "culture saves lives," "culture is medicine," and "ceremony is medicine."

Dr. Nel Wieman, Chief Medical Officer, First Nations Health Authority.[26]

Embedding Indigenous Cultural Safety in Health-care Settings

In health care, a culturally safe environment is one that goes beyond providing care that is free from racism, discrimination, and stereotyping. It is an environment that is physically, socially, emotionally, and spiritually safe, and that recognizes and respects the cultural identities of individuals without challenge or denial of these identities.[22]

As a result of settler colonialism, a Western European perspective of health became the dominant lens for health-care service delivery in BC and Canada.[23] Overall, Indigenous **cultural safety** is lacking in BC health-care settings, with 30 per cent of Indigenous survey respondents reporting that they are never treated as if their cultural traditions are appreciated in health-care settings.[22] This lack of cultural safety negatively impacts Indigenous people's access to health care.[22]

To achieve cultural safety in health-care settings for Indigenous patients, services must include an understanding of what health and wellness mean to diverse Indigenous populations.[23] BC First Nations representatives have called on the provincial and federal governments to provide increased funding for both First Nations-specific and culturally safe mainstream alcohol prevention and treatment services and supports.[24] *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* contains recommendations for creating culturally safer spaces in health-care settings for First Nations, Métis, and Inuit people:

Recommendation 10: That design of hospital facilities in B.C. include partnership with local Indigenous peoples and the Nations on whose territories these facilities are located, so that health authorities create culturally-appropriate, dedicated physical spaces in health facilities for ceremony and cultural protocol, and visibly include Indigenous artwork, signage and territorial acknowledgement throughout these facilities.

Recommendation 17: That the B.C. government and FNHA demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.[22]

The 2022 *British Columbia Cultural Safety and Humility Standard* is a guidance document to support anti-racism and cultural safety and humility in health and social service delivery in the province.[25] It helps governing body members and organizational leaders identify, measure, and achieve culturally safer systems and services that better respond to the health and wellness priorities of First Nations, Métis, and Inuit people and communities.[25]

The Mental Wellness and Harm Reduction Sash

The mental wellness and harm reduction sash works to represent the wisdom shared by Métis participants of Métis Nation BC's Alcohol and Community Health Dialogue Sessions.

This custom sash was created by participants, with chosen colours guided by the themes that emerged from the dialogue sessions.

This sash is a testament of Métis resilience and wellness. While the impacts of colonization have contributed to mental health and substance use concerns, we know also that we continually encounter the resilience of our communities rooted in the strengths of Métis culture and worldviews. By wearing this sash and sashing another, you shine light on a symbol of Métis resilience and community connection. – Métis Nation British Columbia[28]

Photo credit: Métis Nation British Columbia

Sashes are a traditional item of clothing for Métis people, serving many practical purposes. They are a symbol of Métis identity.

Colour meanings

- Red: alcohol and addiction awareness
- Green: mental illness awareness
- Purple: overdose and opioid awareness
- Yellow: suicide prevention and awareness
- Teal: recovery awareness
- White: connection to the Earth and Creator

Some of the cultural practices that provide me support in my mental health journey are medicine harvesting (which gives me the opportunity to connect to the land), language revitalization, spiritual practices such as smudging, cleansing with medicines, ceremony, and connecting with community Elders — just to name a few. Having culture present in my life has created growth for me in all aspects of the medicine wheel (Mental, Physical, Emotional, and Spiritual). It has restored a sense of belonging through my pride in my identity, family, community, and my ancestry. Culture is healing.

Métis interviewee in the article "Métis Resilience—Rising from the Ashes" published in *Resilient Roots: Métis Mental Health and Wellness Magazine.*[27]

Alcohol-impaired Driving Harms

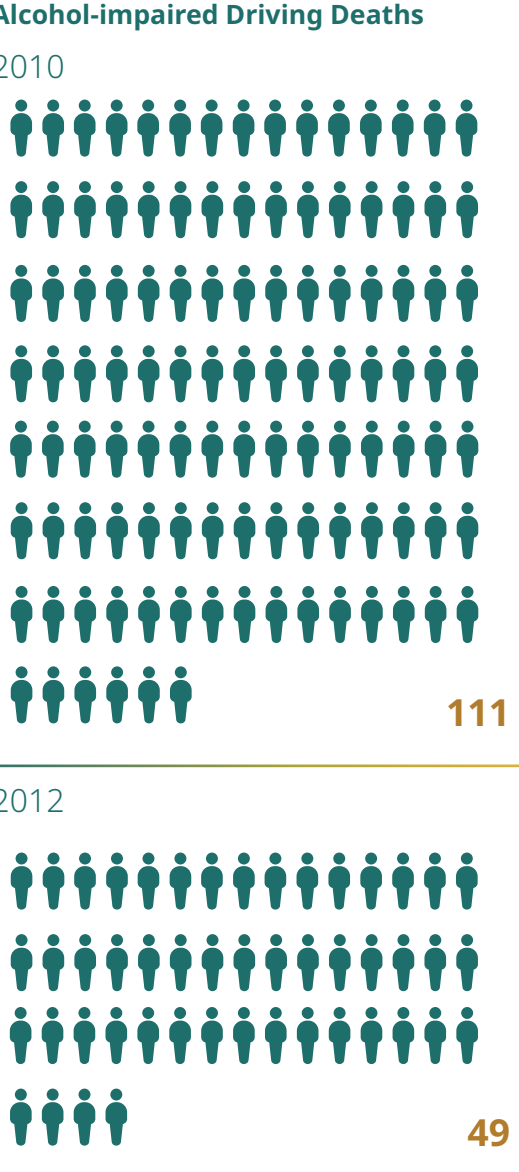
Over the past 15 years, BC has made considerable progress towards preventing deaths from alcohol-impaired driving. Much of this progress has come from the introduction of the Immediate Roadside Prohibition program in September 2010 (see Chapter 5 for more details). Within the first two years of the program's implementation, alcohol-impaired driving deaths were cut in half in the province—from 111 deaths in 2010 to 49 deaths in 2012.[29] These declining numbers demonstrate the real power provincial policy has to reduce alcohol-related harms and save lives.

Despite this improvement, there is still work to be done to make BC's roads safer. The decline in deaths plateaued from 2012 to 2019 and certain segments of the population in BC are still more likely to experience harm from alcohol-impaired driving than others. In this section, alcohol-impaired driving harms are measured by fatalities and injuries from **motor vehicle crashes involving alcohol**. This means alcohol was a contributing factor to the crash and alcohol impairment was either confirmed or suspected by attending police officers.

Data in this section come from ICBC and are gathered from reports completed by police or submitted by individuals to police. The BC Coroners Service also tracks alcohol-impaired driving deaths in the province, with slight variations in annual data compared with ICBC.[9]

Alcohol-impaired **driving deaths decreased** by **more than half** in the first two years of BC's Immediate Roadside Prohibition program.

Alcohol-impaired Driving Deaths



Source: BC Injury Research and Prevention Unit.[29]

Key Information and Terms for This Section

In BC, penalties for **alcohol-impaired driving** begin when a driver has a blood alcohol content level of 50 milligrams of alcohol per 100 millilitres of blood (BAC 0.05).[30] Criminal charges begin at 80 milligrams of alcohol per 100 millilitres of blood (BAC 0.08).[31]

A **fatality victim** is a driver, passenger, pedestrian, or cyclist who dies within 30 days after an injury sustained in a crash that involved at least one motor vehicle on a public roadway.[29]

An **injury victim** is a person who sustained an injury (serious, involving an overnight stay at the hospital, or non-serious) in a crash that involved at least one motor vehicle on a public roadway.[29]

Motor vehicle crashes involving alcohol are crashes where alcohol was a contributing factor. This includes alcohol impairment (suspected or confirmed) or alcohol involvement.[29]

Deaths From Motor Vehicle Crashes Involving Alcohol

In 2022, 44 people in BC died from motor vehicle crashes involving alcohol.[29] At a population level, the death rate from crashes involving alcohol sharply declined from a peak in 2005 of 3.09 deaths per 100,000 to 0.81 deaths per 100,000 in 2022 (Table 3.4). Most of the decline occurred between 2005 and 2011, with a relative plateau in the death rate between 2012 and 2019.

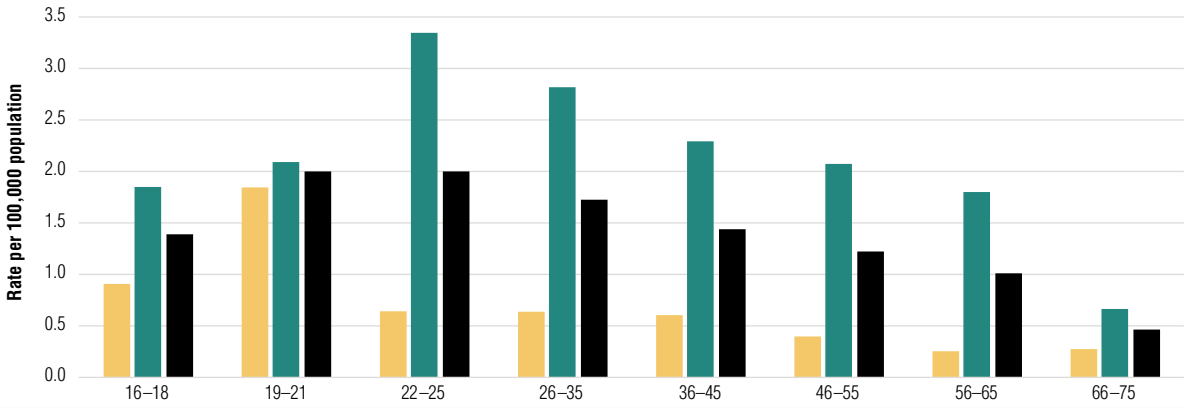
TABLE 3.4 Deaths From Motor Vehicle Crashes Involving Alcohol, BC, 2002 to 2022

Year	Rate per 100,000 Population
2002	2.85
2003	2.50
2004	2.49
2005	3.09
2006	2.70
2007	2.99
2008	2.34
2009	2.09
2010	2.48
2011	1.50
2012	1.07
2013	1.14
2014	1.28
2015	1.30
2016	1.09
2017	1.32
2018	1.15
2019	0.99
2020	0.78
2021	0.67
2022	**0.81**

Notes: A fatality victim (death) refers to a road user who died within 30 days after the date where an injury was sustained in a collision involving at least one motor vehicle on a public roadway as defined by the *Motor Vehicle Act*. Please see Appendix B for more information.
Source: Business Information Warehouse Traffic Accident System, Insurance Corporation of BC. Retrieved from the Injury Data Online Tool, BC Injury Research and Prevention Unit. Prepared by the Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

To allow for a breakdown by age and sex, data on deaths were combined over a ten-year period (Figure 3.5). Male residents of the province are more likely than female residents to die in crashes involving alcohol. In particular, male residents age 22–25 have the highest death rate from crashes involving alcohol (Figure 3.5). Even though male residents experience more deaths from crashes involving alcohol overall, the death rates are nearly the same for male and female residents in the 19–21 age group. It is well established in Canada that impaired drivers are most often men and young adults.[32] The data for BC, as shown in Figure 3.5, are consistent with these findings.

FIGURE 3.5 **Deaths From Motor Vehicle Crashes Involving Alcohol, by Age and Sex, BC, 2013–2022**



	16–18	19–21	22–25	26–35	36–45	46–55	56–65	66–75
Female	0.9	1.8	0.6	0.6	0.6	0.4	0.3	0.3
Male	1.8	2.1	3.3	2.8	2.3	2.1	1.8	0.7
Total	1.4	2.0	2.0	1.7	1.4	1.2	1.0	0.5

Notes: Rates are age-sex-specific. A death refers to a road user who died within 30 days after the date when an injury was sustained in a collision involving at least one motor vehicle on a public roadway as defined in the *Motor Vehicle Act*. The number of deaths of individuals age under 16 and 76 and older were too small to report. Please see Appendix B for more information.

Source: Business Information Warehouse Traffic Accident System, Insurance Corporation of BC. Retrieved from Injury Data Online Tool, BC Injury Research and Prevention Unit. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

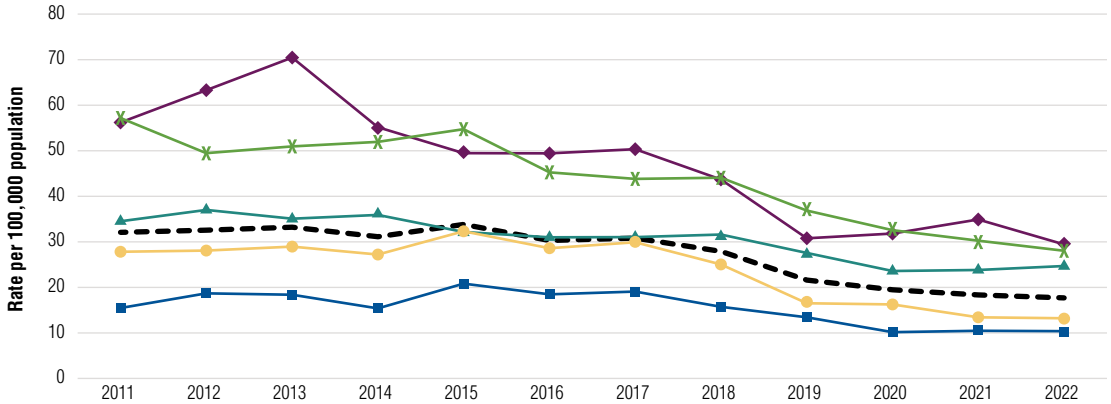
Male residents age 22–25 are nearly **six times more likely** to **die in crashes involving** alcohol than female residents of the same age.

Photo location: nłeʔképmx (Nlaka'pamux) traditional territory, south of Kanaka Bar.

Injuries From Motor Vehicle Crashes Involving Alcohol

Overall, fewer people in BC are being injured in alcohol-impaired driving crashes than in previous years. Since 2015, the rate of victims injured in motor vehicle crashes involving alcohol has continued to decline (Figure 3.6). Rates remain higher in the Northern, Interior, and Island health regions than in other areas of the province. Vancouver Coastal region continues to have the lowest rate of victims injured from crashes involving alcohol.

FIGURE 3.6 Injuries From Police-attended Motor Vehicle Crashes Involving Alcohol, by Regional Health Authority, BC, 2011 to 2022

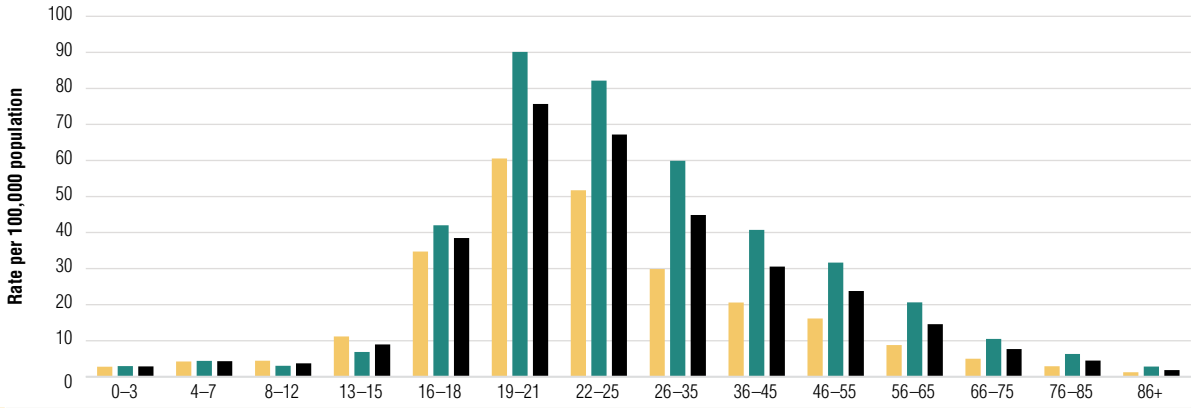


	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Interior	57	49	51	52	55	45	44	44	37	33	30	28
Fraser	28	28	29	27	32	29	30	25	17	16	13	13
Vancouver Coastal	15	19	18	15	21	18	19	16	13	10	10	10
Island	35	37	35	36	32	31	31	32	28	24	24	25
Northern	56	63	70	55	49	49	50	44	31	32	35	29
BC	32	33	33	31	34	30	31	28	22	19	18	18

Notes: An injured victim is a person who sustained an injury (serious, involving an overnight stay at the hospital, or non-serious) in a collision involving at least one motor vehicle on a public roadway as defined in the *Motor Vehicle Act*. Please see Appendix B for more information.

Source: Business Information Warehouse Traffic Accident System, Insurance Corporation of BC. Retrieved from Injury Data Online Tool, BC Injury Research and Prevention Unit. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, November 2025.

FIGURE 3.7 Injuries From Police-attended Motor Vehicle Crashes Involving Alcohol, by Age and Sex, 2013–2022



	0–3	4–7	8–12	13–15	16–18	19–21	22–25	26–35	36–45	46–55	56–65	66–75	76–85	86+
Female	2.8	4.2	4.4	11.2	34.8	60.5	51.8	29.9	20.6	16.1	8.8	5.0	2.9	1.2
Male	3.0	4.4	3.0	6.9	42.0	90.1	82.2	59.9	40.7	31.7	20.6	10.5	6.3	2.8
Total	2.9	4.3	3.7	8.9	38.5	75.7	67.2	44.9	30.5	23.8	14.6	7.7	4.5	1.8

Notes: Rates are age-sex-specific. An injured victim is a person who sustained an injury (serious, involving an overnight stay at the hospital, or non-serious) in a collision involving at least one motor vehicle on a public roadway as defined in the *Motor Vehicle Act*. Please see Appendix B for more information.

Source: Business Information Warehouse Traffic Accident System, Insurance Corporation of BC. Retrieved from Injury Data Online Tool, BC Injury Research and Prevention Unit. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

Male residents age 19–35 are the most likely to be **injured in crashes involving alcohol.**

As was also seen with death rates, male residents in BC age 16 and older are more likely than female residents to be injured from crashes involving alcohol, based on a ten-year span of data (Figure 3.7). This figure shows that male residents age 19–35 are injured the most. However, the gaps between female and male residents are smaller for injury rates than for the death rates.

Social Harms of Alcohol

As shown in this chapter, drinking alcohol causes health harms that can be measured and counted in many ways. It can be more difficult to measure the social harms that people experience from alcohol use. Certain social harms affect not only the person who drinks, but also their friends, family, and the wider community. Some examples of these social harms include violence, unemployment, trouble in relationships, feelings of guilt or shame, loss of loved ones, more contact with police or the criminal justice system, and the negative impacts on children growing up in homes with problematic alcohol use.[33-35]

Violence and Criminal Offences

The link between alcohol and violence has been well established.[36] Drinking alcohol alters a person's mental state and impairs judgement.[10,37] Drinking alcohol can increase aggression, which can lead to violence or even violent crimes.[10,37]

Around 90,000 deaths occurred globally in 2016 due to interpersonal violence from alcohol use.[38] In Canada, surveys of federal inmates indicate that over 40 per cent of offences are associated with substance use, with alcohol being linked to the greatest proportion of these crimes.[11] Alcohol was also associated more with violent (20 per cent) than non-violent (7 per cent) crime.[11]

Gender-based Violence and Intimate Partner Violence

Gender-based violence is violence committed against someone based on their gender, gender identity, gender expression, or perceived gender.[39,40] It can be physical, emotional, psychological, or sexual in nature.[39] Gender-based violence includes but is not limited to physical or sexual assault; criminal harassment (stalking); neglect; and attempts to control, humiliate, intimidate, coerce, deprive, and threaten or harm another person.[39,40] Another form of violence that often falls under the umbrella of gender-based violence is **intimate partner violence**, which is violence perpetrated by a current or former intimate partner (e.g., spouse, dating partner) and can include varying forms of physical, sexual, emotional, and psychological abuse.[41] While people of any gender may experience intimate partner violence, women and 2SLGBTQQIA+ people experience disproportionate rates and higher severity of incidents.[41] Perpetrators of both gender-based and intimate partner violence are most often men, and are often friends, family, or intimate partners of the people they assault.[42,43]

Gender-based violence is shaped and intensified by systemic issues such as sexism, colonialism, racism, ableism, classism, poverty, and a collective history of trauma.[39] Populations that are disproportionately impacted or face barriers to accessing support include women and girls; Indigenous women and girls; Black and racialized women; immigrant and refugee women; 2SLGBTQQIA+ people; women with disAbilities; and women living in northern, rural, and remote communities.[39]

There is an established connection between alcohol use and gender-based violence.[44,45] A higher quantity of alcohol consumption is associated with an increased risk and severity of intimate partner violence.[44] Similarly, the perpetration of sexual violence by men has been linked with heavier drinking.[45-47]

Alcohol use and gender-based violence are connected, but the way they are linked is not fully understood.[12] People who do not drink alcohol also perpetuate gender-based violence, and not all people who drink engage in violence.[12] Policies that decrease availability of alcohol, such as decreasing alcohol outlet density, have shown some evidence of reducing intimate partner violence.[48]

Gaps in data collection and monitoring make it difficult to accurately understand the prevalence of gender-based violence in the BC population, how often it occurs, and the associated short- and long-term impacts on mental, emotional, physical, and spiritual health and wellness.[49] The COVID-19 pandemic and related public health response measures increased the risk—and likely the prevalence and severity of—gender-based violence in the province.[49] Police-reported data in Canada show that women are overrepresented among those who experience intimate partner violence, including as homicide victims.[43] The Provincial Health Officer Report *Examining the*

Societal Consequences of the COVID-19 Pandemic included the consideration for action:

> Integrate efforts to assess and respond to gender-based violence in BC across all government ministries and other partners to ensure a comprehensive understanding of the issue, focusing on improved data collection and analysis methods, and the most coordinated, efficient, and effective response, with optimal outcomes for survivors and their families.[49]

The final report from Canada's National Inquiry into Missing and Murdered Indigenous Women and Girls contains 231 individual calls for justice directed at governments, institutions, social service providers, industries, and all people in Canada to address gender-based violence. These include:

> **1.5:** We call upon all governments to immediately take all necessary measures to prevent, investigate, punish, and compensate for violence against Indigenous women, girls, and 2SLGBTQQIA people.
>
> **1.8:** We call upon all governments to create specific and long-term funding, available to Indigenous communities and organizations, to create, deliver, and disseminate prevention programs, education, and awareness campaigns designed for Indigenous communities and families related to violence prevention and combatting lateral violence. Core and sustainable funding, as opposed to program funding, must be provided to national and regional Indigenous women's and 2SLGBTQQIA people's organizations.
>
> **1.9:** We call upon all governments to develop laws, policies, and public education campaigns to challenge the acceptance and normalization of violence.[50]

Alcohol-related Direct Costs and the "Alcohol Deficit"

Alcohol use comes with serious costs—not just to individual and population health and well-being but to finances across provincial institutions and systems. Diseases, injuries, and even deaths from alcohol place financial strains on BC's health-care system and put pressure on health-care resources, limiting their availability for other purposes. Beyond health care, alcohol contributes to costs in law enforcement and the justice system, including impaired driving and alcohol-related violence. These costs quickly add up.

To understand the scale of this impact, the Canadian Substance Use Costs and Harms study tracks the direct financial burden of alcohol across provinces and territories. In 2020, alcohol use cost BC an estimated $2.81 billion in health care, criminal justice, lost productivity, and other direct costs.[19] Of that, approximately $985 million (or 3.65 per cent of the province's total health-care budget) was spent addressing alcohol-related health harms.[19,51] That year, alcohol cost BC more than any other substance, including tobacco ($1.39 billion) and cannabis ($300 million).[19]

At the same time, alcohol generates government revenue in BC. This revenue comes primarily from alcohol sales as well as from other sources such as licences, permits, fines, and taxes.[52] In 2020, the net income

There is an argument that this is a boost to the economy and it's a price we're willing to pay. I'd like to just challenge that by saying, in fact, this is a loss for us in terms of the economy in B.C. We were in the hole $768 million in 2020 from alcohol and that's without many of the societal and other impacts that aren't measurable in terms of dollars and cents.

Dr. Charmaine Enns, Medical Health Officer, Island Health.[58]

generated in BC from all these sources totalled $2.04 billion.[52,h] However, the costs of alcohol in BC ($2.81 billion) outweigh the income gained by government. In 2020, BC was left with a $768 million deficit from alcohol.[53,19] This is known as an **alcohol deficit**.[54]

There are opportunities to lower this deficit through coordinated action and proven public health strategies. As will be discussed in Chapter 5, public-health-based changes to alcohol policy can lead to lower consumption as well as fewer deaths and hospitalizations from alcohol use.[55-57] In other words, changes to alcohol policy can improve the health of people in BC—and benefit the Province's bottom line.

Conclusion

People in BC continue to experience serious and costly harms from alcohol use, underscoring the importance of collective action to reduce these harms and improve health and well-being. The alcohol-attributable death rate in the province reached a 16-year high in 2021—a year that coincided with the height of the COVID-19 pandemic and record alcohol consumption. Certain regions of the province continue to shoulder a higher burden of alcohol-related harms relative to their populations. The Northern, Interior, and Island health regions all experience higher rates of deaths and hospitalizations attributable to alcohol, as well as higher rates of deaths and injuries from alcohol-impaired driving.

Alcohol-related harms are felt disproportionately across the population in BC. Seniors—in particular, male seniors—have higher rates of alcohol-attributable deaths and hospitalizations than the rest of the population in BC. Young male residents are more likely to die or be injured in motor-vehicle crashes involving alcohol. Women, girls, and 2SLGBTQQIA+ people, especially those facing more than one kind of oppression, experience increased gender-based violence and intimate partner violence, some of which

h "Net income" refers to net income of liquor authorities and total taxes and revenues. This reflects the gross sales for the fiscal year 2020/21, minus cost of goods and administrative and general expenses, plus licence fees and taxes collected, including federal taxes. The $2.04 billion figure referenced comes from Statistics Canada Table 10-10-0012-01, Net income of liquor authorities and government revenue from sale of alcoholic beverages (x 1,000). More recent sales and net income data are available from the BC Liquor Distribution Branch in its annual service plan reports and from Statistics Canada Table 10-10-0012-01.

stems from alcohol use. Not all alcohol-related harms are measurable. But of those that are, their direct costs outweigh government revenue from alcohol.

However, there is some positive change when it comes to alcohol-related harms. Policy can make a real difference—as is seen with BC's reduced impaired driving deaths. There remains substantial opportunity for governments to further policy action on alcohol-related harms to promote health and well-being across the province.

Key Messages

- Alcohol causes deaths and hospitalizations in BC.
- Male seniors in BC are more likely to die or be hospitalized from alcohol than female seniors and residents of other ages.
- People in the Northern, Interior, and Island health regions experience higher rates of alcohol-related harms than people living in other regions of the province.
- Impaired driving deaths have declined over the last two decades.
- Alcohol is linked to violence, including violent crimes and gender-based violence, although data gaps make alcohol's role difficult to measure.
- BC has an alcohol deficit: the direct costs of alcohol-related harms are greater than the alcohol revenue generated for government in the province.

Chapter 4

Individual Health Risks of Alcohol Use

There is no level or threshold of alcohol consumption that is without risk, and even a small amount of alcohol over time can be damaging to health.[1,2] The belief that alcohol offers health benefits remains common, yet it is unsupported by widespread evidence.[3] While some research says alcohol might offer minor health benefits for certain diseases in select population groups, overall, drinking alcohol is more harmful than beneficial to health.[3]

As with other behaviours that carry health risks, decisions about alcohol use require people to balance their tolerance of risk with their preferences and realities of everyday life. Those who want to drink less but have difficulty controlling their drinking may need supports, including medical services, to achieve their desired level of drinking. In order to make informed decisions about alcohol use, first and foremost everyone needs to know about the health risks of drinking.

This chapter provides an overview of some of the key risks for people to consider regarding alcohol consumption. These include increased risks of developing cancer, certain cardiovascular diseases, and alcohol use disorder, as well as the increased health risks that come with alcohol exposure during pregnancy. It concludes with the latest guidance on alcohol and health in Canada and provides resources that support drinking less.

The Confusion About Alcohol and Health

A common belief is that drinking alcohol can benefit health.[3] The ongoing question of whether alcohol has health benefits has been studied,[4-6] and it has been suggested that consuming small amounts of alcohol may lower the risk of certain types of heart disease for both men and women[4] and diabetes for women.[5] Recent BC estimates show a minor health benefit when it comes to endocrine conditions like Type 2 diabetes for women who drink and that this benefit increases with age.[7] However, the human body is an integrated whole. This means that although drinking alcohol may slightly benefit one system or organ, this benefit does not offset the considerable damage—including cancer—that alcohol may cause elsewhere.

More recent research has also begun to debunk earlier studies that claimed alcohol has minor health benefits. In these earlier studies, people classified as "non-drinkers" were more likely to be older and/or have pre-existing health conditions.[8] When they were compared to people who do drink, it created a misleading assumption that people who drink are healthier.[8] In fact, the observed health differences were due to demographic factors: people who drink were not healthier *because* they drink alcohol, they were merely part of a group that was younger and had fewer pre-existing conditions.[8]

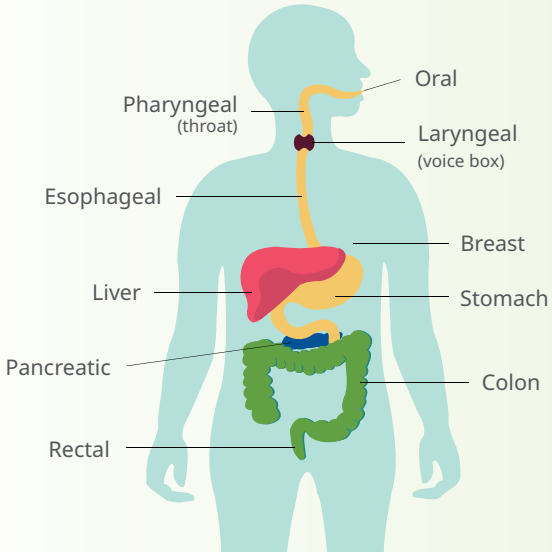
What is known for certain is that the overall health harms of alcohol outweigh any potential, minor benefits. On the whole, drinking alcohol increases one's risk of death and disease.[1,2,9]

Alcohol Use and Cancer

Drinking alcohol increases one's risk of developing at least seven types of cancer. These include cancers of the breast, colon, rectum, mouth and throat, liver, esophagus, and larynx.[10,11]

Alcoholic drinks—such as beer, wine, and spirits—contain a type of alcohol called ethanol. When ethanol is processed in the liver, it becomes acetaldehyde. Acetaldehyde damages cells by causing genetic mutations and interfering with DNA repair mechanisms, both of which can lead to cancer.[2,12,13] Alcohol can also cause cancer by contributing to hormone changes, cell damage, and inflammation.[13] Whether an individual develops cancer from drinking alcohol, however, depends on a variety of factors, including how much they drink,[1] their genetic predisposition to cancer,[14] and other factors,

Cancers Linked to Alcohol Use



Reduce your drinking.
Reduce your risk.

Source: Adapted from BC Cancer. *Cancers Linked to Alcohol Use.*[10]

such as protective lifestyle habits. BC has a higher burden of cancer caused by alcohol than the national average (5.1 per cent).[15] According to BC Cancer and the Canadian Cancer Society, "the percentage of new cancer cases caused by alcohol in 2015 was 5.3 per cent in BC."[16 (p.65)]

While the Canadian public is aware of some health risks related to alcohol, people are not as aware that consuming alcohol contributes to increased cancer risk. For example, a survey of liquor store patrons in Canada demonstrated that just over three-quarters did not know alcohol can cause cancer.[17] In a 2023 national survey, respondents understood that alcohol, regardless of the amount consumed, increases risks for liver disease, diabetes, and harm to a fetus during pregnancy.[18] However, they were less likely to know that alcohol increases risks for mouth, throat, and breast cancers.[18] Additionally, most did not know about the cancer risks associated with low alcohol consumption levels.[18]

Awareness gaps extended beyond cancer: fewer than half of respondents (44 per cent) knew that alcohol increases the risk of heart disease, while others believed alcohol either decreased risk (6 per cent), had no impact (33 per cent), or were unsure (18 per cent).[18] More than half (55 per cent) agreed that alcohol products should display health warnings (a topic that is discussed further in Chapter 5).[18] This gap in understanding underscores the need for improved public education about the full spectrum of alcohol-related health risks, including those affecting cardiovascular health.

Alcohol Use and Cardiovascular Diseases

Alcohol use is associated with an increased risk of developing a range of cardiovascular diseases, which affect the heart and blood vessels.[11] These include heart failure, high blood pressure, atrial fibrillation, and hemorrhagic stroke.[11] Cardiovascular disease has been the leading cause of alcohol-attributable deaths from 2020 onwards in BC. In 2023, the equivalent of 705 alcohol-attributable cardiovascular disease deaths occurred in the province.[7]

There is strong evidence that heavy drinking (i.e., more than two drinks a day, on average) and heavy episodic drinking (i.e., four or five drinks or more per occasion) cause harm to cardiovascular health.[11,19] While the level of risk varies by condition, the risk is evident for high blood pressure, heart attack, stroke, atrial fibrillation (i.e., abnormal heart rhythm), cardiomyopathy (i.e., enlarged heart), and heart failure (i.e., inability for the heart to pump effectively).[19-21]

The evidence is less clear for people who consume low to moderate amounts of alcohol.[19] Some studies have suggested that low to moderate alcohol consumption may be associated with a reduced risk of ischemic heart disease (also known as coronary heart disease),[22] but these findings are not consistent.[23] Additionally, this apparent protective factor is more pronounced in populations with higher socio-economic status, indicating that lifestyle factors and economic privilege, rather than alcohol use, may be the underlying contributors to the lower risk.[24]

Alcohol Use and Alcohol Use Disorder

Alcohol use disorder is a medical condition with criteria for diagnosis laid out in the *Diagnostic and Statistical Manual of Mental Disorders*.[25] Previously referred to as alcohol dependence or alcoholism, it is defined as an inability to stop or control alcohol use despite adverse social, occupational, or health consequences.[25] Alcohol use disorder is considered a brain disorder and is perpetuated by lasting neurological changes from high-risk alcohol use.[26]

Signs of drinking that may lead to alcohol use disorder include having a strong need or craving to drink, being unable to control the amount of alcohol consumed, being unable to remember events that occurred while drinking, being unable to reduce the amount of alcohol consumed, and needing to drink more to get the same effect.[27,28] Drinking before age 15, a family history of the disorder, traumatic experiences, and other mental health conditions can all increase an individual's risk of developing alcohol use disorder.[26]

Results from the 2023 Canadian Substance Use Survey show that 3.8 per cent of people age 15 and older in BC are considered to be at high risk of having or developing alcohol use disorder and 12.2 per cent are at moderate risk for alcohol use disorder due to consuming alcohol at what is considered a hazardous or harmful level.[30]

Treatment of alcohol use disorder should be tailored to the patient's goals. Some may wish to reduce their drinking; others may want to abstain completely. Counselling or therapy, pharmaceutical drugs that help reduce or prevent drinking (e.g., naltrexone, acamprosate),[31] or community-based or peer support programs are some examples of treatment options available.

In BC, clinical guidelines support primary care providers to talk to patients about alcohol use, screen for high-risk drinking, and provide brief interventions around goal setting (such as setting a goal to reduce alcohol use), as well as treatment choices and follow-up referrals to those who need it.[31] The *Canadian Guideline for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder* also supports primary

I am a person living with substance use disorder, that is in "remission" because I am in recovery. Most people (including myself from time-to-time) will revert back to calling me an "addict," or a "person living with addiction." Yes, that is true, however the psychological medical term of diagnosis is substance use disorder, and it is to be taken seriously like all diagnoses—not just another statistic of "the addict or person living with addiction." Language is everything, and to undo many people's beliefs and preconceived ideas; this diagnosis helps to de-stigmatize, streamline, and help many people find themselves in its definition.

Métis interviewee in the article "Métis Resilience- Rising from the Ashes" published in *Resilient Roots: Métis Mental Health and Wellness Magazine.* [29]

care providers in promoting expanded access to the full range of evidence-based treatments for alcohol use disorder.[32]

People with alcohol use disorder can still face barriers in accessing care. They may feel shame that they are not strong enough to handle it on their own or may believe abstinence is the only available treatment.[32] Medications that treat alcohol use disorder are also underused in BC[33] and in primary care in general.[34] Clinicians often have misconceptions about the efficacy of these medications despite clear evidence that their use can improve alcohol consumption outcomes for people with alcohol use disorder.[34,35]

Being unable to access trauma-informed and culturally safe care and treatment is also a barrier for specific populations, including First Nations, Métis, and Inuit people.[36] Resourcing culturally safe, Indigenous-led mental health and wellness and substance use recovery services are foundational obligations for the BC Government as outlined in the *Declaration on the Rights of Indigenous Peoples Act Action Plan*.[37] First Nations leaders in BC have given direction on how to uphold these foundational obligations: increase funding for both First Nations-specific and culturally safe mainstream services and supports.[38]

Researchers in the field of substance use are now considering an expanded definition of recovery from alcohol use disorder that recognizes overall positive changes in functioning and well-being, independent of whether a person stops drinking alcohol.[39]

Alcohol Withdrawal

Most cases of **alcohol withdrawal** occur in the context of alcohol use disorder and can be life-threatening.[31] Symptoms of withdrawal range from mild anxiety, headache, nausea, and tremors to seizures.[31,40] Alcohol withdrawal delirium can also occur, which manifests as fever, tachycardia, agitation, hallucinations, disorientation, and hypertension, and it requires immediate medical attention.[40] In BC, clinical guidelines support primary care providers in assessing withdrawal risk and offering appropriate medical support, including pharmacotherapy and referral to specialized services.[31]

Neuropsychiatric Risks

Chronic alcohol use can also lead to alcohol-related brain injuries, including Wernicke-Korsakoff Syndrome.[41] This is an irreversible form of alcohol-related dementia caused by thiamine deficiency.[41] These risks often go under-recognized, highlighting the need for public awareness about chronic alcohol use as well as access to clinical care.[31,41]

Managed Alcohol Programs

Managed alcohol programs (MAPs) are a harm-reduction approach for individuals with severe alcohol use disorder. The programs aim to address the complex needs of people who do not respond to other forms of treatment and who are also experiencing homelessness or housing instability.[42,43] In a MAP, regulated doses of alcohol are dispensed to participants at intervals throughout the day. The goal of this practice is to stabilize or reduce a person's alcohol consumption and replace non-beverage alcohol (e.g.,

mouthwash, rubbing alcohol, hand sanitizer).[44] MAPs often run in conjunction with the provision of other services such as meals, health care, accommodation, and social supports. Participation in MAPs is associated with drinking more often but in lower total amounts per day, fewer struggles with housing and finances, less consumption of non-beverage alcohol, a greater sense of well-being, and improved access to health care.[45-48]

The Aboriginal Coalition to End Homelessness Society has noted the importance of Indigenous-led MAPs that prioritize the understanding and addressing of issues such as colonization, acculturation, racism, and intergenerational trauma that impact Indigenous people who have alcohol use disorder.[49] The Society runs a program that takes a decolonial approach by having Indigenous Elders on site and offering participants ways to reconnect to culture, identity, and Indigenous ways of healing.[46]

Photo location: xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səlilwətaɬ (Tsleil-Waututh) traditional territory, Capilano.

Alcohol Use and Pregnancy

There are many reasons why people who are pregnant may drink alcohol. Some of these reasons include being unaware of the pregnancy, societal pressure, mixed messaging around the risks of alcohol use in pregnancy as a result of evolving guidelines, conflicting information from health practitioners and the media, coping with adverse life experiences, and alcohol use disorder.[51,52]

Considerable stigma exists surrounding substance use and pregnancy and this can and often does prevent pregnant people from accessing support.[53] Concerns about possible repercussions when accessing support, such as child apprehension, also further prevent pregnant people from engaging with support services.[53-56] Alcohol use during pregnancy comes with health risks not just to the fetus but also to the pregnant person and the pregnancy itself, and no amount of alcohol use is without risk for people who are pregnant.[1] These risks include increased risks of miscarriage, stillbirth, pre-term delivery, hypertensive disorders of pregnancy, gestational diabetes, low amniotic fluid, and placental abruption.[57] People who drink alcohol during pregnancy also have significantly greater odds of reporting perinatal mental health concerns such as depression.[58] The early weeks of pregnancy, when people are often not aware they are pregnant, are a period of high risk for the impact of alcohol use on fetus development.[59]

Métis Nation British Columbia Alcohol and Health Community Dialogue

In 2020, Métis Nation British Columbia (MNBC), under its Ministry of Mental Health and Addictions (now Ministry of Mental Health and Harm Reduction), led an Alcohol and Community Health Dialogue project for its members. More than twenty Métis participants attended four dialogue sessions, which were centred on Métis-led conversations about alcohol and community health.

The sessions focused on what MNBC describes as "connection, relationship, and honouring the deep wisdom of Métis culture." Participants connected with their own wisdom on the topic of alcohol, shared their stories and ideas, learned from one another, and explored new possibilities for health and resilience in the Métis community—all within a safe and supportive environment. Discussions were guided by the belief that combining Métis voices, knowledge, and vision can creatively build on the strengths and resilience that already exist in Métis Chartered Communities.

During the fourth dialogue session, a graphic facilitator (Tiaré Jung from Drawing Change) captured the emerging themes of the dialogues, culminating in the graphic. The illustration summarizes the ideas and wisdom that emerged through each session.

Source: *Resilient Roots: Métis Mental Health and Wellness Magazine.*[50] Words adapted with permission from Métis Nation British Columbia.

Source: Alcohol and Community Health Dialogue, December 12, 2020, Métis Nation BC. Image reproduced with permission from Métis Nation British Columbia.

While most of the research on alcohol and pregnancy has focused on the risks of alcohol use by the person who is pregnant, emerging evidence also indicates that alcohol use before conception, by both parents, may affect child development.[60,61]

Babies exposed to alcohol before birth have a greater likelihood of being diagnosed with low birth weight, respiration distress, difficulty breastfeeding, and other feeding problems.[62] Alcohol exposure before birth also increases the risk of the fetus developing fetal alcohol spectrum disorder (FASD)—a lifelong disAbility that impacts learning, memory, attention, social and motor skills, physical health, communication, and emotional regulation.[63]

The 2023 Canadian Substance Use Survey found that among people in Canada (age 15 and older) who had been pregnant in the past five years, 86.1 per cent reported consuming no alcohol during their pregnancy, while 9.5 per cent reported consuming alcohol once or twice only and 4.5 percent consumed alcohol three or more times.[30] The Canada Fetal Alcohol Spectrum Disorder Research Network estimates that at least 4 per cent of individuals in Canada—or approximately 1.5 million people—have FASD.[64]

Prevention and Support for Parents

Raising public awareness about the health risks of alcohol both to the pregnant person and the fetus is one key prevention method, especially as those who are pregnant do not receive clear and consistent messaging on this topic.[52] The United States has required health warnings about alcohol use during pregnancy on alcohol products since 1989.[65] So far, no such requirement exists federally in Canada. Yukon and the Northwest Territories require post-manufacturer warnings about the risks of drinking during pregnancy.[66]

BC has a provincial guideline for the clinical management of high-risk drinking and alcohol use disorder during pregnancy.[67] This guideline highlights principles of respect for the autonomy and agency of patients, as well as care options such as screening and brief intervention, withdrawal management, pharmacotherapies, psychosocial interventions, treatment facilities, and postpartum care.

BC Women's Hospital provides care to pregnant people who experience substance use issues during their pregnancy and to their families.[68] However, this service is not available universally across the province.

Alcohol and Health: Supports and Resources

The Canadian Centre on Substance Use and Addiction's Guidance on Alcohol and Health

The link between alcohol use and health risks is clear. Knowledge about this link has been strengthened in recent years with further scientific evidence[6,11,13,69,70] and more than ever before, people are encouraged to take steps to reduce their drinking. The Canadian Centre on Substance Use and Addiction's guidance on alcohol and health aims to help people make well-informed decisions about alcohol consumption.[1] Released in 2023, this guidance was funded by Health Canada and developed by health and public health experts across the country.

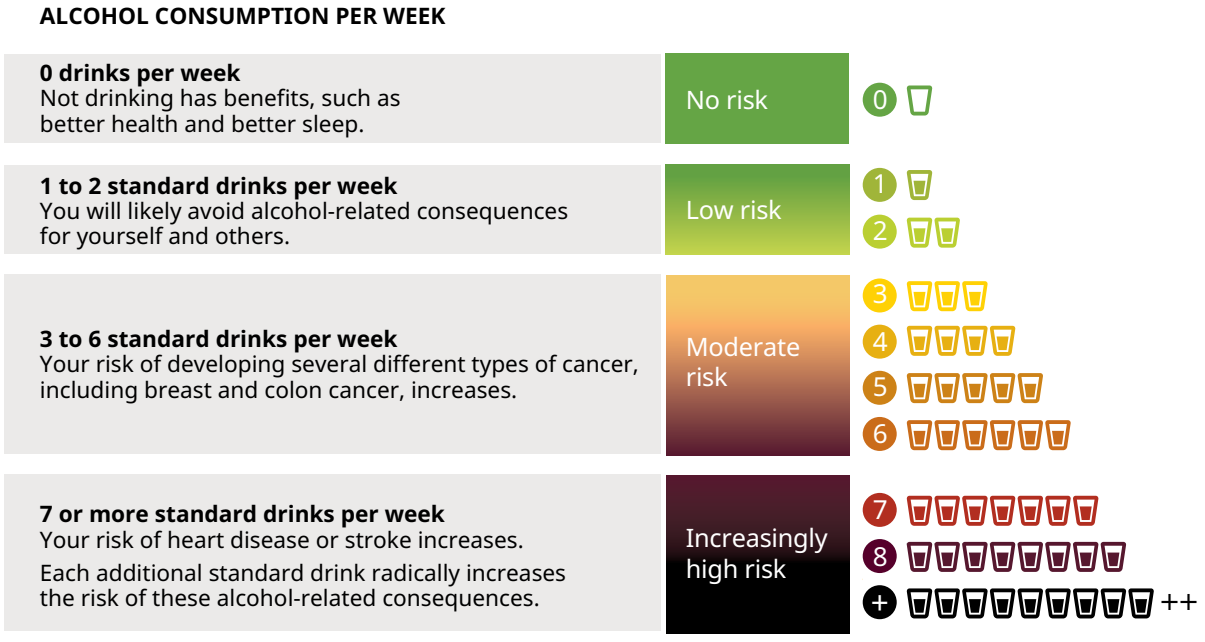
There is no level of alcohol use that is without risk. That said, people who consume one to two standard drinks per week will likely avoid most alcohol-related harms. However, as the number of drinks consumed per week increases, so do the risks of health harms. These health risks increase more steeply for women than men above six drinks per week due to a variety of factors (e.g., genetics, body weight and size, organ function, and metabolism).[11] The updated guidance encourages individuals to consider drinking less, even if they cannot or do not intend to get down to no- or low-risk levels.[1] Any reduction in alcohol use has benefits.[1]

Benefits of Drinking Less

There are many health benefits to reducing alcohol intake or abstaining from alcohol completely. Short-term benefits of reducing alcohol use may include feeling better in the mornings and being less tired and more energetic.[72] Long-term health benefits may include lower risk of stroke, high blood pressure, cancer, liver disease, and other alcohol-related diseases; improved mood, memory, and quality of sleep; and lower caloric intake.[72]

The personal financial benefits of not drinking will vary depending on how much an individual drinks. In 2019, Canadian households spent an annual average of $1,125 on alcoholic

To reduce the risk of harm from alcohol, it is recommended that people living in Canada consider reducing their alcohol use.



Source: Canadian Centre on Substance Use and Addiction's guidance on alcohol and health.[1]

beverages.[73] Of this amount, about 70 per cent was spent in stores and about 30 per cent in bars and restaurants.[73]

A survey of people who participated in "Dry January" by abstaining from alcohol for the month of January found that those who completed the challenge reported certain psychological benefits. These included a sense of achievement, feeling more in control of their drinking, and realizing they do not need alcohol to enjoy themselves.[74]

Measures and Tools for Reducing Alcohol Use

The Canadian Centre on Substance Use and Addiction's guidance on alcohol and health includes ideas for how to drink less.[1] These include setting limits, drinking slowly, drinking lots of water, having one non-alcoholic drink for every drink of alcohol, choosing alcohol-free or low-alcohol beverages, eating before and during drinking, and having alcohol-free weeks or participating in alcohol-free activities.[1]

There are many apps and online tools that can help people track and work to reduce their alcohol use. BC Cancer's *The Proof* website includes an online quiz people can use to find out how many standard drinks they consume per week and the associated alcohol-related cancer risks. It also provides resources and tips to live what the agency calls a "lower proof life."[75] The Canadian Institute for Substance Use Research hosts the Know Alcohol online tool and calculator, which similarly generates personalized estimates of the potential health risks related to a person's alcohol use—and shares the health, financial, and caloric benefits of cutting back.[76]

For First Nations Peoples, land-based treatment and healing can play an important role in reducing substance use, including alcohol use. These approaches provide space to relearn, revitalize, and reclaim traditional wellness practices that have been eroded by the ongoing impacts of colonization and the forced disconnection and dispossession of First Nations Peoples from their traditional territories.[77] Examples of land-based treatment and healing include participating in culture and language groups; traditional food harvesting such as berry picking, fishing, or hunting; and engaging in ceremonies and teachings on the land.[77] Such practices provide culturally grounded support and emphasize holistic healing as part of wellness and recovery.[77]

If you drink alcohol, the safest level is very low amounts. The science is very consistent that when it comes to health, alcohol is unhealthy, and the less you drink, the better.

Dr. Tim Naimi, Director,
Canadian Institute for Substance Use Research.[71]

IDEAS FOR HOW TO DRINK LESS

Set limits

Drink slowly

Drink lots of water

Have one non-alcoholic drink for every drink of alcohol

Choose alcohol-free or low-alcohol beverages

Eat before and during drinking

Have alcohol-free weeks or participate in alcohol-free activities

Source: Adapted from Canadian Centre on Substance Use and Addiction's guidance on alcohol and health.[1]

Conclusion

This chapter helps people better understand and be more aware of the harms they may experience from drinking. Any amount of alcohol consumption comes with health risks, and there is ongoing work to be done to ensure people in BC are better informed of these risks. Governments, policy-makers, health and public health professionals, and others have a role to play in promoting the message that when it comes to alcohol, less is best. Public health professionals can advocate for healthy public policy around alcohol. However, it is important to recognize that messages and approaches to encourage lower-risk alcohol use that are based on individual choices and behaviour are not appropriate for everyone. Work is also needed to ensure that people who are looking for help to manage their drinking can get services and supports that acknowledge the many factors that may influence their alcohol use.

Key Messages

- Being better informed about the risks of alcohol can help people determine how much and how often they will drink.
- Medications and other services and supports can help people with alcohol use disorder reduce or manage their alcohol consumption.
- There is more work to do to uphold the rights of Indigenous Peoples and increase access to culturally safe care for alcohol concerns. Access to land-based healing and treatment can support First Nations people to reduce substance use, including alcohol use.
- No amount of alcohol during pregnancy is without risk.
- The Canadian Centre on Substance Use and Addiction's guidance on alcohol and health describes the health risks associated with different levels of drinking to help people make informed choices about their drinking.
- Drinking less alcohol can lead to better health and save money.

Chapter 5

BC's Alcohol Policy Landscape

Even though drinking alcohol can bring a level of pleasure and social enjoyment, it also causes a wide range of health and social harms.[1-3] While some people can take steps to lower their risks by drinking less, others may find this more difficult. Social lives often revolve around alcohol, and dependence on alcohol, including alcohol use disorder, can make reducing consumption challenging and, in some cases, dangerous. Governments can help by ensuring that people are aware of the risks of drinking and also by fostering environments that support drinking less. Addressing factors that shape drinking behaviours—such as how alcohol is priced, promoted, and made physically available, and whether health and safety messaging is present and visible—can further encourage and empower people in BC to drink less.

Provinces, territories, and a number of First Nations and Inuit governments in Canada set their own rules for alcohol. How alcohol is priced, where and when it can be sold and consumed, and the legal drinking age are just some examples of the control provinces and territories have when it comes to alcohol. These rules make up a large part of what is known more broadly as alcohol policy. Shifts and changes to alcohol policy that prioritize public health can lower the burden of injuries, diseases, and deaths from alcohol in a population.[4,5] In other words, healthy public policy can save lives.

Considering Public Health and Safety in Alcohol Policy

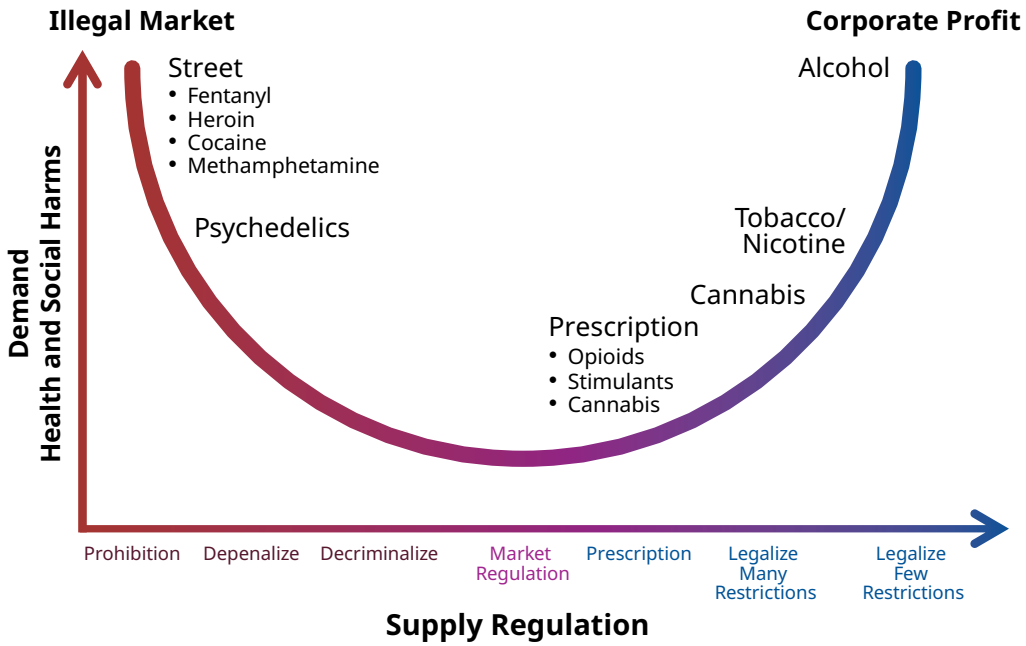
Even with policy changes that reduce consumption, the health and social harms of alcohol use will never be completely eliminated: widespread prohibition is not the goal of public health nor of this report, and prohibition comes with its own range of harms. Maintaining access to a regulated, legal supply of alcohol is generally considered to be better overall for public health and safety than the increased crime and lack of quality control that comes with prohibition.[5,6] At the same time, an unchecked privatized market where alcoholic beverages are heavily promoted and available increases the harms people experience from alcohol use.[7] A public health and safety approach to alcohol policy finds balance between these extremes (i.e., prohibition and the unrestricted free market), with the goal of minimizing alcohol-related harms.

The "Paradox of Prohibition" U-curve graphically depicts the idea that how a psychoactive substance is regulated shapes demand and harms. Alcohol is positioned at the top of the right-hand side of the U, meaning it is a legal substance with few restrictions and a high degree of commercialization relative to other substances. Because alcohol is so widely used, the population-level harms it causes are often equal to or greater than the harms experienced from illegal substances such as illegal opioids or cocaine.[8] All levels of government have the ability to reduce these harms, bringing alcohol closer to the centre of the U-curve on the paradox of prohibition.

Alcohol Industry Influence

There are many ways industries of all kinds exert influence over government and the regulatory process. Some examples include lobbying, campaign contributions, participating in interest groups, funding think tanks, and shaping public opinion through public relations and marketing.[10-12] A cumulative effect of this influence is known as "regulatory capture." **Regulatory capture** occurs when an industry gains significant influence over—or "captures"—regulators and the regulatory process.[13,14] Under this influence, government policies and legislation, which should primarily protect the health and safety of the population, often wind up favouring industry interests instead.[13] Regulatory capture is a concern across many industries.[13] One noted example is the tobacco industry. For decades, tobacco industry representatives used distorted evidence that minimized the risks of smoking to lobby against mandated warning labels for tobacco products.[15-17]

The Paradox of Prohibition U-curve



Source: Adapted from Marks J. The paradox of prohibition. In: *Treatment options in addiction: Medical management of alcohol and opiate use.*[9]

The alcohol industry is not exempt from concerns of regulatory capture.[5] In 2020, alcohol industry representatives interfered with a study on alcohol warning labels in Yukon by lobbying the government to stop the study.[18] The territorial government allowed the study to resume after a two-month pause, on the condition that the label that included a cancer warning no longer be used.[18]

As discussed in Chapter 1, in BC, the Business Technical Advisory Panel (BTAP) serves as an ongoing forum between alcohol industry representatives and the provincial government. Industry members have described BTAP as a "direct line to decision-makers" and a venue for providing "ongoing advice and recommendations" on liquor policy.[19] Some representatives have publicly credited BTAP with influencing alcohol policy changes in BC, such as allowing restaurants and bars to sell and deliver packaged liquor with meals and enabling wholesale liquor pricing for hospitality businesses.[20] The extent of BTAP's influence on government is difficult to assess. Transparency could be improved by making meeting minutes publicly available, as is currently the practice for government meetings with tobacco industry representatives.[21] Establishing similar recurring meetings focused on public safety, public health, and other interests could help diversify information used in policy decision-making.

Governments have a responsibility to engage with a range of interest holders, including industry. However, there is a meaningful distinction between inclusive consultation and disproportionate influence. Maintaining this balance is essential to ensure that public health and safety remain a central priority in policy development. Some strategies for government to avoid regulatory capture include upholding transparency when interacting with industry (e.g., publishing meeting notes[21]), purposefully excluding industry from having input into policy-making (as was done in the development of Canada's 2019 food guide[22]), and prohibiting the acceptance of significant gifts or hospitality from industry.[14]

Reducing Harms of Alcohol in BC Through Policy Evaluation and Change

In BC, alcohol can be sold in private establishments (e.g., bars, restaurants, and retail stores) that are licensed by the Liquor and Cannabis Regulation Branch (LCRB). The Liquor Distribution Branch (LDB) is the primary distributor of alcohol to these establishments. The provincial government also runs its own public retail chain of BC Liquor Stores.

A considerable amount of alcohol policy in the province is set by the LCRB and the LDB. The LDB takes direction from the Minister of Agriculture and Food. For the LCRB, the Ministry of Agriculture and Food oversees licensing and policy and the Ministry of Public Safety and Solicitor General oversees compliance and enforcement.[23,24] Other arms of government such as the Ministry of Health and RoadSafetyBC, a provincial agency under the Ministry of Public Safety and Solicitor General, have their own roles to play. The delivery of health services for patients dealing with alcohol-related health conditions and impaired-driving countermeasures are all considered part of the alcohol policy landscape.

World Health Organization's 10 Key Policy Areas for Reducing Alcohol Harms[25]

- Leadership, awareness and commitment
- Health services' response
- Community action
- Drink-driving policies and countermeasures
- Availability of alcohol
- Marketing of alcoholic beverages
- Pricing policies
- Reducing the negative consequences of drinking and alcohol intoxication
- Reducing the public health impact of illicit alcohol and informally produced alcohol
- Monitoring and surveillance

Over the past decade, many provincial policies related to alcohol pricing and access have made alcohol more readily available to people in BC.[26-37] The remainder of this chapter describes several categories of alcohol policy in BC, from pricing and availability to impaired driving countermeasures. It then presents opportunities to better align policies with the public health and safety goals of reducing harms through reduced consumption. The categories of alcohol policy highlighted in this chapter are not intended to represent all possible policy levers available to government. Rather, they reflect key areas where data and evidence are available, and where policy decisions can have a significant impact on alcohol availability and consumption. Broader frameworks—such as the World Health Organization's global strategy to reduce the harmful use of alcohol—also identify policy action areas for governments and offer valuable guidance.[25]

There are competing interests when it comes to setting alcohol policy: those of public health, economic development, and consumer preferences.[4] Although the costs of the harms of alcohol outweigh the direct revenue it generates for the province (see Chapter 3), government revenue from alcohol and its role in the provincial budget is still considered an interest for government. Striking a balance between these interests is key and is one reason why some jurisdictions in Canada have created provincial/territorial alcohol strategies.[38,39] Alcohol strategies can help ensure that alcohol policies explicitly align health and safety goals alongside economic and other considerations.[4]

We're not recommending increased restrictions. Just as harms are caused by substance use, there are also harms caused by prohibition and enforcement. The public health approach is to minimize harms at either end of the spectrum. Rather, we want to see reasonable regulations maintained, and together with policymakers, take action to raise awareness and support people to protect their health by drinking less.

Dr. Patricia Daly, Vice President, Public Health and Chief Medical Health Officer for Vancouver Coastal Health,[40] writing in a *Vancouver Sun* op-ed in response to the City of Vancouver's proposal to expand alcohol availability by allowing wine on grocery store shelves.

Alcohol Policy Categories Explored in This Chapter

- Alcohol pricing
- Physical availability
- Impaired driving countermeasures
- Promotion of alcohol products
- Health and safety messaging
- Province-wide alcohol strategy

Alcohol Pricing

When the price of alcohol goes up, people drink less, and alcohol-related harms—including deaths—are reduced.[41-44] Alcohol prices can be adjusted through policy changes, most commonly by setting a minimum price for alcohol and levying taxes on alcoholic beverages. The World Health Organization recommends using pricing and taxation strategies to reduce harmful alcohol use.[45] This section presents information on alcohol pricing in BC and describes an approach BC could use to scale minimum prices to alcohol content.

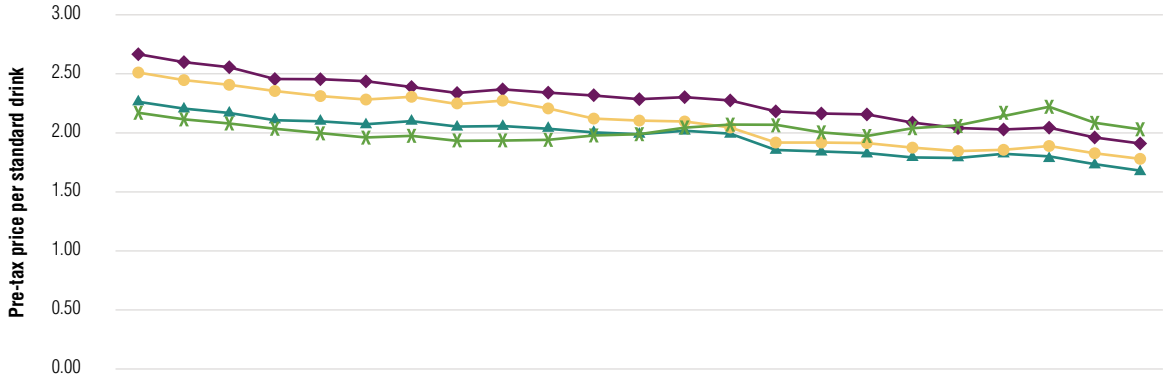
When adjusted for inflation, the price of alcohol in BC has been decreasing since 2001 compared to other products (Figure 5.1). Only the price of coolers has remained relatively stable when adjusted for inflation. This means people in the province are paying less for alcohol now than they did 20 years ago, relative to other goods and services.

Alcohol has gotten **cheaper** in BC over the **past 20 years.**

	2003	2023
BEER	$2.41	**$1.78**
COOLER	$2.08	$2.03
WINE	$2.56	**$1.91**
SPIRITS	$2.17	**$1.68**

Note: Highlighted and bold text indicates a decrease in price per standard drink between 2003 and 2023.
Source: Figure 5.1.

FIGURE 5.1 Retail Prices for Alcohol Products Sold in Government Liquor Stores, Consumer Price Adjusted, by Beverage Type, BC, 2001/02 to 2023/24

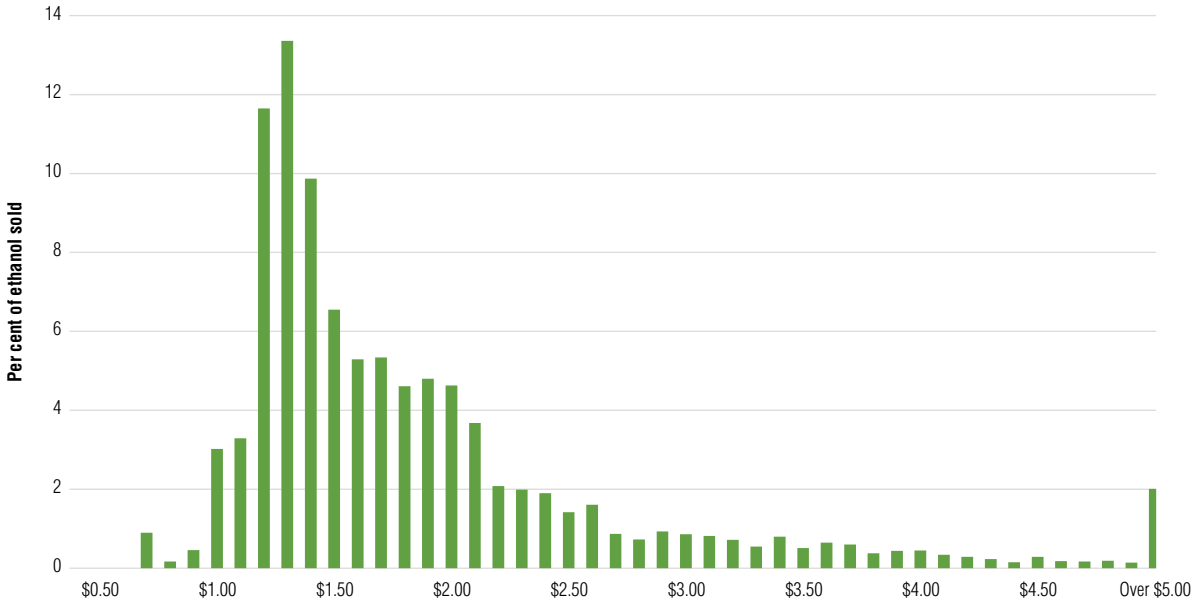


	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Beer	2.51	2.45	2.41	2.35	2.31	2.28	2.31	2.24	2.27	2.21	2.12	2.10	2.10	2.04	1.92	1.92	1.91	1.87	1.85	1.86	1.89	1.83	1.78
Cooler	2.17	2.12	2.08	2.03	2.00	1.96	1.97	1.93	1.94	1.94	1.98	1.99	2.04	2.07	2.07	2.00	1.97	2.04	2.06	2.14	2.22	2.09	2.03
Spirits	2.26	2.21	2.17	2.11	2.10	2.07	2.10	2.05	2.06	2.03	2.00	1.99	2.02	1.99	1.85	1.84	1.83	1.79	1.79	1.82	1.80	1.73	1.68
Wine	2.67	2.60	2.56	2.46	2.45	2.44	2.39	2.34	2.37	2.34	2.32	2.28	2.30	2.27	2.18	2.16	2.16	2.09	2.04	2.03	2.04	1.96	1.91

Notes: Prices are per standard drink, listed in Canadian pre-tax and inflation-adjusted dollars and represent averages as estimated from sales data. Annual mean All-item Consumer Price Index for BC was used to calculate consumer price adjusted dollars referenced to fiscal year 2023/24. Consumer Price Index data were obtained from Statistics Canada Table 18-10-0004-01. Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

FIGURE 5.2 Volume of Ethanol Sold, by Price per Standard Drink, BC, 2021



Notes: Prices are based on government liquor store pricing, listed in 2021 Canadian pre-tax dollars, and are per standard drink. Please see Appendix B for more information.

Source: Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

People in BC are also choosing alcohol products that are sold at low prices per standard drink. In 2021, most alcohol sold at retail liquor stores in BC was sold for a price at or below $1.50 per standard drink (Figure 5.2). While there are more expensive products on the shelves, customers are overwhelmingly choosing cheaper products. Cheaper and stronger alcohol products are more likely to be purchased and consumed by groups at greater risk of harm from alcohol (e.g., minors, people with alcohol use disorder).[46-48] Shifts in alcohol pricing could influence how people in BC purchase and consume these products.

Minimum pricing is a regulatory policy that prohibits selling alcohol for less than a certain price. It is done to lower consumption rates, reduce harms, prevent price wars between businesses, and better stabilize government revenue.[49] Minimum pricing has been used in some form in jurisdictions across Canada since the 1920s.[50]

In BC, minimum prices of alcohol are tied to the volume of liquid in a beverage, regardless of a beverage's alcohol content. For example, a can of beer has the same minimum price whether it contains 3, 5, or 7 per cent pure alcohol. This is a volume-based approach to pricing. Several studies have shown that this approach was initially effective in reducing alcohol consumption, alcohol-attributable hospital admissions, mortality, and crime—including in BC.[50-54] However, the current minimum prices were set in 2014 (for alcohol consumed at restaurants and bars) and 2016 (for alcohol purchased from retail stores), have not been adjusted since, and are not indexed to inflation.[55,56]

The current approach to minimum pricing in BC means that as the alcohol content in a beverage gets stronger, its minimum price per standard drink gets cheaper (Table 5.1). People are therefore incentivized to purchase higher-strength products because they offer better value for price. Additionally, the protective effect of BC's minimum pricing is eroding over time due to inflation. Strengthening the policy—for example, by indexing minimum prices to alcohol content and inflation—could enhance its effectiveness and better align it with international best practices.

Minimum prices for alcohol in BC **get cheaper** as the **drinks get stronger.**

TABLE 5.1 **Minimum Price per Standard Drink at Liquor Stores in BC**

	4%	5%	7%	12%	14%	17%	35%	40%	50%
BEER	$1.36	$1.09	**$0.78**						
COOLER	$1.59	$1.28	**$0.91**						
WINE				$0.91	$0.78	**$0.65**			
SPIRITS							$1.36	$1.19	**$0.95**

Notes: Highlighted and bold text indicates lowest minimum price per standard drink within a drink category. Different minimum prices apply for packaged beer, draught beer, and alcohol sold in bars and restaurants. Please see Appendix B for the method used to calculate minimum price per standard drink.
Source: Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

From a public health perspective, we'd very much like to see pricing that changes with alcohol content. We should have minimum pricing that changes with inflation, and we should have pricing that reflects alcohol content.

Dr. Charmaine Enns,
Medical Health Officer, Island Health.[65]

Higher-strength, higher-risk products become relatively **more expensive under minimum unit pricing**.

Public health experts recommend alcohol pricing that creates a price *incentive* for lower-strength products and a price *disincentive* for higher-strength products.[57-59] Minimum pricing that is based on alcohol *content* rather than volume is known as minimum unit pricing. Under this pricing structure, minimum prices per standard drink would be the same across all beverage categories, rather than being cheaper for high-strength products as they are now. This approach has the potential to shift customers' purchasing habits, encouraging them (through pricing) to purchase lower-strength products instead.

International experience shows that this approach works. In 2018, Scotland became one of the first countries in the world to implement a minimum unit pricing policy for alcohol.[44] In the three years following its implementation, the total volume of pure alcohol sold per person declined by an estimated 3 per cent.[60] It is also estimated that, in the 32 months after implementing a minimum unit price for alcohol, Scotland had 13.4 per cent fewer deaths and 4.1 per cent fewer hospitalizations from alcohol when compared with England, where the policy has not been adopted.[41,44] This equated to avoiding an average of 156 deaths and 411 hospitalizations per year.[44] Most of the avoided deaths were seen in areas of the country with lower socio-economic conditions.[44] This suggests that minimum unit pricing can help address some income-based health inequalities related to alcohol.[44] Further research across several jurisdictions where minimum unit pricing has been implemented shows that the greatest benefits in terms of reduced deaths and diseases from the policy occur for groups facing structural disadvantages. These include people experiencing heavy alcohol use and those with lower incomes.[61]

After introducing **minimum unit pricing**, Scotland had an estimated **13% fewer alcohol-related deaths** compared to England.

It must be noted, however, that when it comes to minimum unit pricing or any alcohol policy shift, BC's context is unique. If BC moves forward with implementing minimum unit

pricing, it must do so in full partnerships with First Nations, Métis, and Inuit Peoples as required under BC's *Declaration on the Rights of Indigenous Peoples Act* and as emphasized by First Nations leadership in the province. There is currently no research on the potential impacts this pricing structure may have for First Nations, Métis, and Inuit people.

The 2008 BC Provincial Health Officer's report *Public Health Approach to Alcohol Policy* and the Ministry of Justice's 2014 B.C. Liquor Policy Review recommended that the province implement minimum unit pricing. This approach has also been recommended by the Canadian Alcohol Policy Evaluation project since 2013 and the Health Officers Council of BC in 2023.[57,62-64]

Physical Availability

Physical availability of alcohol refers to the number and density of **liquor outlets** (e.g., retail stores, restaurants, and bars) in a region, their permitted locations, and hours of sale.[66] Greater numbers and higher density of alcohol outlets are associated with increased consumption, as well as a higher risk of alcohol-related violence, injury, disease, and death.[51,54,67-72] Governments at all levels can limit the physical availability of alcohol through policy interventions. In BC, the Province controls the licensing of liquor establishments and the hours of sale for liquor stores.[73] Municipalities also play a role in the physical availability of liquor through bylaws that determine how late restaurants and bars can serve alcohol.[66,74] Limiting the availability of alcohol is also one of the World Health Organization's key recommended strategies for reducing harmful alcohol use.[45]

Most of the alcohol purchased in the province is from liquor stores. These stores typically fall into one of two categories: government-run liquor stores (i.e., BC Liquor Stores) and privately run liquor stores. The Province once held a monopoly on liquor distribution and sale. But starting in the late 1980s, BC began allowing private retailers to sell alcohol. BC's move towards privatization follows the path of many provincial and territorial governments across Canada, with only Prince Edward Island, New Brunswick, and Northwest Territories still maintaining both distribution and retail monopolies.[75] Partial or full privatization of liquor stores has been shown to increase consumption of alcohol through longer hours of operation and greater selections of chilled beverages.[7,76-78] Increases to the density of **private liquor stores** in BC have also been linked to increases in alcohol-related deaths.[72]

> The **privatization of the liquor retail market** has been linked to **increases in drinking** and in **alcohol-related deaths.**

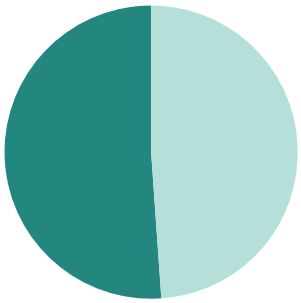
This section describes where people in BC are buying alcohol and how available it is for them to buy. Data in this section refer to private liquor stores, which is a category that includes private retail stores, manufacturers who sell directly to the public, **rural stores**, and **wine stores**. For a complete description, see Appendix B.

Sources of Alcohol in BC

Private liquor stores are the most popular places to buy alcohol in BC. In 2023/24, private liquor stores were responsible for just over half of all alcohol sales in the province, followed by government liquor stores at 34 per cent (Figure 5.3). This has not always been the case—even after partial privatization of the provincial market.

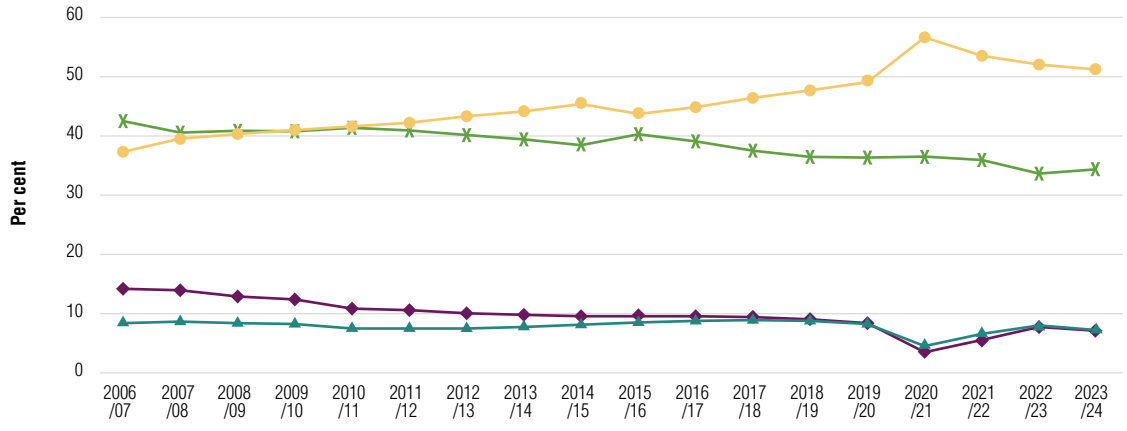
Sales at government liquor stores were higher than those at private stores in 2006/07 (Figure 5.3). Government and private stores then had nearly the same proportion of alcohol sales until 2011/12, when sales at private liquor stores began to surpass those at government stores.

With 34 per cent of the retail market in 2023/24, government liquor stores are still the leading single retailer of liquor in the province.



In 2023/24, **private liquor stores** accounted for **51% of alcohol sales** in the province.

FIGURE 5.3 **Alcohol Sold by Source, BC, 2006/07 to 2023/24**



	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Private Liquor Stores	37	40	40	41	42	42	43	44	45	44	45	46	48	49	57	54	52	51
BC Liquor Stores	43	41	41	41	41	41	40	39	38	40	39	38	36	36	37	36	34	34
Restaurants	8	9	8	8	7	7	7	8	8	9	9	9	9	8	5	7	8	7
Bars	14	14	13	12	11	11	10	10	10	10	10	9	9	8	3	6	8	7

Note: Please see Appendix B for more information.

Source: BC Alcohol and Other Drug monitoring project, Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, November 2025.

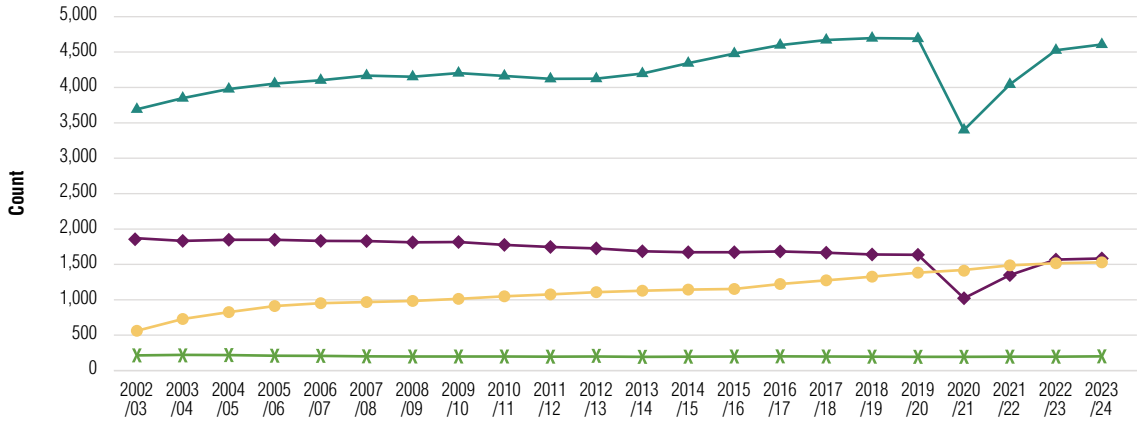
Alcohol sales dipped in restaurants and bars starting in 2020. This coincides with the COVID-19 pandemic, when provincial health officer orders implemented under the *Public Health Act* restricted operations of restaurants and bars.[79] This does not mean people in BC drank less during the pandemic, however, as sales at private retail stores peaked during this time. Alcohol sales in restaurants and bars have since returned to pre-pandemic levels.

Number of Alcohol Outlets in BC

There are more places where people in BC can buy alcohol than ever before. While the number of government liquor stores in BC has remained stable, the number of privately owned liquor stores in the province is on the rise (Figure 5.4). No new private retail stores can be opened in the province due to a government moratorium on licences for these establishments, which began in 1992.[73,80] In 2002, this moratorium was temporarily lifted, which resulted in a near doubling of private liquor stores from 2002/03 to 2006/07, when the moratorium was reimposed.[64]

The gradual increase in the number of private liquor stores from 2006/07 onwards is due to an increase in the number of breweries, wineries, and distilleries that sell take-home alcohol directly to the public (i.e., bottled wine and spirits, packaged beer). As they hold a **manufacturer licence**, the moratorium on private liquor store licenses does not apply to these establishments.[81,82] While manufacturers can function as points of sale, they are only permitted to sell products they produce, meaning they do not operate like typical retail stores that offer a wide variety of alcohol types and brands.

FIGURE 5.4 **Outlets by Type, BC, 2002/03 to 2023/24**



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Private Liquor Stores	562	729	826	911	952	968	985	1,013	1,050	1,077	1,109	1,128	1,145	1,152	1,222	1,275	1,327	1,383	1,422	1,488	1,516	1,529
BC Liquor Stores	214	222	219	211	207	200	199	198	198	197	198	194	196	198	202	199	197	195	195	197	197	200
Restaurants	3,692	3,849	3,978	4,055	4,102	4,167	4,152	4,204	4,162	4,121	4,124	4,196	4,342	4,479	4,598	4,671	4,697	4,691	3,400	4,042	4,525	4,608
Bars	1,870	1,833	1,847	1,847	1,833	1,830	1,812	1,816	1,776	1,747	1,726	1,686	1,671	1,672	1,683	1,665	1,641	1,636	1,022	1,349	1,569	1,583

Notes: In these data, the term "private liquor stores" refers to retail liquor stores and other retail outlets owned by private individuals or companies, not the government. Some examples of private liquor stores are private alcohol retail stores, wineries that sell to the public, and rural general stores that sell alcohol. According to Liquor Distribution Branch service plan reports, 198 BC Liquor Stores were operating in each year from 2023 to 2025. Please see Appendix B for more information.

Source: Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, February 2026.

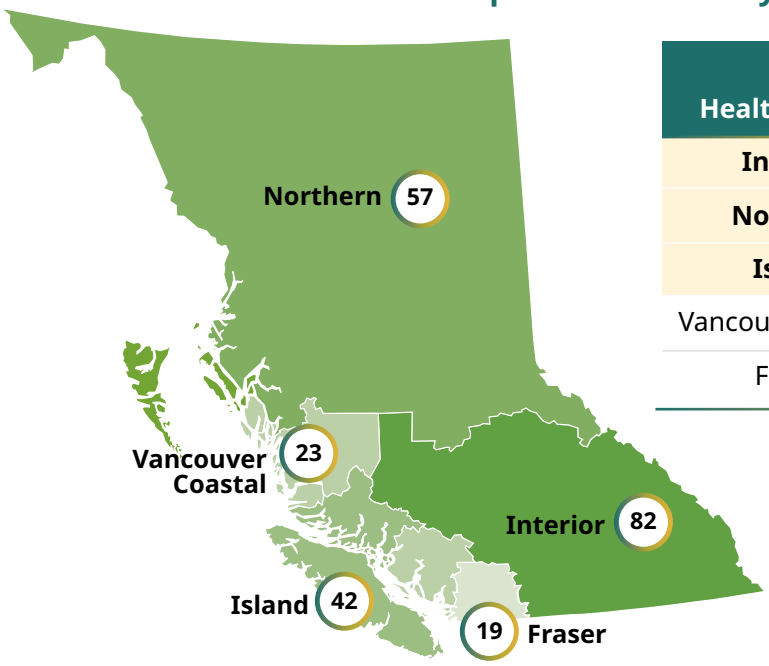
The **Interior health region** has the **highest liquor store density** in the province, followed by the Northern and Island health regions.

Liquor Store Density in BC

Liquor store density refers to how many stores sell alcohol compared to how many people live in a given area. A higher density generally means that people have more places they can go to in their vicinity to purchase alcohol. Province wide, liquor store density in BC is on the rise, from 23 stores per 100,000 population age 15 and older in 2002/03 to 36 stores in 2023/24 (Figure 5.5). Both government and private liquor stores are included in these data.

Liquor store density is considerably higher in the Interior than any other region of the province (Figure 5.5). Nearly half of all manufacturer licensees in the province are located in the region, the majority of which are wineries.[83] This accounts for some of the region's higher liquor store density. Wineries are still points of sale for alcohol, however, and are important to consider when analyzing liquor store density in the province. Additionally, consumption in the Interior health region did not decrease during the COVID-19 pandemic despite travel restrictions imposed at the time (see Chapter 2). This suggests that alcohol sales in this region are not solely driven by tourism.

Liquor Store Density

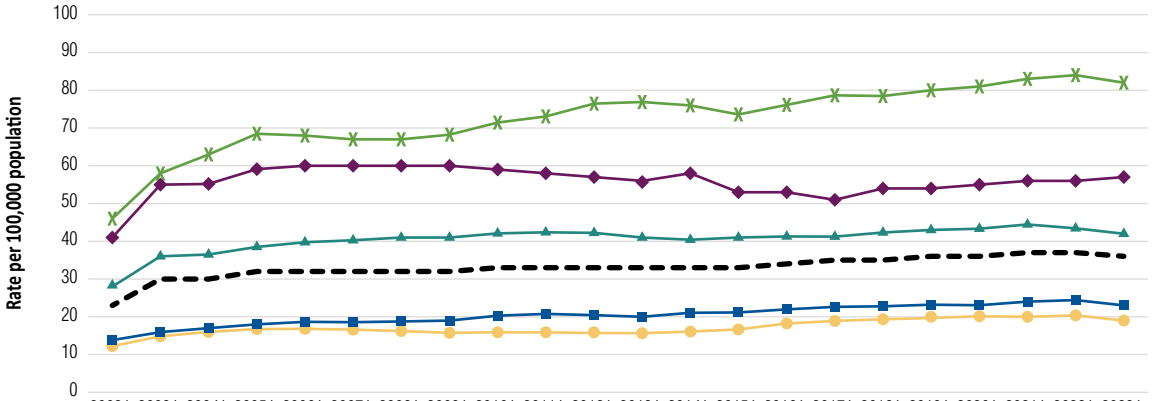


Health Region	2023 Liquor Store Density*
Interior	**82 stores**
Northern	**57 stores**
Island	**42 stores**
Vancouver Coastal	23 stores
Fraser	19 stores

*per 100,000 population

Notes: Liquor store density is represented by the number of private or government liquor stores per 100,000 of the BC population age 15 or older. Bold and highlighted text indicates rates above the provincial rate.
Source: Canadian Institute for Substance Use Research. Prepared by the Office of the Provincial Health Officer, BC Ministry of Health, June 2025.

FIGURE 5.5 Liquor Store Density, by Regional Health Authority, BC, 2002/03 to 2023/24



	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Interior	46	58	63	68	68	67	67	68	71	73	76	77	76	74	76	79	78	80	81	83	84	82
Fraser	12	15	16	17	17	17	16	16	16	16	16	16	16	17	18	19	19	20	20	20	20	19
Vancouver Coastal	14	16	17	18	19	19	19	19	20	21	20	20	21	21	22	23	23	23	23	24	24	23
Island	28	36	36	38	40	40	41	41	42	42	42	41	40	41	41	41	42	43	43	44	43	42
Northern	41	55	55	59	60	60	60	60	59	58	57	56	58	53	53	51	54	54	55	56	56	57
BC	23	30	30	32	32	32	32	32	33	33	33	33	33	33	34	35	35	36	36	37	37	36

Notes: Liquor store density is represented by the number of private or government liquor stores per 100,000 of the BC population age 15 and older. Please see Appendix B for more information.

Source: Canadian Institute for Substance Use Research. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, December 2025.

Photo location: Dane-zaa (Beaver) and nēhiyawak (Plains Cree) traditional territory, Peace River valley.

The Northern and Island health regions have consistently had the second- and third-highest liquor store density among all regions for the past two decades.

Findings about liquor store density should be interpreted with caution. In rural and remote areas, the population is spread out over large distances, and residents may travel long distances to access liquor stores. In such contexts, a higher per-capita number of retailers may reflect efforts to maintain basic accessibility rather than an overconcentration of liquor stores.

Recent Policy Changes in Physical Availability

During the COVID-19 pandemic, the LCRB implemented several alcohol policy changes. Some of these changes were made with the intention to meet physical distancing requirements and to protect populations vulnerable to COVID-19 (e.g., extending operating hours for liquor stores from 9 a.m.–11 p.m. to 7 a.m.–11 p.m.).[30] To aid the hospitality industry, whose sales were impacted by public health orders, the LCRB also temporarily allowed restaurants and bars to sell and deliver packaged liquor with the purchase of a meal.[36] Both policy changes were made permanent in March 2021.[33,34]

BC was not the only region to allow home delivery of alcohol during the pandemic.[84] In areas of the United States where access to home delivery was expanded, people consumed more drinks per week, drank more heavily, and experienced more negative alcohol-related consequences (i.e., medical problems, mental health issues, problems with finances or work, or difficulties with family and friends).[85]

Alcohol Policy: Colonial Histories, Anti-Indigenous Racism, and Ways Forward

In Canada and in BC, alcohol harms are shaped by colonial practices, with alcohol policies having specifically discriminated against First Nations people. The *Indian Act* of 1876 banned alcohol for status First Nations people on and off reserve with offences deemed punishable, and this included a ban on status First Nations people entering establishments where alcohol was served.[86] After World War II, this ban meant that First Nations veterans could not enter Canadian Legions, denying them access to social connections and veterans' benefits that were provided at the legions.[87] Repealing racist policies related to alcohol did not happen in BC until 1962.[88]

In 2023, First Nations representatives identified a need for greater involvement in alcohol policy in BC. This included affirming that alcohol-related engagements and consultations be completed in accordance with the *United Nations Declaration on the Rights of Indigenous Peoples* and with all First Nations regardless of treaty status.[89] Resourcing culturally safe, Indigenous-led mental health and wellness and substance use recovery services are foundational obligations for the BC Government as outlined in the *Declaration on the Rights of Indigenous Peoples Act Action Plan*.[90]

Impaired Driving Countermeasures

Impaired driving remains one of the leading criminal causes of death in Canada and is a substantial public health issue.[91,92] It is also an example of a secondary health harm—where passengers, other drivers, cyclists, and pedestrians may be seriously injured or killed based on the actions of someone else.[91] Impaired driving countermeasures—such as laws, regulations, and policies—can reduce these harms.[66] In legal terms, impaired driving refers to any kind of substance impairment (e.g., alcohol, cannabis, prescription and other drugs). Alcohol-impaired driving accounts for more than 90 per cent of all incidents of impaired driving.[92]

BC has made considerable progress on impaired driving countermeasures. In 2010, the Province introduced Immediate Roadside Prohibition under amendments to the *Motor Vehicle Act.*[94] Under this program, drivers with a blood alcohol concentration of at least 0.05 could have their licences suspended and vehicles impounded onsite, alongside additional administrative penalties such as fines.[94,95] These provisions are in addition to the criminal charges impaired drivers can receive at 0.08 blood alcohol concentration.[96] At the time, these changes made BC a leader in impaired driving legislation in Canada.[94] Within the first two years of the program's introduction, impaired driving deaths in the province were more than halved. Other factors such as improved road and vehicle safety and harsher penalties for excessive speed may have also played a role in reducing deaths.[97] However, Immediate Roadside Prohibition remains a positive example of how government policy can reduce alcohol-related harms.

Statistics Canada reports that in BC the rate of adults criminally charged with impaired driving (i.e., blood alcohol concentrations of 0.08 or higher) was cut roughly in half between 2010 and 2011 (247 per 100,000 in 2010 to 121 in 2011).[98] Although there was a slight increase in 2012 (to 136 per 100,000), the rate has steadily declined since then to 34 per 100,000 in 2023. While once well above the national average, the rate of adults charged with impaired driving in BC has fallen below the national average every year since the introduction of Immediate Roadside Prohibition. Other strategies to reduce impaired driving include strengthening the province's graduated licensing program with a nighttime driving ban, implementing a zero-tolerance blood alcohol concentration for all new drivers, and requiring escalating ignition interlock periods for repeat criminal convictions.[58]

Impaired driving deaths in BC **declined 60%** from 2010 to 2022 after the introduction of **Immediate Roadside Prohibition**.[93]

Promotion of Alcohol Products

Alcohol Advertisements

Alcohol advertisements are direct paid communications promoting an alcohol product. Exposure to advertising for alcoholic beverages increases people's intention to drink and their overall consumption.[99] In Canada, alcohol advertising on television and radio is restricted under the federal Code for Broadcast Advertising of Alcoholic Beverages.[100] Messages advertising alcoholic beverages cannot be directed towards those under the legal drinking age, imply that social status may improve by drinking a product, or attempt to influence people who do not drink to purchase alcohol.[100] The code was implemented in 1996 and has not been updated since. It also does not include controls for digital advertising such as social media platforms. Some provinces and territories have content restrictions on alcohol advertising that go beyond the federal code.[59] In a Canada-wide assessment of alcohol policies, BC falls behind most provinces and territories in its implementation of additional advertising controls.[59]

There are other ways in which alcohol brands can promote their products beyond paid advertisements. These include offering free samples at licensed establishments and providing branded items (e.g., coolers, patio umbrellas, coasters, glasses, T-shirts) for use in licensed establishments or as promotional giveaways to consumers.[5] Another way brands promote their products is through sponsorships.

Alcohol Sponsorships

Alcohol sponsorship occurs when an alcohol brand provides financial or material support, often for a sports or cultural event, in exchange for promotion.[5] It can include advertisements on the event grounds, promotional giveaways, and increased presence of that brand's beverages sold to attendees.[5] Exposure to alcohol sponsorship content at sporting events is associated with heavier consumption among adults as well as school-age children.[101]

A number of European countries have banned alcohol advertising at sporting events and other events such as festivals, with others having partial bans, typically depending on whether the event is viewable by children.[102,103] Even under such restrictions, alcohol brands may still be able to sponsor events and advertise low- or zero-alcohol beverages.[5] For well-known and recognizable brands, this may have the same impact as advertising beverages containing alcohol.[5] Counter-advertisements at sporting events can be effective at bolstering public support for restrictions against alcohol sponsorship and advertising.[5,104]

BC has some restrictions regarding alcohol sponsorship. Alcohol brand agents cannot offer liquor as a prize to participants of a sponsored event and events cannot be sponsored if participants or the audience are primarily minors.[105]

Opportunities for Policy Changes

The World Health Organization's *Global Alcohol Action Plan 2022-2030* acknowledges that alcohol producers and distributers have

moved towards investing in online advertising and marketing, and that digital spaces are increasingly difficult for individual countries to regulate.[106] The action plan recommends that countries take steps to address advertising, sponsorship, and marketing of alcoholic beverages through robust restrictions or complete bans across multiple types of media (including digital media), as well as taxation on alcohol advertising and fines for non-compliance with these regulations. It also highlights the importance of a complete ban of alcohol marketing and advertising that reach minors.

Health and Safety Messaging

Health and safety messaging about alcohol helps consumers make more informed decisions about their alcohol use and its related risks. Health and safety messaging can come in many forms, including labelling on alcoholic beverages (similar to that seen on tobacco products), signs at liquor establishments, and public health and safety campaigns on alcohol use.

Alcohol Awareness Campaigns in BC

In 2023, BC Cancer released an alcohol health and safety campaign called *The Proof*. It aimed to raise awareness of the link between alcohol consumption and several types of cancer. The website for the campaign included information on the Canadian Centre on Substance Use and Addiction's guidance on alcohol and health, a quiz to assess alcohol intake, and tips to reduce alcohol intake.[107,108] The campaign had a strong performance, reaching over 800,000 people on social media, of whom more than 17,000 took the quiz.[109] Of those who saw the campaign and were surveyed afterwards, 52 per cent reported they were likely to drink less.[109]

Source: BC Cancer's *The Proof* campaign website.[108] Reproduced with permission.

Warning Labels

There is currently no federal requirement to include health warning labels on alcohol products in Canada.[110] However, there is some movement on this front. As of 2025, a private member's bill to require warning labels on alcoholic beverages has passed second reading in the Senate. The proposed amendment to the federal *Food and Drugs Act* would require that labels display the number of standard drinks in the package, the number of standard drinks that should not be exceeded to avoid significant health risks, and a message on the causal link between alcohol consumption and cancer.[111]

Health warnings have been **mandatory** on alcohol products in the U.S. **since 1989.**

Canadian consumers have a legal right to know about the hazards of any product they may be interacting with.[112] Warning labels are mandated for other regulated substances such as cannabis and tobacco,[113,114] and health experts have routinely called for mandated warning labels for alcoholic beverages.[17,115-117] A 2025 statement from nearly all provincial and territorial chief medical officers of health in Canada called for the federal government to mandate health label requirements on all alcohol containers for sale in Canada.[118] In a national survey of people living in Canada, more than half (55 per cent) of respondents agreed that alcohol products should display health warnings.[119]

In the United States, warning labels have been required by law on alcohol products since 1989.[120,121] They highlight specific risks around alcohol consumption and pregnancy (birth defects) as well as driving a car or operating machinery. Studies of alcohol warning labels in the United States have shown that they are more likely to be noticed by people who consume alcohol at high-risk levels and by pregnant people.[5] They also help create conversations about alcohol.[5,117] Evidence further shows that well-designed alcohol warning labels (with large, colourful designs and statements that link alcohol use to disease outcomes) can influence consumers' attention and awareness of alcohol risks.[122]

Each province and territory has the authority to implement labelling requirements for products sold within its jurisdiction. The Northwest Territories requires warning labels on alcoholic beverage containers, with information similar to the U.S. warning labels.[123] A pilot project involving alcohol warning labels in the Yukon showed that people who saw the labels had an increased awareness of cancer risks.[124] Alcohol sales were also lower during the pilot project.[125]

In BC, alcohol warning labels could be mandated through provincial legislation or regulation governing liquor control and distribution. For example, the province could require warning labels on alcohol products distributed by the BC Liquor Distribution Branch, which supplies retailers in the province.[110]

Surgeon General Warning on Alcohol Products in the United States

GOVERNMENT WARNING:
(1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects.

(2) Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.

Source: Code of Federal Regulations.[126]

Compared to other legal substances like tobacco and cannabis, labelling is an area where alcohol has clearly been provided that free pass. Think of a bottle of wine, wrapped in fetching packaging showing pictures of a rustic vineyard. Imagine if the same was done for tobacco: a cigarette pack showing sprouting tobacco plants and farm equipment, instead of plain packaging with ominous health warnings.

[...]

In policy and public opinion, alcohol is treated differently than other potentially addictive substances. Alcohol policies like container labelling, minimum unit pricing and advertising regulations provide avenues towards reducing Canada's costly alcohol deficit and, at the same time, improving public health.

Adam Sherk, PhD, Scientist,
Canadian Institute for Substance Use Research.[127]

Required Signs in BC

BC requires liquor licensees in the province to display at least one social responsibility poster or tent card in a prominent location.[128] These are branded as *Alcohol Sense,* and 2026 materials encourage people who consume alcohol to "have a think." The signs are developed by a committee that includes representatives from both the alcohol industry and government.[129,130]

A 2024 survey of BC residents commissioned by the Ministry of Health showed that one-third of people who drank in the past year recalled seeing an Alcohol Sense poster, with some believing it is a good reminder to drink responsibly.[131] The vast majority of those surveyed (81 per cent) agreed that the government has a role to play in educating the public about the risks of alcohol, with 57 per cent wanting to know more about the health risks from drinking.[131]

Some other jurisdictions have mandated warning signs/posters for alcohol. For example, the state of Alaska requires warning signs to be displayed in bars and liquor stores. These signs must explicitly state that alcohol can cause cancer, including breast and colon cancers.[132]

Source: Liquor and Cannabis Regulation Branch.[128]

Coordinating Alcohol Policy and Priorities Through a Provincial Alcohol Strategy

Alcohol strategies are guiding documents that help set priorities for alcohol across government ministries and departments.[133] Without a whole-of-government approach, provincial objectives related to alcohol—and the policies that take shape from them—can be at odds with one another.[4] For example, goals to increase or maintain government revenue from alcohol sales can run counter to the goals of reducing alcohol-related disease and death in the population.

The World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol* can help guide provinces and territories as they consider developing an alcohol strategy.[133,134] It sets out objectives and guiding principles for reducing alcohol harms. These span 10 areas of action, including marketing and availability of alcoholic beverages, pricing policies, impaired driving countermeasures, health service response, and monitoring and surveillance.[134] Researchers and health advocates recommend governments avoid involving the alcohol industry when developing an alcohol strategy because of the risk that industry involvement will limit the effectiveness of strategies to reduce health harms.[59,133]

Regions in Canada With Strategies to Reduce Alcohol-related Harms

Jurisdiction	Year	Key Features	Domain Focus
Newfoundland and Labrador[38]	2022	Delivers 13 actions to reduce alcohol harms and costs.	Prevention and health promotion, treatment, and decreasing availability of alcohol.
The Northwest Territories[39]	2023	Created in consultation with people with lived and living experience and Indigenous leaders. Delivers 15 actions to reduce alcohol harms; five-year work plan in place.	Communications, policy, prevention, public safety, and treatment.
Nunavut[135]	2016	Delivers 15 initiatives to help reduce alcohol-related harm.	Prevention and education, harm reduction, treatment, and enforcement.

A **province-wide alcohol strategy** can **coordinate government priorities** and **reduce alcohol-related harms.**

Other Strategies

Strategies exist at federal and provincial/territorial levels to reduce harms from psychoactive substances. In 2004, BC created a province-wide tobacco strategy to "reduce death, disease and disability caused by tobacco use and to reduce its subsequent cost to the health care system."[136] The *Canadian Drugs and Substances Strategy* aims to save lives and minimize substance-use-related harms through federal legislation and regulation, national surveillance and research, services and supports, and funding for projects that address substance use and its harms.[137]

Conclusion

Reducing alcohol use in society requires a collaborative approach—one where governments not only encourage people to drink less but also create environments that promote healthier choices and provide a broad spectrum of treatment and services for those who need them. In BC, much of this can be accomplished through changes and small shifts to existing alcohol policies developed in partnership with First Nations and leaders, as per the direction set by the Chiefs-in-Assembly of the BC Assembly of First Nations and the Chiefs Council of the Union of BC Indian Chiefs in their resolutions on alcohol regulation, funding, and jurisdiction.[89,138] Setting minimum prices for products by the strength of their alcohol content rather than by volume, maintaining the private liquor store licence moratorium, implementing health warning labels for alcohol products, and creating an overarching provincial alcohol strategy are some of the methods that would help lower alcohol consumption and alcohol-related harms in BC. These small but impactful changes would bring provincial alcohol policy into alignment with updated evidence that shows when it comes to drinking alcohol, less is best.

Key Messages

- Governments can reduce alcohol harms by setting policies in areas such as pricing, advertising, and availability.
- When adjusted for inflation, alcoholic beverages have been getting cheaper over time in BC.
- Minimum unit pricing would help encourage consumers to choose lower-strength products.
- Impaired driving countermeasures in BC have been strengthened over the past decade and a half, helping to save lives.
- People in BC want to know more about the health risks of drinking and believe the government has a role to play in educating the public.
- Provincial/territorial alcohol strategies coordinate alcohol policy and priorities across government.

Chapter 6

Recommendations and Conclusion

More can be done to improve the health and well-being of people in BC when it comes to alcohol. This requires collaboration. Ministries, local governments, health-care leaders, and people in the province—among others—all have roles to play.

This report highlights a range of tools and policies that can help reduce harms related to alcohol. Among them, a provincial alcohol strategy, minimum pricing based on alcohol content, warning labels, public awareness messaging, and a strengthened health-care system response can make the biggest difference.

All approaches going forward must be aligned with the BC *Declaration on the Rights of Indigenous Peoples Act* and centre First Nations, Métis, and Inuit rights and perspectives. Approaches should follow the direction outlined in resolutions by Chiefs-in-Assembly of the BC Assembly of First Nations and Chiefs Council of the Union of BC Indian Chiefs.[1,2]

Recommendations

1. **Uphold the foundational obligations to First Nations, Métis, and Inuit Peoples.** Uphold the foundational obligations to First Nations, Métis, and Inuit Peoples—including those related to rights to health and wellness—to ensure that First Nations, Métis, and Inuit Peoples are safe from Indigenous-specific racism and discrimination, and have access to Indigenous-led, holistic, and culturally safe alcohol prevention and treatment services and supports.

2. **Develop a provincial alcohol strategy.** Develop and implement a cross-government alcohol strategy—co-led by the Ministry of Health, Ministry of Agriculture and Food, and Ministry of Public Safety and Solicitor General—and developed in partnership with First Nations and Métis Nation British Columbia. This strategy should

   - prioritize reducing health harms from alcohol;

- balance government revenues from alcohol with their associated health and social costs to lower BC's alcohol deficit;
- articulate a clear vision, goals, objectives, and measures to guide coordinated action across ministries and sectors to reduce alcohol harms and costs; and
- exclude industry from strategy development. Industry representatives should be engaged with only as needed to advise on the implementation of aspects of the strategy that rely on industry action. Industry representatives should not be involved in setting or influencing vision, goals, objectives, or measures included in a strategy to reduce alcohol harms and costs.

3. **Shift to minimum unit pricing.** Shift alcohol minimum pricing from the current volume-based approach to one based on alcohol content (minimum unit pricing). Implement this shift in full partnership with First Nations, Métis, and Inuit Peoples, as required under BC's *Declaration on the Rights of Indigenous Peoples Act* and as emphasized by First Nations leadership in the province. Ensure that those who have difficulty scaling back their alcohol use are supported during this policy shift. Index minimum unit pricing to inflation to maintain effectiveness over time.
4. **Require warning labels on packaging.** Require evidence-based warning labels and health information on alcohol packaging, including cancer risk, risks to pregnant people, fetal alcohol spectrum disorder risks, and advice from the Canadian Centre on Substance Use and Addiction's guidance on alcohol and health.
5. **Launch an awareness campaign.** Develop and disseminate an ongoing, permanent awareness campaign about alcohol use and risks. This campaign should be free from industry involvement and reflect up-to-date evidence on alcohol use and risk, particularly relating to cancer, as people in BC want to know more about this topic.
6. **Strengthen the health system response.** Monitor and improve implementation of alcohol use disorder screening, brief intervention, and referral to treatment in primary care settings. Improve the capacity of the health-care system to
   - provide culturally safe care to First Nations, Métis, and Inuit patients;
   - recognize and diagnose alcohol use disorder;
   - deliver more comprehensive, evidence-based care for people experiencing alcohol use disorder, including psychosocial and pharmacological treatments; and
   - retain more people in care and treatment.

Conclusion

Supporting a less-is-best approach to alcohol is in everyone's best interests. Shifts in alcohol minimum pricing policy can lower consumption and reduce alcohol-related harms. People in BC have said they want clearer information about alcohol use and health risks. They have a legal right to know the risks associated with alcohol, as with any commercial product. The BC government can help by requiring warning labels for alcohol products and through alcohol use and risk awareness campaigns. For people who have alcohol use disorder and their families, improved screening, brief intervention, and referral to treatment are ways the health-care system can provide support.

Alcohol policies based in settler-colonial worldviews have caused and continue to cause disproportionate harms for First Nations, Métis, and Inuit Peoples in BC. Addressing these harms requires work on several fronts. Upholding inherent rights to self-determination with respect to alcohol for all Indigenous Peoples and developing policy in partnership with Indigenous leaders is essential.

Implementing a health-focused approach to alcohol can bring balance to policy changes that have made alcohol more available and less expensive over the past 20 years. A province-wide alcohol strategy that prioritizes health is one step to achieving this balance. This does not need to ignore or eliminate the social or cultural role alcohol plays in many people's lives, but it can—and should—promote the message that when it comes to alcohol, less is best.

Appendix A
Glossary

2SLGBTQQIA+: 2-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual. The "+" indicates the inclusion of other identities as this abbreviation continues to evolve.

Alcohol: A colourless liquid, also known as ethanol, that is produced by the natural fermentation of sugars. It is the component in wine, beer, spirits, and other drinks that causes intoxication. The word "alcohol" also refers to beverages that contain alcohol.

See also: *ethanol*

Alcohol advertisement: Direct paid communication promoting an alcohol product.

Alcohol-attributable: An event, such as a death or hospitalization, is attributable to alcohol when the death or hospitalization would not have occurred in the absence of alcohol.

Alcohol deficit: The gap between the government revenue generated from the control and sale of alcohol and the costs associated with alcohol consumption, such as the costs to the health-care and criminal justice systems.

Alcohol-impaired driving: Driving a motor vehicle while impaired by alcohol.

See also: *impaired driving*

Alcohol policy: Rules, legislation, and programs to govern how alcohol is produced, sold, and consumed.

Alcohol use disorder: A medical condition in which a person is unable to stop or control alcohol use despite adverse social, occupational, or health consequences. Previously referred to as alcohol dependence or alcoholism.

Alcohol withdrawal: The symptoms that can occur when someone who has habitually consumed amounts of alcohol over a long period of time stops or reduces alcohol consumption. Symptoms include nausea, tremor, vomiting, increased heart rate, fever, and sweating.[1]

Alcoholic beverage: A consumable beverage that contains a certain percentage of alcohol. In Canada, alcoholic beverages are also sometimes referred to as liquor.

Canadian Centre on Substance Use and Addiction's guidance on alcohol and health: An up-to-date and evidence-based guide for people in Canada on how to make informed decisions about alcohol consumption.

Commercial determinants of health: "The private sector activities that affect people's health, directly or indirectly, positively or negatively."[2]

Cultural safety: The experience of feeling safe and being free from discrimination when accessing services or in other settings.[3]

DisAbility: A physical or mental condition that affects or is seen as affecting a person's abilities.[4] The Office of the Provincial Health Officer recognizes that people living with disAbilities are diverse and identify in various ways. The "A" in disability has been capitalized to focus on the abilities of people who live with disAbilities and to help remove deficit undertones of the word.

Ethanol: Consumable pure alcohol.

Fatality victim: A driver, passenger, pedestrian, or cyclist who dies within 30 days after an injury sustained in a crash that involved at least one motor vehicle on a public roadway.

Fetal alcohol spectrum disorder: A range of physical, behavioural, and cognitive changes that result from prenatal alcohol exposure.

Gender-based violence: Violence committed against someone based on their sex or gender identity, gender expression, or perceived gender. It can be physical, emotional, psychological, or sexual in nature.

Government liquor store: A liquor store owned by the BC government; a BC Liquor Store.

Health inequities: Disparities in health that are not only unnecessary and avoidable, but also unfair and unjust. These inequities often arise from social and environmental factors such as racism, sexism, and disparities in income and education. Achieving health equity requires reducing these avoidable disparities so that everyone has a fair opportunity to reach their fullest health potential.[5]

Heavy episodic drinking: Consuming five or more drinks on one occasion for men, or four or more drinks on one occasion for women.

Immediate Roadside Prohibition: A three-, seven-, 30-, or 90-day driving prohibition issued at the roadside to alcohol-impaired drivers under BC's *Motor Vehicle Act*. Criminal charges may be laid separately.

Impaired driving: Driving a motor vehicle while impaired by alcohol, drugs, or medications.

See also: *alcohol-impaired driving.*

Indigenous: A collective term used to describe the original inhabitants of a land and their descendants. First Nations, Métis, and Inuit are the Indigenous Peoples in Canada.

Indigenous-specific racism: "The unique nature of stereotyping, bias and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping and injustice experienced by Indigenous peoples that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from the colonial policies and practices."[6(p.10)]

Injury victim: A person who sustained an injury (serious, involving an overnight stay at the hospital, or non-serious) in a crash that involved at least one motor vehicle on a public roadway.

Intimate partner violence: Violence perpetrated by a current or former intimate partner (e.g., spouse, dating partner). It can include varying forms of physical, sexual, emotional, and psychological abuse.[7]

Liquor and Cannabis Regulation Branch: The branch of the provincial government that administers legislation governing liquor and cannabis. For alcohol, this includes regulating alcohol-serving restaurants and bars, alcohol manufacturers, alcohol retail stores, and special events involving alcohol.[8]

Liquor Distribution Branch: An agency of the BC government responsible for distributing alcohol and cannabis to private and government-run stores, and operating BC Liquor and BC Cannabis stores.[9]

Liquor outlets: Establishments that sell liquor for consumption. These can be liquor stores (privately run or government run), restaurants, or bars.

Liquor stores: Retailers that sell alcohol for consumption off-site. These can be privately run or government-run stores. In this report, manufacturers such as breweries, wineries, and distilleries that also sell liquor for off-site consumption are considered liquor stores.

Liquor store density: The number of liquor stores in an area divided by the number of people who live in that area.

Managed alcohol programs: A harm-reduction approach for individuals with severe alcohol use disorder who are often concurrently experiencing homelessness or housing instability. Managed alcohol programs provide regulated doses of alcohol throughout the day to reduce harmful drinking patterns and substitute non-beverage alcohol. They are typically offered alongside services like meals, health care, housing, and social support.[10,11]

Manufacturer licence: A licence under the Liquor Control and Licensing Regulation that permits the holder to, among other things, make wine, beer, or spirits and sell the products they produce directly to the public, provide samples, conduct tours, and promote their products.[12]

Minimum pricing: Policies that set a minimum price at which alcohol can be sold.

Minimum unit pricing: A policy that sets a minimum price for alcoholic beverages that is based on the beverage's alcohol content.

Motor vehicle crashes involving alcohol: Crashes where alcohol was a contributing factor. This includes alcohol impairment (suspected or confirmed) or alcohol involvement.

Non-beverage alcohol: Types of alcohol that are not intended for human consumption (e.g., rubbing alcohol, mouthwash, hand sanitizer).

Private liquor store: A liquor store or other outlet for the retail sale of alcohol that is owned by a private individual or company, not a government. Some examples of private liquor stores are private alcohol retail stores, wineries that sell to the public, and rural general stores that sell alcohol.

See also: *government liquor store, wine store, manufacturer licence, rural store*

Prohibition: The act of forbidding something by law. Alcohol was prohibited in Canada at a federal level from 1918 to 1920.

Psychoactive substance: Something that, when taken, changes a person's mental processes, such as their mood, emotions, perception, or cognition. Alcohol is a psychoactive substance.

Racism: The process by which systems and policies, actions, and attitudes create inequitable opportunities and outcomes for people based on race.

See also: *Indigenous-specific racism*

Regulatory capture: A phenomenon that occurs when an industry gains significant influence over—or "captures"—regulators and the regulatory process. With this influence, government policies and legislation, which should primarily protect the health and safety of the population, often wind up favouring industry interests instead.

Rural store/rural agency store: A type of liquor licence that permits a general store to sell packaged alcohol products in rural communities and resorts.[13]

Seniors: Definitions of this term vary. In this report, seniors are adults age 65 and older.

Settler colonialism: The process of white European societies taking control over Indigenous land and removing or eradicating Indigenous Peoples for the purpose of building an ethnically distinct national community.

Standard drink: A measure of how much pure alcohol is in an alcoholic beverage. In Canada, a standard drink is 17.05 millilitres or 13.45 grams of pure alcohol.

Unregulated drugs: "Also referred to as illegal drugs, illicit drugs, street drugs, or prohibited drugs, 'unregulated drugs' are drugs prohibited under Canada's laws for all but very limited uses, which are nonetheless made available to the public by illegal sellers without the benefit of quality controls or regulation, and which result in an unpredictable and often toxic supply of drugs."[14(p.59)]

Wine store: A liquor licence category specific to retail stores that sell wine. This is an infrequently used license category that is being phased out.[15]

Youth: Definitions of this term vary. In this report, "youth" refers to individuals age 12–19 who attend school. This is to align with the inclusion criteria of the report's data source on youth and alcohol, the McCreary Centre Society's BC Adolescent Health Survey.[16]

Appendix B

Data Sources, Methods, and Supplemental Information

This appendix provides a summary of the data sources used to present the indicators in this report, and it describes some of the limitations of these data. It also summarizes the methodology used to calculate annual average alcohol consumption, alcohol-attributable death and hospitalization rates, alcohol-impaired driving deaths and injury rates, and alcohol prices in BC. Information on COVID-19 provincial health officer orders impacting alcohol outlets, impaired driving countermeasures, and alcohol minimum pricing is included at the end of the appendix in the Supplemental Information section.

Data Sources

The BC Adolescent Health Survey

The BC Adolescent Health Survey is an anonymous questionnaire given every five years to BC students in grades 7–12 (age 12–19) attending public schools across the province. Since 1992, the McCreary Centre Society has been using the BC Adolescent Health Survey to gather information about the health and wellness of youth in BC.

A limitation of this data source is that it only includes students in public schools, so it may not be representative of data for children in other types of schools such as independent schools, homeschooling, distance education, or First Nations schools. Additionally, in some school districts, not all grades participate in the survey, and not all school districts participate in the survey every cycle.[1]

For more information on the BC Adolescent Health Survey, see:
www.mcs.bc.ca/about_bcahs

Canadian Institute for Substance Use Research

The Canadian Institute for Substance Use Research (CISUR) provided the Office of the Provincial Health Officer with data and analysis for this report that were based on the data sources listed below.

For more information about CISUR, see:
www.uvic.ca/research/centres/cisur/index.php

BC Alcohol and Other Drug Monitoring Project

The BC Alcohol and Other Drug monitoring project is based at CISUR. It combines data from several sources (e.g., the Liquor Distribution Branch, the Liquor and Cannabis Regulation Branch, Statistics Canada, and health administrative data) to provide information about alcohol consumption and alcohol-related hospitalizations and deaths in BC.[2]

Alcohol consumption data for BC and by health region, as well as liquor outlet density, were estimated based on sales data and population estimates generated by BC Stats.

Alcohol-related hospitalizations and deaths are estimates derived from record-level hospital visit information. The estimates include deaths and hospitalizations wholly due to alcohol, as well as those partially due to alcohol (see the methodology section on the alcohol-attributable fraction method for more detail). As such, these estimates are subject to change if the underlying methodology is updated. Unexpected deaths that occur from alcohol are subject to investigation by the BC Coroners Service; recent year data may be incomplete for these deaths until these investigations are deemed closed.[3] Data at the health service delivery area and local health area levels are available on the BC Alcohol and Other Drug monitoring project tool websites.

For more information on the BC Alcohol and Other Drug monitoring project, see: www.uvic.ca/research/centres/cisur/projects/active/projects/aod-project.php

Liquor and Cannabis Regulation Branch; Liquor Distribution Branch

BC's Liquor and Cannabis Regulation Branch and the Liquor Distribution Branch provided data related to alcohol sales, retail prices of alcohol, and number of liquor outlets to CISUR, who provided the analyses for this report.

Canadian Substance Use Costs and Harms Project

Canadian Centre on Substance Use and Addiction and CISUR developed the Canadian Substance Use Costs and Harms project. It provides data on the costs and harms of substance use in Canada and includes an interactive data visualization tool that can be used to explore the data. At the time of writing this report, 2020 was the most recent year with available data.

For more information on the Canadian Substance Use Costs and Harms project, see: www.csuch.ca

Canadian Substance Use Survey

The Canadian Substance Use Survey (CSUS) is a biennial general population survey to collect information on the use of alcohol and drugs in Canada by those age 15 and older. For 2023, the data were weighted to add up to the population projections for 2022 from the 2021 census, based on province, age, and sex at birth.[4,5] CSUS has evolved over time. Previously called the Canadian Alcohol and Drugs Survey and operated by Statistics Canada, the survey was taken on by Health Canada in 2019 and renamed in 2023 following methodological changes. The 2023 CSUS was conducted from May to December 2023 and captured information from over 36,000 respondents in the Canadian population. Results are weighted

to represent 32.7 million people age 15 and older in the Canadian provinces.

Because of the methodological changes, it is recommended that data from the 2023 CSUS not be compared to data from the previous surveys. It is possible that there may be bias in the results due to the sampling methods and as the survey was voluntary and respondents knew that it would be asking about substance use.[5]

For more information on the Canadian Substance Use Survey, see: https://www.canada.ca/en/health-canada/services/canadian-alcohol-drugs-survey/2023-summary.html

Statistics Canada

Control and Sale of Alcoholic Beverages and Cannabis

The Control and Sale of Alcoholic Beverages and Cannabis program is run by Statistics Canada. It collects data from the provincial and territorial governments and disseminates data on the sales and per capita sales of alcoholic beverages by liquor authorities and other retail outlets, by value, volume, and absolute volume.

While data collection coverage for this program is complete, some questionnaires may have missing data, which is then imputed from available auxiliary information.

For more information on the Control and Sale of Alcoholic Beverages and Cannabis program, see: doi.org/10.25318/1010001001-eng

Canadian Community Health Survey

The Canadian Community Health Survey is a cross-sectional survey administered by Statistics Canada. It collects information related to health status, health-care use, and health determinants for the Canadian population. It relies upon a large sample of respondents, age 18 and older, and aims to provide reliable health estimates at the health region level every two years. For this report, the Canadian Community Health Survey provided estimates of heavy drinking in the BC population.

There are some limitations to the data generated by this survey. The Canadian Community Health Survey excludes people living on reserves, full-time members of the Canadian Forces, and people who are institutionalized. Due to substantial survey and sampling redesign and changes in 2015 and 2022, caution is recommended when comparing data for cycles before 2015 with the 2015 to 2021 cycles, and previous cycles with 2022 and later cycles. The Canadian Community Health Survey also had lower survey participation during the COVID-19 pandemic. Longitudinal data can be influenced by cohort effects, where individuals from younger cohorts age into older ones over time. This overlap can complicate interpretations, as observed changes may reflect generational differences rather than true aging effects. Generally, there have been no statistically significant changes in trends of heavy episodic drinking in BC from 2015 to 2023.

For more information on the Canadian Community Health Survey, see: https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3226

Insurance Corporation of British Columbia

The BC Injury Research and Prevention Unit uses Insurance Corporation of British Columbia (ICBC) data (the MV6020 Traffic Accident Report) to report on casualties caused by traffic collisions that occur on BC public roads. The numbers of deaths and injured victims due to collisions where alcohol was a contributing factor were obtained from the Injury Data Online Tool produced and maintained by the BC Injury Research and Prevention Unit.[6] These data reflect traffic collisions where one or more of the vehicles involved had as contributing factors: alcohol involvement, ability impaired by alcohol, or alcohol suspected.

There are several limitations to these data. Casualties due to collisions that occurred on roads where the *Motor Vehicle Act* does not apply (e.g., private driveways, industrial or forest service roads) and off-road snowmobile collisions were not included in the analyses. The analyses also excluded homicides and suicides. Lastly, the MV6020 Traffic Accident Report is completed by police to record details of collisions, and the reporting requirements for police attending crashes have changed over time (see the Supplemental Information section in this appendix for a more detailed explanation).

BC Survey on Population Experiences, Action, and Knowledge

The BC Survey on Population Experiences, Action, and Knowledge (SPEAK) is a web-based population health survey designed to collect information about BC residents' experiences, knowledge, and actions at different phases of the COVID-19 pandemic, and the impacts of the pandemic at local, regional, and provincial levels. There have been three rounds of BC SPEAK in 2020, 2021, and 2023. BC SPEAK was used in this report to provide estimates of heavy drinking in the BC population at the regional health authority level.

Due to the nature of sampling for this survey (respondents self-selected and volunteered to participate) there is potential for selection bias in the data, and the data may not be representative of the entire population of BC. Caution should be taken when interpreting or generalizing the results to the BC population.[7]

For more information on BC SPEAK, see: www.bccdc.ca/health-professionals/data-reports/bc-covid-19-speak-dashboard

Methods

Adjusting Self-reported Alcohol Use Data

Per capita alcohol consumption estimated based on the amount of self-reported alcohol consumption is considerably lower than the estimate based on sales data. In other words, people buy more alcohol than they report drinking.[8-10] For this reason, self-reported alcohol consumption from survey data (specifically the Canadian Substance Use Survey) was adjusted to take into account the sales level in provinces/territories and the country.

Alcohol-attributable Fractions

The BC Alcohol and Other Drug monitoring project calculates death and hospitalization rates for alcohol using the alcohol-attributable fraction method. The alcohol-attributable fraction method calculates the proportion of a health outcome that is caused by alcohol.[11] This allows researchers to describe the number of cases or deaths that are

caused by alcohol across a population, even though alcohol might be only one of several contributing factors in each individual case. Using the attributable fraction method means that a count of 1 death or hospitalization does not necessarily correspond to a specific, single individual or specific event. For example, if a particular condition had an attributable fraction of 0.2, a count of 1 would correspond to five individuals (5 x 0.2).

For more information on the alcohol-attributable fraction method, see: www.uvic.ca/research/centres/cisur/projects/intermahp/index.php or aodtool.cisur.uvic.ca/aod/about.php

Categorization of Liquor Outlets

Liquor outlets referred to throughout this report are defined based on the licence type, as issued by the Liquor and Cannabis Regulation Branch. Table B.1 shows the liquor outlet categorization of different licence types along with the estimated number of licences in BC between July 2024 and June 2025.

Alcohol Pricing in BC and Indexing Prices to Inflation

Alcohol pricing data over time were indexed to inflation. Indexing the price of a good to inflation helps demonstrate whether a good is genuinely becoming more affordable or if its price is merely rising alongside inflation. This was done using the all-items Canadian Consumer Price Index (which uses 2002 as the base year). Pre-tax prices were used due to the fluctuation of sales taxes over the years[12] and due to the variation in how provincial sales tax and other additional charges are applied to different types of alcoholic beverages.[13,14]

For more on the Canadian Consumer Price Index, see: https://doi.org/10.25318/1810000401-eng

TABLE B.1 **Type of Active Liquor Licences in BC Between July 2024 and June 2025**

Category	Licence Type	Estimated Number of Active Licences Between July 2024 and June 2025
Private liquor stores	Licensee retail store	679
	Rural licensee retail store	232
	Manufacturer	783
	Wine store	51
Restaurants	Food primary	5,801
	Catering	35
Bars	Liquor primary	1,773
	Liquor primary club	267
UBrew and UVin		104
Agent		298

Source: BC Liquor and Cannabis Branch. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, November 2025.

Motor Vehicle Crashes Involving Alcohol in BC: Combined Years

For the rates of deaths and injuries from crashes involving alcohol, the years 2013 to 2022 are combined so that enough data are included to permit disaggregation by age and sex.

Rates

Except where noted, all rates presented in the figures and tables in this report are crude rates (non-standardized). Rates noted as standardized are from the BC Alcohol and Other Drug monitoring project and have been adjusted for age and sex based on the 2021 BC Census population (Statistics Canada).

Supplemental Information

COVID-19 Provincial Health Officer Orders Impacting Off- and On-premise Alcohol Outlets, 2020–2022

Restrictions from the COVID-19 pandemic impacted the sales and operations of food and liquor primary establishments. In BC, several orders specific to these establishments were issued by the Provincial Health Officer and were in place from 2020 to 2022. These are summarized below.

Provincial Health Officer Orders for the Food and Beverage Industry During the COVID-19 Pandemic

Date	Restriction Implemented
March 20, 2020	Indoor dining at places at which food and/or drink are prepared and served is closed; takeout service and delivery allowed. Liquor primary establishments that do not offer meals (e.g., nightclubs, lounges, onsite tasting rooms) are closed.
May 15, 2020	Indoor dining at places at which food and/or drink are prepared and served is re-opened with restrictions (e.g., capacity, distancing). Certain liquor primary establishments (i.e., golf courses, manufacturers' onsite lounge endorsements or tasting rooms) re-open with restrictions (e.g., capacity, distancing). Liquor primary establishments that do not offer meals (i.e., nightclubs) remain closed.
July 31, 2020	Nightclubs re-open with restrictions (e.g., capacity, distancing, no dancing).
October 9, 2020	Nightclubs close.
December 30, 2020	Nightclubs remain closed. For all other food and liquor primary establishments: Liquor sales for onsite and offsite consumption are banned between 8 p.m. December 31 and 9 a.m. January 1. Liquor sales for onsite consumption must cease between 10 p.m. and 9 a.m. the following day.
March 31, 2021	Indoor dining at places at which food and/or drink are prepared and served (including food primary and liquor primary establishments) is closed; takeout service and delivery is allowed.
May 23, 2021	Indoor dining at places at which food and/or drink are prepared and served (including food primary and liquor primary establishments) is re-opened with restrictions.

Date	Restriction Implemented
June 30, 2021	Nightclubs can re-open with restrictions (e.g., no mingling between tables, no dancing).
September 10, 2021	Proof of vaccination required for indoor dining at all establishments.
February 16, 2022	All food and liquor establishments return to full capacity with dancing permitted.

Impaired Driving Countermeasures

Several legislative changes to impaired driving countermeasures occurred between 2005 and 2019 at provincial and federal levels that may impact impaired driving data provided in this report. Additionally, changes in how police collected and reported information about crashes to ICBC from 2008 onwards impacted the injury data in this report. Events impacting impaired driving data are summarized below.

Year	Events Impacting Impaired Driving Data
2005	BC introduces Ignition Interlock Programs under amendments to the *Motor Vehicle Act.* Drivers with a driving record that is deemed "unsatisfactory" are required to have ignition lock devices installed through which the ignition of a vehicle will only engage if the driver's provided breath sample shows zero blood alcohol.[15] Other penalties include participation in a driving training course.
2008	Amendments to BC's *Motor Vehicle Act* require police officers to report police-attended collisions to ICBC.[16] However, attendance at "minor collisions" (i.e., those with no serious human injuries and where the vehicle is still driveable) is at police discretion due to resource management.[17,18] Since 2008, the number of police-attended crash reports to ICBC has decreased.[6,18,19] A large discrepancy exists between police-attended crash reports and ICBC claims data (however, claims data do not capture contributing factors such as alcohol involvement).[18,19] The data for injuries from crashes involving alcohol in this report are from police-attended crashes.[6] It is presumed the decline seen in these data from 2008 onwards reflects fewer police-attended crash reports filed to ICBC rather than fewer injuries occuring.[19]
2010	BC introduces Immediate Roadside Prohibition* under amendments to the *Motor Vehicle Act.* It applies to drivers registering a warn (blood alcohol concentration of no less than 50 milligrams per 100 millilitres of blood) and a fail (blood alcohol concentration of no less than 80 milligrams of alcohol per 100 millilitres of blood). Additional penalties for those registering a warn are also implemented including vehicle impoundment and monetary fines.[20]
2018	The federal government passes *Bill C-46, An Act to Amend the Criminal Code* on the heels of cannabis legalization. Impaired driving now includes driving while impaired by drugs, including cannabis. Criminal offences are strengthened under the act for impaired driving (e.g., the maximum indictable penalty for operation while impaired increased from a maximum of five years to 10 years).[21]
2019	Updates to the Motor Vehicle Act Regulations change when police are required to file reports to ICBC for property-damage only crashes.[22] Whereas previously reports were required for property damage exceeding $1,000 for vehicles and $600 for motorcycles, the reporting threshold becomes $10,000 per collision.[22]
2020–2021	The COVID-19 pandemic brings in travel restrictions that likely impact the number of vehicles on the road.

*Immediate Roadside Prohibition went through several court challenges between 2012 and 2015 that resulted in changes to the law (i.e., offering of second Breathalyzer tests, revisions in wording).[23]

Minimum Pricing in BC: Alcohol by Volume

There are two sets of minimum prices in BC depending on whether the alcohol is consumed on premise (e.g., at a licensed venue such as a restaurant or bar) or off premise (e.g., at home). Tables B.2 and B.3 depict these minimum prices, which were set in 2014 and 2016 (respectively) and are not indexed to inflation.[24,25]

As minimum prices for off-premise alcohol are defined per litre of beverage, they have been converted to minimum pricing per standard drink in the body of the report for common alcohol by volume percentages. This can be calculated by determining the number of standard drinks in the litre of beverage based on its alcohol by volume percentage, then dividing the price per litre of beverage by the number of standard drinks.

For example, one litre of 5 per cent beer contains 0.05 litres of ethanol, which is equivalent to 2.93 standard drinks. The minimum price for a packaged beer sold for off-premise consumption is $3.19 per litre which, divided by 2.93, is $1.09 per standard drink.

TABLE B.2 Minimum Prices for On-premise Alcohol by Volume in BC

Liquor Category	On-premise Minimum Price per Ounce (28 mL)
Wine/fortified wine (including sake)	$0.60
Liqueurs/spirits	$3.00
Packaged beer, cider, or cooler	$0.25
Draught beer or cider (if serving size is less than 50 ounces or 1.42 litres)	$0.25
Draught beer or cider (if serving size is 50 ounces or 1.42 litres or greater)	$0.20

Note: Prices do not include sales tax.
Source: BC Liquor and Cannabis Branch, Policy Directive No: 14 – 15. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, November 2025.

TABLE B.3 Minimum Prices for Off-premise Alcohol by Volume in BC

Liquor Category	Off-premise Minimum Price per Litre
Wine	$6.44
Spirits	$27.88
Liqueurs	$20.39
Packaged beer (bottles and tins)	$3.19
Draught beer (kegs 18 litres or greater)	$1.97
Cider and coolers	$3.75

Note: Prices do not include sales tax.
Source: BC Liquor and Cannabis Branch, Policy Directive No: 16 - 04. Prepared by Population Health Surveillance and Epidemiology, Office of the Provincial Health Officer, BC Ministry of Health, November 2025.

Appendix C
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