

Substance Use Mortality Trends in San Francisco through 2024

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1 INTRODUCTION

We are pleased to release the report on substance use mortality through 2024 for the City and County of San Francisco (CCSF). In this report, we analyze trends in all substance-related mortality for 2013 through 2024, with a focus on death attributed to acute toxicity. Acute toxicity herein refers to deaths that were attributed to consumption of a particular substance acutely producing adverse effects. We reserve the term “overdose” for deaths due to respiratory depression from opioids because the etiology of other deaths may be due to complex medical issues. The initial sections review broad classes of substances, while later sections provide details on specific major substances and the demographic characteristics of decedents. The report includes a section on drug-related mortality among Black/African American people, who are most affected in San Francisco.

Like most of North America, San Francisco has been heavily affected by fentanyl, which began to dominate the local drug supply in 2018 and is now the only readily available opioid in the street drug market. As fentanyl came to dominate the street opioid supply, regions throughout North America saw dramatic increases in mortality, and San Francisco has been no exception. The COVID-19 pandemic also influenced overdose mortality, particularly during Shelter-in-Place, which worsened social isolation and contributed to increased mortality in 2020. Overdose deaths declined in subsequent years, escalated again in 2023, and then declined in 2024. While the increase in 2023 occurred across all demographic groups, the increase was most pronounced among Black/African-American people who used cocaine, similar to national trends ([Tanz et al., MMWR 2025](#)).

Unless otherwise noted, all data in this report were sourced from the California Vital Records Business Intelligence System (VRBIS). Because of different inclusion and exclusion criteria applied to VRBIS data, counts may differ slightly from data provided by the San Francisco Office of the Chief Medical Examiner. More detail on data sourcing is available in the Appendix.

We hope this report further informs the many ongoing efforts to support the health and safety of San Franciscans.

2 HIGHLIGHTS

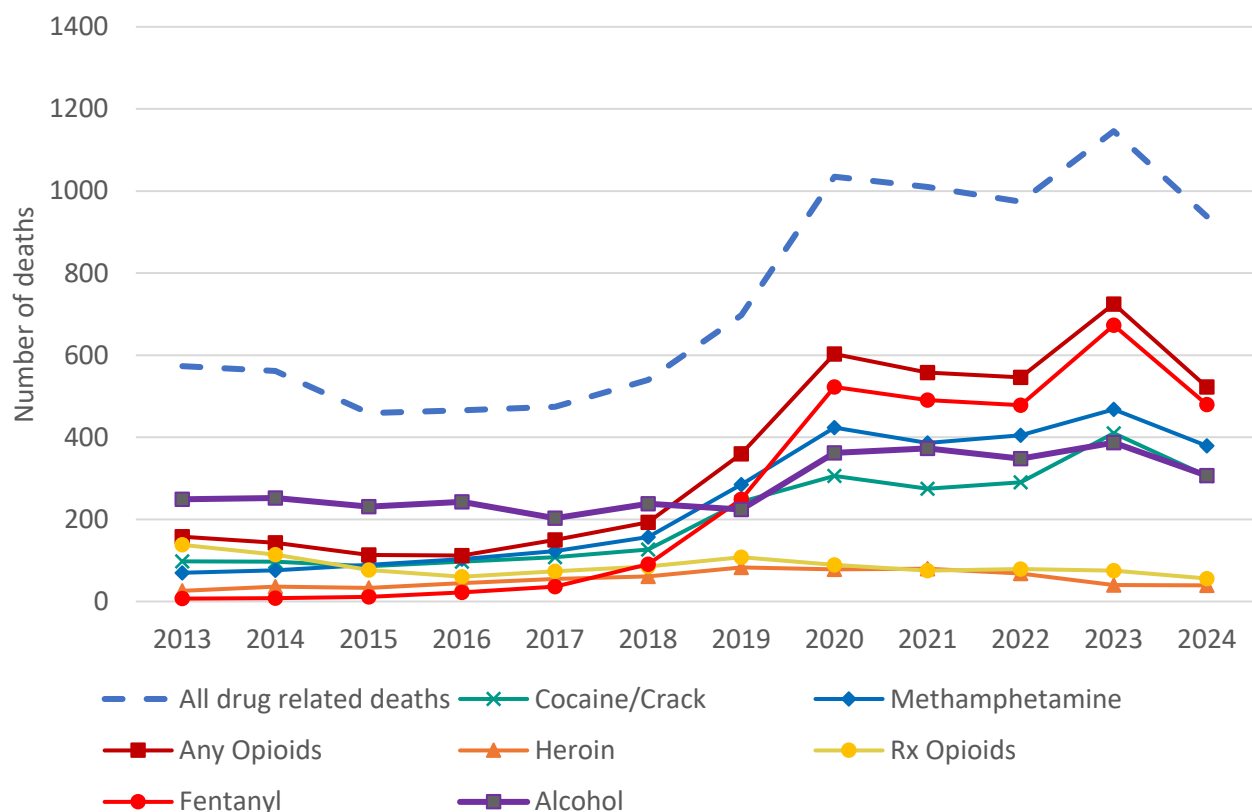
- Substance-related deaths that were not attributed to acute toxicity – i.e. those due to health impacts of chronic substance use – have declined slightly each year since a peak in 2021.
- Deaths attributed to acute toxicity from opioids, cocaine, or methamphetamine decreased by 25% from 2023 to 2024.
- The proportion of opioid overdose deaths attributed to fentanyl and related analogues remained at 95% in 2024.
- Males, persons aged 50-59 years, and Black/African American people had the highest rates of mortality due to acute toxicity from opioids, cocaine, or methamphetamine. While all race and ethnicity groups had a decrease in acute toxicity deaths from 2023 to 2024, the largest decrease occurred among Black/African American people.
- Fentanyl analogues were common in acute toxicity deaths; the most common in 2024 was fluoro-fentanyl, which was present in 79 deaths.
- Xylazine, a veterinary tranquilizer, continued to be present in a small proportion of acute toxicity deaths, 97% of which also involved fentanyl. Xylazine was present in 59 acute toxicity deaths in 2024, representing an increase from 2023.
- Benzodiazepine-involved acute toxicity deaths decreased to 40 in 2024. New designer benzodiazepines, most commonly bromazolam, were present in the majority of benzodiazepine-involved deaths.
- Cannabis was not included in this report, as no deaths were attributed to cannabis.
- Substance-related deaths among people aged 19 and under were very rare in San Francisco (less than 1% of all acute toxicity deaths). Due to small counts of events, we did not report separately on this age group.

3 SUBSTANCE USE MORTALITY, OVERALL

3.1 OVERALL SUBSTANCE-RELATED MORTALITY

Substance-related deaths refer to all non-intentional deaths, including medical or traumatic deaths, in which a drug was reported to be involved in the cause of death or its use was considered a significant contributor to death. This includes acute toxicity deaths, and non-acute substance-related deaths, such as those from hepatic, cardiovascular, pulmonary, or infectious diseases associated with substance use. Prior to 2019, alcohol was the leading substance contributing to substance-related deaths in CCSF (**Figure 1**). Since 2019, opioids, led by fentanyl, surpassed alcohol as the substance contributing to the highest number of deaths. Annual substance-related deaths declined slightly in 2024, to 938, the lowest number since 2019.

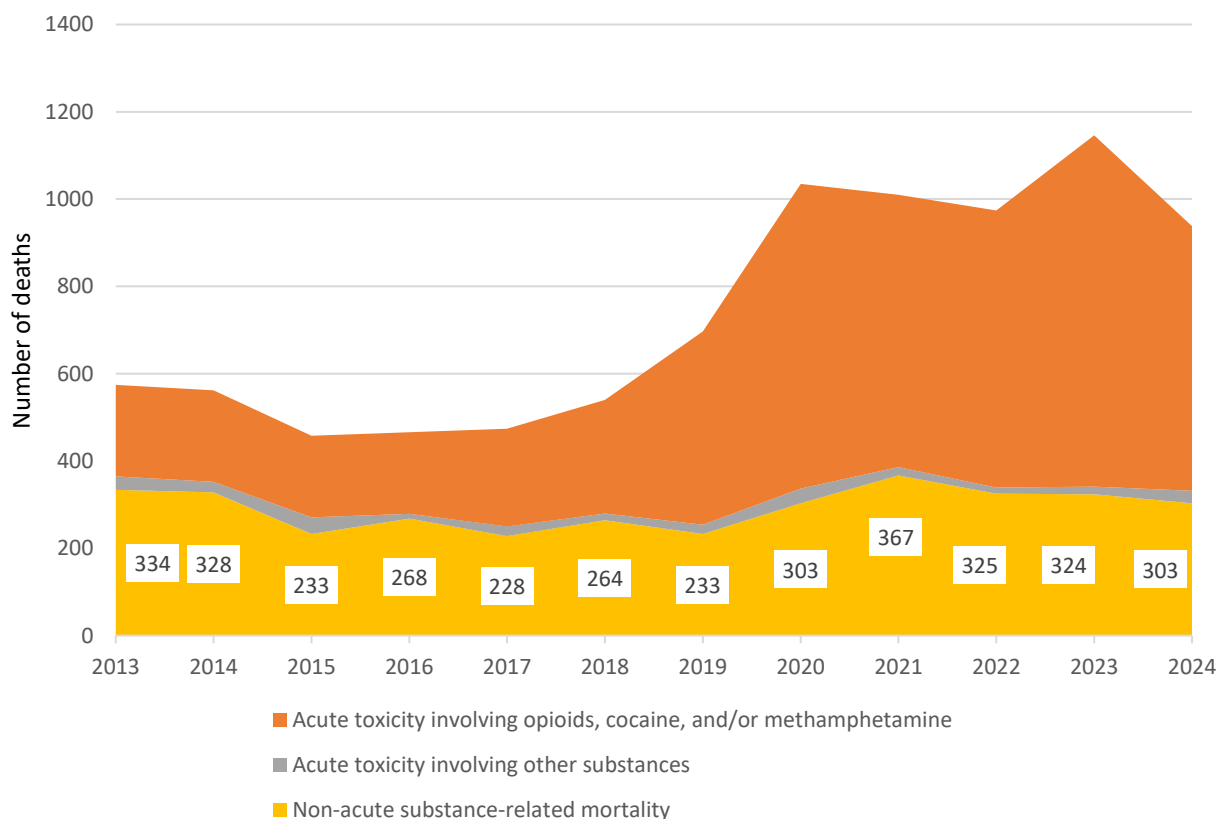
Figure 1: Substance-Related Deaths by Non-Mutually Exclusive Contributing Substance in CCSF, 2013-2024



The total “All drug related deaths” includes substances other than those listed in the legend, but excludes medications with no psychoactive effect (e.g., amiodarone or other cardiovascular medications). See Appendix for detail on data sources.

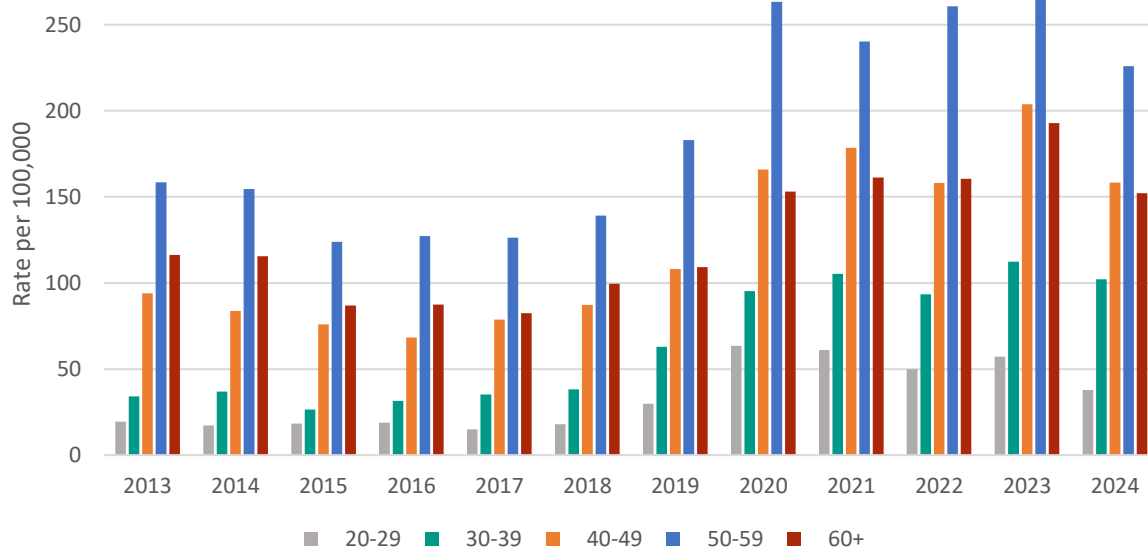
Figure 2 displays the share of substance-related deaths attributed to acute toxicity compared to non-acute substance-related causes. Most non-acute deaths were due to alcohol, while most acute toxicity deaths were due to opioids. The increase in non-acute substance-related deaths since 2019 was largely driven by alcohol-related deaths.

Figure 2: Substance-Related Deaths by Acute and Non-Acute Status in CCSF, 2013-2024



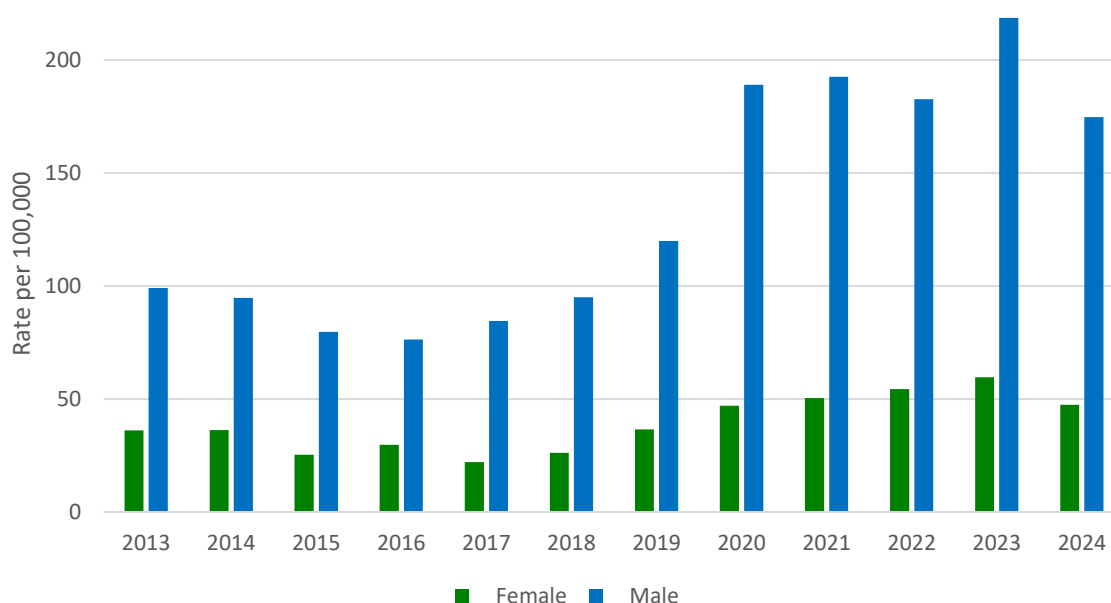
In 2024, the rate of substance-related deaths was highest among people aged 50-59 years (**Figure 3**), males (**Figure 4**), and Black/African American people (**Figure 5**). There has been a four to five-fold disparity in the rate of acute and non-acute substance-related death among Black/African American people compared to all race/ethnicities throughout the period of 2013-2024 (**Figure 5**).

Figure 3: Substance-Related Death Rate by Age in CCSF, 2013-2024



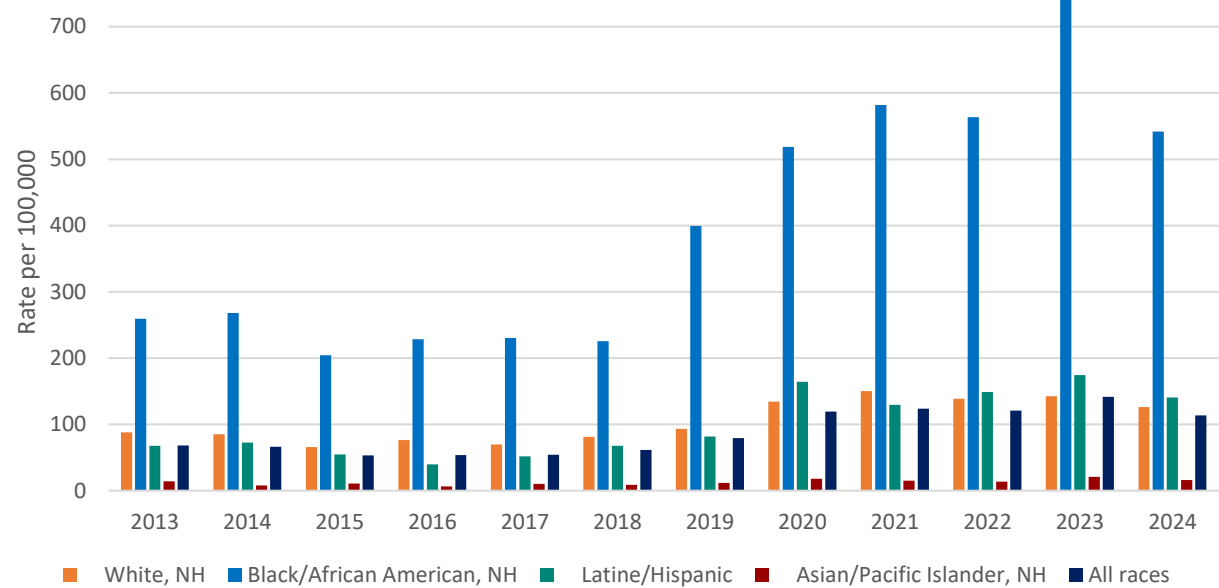
Rate was calculated per 100,000 population. People under age 20 were excluded.

Figure 4: Substance-Related Death Rate by Sex in CCSF, 2013-2024



Rate was calculated per 100,000 population.

Figure 5: Substance-Related Death Rate by Race/Ethnicity in CCSF, 2013-2024



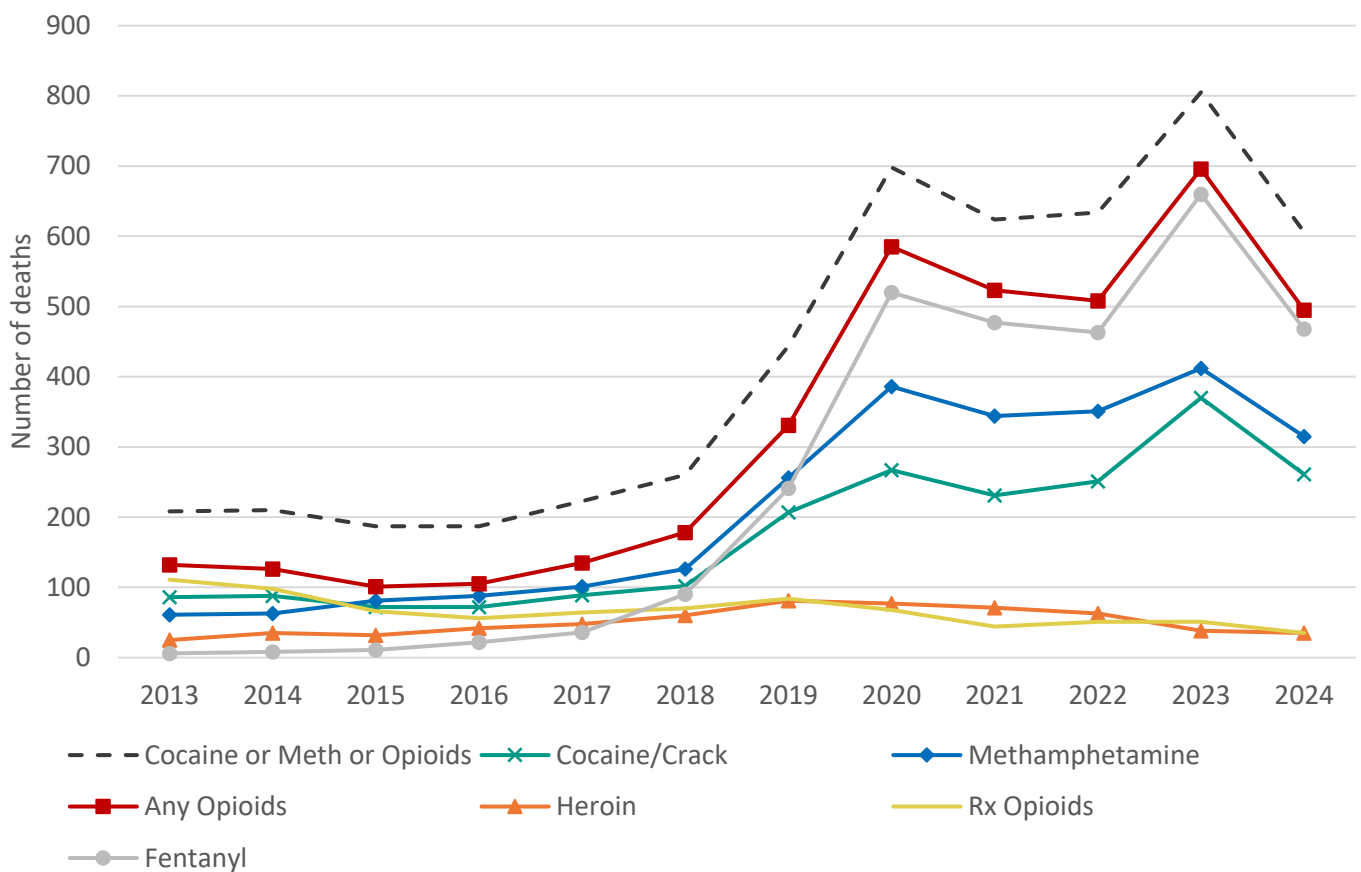
Rate was calculated per 100,000 population. NH = Non-Hispanic.

3.2 OVERALL OPIOID, COCAINE, AND METHAMPHETAMINE ACUTE TOXICITY MORTALITY

Nearly all deaths attributed to acute toxicity in San Francisco involved opioids, cocaine/crack, or methamphetamine (**Figure 2**). Acute toxicity mortality was fairly stable from 2006 to 2016, and then started to rise due to fentanyl. Beginning in 2018, acute toxicity deaths involving cocaine and methamphetamine also started to increase, although mostly in the presence of fentanyl. Acute toxicity deaths involving fentanyl fell 29% from 660 in 2023 to 468 in 2024 (**Figure 6**).

In total, 606 acute toxicity deaths were caused by an opioid, cocaine/crack, or methamphetamine in 2024. Of these, 82% involved an opioid (of the total 606 deaths, 6% involved prescription opioids, 6% involved heroin, and 77% involved fentanyl), 43% involved cocaine/crack, and 52% involved methamphetamine (**Figure 6**).

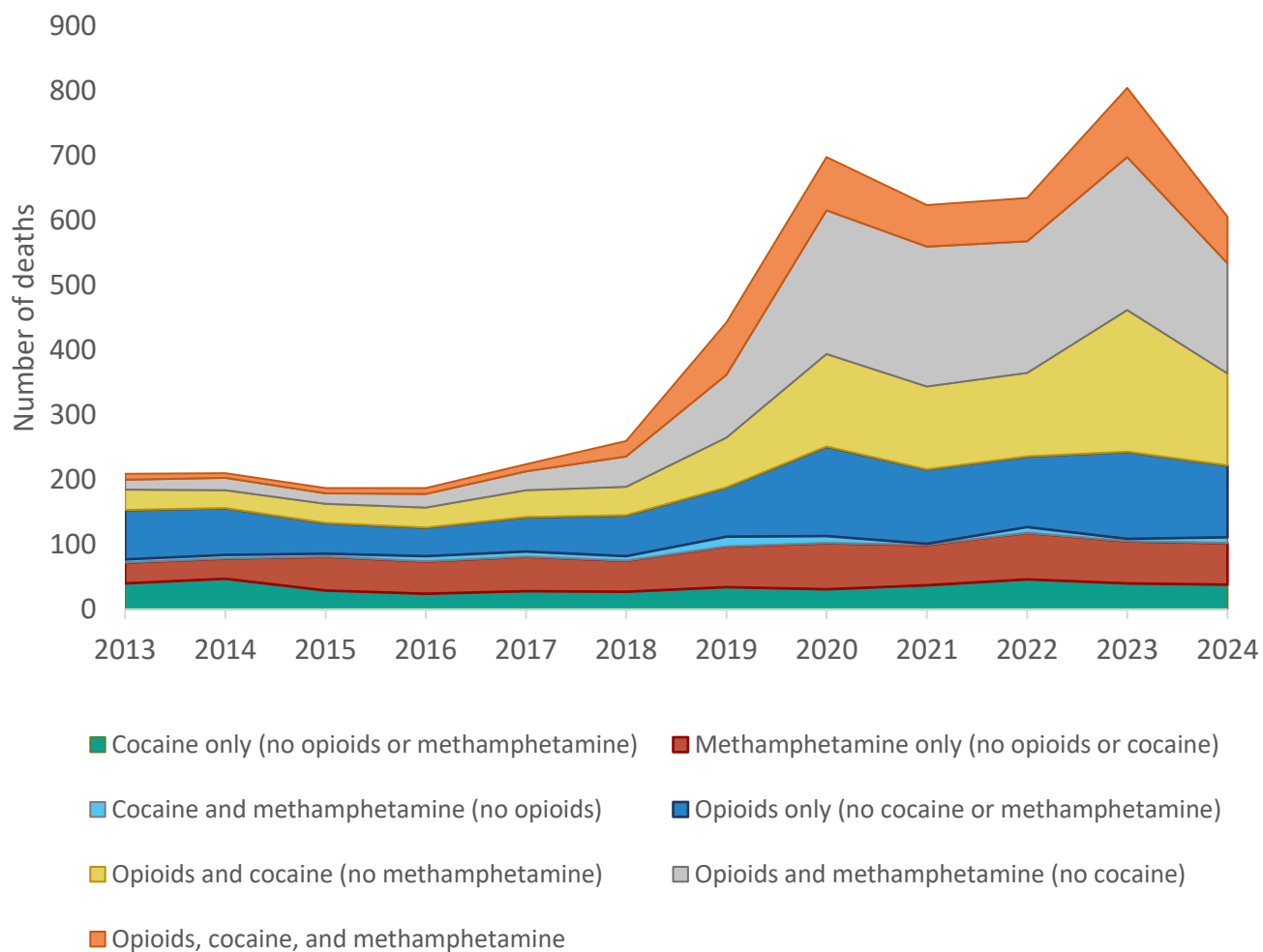
Figure 6: Opioid, Cocaine, or Methamphetamine Overdose Deaths by Non-Mutually Exclusive Substance Category in CCSF, 2013–2024



Fentanyl includes fentanyl analogues.

Recent changes in acute toxicity mortality were driven by opioids (see **Figure 7**); more specifically, these changes were driven by fentanyl (see **Figure 23**).

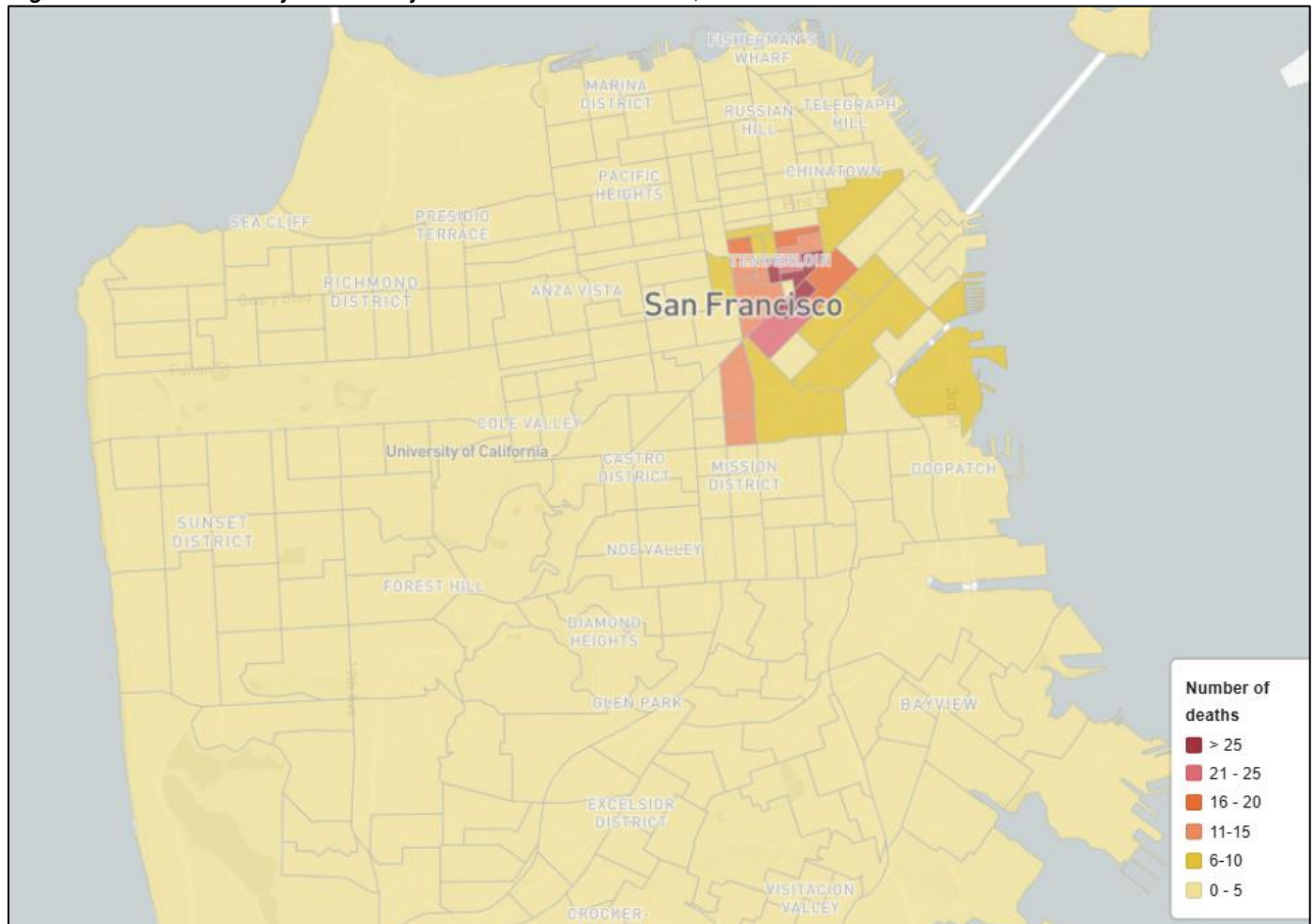
Figure 7: Opioid, Cocaine, and Methamphetamine Acute Toxicity Deaths by Mutually Exclusive Substance Category in CCSF, 2013–2024



The height of each band corresponds to the number of events in that category.

Acute toxicity mortality is concentrated in the Tenderloin and South of Market neighborhoods of San Francisco (**Figure 8**). The map displayed includes all acute toxicity deaths that occurred in San Francisco in 2024 by location of death, excluding 92 (14%) that occurred in hospitals after transport from the location of the initial event.

Figure 8: Acute Toxicity Deaths by Census Tract in CCSF, 2024

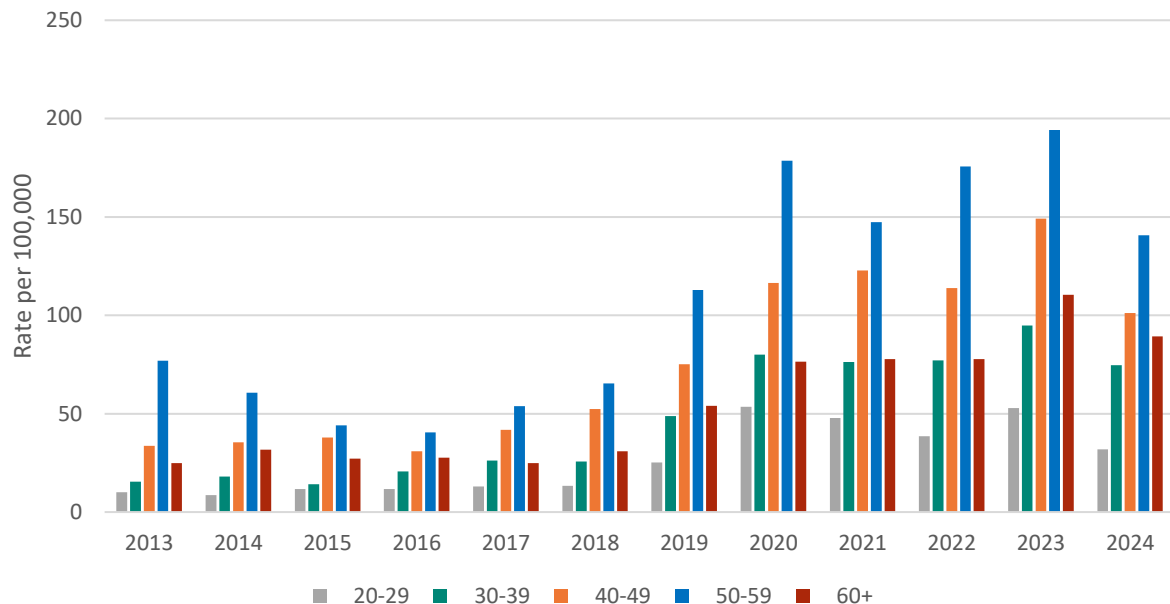


Deaths that occurred in a hospital (n=92) or were unable to be geocoded (n=19) are excluded.

Sources: Mortality data and location of death provided by Office of the Chief Medical Examiner.

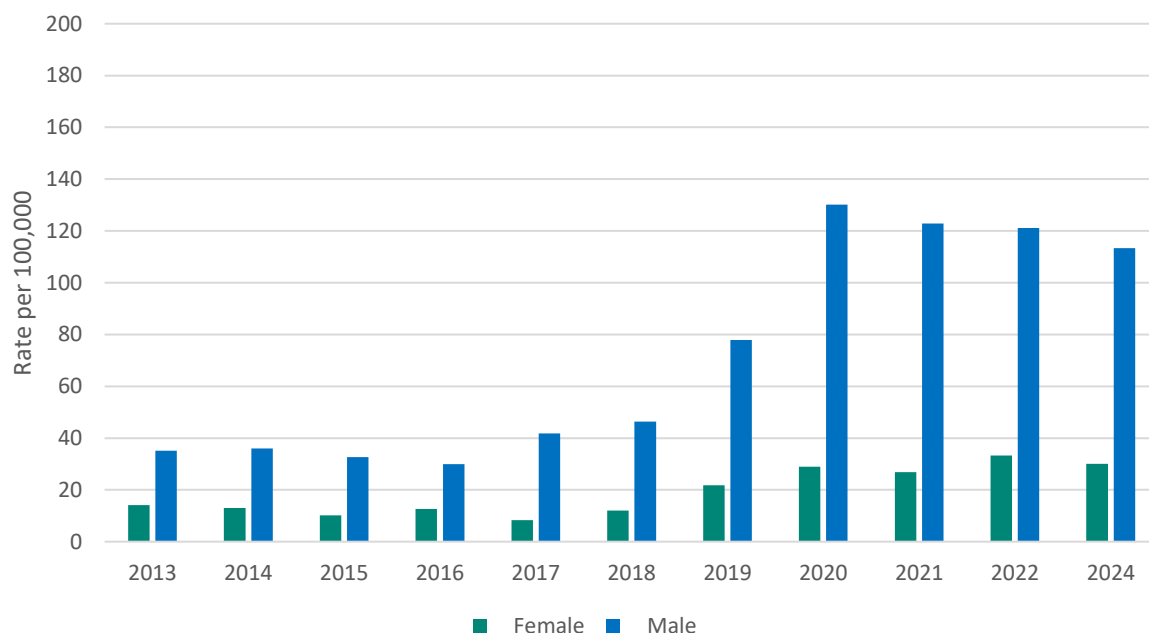
In 2024, the rate of acute toxicity deaths was highest among people aged 50-59 years (**Figure 9**), males (**Figure 10**), and Black/African American people (**Figure 11**). There was an approximately five-fold disparity in the rate of acute toxicity death among Black/African American people compared to all race/ethnicities throughout the period of 2013-2022, which increased to six-fold in 2023 (**Figure 11**) but returned to previous levels in 2024.

Figure 9: Opioid, Cocaine, and Methamphetamine Acute Toxicity Death Rate by Age Category in CCSF, 2013-2024



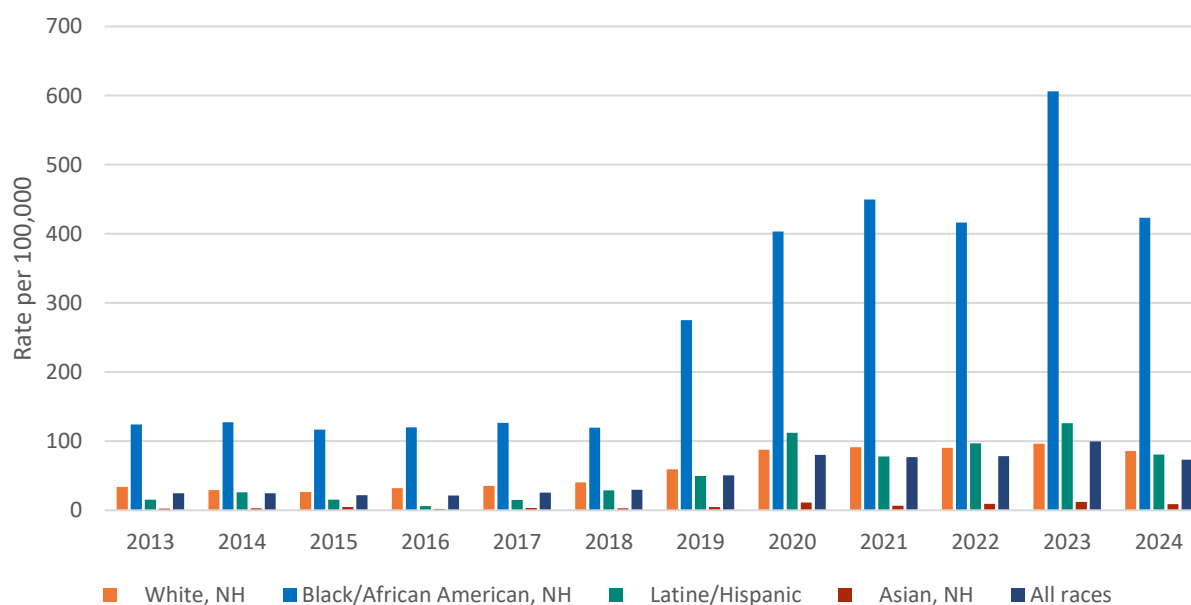
Rate was calculated per 100,000 population. People under age 20 are excluded.

Figure 10: Rate of Opioid, Cocaine, and Methamphetamine Acute Toxicity Deaths by Sex in CCSF, 2013-2024



Rate was calculated per 100,000 population.

Figure 11: Rate of Opioid, Cocaine, and Methamphetamine Acute Toxicity Deaths by Race/Ethnicity in CCSF, 2013-2024



Rate was calculated per 100,000 population. NH = Non-Hispanic.

4 SUBSTANCE USE MORTALITY, BY SUBSTANCE

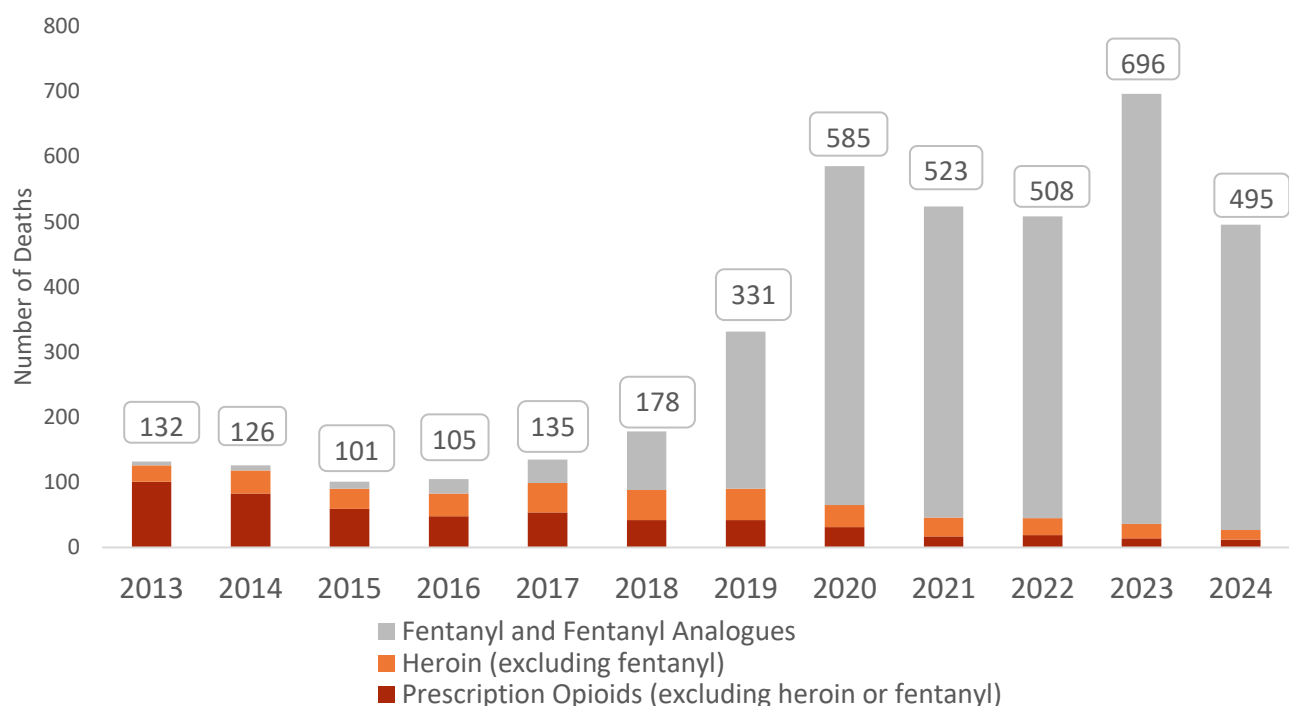
4.1 OPIOIDS

4.1.1 Any Opioids

82% of acute toxicity deaths involved opioids. The number of opioid acute toxicity deaths, driven by fentanyl, decreased to 495 in 2024.

Deaths from other opioids (in the absence of fentanyl) have declined since 2017 (**Figure 12**); in 2024, 95% of opioid acute toxicity deaths were caused by fentanyl. Among the 35 acute toxicity deaths caused by heroin in 2024, 57% involved fentanyl. Heroin in the absence of fentanyl caused 15 deaths in 2024 (see **Figure 12**).

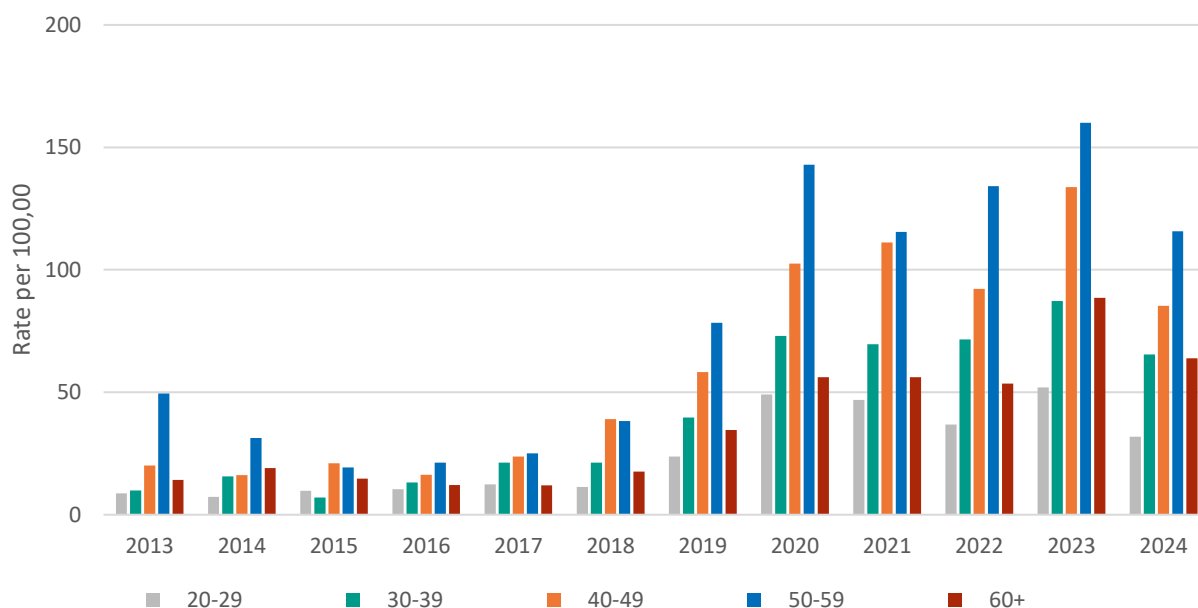
Figure 12: Number of Opioid Acute Toxicity Deaths by Mutually Exclusive Opioid Type in CCSF, 2013–2024



For **Figure 12**, opioids were ranked by relative risk of overdose. Fentanyl acute toxicity death was defined as any death caused by fentanyl or fentanyl analogues, whether or not any other substances were involved; heroin acute toxicity death was defined as any death caused by heroin but not fentanyl, regardless of the involvement of any other substances; prescription opioid acute toxicity death was defined as any opioid acute toxicity deaths (e.g., involving oxycodone, morphine, codeine, methadone, or other opioids that are commonly prescribed) not also caused by heroin or fentanyl.

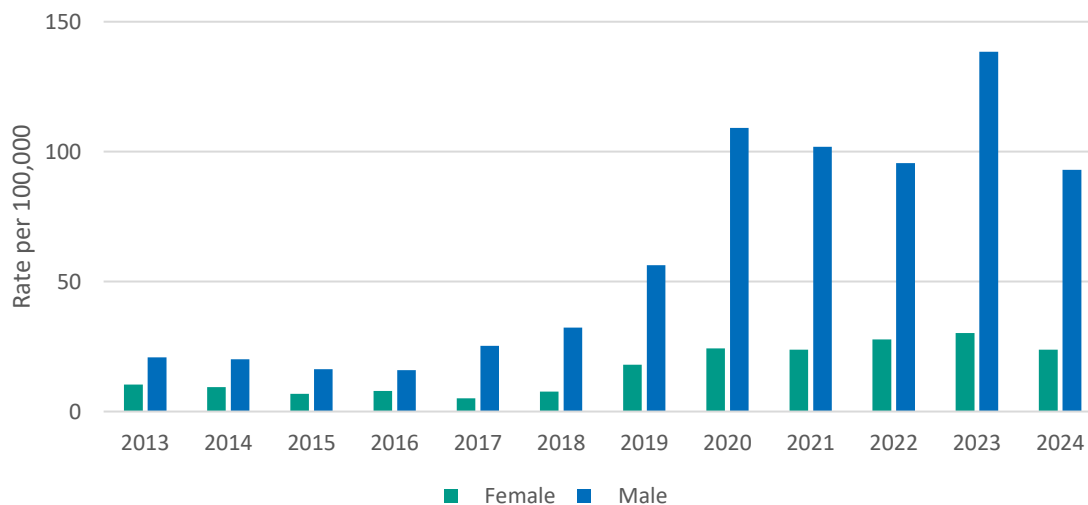
In 2024, the rate of opioid acute toxicity deaths was highest among people aged 50-59 years (**Figure 13**), males (**Figure 14**), and Black/African American people (**Figure 15**). The rate of opioid acute toxicity death declined for all age groups and all races and ethnicities from 2023 to 2024 (**Figure 13**), but most markedly for non-Hispanic Black/African American people, with a 39% decrease from 2023 to 2024 (**Figure 15**).

Figure 13: Opioid Acute Toxicity Death Rate by Age Category in CCSF, 2013–2024



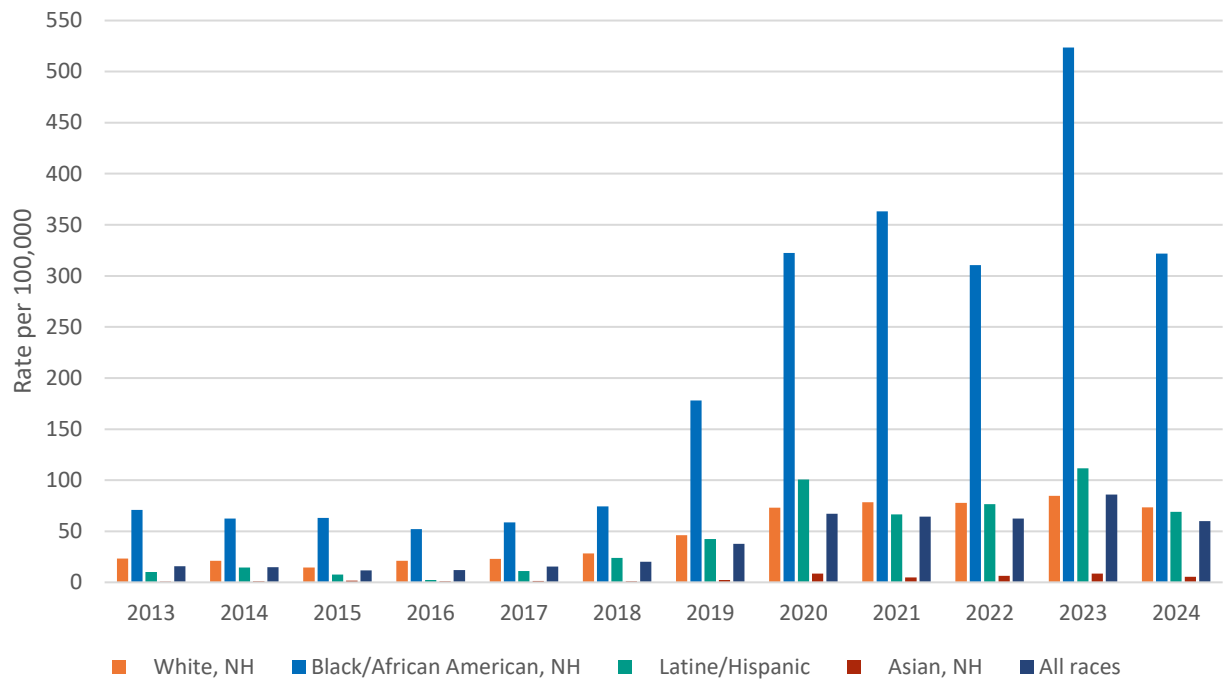
Rate was calculated per 100,000 population. People under age 20 are excluded.

Figure 14: Opioid Acute Toxicity Death Rate by Sex in CCSF, 2013–2024



Rate was calculated per 100,000 population.

Figure 15: Opioid Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2013–2024



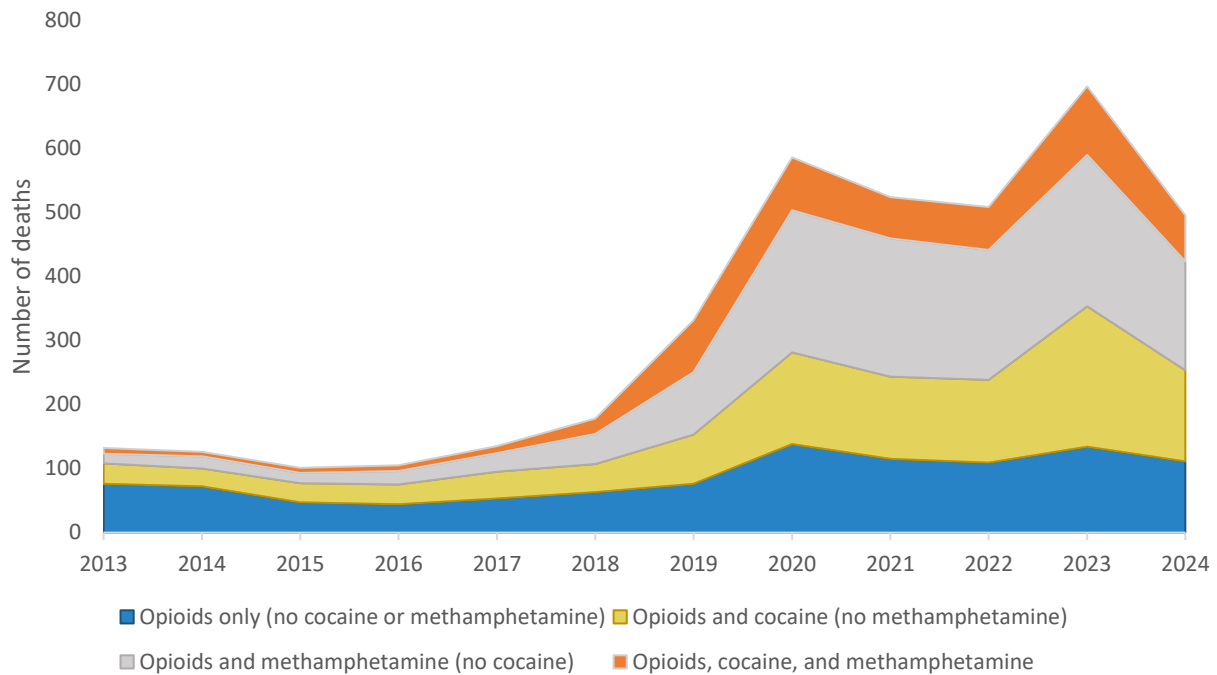
Rate was calculated per 100,000 population. NH=non-Hispanic.

4.1.2 Opioids with Stimulants

The majority (78% in 2024) of opioid acute toxicity deaths were attributed to the combination of opioids and stimulants. (**Figure 16**).

Acute toxicity deaths due to opioids alone and in combination with cocaine, methamphetamine, or both, decreased from 2023 to 2024 (**Figure 16**). While deaths declined in each category, the most substantial decrease was in deaths involving both opioids and cocaine.

Figure 16: Opioid Acute Toxicity Deaths by Mutually Exclusive Involvement of Cocaine or Methamphetamine in CCSF, 2013–2024

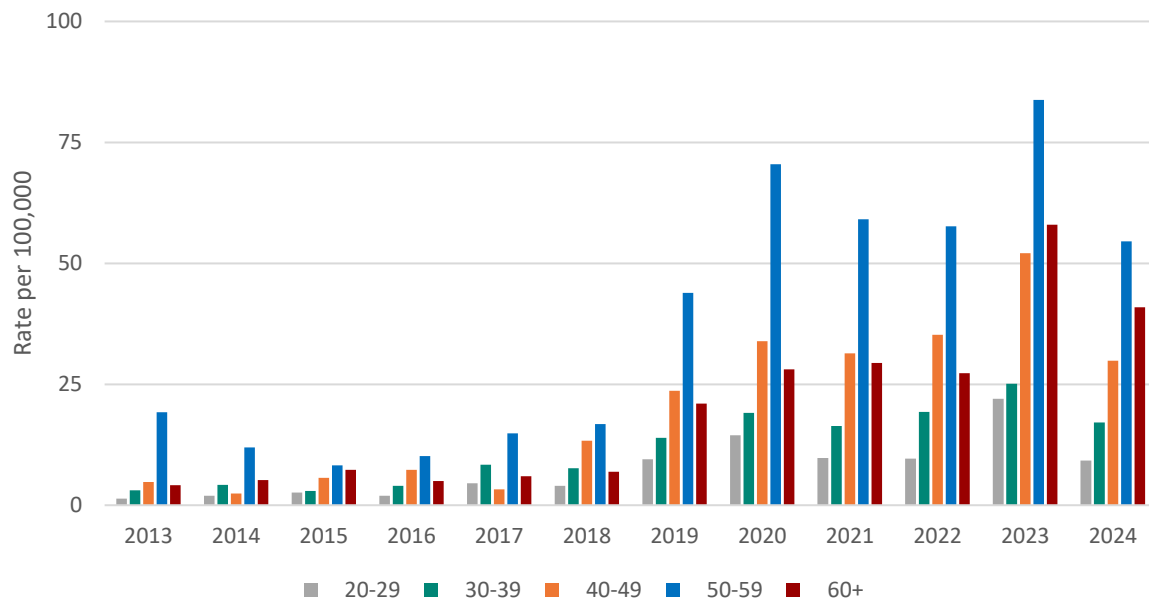


The height of each band corresponds to the number of events in that category.

4.1.2.1 Opioids with Cocaine

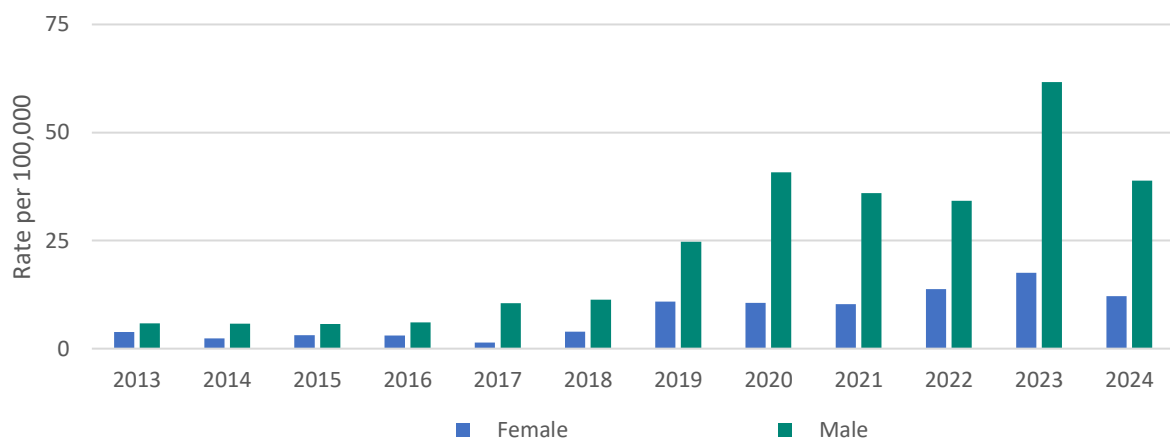
Among 214 deaths attributed to acute toxicity from opioids and cocaine in 2024, 93% involved fentanyl. The rate of opioid with cocaine acute toxicity deaths was highest among persons aged 50-59 years (**Figure 17**), males (**Figure 18**), and Black/African American people (**Figure 19**).

Figure 17: Opioids with Cocaine Acute Toxicity Death Rate by Age Category in CCSF, 2013–2024



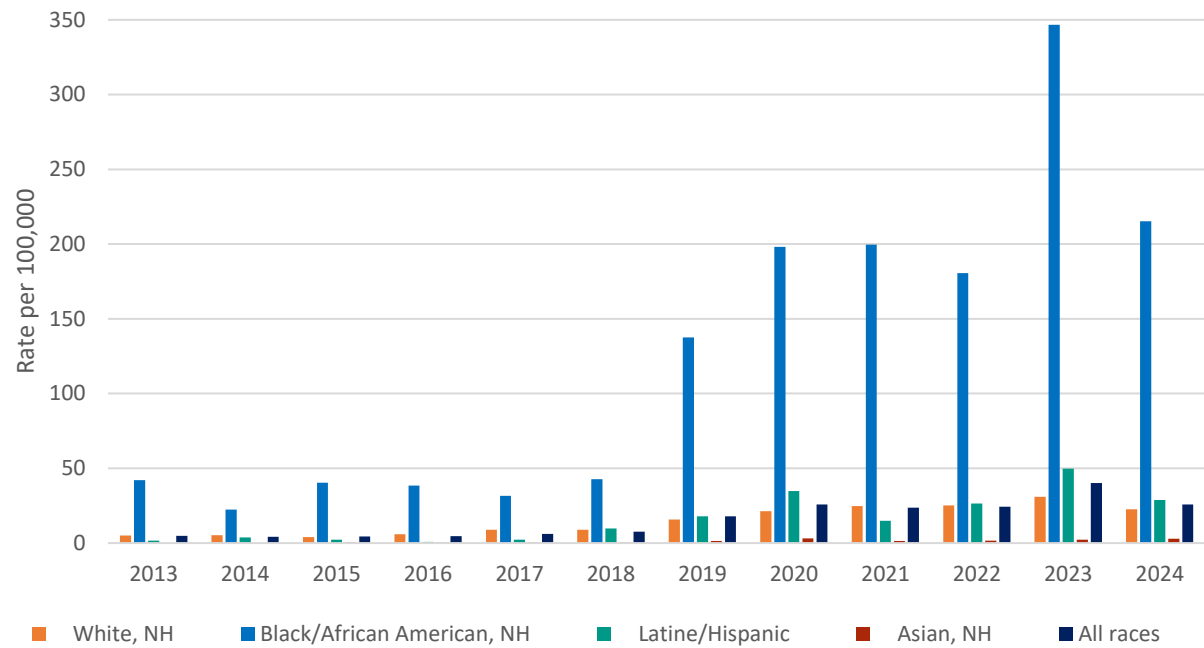
Rate was calculated per 100,000 population. People under age 20 excluded.

Figure 18: Rate of Opioids with Cocaine Acute Toxicity Deaths by Sex in CCSF, 2013–2024



Rate was calculated per 100,000 population.

Figure 19 : Opioids with Cocaine Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2013–2024

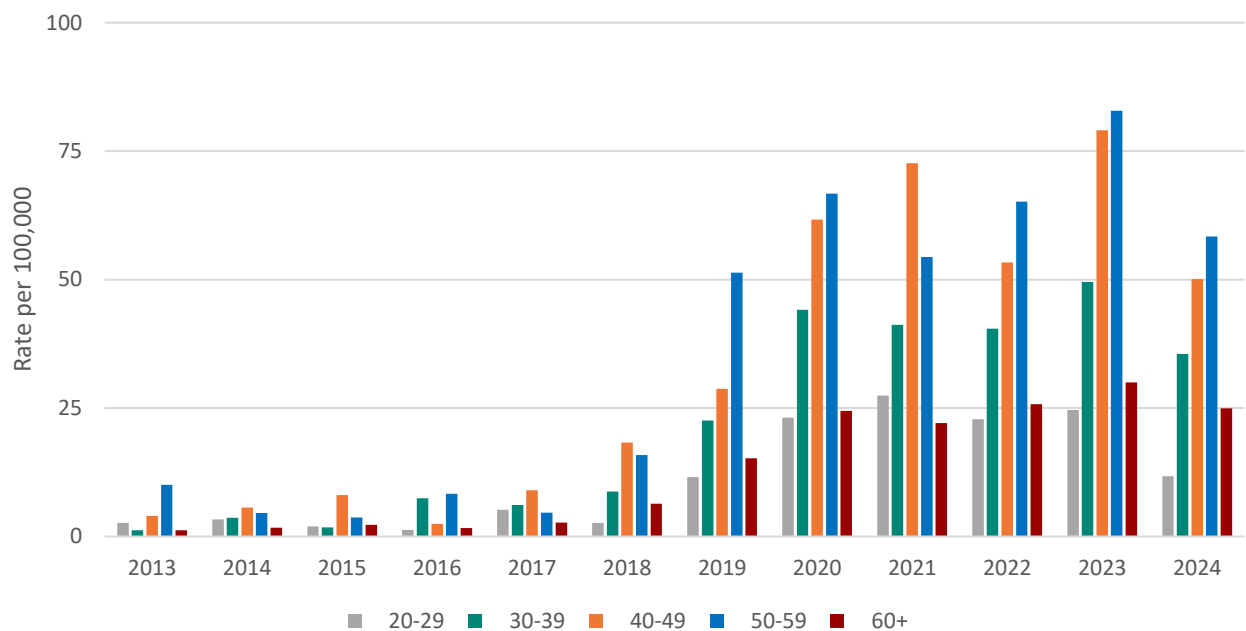


Rate is per 100,000 population. NH=non-Hispanic.

4.1.2.2 Opioids with Methamphetamine

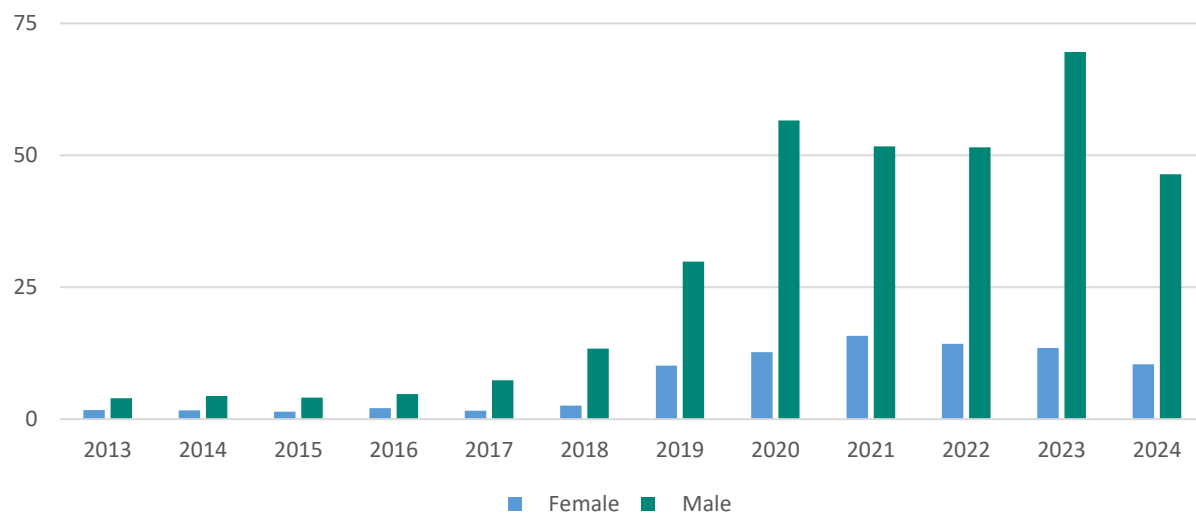
Among 214 deaths attributed to acute toxicity from opioids with methamphetamine in 2024, 97% involved fentanyl. The rate of opioid with methamphetamine acute toxicity deaths was highest among persons aged 50–59 years (**Figure 20**), males, (**Figure 21**), and Black/African American people (**Figure 22**).

Figure 20: Opioids with Methamphetamine Acute Toxicity Death Rates by Age Category, CCSF 2013–2024



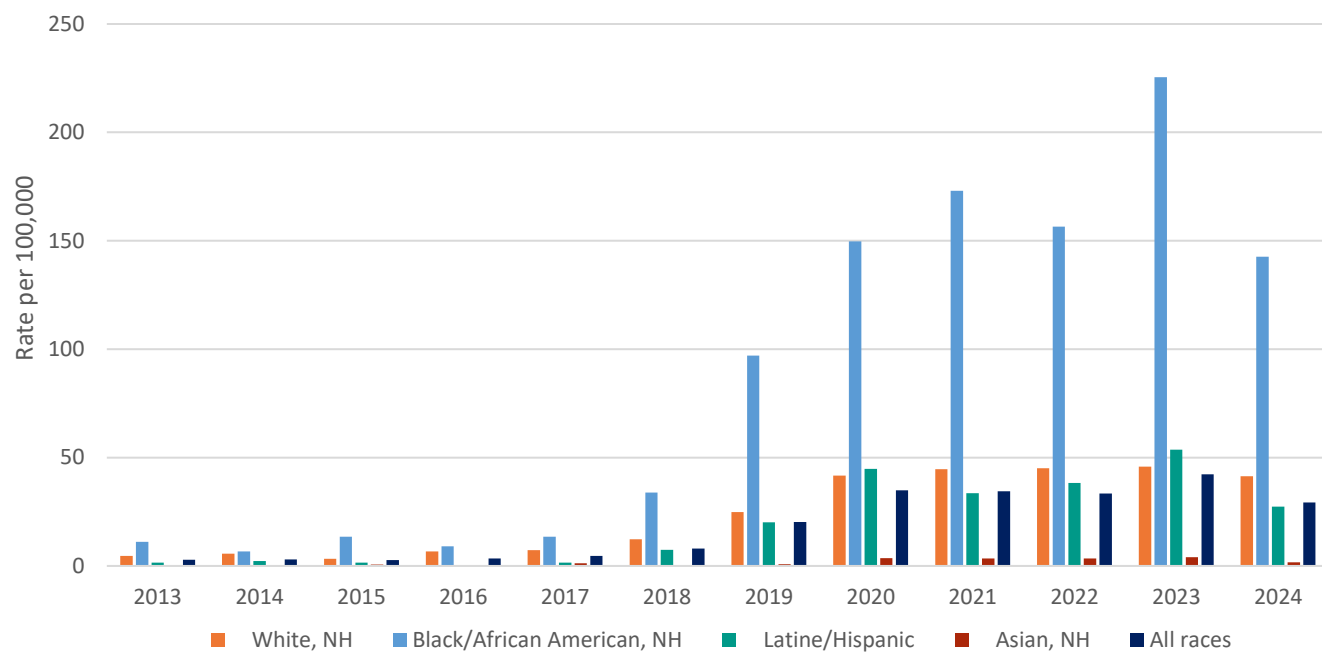
Rate was calculated per 100,000 population. People under age 20 are excluded..

Figure 21: Opioids with Methamphetamine Acute Toxicity Death Rate by Sex in CCSF, 2013–2024



Rate was calculated per 100,000 population.

Figure 22: Opioids with Methamphetamine Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2013–2024



Rate was calculated per 100,000 population. NH=non-Hispanic.

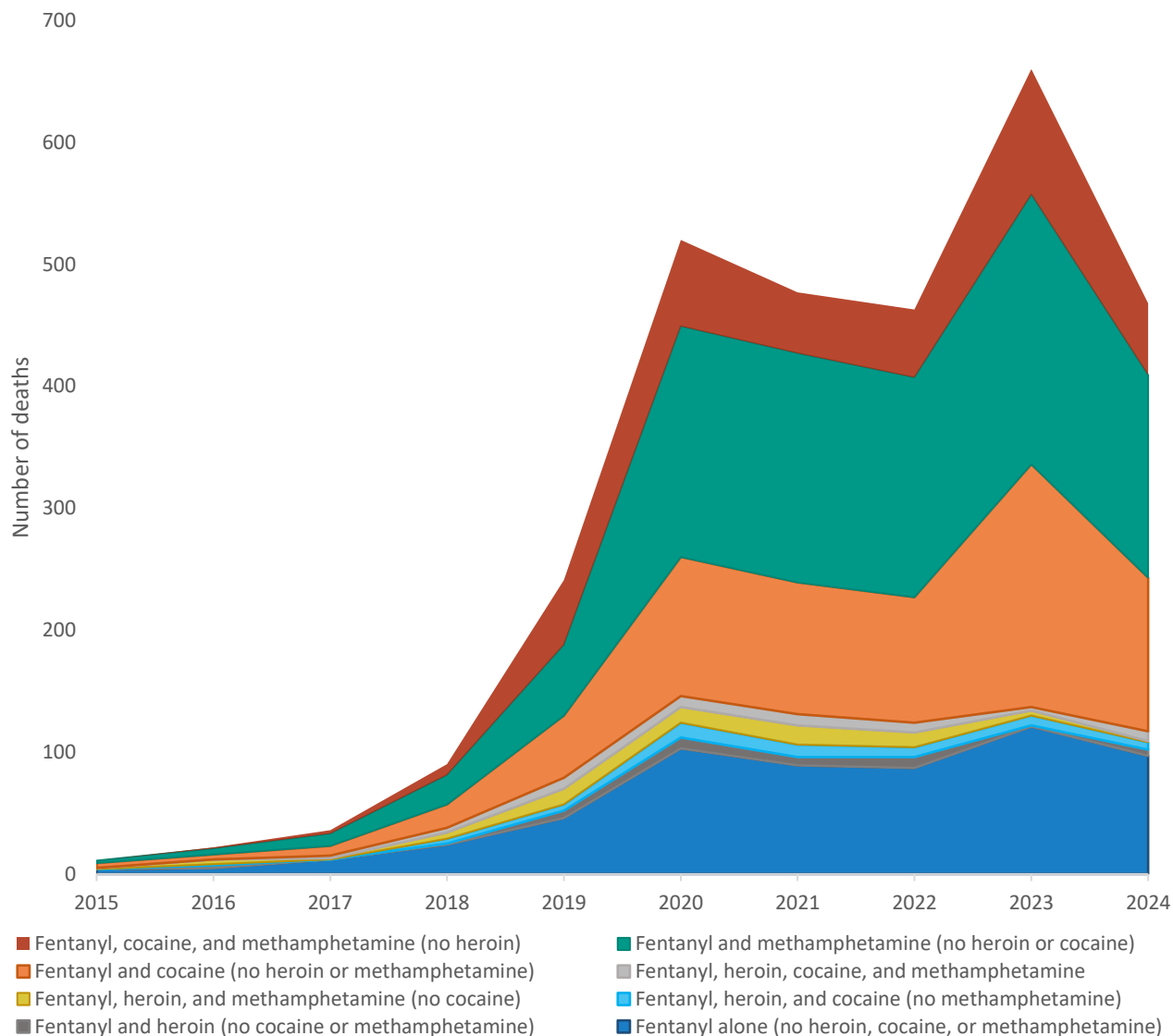
4.1.3 Fentanyl

Fentanyl (including common analogues such as acetyl and flouro fentanyl) has impacted San Francisco substantially. Fentanyl acute toxicity deaths dramatically increased from 2016, with spikes in 2020 and 2023. Among the 468 fentanyl acute toxicity deaths in 2024, 21% involved fentanyl only (without prescription opioids, heroin, cocaine, methamphetamine, or benzodiazepines); 4% involved heroin; 5% involved prescription opioids; 43% involved cocaine; 50% involved methamphetamine; and 7% involved a benzodiazepine.

Fentanyl in San Francisco is commonly smoked and is often sold as white powders or “rocks” that are easily mistaken for methamphetamine, powder cocaine, or crack cocaine. Some people who use non-opioid substances in San Francisco, in particular cocaine or methamphetamine, use fentanyl unintentionally. An analysis of data from a community paramedic overdose response team in San Francisco found that 43% of confirmed opioid overdose events were among people who did not intend to use opioids; 73% of these individuals meant to use cocaine or methamphetamine; Black/African American and Latine persons were more likely to report not intending to use opioids ([Bazazi, et al., J Urban Health, 2024](#)). Data do not suggest that fentanyl is commonly put into other drugs; instead, the similar appearance of fentanyl, cocaine, and methamphetamine, as well as the use of similar smoking devices to consume each product, appears to result in frequent mistaken use of fentanyl ([Bazazi, et al., J Urban Health, 2024](#)). There is no current means to determine the precise proportion of fentanyl acute toxicity deaths that were due to unintentional fentanyl use.

Before 2016, fentanyl acute toxicity deaths were low and constant, but rose significantly after that time (see **Figure 6**). Fentanyl deaths decreased in 2024, most significantly those deaths also involving cocaine, which decreased from 313 in 2023 to 199 in 2024 (**Figure 23**).

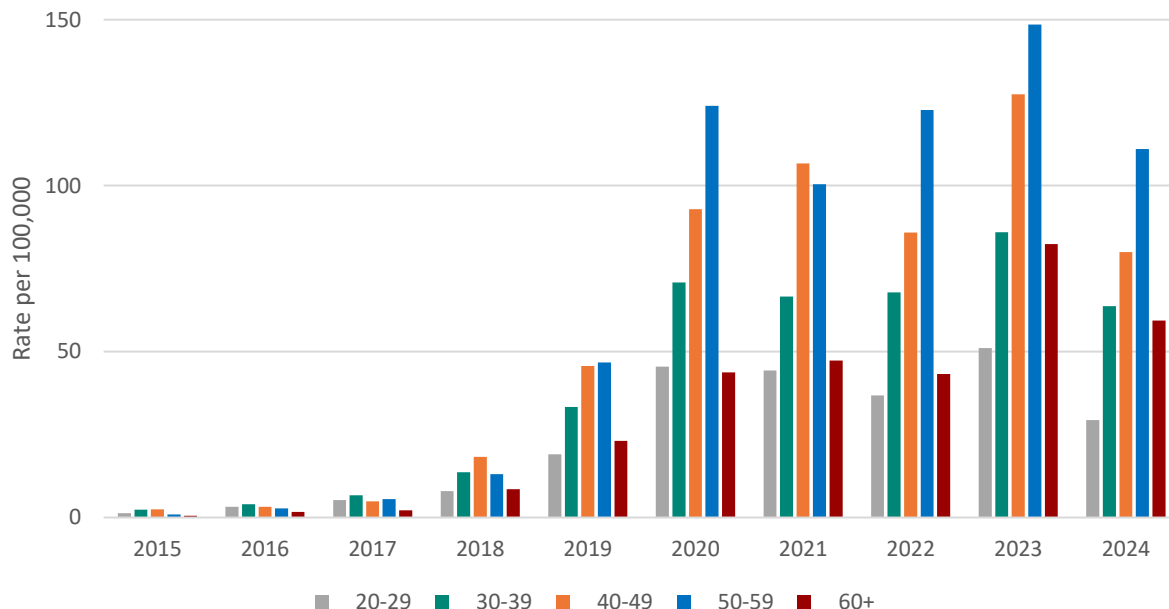
Figure 23: Fentanyl Acute Toxicity Deaths by Mutually Exclusive Involvement of Additional Causative Substance in CCSF, 2013–2024



Fentanyl includes fentanyl analogues. The height of each band corresponds to the number of events in that category.

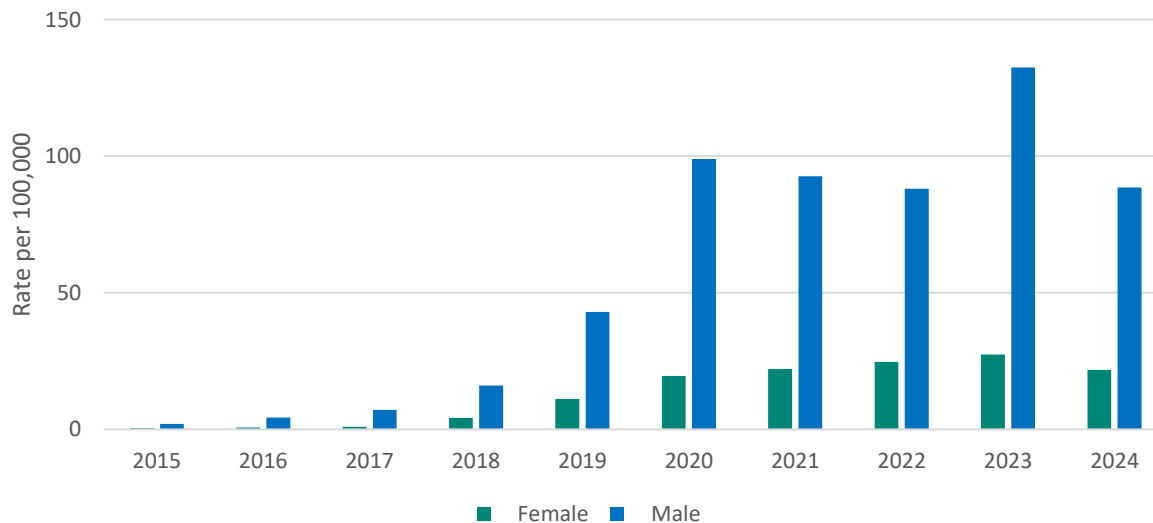
In 2024, the rate of fentanyl acute toxicity deaths was highest among people aged 50-59 years (**Figure 24**), males (**Figure 25**), and Black/African American people (**Figure 26**).

Figure 24: Fentanyl Acute Toxicity Death Rate by Age Category in CCSF, 2015–2024



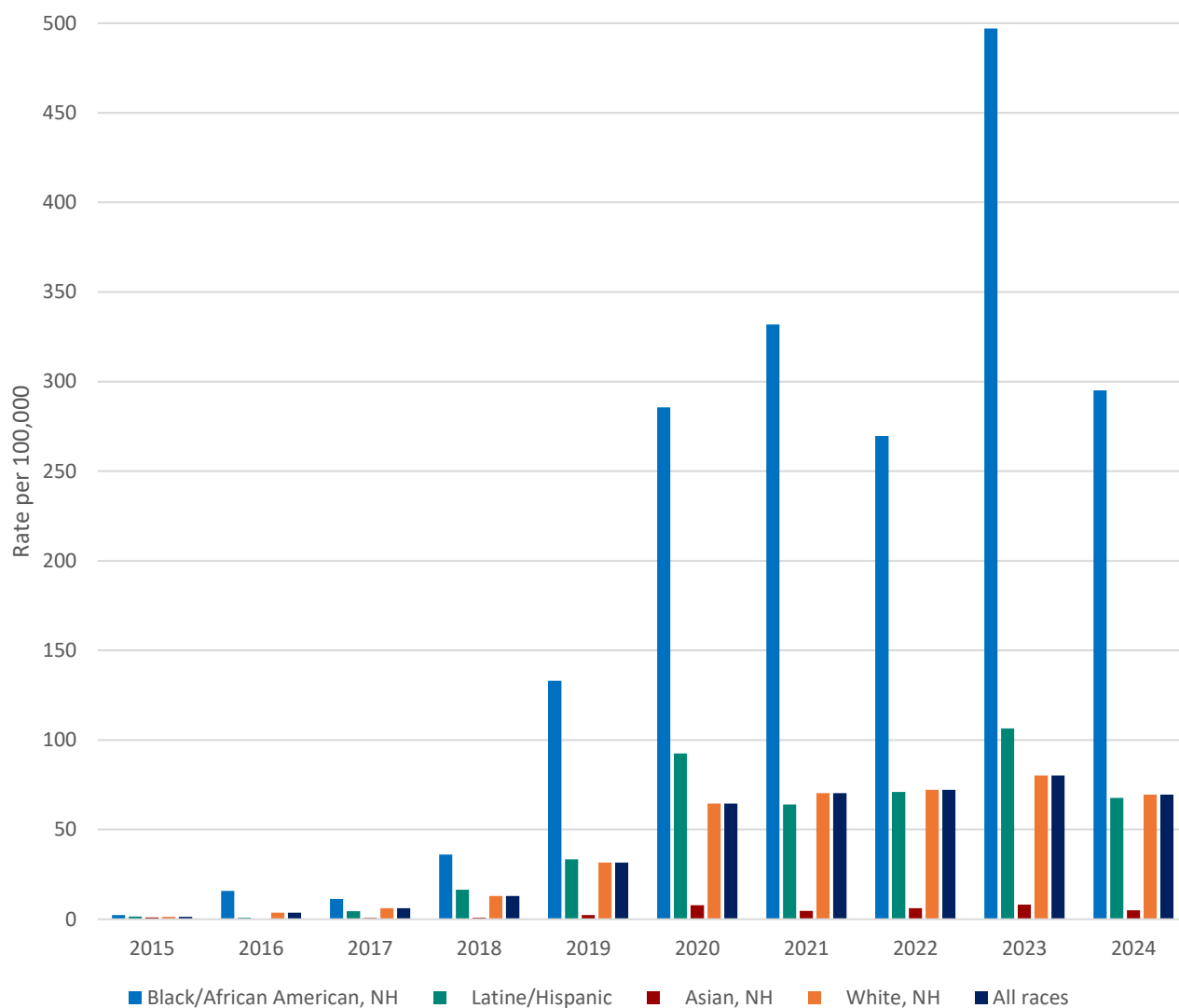
Rate was calculated per 100,000 population. Only data from 2015 onward included due to the rarity of fentanyl acute toxicity deaths in preceding years. People under age 20 are excluded.

Figure 25: Fentanyl Acute Toxicity Death Rate by Sex in CCSF, 2015–2024



Rate was calculated per 100,000 population. Only data from 2015 onward included due to the rarity of fentanyl acute toxicity deaths in preceding years.

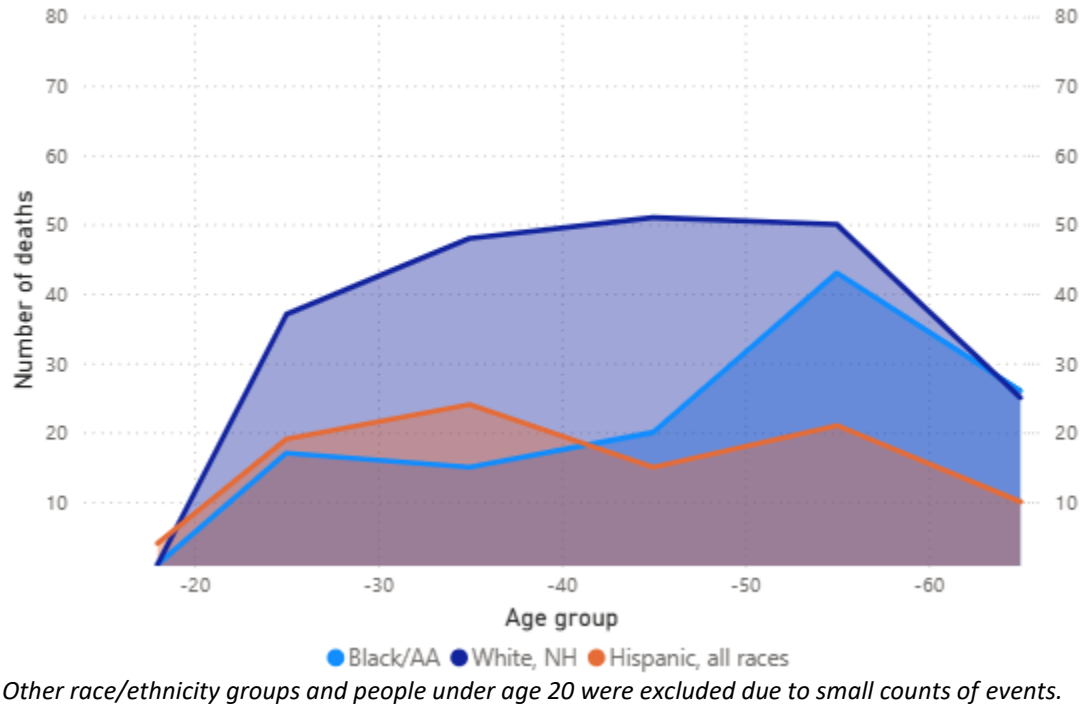
Figure 26: Fentanyl Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2015–2024



Rate was calculated per 100,000 population. NH=non-Hispanic. Only data from 2015 onward included due to the rarity of fentanyl acute toxicity deaths in preceding years.

Stratification of the age distribution of acute toxicity fentanyl deaths by race and ethnicity demonstrates that White and Hispanic decedents from fentanyl acute toxicity were younger than Black/African American decedents from fentanyl acute toxicity (**Figure 27**).

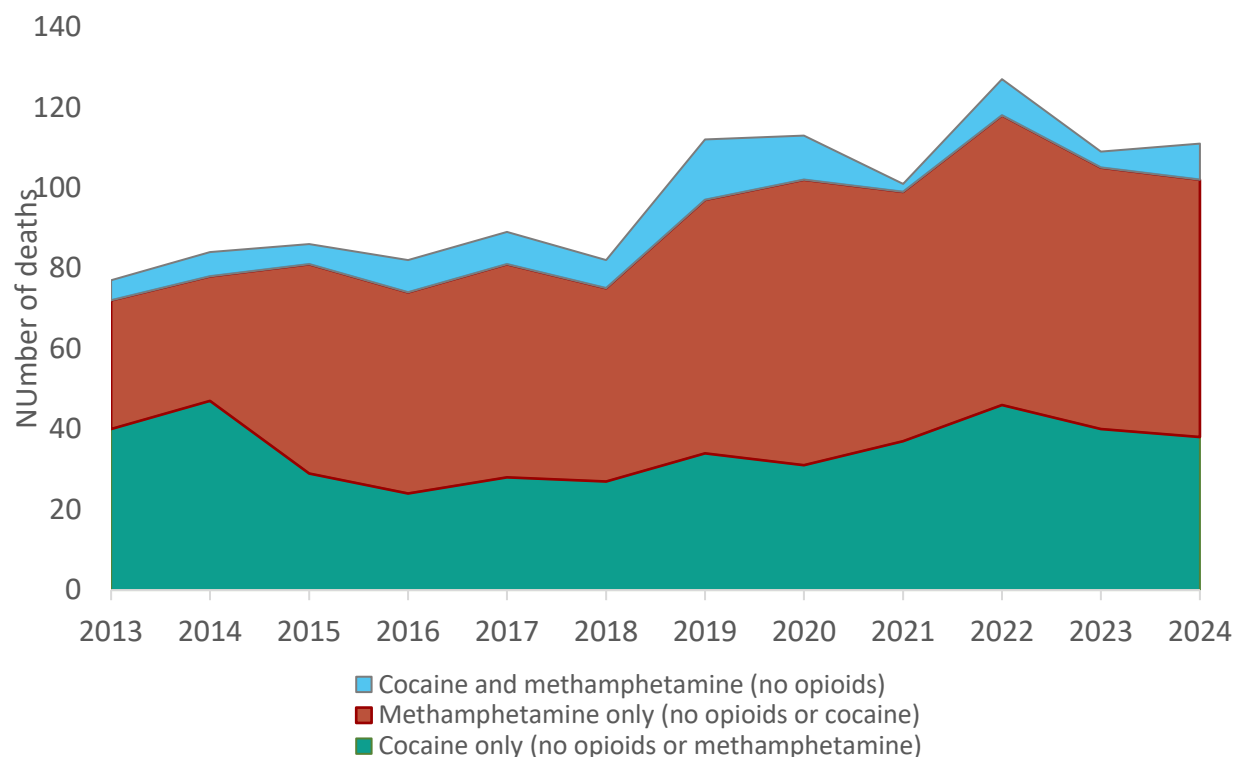
Figure 27: Age Distribution of Fentanyl Acute Toxicity Deaths by Race/Ethnicity in CCSF, 2024



4.2 STIMULANTS

The most commonly used stimulants are cocaine and methamphetamine (considered separately below). Most acute toxicity deaths involving stimulants also involved opioids (**Figure 7**); however, based on an in-depth review ([Chang et al, *Addiction.*, 2025](#)), most deaths attributed to a combination of opioids and stimulants were likely due to opioids and thus are now included in **Section 4.1.2**. Acute toxicity deaths attributed to stimulants without opioids increased only slightly since 2013 (**Figure 28**). The rate of acute toxicity death attributed to stimulants without opioids was higher among older people, and such deaths were rare among those under 50 years (**Figure 29, Figure 32**); most deaths attributed to stimulants without opioids may be due to cardiovascular and cerebrovascular sequelae of long-term stimulant use ([Turner et al, *Drug Alcohol Depend.*, 2018](#); [Riley et al, *J Gen Intern Med.*, 2022](#); [Black et al, *Drug Alcohol Depend.*, 2025](#)).

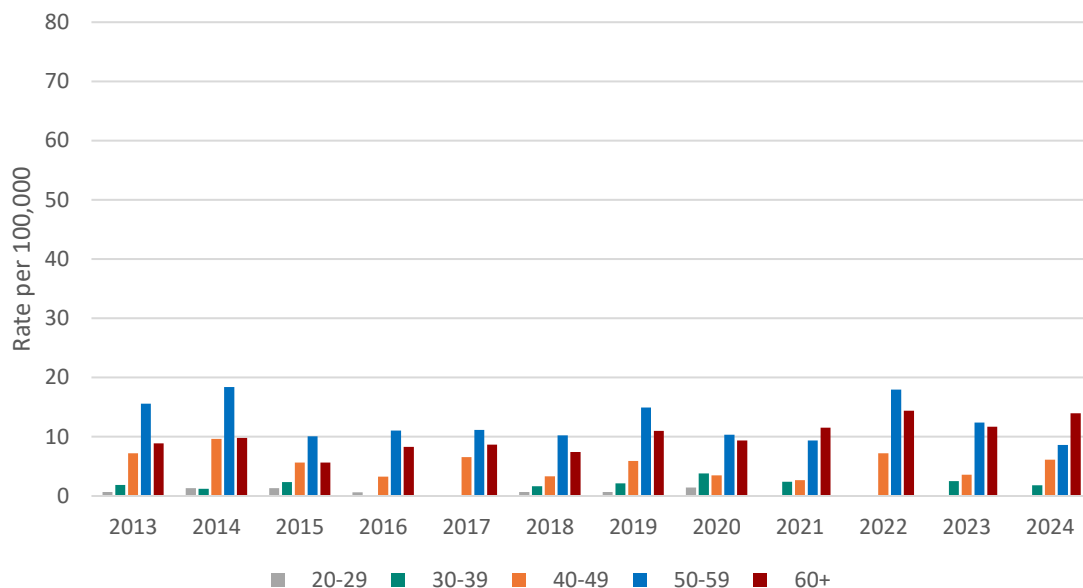
Figure 28: Number of Stimulant Acute Toxicity Deaths by Mutually Exclusive Substance Type in CCSF, 2013–2024



4.2.1 Cocaine/Crack

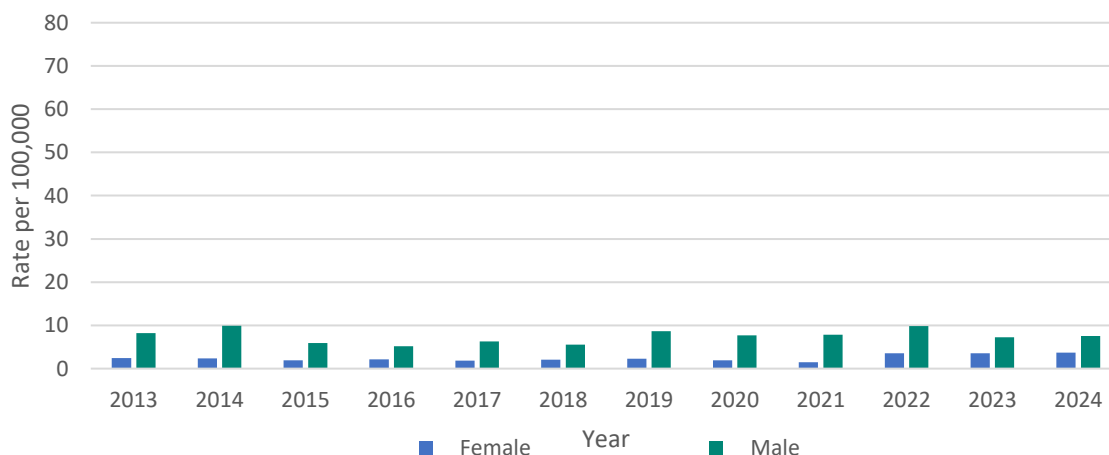
In the absence of opioids, the rate of death attributed to cocaine acute toxicity was highest among persons 50 years or older (**Figure 29**), males (**Figure 30**), and Black/African American people (**Figure 31**). The disparity in deaths attributed to cocaine acute toxicity among Black/African American people was 11 times higher compared to the general population.

Figure 29: Cocaine without Opioids Acute Toxicity Death Rate by Age Category in CCSF, 2013–2024



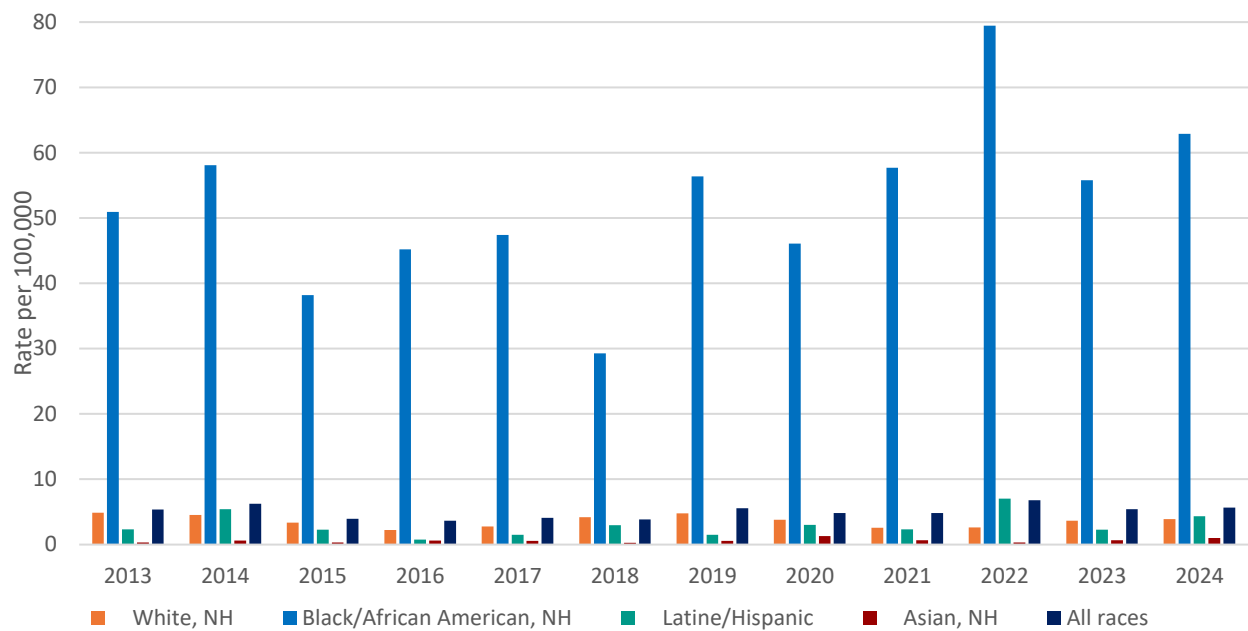
Rate is per 100,000 population. People under age 20 are excluded.

Figure 30: Rate of Cocaine without Opioid Acute Toxicity Deaths by Sex in CCSF, 2013–2024



Rate is per 100,000 population.

Figure 31: Cocaine without Opioid Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2013–2024

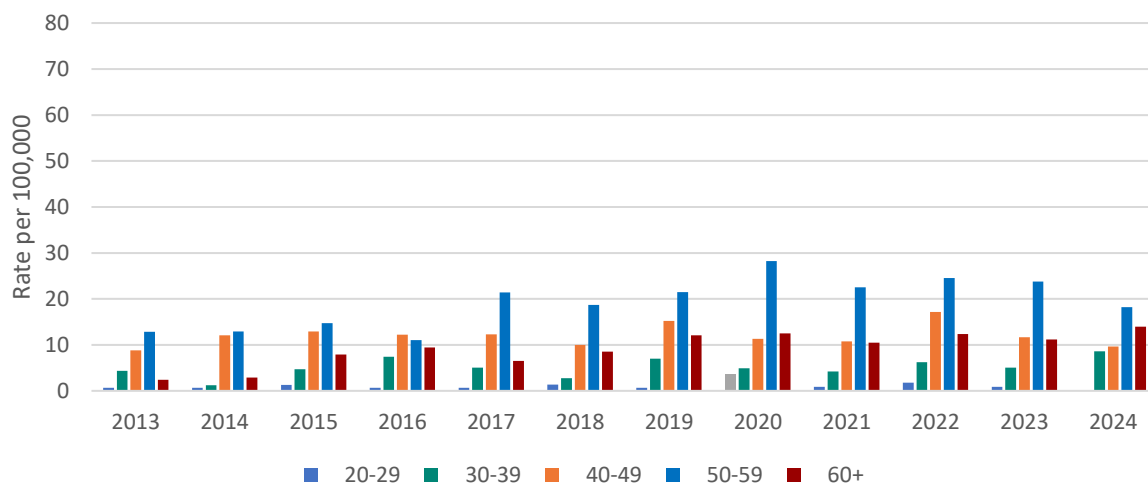


Rate is per 100,000 population. NH=non-Hispanic.

4.2.2 Methamphetamine

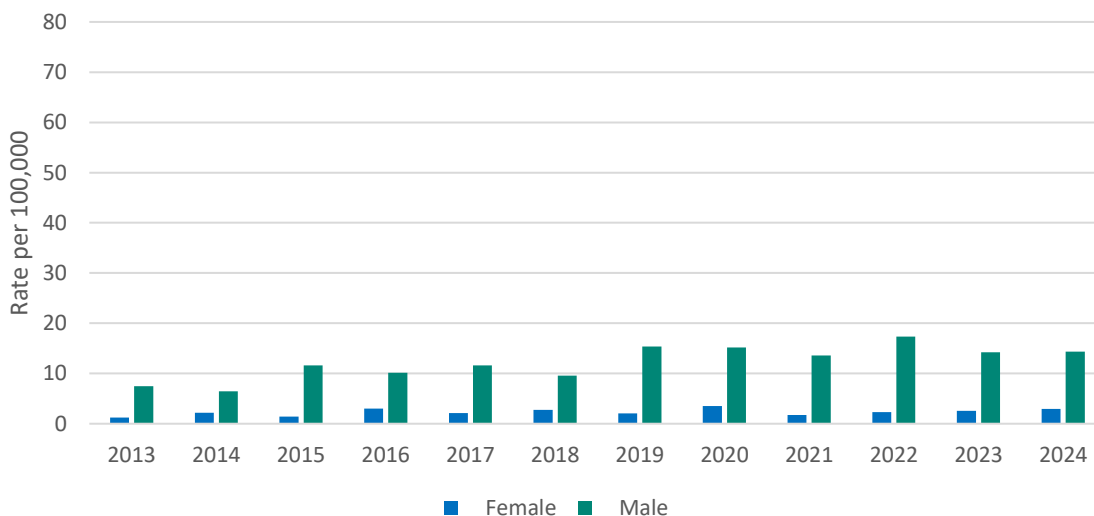
In the absence of opioids, the rate of death attributed to methamphetamine acute toxicity was highest among persons 50-59 years (**Figure 32**), males (**Figure 33**), and Black/African American people (**Figure 34**).

Figure 32: Methamphetamine without Opioid Acute Toxicity Death Rates by Age Category, CCSF 2013-2024



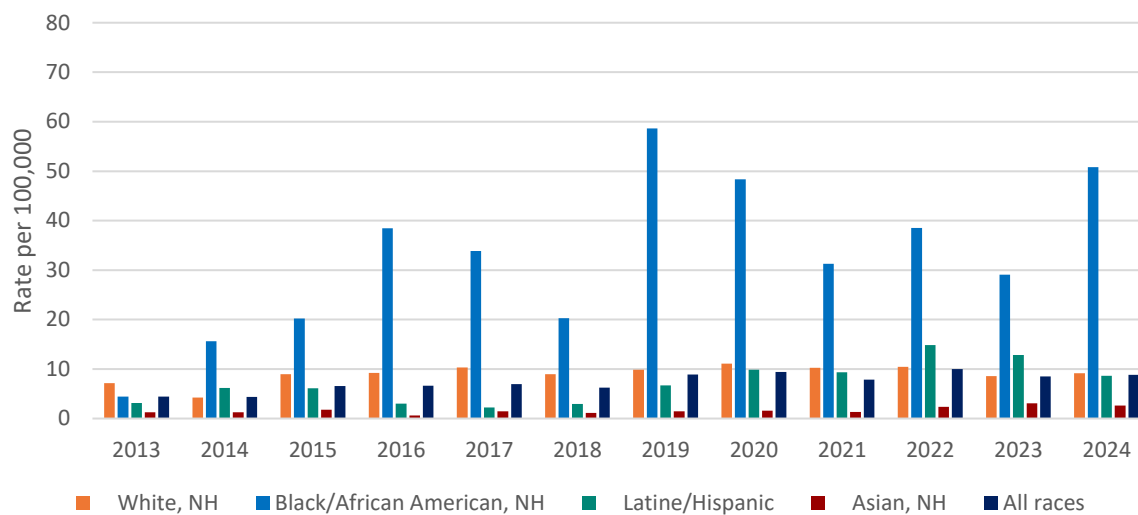
Rate was calculated per 100,000 population. Persons under age 20 were excluded.

Figure 33: Methamphetamine without Opioid Acute Toxicity Death Rate by Sex in CCSF, 2013-2024



Rate was calculated per 100,000 population.

Figure 34: Methamphetamine without Opioid Acute Toxicity Death Rate by Race/Ethnicity in CCSF, 2013–2024



Rate was calculated per 100,000 population. NH=non-Hispanic.

4.3 ACUTE TOXICITY DEATHS AMONG BLACK/AFRICAN AMERICAN PEOPLE

The number of substance-related deaths among Black/African-American persons follows a similar pattern as the rest of San Francisco, with an increase in acute toxicity deaths as fentanyl came to dominate the drug market (**Figure 35**). While acute toxicity deaths increased among all race/ethnicity groups in 2023, the most substantial was a 67% increase in opioid acute toxicity deaths among Black/African American people, widening the existing disparity (**Figure 15** and **Figure 36**). These deaths occurred predominantly among males (**Figure 38**), with the largest increase from 2022 to 2023 among people aged 60 and over (**Figure 37**). The most common combination of substances implicated in acute toxicity deaths among Black/African American people was opioids (96% fentanyl) and cocaine; deaths involving this combination increased by 124% among Black/African American people from 2022 to 2023 (**Figure 36**). In 2024, there were declines in acute toxicity mortality across all race/ethnicity groups, although the most marked decline occurred among Black/African American people and in deaths attributed to opioids with cocaine acute toxicity (**Figure 19, Figure 36**). Taken together, these changes appear to represent a time-limited increase in acute toxicity mortality due to the combination of fentanyl and cocaine among older, Black/African American men in 2023, which mostly resolved in 2024 (**Figure 38**).

In contrast to this pattern, the rate of death among Black /African American people attributed to cocaine *without* opioids declined in 2023, then increased again in 2024 (**Figure 31**); this is the opposite pattern that was observed for deaths attributed to opioids *with* cocaine (**Figure 19**). A similar pattern, although less pronounced, occurred among deaths attributed to methamphetamine. Although available data do not permit determination of the cause of this shift in 2023, the temporary nature of the shift suggests that time-limited factors, such as changes in the drug market, may have played a role.

Figure 35: Substance-Related Deaths Among Black/African American People by Acuity, CCSF 2013-2024

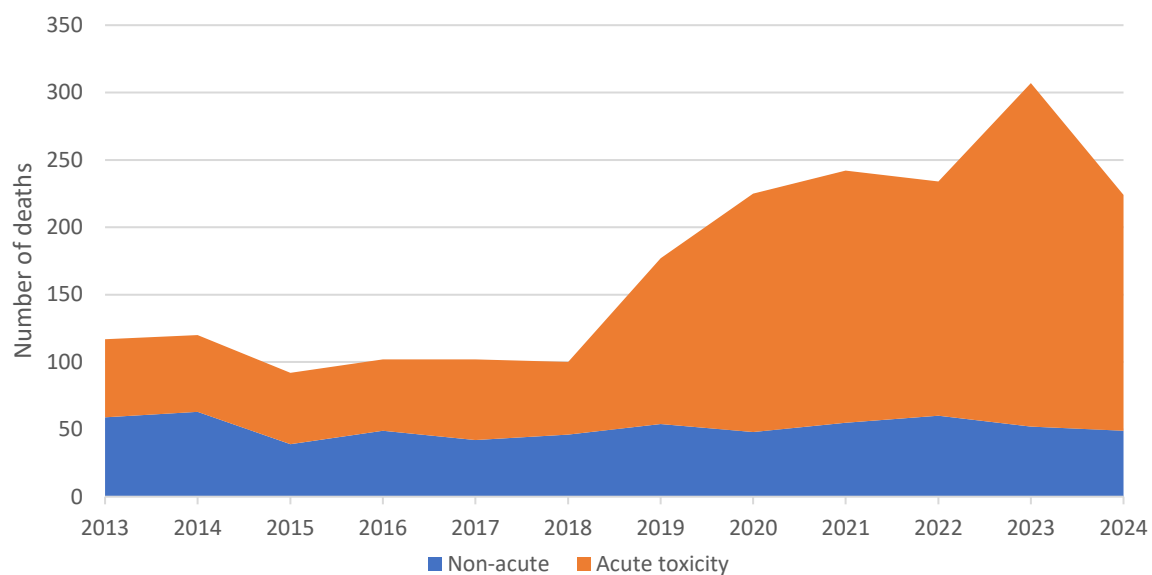
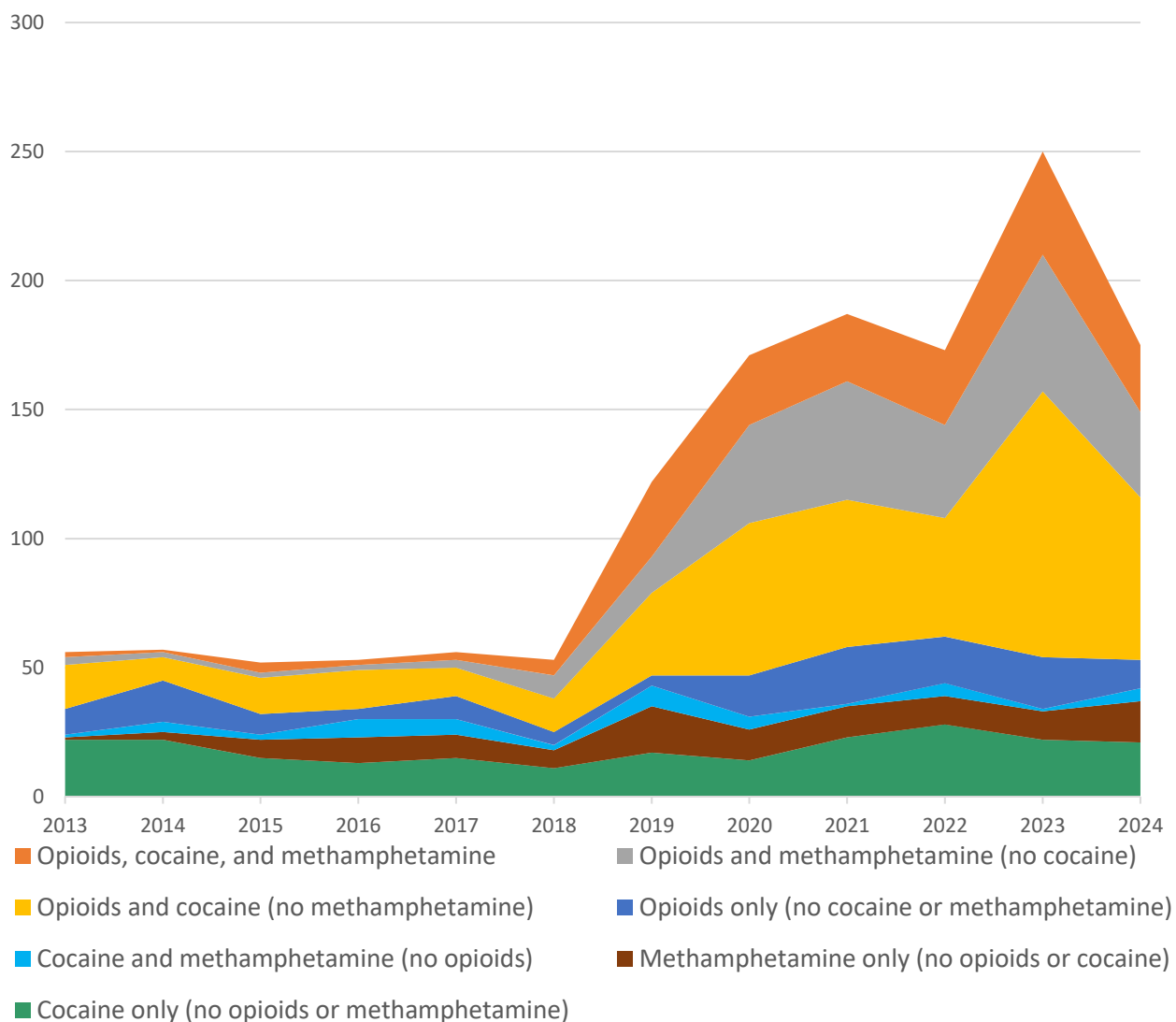
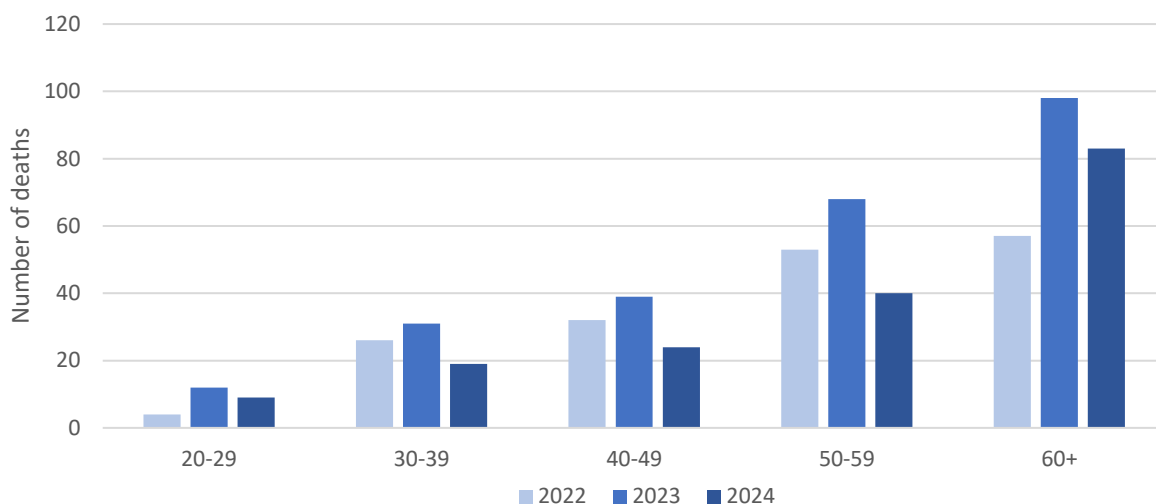


Figure 36: Acute Toxicity Deaths Among Black/African American People by Mutually Exclusive Substances Involved, CCSF 2013–2024



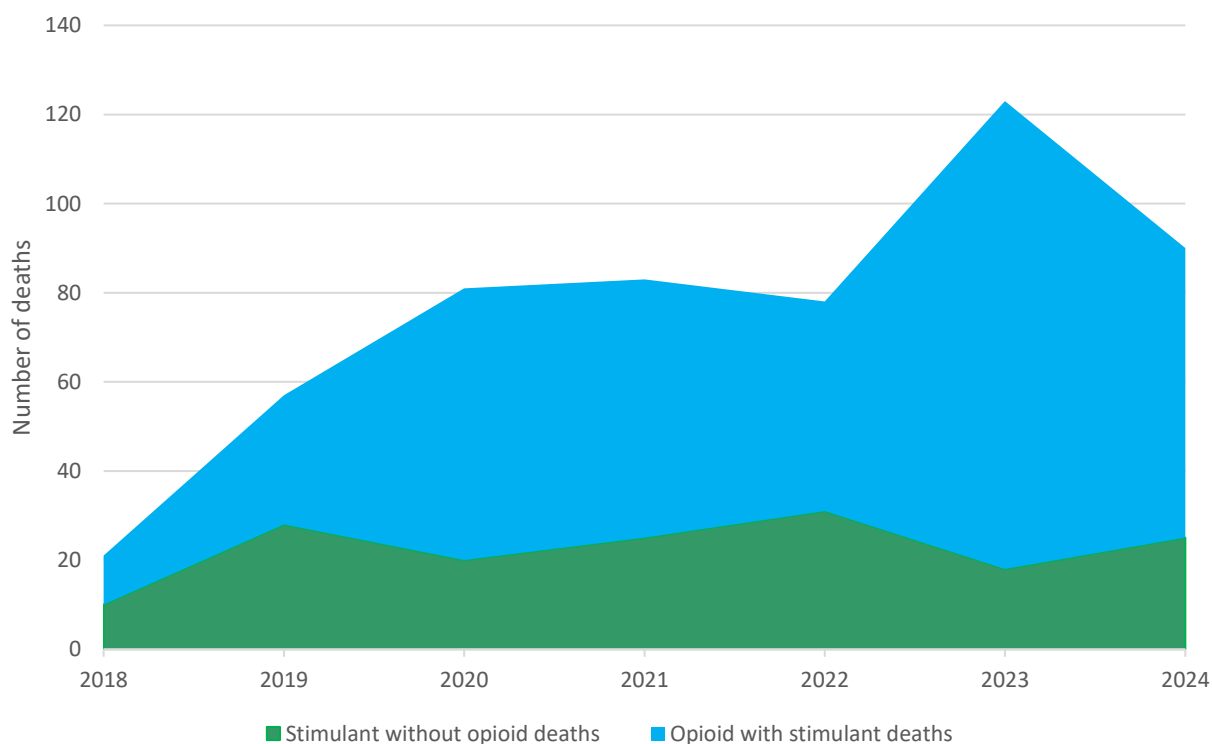
The height of each band corresponds to the number of deaths in that category.

Figure 37: Acute Toxicity Deaths Involving Opioids, Cocaine, and Methamphetamine among Black/African American People by Age Group, CCSF 2022-2024



Includes only decedents with race identified as Black or African American, not of Hispanic or Latine ethnicity. Excludes people under age 30 for privacy reasons.

Figure 38: Stimulant Acute Toxicity Deaths Among Black/African American Men Age 50 and Older, by Opioid Involvement, CCSF 2018-2024

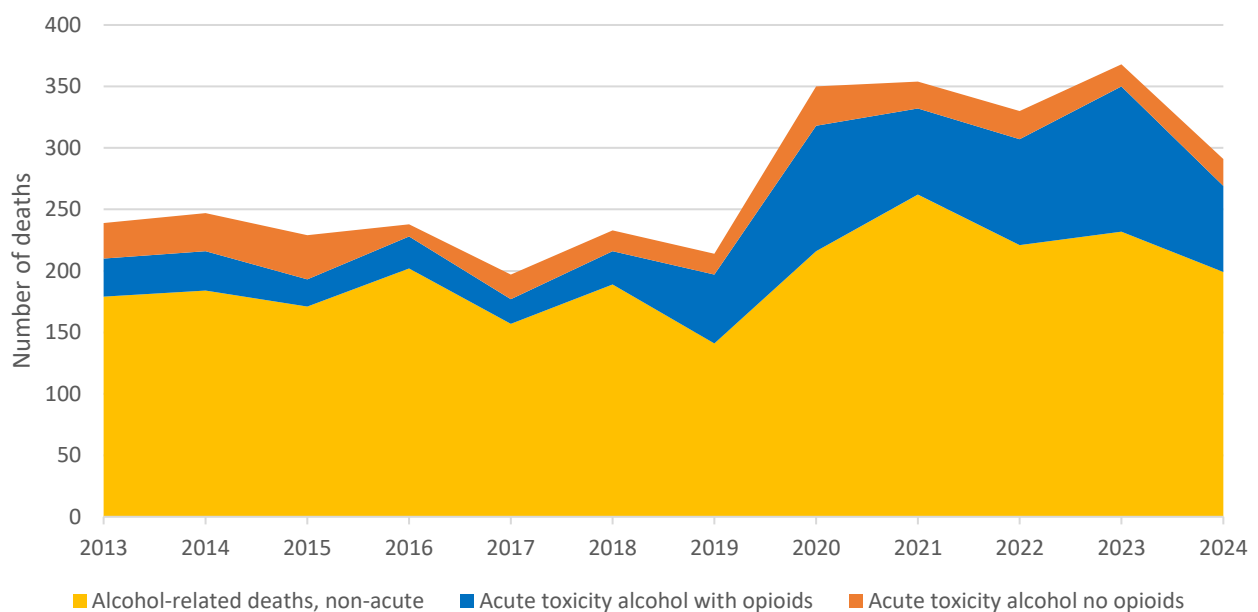


Opioids category may also include stimulants. Stimulants category includes cocaine and/or methamphetamine, but no opioids.

4.4 ALCOHOL

Alcohol was the leading contributor to substance-related mortality in San Francisco until 2019, when it was overtaken by fentanyl. In contrast to other substances, most alcohol-involved deaths were not due to acute toxicity, but rather to complications of long-term use, such as liver disease. Moreover, among alcohol deaths attributed to acute toxicity, 80% involved fentanyl. Alcohol-related deaths sharply increased in 2020 with the COVID-19 pandemic; deaths attributed to a combination of alcohol and opioids decreased in 2024, as did non-acute alcohol-related deaths (0).

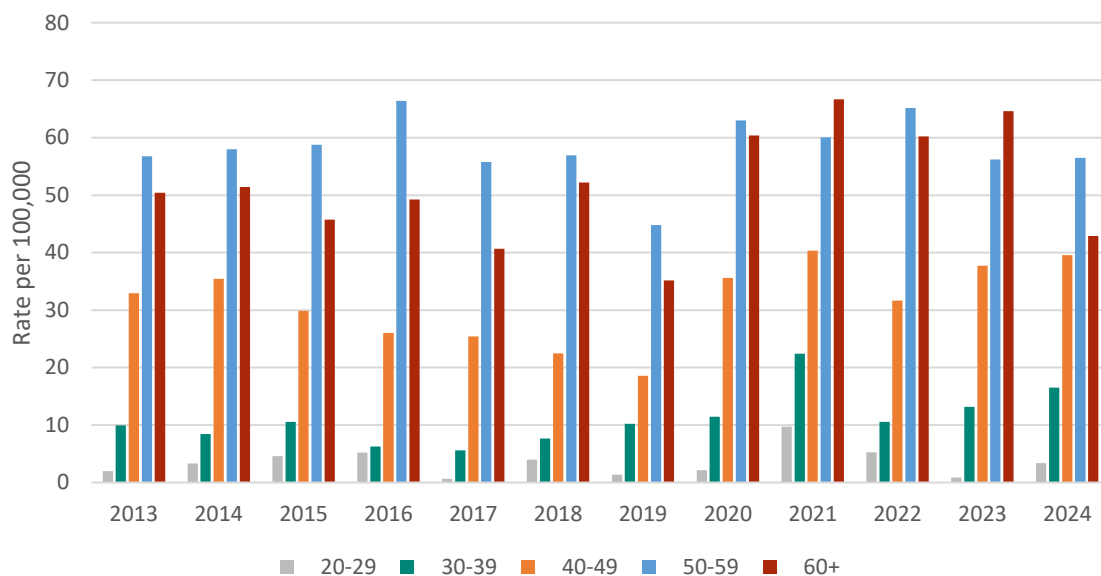
Figure 39: Alcohol Deaths By Acuity and Presence of Opioids, CCSF 2013–2024



Excluding deaths also attributed to opioid acute toxicity, rates of alcohol-related death were highest in 2024 among people aged 50-59 (**Figure 40**), males (**Figure 41**), and Black/African American people (**Figure 42**), though disparities were less substantial than for opioid or stimulant acute toxicity deaths. People of Latino/Hispanic ethnicity also had an elevated rate of alcohol-related mortality.

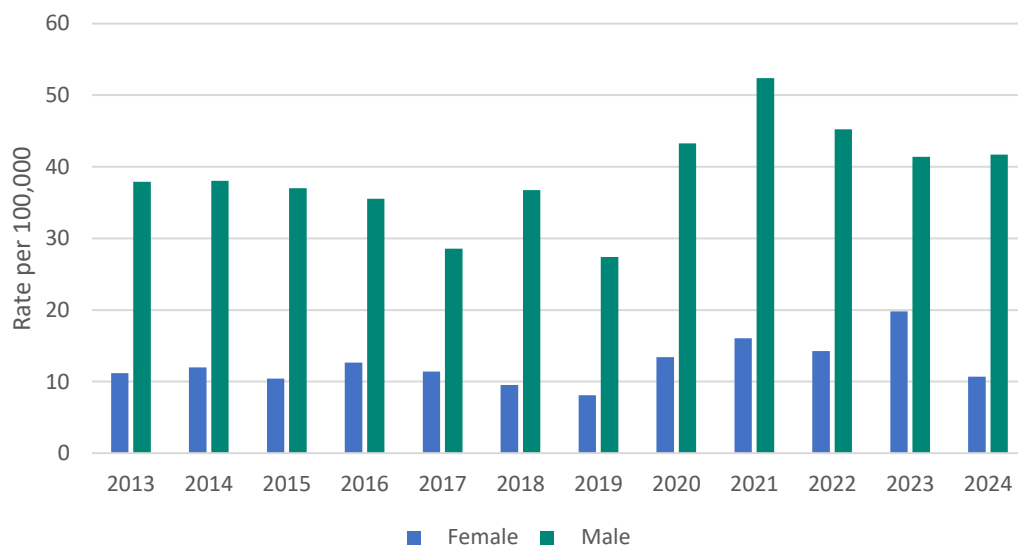
For additional information regarding the impact of alcohol use on CCSF, see **Economic and Administrative Costs Related to Alcohol Abuse in the City and County of San Francisco** at: www.sfbos.org/sites/default/files/BLA_Report_Alcohol_Final-041017.pdf.

Figure 40: Alcohol-Related Death Rate, Excluding Opioid Acute Toxicity, by Age in CCSF, 2013-2024



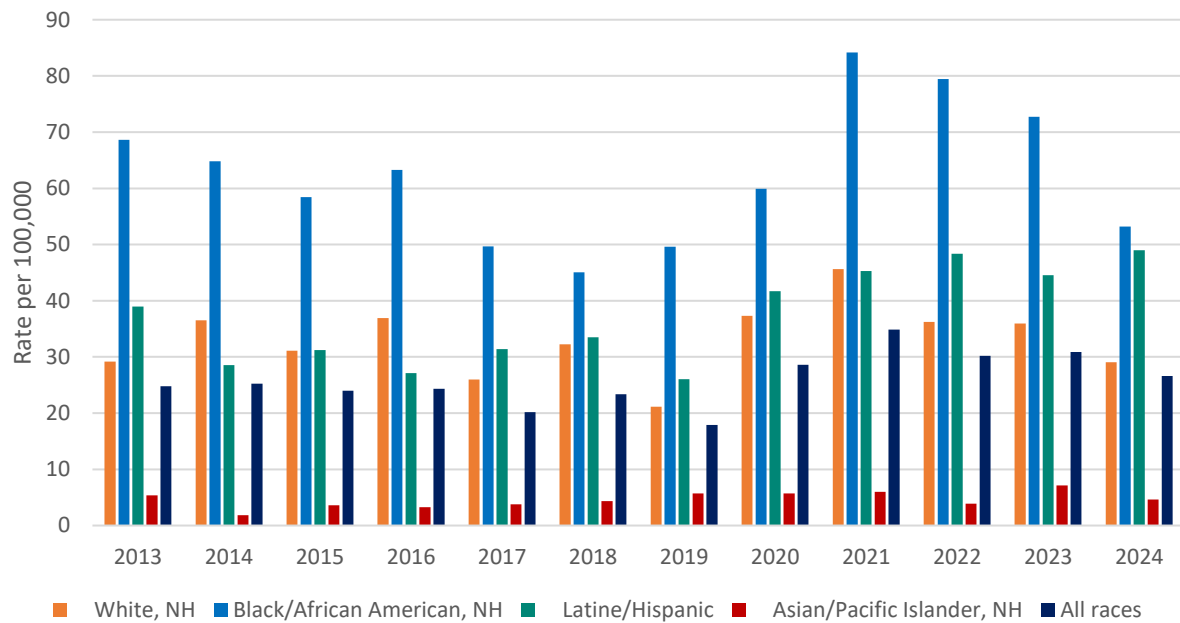
Rate is per 100,000 population. Excludes people under age 20. Includes non-acute deaths caused by alcohol use and deaths caused by acute alcohol toxicity; excludes deaths caused by acute opioid toxicity.

Figure 41: Alcohol-Related Death Rate, Excluding Opioid Acute Toxicity, by Sex in CCSF, 2013-2024



Rate is per 100,000 population. Includes non-acute deaths caused by alcohol use and deaths caused by acute alcohol toxicity; excludes deaths caused by acute opioid toxicity.

Figure 42: Alcohol-Related Death Rate, Excluding Opioid Acute Toxicity, by Race and Ethnicity in CCSF, 2013-2024

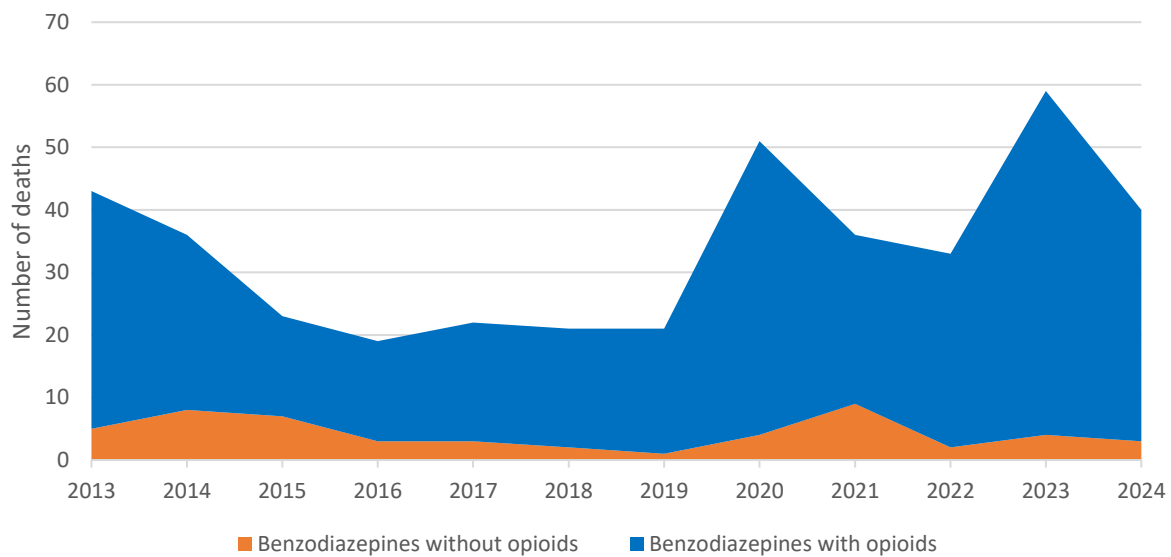


Rate is per 100,000 population. NH = Non-Hispanic. Includes non-acute deaths caused by alcohol use and deaths caused by acute alcohol toxicity; excludes deaths caused by acute opioid toxicity.

4.5 BENZODIAZEPINES

The number of acute toxicity deaths attributed to benzodiazepines decreased from 2023 to 2024 (**Figure 43**). Nearly all benzodiazepine acute toxicity deaths involved opioids; in 2024, 90% of benzodiazepine acute toxicity deaths also involved fentanyl. Benzodiazepine-involved deaths in San Francisco since 2020 were associated with the emergence of novel designer benzodiazepines, most commonly bromazolam ([Rodda, Addiction, 2024](#)).

Figure 43: Benzodiazepine Acute Toxicity Deaths By Presence of Opioids, CCSF 2013–2024



5 APPENDICES

Table 1: Number of Substance-Related Deaths by Non-Mutually Exclusive Substance Category in CCSF, 2013–2024

Substance	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Any Opioid	158	143	113	112	150	193	360	603	558	546	725	523
Fentanyl	*	*	11	22	36	91	249	523	491	478	673	480
Heroin	26	36	33	45	55	61	83	78	80	68	40	39
Prescription Opioid	138	114	77	60	74	85	108	89	75	79	75	56
Cocaine/Crack	98	97	83	95	108	127	243	306	275	290	410	306
Methamphetamine	70	76	89	103	123	157	285	424	386	405	468	379
Benzodiazepines	73	43	26	23	26	26	24	55	43	40	65	49
Alcohol	249	252	231	243	203	238	224	362	373	348	387	307
Cannabis	72	54	*	*	*	*	12	13	*	*	*	*
All substance-related deaths**	574	562	458	466	474	540	697	1035	1010	975	1146	938

Substance-related deaths were identified use textual cause of death fields and significant conditions fields, where substance use was listed as a contributing factor. Homicides and suicides were excluded.

*Fewer than 10 deaths

**Total includes substances not listed in table. Substances included any used for psychoactive purposes (e.g., alcohol, opioids, stimulants, sedatives, inhalants, etc.); deaths attributed to non-psychoactive medications (e.g., cardiovascular or oncologic medications) or medical procedures (e.g., anesthetics not known to be available outside of medical settings) were not included.

Sources: California Electronic Death Registration System (CA-EDRS) via the Vital Records Business Intelligence System (VRBIS).

Table 2: Number of Acute Toxicity Deaths by Non-Mutually Exclusive Substance Category in CCSF, 2013-2024

Substance	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Any opioid, cocaine, or methamphetamine	208	210	187	187	223	260	444	698	623	635	805	606
Any opioid	132	126	101	105	135	178	331	585	523	508	696	495
Fentanyl	*	*	11	22	36	90	241	520	477	463	660	468
Heroin	25	35	32	42	48	60	81	77	71	63	38	35
Prescription opioid	111	98	66	56	64	70	84	68	44	51	51	35
Cocaine	86	88	72	72	89	102	207	267	231	251	370	261
Methamphetamine	61	63	81	88	100	126	256	386	344	351	412	315
Benzodiazepines	43	36	23	19	22	21	21	51	36	33	59	40
Alcohol	59	63	58	36	40	44	73	134	93	110	137	92
Cannabis	17	*	*	*	*	*	*	*	*	*	*	*
Any psychoactive substance**	240	234	225	198	246	276	464	732	643	648	822	635

Acute toxicity deaths were identified use textual cause of death fields. Homicides and suicides were excluded. Substances included any used for psychoactive purposes (e.g., alcohol, opioids, stimulants, sedatives, inhalants, etc.); deaths attributed to non-psychoactive medications (e.g., cardiovascular or oncologic medications) or medical procedures (e.g., anesthetics not known to be available outside of medical settings) were not included.

*= fewer than 10 deaths (inclusive of zero).

**Total includes substances not listed above.

Sources: California Electronic Death Registration System (CA-EDRS) via the Vital Records Business Intelligence System (VRBIS).

Table 3: Number of Fentanyl or Fentanyl Analogue Acute Toxicity Deaths by Mutually Exclusive Substance Categories in CCSF, 2013-2024

Substance	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Fentanyl (with or without any substance)	*	*	11	22	36	90	241	518	472	463	660	468
Fentanyl alone (no heroin, cocaine, or methamphetamine)	*	*	*	*	12	24	46	104	95	89	121	97
Fentanyl and heroin (no cocaine or methamphetamine)	*	*	*	*	*	*	*	*	*	*	*	*
Fentanyl, heroin, and cocaine (no methamphetamine)	*	*	*	*	*	*	*	12	10	*	*	*
Fentanyl, heroin, and methamphetamine (no cocaine)	*	*	*	*	*	*	13	13	16	12	*	*
Fentanyl, heroin, cocaine, and methamphetamine	*	*	*	*	*	*	*	*	*	*	*	*
Fentanyl and cocaine (no heroin or methamphetamine)	*	*	*	*	*	19	50	113	111	103	199	126
Fentanyl and methamphetamine (no heroin or cocaine)	*	*	*	*	10	24	58	189	188	180	221	166
Fentanyl, cocaine, and methamphetamine (no heroin)	*	*	*	*	*	*	53	71	50	56	103	59

Acute toxicity deaths were identified use textual cause of death fields. Homicides and suicides were excluded.

**= fewer than 10 deaths (inclusive of zero).*

Sources: California Electronic Death Registration System (CA-EDRS) via the Vital Records Business Intelligence System (VRBIS).

6 SOURCES

Data	Source and Description
Deaths	California Electronic Death Registration System (CA-EDRS) via the Vital Records Business Intelligence System (VRBIS), accessed on 3 July 2025. Substance-related deaths were identified using textual cause of death fields. Homicides and suicides were excluded. Non-psychoactive substances were excluded. CA-EDRS does not report gender identity; sex options are male and female.
Location of death geocoding (Figure 8)	Office of the Chief Medical Examiner of San Francisco, accessed on 12 August, 2025. Includes all deaths from acute toxicity investigated by the Medical Examiner with manner of death deemed Accidental.
Population Estimates	Population denominators for figures displaying population mortality rates by age, race or ethnicity, and sex were derived from the United States Census Bureau Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin.