Te Puna
Whakaiti Pāmamae
Kai Whakapiri

New Zealand
Drug Foundation

Drug overdoses in Aotearoa

2026

Acknowledgements

We want to acknowledge the teams that assisted us in accessing the data, including the Office of the Chief Coroner (Ministry of Justice) and National Collections Data Services (Health New Zealand | Te Whatu Ora).

In particular, we want to acknowledge Chris Lewis from the National Collections Data Services team for his continued guidance.

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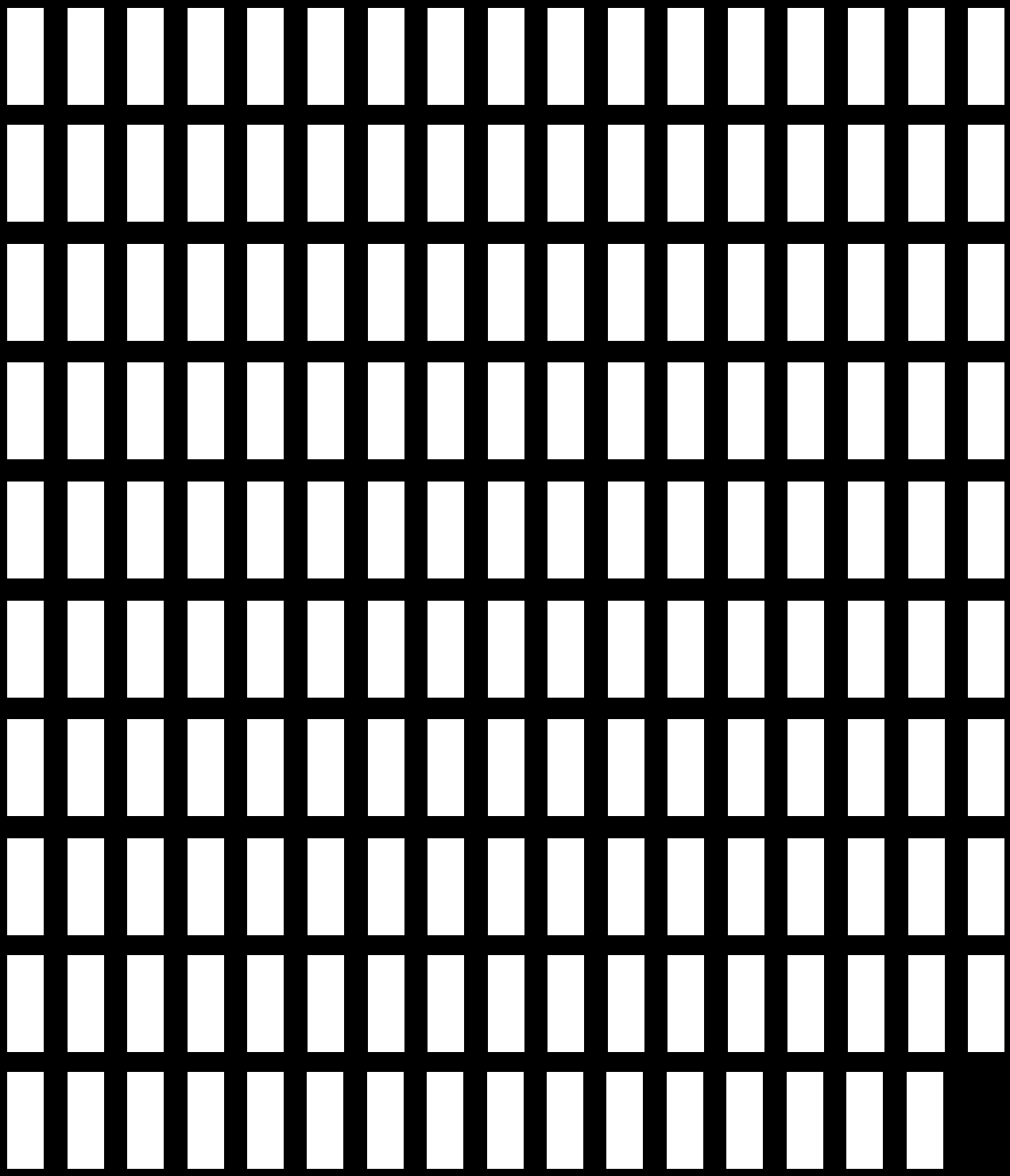
Suggested reference: New Zealand Drug Foundation 2026. *Drug overdoses in Aotearoa*. New Zealand Drug Foundation.

In 2025, 169 people died from preventable overdose.

Behind every statistic in this report is immeasurable pain and loss. Real people who have left behind unfulfilled dreams, grieving loved ones, and broken hearts.

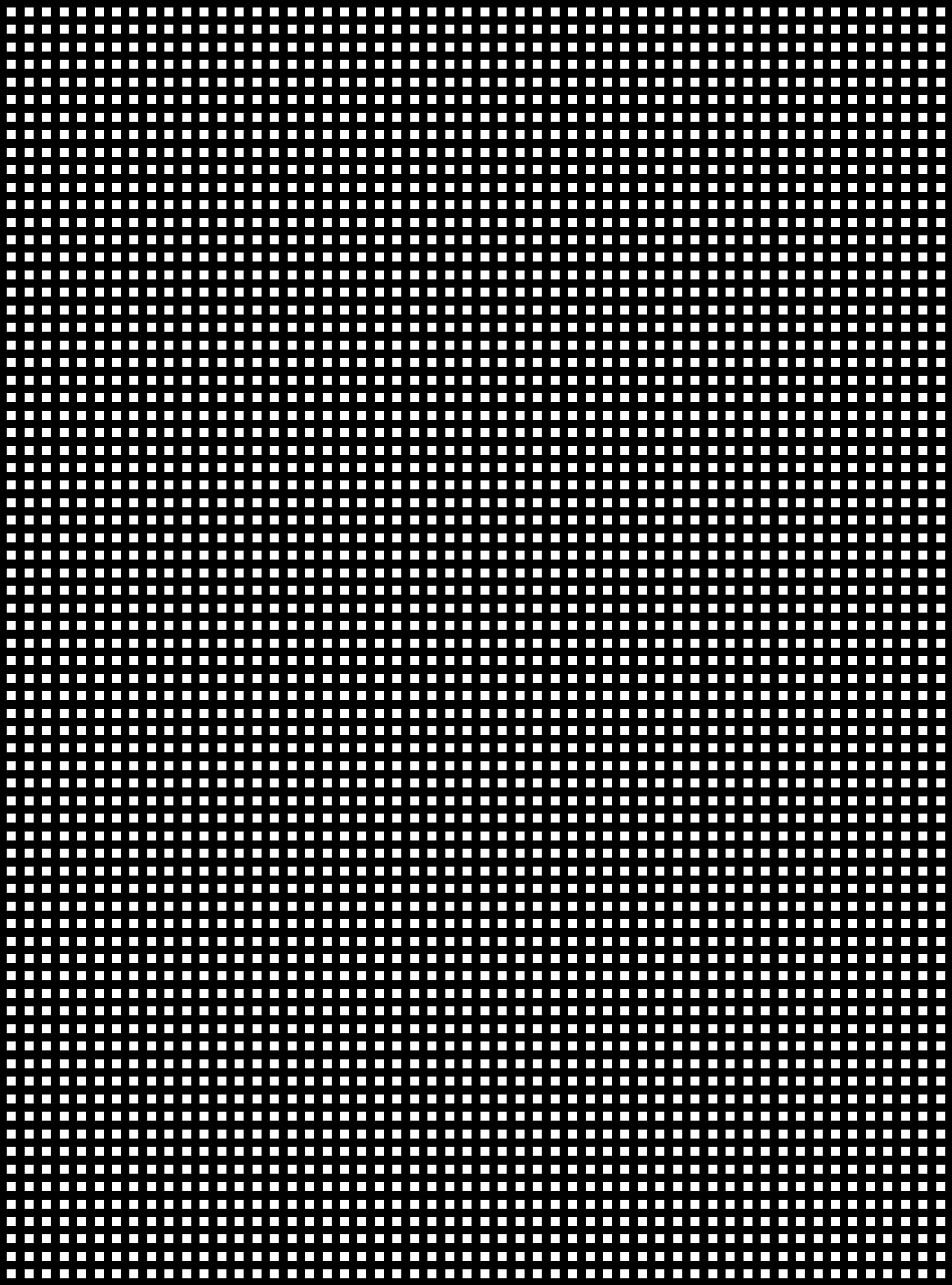


Accidental overdose deaths are preventable. But for the last decade we have failed to reduce them.

On average we lose three people every week.

In 2025, accidental overdose meant 6,659 years of potential life lost.*

Over 39 years per person.



We need a change of approach to turn things around.

A comprehensive, health-based approach to drugs that includes specialist overdose prevention services, an expansion of harm reduction approaches, access to naloxone, and better preparedness for rapidly changing drug supplies.

You can find out more about how this can be achieved in our report *Safer drug laws for Aotearoa New Zealand: Evidence to inform regulatory change*.

There is currently no national standard for tracking overdose numbers and no national body tasked with counting them. Data uncertainties are a big part of the gap in our overdose response, and improving overdose surveillance should be a high priority for our health system.

*Calculated as average years remaining based on life expectancy for a male at average overdose death age (46.2 years; Stats NZ), multiplied by the provisional total number of fatal accidental overdose deaths in 2025.

Overdose deaths in Aotearoa

This section examines coronial data on fatal, accidental overdoses in New Zealand between 2016 and 2025, and Te Whatu Ora mortality data covering the period of 2011 to 2022.

We provide further information about why and how we used the two datasets in this report on pages 2–3 (Datasets and caveats).

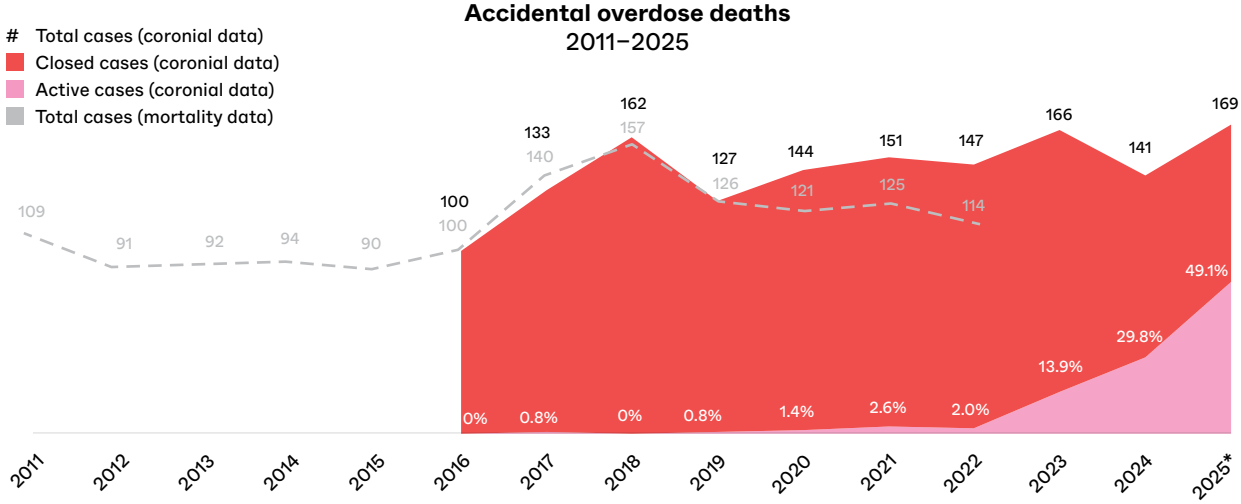
This data includes accidental drug overdose deaths and excludes intentional deaths. A small proportion of cases covered are deaths where intent was undetermined. We have excluded other drug-related death causes, such as communicable diseases, short- or long-term health complications, and chronic health conditions that may occur as a result of drug use.

The number of deaths in 2025 appears to have increased in comparison to previous years. That said, we must interpret that increase with caution considering that nearly half of these are still provisional (active) cases.*

1,440

people died of accidental drug overdose between 2016 and 2025.

Accidental overdose deaths
2011–2025



*Coronial inquiries take time

Recent cases are more likely to be under active investigation. This means that the total numbers we present for recent years are provisional and are subject to change.

For 2025, nearly half of the cases we analysed were still considered active cases under coronial inquiry at the time of publishing. We have marked this year with an asterisk.

Datasets and caveats

No system currently exists which allows for accurate, timely reporting on accidental fatal overdose in Aotearoa.

This year, we have decided to use two datasets for reporting on overdose deaths: coronial data from the Office of the Chief Coroner and Mortality Collection data from Te Whatu Ora. Each has its strengths and limitations, and we present both where practical, for transparency. Presenting both data sources also highlights the current data gaps, and we hope that it will help readers to better understand why such a system is needed in Aotearoa.

Coronial dataset

DATA SOURCE

Office of the Chief Coroner data management system. Obtained by request under the Coroners Act 2006.

STRENGTHS

At present, this dataset is the most timely way to track fatal overdoses.

It includes even the cases in which the Coroner has not yet definitively determined the cause of death.

LIMITATIONS

Inclusion of cases under investigation may result in overcounting or undercounting relevant cases, especially in the most recent years.

The data extraction method does not allow for definitively excluding cases where an accidental overdose was not the main cause of death. This may lead to random fluctuation year to year.

The main contributing class of substance is determined based on our own prioritisation system (see Prioritisation), and not on the totality of evidence for each case, which may overcount cases that are ranked higher in the hierarchy, and undercount cases that are ranked lower.

Some cases do not have toxicology data, and instead rely on other circumstances to determine the cause of death.

Even when toxicological investigations have been done, some novel or rarely occurring substances may not be included in the testing.

HOW DID WE USE IT IN THE REPORT?

Because of its timeliness, we primarily relied on coronial data to identify recent trends in the drugs involved in overdoses, and the overall recent trajectory of overdose deaths.

Mortality dataset

DATA SOURCE

Mortality Collection dataset held by Te Whatu Ora. Obtained under an Information Sharing Agreement.

STRENGTHS

The mortality dataset includes almost exclusively finalised cases with definitive findings, so this data is unlikely to change over time.

It uses a standardised coding system, relying on all the circumstances identified in coronial findings to determine the definitive underlying cause of death.

The data is provided in an information-rich format that allows more robust analyses.

LIMITATIONS

There is a significant reporting lag, which prevents timely assessment of emerging trends.

Some cases do not have toxicology data, and instead rely on other circumstances to determine the cause of death.

Even when toxicological investigations have been done, some novel or rarely occurring substances may not be included in the testing.

HOW DID WE USE IT IN THE REPORT?

We have provided mortality dataset information for a longer time period which starts earlier than the period used in our coronial data analysis.

Where practical, we have presented mortality data on the same graphs to highlight the degree of uncertainty in classified overdose cases. We note that in most cases, despite some numerical variation, both datasets show very similar trends.

We primarily relied on the mortality dataset for demographic (age, gender, ethnicity) analyses, as these have remained relatively consistent over time.

Prioritisation

In the coronial dataset, in cases where multiple drug types were detected in toxicology results, we attributed each case to one drug class using the ranked prioritisation system below:

1. Opioid drugs
2. Synthetic cannabinoids
3. Benzodiazepines
4. Alcohol
5. Stimulants
6. Other drugs (including antipsychotics, SSRIs, GHB/GBL)
7. Hallucinogens

To determine this order, we looked at drug mortality research and guidelines from multiple international sources[1,2] and compared the findings with drug use patterns in New Zealand. This provided us with a framework to prioritise which drug classes were likely to lead to an overdose death. It is important to bear in mind that combining multiple drugs greatly increases the likelihood of death from overdose. In some cases, the final coroner-determined cause of death will differ from our allocated prioritisation of these coronial cases.

1. Hedegaard, H., Bastian, B. A., Trinidad, J. P., Spencer, M., & Warner, M. (2018). Drugs most frequently involved in drug overdose deaths: United States, 2011–2016. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, *67*(9), 1–14.

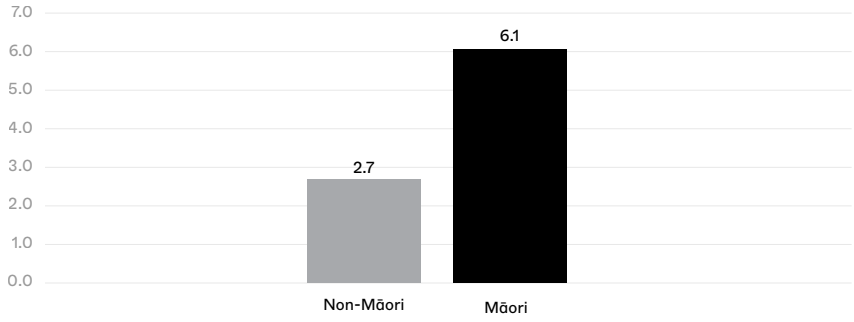
2. Martins, S. S., Sampson, L., Cerdá, M., & Galea, S. (2015). Worldwide prevalence and trends in unintentional drug overdose: A systematic review of the literature. *American Journal of Public Health*, *105*(11), e29–e49. https://doi.org/10.2105/AJPH.2015.302843

Overdose deaths by ethnicity

The graph below presents the average yearly mortality rates among Māori and non-Māori aged 15 and over.

Concerningly, this rate is 2.3 times higher among Māori than non-Māori.

Annual accidental overdose mortality rate
per 100,000 population aged 15 and over
Mortality dataset: 2016–2022



Overdose deaths by gender

Men are more likely to die of an accidental drug overdose than women in New Zealand. In the mortality dataset, between 2016 and 2022, two thirds (66.7%) were male, and the remaining third (33.3%) were female.

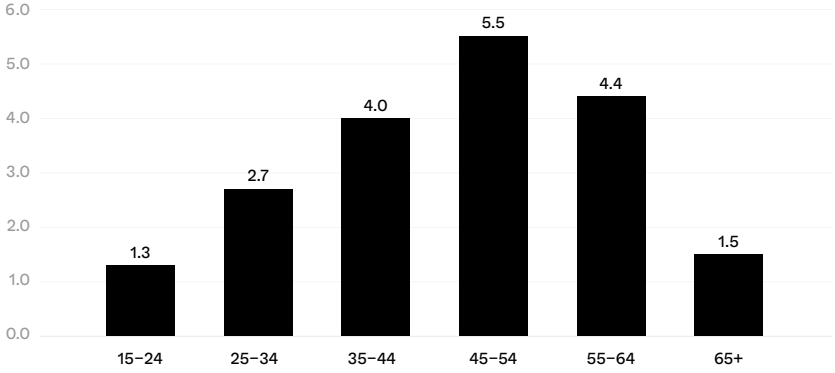
There is currently no data for gender diverse people.

Overdose deaths by gender
Mortality dataset: 2016–2022

Overdose deaths by age group

The graph below presents the average yearly mortality rates by age group. People aged 45–54 suffer the highest rate of any age group.

Annual accidental overdose mortality rate
per 100,000 population aged 15 and over
Mortality dataset: 2016–2022

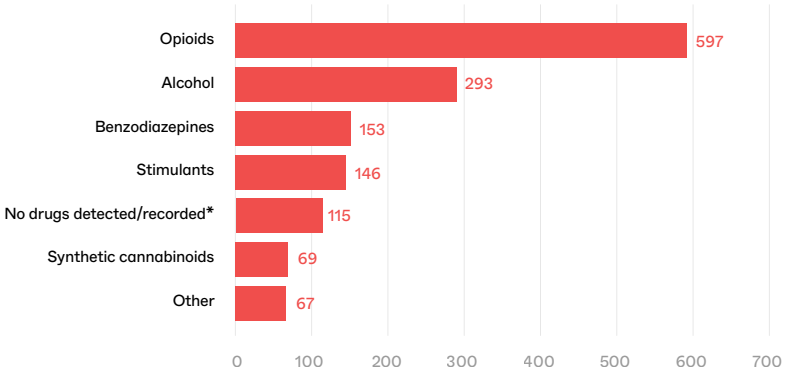


Overdose deaths by drug type

Opioids are responsible for the largest number of overdoses. This includes illicit, prescribed, and diverted opioids.

In the mortality dataset, between 2011 and 2022, opioids were deemed to have been the cause of nearly half (45.6%) of all fatal overdose cases. Coronial data shows a similar pattern (graph presented below).

Deaths by substance type
Active and closed coronial cases: 2016–2025

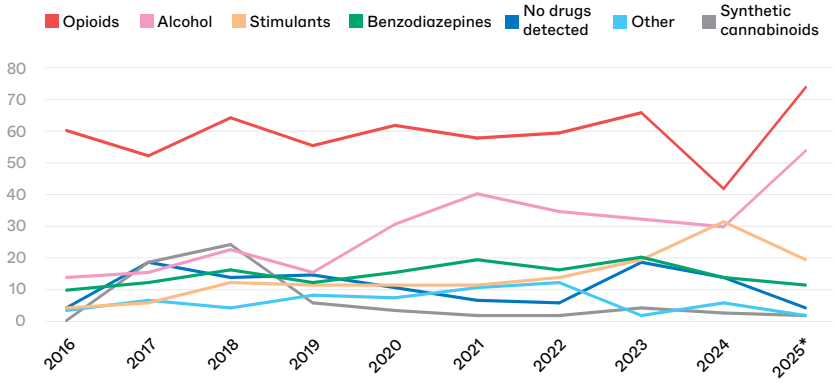


*Cases labelled as 'no drugs detected/recorded' are cases where the death has been coded by the Coroner as a drug overdose, but toxicology data did not show any drugs. This sometimes happens if the drug is difficult to detect, or in cases where toxicology data is not recorded in the coronial information system.

Changes over time

This graph depict the number of cases for each substance group between 2016 and 2025.

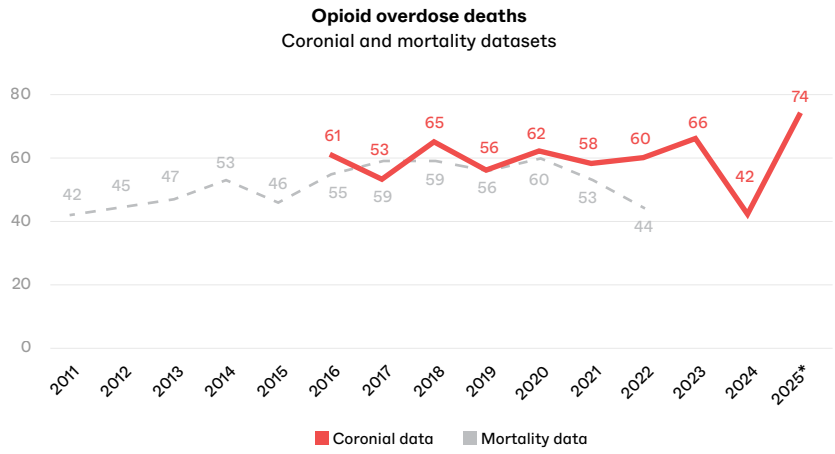
Deaths by substance type
Active and closed coronial cases



*Nearly half of the cases from 2025 are still under active coronial inquiry.

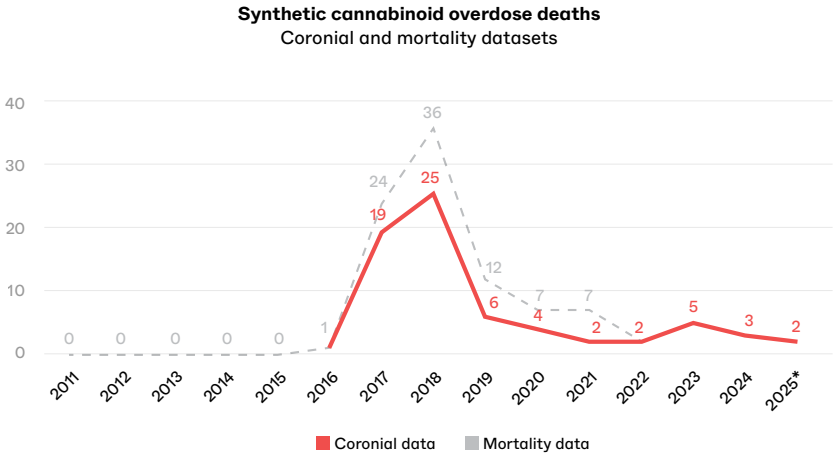
Opioids

e.g., morphine, methadone, heroin, codeine, fentanyl, nitazenes



- According to coronial data, opioids are by far the biggest contributor to overdose deaths in New Zealand, featuring in 41.5% of cases between 2016 and 2025.
- 41% of closed opioid overdose cases involved more than one opioid (for example, codeine and tramadol).
- The risk of overdose from opioids increases when a person also takes another depressant drug. Between 2016 and 2025, 92.9% of closed opioid overdose cases also involved at least one other depressant drug (e.g., alcohol, a benzodiazepine, or another opioid).
- The most commonly featured opioids, in order, are: codeine, morphine,† methadone, and tramadol.

Synthetic cannabinoids



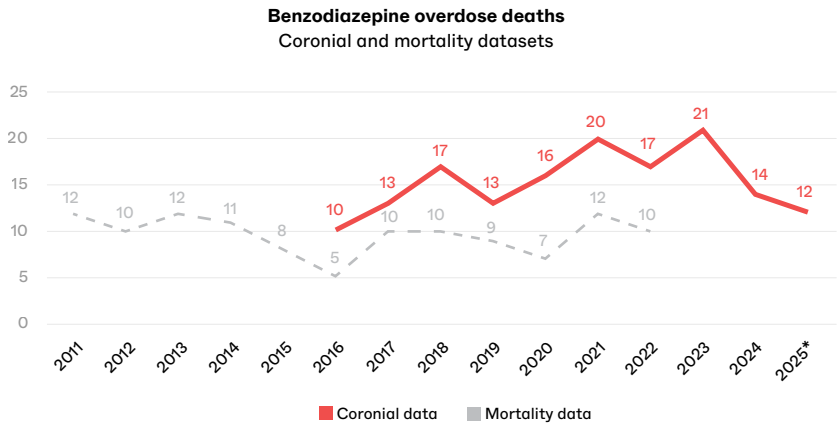
- Synthetic cannabinoid overdose deaths started to increase in 2017 and peaked in 2018, when New Zealand experienced a synthetic cannabinoid overdose crisis.
- Synthetic cannabinoid overdoses have since decreased and remained relatively stable.
- Between 2016 and 2025, 5.9% of closed cases featured a synthetic cannabinoid.

†Many opioids are metabolised to morphine in the body.

*Nearly half of the cases from 2025 are still under active coronial inquiry.

Benzodiazepines

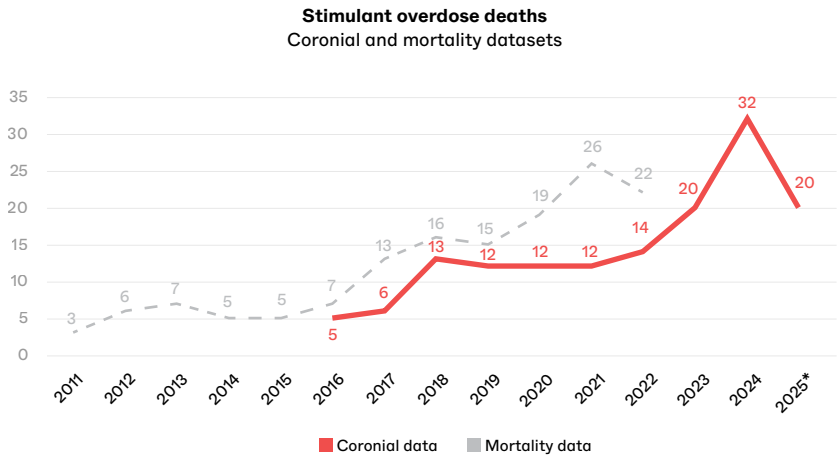
e.g., alprazolam (Xanax), diazepam, etizolam, bromazolam



- Between 2016 and 2025, 33.5% of all closed cases featured one or more benzodiazepines.
- Diazepam was the most common benzodiazepine featured in closed overdose cases, appearing 260 times.
- Benzodiazepines are most dangerous when mixed with other depressant drugs. Of the closed cases that involved benzodiazepines, nearly all (95.3%) also involved at least one other depressant drug (e.g., alcohol or codeine).
- Most benzodiazepines featured are prescription benzodiazepines. However, a novel benzodiazepine was detected in 17 coronial cases between 2016 and 2025.

Stimulants

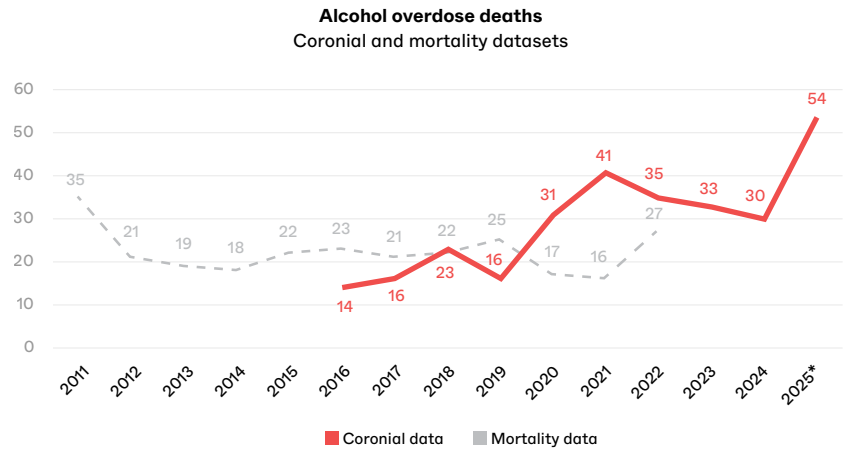
e.g., methamphetamine, methylphenidate, synthetic cathinones



- While case numbers are still small, stimulant overdose deaths in 2025 remained higher than in the period before 2023.
- 58.8% of cases that contained a stimulant drug contained an amphetamine (e.g., methamphetamine).
- Cocaine (or its metabolite) featured in 24 cases – 16 of which occurred between 2023 and 2025.

*Nearly half of the cases from 2025 are still under active coronial inquiry.

Alcohol

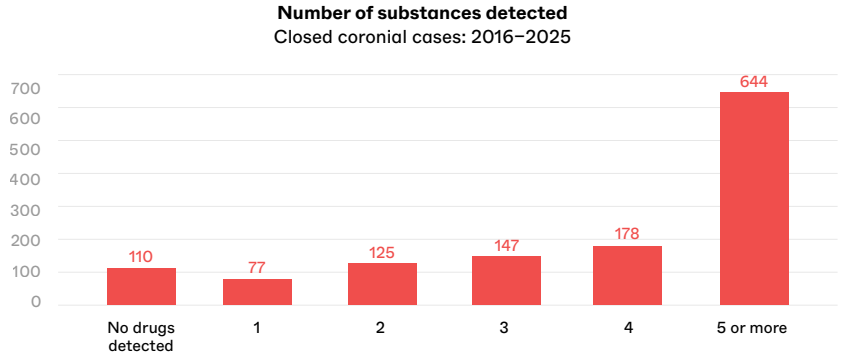


Alcohol features in many overdose cases, particularly those where more than one substance is detected. Alcohol can add to the risk of overdose death, particularly when it is mixed with other depressant drugs such as opioids, benzodiazepines, or synthetic cannabinoids.

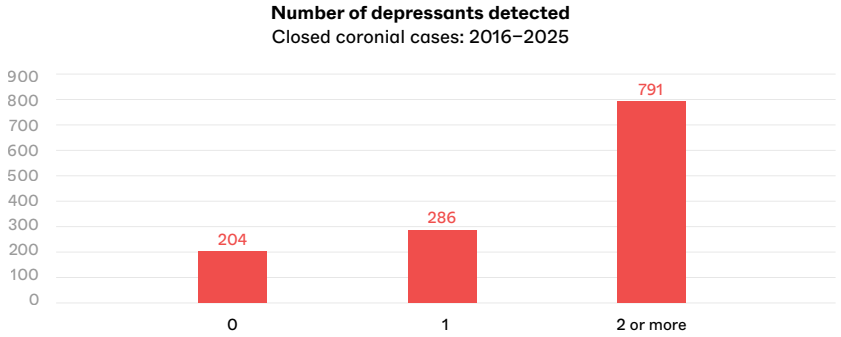
According to mortality data, between 2016 and 2022, alcohol was involved in more than half (53.6%) of all overdose deaths.

Multiple substances and fatal overdose

Most fatal overdoses in New Zealand involve more than one drug or medicine. Between 2016 and 2025, more than one substance was involved in 85.4% of closed cases. Five or more different substances were involved in just over half (50.3%) of the closed cases.



Depressants are substances that slow down the nervous system, and may cause the heart or a person's breathing to slow down. These substances include benzodiazepines, opioids, alcohol, and others. Mixing depressants can be particularly dangerous due to their additive effects. A depressant drug was involved in 84.1% of closed cases. More than one depressant was involved in 61.7% of closed cases.



*Nearly half of the cases from 2025 are still under active coronial inquiry.

Novel psychoactive substances

Novel psychoactive substances (NPS) are manufactured to mimic the effects of well-known illicit drugs. This is a wide group of substances that includes synthetic cathinones ('bath salts'), synthetic cannabinoids ('synnies'), novel benzodiazepines (e.g., etizolam, bromazolam), and novel synthetic opioids (e.g., nitazenes).

NPS can be difficult to test for, and some are not part of routine toxicology screening.

NPS appeared in 9.2% of closed cases between 2016 and 2025, featuring 196 times in total (some cases involved more than one).

Synthetic cannabinoids were most common, but novel benzodiazepines, novel opioids, and novel stimulants also featured in cases.

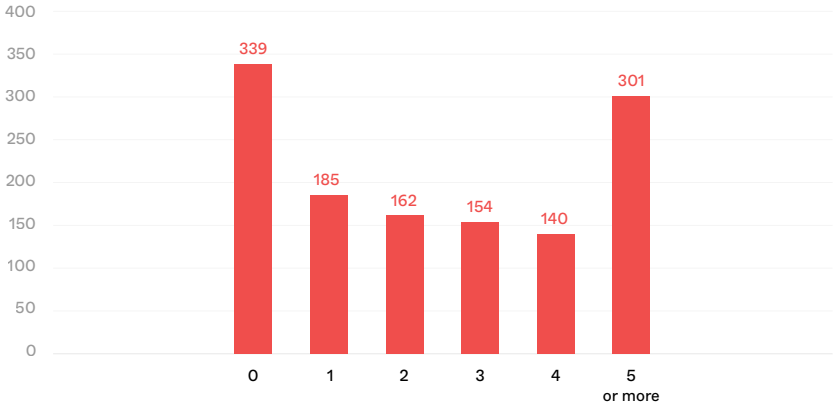
Medicines and fatal overdose

Medicines are involved in many overdose deaths in New Zealand.

We don't know whether these medicines were used as prescribed, diverted, or illicitly made. Either way, it is important to consider how they can interact with illicit drugs.

Closed cases commonly involved medicines. At least one medicine was involved in 73.5% of all closed cases, and 23.5% of closed cases involved five or more medicines.

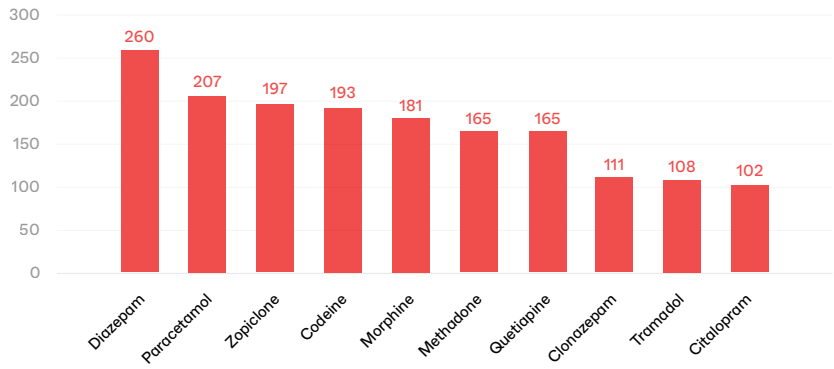
Number of medicines detected
Closed coronial cases: 2016–2025



Some medicines feature more heavily in overdose death cases.

Twenty different medicines featured over 50 times each in closed cases. Diazepam, paracetamol, zopiclone, and codeine were the most common medicines appearing in closed overdose cases.

Ten most commonly involved medicines
Closed coronial cases: 2016–2025



Non-fatal overdoses
Drug poisoning presentations: public hospital discharge data

A non-fatal overdose is a major predictive factor for a future fatal overdose.

Very little research has been done to determine the incidence of non-fatal overdose in New Zealand. In this section, we present hospitalisation data from the National Minimum Dataset (NMDS), provided to the NZ Drug Foundation under an Information Sharing Agreement with the Te Whatu Ora Data Services team.

This data is only the tip of the iceberg of non-fatal drug overdoses in Aotearoa. Our analysis only captures cases where people presented to hospital, were assessed and either admitted, transferred, or discharged. It does not include people who were treated by ambulance teams, received help from members of the community, or presented to after-hours clinics or GPs.

Many people who experience a non-fatal overdose don't receive any help at all.

Some recover without treatment. Others die before getting help and are counted in fatal overdose figures.

Hospitalisation data caveats

The NMDS data we present covers all Te Whatu Ora regions and uses the same measures across all regions between 2016 and 2025. We only included cases of people aged 15 and over in the data.

We present cases where the ICD-10 diagnostic code for the primary diagnosis included poisonings with the following substances:

- Opioids
- Stimulants
- Cannabis (may include some synthetic cannabinoid cases)
- Hallucinogens
- Other narcotics and psychotropics (includes most synthetic cannabinoid cases)
- Benzodiazepines (and barbiturates: very small number of cases)
- Alcohol

We believe that the criteria for selection of cases are conservative and will likely result in undercounting of accidental drug poisoning cases. We removed all cases where there were any codes present that could indicate intentional self-harm or poisoning by assault. We did not include cases where the substance involved was unknown. Cases where poisonings were present as non-primary diagnosis only were also excluded.

Anecdotal evidence suggests that occasionally cases that should have been classified as accidental poisonings are misclassified as intentional self-harm.

This analysis assumes the validity of clinical diagnoses recorded and does not include toxicology data. Because of the limitations of ICD-10 coding and lack of toxicological data, this analysis is unable to provide information on NPS poisonings.

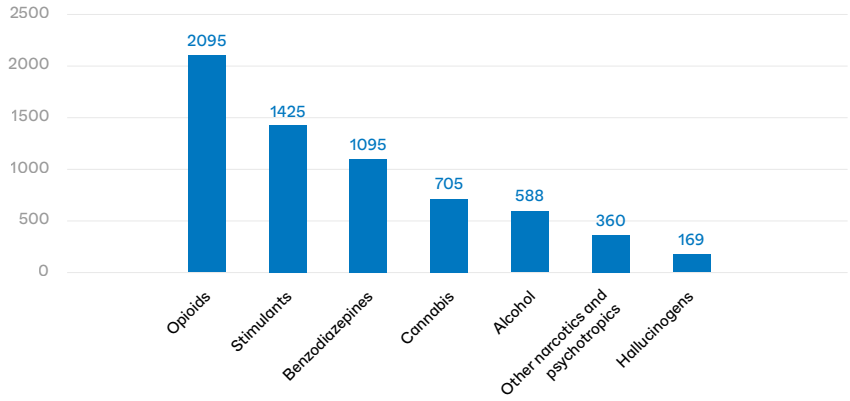
There may be small changes in the data we report on from year to year, due to data-extract coding variations.

It is important to remember that not all accidental poisonings covered in this analysis resulted from deliberate ingestion of a substance. Some cases may involve someone unknowingly consuming a substance, though this is rare among adults.

Hospital presentations for drug poisonings

In 2025, there were 579 hospital presentations for drug poisonings. The most commonly implicated substance class was opioids, followed by stimulants and benzodiazepines.

Drug poisoning hospitalisations by substance class
2016–2025

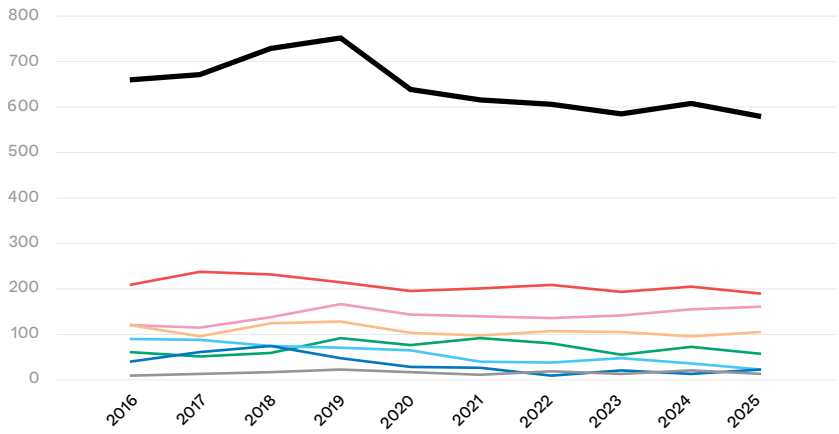


Ten-year trends in drug poisonings resulting in hospital presentation

Hospitalisation trends for most substances have been stable or falling over the past ten years. Stimulant presentations are the exception, and have been rising since 2022.

Wastewater testing data shows significant recent increases in cocaine and methamphetamine use, so we expect this rise to continue.

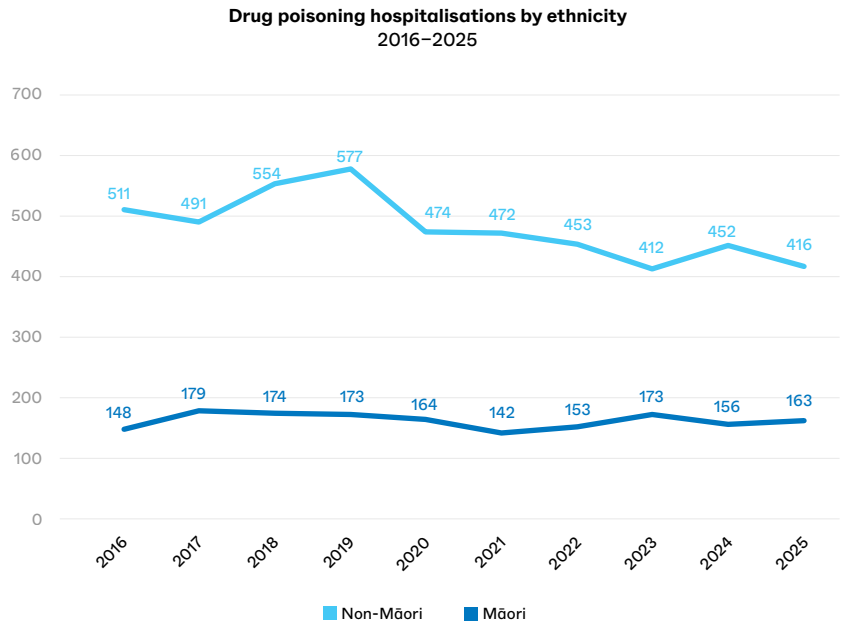
Drug poisoning hospitalisations by substance class
2016–2025



	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Alcohol	91	90	75	72	67	42	40	49	38	24
Benzodiazepines	122	96	126	129	105	99	108	106	97	107
Cannabis	62	52	61	92	77	92	81	57	73	58
Hallucinogens	10	15	18	24	18	12	20	15	22	15
Opioids	210	238	233	216	197	201	210	194	206	190
Other narcotics and psychotropics	42	63	76	49	30	28	11	22	15	24
Stimulants	122	116	139	168	144	140	136	142	157	161
Total	659	670	728	750	638	614	606	585	608	579

Hospital presentations for drug poisonings over time by ethnicity

The number of presentations has been falling for non-Māori New Zealanders over the last five years. However, presentations have remained stubbornly high for Māori.



Deaths among people seen at New Zealand hospitals for drug poisoning

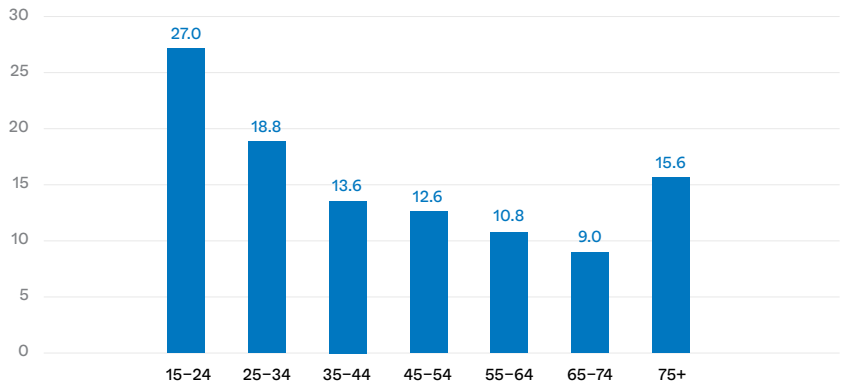
Between 2016 and 2025, 44 (0.68%) of 6,437 hospital presentations for drug poisoning resulted in death.

This low rate is not surprising, as people who reach hospital usually get timely care. Their poisonings may also have been less severe than those of people who died before getting help.

Hospital presentations for drug poisonings by age group

Relative to population size, 15–24-year-olds had the highest rate of poisoning resulting in hospitalisation, much higher than any other age group.

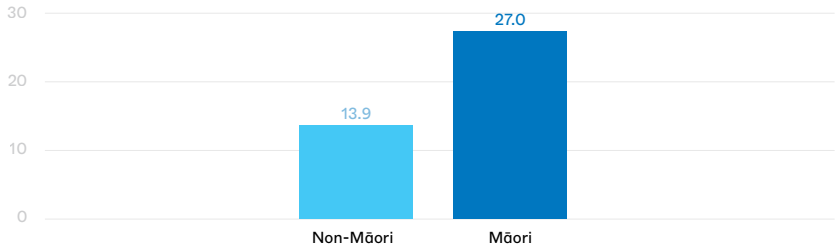
Annual drug poisoning hospitalisations by age group 2016–2025
per 100,000 population aged 15 and over



Hospital presentations for drug poisonings by ethnicity

Relative to population size, Māori had twice the rate of drug poisonings that resulted in hospital visits compared to non-Māori in New Zealand.

Annual drug poisoning hospitalisations by ethnicity 2016–2025
per 100,000 population aged 15 and over



Summary and recommendations

The number of accidental overdose deaths in New Zealand remains stubbornly high, and may be on the rise. While the most recent figures are provisional, the 169 possible overdose deaths in 2025 warrant serious concern.

Māori continue to bear the greatest burden, suffering fatal overdoses at over twice the rate of non-Māori.

At the same time, people aged 45–54 have a higher rate of accidental fatal overdose than other age groups.

We continue to see worrying trends. These include a concerning proportion of stimulant-related deaths and hospitalisations. We also see some novel substances appearing in coronial data for the first time.

While our classification method likely overestimates the number of recent cases where alcohol was the cause of death, the number of recent alcohol-related overdoses may have increased. Alcohol continues to be involved in more than half of overdose cases.

Accidental overdoses are preventable.

We urgently need to shift our approach in order to reduce harm, prevent fatal overdoses, and prepare ourselves for major changes in drug supply.

Our recommendations

1. Develop and resource a comprehensive overdose prevention programme in Aotearoa, including targeted interventions for groups at elevated risk of fatal overdose (e.g., Māori and people aged 45–54)

This should include implementing the recommendations from our overdose prevention plan. There are some key actions that require urgent implementation:

- Interventions should target both those who have presented to hospital for drug poisoning and those who have never been in contact with the health system about their substance use. This is part of a set of interventions that the government has committed to in the *Action Plan to Prevent and Reduce Substance Harm 2026 – 2029*, and it should be rolled out as soon as possible.
- As opioids continue to be the leading underlying cause of death in accidental overdose cases, a funded take-home naloxone programme must be rolled out to avoid these preventable deaths.

2. Build a national overdose surveillance system

Reports like ours cannot replace a sustainable, standardised, and timely mechanism to track overdose deaths and non-fatal overdoses. A dedicated surveillance system is crucial for us to respond effectively and to help shape policies and services that will prevent overdose mortality.

3. Ensure our legislation and regulations enable action, including passing laws that encourage people to call for help when at risk of serious harm, like Good Samaritan overdose laws

Politicians must enable communities to protect each other from harm. Beyond major drug law reform, there are many examples of minor legislative and regulatory changes that will save lives, such as a Good Samaritan amendment or allowing non-commercial distribution of safer drug-use equipment.

Implementing interventions like overdose prevention centres or enabling legal trip sitting will save lives in Aotearoa New Zealand.