



Public Health
England

Protecting and improving the nation's health

Trends in drug misuse deaths in England, 1999 to 2014

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

This report presents year-by-year data on drug misuse deaths in England from 1999 to 2014. The Office for National Statistics (ONS) reported a **17% increase in drug misuse deaths registered in England in 2014**, following an increase of 21% in 2013.

Public Health England, DrugScope and the Local Government Association held a national summit on drug-related deaths in January 2015, leading to a published **report** on the main points of the discussion at the summit and the publication of the first **trends report** by PHE using ONS data in July 2015. This report is an update to incorporate the most recent ONS data.

Presented by year of death, the updated analysis suggests that there was an increase of at least 17% in the number of drug misuse deaths between 2012 and 2013. Data for 2013 is assumed to be an undercount of the actual number occurring in that year as not all deaths in 2013 will yet have been registered. Provisional data for 2014, which will be significantly incomplete, suggests a further increase.

Across the period studied, opiates are the type of substance most frequently mentioned in drug misuse deaths, consistently mentioned in over four-fifths of deaths. The most commonly mentioned opiate drug is heroin, followed by methadone and tramadol. There was an increase of at least 21% in opiate deaths in 2013.

Alcohol was mentioned in combination with illicit drugs in just over one third (36%) of drug misuse deaths in 2012, a proportion that has remained similar in recent years.

Benzodiazepines are the most commonly mentioned non-opiate drug in drug misuse deaths (16% in 2012) and there was an increase of at least 21% in benzodiazepine deaths in 2013. Benzodiazepines are rarely the only drug mentioned in a death.

Mentions of cocaine and amphetamines have risen since around 2010, having fallen markedly before this. Drug misuse deaths where a new psychoactive substance (NPS) was mentioned continued to rise in 2012 (4% of drug misuse deaths), but provisional figures for 2013 suggest a fall, in contrast to the overall rise in drug misuse deaths.

Among heroin deaths, there is a clear long-term trend towards increased mentions of other substances alongside heroin, including alcohol, benzodiazepines and methadone, indicating increasingly complex poly-substance deaths.

The median age at drug misuse death has increased from 32 in 1999 to 41 in 2012. The majority of drug misuse deaths are among men (72% in 2012), although there is a long-term trend of increasing numbers among women.

Over three-quarters of drug misuse deaths in 2012 were accidental poisonings. The remainder are classed as suicide and involve relatively high proportions of women, people from older age groups and mentions of opiates other than heroin and methadone.

An update of the matching undertaken between the ONS data and community treatment data from the National Drug Treatment Monitoring System (NDTMS) for 2007–2014 suggested a continuation of known trends:

- the majority of individuals who suffered opiate misuse deaths in 2012 had not been in treatment since at least the start of 2007
- there was little change in the proportion of opiate misuse deaths where the individual had recently been in treatment (ie, within one year), although there was a slight increase in the proportion where the individual was currently in treatment

In addition, the updated matching found that the substantial increase in opiate misuse deaths in 2013 was slightly more pronounced for those with recent treatment compared to those who had not had treatment in the past year.

PHE continues to investigate the trends around drug misuse death, including setting up a national expert group to lead a national inquiry in 2016. Five local events around England will review what is known nationally about DRDs, what local areas can tell us and what can be done to prevent deaths. The national group will then consider the findings alongside other relevant intelligence and publish conclusions and recommendations on what else needs to be done.

Driven by the findings of the inquiry and by what we already know about drug misuse deaths and their prevention, PHE will:

- now consider what additional advice and support we can provide to local authority commissioners and drug treatment providers
- support improvements in local drug death review processes in 2016–17
- continue to support local areas to further improve access to treatment, which appears to have a continuing protective effect
- continue to provide commissioners with advice on provision of the opioid antagonist naloxone, following the legislative change to allow drug services to more easily supply naloxone
- through the 2016 update to the clinical guidelines for drug misuse and drug dependence, cover many of the factors involved in drug-related deaths, such as smoking behaviour and supervised consumption of opioid substitute medicines
- in 2016–17, improve the collation, analysis and dissemination of intelligence on the adverse health effects of a range of drugs

Introduction

Drug misuse is a significant cause of premature mortality in the UK. Analysis of the Global Burden of Disease Survey 2013 shows that drug use disorders are now the third ranked cause of death in the 15–49 age group in England.¹ Nearly one in nine deaths registered among people in their 20s and 30s in England and Wales in 2014 were related to drug misuse.^a Preventing drug-related deaths should be a core aim of all local drug treatment systems.²

A reported rise in drug misuse deaths registered in 2013 led PHE, DrugScope and the Local Government Association to host a national summit in January 2015. DrugScope's report of the summit described the rise as 'a cause for concern among a wide range of stakeholders in the fields of drug and alcohol treatment, policy and research'.³ PHE presented early findings of its analysis of ONS and National Drug Treatment Monitoring System (NDTMS) data and then published a **more detailed trends report** to follow DrugScope's report. The briefing was intended to provide local authority commissioners and drug treatment providers with further insight on the current situation and recent trends in relation to drug misuse deaths.

A further reported rise in drug misuse deaths registered in 2014 prompted this update to the first trends report and to the convening of a national inquiry. The inquiry will scope further detailed investigation, draw conclusions from the findings and make recommendations for how premature deaths associated with drug misuse can be prevented. The analysis is updated to include drug misuse deaths registered in 2014.

Reporting methodology

Criteria for inclusion and method of reporting

This analysis is based on data from the drug poisoning database collected by the Office for National Statistics (ONS). ONS reports annual mortality statistics based on the year deaths are registered. ONS estimates that the median delay to register a drug misuse death is currently between five and six months and that around half of drug misuse deaths are registered in a different calendar year to the year the person died.⁴ These delays occur because overdose deaths are routinely referred to coroners and are subject to an inquest, and in England a death cannot be registered until an inquest has been completed.⁵

^a Figure supplied by ONS upon request for use in this briefing.

The analysis included in this briefing is reported according to the year that each death occurred, and the reasons for doing so are discussed in our [first briefing](#). To be included in this analysis, a death must have been registered by the end of 2014. This means that figures reported for 2014 will be significantly lower than the actual number of drug misuse deaths that occurred in that year, as many deaths will not yet be registered in time. Figures for 2013 will also be an undercount, though to a much lesser degree, while 2012 and earlier can be regarded as effectively complete.

To account for data incompleteness, the following approaches are taken when reporting by year of death:

- figures for 2013 are reported throughout, but lines between 2012 and 2013 are dotted on graphs
- an overall figure for 2014 is reported in Figure 1 but the line between 2013 and 2014 is both dotted and faded
- 2012 is generally used in the text as the latest complete year. Later years are referred to in the text where these might offer additional insight (eg, where the provisional figure for 2013 already exceeds the figure for 2012)

Reporting by substance and definition of 'drug misuse death'

Where we report by substance, this means that the substance was mentioned on the death certificate. A mention of a substance does not necessarily mean that the substance was implicated in the person's death, unless it is the only substance mentioned. Where the report refers to, for example, 'heroin deaths', this terminology is used for brevity and the above meaning still applies.

Only deaths that fit the UK 'drug misuse' definition are included in this analysis. This definition takes into account the underlying cause of death and mentions of substances controlled under the Misuse of Drugs Act 1971 (MDA), seeking to identify deaths related to drug misuse. Although data is available back to 1993, ONS advises that the baseline year for monitoring deaths related to drug misuse was set as 1999 and accordingly this is used as the start point in this analysis.⁶

Format of report

The report has two sections. The first considers trends in drug misuse deaths in England, including breakdowns by substances mentioned, age, gender, cause of death and regional differences. The second shows the results from matching data on drug misuse deaths to drug treatment data to explore the timing of drug misuse deaths in relation to treatment. The report concludes with the next steps for PHE in this area.

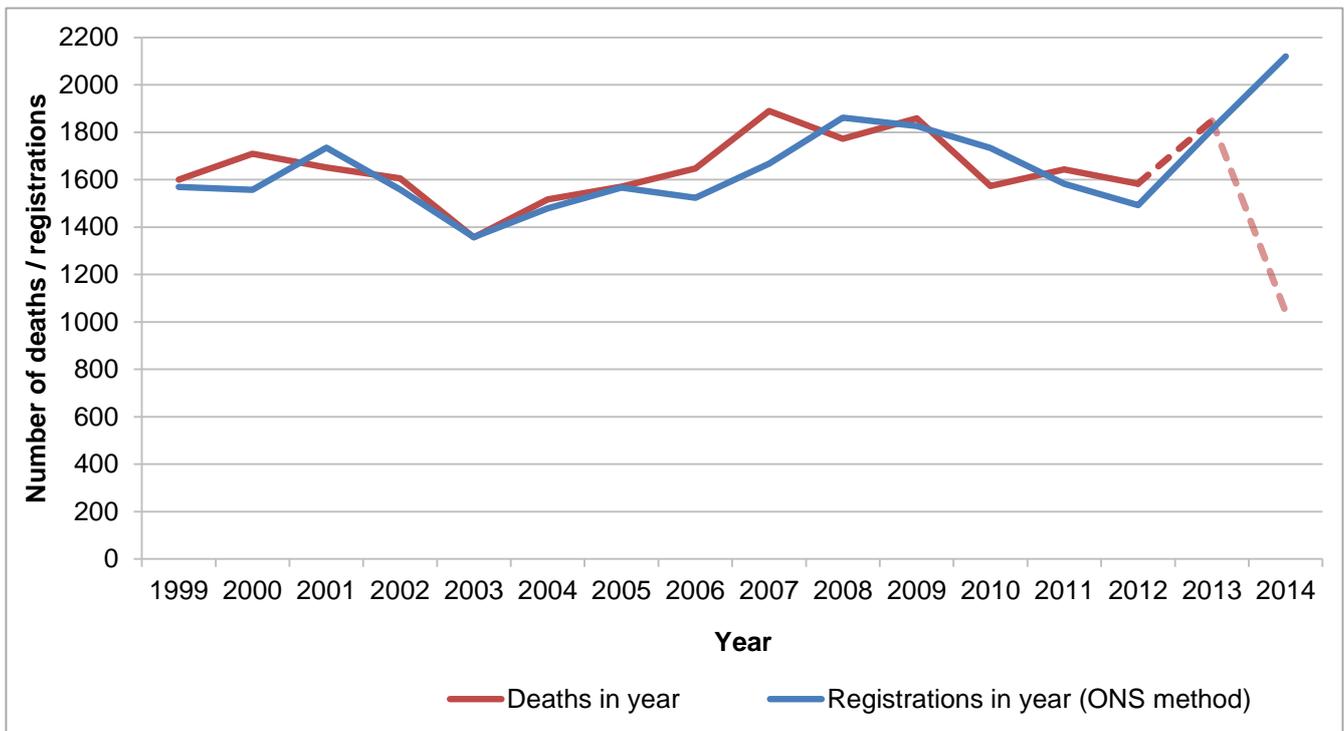
Section 1. Trends in drug misuse deaths in England

Overall trends

Figure 1 shows the trend in drug misuse deaths in England from 1999 onwards. For comparison, the graph also shows the ONS published statistics (based on year of registration). In September 2015, ONS reported a 17% increase in the drug misuse mortality rate in 2014, following a 21% increase in 2013. This translates to a 42% total increase between 2012 and 2014. The recent increases followed four successive annual falls between 2008 and 2012.

As noted in our [first briefing](#), reporting by year of death has in some years resulted in notably different year-on-year changes than reporting by year of registration. However, the updated figure for deaths occurring in 2013 corresponds very closely to the figure reported for 2013 based on year of registration. This suggests at least a 17% increase in drug misuse deaths occurring between 2012 and 2013, and the 2013 figure should still be regarded as provisional.

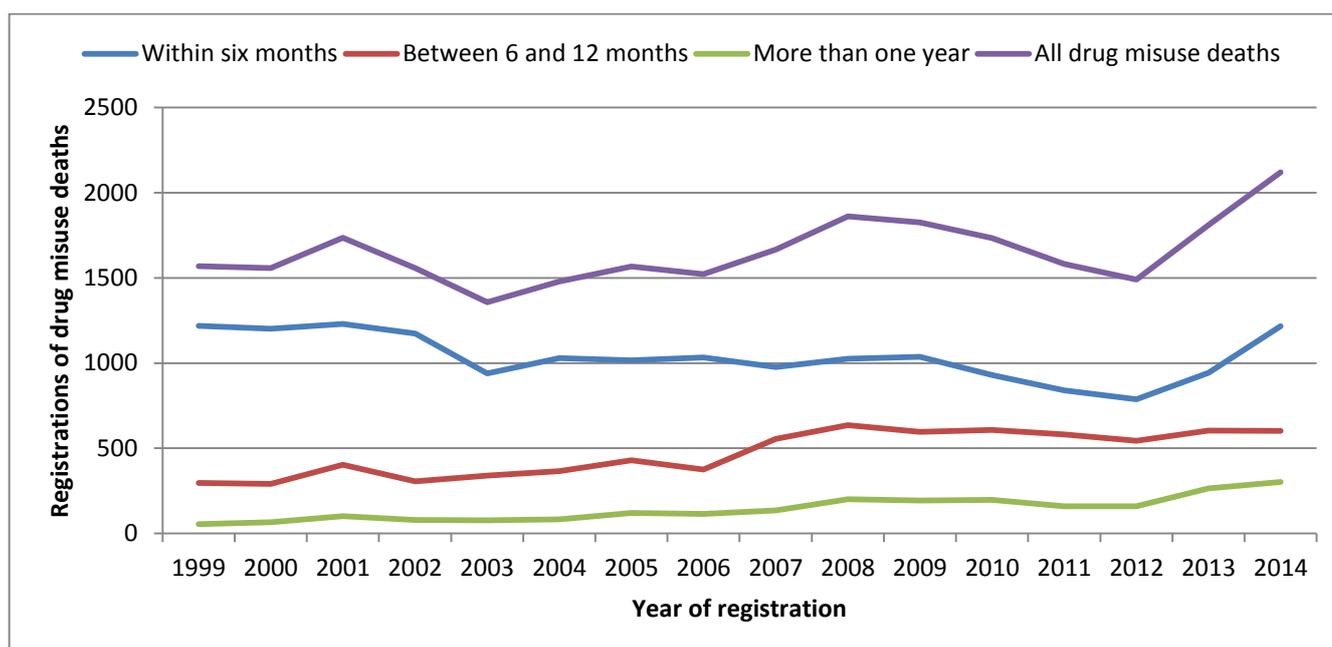
Figure 1. Drug misuse deaths by year of death compared to by registration year



Note: Dotted and faded lines on graphs reflect incomplete data for later years (see reporting methodology)

Figure 2 shows the breakdown of deaths registered in each year according to the time to register the death. In our [first briefing](#), we noted that there had been a large increase among 2013 registrations in the number of deaths which had been registered after more than a year in addition to a large increase in deaths registered within six months. The increase in registrations reported in 2014, by contrast, is predominantly accounted for by deaths registered within six months. There were 1,042 drug misuse deaths occurring in 2014 which were registered in that year, the highest such figure recorded to date, suggesting a likely continuation of this trend.

Figure 2. Drug misuse deaths registered each year, by time to register death



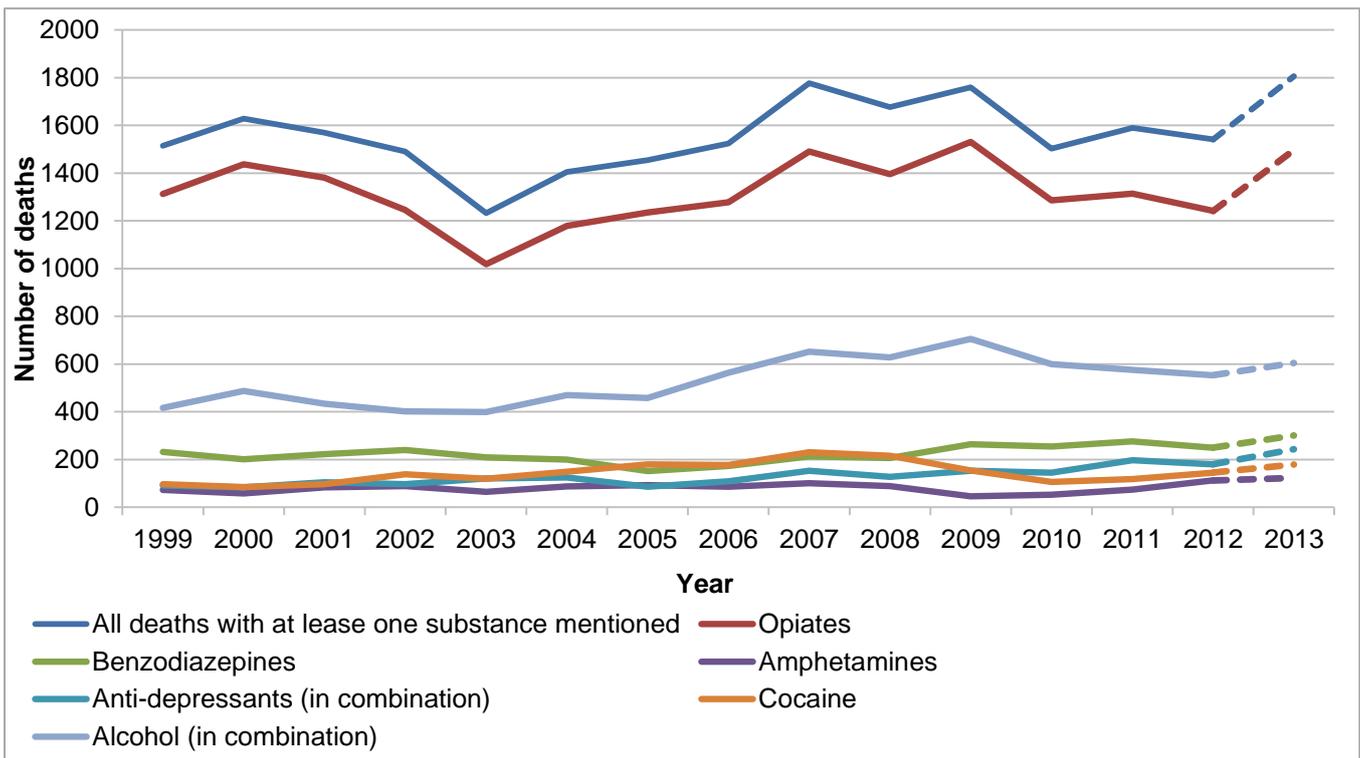
Substances mentioned

Figure 3 shows the breakdown of substances mentioned in drug misuse deaths over the period for key substance groups. For this breakdown, an individual death may be counted in more than one of these classes and drug misuse deaths with unspecific information^b are excluded (3% in 2012). Provisional figures for 2013 confirm that there were increases across all the substance groups reported in Figure 3 – ie, the provisional number of deaths in 2013 exceeds the figure for 2012. Throughout the whole period, the large majority of drug misuse deaths included the mention of at least one opiate (81% in 2012). Changes in numbers of drug misuse deaths over this period, including the increase for 2013, are largely accounted for by changes in deaths involving in opiates. The number of opiate deaths increased by at least 21% in 2013.

^b Where the available information is too vague to enable any classification by substance group, eg, mention of 'drug', 'narcotic'

Alcohol remains the most commonly mentioned other substance (36% in 2012). It should be noted that alcohol must be in combination with an illicit substance to be included in these figures. In total, ONS reported that 6,831 alcohol-related deaths were registered in England in 2014, more than three times the total number of drug misuse deaths registered.⁷ Benzodiazepines have been the most commonly mentioned non-opiate substances in drug misuse deaths for each year since 2009, although they are rarely the only substance mentioned in a death.

Figure 3. Drug misuse deaths in each year, by substance groups



Notes: i) Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology); ii) Where a substance group is listed as 'in combination', this means it would not itself qualify for the drug misuse definition, so must be reported alongside another substance.

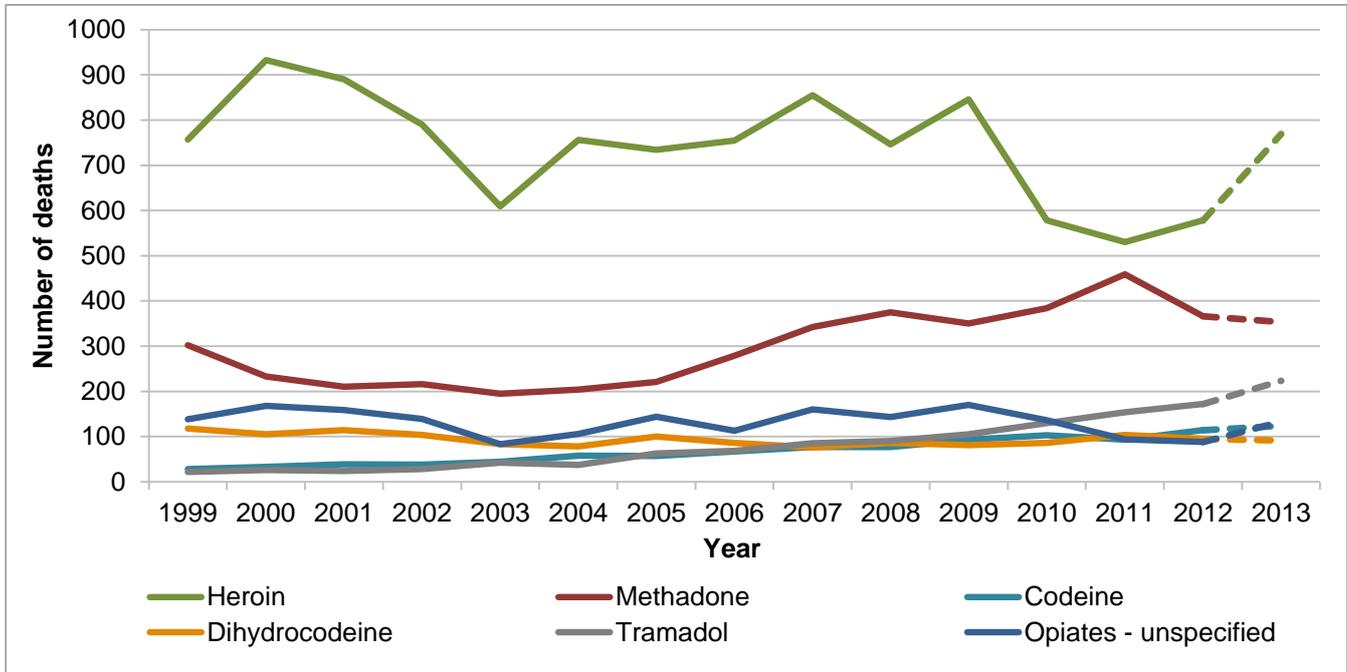
Figure 4 shows a breakdown of opiate deaths by the five most commonly mentioned opiate drugs in recent years. In a substantial number of cases, no further information was available beyond that an opiate was mentioned, and this figure is also reported, as 'Opiates – unspecified'.

Heroin was the most commonly mentioned opiate drug in drug misuse deaths throughout the period.^c The peak year for heroin deaths was 2000 (933 deaths), following which there were several year-on-year falls through to 2003 (609 deaths). Heroin deaths then generally increased until 2009 (846 deaths), followed by a sharp fall in 2010 and a further small fall in 2011 (575 and then 530 deaths). However, heroin

^c 'Heroin deaths' in this report may also include deaths where morphine was mentioned.

deaths increased again in 2012 (578 deaths) and then rose by at least a third in 2013 (at least 769 deaths). Provisional 2014 data suggests a further increase is likely.

Figure 4. Mentions of opiates, by year



Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

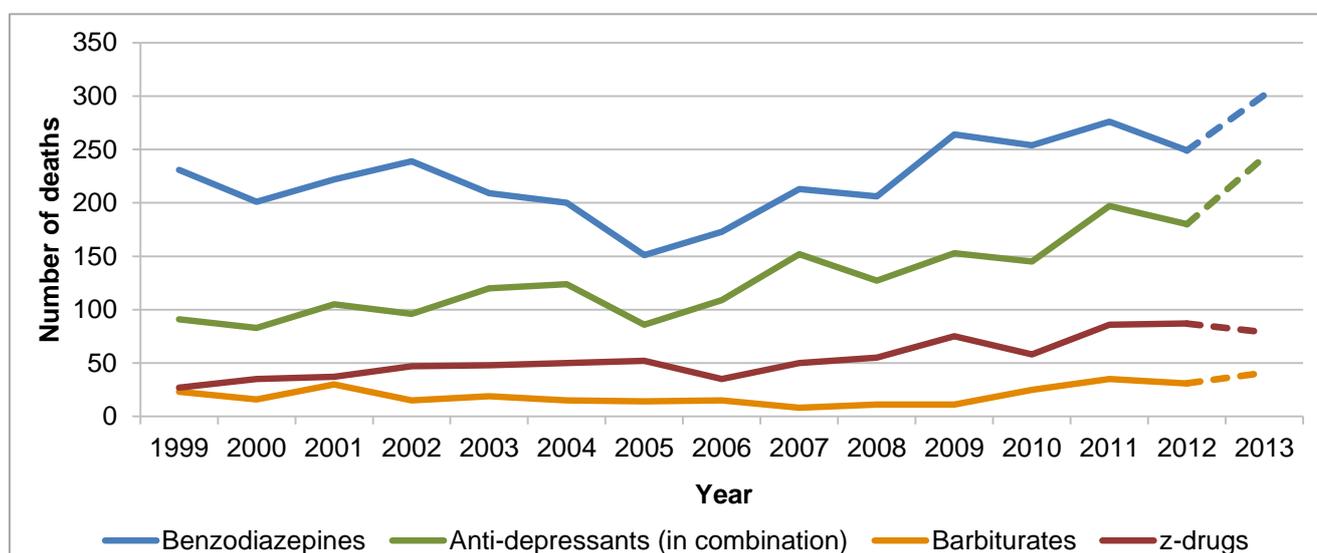
Having fallen from a peak of around 300 deaths in the late 1990s, mentions of methadone in drug misuse deaths began to increase from 2004. The drug treatment system rapidly expanded throughout the 2000s and there was therefore a considerable increase in the amount of methadone prescribed, which may partially explain increases in methadone deaths. Strang et al (2010) developed an index to show this relationship and found that methadone deaths as a function of methadone prescriptions in England had reduced from the late 1990s (up to 2008), which they suggested was ‘closely related to the introduction of supervised dosing of methadone’.⁸ Following a slight fall in 2009, methadone deaths increased again, peaking at 459 in 2011, when heroin deaths were at their lowest. However, again in contrast to heroin deaths, methadone deaths fell in 2012 (366 deaths). The provisional figure for 2013 is similar to 2012.

In recent years, tramadol has been the third most commonly mentioned opiate on death certificates, with year-on-year increases from 2004 onwards to 172 in 2012 and at least 223 in 2013. Current figures still predate tramadol being controlled as a Class C drug under the MDA in 2014 and, therefore, it remains to be seen what impact this change may have in counteracting this rising trend. Drug misuse deaths where codeine was mentioned have also increased in recent years, with 114 in 2012 and at least 124 in

2013, while mentions of dihydrocodeine have remained at a similar level to this since the late 1990s, with 95 deaths in 2012 and at least 91 in 2013.^d Oxycodone and fentanyl remain the next most commonly mentioned opiate drugs, with at least 44 and 31 in 2013 respectively, and buprenorphine was mentioned in at least 18 deaths in 2013. Mentions of other opiates are rare at present, although some have been more commonly mentioned historically, such as dextropropoxyphene.

Figures 5a and 5b show the numbers of mentions of selected non-opiate substances in death certificates, in more detail than Figure 3 allows. These are split into two categories: Figure 5a shows anti-depressants, sedatives and hypnotics, while Figure 5b shows deaths related to stimulants (cocaine and amphetamines) as well as new psychoactive substances.

Figure 5a. Mentions of anti-depressants, sedatives and hypnotics, by year



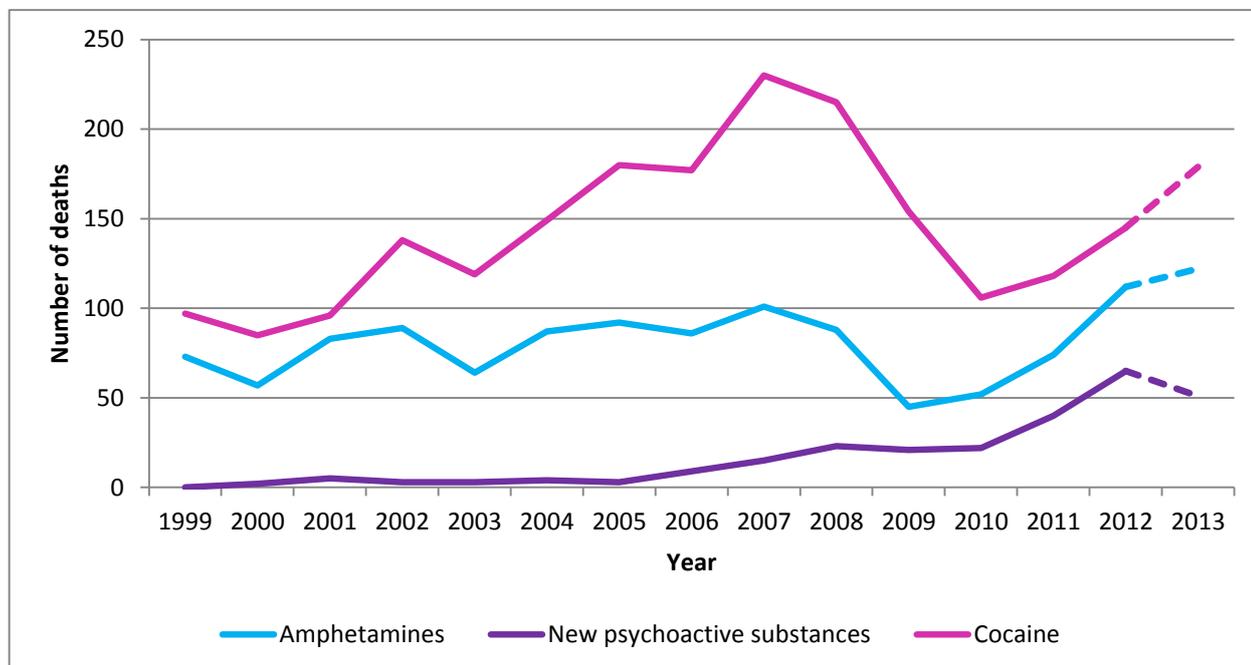
Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

Benzodiazepines are the most commonly mentioned substance in drug misuse deaths aside from opiates and alcohol (249 deaths, 16% of deaths in 2012). There was at least a 21% increase in benzodiazepine deaths in 2013, to a provisional figure of 301 deaths. In 2012, the majority of benzodiazepine deaths mentioned diazepam (166 deaths, or 67%), while there has been a reduction in the number of mentions of temazepam from (29 in 2012). The large majority of benzodiazepine deaths involve other substances (96% in 2012), mainly opiates (87%). Mentions of anti-depressants in combination with illicit substances have risen in recent years with 180 deaths in 2012 and at least 243 deaths in 2013 (at least a 35% increase). As with alcohol, it should be noted that anti-

^d Codeine and dihydrocodeine mentioned as part of a compound (eg co-codamol) are not counted towards the definition of drug misuse, so totals for codeine and dihydrocodeine do not represent all poisonings involving these drugs.

depressants do not meet the definition of drug misuse, so this represents a subset of anti-depressant deaths where an illicit substance is also mentioned.

Figure 5b. Mentions of stimulants and new psychoactive substances, by year



Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

Figure 5b shows that mentions of cocaine and amphetamines had fallen markedly after peaking around 2007, but they have increased again in recent years. Provisional figures for 2013 indicate at least 179 deaths mentioning cocaine (at least a 23% increase on 2012) and 122 mentioning amphetamines. Within the amphetamines category, mentions of MDMA dropped sharply after 2007 but appear to be increasing again (40 in 2012). Another recent development has been deaths involving PMA or PMMA: there were at least 57 such deaths in 2012 and 2013, with very few prior to 2012.

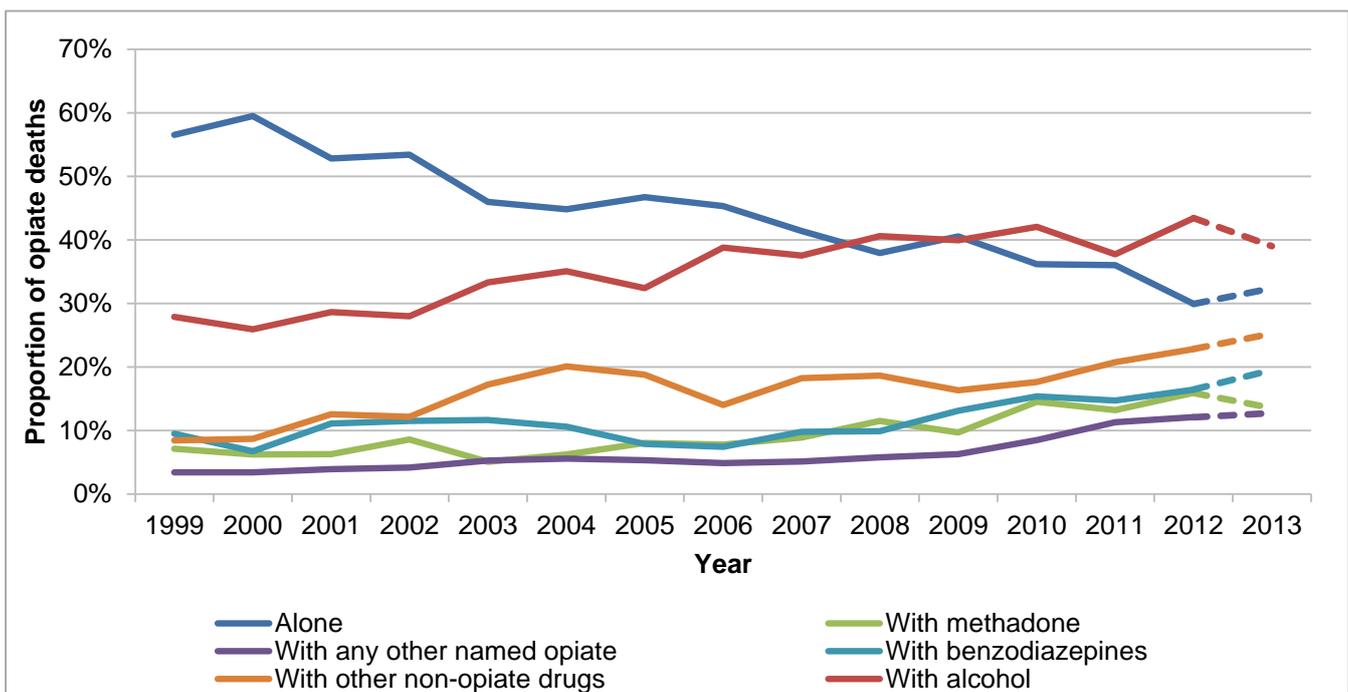
From 2006, mentions of new psychoactive substances (NPS) classed as drug misuse deaths, using the definition provided by ONS⁵, increased to 65 deaths in 2012 (4% of all drug misuse deaths). This included a range of different drugs classed as NPS. However, provisional data for 2013 indicates a possible small fall in that year – there are 51 known NPS deaths, which is 3% of all known drug misuse deaths in this year. Despite often being referred to as ‘legal highs’, the NPS mentioned are often controlled substances under the MDA (such as mephedrone and GHB), and most NPS deaths are counted as ‘drug misuse’ deaths using the ONS definition.

As well as considering each substance mentioned individually, it is also useful to consider the combinations of substances reported against drug misuse deaths. Figure 6 shows the breakdown of heroin deaths by the other substance(s) mentioned alongside heroin. This shows a general falling trend in the proportion of heroin deaths where only

heroin was mentioned (30% in 2012), whereas the proportion where alcohol was mentioned alongside heroin has increased and now exceeds the figure for heroin alone (being 43% in 2012). Provisional data suggests that this gap may have narrowed in 2013. The proportion of heroin deaths where benzodiazepines were also mentioned has increased markedly in recent years, from under 10% in 2006 to 16% in 2012. The proportion where another opiate was mentioned has also increased, with methadone mentioned in 16% of heroin deaths in 2012 and other opiates mentioned in 12%, as has the proportion where other substances are mentioned: 23% in 2012, the largest shares of which were mentions of anti-depressants (10%) and cocaine (8%).

As discussed in our [first briefing](#), the clear overall trend is that heroin deaths increasingly also include other substances, and this presents a significant challenge for interpretation of the data, as it is more difficult to determine the role each substance may have had in any death.

Figure 6. Heroin deaths by other substances mentioned alongside heroin, by year



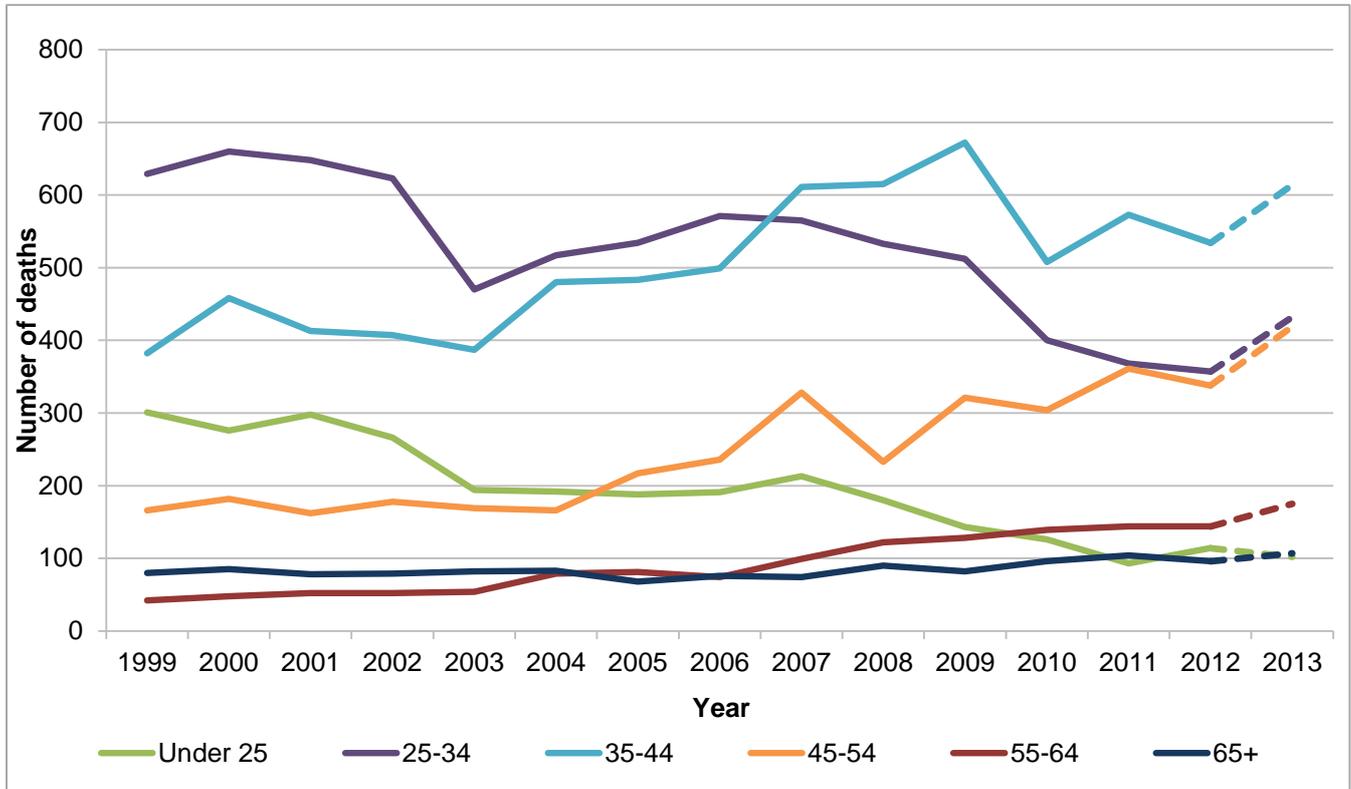
Notes: i) Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology) ii) An individual death may be counted under more than one category, except 'Alone' which is exclusive from other categories

Age and sex

Figure 7 shows the trend over time in drug misuse deaths by age group. Figures for 2013 suggest that increases were seen for all age groups compared to 2012, apart possibly from the youngest (under 25) age group, with the largest increases in the age groups between 25 and 54, which see the largest numbers of drug misuse deaths. Over this period, the median age at death increased from 32 in 1999 to 41 in 2012. This

correlates with other indications of an ageing drug using population, including those from treatment data⁹ and estimated prevalence of opiate and/or crack cocaine use.¹⁰

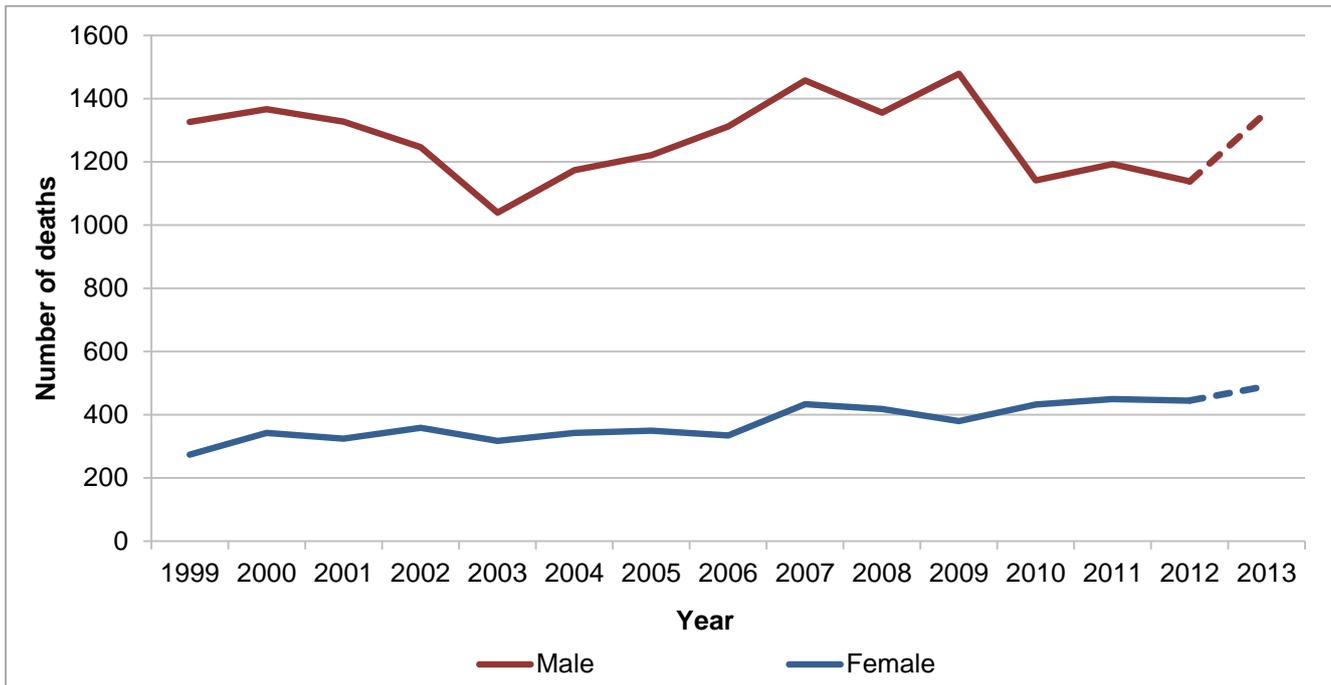
Figure 7. Drug misuse deaths, by age and by year



Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

Figure 8 (overleaf) shows the breakdown of drug misuse deaths by sex over the period. Across the period, the majority of drug misuse deaths have been among men (72% in 2012). However, deaths among women have been on a general increasing trend over the whole period. The median age at death for women who suffered a drug misuse death was higher than for men (44 compared to 39 in 2012), with the median age for both sexes generally increasing over the period.

Figure 8. Drug misuse deaths, by sex



Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

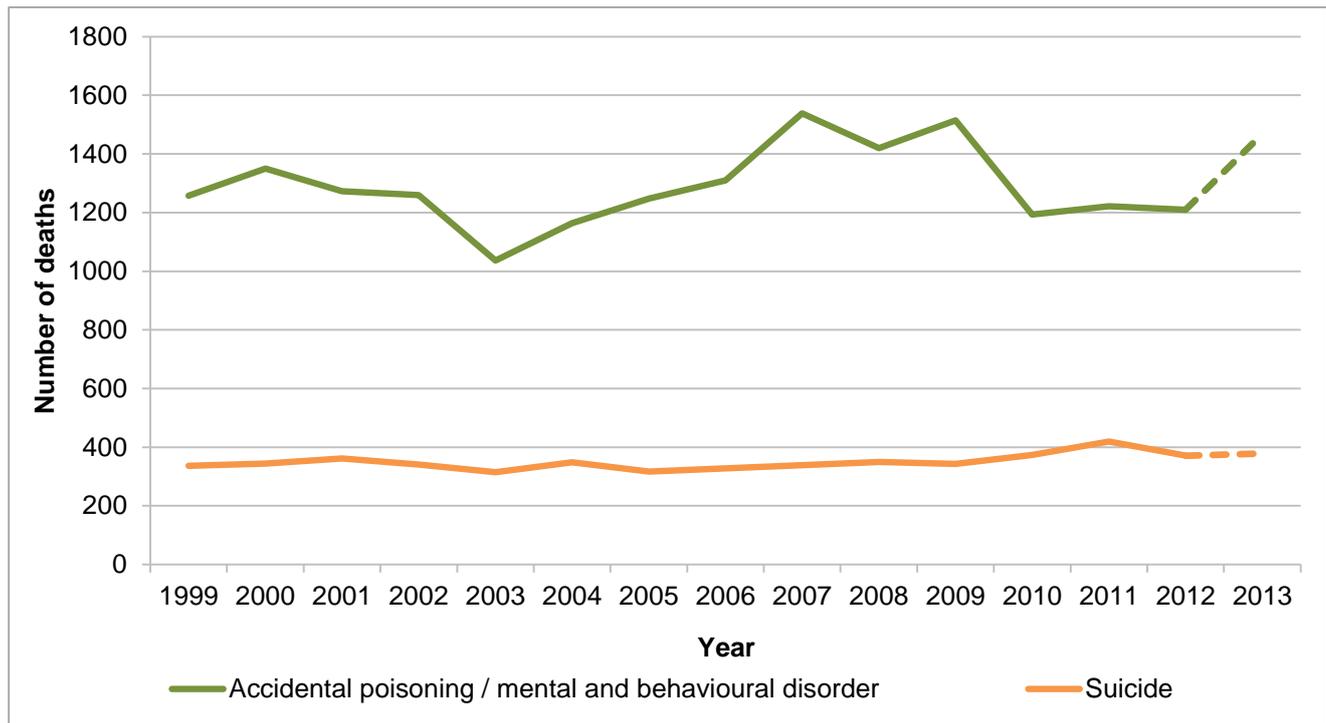
Cause of death

Figure 9 (overleaf) shows the breakdown of drug misuse deaths by the underlying cause of death. For this analysis, deaths attributed to mental and behavioural disorders due to drugs are counted as accidental poisonings^e, and in keeping with ONS methodology the term ‘suicide’ covers both intentional self-poisonings and poisonings with undetermined intent. Over three-quarters of drug misuse deaths are accidental poisonings (77% in 2012). The number of suicides (as defined by ONS)¹¹ among drug misuse deaths has slightly increased across the period.

There are considerable differences between accidental poisonings and suicides among drug misuse deaths when considered by age, sex and substances mentioned: 38% of drug misuse deaths in 2012 among those aged 45 or over and 34% of deaths among women were classed as suicides, compared to 15% of drug misuse deaths among those aged under 45 and 19% among men; 43% of drug misuse deaths involving an opiate other than heroin or methadone in 2012 were classed as suicides, compared to 15% of heroin deaths, 11% of methadone deaths, 9% of amphetamine deaths and 7% of cocaine deaths.

^e This is partly due to changes in coding practice during the period which affected the prioritisation of poisoning and mental and behavioural disorders when determining underlying cause of death.

Figure 9. Drug misuse deaths, by underlying cause of death^f



Note: Dotted line for 2013 reflects partially incomplete data and 2014 data is omitted due to being substantially incomplete (see reporting methodology)

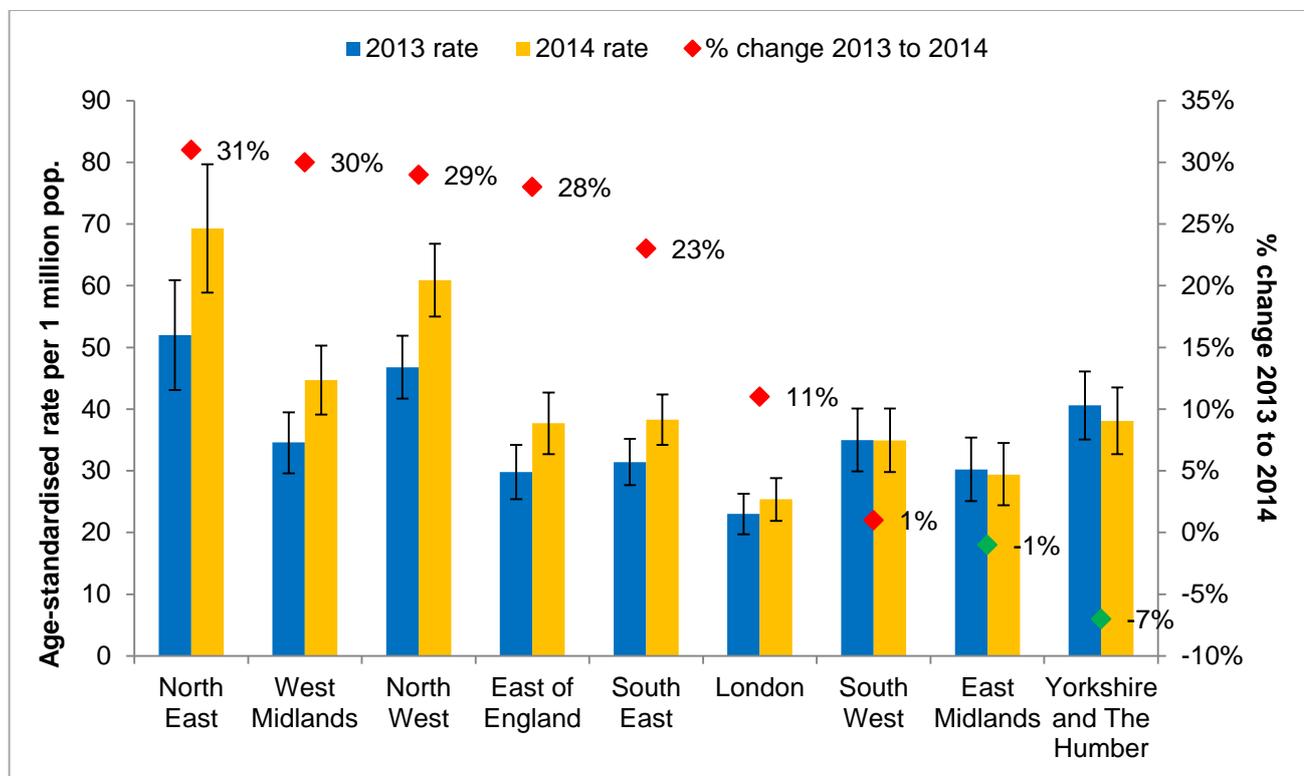
Regional variations

As in our **first briefing**, region-specific analysis is not included in this report as trends become more difficult to present and interpret at regional level. Our analyses tend to support the findings on geographical variation in drug misuse death that ONS have published.¹² We have, however, presented region-specific versions of the analyses shown in this report at regional forums in support of regional work on drug-related deaths.

Rates calculated by ONS and shown in Figure 10 show that that the North West and North East regions have significantly higher rates of drug misuse death than all other regions, while only London has a significantly lower rate than the national average.¹³ Notably, Figure 10 demonstrates that the national increases in the number of drug misuse deaths registered between 2013 and 2014 were not evident in all regions, with some regions seeing little change while other regions saw large increases, although these changes should be interpreted in the context of the broad confidence limits shown.

^f 'Assault by drugs' also falls under the definition, but is disregarded here due to low numbers.

Figure 10. Age-standardised drug misuse death rates (based on registration year), by region



Note: The source for this graph is Figure 7 of the reference table for the ONS report.

In addition, ONS published mortality rates for deaths related to drug misuse at local authority level for the first time in their 2015 bulletin.¹⁴ These are pooled into three-year periods, but nevertheless numbers are small in many areas and even more careful interpretation is required than at regional level.

Section 2. Results from matching between drug poisoning and drug treatment data

To assess the relationship between drug misuse deaths and contact with drug treatment, we undertook a high-level matching exercise between the ONS database and data from NDTMS. This is an update of equivalent analysis in our [first trends report](#).

We matched all drug misuse deaths between 2007 and 2014 to all drug treatment contacts in the community (ie, excluding prison) in the National Drug Treatment Monitoring System (NDTMS) over the same time, using a matching methodology developed for a previous published analysis.¹⁵ We then categorised deaths into mutually exclusive categories according to whether the person died:

- while in treatment
- outside of treatment, but had received treatment in the previous year. This category was divided into four further categories, reflecting both the time since the person exited and the reason for their exit:
 - successfully completed treatment within the last six months
 - successfully completed treatment between six and 12 months prior
 - exited treatment in an unplanned way within the last six months
 - exited treatment in an unplanned way between six and 12 months prior
- outside of treatment and had received treatment at some time during this period, but not in the previous year^g
- having had no treatment contact during the period studied (ie, since the start of 2007)^h

Figure 11 shows the results of this match for drug misuse deaths where an opiate was mentioned (or ‘opiate misuse death’, for brevity) for each year between 2008 and 2013 – the latter year should be regarded as partially incomplete, as in the rest of this analysis.ⁱ In 2012, 268 people suffered an opiate misuse death while in contact with drug treatment. This was around 22% of all opiate misuse deaths in that year, a proportion that has been gradually increasing (from 18% in 2008). The proportion who had successfully completed treatment in the year before an opiate misuse death was 4% in 2012, up slightly from 3% in 2008, while the proportion who had exited treatment in an unplanned way in the previous year decreased to 6% in 2012 from 9% in 2008.

^g Note that as this analysis progresses the available treatment histories are expanded, and so this group will be expected to accumulate in size as an artefact of this.

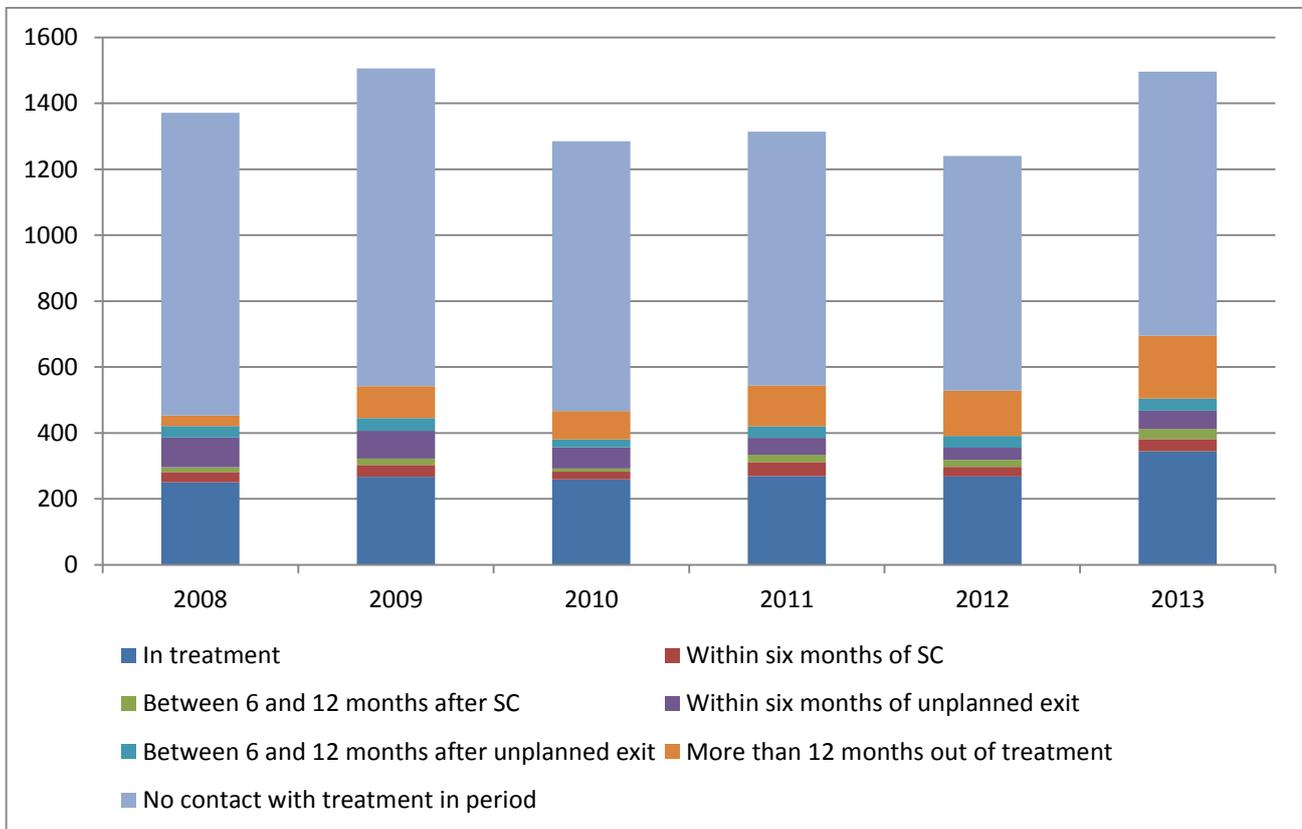
^h Conversely, this group would be expected to decrease in size over the time period as treatment histories are expanded.

ⁱ 2007 was disregarded in order to ensure that each individual was followed up for at least a year in NDTMS.

These changes may in part be accounted for by increasing numbers of people completing treatment successfully and reduced numbers dropping out of treatment over the period studied.⁹ Altogether, the proportion who had recent treatment (defined as either being in treatment when they died or having received treatment in the preceding 12 months) increased only slightly over the period: 31% in 2008 and 32% in 2012. The overall proportion with any treatment history increased from 33% to 43% between 2008 and 2012, but the large majority of this difference was attributable to those who had treatment contact more than a year previously. In 57% of opiate misuse deaths in 2012, the person had no contact with community treatment since at least 2006.

As noted in our [first briefing](#), treatment data and prevalence estimates indicate for several consecutive financial years up to 2011/12 that the majority of opiate users had recently received treatment. Considering this alongside our finding that the majority of opiate misuse deaths are outside treatment, our analysis suggests that treatment is likely to be generally protective against risk of opiate misuse death, as demonstrated in a previous paper by a research group including PHE researchers.¹⁵ However, assuming treatment penetration has remained stable in the latter years, the reasonably stable proportion of opiate misuse deaths where the person had recently received treatment would suggest little change in the protective effect of treatment in recent years.

Figure 11. Breakdown of opiate misuse deaths by treatment status, 2008–2013



Note: figures for 2013 should be regarded as partially incomplete.

Provisional 2013 figures broadly indicate a continuation of the trends described above. There were 345 known opiate misuse deaths where the person was in treatment, and this is 23% of all known opiate misuse deaths in that year. Including these, 34% had received treatment in the preceding 12 months, a 2% increase on the equivalent proportion for 2012. Figure 11 shows that the provisional substantial increase in 2013 was also observed in the numbers who suffered an opiate misuse death with no recent treatment history, but that the increase was slightly more pronounced for those with recent treatment.

In addition to updating this analysis, we have now been able to carry out a tentative match with data on drug treatment in prison, covering the period April 2012 to March 2014. This identified that 6% of those known to have suffered an opiate misuse death in the latter half of this period (April 2013 to March 2014) had been in prison treatment in the previous year. As they may also have been in community treatment, it is useful to combine this with the above analysis. Based on this, 2% of opiate deaths were among people who had received prison treatment in the past year without also receiving community treatment. It should be borne in mind that this analysis is based on a single year of data and a longer time series is needed to draw firmer conclusions. However, this initial analysis suggests that the majority of those who suffer opiate deaths had not been in drug treatment either in prison or in the community in the year prior to death.

Next steps

Following the publication of our [first briefing](#), PHE continued to investigate the trends around drug misuse death. We have convened a national inquiry into the causes and prevention of premature deaths. A national expert group has reviewed what we know and scoped the commission of further investigation, including further analysis of DRDs and related data, and of the findings of local reviews or inquiries. Five local events around England will also review what is known nationally about DRDs, what local areas can tell us, and what can be done to prevent deaths. The national group will then consider the findings and publish conclusions and recommendations on what else needs to be done.

Driven by the findings of the inquiry and by what we already know about drug misuse deaths and their prevention PHE will:

- now consider what additional advice and support we can provide to local authority commissioners and drug treatment providers
- support improvements in local drug death review processes in 2016-17
- continue to support local areas to further improve access to treatment, which appears to have a continuing protective effect

- continue to provide commissioners with advice on provision of the opioid antagonist naloxone, following the legislative change to allow drug services to more easily supply naloxone
- through the 2016 update to the clinical guidelines for drug misuse and drug dependence, cover many of the factors involved in drug-related deaths, such as smoking behaviour and supervised consumption of opioid substitute medicines
- in 2016-17, improve the collation, analysis and dissemination of intelligence on the adverse health effects of a range of drugs

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