

MAINE MONTHLY OVERDOSE REPORT

For September 2024

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Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine during September 2024 as well as for the period January 2023–September 2024 (Table 1). The total number of confirmed and suspected fatal overdoses January–September 2024 is 372, 18.8% lower than the total confirmed fatal overdoses for the same period in 2023, 458. The total number of nonfatal overdoses January–September 2024 is 6,324, 12.8% lower than the total reported nonfatal overdoses for the same period in 2023, 7,252. During September 2024, the proportion of fatal overdoses averaged 5.1 of total overdoses. Monthly proportions of 2024 fatalities fluctuated from a low of 4.8% in May to a high of 7.2% in March. During the first nine months of 2024, fatal overdoses constituted 5.6% of all overdoses, lower than January–September 2023 (5.9%).

Data derived from multiple statewide sources were compiled and deduplicated to calculate fatal and nonfatal overdose totals (Table 1). These include nonfatal overdose incidents reported by hospital emergency departments (ED), nonfatal emergency medical service (EMS) responses without transport to the ED, overdose reversals reported by law enforcement in the absence of EMS, and overdose reversals reported by community members or agencies receiving state-supplied naloxone through the Maine Naloxone Distribution Initiative. There are also an unknown number of private overdose reversals that were not reported and an unknown number of community-reported reversals that may have overlapped with emergency response by EMS or law enforcement. The total number of fatal overdoses in this report includes those that have been confirmed, as well as those that are suspected but not yet confirmed for June, August and September 2024 (see Figure 1).

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for September 2024, 671, is displayed in Table 1 near the bottom row. Of those 671, there were 34 (5.6%) confirmed and suspected fatal overdoses, 317 (47.2%) nonfatal emergency department visits, 200 (29.8%) nonfatal EMS responses not transported to the emergency department, 114 (17.0%) reported community overdose reversals, and 6 (0.9%) law enforcement reversals in incidents that did not include EMS.

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2023 through September 2024

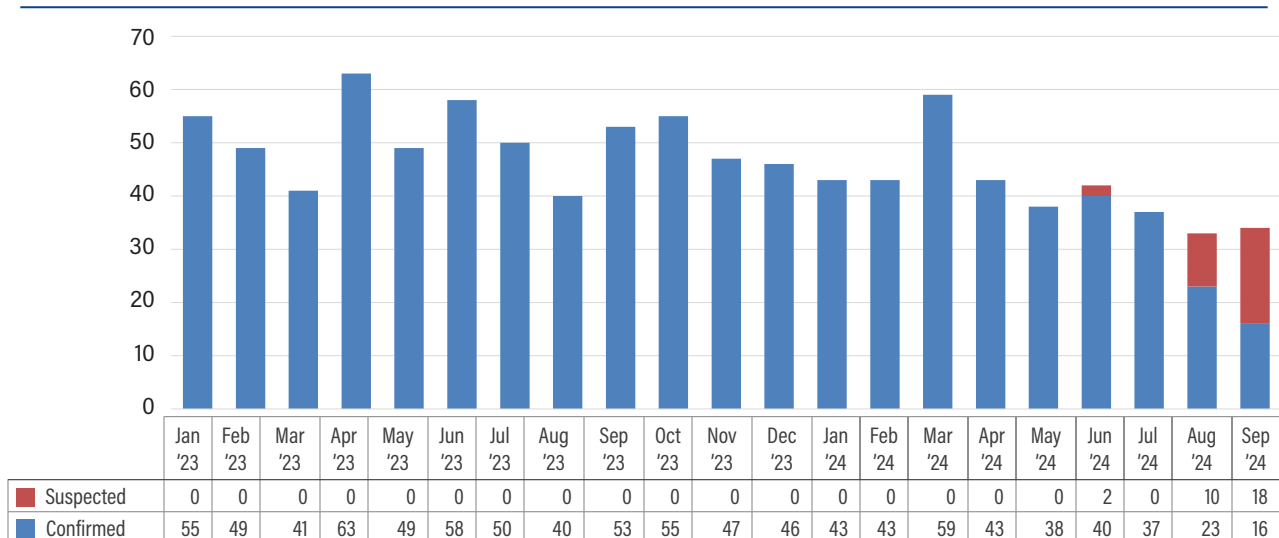


Table 1: Composite reported overdose totals, all drugs, January 2023–September 2024

	Nonfatal				Total nonfatal overdoses	Total confirmed and suspected fatal overdoses	Total overdoses
	Emergency Dept.	EMS not transported to emergency	Community reversals with naloxone	Law enforcement nonfatal overdose response without EMS			
January 2023	296	238	184	48	766	55	821
February 2023	348	204	192	30	774	49	823
March 2023	382	260	237	54	933	41	974
April 2023	270	232	202	29	733	63	796
May 2023	295	238	165	47	745	49	794
June 2023	378	232	219	35	864	58	922
July 2023	340	307	173	34	854	50	904
August 2023	330	266	152	22	770	40	810
September 2023	390	256	141	26	813	53	866
October 2023	317	274	147	17	754	55	809
November 2023	255	214	101	20	590	47	637
December 2023	325	202	129	23	678	46	724
2023 YTD total	3926	2921	2042	385	9274	606	9880
% of 2023 YTD total	40.6%	28.0%	21.1%	4.0%	93.9%	6.1%	100%
January 2024	269	226	139	9	644	43	687
February 2024	305	242	136	20	706	44	750
March 2024	379	233	119	13	743	59	802
April 2024	253	205	190	10	656	43	699
May 2024	311	256	165	16	741	38	779
June 2024	344	232	202	11	790	43	833
July 2024	293	235	166	14	708	35	743
August 2024	290	213	119	14	633	36	669
September 2024	317	200	114	6	637	34	671
2024 YTD total	2761	2043	1350	170	6324	372	6696
% of 2024 YTD total	41.2%	30.5%	20.2%	2.5%	94.4%	5.6%	100%

Law Enforcement Response to Fatal and Nonfatal Overdose Incidents

Due to the method used to deduplicate nonfatal overdose incidents to derive a composite number of overdoses for the month, the total activity of both law enforcement officials and EMS agencies is underrepresented in Table 1 because of the overlap between them. The process used to deduplicate overdoses begins by removing fatal overdoses from the emergency department and EMS overdose incidents. Then the number of patients transported to emergency departments by Maine EMS are removed from the EMS overdose incidents. Finally, EMS involvement and fatal overdose incidents are removed from law enforcement responses.

Table 2 shows the public safety response to fatal and nonfatal overdose events in January–August 2024 as well as January–December 2023. During January–September 2024, law enforcement officers responded to a reported 913 overdose incidents (340 fatal; 573 nonfatal), and Maine EMS responded to a reported 7,382 incidents (300 fatal; 7,082 nonfatal). During 2023, law enforcement officers responded to a reported 1,617 incidents (564 fatal; 1,053 nonfatal), and Maine EMS responded to a reported 10,318 incidents (480 fatal; 9,838 nonfatal).

Table 2: Fatal and nonfatal overdose emergency response counts from law enforcement and EMS, including overlapping cases

	Fatal overdose response Jan–Dec 2023	Nonfatal overdose response Jan–Dec 2023	Total overdose response Jan–Dec 2023	Fatal overdose response Jan–Sep 2024	Nonfatal overdose response Jan–Sep 2024	Total overdose response Jan–Sep 2024
Maine EMS	480	9838	10318	300	7082	7382
Law Enforcement	564	1053	1617	340	573	913

*Please note numbers will fluctuate from month to month as public safety agencies catch up their reporting. Due to methodological convention, alcohol-only cases are excluded from this table. However, we recognize that alcohol is a large part of substance misuse epidemic. Cases with both drugs and alcohol are included. Please note these numbers may fluctuate higher than the data in Table 1. This is due to the fact that some EMS overdoses responses, once the patient is transported to the hospital, are deemed to be non-overdose emergencies such as cardiac arrest or diabetic coma.

County Distribution of Suspected Nonfatal Overdoses with EMS Response

Table 3 shows the frequency distribution of nonfatal overdoses to which EMS responded at the county level. Overdose reversal totals reported by community partners and emergency departments are not reported by county; only EMS case data include county frequencies. The August 2024 monthly totals in the far right column can be compared to the percentage of the census population on the far left, the percentage of nonfatal overdoses for the year in 2023, or the January–September 2024 year-to-date total. Caution must be exercised viewing single counties, especially for a single month, due to small numbers. These may fluctuate randomly, without reflecting any statistically significant trend.

January–September 2024 percentage totals for most counties fall within 0 to 1 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Cumberland County is 3 percentage points higher, Androscoggin County is 2 percentage points higher, and York County is 4 percentage points lower.

Table 3: County of EMS incident among suspected and confirmed nonfatal overdoses

	% 2020 estimated Census population	Jan–Dec 2023 Est. N = 9838	Jan–Sep 2024 Est. N = 7082	Sep 2024 Est. N = 741
Androscoggin	8%	1009 10%	730 10%	70 9%
Aroostook	5%	485 5%	409 6%	47 6%
Cumberland	22%	2309 23%	1763 25%	177 24%
Franklin	2%	160 2%	122 2%	14 2%
Hancock	4%	276 3%	199 3%	23 3%
Kennebec	9%	963 10%	710 10%	84 11%
Knox	3%	327 3%	205 3%	15 2%
Lincoln	3%	227 2%	124 2%	6 1%
Oxford	4%	397 4%	262 4%	27 4%
Penobscot	11%	1351 14%	869 12%	97 13%
Piscataquis	1%	114 1%	72 1%	10 1%
Sagadahoc	3%	151 2%	117 2%	17 2%
Somerset	4%	471 5%	313 4%	21 3%
Waldo	3%	220 2%	152 2%	19 3%
Washington	2%	215 2%	176 2%	15 2%
York	16%	1163 12%	859 12%	99 13%

*EMS nonfatal overdose counts include incidents where a patient may have died after admission to the ED. Please note numbers will fluctuate from month-to-month as public safety agencies catch up their reporting. Due to methodological convention, alcohol-only cases are excluded from this table. However, we recognize that alcohol is a large part of substance misuse epidemic. Cases with both drugs and alcohol are included.

Age and Gender Distribution of Suspected Nonfatal Overdoses with EMS Response

Table 4 displays the age composition of individuals suspected of experiencing nonfatal overdoses involving EMS response in September 2024, January–September 2024, as well as January–December 2023. Overdose reversal totals reported by community partners and emergency departments are not categorized and reported by age; only EMS case data include monthly age frequencies. Age group totals can be compared to the 2020 census proportion in the far left column. Caution must be exercised as the small number of cases in each month is vulnerable to random fluctuation that may not reflect a significant statistical trend. The age distribution for both 2023 and 2024 year to date compared to the 2020 census proportion shows a disproportionately large impact of suspected nonfatal overdose victims with EMS involvement for those aged 25–54. This impact is illustrated by looking at the 25–54 year age groups, which comprise 36% in the 2020 census compared to 64% in the overdose population during 2023 and 62% in during the first nine months of 2024. In 2024 there are 14 percentage points fewer overdose victims among those under the age of 18 compared to the percentage of the census population in that age group. Similarly, there were 3 percentage points fewer overdose victims among those aged 55–64, and 11 percentage points fewer overdose victims among those 65 and older compared to the percentages of the census population for those age groups.

Table 4: Reported age group among suspected nonfatal overdose victims involving EMS response

	% 2020 estimated Census population	Jan-Dec 2023 Est. N = 9775	Jan-Sep 2024 Est. N = 7120	Sep 2024 Est. N = 751
< 18	18%	402 4%	307 4%	32 4%
18–24	7%	903 9%	652 9%	63 8%
25–34	12%	2085 21%	1398 20%	153 20%
35–44	12%	2603 27%	1825 26%	202 27%
45–54	12%	1522 16%	1155 16%	118 16%
55–64	16%	1317 13%	927 13%	82 11%
> 64	23%	944 10%	856 12%	101 13%

Table 5 displays the reported gender of individuals experiencing nonfatal overdoses involving EMS response in September 2024, January–September 2024, as well as January–December 2023. Overdose reversal totals reported by community partners and emergency departments are not categorized by gender; only EMS case data include monthly gender categories. Gender group totals can be compared to the 2020 census proportion by age group in the far left column or the January–December 2023 totals in the center column. When comparing the January–September 2024 with 2023, as well as the census population proportion, caution must be exercised as the small number of cases in each month is vulnerable to random fluctuation that may not reflect a significant statistical trend. Males represent 49% of the 2020 estimated census population and 59% of the nonfatal overdose victims with EMS involvement during January–September 2024.

Table 5: Reported gender among suspected nonfatal overdose victims involving EMS response

	% 2020 estimated Census population	Jan-Dec 2023 Est. N = 9794	Jan-Sep 2024 Est. N = 6847	Sep 2024 Est. N = 726
Male	49%	5970 61%	4010 59%	387 53%
Female	51%	3798 39%	2836 41%	339 47%
Transgender	Not collected	26 0.3%	1 0%	0 0%

County Distribution of Suspected and Confirmed Fatal Overdoses

Table 6 shows the frequency distribution of fatal overdoses at the county level.¹ The August 2024 monthly totals in the far right column can be compared either to the percentage of the census population in the far left column, the percentage of county fatal overdoses for 2023, or the January–September 2024 year-to-date percentages. Caution must be exercised when viewing single counties with small numbers for a single month. These may fluctuate randomly, without reflecting any significant statistical trend. The January–September 2024 percentages for most counties fall within 0 to 1 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Aroostook County is 3 percentage points higher, Penobscot County, Knox County and Washington County are 2 percentage points higher, York County is 5 percentage points lower, Cumberland County is 4 percentage points lower, and Hancock County is 2 percentage points lower.

Table 6: County of death among suspected and confirmed fatal overdoses

	% 2020 estimated Census population	Jan-Dec 2023 Est. N = 606	Jan-Sep 2024 Est. N = 372	Sep 2024 Est. N = 34
Androscoggin	8%	69 11%	35 9%	7 21%
Aroostook	5%	40 7%	29 8%	0 0%
Cumberland	22%	118 19%	67 18%	4 12%
Franklin	2%	6 1%	2 1%	0 0%
Hancock	4%	22 4%	9 2%	1 3%
Kennebec	9%	60 10%	38 10%	2 6%
Knox	3%	16 3%	17 5%	0 0%
Lincoln	3%	7 1%	11 3%	2 6%
Oxford	4%	25 4%	19 5%	3 9%
Penobscot	11%	91 15%	47 13%	3 9%
Piscataquis	1%	17 3%	3 1%	0 0%
Sagadahoc	3%	7 1%	7 2%	3 9%
Somerset	4%	29 5%	17 5%	1 3%
Waldo	3%	10 2%	16 4%	3 9%
Washington	2%	25 4%	14 4%	4 12%
York	16%	64 11%	41 11%	1 3%

Age and Sex Distribution of Fatal Overdose Victims

Table 7 displays the age and sex composition² of the fatal overdose population for September 2024, January–September 2024, and January to December 2023, compared to the 2020 estimated census population. When comparing the September 2024 data with 2023 as well as the census population proportion, caution must be exercised as the small number of cases in each month is vulnerable to random fluctuation that may not reflect a significant statistical trend.

The cumulative proportion of males is lower in January–September 2024 (65%) compared to January–December 2023 (73%).

The age distribution for 2024 compared to the 2020 census proportion shows a disproportionately large impact of fatal overdoses in those aged 35–64, as was true in 2023. That group includes 36% of the 2020 estimated census population, compared to 75% in the fatal overdose population in 2023 as well as 75% during January–September 2024. Compared to the census population, in 2024 year to date, there were 4 percentage points fewer

¹ This table reports the county of death rather than the county of residence.

² Note that death certificate reports sex as male or female without other gender categories.

fatal overdoses among those aged 18–24 and 15 percentage points fewer among those 65 and older compared to the census estimated population for those age groups.

There were, however, differences between the age structures of the nonfatal overdoses (Table 4) and the fatal overdoses. In 2024 year to date, the highest proportion of overdoses was among those aged 35–44 (26% among nonfatal and 28% among fatal). The second highest age group for nonfatal overdoses was 25–34 (20%) among nonfatal, but age group 45–54 (27%) among the fatal overdoses.

Table 7: Decedent reported age group and sex among suspected and confirmed fatal overdoses*

	% 2020 estimated Census population	Jan-Dec 2023 Est. N = 606	Jan-Sep 2024 Est. N = 372	Sep 2024 Est. N = 36
Male	49%	440 73%	242 65%	20 59%
< 18	18%	3 0%	3 1%	0 0%
18-24	7%	28 5%	10 3%	0 0%
25-34	12%	85 14%	48 13%	6 18%
35-44	12%	199 33%	106 28%	9 26%
45-54	12%	135 22%	99 27%	9 26%
55-64	16%	118 19%	75 20%	6 18%
> 64	23%	38 6%	31 8%	4 12%

*Percentages may not total 100 due to rounding.

Table 8 displays the reported race and ethnicity of confirmed and suspected fatal overdoses in July 2024, January–September 2024, and January–December 2023 compared to the 2020 estimated census population. Note that race and ethnicity are not finalized until the full death certificate is entered into Vital Records, and a small number of decedents' records currently lack information about these variables. Out of 369 decedents for whom race was reported January–September 2024, 92% of the victims were identified as White, 0% as Black/African American, and 2% as American Indian/Alaska Native. Out of 363 decedents for whom Hispanic ethnicity status was reported, 3% were identified as Hispanic.

Table 8: Decedent race (A) and ethnicity (B) among suspected and confirmed fatal overdoses*

A: Race	% 2020 estimated Census population	Jan-Dec 2023 Race N = 605	Jan-Sep 2024 Race N = 369	Sep 2024 Race Est. N = 33
White alone	91%	554 92%	341 92%	31 94%
Black/African American alone	2%	25 4%	1 0%	0 0%
American Indian/Alaska Native alone	1%	12 2%	8 2%	0 0%
Other race and 2+ races combined	6%	14 2%	19 5%	2 6%
B: Ethnicity	% 2020 estimated Census population	Jan-Dec 2023 Ethnicity N = 589	Jan-Sep 2024 Ethnicity N = 363	Sep 2024 Ethnicity Est. N = 33
Hispanic/Latinx	2%	7 1%	11 3%	2 6%

*Race and ethnicity data for some cases are unavailable until drug deaths are confirmed. †Percentages may not total 100 due to rounding.

Military Status and Housing Stability of Fatal Overdose Victims

Out of the 371 cases for which military background was reported January–September 2024, 18 (5%) were identified as having a military background. Out of the 33 cases in September 2024 where military background was reported, 1 (3%) was identified as having a military background.

Of the 372 total suspected and confirmed fatal overdose cases year to date in 2024, undomiciled or transient housing status was reported for 49 (13%) victims. Among those 49, the largest proportions of undomiciled persons

were found in Cumberland County (13, 27%), Androscoggin County (11, 22%) and Penobscot County (7, 14%). In September 2024, 6 fatal overdose victims (18%) were identified as undomiciled.

Basic Incident Patterns of Fatal Overdoses

Table 9 reports basic incident patterns for fatal overdoses. September 2024 can be compared to 2023 as a whole or to January–September 2024 year to date totals. Caution must be exercised interpreting a single month of data as numbers may fluctuate randomly and not reflect a statistically significant trend. In addition, data totals may change slightly as suspected cases are confirmed or eliminated.

Both EMS and police responded together to most fatal overdoses (72%) in 2024 year to date. Law enforcement was more likely to respond to a scene alone (19%) than EMS (8%). The overwhelming majority (92%) of confirmed fatal drug overdoses were ruled as, or suspected of being, accidental manner of death.

Of the 372 confirmed or suspected fatal overdoses in 2024, 122 (33%) had a history of prior overdose.

Although most cases had bystanders or witnesses present at the scene by the time first responders arrived, the details about who was present at the time of the overdose were frequently unclear. However, responding family and friends or other bystanders administered naloxone for 51 (14%) of the 2024 fatal overdoses, slightly higher than the proportion in 2023 (13%). Often, EMS and/or law enforcement administered naloxone in addition to bystanders or witnesses. During 2024, 26% of suspected and confirmed fatal overdose cases had naloxone administered at the scene by EMS, bystanders, and/or law enforcement. This rate is the same as 2023 (26%).

Of the 300 suspected or confirmed drug death cases with EMS involvement during 2024, 154 (51%) victims were already deceased when EMS arrived. In the remaining 146 (49%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. One case had an unreported response once EMS arrived. Of those 146 who were still alive when EMS arrived, 57 (39%) were transported, and 89 (61%) did not survive to be transported. Thus, out of 300 ultimately fatal cases with EMS response, only 57 (19%) remained alive long enough to be transported but died during transport or at the emergency room. This outcome is likely due to a combination of the high number of cases with fentanyl as a cause of death and individuals using alone. Fentanyl acts more quickly than other opioids, and there is less time for bystanders to find an overdose victim alive, administer naloxone, and call 911.

Table 9: Incident characteristics among suspected and confirmed fatal overdoses

	Jan-Dec 2023 Est. N = 606	2024 Jan-Sep Est. N = 372	Sep 2024 Est. N = 34
EMS response alone	36 6%	31 8%	4 12%
Law enforcement alone	120 20%	71 19%	8 24%
EMS and law enforcement	443 73%	269 72%	22 65%
Private transport to Emergency Dept.	5 1%	0 0%	0 0%
Naloxone administration reported at the scene	155 26%	98 26%	7 21%
Bystander only administered	39 6%	39 10%	1 3%
Law enforcement only administered	15 2%	8 2%	2 6%
EMS only administered	43 7%	32 9%	4 12%
EMS and law enforcement administered	10 2%	1 0%	0 0%
EMS and bystander administered	30 5%	7 2%	0 0%
Law enforcement and bystander administered	8 1%	4 1%	0 0%
EMS, bystander, and law enforcement administered	4 1%	1 0%	0 0%
Naloxone administered by unspecified person	3 0%	2 1%	0 0%
History of prior overdose	205 34%	122 33%	15 44%

Table 10 displays the frequencies of the most prominent drug categories causing death among confirmed drug deaths. As expected, within the confirmed drug death cases so far in 2024, nonpharmaceutical fentanyl was the most frequent cause of death, mentioned on the death certificate of 252 (74%) victims.

Fentanyl is nearly always found in combination with multiple other drugs. Heroin involvement, declining rapidly in recent years, was reported as a cause of death in 11 (3%) of 2024 year-to-date deaths and 12 (2%) of 2023 deaths. Xylazine and nonpharmaceutical tramadol were identified as co-intoxicants with fentanyl for the first time in 2021. Among 342 confirmed deaths in 2024, there were 47 cases (14%) with xylazine listed in addition to fentanyl as a cause of death, and 1 case (<1%) with tramadol listed along with fentanyl.

Stimulants continue to increase as a cause of death, usually in combination with other drugs, particularly fentanyl. Cocaine-involved fatalities constituted 150 (44%) of confirmed cases so far in 2024, higher than 2023 (37%) and an increase from 29% in 2022. Fentanyl is mentioned as a cause in combination with cocaine in 117 cases, 78% of 2024 year-to-date cocaine cases. Methamphetamine was cited as a cause of death in 129 (38%) of the confirmed fatal overdoses so far in 2024, higher than in 2023 (33%); 102 (79%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 35 (9%) death certificates in 2024, in most of those cases (29, 83%) as co-intoxicants of fentanyl.

Table 10: Key drug categories and combinations causing death among confirmed overdoses

Cause of death (alone or in combination with other drugs) Sample size for confirmed cases only	Jan-Dec 2023 Est. N = 606	Jan-Sep 2024 Est. N = 342	Sep 2024 Est. N = 16
Fentanyl or fentanyl analogs	472 78%	252 74%	12 75%
Heroin	12 2%	11 3%	1 6%
Cocaine	226 37%	150 44%	12 75%
Methamphetamine	199 33%	129 38%	6 38%
Pharmaceutical opioids**	108 18%	54 16%	1 6%
Fentanyl and heroin	12 2%	11 3%	1 6%
Fentanyl and cocaine	192 32%	117 34%	9 56%
Fentanyl and methamphetamine	163 27%	102 30%	6 38%
Fentanyl and xylazine	60 10%	47 14%	1 6%
Fentanyl and tramadol	3 0%	1 0%	0 0%

**Nonpharmaceutical tramadol is now being combined with fentanyl in pills and powders for illicit drug use. When found in combination with fentanyl, and in the absence of a known prescription, tramadol is categorized as a nonpharmaceutical opioid.

Highlight of the Month

The Role of Community Coalitions in Maine's Opioid Response Plan

As Maine's overdose rate, both fatal and nonfatal, continues to decline, the positive role of community coalitions cannot be overstated. Since 2018, there has been a significant increase in the number of communities/counties that have formed robust coalitions to address substance use disorder (SUD) in their communities. A recent review showed that at least 20 such coalitions are active across the state. While a complete listing is beyond the scope of this Highlight note, some of the more active coalitions include the following:

- Cumberland County Coalition on Substance Use Prevention (CCCSUP)
- Lewiston Auburn Area Recovery Collaborative (LAARC)
- Washington County Substance Use Response Collaborative (SURC)
- Somerset County Substance Use Task Force (SCSUTF)
- Maine Re-entry Network (MERN)
- Waldo County Recovery Committee
- Western Maine Addiction Recovery Initiative (WMARI)
- Downeast Substance Treatment Network (DSTN)
- Bangor Area Recovery Community Coalition
- Greater Bangor Leadership Board (GBLB)
- Knox County Recovery Collaborative
- Midcoast Recovery Alliance
- Rural York County Consortium
- Choose to be Healthy and Youth Resilience Coalition (York County)
- Healthy Community Coalition (Franklin)
- Race to Recovery Consortium
- River Valley Recovers Strong (Oxford County)

While no two coalitions are exactly alike, there are several features that most of the coalitions share: (1) They are homegrown and made up primarily of local citizens, many of whom are in recovery or are recovery allies who have family members or friends with SUD; (2) They engage in weekly, bi-weekly, monthly or quarterly meetings, frequently via zoom but many also meet in person; (3) They engage in many community activities that are educational and help to break down the stigma all too frequently associated with SUD.

Many of the coalitions have been instrumental in establishing recovery community centers in their region. Perhaps there is no better example of this phenomenon than the Western Maine Addiction Recovery Initiative, established in 2019, which successfully applied for grants allowing it to open Hills Recovery Center in Norway in 2023. The Center held a grand opening attended by Governor Mills and other state and regional leaders and has been active ever since hosting 12 step meeting, community events and offering recovery coaching.

Strategy 3 in the state's Opioid Response Strategic Action Plan calls upon the state to support community-based and faith-based organizations and networks, prioritizing populations that are disproportionately impacted by substance use disorder and opioid use disorder. Strategy 31 calls for increasing the availability of recovery coaching services while Strategy 34 calls upon the state to promote stories of connection, hope, and recovery in Maine communities. The activities implementing these three strategies are supported by these coalitions.

Hundreds of individuals are part of the opioid response effort through the work of these coalitions. The state will continue to evaluate the work of these important groups and will invest in them to ensure their long-term sustainability. While appropriate and compassionate state and federal drug policies can help, lives are saved at the community level. And these community coalitions and their accompanying recovery community centers, are making a difference every day.

Gordon Smith
Director of Opioid Response

Background Information about this Report

This report, funded jointly by the Maine Office of Attorney General and the Office of Behavioral Health,¹ provides an overview of statistics regarding suspected and confirmed fatal and nonfatal drug overdoses each month. Data for the fatal overdoses were collected at the Office of Chief Medical Examiner and data regarding nonfatal overdoses were contributed by the Maine CDC, Maine Emergency Medical Services, Maine ODMAP initiative, Maine Naloxone Distribution Initiative, and Office of Attorney General Naloxone Distribution. Year-to-date numbers are updated as medical examiner cases are finalized, and their overdose status is confirmed or ruled out, and as occasional lagged EMS, ED, and ODMAP data totals are finalized. The totals are expected to shift as case completion occurs. In addition, due to the small sample size in each month, we expect totals to fluctuate from month to month because of random variation. The monthly reports are posted on mainedrugdata.org.

A “drug death” is confirmed when one or more drugs are mentioned on the death certificate as a cause or significant contributing factor for the death. Most drug-induced fatalities are accidents related primarily to drug lethality, the unique vulnerability of the drug user, such as underlying medical conditions, and the circumstances surrounding drug use during that moment.

A “suspected” drug fatality is identified by physiological signs of overdose as well as physical signs at the scene and witness information. To be confirmed as a drug death, the medical examiner must have issued a final death certificate which includes the names of the specific drugs. A forensic toxicology exam must also have been done, which includes a minimum of two toxicology tests, one to screen for drugs present, and another that will quantify the levels of drugs in the decedent’s system. All cases receive a thorough external examination and comprehensive toxicology tests. In some cases, a complete autopsy is also done. Additional data, such as medical records and police incident reports are also collected. Normally cases are completed within one month; however, due to recent problems being experienced by our national toxicology testing service, completion of cases is occurring at about 6–8 weeks after death, and occasionally longer.

By highlighting drug deaths at the monthly level, this report brings attention to the often-dramatic shifts in totals that can occur from month to month. These fluctuations are common with small numbers and will tend toward an average over time. Whereas the overall number of overdose deaths are a critical indicator of individual and societal stress, this metric itself can be quite resistant to public policy interventions due to its complexity. Overdose fatalities occur because of multiple unique and interacting factors, as mentioned above. For that reason, these reports will seek to monitor components that can be directly affected by specific public health education and harm reduction interventions. The statistics in this report reflect both suspected and confirmed “occurrent” deaths, that is, deaths that occur in the State of Maine, even though they may not be Maine residents. These totals also do not include Maine residents who die in other states. For these reasons, totals will differ slightly from the statistics reported by the National Center for Health Statistics, which reports only confirmed “resident” deaths. In addition, due to recently reported updates of toxicology results and newly confirmed or eliminated drug death cases, both the 2021 and 2022 statistics have changed slightly from those reported in the previous monthly report.

¹ The Office of Attorney General supports ongoing research regarding research on fatal overdoses by the University of Maine. Additionally, the Overdose Data to Action cooperative agreement from the U.S. Centers for Disease Control & Prevention also provides funding to the State of Maine’s Office of Behavioral Health and Maine Center for Disease Control, which also supports university programs involving fatal and nonfatal overdoses surveillance and enables the collection of nonfatal metrics included in this report. The conclusions in this report do not necessarily represent those of the U.S. Centers for Disease Control and Prevention.