

MAINE MONTHLY OVERDOSE REPORT

For March 2025

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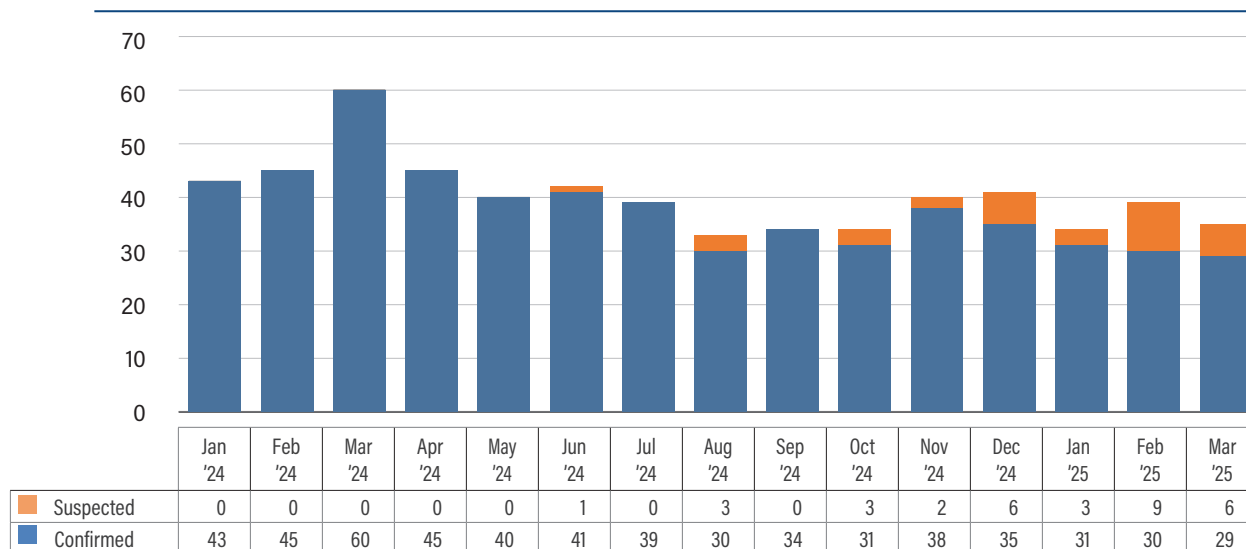
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine during March 2025 as well as for the period January 2024–March 2025 (Table 1). The total number of confirmed and suspected fatal overdoses January–March 2025 is 108, 27.0% lower than the total confirmed fatal overdoses for January–March 2024, 148. The total number of nonfatal overdoses during January–March 2025 is 1,678, 21.1% lower than the total reported nonfatal overdoses for January–March 2024, 2,127. Thus, comparing first quarter 2024 to first quarter 2025, fatal overdoses have declined slightly more (5.9%) than have nonfatal overdoses. Monthly proportions of 2025 fatalities from January to March averaged 6.0%. They ranged from a high of 7.1% in February to a low of 4.9% in March. (%). During January–March 2024, the average was 6.5%. During 2024 as a whole, fatal overdoses constituted 5.8% of all overdoses, lower than 2023 (6.1%).

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, October, November, and December 2024 as well as January, February, and March 2025 (see Figure 1).

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for March 2025, 711, is displayed in Table 1 near the bottom row. Of those 711, there were 35 (4.9%) confirmed and suspected fatal overdoses, 374 (52.6%) nonfatal emergency department visits, 200 (28.1%) nonfatal EMS responses not

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2024 through March 2025



transported to the emergency department, 71 (10.0%) reported community overdose reversals, and 31 (4.4%) law enforcement reversals in incidents that did not include EMS.

Table 1: Composite reported overdose totals, all drugs, January 2024–March 2025

	Nonfatal					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	Total nonfatal overdoses		
January 2024	269	225	139	26	659	45	704
February 2024	305	242	136	28	711	43	754
March 2024	379	232	119	27	757	60	817
April 2024	253	205	190	14	662	45	707
May 2024	311	257	165	24	757	40	797
June 2024	344	232	202	12	790	42	832
July 2024	293	235	166	23	717	39	756
August 2024	288	215	119	10	632	33	666
September 2024	317	199	114	6	636	34	671
October 2024	301	198	86	17	602	34	636
November 2024	261	173	58	18	513	40	553
December 2024	352	190	49	12	603	41	645
2024 YTD total	3673	2606	1543	217	8039	496	8538
% of 2024 YTD total	43.1%	30.6%	18.1%	2.6%	94.3%	5.8%	100%
January 2025	234	193	53	15	495	34	529
February 2025	256	159	74	18	507	39	546
March 2025	374	200	71	31	676	35	711
2025 YTD Total	864	552	198	64	1678	108	1786
% of 2025 YTD Total	48.4%	30.9%	11.1%	3.6%	94.0%	6.0%	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–March 2025 as well as January–December 2024. During 2024, law enforcement officers responded to a reported 1,158 overdose incidents (453 fatal; 705 nonfatal), and Maine EMS responded to a reported 9,498 incidents (390 fatal; 9,108 nonfatal). During 2025, law enforcement officers responded to a reported 219 incidents (94 fatal; 125 nonfatal), and Maine EMS responded to a reported 2180 incidents (78 fatal; 2102 nonfatal).

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

	Fatal overdose response Jan-Dec 2024	Nonfatal overdose response Jan-Dec 2024	Total overdose response Jan-Dec 2024	Fatal overdose response Jan-Mar 2025	Nonfatal overdose response Jan-Mar 2025	Total overdose response Jan-Mar 2025
Maine EMS	390	9108	9498	78	2102	2180
Law Enforcement	453	705	1158	94	125	219

*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 March 2025 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 2025, or in 2024. 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.

The 2025 percentage totals for most counties fall within 0 to 2 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Androscoggin County and Cumberland County are 4 percentage points higher, and Penobscot County is 3 percentage points higher. York County is 6 percentage points lower.

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

	% 2020 estimated Census population	Jan-Dec 2024 Est. N = 9108	Jan-Mar 2025 Est. N = 2102	Mar 2025 Est. N = 761
Androscoggin	8%	913 10%	252 12%	96 13%
Aroostook	5%	488 5%	84 4%	32 4%
Cumberland	22%	2309 25%	554 26%	179 24%
Franklin	2%	165 2%	36 2%	16 2%
Hancock	4%	241 3%	49 2%	18 2%
Kennebec	9%	907 10%	202 10%	75 10%
Knox	3%	262 3%	60 3%	23 3%
Lincoln	3%	171 2%	41 2%	16 2%
Oxford	4%	334 4%	69 3%	32 4%
Penobscot	11%	1138 12%	301 14%	115 15%
Piscataquis	1%	101 1%	20 1%	4 1%
Sagadahoc	3%	152 2%	31 1%	12 2%
Somerset	4%	399 4%	88 4%	38 5%
Waldo	3%	197 2%	48 2%	14 2%
Washington	2%	225 2%	61 3%	22 3%
York	16%	1106 12%	206 10%	69 9%

*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 March 2025, 2025 year to date, as well as 2024. 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 2024 and 2025 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 constitute 36% of the population in the 2020 census compared to 62% in the nonfatal overdose population in 2025. In 2025 there are 13 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 4 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 2024 Est. N = 9152		Jan-Mar 2025 Est. N = 2105		Mar 2025 Est. N = 765	
< 18	18%	383	4%	101	5%	45	6%
18-24	7%	829	9%	175	8%	70	9%
25-34	12%	1782	19%	402	19%	145	19%
35-44	12%	2344	26%	587	28%	208	27%
45-54	12%	1483	16%	320	15%	111	15%
55-64	16%	1225	13%	258	12%	94	12%
> 64	23%	1106	12%	262	12%	92	12%

Table 5 displays the reported gender of individuals experiencing nonfatal overdoses involving EMS response in March 2025, 2025 year to date, as well as 2024. 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 2024 totals in the center column. When comparing the January–March 2025 with 2024, 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, 58% of the nonfatal overdose victims with EMS involvement in 2024, and 58% during January–March 2025.

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

	% 2020 estimated Census population	Jan-Dec 2024 Est. N = 8800		Jan-Mar 2025 Est. N = 2025		Mar 2025 Est. N = 726	
Male	49%	5116	58%	1169	58%	411	57%
Female	51%	3683	42%	854	42%	313	43%
Transgender	Not collected	1	0.0%	2	0.1%	2	0.3%

County Distribution of Suspected and Confirmed Fatal Overdoses

Table 6 shows the frequency distribution of fatal overdoses at the county level.¹ The March 2025 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 2024, or the 2025 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 2025 percentages for most counties fall within 0 to 2 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Penobscot County is 6 percentage points higher, Washington County is 4 percentage points higher, Kennebec County is 4 percentage points lower, and Sagadahoc County and York County are 3 percentage points lower.

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

	% 2020 estimated Census population	Jan–Dec 2024 Est. N = 496		Jan–Mar 2025 Est. N = 108		Mar 2025 Est. N = 35	
Androscoggin	8%	46	9%	10	9%	5	14%
Aroostook	5%	39	8%	6	6%	2	6%
Cumberland	22%	94	19%	26	24%	10	29%
Franklin	2%	6	1%	4	4%	0	0%
Hancock	4%	15	3%	2	2%	1	3%
Kennebec	9%	47	9%	5	5%	0	0%
Knox	3%	22	4%	3	3%	0	0%
Lincoln	3%	18	4%	1	1%	0	0%
Oxford	4%	20	4%	3	3%	1	3%
Penobscot	11%	65	13%	18	17%	5	14%
Piscataquis	1%	5	1%	3	3%	0	0%
Sagadahoc	3%	7	1%	0	0%	0	0%
Somerset	4%	22	4%	3	3%	2	6%
Waldo	3%	18	4%	4	4%	2	6%
Washington	2%	16	3%	6	6%	3	9%
York	16%	56	11%	14	13%	4	11%

Age and Sex Distribution of Fatal Overdose Victims

Table 7 displays the age and sex composition² of the fatal overdose population for March 2025, 2025 year to date, and 2024, compared to the 2020 estimated census population. When comparing the March 2025 data with 2024 as well as with 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 higher so far in 2025 (69%) compared to 2024 (66%). The age distribution for 2025 compared to the 2020 census proportion shows a disproportionately large impact of fatal overdoses in those aged 35–64, as was true in 2024. That group includes 40% of the 2020 estimated census population, compared to 72% in the fatal overdose population in 2025 and 73% during 2024. Those ages 18–24 constitute 7% of the 2020 census population, about the same as their percentage of 2025 fatal overdoses, 6%. Those 65 and older comprise 23% of the census population but only 7% of the fatal overdoses.

There were, however, differences between the age structures of the nonfatal overdoses (Table 4) and the fatal overdoses. In 2025, the highest proportion of both fatal and nonfatal overdoses was among those aged 35–44

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 gender categories.

(28% among nonfatal and 34% among fatal). The second highest age group for nonfatal overdoses was 25–34 (19%), but 55–64 (21%) among fatal overdoses.

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

	% 2020 estimated Census population	Jan-Dec 2024 Est. N = 496	Jan-Mar 2025 Est. N = 108	Mar 2025 Est. N = 35
Male	49%	325 66%	75 69%	27 77%
< 18	18%	5 1%	0 0%	0 0%
18–24	7%	13 3%	7 6%	2 6%
25–34	12%	66 13%	15 14%	6 17%
35–44	12%	144 29%	37 34%	12 34%
45–54	12%	125 25%	18 17%	6 17%
55–64	16%	100 20%	23 21%	7 20%
> 64	23%	43 9%	8 7%	2 6%

*Percentages may not total 100 due to rounding.

Table 8 displays the reported race and ethnicity of confirmed and suspected fatal overdoses in March 2025, 2025 year to date, and 2024 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 106 decedents for whom race was reported in 2025, 97% of the victims were identified as White, 0% as Black/African American, and 2% as American Indian/Alaska Native. Out of 105 decedents for whom Hispanic ethnicity status was reported, 2% were identified as Hispanic.

Table 8: Decedent race and ethnicity among suspected and confirmed fatal overdoses*

A: Race	% 2020 Estimated Census Population	Jan-Dec 2024 Race N = 494	Jan-Mar 2025 Race N = 106	March 2025 Race N = 35
White alone	94%	457 93%	103 97%	35 100%
Black/African American alone	2%	19 4%	0 0%	0 0%
American Indian/Alaska Native alone	1%	9 2%	2 2%	0 0%
Other race and 2+ races combined	3%	9 2%	1 1%	0 0%
B: Ethnicity	% 2020 Estimated Census Population	Jan-Dec 2024 Ethnicity N = 487	Jan-Mar 2025 Ethnicity N = 105	Mar 2025 Ethnicity N = 34
Hispanic/Latinx alone	2%	10 2%	2 2%	0 0%

*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 105 cases for which military background was reported in 2025, 6 (6%) were identified as having a military background. Out of the 34 cases in March 2025 where military background was reported, 2 (6%) were identified as having a military background.

Of the 108 total suspected and confirmed fatal overdose cases year to date in 2025, undomiciled or transient housing status was reported for 12 (11%) victims. Among those 12, the largest proportions of undomiciled persons were found in Cumberland County (3, 25%) and Androscoggin County (3, 25%). In March 2025, 3 fatal overdose victims (9%) were identified as undomiciled.

Basic Incident Patterns of Fatal Overdoses

Table 9 reports basic incident patterns for fatal overdoses. March 2025 can be compared to 2024 or 2025 as a whole. 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 (60%) in 2025. Law enforcement was more likely to respond to a scene alone (24%) than EMS (9%). The overwhelming majority (86%) of confirmed fatal drug overdoses were ruled as, or suspected of being, accidental manner of death.

Of the 108 confirmed or suspected fatal overdoses in 2025, 25 (23%) had a reported 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 9 (8%) of the 2025 fatal overdoses, lower than the proportion in 2024 (13%). Often, EMS and/or law enforcement administered naloxone in addition to bystanders or witnesses. During 2025, 27% of suspected and confirmed fatal overdose cases had naloxone administered at the scene by EMS, bystanders, and/or law enforcement. This rate is higher than 2024 (25%).

Of the 78 suspected or confirmed drug death cases with EMS involvement during 2025, 30 (38%) victims were already deceased when EMS arrived. In the remaining 48 (62%) 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 48 who were still alive when EMS arrived, 10 (21%) were transported, and 38 (79%) did not survive to be transported. Thus, out of 78 ultimately fatal cases with EMS response, only 10 (13%) 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 2024 Est. N = 496		Jan-Mar 2025 Est. N = 108		Mar 2025 Est. N = 35	
EMS response alone	39	8%	10	9%	4	11%
Law enforcement alone	97	20%	26	24%	8	23%
EMS and law enforcement	351	71%	65	60%	18	51%
Private transport to Emergency Dept.	0	0%	0	0%	0	0%
Naloxone administration reported at the scene	126	25%	29	27%	9	26%
Bystander only administered	48	10%	6	6%	3	9%
Law enforcement only administered	9	2%	3	3%	1	3%
EMS only administered	41	8%	12	11%	3	9%
EMS and law enforcement administered	2	0%	4	4%	1	3%
EMS and bystander administered	12	2%	2	2%	0	0%
Law enforcement and bystander administered	4	1%	1	1%	0	0%
EMS, bystander, and law enforcement administered	1	0%	0	0%	0	0%
Naloxone administered by unspecified person	2	0%	0	0%	0	0%
History of prior overdose	147	30%	25	23%	5	14%

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 2025, nonpharmaceutical fentanyl was the most frequent cause of death, mentioned on the death certificate of 54 (60%) victims. The small number of

confirmed cases in 2025 makes analysis based on drug categories not meaningful as numbers will fluctuate greatly as toxicology results are confirmed.

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 3 (3%) of 2025 deaths, 11 (2%) of 2024 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 90 confirmed deaths in 2025, there were 11 cases (12%) with xylazine listed in addition to fentanyl as a cause of death, and 0 cases (0%) 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 34 (38%) of confirmed cases so far in 2025, lower than 2024 (43%) and an increase from 37% in 2023. Fentanyl is mentioned as a cause in combination with cocaine in 22 cases, 65% of 2025 year-to-date cocaine cases. Methamphetamine was cited as a cause of death in 32 (36%) of the confirmed fatal overdoses so far in 2025, lower than in 2024 (38%); 21 (66%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 5 (6%) death certificates in 2025, in all of those cases (5, 100%) 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 2024 Est. N = 481	Jan-Mar 2025 Est. N = 90	Mar 2025 Est. N = 29
Fentanyl or fentanyl analogs	335 70%	54 60%	21 72%
Heroin	11 2%	3 3%	1 3%
Cocaine	209 43%	34 38%	13 45%
Methamphetamine	181 38%	32 36%	8 28%
Pharmaceutical opioids**	81 17%	20 22%	4 14%
Fentanyl and heroin	11 2%	3 3%	1 3%
Fentanyl and cocaine	160 33%	22 24%	8 28%
Fentanyl and methamphetamine	135 28%	21 23%	6 21%
Fentanyl and xylazine	70 15%	11 12%	3 10%
Fentanyl and tramadol	1 0%	0 0%	0 0%

**Nonpharmaceutical tramadol is now being combined with f9*9entanyl 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.

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 is 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, the 2024 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.