MAINE MONTHLY OVERDOSE REPORT

For October 2025

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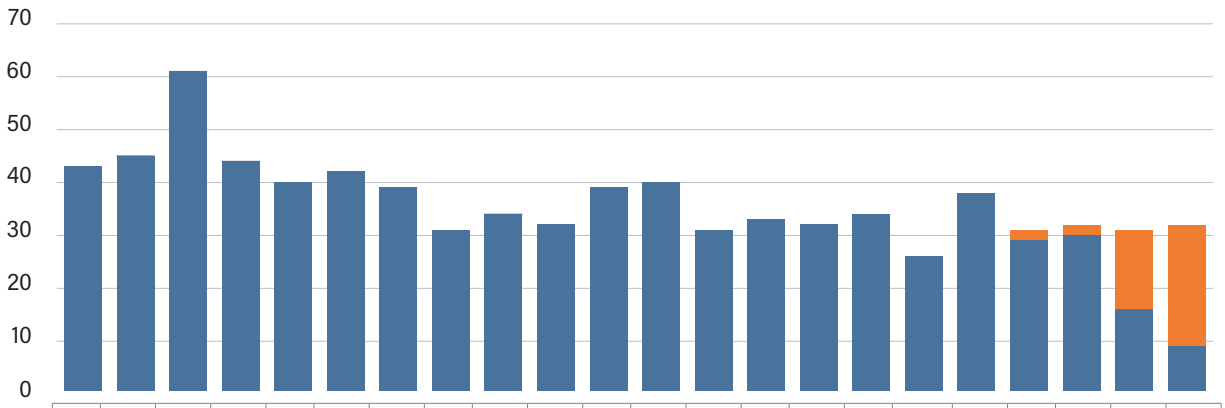
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine during October 2025 as well as for the period January 2024–October 2025 (Table 1). The total number of confirmed and suspected fatal overdoses during 2025 is 320, 22.1% lower than the total confirmed fatal overdoses for January–October 2024, 411. The total number of nonfatal overdoses during January–October 2025 is 6,180, 10.7% lower than the total reported nonfatal overdoses for January–October 2024, 6,922. Monthly proportions of 2025 fatalities from January to October averaged 4.9%, moderately lower than the 5.7% in 2024 and the 6.1% in 2023. Monthly proportions in 2025 ranged from a high of 6.1% in February to a low of 3.9% in September.

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 July, August, September and October 2025 (see Figure 1).

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for October 2025, 587, is displayed in Table 1. Of those 587, there were 32 (5.5%) confirmed and suspected fatal overdoses, 251 (42.8%) nonfatal emergency department visits, 193 (32.9%) nonfatal EMS responses not transported to the emergency department, 100 (17.0%) reported community overdose reversals, and 11 (1.9%) law enforcement reversals in incidents that did not include EMS.

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



	Jan '24	Feb '24	Mar '24	Apr '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25	Apr '25	May '25	Jun '25	Jul '25	Aug '25	Sep '25	Oct '25
Suspected	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	15	23
Confirmed	43	45	61	44	40	42	39	31	34	32	39	40	31	33	32	34	26	38	29	30	16	9

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

	Nonfatal						
	Emergency Dept.	EMS not transported to emergency	Community reversals with naloxone	Law enforcement nonfatal overdose response without EMS	Total nonfatal overdoses	Total confirmed and suspected fatal overdoses	Total overdoses
January 2024	269	226	139	26	660	45	705
February 2024	305	242	136	28	711	43	754
March 2024	379	233	119	27	758	61	819
April 2024	252	205	190	14	661	44	705
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	287	215	119	10	631	31	662
September 2024	318	199	114	6	637	34	671
October 2024	299	198	86	17	600	32	632
November 2024	261	177	58	18	514	39	553
December 2024	353	190	49	12	604	40	644
2024 YTD total	3671	2609	1543	217	8040	490	8530
% of 2024 YTD total	43.0%	30.6%	18.1%	2.5%	94.3%	5.7%	100%
January 2025	234	193	53	15	495	31	526
February 2025	254	159	74	18	505	33	538
March 2025	375	202	71	31	679	32	711
April 2025	295	212	90	18	615	34	649
May 2025	310	202	88	13	613	26	639
June 2025	399	233	96	21	749	38	787
July 2025	321	247	70	15	653	31	684
August 2025	273	191	76	13	553	32	585
September 2025	389	243	118	13	763	31	794
October 2025	251	193	100	11	555	32	587
2025 YTD Total	3101	2075	836	168	6180	320	6500
% of 2025 YTD Total	47.7%	31.9%	12.9%	2.6%	95.1%	4.9%	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–October 2025 as well as January–December 2024. Monthly averages in 2025 are lower for fatal EMS and law enforcement incidences than in 2024. During 2024, law enforcement officers responded to a reported 1,156 overdose incidents (451 fatal; 705 nonfatal), and Maine EMS responded to a reported 9,507 incidents (385 fatal; 9,122 nonfatal). During January–October 2025, law enforcement officers responded to a reported 706 incidents (271 fatal; 435 nonfatal), and Maine EMS responded to a reported 7,787 incidents (224 fatal; 7,563 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–Oct 2025	Nonfatal overdose response Jan–Oct 2025	Total overdose response Jan–Oct 2025
Maine EMS	385	9122	9507	224	7563	7787
Monthly average	32	760	792	22	756	779
Law Enforcement	451	705	1156	271	435	706
Monthly average	38	59	96	27	44	71

*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 October 2025 monthly proportions in the far right column can be compared to the percentage of the census population on the far left, or to 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 January–October 2025 percentages for most counties fall within 0 to 2 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Cumberland County is 5 percentage points higher, and Androscoggin County is 4 percentage points higher. York County is 5 percentage points lower.

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

	% 2020 estimated Census population	Jan–Dec 2024 Est. N = 9122		Jan–Oct 2025 Est. N = 7563		Oct 2025 Est. N = 717	
Androscoggin	8%	913	10%	870	12%	81	11%
Aroostook	5%	488	5%	313	4%	21	3%
Cumberland	22%	2309	25%	2040	27%	180	25%
Franklin	2%	165	2%	138	2%	16	2%
Hancock	4%	242	3%	196	3%	16	2%
Kennebec	9%	907	10%	661	9%	59	8%
Knox	3%	262	3%	211	3%	26	4%
Lincoln	3%	171	2%	133	2%	10	1%
Oxford	4%	334	4%	280	4%	25	3%
Penobscot	11%	1139	12%	999	13%	117	16%
Piscataquis	1%	101	1%	90	1%	5	1%
Sagadahoc	3%	152	2%	124	2%	9	1%
Somerset	4%	399	4%	296	4%	36	5%
Waldo	3%	197	2%	169	2%	18	3%
Washington	2%	225	2%	181	2%	16	2%
York	16%	1118	12%	862	11%	82	11%

*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 October 2025, 2025 year to date, and 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 proportions 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 63% of the nonfatal overdose population in 2025. In 2025, 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 4 percentage points fewer overdose victims among those aged 55–64, and 10 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 = 9166		Jan–Oct 2025 Est. N = 7569		Oct 2025 Est. N = 716	
< 18	18%	384	4%	308	4%	25	3%
18–24	7%	829	9%	605	8%	59	8%
25–34	12%	1784	19%	1360	18%	134	19%
35–44	12%	2346	26%	2094	28%	187	26%
45–54	12%	1484	16%	1295	17%	118	16%
55–64	16%	1231	13%	928	12%	87	12%
> 64	23%	1108	12%	979	13%	106	15%

Table 5 displays the reported gender of individuals experiencing nonfatal overdoses involving EMS response in October 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 proportions in the EMS data can be compared to the 2020 census proportion by gender in the far left column or the January–December 2024 proportions in the center column. When comparing the January–October 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 60% during January–October 2025.

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

	% 2020 estimated Census population	Jan–Dec 2024 Est. N = 8813		Jan–Oct 2025 Est. N = 7295		Oct 2025 Est. N = 693	
Male	49%	5124	58%	4350	60%	438	63%
Female	51%	3688	42%	2942	40%	254	37%
Transgender	Not collected	1	0.0%	3	0.04%	1	0%

County and City Distribution of Suspected and Confirmed Fatal Overdoses

Table 6 shows the frequency distribution of fatal overdoses at the county level including some metro cities.[1] Other non-metropolitan areas or cities have not been included in this table due to lack of significant statistical relevance and concerns about confidentiality. The October 2025 monthly percentages in the far-right column can be compared either to the percentage of the census population in the far-left column, the percentages for 2024, or the 2025 year-to-date percentages. Caution must be exercised when viewing single counties or cities with small numbers for a single month. These may fluctuate randomly, without reflecting any significant statistical trend. The January through October 2025 percentages for most counties fall within 0 to 3 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Penobscot County is 4 percentage points higher. At the city level, Lewiston and Bangor are 5 percentage points higher and Portland is 8 percentage points higher than the 2020 census population.

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

	% 2020 estimated Census population	Jan–Dec 2024 Est. N = 490		Jan–Oct 2025 Est. N = 320		Oct 2025 Est. N = 32	
Androscoggin	8%	46	9%	35	11%	5	16%
Lewiston	3%	26	5%	27	8%	5	16%
Aroostook	5%	39	8%	22	7%	3	9%
Cumberland	22%	90	18%	71	22%	4	13%
Portland	5%	50	10%	40	13%	2	6%
Franklin	2%	6	1%	5	2%	0	0%
Hancock	4%	15	3%	6	2%	2	6%
Kennebec	9%	47	10%	23	7%	5	16%
Knox	3%	22	4%	6	2%	0	0%
Lincoln	3%	18	4%	6	2%	2	6%
Oxford	4%	20	4%	9	3%	0	0%
Penobscot	11%	64	13%	47	15%	3	9%
Bangor	2%	29	6%	22	7%	1	3%
Piscataquis	1%	5	1%	3	1%	0	0%
Sagadahoc	3%	7	1%	2	1%	2	6%
Somerset	4%	22	4%	8	3%	3	9%
Waldo	3%	18	4%	13	4%	0	0%
Washington	2%	16	3%	16	5%	2	6%
York	16%	55	11%	48	15%	1	3%

Age and Sex Distribution of Fatal Overdose Victims

Table 7 displays the age and sex composition2 of the fatal overdose population for October 2025, 2025 year to date, and 2024, compared to the 2020 estimated census population. When comparing the October 2025 data with 2024 or 2025 year to date, 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 year to date in 2025 (65%) is 1 percentage point lower than the 2024 proportion (66%) but 16 percentage points higher than the census population (49%). The age distribution for

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

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

January through October 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, but 75% of the fatal overdose population in 2025 and 2024. Ages 18–24 constitute 7% of the 2020 census population but only 2% of 2025 fatal overdoses. Those 65 and older comprise 23% of the census population but only 10% of the 2025 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 = 490		Jan–Oct 2025 Est. N = 320		Oct 2025 Est. N = 32	
Male	49%	322	66%	209	65%	23	72%
< 18	18%	5	1%	0	0%	0	0%
18–24	7%	13	3%	6	2%	0	0%
25–34	12%	65	13%	41	13%	2	6%
35–44	12%	143	29%	100	31%	13	41%
45–54	12%	126	26%	83	26%	8	25%
55–64	16%	98	20%	57	18%	4	13%
> 64	23%	40	8%	33	10%	5	16%

*Percentages may not total 100 due to rounding.

Table 8 displays the reported race and ethnicity of confirmed and suspected fatal overdoses in October 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 319 decedents for whom race was reported in 2025, 95% of the victims were identified as White, 2% as Black/African American, and 1% as American Indian/Alaska Native. Out of 316 decedents for whom Hispanic ethnicity status was reported, 1% 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 = 490		Jan–Oct 2025 Race N = 319		Oct 2025 Race N = 31	
White alone	94%	452	92%	304	95%	29	94%
Black/African American alone	2%	19	4%	6	2%	0	0%
American Indian/Alaska Native alone	1%	10	2%	3	1%	0	0%
Other race and 2+ races combined	3%	9	2%	6	2%	2	6%
B: Ethnicity	**% 2020 Estimated Census Population**	**Jan–Dec 2024 Ethnicity N = 483**		**Jan–Oct 2025 Ethnicity N = 316**		**Oct 2025 Ethnicity N = 29**	
Hispanic/Latinx alone	2%	9	2%	4	1%	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 317 cases for which military background was reported in 2025, 21 (6.6%) were identified as having a military background. Out of the 29 cases in October 2025 where military background was reported, 2 (7%) cases were identified as having a military background.

Of the 320 total suspected and confirmed fatal overdose cases year to date in 2025, undomiciled or transient housing status was reported for 42 (13%) victims. Among those 42, the largest county proportions of undomiciled persons were found in Androscoggin County (9, 21%), Cumberland County (10, 24%), Kennebec County (5, 12%) and York County (5, 12%). In October 2025, 9 fatal overdose victim (28%) were identified as undomiciled.

Basic Incident Patterns of Fatal Overdoses

Table 9 reports basic incident patterns for fatal overdoses. October 2025 can be compared to 2025 year to date or to 2024. 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 (57%) in 2025. This is a substantial change from 2024 when EMS and law enforcement responded together in 71% of the cases. During January through October 2025, law enforcement was more likely to respond to a scene alone (27%) than EMS (13%).

The majority (90%) of confirmed fatal drug overdoses were ruled as, or suspected of being, accidental manner of death year to date in 2025.

Of the 320 confirmed or suspected fatal overdoses in 2025, 73 (25%) had a reported history of prior overdose, fewer than in 2024 (30%).

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 30 (9%) of the 2025 year to date 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, 24% of suspected and confirmed fatal overdose cases had naloxone administered at the scene by EMS, bystanders, and/or law enforcement, which is slightly lower than the cases in 2024 (26%).

Of the 224 suspected or confirmed drug death cases with EMS involvement during 2025, 94 (42%) victims were already deceased when EMS arrived. In the remaining 130 (58%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 130 who were still alive when EMS arrived, 53 (41%) were transported, and 77 (59%) did not survive to be transported. Thus, out of 224 ultimately fatal cases with EMS response, only 53 (24%) 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

	2024 Jan–Dec Est. N = 490		Jan–Oct 2025 Est. N = 320		Oct 2025 Est. N = 32	
EMS response alone	35	7%	40	13%	0	0%
Law enforcement alone	96	20%	87	27%	13	41%
EMS and law enforcement	350	71%	181	57%	18	56%
Private transport to Emergency Dept.	0	0%	0	0%	0	0%
Naloxone administration reported at the scene	125	26%	77	24%	5	16%
Bystander only administered	48	10%	14	4%	1	3%
Law enforcement only administered	9	2%	6	2%	0	0%
EMS only administered	41	8%	36	11%	3	9%
EMS and law enforcement administered	2	0%	5	2%	0	0%
EMS and bystander administered	12	2%	9	3%	1	3%
Law enforcement and bystander administered	4	1%	4	1%	0	0%
EMS, bystander, and law enforcement administered	1	0%	2	1%	0	0%
Naloxone administered by unspecified person	2	0%	0	0%	0	0%
History of prior overdose	145	30%	73	23%	6	19%

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 167 (60%) victims. Totals may fluctuate as toxicology cases are confirmed.

Fentanyl is nearly always found in combination with multiple other drugs. The most common co-intoxicant tends to be a stimulant, either cocaine or methamphetamine, or both.

Heroin involvement, declining rapidly in recent years, was reported as a cause of death in 7 (3%) of 2025 deaths, and 12 (2%) of 2024 cases. Xylazine was identified as a co-intoxicant with fentanyl for the first time in 2021. Among 278 confirmed deaths year to date in 2025, there were 26 cases (9%) with xylazine listed in addition to fentanyl as a cause of death compared with 15% in 2024.

Stimulants continue to increase as a cause of death, usually in combination with other drugs, particularly fentanyl. Cocaine-involved fatalities constituted 125 (45%) of confirmed cases so far in 2025, slightly higher than 2024 (43%). Fentanyl is mentioned as a cause in combination with cocaine in 78 cases, which is 62% of 2025 year-to-date cocaine cases. Methamphetamine was cited as a cause of death in 96 (35%) of the confirmed fatal overdoses so far in 2025, slightly lower than 2024 (38%); 65 (68%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 29 (9%) death certificates in 2025, in most of those cases (22, 76%) as co-intoxicants of fentanyl. Thus, out of 167 fentanyl deaths, 121 (72%) included a stimulant (cocaine, methamphetamine, or both).

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 = 490		Jan–Oct 2025 Est. N = 278		Oct 2025 Est. N = 9	
Fentanyl or fentanyl analogs	339	69%	167	60%	9	100%
Heroin	12	2%	7	3%	0	0%
Cocaine	213	43%	125	45%	7	78%
Methamphetamine	184	38%	96	35%	4	44%
Pharmaceutical opioids**	84	17%	57	21%	2	22%
Fentanyl and heroin	12	2%	7	3%	0	0%
Fentanyl and cocaine	161	33%	78	28%	4	44%
Fentanyl and methamphetamine	137	28%	65	23%	3	33%
Fentanyl and xylazine	72	15%	26	9%	0	0%
Fentanyl and tramadol	1	0%	0	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

Rural Health Transformation Project

The State of Maine has recently applied for a portion of $1 billion over five years in federal funding through the Rural Health Transformation Program (RHTP). The RHTP was created within the federal July 2025 budget reconciliation bill and provides one-time resources to help states protect and sustain access to care in rural communities. The budget bill also includes cuts to federal health care spending that are projected to cost states just over a trillion dollars over the next five years. The total amount available to states in the RHTP is $50 billion, with the first $25 billion distributed evenly among states with each state expected to receive a minimum of $100 million a year for five years. The second $25 billion will be distributed by the U.S. Centers for Medicare and Medicaid Services (CMS) over the next five years to a limited number of states with approved plans based on a variety of factors, including the state's rurality and other factors to be specified. States expect to hear federal funding decisions in response to their applications in December.

Maine's RHTP proposal outlines a coordinated strategy to strengthen and modernize rural health systems across the state, including improving access to substance use treatment. Maine's proposed plan is organized around five specific initiatives.

1. Population Health: Promoting timely access to high-quality care
2. Workforce: Strengthening Maine's rural health workforce
3. Technology Innovation: Modernizing rural care delivery with digital health technology
4. Access: Bridging the healthcare affordability gap for rural Mainers
5. Sustainable rural health ecosystems: Addressing financial instability of providers serving rural Mainers.

Within these five initiatives, there are several provisions intended to expand access to SUD treatment in rural Maine:

a. Support access to the continuum of care for mental health and SUD services for special populations
b. Expand Community Health Worker and Peer Support programs
c. Expand access to methadone by adding 6 Opioid Treatment Programs in rural Maine (adding at least one new program per year)
d. Increase by 5% the proportion of MaineCare rural population with behavioral health needs that access ambulatory or primary care
e. Increase by 20% the relative percentage of youth behavioral health visits delivered via telehealth
f. Increase the initiation of new SUD treatment episodes for adults in the uninsured pool with initiation of treatment within 14 days

Although not specifically focused on SUD or behavioral health, many other initiatives in the Project should also result in increased access to all types of behavioral health treatment including enhancing workforce, expanding telehealth, providing payments for uncompensated care, improving transportation options, and improving the financial stability of rural hospitals.

For more information, including access to an 8-page summary of the project and a 60-page project narrative, go to https://www.maine.gov/dhhs/ruralhealth

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, expect totals to fluctuate from month to month because of random variation. 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, the 2024 statistics have changed slightly from those reported in the previous monthly report.

1 The Office of Attorney General supports ongoing 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.