MAINE MONTHLY OVERDOSE REPORT

For February 2026

Marcella H. Sorg, Prianka Maria Sarker, and Daniel S. Soucier
Margaret Chase Smith Policy Center, University of Maine

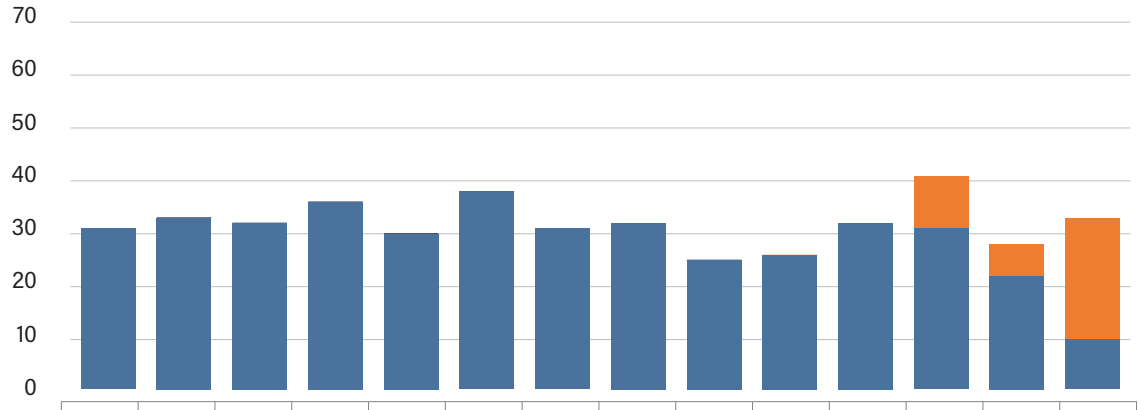
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine for the period January 2025–February 2026 (Table 1). The total number of confirmed and suspected fatal overdoses for January–February 2026 is 61, 4.7% lower than the total confirmed fatal overdoses for January–February 2025, 64. The total number of nonfatal overdoses for January–February 2026 is 1052, 4.9% higher compared to the reported nonfatal overdoses for January–February 2025, 1000. Monthly proportions of fatalities in January and February 2026 averaged 5.5%. During 2025, monthly proportions of fatalities averaged 5.0%, ranging from a high of 6.3% in December to a low of 3.2% 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 December 2025, January 2026, and February 2026 (see Figure 1).[1]

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for February 2026, 554, is displayed in Table 1. Of those 554, there were 33 (6.0%) confirmed and suspected fatal overdoses, 264 (47.7%) nonfatal emergency department visits, 149 (26.9%) nonfatal EMS responses not transported to the

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2025 through February 2026



	Jan '25	Feb '25	Mar '25	Apr '25	May '25	Jun '25	Jul '25	Aug '25	Sep '25	Oct '25	Nov '25	Dec '25	Jan '26	Feb '26
Suspected	0	0	0	0	0	0	0	0	0	0	0	10	6	23
Confirmed	31	33	32	36	30	38	31	32	25	26	32	31	22	10

1 Until overdose is confirmed as a cause of death, the manner of death is not certified. The vast majority of the suspected fatal overdoses are ultimately certified accidental manner of death, approximately 90%.

emergency department, 96 (17.3%) reported community overdose reversals, and 12 (2.2%) law enforcement reversals in incidents that did not include EMS.

Note that we have modified reporting methods for subpopulations. Data tables now report a rolling three-month total rather than a total for a single month. This improves confidentiality protections and reduces the focus on very small totals that are not statistically significant. In addition, we are now suppressing subpopulation totals less than 5.

Table 1: Composite reported overdose totals, all drugs, January 2025–February 2026

	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 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	36	651
May 2025	311	202	88	13	614	30	644
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	385	244	118	13	760	25	785
October 2025	254	194	100	11	559	26	585
November 2025	267	177	70	9	523	32	555
December 2025	318	178	104	8	608	41	649
2025 YTD Total	3686	2432	1010	185	7313	387	7700
% of 2025 YTD Total	47.9%	31.6%	13.1%	2.4%	95.0%	5.0%	100%
January 2026	256	156	105	14	531	28	559
February 2026	264	149	96	12	521	33	554
2026 YTD Total	520	305	201	26	1052	61	1113
% of 2026 YTD Total	46.7%	27.4%	18.1%	2.3%	94.5%	5.5%	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–February 2026 as well as during January–December 2025. During 2025, law enforcement officers responded to a reported 855 overdose incidents (321 fatal; 534 nonfatal), and Maine EMS responded to a reported 9,167 incidents (291 fatal; 8,876 nonfatal). In January–February 2026, law enforcement officers responded to a reported 120 overdose incidents (55 fatal; 65 nonfatal), and Maine EMS responded to a reported 1285 incidents (41 fatal; 1244 nonfatal).

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

	Fatal overdose response Jan–Dec 2025	Nonfatal overdose response Jan–Dec 2025	Total overdose response Jan–Dec 2025	Fatal overdose response Jan–Feb 2026	Nonfatal overdose response Jan–Feb 2026	Total overdose response Jan–Feb 2026
Maine EMS	291	8876	9167	41	1244	1285
Monthly average	24	740	764	21	622	643
Law Enforcement	321	534	855	55	65	120
Monthly average	27	45	71	28	33	60

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. To improve statistical reliability and protect data confidentiality, the county level totals are presented as a yearly total for 2025 and as a rolling 3-month aggregate for the period December 2025–February 2026. The rolling 3-month aggregate percentage in the rightmost column can be compared to the percentage of the census population, or to the percentage of nonfatal overdoses for the year 2025. Caution must be exercised viewing single counties, even the three-month totals, as these totals may fluctuate randomly, without reflecting any statistically significant trend.

During December 2025–February 2026, 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 3 percentage points higher. York County is 3 percentage points lower.

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

	% 2020 estimated Census population	Jan–Dec 2025 Est. N = 8876		Dec 2025–Feb 2026 Est. N = 1905	
Androscoggin	8%	1004	11%	210	11%
Aroostook	5%	372	4%	86	5%
Cumberland	22%	2374	27%	510	27%
Franklin	2%	152	2%	27	1%
Hancock	4%	236	3%	65	3%
Kennebec	9%	799	9%	177	9%
Knox	3%	257	3%	53	3%
Lincoln	3%	165	2%	41	2%
Oxford	4%	331	4%	58	3%
Penobscot	11%	1147	13%	223	12%
Piscataquis	1%	96	1%	20	1%
Sagadahoc	3%	144	2%	31	2%
Somerset	4%	358	4%	82	4%
Waldo	3%	194	2%	36	2%
Washington	2%	217	2%	47	2%
York	16%	1030	12%	239	13%

Note: 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. Overdose reversal totals reported by community partners and emergency departments are not categorized and reported by age; only EMS case data include age frequencies. To support statistical reliability and data confidentiality, subpopulation age group proportions are presented as annual figures for the year 2025 and as rolling 3-month totals for December 2025–February 2026.

The age distribution for both the 2025 yearly total and the rolling 3-month total (December 2025–February 2026) 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% of the nonfatal overdose population in 2025, and 59% of the nonfatal overdose population during December 2025–February 2026. In the most recent three months, 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 9 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 2025 Est. N = 8886		Dec 2025–Feb 2026 Est. N = 1914	
< 18	18%	367	4%	84	4%
18–24	7%	726	8%	179	9%
25–34	12%	1585	18%	326	17%
35–44	12%	2423	27%	502	26%
45–54	12%	1532	17%	305	16%
55–64	16%	1091	12%	244	13%
> 64	23%	1162	13%	274	14%

Table 5 displays the reported gender of individuals experiencing nonfatal overdoses involving EMS response. Overdose reversal totals reported by community partners and emergency departments are not categorized by gender; only EMS case data include gender categories. To support statistical reliability and maintain data confidentiality, gender group proportions are presented as annual figures for the year 2025 and as rolling 3-month totals for December 2025–February 2026.

Gender group proportions in the EMS data for the year 2025 or for the rolling 3-month aggregates can be compared to the 2020 census proportion in the leftmost column. Males represent 49% of the 2020 estimated census population, 59% of the nonfatal overdose victims with EMS involvement in 2025, and 56% during December 2025–February 2026.

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

	% 2020 estimated Census population	Jan–Dec 2025 Est. N = 8572		Dec 2025–Feb 2026 Est. N = 1842	
Male	49%	5076	59%	1040	56%
Female	51%	3492	41%	802	44%

County and City Distribution of Suspected and Confirmed Fatal Overdoses

Table 6 shows the frequency distribution of fatal overdoses at the county level including larger metro cities.[2] To mitigate monthly volatility and confidentiality concerns due to small cell sizes, county/city level estimates are presented as yearly totals for 2025 and as rolling 3-month totals for December 2025–February 2026, instead of monthly figures, and totals below 5 are suppressed.

During December 2025–February 2026, the 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 7 percentage points higher, and Washington County is 4 percentage points higher. At the city level for December 2025–February 2026, Bangor is 12 percentage points and Portland is 10 percentage points higher than the 2020 census population.

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

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

	% 2020 estimated Census population	Jan–Dec 2025 Est. N = 387		Dec 2025–Feb 2026 Est. N = 102	
Androscoggin	8%	42	11%	7	7%
Lewiston	3%	29	7%	5	5%
Aroostook	5%	26	7%	7	7%
Cumberland	22%	86	22%	25	25%
Portland	5%	50	13%	15	15%
Franklin	2%	6	2%	<5	*
Hancock	4%	6	2%	<5	*
Kennebec	9%	26	7%	6	6%
Knox	3%	9	2%	<5	*
Lincoln	3%	8	2%	<5	*
Oxford	4%	13	3%	<5	*
Penobscot	11%	68	18%	18	18%
Bangor	2%	35	9%	14	14%
Piscataquis	1%	<5	*	<5	*
Sagadahoc	3%	<5	*	<5	*
Somerset	4%	10	3%	<5	*
Waldo	3%	15	4%	<5	*
Washington	2%	14	4%	6	6%
York	16%	53	14%	14	14%

<5 Estimates with a count of less than 5 are suppressed due to statistical reliability and confidentiality purposes.
* Percentages are suppressed due to small cell sizes (n <5).

Age and Sex Distribution of Fatal Overdose Victims

Table 7 displays the age and sex composition[3] of the fatal overdose population for the year 2025 and for the rolling 3-month period of December 2025–February 2026.

The rolling 3-month aggregate proportion of males for December 2025 to February 2026 is 61%, which is 12 percentage points higher than the census population. The cumulative proportion of males in 2025 is 66%. The age distribution for both the year 2025 and the period December 2025–February 2026 compared to the 2020 census proportion shows a disproportionately large impact of fatal overdoses in those aged 35–64. That group includes 40% of the 2020 estimated census population, compared to 73% of the fatal overdose population during December 2025–February 2026 and 76% of the fatal overdose population in 2025. Those ages 18–24 constitute 7% of the 2020 census population but 2% of 2025 fatal overdoses. Those 65 and older constitute 23% of the census population but only 10% of the 2025 fatal overdoses.

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

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

	% 2020 estimated Census population	Jan–Dec 2025 Est. N = 387	Dec 2025–Feb 2026 Est. N = 102
Male	49%	254 66%	62 61%
< 18	18%	<5 *	<5 *
18–24	7%	6 2%	<5 *
25–34	12%	48 12%	12 12%
35–44	12%	114 29%	30 29%
45–54	12%	98 25%	25 25%
55–64	16%	81 21%	19 19%
> 64	23%	40 10%	15 15%

<5 Estimates with a count of less than 5 are suppressed due to statistical reliability and confidentiality purposes.
* Percentages are suppressed due to small cell sizes (n <5).
Note: Percentages may not total 100 due to rounding.

Table 8 displays the reported race and ethnicity of confirmed and suspected fatal overdoses during January–December 2025 and December 2025–February 2026, 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 102 decedents for whom race was reported in December 2025–February 2026, 93% of the victims were identified as White.

Table 8: Decedent race and ethnicity among suspected and confirmed fatal overdoses[4]

A: Race	% 2020 estimated Census population	Jan–Dec 2025 Race N = 387	Dec 2025–Feb 2026 N = 102
White alone	94%	373 96%	95 93%
Black/African American alone	2%	7 2%	<5 *
American Indian/Alaska Native alone	1%	<5 *	<5 *
Other race and 2+ races combined	3%	<5 *	<5 *
B: Ethnicity	**% 2020 estimated Census population**	**Jan–Dec 2025 Ethnicity N = 384**	**Dec 2025–Jan 2026 N = 99**
Hispanic/Latinx alone	2%	<5 *	<5 *

<5 Estimates with a count of less than 5 are suppressed due to statistical reliability and confidentiality purposes.
* Percentages are suppressed due to small cell sizes (n <5).
Note: Percentages may not total 100 due to rounding.

Military Status and Housing Stability of Fatal Overdose Victims

Out of the 387 cases for which military background was reported in January–December 2025, 29 (7.5%) were identified as having a military background. Out of the 102 cases in December 2025–February 2026 where military background was reported, 6 (5.9%) cases were identified as having a military background.

Of the 387 total suspected and confirmed fatal overdose cases in January–December 2025, undomiciled or transient housing status was reported for 52 (13.4%) victims. Of the 102 total suspected and confirmed fatal overdose cases in December 2025–February 2026, 13 (12.7%) fatal overdose victims were identified as undomiciled.

Basic Incident Patterns of Fatal Overdoses

Table 9 reports basic incident patterns for fatal overdoses. For statistical relevance and confidentiality purposes, totals are reported for 2025 as a whole and as rolling 3-month totals for December 2025–February 2026. Caution must be exercised since data totals may change slightly as suspected cases are confirmed or eliminated.

4 Race and ethnicity data for some cases are unavailable until drug deaths are confirmed.

Both EMS and police responded together to most fatal overdoses (49%) in December 2025- February 2026. Law enforcement was more likely to respond to a scene alone (31%) than EMS (18%) was. Most (92%) suspected and confirmed fatal drug overdoses were accidental manner of death. Of the 87 confirmed or suspected fatal overdoses in December 2025–February 2026 for which overdose history was known, 23 (26%) had a reported history of prior overdose.

In most overdose cases, bystanders or witnesses were present at the scene by the time first responders arrived, although the details about who was present at the time of the overdose were frequently unclear. In some cases, responding family and friends or other bystanders administered naloxone. Often, EMS and/or law enforcement administered naloxone in addition to bystanders or witnesses. During December 2025–January 2026, 17% of the suspected and confirmed fatal overdose cases had naloxone administered at the scene by EMS, law enforcement, or bystanders, or by combinations of these entities.

Of the 68 suspected or confirmed drug death cases with EMS response during December 2025– February 2026, 23 (34%) victims were already deceased when EMS arrived. In the remaining 45 (66%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 45 ultimately fatal victims who were alive when EMS arrived, 18 (40%) were transported, and 27 (60%) did not survive to be transported. Thus, out of 68 ultimately fatal cases with EMS response, only 18 (26%) 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 2025 Est. N = 387		Dec 2025–Feb 2026 Est. N = 102	
EMS response alone	57	15%	18	18%
Law enforcement alone	86	22%	32	31%
EMS and law enforcement	234	60%	50	49%
Naloxone administration reported at the scene	95	25%	8	8%
EMS administered naloxone	62	16%	9	9%
Law enforcement administered naloxone	22	6%	<5	*
Bystander administered naloxone	40	10%	5	5%
History of prior overdose	95	26%	23	26%

<5 Estimates with a count of less than 5 are suppressed due to statistical reliability and confidentiality purposes.

* Percentages are suppressed due to small cell sizes (n <5).

Key Drug Categories of Fatal Overdoses

Table 10 displays the frequencies of the most prominent drug categories causing death among confirmed drug deaths. Similarly to most other frequency distributions in this report, the drug category estimates are presented for the whole year of 2025 and for the rolling aggregate of the period December 2025–February 2026. As expected, within the confirmed drug death cases in December 2025–February 2026, nonpharmaceutical fentanyl, including nonpharmaceutical fentanyl analogs, was the most frequent cause of death, mentioned on the death certificate of 37 (59%) victims. The proportion of confirmed fentanyl overdose deaths has declined from its 2023 peak of 78% to 69% in 2024, and an estimated 55% for confirmed overdoses in 2025.

Fentanyl is nearly always found in combination with multiple other drugs. Xylazine was identified as a co-intoxicant with fentanyl for the first time in 2021. Among 377 confirmed deaths in 2025, there were 30 cases (8%) with xylazine listed in addition to fentanyl as a cause of death. During December 2025- February 2026, there were fewer than 5 confirmed cases that involved xylazine in addition to fentanyl. In 2025, 2% of the confirmed drug

deaths involved heroin. There was no mention of heroin involvement as a cause of death among confirmed cases in the last three months.

Stimulants continue to increase as a cause of death, usually in combination with other drugs, particularly fentanyl. Cocaine-involved fatalities constituted 30 (48%) of confirmed cases so far in December 2025–February 2026. The percentage of cocaine cases among confirmed deaths in 2025 was 45%, slightly higher than the percentage in 2024 (43%) and higher than in 2023 (37%). Fentanyl is mentioned as a cause in combination with cocaine in 17 of the December 2025–February 2026 cases, 57% of the cocaine cases. Methamphetamine was cited as a cause of death in 19 (30%) of the confirmed fatal overdoses in December 2025–February 2026; 12 (63%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 6 (10%) death certificates in the most recent three months.

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 2025 Est. N = 377		Dec 2025–Feb 2026 Est. N= 63	
Fentanyl or fentanyl analogs	207	55%	37	59%
Heroin	8	2%	<5	*
Cocaine	168	45%	30	48%
Methamphetamine	121	32%	19	30%
Pharmaceutical opioids	83	22%	14	22%
Fentanyl and heroin	8	2%	<5	*
Fentanyl and cocaine	104	28%	17	27%
Fentanyl and methamphetamine	79	21%	12	19%
Fentanyl and xylazine	30	8%	<5	*
Cocaine and methamphetamine	41	11%	6	10%
Fentanyl, cocaine and methamphetamine	30	8%	<5	*

Note: 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.

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. Starting in 2026, in order to support greater statistical reliability and due to confidentiality concerns, we will be using rolling three-month aggregations instead of single month totals in the tables. In addition, we will suppress totals less than 5.

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 2025 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 some of the 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.