

# MAINE MONTHLY OVERDOSE REPORT

For April 2026

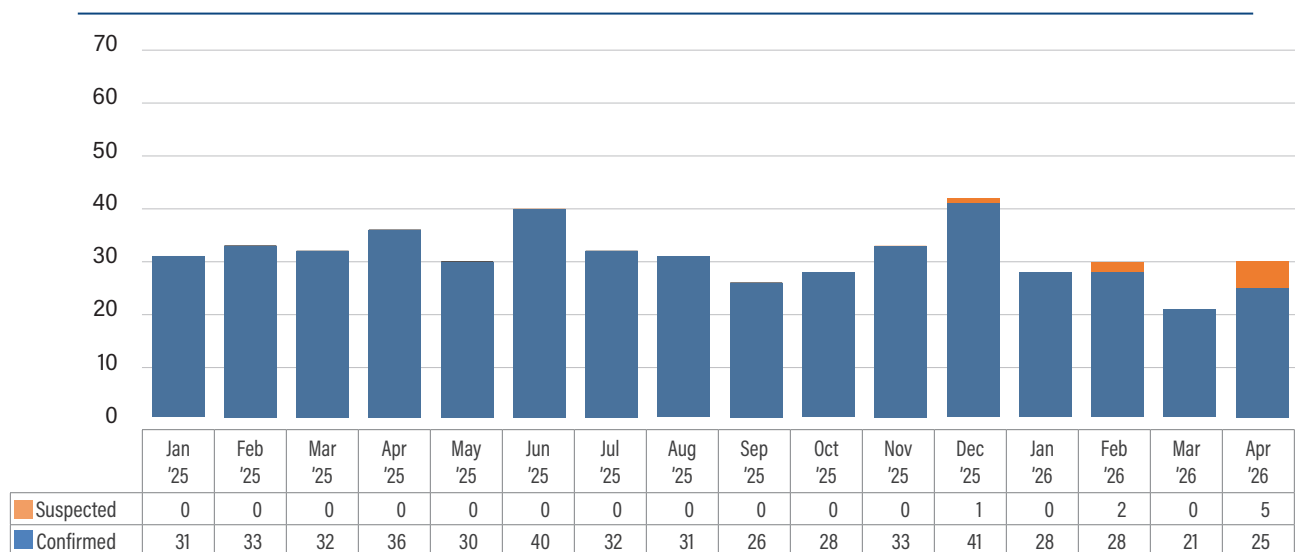
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## Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine for the period January 2025–April 2026 (Table 1).<sup>1</sup> The total number of confirmed and suspected fatal overdoses for January–April 2026 is 109, 17.4% lower than the total confirmed fatal overdoses for January–April 2025, 132. The total number of nonfatal overdoses for January–April 2026 is 2,878, 3.6% higher compared to the reported nonfatal overdoses for January–April 2025, 2,777. Monthly proportions of fatalities during January–April 2026 averaged 3.6%. During 2025, monthly proportions of fatalities averaged 4.2%, ranging from a high of 5.2% in December to a low of 2.8% 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, February 2026, and April 2026 (see Figure 1).<sup>2</sup>

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



- 1 In this report, there is a noticeable increase in the EMS overdose numbers for the period January 2025–March 2026. There was a technical issue with the EMS patient care reporting system, which was causing underreporting of the overdose data. The problem has now been resolved.
- 2 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%.

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for April 2026, 800 is displayed in Table 1. Of those 800, there were 30 (3.8%) confirmed and suspected fatal overdoses, 291 (36.4%) nonfatal emergency department visits, 322 (40.3%) nonfatal EMS responses not transported to the emergency department, 139 (17.4%) reported community overdose reversals, and 18 (2.3%) 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–April 2026

	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 2025	234	321	53	15	623	31	654
February 2025	254	275	74	18	621	33	654
March 2025	375	330	71	31	807	32	839
April 2025	295	323	90	18	726	36	762
May 2025	311	341	88	13	753	30	783
June 2025	399	367	96	21	883	40	923
July 2025	321	438	70	15	844	32	876
August 2025	272	415	76	13	776	31	807
September 2025	385	392	118	13	908	26	934
October 2025	254	351	100	11	716	28	744
November 2025	267	307	70	9	653	33	686
December 2025	319	331	104	8	762	42	804
2025 YTD Total	3686	4191	1010	185	9072	394	9466
% of 2025 YTD Total	38.9%	44.3%	10.7%	2.0%	95.8%	4.2%	100%
January 2026	257	321	105	14	697	28	725
February 2026	270	284	96	12	662	30	692
March 2026	325	310	97	17	749	21	770
April 2026	291	322	139	18	770	30	800
2026 YTD Total	1143	1237	437	61	2878	109	2987
% of 2026 YTD Total	38.3%	41.4%	14.6%	2.0%	96.4%	3.6%	100%

## Law Enforcement and EMS 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–April 2026 as well as during January–December 2025. During 2025, law enforcement officers responded to a reported 862 overdose incidents (328 fatal; 534 nonfatal), and Maine EMS responded to a reported 16,740 incidents (297 fatal; 16,443 nonfatal). In January–April 2026, law enforcement officers responded to a reported 241 overdose incidents (95 fatal; 146 nonfatal), and Maine EMS responded to a reported 5,018 incidents (76 fatal; 4,942 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–Apr 2026	Nonfatal overdose response Jan–Apr 2026	Total overdose response Jan–Apr 2026
Maine EMS	297	16443	16740	76	4942	5018
Monthly average	25	1370	1395	19	1236	1255
Law Enforcement	328	534	862	95	146	241
Monthly average	27	45	72	24	37	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 February–April 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 February–April 2026, percentages 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 3 percentage points higher.

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

	% 2020 estimated Census population	Jan-Dec 2025 Est. N = 16443		Rolling 3-month total Feb-Apr 2026 Est. N = 3721	
Androscoggin	8%	1687	10%	406	11%
Aroostook	5%	634	4%	156	4%
Cumberland	22%	4102	25%	926	25%
Franklin	2%	376	2%	107	3%
Hancock	4%	542	3%	114	3%
Kennebec	9%	1424	9%	285	8%
Knox	3%	472	3%	83	2%
Lincoln	3%	364	2%	70	2%
Oxford	4%	702	4%	154	4%
Penobscot	11%	1948	12%	452	12%
Piscataquis	1%	191	1%	37	1%
Sagadahoc	3%	344	2%	86	2%
Somerset	4%	712	4%	156	4%
Waldo	3%	366	2%	87	2%
Washington	2%	377	2%	82	2%
York	16%	2202	13%	520	14%

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 February–April 2026.

The age distribution for both the 2025 yearly total and the rolling 3-month total (February–April 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 51% of the nonfatal overdose population in 2025, and 51% of the nonfatal overdose population during February–April 2026. In the most recent three months, there are 16 percentage points fewer overdose victims among those under the age of 18 compared to the percentage of the census population in that age group. There were 1 percentage point more overdose victims among those aged 55–64 and 1 percentage point 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 = 16645		Rolling 3-month total Feb-Apr 2026 Est. N = 3742	
< 18	18%	464	3%	90	2%
18-24	7%	1322	8%	309	8%
25-34	12%	2373	14%	521	14%
35-44	12%	3466	21%	794	21%
45-54	12%	2619	16%	588	16%
55-64	16%	2746	16%	629	17%
> 64	23%	3655	22%	811	22%

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 February–April 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 and 61% of the nonfatal overdose victims with EMS involvement in 2025 and 62% in February–April 2026.

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

	% 2020 estimated Census population	Jan-Dec 2025 Est. N = 15969		Rolling 3-month total Feb-Apr 2026 Est. N = 3612	
Male	49%	9737	61%	2251	62%
Female	51%	6232	39%	1361	38%

### 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.<sup>3</sup> 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 February–April 2026, instead of monthly figures, and totals below 5 are suppressed.

During February–April 2026, the percentages for most counties fall within 0 to 3 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Cumberland County is 5 percentage points higher, Penobscot County is 9 percentage points higher, and York County is 6 percentage points lower. At the city level for February–April 2026, Bangor is 9 percentage points and Portland is 14 percentage points higher than their respective 2020 census populations.

<sup>3</sup> 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 = 394		Rolling 3-month total Feb-Apr 2026 Est. N = 81	
Androscoggin	8%	41	10%	5	6%
Lewiston	3%	28	7%	<5	*
Aroostook	5%	27	7%	<5	*
Cumberland	22%	86	22%	22	27%
Portland	5%	51	13%	15	19%
Franklin	2%	7	2%	<5	*
Hancock	4%	6	2%	<5	*
Kennebec	9%	27	7%	8	10%
Knox	3%	9	2%	<5	*
Lincoln	3%	8	2%	<5	*
Oxford	4%	16	4%	<5	*
Penobscot	11%	69	18%	16	20%
Bangor	2%	36	9%	9	11%
Piscataquis	1%	<5	*	<5	*
Sagadahoc	3%	<5	*	<5	*
Somerset	4%	10	3%	5	6%
Waldo	3%	14	4%	<5	*
Washington	2%	14	4%	<5	*
York	16%	54	14%	8	10%

<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<sup>4</sup> of the fatal overdose population for the year 2025 and for the rolling 3-month period of February–April 2026.

The rolling 3-month aggregate proportion of males for February to April 2026 is 62%, which is 13 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 February–April 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 68% of the fatal overdose population during February–April 2026 and 75% of the fatal overdose population in 2025. Those ages 18–24 constitute 7% of the 2020 census population but only 2% of 2025 fatal overdoses. Those 65 and older constitute 23% of the census population but only 11% of the 2025 fatal overdoses and 10% of the February–April 2026 fatal overdoses.

<sup>4</sup> 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 = 394		Rolling 3-month total Feb-Apr 2026 Est. N = 81	
Male	49%	260	66%	50	62%
< 18	18%	<5	*	<5	*
18–24	7%	6	2%	6	7%
25–34	12%	49	12%	12	15%
35–44	12%	115	29%	23	28%
45–54	12%	98	25%	16	20%
55–64	16%	82	21%	16	20%
> 64	23%	44	11%	8	10%

<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 February–April 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 80 decedents for whom race was reported in February–April 2026, 90% of the victims were identified as White.

**Table 8:** Decedent race and ethnicity among suspected and confirmed fatal overdoses<sup>5</sup>

A: Race	% 2020 Estimated Census Population	Jan-Dec 2025 Race N = 394		Rolling 3-month total Feb-Apr 2026 Race N = 80	
White alone	94%	380	96%	72	90%
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 = 391		Rolling 3-month total Feb-Apr 2026 Ethnicity N = 77	
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 394 cases for which military background was reported in January–December 2025, 29 (7%) were identified as having a military background. Out of the 79 cases in February–April 2026 where military background was reported, fewer than 5 cases were identified as having a military background.

Of the 394 total suspected and confirmed fatal overdose cases in January–December 2025, undomiciled or transient housing status was reported for 50 (13%) victims. Of the 81 total suspected and confirmed fatal overdose cases in February–April 2026, 16 (20%) victims were identified as undomiciled.

<sup>5</sup> Race and ethnicity data for some cases are unavailable until drug deaths are confirmed.

## 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 February–April 2026. Caution must be exercised since data totals may change slightly as suspected cases are confirmed or eliminated.

Both EMS and police responded together to most fatal overdoses (56%) in February–April 2026. Law enforcement was more likely to respond to a scene alone (32%) than EMS (11%) was. Most (93%) suspected and confirmed fatal drug overdoses were accidental manner of death. Of the 75 confirmed or suspected fatal overdoses in February–April 2026 for which overdose history was known, 21 (28%) 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 February–April 2026, 22% 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 54 suspected or confirmed drug death cases with EMS response during February–April 2026, 19 (35%) victims were already deceased when EMS arrived. In the remaining 35 (65%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 35 ultimately fatal victims who were alive when EMS arrived, 12 (34%) were transported, and 23 (66%) did not survive to be transported. Thus, out of 54 ultimately fatal cases with EMS response, only 12 (22%) 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 = 394	Rolling 3-month total Feb–Apr 2026 Est. N = 81
EMS response alone	57 14%	9 11%
Law enforcement alone	87 22%	26 32%
EMS and law enforcement	240 61%	45 56%
Naloxone administration reported at the scene	95 24%	18 22%
EMS administered naloxone	62 16%	<5 *
Law enforcement administered naloxone	22 6%	<5 *
Bystander administered naloxone	39 10%	5 7%
History of prior overdose	96 26%	21 28%

<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 February–April 2026. As expected, within the confirmed drug death cases in February–April 2026, nonpharmaceutical fentanyl, including nonpharmaceutical fentanyl analogs, was the most frequent cause of death, listed on the death certificate of 42 (57%) victims. The proportion of confirmed fentanyl overdose deaths has declined from its 2023 peak of 78% to 69% in 2024, and an estimated 54% so far 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 393 confirmed deaths in 2025, there were 30 cases (8%) with xylazine listed in addition to fentanyl as a cause of death. During February–April 2026, there were 6 (8%) 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 33 (45%) of confirmed cases so far in February–April 2026. The percentage of cocaine cases among confirmed deaths in 2025 was 45%, which is higher than the percentage in 2024 (43%) and in 2023 (37%). Fentanyl is listed as a cause in combination with cocaine in 20 of the February–April 2026 cases, 61% of the cocaine cases. Methamphetamine was cited as a cause of death in 23 (31%) of the confirmed fatal overdoses in February–April 2026; 17 (74%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 8 (11%) 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 = 393	Rolling 3-month total Feb-Apr 2026 Est. N = 74
Fentanyl or fentanyl analogs	213 54%	42 57%
Heroin	8 2%	<5 *
Cocaine	178 45%	33 45%
Methamphetamine	122 31%	23 31%
Pharmaceutical opioids	90 23%	19 26%
Fentanyl and heroin	8 2%	<5 *
Fentanyl and cocaine	109 28%	20 27%
Fentanyl and methamphetamine	79 20%	17 23%
Fentanyl and xylazine	30 8%	<5 *
Cocaine and methamphetamine	41 10%	8 11%
Fentanyl, cocaine and methamphetamine	30 8%	6 8%

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.

### Emerging Substances Causing Death

The Maine Office of Chief Medical Examiner keeps close tabs on emerging substances that may cause death, most found in combination with fentanyl. When new substances are detected in Maine decedents by the National Medical Services Lab, the Office receives a report. Those substances are then quantified in the victim’s toxicology report and may be added as a cause of death. In most cases, Maine has not seen many of the new and emerging substances reported nationally. Frequencies have been very low, generally under 5. One exception is bromazolam, a nonpharmaceutical benzodiazepine, which was found in 10 (3%) of cases during 2025 and four cases so far in 2026. The other exception is ortho-methylfentanyl, a nonpharmaceutical fentanyl analog (an opioid), which was found in 8 (2%) of cases during 2025 and two cases so far in 2026. Carfentanil (an opioid) is not new but is a particularly lethal veterinary tranquilizer. It was found in 9 (2%) of 2025 Maine cases and two so far in 2026. Another dangerous veterinary sedative, medetomidine, which is not an opioid, is being found more often in other states, but was only found in one case during 2025 and none so far in 2026. Bromazolam and medetomidine overdoses cannot be reversed by naloxone.

## Highlight of the Month

### Governor's Annual Opioid Response Summit

Since June 2019, Governor Janet T. Mills has hosted an annual opioid response summit. Her eighth and final summit will be held in Bangor on Thursday, July 16 at the Cross Insurance Center and will feature the theme of Building Hope, Honoring Progress and Inspiring Change. The summits provide an opportunity each year to convene leaders from around Maine and the nation to share ideas, strategies, and best practices to help Maine people affected by the opioid epidemic. While remarkable progress has been made during the previous seven years, there is still much work to be done.

Emphasizing the theme of HOPE, the keynote speaker this year is Kathryn Goetzke, MBA, the CEO and Chief Hope Officer of the Shine Hope Company. Kathryn is the author of *The Biggest Little Book About HOPE*, a 2022 publication which is a skill-based guide for anyone seeking personal growth and discovery that leads into a more hope-filled future. And, as in previous years, each talk at the summit, including the 39 breakout sessions, will begin with a Voice of Recovery. These voices offer a poignant reminder of the possibilities of sustained recovery after a period of experiencing substance use disorder.

Highlighting successes and challenges over the past eight years, the breakout sessions offer programming in the four essential pillars of Prevention, Harm-Reduction, Treatment, and Recovery. The 39 sessions are offered over three periods during the all-day program.

Additional presenters include Governor Mills, Attorney General Aaron Frey, Maine CDCP Director Puthiery Va, D.O., Director of the Office of Behavioral Health Sarah Squirrell, and Director of the Office of MaineCare Services Michelle Probert.

A preconference program will be offered the evening before the Summit (Wednesday, July 15), also at the Cross Insurance Center in Bangor. Hosted by the Bangor Office of Public Health & Community Services and the Maine Centers for Disease Control and Prevention, the program features a panel discussion with physician and author Jeremy Nobel, M.D., MPH. Dr. Nobel is a primary care physician, public health practitioner, and award-winning poet with faculty appointments at the Harvard TH Chan School of Public Health and Harvard Medical School. He is the founder and president of The Foundation for Art & Healing, whose signature initiative, Project UnLonely, addressing the personal and public health challenges of loneliness and social isolation, has gained national visibility. This program, which is free to all attendees, will be held from 6:00 to 7:30 pm.

This year's summit will also feature an art show highlighting curated selections from several regional art shows hosted by recovery community centers and supported by the Maine CDCP through its PDO (Preventing Drug Overdose) federal grant. This initiative, titled, *See the Person, not the Use* is taking place currently at several sites across the state.

Persons wishing to register for either the pre-conference program or the Summit may do so at <https://cvent.me/y9vZ8l>

## Background Information about this Report

This report, funded jointly by the Maine Office of Attorney General and the Office of Behavioral Health,<sup>1</sup> 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](http://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 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.