MAINE MONTHLY OVERDOSE REPORT

For May 2026

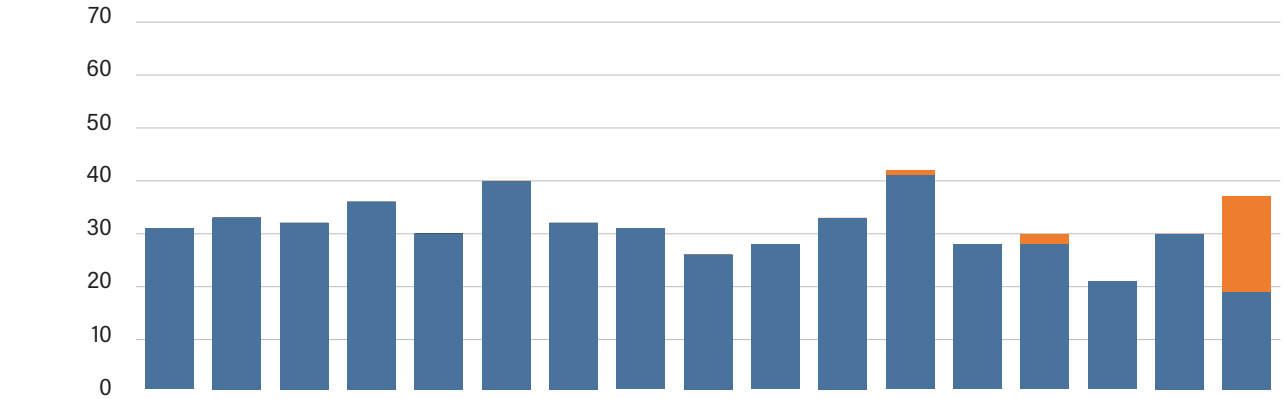
Marcella H. Sorg, Prianka Maria Sarker, and Daniel S. Soucier
Margaret Chase Smith Policy Center, University of Maine

Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine for the period January 2025–May 2026 (Table 1). The total number of confirmed and suspected fatal overdoses for January–May 2026 is 146, 9.9% lower than the total confirmed fatal overdoses for January–May 2025, 162. The total number of nonfatal overdoses for January–May 2026 is 3,669, 3.9% higher compared to the reported nonfatal overdoses for January–May 2025, 3,530. Monthly proportions of fatalities during January–May 2026 averaged 3.8%. 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 May 2026 (see Figure 1).[1]

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2025 through May 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	Mar '26	Apr '26	May '26
Suspected	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0	0	18
Confirmed	31	33	32	36	30	40	32	31	26	28	33	41	28	28	21	30	19

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%.

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for May 2026, 827 is displayed in Table 1. Of those 827, there were 37 (4.5%) confirmed and suspected fatal overdoses, 302 (36.5%) nonfatal emergency department visits, 347 (42.0%) nonfatal EMS responses not transported to the emergency department, 134 (16.2%) reported community overdose reversals, and 7 (0.8%) 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.[2] 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–May 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	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	326	310	97	17	750	21	771
April 2026	291	322	139	18	770	30	800
May 2026	302	347	134	7	790	37	827
2026 YTD Total	1446	1584	571	68	3669	146	3815
% of 2026 YTD Total	37.9%	41.5%	15.0%	1.8%	96.2%	3.8%	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

2 We have also incorporated year-to-date (YTD) totals for subpopulations for the current reporting year.

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–May 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–May 2026, law enforcement officers responded to a reported 289 overdose incidents (126 fatal; 163 nonfatal), and Maine EMS responded to a reported 6,399 incidents (102 fatal; 6,297 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–May 2026	Nonfatal overdose response Jan–May 2026	Total overdose response Jan–May 2026
Maine EMS	297	16443	16740	102	6297	6399
Monthly average	25	1370	1395	20	1259	1280
Law Enforcement	328	534	862	126	163	289
Monthly average	27	45	72	25	33	58

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, year-to-date total for 2026, and a rolling 3-month aggregate for the period March–May 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 or year-to-date 2026. Caution must be exercised viewing single counties, as these totals may fluctuate randomly, without reflecting any statistically significant trend.

During January–May 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		YTD (Jan–May 2026) Est. N = 6297		3-month rolling totals (Mar–May 2026) Est. N = 3926	
Androscoggin	8%	1687	10%	671	11%	438	11%
Aroostook	5%	634	4%	262	4%	157	4%
Cumberland	22%	4102	25%	1583	25%	975	25%
Franklin	2%	376	2%	167	3%	106	3%
Hancock	4%	542	3%	214	3%	118	3%
Kennebec	9%	1424	9%	496	8%	301	8%
Knox	3%	472	3%	151	2%	90	2%
Lincoln	3%	364	2%	128	2%	78	2%
Oxford	4%	702	4%	281	4%	173	4%
Penobscot	11%	1948	12%	730	12%	472	12%
Piscataquis	1%	191	1%	70	1%	40	1%
Sagadahoc	3%	344	2%	147	2%	85	2%
Somerset	4%	712	4%	254	4%	165	4%
Waldo	3%	366	2%	145	2%	104	3%
Washington	2%	377	2%	144	2%	93	2%
York	16%	2202	13%	854	14%	531	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, year-to-date totals for 2026, and as rolling 3-month totals for March–May 2026.

Compared to the 2020 census proportion, the age distributions for 2025, 2026 year to date, and recent 3-months aggregate, all show 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 2026 so far. In year-to-date 2026, there are 15 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 2 percentage points fewer overdose victims among those 65 and older compared to the percentage of the census population for that age group.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 16645		YTD (Jan–May 2026) Est. N = 6345		3-month rolling totals (Mar–May 2026) Est. N = 3943	
< 18	18%	464	3%	180	3%	113	3%
18–24	7%	1322	8%	552	9%	345	9%
25–34	12%	2373	14%	887	14%	551	14%
35–44	12%	3466	21%	1312	21%	824	21%
45–54	12%	2619	16%	1018	16%	646	16%
55–64	16%	2746	16%	1044	16%	653	17%
> 64	23%	3655	22%	1352	21%	811	21%

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 2025 totals, 2026 year-to-date totals, and rolling 3-month totals for March–May 2026.

Gender group proportions in the EMS data for the year 2025 or year-to-date 2026 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% during January–May 2026.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 15969		YTD (Jan–May 2026) Est. N = 6107		3-month rolling totals (Mar–May 2026) Est. N = 3800	
Male	49%	9737	61%	3779	62%	2365	62%
Female	51%	6232	39%	2328	38%	1435	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.[3] To mitigate monthly volatility and confidentiality concerns due to small cell sizes, county/city level estimates are presented as yearly totals for 2025, year-to-date totals for 2026, and as rolling 3-month totals for March–May 2026, instead of monthly figures, and totals below 5 are suppressed.

During January–May 2026, the 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 3 percentage points higher, Penobscot County is 8 percentage points higher, and York County is 4 percentage points lower. At the city level, Bangor is 10 percentage points and Portland is 11 percentage points higher than their respective 2020 census populations.

3 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		YTD (Jan–May 2026) Est. N = 146		3-month rolling totals (Mar–May 2026) Est. N = 88	
Androscoggin	8%	41	10%	11	8%	7	8%
Lewiston	3%	28	7%	6	4%	<5	*
Aroostook	5%	27	7%	<5	*	<5	*
Cumberland	22%	86	22%	36	25%	22	25%
Portland	5%	51	13%	24	16%	14	16%
Franklin	2%	7	2%	<5	*	<5	*
Hancock	4%	6	2%	5	3%	<5	*
Kennebec	9%	27	7%	11	8%	7	8%
Knox	3%	9	2%	<5	*	<5	*
Lincoln	3%	8	2%	<5	*	<5	*
Oxford	4%	16	4%	<5	*	<5	*
Penobscot	11%	69	18%	28	19%	19	22%
Bangor	2%	36	9%	17	12%	11	13%
Piscataquis	1%	<5	*	<5	*	<5	*
Sagadahoc	3%	<5	*	5	3%	<5	*
Somerset	4%	10	3%	8	5%	6	7%
Waldo	3%	14	4%	<5	*	<5	*
Washington	2%	14	4%	6	4%	<5	*
York	16%	54	14%	17	12%	9	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[4] of the fatal overdose population for 2025, 2026 year to date, and for March–May 2026.

The cumulative proportion of males in 2026 so far is 72%, which is higher than 2025 proportion (66%) and the census proportion (49%). The age distribution for both 2025 and 2026 year to date 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 78% of the fatal overdose population during year-to-date 2026 and 75% of the fatal overdose population in 2025. Those ages 18–24 constitute 7% of the 2020 census population but 5% of 2026 fatal overdoses and only 2% of 2025 fatal overdoses. Those 65 and older constitute 23% of the census population but only 11% of the 2026 and 2025 fatal overdoses.

4 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		YTD (Jan–May 2026) Est. N = 146		3M rolling totals (Mar–May 2026) Est. N = 88	
Male	49%	260	66%	96	72%	58	66%
< 18	18%	<5	*	<5	*	<5	*
18–24	7%	6	2%	7	5%	6	7%
25–34	12%	49	12%	18	13%	11	13%
35–44	12%	115	29%	44	33%	25	28%
45–54	12%	98	25%	38	28%	25	28%
55–64	16%	82	21%	23	17%	16	18%
> 64	23%	44	11%	16	11%	5	6%

<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 2025, January–May 2026 and March–May 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 146 decedents for whom race was reported in January–May 2026, 93% of the victims were identified as White.

Table 8: Decedent race and ethnicity among suspected and confirmed fatal overdoses[5]

A: Race	% 2020 estimated census population	Jan–Dec 2025 Race N = 394		YTD (Jan–May 2026) Race N = 146		3-month rolling total (Mar–May 2026) Race N = 88	
White alone	94%	380	96%	136	93%	84	95%
Black/African American alone	2%	7	2%	5	3%	<5	*
American Indian/Alaska Native alone	1%	<5	*	<5	*	<5	*
Other race and 2+ races combined	3%	<5	*	<5	*	<5	*
B: Ethnicity	**% 2020 estimated census population**	**Jan–Dec 2025 Ethnicity N = 391**		**YTD (Jan–May 2026) Ethnicity N = 140**		**3-month rolling total (Mar–May 2026) Ethnicity N = 83**	
Hispanic/Latinx alone	2%	<5	*	<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 144 cases for which military background was reported in January–May 2026, fewer than 5 cases were identified as having a military background. During 2025, out of the 394 cases with reported military background, 29 cases (7%) were identified as having a military background.

Of the 146 total suspected and confirmed fatal overdose cases in January–May 2026, undomiciled or transient housing status was reported for 27 (18%) victims. Of the 394 total suspected and confirmed fatal overdose cases in 2025, 50 (13%) victims were identified as undomiciled.

5 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, 2026 year to date, and as rolling 3-month totals for March–May 2026. Caution must be exercised when comparing since data totals may change slightly as suspected cases are confirmed or eliminated.

Both EMS and police responded together to most fatal overdoses (57%) in 2026. Law enforcement was more likely to respond to a scene alone (29%) than EMS (13%) was. Most (92%) suspected and confirmed fatal drug overdoses were accidental manner of death. Of the 136 confirmed or suspected fatal overdoses in 2026 for which overdose history was known, 39 (29%) 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 January–May 2026, 21% 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 102 suspected or confirmed drug death cases with EMS response during January–May 2026, 40 (39%) victims were already deceased when EMS arrived. In the remaining 62 (61%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 62 ultimately fatal victims who were alive when EMS arrived, 24 (39%) were transported, and 38 (61%) did not survive to be transported. Thus, out of 102 ultimately fatal cases with EMS response, only 24 (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

	Jan–Dec 2025 Est. N = 394		YTD (Jan–May 2026) Est. N = 146		3-month rolling totals (Mar–May 2026) Est. N = 88	
EMS response alone	57	14%	19	13%	13	15%
Law enforcement alone	87	22%	43	29%	27	31%
EMS and law enforcement	240	61%	83	57%	47	53%
Naloxone administration reported at the scene	95	24%	31	21%	23	26%
EMS administered naloxone	62	16%	15	10%	11	13%
Law enforcement administered naloxone	22	6%	9	6%	7	8%
Bystander administered naloxone	39	10%	20	14%	13	15%
History of prior overdose	96	26%	39	29%	27	33%

<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 2025, 2026 year-to-date, and the rolling 3-month period of March–May 2026. As expected, within the confirmed drug death cases in 2026 year to date, nonpharmaceutical fentanyl, including nonpharmaceutical fentanyl analogs, was the most frequent cause of death, listed on the death certificate of 79 (63%) victims. The

proportion of confirmed fentanyl overdose deaths has declined from its 2023 peak of 78% to 69% in 2024, and an estimated 54% for confirmed overdoses in 2025.

Fentanyl is often found in combination with multiple other drugs. Xylazine was identified as a co-intoxicant with fentanyl for the first time in 2021. Among 126 confirmed deaths of 2026 so far, there were fewer than 5 cases with xylazine listed in addition to fentanyl as a cause of death. During 2025, there were 30 (8%) confirmed cases that involved xylazine in addition to fentanyl. In 2026 year to date, there has been no mention of heroin involvement as a cause of death among confirmed cases. During 2025, only 2% of the confirmed drug deaths involved heroin.

Stimulants continue to increase as a cause of death, usually in combination with other drugs, particularly fentanyl. Cocaine-involved fatalities constituted 61 (48%) of confirmed cases so far in 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 42 (69%) of the cocaine cases in 2026 year to date. Methamphetamine was listed as a cause of death in 36 (29%) of the confirmed fatal overdoses in 2026 year to date; during this same period, 28 (78%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 13 (10%) death certificates in 2026 year to date, in most of those cases (10, 77%) as co-intoxicants of fentanyl.

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

Cause of death (alone or in combination with other drugs) Sample size for confirmed cases only	Jan–Dec 2025 Est. N = 393		YTD (Jan–May 2026) Est. N = 126		3-month rolling totals (Mar–May 2026) Est. N = 70	
Fentanyl or fentanyl analogs	213	54%	79	63%	46	66%
Heroin	8	2%	<5	*	<5	*
Cocaine	178	45%	61	48%	34	49%
Methamphetamine	122	31%	36	29%	22	31%
Pharmaceutical opioids	90	23%	28	22%	12	17%
Fentanyl and heroin	8	2%	<5	*	<5	*
Fentanyl and cocaine	109	28%	42	33%	24	34%
Fentanyl and methamphetamine	79	20%	28	22%	18	26%
Fentanyl and xylazine	30	8%	<5	*	<5	*
Cocaine and methamphetamine	41	10%	13	10%	7	10%
Fentanyl, cocaine and methamphetamine	30	8%	10	8%	6	9%

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 4 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 2 cases in year-to-date 2026. Carfentanil (an opioid) is not new but is a particularly lethal veterinary tranquilizer. It was found in 9 (2%) of Maine's 2025 cases and 2 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 two cases so far in 2026. Bromazolam and medetomidine overdoses cannot be reversed by naloxone.

Highlight of the Month

Breaking Down Stigma Through Community Events

By Gordon Smith, Director of Opioid Response

I recently spent an evening in Belfast at the historic Colonial Theatre joining a good-sized audience to watch three recovery-related films. Our Recovery in Maine film series, produced by Points North Institute with funding through the State of Maine, began in 2018 and has resulted in more than a half-dozen short documentary films featuring individuals in recovery from substance use disorder and associated topics. Following the film screenings, a panel of individuals addresses issues raised in the films and takes questions from the audience. After 8 years, these community events have shown their value in both breaking down the stigma associated with substance use disorder and supporting individuals in recovery.

This spring and summer have also seen the advent of an art project entitled, See the Person, Not the Use with art being developed by persons associated with our 19 recovery community centers. This project is sponsored by the Preventing Drug Overdose (PDO) grant administered by the Maine Center for Disease Control and Prevention. A selection of the art projects will be displayed at the Governor's 8th Annual Opioid Response Summit on July 16 in Bangor.

Both Executive Order II (Feb. 6, 2019) and the Opioid Response Strategic Action Plan (SAP) acknowledge the role of stigma in the opioid/substance use ecosystem. Strategy #6 in the SAP calls for the state to *invest in local and statewide efforts to improve public understanding and reduce stigma and discrimination regarding substance use disorder and opioid use disorder.* There are seven specific activities included in the SAP under Strategy #6, including hosting and participating in forums, presentations, and recovery events in local communities and key sectors. The presence of stigma creates barriers to harm reduction, treatment, and recovery and is found in all parts of the system: health care, law enforcement, first responders, housing, employment, etc. Until such time as substance use disorder is fully recognized as a chronic illness deserving of treatment, our Maine families and communities will continue to struggle. These community events can help lift Maine families up and provide hope.

Strategy #34 of the SAP calls for the state *to promote stories of connection, hope and recovery in Maine communities.* The art shows and the movie screenings will continue after the Summit. Watch for announcements in your area for the times and location.

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.