MAINE MONTHLY OVERDOSE REPORT

For July 2026

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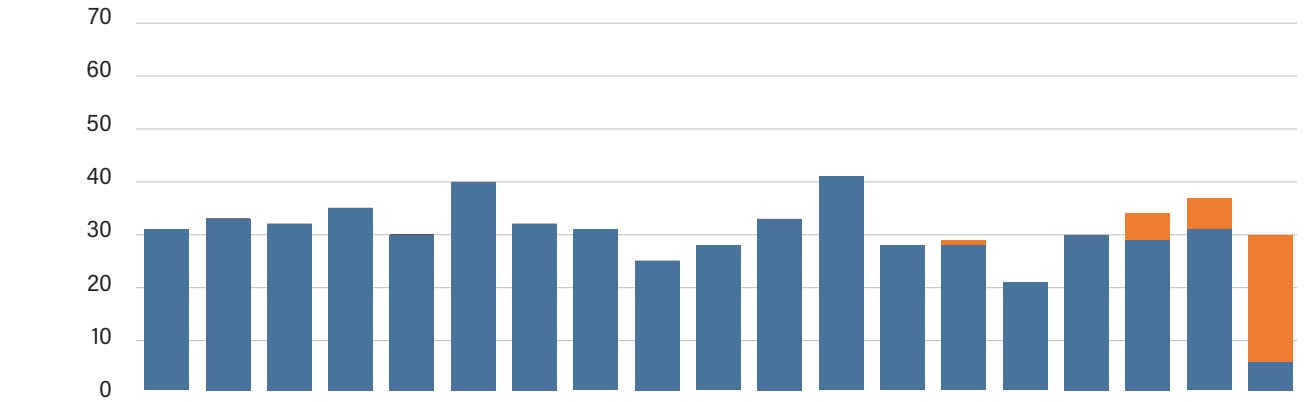
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine for the period January 2025–July 2026 (Table 1). The total number of confirmed and suspected fatal overdoses for January–July 2026 is 209, 10.3% lower than the total confirmed fatal overdoses for January–July 2025, 233. The total number of nonfatal overdoses for January–July 2026 is 4,343, 2.3% higher compared to the reported nonfatal overdoses for January–July 2025, 4,246. Monthly proportions of fatalities during January–July 2026 averaged 4.6%, ranging from a high of 5.3% in February to a low of 3.4% in March. During 2025, monthly proportions of fatalities averaged 5.2%, ranging from a high of 6.4% 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, February, May, June, and July (see Figure 1).

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for July 2026, 714, is displayed in Table 1. Of those 714, there were 30 (4.2%) confirmed and suspected fatal overdoses, 304 (42.6%) nonfatal emergency department visits, 208 (29.1%) nonfatal EMS responses not transported to the emergency department, 147 (20.6%) reported community overdose reversals, and 25 (3.5%) law enforcement reversals in incidents that did not include EMS.

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2025 through July 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	Jun '26	Jul '26
Suspected	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	5	6	24
Confirmed	31	33	32	35	30	40	32	31	25	28	33	41	28	29	21	30	29	31	6

Note that the reporting methods for subpopulations in this report has changed. 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 through July 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	190	53	15	492	31	523
February 2025	254	152	74	18	498	33	531
March 2025	375	191	71	31	668	32	700
April 2025	294	204	90	18	606	35	641
May 2025	311	189	88	13	601	30	631
June 2025	399	224	96	21	740	40	780
July 2025	321	235	70	15	641	32	673
August 2025	272	177	76	13	538	31	569
September 2025	385	234	118	13	750	25	775
October 2025	254	186	100	11	551	28	579
November 2025	267	167	70	9	513	33	546
December 2025	318	166	104	8	596	41	637
2025 YTD total	3684	2315	1010	185	7194	391	7585
% of 2025 YTD total	48.6%	30.5%	13.3%	2.4%	94.8%	5.2%	100%
January 2026	257	151	105	17	530	28	558
February 2026	270	138	96	13	517	29	546
March 2026	327	156	97	20	600	21	621
April 2026	291	178	139	17	625	30	655
May 2026	327	188	134	8	657	34	691
June 2026	391	205	126	8	730	37	767
July 2026	304	208	147	25	684	30	714
2026 YTD total	2167	1224	844	108	4343	209	4552
% of 2026 YTD total	47.6%	26.9%	18.5%	2.4%	95.4%	4.6%	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–July 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 8,501 incidents (296 fatal; 8,205

nonfatal). In January–July 2026, law enforcement officers responded to a reported 408 overdose incidents (180 fatal; 228 nonfatal), and Maine EMS responded to a reported 4,740 incidents (137 fatal; 4,603 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–Jul 2026	Nonfatal overdose response Jan–Jul 2026	Total overdose response Jan–Jul 2026
Maine EMS	296	8205	8501	137	4603	4740
Monthly average	25	684	708	20	658	677
Law Enforcement	328	534	862	180	228	408
Monthly average	27	45	72	26	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 May–July 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–July 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 is 5 percentage points higher, and Cumberland County is 7 percentage points higher. York County is 4 percentage points lower than the 2020 census proportion.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 8205		YTD (Jan–Jul 2026) Est. N = 4603		3M rolling total (May-Jul 2026) Est. N = 2179	
Androscoggin	8%	930	11%	595	13%	302	14%
Aroostook	5%	345	4%	182	4%	85	4%
Cumberland	22%	2204	27%	1316	29%	620	28%
Franklin	2%	138	2%	59	1%	24	1%
Hancock	4%	200	2%	103	2%	49	2%
Kennebec	9%	743	9%	347	8%	160	7%
Knox	3%	243	3%	86	2%	38	2%
Lincoln	3%	145	2%	93	2%	48	2%
Oxford	4%	308	4%	153	3%	67	3%
Penobscot	11%	1078	13%	615	13%	277	13%
Piscataquis	1%	89	1%	48	1%	25	1%
Sagadahoc	3%	131	2%	76	2%	35	2%
Somerset	4%	342	4%	188	4%	101	5%
Waldo	3%	185	2%	103	2%	48	2%
Washington	2%	202	2%	105	2%	50	2%
York	16%	922	11%	534	12%	250	11%

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 May–July 2026.

Compared to the 2020 census proportion, the age distributions for 2025, 2026 year to date, and recent 3-month 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 63% of the nonfatal overdose population in 2025 and 62% of the nonfatal overdose population in 2026 so far. In year-to-date 2026, there are 13 percentage points fewer overdose victims among those under the age of 18 compared to the percentage of the census population in that age group. Similarly, there were 11 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 = 8205		YTD (Jan–Jul 2026) Est. N = 4596		3M rolling total (May–Jul 2026) Est. N = 2174	
< 18	18%	360	4%	236	5%	125	6%
18–24	7%	692	8%	425	9%	208	10%
25–34	12%	1497	18%	798	17%	375	17%
35–44	12%	2294	28%	1241	27%	561	26%
45–54	12%	1407	17%	795	17%	414	19%
55–64	16%	929	11%	572	12%	250	11%
> 64	23%	1026	13%	529	12%	241	11%

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 May–July 2026.

Gender group proportions in the EMS data for the year 2025, 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 59% of the nonfatal overdose victims with EMS involvement in 2025 and 59% during January–July 2026.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 7903		YTD (Jan–July 2026) Est. N = 4411		3M rolling total (May–July 2026) Est. N = 2087	
Male	49%	4637	59%	2615	59%	1230	59%
Female	51%	3266	41%	1796	41%	857	41%

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. To mitigate monthly volatility and confidentiality concerns due to small cell sizes, county and city level estimates are presented as yearly totals for 2025, year-to-date totals for 2026, and as rolling 3-month totals for May–July 2026, instead of monthly figures, and totals below 5 are suppressed.

During January–July 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 5 percentage points higher, Penobscot County is 8 percentage points higher, and York County is 5 percentage points lower. At the city level, Bangor is 9 percentage points and Portland is 12 percentage points higher than their respective 2020 census populations.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 391		YTD (Jan–Jul 2026) Est. N = 209		3M rolling total (May–Jul 2026) Est. N = 101	
Androscoggin	8%	41	10%	16	8%	10	10%
Lewiston	3%	28	7%	9	4%	5	5%
Aroostook	5%	26	7%	6	3%	<5	*
Cumberland	22%	85	22%	56	27%	29	29%
Portland	5%	50	13%	36	17%	18	18%
Franklin	2%	7	2%	<5	*	<5	*
Hancock	4%	6	2%	5	2%	<5	*
Kennebec	9%	27	7%	20	10%	10	10%
Knox	3%	9	2%	<5	*	<5	*
Lincoln	3%	7	2%	<5	*	<5	*
Oxford	4%	16	4%	<5	*	<5	*
Penobscot	11%	68	17%	39	19%	18	18%
Bangor	2%	35	9%	24	11%	12	12%
Piscataquis	1%	<5	*	5	2%	<5	*
Sagadahoc	3%	<5	*	5	2%	<5	*
Somerset	4%	10	3%	10	5%	<5	*
Waldo	3%	15	4%	5	2%	5	5%
Washington	2%	14	4%	7	3%	<5	*
York	16%	54	14%	24	11%	12	12%

<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 of the fatal overdose population for 2025, 2026 year to date, and for May–July 2026.

The cumulative proportion of males in 2026 so far is 65%, which is slightly lower than the 2025 proportion (66%), but higher than 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 74% 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 4% 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.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 391		YTD (Jan–Jul 2026) Est. N = 209		3M rolling total (May–Jul 2026) Est. N = 101	
Male	49%	259	66%	136	65%	67	66%
< 18	18%	<5	*	<5	*	<5	*
18–24	7%	6	2%	8	4%	<5	*
25–34	12%	49	13%	24	11%	10	10%
35–44	12%	112	29%	61	29%	26	26%
45–54	12%	97	25%	57	27%	33	33%
55–64	16%	83	21%	37	18%	19	19%
> 64	23%	44	11%	22	11%	10	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 2025, year-to-date 2026, and May–July 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 209 decedents for whom race was reported in January–July 2026, 93% of the victims were identified as White.

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

A: Race	% 2020 estimated census population	Jan–Dec 2025 Race N = 391		YTD (Jan–Jul 2026) Race N = 209		3M rolling total (May–Jul 2026) Race N = 101	
White alone	94%	377	96%	194	93%	96	95%
Black/African American alone	2%	7	2%	8	4%	<5	*
American Indian/Alaska Native alone	1%	<5	*	5	2%	<5	*
Other race and 2+ races combined	3%	<5	*	<5	*	<5	*
B: Ethnicity	**% 2020 estimated census population**	**Jan–Dec 2025 Ethnicity N = 388**		**YTD (Jan–Jul 2026) Ethnicity N = 201**		**3M rolling total (May–Jul 2026) Ethnicity N = 96**	
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 208 cases for which military background was reported in January–July 2026, 7 cases (3%) were identified as having a military background. During 2025, out of the 391 cases with reported military background, 29 cases (7%) were identified as having a military background.

Of the 209 total suspected and confirmed fatal overdose cases in January–July 2026, undomiciled or transient housing status was reported for 31 (15%) victims. Of the 391 total suspected and confirmed fatal overdose cases in 2025, 49 (13%) 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, 2026 year to date, and as rolling 3-month totals for May–July 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 (54%) in 2026. Law enforcement was more likely to respond to a scene alone (33%) than EMS (12%) was. Most (90%) suspected and confirmed fatal drug overdoses were accidental manner of death. Of the 194 confirmed or suspected fatal overdoses in 2026 for which overdose history was known, 56 (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–July 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 137 suspected or confirmed drug death cases with EMS response during January–July 2026, 56 (41%) victims were already deceased when EMS arrived. In the remaining 81 (59%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 81 ultimately fatal victims who were alive when EMS arrived, 34 (42%) were transported, and 47 (58%) did not survive to be transported. Thus, out of 137 ultimately fatal cases with EMS response, only 34 (25%) 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 = 391		YTD (Jan–Jul 2026) Est. N = 209		3M rolling total (Jan–Jul 2026) Est. N = 101	
EMS response alone	55	14%	25	12%	12	12%
Law enforcement alone	86	22%	68	33%	36	36%
EMS and law enforcement	241	62%	112	54%	50	50%
Naloxone administration reported at the scene	96	25%	44	21%	23	23%
EMS administered naloxone	63	16%	20	10%	10	10%
Law enforcement administered naloxone	22	6%	13	6%	7	7%
Bystander administered naloxone	39	10%	27	13%	12	12%
History of prior overdose	96	26%	56	29%	29	31%

<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. Similar 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 May–July 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 103 (60%) 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 often found in combination with multiple other drugs. Xylazine was identified as a co-intoxicant with fentanyl for the first time in 2021. Among 173 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 82 (47%) of confirmed cases so far in 2026. The percentage of cocaine cases among confirmed deaths in 2025 was 46%, which is higher than the percentage in 2024 (43%) and in 2023 (37%). Fentanyl is listed as a cause in combination with cocaine in 55 (67%) of the cocaine cases in 2026 year to date. Methamphetamine was listed as a cause of death in 53 (31%) of the confirmed fatal overdoses in 2026 year to date; during this same period, 39 (74%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 22 (13%) death certificates in 2026 year to date, in most of those cases (15, 68%) 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 = 391		YTD (Jan–July 2026) Est. N = 173		3M Rolling Totals (May–July 2026) Est. N = 66	
Fentanyl or fentanyl analogs	214	55%	103	60%	38	58%
Heroin	8	2%	<5	*	<5	*
Cocaine	181	46%	82	47%	32	48%
Methamphetamine	123	31%	53	31%	22	33%
Pharmaceutical opioids	96	25%	37	21%	12	18%
Fentanyl and heroin	8	2%	<5	*	<5	*
Fentanyl and cocaine	110	28%	55	32%	21	32%
Fentanyl and methamphetamine	79	20%	39	23%	15	23%
Fentanyl and xylazine	30	8%	<5	*	<5	*
Cocaine and methamphetamine	42	11%	22	13%	11	17%
Fentanyl, cocaine and methamphetamine	30	8%	15	9%	6	9%

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 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 3 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

Governor's 8th Annual Opioid Response Summit

By Gordon Smith, JD, Director of Opioid Response, State of Maine

Governor Janet T. Mills convened her 8th and final annual Opioid Response Summit on July 16 at the Cross Insurance Center in Bangor. Over 1,100 registrants participated and heard from Governor Mills, other state officials, keynote speaker Kathryn Goetzke of the Shine Hope Company, and 40 Voices of Recovery. Attendees could also attend any of the 38 75-minute breakout sessions that covered a wide variety of topics ranging from primary and secondary prevention to youth naloxone training. Among the most popular sessions was the Jackson Lab's presentation on the Biological Basis for Addiction and the presentation by Dr. Jeremy Nobel on the connection between loneliness and addiction. Dr. Nobel was also the featured presenter at a pre-summit program the evening before the Summit, which attracted over 100 people. The theme of this year's Summit was Building Hope, Honoring Progress, Inspiring Change.

The annual summits have provided an opportunity for Maine's treatment and recovery communities to come together to share best practices and to network with one another. The Summit has also provided space and speakers for a meeting of our major public safety partners including the Department of Public Safety, the DEA, the MDEA, the U.S. Attorneys' office, the FBI, the Department of Homeland Security, and local law enforcement agencies. This meeting has been convened and chaired each year by Public Safety Commissioner Michael Sauschuck. Over 50 organizations table at the event, which will hopefully continue under a new administration. A facility has been secured for a date next July in order to preserve the possibility of additional summits.

Governor Mills focused her morning address on the progress that has been made over the past eight years while acknowledging the work that remains. She also presented awards to Maine Recovery Council Chair Pat Kimball and Maine Association of Recovery Residences Executive Director Ronald Springel, M.D. In receiving the awards, the recipients were joined on stage by past award recipients including Shelly and David Yankowsky, Scott Pardy, Leslie Clark, and Marcella Sorg, Ph.D.

The event closed with the presentation of an eight-minute video presenting highlights from the previous seven summits and the unveiling of a celebratory cake providing an appropriate and joyous conclusion to the 8th Summit and the final Summit for Governor Mills and her team.

The monthly opioid response webinars, which are held from 11:30am to 12:30pm the first Friday of each month up to the Summit date, will resume in October with programs planned into next February. These programs are recorded and offered free of charge to anyone, and the schedule and the recordings of past webinars can be accessed on the adeptme website.

A special thanks to the team that has put all eight of the Summits together including the Office of Behavioral Health, adeptme, Points North Institute, and AV Technik. And a special thank you to Governor Mills for her extraordinary leadership on opioid response over the past eight years. Overdose deaths continue to decline for the fourth straight year representing an estimated decrease of nearly 49%[1] in fatalities since 2022 during the immediate aftermath of the pandemic,

1 The 2026 total was provisionally estimated using the 2022–2025 average number of confirmed and suspected cases January through July, compared with the final total fatalitites for those years.

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.