MAINE MONTHLY OVERDOSE REPORT

For September 2026

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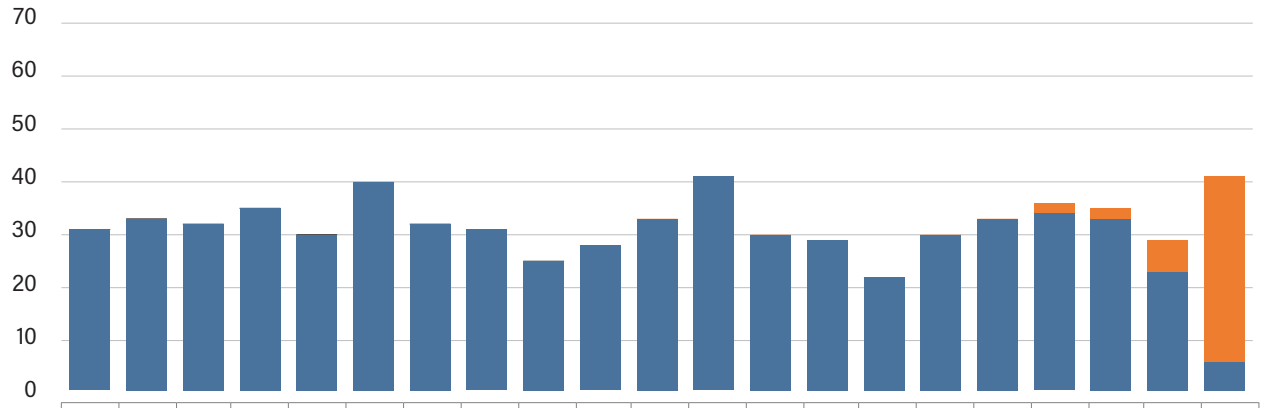
Overview

This report documents suspected and confirmed fatal and nonfatal drug overdoses in Maine for the period January 2025–September 2026 (Table 1). The total number of confirmed and suspected fatal overdoses for January–September 2026 is 285, 1.4% lower than the total confirmed fatal overdoses for January–September 2025, 289. The total number of nonfatal overdoses for January–September 2026 is 5,609, 2.4% higher compared to the reported nonfatal overdoses for January–September 2025, 5,478. Monthly proportions of fatalities during January–September 2026 averaged 4.8%, ranging from a high of 6.9% in September to a low of 3.6% in March. During 2025, monthly proportions of fatalities averaged 5.2%, ranging from a high of 6.4% in December to a low of 3.3% 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 June, July, August and September 2026 (see Figure 1).[1]

The total number of suspected and confirmed fatal overdoses and reported nonfatal overdoses for September 2026, 590, is displayed in Table 1. Of those 590, there were 41 (6.9%) confirmed and suspected fatal overdoses, 280 (47.5%) nonfatal emergency department visits, 163 (27.6%) nonfatal EMS responses not transported to the

Figure 1. Suspected and confirmed fatal overdoses, all drugs, January 2025 through September 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	Aug '26	Sep '26
Suspected	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	2	6	35
Confirmed	31	33	32	35	30	40	32	31	25	28	33	41	30	29	22	30	33	34	33	23	6

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

emergency department, 91 (15.4%) reported community overdose reversals, and 15 (2.5%) law enforcement reversals in incidents that did not include EMS.

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.[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 through September 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	183	53	15	485	31	516
February 2025	254	146	74	18	492	33	525
March 2025	375	188	71	31	665	32	697
April 2025	294	196	90	18	598	35	633
May 2025	311	182	88	13	594	30	624
June 2025	399	219	96	21	735	40	775
July 2025	321	231	70	15	637	32	669
September 2025	272	172	76	13	533	31	564
September 2025	385	223	118	13	739	25	764
October 2025	254	184	100	11	549	28	577
November 2025	267	162	70	9	508	33	541
December 2025	318	165	104	8	595	41	636
2025 YTD Total	3684	2315	1010	185	7130	391	7521
% of 2025 YTD Total	49.0%	29.9%	13.4%	2.5%	94.8%	5.2%	100%
January 2026	258	149	105	23	535	30	565
February 2026	270	130	96	14	510	29	539
March 2026	327	149	97	21	594	22	616
April 2026	291	174	139	18	622	30	652
May 2026	327	181	134	9	651	33	684
June 2026	391	199	126	9	725	36	761
July 2026	304	203	147	28	682	35	717
August 2026	306	171	253	11	741	29	770
September 2026	280	163	91	15	549	41	590
2026 YTD Total	2754	1519	1188	148	5609	285	5894
% of 2026 YTD Total	46.7%	25.8%	20.2%	2.5%	95.2%	4.8%	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–September 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 8,084 incidents (296 fatal; 7,788 nonfatal). In January–September 2026, law enforcement officers responded to a reported 530 overdose incidents (244 fatal; 286 nonfatal), and Maine EMS responded to a reported 5,786 incidents (194 fatal; 5,592 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–Sep 2026	Nonfatal overdose response Jan–Sep 2026	Total overdose response Jan–Sep 2026
Maine EMS	296	7788	8084	194	5592	5786
Monthly average	25	649	674	22	621	643
Law Enforcement	328	534	862	244	286	530
Monthly average	27	45	72	27	32	59

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 July–September 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–September 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 4 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 = 7788		YTD (Jan–Sep 2026) Est. N = 5592		3M rolling totals (Jul–Sep 2026) Est. N = 1896	
Androscoggin	8%	877	11%	679	12%	221	12%
Aroostook	5%	333	4%	229	4%	80	4%
Cumberland	22%	2101	27%	1619	29%	541	29%
Franklin	2%	131	2%	65	1%	27	1%
Hancock	4%	181	2%	135	2%	51	3%
Kennebec	9%	698	9%	431	8%	147	8%
Knox	3%	230	3%	109	2%	35	2%
Lincoln	3%	136	2%	107	2%	40	2%
Oxford	4%	294	4%	186	3%	72	4%
Penobscot	11%	1030	13%	754	13%	234	12%
Piscataquis	1%	86	1%	59	1%	22	1%
Sagadahoc	3%	129	2%	88	2%	26	1%
Somerset	4%	327	4%	232	4%	77	4%
Waldo	3%	174	2%	123	2%	43	2%
Washington	2%	191	2%	128	2%	45	2%
York	16%	870	11%	648	12%	235	12%

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 July–September 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 64% 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 12 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 = 7788		YTD (Jan–Sep 2026) Est. N = 5573		3M rolling totals (Jul–Sep 2026) Est. N = 1879	
< 18	18%	352	5%	301	5%	113	6%
18–24	7%	670	9%	538	10%	182	10%
25–34	12%	1440	18%	973	17%	320	17%
35–44	12%	2167	28%	1503	27%	509	27%
45–54	12%	1341	17%	969	17%	334	18%
55–64	16%	845	11%	662	12%	199	11%
> 64	23%	973	12%	627	11%	222	12%

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 July–September 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 58% of the nonfatal overdose victims with EMS involvement in 2025 and 59% during January–September 2026.

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

	% 2020 estimated census population	Jan–Dec 2025 Est. N = 7497		YTD (Jan–Sep 2026) Est. N = 5355		3M rolling totals (Jul–Sep 2026) Est. N = 1810	
Male	49%	4377	58%	3142	59%	1043	58%
Female	51%	3120	42%	2213	41%	767	42%

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 July–September 2026, instead of monthly figures, and totals below 5 are suppressed.

During January–September 2026, the percentages for most counties fall within 0 to 3 percentage points of the 2020 census distribution. Compared to the 2020 census proportion, Penobscot County is 8 percentage points higher, and York County is 5 percentage points lower. At the city level, Bangor and Portland are 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 = 391		YTD (Jan–Sep 2026) Est. N = 285		3M rolling totals (Jul–Sep 2026) Est. N = 105	
Androscoggin	8%	41	10%	24	8%	10	10%
Lewiston	3%	28	7%	15	5%	7	7%
Aroostook	5%	26	7%	8	3%	<5	*
Cumberland	22%	85	22%	72	25%	22	21%
Portland	5%	50	13%	47	16%	15	14%
Franklin	2%	7	2%	<5	*	<5	*
Hancock	4%	6	2%	8	3%	<5	*
Kennebec	9%	27	7%	27	9%	12	11%
Knox	3%	9	2%	7	2%	<5	*
Lincoln	3%	7	2%	5	2%	<5	*
Oxford	4%	16	4%	5	2%	<5	*
Penobscot	11%	68	17%	55	19%	22	21%
Bangor	2%	35	9%	38	13%	16	15%
Piscataquis	1%	<5	*	7	2%	<5	*
Sagadahoc	3%	<5	*	5	2%	<5	*
Somerset	4%	10	3%	11	4%	<5	*
Waldo	3%	15	4%	6	2%	<5	*
Washington	2%	14	4%	10	4%	<5	*
York	16%	54	14%	32	11%	13	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[4] of the fatal overdose population for 2025, 2026 year to date, and July–September 2026.

The cumulative proportion of males in 2026 so far is 64%, which is slightly lower than the 2025 proportion (66%) but much 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 73% 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 year-to-date 2026 and 11% of 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 = 391		YTD (Jan–Sep 2026) Est. N = 285		3M rolling totals (Jul–Sep 2026) Est. N = 105	
Male	49%	259	66%	183	64%	70	67%
< 18	18%	<5	*	<5	*	<5	*
18–24	7%	6	2%	11	4%	5	5%
25–34	12%	49	13%	32	11%	10	10%
35–44	12%	112	29%	76	27%	25	24%
45–54	12%	97	25%	76	27%	30	29%
55–64	16%	83	21%	55	19%	21	20%
> 64	23%	44	11%	32	11%	11	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 July–September 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 285 decedents for whom race was reported in January–September 2026, 92% 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 = 391		YTD (Jan–Sep 2026) Race N = 285		3M rolling totals (Jul–Sep 2026) Race N = 105	
White alone	94%	377	96%	263	92%	93	89%
Black/African American alone	2%	7	2%	11	4%	6	6%
American Indian/Alaska Native alone	1%	<5	*	7	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–Sep 2026) Ethnicity N = 276**		**3M rolling totals (Jul–Sep 2026) Ethnicity N = 101**	
Hispanic/Latinx alone	2%	<5	*	5	2%	<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 284 cases for which military background was reported in January–September 2026, 17 cases (6%) 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 285 total suspected and confirmed fatal overdose cases in January–September 2026, undomiciled or transient housing status was reported for 39 (14%) victims. Of the 391 total suspected and confirmed fatal overdose cases in 2025, 49 (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 July–September 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 (56%) in 2026. Law enforcement was more likely to respond to a scene alone (30%) than EMS (12%) was. Most (88%) suspected and confirmed fatal drug overdoses were accidental manner of death. Of the confirmed or suspected fatal overdoses in 2026 for which overdose history was known, 68 (26%) had a reported history of prior overdose.

In most overdose cases, bystanders or witnesses were present at the scene by the time first responders arrived, although the details about who was present at the time of the overdose were frequently unclear. In some cases, responding family and friends or other bystanders administered naloxone. Often, EMS and/or law enforcement administered naloxone in addition to bystanders or witnesses. During January–September 2026, 25% 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 194 suspected or confirmed drug death cases with EMS response during January–September 2026, 74 (38%) victims were already deceased when EMS arrived. In the remaining 120 (62%) cases, resuscitation was attempted either at the scene or presumably in the ambulance during transport to the emergency room. Of those 120 ultimately fatal victims who were alive when EMS arrived, 49 (41%) were transported, and 71 (59%) did not survive to be transported. Thus, out of 194 ultimately fatal cases with EMS response, only 49 (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–Sep 2026) Est. N = 285		3M rolling totals (Jul–Sep 2026) Est. N = 105	
EMS response alone	55	14%	35	12%	13	12%
Law enforcement alone	86	22%	85	30%	30	29%
EMS and law enforcement	241	62%	159	56%	58	55%
Naloxone administration reported at the scene	96	25%	70	25%	33	31%
EMS administered naloxone	63	16%	32	11%	16	15%
Law enforcement administered naloxone	22	6%	21	7%	11	10%
Bystander administered naloxone	39	10%	34	12%	10	10%
History of prior overdose	96	26%	68	26%	19	20%

<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 July–September 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 130 (54%) 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 240 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 118 (49%) 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 73 (62%) of the cocaine cases in 2026 year to date. Methamphetamine was listed as a cause of death in 66 (28%) of the confirmed fatal overdoses in 2026 year to date; during this same period, 43 (65%) of the methamphetamine deaths also involved fentanyl as a co-intoxicant cause of death. Cocaine and methamphetamine are named together on 30 (13%) death certificates in 2026 year to date, in most of those cases (18, 60%) 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–Sep 2026) Est. N = 240		3M rolling totals (Jul–Sep 2026) Est. N = 62	
Fentanyl or fentanyl analogs	214	55%	130	54%	28	45%
Heroin	8	2%	<5	*	<5	*
Cocaine	181	46%	118	49%	33	53%
Methamphetamine	123	31%	66	28%	14	23%
Pharmaceutical opioids	96	25%	57	24%	18	29%
Fentanyl and heroin	8	2%	<5	*	<5	*
Fentanyl and cocaine	110	28%	73	30%	18	29%
Fentanyl and methamphetamine	79	20%	43	18%	<5	*
Fentanyl and xylazine	30	8%	<5	*	<5	*
Cocaine and methamphetamine	42	11%	30	13%	9	15%
Fentanyl, cocaine and methamphetamine	30	8%	18	8%	<5	*

Note: Nonpharmaceutical tramadol is now being combined with fentanyl in pills and powders for illicit drug use. When found in combination with fentanyl, and in the absence of a known prescription, tramadol is categorized as a nonpharmaceutical opioid.

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. Maine has not seen many of the new and emerging substances reported nationally. Frequencies of the new substances detected have been very low, generally under 5 for the year. 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 4 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 in 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 found in only 1 case during 2025 and 4 cases so far in 2026. Bromazolam and medetomidine overdoses cannot be reversed by naloxone. The Highlight section this month focus on mitragynine (kratom), which is named in 7 cases so far this year, 5 of which occurred during the summer.

Highlight of the Month

Gas Station Drug: Kratom

By Gordon Smith, J.D., Director of Opioid Response, State of Maine

In the last several months, there has been an increasing concern expressed regarding substances readily available to minors and adults at gas stations and smoke shops, with kratom and its derivatives currently being among the most popular. Kratom is a naturally occurring plant, which contains an alkaloid identified as mitragynine. It is sometimes referred to as "7-OH."

Mitragynine has been cited on the death certificates of 95 overdoses in Maine as a cause of death beginning in 2016. About three-quarters of those cases also involved nonpharmaceutical fentanyl. Most of the deaths involving mitragynine are multi-drug toxicology deaths. The average number of drugs named as co-intoxicants in the 95 cases since 2016 is 4, with a range from 1 to 10 drugs.

Of the 95 mitragynine deaths, 72 (76%) were male and 23 (24%) were female. Ages ranged from 19 to 68, the average age being 39.

Mitragynine has been identified by the federal DEA as a substance of concern for ten years but it was not until this year that the federal government announced plans to temporarily schedule 7-OH as a Schedule 1 substance under the controlled substances act. Some states have not waited for federal action. Massachusetts has banned the sale of such products in that state, and Vermont has taken similar action. In other federal action, the FDA advises against kratom use for medical purposes. The Maine Medical Association and the Maine Public Health Association have announced plans to submit legislation in 2027 to either regulate the drug or prohibit its sale, including certainly the sale to minors.

Why do individuals take kratom or its synthetic derivatives? In part because, depending upon the dose, the substance can produce a stimulant effect (increased energy, focus and activity), and at high doses can have an opioid-like effect (relaxation, pain relief, endorphin release). Addiction specialists in Maine have also reported patients using kratom to treat their opioid addiction, but then having difficulty withdrawing from the drug. A kratom overdose can look like an opioid overdose but with stimulant features and without respiratory depression. The impact of naloxone on such an overdose is not yet certain.

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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.