Initiative to Improve Access to Youth Mental Health Access in Maine

Report 1 - Baseline Indicators of Access to Services

January 2026

This youth mental health initiative is a project of the Healthy Mental Development Committee of the Maine Chapter of the American Academy and the Maine Council of Child and Adolescent Psychiatry.

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We are grateful to the Maine Health Access Foundation for their support of this project.

I. Summary

A. Rationale and Goals

Mental health services to children, adolescents, and their families are currently insufficient to meet needs, both nationally and in Maine, with many of those with serious illness not receiving treatment. The American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a National Emergency in Child and Adolescent Mental Health in 2021 (1), and jointly stated in 2025 that the National Emergency continues. "The emergency we declared four years ago has not ended. Children still face unacceptable waits and barriers to care" (2).

Decisions at the federal level, however, under the "One Big Beautiful Bill Act" (OBBA, H.R.1) include major funding cuts to Medicaid and to subsidies to insurance under the Patient Protection and Affordable Care Act's (ACA) insurance exchanges, and changes in requirements to prove eligibility and maintain enrollment.

These decisions are creating major crises in the affordability of health insurance. They will decrease the number of those insured, with major effects on availability of care. Careful assessments of the consequences which indicate they will lead to the loss of health insurance by 16 million, and over 140,000 preventable deaths (3, 4). Access to mental health care, as to all healthcare, will decline.

Consequences throughout healthcare in the United States will be profound (5). They will affect not only those on ACA marketplace insurances and Medicaid but on all hospitals and healthcare systems, due both to direct economic effect including the need to continue care to larger numbers of uninsured patients, and because of costs associated with deferred care and less preventive care for those with serious illnesses. Financial pressures on hospitals, including rural hospitals already under stress, will increase, with significant economic effects on the regions they serve (6). Even in the past year, in advance of the effects of the OBBB, Maine has experienced closures of important hospitals and clinics.

Decreased availability of mental health treatment for the young and their families will have lasting effects. Most major mental illnesses have onset within the first two decades of life, with a peak on age-of-onset at 14.5 years (7). As in all of medicine, earlier treatment is often more effective, and untreated illness is associated with school failure, disability in adulthood, and preventable early deaths (8, 9, 10, 11). Individuals, families, and all of society will carry a greater burden of illness.

Action is imperative to identify decreases in access to life-changing services as early as possible, to enable remedial action. Too often, the consequences of decisions affecting public health are not identified until years later. To enable timely, constructive responses, pediatricians and child and adolescent psychiatrists in Maine have begun to monitor indicators reflecting access to mental health services for young people, using local, publicly available, reliably available data**.** The findings of this Access Initiative will be made available through quarterly reports.

The First Goal of the Access Initiative is to provide actionable information regarding changes in access to care, as promptly as possible, both in order to support efforts to mitigate damaging consequences to the health of the population. Accurate, timely information is necessary for the public and policy leaders to make decisions based on population health needs and on considerations of effectiveness and cost-effectiveness.

The Second Goal of the Access Initiative is to improve understanding of needed improvements in the array of services and in the processes of implementation and support of evidence-based, cost-effective services, to improve future access to treatment that works.

We have chosen to monitor data which reflect difficulties in access to effective care and support. Limitations in access to prompt evaluation and initiation of effective treatment are often associated with assessment in hospital

emergency departments, urgent psychiatric hospitalization, referral to residential treatment, long waiting times for home and community services, absenteeism and drop-out from school, greater substance abuse, more children entering foster care, and more children and adolescents becoming involved with law enforcement.

We have identified local, Maine-based sources of data, prioritizing, when possible, reports that can be expected to be reliably available, that are available recurrently, and with minimal delays.

This first report is intended to serve as a baseline, reflecting data gathered prior to the effects of the changes initiated by the OBBBA. It is being distributed to the public and the press, to healthcare providers and policy leaders, to others involved with the development of children and adolescents,

Subsequent quarterly reports will update these data as information becomes available. Future reports will also include observations from narrative reports and focus groups with parents, healthcare providers, and others regarding the process of finding help for young patients, with the hope of identifying pathways towards developing a more effective array of services.

We are grateful to the parents, healthcare professionals, educators, law-enforcement officers, Maine government workers, and non-governmental organizational leaders whose consultation has helped to shape the Access Initiative.

We are particularly grateful for the grant support provided by the Maine Health Access Foundation.

B. Methods

Phase 1 will track publicly reported indicators, including emergency department visits, psychiatric hospitalizations, residential treatment use, home- and community-based treatment waitlists, educational challenges, entries into foster care or other state custody, and minors' contacts with law enforcement related to unmet mental health needs.

We anticipate small changes, in a limited population, so we do not expect statistically-significant findings. We are reporting de-identified data and trends for consideration regarding the needs in Maine's population, rather than testing hypotheses with broader implications. We see this as a quality-assurance or improvement project, rather than as research. We are requesting guidance from the MaineHealth Institutional Review Board on this point and for review of our management of Protected Health Information.

Phase 2 will continue quarterly reporting of Phase 1 measures and add reports from primary care and mental health providers, along with analyses of national and local data sources such as Kids Count data (Annie E. Casey Foundation), the National Survey of Children's Health, and Centers for Disease Control and Prevention data (3–7). Phase 2 will assess service gaps, cost and policy implications, parental challenges in obtaining services and accessing care, and the time and financial burden placed on primary care practices serving as the frontline for youth mental health care.

C. Data Collected: Indicators of Difficult Access to Behavioral Health Services

The Access Initiative has consulted with parents, physicians, nurse practitioners, social workers, psychologists, educators, law enforcement officials, government leaders, and others regarding how to approach the dilemmas of improving access to effective care. Many have helped us to identify reliably-available sources of data that may help us to better understand factors relevant to access to mental health care for youth in Maine. We have encountered a very high level of support and cooperation from those with whom we have discussed this project.

II. Analysis of Access to Behavioral Health Services

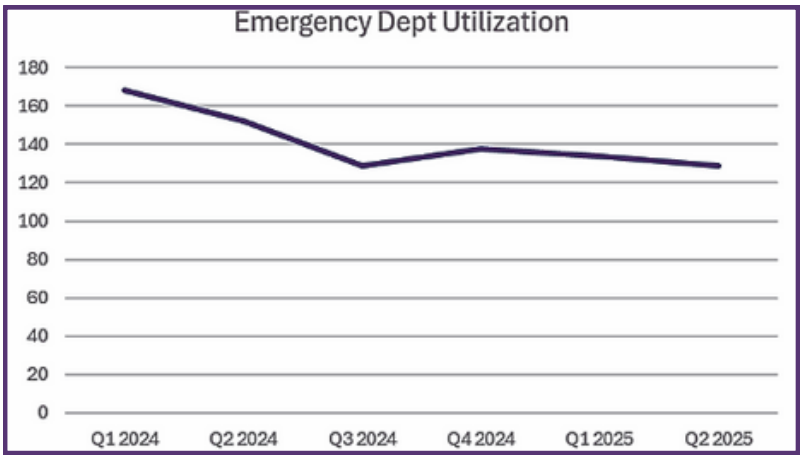
1. Emergency Department Contacts due to Youth Mental Illness

Data Source: Maine DHHS, Office of Behavioral Health
Youth include those people under 18 years old at time of Inpatient Psychiatric stay as identified by unique MaineCare (Medicaid) number

Data Frequency: Monthly

Youth mental health needs are often identified during crisis situations, making ED utilization an important indicator of unmet or escalating behavioral health needs in the community. The Access Initiative reviewed medical claims data provided by the Office of Behavioral Health. The population includes individuals under 18 years of age at the time of ED visit. While needs exist across all sectors of the population, data for those with MaineCare/Medicaid are more readily available than for those with commercial insurance. The Access Initiative reviewed MaineCare (Medicaid) medical claims data to identify emergency department utilization and psychiatric inpatient stays for calendar year (CY) 2024 and the first two quarters of 2025. Claims have run through September 2025.

In total, 587 youth on MaineCare visited the Emergency Department (ED) in 2024. As of June 30th, 2025, 268 youth visited the ED during that year to date.



Most ED visits occurred at MaineHealth (Greater Portland) and St. Mary's (Lewiston), which aligns with higher population density in those regions.

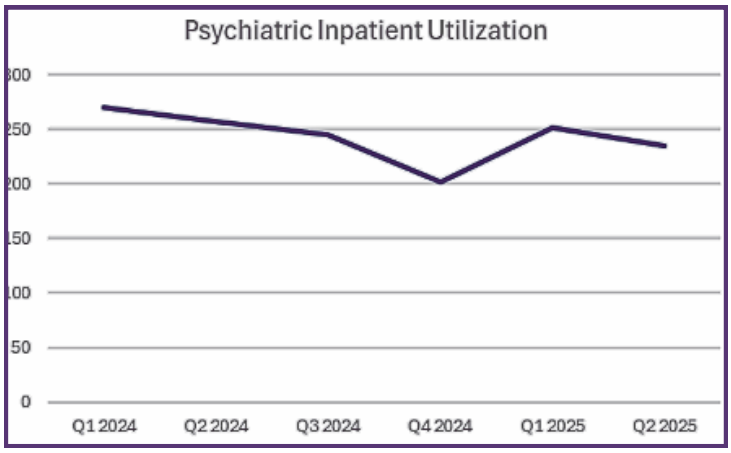
2. Psychiatric Hospitalization

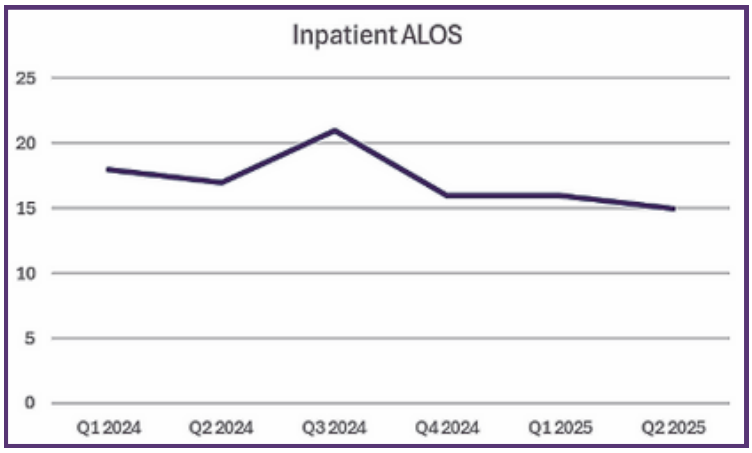
Data Source: Maine DHHS, Office of Behavioral Health
Youth include those people under 18 years old at time of Inpatient Psychiatric stay as identified by z unique MaineCare (Medicaid) number

Data Frequency: Monthly

The Access Initiative reviewed MaineCare (medicaid) claims using data provided by the Maine Office of Behavioral Health. The population includes individuals under 18 years of age at the time of an inpatient psychiatric stay. Psychiatric inpatient stay patterns were similar: more youth were hospitalized in Q1 and Q2 of 2024 compared to the same quarters in 2025. Acadia (Bangor) and St. Mary's had the highest volume of MaineCare psychiatric admissions, while MaineHealth had lower numbers—possibly due to serving a larger proportion of privately insured youth. Early indications suggest fewer hospitalizations and shorter average lengths of stay (ALOS) in 2025, though the reasons for these trends remain unclear.

We do not have data at this time on readmissions to psychiatric hospitals within 30 days of discharge. We anticipate adding these data in future reports.





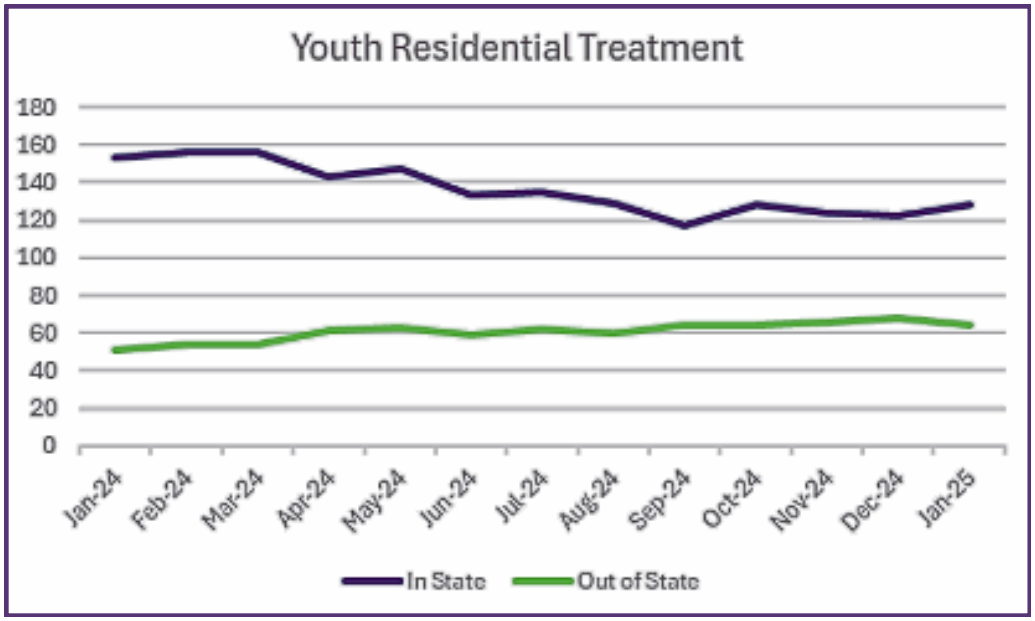
3. Residential Treatment

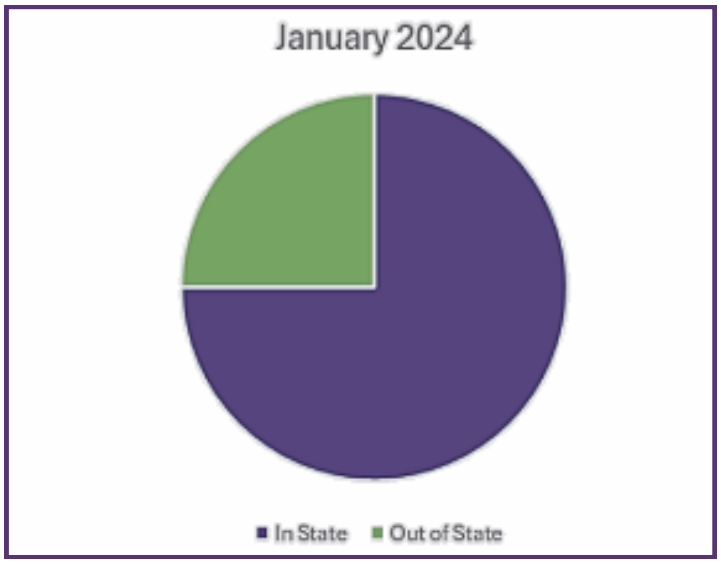
Data Source: Maine DHHS, Office of Child and Family Services
Data includes youth (up to 21 years old) with a mental health or dual diagnosis who require treatment provided in an out of home intensive treatment setting

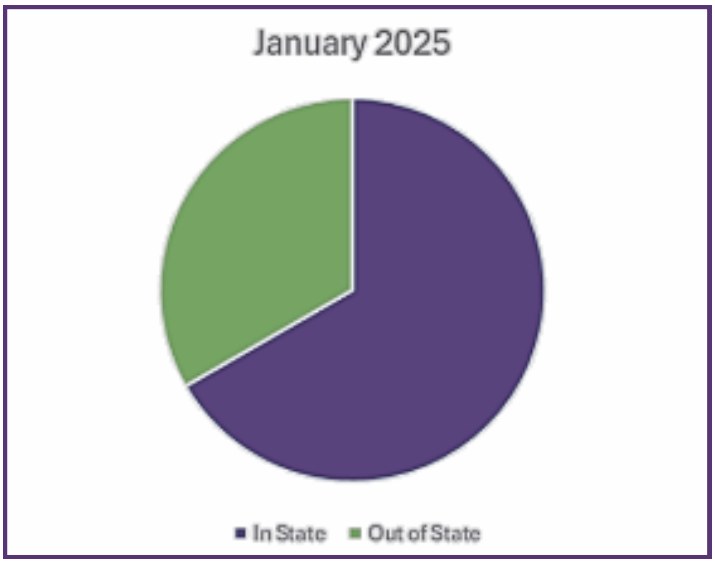
Data Frequency: Monthly (last update January 2025)

Treatment in a residential setting includes youth with a mental health or dual diagnosis (mental health and substance abuse) who require an out of home intensive treatment setting.

In CY2024, 1,643 youth received in-state residential treatment, and 726 youth were placed in out-of-state facilities. While the number of youth receiving residential treatment has decreased (January 2025 compared to January 2024), the proportion of those children receiving that treatment out of state has increased. The overall decrease reflects a significant decrease in beds available in Maine, not a decreased need. The shift is evident in the increased number of youth in out-of-state placement.







4. Wait Listed for Home and Community Mental Health Services

Data Source: Maine DHHS, Office of Child and Family Services
Data includes youth (up to 21 years old) with serious emotional disturbance

Data Frequency: Monthly (last update January 2025)

Home and Community-Based Mental Health Services are designed to provide intensive, family-centered treatment in youth's natural environments, including the home, school, and community. Services focus on stabilizing mental health symptoms, improving daily functioning, strengthening family capacity, and preventing unnecessary emergency department visits or psychiatric hospitalizations. Maine's Office of Child & Family Services (OCFS) works to provide timely access to community based behavioral health services, in recognition of the value of treatment actively including the family, the school, and community resources.

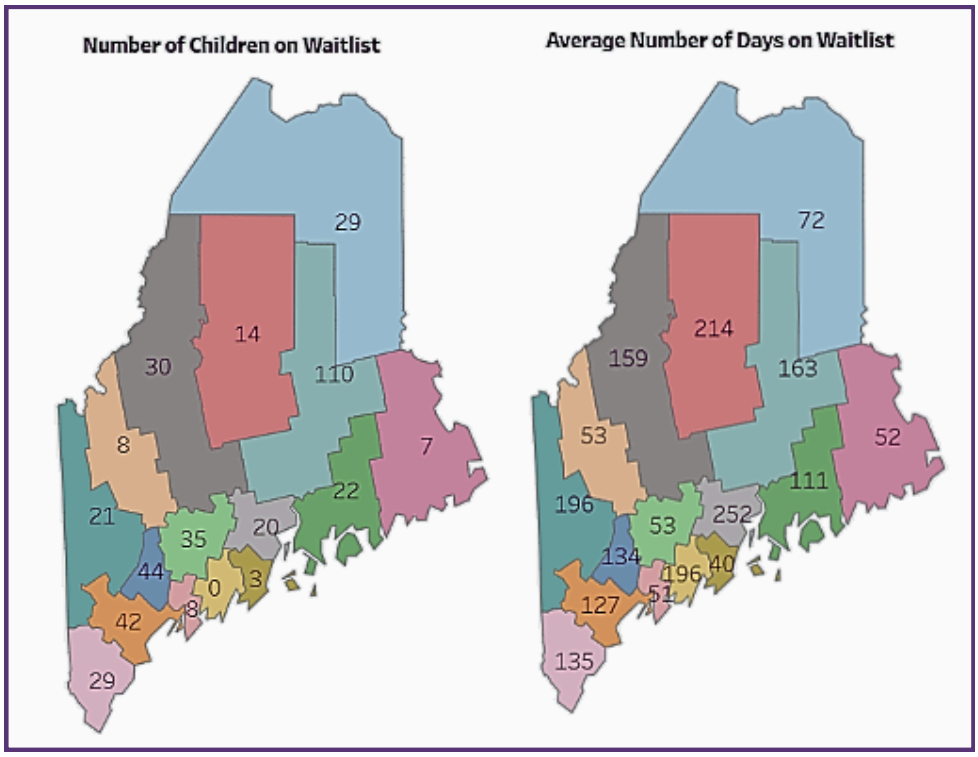
Youth included in this measure meet criteria for "Serious Emotional Disturbances" which includes meeting criteria for a designated mental illness and experiencing significant impairment in functioning intermittently or continually, over the past 12 months. The Access Initiative monitors the number of youth waiting for Home and Community-Based Services and average length of time youth remain on the waitlist prior to service initiation.

Measure	Total in CY'24
Number of Youth Waiting	5,642
Average Time on Waitlist	144.6 days

The snapshot below represents a point in time (January 2025) showing the number of youth waiting for Home and Community Based Services.

In January 2025, there were 422 youth waiting for Home and Community Based Services. Of those on the waiting list in January, individuals averaged 125.5 days on the waiting list.

II. Analysis of Access to Behavioral Health Services



Youth in rural areas have considerably longer wait times than the state average. Rural counties typically have the fewest number of resources. Waldo County youth experienced the longest monthly wait time averages, with the highest average of 252 days on the waiting list.

Data on map: January 2025

Comparison with January 2024 below.

Average Days on Waitlist by County:

	Androscoggin	Aroostook	Cumberland	Franklin	Hancock	Kennebec	Knox	Lincoln	Oxford	Penoscot	Piscataquis	Sagadahoc	Somerset	Waldo	Washington	York
JAN '24	107	118	107	169	304	143	14	131	210	217	177	53	204	222	144	184
JAN '25	134	72	127	53	111	53	40	196	196	163	214	51	159	252	52	135

5. New Entry into Foster Care

Data Source: Maine DHHS, Office of Child and Family Services (OCFS)

Data Frequency: Monthly

The goal of the child welfare system is to keep children safe from abuse and neglect. When a child cannot be safely kept in their own home, the court may order them into State custody, e.g. foster care. The most recent publicly available data from OCFS is from September 9, 2025, and there were a total of 2,164 children in state custody at that time. The Access Initiative gathered data from the State of Maine Office of Child and Family Services (OCFS) of the number of kids entering state custody for the first time, by month. There is no monthly baseline for first-time removals at the State or Federal Levels.

2025 Month	# Youth in Custody - First Time
July	38
August	52
September	56
October	35
November	32
December (partial)	18

The mean number entering foster care for the first time, per month, from July through November, 2025, was 42.6.

6. Education: High School Graduation Rates and Chronic Absenteeism

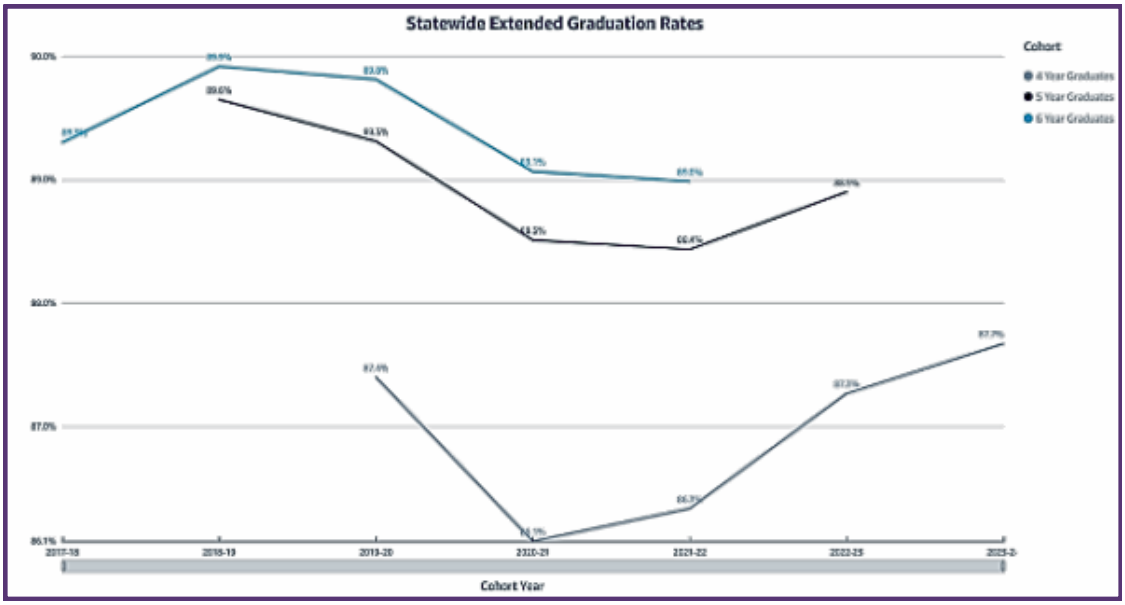
Data Source: Maine Department of Education; Maine Integrated Youth Health Survey (MIYHS)

Data Frequency: DOE: Annual; MIYHS: Biennial

DOE data are used to report rates of chronic absenteeism and demographic disparities. MIYHS data provide contextual information on student mental health and self reported factors associated with school attendance. The Access Initiative reviewed the Department of Education absenteeism and graduation rates as well as results from the Maine Integrated Youth Health Survey (MIYHS). Other factors will be considered and added as available.

A. High School Graduation Rates

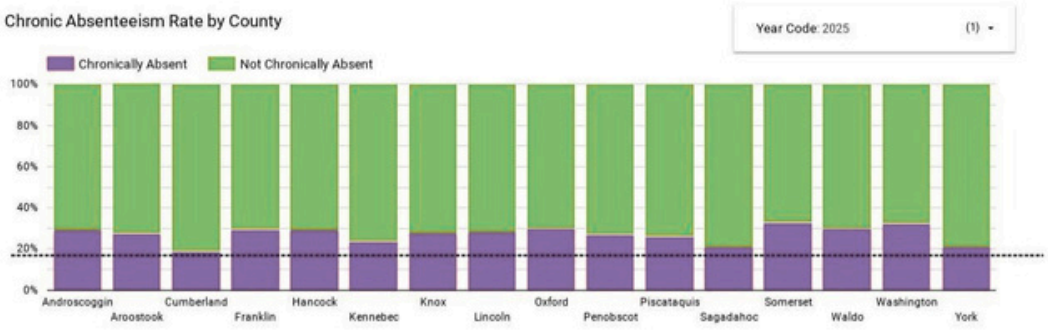
In 2024, the Maine statewide graduation rate was 87.67%. According to US News and World Reports, the nationwide average was 86.4%.

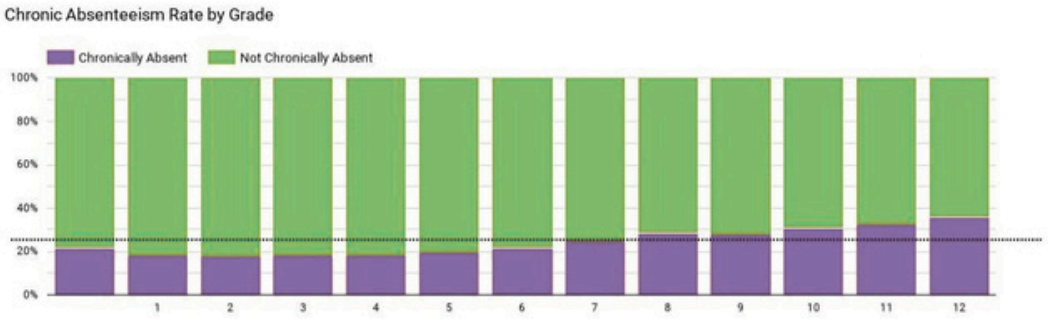


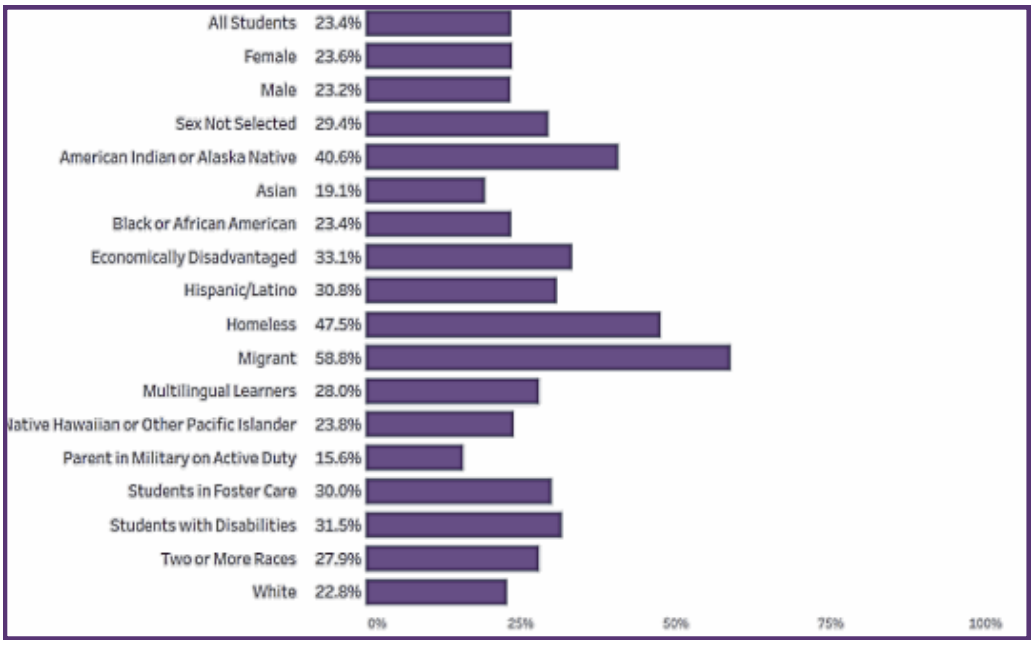
B. Chronic Absenteeism

Chronic absenteeism, defined by the DOE as missing at least 10 school days each year, is closely linked with youth mental health. The relationship is bi-directional with poor mental health being a major reason many students miss school. Frequent absences can, in turn, worsen mental health by increasing social isolation and creating an escalation in missed work resulting in declining academic performance and maintenance of grade level work/expectations.

In the 2024-25 school year, nearly a quarter of all students were chronically absent. The highest rates of absenteeism were found among migrants (58.8%), unhoused students (47.5%) and students who identify as American Indian or Alaska Native (40.6%). These disparities highlight the intersection of educational access, housing stability, cultural responsiveness, and mental health in shaping student attendance outcomes.







These subpopulations may require further monitoring and investigation to understand the connections between school attendance and other measures of mental health need and access issues.

7. Youth Mental Health and Substance Abuse

Data Source: A. Maine Department of Education and Maine DHHS, Maine Integrated Youth Health Survey (MIYHS), School-based student survey. **Data Frequency:** Biennial. (Most recent report: 10/2025)

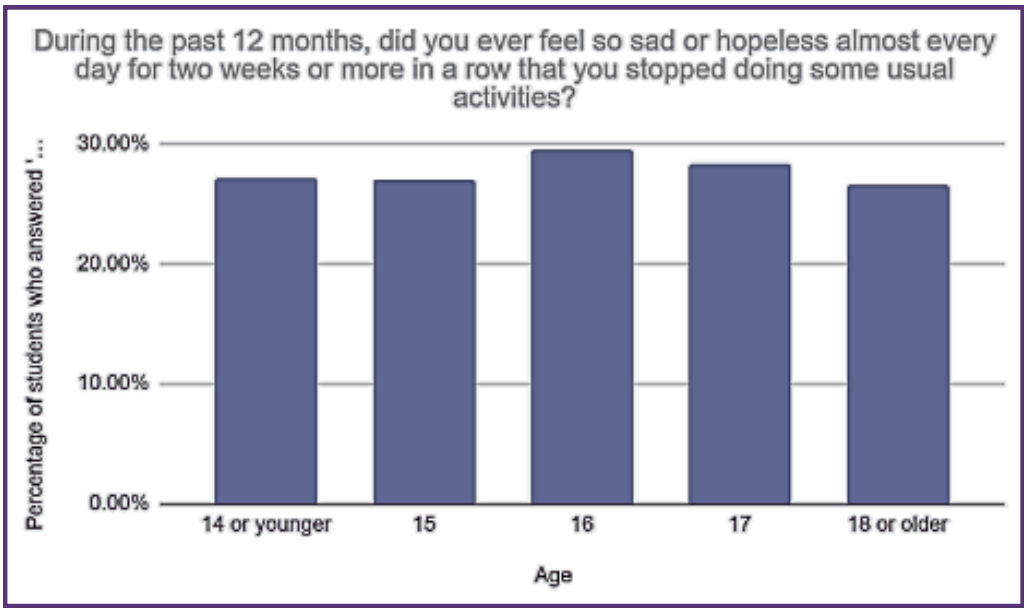
Data Source: B. National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration - Household-based survey. **Data Frequency:** Annual. (Note - federal source which may not continue to be available)

A. Maine Integrated Youth Health Survey (MIYHS)

The biennial MIYHS report was released in October, 2025. This survey provides detailed information provided by middle and high school students focusing on (1) youth feelings of depression and/or suicidal ideation, (2) youth use of alcohol and drugs, and (3) youth perceptions of how easy these substances are to access, which the National Institute on Drug Abuse (NIDA), has found to be associated with of substance use patterns.

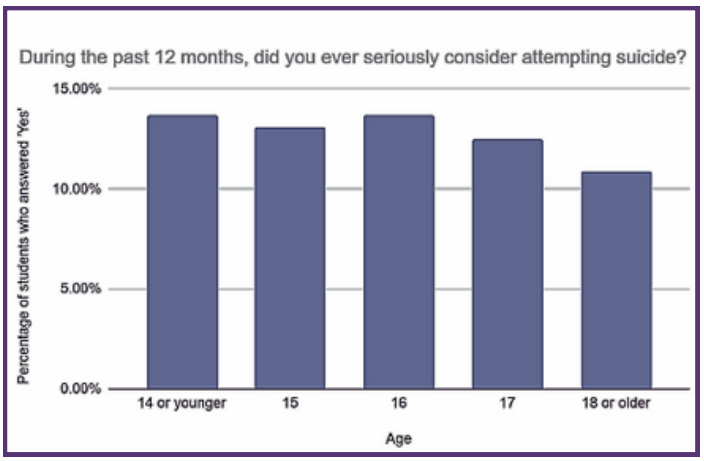
i. Mental Health

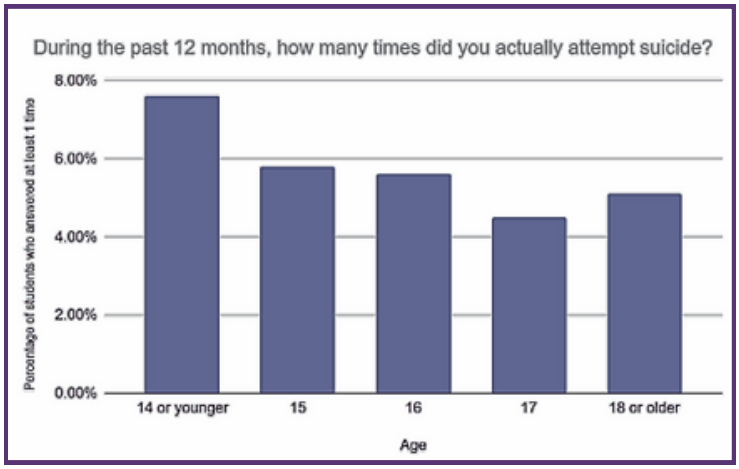
The MIYHS results indicate that nearly 30% of high school teenagers are feeling sad or hopeless every day for two weeks. The highest percentage of those feeling depressed are age 16.



ii. Suicide and Suicidal Ideation

Suicidal thoughts and behavior need to be carefully defined. Thoughts of taking one's life may vary in their intent and intensity. Self-harm behavior can vary from minor to potentially-lethal or lethal. The social context and association with other psychiatric symptoms need to be considered. The data referenced are valuable as part of this baseline report, however, because they are a part of a consistent population survey. They will be discussed with more background in future reports.





iii. Substance Use

Among middle school students who had used cannabis, 26.2% had started before the age of 11.
Among middle school students who had ever had more than a few sips of alcohol, 37.4% did this before the age of 11.

Of those who consumed more than a few sips of alcohol, 27.5% started before the age of 13.

MIYHS 2025: Middle School

Substance	Percentage who used at least one in the past 30 days	Additional Notes
Cigarettes	1.6%	
Electronic Vapor Device	4.3%	
Alcohol	3.6%	40.8% of this group report binge drinking in the past 30 days
Cannabis	3.3%	
Prescription Medication without a Doctors Prescription*	4.0%	31.8% perceive weekly use as low risk

*Includes medications such as Adderall, Xanax, Ritalin, Oxycontin, and Percocet.

Among HS students who have used Cannabis, 22.9% initiated before the age of 13.

Earlier onset of substance use and the greater the frequency of use, are associated with greater probability of developing a substance use disorder. Adolescents with substance use disorders are have high levels of comorbid mental health disorders, with increased risk of death by suicide, and have substantial social, educational, and vocational impairments that may linger into adulthood (12,13). The current increase in fentanyl use and an associated increase in drug overdose deaths requires active work to identify those at risk and to increase access to treatment (14).

MIYHS 2025: High School

Substance	Percentage who used at least one in the past 30 days	Additional Notes
Cigarettes	5.1%	
Electronic Vapor Device	13.0%	
Alcohol	16.5%	41.5% of this group had 5 or more drinks in the past 30 days. 32.7% believe drinking 1-2 drinks causes little harm.
Cannabis	14.6%	8.3% of students have been drunk or high in school.
Prescription Medication without a Doctors Prescription*	4.7%	12.7% view little or no risk in this behavior.

*Includes medications such as Adderall, Xanax, Ritalin, Oxycontin, and Percocet.

National Survey of Drug Use and Health (NSDUH)

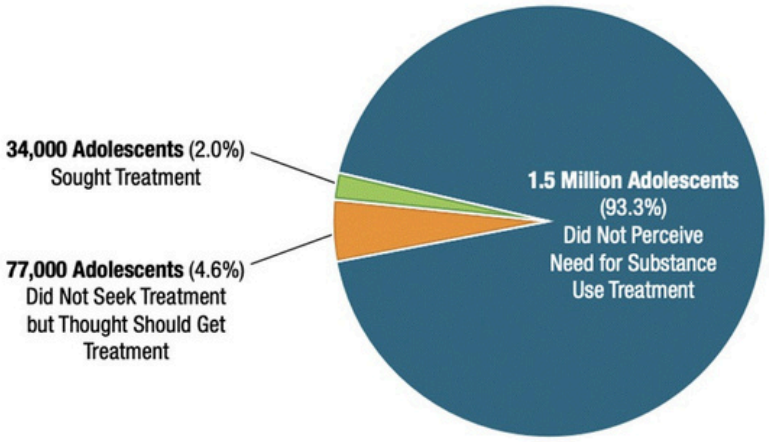
Data are limited regarding incidents of treatment or how treatment is accessed. The NSDUH data indicates 4.47% of youth in the 12–17-year age group received treatment in Maine in the past year - the highest percentage compared to other states in this category. [NSDUH- State Tables -Table 30] Treatment is defined as including inpatient and outpatient counseling and medications for SUD.
National models suggest only 4.6% of adolescents ages 12-17 with a SUD perceive the need for any type of treatment [NSDUH - 2024 page 46], suggesting that over 90% of youth who might benefit from treatment are not receiving it.

Data from the National Survey on Drug Use and Health [NSDUH] estimate that from 2023-2024 12.08% of youth ages 12-17 met criteria for a substance use disorder in Maine. [Table 24 page 48 NSDUH State level tables estimates past year SUD by age].

Maine has the highest estimate of substance use disorders in the 12-17 age group relative to other states, in this national survey. Youth with substance abuse often experience co-occurring mental illness, with estimates as high as 60%.

The current increase in fentanyl use and an associated increase in drug overdose deaths requires active work to identify those at risk and to increase access to treatment (14).

Figure 72. Perceptions of Need for Substance Use Treatment: Among Adolescents Aged 12 to 17 with a Past Year Substance Use Disorder Who Did Not Receive Substance Use Treatment in the Past Year; 2024



1.7 Million Adolescents with a Substance Use Disorder Who Did Not Receive Substance Use Treatment

Note: The percentages may not add to 100 percent due to rounding.

Note: Adolescents with unknown information for perceptions of need for substance use treatment were excluded; therefore, the sum of the interior pieces does not add to the whole.

8. Law Enforcement Contacts Associated with Mental Health Crisis or Needs

Data Source: Portland Police Department, Behavioral Health Unit; Data includes Youth Under 18

Data Frequency: Monthly

The Portland Maine Police Department has a Behavioral Health Unit (BHU) Response Program designed to respond directly to calls for service involving mental health and substance use disorders. The primary function of the BHU is to help resolve whatever immediate crisis is occurring and connect individuals to appropriate resources in the community, including case management, detox, substance use treatment, or crisis stabilization.

The Access Initiative gathered data from the Portland Police BHU involving calls for youth under 18 for the time period of July 22, 2025 through December 18, 2025. We are hopeful that similar data will be available from other law enforcements/jurisdictions, to allow consideration of regional and rural/urban differences in access to needed services. Additional detail will be available in future monthly reports.

July 22, 2025 - December 18, 2025

Total Behavioral Health Unit Contacts Overall*	Total Number of Unique Contacts	Total Number Recommend Follow-up	Total Number of Crisis Resolved on Scene	Mean Number of Unique Contacts per Month
58	42	19	39	8.4

*Includes interactions with same individual more than once

III. Conclusions

This baseline of current difficulties in access to mental health services for Maine's children, adolescents, and families will not surprise parents, healthcare providers, teachers, or police officers. Despite significant efforts by many to improve the availability and effectiveness of treatment, access to care at this time is a significant challenge.

These data points and observations will serve as a baseline for future reports and recommendations.

Observations in this report include:

1. **Hospital emergency department admission** is often a default action when mental health/behavioral health crises or urgent needs cannot be met by other care. Medical claims for youth insured by MaineCare (Medicaid) indicate 587 youth were admitted to EDs in 2024. Data through June, 2025 indicate a similar rate of ED utilization.

2. **Psychiatric inpatient utilization** has been high, with patients often waiting in EDs for beds, and some requiring readmission within 30 days due to difficulties in the availability of effective aftercare (further data pending). Furthermore, many patients must wait in costly inpatient beds due to follow-up care not being available.

3. **Residential treatment** was provided to 1,643 youth in Maine, and an additional 726 were placed in facilities in other states. An undetermined number of these patients might have been effectively treated in closer proximity to their families with intensive home-based interventions.

4. **Home and Community/Family-based Services,** often the most effective, enduring treatment for young people with serious emotional disturbances, are often not readily available. Despite active work by Maine's Office of Child and Family Services and Office of Behavioral Health to provide such treatment, in January, 2025, 422 were waiting for Home and Community Based Services , with an average of 125.5 days, over 4 months, on the waiting list.

5. **Foster Care Admissions** - Between 35 and 52 children and adolescents entered Foster Care for the first time each month between July and October, 2025. The number of children entering foster care may also reflect unmet needs of their parents, many of whom are under increasing strain and struggling to manage daily life, including challenges related to mental illness and substance use disorders.

6. **Education** is often disrupted by mental illness. High school graduation rates are low, and chronic school absenteeism – missing at least 10 school days each year – in the 2024-2025 school year was 23.4% for all students, and much higher in some vulnerable populations. Mental health challenges are frequently seen in those who miss school, and absences, in turn, may worsen mental health.

7. **Substance Use** is a major and growing problem for young people and the great majority of those at risk or already using substances are not in treatment. Maine Middle School students are starting to experiment with substances and they are experimenting with prescription medication at rates similar to other commonly used substances by adolescents. Experimenting with non-prescribed prescription medication increases the risk of accidental overdose with substances like fentanyl and synthetic fentanyl. Treatment options for adolescents are limited.

8. **Law enforcement contacts related to mental health needs** in those under 18, by the Portland Police Department, Behavioral Health Unit, averaged over 8 per month in late 2025. These contacts are recorded monthly, and are related to the prevalence of needs, the availability of mental health and other services, and the difficulties in engaging some young people and their families – an important but challenging, labor-intensive aspect of mental health services.

Future Data Points for Inclusion:

Future quarterly reports will update data for the 8 indicators of access to services described above, as data become available. We will also begin the Phase 2 of the Access Initiative, with narratives and focus group reports involving parents and healthcare providers.

We will also review the data from Maine in the context of national reports reflecting mental health needs and access to services for children, adolescents and their families.

These include the following:

- Maine Kids Count Data Book – Maine Children's Alliance and Annie E. Casey Foundation (15)
- National Survey of Children's Health, Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) (16)
- Youth Behavior Risk Surveillance System - CDC (17)
- Morbidity and Mortality Weekly Report – CDC (18)

The Access Initiative is intended to do more than monitor and mitigate the deterioration in access to mental health services that may result from recent funding and policy decisions. That first goal is vitally important—with the potential to save lives and to prevent profound tragedy and long-term burden for future generations.

Consistent with its second goal, the Access Initiative also seeks to inform the development and implementation of a more clinically effective and cost-effective continuum of supports and services (19, 20, 21), enabling earlier and more effective intervention for young people and their families.

Achieving this will require more than increased funding alone. It will also demand focused attention to the implementation of evidence-based care and a reconsideration of how care is financed which includes topics that are often difficult to address in today's national discourse. Nonetheless, this work is essential to minimizing disability and strengthening health and human capital, both of which are critical to the future well-being of our society.

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