A Report on Children's Residential Treatment Services and Implementation of the Department's Strategic Priorities for Children's Behavioral Health Services

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Legislative Requirement

LD 435, passed in 2024, requires the Department of Health and Human Services (Department) to study children's residential treatment services and submit a written report to the joint standing committee of the legislature that details:

I. Analysis of residential bed capacity, occupancy, availability, and access within in-state and out-of-state services provided to Maine youth.
II. Information about the Department's progress in implementing the 2019 children's behavioral health services strategic plan for Maine.
III. Information on the Department's current priorities to ensure availability, quality, consistency, and access in behavioral health care services for children.

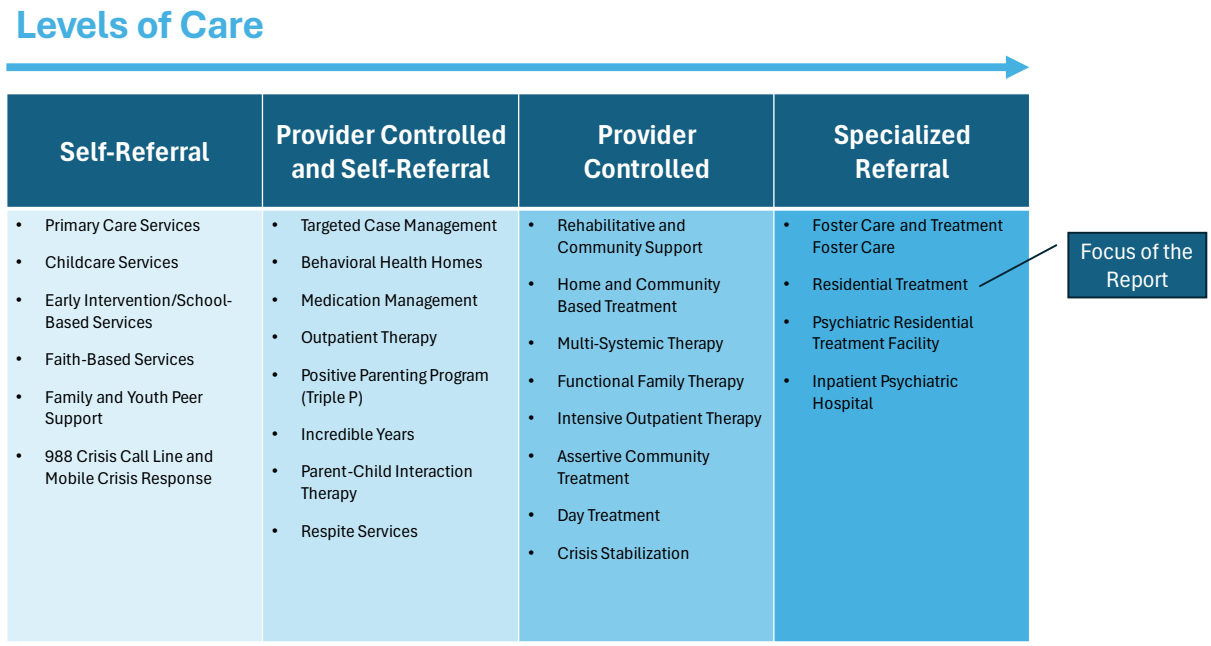
This report addresses the requirements outlined in LD 435. It is organized into three main sections, corresponding to the Roman numerals listed above, and ends with a conclusion and recommendations.

Section I: Analysis of Children's Residential Treatment Services

I.i. Introduction

Children's Residential Care Facilities (CRCF) provide 24-hour care to youth with high-acuity behavioral health needs on a short-term basis, ideally one-six months. These facilities serve youth with mental health (MH), intellectual disability (ID), or developmental disability (DD) diagnoses with symptoms dangerous to self or others and too severe to treat in community settings. CRCFs are staffed and equipped to provide specialized comprehensive, trauma-informed, child-centered, and family-focused treatment. Their services occur in a supervised therapeutic milieu in which skills and principles learned in clinical treatment are reinforced and practiced, with the goal of safely transitioning youth back into community within a family setting. Within the context of youth behavioral health services, CRCFs are known synonymously as Private Non-Medical Institutions (PNMIs).

Figure 1: Maine Children's Behavioral Health Services Levels of Care



The Department considers residential treatment services for youth as treatment requiring a high level of care and therefore a specialized referral (Figure 1). Per Department policy, mental health services must be provided to youth in the least restrictive setting suitable to their needs; thus, CRCF treatment is not recommended for youth whose needs can be addressed in a less restrictive family or community setting. Further, when CRCF treatment is indicated, placements should be as close to the youth's home as possible, and families and/or caregivers are required to remain actively informed and involved in the youth's treatment. CRCFs are subject to rules in the MaineCare Benefits Manual (MBM), Chapter III, Section 97 Appendix D.[1]

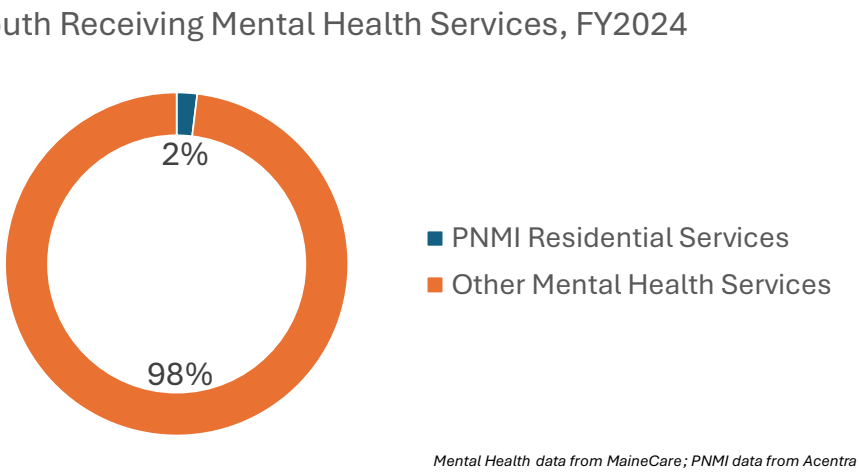
Youth access CRCF services via a specialized referral. A youth's needs are clinically assessed with a family-centered process and a standardized assessment instrument. If the youth is deemed eligible for CRCF, they are referred to suitable programs authorized by the family. Providers who receive the referral often schedule an interview with the youth to determine if they are a good fit for that treatment program. Following the interview, the provider admits or declines the referral and sends a decision letter to the family.

[1] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s097.docx

I.ii. CRCF Data Trends

Youth in residential care represent a small fraction of the total youth receiving behavioral health services. In 2024, a total of 19,975 youth received mental health services as estimated from MaineCare claims, while data from Acentra Health, which serves as the Department's Administrative Services Organization, show that 384 youth received treatment in a CRCF/PNMI facilities (Figure 2).

Figure 2: Fraction of Youth Receiving Residential Services vs. Other Mental Health Services

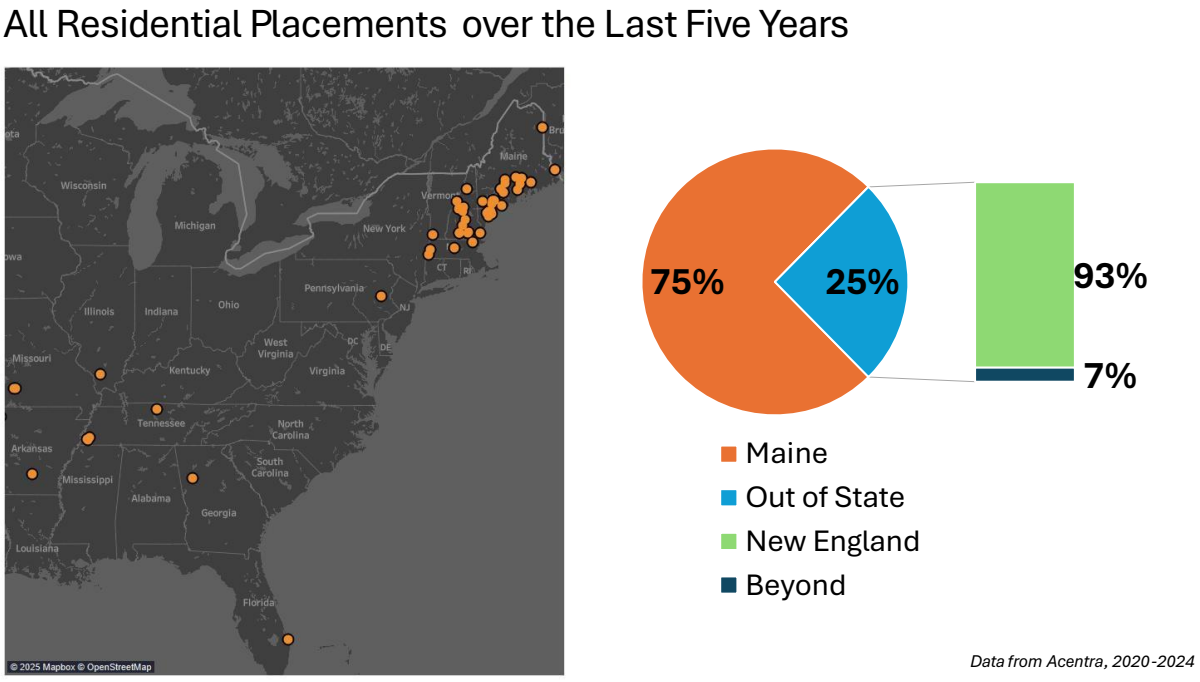


Between 2019 and 2024, 75% of youth receiving CRCF services were placed within the state of Maine and 25% were placed in out-of-state facilities (Figure 3). Of the youth placed out-of-state, 93% received care in New England and only 7% were placed outside the region (Figure 3). The Department's policies and procedures that inform CRCF placement are detailed in subsequent sections of this report.

The total number of Maine youth in residential treatment has decreased since 2021 (Figure 4), corresponding with a reduction in in-state beds. This decline is consistent with similar national trends; a 2023 study evaluating treatment capacity from 2010-2022 found that 94% of states experienced a decline in psychiatric residential treatment beds over that time frame.[2] We discuss the impact of this trend in Maine, as well as other factors, on CRCF service capacity and utilization in the next section.

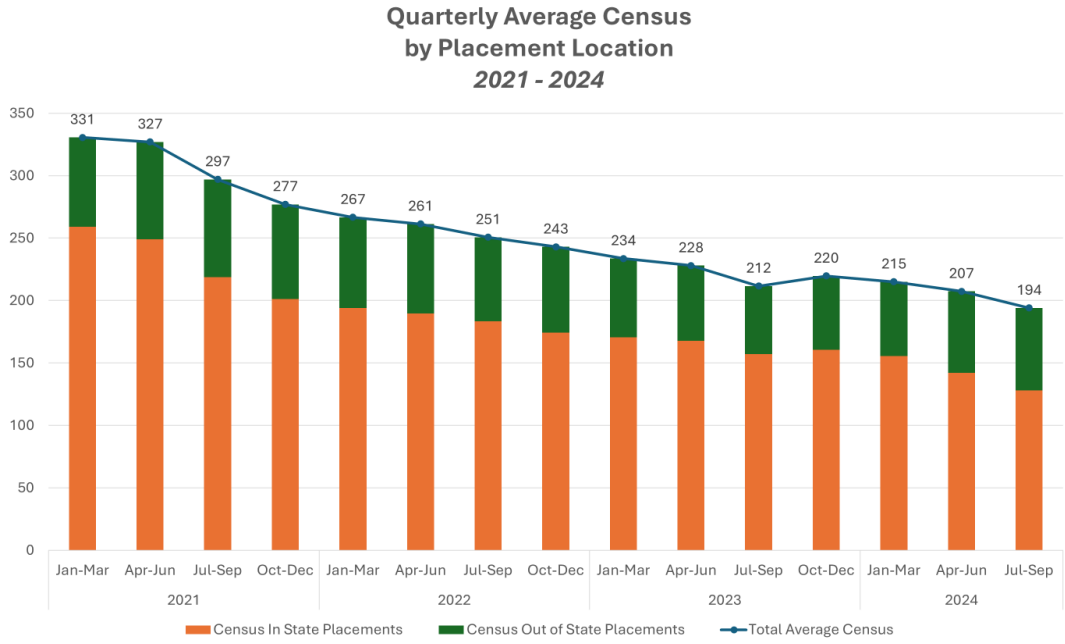
[2] Ghose, S. S., Beehler, S., Pinals, D. A., Crocker, L., Hoey, T., Masiakowski, N. P., ... & Patel, N. A. (2025). Youth Inpatient and Residential Treatment Psychiatric Beds: National Trends and Potential Causal Factors, 2010–2022. *Psychiatric Services*, (0), 00-00.

Figure 3: Youth CRCF Treatment Locations, 2020-2024



Data from Acentra, 2020-2024

Figure 4: Number of Youth in CRCF Placements Over Time



I.iii. In-State Residential Services

As of February 2025, there were eight agencies offering CRCF services in Maine. There were a total of 185 licensed residential beds in service, and of these, 129 were occupied. (Figure 5). Two of these eight agencies offered programming specific to youth with intellectual and developmental disabilities (IDD).

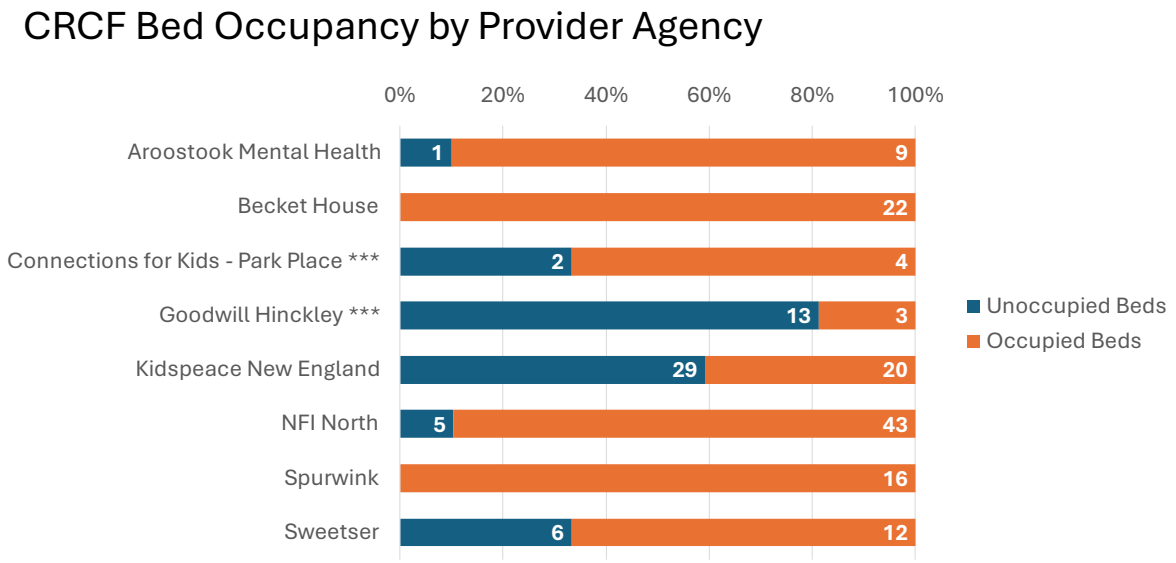
In April 2025, two of the eight agencies previously operating in Maine closed, lowering Maine's total in-state licensed capacity to 152 beds. The six agencies and services that remain operational include:

- **Aroostook Mental Health Services.** Operates the Calais Children's Residential Treatment Program, a 10-bed mental health-focused facility that serves co-ed youth aged 12-16.
- **Becket Maine.** Operates two locations. The Lewiston facility has 8 beds and serves only female patients aged 13-18. The Belgrade facility has 14 beds with a service focus on male patients aged 13-18 exhibiting problem sexualized behaviors (PSB).
- **KidsPeace New England.** Operates a multi-unit campus located in Ellsworth serving youth with mental health and/or autism spectrum disorder. It has 38 beds of active capacity spread across units serving youth ages 8-20 (Rangeley, 10 beds; Liberty, 10 beds; Chamberlain, 7 beds; and Schoodic, 11 beds); its 11-bed Belgrade unit is temporarily closed.
- **NFI North.** Operates co-ed mental health programs. Its facilities are located in Buxton (Beacon House, 8 beds, ages 13-20), Bridgton (Bridge Crossing, 12 beds, ages 5-14), Bath (Oliver Place, 6 beds, ages 15-20), Sidney (Riverbend, 8 beds, ages 10-20), Stetson (Stetson Ranch, 8 beds, ages 10-20), and Bangor (Summit View, 6 beds, ages 10-20).
- **Spurwink.** Operates Brook House in Westbrook, a 16-bed facility serving co-ed youth aged 5-20 with intellectual disabilities / autism spectrum disorder.
- **Sweetser.** Operates two co-ed facilities serving youth with mental health diagnoses. Its Winterport location has 9 beds and serves a mix of ages; its Saco Staff Intensive B facility has 9 beds and serves ages 11-17.

One additional agency, Day One, operates 14 co-ed residential beds specializing in treatment for youth with substance use disorder (SUD). This program is not classified as a CRCF and operates under materially different licensure and reporting regulations.

The CRCF facility closures that occurred in April are part of a long-term trend toward reduced residential bed capacity in the state. Within the past year alone, five agencies have closed children's residential programs, resulting in 111 beds coming permanently offline and 12 beds closing temporarily. A review of CRCF licensing data from 2007 to 2025 provides a cross-decadal picture of the long-term trend: including the most recent closures, the number of agencies providing services decreased 57%, and the number of individual programs dropped 79%. Altogether the total number of licensed beds fell 78% over those 17 years (Table 1).

Figure 5: Point in Time CRCF Bed Occupancy by Provider Agency, February 2025



Current as of Feb 20, 2025 provider reporting
Data labels show number of beds
****Anticipated program closures*

Table 1: In-State CRCF Capacity Reductions, 2007-Present

CLOSED AGENCIES (Since 2007)	CURRENTLY OPEN AGENCIES (As of May 2025)
8	6

CLOSED PROGRAMS (Since 2007)	CURRENTLY OPEN PROGRAMS (As of May 2025)
70	19

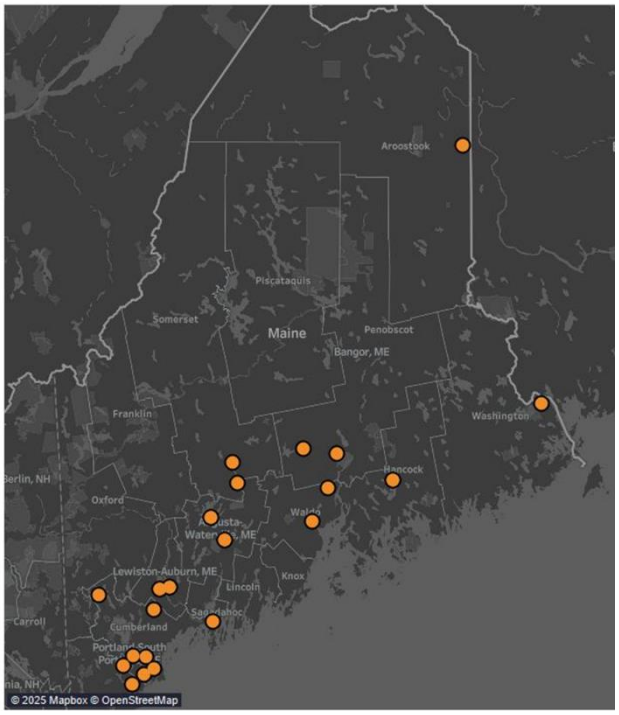
TOTAL LICENSED BEDS (Since 2007)	CURRENT LICENSED BEDS (As of May 2025)
642	178

The Department consulted widely with providers in the preparation of this report; they self-identified a number of factors contributing to the reductions in in-state CRCF capacity, including:

- **Meeting the needs of high-acuity youth.** While there is demonstrable demand for residential care, many in-state providers do not feel resourced and equipped to meet the level of need presented by some youth referred to their facilities. Providers have declined referrals as a result.
- **Lack of appropriate referrals.** Providers also reported receiving fewer referrals of lower acuity youth who would fit within their service design and current milieu.
- **Staffing shortages, hiring challenges, and turnover.** Providers referenced workforce challenges as a constraint across several job classifications needed to staff CRCF facilities, including clinicians, behavioral health professionals, board-certified behavioral analysts, registered behavior technicians, and nursing roles.
- **Financial challenges.** Over time, low acceptance rates have resulted in insufficient revenue to meet costs, and this has challenged provider viability. Providers articulated financial challenges in the following ways:
    - Inability to bill for home visits or extended time away from program. While the rate methodology includes an occupancy adjustment for planned time out of the program, this adjustment is not sufficient to cover lost revenue for children on home visits, who are hospitalized, or who have eloped overnight. MaineCare policies prevent the provider from billing for these days, even if the youth was in program the majority of the day;
    - Reimbursement rates that have not kept pace with inflation, including for standard room and board and temporary high intensity staffing;
    - Standardized reimbursement rates that do not provide optimal flexibility to support programming for individualized need, i.e. high acuity youth or medically complex youth; and
    - Issues with Family Transition Specialist billing during AfterCare services; for example, being unable to bill when families refuse AfterCare services or when sessions are declined or cancelled due to weather;
- **Licensing compliance issues.** CRCF facilities are licensed and subject to significant regulatory oversight in order to comply with Maine law and promote the safety and appropriate treatment of youth in their care.

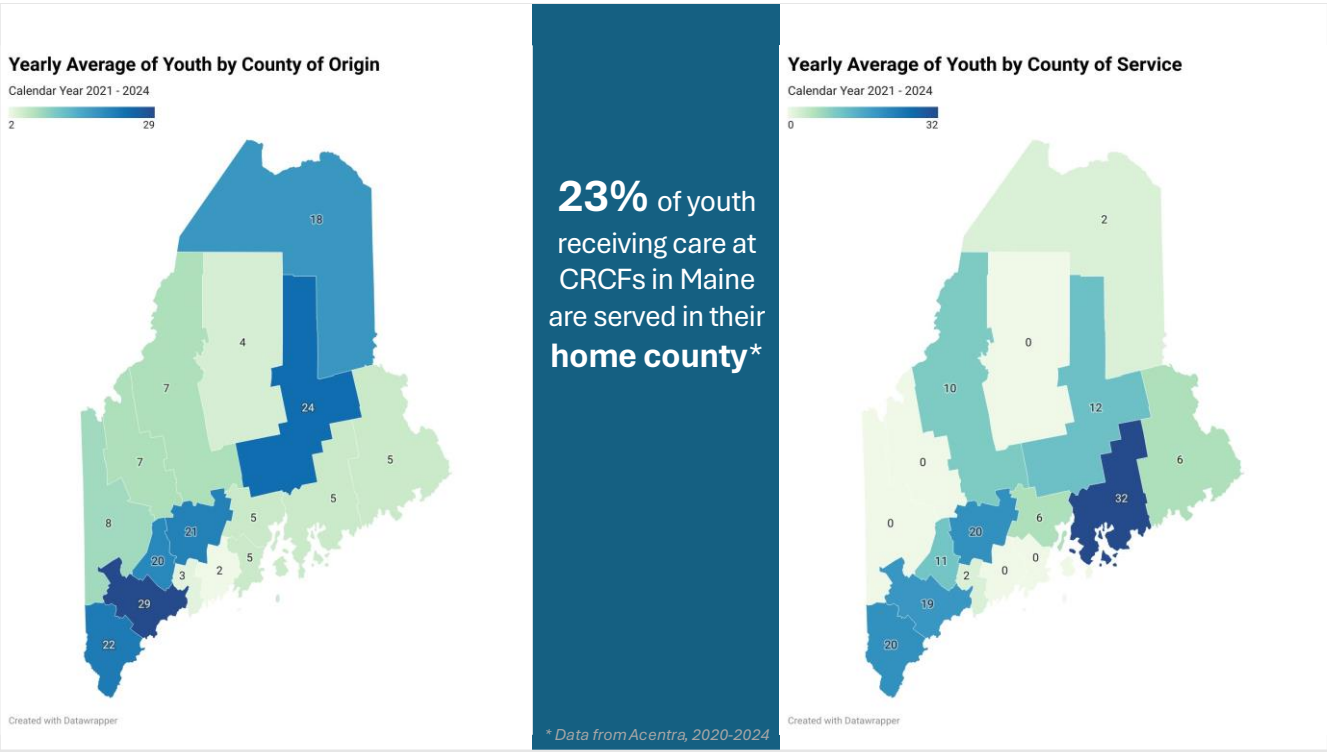
Of note, three providers consulted in the preparation of this report submitted additional data to illustrate the staffing and operational challenges related to delivering services at this level of care. They all noted workforce challenges, with an average 59% turnover rate; one provider noted a 80% voluntary and involuntary turnover rate. Providers also highlighted that staff injuries and property damage associated with caring for high acuity youth exacerbated workforce and financial challenges in an already stressed residential delivery system.

Figure 6: All Youth CRCF Treatment Locations in Maine, 2020-Jan 2025



A map of all treatment locations active during the last five years can be seen in Figure 6. Between 2021 and 2024, 23% of youth receiving care at CRCFs in Maine were served in their home counties (Figure 7). Youth in more rural northern and inland regions of the state appeared more likely to leave their home county to receive care, as necessitated by the aggregation of existing facilities in more urban and coastal regions of the state.

Figure 7: Maps Showing Youth by County of Origin (left) and County of CRCF Service (right).



I.iv. Eligibility and Access to CRCF Treatment:

As described in Section I.i, eligibility for and admission to CRCF treatment requires a multi-step level of care assessment and referral process. To be considered for treatment, youth must first have: (1) a mental health or ID/DD diagnosis, and (2) be enrolled in MaineCare (up to age 21) or have a Katie Beckett waiver (up to age 19). While youth under age 10 can be considered, every effort is made to minimize this level of care for young children, and CRCF treatment at these ages is rare.

For a youth to be considered for CRCF treatment, they must additionally:

- Have a specific diagnosis that can be treated in a residential treatment program;
- Be at risk for a psychiatric hospital stay and/or at high risk of harming self or others;
- Have received intensive community-based services that have not been successful, such that their symptoms have become too intense and frequent for caregivers to manage; and
- Need more (24/7) help managing day-to-day activities than other youth the same age.

The referral process for CRCF treatment begins when a youth's case manager engages the Department's county-based children's Behavioral Health Program Coordinator (BHPC) to discuss the potential appropriateness of CRCF level of care for the youth. Afterwards, the BHPC completes a consultation form and includes it within a formal CRCF application. Parents must also give their permission to apply and sign the application for the process to proceed.

The BHPC submits the CRCF application to Acentra Health, the Department's administrative services organization, through their Atrezzo system. The CRCF application includes prior psychological assessments, relevant school records (test scores, 504s, IEPs), and pertinent medical records including a Comprehensive Child Health Assessment. The complete list of required documentation can be found on Acentra's website.[3]

The Acentra clinical team reviews each CRCF application and verifies its completeness. If the application requires additional documentation, it will be placed on administrative hold for 7 days. If information is still missing after that hold, the application will be administratively denied.

Within 5 business days of receiving a complete application, Acentra reaches out to the youth's guardian to schedule a Service Intensity Assessment meeting, necessary to determine if the youth meets clinical eligibility for CRCF. Acentra invites all of the youth's care team members to the meeting as well and gathers information to determine the needed level of care. When Acentra finalizes its determination, it shares the results in an Assessment Outcome Summary with guardians and other members of the care team at a separate read-out meeting. The read-

[3] https://me.acentra.com/children-services/

out meeting is generally scheduled within two (2) business days of the initial Service Intensity Assessment.

The Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) tool or an age-appropriate analog supports the determination of CRCF eligibility. The CALOCUS-CASII is a standardized tool for youth aged 6-18 years old. Youth outside this age range receive the analogous tools ESCII (for ages 0-5) and LOCUS (age 18+). The CALOCUS-CASII and related tools link the results of a clinical assessment with a defined level of service intensity using clinically derived and empirically tested algorithms. The tools are user-friendly, culturally informed, and support active participation by the youth and their guardians. The CALOCUS-CASII and related tools incorporate holistic information on the child within the context of their family and community by assessing service intensity needs across six key dimensions:

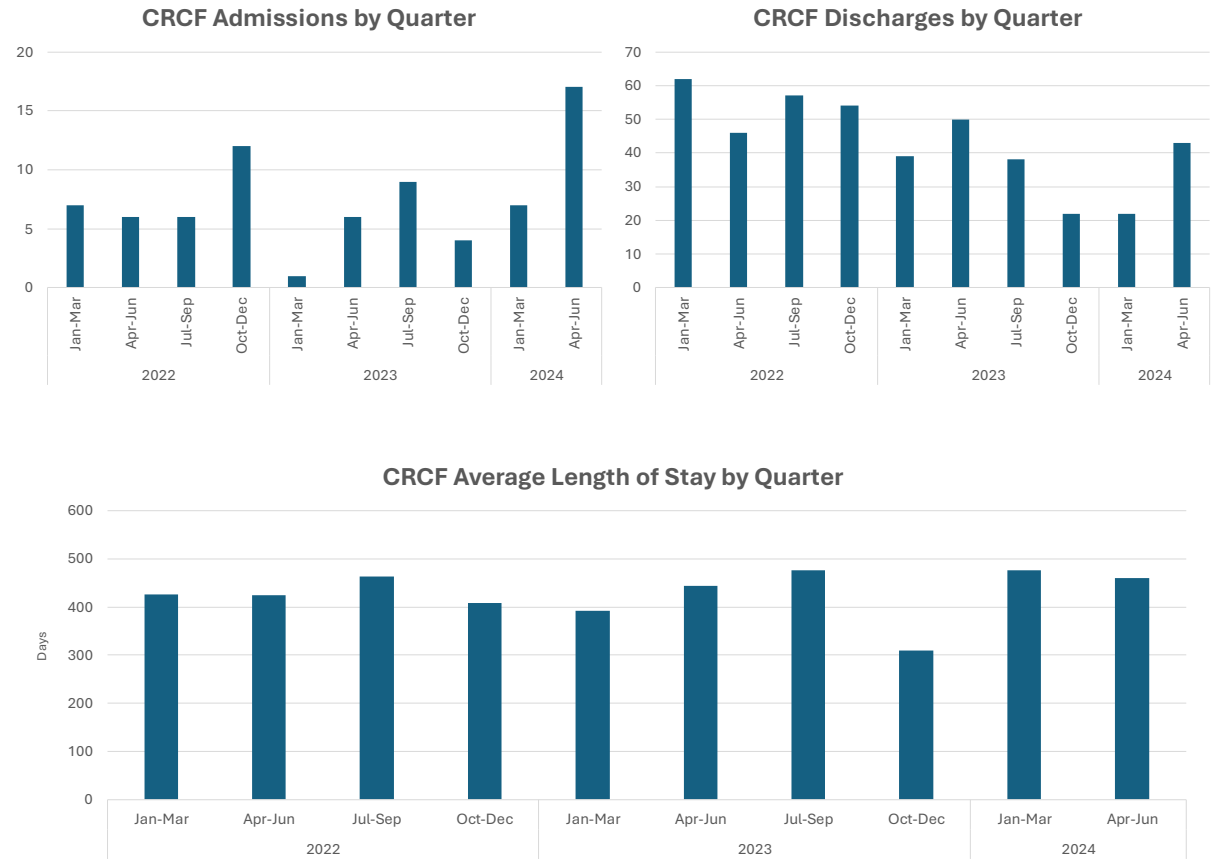
- Risk of harm
- Functional status
- Co-occurrence of conditions: developmental, medical, substance use, and psychiatric
- Recovery environment
- Resilience and response to services
- Engagement in services

At the end of the Assessment process, Acentra recommends a level of care that ranges from zero (0), indicating a need for basic services for prevention and maintenance, to six (6), indicating a need for medically managed intensive integrated services that include secure, 24-hour services with psychiatric management. If a CRCF level of care is found to be appropriate, the youth may be referred to providers for service.

An approval from Acentra based on CALOCUS-CASII indication and subsequent referral to an individual CRCF location does not, however, guarantee that treatment will occur. Guardians are central to decision-making for the treatment of youth in their care. Also, each CRCF provider and location determines its own service population and admission criteria: providers can and do make discretionary admission decisions based on considerations including their staff caseloads and workflows, the needs of a particular youth and how these fit with the milieu of youth currently in their care, and the safety of all involved.

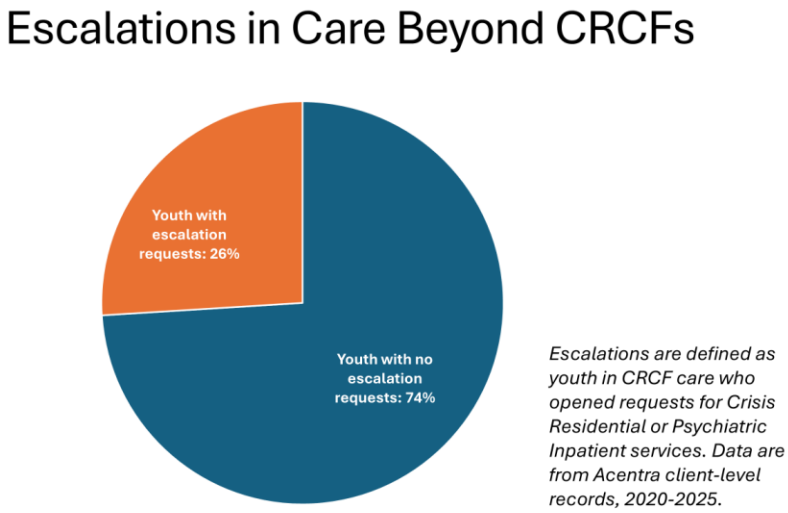
The Department has, in recent years, placed renewed emphasis on serving the mental health needs of youth in family and community settings and on facilitating the successful and timely return home of youth receiving residential treatment. Between 2022 and 2024, there were fewer quarterly admissions to CRCF locations than discharges (Figure 8), a finding consistent with the long-term trend toward lower census numbers as described in Section I.ii (Figure 4). There was no clear trend in length-of-stay at CRCFs for youth over this time frame (Figure 8).

Figure 8: Admissions, Discharges, and Length of Stay over Time



Of youth who receive CRCF care, 26% escalate in symptom severity and request higher intensity residential services, either psychiatric inpatient hospital or Crisis Residential Unit (CRU) stays (Figure 9). These data illustrate the significant care needs and levels of acuity involved in some CRCF cases that can result in long-term (multi-year) residential placements for some youth.

Figure 9: Escalations in Care by Youth Admitted to CRCFs



I.v. Out-of-State Residential Services

If a youth's needs cannot be met by in-state CRCF programs or if all in-state CRCFs decline referrals for that youth, then the Department will seek CRCF services out-of-state. It is Department policy that referrals for out-of-state placements are approved only if the youth is first declined care from appropriate in-state programs.

Youths are typically referred to out-of-state programs based on case-specific reasons; however, some common themes include the acuity or specificity of service needs and the timing of a youth's application for treatment in relation to availability of otherwise suitable in-state beds. We highlight additional concrete examples of circumstances leading to out-of-state placements in Table 2.

An additional factor impacting the placement of youth out-of-state pertains to the rules by which CRCFs operate as compared with more restrictive Psychiatric Residential Treatment Facilities (PRTFs). All facilities currently located in Maine and the rest of New England are CRCFs, which do not lock their doors from the inside as a matter of protocol. Some facilities have doors with delayed egress, a locking mechanism that delays the opening of a door, typically by fifteen seconds. At these facilities, youth who do not wish to remain in care have the ability to run away, sometimes eloping together without the consent of their guardians. Youth with case histories of leaving CRCFs in this manner are more likely to be denied care by in-state and New England based CRCF providers, and end up in more restrictive PRTF facilities located outside New England. One program in New England, associated with Dartmouth Health in New Hampshire is a 12 bed PRTF, but Maine currently does not contract with or send youth to this facility.

Table 2: Common Reasons for Out-of-State Referrals

Common Reasons Youth are Referred Out-of-State	Real-World Example
All in-state beds for a specialized treatment are full	No in-state bed was available for a youth requiring treatment for Problem Sexualized Behaviors
Few providers are equipped to support youth with multiple needs	Only two in-state providers support behavioral health needs for those with ID and Autism diagnoses, and both facilities were at capacity when a youth required treatment
Service provider safety concerns	A youth with a history of physical assault was denied care by multiple in-state providers before seeking treatment out-of-state

If the youth is eligible for out-of-state care, the Department's children's Behavioral Health Program Coordinator assigned to the youth collects agencies' referral decision letters, uploads them to the youth's chart in the Department's internal EIS records system, creates a case summary using clinical and qualitative information available, and submits an out-of-state request note to the Department's Children's Behavioral Health Manager.

If the Manager approves the request, then they forward it via EIS to the Department's children's out-of-state Residential Services Specialist. The specialist reviews available documentation – including information about the services the youth is receiving, their diagnoses and intellectual disability status, a case summary of the issues leading to the CRCF referral, and reasons for in-state denials – gathers clarification or additional information, and identifies potentially appropriate facilities in New England.

If a suitable New England program denies a youth's application, or (as is rare) if the youth's needs truly require a higher level of service, such as a Psychiatric Residential Treatment Facility (PRTF), the Residential Service Specialist seeks an additional authorization. Currently, all youth residential treatment programs with which the Department contracts outside New England are PRTFs. The Associate Director of the Department's Children's Behavioral Health Services (CBHS) unit approves referrals to programs outside New England, and the specialist coordinates ensuring that all information is provided and details necessary to the youth's care are accounted for in the placement process.

A total of 69 youth were in out-of-state placements as of April 2025 (Figure 10), with 63 remaining in New England to receive care. We include a list of out-of-state provider agencies currently licensed to serve Maine youth in Table 3.

Between 2021 and 2024, the Maine counties that sent the highest numbers of youth out-of-state were clustered along the 1-95 corridor, reflective of Maine's population centers. Cumberland County, home to the Portland metropolitan area, had the highest overall annual number of youths in out-of-state residential care (Figure 11). When we consider these same data on a county per-capita basis, however, a different picture emerges. Piscataquis and Aroostook counties had the highest per-capita rates of children sent to out-of-state CRCFs, illustrative of an apparent trend toward more rural counties having higher per-capita rates of children sent to out-of-state placements (Figure 11). On a percentage basis, Piscataquis, Waldo, and Knox counties sent the highest proportion of their total youth served in CRCFs to out-of-state placements (Figure 11). When we compare these data with the locations of in-state CRCF facilities over an overlapping time period (Figure 6), it appears that youth originating in counties without CRCF facilities may have been disproportionately likely to experience out-of-state referrals. It is important to view this observation within a broader context, however. Access to basic resources of many kinds – including adequate food and housing, healthcare, educational opportunity, and community-based mental health resources – are unevenly distributed across the state, with services gaps in many rural communities. It is likely that the relatively high per-capita rates of CRCF placements among youth from regions with known services gaps could be substantially mitigated by improving access to community-based resources in these areas.

Figure 10: Recent Census of Out-of-State Residential Placements

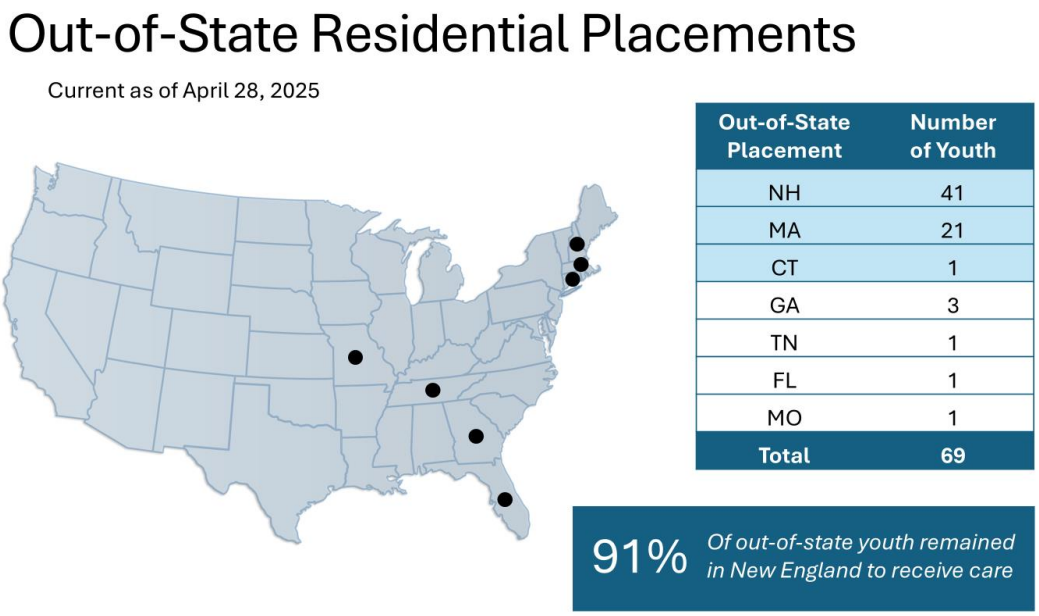
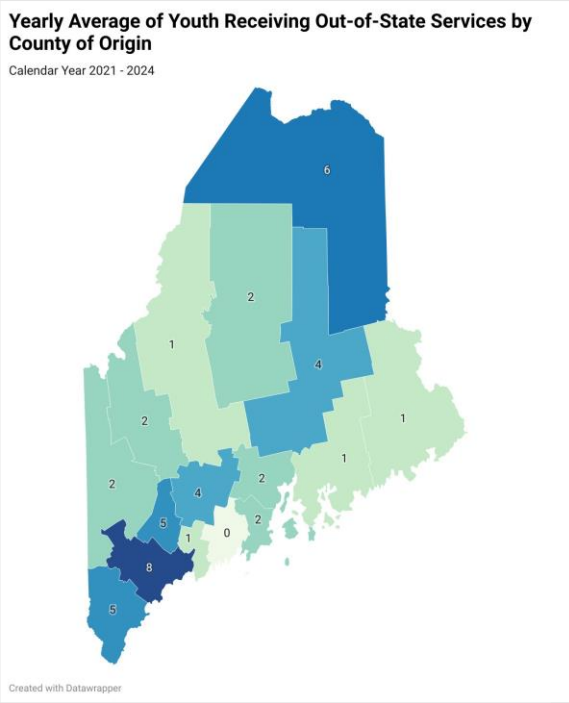


Table 3: List of Out-of-State Residential Provider Agencies and Locations

Provider Agency	Type	Site Location(s)
Easter Seals	CRCF	• Lancaster, NH • Manchester, NH
Mount Prospect Academy	CRCF	• Campton, NH • Hampton, NH • Pike, NH • Plymouth, NH • Rumney, NH
Seven Hills	CRCF	• Greenfield, NH
Hillcrest	CRCF	• Great Barrington, MA • Lenox, MA • Pittsfield, MA
Stetson School	CRCF	• Barre, MA
American School for the Deaf	CRCF	• West Hartford, CT
Youth Villages	PRTF	• Douglasville, GA • Bartlett, TN • Arlington, TN
Millcreek	PRTF	• Fordyce, AR
Sandy Pines	PRTF	• Tequesta, FL
Lakeland	PRTF	• Springfield, MO

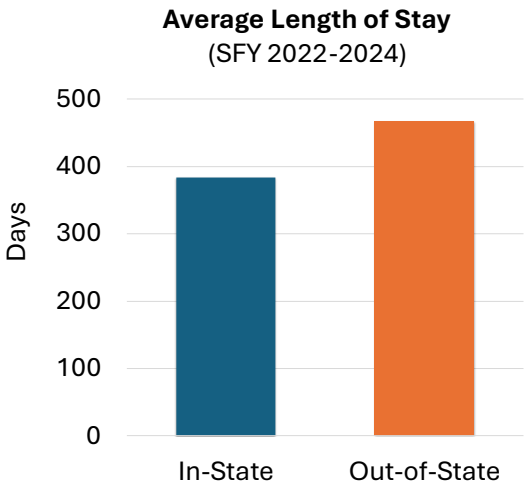
Figure 11: County-Level Yearly Averages of Youth in Out-of-State CRCFs



Youth County of Origin	Number of OOS Youth Per Capita (per 10,000 youth in US Census)	Percentage of CRCF Youth Served OOS
Androscoggin	2	25%
Aroostook	4	31%
Cumberland	1	28%
Franklin	2	28%
Hancock	2	21%
Kennebec	2	19%
Knox	3	33%
Lincoln	0	0%
Oxford	1	20%
Penobscot	2	18%
Piscataquis	6	55%
Sagadahoc	2	31%
Somerset	1	10%
Waldo	2	39%
Washington	2	21%
York	1	21%

Youth placed in out-of-state CRCFs experienced longer average lengths of stay than youth placed at in-state CRCFs (Figure 12). Given the multiple reasons described above for which higher-acuity youth are more likely to be placed in out-of-state care, one explanation for this finding is that youth with more significant care needs may, on average, require longer treatment periods to stabilize and develop the capacities for successful community return. We highlight an additional and important layer of context regarding residential placements of youth with intellectual disabilities below in Section I.vi.

Figure 12: Average Length of Stay for In-State vs. Out-of-State CRCFs



I.vi. Residential Placements of Youth with Intellectual Disabilities

Among youth requiring CRCF services between 2020 and 2025, those with an intellectual disability were more likely to be in an out-of-state placement: 34% with an ID diagnosis were placed out-of-state, while 23% of youth with a mental health diagnosis were placed out-of-state (Table 4). Over this same time period, youth with intellectual disabilities also experienced longer stays in residential treatment than their peers with mental health diagnoses (Figure 13).

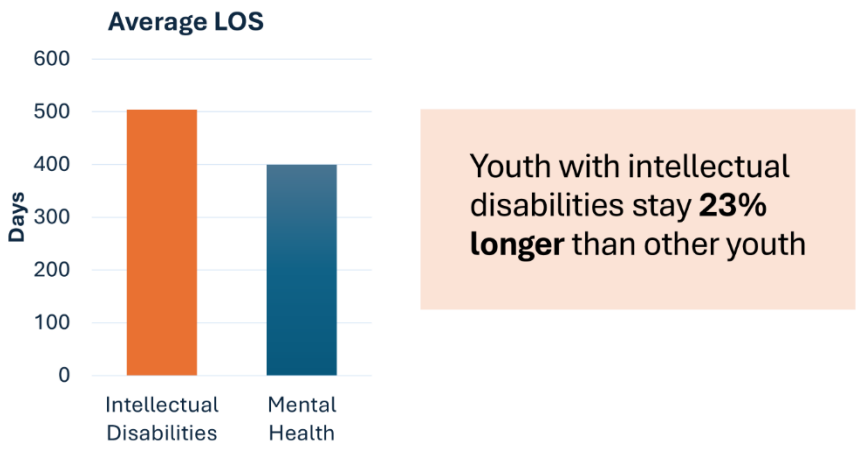
Table 4: Youth in Residential Services by Major Service Description

Number of Youth in Residential Services During The Last Five Years (2020-2024)

Service Description	Total	In-State	Out-of-State
Child PNMI - Intellectual Disabilities	188	123	65
Child PNMI - Mental Health Level	660	508	152
TOTALS	**848**	**631**	**217**

Data from Acentra

Figure 13: CRCF Length of Stay (LOS) by Major Service Description



These data point to the very real challenges of adequately supporting youth with multiple intersecting needs and highlight the importance of prioritizing these youth in system improvement efforts so as to ensure that solutions developed will meet the often specialized needs of these youth and continue to move the Department in the direction of improved outcomes for all.

I.vii. Quality Assurance Reviews of CRCF Facilities

The Department is strengthening its protocols for the review of CRCF facilities. Beyond current processes, the Department will, in the future, require all CRCF facilities serving Maine youth, whether in-state or out-of-state, to participate in standardized Quality Assurance Reviews. These reviews will ensure that CRCFs are providing safe, effective, ethical, and high-quality care. Providers will be expected to administer services that prioritize the successful reintegration of youth into family and community settings upon discharge.

The specific goals of CRCF Quality Assurance Reviews are to:

1. **Ensure compliance.** Make sure facilities adhere to applicable regulations including those outlined in MaineCare Section 97 Appendix D, Licensing, and the *Families First Act*.
2. **Assess quality of care.** Evaluate whether children are receiving appropriate mental health services and review individualized treatment plans to ensure they align with individual and family needs.
3. **Improve treatment outcomes**. Review and ensure efforts are made to equip youth for long-term success through discharge planning and AfterCare support.
4. **Identify areas for improvement.** Detect deficiencies and recommend corrective actions, noting strengths and encouraging continuous improvement in service delivery and best practice by providers.
5. **Engage stakeholders.** Gather feedback from youth, families, and staff to improve the operations of CRCF facilities that serve Maine youth.

The Department will lead annual Quality Assurance Reviews at each provider location. The annual schedule may be modified in consultation with the Maine Department of Licensing and Certification and the program coordination team, for example, to address any emergent concerns about a location or to avoid overlapping reviews. The Department will conduct a Quality Assurance Review prior to placing a youth in any newly enrolled programs or sites that have not been utilized in a set number of months, as indicated by appropriate policy.

Each Quality Assurance Review will include the following elements at minimum:

- Record review
- Site tour
- In-person staff interviews (including new staff, seasoned staff, and program manager)
- In-person clinician interview
- In-person youth interview (on a volunteer basis as youth are willing)
- Family interview (via phone)

I.viii. Relationships and Ongoing Support for Providers

Staff from the Department's Children's Behavioral Health Services (CBHS) unit currently meet with individual in-state CRCF providers on a monthly basis. This keeps open lines of communication, offers opportunities for support, and allows regular discussion of the following agenda items as applicable:

- Referrals
- Discharges
- Current clients
- Staffing
- Review of challenging cases
- Family involvement
- Barriers to treatment
- Reportable events and trends
- Transition to adulthood
- CRCF program updates
- Children's Behavioral Health Services unit program updates

Department staff also host bimonthly Continuum of Care Provider meetings, including community providers, residential providers, and other interested stakeholders. These meetings provide group forums to discuss updates, process challenges, and facilitate mutual support among the provider community.

The Department's children's residential specialists regularly communicate and coordinate with CRCF providers across a range of topics, offering technical assistance. The specialists monitor Reportable Events reports for trends and concerns that may be pertinent to providers, offer Reportable Events support and training, monitor and supply technical support with AfterCare, and review treatment records. As detailed above (Section I.vii.) they also engage in Quality Assurance Review site visits which act as an important feedback mechanism for provider continuous improvement.

Section II: Strategic Priorities Implementation Update

II.i. Introduction

In 2018, the Department contracted with Public Consulting Group to conduct a comprehensive and forward-looking assessment of the Children's Behavioral Health Services (CBHS) unit, the first undertaken for these programs in more than 20 years. The assessment was completed over five months with input from advocacy organizations, providers, parents, youth, and other stakeholders. The 140-page assessment report[4] identified strengths, barriers to service delivery, and initial recommendations to address systemic challenges.

Five major system findings were identified by the assessment:

1) *Access: Children's behavioral health services are not available immediately (or at all).*
2) *Proximity: Behavioral health services are not always available close to the community where children live.*
3) *Appropriateness: When children do get services, it's not always the right service.*
4) *Quality: The quality of behavioral health services is not consistent.*
5) *Coordination: Coordination with other child-serving agencies and transition to adult services is inadequate.*

These findings, along with assessment's 24 specific recommendations, became the basis for a set of 13 strategic priorities developed by the Department in 2019 and used to inform service improvements. We provide a status update on work addressing these 13 priorities below in Section II.ii.

It is important to note when considering the Department's implementation progress that minor revisions were codified in 2020[5] and then more substantially updated to align with the Department's strategic framework in 2022. This latter update integrated past streams of work with an evolving landscape that included pressing realities presented by the COVID-19 pandemic, economic factors, and workforce challenges.[6] Per that 2022 update, the CBHS unit identified three main goals to improve the accessibility, availability, and quality and consistency of services:

- *Establish a single point of access for children's behavioral health services for youth*
- *Eliminate wait times for youth seeking behavioral health services*
- *Improve the quality and consistency of children's behavioral health services*

[4] ME-OCFS-CBHS-Assessment-Final-Report.pdf
[5] CBHS Annual Report 2020 FINAL.pdf
[6] 2022 CBHS Annual Report.pdf

These three goals encompass the 13 strategies from 2019 and have been integrated into the Department's current strategic priorities, outlined below in Section III.

II.ii. Status Update: 2019 Strategic Priorities

The 13 strategies noted in the section above were divided into short-term vs. long-term goals. These original strategies served as a roadmap for CBHS for the next four years, supporting many systemic investments. As priorities changed, so too did some areas of focus: for example, PRTF moved from a long-term goal to a short-term goal in 2021. While that shift reflected the work priorities at the time, the fluid nature of service development revealed that more intentional work would be required. The Department made considerable effort to understand the barriers to PRTF and to identify strategies to overcome them. To this end, the Department is excited to announce that with legislative support and following a competitive procurement process, Sweetser has been awarded up to $2m in capital funding to establish a PRTF in Maine and operate it within MaineCare policies and rates. CBHS is looking forward to working collaboratively with Sweetser to establish this needed level of care in Maine.

As work continues, including in newly identified areas, the Department is proud to note that many short-term and long-term goals have been accomplished (Table 5). Those that are yet to be accomplished have significant efforts underway. We provide a snapshot of the 13 prioritized strategies below, with a full breakdown of the 24 recommendations noted in the 2018 Assessment as an Appendix. Below is the original list of strategies by category as published in August 2019.

Table 5: Status of 2019 Strategic Priorities

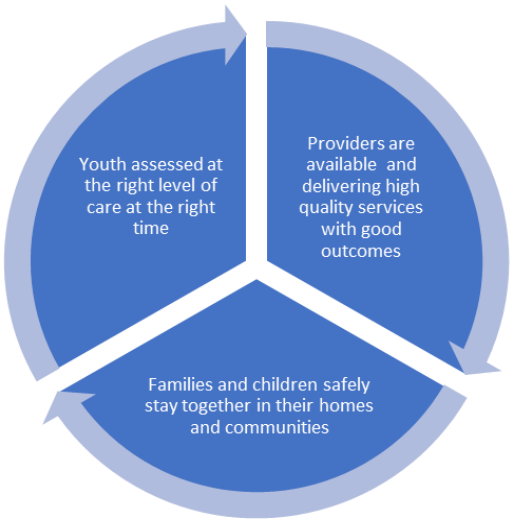
Strategic Priority	Status
Short-term (2019-2022)	
Hire a full-time, on-site OCFS Medical Director	**Completed**
Revise the waitlist process	**Completed**
Improve coordination for transition-aged-youth's behavioral health services	**Completed**
Facilitate access to parent support services	**Completed**
Explore options to amend current service definition for Section 28	*In Progress*
Clarify CBHS roles, responsibilities, procedures, policies, and practices	**Completed**
Long-term (2019-2025)	
Address shortages in the behavioral health care workforce	*In Progress*
Align residential services to best practices and federal quality standards	**Completed**
Improve CBHS crisis services	*In Progress*
Expand the use of evidence-based models and evidence informed interventions	*In Progress*
Enhance the skills of the early childhood education workforce to address challenging behaviors	*In Progress*
Explore a statewide or regional "single point of access"	*In Progress*
Establish one or more Psychiatric Residential Treatment Facilities (PRTF)	*In Progress*

Section III: Current Priorities for Children's Behavioral Health Services

Organizationally, the Department's Children's Behavioral Health Services (CBHS) unit experienced significant change in 2024, moving from the oversight of the Office of Child and Family Services (OCFS), where it had long been housed, to the Office of Behavioral Health (OBH). This merger integrates behavioral health resources and expertise across a lifespan continuum, providing vital opportunities for coordination and continuity of care from youth to adulthood, and across the pillars of wellness, prevention, early intervention, treatment and recovery.

Throughout this transition, CBHS services have continued without undue interruption, guided by lessons from the history described in Section II and underpinned by a new set of CBHS strategic priorities described in the 2022 and 2023 CBHS Annual Reports.

Figure 14: Implementing CBHS's Vision for an Integrated System of Care



It is CBHS's vision that all Maine children and their families receive the services and supports they need to live safe, healthy, and productive lives in their home, school, and community. To achieve this vision, CBHS aims to ensure youth are assessed at the right level of care at the right time, services are available to meet the diverse needs of children and families, and services received by children and families are high quality and producing good outcomes (Figure 14).

CBHS identifies Accessibility, Availability, and Quality and Consistency as the foundational pillars of the children's behavioral health system (Figure 15). Accessibility addresses how youth and families access behavioral health services for children. Availability references addressing service needs through a variety of training initiatives and closing identified gaps in the delivery system. Quality and Consistency concentrate on updating the rules and regulations that govern CBHS so that it might expand its quality assurance activities.

CBHS's refocused priorities align with the underlying premise of the US Department of Justice Settlement Agreement: that all Maine children might have their needs met within a family, in a family home. CBHS's efforts to implement a Single Assessment by which youth are assessed and gain access to medium-to-high intensity levels of behavioral health care, to enhance our community-based system of care, to close gaps in the delivery system, and to elevate quality and consistency of service delivery match the goals of the US Settlement Agreement.

A key purpose of CBHS's strategic priorities is to support children and families safely staying together in their homes and communities (Figure 15). With the finalization of a legal Settlement Agreement between the State of Maine and US Department of Justice in December of 2024, this goal is reaffirmed, and significant work is presently being undertaken to (1) develop and strengthen the suite of community-based services needed to support youth with high-acuity needs receiving care in family and community settings; and (2) build and support pathways to successful community return for youth receiving residential treatment now and in the future.

Figure 15: Current Priorities for Children's Behavioral Health Services

We have outlined below CBHS's current strategic priorities, with an emphasis on initiatives that directly align with the activities of the Settlement Agreement. It is the goal of CBHS to support access to services across the continuum of care, recognizing that a good system will have services available at all levels of care.

Figure 16: CBHS Strategic Priorities and Alignment with Settlement Agreement

CBHS Strategic Priorities

Improving Accessibility
Strengthening how youth and families access behavioral health services

- ✓ Implement Single Assessment
- ✓ Strengthen Care Coordination supported by Wraparound principles
- ✓ Implement public education campaign
- ✓ Maine Pediatric Behavioral Health Partnership

Note: Items in red are part of the DOJ Settlement Agreement

Improving Availability
Strengthening and expanding services

- ✓ Implement and provide training in evidence based models of care:
  - High-Fidelity Wrap Around
  - Multi-Dimensional Family Therapy
  - Adolescent Community Reinforcement Treatment Approach (ACR -A)
  - Triple P (Positive Parenting Program)
  - Trauma-Focused Cognitive Behavioral Therapy
  - Therapeutic Intensive Homes (TIH)
- ✓ Provide catalyst funding to increase service availability:
  - Multi-systemic Therapy and Functional Family Therapy catalyst contracts
  - Youth Substance Use Disorder catalyst contracts
  - Assertive Community Treatment catalyst funding
- ✓ Establish Psychiatric Residential Treatment Facility (PRTF)
- ✓ Crisis system reform – improving crisis services
- ✓ Implement Certified Community Behavioral Health Clinics
- ✓ Pilot pediatric urgent care

Improving Quality & Consistency

- ✓ Quality assurance reviews
- ✓ Expanding provider training
- ✓ Expanding data & monitoring of outcomes of service delivery
- ✓ Revision of Rights of Recipients
- ✓ Providing professional training and certification

Conclusion and Recommendations

The strategic priorities developed in 2019, the revisions in 2022, and the current direction of the Department (Section III) all underscore the need to strengthen community-based services so that children and families can safely stay together in their homes and communities. And for those Maine children and youth for whom this is not possible, the Department is strengthening residential treatment programs critical to their care.

Multi-year analyses of youth in residential placements show a clear reduction in the total number of Maine youth in Children's Residential Care Facilities (CRCFs) and a reduction in number of active beds over time. While it is encouraging that more youth receive services in their home and communities, CRCFs remain an important level of treatment and care for those youth who have intensive clinical treatment needs that cannot be met appropriately in a home or community setting. Residential service providers in Maine are challenged in their operational viability, resulting in fewer facilities and a 78% drop in the number of licensed beds available for Maine youth since 2007. These capacity reductions increase the risk that youth requiring residential services will be placed out-of-state.

The multi-faceted nature of the challenges impacting residential services suggest the need for multi-faceted solutions, including but not limited to:

1) Continued support for community-based services, especially in underserved areas of the state;
2) Ongoing work to support community return for youth discharged from residential treatment, which will help to facilitate timely access to care for youth awaiting placement; and
3) Support for retention and development of in-state residential treatment programs to care for Maine youth with high-acuity needs, including offering agencies recruitment and retention support to help stabilize staff turnover.

In the Department's engagement sessions with stakeholders, providers expressed interest in reevaluating the service design and reimbursement structure for residential services. In an effort to be responsive to provider needs, the Department evaluated the current Temporary High Intensity Staffing (THIS) rate, utilized by providers to support high-acuity youth requiring 1:1, 2:1, or 3:1 staffing patterns. This rate was prioritized for review by MaineCare, with a rate determination completed and implemented this spring, resulting in a 28% increase in reimbursement. The Department is interested in exploring tiered service and rate model options for CRCFs rather than relying on this rate for members with high intensity needs.

The Department has demonstrated and shares an ongoing commitment to evaluating and enhancing the residential treatment model to align with the acuity and clinical needs of Maine youth and special populations. We remain committed to working with legislators, providers,

families, advocates and other stakeholders to strengthen the continuum of behavioral health care and services for children and youth, to ensure timely access to high quality services and supports, and to serve children and youth in the least restrictive settings possible close to their home and community.

Appendix: 2018 CBHS Assessment Original Strategies with Updates

Timeframe		Recommendation Name	Status	Updates
1	Short-Term	Develop a strategic plan and vision for CBHS that engages all system of care stakeholders and builds off this CBHS assessment and recommendations.	***Completed***	Vision located: https://www.maine.gov/dhhs/obh/support-services/childrens-behavioral-health
2	Short-Term	Establish advisory committee(s) that includes child-serving agencies and stakeholders to improve outcomes for children.	***Completed***	CBHS hosts bi-monthly Continuum of Care meetings with providers to advise on the service delivery system
3	Short-Term	Hire a full-time on-site OCFS Medical Director.	***Completed***	Dr. Adrienne Carmack was hired in 2020.
4	Short-Term	Amend current service definition for Section 28 (Rehabilitative and Community Services) to focus on effective, targeted interventions for ID/DD and Autism.	***In-Progress***	In progress along with rulemakings associated with the Settlement Agreement
5	Short-Term	Revise the waitlist procedure for home- and community-based services to ensure optimal client/provider assignment.	***Completed***	Completed and addressed, in 2021 following work of the waitlist advisory group. Under consideration for further revision following establishment of the Single Assessment.
6	Short-Term	Expand access to respite care services for families.	***Completed***	P.L. 2023, ch. 83 passed removing cost sharing for parents receiving respite services.
7	Short-Term	Improve coordination for youth transitioning from child to adult behavioral health services.	***Completed***	Transition specialists hired through OADS to support provider trainings and individualized support for youth with transition age needs.
8	Long-Term	Develop regional Care Management Organizations (CMOs) to provide intensive care coordination for children with moderate to high behavioral health needs.	***Deprioritized***	Maine does not leverage Managed Care Organizations to administer its Medicaid system.
9	Long-Term	Review and align residential services to best practices and new federal quality standards.	***Completed***	Section 97 adding Qualified Residential Treatment Program standards was adopted in 2021.
10	Short- and Long-Term	Improve the quality, responsiveness, and role of children's behavioral health crisis services.	***In Progress***	Work in progress to develop CMS Qualifying mobile crisis response including peer co-response and firehouse model following receipt of a CMS planning grant.

11	Long-Term	Develop a CBHS Data Task Force to use collect, analyze, and report on data that drives decision-making in CBHS.	***Deprioritized***	Work was previously deprioritized by stakeholders in 2019. OBH has a dedicated data team supporting data driven decision-making.
12	Long-Term	Facilitate access to services that can help families support children with behavioral health needs.	***Completed***	Services include establishing MaineCare coverage for Triple P, Incredible Years, and Parent-Child Interaction Therapy. CBHS continues work to enhance services offered to families, including rolling out *Triple P Online*, a self-directed parent support module with clinical support access as needed.
13	Long-Term	Develop MaineCare funded out of home placement for children with behavioral health issues (aka Treatment or Therapeutic Foster Care).	***In Progress***	Therapeutic Foster Care service definitions are currently being revised. Also establishing Therapeutic Intensive Homes leveraging the evidence-based model, Treatment Foster Care – Oregon.
14	Long-Term	Continue to review how Accountable Communities can support the behavioral health needs of children in Maine.	***Completed***	MaineCare has an active Accountable Communities program that includes considering behavioral health needs of children: https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/accountable-communities
15	Long-Term	Conduct further analysis on the coordination between behavioral health services and substance use disorder treatment for youth.	***Complete***	Care for youth with co-occurring behavioral health and substance use needs continues to be a priority for strategic planning and investments in evidence-based practices tailored to treat youth. CBHS hired two substance use specialists to support adolescent substance use programming and coordination with internal and external partners.
16	Long-Term	Develop a statewide strategy to address shortages in the health care workforce.	***In Progress***	COVID exacerbated workforce shortages creating unprecedented needs. DHHS continues to strategize with partners how to address this need.

17	Long-Term	Clarify roles, responsibilities, and mechanisms to ensure that children's behavioral health services are safe, effective, and high quality.	***Completed***	OCFS, supported by PCG, analyzed roles and responsibilities of CBHS staff to optimize efficiency starting with their assessment in 2018.
18	Long-Term	Establish local Care Review process to support team decision making and best practices.	***Deprioritized***	Does not fit in our delivery system.
19	Long-Term	Expand access to high-quality children's behavioral health expertise across the state.	***In Progress***	DHHS continues to support strategic investments to expand access to evidence-based practices. CBHS now has a dedicated team to support Quality Assurance reviews of behavioral health provider agencies.
20	Long-Term	Develop behavioral health urgent care clinics.	***In Progress***	CBHS piloted a successful behavioral health urgency care model through Community Health and Counseling Services. This model has been rolled into their CCBHC and will be analyzed for potential of future replication in other areas of the state.
21	Long-Term	Explore the use of Pay for Success to leverage philanthropic investments in evidence-based practices.	***Deprioritized***	Work was previously deprioritized by stakeholders in 2019.
22	Long-Term	Strengthen the relationship between juvenile justice and CBHS.	***Completed***	CBHS and the Juvenile Justice team at DOC have a strong collaborative working relationship, meeting regularly to coordinate cases that involve both systems. DHHS and DOC have a shared strategic plan for justice involved youth.
23	Long-Term	Conduct further analysis on the coordination between behavioral health services and the educational system.	***Deprioritized***	Work was previously deprioritized by stakeholders in 2019.
24	Long-Term	Support initiatives to enhance skills of early childhood and home-based workers to address challenging behaviors in young children.	***In Progress***	Recognized as a part of the assessment, this work lives in OCFS and their Early Childhood and Education team. Notable work includes developing HelpMEGrow and the Early Childhood Consultation Program.