Beyond the Breaking Point:
Maine's Behavioral Health Workforce Crisis

by Emily Stultz and Bridget Monteith

INTRODUCTION

Maine's behavioral health workforce is collapsing, and nowhere is this more visible than in the state's rural and remote communities. What began as a manageable staffing shortage has evolved into a full-scale system breakdown—one that is eroding the basic supports families, schools, and local providers depend on. This is no longer just a crisis of care; it is a destabilizing force undermining the well-being of rural towns across the state.

The need for behavioral health services continues to rise statewide, but the divide between demand and capacity is widest in the northern, western, and downeast regions. Providers in these areas describe months-long waitlists, often involving hundreds of patients who have no other options, and a shrinking pool of professionals available to meet those needs. In some communities, losing even a single clinician can restrict access for an entire county. These are not isolated gaps or temporary challenges; they are the daily conditions rural Mainers must navigate.

Much of this strain stems from years of underinvestment in the essentials: training pathways, workforce capacity, competitive wages, broadband access, and the basic infrastructure agencies need simply to function. Rural providers tell us repeatedly that they are doing everything they can with far too few resources—relying on outdated systems, juggling overwhelming caseloads, and trying to keep services afloat despite staffing levels that fall well below what any sustainable system can bear.

This commentary draws on our work with providers, agencies, and community leaders across rural Maine who have been sounding the alarm for years. The solutions they call for are clear: stronger workforce pathways, reliable telehealth, sustainable reimbursement, and the operational supports needed to keep services stable. Strengthening behavioral health in rural Maine begins with acknowledging what those on the front lines already know: without a supported workforce and the infrastructure to sustain it, rural communities will continue to face barriers that no amount of individual effort can overcome.

CURRENT STATE OF THE BEHAVIORAL HEALTH WORKFORCE

Those of us in the behavioral health field no longer need data to confirm what we see every day: the system is buckling. Waitlists stretch for months. Agencies juggle empty shifts. Burnout isn't an exception anymore, it is what most providers describe as their day-to-day reality. Thousands of Mainers are left in crisis because there simply aren't enough professionals to respond.

Data from the Behavioral Health Access and Workforce Coalition's 2024 analysis reinforces what providers across the state have been reporting. Twenty organizations documented nearly 9,000 people waiting for mental health counseling, with an average wait of 32 weeks and almost 70 percent waiting 10 months or longer. Independent clinicians reported more than 1,000 individuals waiting an average of 33 weeks, with over a third waiting 10 months or more (Schirmer and Johnson 2024). These are not specialty referrals, and these delays affect essential services like counseling and mental health medication evaluations.

This workforce crisis is a structural failure with cascading consequences. Providers across rural Maine report that long waits for care are contributing to higher levels of acuity by the time people finally reach services. As symptoms worsen during these delays, individuals are more likely to require crisis intervention, inpatient treatment, and other high-cost forms of care (Schirmer and Johnson 2024). When basic outpatient services are delayed for months, manageable concerns escalate into emergencies, placing additional strain on schools, emergency departments, and already overextended crisis teams.

The strain cuts across every corner of the workforce. Clinical providers are carrying overwhelming caseloads while reimbursement rates remain far below what it takes to keep agencies staffed and stable. MaineCare's low rates leave budgets so thin that many organizations cannot offer competitive wages, and high turnover has become a familiar part of the landscape (Popp 2023). Vacancy data underscores what providers describe every day: across the behavioral health continuum, organizational vacancy rates range from 6 percent to 21 percent, with some agencies reporting vacancies as high as 21 percent for mental health clinicians and 19 percent for dual-licensed clinicians. Among independent providers, who fill

critical gaps in rural regions, the workforce is aging rapidly. Forty percent are already over age 60, 45 percent plan to retire within five years, and two-thirds expect to retire within the next decade, threatening to widen gaps that are already unsustainable (Schirmer and Johnson 2024).

The pressure is just as intense in nonclinical roles like certified intentional peer support specialists (CIPSS) and mental health rehabilitation technicians/community (MHRT/C). These professionals are the backbone of person-centered, community-based care. Yet as of 2024, nearly a third of CIPSS-certified individuals were working outside the field, and 40 percent of MHRT/Cs reported part-time status due to limited job opportunities or poor compensation (CCI 2024). These are not auxiliary staff or nice-to-have roles; providers rely on them to deliver the bulk of community-based care, and losing them has real, immediate consequences for clients and communities.

On top of that, the pathways into the field are riddled with barriers that hit rural and immigrant Mainers hardest. Many training programs do not connect cleanly to supervised fieldwork or job placement. Agencies tell us they want to take more interns but do not have enough qualified supervisors to support them, leaving students stuck in limbo and employers short of workers. Meanwhile, equity gaps persist: materials available only in English, unclear requirements, and limited support for multilingual workers make it harder to build a workforce that reflects the communities it serves. And with so many seasoned providers nearing retirement, the gap between who is leaving the field and who is coming in grows wider every year (Popp 2023). Without meaningful investment in wages, training, and basic infrastructure, the cycle continues – the need is clear, but too few people are able to stay in the work long enough to meet it.

ECONOMIC CONSEQUENCES

Untreated mental health conditions take a real and noticeable toll on Maine's workforce. A study by Greenberg et al. (2023) estimated that major depressive disorder alone cost the US economy $333.7 billion in 2019, with approximately 62 percent of that burden—$206.4 billion—stemming from indirect costs such as presenteeism, absenteeism, and unemployment. Furthermore, burnout correlates with a 180 percent higher likelihood of developing depressive disorders and a 57 percent increase in illness-related absences (Webster 2025). In our experience, these challenges land especially hard in rural Maine. When even one worker is struggling, the ripple effect on a small team or business can be immediate, and employers often tell us they can feel the strain almost overnight.

Stagnant MaineCare reimbursement rates have compelled many behavioral health agencies to limit their caseloads or stop accepting low-income patients altogether. As of early 2025, more than 13,000 Mainers were on behavioral health service waitlists, including 8,000 awaiting mental health counseling, some for up to 24 months (Washington 2025). Providers are clear about what this means in practice: the need keeps growing, but their capacity to meet it continues to decline.

Behavioral health spending now represents a substantial share of Maine's healthcare landscape—accounting for roughly 13 percent of all public and private insurance expenditures and one-third of the entire MaineCare budget. Telehealth alone represents a significant portion of this spending, making up about one-third of commercial behavioral health payments, nearly one-fifth of Medicare spending in this area, and just over one-tenth of MaineCare behavioral health expenditures (Schirmer and Johnson 2024). In our experience, rural communities feel this concentration of spending more acutely, because it limits their ability to invest in prevention, infrastructure, or long-term development. When workforce shortages force clinical supervisors to handle in-house training on top of full caseloads and supervisory duties, or when direct care staff are mandated to cover shifts because a coworker cannot come in, organizations have little capacity left to develop new programs, expand outreach, or build partnerships that could strengthen behavioral health access over time.

The financial strain is especially acute in Maine's rural counties, where access to behavioral health services remains dangerously limited. When looking at Medicaid enrollment rates, the contrast between Maine's regions becomes striking. Northern and downeast counties—Aroostook (26.2 percent), Somerset (26.5 percent), Oxford (25 percent), Piscataquis (25.7 percent), Penobscot (24 percent), and Washington (27.8 percent)—have some of the highest enrollment levels in the state, far exceeding those in southern counties like Cumberland (18.4 percent) and York (19.7 percent) (Pendharkar 2025). As of 2023, only around 290 licensed psychiatrists served Maine's 1.3 million residents, a ratio that falls short of meeting demand and exacerbates regional disparities (Popp 2023). This ratio does more than indicate a statewide shortage— it sharpens the divide between rural and urban access.

Limited access to outpatient treatment pushes demand onto other parts

of the behavioral health system, leading to increased reliance on higher-cost services such as emergency departments, residential programs, and inpatient hospitalization (Schirmer and Johnson 2024). With so few psychiatrists, most naturally cluster in southern Maine where hospitals and specialty practices are located. Large parts of the northern and eastern counties are left with little or no psychiatric coverage, forcing residents to wait longer, travel farther, or go without care altogether. In the end, the communities with the least infrastructure feel the shortage most acutely, deepening long-standing geographic disparities in behavioral health access.

POLICY SOLUTIONS: INVESTING IN RESILIENCE

The scale of Maine's behavioral health workforce crisis has made one thing clear: rebuilding Maine's behavioral health infrastructure is not optional. After years of hearing from rural agencies that simply cannot keep up with rising demand, it is evident that rebuilding our behavioral health system has to be treated as core state policy, not a side conversation. The first step is removing the structural barriers that make it so hard for people to build lasting careers in this field. If Maine invests in the basics—access, workforce development, compensation, and the infrastructure that ties them together—rural communities will finally have a chance to stabilize. These areas feel the strain most acutely, and they have the most to gain from a coordinated approach.

Access

To begin, addressing access is foundational, as it determines whether rural residents can engage with the behavioral health system at all. Based on our direct work with behavioral health agencies across rural Maine, we continue to see many providers relying on aging technology, limited broadband capacity, and administrative systems that were never designed for the reporting and coordination demands they face today. These gaps are not abstract policy issues; they are daily operational realities that force agencies to spend their time keeping basic functions afloat rather than expanding services or improving the quality of care.

From what we have seen in rural counties, consistent broadband is not a luxury—it is the difference between being able to offer telehealth reliably or having to cancel sessions when the connection drops. When telehealth works the way it is supposed to, it gives providers breathing room, opens up scheduling, and offers care options to people who live miles from the nearest clinic. The same is true for technology and shared-service supports. The moment agencies gain access to updated data systems, streamlined reporting tools, or regional billing help, their day-to-day operations stabilize. Staff spend less time troubleshooting and more time focusing on clients.

Education

Improving access alone is not enough. Even the most flexible care models collapse if the workforce behind them is stretched thin, which is exactly what we hear from rural providers over and over again. Many agencies want to train the next generation of workers, but they simply do not have the staff capacity to take it on. Chronic vacancies create bottlenecks in licensure pathways, limit opportunities for professional growth, and make long-term planning almost impossible.

Building a stronger pipeline means expanding the training programs we already know work and making them easier for rural Mainers to navigate. Adult education programs, local libraries, community colleges, and regional partnerships can serve as natural entry points, especially for community members who want to build careers close to home. This is especially important for rural, immigrant, and multilingual Mainers, who routinely tell us how difficult it is to access supervision, get clear answers about requirements, or find the support they need to move forward. When these barriers are reduced, we see people advance and stay in the field.

We have seen the promise of grow-your-own models when supported by partnerships with high schools, adult education programs, community colleges, and the University of Maine System. Paid rural field placements, stronger supervision capacity, and stackable credentials give direct care workers, peer specialists, and community health workers the opportunity to advance without leaving their hometowns. These strategies support both the workforce and the local economy.

Compensation

At the systems level, reimbursement reform is essential. After years of watching agencies across the state do everything they can to stretch limited dollars, the story is the same no matter where we go: MaineCare rates simply do not reflect the real cost of care. Agencies are underfunded, wages fall behind, and eventually programs shrink or disappear because there just is not enough money to staff them.

When reimbursement rates do not match operational realities, the strain hits every part of the system. Agencies cannot offer competitive pay or keep the staff they have trained, and they cannot expand services even when the need is obvious. Providers often tell us that this is not about padding budgets, it is about having enough stability to plan beyond the next payroll cycle. Updating rates would give agencies room

to focus on delivering care rather than scrambling to stay open.

Compensation reform must go beyond rates alone. Expanded loan repayment opportunities tied specifically to rural service would make a meaningful difference in recruitment, especially for new graduates facing high debt loads. Clearer career ladders for the direct care workforce would help agencies retain the staff they invest in rather than constantly rebuilding their teams from scratch. And for many rural organizations, even modest improvements in financial stability determine whether they can maintain essential programs or are forced to scale back or close entirely.

These insights come directly from what we have heard—and witnessed—across Maine's behavioral health landscape. Providers are committed to meeting the needs of their communities, but without adequate compensation structures, the system cannot sustain the workforce required to do so.

Infrastructure

One theme that has come up repeatedly in our work with rural agencies and state partners is how deeply intertwined Maine's behavioral health system is with the strength of its workforce. In many towns, you simply cannot separate the two. When people cannot get timely care—whether for mental health, substance use, or the chronic stress that comes from living without support—the impact shows up immediately in absenteeism, turnover, and strained local employers, as we have heard from providers and community leaders in every corner of rural Maine.

In practical terms, this integration means bringing behavioral health considerations into the same planning conversations that shape Maine's workforce and industry strategies. Workforce planning needs to account for the impact of untreated mental health and substance use concerns on the availability and reliability of workers. Industry development efforts should include structured partnerships with employers and sector leaders to address behavioral health needs in the workplace, reduce disruptions, and support long-term retention.

We also know from working directly with rural agencies that none of this is possible without the infrastructure necessary to deliver reliable, high-quality care. Providers consistently point to the same needs: broadband strong enough to support telehealth, data systems that ease reporting rather than overwhelm staff, training capacity that keeps the workforce pipeline moving, and reimbursement rates that reflect the real cost of doing this work. These are not abstract requests—they are operational necessities. Communities cannot retain workers or attract new residents if people cannot access basic behavioral health services without long waits or long drives.

Grounding Maine's economic development strategy in these realities simply reflects what providers, employers, and community leaders have been saying for years: economic growth and behavioral health cannot be separated. A state cannot strengthen its workforce or revitalize rural regions without a behavioral health system capable of supporting the people who live and work there.

Defining Maine's Path Forward

Looking across all of these areas, the lesson we have taken from years of work with rural providers is straightforward: Maine will not stabilize its behavioral health system unless it strengthens every part of the workforce ecosystem at the same time. Access, training, compensation, and infrastructure are not separate issues—they are interdependent. If any one of them is neglected, rural agencies struggle to keep services going, and communities feel the effects almost immediately.

When agencies have modern systems, a strong training pipeline, adequate reimbursement, and the technical capacity to meet statewide expectations, they are able to shift from crisis management to true service delivery. And when workers are supported, paid competitively, and given clear pathways to advance, they stay in their communities and build the stable workforce rural Maine depends on.

The path forward is not mysterious. Providers across the state have been giving us the same message for years: invest in the foundations, and the system will stabilize. Maine's opportunity now is to act on what the field already knows—to make strategic, coordinated investments that allow behavioral health to function as the economic anchor it already is. By doing so, the state can transform a long-standing point of fragility into a source of lasting resilience for rural communities.

CONCLUSION

If there is one message we have heard consistently from rural providers, it is that the entire behavioral health system depends on the people who show up every day to keep it running. When those workers are exhausted, underpaid, or working without the tools they need, whole communities feel the strain. In many rural regions, a single clinician's departure can leave several towns without care, and the effects ripple out quickly. These are not abstract problems; they're the lived reality of rural Maine.

Across our conversations with agency leaders, direct care workers, clinicians, and community partners, the message has been remarkably consistent. The challenges facing rural behavioral health are not mysterious. They

are the predictable result of years of underinvestment in the workforce and the infrastructure required to sustain it. And because the causes are familiar, the solutions are not elusive either.

From everything we have seen, if Maine strengthens access, builds real workforce pathways, addresses compensation in a meaningful way, and ensures rural providers have the operational tools they need, the system will stabilize. Agencies will be able to keep the staff they train instead of constantly starting over. Clinicians will finally have room to do their jobs without carrying the weight of an entire region on their shoulders. Direct care workers and peer specialists, who often enter the field because they want to stay in their home communities, will see a future for themselves rather than a series of temporary, low-wage positions they cannot sustain.

Maine has a real opportunity right now to listen to the people who have carried this system through its most difficult years. Not with another task force or temporary pilot, but with investments that acknowledge behavioral health as essential to the survival of rural communities. When we invest in the workforce, the people at the center of this system, we invest in the stability of the towns, schools, and families who depend on them.

The future of rural behavioral health will not be defined by a single program or policy change. It will depend on our willingness to act on what rural providers have been saying for years: when we strengthen the workforce, we strengthen the entire community. If Maine chooses to reinforce that foundation now, rural communities that have spent years at the edge can instead become places where behavioral health care is reliable, accessible, and deeply rooted in the resilience of the people who call this state home.

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