

How can Penobscot County support inmate mental and behavioral health and reduce avoidable detention in a new facility?

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Penobscot County Jail at 85 Hammond Street, Bangor, dates to 1869; its last substantial renovation was in 1988. Its reported licensed capacity is 157 people, and an average of 69 people were boarded in other jails in 2024.

A 2025 Maine Judicial Branch report found that pending criminal cases were approximately 30% above the 2019 average and reported a criminal-process pilot beginning at the Penobscot Judicial Center in January 2026 that was expected to bring in even higher population rates.¹ County officials describe the building as being in poor condition, and are actively working towards a new build.^{2,3}

As they plan for the new development, county leaders are actively seeking best practices for supporting mental health and substance use, as well as minimizing avoidable detentions.



Research evidence supports a combined approach to address mental health, substance use, and avoidable detention:

1. Address immediate safety and care needs
2. Strengthen treatment during custody and after release
3. Reduce avoidable detention through collaboration with courts and community providers.

A replacement building may address physical deficiencies, but the studies reviewed do not establish that construction alone improves health, reduces repeat incarceration, or saves money.

Facility decisions need a separate local engineering and financial assessment.⁴⁻¹⁰

Relevant Research Findings

Mental health diversion has modest average benefits

A 2018 meta-analysis of 17 studies involving 16,129 adults found that mental health courts participation had a modest effect on reducing recidivism (standardized mean difference = -0.20); findings were stronger for jail time and charges than for arrests and convictions.⁴

Mental health courts had modest effects on reducing recidivism



Results varied considerably, and lower-quality studies showed larger effects. The pooled measure combines different outcomes and cannot responsibly be translated into one percentage reduction in arrests or beds. Only one included study was randomized.

Recommendation: Based on these findings, consider establishing treatment availability, referral criteria, and defense participation before expanding a specialized court pathway.⁴

Opioid treatment with continuity after release may reduce negative outcomes

A study of 6,400 people with probable opioid use disorder in Massachusetts county jails found that individuals receiving medication in jail had a 52% lower adjusted hazard of fatal overdose after release (hazard ratio 0.48; 95% CI 0.36–0.64) and a 12% lower adjusted hazard of reincarceration. Within 30 days, 60.2% received medication in the community, versus 17.6% of those untreated in jail—an unadjusted difference of about 43 people per 100.⁵

52%

lower adjusted hazard of fatal overdose after release for individuals receiving medication

12%

lower adjusted hazard of reincarceration for individuals receiving medication in jail

Recommendation: The authors of this study recommend auditing existing services, maintaining clinically indicated medication, ensuring access to appropriate treatment, and arranging a confirmed community handoff. Measuring continuity after release as well as treatment during custody is important.^{5,8}

Guidance from National Resources

A systems approach is key for a comprehensive design for new facilities

June 2026 reporting described preliminary plans for 258 beds at the new facility costing \$72.7–\$84.5 million; the site and plans are not finalized.¹¹

The National Institute of Corrections recommends a systems approach to capacity planning, accounting for admissions, length of stay, population peaks, and classification requirements.¹⁰

Recommendation: Collect and analyze baseline data to identify whether admissions, duration, or both create pressure.¹⁰ This could be done via joint operational and clinical review, led by the sheriff and medical provider. The report would inventory current withdrawal, medication, suicide-prevention, sick-call, and discharge practices before deciding what must expand in the new facilities.^{8,9} Obtain at least 24 months of monthly admissions, releases, daily population, and boarding records. Consider using aggregate reporting and protected record linkage for evaluation.

Consider approaches for managing inmate substance withdrawal

The federal Guidelines for Managing Substance Withdrawal in Jails suggest screening, clinical monitoring, treatment, and transfer when a jail cannot safely manage a person's condition. These are expert practice guidelines, not an impact evaluation.⁸

Recommendation: Compare current protocols and staffing against the guidance, identify gaps, and document who can order treatment and when hospital transfer is required.

Treat suicide prevention as an ongoing process

The NCCHC–American Foundation for Suicide Prevention resource guide emphasizes assessment, intervention and treatment, and staff training. It supports a coordinated prevention system rather than reliance on a single admission screen.⁹

Recommendation: The guide recommends reassessment after changes in clinical or custody status; communication between custody and clinical staff; safe observation space; emergency response drills; and multidisciplinary review after self-harm incidents. These are implementation recommendations informed by professional guidance, not quantified predictions of suicide reduction.⁹

What's happening in other states?

New York

A randomized trial of the Rochester forensic assertive community treatment model showed that participants assigned to the model averaged 21.5 jail days versus 43.5 with enhanced usual care—22 fewer days per person. Hospital days averaged 4.4 for participants assigned to the model versus 23.8 for participants with enhanced usual care.⁶

Application: For Penobscot, the transferable option is a small, evaluated pathway linking eligible people to an adequately staffed community treatment team. Court coordination and actual service capacity are essential; a referral list alone does not replicate the program.⁶

Illinois

An evaluation of over 11,000 felony defendants before and after a 2017 bond reform showed that the proportion securing pretrial release rose from approximately 77% to 81%. About 17% of released defendants in both periods had alleged new criminal activity; roughly 3% had alleged new violent activity. The descriptive failure-to-appear rate rose from 17% to 20%.⁷

Application: Penobscot can examine delays and barriers to release with judges, defense counsel, prosecutors, and pretrial staff, while monitoring court appearance and new alleged offenses separately. Local proposals should address transportation and communication barriers and avoid unnecessary supervision requirements. Commissioners should convene and fund collaboration without attempting to determine individual judicial release decisions.

Massachusetts

The seven-jail medication initiative offers a regional example of combining treatment in custody with community continuity.⁵

Application: Penobscot can fund the clinical pathway and discharge arrangements together.

Funding & Support



This brief was completed as part of a project funded by the William T. Grant Foundation and is a joint effort of the HEDCO Institute for Evidence-Based Educational Practice at the University of Oregon and Johns Hopkins University. All information provided is the viewpoints of the brief authors and do not reflect the official views of the University of Oregon, Johns Hopkins, or Project LINK. For more information, please email linkproject@uoregon.edu.

Methods

Findings presented in this brief come from a literature review of academic peer-reviewed studies, as well as a review of research and findings from non-partisan think tanks, foundations, and organizations. Given the rapid nature of this search, other relevant studies may exist. In addition, please note that we did not use formal statistical methods for summarizing results and exploring reasons for differences in findings across studies.

References

Numbered references correspond to citations in the text. Peer-reviewed studies support intervention findings; local reporting supports background only. Guidance documents inform implementation and do not establish causal effects. This is a focused evidence overview, not an exhaustive systematic review.

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