



SPECIALISED MENTAL HEALTH SUPERVISION: OFFICER STRESS AND IMPLEMENTATION

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Abstract

Across the globe, criminal justice systems face high rates of mental illnesses among their correctional populations (e.g. prisons, jails, and community supervision) and aim to implement specialised approaches to improve mental health and criminal justice outcomes. Studies have documented the association between supervising persons with mental illnesses and stress among community supervision officers (CSOs); however, no studies have examined the impact of stress on CSOs' implementation of these specialised mental health approaches. To address the gap in research and practice knowledge, our study utilises statewide, self-report survey data to compare the stress levels of CSOs assigned to a Specialised Mental Health Supervision (SMHS) caseload with those of officers supervising a non-SMHS caseload. Additionally, we link our survey data to administrative data to assess the impact of stress levels on SMHS implementation outcomes (e.g. adoption, fidelity), including measures of resource referrals and follow-ups, the use of problem-solving skills, and other supervision techniques designed to assist individuals with simultaneously navigating their mental health treatment and probation or parole terms. Findings revealed no difference in stress levels between SMHS officers and non-SMHS officers. However, results indicate that SMHS officers reporting higher stress levels show lower SMHS implementation fidelity.

Keywords

Community supervision; probation; occupational stress; mental illness; fidelity

Introduction

The overrepresentation of people with mental illness in legal systems is a problematic trend worldwide (Barayani et al, 2022; Sirdifield, 2012). In the United States, where this study takes place, rates of mental illness are doubled among justice-involved people compared to the general population (Al-Rousan et al., 2017; Prins, 2014). Among the community supervision population (i.e. probation and parole), where we find most people under correctional control, it is estimated that up to 1 million people have mental health needs (Buehler & Kluckow, 2024; Crilly et al., 2009; Van Deinse et al., 2023). Given the challenging circumstances that often accompany mental illness and legal-system involvement (e.g. homelessness, addiction and victimisation), it is not surprising that these individuals fare worse on supervision than those without a mental illness (Van Deinse et al., 2023). Indeed, persons with mental illnesses are more likely to be rearrested or incarcerated for violating the terms of their supervision (Powell et al., 2024).

Specialised Mental Health Supervision (SMHS) is a promising strategy for enhancing the capacity of Community Supervision Officers (CSOs) to support individuals with mental health needs, thereby improving criminal justice outcomes (Council of State Governments, 2002; Skeem et al., 2006; Wolff et al., 2014). SMHS implements changes to both the structure of CSO caseloads and expectations for CSO supervision. At the agency level, organisations create reduced caseloads comprised exclusively of individuals with mental health concerns. Then, agencies assign these caseloads to specialised officers who receive ongoing training in a wide range of mental health topics, such as de-escalation and symptom recognition. At the officer level, CSOs are expected to employ a problem-solving approach to assist individuals in addressing their mental health needs and overcoming barriers to complying with their supervision terms. Additionally, SMHS officers collaborate with resource providers to ensure that individuals are linked with mental health and other supportive services they need to improve their chances of success on community supervision (Council of State Governments, 2002; Skeem et al., 2006; Van Deinse et al., 2023).

However, the effectiveness of SMHS remains unclear. Whereas SMHS models show gains in mental health and related treatment among people on community supervision, research on criminal justice outcomes, such as arrests and revocations, has yielded mixed results (Manchak et al., 2014; Powell et al., 2024; Skeem et al., 2006; Van Deinse et al., 2021a; Wolff et al., 2014). One possible explanation is that variation in the implementation of SMHS can also result in variation in outcomes. Yet, there is no available research on the implementation fidelity of SMHS. While a few studies have examined implementation strategies and organisational-level adjustments to enhance the effectiveness and fidelity of SMHS (Powell et al., 2024; Van Deinse et al., 2025a), little attention has been paid to the interplay between officer-level factors and the implementation of the officer-level components of SMHS. For example, despite a known relationship between supervising people with mental illness and officers' psychological well-being (Gayman et al., 2018; Powell & Gayman, 2020), no studies have assessed the impact of stress on the implementation fidelity of SMHS officers.

To fill this gap in the research literature and improve practice knowledge, we combine administrative and survey data to assess whether SMHS officers reporting higher stress

levels show lower SMHS implementation fidelity. We employ bivariate and multivariate analyses to answer two research questions: (1) Do SMHS officers report higher stress levels than officers supervising a non-SMHS caseload? (2) Are SMHS officers who report higher stress levels implementing SMHS with lower fidelity? Specifically, are SMHS officers less likely to address mental health needs, utilise problem-solving skills, or monitor individuals' treatment progress when experiencing higher levels of stress?

Background

Research Question 1: SMHS Officers and Stress

Often faced with challenging life circumstances (e.g. homelessness, victimisation, and addiction), people with mental health needs do not fare well under supervision (Cloyes et al., 2010; Ostermann & Matejkowski, 2014; Van Deinse et al., 2023). Technical violations and rearrests are more prevalent among people with mental health needs compared to those without (Powell et al., 2024). Challenging circumstances, coupled with poor outcomes, have officer-level consequences, such as increased job difficulty for CSOs assisting clients with mental health needs (Van Deinse et al., 2018). However, it is unclear whether the combination of challenges and outcomes translates into greater stress for SMHS officers than for other CSOs.

On the one hand, SMHS officers may experience more stress than their non-SMHS counterparts because they are working exclusively with clients who have mental health needs. In one study, Gayman and colleagues (2018) found that the greater the number of people with mental health needs assigned to CSOs' caseloads, the greater their risk for experiencing emotional exhaustion. A follow-up study then linked supervising more people with mental illnesses to increased work stress via role conflict and overload (Powell & Gayman, 2020). CSOs assisting clients with mental health needs may encounter role conflict when attempting to balance providing support with monitoring sentence compliance (Skeem et al., 2007) and experience role overload when taking on additional roles, such as navigating mental health treatment and related services (Epperson et al., 2014). Thus, it is plausible that SMHS officers supervising a caseload comprised exclusively of persons with mental illness experience higher levels of stress than other officers.

On the other hand, a core component of SMHS programmes is a caseload cap of 40-50 clients (Wolff et al., 2014). The reduction may quell the stress stemming from the number of people with mental illness on their caseloads for SMHS officers. Although no studies have examined the relationship between SMHS caseload size and stress, exploring research in other human service fields may prove helpful. For instance, a study of social workers found a significantly positive association between caseload size and stress (Quinn et al., 2019). Similarly, prior research has linked higher caseloads to increased stress among counsellors (Mullen et al., 2021). Given the implications of caseload size for psychological well-being in other helping professions, a regulation mechanism, such as the SMHS caseload cap, may counteract the impact of stress on SMHS officers.

Research Question 2: SMHS Officer Stress and Implementation Fidelity

When implemented with fidelity, there is evidence that SMHS programmes improve criminal justice outcomes (Manchak et al., 2014). However, there are mixed results on the effectiveness across programmes (Powell et al., 2024; Van Deirse et al., 2021a). These limitations in the research are likely influenced by variation in SMHS implementation and insufficient consideration of officer-level implementation factors. The responsibility of implementing SMHS programmes falls to CSOs. Therefore, it stands to reason that officer-level factors, such as stress, may impede CSOs' willingness or ability to implement SMHS with fidelity. While no studies have examined the relationship between officer stress and implementation of SMHS components, such as addressing mental health needs, utilising problem-solving skills, or monitoring individuals' treatment progress, there are reasons to believe this relationship exists.

Occupational stress theories offer a valuable lens for understanding this dynamic. The Job Demands–Resources (JD–R) model (Bakker & Demerouti, 2007) posits that high job demands—such as emotional strain, role conflict, and complex caseloads—must be counterbalanced by adequate resources, including training, manageable caseload sizes, and supervisory support. When resources are insufficient, the imbalance leads to burnout and reduced capacity to perform core job functions, including the consistent application of specialised supervision practices. Similarly, the Conservation of Resources (COR) theory (Hobfoll, 1989) emphasises that stress arises when individuals experience, or anticipate, the loss of valued resources, such as time, emotional energy, or role clarity. Within SMHS settings, officers under stress may conserve their remaining resources by 'cutting corners' or prioritising administrative compliance over fidelity to problem-solving, rapport-building, and treatment monitoring. Together, JD–R and COR provide theoretical grounding for why officer stress may undermine the effective implementation of SMHS.

Building on these frameworks, prior research highlights specific pathways through which stress affects officer practice. First, the composition and events of a CSO's caseload alter their perceptions. When repeatedly exposed to stressful situations, like the difficult life circumstances that often accompany clients with mental health needs, officers lose trust and develop a pessimistic attitude towards their jobs (Lewis et al., 2014). This 'distorted worldview' may negatively impact the work performance of SMHS officers, as they are more likely to categorise clients as criminals rather than promoting their success, which is a best practice for SMHS (Lewis et al., 2013). Second, CSOs report becoming more authoritative and spending less time building rapport with clients when psychologically distressed (Salyers et al., 2015). Finally, and most relevant to this study, CSOs experiencing stress are more prone to perpetuating stigmas and less competent in assisting people with mental health needs (White et al., 2015). Therefore, it is plausible that SMHS officers' stress impacts their likelihood of addressing mental health needs, using problem-solving skills, and monitoring treatment compliance.

Data and Methodology

Sample

This project utilises data from a broader 2022 study, which administered a statewide survey to all community supervision officers (CSOs) employed by the Georgia Department of Community Supervision (DCS). Given that Georgia officers supervise both probation and

parole cases, there is no distinction between the two in this study. All CSOs were invited to participate, and 308 completed the survey. Of those who participated, 32 respondents indicated that they supervise a SMHS caseload. Because information on age, race, and gender was not asked as part of the survey, administrative data were used to identify the age, race, and gender of the study respondents. The researcher's Institutional Review Board approved the study protocol on 8 June 2022.

Measures

Organisational and Job Stress. Work-related stress was assessed with questionnaires commonly used in probation and parole stress research (Gayman & Bradley, 2013). Organisational stress was measured using 25 statements from the Internal Organization Subscale (Blankenship, 2016; Slate, 2003), which represent stressors internal to the organisation, such as inadequate salary and lack of adequate training. Job stress was measured using 14 statements from the Job/Task Subscale (Blankenship, 2016; Slate, 2003). These statements represent task-related stressors such as excessive paperwork and the expectation to do too much in too little time. Respondents rated the degree of stress caused by the stressor on a six-point scale (1 - *not stressful*, 6 – *very stressful*). Two severity scores were created for organisational stress and job-related stress by adding the severity ratings for the statements from the corresponding subscales. The severity score reflects the total perceived stress in that work domain.

Major Life Stress. Life stress was measured based on major life events, including changes such as marriage and exposure to crime, within the past 12 months. We used this measure to assess the non-work-related stress experienced by officers in their personal lives. Officers responded to whether any of the 32 major life events (e.g. 'were you or members of your immediate family assaulted or mugged?') occurred in the past year. If officers responded yes, they rated the experience on a 6-point scale (1 – very good, 6-very bad) because some major life events can be perceived as positive or negative (e.g. getting married). Similar to work stress, we calculate a severity score by summing the severity ratings of 4 and above, which indicate negative experiences from the events.

SMHS Implementation. Data about officers' implementation of the SMHS components during client interactions was obtained through administrative data collected by DCS as part of routine procedures to document CSOs' caseload management across several domains. For this study, data were obtained for three fields. First, *address mental health needs*. This category encompasses discussion topics, including referrals and follow-ups, between officers and clients regarding a range of mental health and related services, such as treatment, employment and housing. Second, *utilise problem-solving skills*. This category reflects a subset of person-centred communication techniques, in which the officer identifies perceived challenges and options to assist clients in weighing the costs/benefits to make an informed decision. Third, *treatment check*. This category reflects discussions between officers and clients regarding their progress in mental health treatment, including attendance at appointments and compliance with medication.

Controls. Age (continuous), race (1 = White and 0 = Black), and gender (1 = Women and 0 = Men) were measured using employee administrative data.

Analytical Strategy

Descriptive statistics on the study sample and variables are provided in Table 1. Table 2 presents correlations used to assess the bivariate relationships between officer stress and SMHS implementation variables. Ordinary least squares (OLS) regression was used to determine whether SMHS officer stress is associated with the implementation of SMHS (Table 3). Because several measures of stress and SMHS fidelity were used, only officer stress and implementation relationships that were significant at the bivariate level were included in the regression models. Models evaluate the bivariate and independent relationships, respectively.

Results

Descriptives

Table 1 provides descriptive statistics on the sample and study variables. The average organisational stress score was 8.28 with a standard deviation of 5.38. On average, respondents reported a job stress score of 3.56 with a standard deviation of 2.5. The mean score for major life stress was 1.54 with a standard deviation of 2.41. Sixty-nine percent of the respondents were women ($n = 22$), and 41% were White ($n = 13$). Finally, the average age was 38.02 years with a standard deviation of 7.02.

Table 1. Descriptive Statistics for SMHS Officers.

	%(N)	M(SD)
<i>Sex</i>		
Female	68.8 (22)	
Male	31.2 (10)	
<i>Race</i>		
White	40.6 (13)	
Black	50 (16)	
Other	9.4 (3)	
<i>Age</i> ¹		38.02 (7.02)
Organizational Stress		8.28 (5.38)
Job Stress		3.56 (2.50)
Major Life Event		1.53 (2.41)
Address Mental Health Needs		401.44 (340.19) ²
Problem Solving		11.43 (14.41) ³
Treatment Check		343.52 (413.23) ⁴

Notes. $N = 32$. ¹Years (Range = 27-53). ²Min = 19, Max = 1,102. ³Min = 1, Max = 55. ⁴Min = 2, Max = 1,633.

Bivariate

To answer the first research question, 'Do SMHS officers report higher stress levels than officers supervising a non-SMHS caseload?', we conducted an independent samples t-test to compare the stress scores between SMHS officers and officers supervising a regular caseload. We found no significant difference between the two groups. Therefore, results are not shown but are available upon request.

To answer the second research question, ‘Are SMHS officers who report higher stress levels implementing SMHS with lower fidelity?’, we conducted a Pearson correlation test to measure the strength and direction of the linear relationship between stress variables (organisational, job and major life) and SMHS implementation variables (address mental health needs, problem solving and treatment check). Table 2 consists of a correlation matrix for all continuous study variables. Decreased engagement in addressing mental health needs among SMHS officers is associated with increased levels of job stress ($r = -0.449$, $p \leq 0.01$). Increased major life stress is associated with decreased use of problem-solving skills among SMHS officers ($r = -0.827$, $p \leq 0.001$). Finally, given that the highest correlation between predictor variables is 0.564, there is no indication of potential multicollinearity in the subsequent multivariate analysis.

Table 2. Correlation Matrix.

	(1)	(2)	(3)	(4)	(5)	(6)	(7)
(1) Age	-						
(2) Organizational Stress	.081	-					
(3) Job Stress	.054	.564***	-				
(4) Major Life Stress	-.189	.247	.211	-			
(5) Address Mental Health Needs	.009	-.203	-.449**	.061	-		
(6) Problem Solving	.111	.386	-.582*	-.827***	.114	-	
(7) Treatment check	.195	-.141	-.357*	-.010	.232	-.086	-

Notes. N=32. * $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Multivariate

Table 3 displays the regression of SMHS implementation on key study variables (standardised OLS regression coefficients shown). Results in Model 1 indicate that higher levels of job stress among SMHS officers are associated with decreased engagement in addressing mental health needs ($\beta = -.551$, $p \leq .05$). Also shown in Model 1, the reduced engagement in addressing mental health needs is independent of all control variables – age, race, and sex.

Table 3. SMHS Implementation Regressed on Study Variables.

	Address Mental Health Needs I	Problem Solving II	Treatment Check III
Organizational Stress	.067 (14.3)	.026 (.486)	.120 (17.7)
Job Stress	-.551* (31.0)	.223 (1.33)	-.449 (39.9)
Major Life Stress	.157 (26.5)	-.682** (.663)	.113 (32.3)
Age	.041 (9.98)	.288 (.382)	.298 (12.8)

Sex (ref Male)	-.077 (150.7)	.066 (4.91)	.057 (184.42)
Race (ref Black)	-.169 (125.4)	-.343 (4.13)	.083 (162.49)
	R ² =.257	R ² =.812	R ² =.048

Notes. N=44. Standardised regression coefficients are shown (Std Error).

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Therefore, Model 1 demonstrates that the higher degree of job stress among SMHS officers is associated with a decrease in their likelihood to assist clients with addressing their mental health needs.

Model 2 tests whether stress impacts SMHS officers' use of problem-solving skills. As shown, the results indicate that higher levels of major life stress are associated with decreased use of problem-solving skills among SMHS officers ($\beta = -0.682$, $p \leq 0.01$). The relationship in Model 2 remained significant when controlling for age, race, and sex.

Finally, Model 3 assesses the relationship between all three stress measures and SMHS officers' likelihood of discussing treatment progress with clients who have mental health needs. There were no significant relationships found. Together, the findings illustrate the impact of officer stress on implementing SMHS to assist clients with mental health needs.

Discussion

Given the high rates of persons with mental illness in the legal system (Barayani et al, 2022; Sirdifield, 2012), their increased odds of supervision failure (Powell et al., 2024), and the psychological toll that assisting these clients has on officers (Powell & Gayman, 2020), factors impacting the implementation of SMHS are worthy of attention for practitioners, scholars and administrators alike. This study fills a notable gap in the research literature, as it is the first of its kind to examine the interplay between officer-level factors, particularly officer stress, and the implementation of SMHS. Our findings demonstrate that SMHS officers do not experience higher stress than their non-SMHS counterparts. There are several reasons why these results were unexpected at first. For one, there is a known link between the number of individuals assigned to a CSO's caseload and their risk for experiencing stress (Powell & Gayman, 2020).

Additionally, research in other human service fields shows an association between caseload size and increased stress (Mullen et al., 2021; Quinn et al., 2019). However, no prior studies have examined the relationship between SMHS caseload size and officer stress. Moreover, a core component of SMHS programmes is a caseload cap of 40-50 clients (Wolff et al., 2014), which was incorporated into the caseloads of the SMHS officers in our study. Therefore, this finding, or lack thereof, may provide initial evidence in support of caseload caps because of the potential for reduced caseloads to quell stress stemming from the number of people with mental illness on officers' caseloads.

Furthermore, although we did not find higher stress levels among SMHS officers than among other officers, we did find a correlation between SMHS officers' stress and the implementation of SMHS. For SMHS officers, those experiencing higher levels of job stress were less likely to assist clients with addressing mental health needs. This finding highlights the importance of agencies being mindful of the impact of stress on SMHS officers' work

and providing additional support and resources to maintain program fidelity. Finally, our analyses showed that SMHS officers experiencing stress outside of work are less likely to engage in problem-solving with clients who have mental illnesses. This finding demonstrates that CSOs' needs for resources and support are contingent on events in their personal lives.

Implications

Our study advances knowledge about what impacts the implementation of SMHS, namely, officer stress. This finding offers actionable information in three ways. First, agencies can focus on the specific supports that officers need to supervise specialty mental health caseloads. One strategy deployed for SMHS is clinical case consultation. Developed as part of SMHS in North Carolina, clinical case consultation is a practical implementation strategy to support the uptake of evidence-based practices (EBPs) in mental health settings (Ghezzi et al., 2020; Van Deinse et al., 2021b). Through feedback and coaching from a licensed mental health professional, SMHS officers receive ongoing training and support for assisting clients with their mental health needs. As part of Georgia's current efforts to support SMHS, clinical case consultation is being implemented (Van Deinse et al., 2025b).

Second, case consultation is just one example of how agencies can draw on implementation science to develop strategies that enhance the uptake of interventions. Understanding the multilevel factors that impact implementation is crucial, ranging from factors that influence the adoption of an intervention (i.e., the decision to implement) to its widespread use and sustainment (implementation and fidelity). Implementation science methods can help agencies throughout the entire implementation process (Van Deinse et al., 2025a). For example, conducting a pre-implementation assessment using rapid qualitative methods provides agencies with actionable information for enhancing the implementation of SMHS in real-world conditions (Van Deinse et al., 2025b)

Third, agencies should consider organisational-level factors that can impact officer stress. Research suggests that workplace factors contribute to stress among CSOs. Role overload, for example, reflects a critical operational shortcoming. Agencies should therefore prioritise the mitigation of its effects through organisational structure, leadership support, and culture (Solinas-Saunders et al., 2025)

Limitations and Future Directions

To guide further research on this topic, we must identify and address the limitations of this investigation. First, current analyses rely exclusively on self-reported stress, which introduces a standard method bias because both stress and adoption of SMHS are measured through subjective reports. Officers reluctant to adopt SMHS skills may simultaneously perceive and report higher levels of stress, artificially strengthening the observed association. To mitigate this limitation, future research should expand the understanding of officer stress by incorporating objective biological stress measures, such as salivary cortisol, which provide independent indicators of physiological stress responses and reduce reliance on a single method of measurement. Furthermore, with cross-sectional data, we cannot draw definitive conclusions regarding the temporal relationship between

study variables. Longitudinal research is needed to identify these pathways and their relative strength over time.

Finally, measuring SMHS skills through self-reported case notes provides only a rough count of whether officers indicate using these strategies. While this serves as a helpful starting point, it does not accurately reflect the quality or authenticity of the interactions between CSOs and individuals involved in community supervision. Because SMHS approaches are designed to foster rapport and strengthen a working relationship between officers and clients, relying solely on quantitative measures provides limited insight into how well these objectives are being met. Incorporating body camera footage presents an opportunity to capture these dynamics more objectively, allowing for evaluation of whether SMHS skills are actually employed in practice and how they shape the emotional tone, sentiment and rapport within supervision encounters.

Conclusion

This study highlights the critical interplay between officer stress and the practical implementation of Specialised Mental Health Supervision (SMHS). While SMHS officers do not report higher overall stress levels than their non-SMHS counterparts—a finding potentially attributable to adherence to caseload caps—the research clearly demonstrates that increased job stress among SMHS officers is linked to a reduced likelihood of addressing clients' mental health needs. Furthermore, personal life stressors negatively impact the engagement of SMHS officers in problem-solving with clients. These findings underscore the importance of recognising the multifaceted nature of officer stress, encompassing both occupational and personal domains, and its direct influence on the fidelity of SMHS practices. To optimise SMHS outcomes and improve support for justice-involved individuals with mental illnesses, agencies must prioritise strategies that mitigate officer stress, such as providing ongoing clinical case consultation and fostering a supportive work environment. Future research incorporating objective stress measures and longitudinal designs will further elucidate these complex relationships, ultimately informing more robust and effective SMHS models.

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