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Training Federal Probation Officers as Mental Health Specialists

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APPROXIMATELY FIVE PERCENT of the U.S. population has a serious mental illness, and those with mental illnesses are significantly more likely to come into contact with the criminal justice system (Council of State Governments et al., 2002). In fact, the President's New Freedom Commission on Mental Health (2003) estimated that the rate of serious mental illness for persons in jail in this country is three to four times more than that of the general, non-inmate population, and, according to a recent Human Rights Watch Report, jails and prisons in the U.S. hold three times more persons with mental illness than do psychiatric hospitals in America (Satel, 2003). Further, Ditton (1999) reported that 16 percent of jail and prison populations, as well as 16 percent of probationers in the U.S., have mental illnesses.

Consistent with the estimates above and with prevalence estimates by others (see Steadman et al., 1987; Teplin, 1990; Teplin et al., 1996; Pinta, 1999) of similar populations, in 2003, 18 percent (n=19,731) of those on federal parole, supervised release, conditional release, or probation had a special condition for mental health treatment (Slate, et al., 2003). With burgeoning caseloads filled by consumers of mental health services and a typical lack of reentry planning within the criminal justice system (see Osher, Steadman, and Barr, 2003), some state and local jurisdictions, as well as the federal government, have begun to develop specialized models of supervision for persons with mental illness.

Horn (2004) argues that offenders should not be released unprepared and unassisted at the culmination of their sentence. Even so, such abdications of responsibility have led to a settlement in which the New York City Departments of Corrections and Health have agreed, under pressure of a class action lawsuit, to provide discharge planning services to offenders with mental illness released from custody (see Barr, 2003; *Brad H. v. Giuliani*, 2003; Urban Justice, 2004). Other states have also become engaged in the reentry process from prison by, for example, ensuring that medical benefits are conferred upon individuals on the date of discharge into the community; some corrections departments provide assistance in filling out applications for re-instatement of benefits to those being released from prison (see Human Rights Watch, 2004).

Looking to the future, Horn (2004) maintains that public safety can be improved by equipping offenders with necessary elements to succeed and better ensuring responsible offenders upon release; there needs to be recognition of the magnitude of the problem of sobriety, and mastery of this problem is crucial to ensuring successful reentry into society. It has been estimated that 75 percent of the individuals with symptoms of serious mental illness present upon entering jails annually meet the requirements for a co-occurringg disorder (a serious mental illness and co-occurring substance abuse disorder) (Teplin, Abram, and McClelland, 1996; Osher, Steadman, and Barr, 2003).

A myriad of explanations have been offered as to why the criminal justice system has become the de facto mental health system (see Slate, 2004). Yet, as reported by Lurigio and Swartz (2000), only 15 percent of probation agencies across the country indicated having a specialized program for probationers with mental illness, and fewer than 25 percent of parole administrators acknowledged having specialized programs for parolees with mental illness (Lurigio, 2001), with Camp and Camp (1997) finding no parole departments reporting the provision of any specialized mental health services for offenders in need of such services. Furthermore, probation agencies have been criticized for a disconnect from the community and for lack of systematic development of real interagency cooperation with the police, treatment and service providers and other community organizations (Reinventing Probation Council, 2000; Clear and Corbett, 1999).

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Looking to the Future—Probation Officers as Change Agents

In accordance with the principle of therapeutic jurisprudence, some criminal justice agencies have begun to explore development of trained specialists to assist the progress of offenders released on supervision in the community. The concept of therapeutic jurisprudence operates on the belief that the application of the law can have therapeutic and anti-therapeutic consequences, and, unlike the traditional criminal justice process, does not advocate solely looking back, finding fault, assessing blame, meting out punishment, and ignoring the consequences of the imposition of punishment (see Wexler and Winick, 1991; Finkleman and Grisso, 1994; Miller, 1997). Instead, the focus is to be on the future, with consideration of public safety and successful offender reintegration into society long after an individual's contact with the criminal justice system has ended (Slate, 2003).

As we have previously maintained, probation officers are logically positioned to operate as change agents in the spirit of therapeutic jurisprudence (see Slate, Roskes, Feldman, and Baerga, 2003). Probation officers have been identified in the research literature as resource brokers or boundary spanners based on their ability to be aware of available services and to properly match those released into the community to such services and/or benefits in such areas as mental health, housing, and vocational/employment opportunities (McCampbell, 2001; Steadman et al., 2001).

While, in general, most probation officers are inadequately prepared to handle persons with mental illness in the community (Veysey, 1994), some agencies have developed specialized programs to deal with this population. For example, specialized programs for probationers with mental illness can be found in Chicago (Lurigio and Swartz, 2000) and for parolees in California (Lurigio, 2001). Specialized mental health caseloads have been developed for those under federal supervision in the community in Baltimore (Lurigio, 2001; Roskes and Feldman, 1999, 2000),

the Northern District of Illinois, the Western District of Texas, the Eastern District of Tennessee, and New Jersey, as well as other districts. Probation officers have even become members of Assertive Community Treatment teams in Sacramento, California (Sheppard, Freitas, and Hurley, 2002). Such specialized programs are typically supported by an augmentation of resources and added training and can result in improved monitoring of special conditions of release such as mandates for mental health treatment (Lurigio and Swartz, 2000; Roskes and Feldman, 1999, 2000). Training programs that are in place are often aimed at identifying local resources and helping link persons with mental illness to the appropriate services, such as in Broward County, Florida (Slate et al., 2003).

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The New York State Example

Throughout New York State, where local services and resources vary greatly, the state has tried to introduce flexible, adaptable, and customizable training modules for probation officers supervising persons with serious mental illness and co-occurring substance abuse disorders; these training modules can be molded to fit the characteristics of a particular jurisdiction (Massaro, 2003). In accordance with the principles of therapeutic jurisprudence, the goals of the New York training program are to lessen recidivism, promote wellness and recovery, and improve public safety (Massaro, 2003). Components included in the training of New York state probation officers are as follows: understanding and responding to persons with serious mental illness and co-occurring substance abuse disorders, matching services to needs for this population, developing and improving partnerships between probation and other service providers—such as in the mental health arena—and identification of key issues pertaining to supervision of persons with serious mental illness and co-occurring substance abuse disorders (Massaro, 2003).

Depending on the degree of readiness and level of sophistication, in somewhat of a cafeteria style, individual supervisors can pick and choose the components and topics that make the most sense for their particular jurisdictions. Available topics include: persons with serious mental illness and co-occurring substance abuse disorders in the criminal justice system, challenges for probation officers, identifying persons with serious mental illness and co-occurring substance abuse disorders, red flags pertaining to safety issues, responding to persons with serious mental illness and co-occurring substance abuse disorders, recovery and wellness, best practices to meet needs and promote wellness, benefits and exploration of collaborative relationships, promising practices for enhancing service delivery, mental health and mental illnesses, signs and symptoms of mental illness, mental illness diagnosis, severe and persistent mental illness, and key issues in mental health (Massaro, 2003).

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Crisis Intervention Training

While there currently is no standardized/centralized training for federal probation officers who deal with persons with serious mental illness and co-occurring substance abuse disorders, there are probation officers designated as mental health specialists in judicial districts throughout the country. It is not uncommon for these officers serving as specialists to have an extensive mental health educational background; some are actually licensed counselors, clinical social workers, or psychologists (Slate, et al., 2003).

A logical place to look for relevant training has emerged from crisis intervention training curriculum protocols sometimes found in the law enforcement arena. For example, the Administrative Office of the U.S. Courts has served as a catalyst by opening doors for federal probation officers and pretrial services officers in the Washington, D.C. office and surrounding metropolitan area in Virginia and Maryland to attend crisis intervention training with the Montgomery County police in Maryland. Such law enforcement crisis intervention training typically includes components emphasizing: signs and symptoms of mental illness, psychotropic medications, co-occurring substance abuse disorders, suicide risk assessment and interventions,

de-escalation techniques for authorities when responding to a person with mental illness in crisis, police discretion and decision-making concerning civil commitment procedures and processing, awareness of the acute care system within a jurisdiction (which may include making site visits), familiarization with community resources, consideration of special populations (i.e., juveniles with mental illness, mental retardation, behavioral conditions that mimic mental illness, Alzheimer's, epilepsy, and homelessness), and perspectives of persons with mental illness and family members of persons with mental illness (Florida Mental Health Institute, 2003).

Many of the law enforcement crisis intervention training curriculums currently in place are modeled after the Memphis Police Department Model in Memphis, Tennessee (Reuland, 2004). Although there are other types of law enforcement interventions for dealing with persons with mental illness, such as trained social workers riding with police and mobile crisis units partnering with law enforcement (Steadman, et al., 2000), the Memphis Model of Crisis Intervention Team training has become very popular, and the Montgomery County, Maryland curriculum, which has been utilized to train federal probation officers, is based on the Memphis Model.

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Other Mental Health Specialist Training Initiatives for Federal Probation Officers

Again, while there currently is no standardized/centralized training for federal probation officers who specialize in supervising persons with serious mental illness and co-occuring substance abuse disorders, three separate two-hour training modules have been produced and broadcast live (also available on video) to interested parties around the country via the Federal Judicial Television Network. The modules that were broadcast (now available on video cassette from the Federal Judicial Center) present an overview of mental health disorders (psychotic disorders, mood disorders, anxiety disorders, personality disorders), means for identifying the signs and symptoms of mental illness, and the nuances of supervising persons with mental illness. Sources to rely upon for identification purposes include: the review of previous records and reports concerning the offender, the interview of the offender, behaviors observed in the offender, and information ascertained from collateral contacts (medical, familial, employment, financial, etc.). Factors and rationales for special conditions of release pertaining to mental health supervision are also explored in the training videos, as well as how to determine the need for special conditions and the wording of such conditions to maximize the potential of treatment strategies for persons with mental illness. Those strategies include the referral process, which deals with identifying treatment providers, designating prospective interview questions to be posed to treatment providers, identifying how to ask for services, determining how providers of services will be compensated, and teaching an offender with mental illness how to access and utilize services. Also, special supervision issues such as maintaining relationship boundaries, assessment of potential violence from clients, crisis intervention strategies, psychotic episodes, potential for suicide and homicide, and the requirements for documenting a crisis situation are covered by this training material.

It is our belief that there should be some uniformity in job performance and expectations for mental health specialists within the federal probation system, and this uniformity could be instilled via a centralized training process that could culminate with certifications qualifying officers as specialists. While traditionally probation officers may experience role conflict, being torn between law enforcement and social work responsibilities and expectations (see Slate, Johnson, and Wells, 2000), we believe that probation officers serve as brokers between those being supervised and those providing services to persons with mental illness under supervision.

The primary function of probation officers acting as mental health specialists is to ensure public safety; however, much of the day-to-day operation is not directly focused on protection but is oriented to ensuring that persons with mental illness are linked with appropriate resources. In so doing, probation officers, acting as navigators, move among various systems to provide persons with mental illness with meaningful and lasting outcomes that hopefully will continue and be maintained long after supervision is terminated.

Federal probation officers who are mental health specialists are expected to advocate within various systems for the client or for implementation of the Court's order for treatment or for restraining specific behaviors. The following entities are included among those systems within which mental health specialists must navigate and develop expertise.

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System I—Corrections

Bureau of Prisons

While all Federal Bureau of Prisons (BOP) facilities are capable of providing adequate health care for most offenders, there are currently seven inpatient Medical Referral Centers situated within the BOP (Bureau of Prisons, 2004). The Medical Center for Federal Prisoners (MCFP) is located within the North Central Region in Springfield, Missouri; also within this region is the Federal Medical Center (FMC) in Rochester, Minnesota. Other FMCs can be found in the Mid-Atlantic Region (Butner, North Carolina; Lexington, Kentucky), the Northeast Region (Devens, Massachusetts), and the South Central Region (Carswell, a facility for females in Fort Worth, Texas, and a center for males in Ft. Worth).

Many mental health cases arrive on probation officers' desks from the Bureau of Prisons (BOP). United States Probation Officers (USPOs) trained as mental health specialists should be aware of the mental health facilities in the BOP and should have a knowledge of treatment modalities within those facilities. USPOs should be engaged in the reentry process and have the capability to advocate for certain services, such as medication upon release from custody and the reinstatement of disability benefits or submission of applications for benefits. They should be aware of the similarity and divergence of the BOP's goals (maintenance and risk management) and the goals of USPOs (successful integration). USPOs trained as mental health specialists should be able to converse readily with caseworkers, psychiatrists, and psychologists and have a command of the treatment nomenclature and protocols. A complete understanding of civil commitment cases (18USC4246) and the requirements of supervision of conditional release cases should also be required.

Release to a Community Corrections Center (CCC), on prerelease status, is standard procedure for many offenders. Although this would seem especially important in the reentry process for mentally ill offenders, access to these centers is often difficult. A training curriculum might include strategies for assisting CCCs in developing community resources to maximize acceptance and continuum of care for mentally ill releasees. Last, specialists should be trained in methods to coordinate with local correctional facilities if an offender is in custody pending a Federal violation hearing.

The Courts

Mental health specialists must be able to articulate all the facets of a mental health case under supervision to the Court. This includes an understanding of a diagnosis, outpatient and inpatient treatment modalities, a current knowledge of medications and their side effects, strategies of placement and supervision, and an understanding of common behaviors of offenders with mental illness.

Mental health specialists should be aware of the appropriate Court strategies for revocation of a mental health case. In addition to knowing their own role and serving as consultants, mental health specialists should be familiar with the roles of defense counsel, prosecutor, judge, and mental health experts in the revocation process.

Specialists need to be able to prepare reports with practical recommendations to the Court that accomplish the goals of therapeutic jurisprudence. Yet, while trying to achieve such goals via recommendations, mental health specialists must be ever vigilant to deal with and attempt to comprehend issues of dangerousness and unpredictability when interacting with persons with

mental illness.

Probation

During training, areas of discussion may include traditionally sensitive areas of presentence and case assignment. Essential information pertaining to a person with mental illness to be entered into a presentence report should be included in any specialized training course.

If mental health specialists are consultants, they need to be taught how to best operate in that capacity. This should include how to develop cachet within our offices as experts. Furthermore, supervision of a specialized caseload by probation officers has been found to be a significant cause of workplace stress (see Slate, Johnson, and Wells 2000). Thus, inclusion of avenues to alleviate stress, including organizational means such as opening up avenues for line officers to participate in decisions that affect them in the workplace, should be considered in the training of mental health specialists.

Guidance on the logistical realities of how quickly various types of supervision strategies can be implemented should also be discussed. The supervision strategies of mental health specialists and how they differ from those of general officers should be addressed, including the maximum caseload of offenders with mental illness and specialized supervision needs that can be assigned to a specialist. Techniques for USPO safety and limiting risk should be instilled in officers. Instruction on suicidal signs and prevention should be given, as well as suggestions on what high-tech tools (phones, pagers, internet, personal digital assistants [pdas]) might be employed to effectively manage persons with mental illness under supervision.

Specific guidance on the mechanics of developing mental health contracts and connecting with local resources should be communicated to mental health specialists. Methods for ensuring accountability from treatment providers, such as through the development and use of memoranda of understanding (MOUs), need to be specified.

As mentioned previously, defendants supervised on Conditional Release require close coordination with the BOP and Courts. Matters of dangerousness, termination issues and knowledge of pertinent federal codes, as well as how to coordinate treatment with local resources, should be examined.

Law Enforcement

When mental health specialists are fortunate enough to be employed within a jurisdiction that has law enforcement personnel trained in CIT, then the police may prove to be valuable allies in the face of crises. Collaborative partnerships with CIT-trained police may also lead to meaningful training opportunities for mental health specialists, as seen in Montgomery County (Maryland), Memphis, and elsewhere.

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System II—The Community Mental Health System

Instruction on strategies for developing long-term relationships with the locals in the mental health community should be offered. Mental health specialists should be taught the mechanics of accessing the community mental health system and clinics, both public and private, and establishing successful collaborations therein. The availability of psychiatric housing programs (including independent, supportive, and supervised settings), day treatment, psychiatric rehabilitation programs, medication treatments, partial hospital and inpatient programs, dual diagnosis (mental health plus substance abuse) treatment, transportation, and the availability of local, state and federal funding for entitlements should also be addressed. The process of brokering by centralized parties within cities or states should be explored as well.

It is important for mental health specialists to develop an understanding of the community mental health system to explain to officers, managers, and the Court. Also, probation officers,

especially those who may also have degrees in a clinical area, should be versed in local laws and statutes relating to third-party risk and confidentiality of protected health information. Explaining how to define the criminal activities of offenders to community liaisons should also be considered. This may include the expansion of communication to daily or weekly contact to verify compliance or treatment planning of offenders.

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System III—The Offender/Patient

It is important for mental health specialists to understand the clinical aspects of an offender, including AXIS I (major mental illnesses), AXIS II (personality disorders) and AXIS III (medical problems) disorders, and how such disorders can have an impact on issues of compliance, criminal behavior, dangerousness and even time management. With the level of sophistication required, policy should be designed that defines which types of cases are suitable for staffing with non-specialists in the office. The proper philosophy and attitude to be exhibited by mental health specialists and strategies for developing rapport with persons with mental illness should be explored. Methods for establishing expertise with offenders while motivating them for change, stabilization, and compliance should be considered.

An offender's history in the community as well as relationships (including familial relationships) may positively or negatively affect supervision strategies. As such, consumers of mental health services and family members of persons with mental illness should be included as speakers and facilitators in the training process.

Applying Abraham Maslow's (1943) hierarchy of needs to persons under the supervision of mental health specialists, it is important to remember that individuals are at various stages of adaptation to their surrounding circumstances. For example, it doesn't make sense to begin working on self-esteem needs with a defendant/offender who is homeless and struggling to meet basic survival needs. Likewise, Massaro (2004) cautions that there are often gender differences in those being supervised, with women often primarily focused on parenting issues that must be met first, while men often strive for independence and self-sufficiency. These various levels of adaptation should be considered as supervision/treatment plans are developed.

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The Mission and Goals of Mental Health Specialists

The mission of USPOs as mental health specialists should be to identify, assess, and/or provide treatment for those with mental health and/or co-occurring disorders appearing before the court. The aim should be to foster intervention strategies to stabilize individuals, maximizing public safety and the potential for individuals to function and live law-abiding lives successfully within society. In accomplishing this mission, mental health specialists should serve as a resource for the court and within their district.

Mental health specialists should be equipped with the necessary skills to promote and realize their mission. Thus, the goal of developing a centralized mental health specialist training program should be to ensure that such specialists acquire the requisite knowledge, skills, and abilities to successfully supervise persons with mental health and/or co-occurring disorders within the community.

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Knowledge

Mental health specialists should have an extensive knowledge of specialized areas of mental health (including conditional releases, sex offenders, those with co-occurring disorders, and persons with severe, persistent mental illness) and substance abuse and their fit with correctional supervision. Federal probation and pretrial services mental health specialists should obtain a keen

knowledge of existing community resources relevant to these specialized areas. Mental health specialists should also have an extensive knowledge of mental illness, understanding signs and symptoms, diagnostic protocols, available treatments, and types of psychotropic medications. Familiarity with national, state, and local policies and regulations as well as educational materials pertaining to mental illness should be maintained.

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Abilities

Mental health specialists will need to communicate effectively orally and in writing both within the organization and with external agencies. Specialists will also be expected to assess statutory mandates and other requirements and should be consulted within their respective districts concerning the investigation, processing, and treatment of persons under their supervision. Specialists should be aware of and become engaged in the contractual process for procuring mental health treatment and be prepared to assist community providers in seeking, negotiating, obtaining, monitoring, and complying with such contracts. Specialists should also be capable of assisting with mental health policy making and the coordination of supportive services from organizations in the local community. A resource manual should be constructed to provide information on identifying persons with mental illness, referral procedures, local resources, current policies and potential penalties/alternatives for those who fail to comply with conditions.

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Caseloads and Supervision Requirements

We believe that a mental health specialist should have a total caseload of no more than 35 persons with severe, persistent mental health or co-occurring disorders. Furthermore, if the geographic location of these cases is widely dispersed, as in rural areas, we believe the number of such persons supervised should be even smaller. Likewise, those involved in obtaining and monitoring contractual services should have even further reduced caseloads.

Field supervision should be employed by mental health specialists, and it should be individualized and incorporate non-traditional means—including contacts with family members and service providers where warranted. Mental health specialists should not be burdened with duties outside of their area of expertise.

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Recommended Training Curriculum

We recommend that at least half to three-fourths of the annual required 40-hour training should focus on mental-health-related issues. Supplemental resources available for such training include familiarization with existing policies and procedures in Monographs 109 to 112 and the *Handbook on Working with the Mentally Disordered Defendant and Offender* (Federal Judicial Center publication); pertinent websites, such as that offered by the Office of Probation and Pretrial Services on Mental Health and Substance Abuse; the Federal Judicial Center's relevant videos on mental health and substance abuse concerns; The National GAINS Center for People with Co-Occurring Disorders in the Justice System (www.gainsctr.com); The Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion (www.tapacenter.org); the Criminal Justice/Mental Health Consensus Project (www.consensusproject.org); Center for Sex Offender Management (www.csom.org); Bazelon Center for Mental Health Law (www.bazelon.org); Dual Diagnosis Recovery Network (www.dualdiagnosis.org); National Mental Health Association (www.nmha.org); and the National Alliance for the Mentally Ill (www.nami.org).

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Essential Training Curriculum Components for Mental Health Specialists

While the specifics of training may vary from district to district, we believe that the following elements comprise the overall general components of training for mental health specialists and may serve as a template for further refinement within districts. We do not believe that all mental health specialists should possess the level of sophistication and expertise of clinicians such as psychiatrists and psychologists; however, they should possess the requisite knowledge to recognize when problems exist and the resourcefulness to link persons with mental illness under supervision to appropriate treatment and follow-up.

Components of the training should include a discussion of how in many respects the criminal justice system has become the de facto mental health system. The signs and symptoms of mental illness and co-occurring disorders should also be included in the training, as well as reasons individuals might not comply with treatment regimens, i.e. cognitive limitations, organizational problems, adverse side effects, lack of insight into one's illness (agnosia), lack of access to treatment/medications, and prohibitive insurance requirements. A segment on mental health medications and their effects on recipients should be included.

Training participants should be familiarized with de-escalation techniques for crisis situations, and links need to be established with specially trained law enforcement officers, where available, to assist with such crises. Site visits to area receiving facilities, clinics, crisis stabilization units, drop-in centers, and detoxification units for specialists undergoing training should be arranged. Specialists should understand the local civil commitment process related to mental health and substance abuse disorders in their district.

Contacts with any established alternatives to incarceration programs, specialty courts (drug or mental health), or community task forces aimed at diverting persons with mental illness or co-occurring disorders from confinement or assisting them with reentry into the community should be facilitated. Consumers of mental health/substance abuse services and family members of consumers should be brought in to discuss their unique perspectives with trainees. Information on other special populations, such as the homeless, persons with mental retardation, those at risk of suicide, those who are developmentally disabled, and those with disorders related to aging should also be provided.

A module on the mechanics of successfully writing and monitoring contracts and establishing solid memoranda of understanding between parties should be included. Detailed information on the services offered by each of the seven BOP Medical Referral Centers and contacts with each of the Centers to facilitate the flow of information and enhance supervision/treatment for mental health specialists should be provided.

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Conclusion

A significant barrier to care of offenders has been said to be the mutual distrust that exists between mental health providers and community corrections officials (Roskes and Feldman, 1999). Understanding each other's role and attitude in the delivery of services to an offender is certainly an important aspect of collaborative dynamics. Specifically, community mental health professionals are concerned that some probation/parole officers may monitor offenders with the primary goal of violating supervision or remanding them to confinement. Conversely, criminal justice officials tend to view mental health counselors as "soft" or non-cooperative in providing information that is required to enforce treatment conditions of community supervision.

Small, specialized caseloads offer community corrections officers greater opportunities to establish effective relationships with providers of mental health care (Council of State Governments et al., 2002). Some point out that a potential drawback of this method of supervision, however, may lie in what happens when more attention is focused on an offender. Problematic behavior is the more readily picked up and reported with negative consequences for a person under supervision (Solomon, Draine, and Marcus, 2002). We believe that with appropriate attention to the clinical needs of the offender (i.e., a "treatment-first" philosophy),

this risk can be minimized (Roskes et al., 1999).

Perhaps the simplest method of ensuring cohesion and collaboration between criminal justice and mental health systems is to establish a financial relationship from which the two can mutually benefit. An example of this is the federal legislation enacted in the Contract Services for Drug Dependent Offender Act of 1978, which authorized the Administrative Office of the U.S. Courts to contract for drug treatment services in 1978; it was later expanded to include mental health services (Henkel, 1997). This authority was eventually decentralized so that Federal District Courts, through their Chief Judges, could delegate contracting duties to their respective probation and pretrial offices. The purpose of this was to permit "more flexibility in managing substance abuse and mental health allocation" (Henkel, 1997:105). More uniquely, the major responsibility for initiating and monitoring contracts for mental health services to federal supervisees lies with the Mental Health Specialist, who also supervises mentally ill offenders (Freitas, 1997). In this manner, the momentum toward collaboration with a completely different system is encouraged through a natural self interest on the part of the payee and vendor.

Supervising a special caseload of mentally ill offenders offers many benefits. First, the practitioner quickly develops skills in "surfing" the two systems in which offenders must be involved. Many offenders with mental health problems have difficulty complying with conditions of supervision, including standard conditions. It follows, therefore, that a probation officer will need to be an expert in assisting the authority of jurisdiction in deciding how to best deal with corresponding legal sanctions and perhaps modulate them in accordance with the specific needs of the offender. Experience being the best teacher, having a specialized caseload provides a community corrections agent with many opportunities to learn the most efficient methods of doing this. Dealing with a variety of offenders with different diagnoses and in varied treatment settings or modalities also helps probation officers to become aware of community mental health resources and to develop an awareness of various providers' efficacy in treating forensic patients. Over time, mental health specialists should be able to assess the benefits available to offenders referred for treatment.

The optimum number of offenders efficiently supervised within a caseload is difficult to determine. It is said that the average number of probation cases should be no more than 50 persons, with a specialized caseload being half that. Without a time study it is hard to find data as to what a "good" number of offenders within a specialized caseload should be. It seems clear to practitioners, however, that probation officers need to devote a proper amount of time to crisis intervention, community field visitation, and follow-up with community resources and family members, in order to make a contribution to monitoring and developing stability for an offender. As anyone in the field of supervising this type of offender would agree, working with patient-offenders is both time consuming and time sensitive, requiring intensive involvement in problems while attending to them quickly.

The ability to collaborate with community resources is essential in referring offenders to treatment and in monitoring offenders' compliance with mandated treatment conditions of supervision. Since community mental health resources are usually the provider of treatment, their cooperation is essential. However, if memoranda of understanding (MOUs) are not prearranged, then it falls to the individual probation officer to establish informal professional relationships with care providers. The difficulties at this micro level are evident. First, there is often no requirement for clinics to accept court-mandated patients who they may view as dangerous, antisocial, or consistently noncompliant with the treatment regimen. Also, treatment staff may be concerned that their actions and communications with a patient will be under close scrutiny or that they will be subpoenaed to testify in Court. These and other concerns undercut the ability and motivation of treatment programs and their staff to participate in the synergy that develops in multiple systems attempting to effect positive change in offenders with mental illness.

Probation officers will often be able to minimize issues of professional opposition if they are actually a part of the mental health profession. It is easier to find an "open door" if the community corrections agent is a member of the "guild" as a social worker or licensed as a counselor in a related field. Training for federal probation officers resulting in certification of

officers as mental health specialists may serve to enhance credibility and foster rapport. This does present some interesting difficulties as well as potential for successful collaboration. However, a probation officer who is also a licensed professional human service worker must be careful to understand his/her role as an authority figure. This may be difficult when they are trained to determine the causal factors of mental health decompensation, while required to implement legal sanctions for the behaviors related to mental illness. The problem of dual agency is inherent in these roles, and community corrections agents must be aware of this dual agency and of their primary mission as agents of public safety and of the Court. Navigating through the various systems to strike the crucial balance between treatment and public safety may not be easy, but it is our hope that the recommendations contained here will lead to the development of a certified training model for mental health specialists within the federal probation system. Meanwhile, perhaps an assessment of the various approaches to training from district to district with input from those currently performing as mental health specialists would prove enlightening.

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