CHANGES IN THE USE OF TELEHEALTH SERVICES AND USE OF TECHNOLOGY FOR COMMUNICATION IN U.S. COMMUNITY SUPERVISION AGENCIES SINCE COVID-19

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The U.S. community corrections system supervises and provides services for nearly 4.4 million individuals. This study explored agency responses during the COVID-19 pandemic using data from 347 surveys of community supervision directors. We examined whether agency and local geographical factors were associated with increased use of telehealth services for mental health, substance use disorders, and criminal behavior. We also assessed whether these factors were significant predictors of changes in agencies' supervision strategies. Findings indicated a positive association between prepandemic access to telecommunications technology and use of telehealth services, with observed differences regarding urbanicity and type of agency. Agencies with more COVID-19 mitigation strategies tended to avoid in-person contact. Given the vast needs and increased risks present within the community supervision population, it is important to understand the barriers and facilitators associated with innovation and change in the post-COVID-19 era to inform future reform efforts.

Keywords: community supervision; probation; parole; COVID-19; telehealth; mental health; substance use

The coronavirus disease 2019 (COVID-19) pandemic has impacted nearly every aspect of life across the globe. To date, over 233 million individuals have been infected with over 4.7 million deaths reported worldwide (World Health Organization [WHO], n.d.). As a result of COVID-19, many state and local jurisdictions across the United States implemented a range of mitigation policies to try to curb spread such as "stay at home" orders, mask mandates, and school closures. Businesses were also forced to develop strategies to prevent, contain, and respond to the spread of the virus, while also following local and state mandates (Schuchat, 2020). Likewise, the pandemic has impacted the criminal justice system in inevitable ways, including drawing immediate attention to the use of incarceration, a setting that already presents risks for infectious disease, and a need for prison/jail releases,

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court closures, and changes to the operations of community supervision (Vera Institute of Justice, 2020).

Most individuals sentenced in the United States are placed on some form of community supervision, with nearly 4.4 million individuals supervised on probation or parole (Kaeble, 2020). Individuals on community supervision represent vulnerable populations already at a greater risk for infectious disease due to prevalence of preexisting medical risk factors (e.g., sexually transmitted diseases, hepatitis, asthma; Clark et al., 2013; Vaughn et al., 2012), disproportionate levels of social and economic disadvantage (Vaughn et al., 2012), and behavioral risk factors (e.g., substance use; Fearn et al., 2016). In addition, individuals on probation or parole often do not have adequate access to health care (Marlow et al., 2010) or consistent access to needed medications (Baillargeon, 2009) and may experience deterioration in health (Binswanger et al., 2012). While community corrections agencies did not have the immediate concern regarding close living quarters that prisons and jails had to grapple with, they still were faced with challenging decisions involving a vulnerable population.

To prevent COVID-19 spread, early guidance (EXiT, 2021; Vera Institute of Justice, 2020) called for immediate limitations on in-person contacts, suspension/limitation on use of technical violations, reduce new intakes, reduce length of probation/parole supervision terms, provision of training for staff, and development of guidance for clients. The Vera Institute of Justice (2020) also produced guidelines for containment and response strategies, including use of a Centers for Disease Control and Prevention (CDC)-informed screening tool to identify risk of infection, sharing educational information, creating medical care plans, and implementing policies to protect staff if they become ill or to ensure operations of the office if multiple staff were out sick. Prior to the pandemic, 67% of community corrections agencies had crisis protocols in place (Swan et al., 2020); however, little is known regarding the content of these protocols, the type of crisis they addressed, or the applicability for the COVID-19 pandemic.

A recent study examining strategies implemented in response to COVID-19 found increased use of technology in community supervision departments across the United States to support two key functions: (a) continuance of required meetings between supervision officers and clients, and (b) provision of mental health and substance use treatment (Viglione et al., 2020). First, this study reported that 16% of community supervision agencies were no longer seeing clients face-to-face, while 59% continued office visits and 46% continued field visits and a large shift to remote supervision via technology, primarily through videoconferencing and telephone. In doing so, officers were able to complete meetings previously required to be face-to-face through electronic means, referred to as remote supervision. A recent study of community supervision in several regions in the United Kingdom, Dominey and colleagues (2020) found similar shifts to remote supervision, including increased use of telephone calls, text messaging, and e-mailing. Interestingly, they found videoconferencing was not commonly used to meet with clients, but rather other professionals, with most supervision contacts made through telephone instead (Dominey et al., 2020).

Use of telecommunications technology to meet with individuals on supervision is a major new development in the field (Schwartzapfel, 2020; Viglione et al., 2020). Technological tools used in the community supervision field have often focused on those designed to support surveillance of individuals under supervision, such as electronic

monitoring/global positioning systems (GPS), devices to monitor compliance with home confinement, and remote alcohol detection systems (DeMichele, 2020). In fact, agencies across the United States and Western Europe have used these types of tools to monitor community supervision populations since the early 1980s (Conway, 2007). Historically, focus has been on the use of technology to conduct real-time tracking of individuals under supervision for monitoring purposes (Ballard & Mullendore, 2002) and identify noncompliance (Burrell & Gable, 2008) rather than providing treatment and applying best practices designed to reduce criminogenic risk factors. The use of technology to replace traditional in-person contacts for individuals of all risk levels is a rather new development, used infrequently prior to the COVID-19 pandemic. Previously, adult community corrections agencies have implemented kiosk (Barnes et al., 2012) or telephone reporting (Viglione & Taxman, 2018) to allow low-risk individuals an option for remote reporting, reducing their need to travel to the probation office and disrupt prosocial networks (e.g., employment, education, family responsibilities). Research on these efforts is limited; however, research on kiosk reporting found that the use of remote supervision for low-risk individuals does not result in increases in reoffender, rearrest, and reincarceration (Barnes et al., 2012) with evidence of recidivism reductions (Belshaw, 2011; Ogden & Horrocks, 2000; Wilson et al., 2007). Despite promising results, research also identified resistance to the use of remote supervision, with probation officers avoiding the use of telephone supervision with low-risk individuals and noting concerns of increased risk and liability with decreased face-to-face contact (Viglione & Taxman, 2018). Thus, the rapid and wide use of technology to carry out place of face-to-face contact across all risk levels is a significant new development for the field of community supervision.

Since the COVID-19 pandemic began, the federal government implemented major changes to encourage health care providers to use telehealth to see patients via virtual appointments (Health Resources & Service Administration [HRSA], 2021). Telehealth is defined as "the delivery and facilitation of health and health-related services including medical care, provider and patient education, health information services, and self-care via telecommunications and digital communication technologies" (New England Journal of Medicine Catalyst [NEJM], 2018; np). Like use of technology for remote supervision, technologies to provide telehealth often also include telephones, videoconferencing, e-mail, text, wearable devices, and mobile devices. A number of major changes have rapidly reduced barriers to telehealth use for substance abuse disorder (SUD), including the Drug Enforcement Administration's guidelines on telemedicine use that allows authorized clinicians to start buprenorphine treatment of opioid use disorder (Lin et al., 2020). The cumulative outcome of these undertakings on justice-involved individuals who carry a disproportionally higher burden of mental health needs, SUD, and COVID-19 is largely unknown (Nguyen et al., 2021).

Viglione and colleagues (2020) identified large increases in the use of telehealth for mental health and substance use treatment provisions in community corrections, which were not commonly used prepandemic (Viglione et al., 2020). The findings of Viglione and colleagues (2020) were supported by recent research that found nearly 63% of mental health professionals reported great increases in their use of videoconferencing to provide telehealth in criminal justice settings because of the pandemic (Kirschstein et al., 2021). While prior to the pandemic, approximately 20% of telehealth services involved justice-involved individuals (Lowes, 2001), these were primarily focused on individuals in prison or jail

(Ax et al., 2007). There is very little research on the use of telehealth within justice agencies, including a lack of information regarding recent trends in prevalence and the availability of necessary technology to support telehealth interventions in the community (Schwartzapfel, 2020).

Existing research on the impact of the pandemic in community corrections has largely been descriptive. Little is known regarding factors that influenced agency adaptations and responses to COVID-19. It is critical to understand the agency and local geographic factors that associate with changes in supervision strategies and patients' access to essential telehealth services given variations in the application of nonpharmaceutical interventions across agencies due to short-lived mandated stay-at-home orders (Abouk & Heydari, 2021; Viglione et al., 2020). The current study seeks to address these gaps by answering the following research questions: (a) What agency and local geographical factors are associated with the increased access to telehealth services for mental health, substance use, and cognitive behavioral treatment by clients in the U.S. community corrections system, both overall and by urbanicity and type of community corrections agency? And (b) what agency and local geographical factors are associated with changes in supervision practices, both overall and by urbanicity and agency types? The first key predictor of interest is the infrastructure which is necessary to support the adoption of telehealth access to clients in the community corrections system. We hypothesized that the number of available telecommunication technologies (videoconference, email, telephone, and text) used prior to the pandemic is positively associated with the increased access of telehealth services in community corrections agencies since COVID-19. The second key predictor of interest is the adoption of COVID-19 mitigation strategies. We hypothesized that agencies with more COVID-19 mitigation strategies in place would be more likely to alter the traditional face-to-face structure of community supervision practice.

Given the decentralized nature of the pandemic responses across the United States, it is also unclear how these changes varied across different settings or facilitators that may lead agencies to implement more adequate approaches, including urbanicity, types of agencies, and geographic factors. The goal of the current study is to explore this gap in knowledge through an examination of the agency and county-level factors that predict changes in the provision of treatment and use of key supervision strategies as a result of COVID-19.

METHOD

SOURCES OF DATA AND STUDY SAMPLE

The current study examined data collected during June through August 2020 from surveys of community supervision agency directors across the United States. These data reflect wave one of a larger, ongoing longitudinal examination of the impact of COVID-19 on community corrections agencies and officers. The goal of surveys was to understand how agencies have been impacted and how they altered policies during the pandemic. A database of community corrections agencies across the United States was compiled and contact information for directors was obtained through public searches and contacting agencies (for more information, see Viglione et al., 2020). Due to variances in the structure of community supervision systems across the country, in some states these reflected regional ($n = 8$) or state-level ($n = 3$) contacts while the majority were office-level. In these instances, the regional or state authorities selected one individual to respond on their behalf. Twelve states

required approval from a centralized review board, with three declining participation and seven outstanding requests at the time of survey closure.

Using Qualtrics, electronic surveys[1] were distributed to all identified directors. Survey administration protocols followed an adapted Dillman (2014) method, with invitations sent in Week 1 containing detailed information regarding the purpose of the study, including confidentiality and documentation of institutional review board approval. Following this initial contact, respondents received reminder emails weekly, including a reminder telephone call during Week 5. The survey was also advertised via the Center for Advancing Correctional Excellence! (ACE!) email list serve.

A total of 1,100 community supervision directors of local and state probation and parole agencies were invited directly to participate in the study. A total of 337 unique responses were received (31%), with response rates ranging from 0% ($n = 6$) to 100% ($n = 3$) across states. An additional 10 survey completions were received from the ACE! advertisement, resulting in a total sample of 347 directors representing 42 states (see Table 1). Most participating agencies reported serving adult populations (91%) and rural areas (57%). Participating agencies supervised multiple types of community supervision sentences, with 50% representing county-level agencies who supervised individuals on probation and/or parole; 26% representing state-level agencies who supervised individuals on probation and/or parole; 23% representing agencies who supervised individuals sentenced to county- or state-level probation and/or parole; and 9% supervising individuals on federal supervision. Participating agencies supervised individuals convicted of both felony and misdemeanor (71%) offenses. On average, agencies reported caseloads of 88 clients per officer, with the most common total population size ranging from 20 to 499 (35%). At the time of this survey, only three offices reported they were entirely shut down and not actively supervising clients at all.

OUTCOME VARIABLES

To examine the first hypothesis, the outcome variable was the binary indicators of whether a community supervision agency reported their clients used telehealth more frequently compared with the prepandemic use for each of the following services: mental health, substance use disorders (SUD), and criminal behavior. Directors were asked to respond to the following question: "Are officers in your agency using any of the following technologies to continue supervising individuals during the COVID-19 pandemic?" While response options included a range of items (e.g., telephone calls, videoconferencing, texting), this outcome variable reports only on responses to items inquiring about telehealth services to address mental health, substance use, or criminal behavior. This variable was measured as a dichotomous variable, with 1 assigned if the respondent chose "More frequently than before COVID-19" versus "Not currently using, but we plan to," "Not currently using and never have," "Less frequently than before COVID-19," and "The same frequency as before COVID-19" (see Table 2).

To examine the second hypothesis, the outcome variables were the binary indicators of having following changes in general supervision activities, including (a) changes in conducting face-to-face meetings in the office, (b) changes in conducting face-to-face meetings in the field, (c) fewer new community supervision clients referred due to COVID-19, (d) changes in collection of supervision fees (either suspend collection of fees or no penalties

TABLE 1: Sample Characteristics—Predictors and Covariates ($N = 347$)

Variables		*n* (%)	*M*	*SD*
Panel 1: Key predictors				
Number of current technologies				
	0	32 (9.2%)	—	—
	1	39 (11.2%)	—	—
	2	93 (26.8%)	—	—
	3	167 (48.1%)	—	—
	4	16 (4.6%)	—	—
	No response	14 (4.0%)	—	—
Number of COVID-19 mitigation policies				
	0	16 (4.6%)	—	—
	1	12 (3.5%)	—	—
	2	14 (4.0%)	—	—
	3	20 (5.8%)	—	—
	4	28 (8.1%)	—	—
	5	38 (11.0%)	—	—
	6	53 (15.3%)	—	—
	7	54 (15.6%)	—	—
	8	53 (15.3%)	—	—
	9	33 (9.5%)	—	—
	10	19 (5.5%)	—	—
	11	7 (2.0%)	—	—
Panel 2: Agency-level characteristics				
Geographic regions served	Urban/suburban/mix	150 (43.2%)	—	—
	Rural	197 (56.8%)	—	—
U.S. region	Northeast	50 (14.4%)	—	—
	Midwest	116 (33.4%)	—	—
	West	79 (22.8%)	—	—
	South	102 (29.4%)	—	—
Type of supervision	State/federal probation/ parole	172 (49.6%)	—	—
	County probation/parole	175 (50.4%)	—	—
Caseload	—	—	88.48	51.20
Officers with caseloads	—	—	50.76	231.17
Confirmed client cases of COVID-19	Yes	105 (30.3%)	—	—
	No	93 (26.8%)	—	—
	Not sure	149 (42.9%)	—	—
Confirmed staff cases of COVID-19	Yes	42 (12.1%)	—	—
	No	215 (62.0%)	—	—
	Not sure	90 (25.9%)	—	—
Panel 3: County-level characteristics				
County-level COVID-19 case rate	—	—	0.23	0.41
SAH weeks	—	—	4.80	1.69
Court closure weeks	—	—	9.76	3.80
Jail population rate per 100,000	—	—	364.39	1,034.97
Median household income	—	—	56,526.67	13,975.99
Population	—	—	2.2e+05	(3.8e+05)

Note. Technologies include those used to continue supervising individuals during the pandemic: telephone, texting, e-mail, and videoconference. SAH = stay-at-home order in place.

TABLE 2: Outcome Measures (*N* = 347)

Outcome measures (questions)	Level (responses)	*N* (%)
Are officers in your agency using telehealth services to address mental health issues?	Not currently using, but we plan to	66 (19.0%)
	Not currently using and never have	91 (26.2%)
	Less frequently than before COVID-19	1 (0.3%)
	The same frequency as before COVID-19	32 (9.2%)
	More frequently than before COVID-19	143 (41.2%)
	No response	14 (4.0%)
Are officers in your agency using telehealth services to address substance use issues?	Not currently using, but we plan to	62 (17.9%)
	Not currently using and never have	85 (24.5%)
	The same frequency as before COVID-19	27 (7.8%)
	More frequently than before COVID-19	159 (45.8%)
	No response	14 (4.0%)
Are officers in your agency using telehealth services to address criminal behavior issues?	Not currently using, but we plan to	81 (23.3%)
	Not currently using and never have	110 (31.7%)
	Less frequently than before COVID-19	1 (0.3%)
	The same frequency as before COVID-19	31 (8.9%)
	More frequently than before COVID-19	110 (31.7%)
	No response	14 (4.0%)
Having changes in conducting F2F meetings	No	93 (26.8%)
	Yes	189 (54.5%)
	No response	65 (18.7%)
Having changes in conducting F2F meetings in field	No	58 (16.7%)
	Yes	155 (44.7%)
	No response	134 (38.6%)
Having fewer new community supervision clients due to COVID-19	No	94 (27.1%)
	Yes	235 (67.7%)
	No response	18 (5.2%)
Having changes in collection of supervision fees	No	249 (71.8%)
	Yes	61 (17.6%)
	No response	37 (10.7%)
Having early terminated individuals due to COVID-19	No	263 (75.8%)
	Yes	67 (19.3%)
	No response	17 (4.9%)

for late payments), and (e) early termination of supervision terms due to COVID-19 (0 = no; 1 = yes) (see Table 2). The changes in conducting face-to-face meetings in the office or in the field include meeting in a location other than usual office space or outside of an individual home rather than inside.

PREDICTOR VARIABLES

In the first analyses, the key predictor of using telehealth to address relevant health issues was the number of available telecommunications technologies (e.g., telephone, texting, e-mail, videoconferencing) used prior to the pandemic to account for whether agencies had tools in place to support remote services prior to the pandemic (Panel 1, Table 1). Directors were asked to respond to the following question: "Are officers in your agency using any of the following technologies to continue supervising individuals during the pandemic?" We considered four supervision technologies: telephone, texting, email, and videoconference. A telecommunications technology was available prior to the pandemic if the respondent

selected "not new" versus "new," or "not using" to the following question: "Of these technologies, which are new strategies used to supervise individuals now that were not used prior to COVID-19?," calculated as a continuous variable with a higher number reflecting a greater number of technologies used prior to the pandemic. In response to this question, the majority of directors reported telephones (82%), texting (65%), and e-mail (84%) as tools previously used. However, only 7% of directors reported using videoconferencing prior to the pandemic.

In the second analyses, the key predictor of having changes in face-to-face meetings was the number of COVID-19 mitigation policies which were implemented to prevent and contain COVID-19 transmission (Panel 1, Table 1). In particular, each respondent was asked to check all 11 applicable fields of COVID-19 mitigation strategies in the questionnaire: (1) "Use of a screening tool (e.g., CDC) to identify people with possible exposure to COVID-19"; (2) "Use of a screening tool (e.g., CDC) to identify people at a higher risk of COVID-19 infection"; (3) "We share information and guidance about COVID-19 prevention with individuals on supervision"; (4) "We share information and guidance about COVID-19 prevention with staff"; (5) "Creation of medical care plans for individuals on supervision in case they develop COVID-19" (such as guidance on medical insurance, accessing emergence care/hospitals, transportation plan); (6) "Training for staff in special procedures for responding to COVID-19"; (7) "We require supervision officers to wear a face mask"; (8) "We provide masks for officers who work in this agency"; (9) "We require individuals on supervision to wear a face mask"; (10) "We provide masks for individuals on supervision"; and (11) "We have implemented other strategies, please specify." The count of these checked options was calculated to measure the total number of COVID-19 mitigation policies implemented to prevent and contain COVID-19 transmission (Kaiser Family Foundation, n.d.; Health Resources & Service Administration, n.d.).

COVARIATES

It is important to account for confounding factors such as agency-level and county-level available resources. As a result, we controlled for a number of agency-level characteristics which might predict decisions of using telehealth services, including the number of probation/parole officers with active caseloads, average caseload size, type of supervision (0 = state/federal probation/parole; 1 = county probation/parole), geographic region (0 = urban/suburban/mix; 1 = rural), and U.S. region (Northeast, Midwest, West, South). To account for jail populations and available resources in local areas, we also controlled for several key county-level demographic factors including jail population rates, median household income, and population sizes. County jail population rates were obtained from the Vera Institute of Justice Incarceration Trends database (Vera Institute of Justice, 2018). In a sensitivity analysis, we added other six regressors, including having confirmed COVID-19 cases among clients and staff derived from the survey data, population density, number of active MDs per population, unemployment rates, and whether a county is in states expanded their Medicaid programs prior to the survey period. The county-level sociodemographic variables were derived from the 2020 Area Health Resources Files and County Health Rankings database. Medicaid expansion status information comes from the Kaiser Family Foundation.

In the second set of analyses, we controlled for the agency-level and county-level COVID-19 exposure measures which substantially changed traveling and mobility decisions (Gupta et al., 2020). These factors include confirmed count of cases among individuals under

supervision and among officers/staff (both derived from the survey), number of cases per county populations (USA Facts, 2020), weeks of stay-at-home orders prior June 2020 (Fullman et al., 2021), and weeks of court closure. To measure weeks of court closure, the research team created a database using data pulled from the National Center for State Courts (NCSC, 2020) as well as each individual county courthouse administrative orders. Similar to the first analysis, we also conducted a sensitivity analysis.

ANALYSES

Logistic regressions were used to identify which factors were associated with the likelihood of using telehealth and having changes in supervision activities in a community supervision agency during the COVID-19 pandemic. A second set of logistic regressions were conducted to examine how the use of telehealth and changes in supervision practice vary by urbanicity and type of community corrections agency. As the data come from a survey of agencies representing 42 states, the standard errors were clustered within states to account for clustering of the agencies within states. All logistic regression coefficients were converted to Average Marginal Effects, which allows for a straightforward interpretation of results (Hauser & Peck, 2017). All statistical analyses were conducted using Stata MP (version 16.1).

STUDY RESULTS

The logistic regression results in Table 3 imply a positive association between the number of available communication technologies (videoconference, email, telephone, and text) used prior to the pandemic and the increased use of telehealth services in community corrections agencies during the pandemic. One additional available communication technology is associated with an increase in the likelihood of using telehealth more frequently for SUD (6.5%, $p = .02$). The estimates are positive but less precise for the increased use of telehealth for mental health (5.2%, $p = .07$) and for criminal behavior (4.5%, $p = .16$). As a falsification test, we did not observe the positive association between the number of available communication technologies and regular services including SUD and drug test referrals at the 5% significant level. We also found that community corrections agencies in Western and Midwestern states tended to use telehealth more frequently during the pandemic compared with the agencies in Southern states (Western states: 20%–22% for mental health, SUD, and criminal behavior with $p = .005$ to $p = .02$; Midwestern states: 17% for criminal behavior with $p = .002$). There were not significant differences in the use of telehealth among agencies in Northeastern states compared with agencies in Southern states. In addition, the caseload size is negatively associated with the increased use of telehealth for mental health services. Supplemental Table S1 (available in the online version of this article) presents a sensitivity analysis with six additional regressors to account for access to health care (active MDs per capita, Medicaid expansion), socioeconomic factors (unemployment rate and population density), and agency's confirmed cases (column 2). The results are fairly similar to those of the baseline models (column 1). The additional regressors are not significantly associated with increased use of telehealth for mental health and SUD services.

When restricting the analysis sample to the agencies in rural versus urban counties (Panel 1 of Table 4), we found that positive associations between the available technologies and

TABLE 3: Logistic Regression of Using Telehealth for Health-Related Issues

	(1)	(2)	(3)	(4)	(5)
Predictor	Telehealth for mental health	Telehealth for SUD	Telehealth for criminal behavior	SUD referrals	Drug test referrals
Number of current technologies	.052 [–.0050 to .11]	.065* [.010 to .12]	.045 [–.018 to 9.11]	.034 [–.0092 to .077]	.0074 [–.041 to .056]
Officers	.047 [–.022 to .12]	.046 [–.022 to .11]	.037 [–.011 to .084]	.0064 [–.013 to .026]	–.016 [–.058 to .027]
Caseload	–.070* [–.13 to –.0086]	–.019 [–.090 to .051]	.013 [–.077 to .10]	–.037 [–.085 to .0098]	–.022 [–.085 to .040]
County vs. state/ federal agency	.030 [–.081 to .14]	.030 [–.064 to .12]	–.095 [–.20 to .0087]	–.021 [–.069 to .026]	–.027 [–.12 to .070]
Rural vs. urban/ suburban/mix	.12 [–.0072 to .25]	.045 [–.083 to .17]	.066 [–.086 to .22]	.071 [–.015 to .16]	–.014 [–.090 to .062]
Northeast vs. Southern states	.093 [–.075 to .26]	.057 [–.12 to .23]	.084 [–.15 to .32]	.045 –.029 to .12]	–.0070 [–.14 to .12]
Midwest vs. Southern states	.13 [–.0080 to .26]	.12 [–.037 to .28]	.17** [.063 to .28]	.032 [–.035 to .10]	.0081 [–.073 to .089]
West vs. Southern states	.20** [.061 to .35]	.22** [.057 to .38]	.20* [.031 to .37]	.046 [–.043 to .13]	–.0068 [–.13 to .11]
Jail population rate	–.063* [–.12 to –.0057]	–.036 [–.12 to .051]	.0042 [–.058 to .067]	–.027 [–.059 to .0041]	–.013 [–.054 to .029]
Median household income	.077 [–.24 to .39]	.13 [–.21 to .48]	.031 [–.30 to .36]	–.012 [–.17 to .14]	–.0063 [–.23 to .22]
County populations	.018 [–.051 to .088]	.0052 [–.060 to .070]	.039 [–.015 to .093]	.0049 [–.025 to .035]	–.026 [–.063 to .011]
Dep. variable *M*	.43	.48	.33	.05	.12
Dep. variable *SD*	.50	.50	.47	.22	.32
Observations	331	331	331	321	290
Degrees of freedom	11	11	11	11	11
Model chi-square (*p* value)	.001	.002	.003	.105	.696
McFadden's Adj *R*-squared	.02	.01	.01	–.05	–.08

Note. Each column presents the average marginal effects and their 95% CIs of a separate logistics regression on each outcome measure. The following variables were logged: number of officers, average caseload, jail population rate (per 100,000), median household income, and county population. The standard errors were clustered within states. Observations with missing data excluded in the regression analysis.
*$p < .05$. **$p < .01$.

use of telehealth were stronger in rural areas (9.4%–12%, $p < .001$ to $p = .01$ in rural areas versus .7%–.9%, $p = .86$ to $p = .89$). In a similar subgroup analysis (Panel 2 of Table 4), the positive associations between the available technologies and use of telehealth were stronger among state/federal correction agencies versus county community correction agencies (8.1%–13%, $p < .001$ to $p = .05$ among state/federal agencies vs. 1.6%–2.8%, $p = .58$ to $p = .76$ among county agencies).

Table 5 presents the average marginal effects of various predictors on the likelihood of having altered policies and procedures in community corrections agencies during the pandemic. When community corrections agencies have one additional COVID-19 mitigation strategy, the likelihood of having changes in face-to-face meetings increases by 3.8%

TABLE 4: Logistic Regression of Using Telehealth by Urbanicity and Type of Community Correction Agency

	(1)	(2)	(3)	(4)
	Offices in rural counties		Offices in urban counties	
	Telehealth for mental health	Telehealth for SUD	Telehealth for mental health	Telehealth for SUD
Panel 1	Agencies in rural counties		Agencies in urban counties	
Number of current technologies	.094* [.021 to .17]	.12*** [.055 to .18]	.0086 [–.088 to .11]	.0068 [–.094 to .11]
Dep. variable *M*	.43	.46	.43	.50
Dep. variable *SD*	.50	.50	.50	.50
Obs.	190	190	141	141
Panel 2	County agencies		State/federal agencies	
Number of current technologies	.028 [–.073 to .13]	.016 [–.090 to .12]	.081 [–.0013 to .16]	.13*** [.062 to .19]
Dep. variable *M*	.44	.48	.42	.48
Dep. variable *SD*	.50	.50	.50	.50
Obs.	165	165	166	166

Note. Each column presents the average marginal effects and their 95% CIs of a separate logistics regression on each outcome measure. Other control variables were not reported in the Exhibit (see Table 3 for the full list of predictors). The standard errors were clustered within states.
*$p < .05$. **$p < .01$. ***$p < .001$.

($p = .002$). The number of strategies, however, is not significantly associated with likelihood of having changes in face-to-face meetings in the field, having fewer new community supervision clients, early terminated clients, or changes in collection of supervision fees.

Agencies with confirmed COVID cases among clients were more likely to meet in a location other than usual office space (14%, $p = .04$) and to have fewer new community supervision clients (27%, $p < .001$). Agencies with confirmed cases among staff also were more likely to have fewer new community supervision clients (28%, $p = .008$). Many state- or county-level measures of COVID-19 exposure and response are not significant predictors of the likelihood of having changes in meeting procedures, collection of supervision fees, or early termination of supervision with one exception. A longer stay-at-home order (SAH) (5.1%, $p = .001$) is positively associated with the likelihood of having fewer new community supervision clients due to COVID-19.

The average caseload (1% increase in the caseload size) is negatively associated with the likelihood of changes in face-to-face meetings in the field (11% decrease, $p = .03$, column 2 of Table 5). In contrast, a 1% increase in the number of officers with active caseloads is associated with a 11% increase in the likelihood of changes in face-to-face meetings in the field ($p = .002$). Supplemental Table S2 (available in the online version of this article) presents sensitivity analyses with additional regressors. These sensitivity analyses do not fundamentally alter the abovementioned findings.

In subgroup analyses (Table 6), we found stronger positive associations between the number of COVID-19 mitigation strategies and changes in face-to-face meetings among rural community corrections agencies compared with urban agencies (4.3%, $p = .004$ among rural agencies vs. 2.7%, $p = .24$, see Panel 1 of Table 6). There were smaller differences in these associations regarding county versus state/federal agencies (Panel 2 of Table 6).

TABLE 5: Logistic Regression of Changes in Conducting Face-to-Face Meetings and Other Supervising Policies

	(1)	(2)	(3)	(4)	(5)
	Changes in F2F meetings in office	Changes in F2F meetings in field	Fewer new clients	Changes in supervision fees	Early termination
Number of COVID-19 mitigation policies	.038** [.013 to .063]	.028 [−.014 to .070]	−.0051 [−.028 to .018]	.015 [−.010 to .041]	.0028 [−.021 to .027]
Confirmed client COVID cases	.14* [.0093 to .28]	−.034 [−.14 to .072]	.27*** [.17 to .37]	−.066 [−.14 to .0089]	−.0031 [−.098 to .091]
Confirmed staff COVID	.15 [−.035 to .34]	−.18 [−.39 to .036]	.28** [.074 to .49]	.091 [−.091 to .27]	−.0068 [−.14 to .13]
County COVID-19 case rate	.077 [−.062 to .22]	.029 [−.100 to .16]	−.043 [−.14 to .053]	−.053 [−.17 to .066]	.060 [−.049 to .17]
SAH weeks	−.032 [−.079 to .015]	−.016 [−.045 to .013]	.051** [.021 to .082]	−.0097 [−.043 to .024]	−.022 [−.055 to .012]
Court closure weeks	−.012 [−.026 to .0033]	.0070 [−.011 to .025]	.012 [−.0014 to .025]	.0020 [−.0070 to .011]	.0032 [−.011 to .017]
Number of current technologies	.049 [−.0019 to .100]	−.041 [−.12 to .039]	−.0034 [−.045 to .038]	−.015 [−.075 to .045]	.0061 [−.033 to .045]
Officers	−.049** [−.082 to −.016]	.11** [.038 to .17]	.0057 [−.037 to .049]	.020 [−.020 to .061]	−.062* [−.12 to −.0080]
Caseload	−.065 [−.20 to .072]	−.11* [−.21 to −.0093]	.00028 [−.081 to .082]	.0021 [−.075 to .079]	.021 [−.050 to .092]
County vs. state/federal agency	.10 [−.065 to .27]	.083 [−.030 to .20]	.033 [−.068 to .14]	.038 [−.073 to .15]	.025 [−.072 to .12]
Rural vs. urban/suburban/ mix	−.0028 [−.15 to .15]	.021 [−.14 to .18]	−.0080 [−.13 to .12]	−.096 [−.22 to .027]	.038 [−.083 to .16]
Northeast vs. Southern states	−.029 [−.19 to .13]	−.054 [−.19 to .078]	−.094 [−.30 to .12]	.11 [−.076 to .31]	.14 [−.0099 to .30]
Midwest vs. Southern states	.043 [−.088 to .17]	−.068 [−.20 to .060]	−.14* [−.27 to −.011]	−.065 [−.19 to .064]	.13 [−.072 to .33]
West vs. Southern states	.091 [−.11 to .29]	.0043 [−.17 to .18]	−.30*** [−.46 to −.13]	.013 [−.11 to .14]	.15 [−.011 to .32]
Jail population rate	−.11** [−.18 to −.045]	.018 [−.089 to .12]	−.035 [−.12 to .047]	.046 [−.016 to .11]	.046 [−.055 to .15]
Median household income	−.030 [−.30 to .24]	.026 [−.30 to .35]	.14 [−.19 to .46]	.0078 [−.27 to .29]	.11 [−.11 to .34]
County populations	−.013 [−.080 to .055]	−.023 [−.099 to .052]	−.031 [−.091 to .030]	−.029 [−.091 to .033]	.060* [.0054 to .12]
Dep. variable *M*	.69	.75	.72	.80	.20
Dep. variable *SD*	.46	.43	.45	.40	.40
Observations	271	204	325	306	326
Degrees of freedom	17	17	17	17	17
Model chi-square (*p*-value)	.001	.076	<.001	.352	.368
McFadden's Adj R-squared	.02	−.04	.06	−.06	−.05

Note. Each column presents the average marginal effects and their 95% CIs of a separate logistics regression on each outcome measure. Observations with missing data were excluded in the regression analysis. The standard errors were clustered within states. The following variables were logged: officers, caseload, jail population rate, median household income, and county population. Other control variables, including county parole, rural, regions, jail population rate, household income, and county populations, were not reported in this Table. SAH = stay-at-home.
*$p < .05$. **$p < .01$. ***$p < .001$.

DISCUSSION

The community corrections system in the United States is the largest form of correctional control that provides services for a vulnerable population at an increased risk for infectious disease. Individuals on community supervision typically receive all services in person via meetings with their supervision officer, who may provide assistance across a range of areas

TABLE 6: Factors Associated With Likelihood of Having Changes in Conducting Face-to-Face Meetings by Urbanicity and Type of Community Corrections Agency

	(1)	(2)	(3)	(4)
	Offices in rural counties		Offices in urban counties	
	Having changes in conducting F2F meetings	Having changes in conducting F2F meetings in field	Having changes in conducting F2F meetings	Having changes in conducting F2F meetings in field
Panel 1	Agencies in rural counties		Agencies in urban counties	
Number of COVID-19 mitigation policies implemented	.043** [.013 to .073]	.038 [–.0085 to .085]	.027 [–.018 to .073]	.010 [–.036 to .056]
Dep. variable *M*	.68	.72	.70	.80
Dep. variable *SD*	.47	.45	.46	.41
Obs.	161	116	110	88
Panel 2	County agencies		State/federal agencies	
Number of COVID-19 mitigation policies implemented	.049*** [.022 to .076]	.036 [–.016 to .087]	.037* [.0077 to .067]	.028 [–.029 to .086]
Dep. variable *M*	.71	.76	.65	.74
Dep. variable *SD*	.45	.43	.48	.44
Obs.	132	91	133	113

Note. Each column presents the average marginal effects and their 95% CIs of a separate logistics regression on each outcome measure. Other control variables were not reported in the Exhibit (see Table 5 for the full list of predictors). The standard errors were clustered within states.
*$p < .05$. **$p < .01$. ***$p < .001$.

such as obtaining employment, housing, health care, and mental health/substance use treatment. In addition, most mental health and substance use treatment programs available to individuals on community supervision are held in-person and often in group settings. As a result, the COVID-19 pandemic rapidly halted traditional supervision and treatment services, with many agencies having little to no infrastructure in place to support remote operations (Viglione et al., 2020). Prior research suggests rates of telehealth use for SUD for the general population is low and much lower than the use of telehealth for mental health treatment (Huskamp et al., 2018). The results of our study suggest that surveyed community corrections agencies with more access to technology to continue provision of services (e.g., videoconferencing, e-mail, telephone, and text) were more likely to use telehealth services for SUD treatment during the pandemic (6.5% increase). However, available technology did not predict use of SUD referrals. These results suggest that in the context of the early stages of the pandemic, the prepandemic access to technology is a facilitator for the transition to telehealth for SUD treatment in the community corrections system. This finding is consistent with the prior work on the continued access to opioid use disorder treatment which may be attributable to federal emergency guidelines of expanded telehealth care (Uscher-Pines et al., 2020). We also found telehealth was used more frequently during the pandemic in Western and Midwestern states compared with Southern states among participating agencies. This finding is consistent with research conducted on the use of telehealth during the COVID-19 pandemic that found telehealth use was more likely to occur in the Northeastern, Midwestern, or Western regions of the United States (Jaffee et al., 2020). While more research is needed to explain these findings, this could be due to lower

implementation of COVID-19 mitigation policies in the South (National Academy for State Health Policy [NASHP], 2021) and thus a less pressing need for telehealth services (Jaffee et al., 2020).

Our study also found that the relationship between available technologies and use of telehealth was stronger in rural areas and in surveyed state or federal probation/parole agencies. Given the challenges rural communities (e.g., limited treatment resources, few providers) (Skubby et al., 2013) and individuals residing in those communities face (e.g., transportation, service costs, wait lists; Bouchard et al., 2004; McCord et al., 2015), this finding suggests the important role that available infrastructure—the telecommunications technologies themselves—can play in generating an environment conducive to the use of telehealth. The fact a stronger relationship was found in state or federal probation/parole agencies compared with county-level agencies is not surprising as over half of state correctional institutions and nearly 40% of federal correctional institutions had implemented telehealth in 2004 (Larsen et al., 2004). Federal agencies are often at the forefront of innovation and often have better access to resources and funding.

One of the primary recommendations given to community corrections agencies at the start of the pandemic to reduce risk of COVID-19 transmission was to suspend in-person reporting (Vera Institute of Justice, 2020). Based on earlier research that found most agencies did not suspend in-person reporting (Viglione et al., 2020), we examined whether agencies implemented changes in protocols for meeting face-to-face either in the office or in the field (e.g., home visit). We found that surveyed agencies who implemented more COVID-19 mitigation strategies (e.g., screening tools, masks, staff training) were more likely to change policies for in-person contact, such as meeting outdoors or in large conference rooms to accommodate social distancing. Not surprisingly, agencies with greater access to technology were also more likely to change protocols for in-person contact. Agencies whose officers carry larger caseloads, thus needing to provide assistance and services for more individuals, were less likely to implement changes for conducting field visits; however, agencies who employed more supervision officers were more likely to implement changes in field visits. These findings suggest that agencies may have made adaptions to office policy based on the number of staff versus the number of individuals on supervision. Taken together, these findings suggest that surveyed agencies who were better resourced and implemented more thorough COVID-19 response plans were more likely to formally change procedures for face-to-face contact in line with recommendations. Perhaps also not surprising, we identified a stronger association between the number of COVID-19 mitigation strategies and changes made to in-person reporting in rural supervision agencies compared with those in urban areas. Clients living in rural areas often face transportation barriers, likely worsened by COVID-19 making it more difficult for rural clients and their officers to meet face-to-face. It is plausible that rural offices were more incentivized to alter their in-person reporting strategies, such as meeting in a public location rather than in the office. In addition, officers were more likely to meet in-person outside of their usual office space in those agencies with known client COVID-19 cases. It is likely that the known presence of the virus influenced officers to take additional safety measures, such as meeting in areas that allowed adequate social distancing or outdoors where transmission is less likely.

Finally, we also examined associations between multiple predictors and several key recommendations for community supervision agencies to reduce the spread of COVID-19: reductions in total supervision clients, terminating supervision terms early, and suspending

the collection of supervision fees (Vera Institute of Justice, 2020). Results indicated that surveyed community corrections agencies were more likely to receive fewer new correctional clients in areas with longer stay-at-home orders and in agencies with confirmed COVID-19 cases among staff. Interestingly, the receipt of new clients is likely not within the control or discretion of individual supervision agencies, but rather the actions of the courts are likely influential (and likely influences early termination and fee suspension as well). However, our analyses found no association between court closures and these changes. It is possible our data were collected too early in the pandemic to account for these impacts, as there is likely a lagged effect between changes within the court system and changes in community supervision systems.

POLICY IMPLICATIONS

Community supervision agencies are a source of assistance and treatment for millions of individuals across the United States. While justice agencies are typically resistant and slow to change (Latessa, 2004), the unique challenges of the COVID-19 pandemic may result in dramatic responses and solutions. Much of the change instituted during the pandemic revolved around increased use of technology, both for making regular contact and for providing critical treatment services. This has been a vastly underused innovation in the community corrections field. Given research finding telehealth services for substance use (Batastini et al., 2016) and mental health (Batastini et al., 2020) with justice-involved populations is as effective as in-person treatment, this suggests an important area of change to continue building momentum on. Efforts must be taken to understand the facilitators and barriers to use of technology and telehealth within community corrections agencies to support movement across the field. Particular attention should be paid to understanding differences in access to technology and telehealth across different jurisdictions and types of community supervision agencies. The use of technology for provision of community supervision services and behavioral health treatment has the potential to improve access to care and reduce barriers to success.

Our results indicated that agencies who implemented more COVID-19 mitigation strategies were more likely to institute changes to meet more safely face-to-face with individuals on supervision. While there are no current data that report on the number of COVID-19 infections within community corrections populations, future research should seek to understand whether those agencies who were able to implement more safety protocols had lower rates of COVID-19 cases. Given the likelihood of future pandemics and the lack of preparation for such events within the correctional system, understanding the factors that both influenced better adherence to published guidelines as well as overall COVID-19 transmission would provide evidence to inform improved emergency preparedness plans. For example, our results suggest a need to understand external factors at the county, state, and federal level (e.g., resources and funding) that may hinder or support mitigation efforts.

LIMITATIONS

This study has several limitations. First, there may be a nonresponse bias. Our data came from a sample of 347 agencies representing 42 states. Thus, the findings may not be generalized in other states. There were several reasons why directors opted out of the survey, with the most common reason being that they were overwhelmed overseeing their agency during

the pandemic. The data reported in this paper were collected relatively early in the pandemic, thus directors were tasks with many additional challenges as they adapted in response to COVID-19. An additional reason directors opted out included an influx of spam and phishing attempts, with some jurisdictions reporting major disruptions to their systems as a result. In these instances, the research team provided alternative methods of taking the survey. However, it is possible that some directors never responded due to this concern. As a result, findings from the current study may not be generalizable, though they do provide perspectives from a range of locations, agencies, and experiences. Second, the findings of this cross-sectional analysis do not imply causal determinants of altered policies and procedures in community corrections agencies during the pandemic. Third, we did not ask directors to report who provided the telehealth services their clients used. As a result, we are unable to identify whether increases in use were a result of policy change within the community supervision agency or external treatment provider. We were able to quantify the change in access to telehealth services; however, this study cannot draw conclusions on the telehealth service provisions in the surveyed units, including the changes in contracted versus in-house healthcare providers or changes in specific technologies used to provide the telehealth services. It is also possible surveyed directors may have underreported use of telehealth depending on their interpretation of the question and whether they considered both in-house and contracted services. Given the longitudinal nature of this study, we will examine this possibility in follow-up surveys.

CONCLUSION

The COVID-19 pandemic imposed unprecedented challenges and exposure in the community corrections system. The current investigation contributes a deeper understanding of factors associated with increased use of telehealth services to provide ongoing treatment to vulnerable populations (e.g., individuals with opioid and other substance use disorders) during the pandemic and changes to in-person supervision processes. These findings build on an emerging body of literature examining responses of the U.S. correctional system to the COVID-19 pandemic. Our findings point to the important role that agency and county factors play in supporting change to both prevent infectious disease transmission while reducing disruptions in services and treatment. Given the vast, complex needs of the community supervision population, our research provides a foundation for understanding how to sustain and expand innovations implemented as a result of the pandemic. In addition, this research suggests the benefit of embracing technology to support supervision work that might be beneficial in other countries outside of the United States. In doing so, the field of community corrections has the potential to increase access to care, remove client barriers to treatment, and develop evidence-based plans for future emergency situations.

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SUPPLEMENTAL MATERIAL

Supplemental Tables S1 and S2 are available in the online version of this article at http://journals.sagepub.com/home/cjb.

NOTE

1. The survey used in this study was developed by the research team. Given the unprecedented nature of the COVID-19 pandemic, there was no preexisting instrument available. Multiple versions of the instrument were reviewed by experts across multiple settings (i.e., community corrections field, academia, and professional organizations) to generate an instrument to capture key issues relating to supervision during the pandemic.

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