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Bridging institutional logics: Implementing naloxone distribution for people exiting jail in three California counties

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ABSTRACT

Drug overdose is the leading cause of death among formerly incarcerated people. Distribution of the opioid overdose medication naloxone to people who use drugs reduces overdose mortality, and officials in many jurisdictions are now considering or implementing programs to offer naloxone to people exiting jails and prisons. The principles and practices of harm reduction programs such as naloxone distribution conflict with those of penal institutions, raising the question of how organizations based on opposing institutional logics can collaborate on lifesaving programs. Using in-depth interviews and observations conducted over four years with 34 penal, medical, public health, and harm reduction practitioners, we introduce and conceptualize two organizational features to explain why this therapeutic intervention was implemented in local jails in two of three California counties. First, interorganizational *bridges* between harm reduction, medical, and penal organizations facilitated mutual understanding and ongoing collaboration among administrators and frontline workers in different agencies. Second, respected and influential *champions* within public health and penal organizations put jail-based naloxone distribution on the local agenda and cultivated support among key officials. Our findings offer guidance for future studies of institutional logics and policy responses to the overdose crisis.

Prison and jail populations in the United States have grown dramatically over the past fifty years, and despite recent decreases remain extremely high by historical standards at over 2.2 million in 2018 (Carson, 2020; Zeng, 2020). The passage of punitive drug laws as part of the "War on Drugs" accompanied and contributed to this expansion (Alexander, 2010; Pfaff, 2017). Penalization has become a primary technique for managing inequality, insecurity, and social suffering at the expense of therapeutic alternatives (Wacquant, 2009). Scholars describe organizational strategies such as penalization as "institutional logics," patterns of "material practices, assumptions, values, beliefs, and rules" that structure perceptions, decisions, and actions of individuals within organizations (Thornton & Ocasio, 1999, p. 804, 2008). In "total institutions" such as jails and prisons in which staff oversee every dimension of residents' lives (Goffman, 1961), institutional logics have profound ramifications for their clients' health and wellbeing. Ethnographic research reveals that in the context of an expansive penal system, even putatively therapeutic drug courts and treatment programs can also be used as instruments of surveillance and discipline, often along racially discriminatory lines and with particularly harsh consequences for women (Kaye, 2019; McCorkel, 2013; McKim, 2017; Sue, 2019).

Overdose is the leading cause of death among formerly incarcerated people, and opioids such as fentanyl, heroin, or pharmaceutical analgesics are the most commonly involved substances (Binswanger et al., 2013; Lim et al., 2012; Merrall et al., 2010; Ranapurwala et al., 2018). Opioid overdose mortality rates have more than quadrupled in the United States since 2000 (Hedegaard et al., 2020). In response, policymakers across the United States have increased access to naloxone, a medication that can safely reverse opioid overdoses, particularly through community-based overdose education and naloxone distribution (OEND) programs (Sporer and Kral, 2007). OEND programs are harm reduction services designed to help people who use drugs (PWUD) protect themselves and one another from the consequences of criminalized drug use. The logic of harm reduction emphasizes the autonomy

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and human rights of PWUD and supports self-directed, incremental improvements in health and wellbeing over the disciplinary, paternalistic, and abstinence-based approaches used by law enforcement and penal institutions. Trainings and partnerships between these groups can soften law enforcement officers' attitudes toward harm reduction and contribute to progressive policy change, but can also reinforce some officers' opposition to harm reduction (Cloud et al., 2018; Khorasheh et al., 2019; Winograd et al., 2020). Less is known about how law enforcement collaborations influence harm reduction providers, though increasing official support for harm reduction has been accompanied in some cases by more clinical and disciplinary practices (McLean, 2011, 2013; Roe, 2006; Watson et al., 2020).

To address high rates of overdose among people exiting incarceration, some jurisdictions have implemented OEND programs in correctional facilities in which people are offered a brief training on how to respond to opioid overdoses using naloxone and, if they wish, receive a kit containing naloxone upon their release (Anthony-North et al., 2018; Horton et al., 2017; Wenger et al., 2019a). We analyze the case of naloxone distribution to people exiting jail to investigate how organizations with conflicting institutional logics can effectively collaborate to provide lifesaving programs. We use in-depth interviews and observations conducted over four years to describe how penal, health, and harm reduction practitioners in three California counties pursued implementation of jail-based OEND programming. We define implementation as the development and execution of procedures to provide OEND on an ongoing basis to at least some people exiting county jail facilities, and we introduce two organizational features to explain why OEND was implemented in two of the three counties. First, institutionalized *bridges* between health and penal organizations facilitated collaboration among administrators and frontline workers who adhered to different institutional logics. Second, respected and influential *champions* within health and penal agencies in each county used these bridges to cultivate support for OEND among key officials. Our findings contribute to research on conflicting institutional logics (Chiarello, 2015; Dunn and Jones, 2010; Goodrick and Reay, 2011; Reay and Hinings, 2009) and offer guidance for policy responses to the overdose crisis.

1. Collaborating across institutional logics

The institutional logics approach provides an appropriate framework for investigating how policymakers and practitioners reacted to and participated in the implementation of a novel intervention. Institutional logics are typically associated with influential social institutions, including the capitalist market, bureaucratic state, nuclear family, and Christian church (Friedland and Alford, 1991). The "often contradictory logics" that develop between institutions "form the bases of political conflicts," and can therefore be analyzed to explain why some initiatives to change organizations succeed while others fail (Thornton and Ocasio, 1999, p. 805).

From an institutional logics perspective, the growth of penal populations is part of a broader transformation in the "bureaucratic field" of state organizations in which disciplinary and coercive legal authorities have gained prominence over nurturing and therapeutic educational, welfare, and health agencies (Wacquant, 2010). The logic of harm reduction directly contrasts with punitive approaches by destigmatizing drug use, returning PWUD to full social membership, and rejecting drug policies that are based on moral condemnation or demands for abstinence (Tammi and Hurme, 2007). Following this logic, harm reduction service providers see naloxone as a safe, therapeutic tool that facilitates personal autonomy and mutual aid among PWUD (Campbell, 2020). Studies of organizations that combine penal and therapeutic institutional logics in their everyday practice, such as drug courts and court-mandated treatment programs, have shown that when the two conflict, penal logics often take precedence (Burns and Peyrot, 2003; Gowan and Whetstone, 2012; McKim, 2017; McPherson and Sauder, 2013; Tiger, 2013). The "hybrid" forms of "therapeutic jurisprudence" and "enlightened coercion" practiced in these settings bundle treatment and other services with intense surveillance, strict and demeaning rules, and harsh sanctions (Kaye, 2019; Tiger, 2013; Whetstone and Gowan, 2017). Implementing jail-based OEND required jail staff to assent to the storage and distribution of medication and medical devices and participate in the delivery of a non-punitive service, making it an important case for studying how conflicts between institutional logics can be worked out in practice to less punitive ends.

To explain how stakeholders in two of three study counties overcame the barriers produced by conflicting institutional logics, we introduce and conceptualize two organizational features that facilitated implementation. First, interorganizational *bridges*, such as interagency workgroups and jointly managed programs, are formalized linkages that convene representatives of multiple institutional logics. Bridges provide venues of ongoing collaboration between agencies with overlapping clientele or jurisdictions, in which practitioners from diverse professional backgrounds can focus on shared goals and, in the process, learn about each other's priorities, skills, and responsibilities. By obligating people from different agencies to repeatedly interact and collaborate, bridges function as platforms for policymakers to pursue issues and ideas that might otherwise not be discussed. Bridges have been shown to facilitate program implementation in other programs and services for PWUD in the criminal legal system that involve reconciling penal and therapeutic logics (Henderson et al., 2009; Lehman et al., 2009; Welsh et al., 2016; Wenzel et al., 2001).

Second, motivated stakeholders use the influence they hold as members of interorganizational bridges to become internal *champions* of OEND implementation. Though bridges provide favorable opportunities for interagency collaboration, implementation of a novel program like jail-based OEND also demands active and consistent engagement from representatives of the organizations involved. The combination of passionate interest in a policy and the means to exert influence on professional peers provided by bridges enable champions to coordinate program development, respond to other stakeholders' concerns, and monitor implementation. Champions play a similar role in organizations as "policy entrepreneurs" do in politics by using their status and relationships to advance favored policies (Roberts and King, 1991). People who occupy boundary spanning roles between agencies are especially apt to serve as champions due to their existing interorganizational relationships and credibility (Williams, 2002). For instance, members of law enforcement and related agencies such as emergency services can be effective messengers for harm reduction to law enforcement audiences, who may be skeptical that outsiders appreciate the difficulties of their work (Khorasheh et al., 2019; Story et al., 2018). Champions have also been identified as important facilitators for medical quality improvement and implementation of innovative technologies and techniques (Greenhalgh et al., 2004; Howell and Higgins, 1990; Woo et al., 2017).

Conflicting institutional logics are not the only factors affecting implementation of OEND and other controversial programs. Another is the division of governmental authority in the United States among national, state, and local governments on issues of law enforcement, incarceration, and public health. Federalized systems fragment decision making across multiple venues, enabling local experimentation but exacerbating geographic disparities in policy outcomes (Bednar, 2011; Pierson, 1995). State and local control of syringe services programs, another harm reduction intervention, allowed some progressive states and urban areas to rapidly embrace them, but also exacerbated disparities with conservative and rural areas that resisted them (Showalter, 2018, 2020). A third influence on policy change is the interplay between social conditions and political agendas. Though agendas can remain relatively stable for long periods of time, upheavals like those provoked by epidemics or mass movements can quickly move contentious proposals from the margins to the mainstream (Baumgartner and Jones, 2009). In the US, harm reduction programs expanded most rapidly during the HIV/AIDS crisis of the 1980s and 1990s and as the overdose crisis escalated during the 2010s (Showalter, 2018, 2020) As we

describe in the next section, the overdose crisis continues to push policymakers to expand naloxone access to new places and groups, including people exiting incarceration.

2. Overdose prevention and post-release overdose risk

Naloxone has been a standard medication for opioid-related emergencies in health care facilities and on ambulances since the 1970s. However, fear of arrest and stigma often dissuades people from calling emergency medical services if they witness an opioid overdose (Koester et al., 2017; Wagner et al., 2019). To overcome these barriers, harm reduction providers in the United States began providing injectable naloxone to PWUD and others who were likely to witness overdoses in the late 1990s (Sporer and Kral, 2007). People who receive a naloxone kit and a brief training frequently use naloxone to reverse opioid overdoses (Giglio et al., 2015; McDonald and Strang, 2016). Between 1996 and 2014, community-based OEND programs distributed naloxone to 152,283 laypeople and received 26,463 reports of overdose reversals (Wheeler et al., 2015). In response to the overdose crisis, every state and the District of Columbia have taken steps to facilitate naloxone access, typically through "standing orders" that allow distribution of naloxone to PWUD and others likely to witness opioid overdoses (Lambdin et al., 2018; Legal Science, 2017). As a result, naloxone distribution has expanded significantly: in 2019, 237 community-based programs reported distributing 702,232 doses in the preceding 12 months, up from 90 programs distributing 140,053 doses in calendar year 2013 (Lambdin et al., 2020; Wheeler et al., 2015).

California was an early adopter of harm reduction services, particularly in its more progressive coastal cities (Showalter, 2020). Naloxone distribution for laypeople was pioneered in Chicago in 1996 by Dan Bigg of the Chicago Recovery Alliance, who brought the intervention to San Francisco Needle Exchange in 1999 as the second US site and first in California (McDonald et al., 2017). The Drug Overdose Prevention and Education (DOPE) Project began providing overdose prevention trainings without naloxone in San Francisco in 2001, and in 2003, after a successful pilot study of naloxone distribution, partnered with the city's public health department to create the first government-sanctioned OEND program in the US (Enteen et al., 2010; Seal et al., 2005). California was also one of the first states to provide liability protections for those who prescribe or administer naloxone, since 2008, and to authorize naloxone distribution under standing orders in state law, since 2014 (Legal Science, 2017).

Post-release overdose risk is a consequence of the conditions of incarceration and release (Joudrey et al., 2019). As a result of drug criminalization as well as the roles of intoxication and substance use in many non-drug offenses, histories of substance use are common among incarcerated people (Bronson et al., 2017; Yi et al., 2017). Opioid use is often interrupted during incarceration, and very few people who use opioids receive medications for opioid use disorder (MOUD) such as methadone and buprenorphine (Krawczyk et al., 2017). As a result, people who use opioids typically exit incarceration with reduced opioid tolerance, and after release many quickly return to use, often under isolated and risky circumstances (Binswanger et al., 2012; Joudrey et al., 2019). Risks of overdose in the first two weeks post-release are three to eight times higher than in the following ten weeks, and 40 to 129 times higher than in the overall population (Binswanger et al., 2007; Merrall et al., 2010; Ranapurwala et al., 2018). In addition to experiencing high rates of overdose, many people exiting incarceration have witnessed overdoses, providing opportunities to intervene with naloxone (Davidson et al., 2019; Wenger et al., 2019a). OEND programs in jails and prisons equip this high-risk population with knowledge and tools to protect themselves and others from overdose at a critical moment of high risk.

Researchers in the United Kingdom first identified high rates of post-release drug-related mortality and the need for naloxone at release in the late 1990s (Bird et al., 2003; Seaman et al., 1998; Strang et al., 2013). A series of studies, beginning with a 2007 article in the *New England Journal of Medicine* (Binswanger et al., 2007), then established similar risks in the US (Binswanger et al., 2013; Lim et al., 2012; Merrall et al., 2010; Ranapurwala et al., 2018).The publication of these US studies coincided with increasing opioid overdose mortality and growing attention to overdose prevention, potentially explaining the lag between initial recognition of post-release overdose risk and policy change. High rates of fatal overdose immediately after release pose challenges to conventional OEND programs, because people released from jail or prison may not know how or be able to access them before returning to risky opioid use. In response, several countries and multiple U.S. jurisdictions have implemented OEND in correctional facilities and post-release programs, with California again among the first (Anthony-North et al., 2018; Horton et al., 2017; Parmar et al., 2017). The San Francisco Jail OEND program began in 2013 as a collaboration between the DOPE Project, jail health services, and the San Francisco Sheriff's Department, indicating the relevance of active interorganizational linkages for bridging institutional logics. In a study of that program, Wenger and colleagues (Wenger et al., 2019a) found that of 637 people who received OEND training, two-thirds asked to receive a naloxone kit upon release. One quarter of those who received a kit had previously overdosed, while 87 % reported that people they knew were at risk of overdose. Less than 4 % of those who received a kit had previously received OEND services, and nearly one third later reported using the kit to reverse an overdose. Jail-based OEND services serve people at high risk of experiencing or witnessing overdose that community-based OEND programs have not reached.

Barriers to correctional OEND programs exist on the side of correctional facilities as well as among community-based harm reduction services providers. On the correctional side, barriers include misinformation among staff and people in custody, lack of staff commitment to OEND, competing programmatic priorities, logistical obstacles owing to security protocols, and lack of funding (Anthony-North et al., 2018; Pearce et al., 2019; Sondhi et al., 2016; Woollett, 2017). For instance, while community-based OEND programs typically distribute low-cost vials of injectable naloxone in kits with intramuscular syringes, restrictions on syringes in correctional facilities require OEND programs to offer more expensive intranasal naloxone. On the other hand, harm reduction services providers may be reluctant to collaborate with correctional staff due to previous conflicts with law enforcement, opposition to drug prohibition, or affinity for prison and police abolition (Beletsky et al., 2011; Robinson, 2020). Collaboration between harm reduction organizations and law enforcement or correctional staff entails mutual compromise and can be emotionally fraught, potentially exposing each side to criticism from their peers (Castillo, 2018). We contribute to theories of institutional logics and research on policy responses to opioid overdose by showing how bridges and champions helped two of three study counties overcome these barriers and implement jail-based OEND.

3. Methods

Data for this paper were derived from a National Institute on Drug Abuse-funded study of the implementation of OEND programming in correctional settings (grant number 5R34DA039101-03). The initial study design and methods were guided by the five key domains of the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009). These include 1) characteristics of the intervention; 2) outer setting factors such as political, demographic, and budgetary trends; 3) inner setting features such as organizational procedures and culture; 4) characteristics of the individuals involved in the intervention; 5) and processes to promote effective implementation. We conducted initial and follow-up in-depth interviews, observations and correspondence with key stakeholders in three California counties from December 2015 through January 2020. Initial interviews were conducted from December 2015 through December 2016, follow-up

interviews were conducted from September 2016 through January 2020, and correspondence via email and phone calls were conducted during the entire study period. These counties were initially selected for variation in area, population, urbanicity, and jail capacity (see Table 1). We have given the counties pseudonyms and approximated details such as county size and other county level characteristics for confidentiality. Birch County combined clusters of small cities and towns with expanses of forest, chaparral, and agricultural land, and, commensurate with its relatively small area and population, featured lean government agencies and a modest jail facility. Juniper and Cottonwood Counties included urban centers and sprawling suburbs with extensive government bureaucracies and large jails. Jail health services were provided by county agencies in Birch and Juniper Counties, while Cottonwood County contracted with a private correctional health care provider.

Our goal was to understand the complete implementation process from program conception to delivery of services, so we provided technical assistance in all counties to help stakeholders overcome the barriers they identified at each stage of the process. Technical assistance included providing basic information about OEND and local overdose rates, answering specific implementation questions, and sharing protocols utilized in other settings. We provided technical assistance during initial interviews and throughout the follow-up process. To provide this assistance, the study team included qualitative research experts, epidemiologists, representatives of harm reduction organizations, an implementation scientist, and a medical professional.

Stakeholders were recruited using purposeful sampling methods, which prioritize individuals that are especially knowledgeable about or experienced with a phenomenon of interest (Coyne, 1997; Palinkas et al., 2015). We used online searches and organizational charts for each county's jail facilities and departments of substance use services, behavioral health, public health, and reentry services to compile profiles of outer setting characteristics, and identified 47 key stakeholders and 19 organizations relevant to OEND programming. We recruited and interviewed 19 stakeholders by contacting these organizations using publicly available information. We also used a modified form of snowball sampling to recruit an additional 15 stakeholders (Biernacki and Waldorf, 1981). At the end of each interview, we asked participants for referrals and introductions to additional stakeholders who could discuss the topic further or influence the implementation process. We also attended eight meetings of opioid overdose coalitions, jail health services, and reentry services to facilitate introductions to stakeholders and learn about local policymaking processes.

Thirty-four stakeholders representing 18 organizations across the three counties participated in qualitative in-depth telephone interviews. Stakeholders included staff in county public health and behavioral health services, drug courts, pharmacy services, substance use treatment, correctional health, probation, harm reduction, coroners' offices, organizations that provide services in the criminal legal system, jail discharge planners, correctional officers, jail administrators, and reentry service providers. One individual declined to be interviewed. Our institution's Institutional Review Board granted us a Category 2 exemption under 45 CFR 46.104(d)(2). This exemption was awarded because the research consisted of interviews and observation of public behavior and the review board determined that disclosure of participants' responses outside of the research would not reasonably place the participants at risk (National Institutes of Health, 2020). Therefore, we did not read a formal consent form to participants prior to their interview. We did, however, administer a consent script during which we explained the study in detail, asked for their permission to be recorded and allowed for any questions or concerns to be voiced prior to beginning. Interviews lasted 30–45 min, were digitally recorded and transcribed by a professional transcription service and following each the interviewers (first two authors) wrote detailed notes. To protect participants' confidentiality all interview transcripts were identified by number not by name and any identifying information mentioned during the interview was removed during the transcription process. The study team stored interview recordings as well as a separate password protected file containing participants' contact information that was used for follow-up on a password protected drive encrypted with PointSec security software and accessible only to the research team.

Interview topics were derived from the five CFIR domains, including 1) characteristics of OEND programs; 2) local overdose rates, county politics, and budgetary trends; 3) agencies' policymaking processes and culture; 4) stakeholder attitudes toward OEND and willingness to participate in implementation; 5) and processes to facilitate implementation such as existing overdose-related meetings and working groups. If during the interview a participant needed more information on a topic, the interviewers offered it. For example, a few participants did not realize that people exiting incarceration were at elevated risk of overdose. In such cases, we discussed post-release overdose risk during the interview and sent additional information if they expressed interest. A few participants had not heard about OEND before the interview, so we first described OEND to give a basic understanding of the topic. At the end of the interview, we provided study participants with a summary of published research findings on overdose risk and OEND services.

We analyzed these data using a process tracing approach, which combines theoretical mechanisms, multiple data sources, and comparison across cases to explain how and why policymakers make the decisions they do (Beach and Pedersen, 2019; Kay and Baker, 2015). Process tracing uses inductive and deductive approaches to explain specific cases and conceptualize more general mechanisms (Trampusch and Palier, 2016). We began by using the CFIR domains and prior research to structure our preliminary interview questions. The first two authors reviewed notes and transcripts from these interviews, and inductively coded them for salient themes (Thomas, 2006). The preliminary code list was developed directly from the interview guide. As analysis progressed the code list was modified to include emergent themes (Thomas, 2006). Disagreements over coding decisions were resolved through discussion among the first two authors and principal investigator. After close reading and coding of the in-depth interview data, we attended stakeholder meetings in each county, presented information about jail-based OEND services, answered questions, and recruited additional interview participants. Based on these meetings, we refined our research questions and developed analytic memos focusing on barriers and facilitators to OEND implementation. The recurrent themes that emerged from this analysis were informational and logistical barriers to program implementation and interorganizational bridges and internal champions as facilitators of implementation. We followed up with our initial research participants and sought out the views of additional stakeholders over four years of implementation efforts to receive updates and offer technical support on emerging obstacles. This repeated, long-term follow-up allowed us to confirm our analysis through ongoing comparison across counties and over time.

Table 1
County characteristics.

	Birch County	Juniper County	Cottonwood County
Area in sq. miles (approx.)	<1000	>1000	<1000
Population (approx.)	250,000–500,000	1–2 million	1–2 million
Urbanicity	suburban/rural	urban/ suburban	urban/suburban
Total jail capacity (approx.)	<500	>1000	>1000
Jail health services provider	County	County	Private
Number of interview participants	6	14	14

4. Findings: bridges and champions in OEND implementation

Jail-based OEND was implemented in two of three counties during

the four-year study period. All three counties shared similar barriers to implementation stemming from clashes between penal and therapeutic logics, such as misconceptions about naloxone and logistical obstacles to dispensing the medication. Harm reduction services were not new or untested in any of the study counties: organizations in all three had offered community-based syringe services and OEND for many years. Since these features and the technical assistance we provided were similar across counties, they alone could not explain differences in implementation outcomes. The two implementing counties (Birch and Juniper) also differed from each other significantly in geography, urbanicity, population, jail capacity, and other characteristics, but shared two key organizational features that facilitated implementation. First, bridges such as opioid overdose prevention coalitions and county-operated jail health services facilitated collaboration across institutional logics. Second, champions used their interest in OEND and influence with other stakeholders to garner support and advance implementation. The county that failed to implement jail-based OEND (Cottonwood) shared some characteristics with the implementing counties, but lacked bridges to facilitate collaboration and provide potential champions with influence over implementation.

4.1. Common barriers to implementation

Stakeholders in all three counties raised objections to the implementation of jail-based OEND. An initial set of *informational barriers* were based on lack of knowledge, misconceptions regarding opioid overdose or naloxone, and disparaging attitudes toward PWUD. In response to these concerns, we provided information on overdose risk factors, the effectiveness of naloxone, and OEND program models (Wenger et al., 2019b). Learning more helped stakeholders think practically about offering jail-based OEND, which elicited a second set of *logistical barriers* related to policies and procedures, staffing, and funding. These two sets of barriers are consistent with findings from previous research and were similar across all counties (Drainoni et al., 2016; Winstanley et al., 2016). Many derived directly from correctional facilities' penal logics and their priorities of security and behavioral control.

Most stakeholders were unaware of local trends in overdose rates, uninformed about post-release overdose risk, and unfamiliar with OEND services. Jail staff did not receive training on these topics. What information stakeholders did possess was often incomplete or incorrect. Many believed that dispensing naloxone required a prescription obtained in the context of a traditional patient-provider relationship, though standing orders have been used for community-based OEND services in California since 2003 (Enteen et al., 2010). Others raised the common but unfounded concern that providing naloxone would increase drug use or were unconvinced that it was safe and effective for layperson use (Doe-Simkins et al., 2014; Jones et al., 2017). In an initial interview with Cottonwood County's director of pharmacy services, he, like other study participants claimed that some target populations for jail-based OEND services were not at risk for overdose or would be incapable of using naloxone.

> [Overdose prevention] fits in, although, at least for the SMI [severely mentally ill] population, I don't think it's huge. I don't think the SMI population has it together to be a good enough [opioid] user… [T]hey're opportunistic, [if] things are in front of them they're going to use it, but they don't have that executive functioning and the wherewithal… to do what it takes to be a full-time user.

Jail staff were also concerned about unspecified "liability" concerns. A jail lieutenant in Birch County worried that providing OEND could result in a lawsuit against the jail, even after we explained that California state law contains comprehensive protections against criminal, civil, and professional liability for people who provide and use naloxone to reverse opioid overdoses (California Civil Code, section 1714.22).

Though most acknowledged that OEND would benefit some people exiting jail, stakeholders often pointed out that these people faced a wide range of unmet needs. This lengthy list offered during an initial interview with Cottonwood County's director of jail mental health services was typical:

> Transportation, housing, same day mental health services, obviously employment… [L]egal support, maybe they get out and they find that they've been evicted from their place of housing or they've lost their job… [There's] a lot of individuals who also have other kinds of disabilities who are eligible for benefits that are not being able to connect with them. There's a lack of crisis services… I mean, if I need help on a Saturday at 10 o'clock at night, is there somebody to support and assist someone like that?

The director bemoaned the lack of funding and staff to meet needs that had already been identified, let alone add new, unfunded services.

> Some of the organizations [are] feeling under-resourced and understaffed, [and if] the offer to provide additional services… creates more work for somebody on their staff, [that's] a challenge. I think the sheriff's department [which manages the jail] has that challenge. I know for our staff… we definitely do.

Without additional resources, the cost of naloxone alone could become prohibitive, as Birch County's head of addiction services explained during their initial interview.

> [W]e've got to figure out a funding stream for the jail to be able to do [OEND]… [The county] department of health and human services have been purchasing [naloxone] kits and have been kind of distributing them to get them out the door, but it's certainly not sustainable to do it that way because, you know, you're at $75 a pop… when you start getting into hundreds of kits you start talking about real money.

Though community-based OEND programs had operated in all three counties for years, harm reduction approaches had not penetrated other local substance use services and some stakeholders believed that harm reduction was antithetical to the goals of treatment. During their initial interview, the medical director of Cottonwood County's Behavioral Health services described the absence of harm reduction principles in county-funded substance use treatment services.

> Almost all of the substance use-focused programs in [Cottonwood County] come from a 12-step social model, recovery oriented philosophy exclusively… the residential programs, most of the outpatient programs, are all coming from that 12-step social model. We have a detox, we have a sobering center, sweat-it-out places, you know, [where] there's no medical support.

Jail security procedures raised a complex set of challenges. Though community-based substance use services providers were obvious potential partners for implementing OEND in jails, obtaining security clearance for their staff was difficult. Movement was highly restricted in Juniper County's large jail, making it difficult to ensure adequate and timely attendance for trainings. Jail release dates and times were typically not available ahead of time, and jail health providers had trouble ensuring that standard medications were dispensed properly upon release, let alone naloxone offered through OEND trainings. Though in community settings naloxone is typically not distributed through a prescription that must be filled at a pharmacy, jail health services required a prescription and were the sole dispenser of all medications given to jail residents. During an initial interview with the public health officer from Birch County, he explained how this system posed a challenge to implementing OEND.

> If we're seeing naloxone as a medication that is being administered, there's almost like a reflex of like, "Oh, geez, you know, who is

prescribing it, who is authorized, who is licensed, you know, how do we get around all that?" [There are] all these assumptions that we make about how medicine ends up being delivered to an individual [in the jail].

Birch County's director of addiction services described additional concerns raised by frontline jail staff about how naloxone distribution would affect their job responsibilities and the cleanliness of their facilities. He also illustrated how impervious closed correctional facilities can be to efforts at introducing new services.

They're worried about litter, they're worried about having to do screenings on people, which they don't do already, so the idea of putting it into their belongings, despite the fact that, I think we've all told them a hundred times… [that OEND] is being done and has been done for a while now," but the jail is [an] insular [place], and they've got their own internal protocols.

The lieutenant in Birch County's relatively small jail also complained about the challenge of maintaining orderly facilities during a follow-up interview.

Inmates receive their property and are released through the lobby, [which] is also the waiting area where there are lots of children and families hanging out… The lobby is chaotic: people have urinated in the lobby and people have received their property and just thrown it on the ground… the distribution of intranasal naloxone [as opposed to injectable] decreases my anxiety… I imagine kids getting ahold of the property and sticking people with the naloxone [needles].

Stakeholders in all three counties reported little prior knowledge of OEND, inadequate resources to address needs that had already been identified, and no experience offering harm reduction services in correctional settings. Many of these barriers resulted from the dissimilar institutional logics of therapeutic and penal organizations, in particular their respective prioritizations of health and security. Because the barriers to offering OEND for people exiting jail and the technical assistance we provided in response were similar across counties, they could not account for the counties' contrasting implementation outcomes.

4.2. Interorganizational bridges

Our interviews and observations over time revealed two key organizational features that helped stakeholders in Birch and Juniper Counties overcome the barriers they faced. The first were interorganizational bridges, which created opportunities for stakeholders from different professional backgrounds to discuss OEND in a context of trust and collaboration. Like many California counties, Birch and Juniper Counties established interagency coalitions to address opioid use and overdose (Max et al., 2017). Birch County's opioid overdose coalition included active participants from the county department of health and human services and the offices of the sheriff, district attorney, and public defender. Members of the coalition, including the county contracts manager for substance use services, had already worked to increase naloxone access for first responders and PWUD by offering OEND trainings for law enforcement and piloting OEND programs in treatment programs and local schools. The health and human services department purchased naloxone for these projects, and the county head of addiction services conducted the trainings. During his initial interview, Birch County's public health officer aptly illustrated how the coalition's diverse membership and record of success facilitated expanding OEND services into the jail.

We have the D.A. [district attorney] involved [in the coalition, so] we have a structure where we're able to say, "There's this tool called naloxone that we think would help, and this is how." They're already engaged in seeking solutions so it becomes easier… because of the framework that's been created for the effort as a whole.

The opioid overdose coalition included members who were motivated to implement new services and gave them a meaningful platform to consistently press their cause. Birch County's smaller size and more modest government staff also meant that agency leaders—like the head of addiction services—were more directly involved in the development and delivery of new services. Bringing decision makers themselves together rather than their subordinates made the opioid overdose coalition an especially effective venue for collaboration.

Juniper County, larger than Birch County, featured multiple bridges between health care, substance use services, and law enforcement, including the opioid overdose coalition, a reentry program near the jail, and the county-operated jail health program. Members of the coalition included health care, behavioral health, and substance use treatment providers, syringe services staff, re-entry services program staff, and people who had been personally affected by overdose. The coalition provided education on safer opioid use and disposal and worked to improve access to treatment and naloxone. We attended a coalition meeting in January 2017 during which we described how naloxone prevents fatal overdose, standing orders for layperson naloxone distribution, and jail-based OEND programs elsewhere. The ensuing discussion raised logistical barriers, including strict protocols for prescribing medications and challenges identifying who should provide and participate in OEND trainings. The reentry program served five to six thousand people each year, including approximately 1,200 in its medical clinic, and its physicians prescribed naloxone to patients who were known to use opioids. But the clinic's requirement that every medication decision be made by a doctor limited the number of people who could receive naloxone. After we provided the reentry clinic physician with information on the use of standing orders instead of individual naloxone prescriptions, he directed the clinic's nurse coordinator to develop a plan to implement OEND.

In contrast to Birch and Juniper Counties, Cottonwood County lacked an interorganizational bridge that regularly brought together health care, substance use, and correctional staff to discuss issues of common concern. While the county did have an opioid overdose coalition, it was focused exclusively on prescription opioid misuse and disposal, and did not consistently include staff from the jail or community-based OEND services. As we describe in the next section, the program coordinator at one community-based OEND program assisted other organizations in the county to offer OEND to their staff, clients, and residents, but was unable to make similar inroads with the jail. The medical director of Cottonwood County's health services agency convened a group of medical providers at the public hospital to discuss distributing naloxone to patients in the emergency department but was not able to identify a reimbursement mechanism. There was no discussion in this group about expanding OEND to the jail. The probation department in Cottonwood County held a monthly meeting focused on coordinating reentry services attended by local and state elected officials, community- and faith-based organizations, people with criminal records and their families, and victims of crime and their families. Through this group and other study participants we met service providers in Cottonwood County who were interested in implementing OEND for people exiting jail. But neither the reentry services meeting nor the opioid-related groups obligated stakeholders from conflicting institutional logics to engage in serious and sustained discussion of the topic.

4.3. Internal champions

Though interorganizational bridges provided a foundation for discussion of jail-based OEND in Birch and Juniper Counties, discussion alone could not lead to implementation without additional effort from stakeholders who possessed both motivation and influence. These internal champions used their positions in the interorganizational bridges to maintain discussion of jail-based OEND and address obstacles to implementation.

In Birch County, the head administrator for county substance use services oversaw the jail's substance use treatment program and had personally trained law enforcement officers and jail nurses to carry and use naloxone. As a result of his direct involvement in service delivery, he was already well-known and trusted by other important stakeholders. This track record of collaboration across organizational lines, including with correctional staff, was a critical aspect of his credibility as a champion. During a follow-up interview, he explained why it was important for advocates of new services to be respected local officials who could garner trust from other stakeholders and would bear some responsibility for the outcome of the project.

> I'm working on the county law enforcement side of things, and in tandem was working on the jails and trying to get pharmacies to carry [naloxone]… What has come of this, at least to date, has been a receptiveness to think about it when it's coming from me, but if we try to bring in third-party people, like for example you folks [the research team], their eyes just glaze over and they say, "Well, they're not [Birch County] people, they don't have any skin in this game."

In this context, OEND for people exiting jail was one of a series of incremental expansions of naloxone access led by the substance use services administrator. This history of success prepared him to be a champion for OEND for people exiting jail and prepared his colleagues to consider and accept the proposal. After deciding to pursue OEND in the jail, he sought our input on solutions to the logistical barriers that had been identified in discussion with other stakeholders. To avoid skepticism of outsiders and the need to obtain new security clearances or design new screenings, we suggested initially offering OEND in existing substance use treatment groups. Piloting the service in these smaller groups helped to convince staff that broader implementation was practicable. OEND trainings began in Birch County's jail in November 2017, though the program did not begin equipping those who had been trained with naloxone upon release until the county health and human services department provided a supply of the medication in February 2018.

The reentry clinic nurse coordinator in Juniper County was an exemplary champion for OEND. She was responsible for program development as well as direct patient care, and described herself as a someone who liked to "knock down barriers" and wanted to do "whatever's the easiest, whatever's the most helpful, and whatever can get the most [naloxone] kits into the hands that need it." To ensure that the topic received sustained attention, she invited us to overdose coalition meetings to provide information and respond to concerns. After our initial presentation to the coalition, the reentry clinic physician authorized her to find a source of naloxone, train staff to provide OEND trainings, and inform patients about the service. We shared with her a free training for OEND trainers provided by the National Harm Reduction Coalition. The county director of addiction medicine, who chaired the opioid overdose coalition, allocated 75 doses of intranasal naloxone to the reentry clinic from a state grant of 1,000 doses. These resources allowed the nurse coordinator to begin offering OEND trainings to some reentry clinic patients in January 2018.

That December, a second champion for jail-based OEND emerged in Juniper County. A physician working in the county's jail contacted us on the suggestion of the jail's medical director, whom we had interviewed, hoping we could support her desperate efforts to implement OEND. We answered her questions and provided technical support via email and subsequently conducted a follow-up interview with her. During this interview, the physician described her motivation to champion implementation of OEND in the Juniper County jail:

> My patients were dying. I was hearing about people overdosing after leaving jail and I felt like I was seeing people as their primary care doc and not helping them. I felt it was stupid to talk to folks who came back to jail six times in the past year about their cholesterol when opioid overdose prevention seemed to be way more of a priority.

A portion of the same naloxone allocation that was provided to the reentry clinic was delivered to the jail pharmacy for distribution but negotiating with jail staff how naloxone would be put in OEND participants' property proved more difficult. The physician's favored solution was eventually accepted after she first invested time in hearing and responding to concerns raised by frontline correctional staff, and then made a passionate pitch to a key decision maker based on her thorough understanding of jail protocols.

> I had multiple discussions about stapling it or taping it to the property. The primary concern was that it would fall off the person's property… Finally, I stomped into the captain's office angry about the roadblock, [and he] eventually agreed to start the program. It helped that I had already done the leg work, talking to everyone who would be involved, and I was ready to implement. [Jail leadership] decided that the paper bag with the naloxone in it would be taped to the person's property.

If individuals disclosed opioid use to nurses during intake, a pharmacy order was opened for opioid withdrawal medications, such as antidiarrheals or sleep medication. The jail physician added overdose prevention to this order and nurses were instructed to check a box for OEND training, which patients received two to four weeks later. A county-funded substance use treatment program that was already operating in the jail volunteered to provide the trainings, eliminating the need for additional staff. Juniper County dispensed approximately 300 doses of naloxone to people exiting incarceration from May 2019 through January 2020.

Cottonwood County had practitioners motivated to implement jail-based OEND, but the absence of a collaborative bridge with jail staff prevented them from converting their passion into effective action. During their follow-up interview, the supervisor of the jail's reentry program center told us they did not oppose implementing OEND, especially since it did not pose a threat to correctional staff's control inside the facility.

> I think the more education on the topic [of overdose prevention] the better, and… you're not bringing something into the facility and getting to the inmates that they're going to possess in the facility, it's on their property and it's not unlawful for them to possess when they're walking down the street [after being released].

But while stakeholders in Cottonwood County recognized that people exiting incarceration were at risk for overdose and agreed that OEND training in the jail would be a lifesaving service, each preferred that others lead implementation. Mental health care providers suggested pharmacists, who suggested substance use services providers, who suggested probation officers, who suggested mental health care providers.

Even community-based harm reduction programs with resources and opportunities to expand OEND services could not collaborate effectively with jail staff. The OEND coordinator at Cottonwood County's largest harm reduction program wanted to provide OEND in the jail, had the resources to do so, and had jail security clearance and worked inside the facility in another professional role. She had trained treatment programs and other organizations serving PWUD in Cottonwood County to provide OEND services to their staff, clients, and residents. As a social worker and former counselor in a methadone clinic, she was comfortable and experienced working at the intersection of therapeutic and disciplinary institutions. She made a presentation to Cottonwood County's jail health providers about OEND and invited the research team to join her for a second presentation. These meetings were hosted by the jail's discharge coordinator, who told us in an interview that he was also supportive of OEND. He explained that because implementing new services took incremental planning and education with staff and people

in jail, he scheduled multiple presentations on OEND. But after the second presentation he and the reentry services center supervisor failed to respond to multiple contacts over four months. The jail discharge coordinator was employed by the county's private correctional health services provider, which switched from one company to another during the study period amid criticism of their services. That controversy and organizational transition may have presented additional obstacles to implementing new services. In any case, motivation alone was not enough for OEND supporters to find success as champions. Even highly motivated advocates could not keep attention focused on OEND long enough to make progress without an interorganizational bridge that obligated staff from different agencies to communicate and collaborate.

5. Discussion

In our study, the two counties that implemented jail-based OEND featured interorganizational bridges that helped stakeholders from opposed institutional logics discuss the topic as part of ongoing collaborative efforts. In the county that did not implement jail-based OEND, no such bridges existed to provide a basis for cooperation across institutional logics, and efforts by OEND advocates to draw attention to the issue repeatedly dissipated. In both implementing counties, one or more stakeholders who were members of interorganizational bridges used their positions to become champions of OEND, adopting a commitment to the issue that motivated them to garner support and tackle emerging obstacles to implementation. Our findings show how institutional logics affect program implementation by leading people from agencies that reflect divergent principles and priorities to perceive the same intervention very differently. Harm reduction practitioners argued that OEND would empower people exiting jail to protect themselves and others, but jails' emphases on abstinence and restrictions on property, movement, and medication impeded the implementation of an intervention that offered free, nonjudgmental trainings and tools related to active drug use. By showing how bridges and champions helped to reconcile these divergent views and build support for implementation, we contribute to research on institutional logics and on opioid overdose prevention policies.

Our research design allowed us to check our analysis across three different jurisdictions and under changing circumstances over time. However, our findings are subject to some limitations. Jail-based OEND may be facilitated in California relative to other states by a statewide standing order and dedicated funding streams to support the distribution of naloxone by local organizations (Department of Health Care Services, 2020). Community-based OEND programs were already operating in our three counties but are not in most counties in the United States (Lambdin et al., 2018). Their presence did not eliminate misinformation or opposition to jail-based OEND among the stakeholders we interviewed, but their absence in other places may make these barriers more difficult to overcome. Finally, while we found that respected locals were more effective than outsiders at garnering support for policy change, the technical assistance we provided could have accelerated the implementation process, including by putting OEND for people exiting jail on local agendas for the first time.

The successes we observed gave us the opportunity to develop recommendations for local policymakers who wish to implement OEND for people exiting incarceration. First, widespread informational and logistical barriers to OEND among correctional staff must be addressed. Curricula and trainings for correctional staff and policymakers should include information on the links between incarceration and substance use disorders, post-release health risks including overdose, and non-abstinence based approaches such as harm reduction. Second, local officials should support interorganizational bridges that allow staff from multiple agencies serving PWUD, including harm reduction organizations, to collaborate as coequal partners. Third, people who are motivated to advocate for harm reduction services by their own experience using drugs or their personal connections and work with PWUD should be included in such bridges and empowered as champions to coordinate program implementation. Finally, more should be done to address the causes of post-release overdose risk, including providing MOUD to people in jail and prison and direct linkages to community-based services immediately upon release.

Our findings also suggest additional paths of research on collaboration across institutional logics. On the theoretical side, bridges and champions are not entirely new notions in applied research on organizational behavior. Powell and colleagues (Powell et al., 2012) include identifying and preparing champions and building coalitions in their comprehensive compilation of implementation strategies, and Shea (2021) integrates previous research on champions' commitment, performance, and impact into a unified conceptual model. Our findings illustrate the importance of considering the qualities and activities of champions in relation to their organizational contexts. In our study, committed and capable champions were present in each county but required the opportunities for collaboration provided by interorganizational bridges to achieve implementation. On the empirical side, research on the outcomes of OEND programs in correctional settings remains very limited, though initial findings are promising (Parmar et al., 2017; Pilj et al., 2017; Reed et al., 2021; Wenger et al., 2019a). OEND and other harm reduction interventions are also being implemented in novel settings such as homeless shelters, residential buildings, emergency departments, and community health centers (Bardwell et al., 2019, 2020; Wallace et al., 2018; Welch et al., 2019). Investigating whether bridges and champions are effective for other harm reduction interventions and in non-correctional settings will aid efforts to make these services more widely available. For instance, interorganizational linkages similar to the bridges we identified have been shown to facilitate implementation of MOUD in correctional settings (Grella et al., 2020). On the other hand, syringe services currently operate in correctional facilities in several European countries but not in the US (Moazen et al., 2020). In our study, jail staff consistently rejected outright the prospect of distributing syringes with injectable naloxone, which could make implementing syringe services in correctional settings more difficult.

This study shows that beneficial collaborations between correctional, medical, and harm reduction organizations can be implemented under certain conditions. But the need for bridges, champions, and other organizational workarounds to mitigate the clash between penal and therapeutic logics reflects a deeper contradiction in the management of drug use in the United States. Historically, cycles of punitive and prejudiced moral panic around drug use have alternated and overlapped with periods of reform and increasing acceptance of medical models of addiction (Campbell, 2007; Musto, 1999). The rise in incarceration and the "War on Drugs" tipped the balance of public policy decisively toward penal logic, to the severe detriment of the health and wellbeing of PWUD. While the COVID-19 pandemic has recently amplified and accelerated efforts to reduce correctional populations, self-quarantine and social distancing requirements and disruptions in harm reduction services could increase risk of overdose post-release (Mukherjee and El-Bassel, 2020; Nguyen and Buxton, 2021). Collaborations of the kinds we have described here can help reduce some of the harms of incarceration, including fatal overdose after release. Responding more systematically to the health effects of incarceration will require reducing our reliance on punishment to manage drug use.

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