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Community coalitions' navigation of policies to address the opioid epidemic: insights from qualitative interviews in four states

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ABSTRACT

Introduction The opioid epidemic in the USA presents a multifaceted challenge regulated by a patchwork of federal, state and local policies. In some communities, cross-sector coalitions navigate this complex policy environment to address the epidemic. However, limited research has explored these public health-oriented community coalitions and their interactions with the policy landscape. This study explores how cross-sector public health-oriented community coalition members perceive and navigate the multidimensional policy landscapes to address the opioid epidemic.

Methods Using data from 304 semistructured HEALing Communities Study coalition member interviews conducted April–June 2021 in 67 communities in Kentucky, New York, Massachusetts and Ohio, we inductively analysed participants' discussions of opioid-related policies to characterise themes and subthemes.

Results We describe two themes where coalitions and policy intersect: policy landscape barriers and navigation and mitigation strategies to address policy barriers. Participants revealed community misunderstandings and lack of knowledge of opioid-related policies. Furthermore, participants shared how these policies often hindered coalitions' initiatives to address substance use. Nevertheless, community coalitions functioned despite these policy challenges through knowledge sharing, innovation and policy advocacy.

Conclusions Cross-sector public health-oriented community coalitions serve a vital role in navigating the complexities of the multidimensional policy landscape regulating substance use services. Insights from these findings may encourage policy-makers to support community coalitions in pursuing solutions to the opioid crisis and other public health crises.

Trial registration number NCT04111939.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Multisector community coalitions are a useful approach to address public health issues, such as the opioid epidemic, yet little is known about how these coalitions are affected by and affect policies.

WHAT THIS STUDY ADDS

⇒ Community coalitions are valuable in navigating the complexity and multidimensionality of public health policies.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Policy-makers, community stakeholders and public health advocates wishing to address public health issues in communities should encourage and support cross-sector coalitions' initiatives.

INTRODUCTION

The opioid epidemic is a significant and worsening public health crisis. Despite a minor decline in opioid-related overdose deaths in 2018 and more recent declines, fatalities due to opioids have increased dramatically each year since 2015.[1 2] In the USA, the regulatory response to this crisis comprises a complex patchwork of federal,[3] state[4 5] and local[6] policies that address the continuum of substance use services from prevention to treatment. Historically, policies emphasised criminalisation of specific opioids and control of drug supply, primarily through prescription drug monitoring programmes implemented to reduce overprescribing and prevent diversion.[7 8] However, recent policy approaches have shifted towards harm reduction strategies, such as increasing access to naloxone—a drug that can reverse an opioid overdose—through standing orders at pharmacies,[8 9] and laws to support naloxone use by bystanders as well as distribution of naloxone by laypersons.[10] Additionally, efforts to expand access to opioid use disorder (OUD) treatment relaxed

the requirement for providers administering medications for OUD (MOUD) to carry specialty waivers.[11]

These policy changes affect various stakeholders and organisational sectors, including service users and providers within healthcare and criminal-legal settings.[5] Coalitions play a crucial role in convening these diverse groups to address topics of concern, such as the opioid epidemic.[12–15] Coalitions typically focus on information sharing, intervention implementation and policy advocacy.[14] Research has identified key factors associated with coalition effectiveness, including explicit governance guidelines, equitable leadership expectations, diverse membership, cross-sector/agency collaboration and group cohesion.[15 16] However, existing research has largely overlooked how cross-sector public health-oriented community coalitions manage service delivery within the context of complex health policies at the local, state and federal levels. This gap leaves important questions unanswered about how coalitions navigate and influence opioid and substance use-related policies.

In the current analysis, we explore how coalition members perceive the opioid policy landscape and how they leverage community coalitions to negotiate policies impacting their efforts to address the crisis. Our findings will be valuable for policy-makers aiming to implement community-level changes and for community coalitions advocating for policy shifts specific to their causes.

MATERIALS AND METHODS

Study setting and design

This analysis is part of the HEALing Communities Study (HCS), a four-state, wait-listed, community-level cluster randomised trial designed to test the effectiveness of the Communities That HEAL (CTH) intervention on reducing fatal opioid overdose in high burden communities.[17] The CTH intervention involved community engagement, facilitation and data-driven decision-making to select evidence-based practices (EBPs) for preventing opioid overdoses.[18–21] The eligibility criteria for states included certain measures of willingness to address implementation of MOUD and OEND, as well as interest in developing cross-sector relationships.[17] Additionally, states were only considered eligible if at least 30% of selected communities within each state were rural and each state reported at least 150 opioid-related overdose fatalities with a rate of at least 25 opioid-related fatalities per 100 000 in 2016.[17] Additional detail about the epidemiological considerations for state and community selection can be found in other published study literature including the study protocol (please reference cited literature).[17] Researchers selected and randomised 67 communities (ie, towns or counties) across Kentucky (KY), New York (NY), Massachusetts (MA) and Ohio (OH) into two waves: active intervention in wave 1 and wait-listed control in wave 2. A total of 66 communities participated.

HCS engaged community coalitions to represent communities and implement the CTH intervention. Over 80% of participant communities had various forms of pre-existing coalitions related to substance use or prevention prior to HCS.[13 22] The CTH intervention had specific requirements for coalitions, such as including cross-sector (behavioural health, healthcare and criminal legal) organisations and creating a coalition charter.[20] HCS created coalitions in communities without existing coalitions, and all coalitions received training and support during the CTH intervention to meet study milestones, such as developing a community action plan to select EBPs.[20]

Sampling, recruitment and data collection

Researchers used purposive sampling based on a pre-established target number of coalition members from relevant sectors (healthcare, behavioural health and criminal legal) to participate in virtual, semistructured interviews. In one community that did not have a pre-existing coalition, we sampled key informants who had relevant professional and community-specific knowledge. The interview guide was inspired by the Reach, Effectiveness, Adoption, Implementation, Maintenance/Practical, Robust Implementation and Sustainability Model (RE-AIM/PRISM) framework.[23] Although no policy-specific questions were included, sections of the guide focused on the internal coalition and the external community context (see online supplemental appendix 1 for interview guide).[22] Researchers collected demographic information on participants prior to or during the interview using a REDCap survey. Across and within each site, senior qualitative researchers trained interviewers to ensure consistency and quality of the interviews across sites. Additional details about cross-site shared protocols for recruitment and interview methods can be found in other published manuscripts.[18 22 24]

Data analysis

Interviews were audio recorded and transcribed; NVivo V.12.0 was used to support coding and analysis. A cross-site core of researchers created an original codebook based on the RE-AIM/PRISM framework concepts. During earlier phases of the project, as part of an iterative deductive-inductive process, the cross-site team refined the codebook, adding some codes that were grounded in the data and were agreed on after a lengthy consensus process.[24] Researchers at each site who received training on this study and the coding protocol from senior researchers conducted a deductive primary coding process for all interview data using the shared codebook. Site-level coding teams and cross-site researchers met regularly to discuss concerns and reach consensus on codes and codebook definitions. The primary coding process is described in depth elsewhere.[22 24]

For this study, we present the analysis of a subset of data from one round of interviews, conducted between April and June 2021. Two researchers (RGO and AGC)

conducted additional reflective thematic analysis[25] of participant perceptions of the 'policy' code that had been added to the codebook in a previous iteration of the primary codebook during a cross-site session discussing the 'external context' category. This reflective analysis found saturation of the themes in the data and minimal differences between wave 1 and wave 2 data; thus, data were analysed without concern for wave. RGO and AGC met regularly to develop novel inductive codes, coded all interviews, created themes and subthemes through consensus, and regularly conferred with M-LD and DMW to discuss process and progress. Peer debriefings of findings with all the authors, including policy experts, ensured analytical rigour.

RESULTS

Participants' characteristics

We interviewed 304 participants across the 4 sites (table 1). Most participants were between 35 and 64 years old (75.0%) and the majority were female (62.5%). The sample had minimal ethnic and racial diversity with nearly all participants self-identifying as non-Hispanic (91.8%) and White (89.5%). Nearly all participants had at least some higher education, with the largest proportion of the sample reporting having completed a master's degree.

Table 1 Characteristics of interview participants

	n (%)
Research site	
Kentucky	67 (22.0)
Massachusetts*	71 (23.4)
New York	89 (29.3)
Ohio	77 (25.3)
Age, n (%)	
18–34 years	32 (10.5)
35–49 years	114 (37.5)
50–64 years	114 (37.5)
65–74 years	28 (9.2)
75 years or older	2 (0.7)
Missing/refused	14 (4.6)
Ethnicity, n (%)	
Non-Hispanic/Non-Latinx	279 (91.8)
Hispanic/Latinx	9 (3.0)
Missing/refused	16 (5.3)
Race,† n (%)	
African American/arti	9 (3.0)
American Indian/Alaska Native	3 (1.0)
Asian	3 (1.0)
Caucasian/White	272 (89.5)
Other	7 (2.3)
Missing/refused	14 (4.6)
Gender, n (%)	
Male	100 (32.9)
Female	190 (62.5)
Genderqueer	1 (0.3)
Missing	13 (4.3)
Education, n (%)	
HS degree or equivalent	4 (1.3)
Some college, no degree	24 (7.9)
Associate's degree	13 (4.3)
Bachelor's degree	82 (27.0)
Master's degree	137 (45.0)
Professional degree	16 (5.3)
Doctorate degree	15 (4.9)
Missing	13 (4.3)

*Includes key informants from one community that did not have a pre-existing coalition (n=4).
†Percentages may not add up to 100 due to participants being able to select more than one race.

Overview of results

Our analysis centred around two major themes: (1) policy landscape barriers and (2) coalition navigation and mitigation strategies to address these barriers (figure 1). Participants across the four sites discussed how policies sometimes hindered efforts to combat opioid overdoses in their communities. The policy landscape, as described by participants, encompassed federal, state and local policies regulating drug use, associated harm reduction activities, substance use disorder (SUD) treatments (specifically OUD) and funding (see online supplemental appendix 2 for details of policies referenced in participants' interviews). Participants' perceptions of these policies and policy changes varied based on state and community policy context. While these policies created barriers for some activities, participants also highlighted that cross-sector coalitions facilitated navigation and mitigation of these policy obstacles—the second overarching theme. Below we highlight details of these two overarching themes using two illustrative case examples: policy knowledge and policies regulating substance use services. Within each case, we outline subthemes that further elucidate the themes described by participants. Additional quotes illustrating policy knowledge are reported in table 2; additional quotes for policies regulating substance use services are reported in table 3.

Case 1: policy knowledge

Policy landscape barriers to knowledge

Lack of awareness of policy changes

Interviewees explained that a particularly challenging aspect of working in the field was remaining attentive

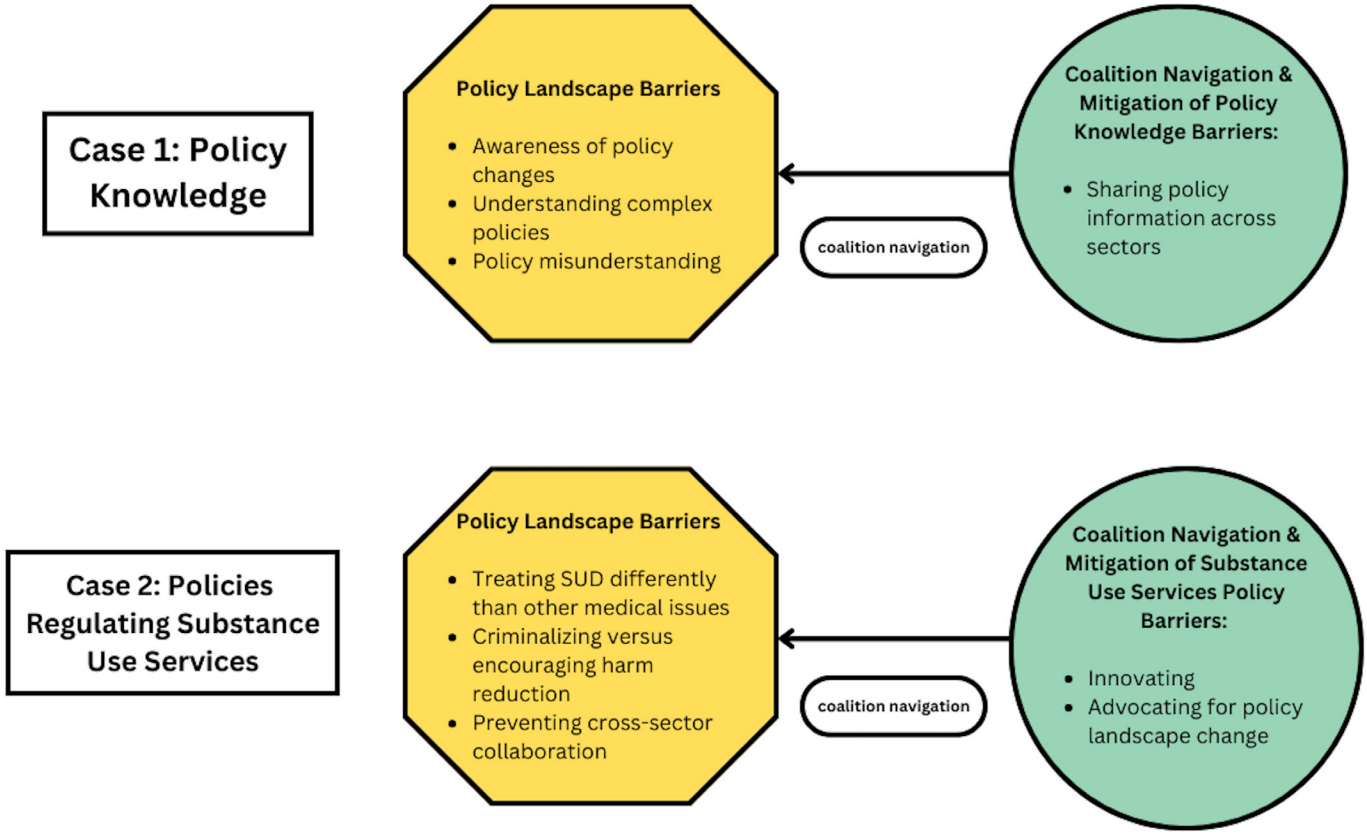

Figure 1 Themes and subthemes across two illustrative examples. SUD, substance use disorder.

to all the policy changes continually taking place. Interviewees discussed recent and forthcoming local, state and federal policy changes, such as COVID-19-related changes to telehealth prescribing of MOUD, and state and federal MOUD policy transformations (ie, DATA 2000/X-waiver). For participants whose work was less directly impacted by a specific policy change, like those whose organisations did not prescribe MOUD, they seemed to be vaguely aware of continuous policy changes. For instance, one participant acknowledged:

> "I know that there were some things that happened through Medicaid about certain things being covered. I just don't know specifics… I feel like that there was some changes on the national level, that change national or state" (KY participant)

Understanding complex policies

Participants mentioned the complexity of policies governing their community-driven activities. They described facing daunting and convoluted rules and guidelines when attempting to implement new initiatives, such as starting harm reduction activities or distributing MOUD in jails. Further, interviewees found it particularly challenging when local, state and federal policies intertwined to govern initiatives, requiring additional effort to understand and work through the multiple layers of policies, as one person offered:

> "Internally [in the organization], I'm keeping on top of insurance guidelines, state guidelines, federal guidelines. For all of this stuff, it was incredibly complicated" (OH participant)

Policy misunderstandings

Some participants noted that the complicated policy landscape resulted in policy misunderstandings. They described trying to implement activities, such as encouraging naloxone distribution or increasing MOUD initiation in the community and encountering others who were misinformed or lacked full understanding of the relevant policy details. Such policy misunderstandings led to fear of liability and inaction in implementing initiatives for some members of the community. For example, a participant discussed how the local sheriff did not fully grasp the nuances of Kentucky's Good Samaritan law, which allows bystanders, including his officers, to intervene during an overdose, and thus was reluctant to act:

> I personally have gone to our sheriff and tried to get him to let the deputies carry it, Narcan [naloxone]. He's been very resistant to it because of the political implications, and I've stayed on him. Most recently he said, 'I think I'm going to let my deputies do it, who want it.' Because he said, 'I attended a conference of sheriffs and they were saying it was good stuff, but I'm still worried about the liability.' And it goes over his head." (KY participant)

Table 2 Policy landscape barriers and coalitions' navigation and mitigation of barriers to policy knowledge

Subthemes: policy landscape barriers to policy knowledge	Exemplar participant quotes	Subthemes: coalition navigation and mitigation of policy knowledge barriers	Exemplar participant quotes
Lack of awareness of policy changes	"I know that one of our, one of the Methadone providers that we work with has, when COVID began to get really bad, they immediately pivoted to giving the majority of their folks a week's take home doses, and it has worked out very well for them. And they would like to continue doing it, but they have concerns that, you know, once we begin to come out the other side of COVID, that, you know, [the state] will come back in, and the DEA [Drug Enforcement Agency] will come back in and you know, sort of clamp down on them." (NY participant)	Sharing policy information across sectors	"We've heard a lot about our partner from our partners about the increased access to buprenorphine. So [Hospital], has talked about how their providers are increasingly becoming X-waivered. And then there was the regulation change that you don't have to get the waiver if you're only going up to 30 prescriptions." (MA participant) "To flood the community with Narcan that's easier said than done, because there's so much policy, and law, and fear of civil liability and how do we do this? We had to overcome all of that…[working across sectors]" (OHparticipant) "We had the legislation that was modified and changed. Good Samaritan laws. Access was provided. Legislatively, funds were introduced, and then a few people were doing it. A few groups were doing it, and then additional funding from KORE [Kentucky Overdose Response Effort], and from the HEALing Communities Study, like just kicked that into high gear. And now you're able to get it at all your different treatment providers. You can get it at the pharmacy. You can get it here at the jail. You can get it from the Office of Drug Control Policy. You can get it from the health department. Like it's really increased the amount of access points and therefore access to this life saving medicine." (KY participant)
Understanding complex policies	"To start a methadone clinic, it's a whole federal process through the DEA [Drug Enforcement Agency] and all this other craziness, so we would've needed somebody to take it on." (MA participant)		
Policy misunderstandings	"Misunderstanding or misinterpretation potentially of regulatory requirements and things getting bogged down… Because it feels like [our law department] doesn't completely understand exactly what is required, and I feel like there's this untapped resource of [University of Kentucky]… that could help with that, that we need better access to." (KY participant)		

KY, Kentucky; MA, Massachusetts; NY, New York; OH, Ohio.

Coalition navigation and mitigation of policy knowledge barriers

Sharing policy information across sectors

Some participants mentioned how coalitions functioned as a cross-sector community resource where they gained knowledge about the complex and changing policy landscape. While participants shared how challenging it was to keep abreast of changing policies affecting their sector's particular work, the policy changes often affected the cross-sector, broader community efforts to reduce opioid overdoses. For example, a participant mentioned that she learnt about an MOUD policy transition during a coalition meeting:

> And if I'm not mistaken, I believe I heard, at one of the recent coalition meetings, that New York State might be doing away with the X-waiver, which, yay-hoo, wouldn't that be lovely… because I think that will open up MAT [Medication-Assisted Treatment, a different term for MOUD] services. (NY participant)

Beyond communication of policy changes, participants discussed how cross-sector information sharing and support helped address community members' policy misunderstandings. As a follow-up to the discussion above about the sheriff in Kentucky who was hesitant to act based on fear of liability and misunderstanding of the Good Samaritan laws, the interviewee continued:

> I've explained to him that I'm a lawyer in addition to doing this drug thing. There is no liability; there's Good Samaritan laws built into that. He says, 'Well, but you can still be sued'. I said, 'Yes, but you can still have the court throw them out real quick too'. But they're people who do not understand law and they do not understand the disease concept of addiction. But anyway, I think we're making

Table 3 Policy landscape barriers and coalitions' navigation and mitigation of barriers to drug-specific policies

Subthemes: policy landscape barriers to drug-specific policies	Exemplar participant quotes	Subthemes: coalition navigation and mitigation of drug-specific policies barriers	Exemplar participant quotes
Treating SUD differently than other medical issues	"Medication-assisted treatment, federal laws have been a struggle for our prescribers in the community. The number of hoops they have to go through to be approved to prescribe it, has been a big issue." (NY participant)	Innovating	"What we [at an organization doing harm reduction] do is kind of extra-legal. But the guidance that was put out by the state was like, basically do what you need to do to make sure that people still get Narcan [brand of naloxone], right. So, we pre-packaged what we're, what we've been calling "Narcan To-go Bags", where we stick the regular, the regular blue kit inside of a paper bag, with all of the instructions that we normally hand out, and the, scan, like QR code and link to a YouTube video that actually shows how to administer it." (NY participant)
Criminalising vs encouraging harm reduction	"But in Massachusetts, we have to go to each town to ask the Board of Health permission before we do needle exchanges or handing out needles or anything like that." (MA participant)	Advocating to change policy landscape	"I just know that some of the major programming we have in Northern Kentucky, Casey's Law [which involves involuntary treatment]… That was all due to grassroots organizations, such as Northern Kentucky Hates Heroin, and small like parent groups who lost children to an overdose. They came together and really made some of these drastic changes." (KY participant)
Preventing cross-sector collaboration	"I think that in New York State, we have such silos with our funding… So when we have people that come in here [to the agency] who can't work because they have a substance use disorder, right now, they must be referred to [a certified] treatment provider… we have to still work under the regulations." (NY participant)		

KY, Kentucky; MA, Massachusetts; NY, New York; SUD, substance use disorder.

some strides, and I think it's making a difference. (KY participant)

Case 2: policies regulating substance use services

Policy landscape barriers to substance use services

Treating SUD differently than other medical issues

Participants explained that policies regulating treatment of SUD, and OUD particularly, often limited health providers' abilities to treat addiction in similar ways to other health issues. Several participants mentioned the rules regulating MOUD prescribing as particularly restrictive, especially in dispensing methadone. In general, the policy challenges of treating a person with OUD are burdensome, as a behavioural health practitioner explained:

> I can get a cardiac person or a diabetic patient, I can call their cardiologist and get them an appointment and it's all set up … and they know what they're doing when they walk out the door. But for my substance use disorder patients, I can't even help them with that.… But because of this 42 CFR Part 2 [regulation of confidentiality for SUD patient records], I can't convey any of their information. So, I have to let them do it for themselves. And sometimes they just give up. (MA participant)

Criminalising versus encouraging harm reduction

Additionally, participants described how some drug-related policies limited what communities could accomplish because they criminalise addiction instead of treating it as a medical condition. This approach is

especially true in relation to harm reduction activities, such as regulations of syringe services programme and fentanyl test strip distribution, both strategies some communities hoped to implement but that participants reported were hindered by policies. For example, at the time of the interviews, two HCS states considered the fentanyl test strips as drug paraphernalia and thus their possession fell under criminal regulations. As one participant explained:

> So, to distribute through our syringe exchange it's to our knowledge—everything that we've researched so far—still feel like that we could be penalized through law enforcement that the fentanyl strips are considered drug paraphernalia. And so, until we get a firm thing, we don't want to have any more clients that are put in jail because we give them fentanyl strips and somebody pulls them over and sees them and puts them in jail when all we were trying to do is to let them be safe as they possibly can be as they are using their method of addiction. (KY participant)

Preventing cross-sector collaboration

Finally, some participants discussed drug-specific policies that limited aspects of cross-sector efforts, including funding mechanisms that siloed sectors and data sharing policies that prevented information sharing. Participants noted how regulations, like confidentiality for SUD patient records (ie, 42 CFR Part 2), created difficulties for ease of sharing data about opioid overdose and treatment between healthcare providers and within coalitions. Some interviewees described policies that perpetuated silos blocking cross-sector collaboration, such as discussed by this participant:

> So, when I first started the coalition, you always hear talks about silos. I have no problem with someone being in our silo; I'm not a doctor… so I should not tear down a doctor silo. What I should do is have a key to the front door, the back door, and we should be able to go into each other's silos openly, share information, figure out what we need… and become advocates… Some of it is regulations and laws… They force silos onto communities and they're not as flexible as they should be there. (OH participant)

Coalition navigation and mitigation of substance use services policy barriers

Innovating

In building cross-sector collaborations, interviewees discussed ways that they worked through the policy barriers preventing action to address addiction and overdose deaths in their communities. Participants explained that working together, especially in cross-sector partnerships, created novel ways to initiate or expand on community-driven activities. In communities receiving the CTH intervention, some of this innovation may have been bolstered by support from the study. For example, the changing rules around naloxone distribution allowed communities to try new activities, as this participant described:

> We never really knew if there was any formalized, specific, training that a coalition needed to have … to give a Narcan [naloxone] training. Or if there was an age that you can get Narcan. And we've learned through [HCS], and just I think the attention the study's brought to it, that there is no formal training that's required to give a Narcan training. And there's also no mandate within the state or law around how young someone can be to give it. (MA participant)

In another example, participants noted that by working with others, like emergency medical technicians working with emergency rooms and health departments, they were able to figure out how they could distribute naloxone after initially encountering barriers. Other times, funding regulations prevented specific interventions from being implemented as first conceived, but through innovative and collaborative work, coalitions were able to act in the community. One participant described:

> The funding that we receive can't purchase needles, so we've had to figure out other ways to purchase the clean needles … Initially, for ours, we had a hospital that had closed down and they donated needles from there, so we had a large supply… To be honest, I am not sure what funding they use, but I think the health department funds it from their main lines. It just can't be through the… federal funds because they're SAMSHA [Substance Abuse and Mental Health Services Administration] funds and it's prohibited, which is comical to me that they can fund a needle exchange, but not the needles. But that's the way bureaucracy works. (OH participant)

Advocating to change policy landscape

One of the ways that participants mentioned responding to drug-specific policy barriers was through grassroots advocacy, working with supportive politicians, and lobbying for policy change. Advocacy efforts involved engaging local and state politicians in policy discussions as well as lobbying for policy change at the federal level. While many participants referenced some kind of political advocacy, this participant thought their community was unique:

> "We're a different beast than probably some of the places around the state. So, we call them 'our moms', and there are dads too, but it's our advocate moms. They get up. They go to city council meeting. They'll shout. They say they need answers. They call their legislators. They call their county judge executives. They ask the questions. They push the envelope… But I think our folks know who are the policymakers, who has the ability to make some change. And our group of moms have led that for the last decade." (KY participant)

DISCUSSION

This study explored how individuals involved in substance use-focused coalitions understand and navigate the complex policy landscape. Our findings reveal that community members involved in SUD prevention and treatment encounter barriers due to insufficient knowledge or misunderstandings related to the ever-changing,

multidimensional policy environment in which they work. Substance use policies may hinder, or even block, the implementation of community-initiated prevention, treatment and harm-reduction initiatives. However, we also found that cross-sector coalitions empower communities through knowledge sharing, advocacy and innovative strategies, mitigating policy misunderstandings and reducing barriers.

Participants often struggled to implement initiatives without a comprehensive understanding of the multifaceted policies at federal, state and local levels. This aligns with existing research which shows that public health interventions are often hindered by the complexity of an evolving policy environment.[5 7] The rapid evolution of policies addressing the opioid epidemic were hastened in response to the COVID-19 pandemic.[26–28] The pandemic severely restricted in-person healthcare, disrupting treatment and compounding health risks for people with OUD. Federal and state governments responded by revising regulations, which were quickly implemented by treatment organisations.[28] For example, in March 2020, the US Substance Abuse and Mental Health Services Administration allowed for patients to receive up to 28 days of agonist medication and expanded buprenorphine prescribing through telehealth services, even for new patients.[29] Notably, participants expressed difficulties in keeping abreast of these rapid policy changes, echoing Bowen and Irish's findings that fear of opioid-related policy non-compliance is exacerbated with lack of timely and accurate policy knowledge.[3]

Our analysis highlights the challenges faced by participants when initiating interventions within a shifting policy landscape. For instance, the uncertainty of COVID-19-related policies' permanence raised questions about their ongoing impact on treatment.[30] Studies assessing the implementation of new COVID-era policies revealed organisational concerns related to government oversight, liability and sustainment of sufficient funding, even as relaxed regulations suggested the potential for increased patient access.[28 30–32] In some cases, managers were suspicious about the loosening of federal and state policies and responded by creating more internal controls over service delivery.[33]

Our work also documents how coalitions facilitate increased knowledge about substance use services policies. Like other research conducted during the COVID-19 public health emergency, we found positive relationships between providers' policy knowledge and support for those policies.[34] Cross-sector collaboration facilitates knowledge sharing, enhancing education, breaking down informational silos, and generating innovation, and may improve coalition effectiveness in changing health outcomes.[14 35] We also build on research showing how bidirectional communication with policy-makers can coproduce substance use services policies responsive to real-time logistical barriers[36] to highlight how coalitions go beyond supporting policies to engaging in advocacy. As individual providers and organisations may experience policy challenges, cross-sector coalitions can have important impacts, and our work underscores the vital role these coalitions play in facilitating the previously documented complex processes of policy change.

Limitations

This study has limitations that should be considered in interpreting results. First, we did not explicitly ask participants about policies. Consequently, our information on policies relies solely on instances where participants organically raised the topic, although participants regularly discussed policy issues. Second, our sample included participants from communities who were actively involved in the study intervention (wave 1), where coalition work may have been influenced by the CTH intervention. Additionally, the HCS included a policy workgroup that engaged in initiatives during later phases of the study, but at the time of the interviews, this workgroup was not actively involved with coalitions. Finally, our sample was predominantly female, non-Hispanic White, highly educated and located across diverse states and geographies. As a result, the challenges navigating policies reported in our findings may not fully represent perspectives from more racially diverse or under-resourced populations, who are increasing affected by opioid crisis[37 38] yet may face different obstacles.

Public health implications and future research

Given strategic benefits of community coalitions in navigating multidimensional policy complexity and change, policy-makers should consider investing in community coalitions to support implementation of public health initiatives. The value of community coalitions, as illustrated by our findings, aligns with broader research on the power of local governance and organisational social networks in knowledge sharing and policy implementation. Coalition effectiveness may be predicated on pre-existing community social capital.[39] However, it may be that community-based, multisectoral coalitions can facilitate policy implementation because they leverage local governance structures and values, as well as the trust,[12] and social capital built within local networks.[40–42] Moreover, because community coalitions draw on both formal and informal local network structures and multisectoral expertise, they are well suited to play a role in strategic actions across a broad range of complex health challenges beyond opioid and substance use. As examples, the community coalition model could play a beneficial role in local navigation of issues related to human trafficking, immigration, food apartheid and environmental exposures.

Future research should build on the novel aspects of this study to explore the different ways in which cross-sector public health-focused coalitions navigate the policy landscape. We recommend that researchers exploring external factors affecting community coalitions should specifically consider investigating the policy landscape. Further, we recommend that research should study

coalitions that include more diverse populations that may have different experiences navigating policy. Researchers may consider investigating the policy context of other health topics or diseases that coalitions address, such as general community wellness or maternal health.

CONCLUSIONS

Community coalitions serve a vital role in navigating the complexities of the policy landscape regulating substance use services. Communities encumbered by numerous and multidimensional policies shaping public health issues, like the opioid epidemic, may find that bringing disparate organisations and individuals together can help leverage assets, including policy knowledge and service innovation to address public health concerns. Policymakers should encourage community coalition creation and financially support their activities as these coalitions can facilitate community-empowered dissemination of policy information and engagement in public health initiatives.

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REFERENCES

1 Centers for Disease Control and Prevention. State unintentional drug overdose reporting system (SUDORS). Final data. sudors dashboard: fatal overdose data. 2024. Available: https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html [Accessed 11 Apr 2024].
2 National Center for Health Statistics, Centers for Disease Control. Vital statistics rapid release - provisional drug overdose data. 2024. Available: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm [Accessed 19 Dec 2024].
3 Bowen EA, Irish A. A policy mapping analysis of goals, target populations, and punitive notions in the U.S. congressional response to the opioid epidemic. *Int J Drug Policy* 2019;74:90–7.
4 Kennedy-Hendricks A, Song M, McCourt AD, *et al*. Licensure Policies May Help States Ensure Access To Opioid Use Disorder Medication In Specialty Addiction Treatment. *Health Aff (Millwood)* 2024;43:732–9.
5 Schuler MS, Heins SE, Smart R, *et al*. The state of the science in opioid policy research. *Drug Alcohol Depend* 2020;214:108137.
6 Swann WL, Schreiber TL, Wright SL, *et al*. Local Policy and Programmatic Activity to Address the US Opioid Crisis: A Cross-Sectional Survey of County Governments. *J Public Health Manag Pract* 2021;27:342–51.
7 Lee B, Zhao W, Yang KC, *et al*. Systematic Evaluation of State Policy Interventions Targeting the US Opioid Epidemic, 2007-2018. *JAMA Netw Open* 2021;4:e2036687.
8 Peglow SL, Binswanger IA. Preventing Opioid Overdose in the Clinic and Hospital. *Medical Clinics of North America* 2018;102:621–34.
9 Pitt AL, Humphreys K, Brandeau ML. Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *Am J Public Health* 2018;108:1394–400.
10 Rees DI, Sabia JJ, Argys LM, *et al*. With a Little Help from My Friends: The Effects of Good Samaritan and Naloxone Access Laws on Opioid-Related Deaths. *The Journal of Law and Economics* 2019;62:1–27.
11 Jones KF, O'Reilly Jacob M, Spetz J, *et al*. Eliminate the buprenorphine DEA X waiver: Justification using a policy analysis approach. *J Nurs Scholarsh* 2023;55:655–64.
12 Felmingham T, Backholer K, Hoban E, *et al*. Success of community-based system dynamics in prevention interventions: A systematic review of the literature. *Front Public Health* 2023;11:1103834.

13 Chen S, Walt G, Aldrich A, *et al*. A Qualitative Study of Health Equity's Role in Community Coalition Development. *Health Educ Behav* 2024;51:613–24.
14 Hogg RA, Varda D. Insights Into Collaborative Networks Of Nonprofit, Private, And Public Organizations That Address Complex Health Issues. *Health Aff (Millwood)* 2016;35:2014–9.
15 Zakocs RC, Edwards EM. What explains community coalition effectiveness?: a review of the literature. *Am J Prev Med* 2006;30:351–61.
16 Nagorcka-Smith P, Bolton KA, Dam J, *et al*. The impact of coalition characteristics on outcomes in community-based initiatives targeting the social determinants of health: a systematic review. *BMC Public Health* 2022;22:1358.
17 Walsh SL, El-Bassel N, Jackson RD, *et al*. The HEALing (Helping to End Addiction Long-term SM) Communities Study: Protocol for a cluster randomized trial at the community level to reduce opioid overdose deaths through implementation of an integrated set of evidence-based practices. *Drug Alcohol Depend* 2020;217:108335.
18 Knudsen HK, Drainoni M-L, Gilbert L, *et al*. Model and approach for assessing implementation context and fidelity in the HEALing Communities Study. *Drug Alcohol Depend* 2020;217:108330.
19 Lefebvre RC, Chandler RK, Helme DW, *et al*. Health communication campaigns to drive demand for evidence-based practices and reduce stigma in the HEALing communities study. *Drug Alcohol Depend* 2020;217:108338.
20 Sprague Martinez L, Rapkin BD, Young A, *et al*. Community engagement to implement evidence-based practices in the HEALing communities study. *Drug Alcohol Depend* 2020;217:108326.
21 Winhusen T, Walley A, Fanucchi LC, *et al*. The Opioid-overdose Reduction Continuum of Care Approach (ORCCA): Evidence-based practices in the HEALing Communities Study. *Drug Alcohol Depend* 2020;217:108325.
22 Drainoni M-L, Knudsen HK, Adams K, *et al*. Community coalition and key stakeholder perceptions of the community opioid epidemic before an intensive community-level intervention. *J Subst Abuse Treat* 2022;138:108731.
23 Glasgow RE, Harden SM, Gaglio B, *et al*. RE-AIM Planning and Evaluation Framework: Adapting to New Science and Practice With a 20-Year Review. *Front Public Health* 2019;7:64.
24 McAlearney AS, Walker DM, Shiu-Yee K, *et al*. Embedding Big Qual and Team Science into Qualitative Research: Lessons from a Large-scale, Cross-site Research Study. *Int J Qual Methods* 2023;22:16094069231165933.
25 Braun V. Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res* 2021;21:37–47.
26 Au-Yeung CM, Blewett LA, Winkelman TNA. Increasing access to medications for opioid use disorder: policy strategies during and after covid-19 pandemic [Milbank Memorial Fund]. 2021. Available: https://www.milbank.org/wp-content/uploads/2021/10/Au-Yeung_Brief_5.pdf
27 Davis CS, Samuels EA. Opioid Policy Changes During the COVID-19 Pandemic - and Beyond. *J Addict Med* 2020;14:e4–5.
28 Goldsamt LA, Rosenblum A, Appel P, *et al*. The impact of COVID-19 on opioid treatment programs in the United States. *Drug Alcohol Depend* 2021;228:109049.
29 Substance Abuse and Mental Health Services Administration (SAMHSA). FAQs: provision of methadone and buprenorphine for the treatment of opioid use disorder in the covid-19 emergency. 2020. Available: https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf [Accessed 09 Dec 2024].
30 Krawczyk N, Rivera BD, King C, *et al*. Pandemic telehealth flexibilities for buprenorphine treatment: A synthesis of evidence and policy implications for expanding opioid use disorder care in the U.S. *medRxiv* 2023.
31 Levander XA, Pytell JD, Stoller KB, *et al*. COVID-19-related policy changes for methadone take-home dosing: A multistate survey of opioid treatment program leadership. *Subst Abus* 2022;43:633–9.
32 Madden EF, Christian BT, Lagisetty PA, *et al*. Treatment provider perceptions of take-home methadone regulation before and during COVID-19. *Drug Alcohol Depend* 2021;228:109100.
33 Pérez-Chiqués E, Strach P, Zuber K. Competing Emergencies: A Policy Analysis of the Opioid Epidemic during COVID-19. *Journal of Comparative Policy Analysis: Research and Practice* 2021;23:85–94.
34 Mandavia AD, Campbell A, Henry BF, *et al*. Support for COVID-19-Related Substance Use Services Policy Changes: a New York State-Wide Survey. *J Behav Health Serv Res* 2022;49:262–81.
35 Varda DM, Chandra A, Stern SA, *et al*. Core dimensions of connectivity in public health collaboratives. *J Public Health Manag Pract* 2008;14:E1–7.
36 Henry BF, Campbell A, Hunt T, *et al*. COVID-19 related substance use services policy changes: Policymaker perspectives on policy development & implementation. *J Subst Abuse Treat* 2022;133:108550.
37 Gibbons JB, Harris SJ, Solomon KT, *et al*. Increasing overdose deaths among Black Americans: a review of the literature. *Lancet Psychiatry* 2023;10:719–26.
38 Gondré-Lewis MC, Abijo T, Gondré-Lewis TA. The Opioid Epidemic: a Crisis Disproportionately Impacting Black Americans and Urban Communities. *J Racial Ethn Health Disparities* 2023;10:2039–53.
39 Puro N, Kelly RJ. Community social capital or health needs: What is driving hospital-community partnerships to address social determinants of health? *SSM Popul Health* 2022;18:101129.
40 Walker RM, Andrews R. Local Government Management and Performance: A Review of Evidence. *J Public Adm Res Theory* 2015;25:101–33.
41 Paldam M. Social Capital: One or Many? Definition and Measurement. *J Econ Surv* 2000;14:629–53.
42 Provan KG, Milward HB. Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks. *Public Adm Rev* 2001;61:414–23.