

Established *Tables* and Emergent *Huddles*: Exploring the Processes of Participation Associated With the Policy Changes to Opioid Pharmacotherapy Treatment in Australia in the Context of COVID-19

Contemporary Drug Problems
2022, Vol. 49(4) 385-404
© The Author(s) 2022
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/00914509221123001
journals.sagepub.com/home/cdx



Richard Mellor¹ , Matthew Kearnes², Kari Lancaster³ ,
Laura McLauchlan¹, and Alison Ritter¹

Abstract

In this paper we document and analyze emergent participatory processes in drug policy, focusing on the relations between established modes of engagement and emergent participatory formats. We do this through analysis of a case example, attending to policy changes to opioid pharmacotherapy treatment in the context of COVID-19 in Australia. Semistructured interviews ($n = 22$) were undertaken between August 2020 and March 2021 with people closely involved in the recent policy changes and discussions surrounding opioid pharmacotherapy treatment in Australia. The analysis of the interview accounts followed work which has forged relational, co-productionist and materialist understandings of participation. Two figures of participation were encountered in the interview accounts: *the tables* of participation and *the huddles* of participation. The tables seemingly represented a standardized set of bureaucratic mechanisms for the inclusion of the “voices” of people who use drugs. The huddles emerged as a responsive and less coherent set of ad hoc participatory collectives in the context of rapid policy changes during COVID-19. Instead of viewing emergence as distinct from existing participatory formats, emergence was conceptualized ecologically in this article—that is in relation to established forms of participation. As the institutionally mandated tables served the basis for the emergent huddles of participation in this case study, it demonstrates that even the most

¹ Drug Policy Modelling Program, Social Policy Research Centre, University of New South Wales, Sydney, Australia

² School of Humanities and Languages, University of New South Wales, Sydney, Australia

³ Centre for Social Research in Health, University of New South Wales, Sydney, Australia

Received February 6, 2022. Accepted for publication August 1, 2022.

Corresponding Author:

Alison Ritter, Drug Policy Modelling Program, Social Policy Research Centre, University of New South Wales, Sydney 2052, Australia.
Email: alison.ritter@unsw.edu.au

foreclosed participatory structures can adapt and be responsive to evolving situations of need, perhaps also in ordinary times and not just in emergency conditions.

Keywords

participation, drug policy, opioid agonist treatment, medication assisted treatment for opioid dependence, COVID-19

Introduction

Over the last forty years the interface between science, policy and public reason has been increasingly characterized by diverse efforts to include public perspectives—either the “general” public, or specific—in decision making (Jasanoff, 2012). Across areas as diverse as medical advice, environmental policy, and the governance and regulation of new and emerging technologies, the language of public participation and engagement, alongside more specific notions of political deliberation, citizen control and representation, increasingly feature as the basic terminology of contemporary governance (Kelty, 2019). Informing this broad shift are a series of overlapping “normative, instrumental and substantive rationales” (Landström, 2019, p. 11). Diagnoses that speak of deficits in public trust in, and perceived legitimacy of, the institutions of governance have propelled overlapping efforts to make the practices of governing more legible and approachable to citizens. At the same time, the emergence of more reflexive and questioning public dispositions in response to performances of authoritative judgment (Bijker et al., 2009) have informed strategies designed to diversify the forms of expertise that shape and influence policy formulation and decision making. Alongside these developments, normative accounts of public participation have emphasized the need for those impacted by policies to be represented—to have a “seat at the table”—in these decision-making processes.

This “participatory turn” (Chilvers & Kearnes, 2015) in contemporary modes of governing has had particular implications in the area of drug policy making. Emblematic of wider efforts to promote the participatory democratization of the mobilization of specialized expertise in decision making (Delvenne & Macq, 2020; Wynne, 2007), drug policy processes have, for many years, sought to include a wider range of “voices.” Prescribed participatory techniques are often called into action in order to promote “greater participation”; including through consultative committees, consumer panels, roundtables, drug summits, and so on (Ritter et al., 2018). It is common in progressive policy contexts for a range of actors, including “drug user representatives,” to be included in processes of policy design, deliberation, implementation, and evaluation (Bjerger et al., 2016; Goodhew et al., 2019; Treloar et al., 2011). Indeed, although it need not necessarily be delimited in this way, in the context of drug policy the notion of participation has become almost synonymous with concerted efforts to promote “consumer participation” (Australian Injecting and Illicit Drug Users League, 2012; Jürgens, 2005; Rance & Treloar, 2015).

Intensifying complexity, however, this participatory impulse is set in the context of wider commitments to evidence-based drug policy, which as Madden et al. (2021, n.p.) suggest, functions to “authorise certain knowledge practices and de-legitimise others.” When enacted in highly politicized drug policy contexts, efforts to promote “greater participation” have been shown to delimit the subjectivities and capacities afforded to those participating in policy processes, especially for people who use drugs in drug policy discussions (Bartoszko, 2021; Fraser et al., 2018; Lancaster et al., 2017; Ritter et al., 2018). As Lancaster et al. (2017) argue: “calls for greater ‘consumer participation’ in health policy decision-making and drug policy processes” (p. 60)—commonly envisaged and coordinated through the slogan “nothing about us without us”—have resulted in the creation of formalized processes for the inclusion of the “voices” and perspectives of people with lived experiences of drug use (often framed as “consumers”) in policy processes. In a context where “policies and

practices already constitute people who use drugs as irrational and illegitimate political subjects” (Lancaster et al., 2017, p. 66), the inauguration of formalized mechanisms for “consumer participation,” in practice can produce delimiting effects, including for how participation is imagined and done.

This represents something of an impasse. While consumer participation in drug policy reform might be regarded as a hard-fought outcome, and the product of long standing advocacy and activism, in practice policy processes have been characterized by the slow pace of formal decision-making processes, byzantine bureaucratic structures and the continuing experience of stigma and discrimination for people who use drugs in the everyday experience of drug policy outcomes (Mellor et al., 2021). Dual commitments to consumer participation and evidence-based policy making—especially where the nature of evidence is defined both narrowly and rigidly—can paradoxically result in consumers and advocates being excluded the moment they engage in participatory processes.

Taking a broader view of participation, and extending beyond the focus on consumer participation, recent drug policy scholarship is increasingly informed by theories and concepts drawn from wider bodies of work in participatory democracy (Fraser et al., 2018; Lancaster et al., 2018; Ritter et al., 2018). Contemporary thinking in participatory and deliberative democracy is increasingly oriented toward approaches that extend beyond event-based participatory practice, and encompass systems-based and ecological understandings of participation (Marres, 2007). For example, work from Chilvers and Kearnes (2015, 2020) on emergent publics, alongside work in deliberative systems theory (Parkinson & Mansbridge, 2012) and object-oriented and materialist analyses of participation (Marres, 2012; Nielsen & Langstrup, 2018; Ryghaug et al., 2018; Throndsen & Ryghaug, 2015), invites analyses which situates event (participation as “mini-publics”) and process (participation as an institutional capacity for consultation) based accounts of participation in a wider network of relations. More generally this work has sought to diversify accounts of participation in ways that decenter the dominant figures of participation; whether that be the central figure of “opinionated publics”—a member of the general public who possesses unique preferences and attitudes concerning matters of contemporary public policy—or the “community representative”—a mediating figure that translates between processes of policy development and embodied membership of communities affected or targeted by these policy processes. In place of these figures this work is characterized by notions of uninvited, disruptive, insurgent and counterpublics (Warner, 2002; Wehling, 2012; Wynne, 2007), where participatory collectives appear as emergent, often unstable, and temporally contingent. In this account new participatory spaces appear as emergent and often overflow into multivalent forms of activism and “bottom-up” participatory collectives, often mobilizing alternative, issue-based and embodied forms of expertise and evidence (Callon et al., 2009; Epstein, 1995).

A key conceptual issue in this literature, which is the subject of this paper, is the relations between established—often highly standardized, and institutionally mandated—forms of participation, and the more insurgent and emergent participatory formats. Emergent participatory processes are rarely the focus in drug policy studies, the exception being the work from Fraser et al. (2018). Using Warner’s (2002) notion of publics and counterpublics, Fraser et al. (2018) focus on how publics are made in drug policy, and in doing so scrutinize the widely accepted model of “consultation” in policy development, arguing that this format of participation problematically enacts publics as singular, already-made, and manageable. In order to understand and promote publics as emergent, Fraser et al. (2018) tentatively propose an alternative to “consultation,” namely that of a conference: “Here we are thinking of conferences that arise out of previously dispersed and divergent subjects, that offer a temporary space of convergence around a specific concern, and that take for granted that all participants will emerge from the process of conference changed in some way: will become new subjects-in-the-making” (p. 77). In this analysis, emergent publics are envisioned as arising as an otherwise unaccounted for set of dispersed subjects who seemingly come together around a shared issue or concern (Fraser et al., 2018). This shares features with the notions of the “uninvited public” who are “independent from

institutional policy making [...] and thus normally have an agenda of issues and concerns,” and who are viewed of as different from the “invited public” who are “connected institutionally with policy making [...] and have a preordained agenda and framing” (Wynne, 2007, p. 107). Suggested in these studies is the idea that compared to established and institutionally mandated publics and policy processes, uninvited and emergent publics operate differently, with different effects.

Developing a better understanding of the theory and practice of emergence in drug policy is crucial when moving beyond the delimiting effects encountered when calling for greater participation through established procedures and structures. While the notion of emergence is an inherently ambiguous concept with multiple characteristics and effects depending on context, it in general involves portraying new spaces of engagement (Revez et al., 2022). Documenting and exploring emergence can be helpful when addressing “those moments of ontological disturbance in which the things on which we rely as unexamined parts of the material fabric of our everyday lives become molten” (Whatmore & Landström, 2011, p. 583). With our focus on emergence in this article we aim to document the seemingly alternative and perhaps disruptive and temporarily contingent participatory processes, and how they are situated in a wider network of relations. Particularly, we are interested in the relations between emergent participatory processes and established participatory structures and modes of engagement. The case study through which we study the relations between emergent and established forms of participation covers the policy changes to opioid pharmacotherapy treatment in the context of COVID-19 in Australia.

Case Study

The provision of methadone and buprenorphine assisted treatment for people experiencing opioid dependence, herein referred to as opioid pharmacotherapy treatment, has been a contentious topic for many years (Ritter & Di Natale, 2005). For decades, there have been concerns that many features of opioid pharmacotherapy treatment policy, such as the restrictions on take-away dose policies, the prohibitive cost of dispensing fees for clients, and restrictive service models, perpetuate experiences of stigma and discrimination and have a negative impact on treatment outcomes (Australian Injecting and Illicit Drug Users League, 2011; Berends et al., 2015; Crawford, 2013; Treloar et al., 2007). Concerted advocacy has been directed towards allowing more flexible treatment delivery models, yet until COVID-19, changing policies and practices has remained politically elusive.

One striking feature of COVID-19 in drug policy contexts has been the adoption of patient-oriented policy changes to opioid pharmacotherapy treatment. There are many well-documented reasons why the COVID-19 pandemic presents unique challenges for people involved in opioid pharmacotherapy treatment. Pharmacotherapy clients are more likely to experience poorer outcomes if they contract COVID-19 (Dubey et al., 2020; Volkow, 2020; Wang et al., 2021). Many clients also experience poor quality and unstable housing, and may reside in crowded living conditions, thus increasing the risk of exposure to SARS-CoV-2 and posing challenges for self-isolation (Dunlop et al., 2020; Khatri & Perrone, 2020; Marsden et al., 2020). Daily supervised dosing at clinics with high numbers of patients and short opening hours poses challenges for maintaining social distancing, and treatment continuity becomes a major issue if and when a clinic is required to close due to a COVID-19 outbreak (Dunlop et al., 2020). All these issues are compounded by other challenges associated with the COVID-19 pandemic, including disruptions to the supply of illicit opioids, unemployment, and mental health concerns (Marsden et al., 2020).

In terms of the regulatory changes, many countries temporarily allowed for more flexible service delivery models in the context of COVID-19, for instance, allowing clients to obtain more takeaway (take-home) doses of methadone and buprenorphine, using telemedicine for reviews and evaluations, accelerating the expansion of long-acting injectables (e.g., depot buprenorphine), delivering medications to clients where possible, extending the duration of prescriptions, and increasing access to

take-home naloxone (British Columbia Centre on Substance Use, 2020; Farhoudian et al., 2020; Lintzeris et al., 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Despite some concerns around policy implementation (Becker et al., 2021; Pérez-Chiqués et al., 2021), early evaluations suggest that these regulatory changes have led to few if any unintended consequences (Brothers et al., 2021; Caton et al., 2021; Kitchen et al., 2022; Lintzeris et al., 2021; Saloner et al., 2022; Welsh et al., 2022), and clients have reported greater self-efficacy and recovery capital as a result of the increased flexibility in treatment (Levander et al., 2021). There have been calls to sustain and expand these improvements to treatment delivery beyond the pandemic (Corace et al., 2022; Durand et al., 2022; Grebely et al., 2020; Green et al., 2020), and in the US the Substance Abuse and Mental Health Services Administration have recently extended the temporary policy changes for another year, and also have plans to make them permanent (SAMHSA, 2021).

In Australia, changes to opioid pharmacotherapy policies and practices were actioned in early-mid 2020 in the context of the first wave of COVID-19. This study focused on three Australian jurisdictions: New South Wales (NSW), Victoria, and the Australian Capital Territory (ACT).¹

In terms of the wider COVID-19 policy landscape in Australia in 2020, the first COVID-19 cases were reported in late January 2020, and by the end of March 2020, national “stay at home orders” were introduced, which involved government guidance to only leave home for essential reasons, including: shopping for food or essential items, medical care or compassionate needs, exercise, and work or education that cannot be performed from home. Compared to other countries like the US and the UK, the COVID-19 case numbers and deaths in Australia were extremely low in 2020, the exception being the state of Victoria which experienced increased cases and deaths compared to other jurisdictions in Australia. Stricter and longer lockdowns were introduced in Victoria, for instance curfews were mandated where persons had to remain home between 8 pm and 5 am lasting some months, and people in some areas were not allowed to travel outside a 5-kilometer radius of their residence. In all jurisdictions, opioid pharmacotherapy treatment was defined as an essential health service, which meant people could still leave their residence and travel the necessary distance when accessing their medications.

The main changes to opioid pharmacotherapy in Australia, actioned between March and July 2020, included the increased provision of takeaway unsupervised dosing, the delivery of medications to people in isolation or quarantine, increased use of telemedicine, increased expansion of long acting injectables, and the expansion of more flexible prescribing practices (for more details see Mellor et al., 2021).

Method

Sample

Taking policy changes to opioid pharmacotherapy treatment described above as our case study, we generated empirical data for analysis via qualitative interviews. Overall, 22 semistructured interviews were conducted with 21 people: one participant was interviewed twice because they were closely involved in the policy processes in two jurisdictions. The interviews were conducted with a range of people who were identified as being involved in the policy changes and discussions surrounding pharmacotherapy treatment in the ACT, NSW, and/or Victoria, and included: treatment providers and clinical directors ($n = 7$), government policymakers ($n = 5$), representatives of people who use drugs ($n = 5$), researchers ($n = 2$), and representatives from peak bodies of alcohol and other drug treatment services ($n = 2$). Besides one interview which had a national focus, the remaining interviews focused on a single jurisdiction: 6 interviews focused on the ACT, 7 on NSW, and 8 on Victoria.

Potential participants were initially identified based on the research team's existing knowledge of the drug policy field and publicly available reports and communications. In the interview encounter participants also mentioned the names of other people closely involved in the policy processes, and these individuals were then invited by the research team to participate in an interview.

In the quotes given below, participants are identified only by an interview number, and not which jurisdiction they are from or their professional role, given the risk of identification when conducting interviews with a relatively small group of key actors who potentially know each other and have a long history of working together (Lancaster, 2017). Ethics approval was received from the University of New South Wales (UNSW) ethics committee.

Data Generation

All semistructured interviews were conducted between August 2020 and March 2021 over videoconference, by the first and second authors (RM and MK). The interviews elicited talk across a range of domains related to the policy changes surrounding pharmacotherapy treatment, including what policies were changed, how the policies were changed, who was involved in meetings and discussions, the role of participation in drug policy more broadly and within the case study, the backdrop of these changes (what brought them about), and the permanence of the policy changes. Although the primary focus of this study was on participation in drug policy, the strategy was to wait until the end of the interview encounter to ask explicitly about the role of participation in drug policy, allowing unrehearsed and possibly novel accounts of participation to arise in the prior sections of the interview encounter, for instance when talking about how meetings were convened and who was involved. The interviews lasted between 32 and 78 minutes (average length 60 minutes), were audio-recorded and transcribed verbatim with informed consent, and organized for analysis with the assistance of NVivo software.

Analysis

In the analysis we draw on work that has forged relational, co-productionist and materialist understandings of participation. This work takes participation as the object of the analysis, and focusses on the ways publics, and the very forms of participation themselves, are coproduced and in the making and emergent through practices. A relational understanding also considers a wider network of relations and specifically how forms of participation impact and are impacted by social and political orders. This approach has the potential to document emergent participatory processes and can offer alternative formulations of participation and science and democracy (Chilvers & Kearnes, 2020; Lancaster et al., 2018).

Based on initial coding (Neale, 2016), two figures of participation were encountered which offered contrasting understandings of participatory processes. These were the *tables* of participation and the *huddles* of participation. A second round of coding was conducted focusing on the figures of the tables and the huddles, which involved coding extracts any time the term tables and huddles were mentioned in the interview encounters, and also extracts which provided an implied understanding of or reference to these figures of participation. We focused on what the formats of the tables and the huddles of participation make possible and delimit, and what this tells us about existing and possibly emergent participatory formations. Additionally, focusing on the tables and the huddles allowed us to explore the relations between established and emergent participatory processes.

Findings

Through our analysis of participants' accounts, the figures of the tables and the huddles encapsulated two very different forms of participation. The figure of the table invoked the established procedures for the inclusion and representation of "voices" around divergent issues of concern, while the figure of the huddle emerged to capture a more adaptive set of practices in the context of rapid policy changes adopted in responses to COVID-19.

The Established Tables of Participation

In the interview accounts, participants often talked about the role of existing formal committees when describing the policy processes that surrounded the policy changes to pharmacotherapy treatment in the context of COVID-19. These committees included advisory committees, consumer panels, and working groups, formally established for some years within systems of governance, with terms of reference and specific membership. Membership was often determined by concepts of "representation," and generally configured in relation to pre-existing formalized organizational structures—be it state government departments, treatment organizations and professional groups, or recruited via established national and statewide community organizations who represent people who use drugs in Australia. The configuration of these committees according to the terms of "representation" assumed pre-existing groups and interests which needed to be "brought together" (Lancaster et al., 2017).

The figure of the table was often used when describing the events and participatory processes associated with these formal committees.

A seat at the table.

Participation is a strange beast, but it's just about having a seat at the table. The facts of the matter are, if you are not at the table, you are on the menu. (Interview 11)

In the interview accounts, participation was often equated to having a "voice at the table" or a "seat at the table," and at best "being at the table from the beginning." This was especially the case for people who represent people who use drugs in drug policy who were said to always have a "seat at the table" and a "strong voice" in existing formal committees. It was emphasized that this achievement was a "hard graft" and "not something that I think we as [a drug user organization] can take for granted" (Interview 1). More broadly, the figure of the table appeared to be situated in a particular historical context:

So, like 10 years ago, [one drug user organization] were like off on the side as like, I don't know, the annoying consumer group that said things that people didn't like, that were annoying and were kind of on the outside. So, this kind of process over the last decade was about kind of bringing them in to give them equal status within the field.[. . .] We as a sector have worked really hard to make sure that [the drug user organization] is *at the table* and a respected like *voice at the table*, like a trusted voice, like if someone wants to know what's going on in [pharmacotherapy treatment], talk to them and they will tell you what the good bits are and the not so good bits. (emphasis added, Interview 5)

This shows how the figure of the table is historically contingent, and could be seen to represent a formatting of consumer participation and the wider drug user movement in Australia (Madden & Wodak, 2014). Recent work that has documented the diverse forms of participatory practice deployed in contemporary policy making has documented the relationship between the *formats* of public participation and the *formatting* of participatory *publics* (Pallett et al., 2019; Thévenot, 2014). In the

context of our study, this is evident in the way those who represent people who use drugs are no longer seen to be “standing on the outside, criticizing and throwing pig’s blood” (Interview 14). Rather they are now “respected,” “embedded,” “enmeshed,” “mainstream,” and “active” in policy activities surrounding opioid pharmacotherapy treatment in Australia.

In terms of the rapid policy changes to pharmacotherapy treatment in the context of COVID-19, it was often noted that the formal committees had not actually met very often in the period that coincided with the policy changes, and if they had met, the practices of the formal committees seemed to have delimiting effects (see below). Nevertheless, the formal committees and the figure of the table were often talked about in the interviews when describing how the policy changes were made. It appeared that having a “seat at the table” was more important than the actual meetings themselves. It provided members with a certain status in the drug policy field, which meant that state governments had to ensure that the members were “comfortable” with whatever policy changes were proposed, even if those conversations happened “out of session”:

For this particular project, look we did a lot of out of session discussions with [the formal committee], so we knew that those members had to be comfortable, because that’s our official pathway of approval for anything [pharmacotherapy] related. I think we only had one actual meeting of [the formal committee] in that period when we were developing the documents, whereas [another group] were meeting weekly, but talking about a whole raft of issues. It’s not that I think one was better than the other, but I am pleased I had access to the [other group] that I normally wouldn’t have. (Interview 21)

This suggests that although the formal committees only met once during the period that coincided with the policy changes, the committees were still the state governments’ “official pathway of approval.” Relatedly, another benefit of the formal committees was that they provided state governments with an “established network of local stakeholders”:

I guess because of [the formal committee] we did have that established network of local stakeholders whom we could quickly and easily draw upon and convene to start working through these issues. (Interview 2)

Given the historical context of the drug user movement in Australia, people who represent people who use drugs were seen to have a seat at the formal committees in each jurisdiction and were therefore seen to be part of the “established network of local stakeholders.” This meant that the policy responses to pharmacotherapy treatment in the context of COVID-19 were linked and connected to particular kinds of situated knowledge:

[One named drug user representative] was our link to getting stuff done in that space, [the drug user representative] is very acquainted with the [pharmacotherapy treatment] program in [the state], sits on [formal committees], you know, got the document reviewed by people actually on [pharmacotherapy treatment] programs which is great. (Interview 21)

This participant viewed “sitting” on formal committees as being an important proxy when understanding who to “link” with in policy discussions, which in this case was one named drug user representative, who ensured that the policy documents were reviewed by and situated in the experiences of pharmacotherapy treatment clients. As further testament to the established role of drug user representatives in the drug policy field, and the situated knowledge this affords, one policy document which was ready to be finalized got “held up for some time” and revised to ensure it was sensitive to concerns around client choice. It was suggested that this process was only possible because of the way “[drug user] organizations like ours are genuinely included in *our* sector” (emphasis added, Interview 14).

The delimiting effects of the tables. A paradox addressed in the broader literature is the way participation is both a hard-won accomplishment and a procedural limitation (Chilvers & Kearnes, 2020; Lancaster et al., 2018). This was also the case with the tables of participation in our study, on the one hand representing a hard-won outcome for the drug user movement but also associated with delimiting effects:

It's about *nothing about us without us* and so that's part of what we've tried to *engineer* with our [formal committee] [...] We make sure that they each have a *voice at the table* [...] We try to *engineer* that discussion so that each perspective is then able to be *brought in*. (emphasis added, Interview 12)

Despite echoing the principle of “nothing about us without us,” this participant goes onto say:

Sometimes of course you guys would know, when the government is making policy it happens sometimes within the cabinet and confidence frame and so you can't always consult as openly as you know during those processes because we are public servants at the end of the day, but what we can do is kind of check in about you know if you were giving some [government] advice about the priorities x, y and z areas, what would it be, so that way we could go forwards with the confidence that we are doing a job of representing as well as serving government.” (emphasis added, Interview 12)

The function of participation in this description was to give policymakers “confidence” and “check-in” as they go on “serving government.” This implies that the process of “serving government” and being a “public servant” is distinct from representing the perspectives of the sector, which renders participation itself as independent to policy processes. The idea that perspectives are “brought in” also implies that they are pre-given and separate from each other (Lancaster et al., 2017). The term “engineered” was also used twice in this description, which we suggest indicates that in this context the fixed and already-made voices of those participating at the tables are viewed as being manageable (Fraser et al., 2018), or indeed engineerable, waiting to be called into action through pre-given participatory mechanisms.

Similarly, another participant in a different jurisdiction gave a description of how the policy process “usually works,” whereby the state government uses the formal committees to reach “consensus,” and then makes decisions out of session: “basically, everyone gets to say their piece and then, I guess, [the government] goes away and thinks about it [laughs]” (Interview 3). This again renders the participatory processes as independent from policy decisions, and the idea that this is how it “usually works” indicates that this represents more established participatory processes. It was also interesting that this participant suggested that reaching “consensus” was the goal of these participatory processes, which itself is an ideal of deliberative democracy, but when triangulated with the above description (Interview 12), a more critical view might be that consensus is sought because it is a “convenient” end-point for governments when reinforcing and giving “confidence” to policy decisions which are made independently to participatory processes (Ritter et al., 2018). Consensus is a practice of tables which smooths difference and contestation, but in doing so, is also political in its effects (Lancaster et al., 2015), silencing difference and obscuring power relations through its presentation of agreement and a united front, and delimiting what is made sayable and how decisions are enacted as justifiable and authoritative.

The figure of the table was also very much animated by the theme of separation and difference. One participant characterized the formal committees as being “battlegrounds,” and participants also frequently mentioned having to “push” issues at these committees, invoking a sense of conflict:

I had to push so hard to *get it on the table* and to get it . . . I had to light a fire you know and then when they did the guidelines, they didn't interact with us at all. (emphasis added, Interview 11)

This underscores an assumption lodged within existing participatory processes of drug policy, whereby those participating in policy discourses have fixed interests which are different from one another, which in effect enacts separateness in the sector even within processes ostensibly aimed at bringing it together (Lancaster et al., 2017).

Recent work exploring the situated practices of participatory processes has documented the ways in which the “what (objects and issues), how (procedural formats), and who (publics)” (Pallett et al., 2019, p. 590) both shapes the forms of interaction and political discourse possible in these participatory spaces, and are in turn shaped by what Chilvers et al. (2018) terms wider “constitutional stabilities.” In the case of the tables of participation, a highly standardized and familiar imagination of participation, our results suggest that the tables favored professionalism and being courteous, which in turn appeared to devalue the experiences of people who use drugs. More specifically, in the interview accounts, drug user representatives were described as people who could not “bang their head on the table,” but instead needed to understand “the committee process, you know, understanding compromise, understanding the realities of, you know, working with achievable outcomes rather than ideal outcomes” (Interview 3). Part of “proving” this “expertise” involved being “kept to that very high standard . . . our professionalism has to be a step above and you know, I swear a lot obviously and maybe I’m not very professional, but in that sense, certainly you have to demonstrate that you can *bring something to the table*” (emphasis added, Interview 11).

We see here a particular form of participation required to have a seat at the table—one that understands “compromise” and consists of “professionalism.” This no doubt favors certain knowledges and expertise over others (Ritter et al., 2018). As a case in point, one participant initially attempted to bring the fears of COVID-19 expressed by the community to a particular formal committee, and despite being “courteous and diplomatic” in the first instance and doing the “background work” and raising it as an “agenda item,” this did not work and they were given the “fob off,” which necessitated a different form of participation that involved an impassionate personal story told outside the committee “in the corridor”:

It got to the point where I used a personal story [. . .] I never do things like that, that’s crazy you know [. . .] these are the games you play at meetings, you use the way the meeting is formulated, the rules of the meeting to put agenda items on and make sure they go through to the right area. (Interview 11)

We see here that established formats of participation are encoded with implied rules that manifest in the anticipated space of participation (Davies, 2013).

In summary, the formal rituals and the governance structures within which the tables are situated meant that they had delimiting effects. Yet, the same “official” character of these participatory processes also offered those who have a seat at the table a particular status in the field, which meant they were seen to be part of the established network of actors who needed to be consulted and comfortable with whatever policy changes were made, even if these key discussions happened in other formats, which we termed the huddles.

The Emergent Huddles of Participation

When describing a set of emergent and ad hoc participatory processes in this case study we use the figure of the huddle. We borrow the term huddle from a state government department in NSW. In early March 2020, they started what they called “COVID huddles,” which initially acted as out of session conversations involving internal employees. In the context of the broader public health response of COVID-19, these initially small and internal “COVID huddles,” were inserted into wider pre-existing communities of practice in NSW (Lyons et al., 2020). Having found the NSW term “huddle” useful for identifying the emergence of small and focused groups of policy actors, in the sections below we use

the concept to describe similar emergent participatory processes encountered in all jurisdictions in our case study.

The first point to make about the huddles is that they generally did not involve any new actors who were unaccounted for in the tables of participation. The “usual suspects” or the “same network of actors” who participated in the tables also participated in the huddles. If someone was a key player in the huddles, they were also a key player in the tables. The huddles were seen to supplant the tables of participation, offering an alternative rather than replacing existing participatory processes.

The key differences between the tables and the huddles were that the huddles were adaptive to the situation of the COVID-19 pandemic, and in so doing two unique contextual features seemingly animated the huddles—a “sense of urgency” and a “common purpose.”

Sense of urgency and common purpose. There were comparatively few cases of COVID-19 in Australia in 2020, particularly in NSW and the ACT, due to the implementation of non-pharmaceutical interventions including border restrictions, so it was mostly news about the rapidly changing COVID-19 situation in other countries which prompted a “sense of urgency” and anticipation:

[From the news overseas], it became obvious that even the normal functions of society were starting to stop . . . we knew we had to push really hard to have a strategy in place, otherwise we’d have [all clients in the state] potentially going without their pharmacotherapy. (Interview 11)

One participant, having been in another country with high COVID-19 case numbers, spoke about “coming from the future”:

I just can’t tell you how coming from the future helped me do the work. You know, it was like freedom of movement will be restricted. How are we going to authorize the people on [pharmacotherapy] to go to the clinic every day? (Interview 5)

Perhaps related to this sense of urgency, participants also spoke about a “common purpose” when explaining how the policy changes to pharmacotherapy were made in a rapid manner. There was a strong sense that the “common purpose” was made available by the apprehended COVID-19 crisis in Australia, and having pharmacotherapy declared an “essential health service”:

I think everyone was working towards the common sense of purpose. There was a . . . I guess we had this underlying assumption and agreement and recognition that the provision of [pharmacotherapy treatment] is an essential health service. (Interview 2)

There was also a sense that the “common purpose” was unique to the pandemic and not something ordinarily seen in the sector:

So, there was definitely something special about this in the middle of a pandemic, that we were all working together more beautifully than normal rather than people pointing fingers and being angry. (Interview 1)

We see here that in this case study the “usual suspects” mobilized around a shared issue and concern in a way not usually done, which involved ensuring the continuation of opioid pharmacotherapy treatment amid a pandemic. From this arose novel modes of engagement within the huddles, which included a pragmatic problem-solving approach towards policy change, and a sense of felt togetherness.

Problem-solving and felt sense of togetherness. In relation to opioid pharmacotherapy treatment, COVID-19 presented a lot of “what-ifs” which animated policy-makers’ concerns. This included questions

about whether pharmacies would remain open in increasingly restrictive lockdown conditions, how isolation rules would impact on access, and how increased policing of public health orders would affect clients. These what-ifs and uncertainties were seemingly aired and managed by convening ad hoc meetings and discussions (the huddles).

Attending to uncertainties within the huddles looked to foster a problem-solving approach. The huddles were often characterized as having a “brainstorming and problem-solving approach” and were a “troubleshooting forum.” The huddles were also where “solutions to tricky problems” were made:

The huddle for example was where we worked through the policy issues for amending takeaway doses, because it seemed like the solution seemed a no brainer. (Interview 12)

It is striking that amending takeaway doses has been described as a “no brainer” in this context, especially because this policy issue has historically engaged diverse views. We suggest that this was made possible by the “common purpose” and “sense of urgency” articulated in and through the huddles, in the context of uncertainty.

The “common purpose” which characterized the huddles also made available transformative experiences. More specifically, for people participating in the huddles it fostered a felt sense of togetherness. The interviewees who were involved in the huddles described them as “fun,” “inspiring,” and “amicable” experiences, involving “shiny, happy people wanting to have hugs at meetings.” This was affectively different and contrasted with both the practices of “consensus” and the separateness and “battleground” like atmosphere described in reference to the tables of participation.

Importantly, this sense of togetherness seemed to have the potential to travel beyond the immediate context of the huddles:

We’ve been really empowered and energized by getting together and working together in that way and it’s shown us that we can formulate, you know, those sort of responses going forward. (Interview 14)

This participant has suggested that “getting together and working together” is something that can be preserved “going forward” and into the future, which reveals how the “common purpose” and the transformative experiences of togetherness which were made available through the huddles, also have the potential to impact how things are done not only in crises but in the everyday (Lancaster et al., 2020).

Despite the huddles opening up different participatory experiences, we also see a different set of consequences entangled with the very practices which made available the more positive experiences of togetherness:

The fact that everybody has come together with a pretty common purpose makes all the difference really . . . some of the things which are done maybe on the basis of you know old biases and judgments or you know moral judgments if you like go out the window and so that’s enabled us just to be much more objective around what can be done and what might be the harms and what might not be. (Interview 22)

Declarations of being “objective” instead of basing discussions on “moral judgments” raises some questions in relation to what kind of knowledge gets to count as “objective” or not, even within these more emergent participatory formats. Similarly, another participant suggested that in the huddles people were able to discuss “what the *true* COVID agenda is versus what, like individual players’ agendas might be” (emphasis added, Interview 18). Arguably, “objectivity” and “truth” are mobilized here as a kind of pragmatism in the face of an urgent situation of need, enabling action. However, policy discussions are inherently entrenched in moral framings and diverse agendas, so it is important to remain alert to what gets relegated in the pursuit of the “objective” “truth” sought in this crisis

situation. One example of what might have been relegated during the process is the stigma and discrimination experienced by pharmacotherapy clients:

It was so difficult, because we just didn't have enough time, these policies had to be developed so quickly, like we literally had a week to get them together and to get the draft together. [...] I've talked about forgetting the important stuff, the judgment and the stigma, like that was just bad enough anyway, COVID aside, but when you're adding COVID, it just ramped up and so you know, like what I'm saying before, you know, pharmacotherapy consumers were fined on a train going to get a dose. [...] The whole stigma and discrimination was something I wish we'd spent a lot more time talking about, but the problem was, it wasn't the time and I'm not good at thinking of everything. (Interview 7)

This serves as a reminder that the rapid policy moves necessitated in the COVID-19 pandemic, and brought forward through an increasing sense of common purpose and solidarity, also might have had unexpected effects, in this case closing down conversations of stigma and discrimination, which have long been at the center of advocacy efforts in opioid pharmacotherapy treatment.

Discussion

Against the backdrop of the anticipated COVID-19 crisis in Australia, we explored two very different figures of participation in drug policy. The tables of participation were seen to be a fixed set of standardized participatory processes gradually established in a particular historical context of the drug user movement in Australia and lodged within formal bureaucratic structures. The huddles of participation emerged as an adaptive and less coherent set of ad hoc participatory collectives in the context of rapid policy changes adopted in responses to COVID-19.

Set in the context of the HIV/AIDS crisis and the drug user movement which arose in Australia in the 1990s, the tables of participation represented a hard-won achievement for the inclusion of the voices of people who use drugs in drugs policy (Australian Injecting and Illicit Drug Users League, 2012). Having a seat at the table was equated with being part of the established network of actors. Although the rituals and restrictive modes of engagement established in the tables prevented policy-making from occurring at the tables themselves, in the context of COVID-19—where policy responses have been characterized by compressed time-frames and policy uncertainty (Lancaster et al., 2020)—the huddles emerged to seemingly supplant the more enduring tables of participation, offering those who have a seat at the table alternative and novel ways to participate in drug policy, which in turn resulted in policy changes.

Recent writing on participation has begun to emphasize notions of emergence—focusing on uninvited and insurgent counterpublics, and how they appear as ad hoc collectives united around a shared concern, often in opposition to invited and established publics (Warner, 2002; Wehling, 2012; Wynne, 2007). While these are important moves, our contrast between the tables and the huddles offers a slightly different picture. More specifically, the huddles and the novel modes of engagement arising in these formats, were seemingly rooted in often long-term participation in more formal and established processes put together in situated contexts, and through concerted institutional work. So, this is not a clear case of an emergence from an uninvited or insurgent counterpublic—rather the huddles were very much seen in our analysis to supplant the established tables of participation. The challenge here then is to conceptualize the emergence of new spaces of participation *ecologically* (Chilvers & Kearnes, 2015)—that is to be attentive to the web of connections between established and more emergent forms of participation.

While we have characterized the tables and the huddles of participation as respectively slow and rapid participatory processes in the context of our study, it is important to note that these are by no means fixed characteristics. In many ways this paper tells a *tale of two crises*, with the tables and the

huddles set in the context of two different emergencies. The tables of participation might be seen as an outworking of institutional responses to advocacy and activism for consumer participation in the HIV/AIDS crisis and the subsequent strength of the drug user movement in Australia. Although in this study the tables represented fixed and standardized mechanisms for the inclusion of the voices of people who use drugs in drugs policy, it is worthwhile noting that these processes were once emergent, consisting of a set of informal peer-to-peer networks sharing information and harm reduction strategies through daily interactions (Madden & Wodak, 2014). In contrast, we have characterized the huddles of participation as adaptive to the COVID-19 crisis in the context of our study. Given the evaluative and linear mode of analysis present in contemporary participation, there too might be an appetite to entrench the huddles of participation, and in so doing transport these formats to different settings with the goal to extract maximum participatory value against a pre-given set of outcomes or for political use (Delvenne & Macq, 2020). This is not where we see the value of our analysis. Both the tables and the huddles of participation should instead encourage a continuous freedom to evolve and in so doing foster flexibility, responsiveness, and adaptation—instead of seeking to entrench or bureaucratize participatory processes which have at one point seemed useful, but in the effort to maximize usefulness into the future and into different settings, might become delimiting.

Approaching matters of participation relationally—that is in situated and material contexts—in addition to attending to the procedural and institutional conditionalities of public participation in policy making, also serves to highlight the differential affordances of different modalities of participation. Much scholarly consideration of public participation in policy making is characterized by what Chilvers and Kearnes (2015) term a “residual realist” depiction of participation; a form of methodological essentialism that broadly suggests that more representative publics are produced through forms of methodological refinement. In contrast, focusing on the relational qualities of participation brings into focus the sense that all forms of participation are characterized by differential openings and closures that shape the ways in which participants interrelate. We see this with the tables and the huddles in our analysis. That is, while the huddles afforded a temporariness with the ability to act swiftly in the face of uncertainty, we also explored how the huddles could be problematic when seemingly operating in isolation from other important participatory processes and established structures, possibly creating situations of exclusion and unilateral truths arising to the dismissal of other viewpoints. We documented that there were concerns from consumers that client choice was being ignored in the context of rapid policy changes, and as testament to the strength of consumer participation in drug policy in Australia, these concerns resulted in the momentary slowing down of policy activity, where policy documents were held up and revised accordingly. This participatory intervention would not have been possible without people who represent people who use drugs having a seat at the table. We also outlined that stigma and discrimination, which have been at the forefront of the drug user movement’s advocacy efforts for decades, might have been silenced in this rapid policy environment, which is worthwhile to note for future work in this area. Scholars will continue to consider the broader implications of the growing public health ethos emphasized during the COVID-19 pandemic, with one possible implication in this study being how this could have overridden well established treatment principles of client choice.

Even though our case study spanned the early stages of the COVID-19 pandemic in Australia, we do not view the forms of participation and rapid policy making encountered in our study as only available in emergency conditions. Instead, we adopt the view that “outbreaks” offer an indication of what is possible in the everyday; with COVID-19 revealing what is always present, existing in potential (Lancaster et al., 2020). While COVID-19 has exposed the many failures of drug and alcohol treatment and policies across the globe (Chang et al., 2020), our study has demonstrated that even in a highly politicized policy context like opioid pharmacotherapy treatment, existing policy structures can rapidly adapt, offering spaces for the “usual suspects” to solve policy issues in a pragmatic manner.

This suggests that even the most foreclosed participatory structures have the potential to be opened-up and be more adaptive, experimental, and responsive to evolving situations of need.

Conclusion

The “participatory turn” in contemporary modes of governing has had particular implications in the area of drug policy making. An issue commonly encountered in this context are a range of delimiting effects produced in practices which seek to increase participation through formalized mechanisms. Focusing on emergence offers a way to expand understandings of participation in drug policy contexts, and while emergence is commonly envisaged as distinct and in opposition to established participatory structures, we found that emergence can arise from even from the most foreclosed and institutionally mandated participatory structures, and therefore emergence was conceptualized ecologically in our article. Conceptualizing the emergence of new spaces of participation in relationship to established formats of participation, perhaps suggests that the novel modes of engagement and rapid policy changes encountered in this case study, can indeed arise from ordinary structures, and not just in emergency conditions.

Acknowledgment

The authors would like to acknowledge and thank everyone who participated in the interviews, for being more than generous with the expertise and knowledge they shared with the research team.


Declaration of Conflicting Interests


The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by an Australian Research Council Discovery Project grant (200100909) and an anonymous benefactor. Alison Ritter receives an NHMRC Research Fellowship (GNT1136944). Kari Lancaster is supported by the UNSW Scientia program.

ORCID iDs

Richard Mellor  <https://orcid.org/0000-0002-7603-5256>

Kari Lancaster  <https://orcid.org/0000-0002-2411-7970>

Note

1. For more details on population numbers, pharmacotherapy treatment data, and COVID-19 related data from these jurisdictions as they pertain to this case study, see table 1 of Mellor et al. (2021).

References

- Australian Injecting and Illicit Drug Users League. (2011). *A report on stigma and discrimination towards the injecting drug user community*. http://aivl.org.au/wp-content/uploads/2018/06/Why-wouldnt-I-discriminate-against-all-of-them_Stigma-and-discrimination_Report.pdf
- Australian Injecting and Illicit Drug Users League. (2012). *The involvement of drug user organisations in Australian drugs policy—A research report from AIVL's 'TrackMarks' project*. AIVL.
- Bartoszko, A. (2021). Shadow committees: On “drug user voice,” representation, and mobilization in a Norwegian drug policy reform. *Contemporary Drug Problems*, 48(2), 168–184. <https://doi.org/10.1177%2F00914509211003731>

- Becker, S. J., Garner, B. R., & Hartzler, B. J. (2021). Is necessity also the mother of implementation? COVID-19 and the implementation of evidence-based treatments for opioid use disorders. *Journal of Substance Abuse Treatment, 122*, 108210. <https://doi.org/10.1016/j.jsat.2020.108210>
- Berends, L., Chalmers, J., & Lancaster, K. (2015). Trust, agency and control: Perspectives on methadone take-away dosing in the context of the Victorian policy review. *Drug and Alcohol Review, 34*(5), 483–486. <https://doi.org/10.1111/dar.12287>
- Bijker, W. E., Bal, R., & Hendriks, R. (2009). *The paradox of scientific authority: The role of scientific advice in democracies*. MIT Press.
- Bjerge, B., Duke, K., Frank, V. A., Rolando, S., & Eisenbach-Stangl, I. (2016). Exploring user groups as stakeholders in drug policy processes in four European countries. In M. Hellman, V. Berridge, K. Duke, & A. Mold (Eds.), *Concepts of addictive substances and behaviours across time and place* (pp. 107–128). Oxford University Press.
- British Columbia Centre on Substance Use. (2020). *COVID-19: Information for opioid agonist treatment prescribers and pharmacists*. <https://www.bccsu.ca/opioid-use-disorder/>
- Brothers, S., Viera, A., & Heimer, R. (2021). Changes in methadone program practices and fatal methadone overdose rates in Connecticut during COVID-19. *Journal of Substance Abuse Treatment, 131*, 108449. <https://doi.org/10.1016/j.jsat.2021.108449>
- Callon, M., Lascoumes, P., & Barthe, Y. (2009). *Acting in an uncertain world: An essay on technical democracy*. MIT Press.
- Caton, L., Cheng, H., Garneau, H. C., Fisher, T., Harris-Mills, B., Hurley, B., Newman, S., & McGovern, M. P. (2021). COVID-19 adaptations in the care of patients with opioid use disorder: A survey of California primary care clinics. *Journal of General Internal Medicine, 36*(4), 998–1005. <https://doi.org/10.1007/s11606-020-06436-3>
- Chang, J., Agliata, J., & Guarinieri, M. (2020). COVID-19-enacting a ‘new normal’ for people who use drugs. *International Journal of Drug Policy, 83*, 102832. <https://doi.org/10.1016/j.drugpo.2020.102832>
- Chilvers, J., & Kearnes, M. (2015). *Remaking participation: Science, environment and emergent publics*. Routledge.
- Chilvers, J., & Kearnes, M. (2020). Remaking participation in science and democracy. *Science, Technology, & Human Values, 45*(3), 347–380. <https://doi.org/10.1177%2F0162243919850885>
- Chilvers, J., Pallett, H., & Hargreaves, T. (2018). Ecologies of participation in socio-technical change: The case of energy system transitions. *Energy Research & Social Science, 42*, 199–210. <https://doi.org/10.1016/j.erss.2018.03.020>
- Corace, K., Suschinsky, K., Wyman, J., Leece, P., Cragg, S., Konefal, S., Pana, P., Barrass, S., Porath, A., & Hutton, B. (2022). Evaluating how has care been affected by the Ontario COVID-19 opioid agonist treatment guidance: Patients’ and prescribers’ experiences with changes in unsupervised dosing. *International Journal of Drug Policy, 102*, 103573. <https://doi.org/10.1016/j.drugpo.2021.103573>
- Crawford, S. (2013). Shouting through bullet-proof glass: Some reflections on pharmacotherapy provision in one Australian clinic. *International Journal of Drug Policy, 24*(6), e14–e17. <https://doi.org/10.1016/j.drugpo.2013.07.004>
- Davies, S. R. (2013). The rules of engagement: Power and interaction in dialogue events. *Public Understanding of Science, 22*(1), 65–79. <https://doi.org/10.1177%2F0963662511399685>
- Delvenne, P., & Macq, H. (2020). Breaking bad with the participatory turn? Accelerating time and intensifying value in participatory experiments. *Science as Culture, 29*(2), 245–268. <https://doi.org/10.1080/09505431.2019.1668369>
- Dubey, M. J., Ghosh, R., Chatterjee, S., Biswas, P., Chatterjee, S., & Dubey, S. (2020). COVID-19 and addiction. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews, 14*(5), 817–823. <https://doi.org/10.1016/j.dsx.2020.06.008>
- Dunlop, A., Lokuge, B., Masters, D., Sequeira, M., Saul, P., Dunlop, G., Ryan, J., Hall, M., Ezard, N., Haber, P., Lintzeris, N., & Maher, L. (2020). Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. *Harm Reduction Journal, 17*(1), 1–7. <https://doi.org/10.1186/s12954-020-00370-7>

- Durand, L., Keenan, E., Boland, F., Harnedy, N., Delargy, Í., Scully, M., Mayock, P., Ebbitt, W., Vázquez, M. O., Corrigan, N., Killeen, N., Pate, M., Byrne, P., & Cousins, G. (2022). Consensus recommendations for opioid agonist treatment following the introduction of emergency clinical guidelines in Ireland during the COVID-19 pandemic: A national Delphi study. *International Journal of Drug Policy*, *106*, 103768. <https://doi.org/10.1016/j.drugpo.2022.103768>
- Epstein, S. (1995). The construction of lay expertise: AIDS activism and the forging of credibility in the reform of clinical trials. *Science, Technology, & Human Values*, *20*(4), 408–437. <https://doi.org/10.1177%2F016224399502000402>
- Farhoudian, A., Baldacchino, A., Clark, N., Gerra, G., Ekhtiari, H., Dom, G., Mokri, A., Sadeghi, M., Nematollahi, P., Demasi, M., Schutz, C. G., Hashemian, S. M., Tabarsi, P., Galea-Singer, S., Carra, G., Clausen, T., Kouimtsidis, C., Tolomeo, S., Radfar, S. R., & Razaghi, E. M. (2020). COVID-19 and substance use disorders: Recommendations to a comprehensive healthcare response. An International Society of Addiction Medicine Practice and Policy Interest Group position paper. *Basic and Clinical Neuroscience*, *11*(2), 133–150. <https://doi.org/10.32598/bcn.11.covid19.1>
- Fraser, S., valentine, k., & Seear, K. (2018). Emergent publics of alcohol and other drug policymaking. *Critical Policy Studies*, *12*(1), 61–81. <https://doi.org/10.1080/19460171.2016.1191365>
- Goodhew, M., Stein-Parbury, J., & Dawson, A. (2019). Consumer participation in drug treatment: A systematic review. *Drugs and Alcohol Today*, *19*(2), 97–112. <https://doi.org/10.1108/DAT-05-2018-0023>
- Grebely, J., Cerdá, M., & Rhodes, T. (2020). COVID-19 and the health of people who use drugs: What is and what could be? *International Journal of Drug Policy*, *83*, 102958. <https://doi.org/10.1016/j.drugpo.2020.102958>
- Green, T. C., Bratberg, J., & Finnell, D. S. (2020). Opioid use disorder and the COVID 19 pandemic: A call to sustain regulatory easements and further expand access to treatment. *Substance Abuse*, *41*(2), 147–149. <https://doi.org/10.1080/08897077.2020.1752351>
- Jasanoff, S. (2012). *Science and public reason*. Routledge.
- Jürgens, R. (2005). “Nothing about us without us”—Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative. Canadian HIV/AIDS Legal Network.
- Kelty, C. M. (2019). *The participant: A century of participation in four stories*. The University of Chicago Press.
- Khatri, U. G., & Perrone, J. (2020). Opioid use disorder and COVID-19: Crashing of the crises. *Journal of Addiction Medicine*, *14*(4), e6–e7. <https://doi.org/10.1097/adm.0000000000000684>
- Kitchen, S. A., Campbell, T. J., Men, S., Bozinoff, N., Tadrous, M., Antoniou, T., Wyman, J., Werb, D., Munro, C., & Gomes, T. (2022). Impact of the COVID-19 pandemic on the provision of take-home doses of opioid agonist therapy in Ontario, Canada: A population-based time-series analysis. *International Journal of Drug Policy*, *103*, 103644. <https://doi.org/10.1016/j.drugpo.2022.103644>
- Lancaster, K. (2017). Confidentiality, anonymity and power relations in elite interviewing: Conducting qualitative policy research in a politicised domain. *International Journal of Social Research Methodology*, *20*(1), 93–103. <https://doi.org/10.1080/13645579.2015.1123555>
- Lancaster, K., Duke, K., & Ritter, A. (2015). Producing the ‘problem of drugs’: A cross national-comparison of ‘recovery’ discourse in two Australian and British reports. *International Journal of Drug Policy*, *26*(7), 617–625. <https://doi.org/10.1016/j.drugpo.2015.04.006>
- Lancaster, K., Rhodes, T., & Rosengarten, M. (2020). Making evidence and policy in public health emergencies: Lessons from COVID-19 for adaptive evidence-making and intervention. *Evidence and Policy*, *16*(3), 477–490. <https://doi.org/10.1332/174426420X15913559981103>
- Lancaster, K., Ritter, A., & Diprose, R. (2018). Recasting participation in drug policy. *Contemporary Drug Problems*, *45*(4), 351–365. <https://doi.org/10.1177%2F0091450918776024>
- Lancaster, K., Seear, K., Treloar, C., & Ritter, A. (2017). The productive techniques and constitutive effects of ‘evidence-based policy’ and ‘consumer participation’ discourses in health policy processes. *Social Science & Medicine*, *176*, 60–68. <https://doi.org/10.1016/j.socscimed.2017.01.031>
- Landström, C. (2019). *Environmental participation: Practices engaging the public with science and governance*. Springer Nature.

- Levander, X. A., Hoffman, K. A., McIlveen, J. W., McCarty, D., Terashima, J. P., & Korthuis, P. T. (2021). Rural opioid treatment program patient perspectives on take-home methadone policy changes during COVID-19: A qualitative thematic analysis. *Addiction Science & Clinical Practice, 16*(72). <https://doi.org/10.1186/s13722-021-00281-3>
- Lintzeris, N., Deacon, R. M., Hayes, V., Cowan, T., Mills, L., Parvaresh, L., Harvey Dodds, L., Jansen, L., Dojcinovic, R., Leung, M. C., Demirkol, A., Finch, T., & Mammen, K. (2021). Opioid agonist treatment and patient outcomes during the COVID-19 pandemic in south east Sydney, Australia. *Drug and Alcohol Review, 46*(1). <https://doi.org/10.1111/dar.13382>
- Lintzeris, N., Hayes, V., & Arunogri, S. (2020). Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: A national response. https://www.racp.edu.au/docs/default-source/news-and-events/covid-19/interim-guidance-delivery-of-medication-assisted-treatment-of-opioid-dependence-covid-19.pdf?sfvrsn=e36eeb1a_4
- Lyons, N., Cox, C., & Clements, V. (2020). Value of clinical engagement in the NSW Health response to COVID-19. *Australian Health Review, 45*(3), 306–307. <https://doi.org/10.1071/AH20165>
- Madden, A., Lancaster, K., Ritter, A., & Treloar, C. (2021). Making legitimacy: Drug user representation in United Nations drug policy settings. *International Journal of Drug Policy, 87*, 103014. <https://doi.org/10.1016/j.drugpo.2020.103014>
- Madden, A., & Wodak, A. (2014). Australia's response to HIV among people who inject drugs. *AIDS Education and Prevention, 26*(3), 234–244. <https://doi.org/10.1521/aeap.2014.26.3.234>
- Marres, N. (2007). The issues deserve more credit: Pragmatist contributions to the study of public involvement in controversy. *Social Studies of Science, 37*(5), 759–780. <https://doi.org/10.1177%2F0306312706077367>
- Marres, N. (2012). *Material participation: Technology, the environment and everyday publics*. Palgrave.
- Marsden, J., Darke, S., Hall, W., Hickman, M., Holmes, J., Humphreys, K., Neale, J., Tucker, J., & West, R. (2020). Mitigating and learning from the impact of COVID-19 infection on addictive disorders. *Addiction, 115*, 1007–1010. <https://doi.org/10.1111/add.15080>
- Mellor, R., Kearnes, M., Lancaster, K., McLauchlan, L., & Ritter, A. (2021). *Making policy in emergencies—Insights for routine policy making: The case example of opioid pharmacotherapy maintenance*. DPMP Monograph No. 35. UNSW Social Policy Research Centre. <https://doi.org/10.26190/thwy-pq45>
- Neale, J. (2016). Iterative categorization (IC): A systematic technique for analysing qualitative data. *Addiction, 111*(6), 1096–1106. <https://doi.org/10.1111/add.13314>
- Nielsen, K. D., & Langstrup, H. (2018). Tactics of material participation: How patients shape their engagement through e-health. *Social Studies of Science, 48*(2), 259–282. <https://doi.org/10.1177%2F0306312718769156>
- Pallett, H., Chilvers, J., & Hargreaves, T. (2019). Mapping participation: A systematic analysis of diverse public participation in the UK energy system. *Environment and Planning E: Nature and Space, 2*(3), 590–616. <https://doi.org/10.1177%2F2514848619845595>
- Parkinson, J., & Mansbridge, J. (Eds.). (2012). *Deliberative systems: Deliberative democracy at the large scale*. Cambridge University Press.
- Pérez-Chiqués, E., Strach, P., & Zuber, K. (2021). Competing emergencies: A policy analysis of the opioid epidemic during COVID-19. *Journal of Comparative Policy Analysis: Research and Practice, 1*–10. <https://doi.org/10.1080/13876988.2020.1845568>
- Rance, J., & Treloar, C. (2015). “We are people too”: Consumer participation and the potential transformation of therapeutic relations within drug treatment. *International Journal of Drug Policy, 26*(1), 30–36. <https://doi.org/10.1016/j.drugpo.2014.05.002>
- Revez, A., Dunphy, N., Harris, C., Rogan, F., Byrne, E., McGookin, C., Bolger, P., Gallachóir, B. O., Barry, J., Ellis, G., O'Dwyer, B., Boyle, E., Flood, S., Glynn, J., & Mullally, G. (2022). Mapping emergent public engagement in societal transitions: A scoping review. *Energy, Sustainability and Society, 12*(1), 1–18. <https://doi.org/10.1186/s13705-021-00330-4>
- Ritter, A., & Di Natale, R. (2005). The relationship between take-away methadone policies and methadone diversion. *Drug and Alcohol Review, 24*(4), 347–352. <https://doi.org/10.1080/09595230500263939>

- Ritter, A., Lancaster, K., & Diprose, R. (2018). Improving drug policy: The potential of broader democratic participation. *International Journal of Drug Policy*, *55*, 1–7. <https://doi.org/10.1016/j.drugpo.2018.01.016>
- Ryghaug, M., Skjølsvold, T. M., & Heidenreich, S. (2018). Creating energy citizenship through material participation. *Social Studies of Science*, *48*(2), 283–303. <https://doi.org/10.1177/0306312718770286>
- Saloner, B., Krawczyk, N., Solomon, K., Allen, S. T., Morris, M., Haney, K., & Sherman, S. G. (2022). Experiences with substance use disorder treatment during the COVID-19 pandemic: Findings from a multistate survey. *International Journal of Drug Policy*, *101*, 103537. <https://doi.org/10.1016/j.drugpo.2021.103537>
- Substance Abuse and Mental Health Services Administration. (2020). *Opioid treatment programs (OTP) guidance*. <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>
- Substance Abuse and Mental Health Services Administration. (2021). *SAMHSA extends the methadone take-home flexibility for one year while working toward a permanent solution* [Press release]. <https://www.samhsa.gov/newsroom/press-announcements/202111181000>
- Thévenot, L. (2014). Voicing concern and difference: From public spaces to common-places. *European Journal of Cultural and Political Sociology*, *1*(1), 7–34. <https://doi.org/10.1080/23254823.2014.905749>
- Thronsen, W., & Ryghaug, M. (2015). Material participation and the smart grid: Exploring different modes of articulation. *Energy Research & Social Science*, *9*, 157–165. <http://dx.doi.org/10.1016/j.erss.2015.08.012>
- Treloar, C., Fraser, S., & valentine, k. (2007). Valuing methadone takeaway doses: The contribution of service-user perspectives to policy and practice. *Drugs: Education, Prevention and Policy*, *14*(1), 61–74. <https://doi.org/10.1080/09687630600997527>
- Treloar, C., Rance, J., Madden, A., & Liebelt, L. (2011). Evaluation of consumer participation demonstration projects in five Australian drug user treatment facilities: The impact of individual versus organizational stability in determining project progress. *Substance Use & Misuse*, *46*(8), 969–979. <https://doi.org/10.3109/10826084.2010.540289>
- Volkow, N. D. (2020). Collision of the COVID-19 and addiction epidemics. *Annals of Internal Medicine*, *173*, 61–62. <https://dx.doi.org/10.7326%2FM20-1212>
- Wang, Q. Q., Kaelber, D. C., Xu, R., & Volkow, N. D. (2021). COVID-19 risk and outcomes in patients with substance use disorders: Analyses from electronic health records in the United States. *Molecular Psychiatry*, *26*(1), 30–39. <https://doi.org/10.1038/s41380-020-00880-7>
- Warner, M. (2002). Publics and counterpublics. *Public Culture*, *14*(1), 49–90. <https://www.muse.jhu.edu/article/26277>
- Wehling, P. (2012). From invited to uninvited participation (and back?): Rethinking civil society engagement in technology assessment and development. *Poiesis & Praxis*, *9*(1–2), 43–60. <https://doi.org/10.1007/s10202-012-0125-2>
- Welsh, C., Doyon, S., & Hart, K. (2022). Methadone exposures reported to poison control centers in the United States following the COVID-19-related loosening of federal methadone regulations. *International Journal of Drug Policy*, *102*, 103591. <https://doi.org/10.1016/j.drugpo.2022.103591>
- Whatmore, S. J., & Landström, C. (2011). Flood apprentices: An exercise in making things public. *Economy and Society*, *40*(4), 582–610. <https://doi.org/10.1080/03085147.2011.602540>
- Wynne, B. (2007). Public participation in science and technology: Performing and obscuring a political–conceptual category mistake. *East Asian Science, Technology and Society: An International Journal*, *1*(1), 99–110. <https://doi.org/10.1007/s12280-007-9004-7>

Author Biographies

Richard Mellor is a Postdoctoral Fellow with the Drug Policy Modelling Program (DPMP) at the Social Policy Research Centre (SPRC), University of New South Wales (UNSW), Sydney, Australia. He applies both quantitative and qualitative methods to the study of drug and alcohol policies, with a particular focus on treatment policies and planning.

Matthew Kearnes is the current convenor of the Environment and Society group, the Environmental Humanities programme and the Geographical Studies programme, based in the School of Humanities and Languages, UNSW. His research is situated between the fields of Science and Technology Studies (STS), social and cultural geography and contemporary social theory.

Kari Lancaster is Scientia Associate Professor at the Centre for Social Research in Health at the University of New South Wales, and Honorary Associate Professor at the London School of Hygiene and Tropical Medicine. She leads a program of qualitative research focused on the development of critical approaches to the study of evidence-making practices, implementation science and intervention translations in health, especially in relation to drugs, hepatitis C, HIV and Covid-19.

Laura McLauchlan is trained in multispecies anthropology, informed by material feminisms, environmental humanities scholarship, medical anthropology and trauma studies; with a particular focus on how transformative change takes place, particularly with respect to environmental and interspecies care and connection.

Alison Ritter, AO, is an internationally recognized drug policy scholar and the Director of the Drug Policy Modelling Program (DPMP) at the University of New South Wales. She is an NHMRC Senior Research Fellow leading a multi-disciplinary program of research on drug policy.