Received: 31 October 2021 | Revised: 8 June 2022 | Accepted: 31 July 2022

DOI: 10.1111/dar.13531

ORIGINAL PAPER

Drug and Alcohol REVIEW APSAD WILEY

People engaged in opioid agonist treatment as a counterpublic during the COVID-19 pandemic in Australia: A qualitative study

Anna Conway[1,2] | **Carla Treloar**[2] | **Sione Crawford**[3] | **Jason Grebely**[1] | **Alison D. Marshall**[1,2]

[1]The Kirby Institute, UNSW Sydney, Sydney, Australia

[2]Centre for Social Research in Health, UNSW Sydney, Sydney, Australia

[3]Harm Reduction Victoria, Melbourne, Australia

Correspondence
Anna Conway, The Kirby Institute, Wallace Wurth Building, High St, Kensington, NSW 2052, Australia.
Email: a.conway@unsw.edu.au

Funding information
National Health and Medical Research Council, Grant/Award Number: 1176131

Abstract

Introduction: People receiving opioid agonist treatment (OAT) are at higher risk of comorbidities, poverty and discrimination, which Big Events like the COVID-19 pandemic may exacerbate. The behaviours of people receiving OAT do not always align with normative behaviours as conceived by ruling institutions and laws, and so the group becomes a counterpublic, not imagined in mainstream public discourse. The aim of this study was to understand how people receiving OAT, as a counterpublic, implemented practises of care to mitigate negative health outcomes during COVID-19.

Methods: Participants were recruited via eight peer-led organisations across Australia. In-depth, semi-structured interviews were completed between August and December 2020 with 40 people receiving OAT. The analysis centres practises of care, allowing interactions that influence the health of participants, to be understood in their unique contexts.

Results: Aspects of the COVID-19 state response were designed for an idealised public, demonstrated by the increased policing that accompanied enforcement of restrictions which was detrimental to the wellbeing of people receiving OAT. Counterpublic health strategies employed by people receiving OAT were disrupted, but participants were often able to adapt to the changing context.

Discussion and Conclusion: This study elucidates how practises of care among people receiving OAT are enacted and disrupted during a Big Event, with implications beyond the COVID-19 pandemic for future Big Events. The study findings evidence the need for policies that mitigate the impact of Big Events such as supporting re-groupment within the counterpublic, legitimising counterpublic health strategies and stopping the criminalisation of people who use drugs.

KEYWORDS
Big Event, counterpublic, peers, practises of care, substance use

1 | INTRODUCTION

The COVID-19 pandemic generated concerns about a syndemic of opioid dependency and COVID-19 transmission [1–3]. People receiving opioid agonist treatment (OAT) and people who inject drugs are at higher risk of poor physical and mental health, poverty and discrimination, which may have been exacerbated by the pandemic [4–6]. Travel restrictions and border closures are likely to have disrupted drug supply [5, 6], influencing the cost and purity of drugs. COVID-19-related restrictions and increased policing during lockdown may have led people to use drugs alone, increasing risk of overdose [6–10]. Isolation and anxiety resulting from COVID-19 and restrictions may have impacted mental health in the short and long term [11]. People who inject drugs may have used drugs to regulate COVID-19-related stress and anxiety [12].

Big Events, such as global pandemics, financial crises or ecological disasters, can lead to repressiveness, disrupt health and social services [13], destabilise environments, and increase income and health disparities [14, 15]. The extent to which Big Events influence the population's health is contingent on certain societal conditions including economic deprivation, social involvement, public health infrastructure and police restraint [16]. Although those societal conditions can produce inequities in how subpopulations experience Big Events, there is some consistency in measures which mitigate the impact. Friedman notes how the actions of people who inject drugs can shape the nature of drug use, reduce the spread of infectious diseases, and reduce other harms which may accompany Big Events [16]. These actions can be characterised as practises of care, whereby people who use and sell drugs care for themselves and others in a society which is hostile to drug use [17, 18]. Centring practises of care ensures interactions are understood in their unique contexts, rather than allowing them to be 'codified in moral terms' [18, p. 87]. Practises of care were pertinent during the COVID-19 period because the pandemic and related restrictions increased pressures on people's health and wellbeing while disrupting access to formal health services [6]. Legitimising practises of care which were employed during the pandemic could inform policies which buffer the population from the negative health impacts of future Big Events [19].

The possibilities of practises of care are predicated upon the societal conditions that surround those who practise. People receiving OAT can be defined as a counterpublic, in that their implied use (or history of use) of illicit drugs does not align with normative behaviours as conceived by ruling institutions and laws [20]. Counterpublics, as defined by Fraser, are born under 'conditions of dominance and subordination' [20, p. 65] and have a 'conflictual relation to the dominant public' [21, p. 85]. As a result, this counterpublic is not often imagined in mainstream public discourse. COVID-19 and related restrictions, in seeking to achieve a 'common goal' of COVID-19 reduction, reinforced the position of people who inject drugs as being outside the public sphere. The discourse of public health during the pandemic addressed one public, to the exclusion of counterpublics who were not able to equally adhere to COVID-19 restrictions due to social inequalities and structural vulnerabilities [22]. As a counterpublic, people who inject drugs and people receiving OAT may have faced distinct challenges to their health and wellbeing during the COVID-19 pandemic.

In contrast to countries in Europe, Australia avoided the first peak of COVID-19 cases in April 2020. At the end of 2020, Australia was maintaining a rate of around 0.5 cases per million people per day while countries in Europe experienced a new peak (371 and 580 cases per million people per day in the United Kingdom and Italy) [23]. Within the country, restrictions were decided at the state and jurisdiction level: for example, the city of Melbourne was in lockdown from July to October 2020, while Adelaide had a lockdown of six days in the middle of the study period [24]. In spite of the comparatively low case numbers, preventative measures were put in place across Australian health services.

The CHOICE study (Considering Health access within OAT settings in the COVID-19 Era Study) sought to evaluate the impact of the COVID-19 pandemic and related restrictions on the delivery of drug treatment services in Australia from the perspectives of health workers and people using services. The aim of this study was to use the lens of the counterpublic to understand how people receiving OAT experienced the COVID-19 pandemic and investigate how people implemented practises of care to mitigate negative health outcomes.

2 | METHODS

Semi-structured interviews were completed between August and December 2020 via telephone and videocall with people receiving OAT. To participate, the person had to be aged 18 or over, currently receiving services from an outpatient OAT program, agree to have the interview recorded, and give informed verbal consent.

An interview guide was proposed by the research team and edited in consultation with a community reference panel of peer workers who use drugs (hereafter referred to as the 'community reference panel'). Topics included access to health and social services, mental and physical health, and changes to drug use and drug

purchasing in the context of the COVID-19 pandemic. Participants were asked to reflect on the time from the beginning of the pandemic in Australia (March 2020) until their interview. Two discussions were held with the community reference panel (first with 13 peer workers from five Australian organisations and second, a follow-up in-depth discussion with two members of the panel). The two panel members participating in the second discussion were each compensated AUD$100 for their time. As a result of these consultations, the consent process was changed to include a more comprehensive explanation of the interview topics to ensure participants understood they would be asked about their illicit drug use and clarify that this information would not be shared with anyone, including their OAT provider. The community reference panel suggested topics to add to the interview guide: processes of consent and confidentiality in relation to telehealth, redirecting people receiving OAT from public to private sector services, naloxone provision and the impact of COVID-19 on income generating activities (formal/informal employment, asking for money on the street).

Members of the community reference panel recruited participants from across the country at their eight respective peer-led organisations. The study was promoted through member mailing lists, social media and flyers. Participants were asked to share the study information with peers who met the inclusion criteria. All semi-structured interviews were conducted by study author (Anna Conway) and lasted 30 minutes on average. Verbal consent was recorded, stored and kept separate from interview recordings. All participants have been pseudonymised. Participants were reimbursed with an AUD$50 gift voucher or bank transfer (according to their preference).

The study protocol was approved by the Human Research Ethics Committee at the University of New South Wales, Sydney (HREC Ref: HC200459).

2.1 | Data analysis

The study defines people receiving OAT as a counterpublic in order to explore non-normative behaviours as practises of care during the pandemic. We employed deductive analysis based on a coding framework derived from the counterpublics literature. Approaching the analysis in this way focuses the scope of the analysis by allowing themes to be assessed for compatibility with the chosen concept [25] of counterpublics.

The COVID-19 pandemic caused rapid and dramatic change in people's day to day lives. The 'one size fits all' state response left critics questioning whether everyone was able to comply with mandated restrictions [26]. Fraser's [20] theory allows understanding of the counterpublic not as a space of marginalisation, but instead as a space of re-groupment where people with common objectives that do not align with mainstream public discourse can gather to concentrate their efforts. On the surface, exclusion from the public sphere seems to imply that a person is not connected to the networks that are needed to promote good health. The counterpublic as a space of re-groupment refutes that assumption and underscores the benefits of re-groupment away from the public sphere so the (non-normative) needs and objectives of the counterpublic can be pursued. The counterpublic of people receiving OAT existed prior to COVID-19, but the analysis herein seeks to understand how these established spaces of re-groupment were utilised by participants during the pandemic. Increased powers bestowed on the police during COVID-19 may have disproportionately impacted the health of specific populations. The analysis sought to understand how participants, in not being the idealised public [27] that COVID-19 response was imagined for, managed the restrictions and policing in the context of having an already contestatory relationship with the dominant public [28]. Previous literature has extended Fraser's theory to investigate counterpublic health [27, 29–32] and understand motivations and consequences of an individual's health protection strategies when the strategies are, superficially, discordant with the dominant discourse. Practises which do not conform to normative conceptions of care are sometimes disregarded in health research because of the tensions they produce with public health guidance [17]. Nonetheless, strategies such as diversion of medication to the community and purchasing drugs for other people have been shown to be effective in producing health and wellbeing [17, 33, 34]. The analysis investigates people's experiences of employing counterpublic health strategies to mitigate the effects of the COVID-19 pandemic and related restrictions.

Specifically, our analysis seeks to understand how people receiving OAT, as a counterpublic, employed practises of care to promote their own and other's health and wellbeing. These interactions were analysed across three main themes: (i) spaces of re-groupment, where people excluded from the dominant publics are united by common objectives and find a space to 'regroup', join efforts and allay the negative impact of a Big Event; (ii) enforcement of restrictions aimed at an idealised public, or how the COVID-19 restrictions were imagined for an idealised collective; and (iii) counterpublic health strategies, where people employ practises of care appropriate to their own needs which may not align with normative conceptions of public health.

Interviews were recorded, transcribed, cleaned of identifying data and stored in a secure folder only

accessible to the research team. Transcripts were coded deductively based on the themes of interest described above. Emerging themes were discussed and agreed among the research team.

3 | RESULTS

Interviews were conducted with 40 people receiving OAT, recruited from all but one Australian jurisdiction (Tasmania). Overall, the median age was 49 years (range 32–62 years), 22 were women and four were Aboriginal or Torres Strait Islander peoples. Participants had been receiving OAT for 10 years on average, and 31 people reported injecting drug since the beginning of the pandemic in Australia (March 2020).

3.1 | Spaces of re-groupment

The experiences of participants during the pandemic reveal how the counterpublic, contrary to being an enclave, can act as a space of re-groupment [20]. Participants refuted the separatism that being in a counterpublic may suggest, by mobilising existing networks to mitigate the negative effects of COVID-19 and related restrictions. People relied on friends, partners and peers to engage in health promoting actions. The interviews revealed that people employed as peer workers extended practises of care outside of their contracted hours and workplace, to supply new injecting equipment to their friends or neighbours.

> '*I live in a block of units and one of the women that lives in the unit works at the needle exchange. So that's where I get* [my sterile syringes] *from*.' (Grace, in her 50s, Western Australia)

Some participants lived with comorbidities (e.g., cancer, autoimmune disorders) which put them at increased risk of COVID-19 and therefore sought to avoid public transport as one strategy to socially distance. The dearth of COVID-19-safe, economically viable transport options caused people to seek alternatives within the counterpublic. Amy carpooled to the pharmacy for dosing, sharing the cost of petrol and reducing the economic burden of dosing for the driver.

> '*There's a girl who picks up all the people* [who are going to the pharmacy in the neighbourhood] *in her car and we chuck in for fuel ... even if you could get public transport, think of all the people you are exposing yourself to there as well.*' (Amy, in her 40s, Western Australia)

The pandemic disrupted drug markets, driving up drug prices in Australia [35]. Participants reported increased prices and/or reduced drug quality. People reported that the strength of heroin decreased, causing them to buy more heroin or seek multiple suppliers. For Sam, the work of 'running around from dealer to dealer' was born by her partner, easing the burden of managing multiple demands and reducing contact with other people in the midst of a pandemic. Participants sought information within the counterpublic to mitigate the impact of changes to the drug market and make informed choices about drug quality before purchasing. For Laura, a positive relationship with a drug seller established prior to COVID-19 gave her confidence in information the person provided about the quality of drugs.

> '*The gear would take longer, because it took them longer to go and buy it and then* [the seller would] *ring up and say "look I've got some but it's a bit more expensive and it's not quite as good, so it's up to you" she's always been a straight shooter*.' (Laura, in her 60s, Western Australia)

The counterpublic as a space of re-groupment did not function equally for everyone. People who had weak social networks noted their reliance on services and businesses which were disrupted by the pandemic. These services have the potential to be protected spaces for the counterpublic to engage with others, make connections and exchange information. Hayley notes how disruptions limited the ability of these services to act as a space of re-groupment.

> '[Community meal providers] *still provide frozen food or a heated meal in a container to take away, but* [the] *social* [part] *where we would usually sit down together is gone. The Church has stopped so I lost good people ... I'm new to the area, so I was unable to tap into services where I could find good people*. (Hayley, in her 40s, Queensland)

3.2 | COVID-19 restrictions and enforcement imagined for an idealised public

Guidance to reduce COVID-19 transmission targeted 'ideal public health subjects' [31], to the exclusion of

those who were not able to equally adhere to restrictions due to social inequalities and structural vulnerabilities [22]. Australia deployed increased surveillance to control COVID-19 transmission, including contact tracing applications [36] and camera surveillance for enforcement during lockdowns [37]. Increased surveillance and restrictions on gathering complicated the usual calculations of health and wellbeing in drug purchase and use. Opportunities for practises of care, such as using drugs in groups, were minimised because of the COVID-19 legislation which restricted gatherings. Participants discussed ways to circumvent the restrictions, including avoiding mobile applications for contact tracing.

> '*We would turn up and meet a dealer at a certain house at a certain time, being very careful not to make any noise because there's six or seven of us all in this flat at the same time. We didn't want the neighbours twigging to the fact that there's a whole bunch of us around there. Essentially, we weren't just breaking the law by taking drugs, we were breaking the law by simply being together. And it also affected me when I was thinking, "do I want to download this COVID tracker app?". I felt "it depends on how much of a tracker it is, because if it is saying that I am meeting with half a dozen people all at once, is that going to lead to me getting in trouble?". So I didn't end up downloading it because I didn't want to be tracked, because I was thinking "I could be tracked while I'm out scoring*"' (Tom, in his 50s, Australian Capital Territory)

The declaration of a state of emergency in Australia bestowed expanded powers on the police to enforce public health directives [38], such as restrictions on gatherings and curfews. Participants saw the increased powers as a threat to their health and wellbeing and employed tactics to firstly, avoid the police and secondly, avoid attention from the police. After curfew in her city, Sam was driving home from work when she was subjected to an aggressive stop and search by police. She consequently changed her route home to avoid a future confrontation.

> *'I am not super assertive with the police, because I didn't want to aggravate the situation but at that stage I was like, "no, you have just broken my 1.5 metres, my personal space, and grabbed my phone" ... which is an easy transmission* [risk for COVID].' (Sam, in her 50s, South Australia)

Being able to 'pass' or hide stigmatised behaviours such as receiving OAT and injecting drugs, can afford people some protection against discrimination [39]. Stigma impacts health due to the chronic stress of discrimination and also acts as a barrier to accessing health services [40, 41]. Restrictions on movement and fewer people in the streets during the pandemic made 'passing' more difficult, and so stigma and fear of policing were felt more acutely.

> '*Here, things are getting back to normal. There are enough people on the streets that you can disappear into the crowd, but for a while there on the road driving around, going to* [buy drugs] *and coming back, I felt a bit vulnerable because there's very little traffic around. Now it has all picked up again and people are going to work, etc, so there's more traffic on the road*.' (George, in his 50s, Australian Capital Territory)

3.3 | Counterpublic health strategies

As counterpublics can be understood by their exclusion from a singular public sphere, counterpublic health can be understood as behaviours which do not align with normative public health guidance [29, 32]. Counterpublic health, by its nature, is often unacknowledged or discredited in public discourse. Acknowledging counterpublic health strategies can support the legitimisation of participants' pursuit of alternative health or wellbeing goals [27].

The importance that people who inject drugs assign to health issues depends on their environment where health, social, legal and financial pressures vie for precedence [42, 43]. Helen rejected the overriding rhetoric of COVID-19 transmission being the only priority, and it became just one of a number of competing priorities.

> Were you worried about picking up drugs during[the pandemic]?
> *'Yeah but it just didn't matter, I did it anyway, because you are always worried about that, COVID or not, it's just part and parcel of scoring drugs - looking out for the police and being as careful as you can, but you were certainly more careful and we tried to meet in places where it wasn't as obvious and things like that, but most of us didn't give two hoots, we just weren't worried about it. You know, you might overdose any day, for something like COVID I*

just didn't give it a second thought, I really didn't think about it.' (Helen, in her 50s, Australian Capital Territory)

Sam acknowledged that the in-person purchase of drugs implied an increased risk of COVID-19 transmission and compensated by applying public health guidance for hygiene/hand washing, demonstrating how the guidance was situated in each person's experience. Despite COVID-19 transmission being one of a number of competing priorities, Sam reported adapting her usual routine of purchasing and using drugs to incorporate new practises of care.

[Did COVID] change how you scored?
'*Well yeah, look, swabbing and washing or hand sanitising hands and swabbing the wrappers before we opened them, yeah*.' (Sam, in her 50s, South Australia)

Strategies employed to reduce COVID-19 risk were sometimes incompatible with practises of care. Concern about transmission and the pandemic-related restrictions disrupted people's knowledge about the 'safest' way to use drugs. For Leah, this complex calculation of risk resulted in a serious injury sustained while using drugs alone in a car.

And do you usually use in your car?
'*No, but I wasn't hanging around where I usually pick up. I usually use at home, but sometimes... I will use at the place if I'm not sure of the gear or if I haven't had that gear before or I've had some time off*.'
And then what made you use in the car that day, was it because you did not want to hang around at the dealer's house?
'*Yeah that's right, because of COVID*.' (Leah, in her 40s, Queensland)

During the pandemic, participants reported having to 'shop around' (contacting multiple people to purchase drugs) due to the unstable drug supply. This complicated the usual negotiated safety of having a sole, reliable drug seller to mitigate risks associated with the lack of safe supply. 'Shopping around' implied involving more people in the transaction and thus increasing risk in terms of COVID-19 transmission, detection by police, and reducing the safety in terms of drug quality afforded by buying from a familiar seller.

'*You go down your list of people that you know and it depends on how far down that list you want to go and when you start dealing with other people, you've got to make sure they can pay for their dope, because if you don't pay for theirs they'll take half of yours* [...] *I'm seeing a much wider network of people than I used to see because I have to, to get the drugs and so far more contact with people than I was having before*.' (Helen, in her 50s, Australian Capital Territory)

Some participants reported changing their drug use to contend with mental health issues that were exacerbated by the pandemic. There were multiple pathways for these changes; Leah attributed the change to work pressures while Ryan attributed the change to the increased police presence. Both demonstrated how knowledge of drugs and their own health were employed in their practises of care, generating conflicts with normative public health guidance aimed at people outside of this counterpublic.

'*Well I've actually started to use GHB a little bit, because I've stopped using ice*.'
Because of the price [increases during COVID-19]?
'*That probably does help, yeah, most definitely, but also for my sanity and my work* [laughs].' (Leah, in her 40s, Queensland)
So you said COVID helped you stop [taking heroin], what exactly was it?
'*Well the fact that when you go out, there was police absolutely everywhere, the stuff wasn't as good and I just felt like I was on show, because there was no one else around, there was police everywhere and here I am out in the middle of the town doing nothing, with no excuses, I just felt very much on show and with my psychological issues, the last thing I need is to be on show*.' (Ryan, in his 40s, New South Wales)

4 | DISCUSSION

People receiving OAT who participated in the study encountered specific challenges to protecting their health and wellbeing during COVID-19. The participants' experiences illustrate how being in a counterpublic can offer a space to interact during a Big Event, demonstrated by the people who were able to mobilise their networks to find spaces of re-groupment. COVID-19-related restrictions, particularly increased policing, were often incompatible with participants' needs and may have exacerbated health inequalities. Participants

had experiences of employing counterpublic health strategies prior to COVID-19, meaning they may have been more prepared than other publics to protect their own health during the pandemic or more ready to adapt public health messages to their needs. Participants' experiences of the pandemic emphasise the value of practises of care, and the importance of creating a societal context which is not hostile to these practises.

Participants used their existing networks as spaces of re-groupment during the COVID-19 pandemic. Where social networks were absent, people were less equipped to mitigate the harms produced by social and health service disruption. These findings corroborate other work which finds that, rather than 'enabling' harmful behaviours, relationships between people who use drugs can support health protection [44–46]. While this analysis focuses on networks which were existent to some extent prior to COVID-19, other work has identified the growth of online spaces of re-groupment which served as spaces for mutual aid for people who use opioids during the pandemic [47]. Policies to support spaces of re-groupment could include a considered and thoughtful expansion of networks of peer support, developed in collaboration with community-led organisations. Such networks could consist of peer workers from needle and syringe programs or drug treatment services, but also extend more widely to peers who participate in education or support activities. Acknowledging the breadth of care provided by peers would ensure that, following a Big Event, those within the networks could be immediately recognised as essential workers by the government and given the exceptions required to continue providing services.

The enforcement of COVID-19-related restrictions, layered on the existing criminalisation of drug use, threatened and constrained the ability of the counterpublic to act as a space of re-groupment. The tension between dominant publics and counterpublics was visible throughout the pandemic [48], when private matters were considered to conflict with the 'common good' of COVID-19 elimination. The restrictions, created for an idealised public, failed to take into account the distinct capacities of population groups to comply [22]. Applying restrictions through policing rather than cooperation increased the potential criminalisation of people who use drugs [49]. By employing tactics normally used to evade criminalisation for behaviours associated with drug use, people were able to somewhat diminish the threat of increased policing. The enforcement of COVID-19-related restrictions by policing may have long term, destabilising effects on the counterpublic which are yet to be fully understood.

Participants reported how counterpublic health strategies contributed to health protection during the pandemic. When the counterpublic health efforts are acknowledged as effective and legitimate, perceptions of the behaviour of people who use drugs as deficient, defective or lacking are challenged [27, 50]. This is especially pertinent during Big Events when heightened panic in the wider population makes it difficult to counter stigmatising presumptions about those who do not comply with the state's public health advice. Rather than being contra public health, people recounted how they situated public health guidance in their local context. The practises of care reported in this study paralleled those of pre-pandemic times [30, 51]: engaging with knowledge about COVID-19 to reduce contact with people in harm reduction services, reducing potential harms resulting from poor drug quality and changing drug use. Structural vulnerabilities, namely criminalisation of drug use, socio-economic inequalities and stigma, impede these strategies and threaten the health of people who use drugs. Consequences of the COVID-19 response, such as interruptions to drug markets, interruptions to health and social services, and increased policing, were anticipated early in the pandemic [6, 7] yet, at the state level, little was done to address these harms. The strategies employed by the counterpublic in this study adds to evidence that practises of care are intrinsic to promoting health in hostile societal contexts [17, 44, 52]. Governments could foster resilience in future Big Events by providing financial and legislative support for flexible delivery of health and social services [53] which complement practises of care. The labour performed by participants, peers, peer workers and drug sellers goes far beyond traditional understandings of harm reduction to create health promoting environments for people receiving OAT and to buffer the fragile health and social services. These efforts not only protected the participants' own wellbeing but may also have reduced burden on health and social services at a time when the sector was stretched.

This study uses the lens of the counterpublic to further knowledge on how people who inject drugs enacted strategies to reduce harms produced by Big Events. Peers are uniquely positioned to negotiate consent to enter spaces reserved for the peer group, and thus should be supported to provide care especially when mainstream health services are disrupted. People performing practises of care can be recognised through membership of peer networks, which would allow them to be designated essential workers during future Big Events. Public health messaging could be made more nuanced by engaging members of the counterpublic to ensure practises of care are acknowledged in public health advice. Panic that

derives from Big Events produce repressive policies that risk damaging civil order [13]. Affording discretionary powers to the police during the pandemic encouraged police encroachment into public health implementation. Asking that police rapidly enforce public health legislation, in which they have no expertise, is challenging for the police to implement and damages relations with the policed population. When COVID-19 was thought to be a short-term issue, policies were developed rapidly on an ad-hoc basis. In light of the ongoing fallout of the pandemic, now is the moment to reflect on how policies could be altered to better meet people's needs.

There are several limitations to the study. This study investigates a heterogeneous population but did not analyse local practises of care by group identities (e.g., gender, race, ethnicity), which could uncover specific needs of subgroups within the sample. The median age of the sample (49 years) is higher than the median age of people receiving OAT in Australia (44 years) [54], and the youngest participant was aged 32. A younger cohort may enact different practises of care which require specific policy support. The participant experiences reflect the COVID-19 restrictions in Australia, yet the likely similarities to other countries' response (restricted access to health and social services, encroachment of policing into public health and restrictions on movement) ensure insights are generated for people receiving OAT in other settings. All interviews took place remotely to comply with COVID-19 restrictions, risking exclusion of people who did not have access to telephones. Community organisations compensated for this by allowing people to use the organisation's phone to complete an interview. The interviews took place over a period of four months and, given the rapidly changing restrictions and differences in state responses, the time of enrolment and location of participant may have influenced participants' responses. The analysis employed a deductive approach, under the assumption that extensive literature on relations between people who use drugs and other publics would be applicable to this study's focus. This allowed exploration of the nuances in participants' experiences, to generate knowledge that could inform policy beyond the COVID-19 period. People who are geographically or socially isolated and did not participate in the described practises of care may have been less likely to be recruited to the study, demonstrating a gap in the analysis.

People's accounts of the COVID-19 pandemic demonstrate the complexity of being in a counterpublic during a Big Event. The counterpublic afforded certain benefits, yet structural vulnerabilities (criminalisation of drug use, housing, access to private transport) limited the capacity of people to protect their own health. Counterpublic health strategies, in adapting and eschewing mainstream public health guidance, may have eased the burden on already-stretched health services. Criminalisation of people who use drugs was reproduced and enacted in new ways by the COVID-19 restrictions and this may have long-term consequences for health and civil rights. Supporting re-groupment within the counterpublic, acknowledging counterpublic health strategies, and stopping the criminalisation of people who use drugs are strategies required to protect health in future Big Events.

AUTHOR CONTRIBUTIONS

Each author certifies that their contribution to this work meets the standards of the International Committee of Medical Journal Editors.

ACKNOWLEDGEMENTS

This work is dedicated to the memory of Jude Byrne, a tireless advocate for the rights of people who use drugs, who passed away in March 2021. Jude Byrne convened the Community Reference Panel which this study relied upon. The authors thank the Community Reference Panel for their input on the conceptualisation of the study, review of the interview guide and recruitment of participants. Panel members: Andy Heslop (New South Wales Users and AIDS Association), Carol Holly (Hepatitis SA), Carolyn Weidner (Harm Reduction Victoria), Diane Lloyd (Peer Based Harm Reduction WA), Esha Leyden (Queensland Injectors Health Network), Geoff Ward (Canberra Alliance for Harm Minimisation and Advocacy), Hunter Morgan (Harm Reduction Victoria), Jane Dicka (Harm Reduction Victoria), Lucy Pepolim (New South Wales Users and AIDS Association), Mark Jones (Tasmanian Users Health & Support League), Paul Dessauer (Peer Based Harm Reduction WA), Peta Gava (Peer Based Harm Reduction WA), Peter Sidaway (Northern Territory AIDS and Hepatitis Council), Shayne Kilford (Northern Territory AIDS and Hepatitis Council). Open access publishing facilitated by University of New South Wales, as part of the Wiley - University of New South Wales agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST

The CHOICE Study was funded through a National Health and Medical Research Council (NHMRC) Investigator Grant (1176131). NHMRC had no role in study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the article for publication. Carla Treloar has received speaker fees from Abbvie and Gilead and has received a research grant from Merck outside the submitted work. Sione Crawford has received speaker fees from

Abbvie outside the submitted work. Jason Grebely is a consultant/advisor and has received research grants from AbbVie, Camurus, Cepheid, Gilead, Hologic, Indivior and Merck outside the submitted work. Anna Conway and Alison D. Marshall have no competing interests to disclose.

ORCID

Anna Conway https://orcid.org/0000-0002-9082-9714

REFERENCES

1. Khatri UG, Perrone J. Opioid use disorder and COVID-19: crashing of the crises. J Addict Med. 2020;14:e6–7.
2. Haley DF, Saitz R. Editorial: the opioid epidemic during the COVID-19 pandemic. JAMA. 2020;69:1189–97.
3. Becker WC, Fiellin DA. When epidemics collide: coronavirus disease 2019 (COVID-19) and the opioid crisis. Ann Intern Med. 2020;173:59–60.
4. Jenkins WD, Bolinski R, Bresett J, Van Ham B, Fletcher S, Walters S, et al. COVID-19 during the opioid epidemic – exacerbation of stigma and vulnerabilities. J Rural Health. 2021;37:172–4.
5. Dietze PM, Peacock A. Illicit drug use and harms in Australia in the context of COVID-19 and associated restrictions: anticipated consequences and initial responses. Drug Alcohol Rev. 2020;39:297–300.
6. Grebely J, Cerdá M, Rhodes T. COVID-19 and the health of people who use drugs: what is and what could be? Int J Drug Policy. 2020;83:102958.
7. Dunlop A, Lokuge B, Masters D, Sequeira M, Saul P, Dunlop G, et al. Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. Harm Reduct J. 2020;17:26.
8. Slavova S, Rock P, Bush HM, Quesinberry D, Walsh SL. Signal of increased opioid overdose during COVID-19 from emergency medical services data. Drug Alcohol Depend. 2020;214:108176.
9. Ochalek TA, Cumpston KL, Wills BK, Gal TS, Moeller FG. Research letter: nonfatal opioid overdoses at an urban emergency department during the COVID-19 pandemic. JAMA. 2020;323:1891–2.
10. Gomes T, Kitchen SA, Murray R. Measuring the burden of opioid-related mortality in Ontario, Canada, during the COVID-19 pandemic. JAMA Netw Open. 2021;4:e2112865.
11. Pan KY, Kok AAL, Eikelenboom M, Horsfall M, Jörg F, Luteijn RA, et al. The mental health impact of the COVID-19 pandemic on people with and without depressive, anxiety, or obsessive-compulsive disorders: a longitudinal study of three Dutch case-control cohorts. Lancet Psychiatry. 2021;8:121–9.
12. Rogers AH, Shepherd JM, Garey L, Zvolensky MJ. Psychological factors associated with substance use initiation during the COVID-19 pandemic. Psychiatry Res. 2020;293:113407.
13. Friedman SR, Rossi D, Braine N. Theorizing "big events" as a potential risk environment for drug use, drug-related harm and HIV epidemic outbreaks. Int J Drug Policy. 2009;20:283–91.
14. Caiaffa WT, Andrade RG. On the cost of big events: are weather-related disasters as bad as economic recessions for health disparities related to drug use? Subst Use Misuse. 2015;50:894–8.
15. Nutton J, Fast E. Historical trauma, substance use, and indigenous peoples: seven generations of harm from a "big event.". Subst Use Misuse. 2015;50:839–47.
16. Friedman SR, Mateu-Gelabert P, Nikolopoulos GK, Cerdá M, Rossi D, Jordan AE, et al. Big events theory and measures may help explain emerging long-term effects of current crises. Glob Public Health. 2021;16:1167–86.
17. Kolla G, Strike C. Practices of care among people who buy, use, and sell drugs in community settings. Harm Reduct J. 2020;17:27.
18. Duff C. Governing drug use otherwise: for an ethics of care. J Sociol (Melb). 2015;51:81–96.
19. Vasylyeva TI, Smyrnov P, Strathdee S, Friedman SR. Challenges posed by COVID-19 to people who inject drugs and lessons from other outbreaks. J Int AIDS Soc. 2020;23:e25583.
20. Fraser N. Rethinking the public sphere: a contribution to the critique of actually existing democracy. Social Text. 1990;26:56–80.
21. Warner M. Publics and counterpublics. Publ Cult. 2002;14:49–90.
22. Schlosser A, Harris S. Care during COVID-19: drug use, harm reduction, and intimacy during a global pandemic. Int J Drug Policy. 2020;83:102896.
23. Ritchie H, Mathieu E, Rodés-Guirao L, Appel C, Giattino C, Ortiz-Ospina E, et al. Coronavirus pandemic (COVID-19) [Internet]. 2020 [cited 24 May 2022]. Available from: OurWorldInData.org
24. Department of Education Skills and Employment. ECEC COVID-19 timeline [Internet]. 2021 [cited 24 May 2022]. Available from: https://www.dese.gov.au/covid-19/resources/ecec-covid19-timeline
25. Neale J. Iterative categorisation (IC) (part 2): interpreting qualitative data. Addiction. 2021;116:668–76.
26. O'Sullivan D, Rahamathulla M, Pawar M. The impact and implications of COVID-19: an Australian perspective. Int J Commun Soc Develop. 2020;2:134–51.
27. Bryant J, Rance J, Hull P, Mao L, Treloar C. Making sense of 'side effects': Counterpublic health in the era of direct-acting antivirals. Int J Drug Policy. 2019;72:77–83.
28. Fraser N. Justice interruptus critical reflections on the "Postsocialist" condition. New York; Routledge; 1997.
29. Bell SA, Aggleton P. Time to invest in a "counterpublic health" approach: promoting sexual health amongst sexually active young people in rural Uganda. Childr Geogr. 2012;10:385–97.
30. Duff C, Moore D. Counterpublic health and the design of drug services for methamphetamine consumers in Melbourne. Health (London). 2015;19:51–66.
31. Farrugia A, Fraser S. Science and scepticism: drug information, young men and counterpublic health. Health (London). 2017;21:595–615.
32. Race K. Pleasure consuming medicine: the queer politics of drugs. Durham, NC: Duke University Press; 2009.
33. Harris M, Rhodes T. Methadone diversion as a protective strategy: the harm reduction potential of "generous constraints.". Int J Drug Policy. 2013;24:e43–50.
34. Koester S, Anderson K, Hoffer L. Active heroin injectors' perceptions and use of methadone maintenance treatment:

cynical performance or self-prescribed risk reduction? Subst Use Misuse. 1999;34:2135–53.
35. Peacock A, Uporova J, Karlsson A, Price O, Gibbs D, Swanton R, et al. Australian drug trends 2020: key findings from the National Illicit Drug Reporting System (IDRS) interviews. Sydney: National Drug and Alcohol Research Centre, UNSW Sydney; 2021.
36. Whitelaw S, Mamas MA, Topol E, Van Spall HGC. Applications of digital technology in COVID-19 pandemic planning and response. Lancet Digit Health. 2020;2:e435–40.
37. The Age. Overstepping the mark in enforcing lockdown undermines the cause [internet]. Melbourne; The Age; 2020. Available from: https://www.theage.com.au/national/victoria/overstepping-the-mark-in-enforcing-lockdown-undermines-the-cause-20200907-p55t1a.html
38. Human Rights Law Centre. Explainer: police powers and COVID-19 [Internet]. Australia. 2020. Available from: https://www.hrlc.org.au/factsheets/2020/9/8/explainer-police-powers-and-covid-19
39. Bennett G. Blacklisted in the city: how stigma affects primary healthcare for people who inject drugs. Aust J Prim Health. 2004;10:121–8.
40. Ahern J, Stuber J, Galea S. Stigma, discrimination and the health of illicit drug users. Drug Alcohol Depend. 2007;88:188–96.
41. Treloar C, Rance J, Backmund M. Understanding barriers to hepatitis C virus care and stigmatization from a social perspective. Clin Infect Dis. 2013;57(Suppl 2):51–5.
42. Harris M, Rhodes T. Hepatitis C treatment access and uptake for people who inject drugs: a review mapping the role of social factors. Harm Reduct J. 2013;10:7.
43. Treloar C, Rhodes T. The lived experience of hepatitis C and its treatment among injecting drug users: qualitative synthesis. Qual Health Res. 2009;19:1321–34.
44. Rance J, Rhodes T, Fraser S, Bryant J, Treloar C. Practices of partnership: negotiated safety among couples who inject drugs. Health (London). 2018;22:3–19.
45. Rhodes T, Rance J, Fraser S, Treloar C. The intimate relationship as a site of social protection: partnerships between people who inject drugs. Soc Sci Med. 2017;180:125–34.
46. Farrugia A, Fraser S, Dwyer R, Fomiatti R, Neale J, Dietze P, et al. Take-home naloxone and the politics of care. Sociol Health Illn. 2019;41:427–43.
47. Bunting AM, Frank D, Arshonsky J, Bragg MA, Friedman SR, Krawczyk N. Socially-supportive norms and mutual aid of people who use opioids: an analysis of Reddit during the initial COVID-19 pandemic. Drug Alcohol Depend. 2021;222:108672.
48. Pienaar K, Flore J, Power J, Murphy D. Making publics in a pandemic: Posthuman relationalities, 'viral' intimacies and COVID-19. Health Sociol Rev. 2021;30:244–59.
49. Chang J, Agliata J, Guarinieri M. COVID-19 - enacting a 'new normal' for people who use drugs. Int J Drug Policy. 2020;83:102832.
50. Treloar C, Holt M. Deficit models and divergent philosophies: service providers' perspectives on barriers and incentives to drug treatment. Drugs Educ Prev Policy. 2006;13:367–82.
51. Southgate E, Hopwood M. The role of folk pharmacology and lay experts in harm reduction: Sydney gay drug using networks. Int J Drug Policy. 2001;12:321–35.
52. Gilbert AR, Hellman JL, Wilkes MS, Rees VW, Summers PJ. Self-care habits among people who inject drugs with skin and soft tissue infections: a qualitative analysis. Harm Reduct J. 2019;16:69.
53. Zolopa C, Hoj S, Bruneau J, Meeson JS, Minoyan N, Raynault MF, et al. A rapid review of the impacts of "big events"on risks, harms, and service delivery among people who use drugs: implications for responding to COVID-19. Int J Drug Policy. 2021;92:103127.
54. Australian Institute of Health and Welfare. National Opioid Pharmacotherapy Statistics Annual Data collection [internet]. 2021 [cited 20 April 2021]. Available from: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-2019/contents/introduction

How to cite this article: Conway A, Treloar C, Crawford S, Grebely J, Marshall AD. People engaged in opioid agonist treatment as a counterpublic during the COVID-19 pandemic in Australia: A qualitative study. Drug Alcohol Rev. 2022. https://doi.org/10.1111/dar.13531