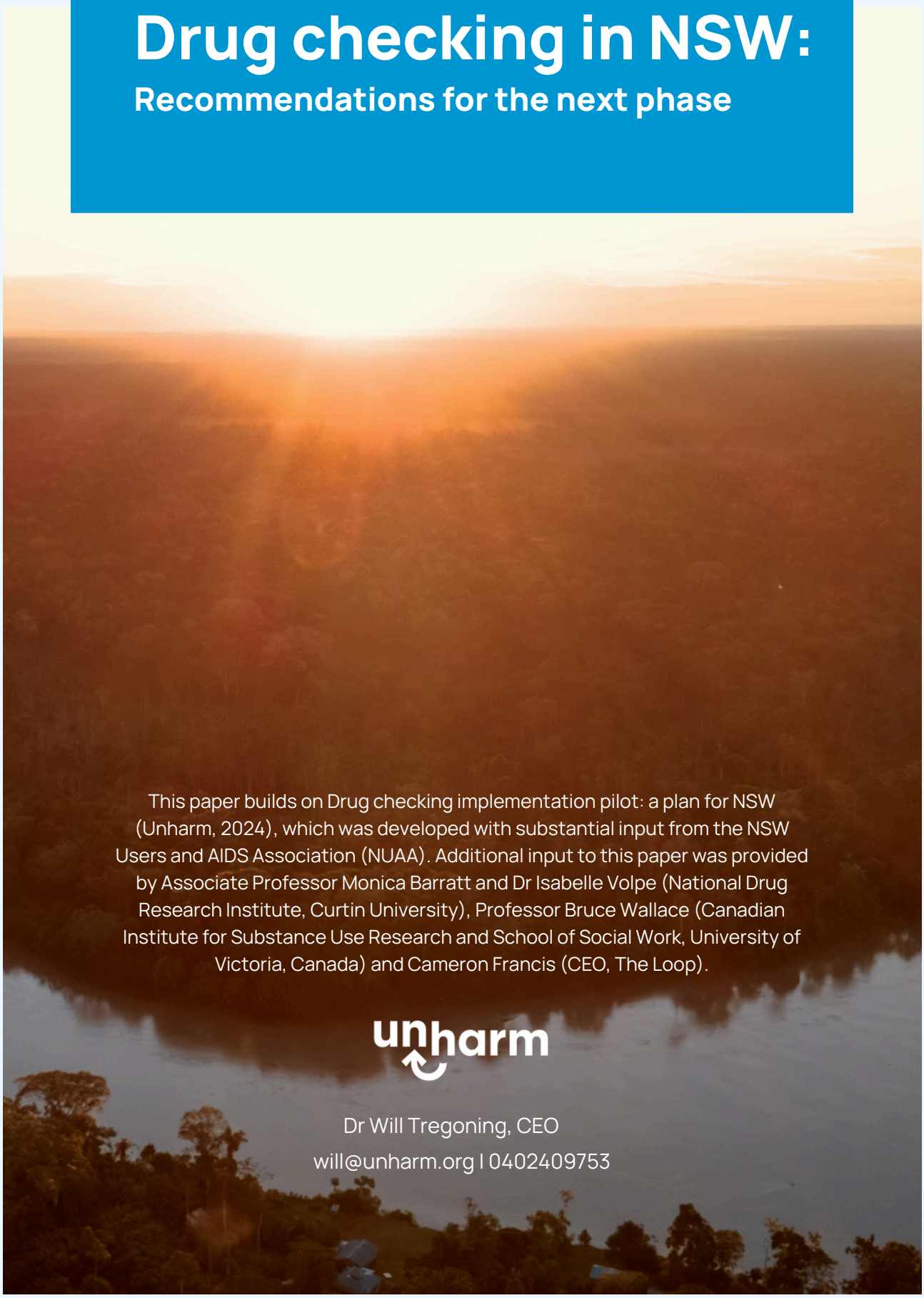
Drug checking in NSW:

Recommendations for the next phase



This paper builds on Drug checking implementation pilot: a plan for NSW (Unharm, 2024), which was developed with substantial input from the NSW Users and AIDS Association (NUAA). Additional input to this paper was provided by Associate Professor Monica Barratt and Dr Isabelle Volpe (National Drug Research Institute, Curtin University), Professor Bruce Wallace (Canadian Institute for Substance Use Research and School of Social Work, University of Victoria, Canada) and Cameron Francis (CEO, The Loop).

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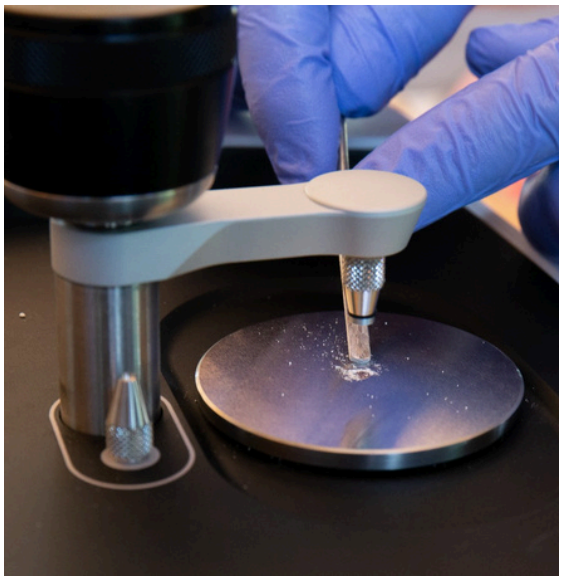
Executive summary



NSW has established that drug checking at festivals is feasible. The question now is how to build on that foundation so that drug checking contributes most effectively to health and safety in NSW, alongside existing harm reduction and surveillance programs.

This paper recommends a phased expansion of drug checking services in NSW, building on the principles and infrastructure established by the festival trial.

The recommended approach has two stages:

Stage one would continue festival-based services and establish one or two fixed-site community drug checking services in metropolitan Sydney. Fixed sites would operate multiple days per week and serve as a hub for comprehensive analysis, confirmatory testing and early warning system coordination. Whether hubs are co-located with existing health services or operate as standalone sites should be determined by which populations they aim to reach and the service delivery context. This stage can be implemented under existing regulatory mechanisms, following the approach used in Queensland, without new legislation.

Stage two would extend geographic reach through a distributed access model, drawing on approaches piloted in Canada. Satellite collection points - embedded within existing harm reduction services such as needle and syringe programs - would use portable analytical equipment (such as FTIR spectrometers) with results interpreted remotely by technicians at the central hub. The hub would govern analytical quality and data integration, while health interventions at satellite sites would operate within the clinical governance of the host service. This maintains the data integration and quality assurance that NSW Health requires while reducing the cost and workforce barriers to expanding access.

The evidence base for drug checking as a harm reduction intervention is strong and growing. A 2024 rapid review commissioned by NSW Health found evidence for positive individual behaviour change, effective market surveillance contributions, and the capacity of drug checking to engage populations who do not otherwise access health services.[1] The evidence for population-level health outcomes from a mature service delivery system is still emerging, but the logic is clear: a distributed network generates richer, more diverse, and more geographically representative data that strengthens early warning systems and extends the reach of harm reduction interventions to people the current model does not serve.

Other Australian jurisdictions have moved to expand drug checking beyond festivals, with the ACT, Victoria and Queensland each establishing or funding community drug checking services. The trajectory across jurisdictions points clearly toward community-based access as the next stage of implementation.

1. The opportunity

Drug checking gives people who intend to use drugs an opportunity to have those drugs chemically analysed, receive the results, and get tailored health and harm reduction advice before making a decision about whether and how to use them.[2] It is a well-established harm reduction intervention operating in at least 26 countries.[3]

NSW has run a government-led trial of drug checking at music festivals. That trial has been independently evaluated, and a decision on the next phase of service delivery is expected in 2026.

This paper sets out a recommended approach for that next phase. It does not re-argue the case for drug checking. Instead, it addresses a practical question: what model of service delivery will allow drug checking to contribute most effectively to population health in NSW, given the scale and diversity of the state's population?

Why festival-only access is not sufficient

The festival trial addressed a real and visible problem - drug-related hospitalisations and deaths at music events, including six deaths in NSW during the 2018-19 summer that prompted a coronial inquest.[4] Festival-based drug checking is an appropriate response in that setting, and should continue.

But festivals represent a narrow slice of drug use in NSW. An analysis of MDMA-related deaths in Australia between 2000 and 2018 found that 73 per cent occurred in private residences and only seven per cent at music festivals or dance parties.[5] In 2022-23, one in six people in NSW aged over 14 reported using an illicit drug in the past year.[6] The drugs reaching these consumers come from an unregulated market characterised by high variability in contents and potency, the emergence of novel substances, and the increasing presence of potent synthetic opioids in products sold as other drugs.[7] These risks affect people who use drugs in all settings, not only those who attend music festivals.

A drug checking service limited to festivals cannot generate the geographic coverage or continuity of data needed to support a robust early warning system. It cannot reach the majority of people who use drugs in NSW. And it cannot provide the kind of year-round market surveillance that would allow NSW Health to identify and respond to emerging threats before they cause harm.

The population health case for expansion

The standard framing of drug checking focuses on individual behaviour change - whether a person decides to discard or use less of a tested substance. That evidence is real: the rapid review found that people consistently modify their behaviour when drug checking reveals unexpected or concerning results, and emerging longitudinal evidence suggests these changes are sustained over time.[8] But the population health case rests on three functions that operate simultaneously at scale:

1. **Reach.**
   Drug checking services engage people who do not otherwise access health or harm reduction services. Across local and international evaluations, between 70 and 97 per cent of drug checking clients report having no previous contact with health services about their drug use.[9] A distributed service model extends this reach across the population rather than concentrating it at specific events.

2. **Early warning system data.**
   A drug checking network generates real-time data on what is actually circulating in the unregulated drug supply - data that existing surveillance systems, which rely on hospital presentations, toxicology reports and police seizures, may only capture after harm has occurred. The ACT's fixed-site service demonstrated this when it identified three entirely new psychoactive substances not detected anywhere else in the world, and issued a public health warning about potent opioids found in counterfeit pharmaceuticals before they caused further harm in the community.[10] A geographically distributed network would generate richer and more representative data than any single site or set of festival deployments.

3. **Market intervention.**
   Because unregulated drug markets have no quality controls, consumers are routinely exposed to products that are mislabelled, contaminated or far more potent than expected - and the health system bears the cost in overdoses, hospitalisations and deaths. Evidence is growing that drug checking influences drug markets at a micro level - service users providing feedback to suppliers, returning adulterated products, and removing harmful substances from circulation at events.[11] The evidence for broader market effects is still developing , but the logic is straightforward: the more widely drug checking results circulate through peer networks and public communications, the greater the aggregate pressure on market quality, and the greater the potential to reduce the population-level health burden of a toxic and unpredictable supply.

These three functions are mutually reinforcing. Greater scale and reach generate better surveillance data. Better data supports more effective and timely public health responses. And the wider circulation of drug checking results creates pressure on higher-risk supplier behaviours, reducing misrepresentation and contamination across the market. These dynamics could generate benefits across the whole population, not only for those who access the service directly.

Normalisation across Australian jurisdictions

NSW is not being asked to pioneer drug checking. The ACT has operated both festival-based and fixed-site services since 2019 and 2022 respectively. Queensland funded fixed-site community drug checking services in Brisbane and Gold Coast in 2024, alongside event-based services.[12] Victoria committed to an 18-month drug checking trial in 2024, encompassing both mobile and fixed-site services.[13] Aotearoa-New Zealand has operated licensed drug checking services across multiple settings since 2021.[14]

The question for NSW is what model of expansion is right for its context: a state of eight million people spread across a vast geography, with an established surveillance infrastructure and a harm reduction system that drug checking needs to complement.

2. A phased approach to expansion

This paper recommends a two-stage approach to expanding drug checking in NSW. Stage 1 would establish core infrastructure: continuing festival-based services while adding fixed-site community drug checking services in metropolitan Sydney. Stage 2 would extend geographic reach through a distributed access model that maintains centralised data integration and quality assurance. Both stages build directly on the principles and service delivery infrastructure established by the festival trial and set out in Unharm's 2024 NSW Drug Checking Implementation Pilot Plan.

Stage 1: Festival services and metropolitan fixed sites

Festival-based services should continue, informed by the findings of the trial evaluation. These services address a known risk environment and provide a mobile testing capability that would also provide a capability to respond to emerging drug-related harm outside of festival settings; for example, in response to overdose clusters in specific communities.

One or two fixed-site services should be established in metropolitan Sydney. These could be co-located with existing harm reduction or health services, or operate as standalone sites with multidisciplinary staffing. Co-location reduces establishment costs and provides natural referral pathways, but standalone services can reach a broader population - including people who do not use traditional harm reduction services - provided they are staffed by teams equipped to provide referrals and health interventions directly. The choice of model and location should be informed by which populations the site aims to serve.

Fixed sites would serve three functions beyond direct service delivery to the public. First, they would house higher-specification analytical equipment capable of comprehensive and confirmatory analysis - including for samples collected at festivals or, in Stage 2, at satellite sites. Second, they would coordinate data integration with NSW Health's existing surveillance and early warning systems, ensuring that drug checking data flows into public health responses in real time. Third, they would provide a training and quality assurance function for the broader network as it develops.

Fixed sites should operate multiple days per week, including outside business hours, reflecting when drug use actually occurs. They should be staffed by multidisciplinary teams that include peer workers, analytical chemists, and health and harm reduction workers.[15] Services should be designed to respond to the specific communities in their catchment.

Workforce is a practical constraint. Qualified analytical chemists are in limited supply, particularly outside metropolitan areas. Concentrating analytical expertise at fixed-site hubs - rather than requiring each service location to employ its own chemists - is a design feature that supports cost-effectiveness.

Stage 2: A distributed access model

Festival services and fixed sites will not, on their own, reach the majority of people who use drugs in NSW, nor provide services at a scale sufficient for meaningful public health reporting on the unregulated drug supply. A state of eight million people spread across a large geography requires a model that can extend access without requiring a fully equipped laboratory and specialist workforce at every location.

The distributed model requires two tiers of analytical capability. Point-of-care testing with portable equipment provides timely results at the site of service delivery. Confirmatory analysis at a central hub, using instruments such as mass spectrometers, enables trace-level detection and quantification - vital for public health reporting and for detecting potent opioids linked to overdose. Both tiers are needed: speed and accessibility at the point of care, precision and depth at the hub.

NSW's harm reduction system already operates tiered service models - such as Primary and Secondary needle and syringe programs - and the distributed drug checking model follows a similar logic of concentrating specialist capability at hubs while extending access through lighter-touch satellite sites.

The distributed model piloted on Vancouver Island in Canada also offers a practical template.[16] In that model, a central hub equipped with comprehensive analytical instruments is connected to multiple remote sites. Each remote site has a portable FTIR spectrometer and a laptop connected to a custom software platform. Trained harm reduction workers at remote sites assist service users to submit samples. The spectra are transmitted to technicians at the central hub for interpretation, and results are returned to the remote site electronically. Where more comprehensive analysis is needed, samples are transported to the hub for confirmatory testing. Results from confirmatory testing can be accessed online, at any connected site, or through a harm reduction worker.

This model directly addresses the core challenges for NSW:

Geographic reach

Remote sites can be established in existing harm reduction services - such as needle and syringe programs - across metropolitan Sydney and in regional centres, at relatively low marginal cost per site. Each site requires one trained worker and portable analytical equipment rather than a full laboratory and specialist chemist.

Data integration

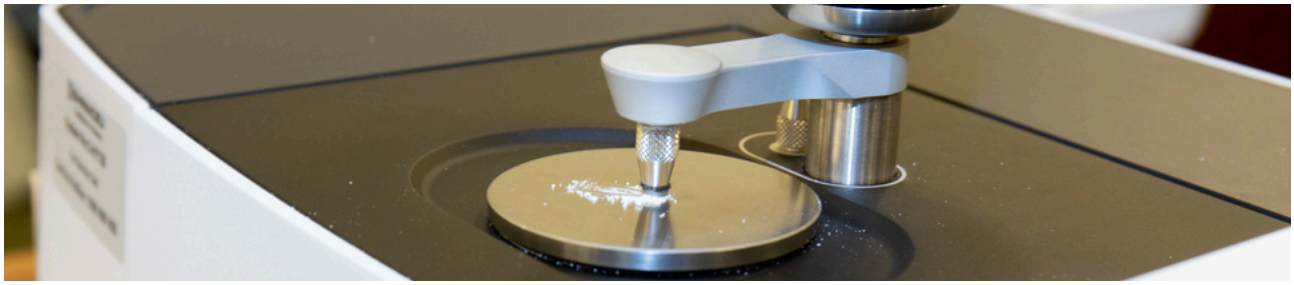
The centralised software platform stores all data across all sites, enabling real-time analysis of trends and rapid identification of emerging threats. This is the mechanism that maintains the networked approach to identifying harm that NSW Health's surveillance infrastructure requires, regardless of how many sites are operating or where they are located.[17]

Clinical governance

Analytical interpretation remains with qualified technicians at the central hub, ensuring consistency and quality of results across the network. Remote-site workers are trained in sample submission and result communication, not in chemical analysis. The health intervention at each satellite site - the conversation with the client, the harm reduction advice - operates within the clinical governance of the host service.

Cost

The hub-and-spoke model concentrates the most expensive inputs - specialist analytical equipment and qualified chemists - at the hub. Adding satellite sites requires only portable analytical equipment and trained staff time at the host service, making the model scalable in a way that replicating full-service fixed sites across the state is not. Once hub infrastructure is in place, the marginal cost of extending the network is low.[18]



A parallel approach operates at the University of North Carolina's Street Drug Analysis Lab, which combines a central laboratory with mail-in services, confirmatory testing for other organisations, and kits that enable public health organisations to build drug checking capacity and submit samples on behalf of clients.[19] Elements of this model, particularly the capacity for other health organisations to collect and submit samples, could be adapted for NSW as the distributed network matures.

The transition from Stage 1 to Stage 2 should be informed by data from fixed-site operations and by consultation with Local Health Districts and harm reduction service providers about where satellite sites would have the greatest impact, and which services have the desire and capacity to integrate drug checking into their operations. Stage 2 does not require Stage 1 to be complete before planning begins, but the fixed-site hub infrastructure needs to be operational before remote sites can connect to it.

Regulatory pathway

Drug checking in NSW can be authorised without new legislation. Queensland established its drug checking services using an existing regulatory pathway under the Medicines and Poisons Act 2019 - a General Approval for a Regulated Poisons Laboratory that authorises the holder to possess, apply and dispose of regulated substances for the purpose of analysis.[20] Approvals were provided with a condition that the applicant comply with the Requirements for drug checking services in Queensland policy. This required no new legislation, only the application of an existing approval category to a new purpose, supported by a short policy document setting out requirements for service delivery, police engagement, monitoring and early warning system participation.

NSW has comparable mechanisms. The current licensing scheme includes an "analysis" category that authorises possession and handling of substances for that purpose. This existing pathway could potentially support drug checking services, provided NSW Health issued guidance clarifying how applicants should complete the licensing process when the source of substances is members of the public submitting samples for checking. Alternatively, a definition of drug checking could be added to the relevant regulation with a corresponding licensing category, creating a clear and permanent legal footing for services. Either approach would be considerably simpler than the legislative route taken in Victoria.

Victoria passed new 'pill testing' legislation and detailed regulations prescribing specific worker qualifications, storage requirements and permit conditions.[21] While comprehensive, this approach limits the flexibility of services to establish new delivery models and sites.[22] A lighter regulatory approach, with clinical governance and quality standards set through licensing conditions rather than legislation, would give NSW the operational flexibility to adapt services as drug markets and service delivery needs evolve.

Whichever pathway is chosen, four requirements should be built into the licensing framework: mandatory participation in NSW Health's early warning and surveillance systems; mandatory data sharing in a format and timeframe specified by NSW Health; a clinical governance framework that ensures the quality and consistency of analytical results and health interventions across all service locations; and explicit authorisation of sample transport between service sites, including from satellite collection points to the central hub for confirmatory analysis. The existing NSW licensing framework for Schedule 8 and Schedule 9 substances already accommodates sample transport for analytical purposes, and the 2024 pilot plan included this capability as part of the mobile service model.[23] A medical courier model, similar to that used for pathology samples, provides a practical precedent.

Police protocols for drug checking services should be adapted from the existing NSW Police guidelines for needle and syringe programs, supplemented by the operational procedures developed during the festival trial.[24] NSW would need to identify an appropriate coordination mechanism between service providers and police. Queensland's approach, in which a dedicated police coordination unit serves as the point of contact, offers one model, though the specific institutional arrangement would need to reflect NSW Police structures.

Community communications

Drug checking generates information with value beyond the individual service interaction. Timely communication of results and drug alerts to affected communities is a core function of the service network. In the current NSW model, this function is already performed by government-funded organisations: NUAA and its DanceWize program disseminate drug alerts to communities of people who use drugs, drawing on information from drug checking services and other sources. Emerging Australian research confirms that people who use drugs engage actively with drug alerts, that most share alert information through their networks, and that harm reduction and peer organisations are substantially more trusted sources of alert information than government agencies or law enforcement.[25]

This communications function should be built into the design of the expanded service model. It does not need to be physically located at the hub or at any specific service site; it is a network-level capability that connects drug checking data to the communities who need to act on it.

A pathway for Local Health District initiative

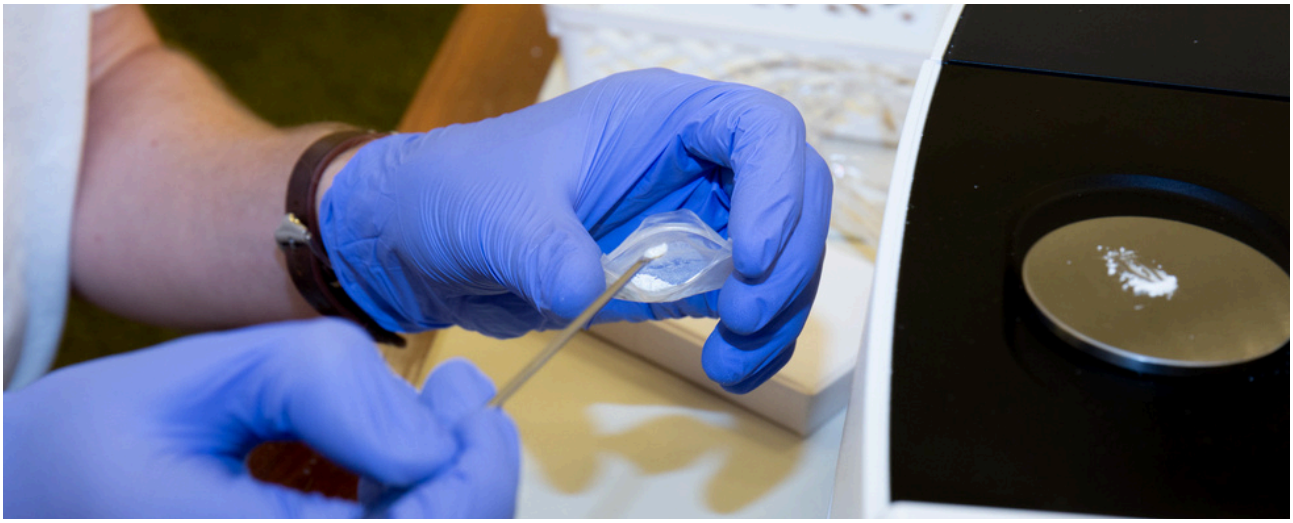
The distributed model described above could, over time, create a pathway for Local Health Districts to commission or host drug checking services tailored to their local populations. For example, under a licensing framework, an LHD could fund a satellite site within an existing harm reduction service in its district, connected to the central hub for analytical interpretation and data integration. This would allow LHDs to respond to local drug market conditions using the tools available within a federated health system, without requiring every initiative to be funded and coordinated centrally.

3. Costs and cost-effectiveness

Comparing drug checking costs across jurisdictions is difficult because service models, scope, and what is included in reported budgets vary considerably. However, the structural economics of the model recommended here are clear.

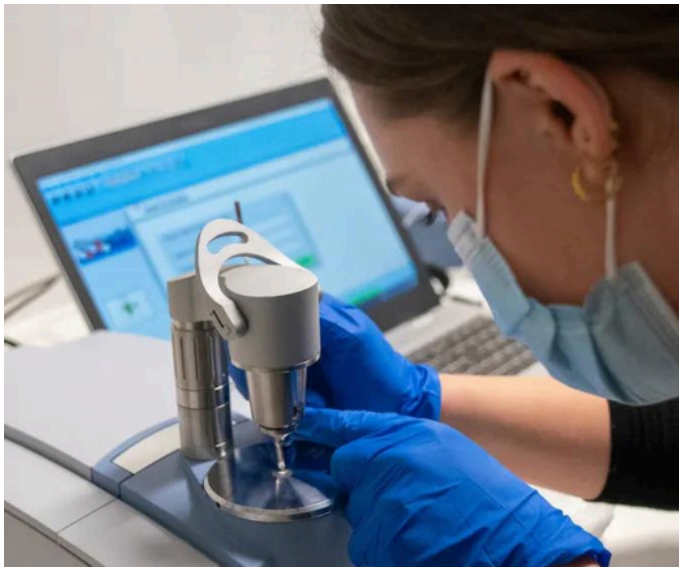
A hub-and-spoke model concentrates the most expensive inputs - specialist analytical equipment, qualified chemists, data infrastructure, and quality assurance functions - at the hub. Once that infrastructure is operational, the marginal cost of adding satellite sites is comparatively low: portable analytical equipment and staff time at the host service. This makes the model scalable in a way that replicating full-service fixed sites is not. Experience from the Vancouver Island distributed model confirms this: once the hub was established, the primary additional cost of new satellite sites was staff hours and equipment, with management and infrastructure costs shared across the network.[26]

On the other side of the ledger, the costs to the health system from drug-related emergency presentations, hospitalisations and deaths across all settings and substances are substantial. The next phase of service delivery should include health economic modelling that compares these costs against the cost of service delivery, building the evidence base for ongoing investment (see section 4).



4. Strengthening the evidence base through the next phase

This paper draws primarily on a 2024 rapid review of 67 studies commissioned by NSW Health, supplemented by service evaluations from the ACT, Aotearoa-New Zealand, Canada, the UK and Europe.[27] The evidence base for drug checking has grown rapidly - one-third of the studies in the rapid review were published since 2023. The next phase of service delivery is an opportunity to build evaluation and research into implementation, strengthening the evidence as services scale.



Population-level health outcomes

A small number of studies have linked drug checking with observed health outcomes, including reduced hospitalisations at events and reduced overdose rates in a supervised consumption facility.[28] The broader population-level case - that drug checking reduces overdose rates, hospitalisations and deaths across the community - is supported by logic and by indirect evidence. Drawing a direct causal line is inherently difficult. Drug checking operates within a complex risk environment alongside other harm reduction interventions, and its effects flow through multiple pathways - individual behaviour change, market surveillance, and peer communication - that are not easily isolated through conventional epidemiological methods. The next phase of service delivery should invest in evaluation approaches suited to this complexity, rather than waiting for a single definitive study that the nature of the intervention makes unlikely (see below).

Cost-effectiveness

A recent cost-benefit analysis of harm reduction interventions in the ACT found that drug checking was not cost-effective under current market conditions but became highly cost-effective under a scenario of increased drug market toxicity.[29] The authors noted that the model could not capture the surveillance and market monitoring functions of drug checking, and that benefits were likely underestimated as a result. The cost-effectiveness of a distributed model operating at scale, with lower marginal costs per site and broader population reach, has not yet been modelled, but the structural economics described in section 3 suggest it would perform significantly better than single-site models. Health economic evaluation should be built into the next phase of NSW service delivery.

Longitudinal evidence

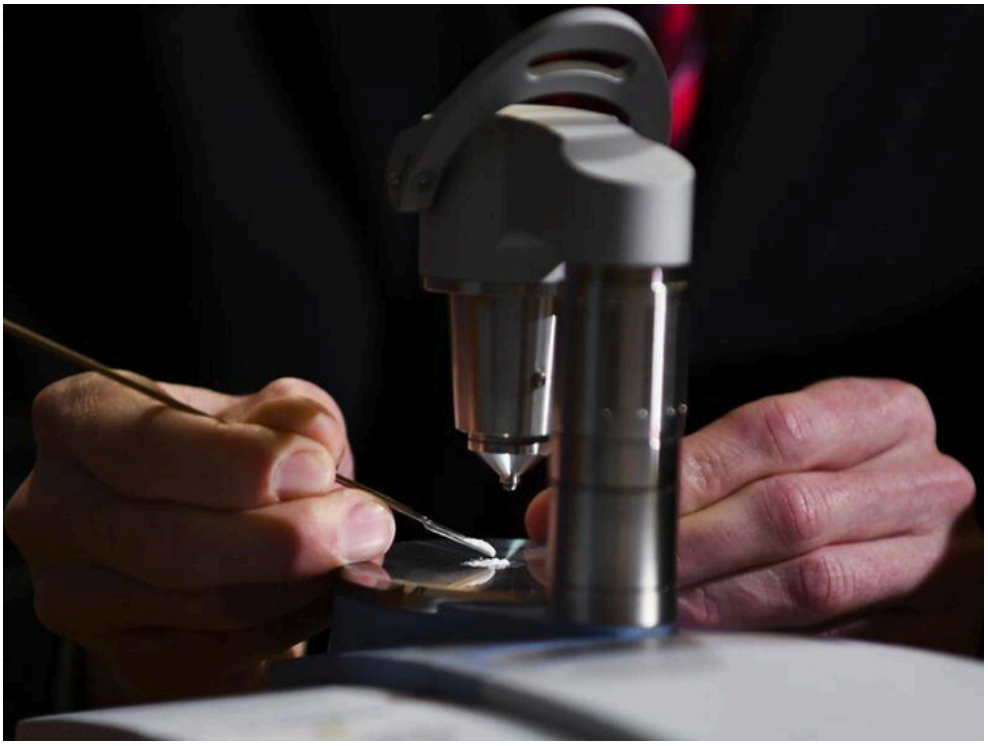
Most studies use cross-sectional designs. The small number of follow-up studies that exist are promising, showing that intentions at the point of service align with behaviours reported at follow-up from three days to six months later, but sample sizes are small and attrition rates are high.[30] Follow-up mechanisms should be embedded in service evaluation to build the evidence for sustained behaviour change.

Community engagement with alerts

Drug checking data feeds early warning systems and public health communications. An Australian survey of people who use drugs found high engagement with drug alerts, with most participants sharing alert information through their networks and over half reporting that they changed their behaviour after seeing an alert.[31] The next phase of drug checking in NSW should build on this evidence by evaluating how effectively alerts reach affected communities and what actions people take in response.

A population health evaluation framework

These evidence questions share a common feature: they reflect the limitations of applying conventional evaluation methods (individual behaviour change measures, epidemiological outcome studies, single-site cost-benefit analyses) to an intervention that operates simultaneously across multiple pathways, from individual behaviour change to market surveillance to community-level risk communication. A key recommendation of this paper is that the next phase of drug checking in NSW should include a funded process to develop a population health evaluation framework for drug checking, designed to capture the surveillance, market monitoring and reach functions that existing evaluation methods struggle to measure, while addressing the data limitations unique to drug checking services, including anonymity and limited follow-up potential.[32]



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32. This recommendation draws on consultation with researchers and practitioners involved in drug checking evaluation across multiple jurisdictions. See also Falzon, D. et al. (2023). '"It would really support the wider harm reduction agenda across the board": A qualitative study of the potential impacts of drug checking service delivery in Scotland,' PLoS One, 18(12): e0292812, which argues that evaluations of community-based drug checking should capture impacts across multiple levels, including effects on harm reduction services, drug market monitoring networks, and community drug literacy, rather than focusing exclusively on individual behaviour change.

It’s safer to know what you’re in for

unharm