Institute for Social Science Research
**4 June 2025**

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# Final Report: Evaluation of Queensland Drug Checking Services 2025

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| **Title:** | Final Report: Evaluation of Queensland Drug Checking Services 2025 |
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| **Prepared by:** | Institute for Social Science Research, The University of Queensland |
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This report is considered finalized for release, as indicated below by inclusion of a signature from the project lead (Institute for Social Science Research). Any draft versions of this report are considered superseded and should not be circulated.

**Project lead**

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*The Institute for Social Science Research at the University of Queensland (UQ) acknowledges the Traditional Owners and their custodianship of the lands on which UQ operates. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country.*

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- Queensland Injectors Health Network (QuIHN)
- Queensland Injectors Voice for Advocacy and Action (QuIVAA)
- The Loop Australia
- Université de Montreal
- University of British Columbia
- University of Tasmania
- WEDINOS Drug Checking Service Wales

# Contents

# Tables



# Figures

# Appendices

# Acronyms and Abbreviations

| Acronym/abbreviation | Definition |
|---|---|
| **ADIS** | 24/7 Alcohol and Drug Support Service |
| **ANU** | Australian National University |
| **AOD** | Alcohol and other drugs |
| **ARC** | Australian Research Council |
| **CAHMA** | Canberra Alliance for Harm Minimisation and Advocacy |
| **DACU** | Drug and Alcohol Coordination Unit, Queensland Police Service |
| **DCS** | Drug checking service |
| **ED** | Emergency Department |
| **EFF** | Earth Frequency Festival |
| **FTIR** | Fourier transform infrared spectroscopy |
| **GC-MS** | Gas chromatograph/mass spectrometer |
| **HRA** | Harm Reduction Australia |
| **HREC** | Human Research Ethics Committee |
| **ISSR** | Institute for Social Science Research |
| **KEQ** | Key evaluation questions |
| **LGBTQIA+SB** | Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual + Sistergirl or Brotherboy |
| **LLE** | Lived and/or living experience (of illicit drug use) |
| **NDARC** | National Drug and Alcohol Research Centre |
| **PTA** | Pill Testing Australia |
| **PWID** | People who inject drugs |
| **PWUD** | People who use drugs |
| **QAEHS** | Queensland Alliance for Environmental Health Science |
| **QAIHC** | Queensland Aboriginal and Islander Health Council |
| **QH** | Queensland Health |
| **QNADA** | Queensland Network of Alcohol and Other Drug Agencies |
| **QPS** | Queensland Police Service |
| **QuIHN** | Queensland Injectors Health Network |
| **QuIVAA** | Queensland Injectors Voice for Advocacy and Action |
| **Requirements** | Requirements for Drug Checking Services in Queensland |
| **REL** | Rabbits Eat Lettuce Festival |
| **Schoolies** | Gold Coast Safer Schoolies Response 2024 |

| | |
|---|---|
| **UQ** | University of Queensland |
| **UNSW** | University of New South Wales |
| **UTas** | University of Tasmania |
| **VAADA** | Victorian Alcohol and Drugs Association |

# Executive summary

*I learned – even just in that waiting room reading about all the different substances, that alone was impacting, or I was just gaining more knowledge about things and about what's going around at the moment with those other substances that have been found...It is reducing people from dying, from overdosing, from taking something that they didn't think they would take, or providing something that they thought was one thing and not the other. (Client 27)*

## Introduction

Drug checking, where chemical analysis of a drug is performed and the potential consumer is informed of the contents, is a harm reduction practice widely available in Europe and the Americas. In Australia, drug checking services were first trialled in the ACT in 2018. Funding from the then Queensland Government enabled the establishment of fixed site and event-based drug checking services in Queensland. These were operated by two service providers, Pill Testing Australia and CheQpoint, from March 2024 to April 2025. The Institute for Social Science Research at The University of Queensland (UQ) was commissioned to design and undertake an evaluation of the introduction of drug checking in Queensland through these funded services. This report presents the evaluation findings.

## Methodology

The evaluation used a mixed-methods approach, drawing on experience from previous evaluations and key findings of the rapid literature review of previous evaluations. This included:

- Document analyses comparing intended and actual service protocol and implementation, as well as the alignment between service protocols and policy/regulatory requirements
- Quantitative analysis of service operational and monitoring data, including drug testing data and point-of-care client measures
- Quantitative analysis of follow-up client surveys collected by the evaluation team
- Stakeholder interviews and qualitative analysis to capture the experiences of clients and key stakeholders
- Media scanning, including traditional and social media, to gather indications of public engagement with drug checking social media and information
- Triangulation of findings with complementary research data, including confirmatory testing, wastewater monitoring, and external research project data.

## Key Findings

### Service implementation and uptake met expectations

- Services were implemented in full accordance with the Requirements for Drug Checking Services and service agreements, and in alignment with major policies of the then government.
- Extensive pre-implementation consultation and planning, including with people with lived-living experience of drug use, as well as support from the then government and its

agencies, clear leadership, and strong existing relationships between services all contributed to successful implementation.

- Fixed-site service uptake increased from April 2024 to November 2024, with an expected slight decline during holiday periods which continued until fixed-site closures. Service uptake was generally comparable to other models, such as CanTEST (ACT).
- Limitations on resourcing and reliance on volunteer and in-kind contributions, particularly for event-based services, presented challenges to service implementation and sustainability.

### Services catered to a diverse client base

- Services reached diverse client groups, including Aboriginal, Torres Strait Islander, and South Sea Islander peoples, LGBTQIA+SB people, and clients with different mental health, physical health, and substance use concerns.
- Drug checking services provided a critical opportunity to engage new health service users: over 3 in 4 clients had never before visited a drug checking service, and more than half of clients had never before spoken about their substance use to a health professional.
- Engagement of clients with complex health needs, including those with significant mental health concerns, provided additional benefit from drug checking services.

### Services provided valuable harm reduction

- Testing results showed only 57% of samples presented contained only the expected substances; significant numbers of samples also contained unexpected psychoactive substances, creating additional risks to consumers. The extensive presence of unexpected adulterants in samples underlines the value of harm reduction strategies offered to people who use drugs. Variation between substances and settings highlights the need to use sample testing to inform individualised harm reduction strategies.
- Services provided valuable harm reduction through the provision of information about substances, drug interactions, drug policy, signs and responses to overdose, and naloxone.
- Services provided access to referrals to other health services, including peer workers, needle and syringe programs, counselling, and GPs. These referrals allowed for the continued provision of harm reduction beyond the drug checking services.
- Harm reduction interventions at the services led to over half of all clients intending to change their substance use, most commonly via taking a smaller amount, spacing out doses, or disposing of the substance. Other intended harm reduction behaviours included alerting friends and acquaintances, seeking assistance where needed, and being careful about mixing substances.
- Follow up surveys and interviews with clients found that many clients changed their actual behaviours: 2 in 5 clients reported not using the tested sample, 1 in 5 used less of the tested sample, and 1 in 10 disposed of at least one tested sample. Clients in both the follow-up survey and interviews also reported reductions in polysubstance use, less frequent use, and increased knowledge of different aspects of their substance use.
- Drug checking information releases and reports shared on service websites and social media reached a considerable audience, highlighting that public drug checking information increased awareness of services among the general public.

### Services contributed to broader health services in Queensland

- Services played a significant role in the continuum of services, providing a 'safe space' for clients to discuss their AOD use, and linking clients to additional services.
- Drug checking results informed the release of several public drug alerts about harmful substances, including several nitazenes and a novel hallucinogen detected. These releases informed broader clinical and service networks across Queensland, and were shared via other national early warning systems.
- Client interactions with drug checking services increased distribution of naloxone to population groups at risk of overdose and into the broader community. Engagement of unexpected clients, such as parents, provided additional opportunities for education and family support.
- Variation between settings of substances detected shows it is not feasible to accurately extrapolate from one event to another to predict findings, further stressing the importance of continued drug checking services as a market monitor.

## Considerations for future service delivery

- **Expanding or reconsidering resourcing** would allow for greater scope of service delivery and increased reach into the community across the state. In particular, longer funding periods would support sustainability of the service by reducing extensive reliance on volunteers for key roles. Future capacity of services could be expanded with more funding, potentially from a range of sources, to increase access, staffing, available equipment and to expand locations. Inclusion of a volunteer workforce is beneficial, particularly in the case of highly skilled professional roles, but heavy reliance on volunteering and in-kind support create challenges to sustainability and continuity.
- **Investment in more sensitive analytical technology**, expanded reference libraries, and broad analytic capabilities are essential to ensuring services are able to detect newer emerging substances on the unregulated drug market, and to providing more specific drug information (such as purity).
- **Expanding fixed-site locations** or establishing mobile services geared towards more regional areas would increase the reach of drug checking services. Variation in client demographics demonstrate the importance of a variety of service modes (e.g., fixed sites, event based and potentially mobile services) to encourage broad participation in drug checking.
- **Expanding the peer worker role** in services, including training to operate the testing equipment, would help further integrate lived and living experience into service operations, and broaden the scope of staff capabilities.
- **Increasing public education** about drug checking services is needed to increase public awareness and understanding of services, and to reduce potential deterrents to new clients.
- **Ongoing engagement** with stakeholders, including clients, will help ensure services remain relevant and acceptable to current needs. Client satisfaction with services across a number of domains suggests a high level of acceptability and reflects well on the extensive co-design work undertaken in preparatory periods. Client feedback should continue to be monitored to inform ongoing service development.

# Service delivery at a glance

28 March 2024–4 April 2025

**104** days of **service**

**89** days **fixed-site** delivery

**15** days **event** delivery

**952** service **visits**

**528** **fixed-site** visits

**424** **event** visits

**1341** **people**

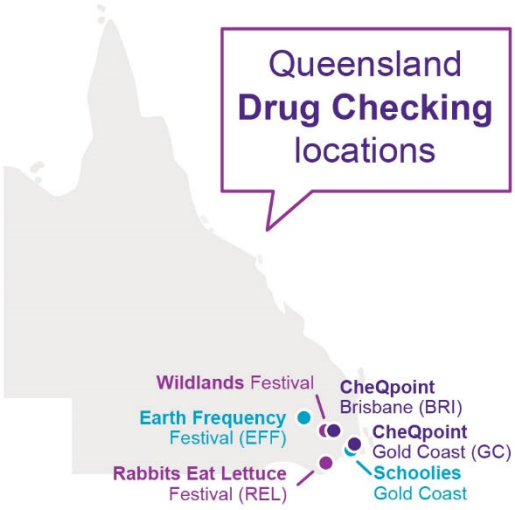
Median **intervention time**
**17–26 minutes**

Median **wait time**
**3–20 minutes**

**78%** of clients had **never before visited a drug checking service**

**54%** of clients had **never before spoken to a health professional** about their substance use

## Queensland **Drug Checking** locations




## Client **demographics**

**4%** identified as **Aboriginal, Torres Strait or South Sea Islander**

**76%** **employed** in full-time, part-time or casual work

**47%** **aged 17–29** (range 17–80)

**27%** identified as **LGBTQIA+SB**

**70%** male

**28%** female

**2%** non-binary

## Presented and detected **substances**

**1530** **samples** were presented for testing

**906** at **fixed-sites**

**624** at **festivals**

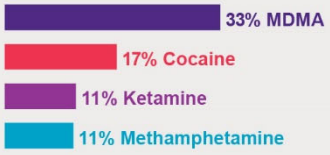
Samples presented by **location**:

- **699** at BRI
- **207** at GC
- **230** at EFF
- **27** at Schoolies
- **210** at REL
- **157** at Wildlands

Across all services, samples expected to contain **MDMA, ketamine, cocaine, 2C-B, and alprazolam** were **most likely to contain an unexpected psychoactive substance**

Most commonly **expected** substances (% of 1503)


Most commonly **detected** substances (% of 1530)



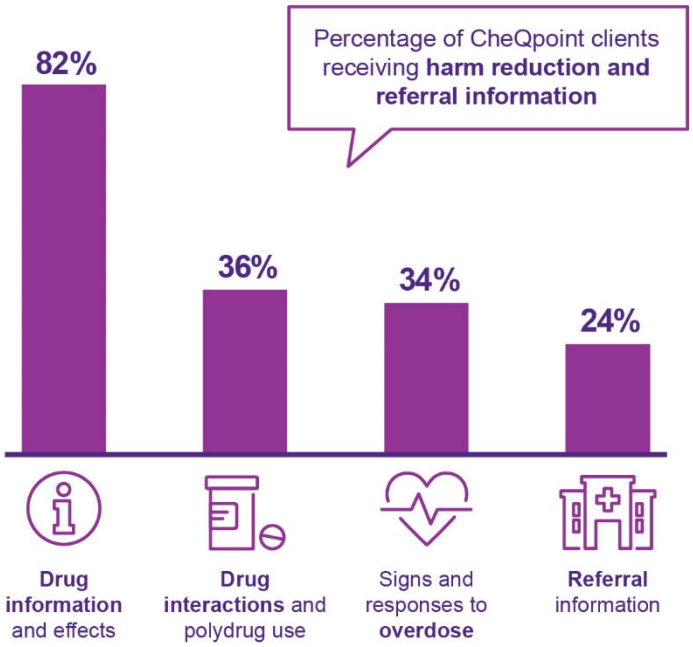

**86%** of samples contained the expected substance

**57%** of samples contained only the expected substance

**12%** detected an unexpected psychoactive

There was substantial variation in samples containing unexpected psychoactive substances across settings

## Drug checking services provided **valuable harm reduction**




**15%** of CheQpoint clients were advised to **discuss their substance use with a GP**

**4%** of CheQpoint clients **referred to external AOD service**

**2%** of CheQpoint clients **referred to QuIHN services**

## **Intended** behaviours


## **Actual** behaviours reported

of clients in the **follow-up survey**

**44%** not using the substance

**29%** spacing out their dose

**29%** not mixing substances

**21%** reducing their dose

**12%** disposing of at least one substance

*"The sample was not what I expected, and I threw it out. Thanks for keeping me safe."*

## Client **feedback**

*"It's a perfect combination of scientists doing the analysis and 'people' people handling harm minimisation discussions. This setup fosters open and honest conversations, providing a safe space to talk openly"*

*"It's a really great service, it will save lives, & should be available everywhere."*

# 1. Background and context

## 1.1 Background

### 1.1.1 International context

Drug checking, where chemical analysis of a drug is performed and the potential consumer informed of the contents, is a harm reduction practice available in 26 countries across Europe and the Americas(1), as well as in Australia and New Zealand. Through the timely provision of robust information, the intention is to reduce the harms associated with consumption of substances obtained through unregulated drug markets. Services are commonly provided at events, or in association with fixed site services, employ a range of analytical modalities, and may include provision of or referral to additional health and harm reduction supports.

### 1.1.2 Broader Australian context

Figure 1 presents a timeline of drug checking in Australia. Broadly supported by the Australian community (2), drug checking was initially trialled at ACT music festivals in 2018 and 2019, and then formally introduced with Government funding as part of a fixed site health service in the ACT in 2022. In NSW, a research project funded by the National Centre for Clinical Research on Emerging Drugs (NCCRED) was conducted through the Medically Supervised Injection Centre in Sydney in 2024. In Queensland, formal requirements for drug checking services were established in 2023, and service provision commenced in Queensland in 2024.

During the operation of Queensland drug checking services, several other jurisdictions continued drug checking services (ACT), conducted research projects involving drug checking (Roid Check, a steroid checking project in QLD, and at the Medically Supervised Injection Centre (MSIC) in NSW), or initiated government funded drug checking services (VIC and NSW). These operated independently of Queensland government funded services, and are not included in this evaluation, but are noted for context. Service models are compared in section 3.5.3.4 below.

### 1.1.3 Drug checking in Queensland

Funding from the then Queensland Government enabled the establishment of fixed site and event-based services, commencing in March 2024. Following a tender process, two not-for-profit service providers were selected.

CheQpoint, a consortium comprising The Loop Australia, Queensland Injectors Health Network (QuIHN) and Queensland Injectors Voice for Advocacy and Action (QuIVAA), was contracted to provide fixed site services at two locations, and at least one event-based service. The Loop Australia was established in 2018 to develop and advocate for drug checking services in Australia.(3) QuIHN(4) (founded in 2004) and QuIVAA(5) (formed in 1988) are peer-based NFP organisations providing health and harm reduction services for people who use drugs in Queensland.

Pill Testing Australia (PTA) was contracted to provide services at between one and four events. PTA(6) was founded in 2017 and operates under the auspices of Harm Reduction Australia (HRA) to provide drug checking services. They provided the first Australian drug checking services at ACT festivals in 2018 and 2019, and provide fixed site drug checking services at CanTEST in the ACT in collaboration with Directions Health Service and the Canberra Alliance for Harm Minimisation and Advocacy (CAHMA).

CheQpoint commenced fixed site operations in Brisbane on 19 April 2024, and at the Gold Coast on 4 July 2024; these services operated until 4 April 2025. CheQpoint also delivered event-based

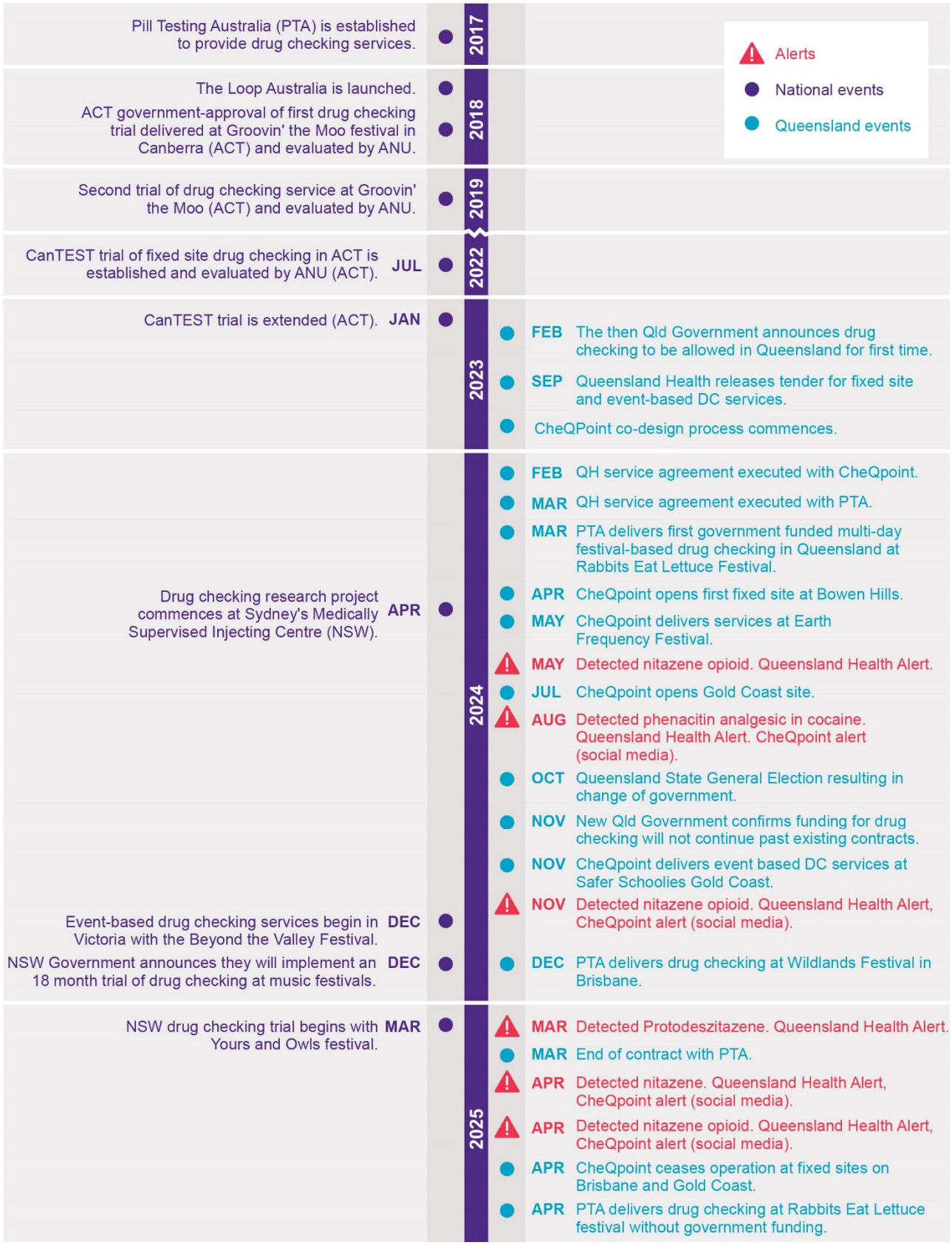
services at the Earth Frequency music festival (EFF) at Willowbank, approximately 20km south-west of Ipswich, from 3–5 May 2024, and as part of the Gold Coast Safer Schoolies Response (Schoolies) from 16–22 November 2024.

PTA delivered drug checking services at the Rabbits Eat Lettuce (REL) music festival at Cherrabah, approximately 30km south of Warwick, from 28–31 March 2024 and at the Wildlands music festival in Brisbane on 31 December 2024.

Figure 1 shows key events in the Queensland and Australian context during the delivery of drug checking services in Queensland.

The Institute for Social Science Research (ISSR) at The University of Queensland (UQ) was commissioned by Queensland Health to design and undertake an evaluation of these funded activities between March 2024 and May 2025. This report delivers the findings of that evaluation.

*Figure 1. Timeline of events relating to drug checking services in Queensland.*



## 1.2 Objectives and scope of the evaluation

The evaluation included both fixed site and event-based services funded by Queensland Health, with key objectives to include:

- **assessment of process and implementation of services,** including models, service establishment, engagement, workforce, resourcing and operation (including policies and protocols for service delivery, and staff perceptions)
- **understanding of characteristics of people accessing services**, including their demographics and substance use
- **assessment of client experience and outcomes** such as service appropriateness, harm reduction conversations delivered/received, experiences of service, uptake and re-use of services, indications of behaviour change and/or reduced harm
- **measurement of service level outcomes,** including service acceptability**,** substance testing and findings
- **contribution to system level outcomes** such as contribution to drug market surveillance and public health notifications about substances.

The evaluation scope, confirmed by Queensland Health, included the following aspects:

- drug checking services' implementation, including aspects relating to design and models of the drug checking services and their development, implementation, and operation (including policies, procedures, protocols for service delivery) and the resourcing available for implementation
- barriers and facilitators to the effective operation and use of drug checking services in Queensland, including perceptions of service accessibility and acceptability
- client characteristics, including their demographics and their substance use
- drug checking service data and outcomes, including engagement, uptake levels, substance types presented and identified, and health conversations delivered, as well as service acceptability
- the impact of the service on client outcomes, including indicators of behaviour change and/or reduced harm
- the contribution of drug checking services to informing identification of and communication about high-risk substances
- other impacts of the services, including within the contexts of service delivery (e.g. local and host health services, festival environments) and unintended (positive or negative) outcomes
- whether the aspects above differ across service providers and service models (e.g. fixed site versus event-based settings)

These areas were out-of-scope for the evaluation:

- detailed evaluation of any training related to drug checking services for staff
- detailed evaluation of the effectiveness of the analytical technology or infrastructure used for drug checking by the drug checking services
- formal cost-effectiveness evaluation of the drug checking services
- review or evaluation of programs that were not part of the Queensland state-funded drug checking services during the specified evaluation period.

## 1.3 Program Logic, theory of change and key assumptions

### 1.3.1 Program Logic

During the evaluation planning phase, a Program Logic (Figure 2) and Theory of Change were developed in consultation with service providers, funders, people with lived and/or living experience of substance use and representatives of the broader AOD sector to reflect the links between the resources required to establish and operate drug checking services, the activities or outputs that occur during services, and the changes or outcomes that may be expected as a result of delivering drug checking services.

It is important to note the following regarding the Program Logic:

- Some of the **Inputs** described were provided as in-kind by services or by volunteers
- **Harm reduction interventions** referred to under Outputs/Activities include the health conversations (terminology used by CheQpoint) and brief interventions (terminology used by PTA)
- **Longer term outcomes** on the far right of the figure were noted as likely to emerge beyond the timeframe of this evaluation
- Outcomes listed below the dotted lines were considered as beyond the **ceiling of accountability** for this program. In other words, a range of factors beyond the drug checking services will have also contributed to these outcomes, and so changes cannot be directly attributed to the delivery of drug checking services, although these services may have contributed to the changes.

*Figure 2. Program Logic for Drug Checking Services in Queensland.*

### 1.3.2 Theory of change and key assumptions

The **Theory of Change** developed as part of the evaluation plan states that:

> People who obtain substances through the unregulated illicit drug market may find the type and purity of substances available varies considerably. The consumption of substances with unknown contents and purity can increase the risk of harm. People who use drugs do not typically have ready access to technology and information to identify the contents and purity of drugs obtained through the unregulated market. They may also not be engaged with harm reduction and treatment services.
>
> Drug checking services can provide credible and reliable information to clients about the contents of illicit substances, offer targeted strategies to reduce the harms of illicit drug use and refer clients to additional support and harm reduction services where required. This supports clients to make better-informed decisions about substance use and offers an avenue to reduce potential individual harms and the related burden on healthcare systems.
>
> Information generated by the drug checking services about the drug types and purity available can also contribute to public health alerts and early warning systems, helping inform individuals, peer networks, services and the community about high-risk substances.

This is predicated on a number of **assumptions**:

- The use of drugs obtained on the unregulated market can result in harm through the consumption of potentially high-risk substances and/or use of multiple substances with interactions and/or contraindications
- People need information and education about the contents of substances obtained on the illicit market and risks associated with these substances to make informed decisions to reduce drug-related harm
- There is a need for rigorous and accessible drug checking services as indicated by reports of community-based drug testing using less rigorous methods.(7, 8)
- Through available drug testing modalities and communication with service staff, drug checking services can provide clients with more information about the contents of the substances submitted for testing
- Through communication with service staff, drug checking services can provide clients with education and information about potential risks associated with the substances submitted for testing
- People who access drug checking services may benefit from harm reduction and other health or education services and drug checking services can refer clients to these where appropriate
- Services will be provided at fixed sites and across several festival events
- Information regarding the content of samples tested will be used to inform clients, harm reduction services and to inform public health and safety alerts.

A number of **external factors** were identified with the potential to affect the implementation and outcomes of drug checking:

- changes in the availability of illicit drugs, particularly high-risk substances, and risk profiles of substances in the local drug market
- changes in legislation or policing practices that may affect access to drug checking services
- changes in government and/or funding arrangements.

Reflections on the program logic, these assumptions and the external factors were examined across the evaluation period and are discussed in the Reflections on the Program Logic below.

## 1.4 Key evaluation questions

The evaluation is based on a series of key questions developed in conjunction with Queensland Health and agreed in the Evaluation Plan. These are articulated below across the four domains of process, efficiency, effectiveness and appropriateness.

The key evaluation questions (KEQs) consider the following areas across models of service and locations to address the objectives of this evaluation:

***Services: Process and Implementation***

1. To what extent were the drug checking services implemented according to the intended plans, and in alignment with the (then) Queensland Government policies?
2. Were the resources available to support drug checking services appropriate, sufficient and sustainable to support quality service provision?
3. What were the barriers to and facilitators of effective drug checking service delivery?

***Services: Outcomes***

4. What did clients expect the substances submitted for testing to be, and what substances were detected by the drug checking services?
5. To what extent were the services considered accessible, acceptable and useful by clients and other key stakeholders?

***Clients: Demographics and Outcomes***

6. What were the key characteristics of those who accessed the services, including demographics and substances used?
7. What were clients' motivations for using drug checking services?
8. Did any potential client groups experience barriers to access of the services?
9. What was the effect of the information, education and support provided by the drug checking services on the attitudes, intentions and behaviours of the clients who accessed the services?

***System Level: Outcomes***

10. How did the drug checking services operate within the broader Queensland context of agencies and services involved?
11. To what extent did the services produce valuable and timely information about illicit drug availability and harms in Queensland, and how was that information used?
12. How did the information collected, and activities conducted, by the drug checking services contribute to broader harm reduction initiatives in Queensland and other jurisdictions?
13. Were there any unexpected consequences of the services?

# 2. Evaluation methodology

## 2.1 Summary of evaluation approach

The evaluation used a mixed-methods approach, with a design drawing on experience from previous evaluations and key findings of the rapid literature review of previous evaluations and intended to facilitate comparison with other similar service evaluations. The evaluation design also incorporated local-specific elements to investigate operation of the services within the Queensland context.

Consultation with stakeholders on the design of the evaluation protocols and instruments was extensive, with input from service providers, Queensland Health and associated researchers, and included a number of sessions with representatives of the lived-living experience (LLE) community. The evaluation was conducted between March 2024 and May 2025; Table 1 below outlines the key activities undertaken.

Full details of the methodology can be found in the Evaluation Plan, but Table 2 overleaf broadly maps our evaluation methods against the key evaluation questions they are intended to address.

We also conducted a data audit, considering information collected by the drug checking services and other stakeholders, along with complementary research data. The range of data sources on which the evaluation draws is outlined in the Data sources section.

*Table 1. Timeline of evaluation activities.*

| Activity | Actual timeframe | Comment |
|---|---|---|
| Consultation with service providers, stakeholders | Mar 2024 – May 2025 | Completed |
| Literature review | No change | Completed |
| Evaluation design | Mar 2024 – Jul 2024 | Completed |
| Ethics and research approvals | May 2024 - Jul 2024 | Completed |
| Process analysis of implementation | May 2024 – Apr 2025 | Completed |
| Quantitative data collection/analysis | Jul 2024 – Apr 2025 | Completed |
| Qualitative data collection/analysis | Aug 2024 – Apr 2025 | Completed |
| Interim report | 31/10/2024 | Completed |
| Final report | 31/5/2025 | Completed |

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*Table 2. Evaluation methodologies addressing key evaluation questions*

| Key Evaluation Questions | Service operational and monitoring data | Service observation data | Client measures (point-of-care) | Follow-up with clients post-visit (survey, qualitative interview) | Qualitative interviews with key stakeholders | Other complementary data |
|---|---|---|---|---|---|---|
| ***Services: Process and Implementation*** | | | | | | |
| To what extent were the drug checking services implemented according to the intended plans, and in alignment with the (then) Queensland Government policies? | ✓ | ✓ | | | ✓ | |
| Were the resources available to support drug checking services appropriate, sufficient and sustainable to support quality service provision? | ✓ | ✓ | | | ✓ | |
| What were the barriers to and facilitators of effective drug checking service delivery? | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| ***Services: Outcomes*** | | | | | | |
| What did clients expect the substances submitted for testing to be, and what substances were detected by the drug checking services? | ✓ | | | | | |
| To what extent were the services considered accessible, acceptable and useful by clients and other key stakeholders? | ✓ | | ✓ | ✓ | ✓ | |
| ***Clients: Demographics and Outcomes*** | | | | | | |
| What were the key characteristics of those who accessed the services, including demographics and substances used? | ✓ | | ✓ | ✓ | ✓ | ✓ |
| What were clients' motivations for using drug checking services? | | | ✓ | ✓ | | |
| Did any potential client groups experience barriers to access of the services? | | | ✓ | ✓ | ✓ | ✓ |
| What was the effect of the information, education and support provided by the drug checking services on the attitudes, intentions and behaviours of the clients who accessed the services? | ✓ | | ✓ | ✓ | ✓ | ✓ |
| ***System Level: Outcomes*** | | | | | | |
| How did the drug checking services operate within the broader Queensland context of agencies and services involved? | ✓ | | | ✓ | ✓ | ✓ |
| To what extent did the services produce valuable and timely information about illicit drug availability and harms in Queensland, and how was that information used? | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| How did the information collected and activities conducted by the drug checking services contribute to broader harm reduction initiatives in Queensland and other jurisdictions? | ✓ | | | ✓ | ✓ | ✓ |
| Were there any unexpected consequences of the services? | | | | ✓ | ✓ | ✓ |

## 2.2 Data sources

We considered data from a broad range of origins in order to generate a nuanced picture of the drug checking service operations over the funded period. These included:

- service operational and monitoring data collected by the drug checking services
- client measures (point-of-care) collected by the drug checking services
- service observation data collected by the evaluation team at fixed and event services
- follow-up with clients post-visit– survey and qualitative interviews conducted by the evaluation team
- qualitative interviews with key stakeholders conducted by the evaluation team
- policy and protocol documents
- traditional and social media articles and
- complementary research data.

### 2.2.1 Operational data generated by services

Information including staffing, budgets and operational reports were provided by both service providers.

### 2.2.2 Client measures (point-of-care) collected by the drug checking services

The drug checking services recorded a range of data on clients, samples and test results during the provision of service. These data include anonymous demographic information, pre- and post-sample testing questionnaires administered by service staff about expectations for the substances submitted for testing, clients' intended behaviours after receiving the test result(s), and their experience using the service. Table 3 displays a summary of data from each drug checking service.

*Table 3. Summary of sample sizes across client point-of-care data sources.*

| Service | Service visits (total) | Visits with consent to evaluation (%) | People attending (total) | People providing in-service feedback (%) | Samples tested (total) |
|---|---|---|---|---|---|
| Rabbits Eat Lettuce festival 2024 | 137 | 135 (99%) | 257 | 123 (48%) | 210 |
| CheQpoint fixed sites | 528 | 505 (96%) | 622 | 285 (46%) | 906 |
| Earth Frequency Festival 2024 | 152 | 107 (70%) | 170 | 28 (16%) | 230 |
| Schoolies 2024 | 22 | 17 (77%) | 53 | 31 (58%) | 27 |
| Wildlands festival 2024 | 113 | 103 (91%) | 239 | 81 (34%) | 157 |
| **Totals** | **952** | **867** (91%) | **1341** | **548** (41%) | **1,530** |

*Notes*. Data focus solely on drug checking service visits (excluding visits involving steroid checking only).
The number of people attending (total) is larger than the number of service visits as some service visits comprised groups of two or more people.
It is not possible to distinguish unique service visitors from repeat visitors, as all were anonymous.

Client measures were obtained from:

- **Rabbits Eat Lettuce Festival** (28-31 March 2024): Data comprise health conservations and drug testing results for 137 service visits, with 99% providing consent for their data to be used for evaluation. The data include demographic information, intended pre- and post-test substance use, harm reduction intervention and referral data, and in-service feedback from 123 clients.
- **CheQpoint fixed site services** (Brisbane/Gold Coast, 19 April 2024 – 4 April 2025): Data comprise health conversation and drug testing data for 528 service visits. A total of 505 (96% of all) clients gave their consent for their data to be used for evaluation (Brisbane *n* = 396, Gold Coast *n* = 109). These data include demographic information, prior service use, and harm reduction intervention and referral data. The data also include anonymous in-service feedback from 285 clients (Brisbane *n* = 191, Gold Coast *n* = 94).
- **Earth Frequency Festival** (3-5 May 2024): Data comprise health conversation and drug testing data from 152 client visits, with 107 clients (or 70% of all) providing consent for their data to be used for evaluation purposes. The data include demographic information, and harm reduction intervention and referral data. A total of 28 clients provided in-service feedback.
- **Schoolies** (16-22 November 2024): Data comprise health conversation and drug testing data from 22 clients, with 17 clients (77% of all) providing consent for their data to be used for evaluation purposes. These data include demographics, prior service use, harm reduction information, and referral data. These data also include anonymous in-service feedback from 31 young people at Schoolies.
- **Wildlands Festival** (31 December 2024): Data comprise health conversation and drug testing data from 113 service visits, of which 103 (91% of all) clients gave their consent for their data to be used for evaluation purposes. The data include demographic information, intended pre- and post-test substance use, harm reduction intervention and referral data, and in-service feedback from 81 clients.

### 2.2.3 Follow up with service clients

The evaluation team collected follow-up data from clients after their visit to drug checking services to gather information on behavioural responses and experiences of the service. Clients were invited at the time of visiting the drug checking service to participate in a follow-up survey and/or interview, and referred to recruitment posters displayed in the services. The survey was also advertised via social media. Surveys were anonymous.

#### 2.2.3.1 Surveys

A total of 47 clients consented to the online survey, with 43 completing at least 60% of the questions; this represents only 3% of all service clients recorded during the evaluation. Respondents included clients from all sites except Schoolies, with most having visited CheQpoint's fixed site in Brisbane (n = 37) and/or Earth Frequency Festival (n = 7).

Surveys were completed between October 2024 – April 2025, typically less than two weeks after service use (64%), with 29% of clients participating between 1 and 6 months after service use, allowing discussion of later behaviour change.

Most were male (72%), and a substantial proportion were members of the LGBTQIA+SB community (28%). The largest age group was aged 40+ (40%), 5% identified as Aboriginal, Torres Strait Islander of South Sea Islander, 72% were born in Australia, and most respondents were from

the Brisbane area. Approximately one in five survey respondents had never before used QuIHN services.

#### 2.2.3.2 Qualitative interviews

Participants who expressed interest in participating in an interview were contacted using details provided online, with interviews subsequently completed on Zoom. Members of the evaluation team also visited the fixed-site services on several days to conduct in person interviews with clients. All participants provided informed consent prior to interviews, and interviews were anonymous.

In total, 30 interviews were completed with clients: 22 clients who attended the Brisbane service (75%), 6 clients who attended the Gold Coast service (20%), and 2 who had attended the service at EFF (7%). The participant group included new clients of the service, recurring clients, and some who had accessed services at multiple locations. Although a small number of interviews were conducted immediately after service use, the majority were interviewed at least one week after accessing the service, which allowed for client behaviour change to be discussed. Demographic information was not collected during interviews in order to maintain participants' anonymity.

### 2.2.4 Interviews with stakeholders

The evaluation team consulted key stakeholders to gain their insights into the implementation of Drug Checking services in Queensland, the perceived effectiveness of drug checking services, and elicit recommendations for improvements to the services.

A total of 41 stakeholders were invited to take part. A total of 30 interviews were completed with 26 participants, including four follow-up interviews. These included 18 staff from the drug checking service providers (peer support workers, analytical chemists, health workers and managers; CheQpoint n = 13, PTA n = 5). Four follow-up interviews were completed with key personnel from service providers to provide additional feedback towards the end of the evaluation period (CheQpoint n = 2, PTA n = 2). Additional interviews were completed with sector professionals (n = 5), and event organisers (n = 3). All participants provided informed consent prior to interviews. Queensland Police were not able to participate in an interview, but provided a written response to interview questions.

**A note on the use of quotations**

Qualitative data were analysed using a coding framework developed using the Key Evaluation Questions, with data managed through NVivo.

We have used direct quotations from interviews throughout this document to illustrate the themes emerging from these analyses and to complement the quantitative analyses where relevant.

It is important to note that the views expressed in these quotations are the opinions of the participants.

### 2.2.5 Policy and protocol documents

The evaluation team identified numerous key policy documents related to the implementation of the drug checking services. These included:

- Requirements for Drug Checking Services in Queensland (Queensland Health, 2023) (9)
- Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022-2027 (Queensland Mental Health Commission, 2022) (10)

- Better Care Together: A Plan for Queensland's State-Funded mental Health, Alcohol and Other Drugs Services to 2027 (Queensland Health, 2022) (11)
- Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2023-2028 (Queensland Mental Health Commission, 2023) (12)
- Queensland Alcohol and Other Drug Treatment Service Delivery Framework (Queensland Alcohol and Other Drugs Sector Network, 2022) (13)
- Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework (Queensland Alcohol and Other Drugs Sector Network, 2019) (14)
- The National Framework for Alcohol, Tobacco and Other Drug treatment 2019-2029 (Commonwealth Department of Health, 2019) (15)
- The National Quality Framework for Drug and Alcohol Treatment Services (Commonwealth Department of Health, 2018) (16)
- Queensland Police Service (QPS) Chapter 14 Operational Skills and Practices (OPM Issue 99.2, effective 3 May 2024) (17)

Additionally, contracts between Queensland Health and the drug checking services (Pill Testing Australia and QuIHN on behalf of CheQpoint) outlined contractual obligations for the services and referred to other policy documents and regulations in accordance with which the services must be delivered.

### 2.2.6 Media scanning

Traditional and social media articles, and social media analytics from PTA and CheQpoint were analysed to scan for broad community perceptions, media portrayals, and to gather indications of public engagement with drug checking social media and information.

### 2.2.7 Complementary research data

Data from a range of complementary research and monitoring activities have been used to provide comparisons and context for the findings of the evaluation. These include findings from:

- Confirmatory testing of samples from checking sites conducted by research partners including UQ and Griffith University
- A research survey conducted of patrons at EFF by The Loop Australia, exploring the use of and attitudes to drug checking services, and preceding research at other festivals (18)
- A research trial testing steroid-related samples operated by Griffith University(19)
- The Queensland arm of the national Illicit Drug Reporting System (IDRS(20); n=103 interviews with people who regularly inject drugs residing in Brisbane/Gold Coast, conducted June 2024) and Ecstasy and Related Drugs Reporting System (EDRS(21); n=101 interviews with people who regularly use ecstasy and/or other illicit stimulants residing in Brisbane/Gold Coast, conducted April-May 2024) as part of the broader Drug Trends monitoring program
- The National Wastewater Drug Monitoring Program undertaken by UQ and partners that provides indications of the drugs of present in wastewater in Queensland during April and June 2024(22)
- Drug checking services based in other jurisdictions.

## 2.3 Analytical methods

Details of the analytical methods are provided in Appendices below.

## 2.4 Ethics approvals

The Evaluation Team applied for ethical clearance through The University of Queensland Human Research Ethics Committee (HREC) in April 2024. Initial approval was received 30/04/2024; subsequent amendments covering alterations to the primary data collection instruments (survey, interview guides) were approved on 28/8/2024. All required ethics and research approvals are attached in Appendix 1: Ethics .

- UQ HREC Approvals for project number 2024/HE000436 (30/4/2024, 28/8/2024)

In addition to ethics clearances through UQ, it was necessary to negotiate formal data sharing agreements with both service providers. These agreements were signed in early August 2024.

# 3. Evaluation findings

Our evaluation findings are discussed in detail below under each key evaluation question, with information from a range of data sources triangulated to address each question. However, reflecting on the Program Logic (in Section 1.3.1) is helpful in providing a high-level summary of the extent to which the funded drug checking services were observed to operate and deliver outcomes in line with the original designs and intents.

## 3.1 Reflections on the Program Logic

The introduction of drug checking services in Queensland aimed to reduce the harms experienced by people who use drugs by providing accurate, timely and credible information on the content of drug samples and offering relevant and acceptable harm reduction strategies.

The funding provided allowed the establishment of both fixed site and event-based services which reached a range of people who use unregulated drugs, often engaging them in health and harm reduction settings for the first time.

Figure 3 below summarises our assessment of how much of the Program Logic was achieved over the evaluation period, where green boxes indicate evidence of achievement, and orange boxes indicate evidence of partial achievement.

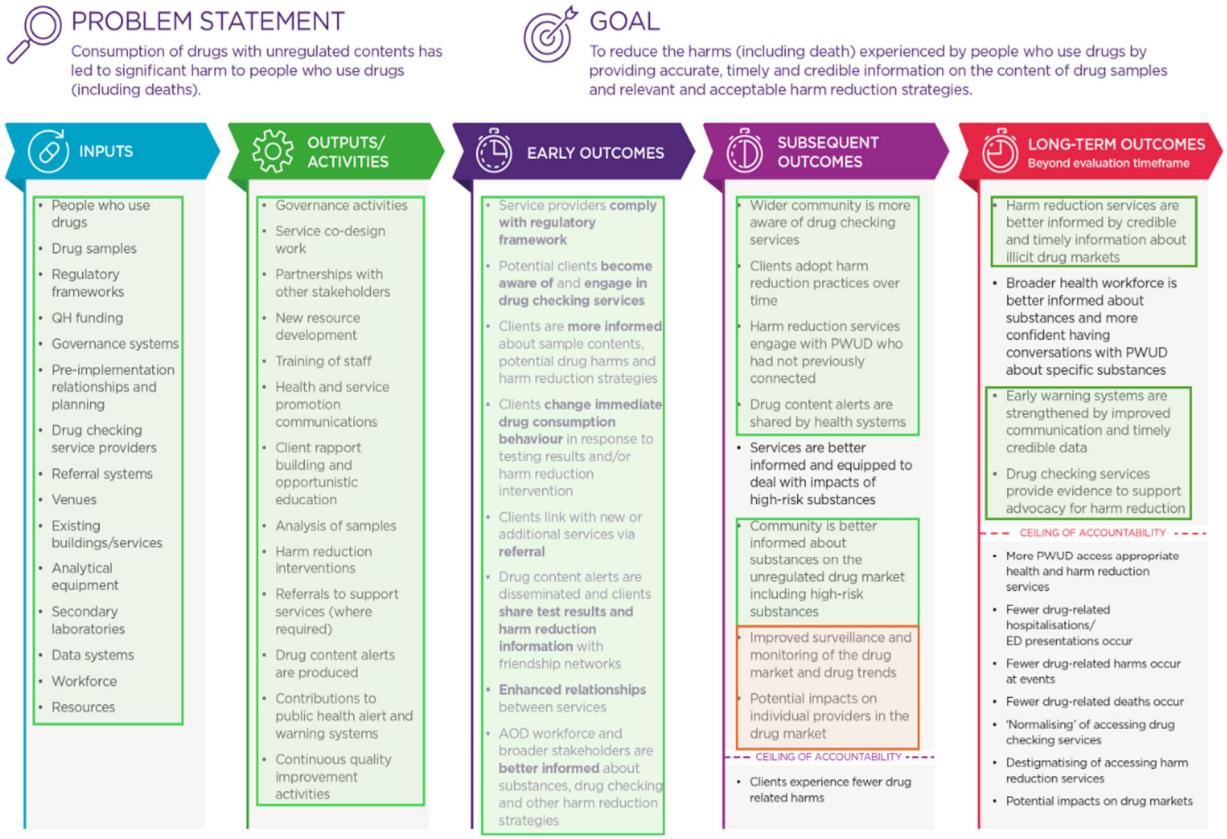
**Inputs** were largely available to the services as planned. Testing systems, including secondary laboratories, delivered accurate information, and the health support workforces worked collaboratively to develop and provide contextualised health and harm reduction information for clients. Pre-implementation networks, planning and collaborations with existing services were central to the swift establishment and uptake of services.

**Activities and outputs** were largely delivered as planned, with ongoing consultation and quality improvement activities informing service delivery. Interactions between services and the broader health sector, as well as strong collaboration with event organisers, supported effective delivery.

**Outcomes** Most of the early outcomes listed in the Program Logic were realised over the course of the first 12 months of operation, with some evidence of the remaining early outcomes emerging, as well as several of the intermediate outcomes and some of those expected to emerge later during implementation. As expected, elements beyond the ceiling of accountability (below dashed lines) were not realised within the one-year evaluation period.

As awareness of the services developed and uptake increased, clients accessed services, sometimes repeatedly, often engaging with drug-related health services for the first time, and reporting uptake of harm reduction behaviours. Complex presentations where broader support requirements were recognized allowed for referral into multiple support systems, broadening the scope for improved client outcomes and drawing on existing relationships between services. Information about novel substances and presentations was used to inform clients, clinicians, and services about emerging risks, and contributed to the national early warning systems as well as the broader drug information landscape.

*Figure 3. Reflections on the Program Logic.*




Our findings on the range of outcomes articulated in the Program Logic are predicated on the **assumptions** underpinning it having held over the period of drug checking operations. Checking on these assumptions is helpful to explain our observation of the extent to which anticipated outcomes have been achieved. Considering where assumptions have held (or not) can also inform future iterations of these services, helping to ensure that expectations of change are based on a rationale that can be supported.

The following Table summarises our reflections and, where applicable, their alignment with specific considerations for future implementation. We also consider the extent to which the **external factors** identified as likely to affect the implementation and outcomes of drug checking services eventuated.

### 3.1.1 Reflection on assumptions underpinning the program logic

| Program logic assumption | Reflection/finding | Importance | *Consideration for future implementation* |
|---|---|---|---|
| *The use of drugs obtained on the unregulated market can result in harm through the consumption of potentially high-risk substances and/or use of multiple substances with interactions and/or contraindications* | Assumption held: Novel substances e.g. nitazenes have recently emerged in Australia's unregulated drug markets and have caused overdoses. Identified high-dose forms of existing drugs (e.g. MDMA) create overdose risks for unwary consumers. Unregulated pharmaceuticals (e.g. benzodiazepines) in the Australian market containing multiple unexpected substances pose health risks to consumers. | Professional drug checking services have the potential to detect new substances in the unregulated market, high-dose supply of existing drugs and contaminated versions of unregulated pharmaceuticals. The changing market requires ongoing monitoring to inform risk-mitigation responses. | Continue monitoring of the unregulated drug market via consumer-accessible drug checking services to ensure ongoing currency of information available to consumers and to the health sector. |
| *People need information and education about the contents of substances obtained on the illicit market and risks associated with these substances to make informed decisions to reduce drug-related harm* | Assumption held: Clients of the drug checking services reported receiving novel harm reduction information during health conversations at the services. Significant numbers reported changes in drug using behaviours in response to this information. | Reliable information and evidence-informed harm reduction strategies are essential to reducing the potential harms of drugs obtained on unregulated markets. Increased use of unregulated pharmaceuticals broadens the need for such information beyond originally-perceived markets (e.g. festival patrons, regular consumers of illicit drugs). | Ensure that analytical methods and reference libraries are continuously updated to keep abreast of emerging substances and contaminants. Ensure that harm reduction information is continuously updated to address emerging substances and/or patterns of use. |
| *There is a need for rigorous and accessible drug checking services as indicated by reports of community-based drug testing using less rigorous methods.* | Assumption held: Drug Trends interviewees reported using test strips/colorimetric tests on samples. Drug checking services identified substances such as new nitazenes, unable to be detected by home-based testing methods (e.g. test strips). Community members expressed support for drug checking services. | Replacement of home-based and less-rigorous testing with high-accuracy testing ensures more accurate and timely information is available to consumers and clinicians. | Continue the provision and promote awareness of drug checking services as a source of trustworthy, timely information on substance contents and harm reduction information. |

| | | | |
|---|---|---|---|
| *Through available drug testing modalities and communication with service staff, drug checking services can provide clients with more information about the contents of the substances submitted for testing* | Assumption held: Samples tested for drug checking clients contained substances not identifiable through home based testing methods; service staff were able to provide resources regarding the contents and potential harms of those substances. | Regular information updates ensure clinicians and health services become better informed about substances on the current market, and are able to provide relevant and current harm reduction information to clients. | Continue to ensure that drug checking findings are used to inform clinicians and health services, who can then best support clients. |
| *Through communication with service staff, drug checking services can provide clients with education and information about potential risks associated with the substances submitted for testing* | Assumption held: Clients of drug checking services opted to take part in health/harm reduction conversations as well as receiving information on the contents of samples submitted for testing. | People who use drugs have been made more aware of the risks associated with substance use, strategies to reduce potential harms, and support services available to them. | Continue to ensure that drug checking services provide health and harm reduction conversations in addition to the findings of drug checking analytics. |
| *People who access drug checking services may benefit from harm reduction and other health or education services and drug checking services can refer clients to these where appropriate* | Assumption held: A significant proportion of drug checking clients were referred on to additional support services by staff. Complex presentations where clients reported multiple health/social needs were recorded by services. Anecdotal reports of referral uptake were significant. | Drug checking services have provided a pathway for people who may otherwise not have engaged with harm reduction or support services to be linked into health and to broader social supports that may not have otherwise been accessible to them. | Ensure that referral pathways are in place to support easy entry of clients (especially those not previously engaged) into health/support systems as needed. |
| *Services will be provided at fixed sites and across several festival events* | Assumption held: Services were provided at 2 fixed sites and at 4 events during the funded period. Client demographics varied between sites, indicating a range of clients beyond those already engaged with AOD services. | A range of people who may otherwise not have engaged with health services took part in drug checking, received information on drugs they had intended to use, and became aware of immediately-available supports. | Continue to provide drug checking services at a variety of sites and events to reach a broad range of people who use drugs in differing circumstances. |
| *Information regarding the content of samples tested will be used to inform clients, harm reduction services and to inform public health and safety alerts.* | Assumption held: Sample content analyses were provided to clients and were used to inform public notices via social media, drug warnings from Queensland Health, and clinical alerts for health practitioners. | Consumers and clinicians have been warned about the risks of newly-identified substances and high-dose or contaminated batches of existing substances. | Ensure that findings from drug checking services are broadly distributed via formal media releases, clinical networks and peer-to-peer mechanisms such as social media. |

### 3.1.2 Reflections on external factors identified

#### 3.1.2.1 Impact of changes in the availability of illicit drugs, particularly high-risk substances, and risk profiles of substances in the local drug market

The detection in Australian markets of nitazenes and emerging analogues, high-dose MDMA formulations and contaminated batches of pharmaceuticals such as benzodiazepines heightened awareness of substance related risks in the general and health communities, and appeared to result in increased public advocacy for drug checking services.

#### 3.1.2.2 Impact of changes in legislation or policing practices that may affect access to drug checking services

One notable change in legislation during the period of drug checking service operations was the expansion from May 2024 onwards of the Queensland Police Drug Diversion Program to include a broader range of substances (previously cannabis only) and vary the circumstances under which Diversion may be offered. This did not appear to have specific impacts on access to drug checking services, likely due to existing protocols for QPS regarding policing near drug checking services.

#### 3.1.2.3 Impact of changes in government and/or funding arrangements

Early communications by the then Queensland Government were supportive of drug checking services. The first Ministerial announcement by the then Minister for Health and Ambulance Services (Minister) about the introduction of drug checking services in Queensland was made on 25 February 2023. The statement announced that the then Government was developing protocols to introduce a drug checking service as part of the commitment to reduce harms associated with illicit drug use, aligning with *Achieving balance 2022-2027*. Thirteen months later, announcements by the then Queensland Government of the introduction and funding of drug checking services bolstered community awareness of the services and the two modalities in which drug checking would operate (event based and fixed site). Three Ministerial Statements by the then Minister, released between 20 March and 20 April 2024, expressed support for the services, advertised opening of the fixed site services, and highlighted initial successful outcomes following the delivery of the first drug checking service at REL festival by PTA. An additional Ministerial Statement by the then Minister, released on 25 July 2024, announced the delivery of drug checking at Schoolies in November 2024. This Statement also provided updates to the outcomes of the fixed site and event-based services. A Ministerial Statement released on 19 September 2024 by the then Minister reiterated the intention for drug checking to be available at Schoolies and provided updates on outcomes from the fixed site services, including the detection of unexpected adulterants found from drug checking and intended behaviour change reported by clients.

Following the State election in October 2024, public statements regarding the inclusion of drug checking in the 2024 Schoolies response appeared to generate confusion among potential service users, who mistakenly believed all drug checking services had ceased. Reduced patronage of fixed site services was visible in subsequent months and until service closure (see Figure 5).

Media coverage in March 2025 noted evidence of nitazenes (lethal synthetic opioids) being detected in Australian wastewater and at Queensland drug checking services (24), and suggested that these findings supported retention of harm reduction strategies such as drug checking.

Significant public advocacy by state and national medical associations and other peak bodies supported continuation of drug checking services.(25-28) The Royal Australian College of General Practitioners and the Australian Medical Association (AMA) QLD issued media releases urging reconsideration and reinstatement of the “life-saving” service.(26-28)[31-33] The Pill Testing For Queensland Alliance (PT4Q), whose members include AMA QLD, The Royal Australian and New Zealand College of Psychiatrists, the Alcohol and Drug Foundation, The Loop Australia and other

peak bodies(25)[34] wrote to the Government in February 2025 urging that the service remain available to the Queensland public.(25)[34]

In March 2025, the new Queensland Government announced that the contracts for drug checking services would not be renewed at their conclusion in March/April and drug checking would not be publicly funded. Consequently, operations ceased at fixed sites on 4 April 2025.(29)[16]

The regulatory environment and *Requirements* for drug checking remain in place, with advocates considering other funding options for future operations. In April 2025, without Government funding but with the required regulatory approval and in line with the *Requirements*, PTA successfully delivered drug checking services at the 2025 REL festival.

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*… if the regulatory environment exists, that leaves options… The short-run focus becomes the resourcing problem, and if we can continue, how we resource this without state government funds, so that's the question that we face now. (Stakeholder 26)*

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## 3.2 Service Processes and Implementation

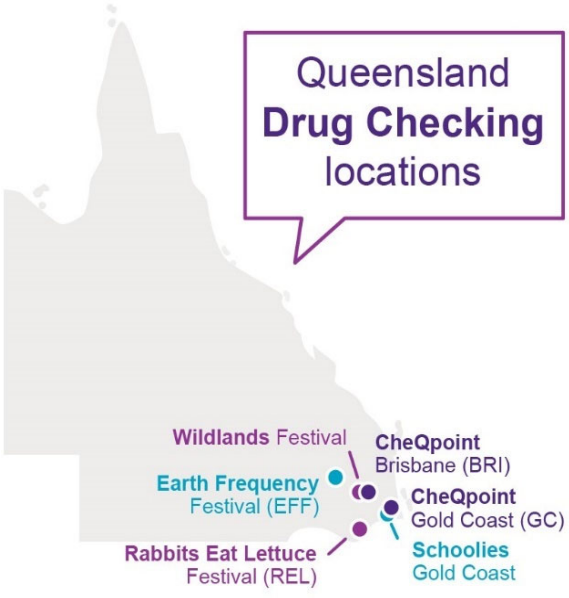
### 3.2.1 To what extent were the drug checking services implemented according to the intended plans, and in alignment with Queensland Government policies?

**KEY OBSERVATIONS**

- Services at 2 fixed sites and 4 events were implemented in full accordance with the expectations regarding *Requirements for Drug Checking Services* and QH service agreements, and in alignment with major (then) government policies.
- Services were implemented according to plans and were observed to run smoothly and effectively. Improvements to service operations were made during the evaluation period in response to staff and client feedback.
- Services recorded 952 visits from March 2024 to April 2025 by 1341 people over 104 operating days, analysing 1530 samples and providing 872 health conversations to service clients.
- Visits per month to fixed site service increased from inception to November 2024, with a slight decline following holiday periods up until site closure. Visits to fixed sites primarily involved one client; intervention times were consistent across sites and wait times were proportional to the number of client presentations at each site.
- Compared to fixed site services, visits to event-based services typically involved larger client groups, shorter wait times, and similar intervention times.
- Extensive pre-implementation consultation and planning, including with people of lived-living experience of drug use, strong existing relationships between services, clear AOD sector and (then) government support all contributed to success.

CheQpoint Brisbane commenced operations on 19 April 2024 and provided 50 days of service across the 12-month period. The service was co-located with QuIHN's harm reduction services at Bowen Hills (see Figure 2). CheQpoint Gold Coast commenced operations on 4 July 2024 at Burleigh, also co-located with QuIHN harm reduction services, and provided 39 days of service over the 8.5-month period. The harm reduction services available at these sites included needle and syringe programs (NSP), HepC and sexual health testing and treatment, counselling and group support, Better Access medical and allied health support and overdose prevention.

*Figure 4. Map of Queensland drug checking locations.*




CheQpoint also delivered event-based services at the Earth Frequency music festival (EFF) on 3–5 May 2024 in collaboration with Hi-Ground, a provider of harm reduction resources and information, and Conscious Nest, who provide harm reduction and mental health outreach services at events, and at the Gold Coast as part of the Queensland Government's Safer Schoolies Response from 16–22 November 2024.

PTA delivered drug checking services at the

Rabbits Eat Lettuce (REL) music festival from 28–31 March 2024, also in conjunction with Conscious Nest, and at the Wildlands music festival in Brisbane on 31 December 2024.

In all settings, service provision involved:

- an initial meeting with a harm reduction worker to determine experience with/knowledge about the presumed substance and intensions for use
- presentation by the client of samples to a qualified chemist for testing
- receipt of test results and
- offer of a brief tailored health intervention/education discussion regarding potential risks and harm reduction strategies.

Referrals to additional support services were offered where deemed appropriate. All services were anonymous and confidential.

These operations are summarised broadly in Table 4 below.

*Table 4. Queensland drug checking operations March 2024-April 2025*

| | CheQpoint Brisbane | CheQpoint Gold Coast | Earth Frequency Festival | Gold Coast Schoolies | Rabbits Eat Lettuce Festival | Wildlands Festival | Total |
|---|---|---|---|---|---|---|---|
| **Operating days** | 50 | 39 | 3 | 7 | 4 | 1 | **104** |
| **Visits** | 411 | 117 | 152 | 22 | 137 | 113 | **952** |
| **People** | 485 | 137 | 170 | 53 | 257 | 239 | **1341** |
| **Samples tested** | 699 | 207 | 230 | 27 | 210 | 157 | **1530** |
| **Health conversations** | 396 | 109 | 107 | 22 | 135 | 103 | **872** |
| **Referral information provided** | 138 | 27 | 6 | 0 | 20 | N/A | **191** |

*Notes*. Note that these data refer only to clients who consented to their data being used in the evaluation. Not all visitors consented to receive a health conversation. Referral information provided includes clients who received general referral information about internal and external services. The Wildlands service did not record referral information.

#### 3.2.1.1 Establishment of services: alignment with policies and requirements

##### *3.2.1.1.1 Fulfilment of Requirements for Drug Checking Services in Queensland*

Queensland Health's *Requirements for Drug Checking Services in Queensland (the Requirements)* features the following:

- Approval and compliance with Queensland regulation: services must apply for general approval – regulated poisons laboratory under section 68 of the *Medicines and Poisons Act 2019* (MPA), which providers approval holders with authority to buy, possess, apply and dispose of Schedule 4,8,9 and 10 substances for certain purposes. Approval holders must

comply with measures specified in guidelines for the disposal of substances. Approval holders must prepare and implemented a substance management plan.

- Engagement with Queensland Health, Queensland Police Service and Queensland Ambulance service: Service providers that intend to deliver drug checking services should engage with Queensland Health (QH) around requirements and expectations. On receipt of approval and before commencement of services (minimum of 60 days), service providers should further engage with QH, and engage with QPS. QH acts as a contact point between approval holders and Queensland Ambulance Service. There are specific requirements detailed in the document about event-based services, and fixed site services.
- Service delivery: Drug checking services are required to provide chemical analysis and testing, and provide a brief intervention. Service delivery needs to be aligned with the National Quality Framework for Drug and Alcohol Treatment Services, the National Framework for Alcohol Tobacco and Other Drug Treatment 2019-29 and the Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework. Services should be free and confidential for clients.
- Staff: Services should have appropriately trained and supported health and harm reduction workers, including peer works, for the delivery of health interventions. Analytical chemists should also be appropriately skilled and trained, and there should be a Lead Chemist for overseeing analysis and reporting.
- Equipment: DC services must be equipped with appropriate technology, with the requirements document specifically mentioning FTIR as a standard.
- Monitoring and evaluation: services must participate in monitoring and evaluation activity for Queensland Health funded drug checking services.
- Early warning systems/drug alerts: Services are required to participate in public health early warning systems, providing advice to QH and QPS of high risk or potentially dangerous substances.

Analysis of protocol documents, reports and site visits by the evaluation team determined that both service providers complied with all requirements, as outlined below.

#### *3.2.1.1.2 Pill Testing Australia – event-based services*

PTA's agreement with Queensland Health stipulated that drug checking services should be delivered between one and four events during the 12-month operational period. The service agreement for PTA began on 01/03/2024 and concluded on 19/03/2025. During the operational period, PTA delivered two event-based drug checking services: at the Rabbits Eat Lettice (REL) festival, held during the Easter long weekend of 28-31 March 2024, and at the Wildlands festival on 31 December 2024. PTA provided drug checking services across all event days.

PTA developed an "Implementation Plan" (dated 15 March 2024), which specified how the service intended to carry out each deliverable outlined in section 6.2 of the Service Agreement. This included the following deliverables:

- An *Establishment Period* to allow the service to conduct the necessary recruitment, induction and training of staff, arrange operational aspects of the service, obtain relevant approvals, accreditation and insurance, and establish service relationships. PTA developed a "Timeline of PTA at REL" which detailed the key milestones in the lead up to the festival.
- *Service delivery* requirements included offering a brief intervention (client-centred and evidence-informed) and providing chemical analysis and testing (including sharing the information with harm reduction workers within the service and contributing to broader early

warning drug alert systems). To comply with the service delivery requirements, PTA developed a “Brief Intervention Form” to structure interactions with and gather relevant information from clients, and developed a “Substance Management Plan” and “Drug Notification Template” to comply with analysis and testing requirements.

- *Service Provider and Staffing Qualifications* requirements included ensuring that the necessary staff had been hired to carry out the service and staff members had received adequate training and supervision. All PTA at REL volunteers had previous experience working in drug-related health and community service roles, the six chemists had graduate qualifications in chemistry, and eight of the 14 team members had previously worked at drug checking services at other festivals. The “Timeline of PTA at REL” outlines the timeframes in which staff recruitment and training were carried out.
- Services were required to comply with specific *Service Governance* requirements, including delivering services in line with relevant legislation and contractual requirements, as well as the pre-existing risk management policies, and implementing appropriate clinical governance at the festival. PTA agreed to comply with all relevant legislation and policy requirements and a Lead Clinician was arranged to provide clinical oversight during service delivery.
- As outlined in the *Facilities* deliverables, services should operate as standalone services, but be situated with other health services, and utilise a service delivery layout that allows for discrete substance drop off and for the brief interventions to be separate from the testing area. PTA at REL was co-located with the HEST Paramedical and Conscious Nest Peer-based festival harm reduction service. The service area included a private shaded queuing area and demountable office area.
- Services were also required to have the necessary *equipment* to carry out comprehensive, high-quality drug checking consistent with best practice. This included access to a FTIR machine and other additional laboratory testing equipment, such as fentanyl testing strips and reagent colorimetric testing. PTA complied with the requirement, and equipment used by the service at REL festival was outlined in the “Substance Management Plan”.

Additionally, as outlined in section 6.3 of the Service Agreement, the service was required to obtain the necessary accreditation prior to service delivery. Providers of AOD treatment are required to obtain accreditation to be compliant with the National Quality Framework for Drug and Alcohol Treatment Services. HRA/PTA received accreditation from ASES Certificate Accreditation, completing the accreditation requirements outlined in the service agreement and aligning the service with national policy requirements. A quote for the ASES Certificate Accreditation was included as an attachment to the Implementation Plan.

In addition to operating drug checking services at REL, PTA also provided a drug checking service at Wildlands Festival in December 2024. Information provided by the service indicates that planning for the event-based service at Wildlands Festival began in early October, almost three months prior the service date. Additional training sessions and training materials were provided to the volunteer workers prior to service delivery, with volunteer agreements and confidentiality deeds submitted by 12 December, mandatory training modules completed on 22 December, and additional training completed by 31 December. Additionally, PTA conducted a pre-event meeting with stakeholders involved in the Wildlands festival to discuss the service delivery, medical operations, and patrons’ wellbeing, as well as challenges and opportunities for the service.

The requirement for “Engagement with service delivery partners” was noted in the Implementation Plan as not applicable to PTA service delivery at festivals. While there were no formal partnership agreements in place for the delivery of the service, PTA worked collaboratively with event organisers, emergency management teams, QPS, HEST paramedical services, Conscious Nest,

and the PTA Queensland Service Stakeholder Group (including members from QuIHN, QuIVAA, Conscious Nest, Directions Health, the Harm Reduction Australia board and the PTA advisory group) to deliver festival based services.

#### *3.2.1.1.3 CheQpoint - fixed sites and event-based services*

CheQpoint's agreement with Queensland Health stipulated the delivery of drug checking services at a minimum of one fixed-site and one event-based service. The service was delivered by a partnership between QuIHN Ltd (the lead agency), the Loop Australia Ltd and QuIVAA Inc. The service agreement ran from 1 February 2024 to 18 April 2025. During this period, CheQpoint delivered two fixed-site services and two event-based services. The first fixed-site service commenced in Bowen Hills, Brisbane, on 19 April 2024, and a second fixed-site service commenced in Burleigh Heads, Gold Coast, on 4 July 2024. The fixed sites operated for four hours each week, initially on Thursdays (Gold Coast) and Fridays (Brisbane). The Gold Coast service changed to Fridays in response to community feedback. CheQpoint also delivered two event-based services: at Earth Frequency Festival (EFF) on the long weekend 3 - 5 May 2024, and as part of the Gold Coast Safer Schoolies Response 16 - 22 November 2024. CheQpoint provided services across all event days.

CheQpoint developed an "Implementation Plan" (dated 28 March 2024), which outlined the intended plans of service delivery at the fixed- and festival- (Earth Frequency Festival) sites and specified how the service intended to carry out each deliverable outlined in section 6.2 of the Service Agreement. This included the following:

- An *Establishment Period* to allow the service to conduct the necessary recruitment, induction and training of staff, arrange operational aspects of the service, obtain relevant approvals, accreditation and insurance, and establish service relationships. The activities to be completed during the establishment period included an extensive Service Co-Design process with individuals with lived-living experience (LLE) of substance use.
- *Service delivery* requirements included offering a brief intervention (which is client-centred and evidence-informed) and providing chemical analysis and testing (including sharing the information with harm reduction workers within the service and contributing to broader early warning drug alert systems). To comply with these requirements, CheQpoint developed Demographic Forms, Sample Forms, and Health Conversation Forms to structure client interactions and gather the relevant information from clients. CheQpoint also developed a "Substance Management Plan", a "CheQpoint Drug Checking Alert and Notifications Process", and specific Chemist Training resources to comply with training, analysis and testing requirements.
- *Service Provider and Staffing Qualifications* requirements included ensuring that the necessary staff were hired to carry out the service and staff members received adequate training and supervision.
    - Fixed sites service delivery involved eight staff members, with four routinely onsite for all operational periods. Rosters were designed to allow two staff members to remain present in the waiting room during opening hours, with two staff delivering brief interventions or carrying out chemical analysis. Training specific to the fixed site service was provided to all staff and service volunteers.
    - Event based service delivery included a larger team to allow the service to operate for longer opening hours with a higher volume of clients. The Earth Frequency Festival Service plan included 21 onsite staff, the majority of whom were volunteers. This included: the project lead, one clinical lead (qualified medical doctor), one chemistry lead, six health and harm reduction volunteers, six volunteer chemists,

and eight volunteer research assistants. Training specific to the festival event was provided to all service staff and volunteers.

- Services were required to comply with specific *Service Governance* requirements, including delivering services in line with relevant legislation and contractual requirements, as well as the pre-existing risk management policies, and implementing appropriate clinical governance at the festival. CheQpoint agreed to comply with all relevant legislation and policy requirements. Additionally, the Loop Lead Chemists were responsible for the coordination and supervision of the laboratory components of testing serviced at the fixed sites and the festival service.
- As outlined in the *Facilities* deliverables, services should operate as standalone services, but be situated with other health services, and utilise a service delivery layout that allows for discreet substance drop off and for brief interventions to be separate from the testing area.
    - The fixed site services at Brisbane and the Gold Coast were co-located with pre-existing QuIHN services. QuIHN currently operates harm reduction and therapeutic AOD services at both locations. Co-location allowed for opportunistic engagement for service clients with other harm reduction interventions. The “Implementation Plan” included a floor plan for the service and its situation within the QuIHN facility.
    - The event based service was co-located with other services, including Conscious Nest, paramedic services and a QuIHN information stand. The “Implementation Plan” included a floor plan for the drug checking service at the festival.
- Services were also required to have the necessary *equipment* to carry out comprehensive, high-quality drug checking consistent with best practice. This included access to a FTIR machine and other additional testing equipment, such as fentanyl testing strips and colorimetric reagent testing. CheQpoint complied with this requirement: the equipment used at the fixed site service was outlined in the “Implementation Plan” and included FTIR, Ultraviolent-Visible Spectrophotometer, colorimetric reagent testing and fentanyl testing strips.

Additionally, the service was required to obtain the necessary accreditation prior to service delivery to comply with section 6.3 of the Service Agreement. As outlined the “Implementation Plan” QuIHN holds current accreditation certification under the ISO 9001 (2015) Quality Management Standards; and The Loop and QuIVAA are registered with the IHCA. QuIHN has medical malpractice, public and product liability insurance, professional indemnity insurance, cyber security insurance, voluntary workers compensation and WorkCover insurance in place. The Loop holds medical malpractice insurance specifically covering the provision of health services to illicit drug users including drug checking.

#### *3.2.1.1.4 Participation in early warning systems and evaluation*

Both service providers participated in public health early warning systems by providing timely notification to QH and QPS of any high-risk detections at the services. Where deemed appropriate by QH, alerts were issued regarding these detections. Service providers also issued alerts via their social media platforms.

Both service providers also engaged actively with the evaluation, participating in design consultations, establishing formal data sharing agreements, providing service data, participating in stakeholder interviews and sharing service documentation and reports as requested.

#### 3.2.1.1.5 Alignment with other Queensland Government Policy

*Achieving balance*, released in 2022, outlines the then Queensland Government's plan to reduce and prevent problematic use of alcohol and other drugs. The policy emphasises the need to enhance treatment and support systems to reduce harm and improve health outcomes. While *Achieving balance* outlines five strategic priorities, the introduction of drug checking services clearly aligns with *Priority 5 - reduce harm*. The plan includes drug checking as an example of a harm reduction strategy and highlights the need to build on existing harm reduction services and lists early warning systems and drug checking services in entertainment settings as priority actions. The policy also highlights the benefits of a peer-led service, which can reduce barriers to help-seeking for clients.

*Better Care Together*, released in 2022, is a 5-year services plan for state-funded, mental health, AOD services. The plan recognises the importance of supporting new and innovative models to reduce AOD-related harms focusing on emerging drug trends and people engaged in illicit and high-risk AOD use under *Priority 1 - strengthening service capacity and the built environment* and *Priority 4 - strengthening quality to reduce harm and improve outcomes.* Better Care Together also promotes co-design with people with lived-living experience and collaborative working arrangements to improve outcomes. (Better Care Together, 2022).(11)

A Ministerial Statement released on 25 February 2023 by the then Minister was the first announcement of the introduction of drug checking services in Queensland. The statement directly aligned the introduction of drug checking as supporting key priorities outlined in the *Achieving balance* (2022) policy to reduce risks and harms associated with alcohol and drug use.

#### 3.2.1.1.6 Prior to implementation

*Better Care Together* and *Achieving balance* both stress the need for collaborative codesign of services, particularly including the voices of people with lived-living experience of AOD use. The extensive planning prior to the opening of CheQpoint drug checking services included a co-design process with members of the community to ensure the service considered the perspectives of individuals who use drugs and met client needs.

> *…initially, there was the co-design and consultation with community. This took place in developing and designing how CheQpoint was going to run. Also, how community would receive and be provided information around the Drug Checking Services. (Stakeholder 23).*

The value of this extensive planning prior to opening of the fixed site services was highlighted by stakeholders during interviews. The collaborative arrangements between the Loop, QuIHN and QuIVAA were nominated as a key enabler of the successful implementation of CheQpoint services.

> *The existing knowledge and networks and collaboration between The Loop, and QuIHN and QuIVAA… bring in a lot of experience and local knowledge of the Queensland environment. (Stakeholder 4)*

While PTA did not develop formal partnership agreements between the service and other delivery or industry partners for festival service delivery, it is apparent that extensive consultations occurred prior to the implementation of the first PTA drug checking service at REL, and in the lead up to providing services at Wildlands festival. During planning for festival services in Queensland, PTA drew substantially on established relationships with festival-based services that had been

developed over years of festival attendance and in delivery of drug checking at the ACT Groovin' The Moo festivals in 2018 and 2019. As stated in the PTA Implementation plan, the service also collaborated with stakeholders with extensive experience working in Queensland, including the event organisers, emergency response teams, QPS, HEST paramedical, Conscious Nest, and the PTA Queensland Service Stakeholder Group (which included representatives from QuIHN and QuIVAA, as well as other organisations). This assisted in the planning of the service prior to implementation.

##### *3.2.1.1.7 Key additional policies*

The *QPS Chapter 14 Operational Skills and Practices* was developed by Queensland Police specifically in preparation for the implementation of drug checking services, and is referenced in the *Requirements*, such that policing protocols are acknowledged and both services were aware of these protocols and their relatedness to and support for service delivery. Specifications include ensuring that policing does not interfere with access to drug checking services.

Guiding AOD frameworks, including the *Queensland Alcohol and Other Drug Treatment Services Delivery Framework*, the *Queensland Alcohol and Other Drug Treatment and Harm Reduction Outcomes Framework* and the *National Framework for Alcohol, Tobacco and Other Drug Treatment 2019 – 2029*, all include references to harm reduction practices, with which the drug checking services align. *Shifting minds: the Queensland Mental Health, Alcohol and other Drugs, and Suicide Prevention Strategic Plan 2023-2028* specifically articulates drug checking as critical to sector reform.

### 3.2.1.2 Preparation and implementation

Long-term support and advocacy for drug checking across the AOD sector provided a positive background for pre-implementation planning, development of partnerships, alignment of service plans with existing policy and international best practice, and supported ongoing positive public messaging throughout the implementation of services both for fixed sites and events.

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*Well, probably that we have been working on it for ages, with [service partners]. So, we had – we already kind of knew what the model could look like on the ground, and so I think that was useful. (Stakeholder 12)*

*The leadership has been really visible and has really valued clear messaging and promoting safety. The changing political climate in Queensland and the stigma and discrimination that surrounds public conversations has been a barrier. The way the service implementation was communicated, there was some really positive experiences in terms of news stories and messaging through social media. (Stakeholder 23)*

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Cross-agency planning and support from the then government, and between community partners, was acknowledged as pivotal to the planning and implementation of services, in terms of contextualising drug checking as a health intervention as well as consideration of logistics, legal issues and communications. Public support from the then government for both fixed site and event based services was widely acknowledged as important in setting the tone of public discourse about drug checking.

*Support from the Queensland Government, Queensland Police, DACU, and health providers, along with community service groups like QuIHN and QuIVAA… have been great factors. (Stakeholder 9)*

Despite the long-term pre-planning activities, services acknowledged that more time would have been helpful to enact the immediate tasks required to get the service ready to commence, such as the recruitment and training of additional staff, building and refinement of data collection systems, physical acquisition of equipment, achieving service accreditation and then promotion of the service to the public. Interestingly, very similar issues had been reported during the earlier evaluation of the ACT-based CanTEST service.

*I think the establishment time we had, probably, in hindsight, should've been longer, and I think there are a lot of factors that played into that, around when the public announcements were going out, and when we could recruit staff. (Stakeholder 4)*

#### *3.2.1.2.1 Fixed site implementation*

Co-location of the drug checking services with an established harm reduction service, QuIHN, provided the opportunity to leverage existing (and known) facilities and infrastructure. This also contextualised the drug checking service as a health response, aligned with existing and recognised harm reduction approaches. It created trust for the new service among existing harm reduction clients, and created awareness among new drug checking clients of other harm reduction supports available. Existing harm reduction clients were also overheard reassuring the newer client groups about the confidentiality and safety of the service environment.

*The logistics were quite easy because we've already got a setup at QuIHN, we've got locations around the drug checking services. (Stakeholder 19)*

Although the services were able to take advantage of current and already-trained peer support workers, health and harm reduction staff, and trained chemical analysts, preparing them to work together in a new service type required extra development.

*I think the training aspect has taken a lot longer than I initially anticipated, and partly, that is not just the chemistry aspect, but the chemist interacting with the client, and communicating those results to the health worker and the client, which I think is a fantastic part of the service. It's great, but as chemists, that's probably not a skillset we necessarily already had. The development of those skills, and monitoring of those skills, has taken a lot more training time than I would've initially anticipated. (Stakeholder 4)*

#### *3.2.1.2.2 Event based implementation*

Although many of the same preparations were required to enable event based operations, with existing collaborations and aligned services again offering substantial support to the operation of drug checking services, some additional considerations were identified for the festival contexts. Large scale events usually involve a long term (at least year-long) lead time for preparations; confirmed participation of the drug checking services in the first festivals attended (REL and EFF)

had not been possible until contracts were signed. Despite this, the event organisers' strong support of drug checking, existing relationships from attendance at festivals prior to drug checking, and broad collaboration across the harm reduction community were all valuable aids to implementation.

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*I thought the service rolled out really well considering as I just said, it was the first time that was done in Queensland. Quite often it takes time to build rapport with the other services there, particularly the health and medical services because in my experience the drug checking service can do a lot better when it's part of that kind of overall healthcare unit, and there's good communication between all the services as well as obviously with the clients that come into the service. (Stakeholder 14).*

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Adaptation of processes for the festival environment, such as destruction protocols, communication of any higher risk findings and referral into other supports, did require time once location and facilities were confirmed. In one case, physical delivery of the testing venue was delayed, necessitating some late planning for potential alternative locations.

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*… they're two entirely different processes…The testing is the same, the clientele is going to be different, the people accessing it are different, the destruction process is different, so they need to be … understood for being what they are. (Stakeholder 3)*

*When you go to a festival you need to set up all the marquees, have a waiting area, have a chill out thing, and then have your chemists in the back and all that sort of stuff. So, I guess there's just more to it in that regard. (Stakeholder 19)*

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Constraints were identified around making the testing equipment available at festival services comparable to that for fixed site services. Specifically, the portability of equipment was raised. FTIR, reagent tests and test strips are all portable (although requiring a stable environment for use), but more sophisticated equipment such as the UPLC in use at other fixed sites was not relocatable for festivals. Samples requiring secondary analysis were sent to university partners for later laboratory analysis.

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*…obviously, the portability of the technology is a driver for festival based services. You won't be able to take the lab with you. The time limited nature of festivals means that any follow up testing … had to be sent offsite for further analysis because it didn't show up in the database, that - those are limitations of those festival based models. (Stakeholder 25)*

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The importance of building strong rapport prior to the event with other festival stakeholders, including the event organisers and other service providers, was noted. Rapport built between stakeholders enabled the successful running of event-based services. Event patrons were also less likely to be familiar with drug checking, so support from these stakeholders was vital in reassuring patrons of the safety of using drug checking services.

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*I think the high level of support that the promoter had for this type of intervention being brought to their site instantly means that things are going to work really*

*smoothly… Same with the really strong partnerships that we had with HEST Medical (Stakeholder 17)*

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As part of the planning process and communication establishment, the service providers created plans to share information between stakeholders and with festival patrons in the event that a high-risk substance was detected at the service.

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*As part of the - at EMT, emergency management team, meetings, it was all through the event coordinator in their emergency communications centre. That was the absolute baseline contact that we would have, which would be the six hourly whip around meetings. That would be just an overview of what's happened in the last six hours. How many clients, how many tests, what kind of trends? (Stakeholder 9)*

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Similar to fixed site services, co-location of drug checking with other festival supports was an advantage, providing easy referral to other services required, and contextualising drug checking with existing harm reduction offerings.

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*At [music festival], being part of the Conscious Nest and close to medics where the tents are open, that gives an immediate sense of understanding what services are available, that this is part of a health service. (Stakeholder 23)*

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Other client considerations specific to the event environment included the higher number of clients at festival services necessitating increased staff numbers and more testing equipment to facilitate the timely flow of clients through the service. This included additional chemists to facilitate testing and additional harm reduction staff to communicate with clients. Harm reduction information also needed to be tailored to particular concerns within the festival environment.

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*I suppose, because people go to festivals, people use drugs at festivals, so you've got an audience there just ready to come and use the service, so it's going to be busier, you're going to have more flow through. (Stakeholder 19)*

*The brief interventions that were supplied at a music festival, there'll be more stuff around just hydration and that sort of stuff. If there's a drug found - because they're all in an enclosed area for potentially a few days, if there was a drug that was tested then the alert would need to get out to everyone in the festival in some capacity. (Stakeholder 19)*

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Delivery of drug checking at Schoolies presented some very specific challenges. Conflicting public discourse about the service's attendance created uncertainty among stakeholders and potential service clients as to whether the drug checking service would be delivered. This, and the short timeframe between confirmation of service attendance and commencement of the event, impacted effective information flow between stakeholders and restricted the service's ability to make timely preparations, such as specific staff accreditations, for commencement. It is also likely to have affected attendance of clients at the service.

*I think unfortunately legislators, regulators, anyone in that government body, there still seems to be this trepidation (Stakeholder 3)*

*… [not hearing about] crucial organising meetings, sending us through information a day before a crucial deadline is due and then missing crucial information that means we can't even complete … the accreditation process for our staff. (Stakeholder 12).*

Despite a number of challenges specific to the delivery of event-based services, stakeholders emphasised that overall, these services ran smoothly. The experience of team members from both service providers in other festival environments, including direct experience with drug checking at previous events such as Groovin' The Moo, was credited as contributing to this. Building on this experience, improvements were made to the running of the services over multiple days of festivals, and implementing improvements in subsequent festival services was noted.

*What I like about event-based service delivery is you're creating a world. You're starting from scratch and it's actually quite easy to implement an innovation from a previous service. So you're like, this is what did or didn't work well. (Stakeholder 9)*

*You work things out as you go along, you're constantly improving it. You get feedback from people and clients and just by observing the service, you go, well that didn't work great, well let's do this one. But yeah, festivals are probably a little bit more unpredictable, but the team's very experience at those, so they do a great job. (Stakeholder 13)*

### 3.2.1.3 Operations

## Service delivery at a glance

28 March 2024–4 April 2025

**104** days of **service**

**89** days **fixed-site** delivery

**15** days **event** delivery

**952** service **visits**

**528** **fixed-site** visits

**1341** **people**

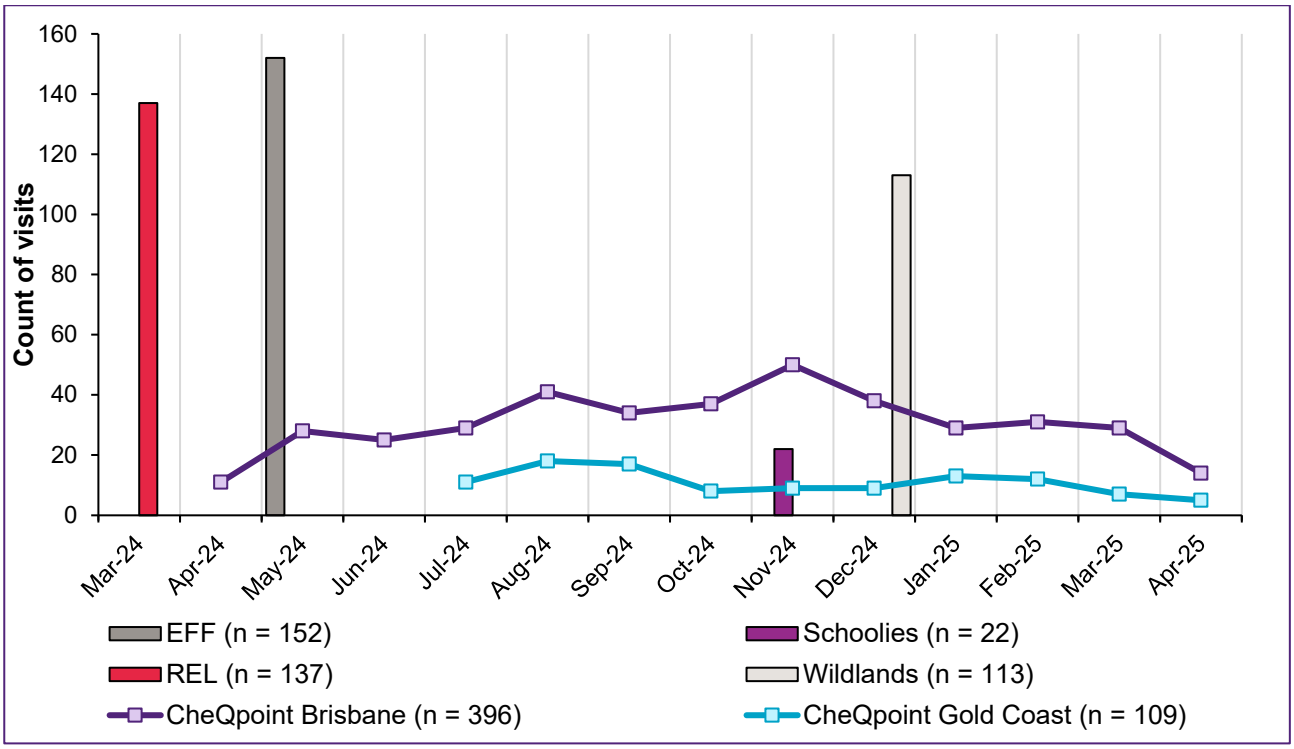
**424** **event** visits

Median **intervention time**
**17–26** **minutes**

Median **wait time**
**3–20** **minutes**

Data discussed below span 12 months of service delivery (28 March 2024 - 4 April 2025) and 929 (of 952[1]) service visits across drug checking services.

*Figure 5. Visits to drug checking services, March 2024 - April 2025 (Source: CheQpoint and PTA data)*




#### *3.2.1.3.1 Fixed site operations*

Visits to CheQpoint Brisbane generally increased from inception to November (see Figure 5), with a slight decline from November to January with public holiday closures and a tapering towards the end of service delivery (services were open for one day only in April 2025). The number of visits to CheQpoint Gold Coast ranged from 6 to 18 per month but was generally stable over time.

[1] Some service visits are excluded from analyses as clients did not provide consent for data use in the evaluation.

CheQpoint Brisbane averaged **8 service visits per day** (*Median* = 8, *Mean* = 7.9, range: 1-14), while CheQpoint Gold Coast had **2-3 visits per day** (*Median* = 2, *Mean* = 2.8, range: 0-7).

Visits to fixed sites primarily involved one client (82-84%), with smaller proportions involving two clients (15%-17%) or three or more clients (0.5-2%). As shown in Figure 6, the average number of clients per visit was similar across fixed sites (see Appendix 3: Detailed quantitative analyses for further information).

*Figure 6. Visitor group sizes across drug checking sites. (Source: CheQpoint and PTA data)*

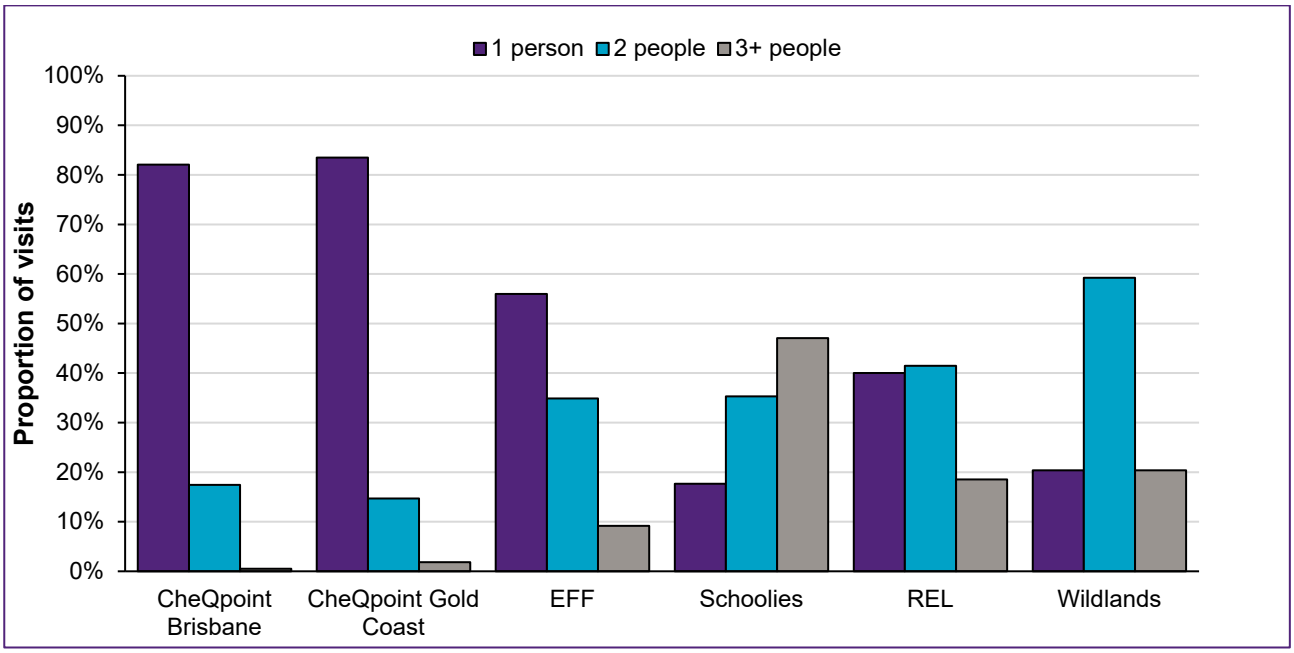


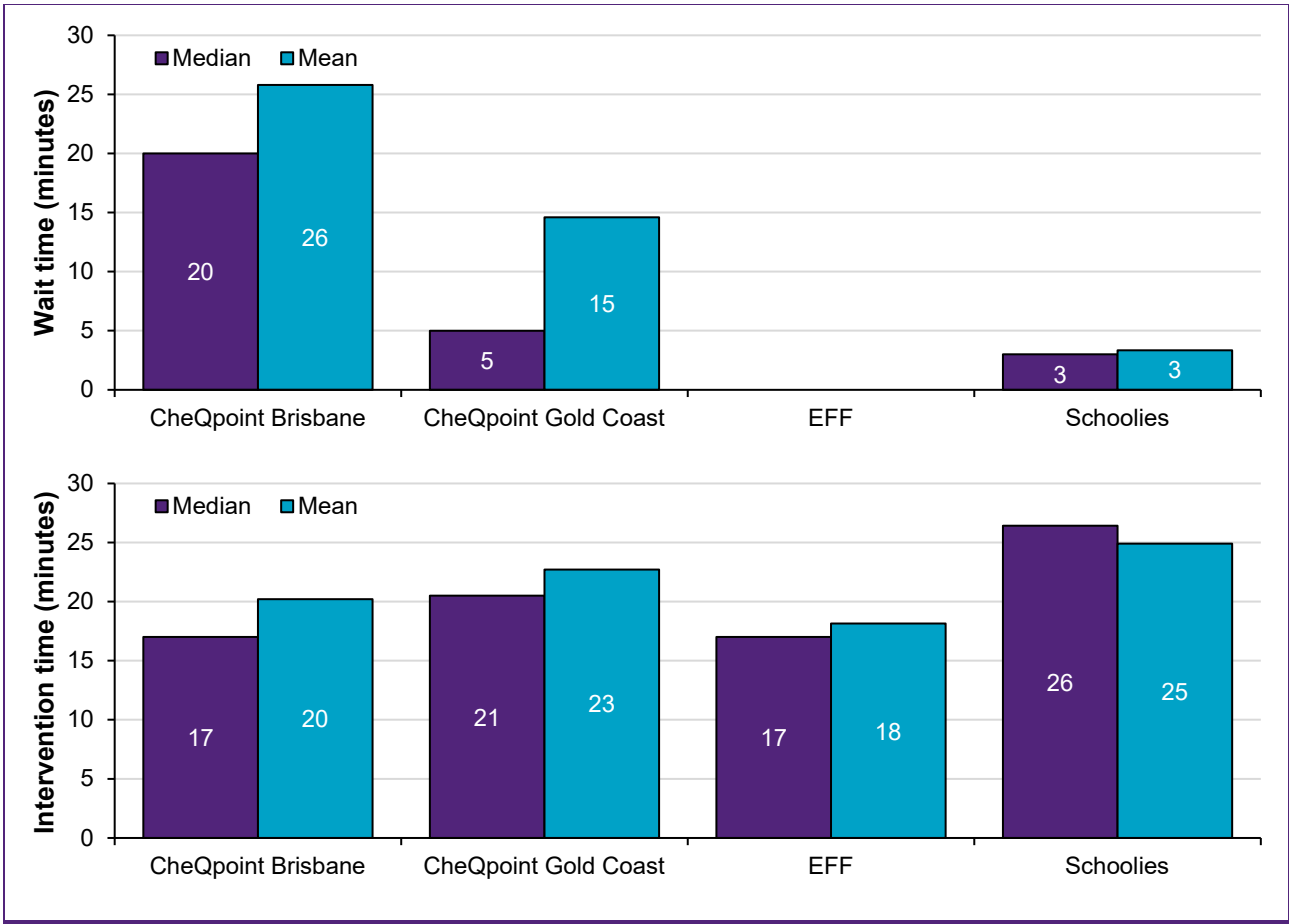

Figure 7 shows the wait times (between submitting a sample and receiving analytical results) and intervention times (spent in a health conversation with a health worker) across CheQpoint fixed sites and at Schoolies. Wait times were not recorded at EFF as clients could drop samples and return later. Data systems for PTA services did not separate wait and intervention time but recorded total time in service.

The average intervention times were slightly longer at the Gold Coast compared to Brisbane. The average wait time at Brisbane was longer than the wait time at the Gold Coast service, potentially reflecting the larger volume of clients visiting the Brisbane service each day. The total time clients spent at fixed-site services (including wait and intervention times) ranged from 6 to 166 mins (median: 38 mins).

Service observations showed that once established, operations proceeded smoothly in most cases. This was also noted by clients.

> *I just want to point out that it was such a positive experience and it was just so easy, it was just in and out. I mean I know I went at a quiet time but it was a really streamlined process and it was just a positive way to look at recreational drug use that, you know, there is the port available for you if you've got a problem with it, if it, you know, reaches that point where it's not a recreational use anymore. (Client 2)*

*Figure 7. Wait and intervention times across CheQpoint sites (Source: CheQpoint data).*




Notes: Wait times were not recorded at EFF as clients could drop samples and return later. Data systems for PTA services did not separate wait and intervention time, but recorded total time in service.

#### *3.2.1.3.2 Event-based site operations*

Client visits to the festival sites typically involved larger groups, shorter wait times, but intervention times similar to the fixed-site services, suggesting maintenance of client support despite the busier environments. Below, we summarise the service delivery for each service.

**CheQpoint event-based sites.** Services at the Earth Frequency Festival received 152 visits over 4 days, and at Schoolies received 22 over 7 days (Figure 5). Compared to the fixed sites, a greater proportion of client visits involved groups of two or more (Figure 6). Over half (56%) of visits at EFF involved a single client, with a further 35% involving two clients, and 9% involving three or more clients (see Figure 6). At Schoolies, only a small proportion of visits involved a single client (18%), with most involving two (35%) or three or more clients (47%).

In order to manage potentially long wait times, clients at the EFF service were able to drop off samples and return hours later; as such, data regarding wait times were unavailable. Figure 7 shows the typical intervention time was 17 minutes (range: 4-60 mins), consistent with the time spent on interventions at the fixed site in Brisbane. This represents consistent support for clients within a very busy service environment with an average of 38 visits, many of them multi-person, per day. At Schoolies, with far fewer visits, the wait time was typically very short (range: 0-8 mins)

and the typical intervention time was longer (range: 15-35 mins), consistent with the times at the Gold Coast fixed site.

**PTA event-based sites.** Services at the Rabbits Eat Lettuce festival received 137 visits over 4 days; services at the one-day Wildlands Festival received 113 visits (see Figure 5). Figure 6 shows that REL had similar proportions of single-client (40%, *n* = 54) and two-client visits (42%; *n* = 56), with a smaller proportion involving three clients or more (19%; *n* = 25). Fewer visits to the Wildlands service involved one client (20%; *n* = 21); most involved two clients (59%; *n* = 61), with the remaining visits involving three or more (20%; *n* = 21).

The REL service recorded the total time spent in the service (including wait and intervention times). Similar to the Brisbane fixed site service, clients at REL typically spent 30 minutes in the service (*Median* = 30, *Mean* = 39, range: 5-125 mins). Data for the total time spent in the Wildlands service are not presented due to a large number of missing responses.

### 3.2.2 Were the resources available to support drug checking services appropriate, sufficient and sustainable to support quality service provision?

**KEY OBSERVATIONS**

- Queensland Health provided an investment of approximately $740,000 ex GST for provision of drug checking services at fixed sites and events over the evaluation period.
- Service providers specified service models, operating parameters and budgets in responses to a tender process.
- Operating within these budgets, resourcing constraints affected opening hours, staffing, equipment access, staff workload, testing capacity, service advertising and communications.
- Testing equipment was primarily FTIR, supplemented by test strips and reagent testing, in accordance with the *Requirements*. Equipment suitable for purity testing was not possible within service budgets. Confirmatory testing was provided by university partners.
- Insurance was a significant cost for the services.
- Staffing costs consumed a major proportion of the fixed site service budgets; event based services used a largely volunteer-based model.
- Fixed sites involved co-location with existing harm reduction services, leveraging existing infrastructure. Event locations were chosen in relation to access, links to related services and service delivery environments.
- Reliance on volunteer time, in-kind contributions and donations poses challenges for service continuity and sustainability.
- Despite the constraints noted, providers were able to deliver consistent and effective services in both fixed site and event environments.

The impacts of the resourcing issues are explored further below.

#### 3.2.2.1 Funding contracts

Queensland Health provided a total of $739,682 ex GST for provision of drug checking services in Queensland between March 2024 and April 2025, following a competitive tender process. This

funding envelope is comparable to that initially provided by the New Zealand government on initiation of drug checking services in that country. Two provider organisations submitted offers and funding amounts based on their proposed models of service and staffing models.

The CheQpoint offer included providing services at two fixed sites and at a single music festival. Additional services were provided as part of the 2024 Schoolies following subsequent procurement and contracting. The PTA offer included providing services at between one and four music festivals.

For both providers, funding was used to address costs relating to:

- Insurance
- Testing equipment and supplies
- Venues
- Staffing (analytical chemists, health workers, peer support workers)
- Transport for events

CheQpoint also used funds to support the initial service establishment.

Table 5 summarises the broad proportion of costs under these headings that were estimated to have been covered by the funding under service agreements (funded through QH), and those that were resourced through in-kind or volunteer provisions by the service provider. These figures are necessarily broad estimates, as the exact expenditure figures are commercial-in-confidence.

*Table 5. Resourcing of drug checking operations*

| Resource item | Funded through QH | In-kind funded |
|---|---|---|
| **Insurance and accreditation** | | |
| CheQpoint fixed site | 60% | 40%§ |
| CheQpoint events | | 100%§ |
| PTA events | 100%* | |
| **Testing equipment** | | |
| CheQpoint fixed site | 100% | |
| CheQpoint events | | 100%§ |
| PTA events | | 100%§ |
| Confirmatory testing | | 100% |
| **Staffing – fixed site** | | |
| Management | 60% | 40% |
| Health workers | 80% | 20% |
| Analytical chemists | 80% | 20% |
| Peer workers | 80% | 20% |
| Data/communications | 100% | |
| **Staffing – events** | | |
| Management | | 100% |
| Health workers | | 100% |
| Analytical chemists | | 100% |
| Peer workers | | 100% |
| Transport/accommodation | PTA 100% | |
| **Site operations and consumables** | | |
| Service establishment costs (fixed site only) | 80% | 20% |
| Operating - Fixed sites | 70% | 30% |

| | Operating - Events | PTA 100% | CP 100%§ |
|---|---|---|---|
| **Location costs** | | | |
| | CheQpoint fixed site | | 100% |
| | CheQpoint events | | 100% |
| | PTA events | | 100% |

*pro-rata for annual national operations; §in-kind from other operations

Specific considerations for major resourcing items are noted below.

Service insurance costs were a primary expense, approximating $10,000 - $15,000 per year, despite being reduced from initial quotes in the range of $50,000 per year. This is noted as an ongoing national issue, particularly as drug checking is regarded for insurance purposes as an emerging service type. Professional indemnity insurance was also costly, although providers were able to leverage insurance under other service operations, and some volunteer health workers leveraged professional indemnity insurance held through their paid appointments. Event based insurance costs were supplemented in some cases by private donations.

*We've seen insurance costs triple. We've seen significant increases just in hitting the right mark with – medical security rates go up, so we're already investing and spending more on harm reduction services across the board (Stakeholder 1)*

*…the … funding we did get from Queensland Health, a large chunk of that went towards our insurance policy and on a pro rata basis and on the cost of our accreditation. (Stakeholder 24)*

Review of budget-related documents for REL showed that the drug checking service operated at a loss. Substantial costs were related to staffing supports (travel to the venue and food for volunteers). Operating costs were reduced by using pre-existing equipment and supplies. The FTIR machine used had been purchased several years prior to the festival, hence the $55,000 cost was not included in the event operating costs. The service noted that costs would have been significantly higher if they had needed to purchase additional equipment for the festival. **Use of existing resources** such as stationery (festival service records were paper based) from previous PTA events provided further cost-savings. The cost of providing services at Wildlands festival was incorporated into the initial funding received, resulting in a greater out of pocket position.

Analyses of planning documents, budgets and spending for CheQpoint services also suggest a **heavy reliance on in-kind contributions** (particularly at EFF). The early development phase for the fixed site services drew heavily on long-standing organisational networks and lead-up advocacy work and these costs were not included in the service budget. The cost of time required for complex governance functions was also not allowed for in the budget. In-kind contributions including lease of facility space, recruitment, some wages and supervision of additional staff, legal and administrative costs and senior management costs, were conservatively estimated to be over $150,000 across the 12-month life of the program. This estimate did not include the contribution of volunteers to the delivery of event-based services.

*At the moment … we're estimating [service] costs us about $290 per sample … so that's taking out the one-off establishment costs of setting the program up, which was the $100,000. That's not counting Schoolies, because Schoolies was so abnormal. That's just looking at the cost of operating fixed sites and Earth Frequency. (Stakeholder 26)*

Subsequent analysis by CheQpoint estimated the cost of service per sample at $335 for fixed sites only. (Event based services were excluded from the estimate due to the difficulty of allowing for volunteer staff contributions.) This **compares favourably with commercial analysis rates** of $250-$1000 per sample (average $667), **which do not include the provision of any health or harm reduction support.**

Client and stakeholder interviews reflected a strong perception that additional funding would better align with needs, reducing constraints on service opening hours, ability to staff the fixed sites with paid harm reduction workers and chemists, and the technology used to test samples.

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*…a lot of this stuff's being done in kind because people are passionate about it and are excited to make it happen. Without that - so yeah, I'm just going to come back to funding there, that governments need to really fund this well to make it work well. (Stakeholder 19)*

*…all that got resourced really was the doors opening for the X number of hours a week, and that's basically all we've been capable of doing. So, beyond that, there was – there's heaps more work that we would like to do but are not able to. (Stakeholder 12)*

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Limitations in funding also precluded the fixed site service's ability to expand opening hours to increase availability to potential clients.

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*I mean the only things that are really not ideal about the current arrangements are that the funding only allows the fixed sites to be opened for a few hours one day a week. (Stakeholder 25).*

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Stakeholders reflected on the small amount of funding that harm reduction initiatives overall are allotted in Australia, and suggested that despite support from Queensland Health, DACU, and health providers, resourcing for drug checking was similarly below need.

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*I don't think it's a surprise when I say that the majority of the budget across Australia goes towards policing, and harm reduction gets like 2.5% of the pie. (Stakeholder 17)*

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Funding provided by Queensland Health ensured that all workers in the original service design were paid at appropriate award levels. However, it appears that the initial scale of operations proposed and the funding available and requested were not sufficient to meet the demand experienced or projected to emerge, particularly when the need for more staff on the ground was identified. Similar issues had been reported during the evaluation of CanTEST.

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*I think the funding isn't enough. It wasn't described as a pilot, but it's only ever been funded at pilot scale. It's absolutely not enough to meet demand for all events in the state, considering the population and geography. The contacts at Queensland Health, DACU, local command, health providers, and ConsciousNest have all been great, but it's not funded to scale. (Stakeholder 9)*

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Clients also supported the need for more funding.

> *Give it more funding...with more funding, they can have more staff and things like that. So I just think more funding to make it - to increase the opening hours, increase the staff, increase the availability and the accessibility of it. (Client 8)*

In addition to the funding envelope involved, stakeholders noted that longer service contracts would have allowed more preparation time within organisations to better deliver the services via earlier staff recruitment, employment contracts to encourage retention, and to address the long-term planning required for larger music festivals.

> *…longer term contracts to ensure that services can roll out and give our organisations more time to actually set up…a world-leading perfect service that prevents harms and does everything when really - particularly for big music festivals, they are months if not years in the making of organising and setting up the infrastructure and where services will sit. (Stakeholder 14)*

The potential and reported impact of drug checking on preventative and community health was noted as underpinning the importance of government support for drug checking services.

> *...government, in terms of stewardship of this space, have a real role to play, because it is an essential ingredient. In an unregulated drug market, it's an essential ingredient for a whole bunch of things, including the early warning system, including the whole AOD, harm reduction treatment service system itself is a part of that larger service system. But also, including a whole longer term, the harder stuff to prove about keeping people out of hospital care and emergency departments and all sorts of things, which are state funded issues. (Stakeholder 26)*

Later in 2024, after the introduction of the Queensland drug checking services, the Victorian Alcohol and Drug Association (VAADA) published a Drug Checking Principles of Practice document which included recommended funding levels (23). In this proposed model, based on services operating in Canada, establishment costs were estimated at $1.6 million, with annual operating costs approximating a further $2 million.

#### 3.2.2.2 Equipment and resources

The primary equipment used to analyse the samples presented was a Fourier Transformed Infra-Red (FTIR) spectrometer, in accordance with the *Requirements*. FTIRs are a type of spectrometer that use infrared light to analyse the different compounds in a sample. FTIRs use libraries of spectra to compare a drug sample to known references. While the libraries used by services are extensive, the evolving nature of novel substances is such that not all substances can be assessed by FTIR. Furthermore, FTIR machines are unable to provide information about the concentration of compounds within the sample or to analyse organic materials such as cannabis flower or mushrooms.

Additional analyses were carried out using colorimetric reagent tests (e.g., for LSD and other hallucinogens) and testing strips (e.g., fentanyl strips). Immunoassay Test Strips (ITS) are a

screening test developed to confirm the absence or presence of a particular compound in a drug sample (such as fentanyl) and provide a binary (yes/no) result. Where results were ambiguous, or components were not recognised from the FTIR reference library, samples were sent for confirmatory testing, provided for free by colleagues at the University of Queensland and Griffith University, however receiving these results incurred some delays.

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*Then with our secondary testing, so all the samples that we receive in, we send off to either Griffith Uni or UQ for secondary analysis which is a bit more sophisticated than we can provide in our free service. But it is slow. It's slow to get those secondary test results. (Stakeholder 21)*

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Clients and stakeholders both noted the desirability of purity testing to help clients calculate dosage of the substance they intended to use, thus reducing the risk of overdose.

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*… having that equipment would enable me to make a more accurate assessment of how much exactly I am taking of the intended substance and could refine my dosage even further there to avoid over-shooting the mark. (Client 10)*

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Stakeholders recognised that the ability to measure purity and test for a broader range of substances came down to the availability of funding for equipment. More sophisticated equipment which would facilitate quantitation of findings, such as gas chromatograph/mass spectrometers (GC-MS) or ultra-performance liquid chromatographs, incur costs approximating $200,000 per unit.

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*…they are doing the best job that they can with the tools at their disposal. I think that, of course, with better equipment, you're going to have more tangible results. You could look at purity. You'd be able to test for more diverse substances. I'm talking like GC-MS [2]as opposed to FTIR technologies. (Stakeholder 18)*

*The better the equipment, the better the outcomes, and the more expensive it is. FTIR is maximum 30 grand. GC-MS takes up a whole room and is insanely expensive. The sociopolitical hurdles we face just running it are the limitations, I reckon. (Stakeholder 2)*

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The fixed site services had originally leased a single FTIR spectrometer. With the Gold Coast site initially operating on a Thursday and the Brisbane site on a Friday, staff volunteered to transport the machine between the two sites.

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*…when the Gold Coast was open on a Thursday, we were having to ferry the FTIR back and forth from locations. Which meant that at the start of service and the end of service, we would have to set it up and then pack it up. So that requires an extra bit of time. Yeah, it definitely - you can feel the under resource there. (Stakeholder 21)*

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Additional funding was provided to enable lease of a second FTIR to support both sites opening on Fridays in response to demand. Even so, the single spectrometer per service impacted

[2] GC-MS: gas chromatograph/mass spectrometer; can identify and quantify a broader range of compounds, including at very low concentrations

testing capacity, limiting the number of people whose samples could be tested in the time available.

> *…we only had the one machine anyway, so we were still like the time limiter and we kind of got people in and out as fast as we could. So, I don't think it would have helped so much more I guess because we could only test the samples as quickly as one machine would allow. (Stakeholder 5)*

Such capacity constraints impacted wait times for clients, particularly during busy periods. As discussed in sections 3.1.1.3.1, total time spent at fixed-site services (including wait and intervention times) ranged from 6 minutes to 166 minutes, with a median of 38 minutes. Some clients commented that wait times were longer than expected for the service, while others found that time in the service allowed them to access other harm reduction information and learn about the services available. Some early clients, unfamiliar with the service, appear to have expected an 'instant' service, and were apprehensive about waiting.

> *…wait times were probably a lot longer than I had expected or would have liked. I was thinking it might be a 10 minute wait time. I think it was like a 40 minute wait time. (Client 22)*

This was particularly noted for festival settings, with concerns that longer wait times may have discouraged people from accessing the service. In response to this concern, CheQpoint allowed clients to drop samples and return later to collect results and engage in a health conversation. As seen in section 3.1.1.3.1, wait times were not recorded between sample drop-off and receipt of analytical results.

> *...the wait time got a bit long, and I think that kind of discouraged people because we just – we didn't turn people away but we told them to come back later …So, we did discuss if it would be beneficial to have two machines running parallel because then obviously you could get through everyone a lot faster. (Stakeholder 5)*

Total time spent in service at REL was similar to fixed sites, with clients spending a median of 30 minutes total in service (range: 5-125 mins), which appears consistent with the intervention times for EFF.

Funding for harm reduction information resources was not included in the service budgets, with partners supplying these materials in-kind.

> *…we basically provided the drug checking service with all of their resources, so that it actually had drug and alcohol information flyers within it, because that wasn't something budgeted into the original budget, to be able to develop harm reduction education materials.... so that all came out of my own funding from something else. (Stakeholder 10)*

#### 3.2.2.3 Staffing

The majority of paid staff at the services were employed as casuals, drawing significantly on personnel already involved with existing services due to funding capacity and the short time frame in which services were established. Stakeholders observed that this affected how many people could be recruited, made it difficult to cover shifts if a worker was absent, and increased training burden due to staff turnover.

> *We don't really have any long-term prospects for a lot of our staff. Maybe that's a good thing, we'll get lots of new people through, but it also increases that training burden. It would be great to look at sustainability, how we keep the service going with the resources that we have long term. (Stakeholder 4)*

Drawing on the chemists and harm reduction workers with previous drug checking experience benefited service delivery, reducing 'ramp up' time during service initiation.

> *...so we did have some chemists up from CanTEST [the Canberra drug checking service]. We certainly had we had three local chemists as well, who were sort of new to the process. We had quite a bit of experience to rely on there...Same for the harm reduction crew, harm reduction workers, quite a bit of experience. (Stakeholder 11)*

While chemists who worked within the services were skilled in analytical processes, extra training and support was needed to help them operate within a harm reduction setting.

> *I think the training aspect has taken a lot longer than I initially anticipated, and partly, that is not just the chemistry aspect, but the chemist interacting with the client, and communicating those results to the health worker and the client, which I think is a fantastic part of the service. It's great, but as chemists, that's probably not a skillset we necessarily already had. The development of those skills, and monitoring of those skills, has taken a lot more training time than I would've initially anticipated. (Stakeholder 4)*

##### *3.2.2.3.1 Workloads*

Workloads at fixed site and festival services varied across the service period. As the service continued and client visits increased, shifts working at the fixed site service became busier, which in turn impacted on staff ability to take breaks during service.

> *In the beginning, it wasn't too crazy because it was - not many people knew about CheQpoint, not many clients came through. The last couple of shifts I've done have been pretty much back to back from open until 5:00 or 5:30. I haven't had the chance to take a good break in the last couple of shifts. Which I don't mind, it's okay. But it's been very back to back. But it's not been anything too overwhelming. We've managed. (Stakeholder 2)*

This however varied between roles and settings, such that chemists at events found the workload easier to manage than the harm reduction workers.

*There was four chemists... to run the machine it only really needed realistically one chemist to physically run the machine. So, it was very easy to switch in and out, like if we needed breaks or interruption or needed time off. The workload was consistent, but it was easy to manage from the chemists' perspective… I guess from the harm reduction worker side, there was just a lot more clients than we were anticipating in terms of the screening process or the pre-interview questions. (Stakeholder 5)*

Observations were also mixed about the impact of hours worked in the service at a music festival.

*I mean, I think that for some of the other personnel, there was a bit of an issue of long hours. This was identified in follow-up debriefing, that potentially we just need to stagger shifts a little better with some of our workers to make sure that they're fine with it. (Stakeholder 11)*

*At the event, I thought that compared to some of the work that I've done at festivals, where you are working a 14-hour day, this felt the most like a normal job, of working from 10:00am 'til about 5:00-6:00pm and having a break in between. (Stakeholder 17)*

Initial estimates of workloads across roles may have been significantly below what eventuated. The workload involved in managing drug checking services, supporting staff and the combining of roles due to small staff numbers had ongoing impacts, with service staff acknowledging that much had been learned during operations to take forward into future implementation.

*We want to do a good job. It's really imperative. But if you look at the diary, I mean, probably this week alone, I've got maybe six hours of meetings just alone. Then we've got two casual peers who need support. You need support, timesheets, and all of those extra things that go with casual workers. It's easy if you've got a full-time - but you have - and then we don't have an existing pool of - so when someone's sick and you've got a casual worker, who's going to cover for them on a Friday night? (Stakeholder 7)*

*I think it's one day a week is the project management funding which is nowhere near enough, like particularly in the early days of the project… there's probably two roles squished in there. There's a project manager and then there's also leading of the health team and those are two different kinds of roles that we've just mashed together. So, each of those are quite big roles on their own. (Stakeholder 12).*

*You've got wages for social media since people don't work for free. A lot has been done in kind by all of us. Resources include printed flyers and advertising boards. The biggest cost is staff time, with many working voluntarily. Resourcing for this is way under where it should be, so budgets need to be reviewed (Stakeholder 19).*

Service staff noted that considerable work was required outside of operating hours for service planning, social media and marketing materials, event preparation, and particularly acquiring accreditation as a health service for one event. This impacted upon concurrent roles commonly held by part-time or casual staff.

*I've probably lost about a month, a month or even more, of my own time from my own role and projects, especially … for the [festival] rollout. I was on site … for an entire week. I was producing a lot of our marketing materials, a lot of our comms, before [we] were able to hire a person for comms, and that was just due to the timeliness of contracts and everything. So I've been this fill-in, step-in person a lot for the project, and I'm probably, yeah, easily five, six weeks now behind in my own projects and my own funding that I receive for different things. (Stakeholder 10)*

*I suppose the one thing that was a lot of work was accreditation… That's been the most time consuming thing by far. It took a lot more work, making sure that we were - had everything in place, provided all the evidence into the QIP portal and went through our assessment, which was two whole days. I want to say it's like quad fold how much work had to go into accreditation, compared to what had to go into deliver … services at one multi-day festival. (Stakeholder 9)*

#### *3.2.2.3.2 Volunteers*

In a limited funding environment, services drew heavily on volunteer and in-kind support to facilitate implementation of the dug checking services. Many workers were volunteers (particularly at events) or paid staff who worked additional unpaid hours. This included management, chemists and harm reduction workers.

*I think one of the challenges early on is that we had initially planned to have a single chemist in service, and I think, to try and maintain the flow of the service, and also to provide support to the chemist as they're training, that hasn't been feasible. So, we've moved to having two chemists per shift in the fixed site which, because we're not budgeted for that, we've been still operating off a lot of volunteer time. (Stakeholder 4)*

*We've got barely enough to just do the operational service delivery and actually not enough to do that which is why we still have voluntary chemists on every shift. But there's no resourcing to do anything beyond really just basic service delivery (Stakeholder 12).*

The high value and specialised training of the volunteer workforce, which included chemists, harm reduction workers and medical specialists, were noted.

*… some of those volunteers are people like an addiction medicine specialist who charges hundreds of dollars per hour and there he is volunteering his time for free. (Stakeholder 8)*

Some had chosen to volunteer as part of study or because professional requirements precluded them from being paid workers at events, but the reliance on volunteering was noted as an issue for service sustainability.

*Just taking that into account and being able to maybe pay enough core staff on the ground, so you're not entirely running just off volunteers, but also just the nature of festivals. (Stakeholder 10)*

*I have a regular job, and I'm doing this as a volunteer. The amount of time that I put in is probably a lot more than I had originally anticipated, so yes, it has had an impact. I don't think, long term, it's sustainable to have as much volunteer input as we do, so looking at the resourcing [is important]. (Stakeholder 4)*

*Having volunteers is fantastic. However, I do worry that we might eventually land up with a second-class workforce of peers working in harm reduction where their skills and efforts aren't being recognised… The more funding we do have, the more we'll be able to keep talented volunteers and teams together in the long, long term. (Stakeholder 17)*

Some volunteers working in senior roles, as well as some harm reduction and chemist workers, spoke of how their volunteer role at the service aligned with their professional employment outside of the service. Some chemists were completing post-graduate studies in chemistry and volunteered at the service for work experience.

*I'm happy to volunteer, firstly because I believe very strongly in drug checking, and I'm passionate about it. Secondly, ... it really benefits me to be involved this kind of cutting-edge area. Although it does add to my workload, I'm very happy for it to add to my workload. (Stakeholder 8)*

#### 3.2.2.4 Location capacity and design

*Fixed site services*

Fixed site services were co-located with existing harm reduction services at both locations, with significant in-kind support of space rental. This leveraged physical resources such as reception areas, counselling rooms, and site security, as well as allowing service provision to clients of existing services. Clients thus had access to dedicated waiting rooms, secure spaces for analytical work, and confidential areas available for the delivery of analytical findings and health conversations. Parking was available at the Brisbane service, with public transport options available within walking distance. At the Gold Coast service, on-site parking was extremely limited, and some public transport options were available.

*Parking was difficult, there was street parking just down the road. It was pay parking, which, that's just annoying, but onsite was very limited (Client 15).*

*They mentioned the location is out of the way. It's not for me since I live about 2km from the testing facility. But having more places spread across the Gold Coast would make it more accessible (Client 20).*

Service records indicate that 13% of fixed-site clients travelled from outside of Brisbane or the Gold Coast to access the services. At festivals, 25% of clients were from elsewhere in Queensland, suggesting a potential market for services in regional areas of the state. While the need for fixed

site services in other areas around the state was noted, the geographical size and spread of the population and the availability of specialist staff across Queensland pose challenges. Periodic pop-up services operate or are approved in other countries (Portugal, Greece, New Zealand) and may provide supplementary capacity.

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*Travelling to a major city for in-person testing is restrictive. Even the one in Bowen Hills can be difficult to access if people don't travel into the city (Stakeholder 5).*

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Implementation of a courier or mail posting service (such as that operating in Wales) was suggested as an effective solution for these locations, but would operate counter to the laws that preclude sending illegal items through the post.

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*For people, it depends on their location. Some regional areas won't get a drug checking service due to a lack of chemists, so they can't find staff. A courier or mail posting service would work well in those settings (Stakeholder 12).*

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Both clients and stakeholder interviewees made recommendations related to service sites. Some participants also suggested that the physical location could be improved to locations which are more central and easier to access. Having a service operating within the nighttime precincts in city centres was perceived as beneficial.

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*I don't think there are any disadvantages to having a drug check facility in every major town or city. I don't think it encourages more drug use. I think it encourages transparency and arguably reduces drug use or risky drug use (Client 14)*

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### *Event based services*

Location, layout and signage at events were seen as essential to encourage patrons to use the service. Stakeholders reported mixed experiences with this. At some events, the services were co-located with other health and support services, and the presence of drug checking was widely promoted by the event, both of which encouraged uptake.

At other events, signage was limited, which may have impacted clients uptake of the service as they were less aware of its presence at the event. Significant promotion of the service at the event, as was noted at the Earth Frequency opening ceremony, helped improve uptake of the service.

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*At Schoolies, we found that because our service wasn't situated on the site map and that was a decision that was not made by our teams, and unfortunately, we couldn't challenge or change that. (Stakeholder 23)*

*Well, maybe a bit better signage, especially at Earth Frequency. No one knew where they were because they were tucked into the back and there was no sign that said pill testing (Stakeholder 6)*

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Space available on festival sites was sometimes limited which, in turn, affected service capacity.

*Our space was smallish…I think the size of the space and the layout of the space could have been better… there would have been room for significant improvements in flow of people around the service so we didn't have bottle necks at the start ... the additional space to see people because oftentimes, you'd be sitting there wanting to see someone … but there just wouldn't be anywhere to talk to them. (Stakeholder 15)*

#### 3.2.2.5 Opening hours

Opening hours were affected by resourcing: in the latter stages of the service period, both fixed sites operated for four hours on Friday afternoons, similar to operations in the ACT. Within these constraints, the afternoon opening (2-6pm) appeared at least partially suitable, and later opening hours would have been constrained by staff and facility availability, with adjacent QuIHN services closing at 7pm. Both in-service client feedback and post-service interviews suggested that increasing operating hours would improve access to services.

*Consumers were saying, we want more hours. …What about people who work? What about people who can't get there on a Friday?... I know it was a trial, but we're almost December now and Brisbane has been so consistently busy with big wait times. Feedback every single week about needing more hours. (Stakeholder 10)*

*It's a shame that it's only open on Fridays because I had to wait a couple of days to get it tested. Some people might decide to use the drug before getting it tested, which puts them at risk. Ideally, I hope the facility can be funded to be open at least a few hours every day, or just weekdays. (Client 14)*

At events, opening hours were aligned with the festival program, typically afternoons, which appeared to work well within a contained setting and a 'captive' client base. The ability of clients (especially at EFF) to drop samples off and return later for results appeared to work well, particularly to ameliorate wait times.

#### 3.2.2.6 Promotion of services

Advertising, on social media or through analogue media, was pivotal to raising awareness of the services. Although some paid roles were budgeted, additional time was required and work was often done on a voluntary basis.

*...we've got a lot of social media happening and that's via QuIVAA, via The Loop Australia. So there's a heap of social media stuff going out...So yeah, so obviously you've got [wages] when it comes to social media, but people just don't do that stuff for free… There wasn't enough money. So, there's a lot of this stuff that's been done in kind, if I'm honest with you, from all of us. (Stakeholder 19)*

### 3.2.3 Key implications for implementation

**KEY IMPLICATIONS**

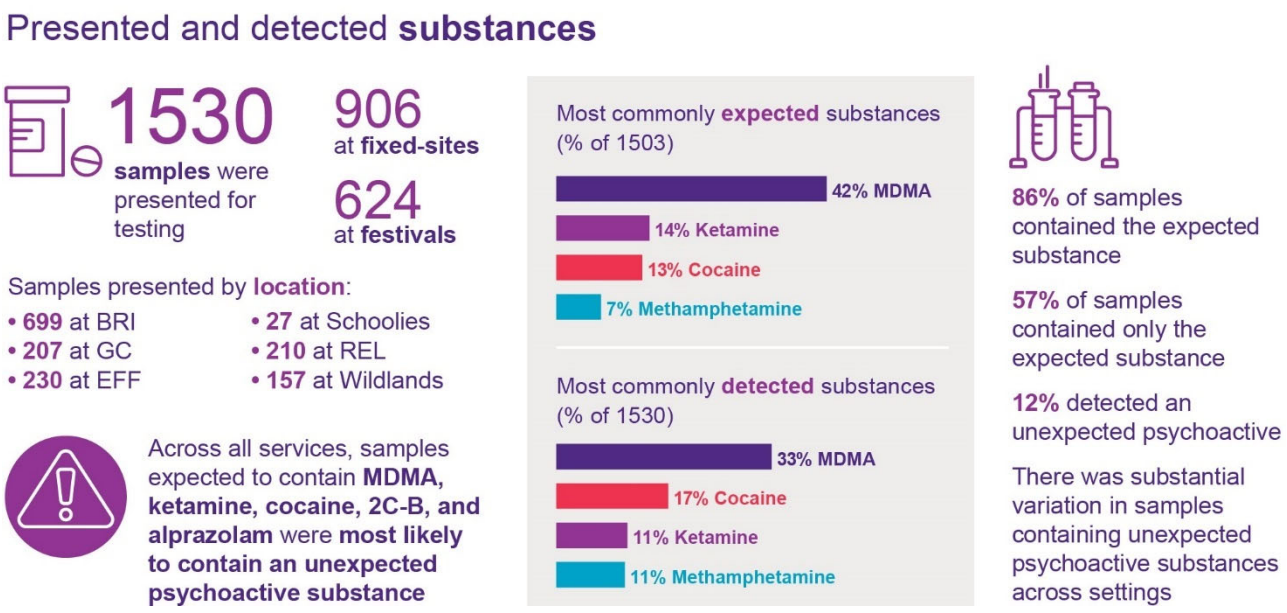
- Clear guidelines for service provision are helpful to ensure a high standard and consistency of service delivery across providers.
- Alignment of services with key government strategy assists with creating conducive legislative and policy environments.
- Long term planning and advocacy played a major role in effective implementation of drug checking services. Future iterations should allow for this planning time.
- Collaboration across the health sector and physical co-location with aligned services provide significant benefits to service provision and should be a feature of future services.
- Future capacity of services could be expanded with more funding, potentially from a range of sources, to increase access, staffing, available equipment and expand locations. Inclusion of a volunteer workforce is beneficial, particularly in the case of highly skilled professional roles, but heavy reliance on volunteering and in-kind support create challenges to sustainability and continuity.
- Longer service contracts would support extended service planning, staff retention and skill enhancement, and continuous service development.
- Consistent and ongoing promotion of services is important to maintain awareness and promote understanding of drug checking services, as well as to share the information generated. Future funding should make provision for this activity.

## 3.3 Service Outcomes

### 3.3.1 What did clients expect the substances submitted for testing to be, and what substances were detected by the drug checking services?

**KEY OBSERVATIONS**

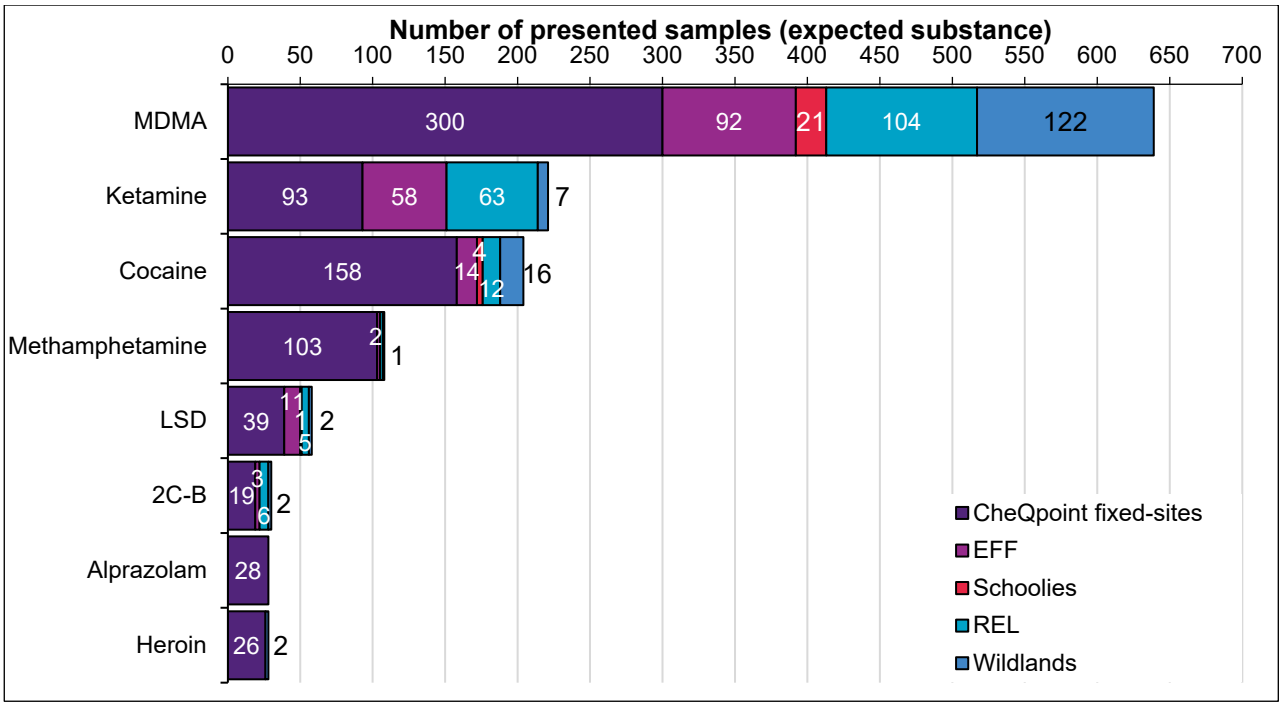
- The most common expected substances were MDMA (>600 samples), ketamine and cocaine (each >200), methamphetamine (>100), and LSD (>50).
- Samples expected to be meth/amphetamine, alprazolam, and heroin were presented at fixed sites but rarely at festival services.
- Substances other than those expected were detected in 25%-66% of presented samples. Unexpected psychoactives were detected in 4-24% of samples.
- Heterogeneity in substances presented was seen between fixed-site and event-based services, potentially reflecting differences in drug markets and substance use profiles of clients in different settings.
- The proportions of samples containing unexpected fillers were generally higher for cocaine and lower for ketamine and LSD. At fixed-sites, alprazolam had the highest proportion of unexpected adulterants; fewer heroin samples were presented but 1 in 3 samples contained unexpected fillers.




#### 3.3.1.1 Samples presented

Across all sites, MDMA was the most commonly **expected** substance, followed by ketamine, although distribution varied between fixed sites and festivals (Figure 8). At fixed sites, cocaine was the second most commonly expected substance; more festival samples were expected to be ketamine than cocaine. Samples expected to be methamphetamine (including amphetamine), alprazolam, and heroin were less commonly submitted at festival services than at fixed sites.

*Figure 8. Most commonly expected substances in samples across drug checking sites (Source: CheQpoint and PTA data).*




In addition to the substances shown in Figure 8, the following were commonly submitted (≥ five samples of each) across all drug checking services: MDA, mescaline, GHB, DMT, diazepam, modafinil, and tapentadol.

The distribution of **detected** substances at all fixed services and festivals combined was very similar to the distribution of expected substances, with an addition of most common fillers (cellulose, creatine, lactose, etc.).

Respondents to the follow up client survey reported expectations similar to the those recorded at fixed sites: the most commonly expected substances were MDMA (47%), cocaine (17%), ketamine (10%), and methamphetamine (7%).

#### *3.3.1.1.1 Complementary data*

The evaluation of the ACT's CanTEST drug checking service found that the most commonly expected substances were MDMA, cocaine, ketamine and methamphetamine, with a small proportion of samples (2%) expected to be benzodiazepines. Again, the detected substances followed a similar pattern, with the exception of benzodiazepines, noting that FTIR may have been limited in its detection of those substances.

We also compared presentations to the drug checking services (Figure 8) with the quantities of illicit substances present in Queensland wastewater samples during April and June 2024 (the most recently available data) to understand the extent to which substances presented at drug checking services reflected those used in the community.

Wastewater analysis findings are expressed as the mean number of doses per 1000 persons per day as an indicator of quantity used. Data from that period for Queensland show that cannabis was the most present substance in wastewater (120 doses/1000 persons/day), however the drug checking services were not able to test organics (e.g. plant matter), so cannabis was not expected in presented samples. Other substances most abundant in wastewater across that period were methamphetamine (40), cocaine (8), heroin (6), ketamine (5) and MDMA (1.7). Apart from heroin,

this profile was similar to that of presentations to drug checking services. Service information in the Client Characteristics section of this report suggest that few drug checking clients consumed heroin.

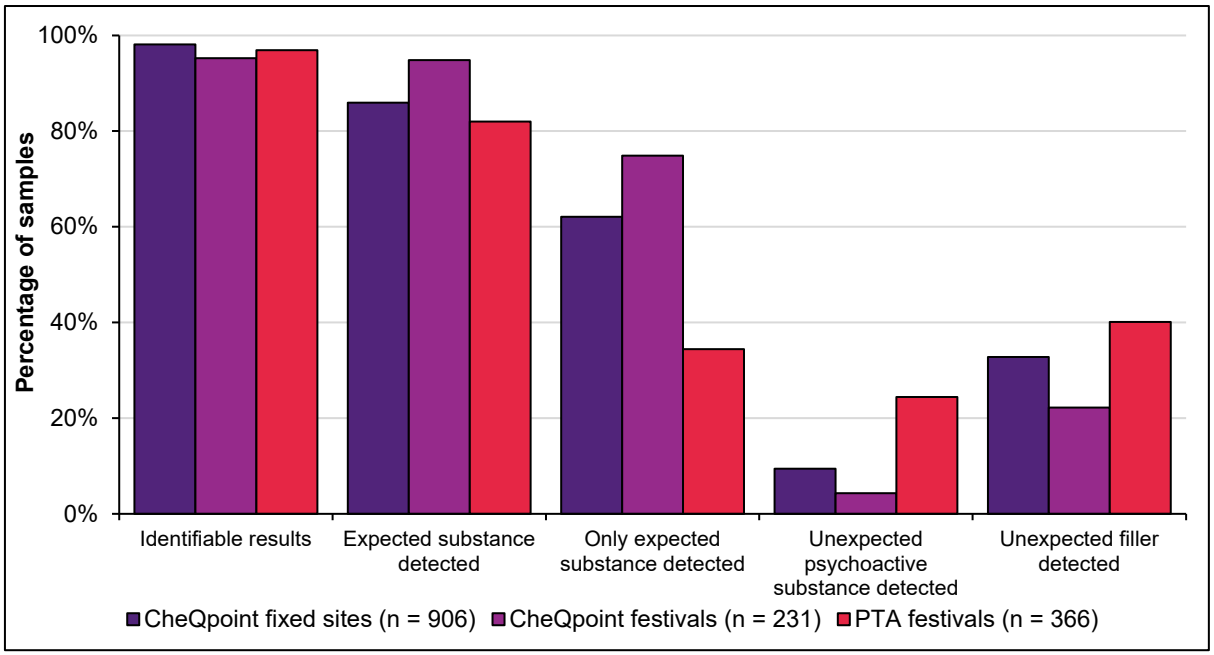
Drug Trends research reports on substances most commonly used by people who regularly use illicit drugs. Brisbane/Gold Coast findings for 2024 also reflected cannabis as the most commonly used substance. Methamphetamine, second most prevalent in wastewater, was also common among people who use illicit drugs (PWUD), more so those who inject than who use ecstasy and related stimulants, but was less reflected in drug checking. Heroin was similar; it appears people who use these drugs were less likely to present them for testing. The presence of "record levels of ketamine" in wastewater noted in the April/June 2024 reports appears to be reflected in the drug checking findings, whereas MDMA, although common in testing samples and among PWUD, may be less abundant in wastewater findings due to its more event-based and thus sporadic use.

#### 3.3.1.2 Concordance of test results with expectations

The vast majority of tests (95-98%) yielded identifiable results, i.e., one or more substances were identified in the sample. The detected substances showed a distribution similar to those expected, despite the frequent detection of unexpected substances, designated as either psychoactives or "fillers"(Figure 9). Fillers were classed as non-psychoactive, with many relatively inert (e.g., cellulose, lactose and sucrose) although some (e.g., creatine) may present other health risks.

The most commonly detected substances at fixed-site services were MDMA (33% of all submitted samples), cocaine (17%), ketamine (11%), and methamphetamine (11%). Testing also identified common fillers, including cellulose (8% of all samples), creatine (6%), lactose (4%), and sucrose (3%). Unexpected psychoactive substances were found in a significant proportion of samples. Notable differences were observed between fixed site samples and those from festivals.

*Figure 9 Broad results of drug testing (Source: CheQpoint and PTA data)*




Note: Samples were excluded where client listed no expected substance.

#### *3.3.1.2.1 Fixed-site services*

A total of 906 samples were presented to fixed sites. Among those with identifiable results, 86% contained the expected substance, and 62% contained *only* the expected substance, with no other psychoactive substances or fillers. In contrast, 9% of samples contained an unexpected psychoactive substance, and 33% contained an unexpected filler.

#### *3.3.1.2.2 Event-based services*

Figure 9 combines data from drug checking samples presented at festivals to CheQpoint (Earth Frequency, n = 204; Schoolies, n = 27) and PTA (REL, n = 209; Wildlands, n = 157) services.

CheQpoint: Similar to the fixed-site services, the majority of samples (95%) at CheQpoint festival services contained the expected substance. Three-quarters (75%) contained solely the expected substance, with unexpected psychoactive substances detected in 4% and unexpected fillers in 22% of samples.

PTA: Of the samples presented at PTA services, the expected substance was detected in 82% of samples. Only one-third (34%) contained solely the expected substance: larger proportions contained unexpected psychoactive substances (24%) and unexpected fillers (40%). This was consistent across the expected substances (see Figure 10).

Notably, the combined data from festivals (CheQpoint and PTA festivals) showed important differences in drug testing results compared to fixed sites. At festivals, less than 50% of tested samples were free of adulterants, whereas approximately 60% of samples tested at fixed sites contained only the expected substances. This discrepancy reflects a higher proportion of unexpected psychoactive substances detected at festivals (17%) compared to fixed sites (9%). Unexpected fillers were found in approximately one in three samples at both fixed sites and festivals.

Drug checking services in Europe also report significant variation between settings in substances presented and detected, and considered this indicative of variations across Europe in unregulated drug markets, as well as fluctuations over time and settings (Lisbon Addictions conference, 2024).

The substantial variation in samples across Queensland locations is likely to reflect fluctuations in the local unregulated drug market, as well as the different populations and drug use cultures associated with different settings. This variation shows it would not be possible to accurately extrapolate from one event to another to predict findings, which further highlights the importance of continued drug checking services as a market monitor as well as supporting provision of individual harm reduction support.

People who sell drugs may adapt their market strategies to capitalise on temporary, high-demand environments, such as music festivals. According to a recent systematic review, sellers of illicit drugs may decrease the purity of their drugs through the use of adulterants in order to maintain short-term supply, despite a significant increase in harm.(30) However the pre-event purchase reported by many festival attendees shows that variations in adulteration are likely to reflect broader market variation.

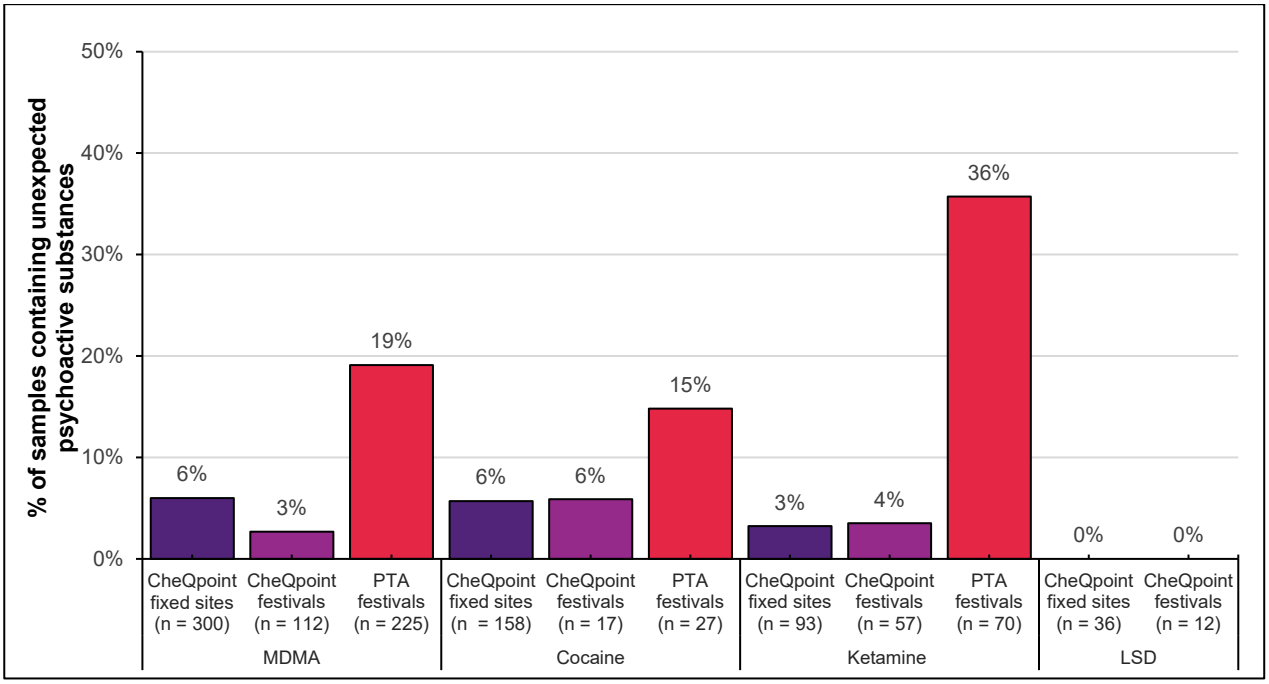
**Unexpected psychoactive substances and unexpected fillers in individual presented substances**

Analysis of adulterants present revealed notable differences between the most commonly presented individual substances (i.e. MDMA, cocaine, ketamine, and LSD), between services and between events.

#### 3.3.1.2.3 Samples containing unexpected psychoactive substances

Substantially larger proportions of samples at PTA-attended festivals contained unexpected psychoactive substances, a pattern that is consistent across the substances shown in Figure 10 (excluding LSD, which was uncommon in samples from these festivals), as well as the results presented in Figure 9. For example, while the proportion of ketamine samples containing unexpected psychoactive substances was below 4% at CheQpoint fixed sites and CheQpoint festivals, it was 35.7% at PTA festivals. As the testing modalities used were quite consistent across services and sites, this suggests heterogeneity in the drug profiles present across settings, potentially reflecting variations in the drug markets in different contexts or over time.

*Figure 10. Proportion of samples containing unexpected psychoactive substances among commonly presented substances (Source: CheQpoint and PTA data)*

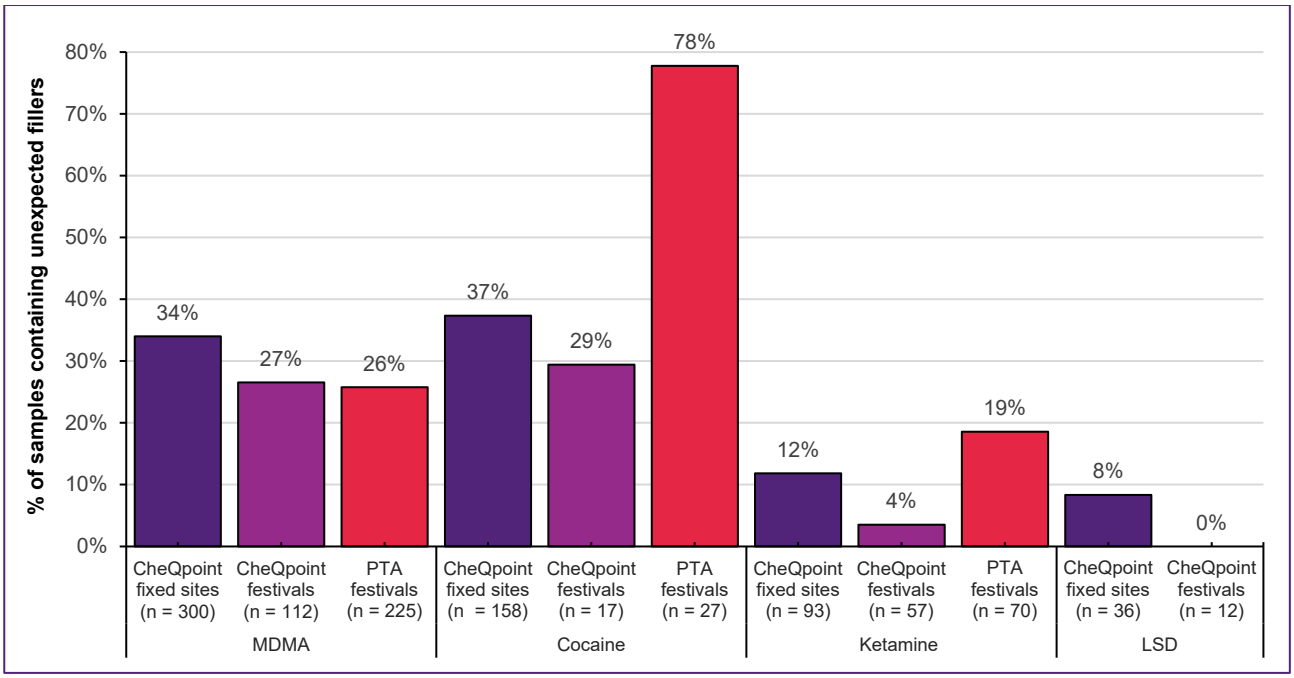



We also examined the detection of unexpected psychoactive substances in methamphetamine, alprazolam, and heroin samples presented at CheQpoint fixed sites, as these substances were uncommon among festival samples. Alprazolam samples most commonly contained unexpected adulterants (unexpected psychoactive substances: 36%; unexpected fillers: 96%). A relatively small proportion of methamphetamine samples contained unexpected psychoactive substances (4%) and fillers (96%), while no unexpected psychoactive substances were found in the smaller number of heroin samples presented, only fillers (36%).

#### 3.3.1.2.4 Samples containing unexpected fillers

Figure 11 shows that fillers were more likely to be detected in MDMA and cocaine samples than unexpected psychoactive substances (compare with Figure 10). While fillers were less commonly detected in MDMA samples submitted at PTA festivals compared to CheQpoint fixed sites, the reverse was true for ketamine and cocaine. At PTA festivals, 77.8% of samples expected to be cocaine contained unexpected fillers. The proportions of samples containing unexpected fillers were lower for ketamine and LSD compared to MDMA and cocaine.

*Figure 11. Proportion of samples containing unexpected fillers for most commonly presented substances (Source: CheQpoint and PTA data)*




### 3.3.2 To what extent were the services considered accessible, acceptable and useful by clients and other key stakeholders?

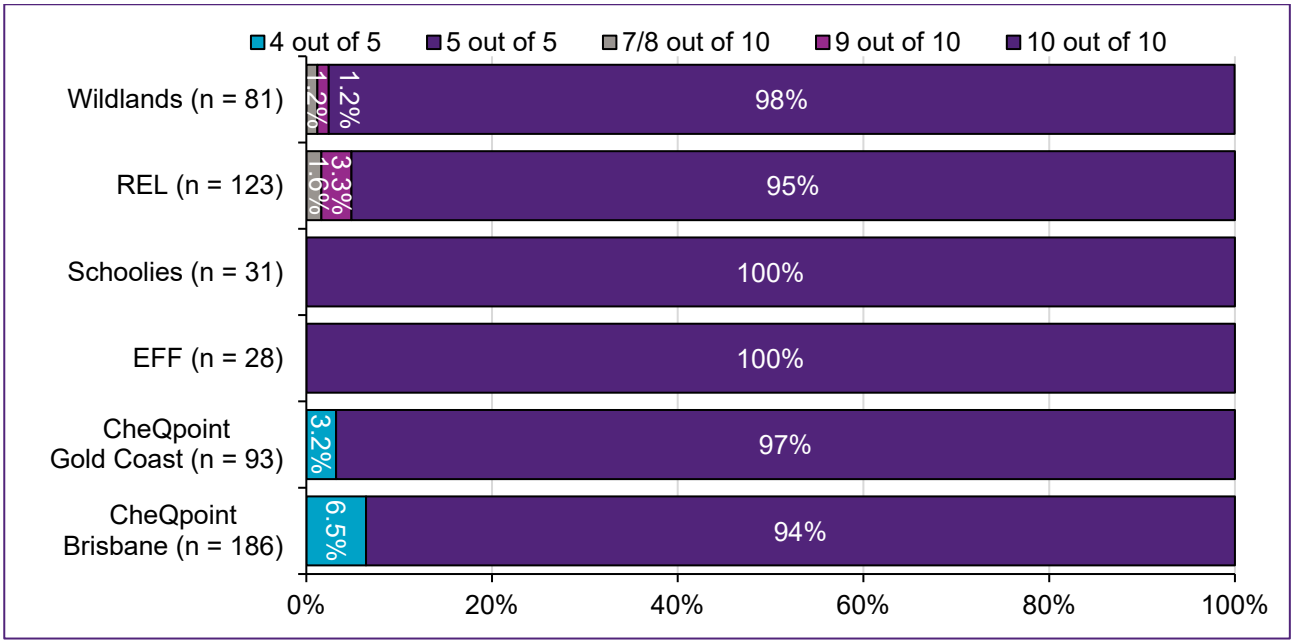
**KEY OBSERVATIONS**

- Service feedback was very positive across sites, with high levels of client satisfaction with both the staff and broader service. Staff were described as friendly, approachable, and professional.
- Overall, the services were viewed as being accessible, acceptable and useful, with many clients noting the importance and value of the harm reduction supports provided.
- Both clients and stakeholders stressed the value of the drug checking services in providing specialised knowledge and advice on improving substance use safety.
- Some accessibility concerns were noted, particularly with respect to wheelchair accessibility.

#### 3.3.2.1 In-service client ratings

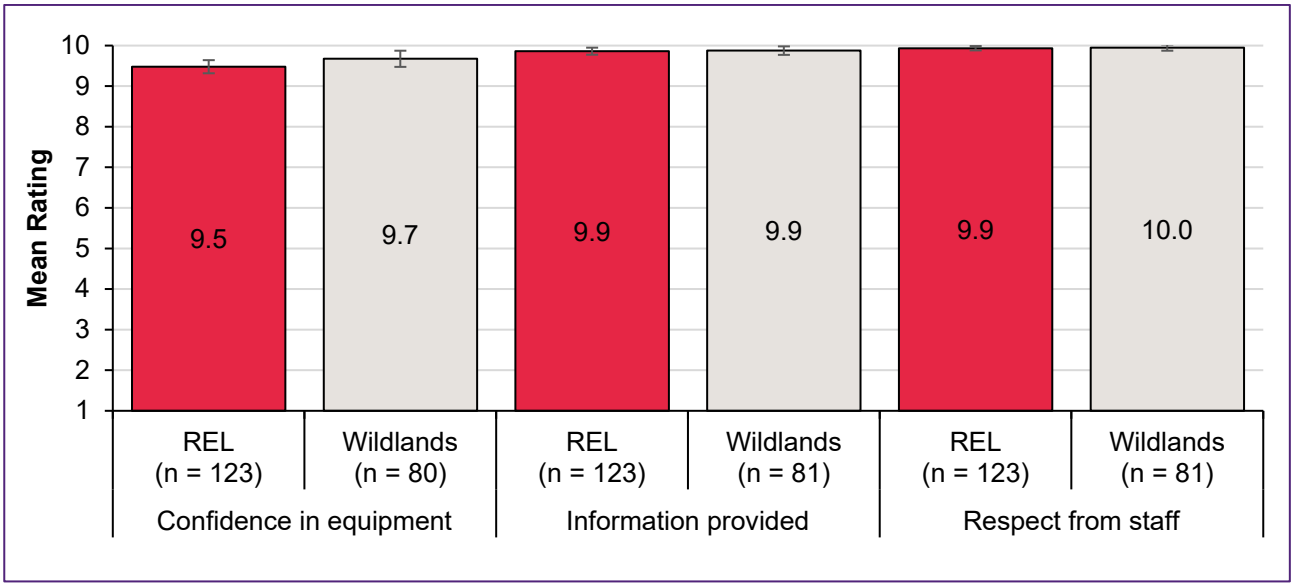
Service clients were asked to provide brief feedback at the point of service on their satisfaction with the drug checking experiences. Overall, client feedback for both fixed- and event-based services was positive, with 94–100% of clients rating services at 10 out of 10 (Figure 12). No significant differences were seen in average ratings across CheQpoint sites ($F(3) = 1.62$, $p = 0.185$) or across PTA sites ($t(202) = -0.34$, $p = 0.736$).

*Figure 12. Client satisfaction with drug checking services (Source: CheQpoint and PTA data)*




Clients at REL and Wildlands were also asked to separately rate their confidence with the equipment used for drug checking, their satisfaction with the information provided, and the respect received from staff (Figure 13). No clients rated the services below 5 out of 10, and the majority rated the service 10 out of 10 across measures. No significant differences emerged between REL and Wildlands sites (see Appendix 3: Detailed quantitative analysis, for further information).

*Figure 13. Mean client ratings of REL and Wildlands services (Source: PTA data)*




#### *3.3.2.1.1 Client written feedback*

Clients were also asked to provide free-text written feedback as they left the services (n = 404). No topical prompts were provided to elicit feedback on specific issues. Content analysis of these written responses revealed several strengths of the services. Almost half of the responses provided generally positive feedback on the services, with responses such as “Great service”, or “Fantastic

job". Other feedback explicitly reported that the staff were friendly and approachable (n = 87), and that the staff and service were informative (n = 59) and professional (n = 20).

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*Amazing staff from the reception to chemists to health workers. The entire experience was smooth comfortable and informative. (CheQpoint client, Gold Coast).*

*I was made to feel very comfortable, no judgment, all the staff were kind and approachable. I feel grateful this service exists and would like to see more clinics and more times during the week or weekend to access the service. (CheQpoint client, Brisbane)*

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Notably, 45 of the free text responses volunteered (unprompted) that clients felt safe in the service, and that it provided informative and valuable harm reduction opportunities.

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*It's a really great service, it will save lives, & should be available everywhere. (REL client)*

*Felt safe and comfortable, really appreciate the service. (Wildlands client)*

*Wonderful staff, very informative throughout the testing process. Great harm reduction. Hopefully it continues to be a service for people as it saves lives. (CheQpoint client, Brisbane)*

*Awesome service - thought that my stuff was suspicious so lots of peace of mind and able to make responsible decisions. (Schoolies client)*

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#### 3.3.2.2 Post-service client feedback

##### *3.3.2.2.1 Surveys*

In the Follow-Up Survey, clients also expressed very positive experiences with the drug checking services. The strongest agreement was expressed with the following statements: "I would recommend the drug checking service to friends", "I felt staff treated me with respect", "I would use the drug checking service again", and, notably, disagreement with the statement "I felt like staff treated me poorly because of my substance use", with 95% or more strongly agreeing (or strongly disagreeing with the last statement).

The vast majority of clients reported the service felt culturally safe, the information on how to reduce risks was easy to understand and helped them make decisions about their substance use, and that the information about testing results and how the service works was clearly explained. The lowest agreement was with statements that the service met their needs and that it was in a convenient location, though more than 9 in 10 of clients still agreed with these statements (a smaller proportion strongly agreed).

##### *3.3.2.2.2 Client and stakeholder interviews*

Overall, the services were viewed as being accessible, acceptable and useful. Drug checking was seen as a valuable tool for harm reduction, providing options and support for safer substance use.

Accessing drug checking services was generally considered trouble-free, but the Brisbane site had accessibility issues for wheelchair users due to stairs. However, a plan was in place to modify the service for those with accessibility needs. The Gold Coast site, while free of such issues, was a smaller space, which could also pose challenges.

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*I had no troubles accessing the service, but if anyone had a wheelchair and you had to go upstairs, it wouldn't have been accessible to them. (Client 15).*

*The Gold Coast lab, while it doesn't have those accessibility issues, the space that we're in is quite small. (Stakeholder 4).*

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Clients and stakeholders agreed that drug checking services should be considered an essential adjunct to primary healthcare. For parents, knowing such services exist offered reassurance as their children reached an age of experimentation. They recognised that GPs could not specialise in all aspects of health, and these services fill a crucial gap by providing expert knowledge on substance use safety.

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*GPs can't be expected to know everything, and having specialised services for substance use is important (Client 10).*

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### 3.3.3 Key implications at service level

**KEY IMPLICATIONS**

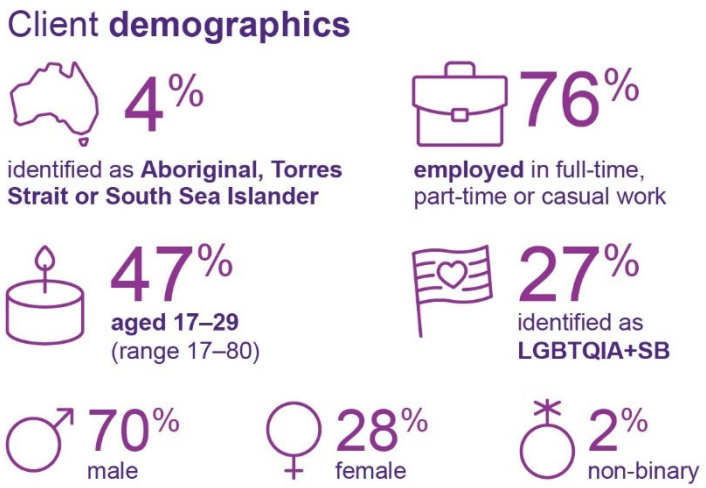
- The extensive presence of unexpected adulterants in samples underlines the value of harm reduction strategies offered to people who use drugs.
- Variation between substances and settings highlights the need to use sample testing to inform individualised harm reduction strategies.
- Variation between settings also shows it would not be possible to accurately extrapolate from one event to another to predict findings, further stressing the importance of continued drug checking services as a market monitor.
- Client satisfaction with services across a number of domains suggests a high level of acceptability and reflects well on the extensive co-design work undertaken in preparatory periods. Client feedback should continue to be monitored to inform ongoing service development.

## 3.4 *Client Characteristics and Outcomes*

### 3.4.1 What were the key characteristics of those who accessed the services, including demographics and substances used?

**KEY OBSERVATIONS**

- Drug checking services reached diverse client groups, including LGBTQIA+SB people, First Nations peoples and some older clients; 77% of CheQpoint clients reported some form of employment.
- Fixed site service clients were more likely to be local: event-based clients were generally younger and more likely to reside in other states or territories.
- Substance use patterns varied, but many festival clients indicated more sporadic than regular use. Polysubstance use was commonly reported. Injecting drug use was not.
- The use of prescription medications was widely reported, reinforcing the importance of conversations about the risks of drug-drug interactions.
- Clients reported a range of substance use and health concerns, including complex presentations requiring support from more experienced health workers.
- Services provided the first opportunity for many clients to connect with health supports.




A total of 867 clients consented to their data being used for evaluation purposes across the CheQpoint Brisbane (n = 396), CheQpoint Gold Coast (n = 109), EFF (n = 107), Schoolies (n = 17), REL (n = 135), and Wildlands (n = 103) drug checking services. Unless otherwise specified, demographic findings are reported as complete-case, with missing data excluded. Response categories with less than 6 responses are suppressed to maintain anonymity, with data from fixed sites, CheQpoint festivals, and PTA festivals combined (where relevant) in instances with small sample sizes. Statistical tests comparing demographics across drug checking sites are presented in Appendix 3: Detailed Quantitative Analysis.

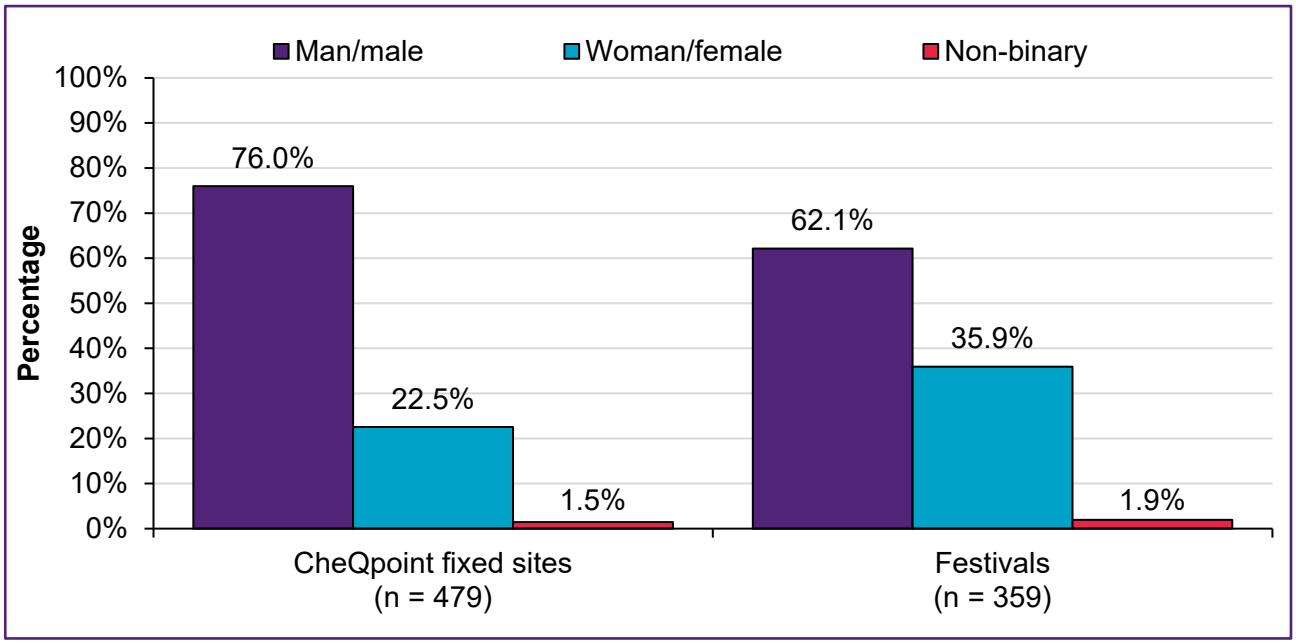
PTA data presented here comprises information on gender, place of residence, and age only, with the remaining demographics stemming solely from CheQpoint data.

These data are triangulated with findings from client interviews and surveys, and from complementary research data.

#### 3.4.1.1 Client demographics

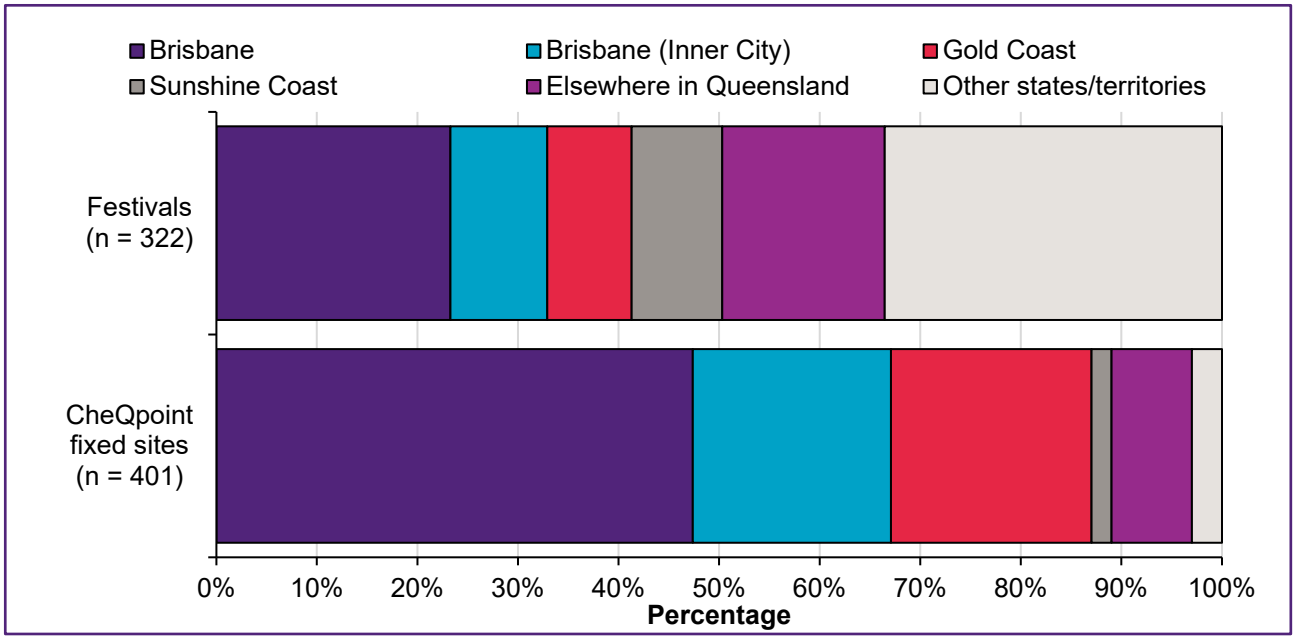
**Gender**. The majority of clients across services identified as men/male (70%; total n = 587) followed by women/female (28%; n = 237) and a small proportion of clients who identified as non-binary (2%; n = 14). Figure 14 displays the gender breakdowns for fixed sites and all festival sites (festival data are combined due to the small sample size of non-binary clients).

*Figure 14. Client gender across drug checking sites (Sources: CheQpoint and PTA data)*



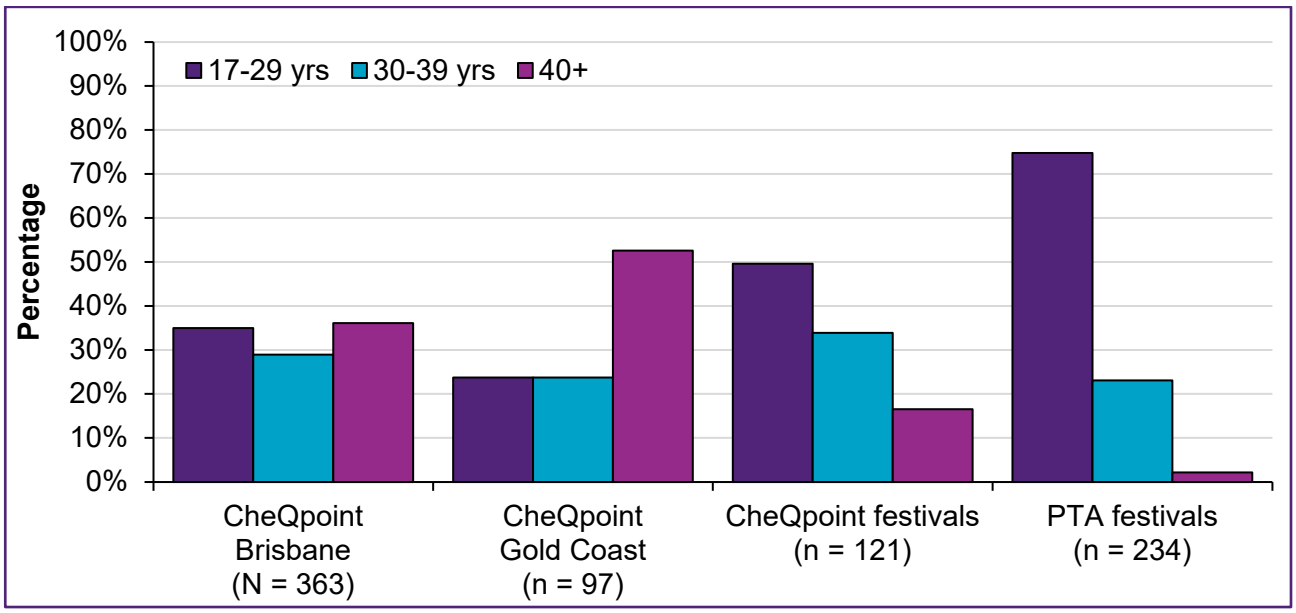

**Place of residence.** Figure 15 shows clients' place of residence across sites. Most CheQpoint Brisbane clients lived in Brisbane (85%), with small proportions travelling from the Sunshine Coast, the Gold Coast, and other areas of Queensland (including Ipswich, Moreton Bay, Wide Bay, Cairns, and Townsville). The CheQpoint Gold Coast site primarily served local clients from the Gold Coast (86%), with the remaining clients largely residing in other states or territories. Schoolies clients all resided in Queensland, mostly in Brisbane and the Sunshine Coast, unsurprising as the Schoolies Response is provided for Queensland school leavers. Non-urban festival services were more likely to attract non-Queensland clients. Over 2 in 5 EFF clients resided in other states/territories and over 1 in 3 REL clients resided in New South Wales. Only 17% of Wildlands clients resided outside of Queensland, potentially due to its location (central Brisbane) and single-day nature.

*Figure 15. Clients' place of residence across drug checking fixed and festival sites (Source: CheQpoint and PTA data)*



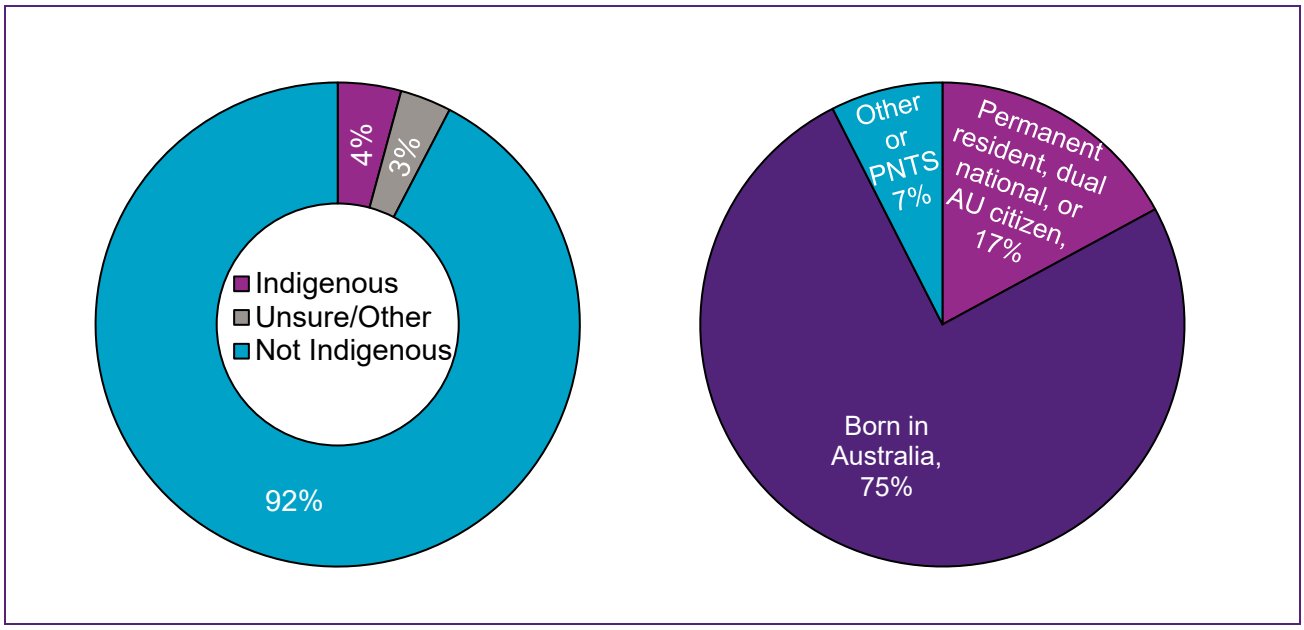

**Age.** Figure 16 shows that services catered to a wide range of age groups (from 17 to 80 years); 47% of all clients fell into the 17-29 age group, with 27% aged 30-39 and 25% aged over 40. More Gold Coast clients were older, and more at festivals were in the youngest group. The age profile of fixed site clients (60% under 39 years) is similar to that seen at CanTEST (69% under 34).

*Figure 16. Client age groups across drug checking sites (Source: CheQpoint and PTA data)*



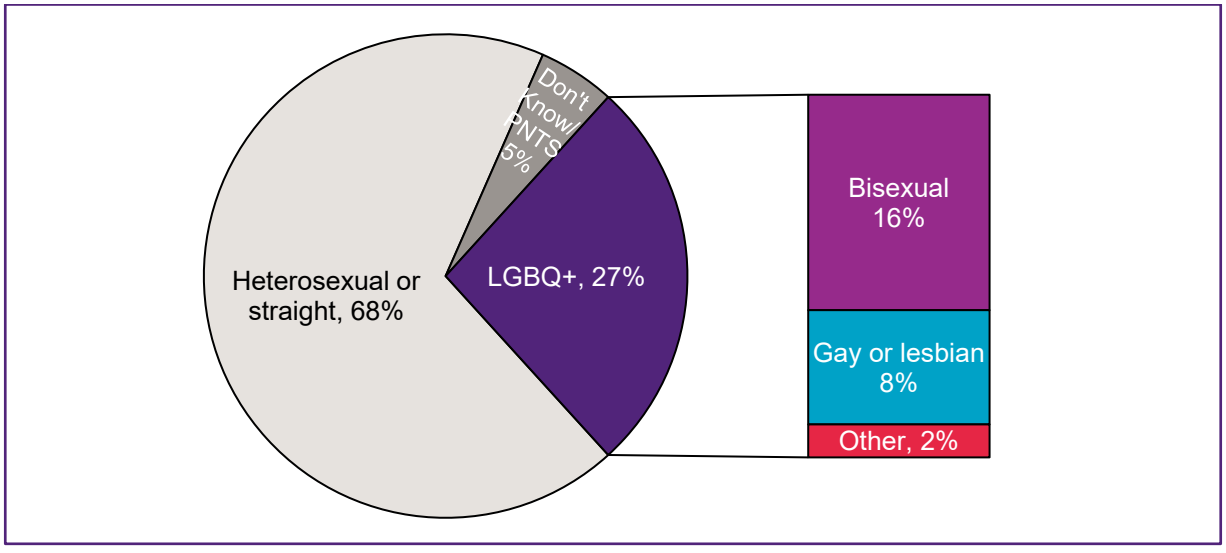

**First Nations and citizenship status.** Across CheQpoint sites, 4% of clients identified as First Nations, which is comparable to the general Australian population (~4%; see Figure 17). Most clients were born in Australia, with a smaller proportion having gained permanent residency or Australian citizenship. Other responses included clients on temporary visas and tourists or travellers. These items were not recorded at PTA services.

*Figure 17. First Nations (n = 614) and citizenship (n = 614) status of CheQpoint clients (Source: CheQpoint fixed-site and festival data)*



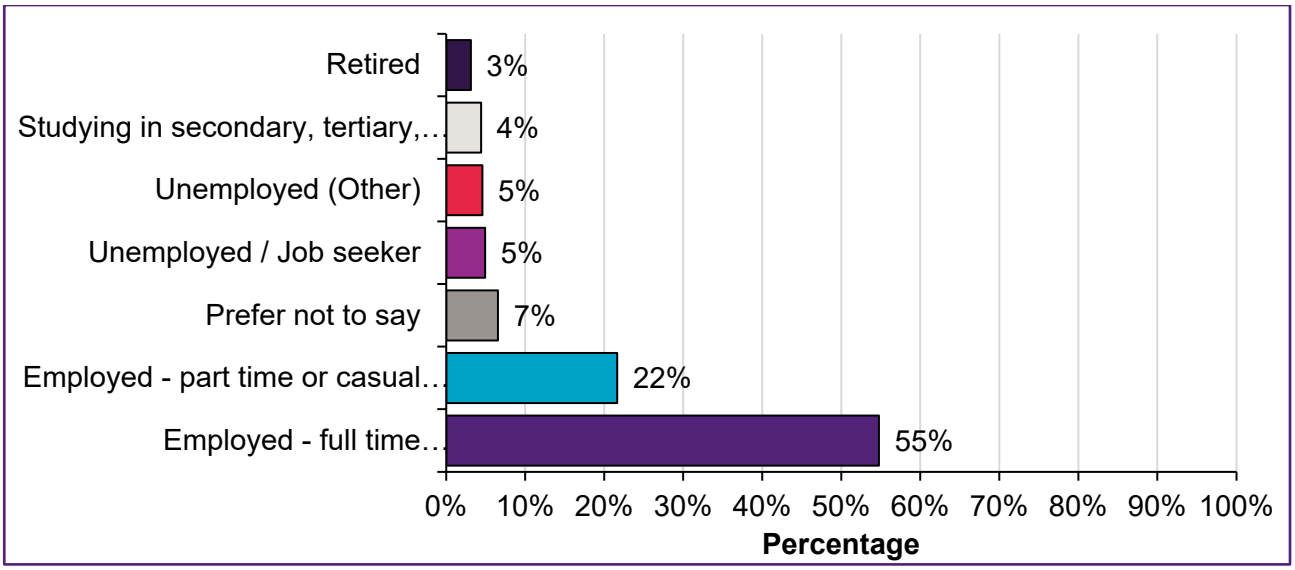

**Sexual orientation.** Figure 18 shows that over 1 in 4 CheQpoint clients identified as LGBTIQA+SB (27%; *n* = 165), with most identifying as bisexual or gay/lesbian. A smaller proportion identified as another sexual identity, including queer, pansexual, and demisexual identities. Sexual orientation was not recorded at PTA services.

*Figure 18. Sexual orientation of CheQpoint clients (n = 622; Source: CheQpoint fixed-site and festival data).*




**Labour force status**. Over half of CheQpoint clients were employed full-time, with a further 22% in part-time or casual work (see Figure 19). A smaller percentage were unemployed, retired, or studying. More Schoolies clients reported part-time employment (53%; n = 9). Further analyses suggests that CheQpoint clients without full-time or part-time employment were more likely to receive referrals to additional services, suggesting this smaller group particularly benefited from the service (further discussion in Section 3.4.4.5). Labour force status was not recorded at PTA services.

*Figure 19. Labour force status of CheQpoint clients (n = 610; Source: CheQpoint fixed-site and festival data)*




*Note*. Unemployed (Other) includes clients caring for family full-time, clients with long-term sickness or disability, and those for whom no response categories applied.

#### *3.4.1.1.1 Demographic differences across drug checking services*

We explored sociodemographic differences between clients at CheQpoint fixed sites, CheQpoint festivals, REL and Wildlands using regression modelling. Details of the modelling can be found in Tables A3 and A4 in Appendix 3. The results revealed several socio-demographic differences between fixed sites, festivals, and among individual festivals. More specifically:

CheQpoint **fixed sites**, compared to CheQpoint **festivals**, were more frequently attended by individuals over 40 years of age, those born in Australia, and residents of Brisbane and the Gold Coast.

When comparing **fixed sites** with **all festivals** (including Earth Frequency, Schoolies, Rabbits Eat Lettuce, and Wildlands), similar patterns emerged: festival clients tended to be younger, particularly aged 17–29, more likely to be women (more fixed site clients were male), and less likely to identify as non-binary or other genders. Festival clients were also more likely to reside in other parts of Queensland (than Brisbane and the Gold Coast) or in other Australian states and territories.

Among the festivals, **Rabbits Eat Lettuce** stood out for having a higher proportion of drug checking clients aged 30–39 and a greater share of residents from other Australian states and territories. **Wildlands** festival clients fell more into the youngest age group (17–29) and more resided in Brisbane. **CheQpoint festivals** (with the majority of clients from Earth Frequency) had a higher proportion of clients aged 30 and over, especially those aged 40 and above.

##### *Stakeholder observations*

During interviews, stakeholders observed that clients were from a wide variety of demographic backgrounds, including socio-economic backgrounds, age groups, and diversity of genders and sexual identities. They noted that the majority of individuals attending the service were male, and that there were few clients from culturally and linguistically diverse communities.

*It's actually, the crowd was a lot more diverse than I initially expected. Yes, we do, particularly early on when we were maybe having a slower start, the Needle and Syringe Program were recommending, or talking to their clients, and we were seeing some people coming in. But, quite a diverse group, from people who are very savvy recreational drug users, and just want a little bit more information, to people who are, I would say, more self-medicating anxiety issues, and have a lot of concern about the materials that they've been buying. (Stakeholder 4)*

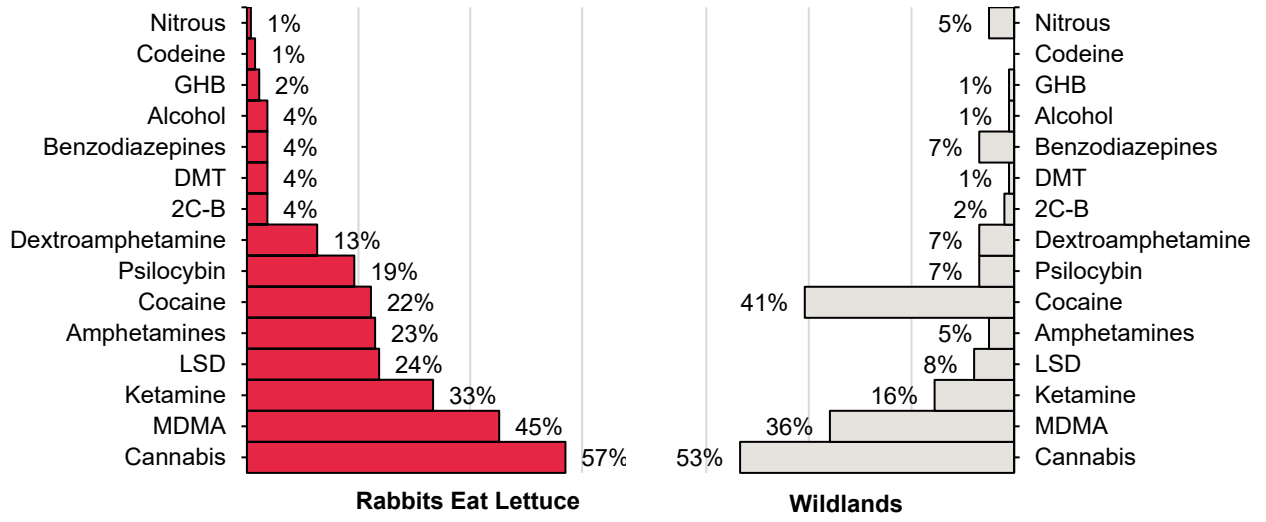
#### 3.4.1.2 Substance use prior to drug checking

PTA collected information about clients' substance use over the past month at both REL (n = 135) and Wildlands (n = 103). CheQpoint services did not record this information. Results indicate some differences in recent substance use profiles across festivals.

A significant proportion (1 in 5 clients at REL and 1 in 3 at Wildlands) reported no use over the month prior, suggesting their use was sporadic rather than regular. The remaining clients mostly reported use of 1 - 4 substances, with 8 individuals using more than 7 substances over the previous month.

The drugs most commonly reported by REL and Wildlands clients were cannabis, MDMA and ketamine (Figure 20). The proportion of Wildlands clients reporting recent cocaine use was almost double that of REL clients: recent use of LSD, amphetamines, and psilocybin was greater among REL clients compared to Wildlands clients.

*Figure 20. Substances used by clients in the month prior to festivals (Source: PTA data)*




Notes. Clients reporting no use in the month prior to the festival have been excluded from this figure

Survey participants reported largely similar profiles of substance use for the six months prior to attending a drug checking service: MDMA (67%), cocaine (56%), cannabis (49%), hallucinogens (LSD, DMT, mescaline, or magic mushrooms) (44%), and ketamine (37%). Fewer (16%) reported injecting drugs, most commonly methamphetamine. The relatively small proportion reporting injection suggests that people who inject drugs may be less represented in drug checking clientele.

Clients interviewed described using a similar range of substances prior to using the drug checking service, but also included ayahuasca, cathinones and a range of non-prescribed pharmaceuticals

(Xanax, codeine, oxycodone, Ritalin, Vyvanse, and Valium). Polysubstance use during the previous six months was identified in nearly four out of five respondents reporting any use, with approximately one in four reporting the use of five or more different substances.

These findings reinforce the need for harm reduction conversations to be tailored to individuals' substance use patterns, including information about regular use and potential drug interactions.

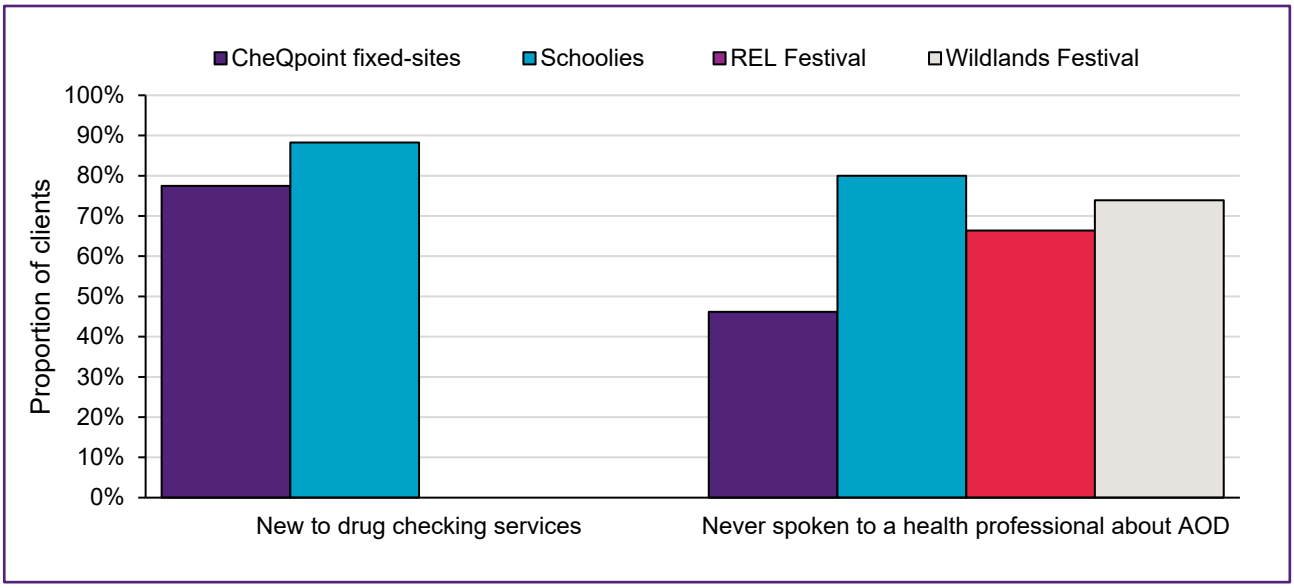
#### 3.4.1.3 Prior service use and health concerns

##### *3.4.1.3.1 Prior service use*

The drug checking services provided a first opportunity for many clients to engage with a health service about their substance use. Overall, over half (54%) of all clients had never before spoken to a health professional about their AOD use.

Figure 21 shows the proportions of novel service users across sites. As shown here, over 2 in 5 clients at the fixed sites had never previously discussed their AOD use with a health professional (46%). This proportion was higher among clients at event-based services (range: 66-80%), particularly the younger clients at Schoolies. Most fixed-site clients (78%) and Schoolies (88%) had not previously visited a drug checking service.

*Figure 21. Clients new to drug checking and AOD health services (Source: CheQpoint & PTA data)*

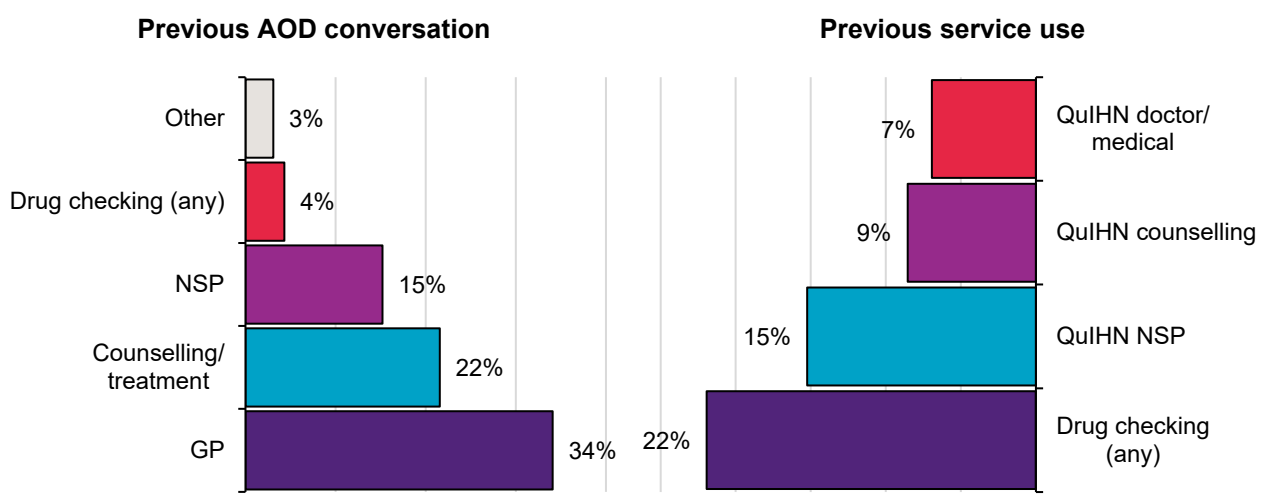



Staff of services made observations about clients' level of experience with drug use and familiarity with services. While some clients became regular users of the service across the evaluation period, other clients were service-naïve and limited in their drug use experience. Stakeholders emphasized the importance of the harm reduction conversations for more inexperienced clients.

> *People who don't have much drug use experience are the sort of people that we really, really want to have coming through because they're the ones who often haven't ever spoken with anyone knowledgeable about drugs before. They might have spoken with their mates but evidence suggests that they've very rarely spoken with a health professional, an expert about their drug use so capturing young people or drug use naïve people is an important thing. (Stakeholder 15)*

Of clients who *had* spoken to a health professional, most reported speaking to their GP, accessing counselling or treatment, or speaking to staff at a needle and syringe program (NSP; Figure 22). One in five clients (19%) at fixed sites, co-located with other QuIHN services, reported having previously used those services, including the NSP, counselling, and medical services, highlighting the opportunity provided by co-location with other health services.

*Figure 22. Prior service use types (n = 433) and AOD conversations (n = 487) (Source: CheQpoint fixed-site and Schoolies data).*




*Note*. "Other" includes psychiatrist, peer support worker, and other health professional. The sample size for drug checking (any) in the previous service use graph differs from the remaining services (*n* = 497).

For the clients who were interviewed and reported having previously spoken to a health professional about their drug use, a range of supports were described. Services included AOD specialists such as the Alcohol and Drug Support Service (ADIS), mental health providers through Better Access, or more general services such as Brisbane Youth Service. Contexts ranged from discussions of mental health concerns to being transparent about factors which could impact required medical care (including when the client was not concerned about their drug use).

> *I let them know because I feel like it's an important factor in my overall understanding of my health and I feel like you should always be truthful with your doctor and your therapist, but I've not ever asked like for support or help because I don't think my behaviour around drugs is worrying and I didn't think I was at a point where it was concerning (Client 6)*

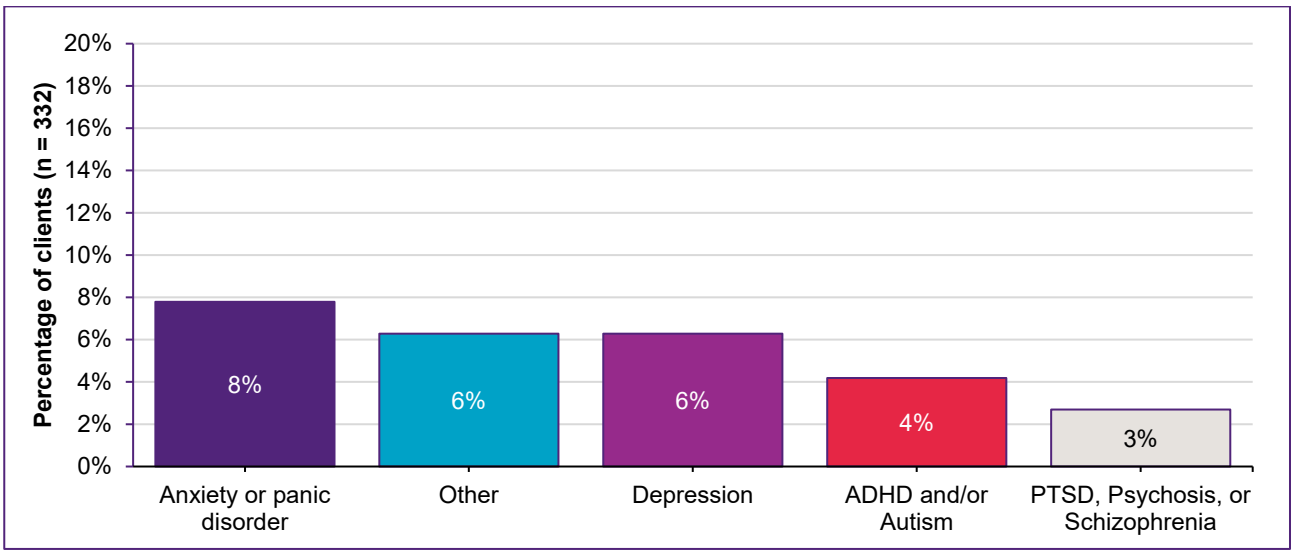
In contrast, other interview participants reported that they had not disclosed their drug use to medical professionals as they felt it was irrelevant to the concerns they were discussing.

> *I just didn't - it didn't feel relevant. I felt pretty knowledgeable and safe about what I was doing. (Client 8)*

#### 3.4.1.3.2 Health concerns

CheQpoint fixed-site and Schoolies clients reported on physical and mental health concerns (Figure 23) s part of data collected to inform health conversations. Of the 334 clients who provided this information, 1 in 4 (25%) reported a physical or mental health concern, most commonly anxiety or panic disorder, depression, ADHD and/or autism, PTSD, psychosis, or schizophrenia. Other concerns (6%) included chronic pain, diabetes, and sleep and substance use disorders.

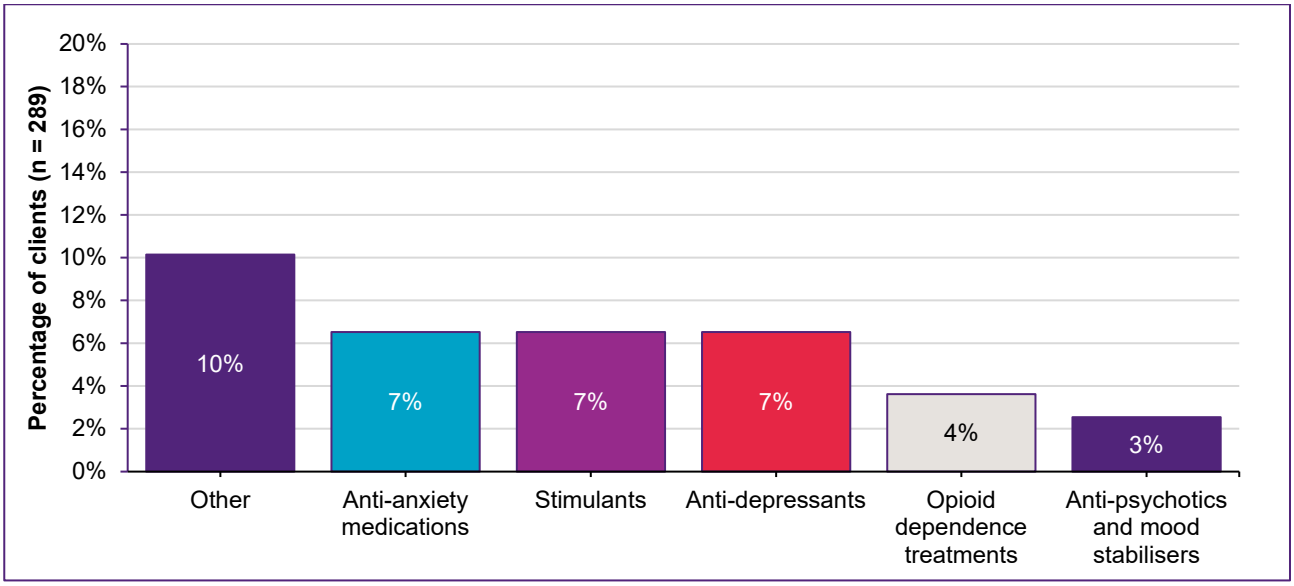
*Figure 23. Client reported health concerns (Source: CheQpoint fixed-site and Schoolies data)*




#### 3.4.1.3.3 Prescription medications

Of the CheQpoint fixed-site and Schoolies clients who answered questions about their prescribed medications (n = 276), almost 1 in 3 reported using prescription medications (32%), highlighting a cohort with higher risk of drug interactions, and the value of including such discussions in the health conversations. Consistent with clients' health concerns, most clients reported prescription anti-anxiety medications, stimulants (e.g., Ritalin), and/or anti-depressants. A small proportion reported prescribed opioid dependence medications (including buprenorphine, suboxone, and methadone), anti-psychotics and mood stabilisers. Other prescription medications included acne treatments, birth control, and pain management treatments.

*Figure 24. Client reported prescribed medications (Source: CheQpoint fixed-site & Schoolies data)*




#### 3.4.1.4 Complex presentations

The high prevalence of mental health concerns, chronic pain issues, non-prescribed use of pharmaceuticals and polysubstance use among service clients all suggest that health conversations offer value to the majority of service clients, as these conversations may include discussions about interactions between different illicit substances, with prescribed medications, and the risks associated with these. Although the original expectation of the health conversations delivered at the point of presenting drug checking results was to discuss harm reduction strategies and address any immediate concerns around substance use, a significant number of discussions at the fixed site services uncovered quite significant and complex challenges for clients.

The staffing mix present at the services enabled such needs to be addressed, often with the involvement of senior staff, but did require longer consultations than had been initially projected. The value of being able to have these conversations and offer relevant referrals, in some cases with clients who had not previously engaged with services, was very high.

*… it has helped us to identify people with complex mental health and drug dependence needs we've managed to refer on, so that wasn't – with hindsight, it seemed really silly to say we didn't expect this, of course we would experience this, but somehow, we didn't quite expect how many complex cases we would get. In some way that was an unintended consequence, that we've managed to meet the needs of people with serious mental health and drug dependence issues. (Stakeholder 8)*

*I don't know whether that's been highlighted very much, but some of those interventions with clients have been incredibly significant, like people who have quite significant mental health concerns, were particularly worried about their substance use and those interventions with the health harm reduction worker and with the peer workers as well and the referrals that have come from that, like we've had quite a number – a few people coming back regularly to get more support. (Stakeholder 13)*

Examples of clients engaging with the drug checking service to assess the contents of illicitly accessed prescription medications used to self-medicate for chronic pain or other ongoing health conditions emerged during the client and stakeholder interviews. For these clients, the services provided valuable health information and encouraged legitimate and appropriate use of medications.

### CASE STUDY: CHRONIC PAIN

In one case, a client reported using opioid pain medication illicitly to help manage chronic pain. They reported they received valuable information from the drug checking service about the impact of the long-term use of tapentadol, which made them understand their doctors' concerns about the amount of medication they were using to manage chronic pain. Ultimately, the tailored health information received at the drug checking service led to the client reducing their use of illicit opioid medications and looking to explore alternative legitimate methods to manage their chronic pain.

*I've been prescribed painkillers and the box was 28 tapentadol and the dosage was one 100 milligram tapentadol twice daily, but the doctor said he legally couldn't prescribe more than one box per month so I was taking it intermittently and as the pain got worse, I needed a further supply so I went down that avenue and, yeah. Then saw all the stuff about the nitazenes and whatever and was concerned, so I came in and got them all checked. (Client 18)*

*I've pretty much stayed away from those sorts of things and lowered the amount of opiate painkillers that I'm using, and really, I suppose, taking them from [unclear] to – not just the, I suppose, narcotic side of medications but medications in general, how they interact and how they affect each other and affect your brain. So yeah, I'm proactively reducing the amount of different medications that I'm using [and combining] and working out a way to function without them. (Client 18)*

### CASE STUDY: PERSON RECEIVING TREATMENT FOR CANCER

In a second example, a staff member described a client who attended the drug checking service to test the contents of cancer medications after they were unable to access treatment through legitimate means. The stakeholder reported that the client had purchased the medication overseas and wanted to have the contents of the medication checked before using it. The client had also reportedly brought in additional, illicitly purchased, prescription medications for other members of their family, including blood pressure medications. While the drug checking service was not able to test these substances, the substances were sent for additional testing, and service workers discussed the use of the medications with the client.

*But there's also been people coming through who have things like cancer and are getting cancer medications overseas. We had a person come in and he had a box of various different tablets, and it was cheaper for him and his family to get their prescription medications, things like blood pressure medications, things like that, overseas (Stakeholder 28)*

*There would be a lot that would have to end up getting secondary tested, and then they'd have to get some more results later. But it seems that people are very happy with the knowledge they've gotten [at the drug checking service]. I think there has been occasions where there was nothing in the substance at all, so they've just been scammed basically, which would happen a lot (Stakeholder 28)*

### 3.4.2 What were clients' motivations for using drug checking services?

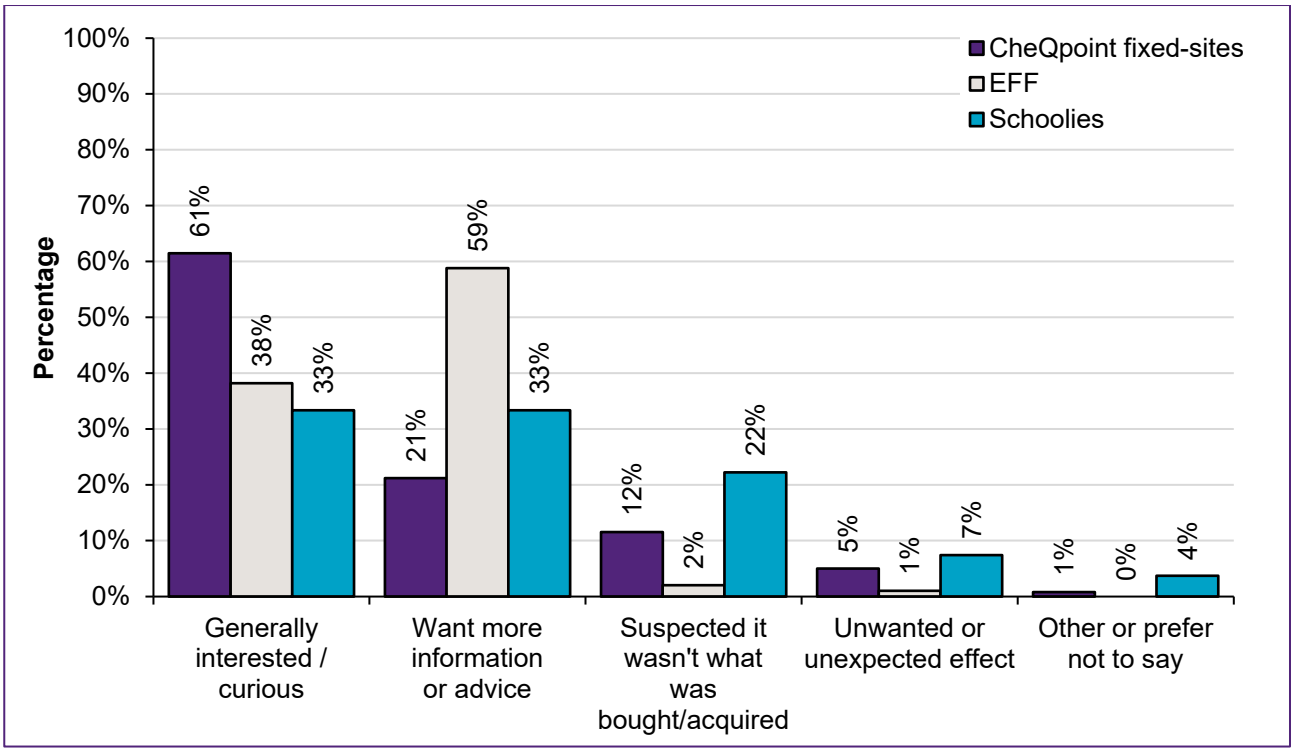
**KEY OBSERVATIONS**

- Most clients presented substances for drug checking because they were generally interested or wanted more information or advice. Some visited drug checking services due to suspicions about their substance, or having experienced a negative effect.
- Motivations differed based on the sample presented for testing: clients were most likely to report using the service due to suspicions about the substance when presenting 2C-B or alprazolam. Clients were more likely to report using the service due to unwanted or unexpected effects when presenting heroin, methamphetamine, ketamine or cocaine for testing. These concerns corresponded with the testing results: these samples were more likely to contain unexpected or unknown substances.

#### 3.4.2.1 Motivations for using services

Client motivations for using drug-checking services, as recorded in service data, varied across CheQpoint fixed- and event-based services (Figure 25). Of the samples submitted for testing at the CheQpoint fixed sites, over half were presented because clients were generally interested or curious, while only a small percentage of samples were presented due to unwanted or unexpected effects (5%). At both EFF and Schoolies, substances were most commonly presented because clients wanted more information or advice or because clients were generally interested or curious. A greater proportion of samples were presented at Schoolies due to suspicions about the drug (22%) or due to unwanted or unexpected effects (7%) compared to samples presented at EFF or fixed sites.

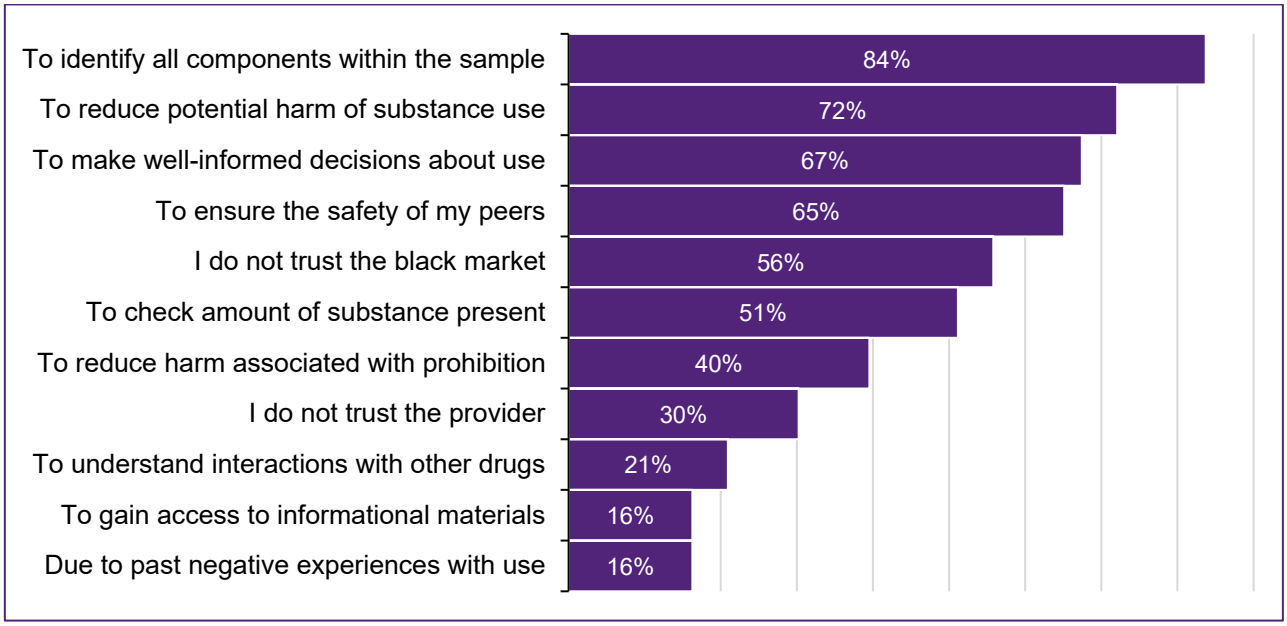
*Figure 25. Motivations for attending drug checking services (Source: CheQpoint fixed-site and festival data)*




Notes. Clients could only provide one reason for attending drug checking services.

We asked respondents who completed the Follow-Up Survey questionnaire about their motivations for attending drug checking services, providing a choice of more detailed motivational factors. The results are presented in Figure 26 below.

*Figure 26. Motivations for attending drug checking services (n = 43, Source: Follow Up Survey data)*



The most commonly reported motivations for attending drug checking services were to identify all components within the sample (84%), reduce the potential harm of using substances (72%), make well-informed decisions about their substance use (67%), and ensure the safety of their peers (65%). A lack of trust in the black market and providers also played a role for many clients. In interviews, clients noted that the service provided an important, credible source of information distinct from their usual sources of information.

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*We bought what we thought was ketamine and tested it with the reagent test kit and it came back with a – I guess, not a – not what a ketamine result would look like on a reagent test kit … So, then we took it to get tested and it wasn't either of those. It wasn't ketamine and it wasn't the one we thought it was. So, it was something completely different. (Client 13)*

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Participants expressed concern that the samples may contain harmful substances, including pharmaceuticals purchased overseas or on unregulated markets, and reported wanting to pre-plan the amounts they intended to use of the tested substance:

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*Because I was taking overseas generic prescription drugs and I was unsure of what they contained. (Client 18).*

*I only use it with my partner. We use it quite often. It was more so just seeing how potent it was. Because we hadn't used for a while, we didn't want to have too much of it. (Client 21).*

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##### *3.4.2.1.1 Where clients looked for information about drugs before drug checking:*

Clients who participated in interviews discussed a variety of sources used for information about drugs prior to using the drug checking service, but acknowledged that information from these sources could be unreliable. Online forums such as Reddit, consumer-driven websites such as Erowid, and medical sites were mentioned, along with discussions with friends. Other sources of information include the person who provided the drug/s, self-testing equipment (e.g., reagent testing strips), information from NSP services (such as QuIHN), peer-reviewed academic journal articles, and talking with a doctor.

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*A combination of searching online, conversations with friends. I try to diversify my sources even online … I go online and I research peer reviewed articles about this and that. Then even going on Reddit and having - there's lots of conversations on Reddit on people using drugs. Some of it's not reliable, but some of it's very illuminating and helpful. So I just try to search the most credible sources all the way to the most popular sources, everything in between. Then just conversations with trusted friends as well. (Client 8)*

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#### 3.4.2.2 Pro-active risk management

Interviewees noted using the service to care for their own health through managing risk, and the risk to others if they had submitted a sample that would potentially be used by other people. They expressed concern that the substances they had purchased may not be what they expected. For example, one used the service:

*For my own health and safety. That would be the number 1 reason, with respect to the substance I was getting tested and whether it was contaminated, how pure it was, whether it was actually something else. So I was motivated by my own health and safety concerns. (Client 14).*

The information provided by the service provided an avenue for clients to engage in harm reduction. For example:

*For us it's about safety, so we understand what is in what we're taking. Also, to learn a bit more, because we don't know everything about what we're taking and the internet only tells you so much. I found it really helpful to speak with professionals and also to have that counselling service at the end, where they ask you other questions. That's just an experience I've never had before, so for us, it's definitely about harm reduction. (Client 11).*

Another key motivation was to share information about the sample with their peers. For example:

*There's been occasions of someone who may be getting more large amounts of substances and maybe sharing that with other people who are accessing the service and that's been good too because that actually means a certain supply of that particular things is safer for a broad amount of people, which I think that's really important. (Client 13).*

*I'd use it to confirm what I am taking and what I'm putting into my body and also other people that I care about. (Client 19)*

#### 3.4.2.3 Negative experiences with substances

Several participants reported that they used the drug checking services because they had experienced an unexpected reaction to the substances submitted for testing:

*Because I was getting reactions to substances that you shouldn't get for that substance. I was using heroin, yet I was hallucinating and having a fit, which shouldn't be happening. (Client 28)*

Service staff also observed that clients had presented after experiencing adverse health effects from substances:

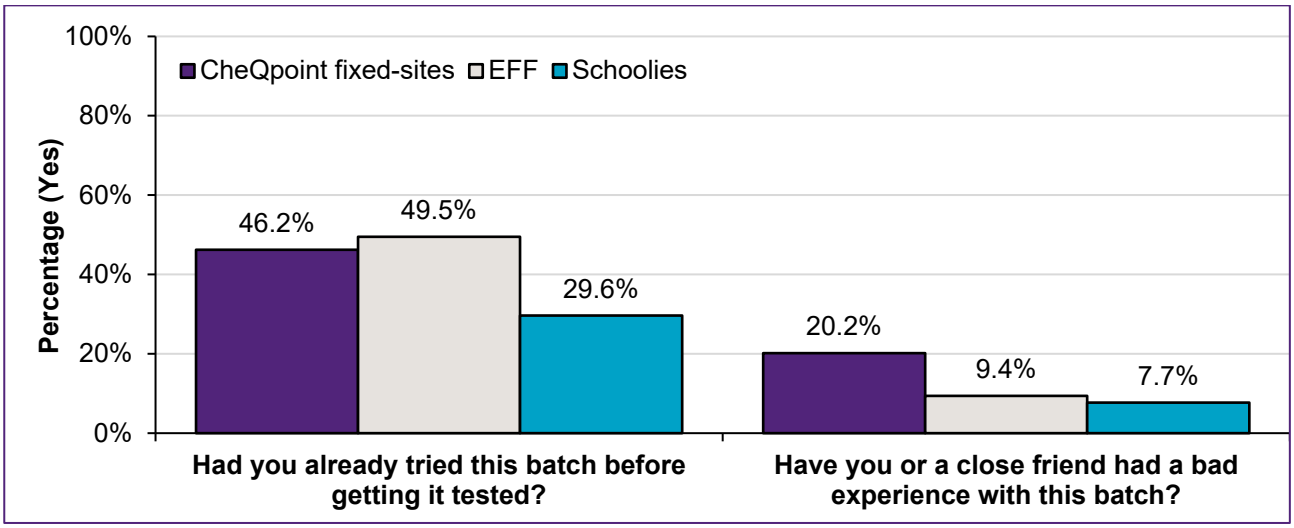
*A few people that are coming in after an adverse health incident, that they've taken something that they have felt that there's something else present. (Stakeholder 4)*

The drug checking service offered clients an opportunity to obtain information about the sample contents and methods for managing risks and reducing harm associated with substance use.

Figure 27 presents clients' experiences with the substances submitted for testing. At CheQpoint fixed-sites and EFF, just under half of the substances had been tried by clients prior to presenting the substance for testing. In contrast, only 27% of Schoolies samples had been tried prior to testing.

While few clients reported bad experiences with substances presented for testing, clients at the CheQpoint fixed sites were more likely to report having had negative experiences with the substance presented. Of the drugs presented to CheQpoint fixed-sites, 14% had caused disappointing or different effects, and 6% had caused clients or their friends to feel sick or unwell. Only 7% of substances presented at EFF had caused disappointing or different effects, with 2% causing clients or their friends to feel unwell, and 1% causing generally negative experiences.

*Figure 27. Client experiences with substance tested (Source: CheQpoint fixed-site & festival data)*




*Motivations for using services, by previous use and experience with substances*

Clients' motivations for visiting the services also corresponded with their experiences with the substances presented. Figure 28 displays the proportion of samples tried prior to testing by clients' motivations for using the service. At CheQpoint fixed sites, clients who had suspicions about the substance were much more likely to have tried the substance prior to testing. Smaller proportions of substances presented at events due to suspicions about the drug had been tried prior to testing.

*Figure 28. Client reported use of substance tested across reasons for attending the drug checking service (Source: CheQpoint fixed-site and festival data).*

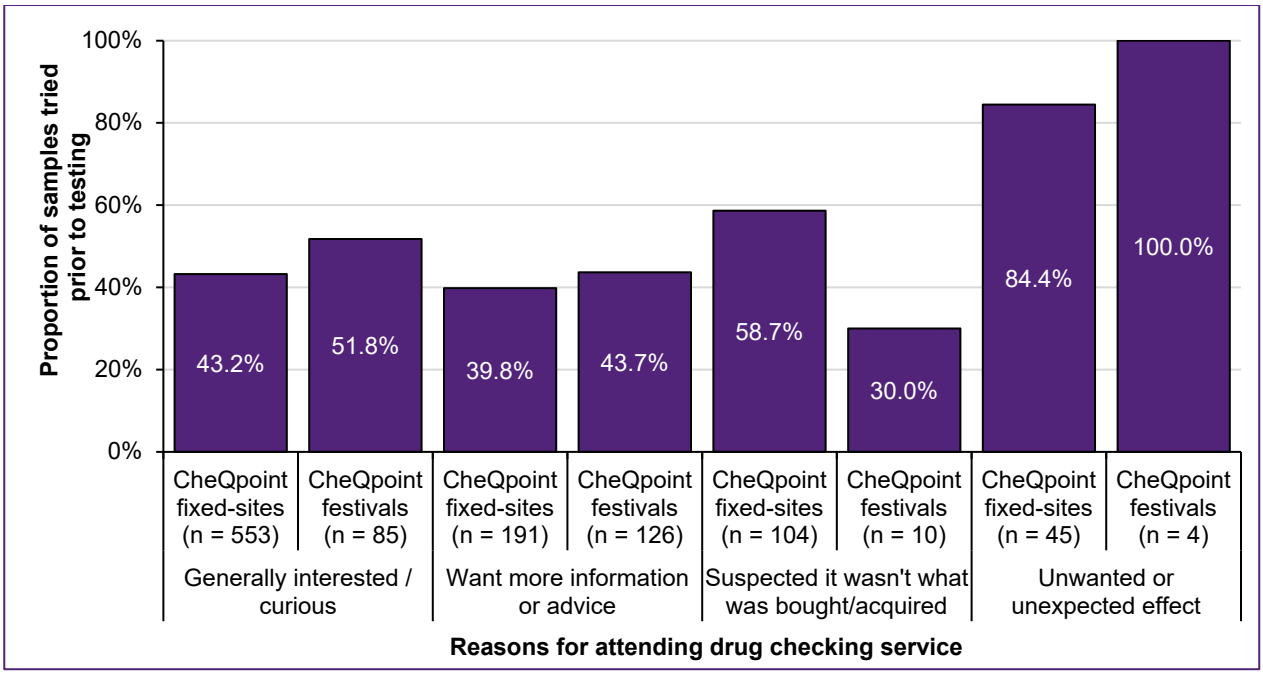
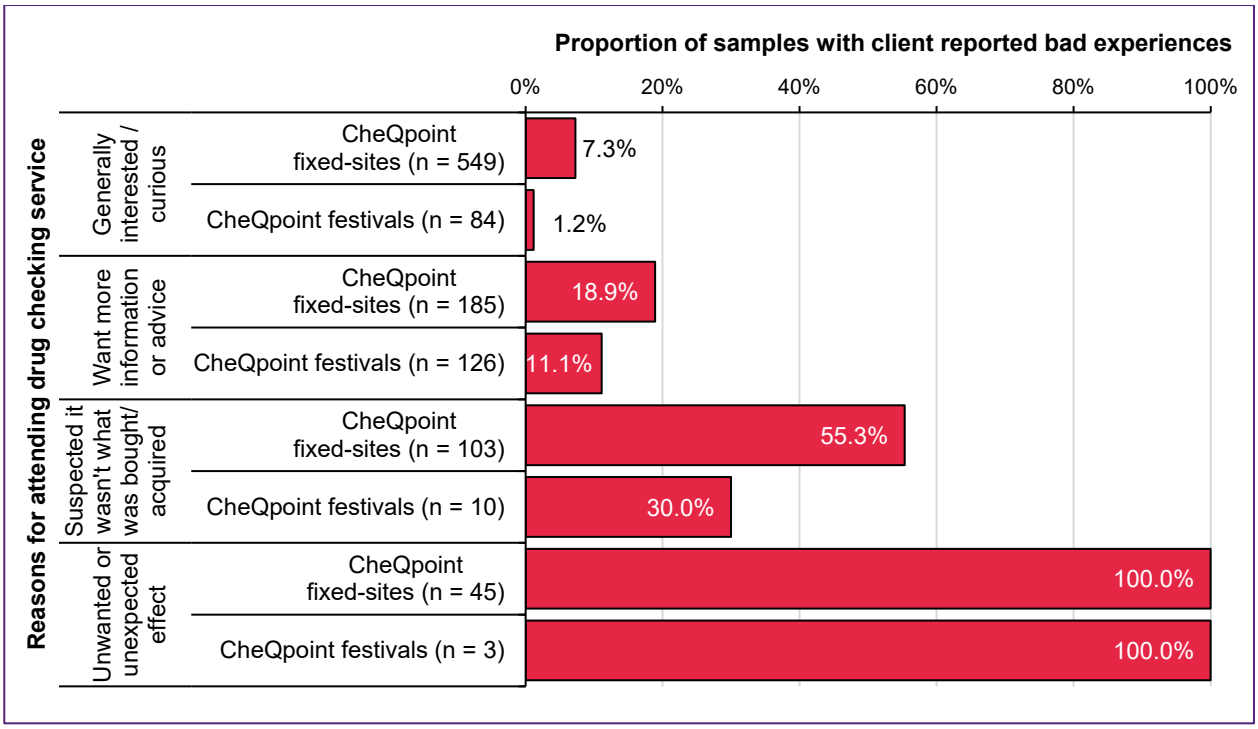



Figure 29 shows clients' reported negative experiences with the substances by their motivations for using the service. As expected, clients who used the drug checking service because they or a friend had an unwanted or unexpected effect exclusively reported having had negative experiences with the substances (100%). Clients who used the fixed-site and event-based services due to suspicions about the drug also reported more negative experiences, compared to clients who wanted more information or advice and clients who were generally interested or curious. Overall, Figure 28 and Figure 29 suggest two “types” of motivations for service use, with clients showing 1) general interest in receiving more information, or 2) suspicions or concerns about negative experiences with the substance prior to testing.

*Figure 29. Client negative experiences with the substance according to reasons for attending the drug checking service (Source: CheQpoint fixed-site and festival data).*

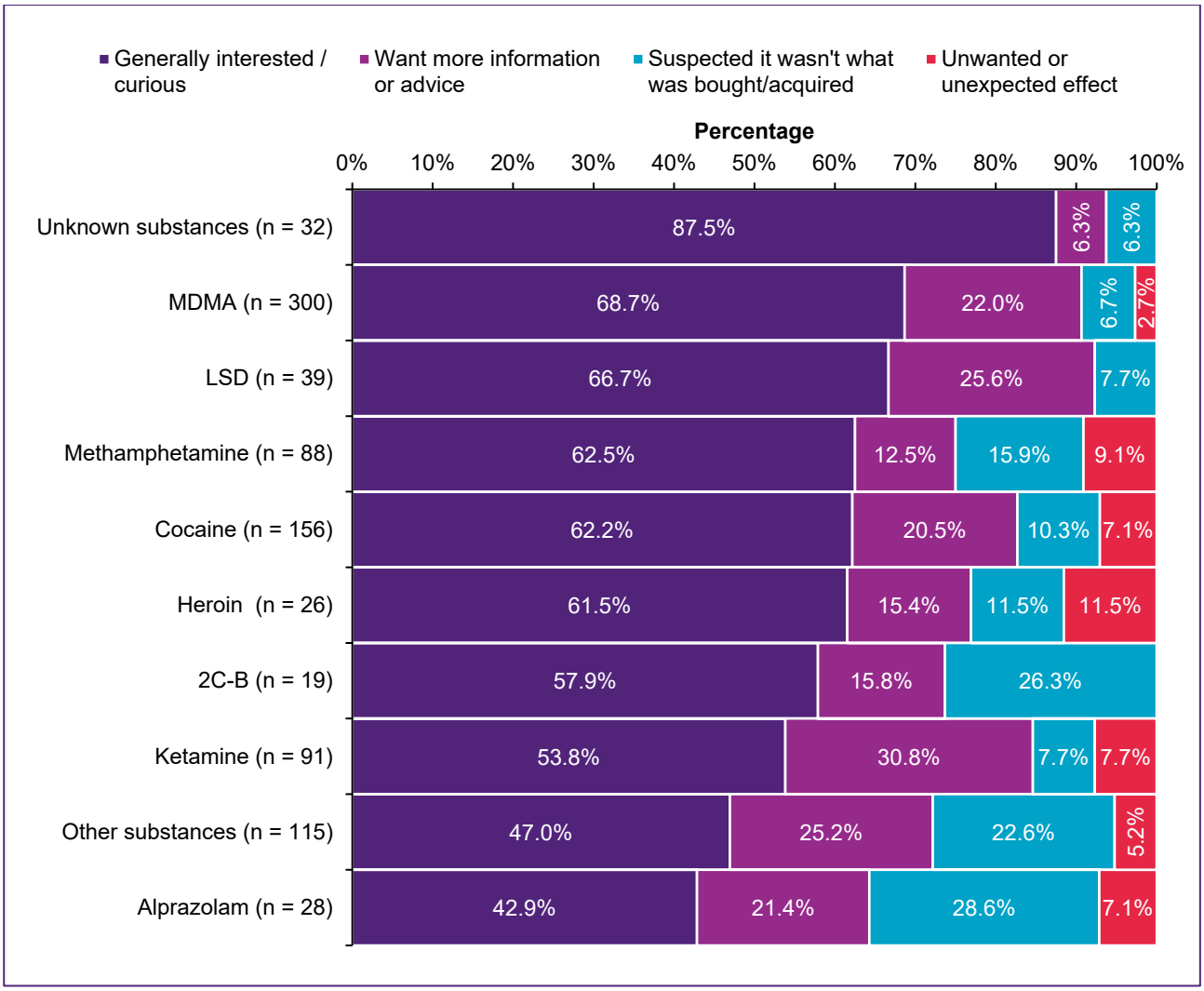



### *Motivations for using services by substance*

Figure 30 displays the motivations for testing the most common substances presented to CheQpoint fixed sites. Clients were mostly motivated by interest or curiosity when presenting unknown substances, MDMA, LSD, methamphetamine, cocaine, and heroin. However, clients presenting these substances also had suspicions about the drug in 6-16% of cases, most commonly with methamphetamine, heroin, and cocaine.

Clients were most likely to report using the service due to suspicions about the substance when presenting 2C-B or alprazolam. Critically, clients were more likely to report unwanted or unexpected effects when presenting heroin, methamphetamine, ketamine, cocaine, or alprazolam for testing, while clients presenting LSD, 2C-B, or an unknown substance did not report having experienced unwanted or unexpected effects.

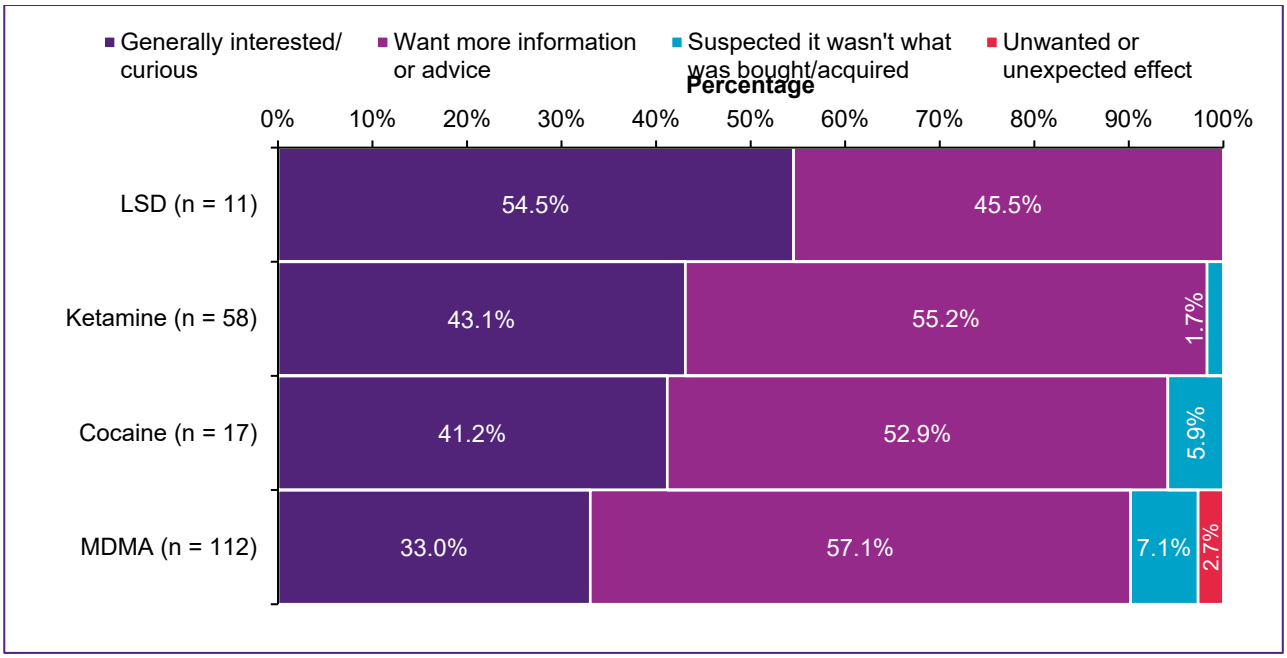
*Figure 30. Reasons for attending the drug checking service by substance tested (Source: CheQpoint fixed-site data).*




Notes. Clients could only select one reason for checking each substance.

Figure 31 shows the breakdown of motivations by substances presented at CheQpoint event-based services. While Tusi and LSD were mostly presented because clients were interested or curious, over half of MDMA, ketamine, and cocaine samples were presented because clients wanted more information or advice. MDMA, cocaine, and ketamine samples were the only samples presented due to clients' suspicions about the drug, while MDMA was the only substance presented for testing because of unwanted or unexpected effects.

*Figure 31. Reasons for attending the event-based drug checking services by substance tested (Source: EFF and Schoolies data)*




Notes. Clients could only select one reason for checking each substance.

#### 3.4.2.4 Trust in the knowledge and expertise of the service

Drug checking provides an important credible source of information that was considered trustworthy by clients. Clients highlighted the trust they placed in the expertise and knowledge of the drug checking service:

> *It's informative. I feel supported and safe and I can trust the people that are behind the desk. It's just something we've never had access to. So, all of a sudden, to have access to something that is only going to help me understand what I'm taking and understand the safety around that, and be able to open up the conversation if I do have concerns or questions, is incredibly valuable. (Interview 11)*

This participant described how the drug checking service played an important role as a healthcare provider specialising in AOD harm reduction:

> *…you can't expect every GP to know everything. Just in that GPs specialise in either reproductive health, or respiratory health, and that sort of thing - this is just another specialism that not every GP would actually be across. So I think having services that people know they can go to and that people there are going to know their shit, is quite important. (Client 10)*

Clients described the service as a more reliable source of information than their usual sources of information. They stated

> *Absolutely yes because they provide a non-judgemental, welcoming service, friendly as well. They provide a lot of knowledge that gives people enough information to*

*make a well-informed decision about whether or not they want to take drugs and it makes me feel like safer. Not necessarily that I will take the drug but if I were to take it, I feel a lot more confident about it. (Client 20).*

Four clients explicitly stated that they had attended to support the service. This client had attended a similar service elsewhere.

*I've used one of these services before overseas at a music festival and I saw the benefits of it there and was really – I guess I was told about the benefits of it and got to see it in action and saw how safe the music festival was as a result. When I heard about it here, I was absolutely delighted to hear about it and happy to support it and really wanted to see those numbers grow and make it work. (Client 29).*

These clients explicitly stated that they attended because they would like to see drug checking services continue in Queensland:

*To support it because I think it's good to do. Like it's a good harm reduction thing to have in place. If people are using it, then it might keep going. (Client 1).*

*I think mostly it was like because I think it's a really valuable thing, and I felt that the more people used it, it creates supply and demand, so that like it could be rolled out across all festivals. So it was less about actual concerns for the drugs that I was consuming myself, and more about just – yeah, like boosting the numbers so like funding would be increased and things like that. (Client 6)*

### 3.4.3 Did any potential client groups experience barriers to access of the services?

**KEY OBSERVATIONS**

- Clients in full-time employment or needing to travel to the services noted difficulty accessing drug checking.
- Although some interviewees perceived a lack of client diversity, service data showed significant representation of First Nations, LGBTIQA+SB clients and different age groups. Few people who inject drugs appear to have used the services.
- EFF attendees who *did not use* the service reported concerns about privacy, being seen by others, and worries about getting in trouble with the police as primary barriers to visiting the service. These concerns mirror those of other stakeholders, who noted that groups that have more contact with the police or negative perception of policing may be concerned about using the services.

#### 3.4.3.1 In-service feedback

While most CheQpoint and PTA clients provided positive feedback on the services, clients also identified some access barriers. Specifically, 117 CheQpoint fixed-site clients (out of 245

responses; 48%) reported suggestions for improving access. A smaller proportion of PTA (*n* = 22 of 115; 19%) and CheQpoint (*n* = 9 of 44; 21%) event-based clients provided suggestions.

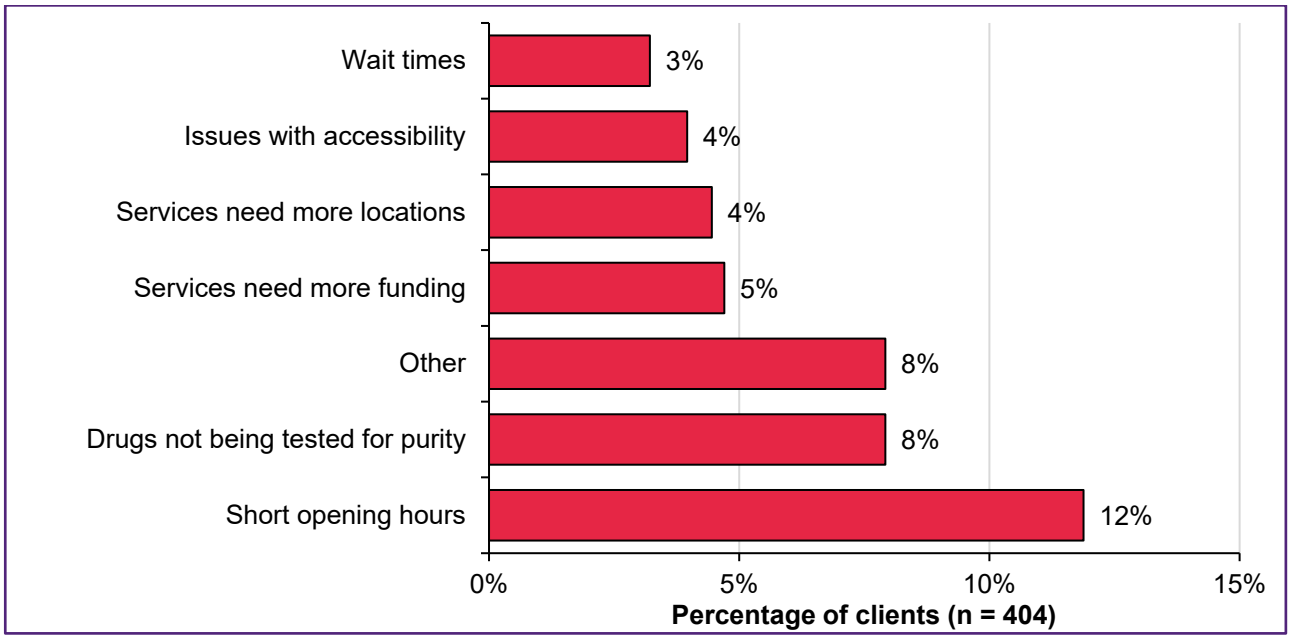
As shown in Figure 32, clients largely noted issues related to opening hours, a lack of purity testing, funding for the services, and service locations. This feedback largely stemmed from CheQpoint Brisbane clients who were travelling to the service and those working full-time:

> *More opening hours would let me use the clinic much more as it can be hard to make with my work commitments. (CheQpoint client, Brisbane).*
>
> *Maybe open more often to allow people better access to your services. (CheQpoint client, Gold Coast)*

Some clients also reported issues with long wait times and accessibility, with suggestions to improve signage, parking, and services in other towns and cities (e.g., Southport) to increase awareness of the services and make them more accessible. Other suggestions included providing drug checking result reports to clients, further advertisement, and text-based emergency alerts for unexpected detections. Finally, a small proportion of REL clients reported unique barriers not identified at CheQpoint sites, including concerns about privacy and police presence.

> *Police presence during the day were within 50m of the service and created barrier to accessing service. Came back later. (REL client)*

*Figure 32. Client suggestions for improvement across sites (Source: CheQpoint and PTA data)*




#### 3.4.3.2 Reasons for not using the service: Earth Frequency Festival

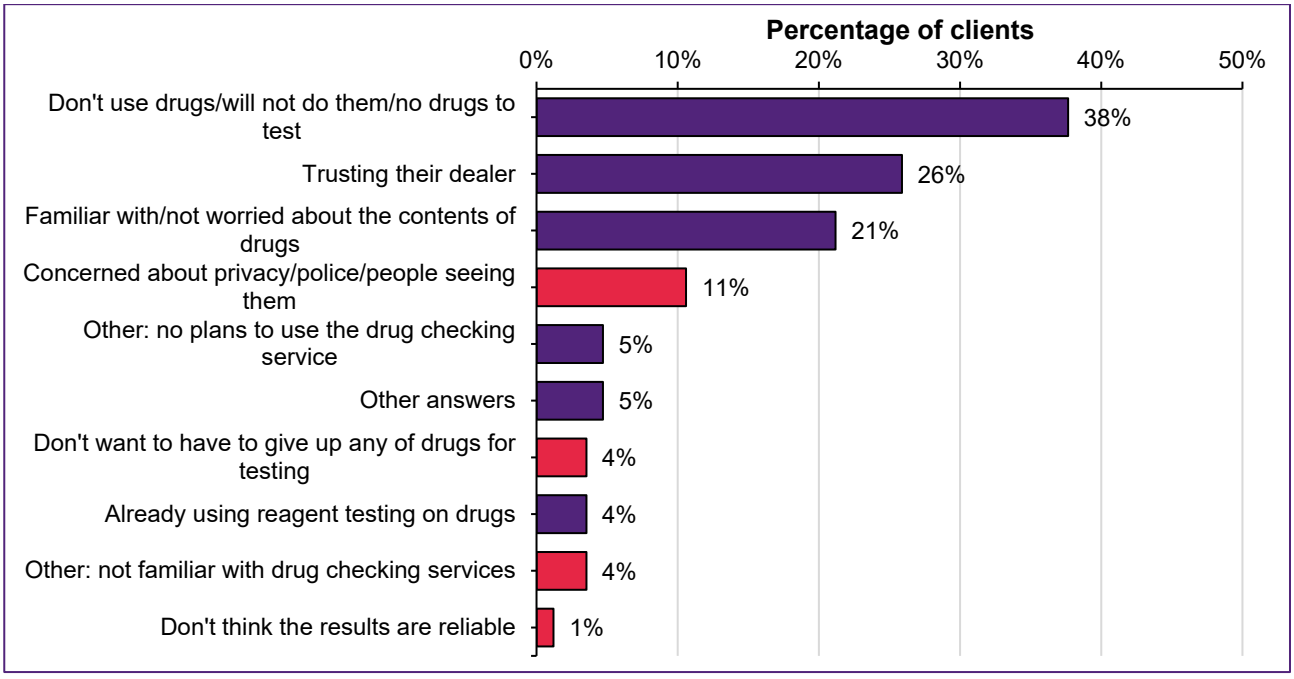
At the Earth Frequency Festival, a survey was conducted by The Loop Australia's research team among attendees, including people who did and did not use substances, as well as those who used or didn't intend to use the drug checking service (total *n* = 161). Participants were also asked

about their reasons for *not* using the drug checking services, some of which could be perceived as barriers to accessing the drug checking service.

Among those who did not use and did not intend to use the service (*n* = 85), the most common reasons provided were not considered barriers (Figure 33). Participants most often indicated that they trusted their dealers, or they were familiar with the drug they have and/or were not concerned about the content of their drugs. One third (38%) indicated they didn't use drugs, didn't intend to use drugs, or didn't have any drugs to test.

The most commonly reported concerns related to privacy, being seen by other people, and worries about law enforcement (a total of 11%), similar to REL patrons. Some participants were unwilling to give up any of their drugs for testing or reported a lack of familiarity with drug checking services. The least endorsed reasons were disbelief in the reliability of the drug testing results and a lack of trust in the government.

*Figure 33. Reasons for not using the drug checking services at Earth Frequency Festival (Source: The Loop survey data, n = 85)*




We combined the aforementioned barriers to identify characteristics of survey respondents who reported at least one barrier to accessing drug checking services, as opposed to those who only cited reasons related to their trust in the drugs they possessed or who did not intend to use drugs. Out of 85 respondents who indicated that they did not intend to use the service, 13 (or 15%) reported at least one barrier for not doing so. In a logistic regression analysis considering socio-demographic predictors, we determined that:

- Women were more likely than men to report barriers to accessing the service
- Individuals aged 40 and older were less likely to report barriers and
- There were no significant differences based on labour force status or whether respondents were born in Australia.

#### 3.4.3.3 Populations not accessing drug checking

While services were considered generally accessible and running well, they did not reach all populations of people who use substances. Some communities, especially those that experience more police contact or are less trusting of government, may be apprehensive about using the service due to concerns about police presence.

> *"Over-policed populations are understandably more apprehensive" (Stakeholder 21).*

Participants suggested a need to expand service delivery “beyond young people and festival goers” to include clients of needle and syringe programs and community health services. Service records show significant numbers of older (40+) clients, but few people who inject drugs. The need to plan ahead to attend a drug checking service may be a barrier for those with less ordered lives, particularly for those with dependence issues.

> *"You have to be really planned and organised, so it brings it back to that other cohort of people who may be addicted to substances or using a lot of things, they’re just not going in" (Stakeholder 7).*

##### *3.4.3.3.1 Socially diverse groups*

Some stakeholders expressed concern about the absence of culturally and/or socially diverse groups at the services, but service records do show the inclusion of First Nations and members of the LGBTIQA+SB community among the client base. Suggestions to improve perceived accessibility included displaying flags to signal support and safety and creating easy-read resources. Ensuring physical accessibility with ramps and flat surfaces was also deemed important. Consistent monitoring of client demographics may help address these issues and ensure services are inclusive for all, although this raises confidentiality concerns.

> *Thinking about other forms of accessibility, I think we could benefit from maybe having an Aboriginal flag and some LGBTQIA+ flags, as well, just to communicate to a broader part of the community that we are supportive and we're a safe space (Stakeholder 17).*
>
> *You don’t see a lot of people of colour coming to the service in my experience. So there might be problems there communicating with ESL communities to get that messaging across (Stakeholder 21).*

##### *3.4.3.3.2 Parents*

Parents of children who used substances were one group observed as wanting to use the service but not able to access testing. Parents brought in substances found in their children's belongings, but as operating guidelines specified that the substance “owner” must present it, these substances were not checked. Staff did however spend time with these individuals to provide information, resources and guidance. One stakeholder reported that this happened regularly.

*People sometimes bring in drugs found in their kid's drawer, but these aren't checked, so no data is collected. Staff spend time with them to provide referrals or help. This happens about once or twice a week at each service (Stakeholder 12).*

#### 3.4.3.4 Complementary data: Drug Trends

Annual interviews with people who regularly use ecstasy and related stimulants (Ecstasy & Related Drugs Reporting System; EDRS) and with people who regularly inject illicit drugs (Illicit Drug Reporting System; IDRS) are conducted in April-May (EDRS) and May-June (IDRS) each year.

Due to the timing of the 2024 interviews (as Brisbane fixed site services were commencing, and before the Gold Coast fixed site service opened), few participants reported having visited the services (one from the EDRS cohort and eight from IDRS). However, participants did report engaging in drug checking *practices*. Almost one quarter (24%) of Brisbane/Gold Coast **EDRS** participants reported that they or someone else had tested the content and/or purity of their illicit drugs in Australia in the past year, similar to reports from 2023. Testing primarily comprised use of colorimetric reagent test kits (65% of testers); few ($n \leq 5$) reported use of testing strips (e.g., BTNX fentanyl strips or other immunoassay testing strips) or professional testing equipment (e.g., Fourier Transform Infrared Spectroscopy).

Among **IDRS** participants, only 15% reported having their drugs tested in the past year, reporting use of FTIR (n=6), with fewer reporting use of colorimetric/reagent tests and test strips ($n \leq 5$ for each). At the time of this report, few (n<5) of 2025 EDRS interviewees had reported using drug checking services. IDRS 2025 interviews had not been completed.

### 3.4.4 What was the effect of the information, education and support provided by the drug checking services on the attitudes, intentions and behaviours of the clients who accessed the services?

**KEY OBSERVATIONS**

- Clients received a broad range of harm reduction information and interventions, most commonly information about drugs, signs and responses to overdose, and supporting friends and peers.
- Services also provided **191 referrals** to additional support services, including to internal and external service providers.
- Following test results and harm reduction interventions, over half of all clients intended to change their use of the substance, most commonly via taking a **smaller dose** or **disposing of the substance**. All Schoolies clients reported **at least one intended harm reduction behaviour**, suggesting that the harm reduction intervention may be especially helpful for young people.
- The follow-up survey with clients reported on actual behaviours, and showed that 2 in 5 clients reported **not using the tested sample**, 1 in 5 **used less** of the tested sample, and 1 in 10 **disposed of at least one** checked sample. Clients in both the follow-up survey and interviews also reported **reductions in polysubstance use**, less frequent use, and **increased knowledge** of different aspects of their substance use.

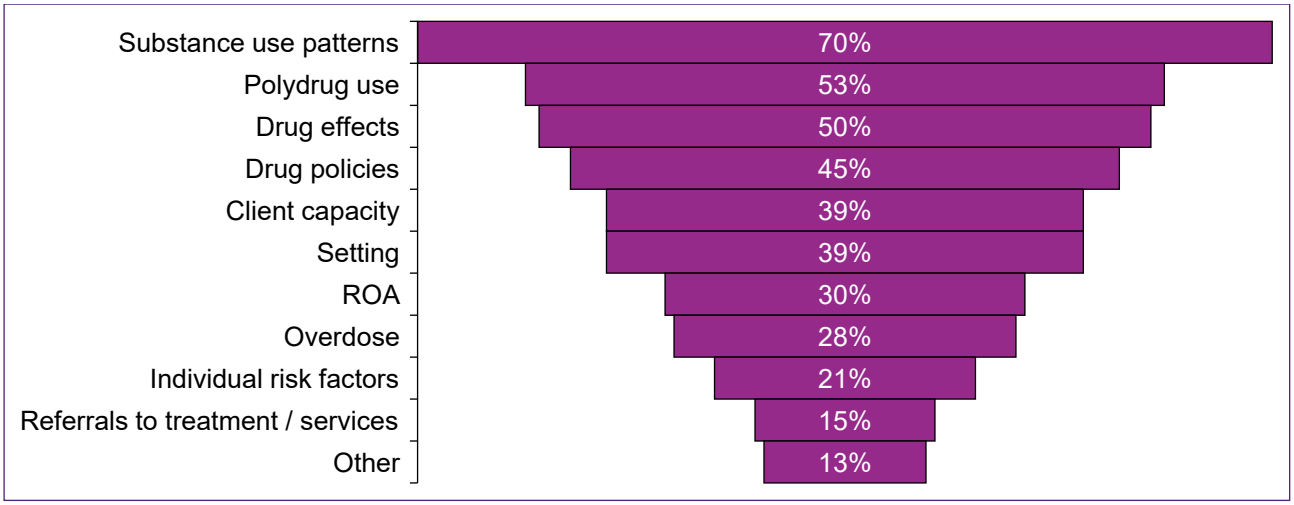
#### 3.4.4.1 Harm reduction supports and referrals provided

##### *3.4.4.1.1 PTA services: Rabbits Eat Lettuce*

PTA's REL service collected slightly different information about clients' harm reduction conversations (note that the service at Wildlands did not collect this data). Figure 34 shows that most REL clients were advised on their substance use patterns, with half advised on polydrug use and broader drug effects and policies. Other harm reduction information and strategies involved discussions of the clients' capacity, the setting of drug use, routes of administration, overdose, and individual risk factors (e.g., pre-existing medical conditions).

Notably, these conversations resulted in **20 clients (15%) being referred to additional services**.

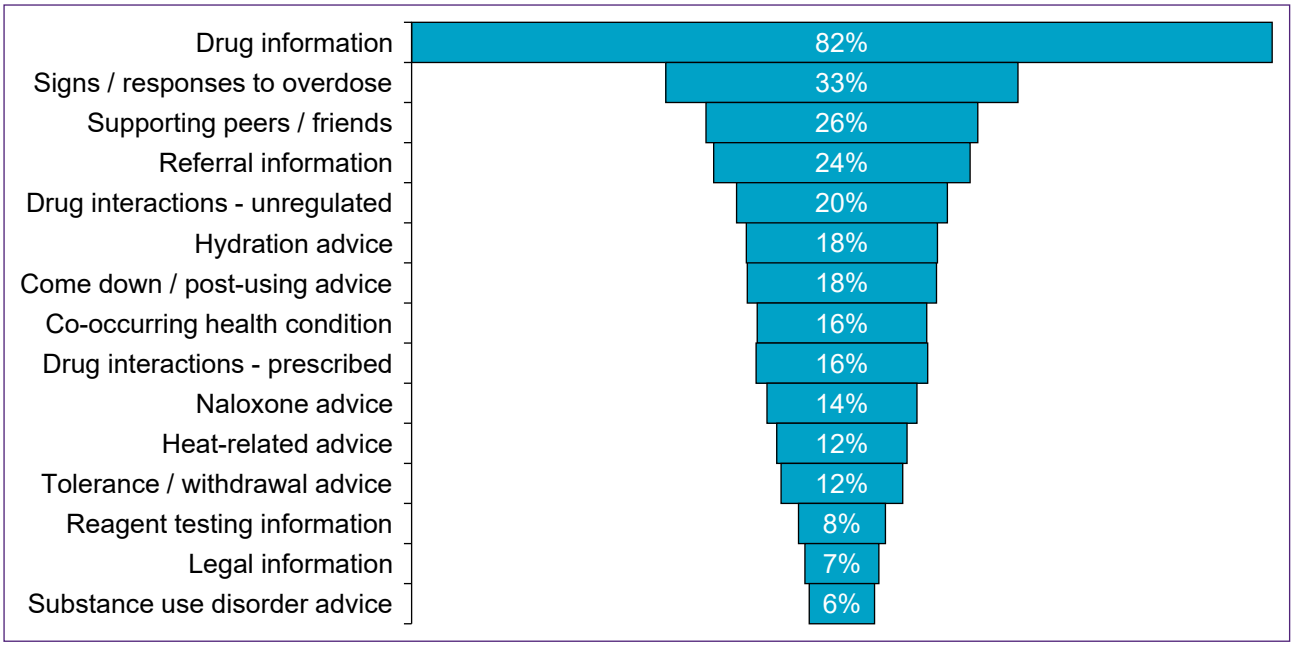
*Figure 34. Content of harm reduction intervention at PTA's REL service (n = 135; Source: PTA REL data)*




##### *3.4.4.1.2 CheQpoint services*

CheQpoint clients (at fixed sites and events) who agreed to a health conversation were all provided with information and advice to encourage harm reduction behaviours. Figure 35 displays the content of harm reduction conversations at CheQpoint fixed sites and Schoolies. Most clients received drug information, followed by information on signs and responses to overdose, and how to support peers and friends. **Nearly a quarter of clients (24%, or 118 people)** participating in a health conversation **received a total of 165 referrals to other services**, noting that clients could receive more than one referral (see Figure 36 for details of referrals). No Schoolies clients received referral information. Note that the EFF service did not record specific information about the harm reduction conversation or referrals.

*Figure 35. Content of harm reduction intervention at CheQpoint fixed-sites and Schoolies services (n = 484; Source: CheQpoint fixed-site and Schoolies data)*



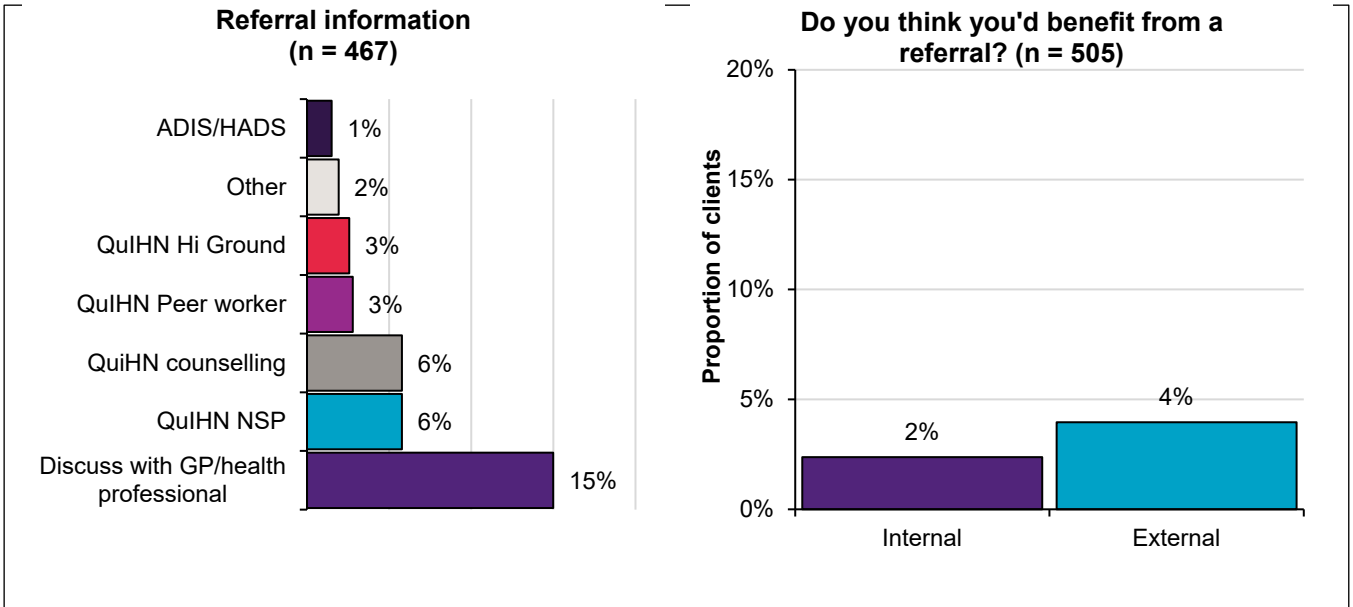

#### 3.4.4.1.3 Referrals to specific services (fixed site clients)

No Schoolies clients felt that they would benefit from a referral.

*Figure 36* shows details of referral information given to CheQpoint fixed-site clients (no Schoolies were given referral information). Of those clients (n = 467), 15% were advised to discuss their substance use with a GP or health professional; smaller proportions (2-6%) were given referral information about specialist AOD services.

A small number of fixed-sites clients believed they would benefit from a referral to a specialist AOD service: 4% from an external referral (e.g., to ADIS or withdrawal services), while 2% thought they would benefit from an internal referral (e.g., to QuIHN counselling services). No Schoolies clients felt that they would benefit from a referral.

*Figure 36. Proportion of clients receiving referral information during health conversations (Source: CheQpoint fixed-site data)*



Interview participants reported receiving referrals or information about other services:

> *Also, at the festival checking thing, I spoke to the doctor there and got some good information. He gave me the information - like the card for the service like ADIS or something. (Client 1)*

Others reported learning more about services available for AOD use:

> *Actually I mean I guess I did in terms of like the colour of MDMA and like I had a really good chat to the pharmacist about that and what causes like different colours in drugs and she was talking about different things that they cut drugs with and stuff. So, I guess in that sense yes I did learn a lot about - I guess I learnt more about it but yeah I would say mainly just about the services that are available to people with drug addictions or drug problems. (Client 2).*

#### 3.4.4.2 Sharing information with others

The information provided by the service equipped clients with the information to reduce or manage the harms related to their substance use:

> *Definitely made me feel more informed. I don't know if it's provided additional knowledge about drugs in general but it's obviously definitely provided additional knowledge around the specific samples of drugs that I've taken there. Providing additional information that allows me to better manage potential harms with taking that substance and sharing that substance with others. Obviously, any additional knowledge means that I can make a better-informed decision around my drug use, I think, is probably the main outcome of it. (Client 13).*

Some clients reported testing substances on the behalf of other people and attending the service with another person to test together, but survey respondents also reported sharing both the drug checking results, and the harm reduction information received, with their friends, other people who use drugs, and family members. A total of 83% of survey participants reported sharing harm reduction information, and 93% reported sharing drug checking results. Information was typically shared by word-of-mouth with trusted individuals, rather than using online channels (social media or online forums), healthcare providers, support services, or providers of substances.

In the qualitative interviews, clients reflected on the value of sharing information with others.

> *That was something new that I learned. That's helpful to share with - information with other people as well. Because people feel really good and they're like, oh, I want more. So then, I was able to tell people that, yeah, there's no point. (Client 1)*

> *The people that I spoke to about it also had - well the people that had used the service had similar stories as well but then there were also people that had never used the service before that I spoke to them about and they were really surprised that a service like that actually existed and that it was free and, you know, so accessible. So, there was definitely a lot of positive conversation about the service. (Client 2)*

#### 3.4.4.3 Intended behaviour change

Receiving drug testing results and harm reduction information were linked to some changes in clients' intentions and harm reduction behaviours. Questions about this were asked differently by the two service providers, so findings are discussed separately here.

##### *3.4.4.3.1 CheQpoint fixed sites and Schoolies*

Of those attending fixed site or Schoolies services (Figure 37), **over 1 in 3 clients reported intending to change their use of the tested substance** (37%). This included taking a smaller amount, disposing of the substance, and asking the service to safely dispose of it. Very few (< 6) reported planning to take a larger amount of the substance.

*Figure 37. Client harm reduction intentions after hearing results and advice (n = 480; Source: CheQpoint fixed-site and Schoolies data)*

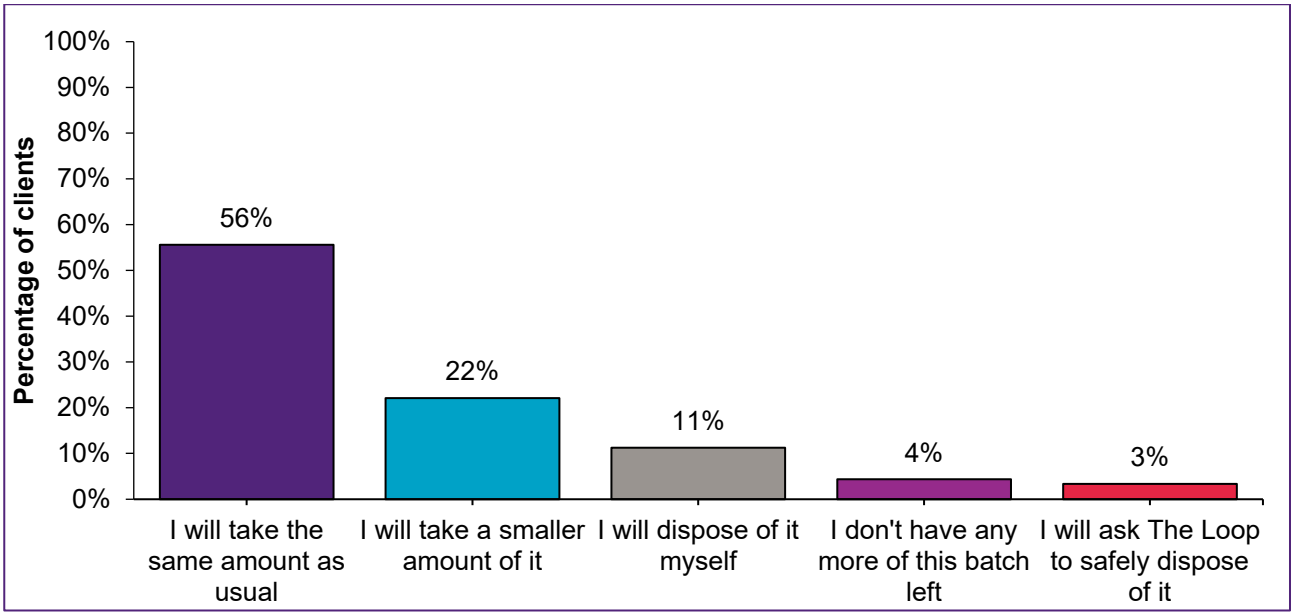
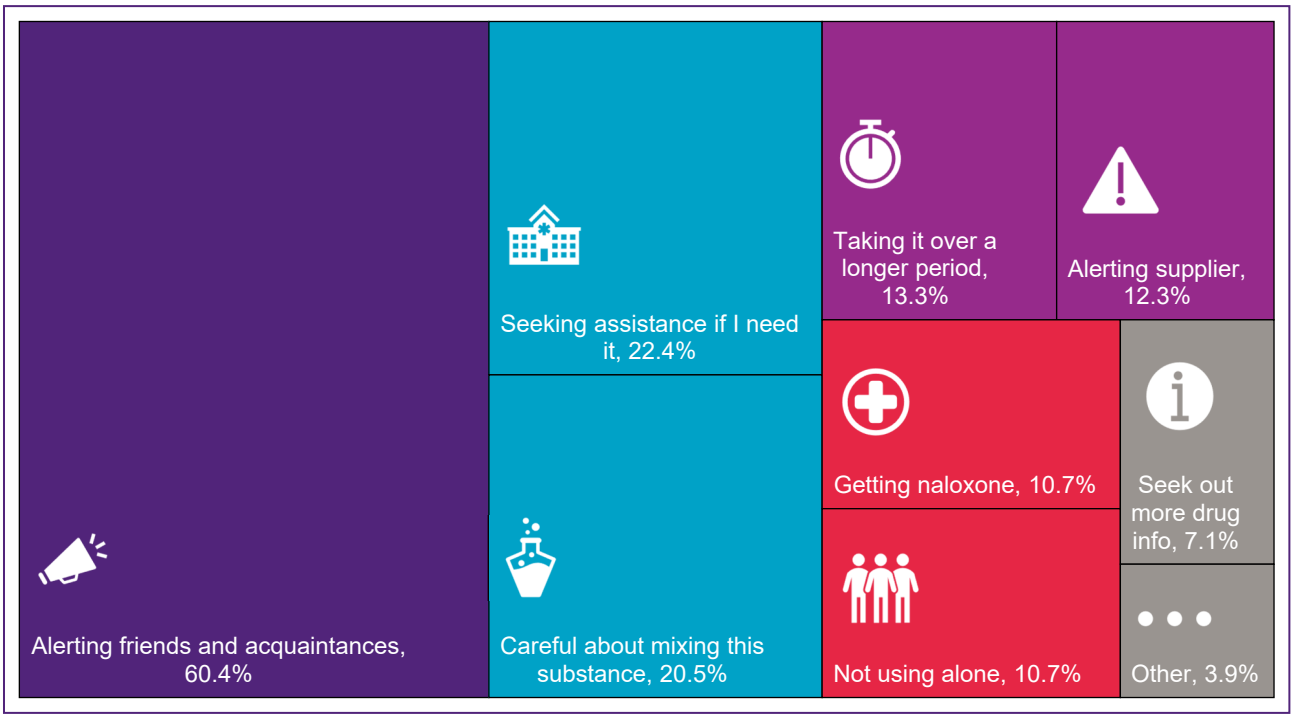



Figure 38 displays other intended harm reduction behaviours reported (note that clients could report multiple intended behaviours). Of clients who responded to the post-intervention questions, most reported they intended to alert friends and acquaintances of their results (Figure 38). Other intended strategies included seeking assistance if needed, being careful about mixing, taking the substance over a longer period, alerting people who sold drugs, getting naloxone, not using alone, and seeking out more drug information.

Notably, **all Schoolies clients reported at least one intended harm reduction behaviour** - most commonly taking the substance over a longer period of time (71%; *n* = 12), seeking assistance if needed (65%; *n* = 11), and being careful about mixing the substance with other substances (65%; *n* = 11). This suggests the health intervention was particularly impactful for these younger clients.

*Figure 38. Additional intended harm reduction behaviours after hearing results and advice (n = 308; Source: CheQpoint fixed-site and Schoolies data)*

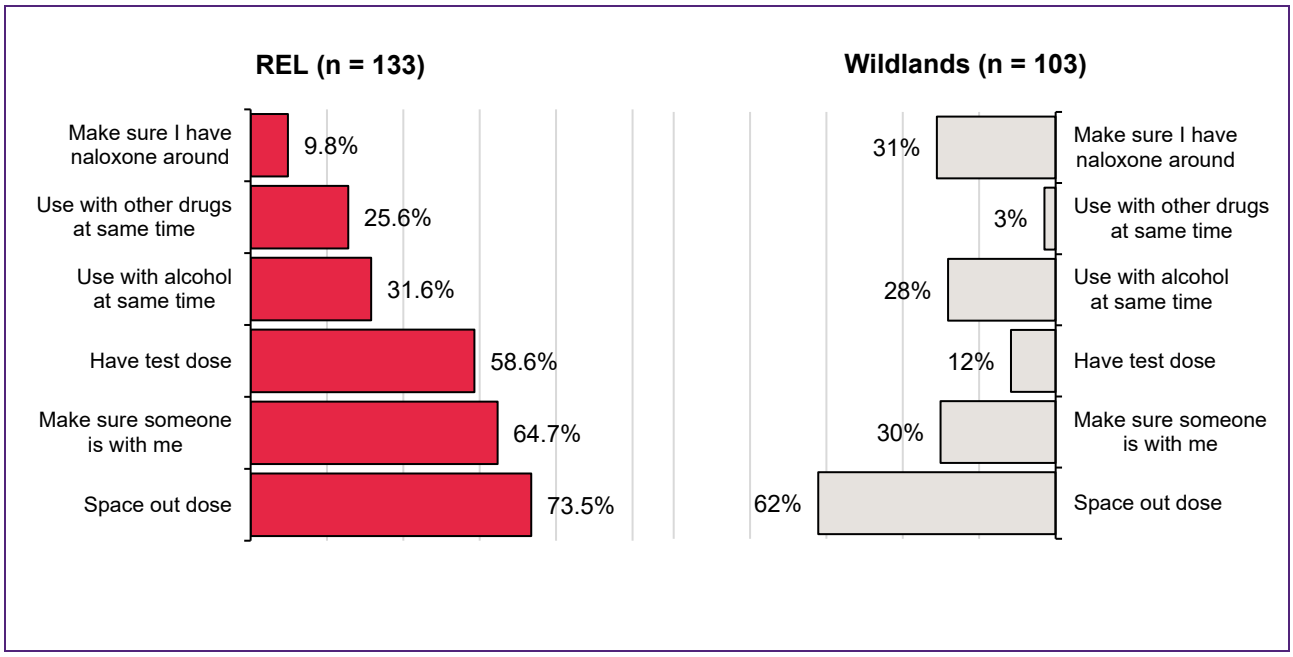



### *3.4.4.3.2 PTA Services*

Clients at the REL and Wildlands services were asked slightly different questions about their harm reduction behaviours. Clients were asked how likely they were to use the presented substance after hearing the results and harm reduction advice on a scale from 0 (definitely not) to 10 (definitely will). Of those who selected an answer (REL n = 103; Wildlands n = 69), most were likely to use the substance, with more than half at REL (52%) and most at Wildlands (83%) choosing 10 (definitely will). (REL *Median* score = 10, *Mean* = 8.05, range: 0-10; Wildlands *Median* score = 10, *Mean* = 9.5, range: 5-10). Only 17% of REL clients selected an answer between 0 (definitely no) and 5 (the mid-point of the scale). A total of 18 clients at REL and 8 at Wildlands were either uncertain or preferred not to answer.

Clients at REL and Wildlands were also asked about actions they would take if they decided to take the drug they presented for testing (Figure 39). A total of 68% of Wildlands (n = 70) and 78% of at REL (n = 105) clients intended to engage in at least one harm reduction behaviour. The most commonly reported harm reduction action was spacing out doses. REL clients were more likely to report intending to make sure others were with them, or that someone knows when they use the drug, or having a test dose. Almost 1 in 3 Wildlands clients intended to ensure they had naloxone. The proportion of clients intending to use the drug alongside other drugs and alcohol was also lower among Wildlands clients than among REL clients.

*Figure 39. Festival clients' intended actions if taking the presented substance (Post test results; Source: PTA data)*




Interview participants reflected on how the drug checking service had impacted on their intentions around future substance use. Some reported intending to use less or to use less frequently.

> *In a positive way as well. I feel I would use the substance less. I would use the substance with less frequency. I wouldn't share it with my friends as much. I feel like I know my doses. I don't know my friends' doses that well. I would know my tolerance so less sharing behaviours, less polypharmacy – like I wouldn't mix MDMA with certain other drugs. Just lots around reducing drug use and just making sure I'm getting it tested because there's lots of dodgy stuff going on – particularly with cocaine at the moment. (Interview 3)*

Other clients expressed that they would be more cautious about future substance use.

> *Yeah. I know them pretty well there and they said, are you actually going to use this now? I was like, hell no. I don't want to have another fit, I don't want to end up in police custody and have no memory of it. I don't choose to do those things on my own and I'm so grateful for the service because I'd still be probably going in my – going insane. Am I having a mental breakdown? (Client 28)*

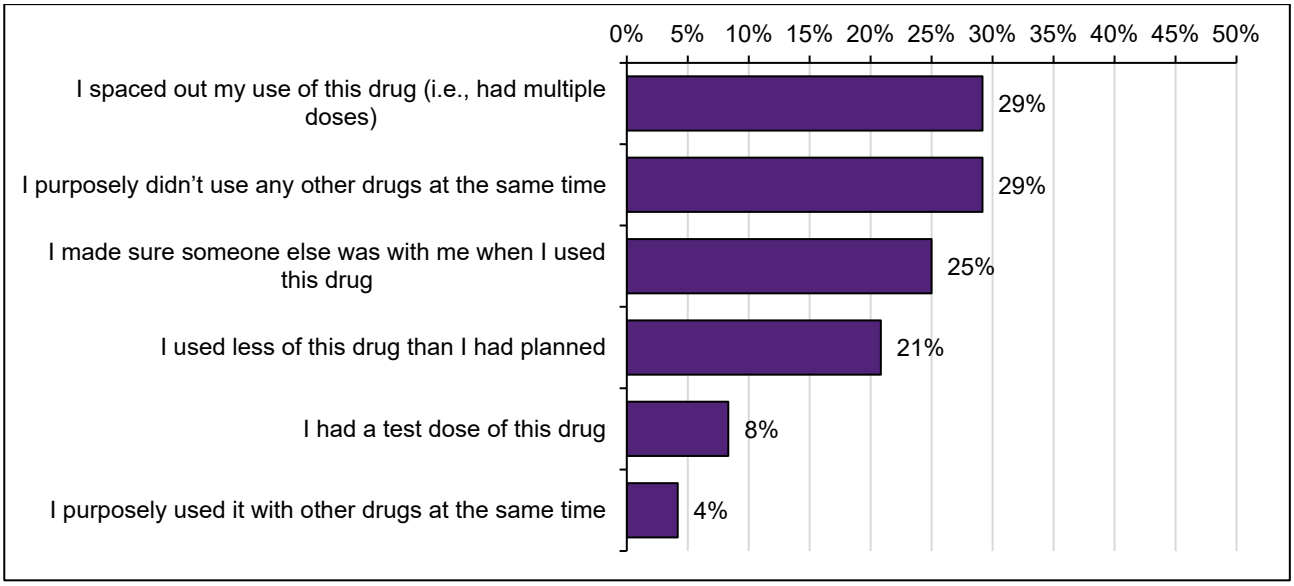
Many explicitly stated that they would reattend the service if they had the opportunity.

> *Yes. I plan on doing so as well in case I get more MDMA from a different source which is also well trusted and well reputed on those dark net forums and also testing other drugs. If I get some ketamine or some other substance, I definitely want to get them tested, especially if it's from a new source, and testing on behalf of friends that don't want to go in themselves out of stigma or fear or fear of police. (Client 3)*

#### 3.4.4.4 Actual behaviour change

In both the survey and in interviews, clients reported a range of actual behaviour changes following their use of drug checking services, most commonly those at fixed sites. In surveys, 44% of clients reported not using the tested sample(s), with 12% reporting disposal of at least one checked substance. Figure 40 presents the adjustments made by survey respondents who chose to use the substance after having it tested.

*Figure 40. Changes made to the way clients used the substance (n = 24, Source: Follow-Up Survey data)*




Several clients reported that they had disposed of the tested substance:

> *Because I had a notification that some of the pressed MDMA pills that I had and my friends had were of an extremely high dose and I wanted to get them checked because I wanted to see how strong they were, which they are very strong, so I disposed of them. (Client 3)*

> *It was fabulous. The sample was not what I expected, and I threw it out. Thanks for keeping me safe. (CheQpoint client, Gold Coast).*

One client explained that the service saved them from potentially harmful effects by confirming a substance was not what they thought and providing detailed information and advice, which they followed:

> *I tested a substance at home, and it was different from what I thought I had purchased. I took it to the drug checking service, and they confirmed it wasn't what I thought or what my home test showed. They printed information about the substance and its detrimental effects, checked if I would take it, and provided advice, which I followed. It wasn't for internal consumption, so I threw it away. The printout helped me understand it better, which was enlightening (Client 11).*

Retention was more common than disposal. which may partly reflect the timing of survey participation, often a few days after visiting the service.

> *Yeah. So, have used bits of them because I guess quite often what happens, a lot of those sort of drugs we use quite small quantities at a time. Because we're not using it frequently, we purchase them, test them, and then they sit at home for – I don't know. (Client 13)*

Among those who did use one or more of the tested substances, most reported changes in their drug use behaviours, spacing out their use, avoiding concurrent use of other substances, ensuring someone else was present when using, or using less than originally planned.

#### *3.4.4.4.1 Avoiding drug interactions*

Interview and survey data show clients reporting having engaged in a wide range of behaviours after their attendance at the drug checking service, ranging from still using the same amount of the substance, to disposing of the substance, and reducing their dose or frequency of use.

Some reported that they used the substances as planned but had made changes to reduce harm, for example by avoiding substances that have interactions. The following participant described the effect of the information on their use of alcohol and ketamine:

> *So, for most of them, used as planned. I guess as a result, the discussion particularly around the ketamine and alcohol mix, that reinforced that hesitance around mixing the two. I know quite a few people that are quite blasé, for lack of a better word, around mixing ketamine and alcohol where we're sort of a bit more conscious and aware of it nowadays. So, I'd say that it's probably reduced the amount that we mix those two – we mix ketamine when we've been having alcohol – as a result of that discussion. (Client 13)*

#### *3.4.4.4.2 Reduced frequency, dose or use of substances*

> *It definitely reduced in total – reduced in frequency, reduced in dosages and then also it reduced in dosage and frequency of people around me quite extensively. Up to 20 people are now reducing their use and frequency because of the information I passed on. (Client 13)*

Several participants shared that the drug checking results had made them reduce their use of substances, and in some cases had made them quit using substances altogether. This participant had received an unexpected result from the substance testing, which led them to 'quit' using substances and cut contact with the person providing their drugs:

> *like I said, it's made me quit because I couldn't trust where I was getting it from, and if I can't trust people I know, I can't trust people I don't know. (Client 28).*

*Going there, I guess it puts a bit of pressure on myself to take more responsibility for my actions and reduce usage over time. So those are reasons why I would continue going there. (Client 15).*

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However, many of the participants reported that the drug checking service had also impacted on their intentions and/or attitudes and knowledge about substances.

#### 3.4.4.5 Client profiles associated with heightened risk of harm

To gain further insights into the profiles of individuals who benefited most from drug checking services, particularly from a harm reduction perspective, and to understand who would thus be most impacted in the *absence* of drug checking services, we conducted a series of regression analyses using data from fixed site services (as these included more potential explanatory factors). We postulated four major risks of harm, constructed indicators of these potential harms, and then analysed service data for factors associated with these recorded risks. The risk categories we identified were: substance contamination by unexpected psycho-active components; polysubstance use; need for medical or specialist AOD support; and multiple potential harms needing to be addressed.

- Substance **contamination by an unexpected psychoactive** was most likely in samples less commonly presented for testing, e.g., 2C-B, diazepam, GHB, MDA, and modafinil.
- **Polysubstance use**, suggested by clients presenting multiple samples for testing, was most likely for clients who presented MDMA, cocaine, ketamine, LSD, and methamphetamine
- **Health concerns requiring medical or specialised AOD support**, suggested by clients receiving a higher number of referrals (to GPs or specialist AOD services), was most likely for those not employed or studying, those who presented methamphetamine or alprazolam, and those who identified as bisexual. Interestingly, those who had previously discussed their alcohol or substance use with a medical practitioner were also more likely to receive a higher number of referrals, suggesting that further *specialised AOD* support was important.
- Clients having **multiple substance-related concerns**, suggested by clients' harm reduction conversations having included a greater number of harm reduction strategies, was most likely for younger clients (aged 17-29), those who presented MDMA for testing, and those who reported obtaining their substances from a regular (rather than occasional) dealer, suggesting regular use.

In summary, these findings suggest that the client profiles most likely to receive benefit, and conversely **most likely to miss out on critical harm reduction interventions in the *absence* of fixed-site drug checking services included:**

- People under 30 years of age
- People who use multiple substances, or who use MDMA, cocaine, ketamine, LSD and methamphetamine
- Members of the LGBTIQA+SB community
- People not engaged in employment or study
- People who have previously had AOD-related conversations with a medical practitioner

Some of these characteristics are also associated with people attending services in festival settings, suggesting that our findings are likely to also be applicable to festival attendees.

(Detailed analyses are presented in Table A5 in Appendix 3).

#### 3.4.4.6 Attitudes

Clients reported that attending the drug checking service had increased their awareness and knowledge about drugs. Many participants stated that the information provided by the service had made them more cognisant of different aspects of their substance use, including dosages, interactions and effects. For example:

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*It's made me a little bit more conscious about dosages which I'm actually really, really careful about that anyway. I'm always lecturing my friends – like people that will get a bag and just dab out of it and it's like, you have no idea how much – you just took loads, this is stupid. (Interview 4)*

*Yeah, it's definitely enhanced my knowledge, yep, I'd say. (Interview 4).*

*Well, it's given me actual, verifiable insight into what I think I know. Even doing reagent tests, you just - okay, great, they're there. But the level that the spectrometer can convey to us is really empowering. (Interview 5).*

*It has changed - it has enhanced my knowledge, but also I guess reinforced stuff that I had found but wasn't 100 per cent certain on the accuracy of. But now having actually had someone, a healthcare professional to talk to and be like, okay, yeah, that is true, that isn't true, so on and so forth. So yeah, I feel like my knowledge has improved as a result of the service for sure. (Client 10)*

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A couple of clients reported that the service alleviated the stigma around their drug use:

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*It made me feel like there was less stigma around it. Just acknowledging that, hey, yeah, this is the real world, people do use drugs. You shouldn't. Very naughty, but it does happen. If you do it in a safer way, people are less likely to engage in more risky behaviours. If they know their MDMA is pure MDMA and not adulterated with meth, they're less likely to get onto meth so I just felt a lot safer, more reassured and knowing if I did have a medical event when taking these drugs, just able to report to health professionals as well if something did go wrong. (Client 3)*

*In the past, we've always been shunned. Even if you're on an OST you go to the chemist, you've got to wait to the side and don't talk to the normal customers, and wait until no one's there, and there'll serve you. There was the pharmacist doing this, and they want to help, they want to make sure the people are safe. When you know the right places that – harm reduction and they don't have a closed point of view on it, it actually opens up a lot more conversations that should be happening from the very beginning. (Client 28)*

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Participants also reported that they were aware of the risks associated with taking drugs, but used drug checking services to be informed and manage their risk:

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*It is a way for me to make a better-informed decision to reduce the risk of my drug use, I guess. Again, as I said before, I don't – I'm not naïve enough to think that what*

*I'm doing is entirely safe but I generally try and make an informed decision before I do things like this and it's weighing up the risks and the benefits and it gives me additional information to help me better understand the risks of what I'm doing. (Interview 13)*

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The majority of participants stated that the drug checking service had not changed their attitude towards talking about their drug use with a healthcare provider. However, many participants considered the service to be non-judgemental, which encouraged them to return.

### 3.4.5 Key implications at client level

**KEY IMPLICATIONS**

- Variation in client demographics demonstrate the importance of a variety of service modes (e.g., fixed sites, event based and potentially mobile services) to encourage broad participation in drug checking.
- Harm reduction strategies and resources offered to clients should reflect the range of demographics presenting at the services, and use accessible language and formats to encourage uptake.
- Efforts should be made to encourage service uptake by groups currently under-represented in client data, such as people who inject drugs and people from CALD backgrounds.
- Harm reduction or health conversations in conjunction with provision of testing results have had demonstrable impact on risky substance use practices and potential for long term harm reduction.
- The number of clients presenting with complex issues indicates an ongoing need for highly-skilled and experienced health workers in the services.
- A number of clients identified as at significantly increased risk of harm would be greatly disadvantaged in the absence of drug checking services.

## 3.5 System Level Outcomes

### 3.5.1 How did drug checking services operate within the broader Queensland context of agencies and services involved?

**KEY OBSERVATIONS**

- Stakeholders and clients reported that drug checking services played an important role in the continuum of services, providing a 'safe space' for clients to discuss their AOD use with a health professional and an adjunct to existing health and AOD specific services.
- Stakeholders generally reported that stakeholder relationships had been well managed, although there were some reports that communication could have been improved in specific instances.
- Stakeholders from the AOD sector, policing, and the media were perceived as supportive of drug checking services.


Drug checking services provide an important step in the continuum of harm reduction responses, proactively identifying potentially high-risk substances and providing an opportunity for intervention at the point of care before someone decides to consume that substance. Stakeholders noted that losing this program would mean losing this step of the continuum of responses. Stakeholders and clients both reported that the drug checking service provides a 'safe space' for clients to discuss their AOD use with a health professional in less stigmatising circumstances. For example:

> *I think it leads to maybe consequences that maybe general community wouldn't think about in terms of providing safer spaces for people to feel comfortable and talk to health professionals about their drug use. Actually, one thing I will say which is more of a reflection of my experience in services with more younger and less experienced*

*people who use drugs, is the opportunities to refer people through to health services. (Stakeholder 14)*

*Yeah, it's a bit hard to open yourself up to your regular GP who you see and you kind of want to keep that life separate to what you see them for, so it's pretty hard to open up. But having somebody who is not there to judge but to offer advice, I think that was really important and is a good thing, yeah. (Client 29)*

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Clients appreciated that drug checking service staff were specifically trained in and had expert knowledge of drug effects, with some noting that this was not generally available through other health services:

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*Yeah, look I mean GPs have a tough job of keeping across absolutely everything [laughs], and I think I would still prefer to have a service like this, where there are people who are specifically interested and trained in illicit drug interactions, and safety, and other sort of care regimes that are good to have around the use of different drugs. I wouldn't expect the majority of GPs to have any awareness of that sort of stuff. So to just dump that kind of healthcare responsibility on GPs alone, I think is not a realistic approach. (Client 1).*

*I think I'd be pretty comfortable to go back to the drug testing facility to get the information as it's come from a reliable, trustworthy organisation. I would trust that more than just looking on the internet or talking to friends. I also know that I can talk to somebody there if I had any questions or concerns, so I'd feel a lot more comfortable getting the resources in person. (Client 29)*

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Importantly, drug checking services were regarded as potentially less stigmatising and more approachable than mainstream health services.

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*… For me, I think about where else would they get that help from if they're too ashamed to talk to their doctor about it, their friends are in very similar situations and they don't see a way out, I'm just so glad that they're able to talk to somebody. (Stakeholder 21)*

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Staff at drug checking services could discuss options with clients and facilitate further conversations with health professionals. The conversations between workers and clients provide opportunities for the provision of a range of information and potentially direction to oher services

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*It's about making people aware of what other options there are for them to talk to people about using drugs or anything that might have come up. I often feel like [unclear] drug checking services aren't considered to be an avenue into more holistic health, thinking more holistically about your health and how you interact with other health services as well. (Stakeholder 14)*

---

These conversations could facilitate further engagement with other health professionals:

> *For a lot of people, they might have other mental health concerns and then they're using substances. So it's often a conversation around, have you talked to your GP around how the medication for whatever their issues are is not really working for them, and they're finding that it's helpful to use something else on top of that, even without disclosing to their GP that they're using a substance. But they could have - encouraging them to have conversations around, what they are being prescribed at the moment may or may not be working for them, and is it time for a review. That sort of stuff is really important as well. (Stakeholder 28)*

#### 3.5.1.1 Stakeholder relationships

To be able to deliver the drug checking service, good relationships with a range of stakeholders were necessary. In the context of festivals, relationships with festival organisers, medical professionals, police, and other harm reduction services were crucial to successful service delivery. For the fixed site drug checking service, stakeholders considered the consortium approach as a strength of the service.

> *A big part of the strength of the model is the consortium that we've got going... Nothing really gets missed, and everybody's got their key core competencies and they bring that capacity to it. So, the Loop are bringing in their technical know-how and their core competency around that. [QuIHN] have got the really strong service know-how and connection and trust and rapport, and that's been really important, that trust and rapport we've got with existing client … and QuIVAA's connection, too, and they did some really awesome work around the codesign stuff. (Stakeholder 26)*

Connections between the technical chemistry roles, clinical knowledge and service delivery and harm reduction services were also important in the festival setting:

> *…there are a lot of positive consequences I think overall of operating these services, and they might not be the ones that are always thought of and in that, referrals as well. That's why we really wanted to have that good relationship with Conscious Nest and QuIHN and QuIVAA because there's no point us having referral information for ACT or Victoria when we're in Queensland running a service. (Stakeholder 14)*

Many of these connections had been established prior to funding by Queensland Health, however the funding formalised and further established these relationships.

Drug checking had been advocated for by the broader AOD sector in Queensland for some years, as the following stakeholder recounted:

> *So 2019 is when I first got introduced to a few people working in the space and an advocacy group called PT4Q was set up for testing for Queensland. There were a couple of like-minded politicians and people from Queensland Health and a few event industry promoters and some people from the drug and alcohol support workspace and there was a broader network of people behind it, willing to put a logo or something like that. But there was a smaller team that would just meet up monthly or bi-monthly, depending on what was going on and just really fleshing out the topic,*

*working out really like how to sell it, how to make it palatable, and also what the mechanisms were that could actually bring it about.*

*So – and obviously there's work that had gone on up till that point. So, it has been a long – it's been a long time coming, but that was when there were enough chess pieces there that someone rang the bell and said, let's officialise this. It was – I think it was some of the people at QNADA that were quite instrumental in that and were hosting some of the meetings as well. (Stakeholder 1)*

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The majority of stakeholders reported that stakeholder relationships were well-managed by both service providers.

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*From what I've observed, very, very seamlessly actually. It seems like a partnership more than anything. (Stakeholder 18)*

*Yeah, very effectively. Everyone - all of the key stakeholders were 100 per cent behind it and really excited and supportive of the whole measure and the service. Yeah, they were all very supportive and they were all - they all worked really well within the pre-event stage in meetings and - they were all involved. It was very positive. (Stakeholder 22)*

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Communication within the consortium was cited as a strength.

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*From my point of view, I think it works well. I mean we have a representative from each of us in all the meetings so we'll get together every single week, if not a few times a week. We have subcontracts with those guys, QuIHN's the lead on this but we have subcontracts with those guys, so it's all written in the contract what's expected of each organisation. But in regard to communication flow, I think it's good. Like I said, we meet every week and we talk about how did the last week go, what could we do to change and so we're all on the same page all the time. We keep minutes of the meetings, we share shared folders and that sort of stuff and we all have access to those things.*

*So, I think the key to it is communication and just making sure everyone's up to date with what's happening, and because we all have our own social media channels and that sort of thing, we all stay on top of each other's as well. We all put out the same sort of information so the same info is going out. (Stakeholder 19)*

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However, stakeholders noted that it was important for messaging to stay consistent with so many stakeholders involved:

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*We really tried clear messaging to counter any stigma and discrimination that was in mainstream media. We've had some really positive reporting on services, but - particularly around Schoolies, it has shaped the way that people engage and, in some ways, reinforced the stigma and discrimination. From our friends in New South Wales and Victoria, our harm reduction friends in other states, there's been incredible amount of support... (Stakeholder 23)*

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Working towards a consistent goal helped:

> *I think how well QuIHN, QuIVAA and The Loop work together. I think that has just been amazing. We've all got really good relationships, we're all heading towards the same goal, so that's been fantastic. I think that, to me, is probably the most important thing, is how well organisations work together and we work extremely well together. (Stakeholder 13)*

A minority of stakeholders believed that communication of expectations could have been improved, referring specifically to confirmatory testing:

> *I think if they were just more clear with their communication, what expectations they had and how quickly they actually would like the turnaround time to be, then it would have been, yeah, a lot better. (Stakeholder 20)*

There was some feedback from stakeholders about the degree of information sharing by the different drug checking service providers at the different festivals. For example:

> *So, the onsite stakeholders the relationship seems to be quite good. I guess the only difference that I've seen again is probably [one service] seem to be a lot more open, a lot free information flow but again that's just off the two that we've done so that has been the experience that I've had. (Stakeholder 3)*

#### *3.5.1.1.1 Peer organisations*

Peer organisations were cited as central to the successful design and implementation of drug checking services in Queensland.

> *Yeah. It also has, you know, because people who look out for community, look out for community. We have had a lot of supportive messaging from our friends interstate who work in health and communities, and other lived-living experience, and peer organisations here in Queensland. That's part of the work. (Stakeholder 23)*

#### *3.5.1.1.2 AOD sector*

Stakeholders noted the overwhelming support for drug checking services more broadly in the AOD sector:

> *Our friends [in the sector] have put a lot of work in kind into promoting the service, and supporting the service and ensuring that we're doing what we can to have success with the service. Because we see the real risks in not having the service. (Stakeholder 23)*

> *So - but I think certainly the sector have been really supportive around it. We've had good engagement from not just the AOD sector, but we've really had contact from a range of other sectors. People do recognise the importance of it, so we've had -*

*when we did Schoolies, we had really good support from the whatever - the [accommodation providers] were really supportive of it.*

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Stakeholders in the AOD sector appreciated the communication of the activities of the drug checking services, along with the testing results:

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*Actually, it's part of educating the community too for those basic stats about the service to be pumped out to say who's using it. I mean I think, particularly CheQpoint with their fixed sites has been really generous with producing summaries of what people are - those of us who are a bit curious as to how things are going have got some good resources to draw upon. (Stakeholder 25)*

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Stakeholders in different roles noted that the drug checking services had added to their capacity to engage in advocacy on AOD issues:

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*I'm across a range of different projects and doing policy response ongoing. It's significantly added to my capacity to speak to, for example, the National Inquiry into AOD harms. Being able to draw on data from CheQpoint has substantiated the arguments that I've made in – [our] response to the Parliamentary Committee, National Inquiry into AOD Harm. It's provided more evidence for me to be able to advocate from an evidence-based harm reduction approach, which is key and vital. Our friends [in the sector] have put a lot of work in kind into promoting the service, and supporting the service and ensuring that we're doing what we can to have success with the service. Because we see the real risks in not having the service. (Stakeholder 23)*

*Well, that was - it was politically difficult for them, as well, and there were some operational issues I think down there with some of the stuff that was happening, not just with us but between the government response led teams and the stakeholders. I think there were some existing relationships that were not quite right in some respects. (Stakeholder 26)*

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#### *3.5.1.1.3 Queensland Health*

Relationships with Queensland Health were generally regarded as very positive. The main difficulty perceived by some stakeholders was delayed communication in some contexts. This appears to have stemmed from a misunderstanding of the established protocols for information release, with service providers able to release findings, but official health alerts requiring laboratory confirmation of findings before release. This stakeholder expressed concern about perceived delays:

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*I know there's been a few times where we've been waiting for their permission to release certain information and they had been wanting us to hold off for mysterious, unknown reasons… and then it's, kind of, got to the point where [name redacted] been, like, we have to release the stuff, we don't want to do it without your support, but we may have to. (Stakeholder 8)*

*I'm curious as to how it's used in Queensland and by Queensland Health. As stakeholder organisations, it's part of the agreement to my understanding, that we're responsible for disseminating, and distributing, and reporting back to the funding bodies the data that we collect. How that's messaged across sector for greater leverage for systems change, I'm not sure, but that's the opportunity for Queensland Health [laughs]...as the funding bodies to lead that. There has been great collaboration in other aspects of services and stuff that have been rolled out in Queensland. (Stakeholder 23)*

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#### *3.5.1.1.4 Police*

While concerns about law enforcement were expressed by clients of the drug checking services, other stakeholders generally reported that relationships with Queensland Police Service (QPS) were positive. The QPS Drug and Alcohol Coordination Unit (DACU) performed a coordination role between Queensland Health, relevant QPS units, districts and local Officers in Charge of stations situated where the drug checking services operated. DACU were involved in the co-design of operational, communication and governance protocols established by Queensland Health.

QPS has supported access to Queensland Health approved harm reduction services in line with the policies and procedures outlined in their *Operational Procedures Manual 14.28.3*. (Response from DACU to request for interview). The manual states that "officers should be mindful of the need for members of the public to freely use these services" and that a person should not be under suspicion if in the vicinity of a drug checking service. It also refers to being mindful of the proximity of Police units to a drug checking service operating at a music festival, to ensure patrons are not deterred from using the service. Service providers were aware of and appreciated these guidelines.

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*I know that we have an agreement with the police in the area that - I'm not sure what they call it but the police have agreed to stay away from our area. Like they're not patrolling the street, they're not looking to target anybody outside. That they see somebody exit and they're not going to go and hassle them because they know that they've just come from the drug checking service. (Stakeholder 21)*

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At events, police and security were included in the coordination processes. Event organisers were appreciative of this.

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*We have a very thorough police presence, obviously, and we work really closely with police across multiple avenues of the festival, external traffic as well as internal behaviour and then also drug checking. So, it was really good that we were all on board. We all understood - so it was part of a separate briefing for us to brief security, police, medical, have [drug checking services] involved so we were all aware of how it was going to roll out for us and everyone well understood and the police understood or were able to let us know as well as - how that is briefed into their commanders on site. (Stakeholder 27).*

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The deliberate visibility of police at Schoolies, a long-established measure intended to improve public safety, was however seen as a potential barrier to attendance at the drug checking service, particularly for younger people who were unaware of these protocols.

*… seems to be one of the drivers between the - behind the low numbers of the Schoolies week service. … when [service staff] went out and talked to young people, they were interested in the service, but were a bit worried about being observed using the service…That, to me, says that there's more space for police to verbalise their support for their services and to commit in public forums that they're not going to interact with anyone just because they've been to a drug checking service. (Stakeholder 25)*

*… that kind of consumer confidence that the cops aren't going to be waiting around to swoop up and grab people is something that just takes time to develop.*

The majority of stakeholders reported that police presence on sites had not been a barrier to service. However, they did discuss differing local policing approaches between events. Outside the REL event, a significant roadside operation was observed, including random breath and drug testing of people *leaving* the festival to support road safety, but police presence on site was minimal.

*…so Rabbits Eat Lettuce Festival, there were two local police there….They did a walk-through. They asked to have a walk-through before any clients – or before the festival started, because then they stated, we're going to be well out of your hair. We promise we're not going to come near this space again, because we don't want to scare people off from using it. We're here so that people have a really good time, a safe time too.*

At EFF, a significant police presence was observed at the *entrance* to the festival for a period during Day 1, with vehicle searches and drug dogs in evidence. This created concern among attendees that *all* festival entrants may be tested (this was not observed). Limited onsite policing was visible during the event.

*A totally different approach then for Earth Frequency Festival, where the police went really heavy-handed. They set up a huge barricade at the entrance of the festival and were doing RBTs and random drug testing to every single person that was going to drive through to the festival. (Stakeholder 10)*

Despite these concerns, overall, the relationships between police and the drug checking services were regarded positively.

The information from drug checking services was used by QPS in a number of ways, including:

- Detections of nitazenes found in substances not expected to contain a synthetic opioid was used to inform the state-wide roll-out of naloxone nasal sprays to all operational vehicles within the QPS.
- Findings from drug checking services have been a source of intelligence on illicit drug markets and drug use trends
- Information from drug checking services informs the Queensland Early Warning System of which the DACU is part. (Response from DACU to request for Interview).

#### *3.5.1.1.5 Media*

B positive and negative (mainstream) media reporting about the introduction of drug checking in Queensland were observed across the evaluation period. Some media and journalists were acknowledged as worked pro-actively in publicising and advocating for drug checking, which supported public knowledge and awareness of the services.

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*They're excellent. They give us background information. We have very good relationships across with several of them. They talk to Ministers. They talk to people that we don't necessarily have access to, and we're able to get that grounding information from them and vice versa, off the record. So, it's those sorts of relationships are handy to have, too, and so yeah, I think that there are some unlikely allies in this space, and just the groundswell. (Stakeholder 26)*

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However, facilitating media coverage required careful management to balance opportunities to promote the services against the tone of representation and protection of clients' privacy.

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*Since the service is confidential and anonymous, we had to prevent media from filming attendees. We spent considerable time organising specific times for media visits (Stakeholder 17).*

*[One news program] wanted to dictate their terms or go undercover and film what they wanted. This added emotional workload, trying to chaperone them without compromising the service and privacy (Stakeholder 1).*

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#### *3.5.1.1.6 Festival environment*

Festival organisers who were interviewed were very supportive of drug checking and wanted to have the service at their festivals as an adjunct to patron safety and reflecting their desires to provide a healthy and safe festival experience.

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*Yeah, well, I thought it worked really well. I thought the service rolled out really well considering as I just said, it was the first time that was done in Queensland. Quite often it takes time to build rapport with the other services there, particularly the health and medical services because in my experience the drug checking service can do a lot better when it's part of that kind of overall healthcare unit, and there's good communication between all the services as well as obviously with the clients that come into the service. (Stakeholder 14)*

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In the festival setting, the drug checking services interact synergistically with a range of stakeholders to reduce harm.

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*So we didn't actually have a single required call out to QPS in the entire four days of – still some pretty decent numbers, …we literally have so many different flavours of harm reduction services there from information to crisis care, to drug checking, to medical, to security, to campsite wardens, it's like this complete holistic approach and we take that side of things seriously. (Stakeholder 1)*

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In particular, the ability of drug checking services to inform medical responses at the festival was highlighted. Festival operational teams met daily, providing opportunities for the drug checking staff to share recent findings, and encourage other festival support operators to remind patrons about drug checking services.

> *We – the management team they had debriefs with the health officials and festival organisers at different parts. I saw at the end of day or opening, and then as well if we had an alarming result they easily popped over to the medic tent and just gave like a heads up. (Stakeholder 5)*

The intelligence provided by drug checking was seen as invaluable by the medical response teams in preparing them to respond to acute presentations.

> *Absolutely, you know, if you can find out that you've got say double or triple strength MDMA out there or you've got say fentanyl laced cocaine out there, when you're getting your patient coming through you're able to have that understanding. We saw a couple of cases of that where when we're having a patient come through and you're hearing someone talk about oh they had some cocaine or whatever it is you are seeing those opiate traits there as well and going well I know that's there because testing has determined it's there so let's go after this thing and sort it out. Previous to that it was always clinical assessment, you know, and we still do full clinical assessment but now we've got information to back that up. (Stakeholder 3)*

Conversely, after an acute drug-related presentation, medical teams were able to request priority testing for a sample that someone had experienced an adverse effect from:

> *There were a couple of instances – there was an instance from just located near the festival, where some people had taken a substance and had an adverse effect. We could filter that in and prioritise that sample in the testing, and get that information fed back. So, yeah, there were very clear paths between our testing, and our testing lead, and the festival organisers, which included all of the medical teams as well. That seemed to work well. (Stakeholder 4)*

Medical service stakeholders reported positive opinions about the service:

> *It's not forced upon anyone. It's optional. All of the stakeholders are on board. I think it just bolsters our medical service department. It also takes the pressure off our medical team because they're getting information first-hand as to what's coming through. The medical team can be more prepared in how they want to handle if someone comes in with a bad reaction, they're already aware of what's going around site in order to be able to treat that patient really quickly which is everything. (Stakeholder 27)*

Overall, local council stakeholders were also seen to be supportive of the drug checking services:

*I just - I certainly think it creates safe - and potentially, look, local councils. Local councils, Ipswich Council, was super-supportive of the Earth Frequency Festival and our role in being there, because this is about creating healthier communities at the end of the day. So, our involvement in that helps them to create a healthier festival, and the festival is a big generator to the local economic environment. (Stakeholder 26)*

The main points of feedback for improvement were to develop plans about how communication about high-risk substances would be made with patrons at festivals where there was limited mobile reception on site or a lack of display screens for public messaging.

*So that kind of did come up at one point of, yeah, if we did find something alarming, how would we tell that to people. I think management kind of spoke to security or the festival organisers about potential options. But yeah, I guess that would be the other communication of something. How do you communicate that? (Stakeholder 5).*

### 3.5.2 To what extent did the services produce valuable and timely information about illicit drug availability and harms in Queensland, and how was that information used?

**KEY OBSERVATIONS**

- Individual clients received valuable information related to harm reduction strategies around using the substances they had tested. This including sharing resources related to different drugs, information related to reducing harms related to dosage, sharing medical information and referrals to other medical services, and providing information on how to access rehabilitation services to address drug addiction.
- Event organisers received regular briefings on drug checking findings and shared via on-site communications and social media.
- The drug checking findings prompted release of several key drug alerts about harmful substances, including several nitazenes that were detected and a novel hallucinogen. These releases informed clinical networks within Queensland but were also shared more broadly via the Prompt Response Network, EDNA and other warning systems.
- Sharing information publicly on social media by both service providers improved reach and engagement with the information, as did sharing on fixed websites such CheQpoint, the Know and having information shared by other jurisdictions.

#### 3.5.2.1 High-risk substance alerts

Queensland Health has released a total of six high-risk substance alerts since the introduction of the drug checking services. These contained information about the substance detected in the community (including an image of the substance), toxic effects of the substance, harm reduction information and advice, and emergency contact information. Of the six alerts released by Queensland Health, four were for substances detected by the CheQpoint Drug Checking Service. The drug alerts issued by Queensland Health included:

- Expected Fake Nucynta Tablets, detected strong Nitazene opioid (May 2024)
- Cocaine containing phenacetin (5 August 2024, detected at CheQpoint)
- Expected Oxycodone (Counterfeit), detected strong Nitazene opioid (November 2024, detected at CheQpoint)
- New Nitazene (strong opioid) Protodesnitazene detected (March 2025)
- Expected Oxycodone Pill, detected strong Nitazene (April 2025, detected at CheQpoint)
- Expected Oxycodone Pill, detected Nitazene (April 2025, detected at CheQpoint)

Over the course of the evaluation period, CheQpoint issued eight public drug alerts. This included:

- Tusi in pink powder expected to be 2C-B (CheQpoint Instagram account 26 June 2024)
- Cocaine containing phenacetin (CheQpoint Gold Coast, 5 August 2024)
- Oxandrolone (‘Anavar) found to contain stanozolol and testosterone (CheQpoint Brisbane 27 August 2024). This release noted the research project ROIDCheck led by Griffith University, and encouraged people to drop samples at CheQpoint if they want to be part of the study.
- Novel dissociative found in methamphetamine (2F-NENDCK) (CheQpoint Brisbane 18 September 2024)
- A Nitazene found in Counterfeit Oxycodone (CheQpoint Brisbane 26 November 2024)
- A Nitazene found in counterfeit Oxycodone pill (CheQPoint Brisbane 31 March 2025)
- A Protonitazene found in “Green Teddy” pressed pill (CheQpoint Brisbane 4 April 2025)
- Ethylbromazolam found in counterfeit Xanax Pills and off-white powder (CheQpoint Brisbane 16 April 2025)

For each alert, the format explained why the substance is concerning, what effects to watch out for, and harm reduction measures that should be employed. This included encouraging individuals to carry naloxone.

Seven drug notices were issued by PTA following the REL festival. All alerts were issued within three days following initial testing. These contained information about substances contained in the sample, and potential harms or negative experiences associated with the substances. Information about the alerted drugs was shared with medical personnel on site for at least four of the seven alerts, and all information was shared with Queensland Health. The seven notices included:

- Caffeine and ketamine found in expected 2CB.
- N,N-dimethylpentylone found in expected MDMA.
- 2F-NENDCK and 2F-DCK found in expected ketamine.
- 2-FDCK found in expected ketamine.
- Ketamine and creatine found in expected MDMA.
- Procaine and tiletamine found in expected ketamine.
- Suspected high-dose MDMA (service unable to confirm pill dosage as further analysis was required beyond festival equipment capabilities and client retained sample).

Following the Wildlands festival, PTA shared information about three unexpected substances found in samples that were tested at the festival. These included:

- N,N-Dimethylpentylone (DMP) found in expected methamphetamine.
- Cocaine found in expected MDMA.
- MDMA found in expected ketamine.

In addition to providing formal alerts about high-risk substances, the drug checking findings also contributed to public information and awareness, formal drug monitoring and surveillance systems, and client facing support services.

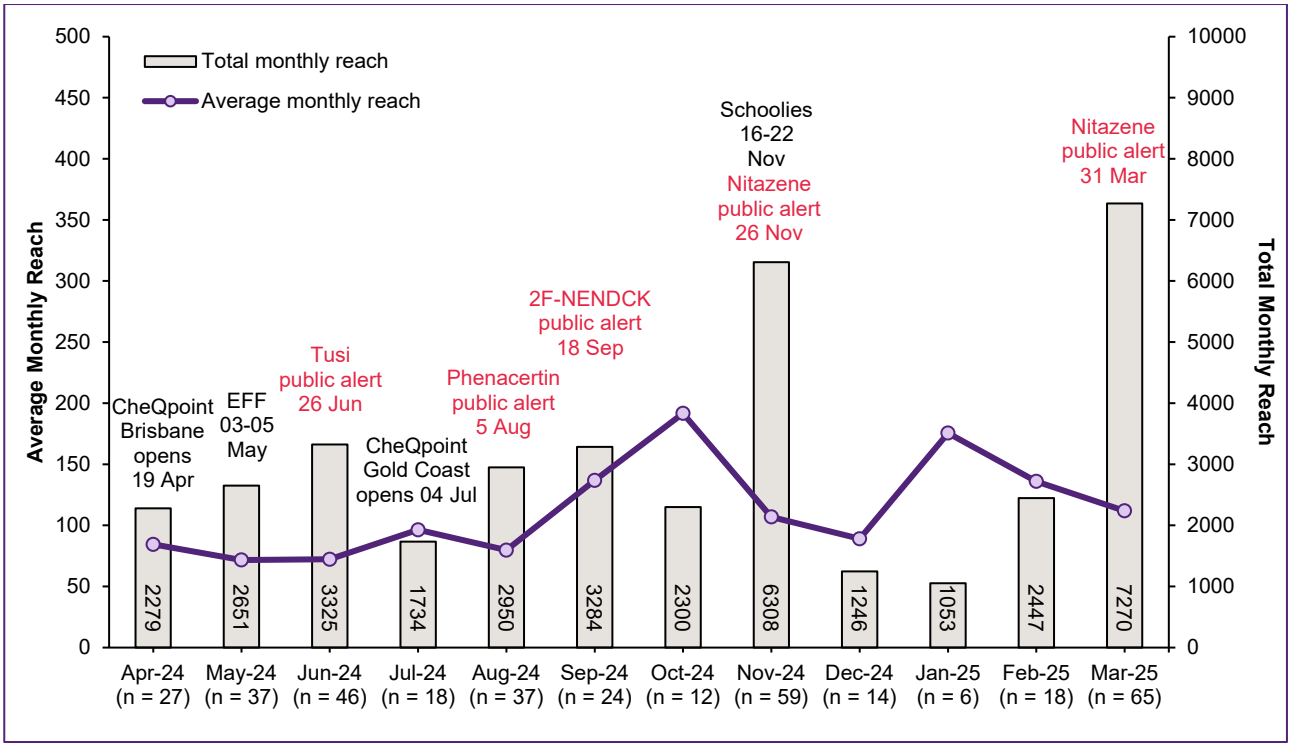
#### 3.5.2.2 Contribution to public information platforms

Information generated by the drug checking services was used by both service providers on social media platforms to promote the uptake of drug checking services. Social media was also actively used by the services to share the findings on drug checking, share information on drug alerts and harm reduction strategies.

> *It also gives us that information, and being able to get alerts out there - so even if people don't engage with a harm reduction service or something, they speak to someone and they know someone and that's really hard to find - but people go, this is what they found, and that gets out there before any kind of social media or any other kind of channel. That filters out really quite rapidly. (Stakeholder 7)*

In addition to sharing this information through the CheQpoint website, posts were made on social media following the discovery of each high-risk substance. Figure 41 shows the reach (the number of unique people who have seen the story) of CheQpoint's Instagram story posts during the service period. As shown here, the total monthly reach of CheQpoint's Instagram stories increased in months with posts related to public drug alerts, particularly alerts related to nitazenes (November 2024 and March 2025). The wide reach of these public social media posts (6000-7000 persons for the nitazene alerts issued in November and March) highlights the contributions of CheQpoint's social media to alerting the general public about harmful substances, well beyond the immediate reach of the physical services.

*Figure 41. Monthly reach of CheQpoint's Instagram stories over the service period (April 2024-March 2025; Source: CheQpoint social media analytics)*

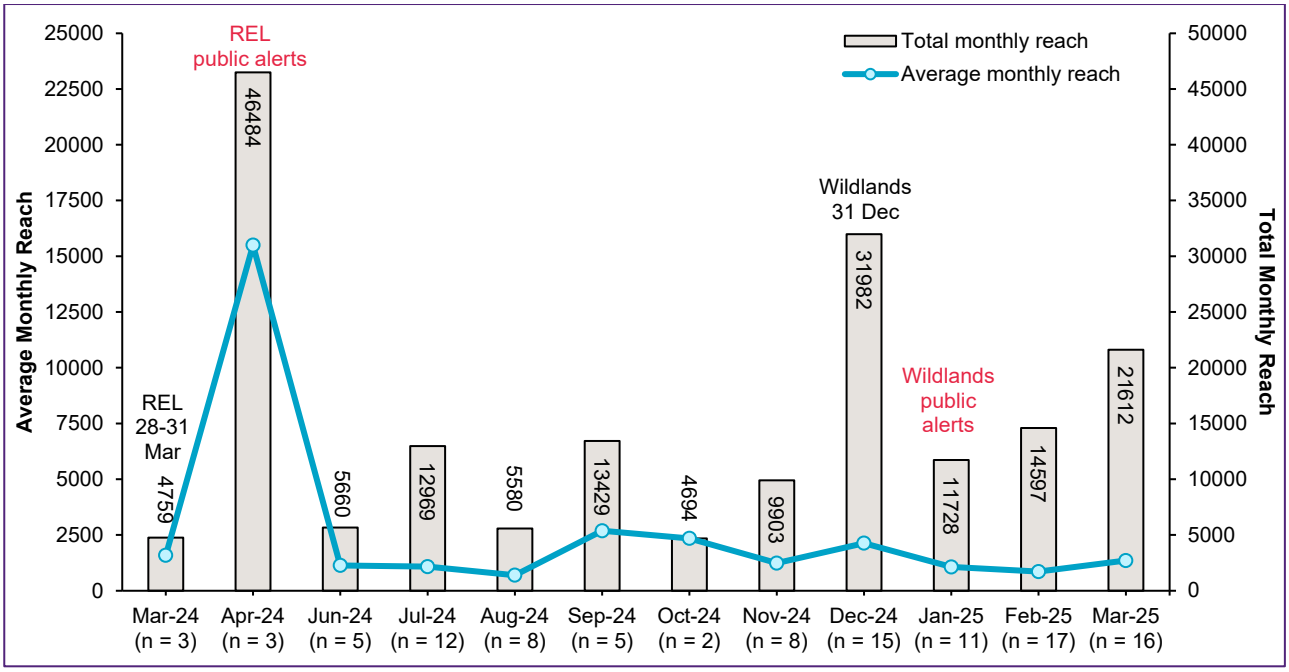



Notes. The average reach refers to the total monthly reach divided by the number of monthly stories (denoted by *n* on the x-axis), given the differences in the number of stories month-to-month.

PTA also shared the testing findings and information about expected effects and risks, and information on harm reduction about each alert on social media following REL and Wildlands festival. Figure 42 displays the monthly reach of PTA's Instagram posts[3] during the service period and shows that the reach of PTA's social media content peaked upon releasing information about the festivals, including public alerts, and appeared to achieve a broader reach again. Similar to CheQpoint, PTA's social media presence provided an important opportunity for information sharing to the broader public, beyond the service clientele and festival patronage.

[3] Note that we discuss the different services' social media separately as the social media data analytics for CheQpoint and PTA are not directly comparable. Specifically, CheQpoint data comprises of analytics for Instagram stories, while PTA data comprises data for Instagram posts.

*Figure 42. Monthly reach of PTA's Instagram posts during the service period (March 2024-March 2025; Source: PTA's social media analytics)*




Notes. The average reach refers to the total monthly reach divided by the number of monthly posts (denoted by *n* on the x-axis), given the differences in the number of posts month-to-month.

Stakeholders discussed the drug checking services' contributions to information sharing on various platforms. They noted the benefits of sharing information on social media to improve reach and engagement with the information, as well as sharing information on fixed websites such as CheQpoint and the Know websites, and having information shared by other jurisdictions.

> *the reach is well over 35,000 people. I've done alerts in New South Wales, and I think the best I've managed to achieve was 25,000. It was really well shared and, I think, helped to get a lot of eyes on harm reduction and on different alerts, and getting people to follow a variety of different pages to be updated, so that they can be continued to be updated about any alerts that come out, whether that's from CheQpoint or from The Know or ACT, New South Wales. (Stakeholder 17).*

During the interviews, stakeholder and client participants described some of the high-risk substances which were found during testing at the services. These included: nitazenes, counterfeit benzodiazepines, high-dose MDMA, a ketamine analogue, phenacetin and tusi. They discussed the value and importance of testing and being able to freely and quickly share the testing results with clients and other stakeholders to ensure people who use drugs are able to do so in an informed way and be aware of concerning substances circulating in the community. Participants also spoke about the benefits of drug checking in terms of contributing to the early detection of high-risk substances and the potential contributions to an early warning system.

> *I think drug checking is great for early detection of dangerous substances or any novel substances. Because otherwise, if they're not getting presented to a drug*

*checking service, who knows how long it will take before we discover it? Then it's already too late. I think it's great for early detection of novel substances or dangerous substances. I think drug checking is also great for preventing suppliers from putting dangerous substances in their drugs before they do sell it because they know drug checking is available. So, I think it'll also prevent the distribution of dangerous stuff before it's already gone out. (Stakeholder 2)*

*Especially with the nitazenes announcement coming out in the last week or so, it's just really stark contrast. They're here in Australia, we need to be aware of them, and people use drugs anyway. It's just how it is. We need to make sure that people are informed of what they're using. (Stakeholder 23)*

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Stakeholders spoke about how they shared information about drug alerts and substances of concern with the clients and the wider community beyond formal drug alerts. They also raised considerations that were needed prior to releasing drug alerts and sharing information about findings from drug testing. This included ensuring that information was released in a timely fashion – especially following the detection of high-risk substances – while also ensuring that the service does not release information so regularly that people become desensitised or in a manner that causes panic among the public.

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*I think this being a community health service, timing is everything, and getting information out to people, the time is very important. It needs to be a fast turnaround. I think having slow, very slow delays to having our reports come out, or being allowed to say, when something's come through, how fast we can put it onto our social media and that sort of stuff." (Stakeholder 10)*

*The alerts are a fine art. We need to get that information out, but people can also begin to - if there are too many of them, it can land up being tuned out. So, if there's MDMA that's just slightly over the dose, so instead of 120 milligrams, let's say it's 125, but when we're 150 milligrams, then yes, we need to get the information out and stuff. (Stakeholder 17)*

*It was just like at the festival, communication, and yeah we kind of were a bit concerned if we did find a high-risk substance how would we get that information out quickly but also without scaring everyone. (Stakeholder 5)*

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However, some comments were made regarding the delays related to approvals to release information to the public. Stakeholders expressed concerns that these delays could impact client safety and the clients' ability to search for accurate information online. In some instances, delays were attributed to a lack of appropriate resourcing and staffing to action the timely sharing of information.

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*…our comms and data positions are just completely overwhelmed, they're both five hours a week, and that pretty much is just enough time to do routine reporting and data cleaning and design the report and produce the regular social media content. So, there's not really enough time or resourcing in it to do bigger or better. (Stakeholder 12)*

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#### 3.5.2.3 Formal drug market monitoring and surveillance systems

Information from the drug checking services (both alerts and regular findings) was regularly shared with research networks established to monitor the illicit drug market in Australia, such as the Prompt Response Network (PRN), the Emerging Drugs Network of Australia (EDNA) and the National Naloxone Reference Group.

Within Queensland, formal alerts about substances of concern were shared with clinical networks and with the QPS.

Stakeholders spoke of the value of the testing services as providing a source of data triangulation and contributing to a better understanding of drug availability and drug trends between different jurisdictions to create a fuller picture of Australian drug markets.

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*But there is a lot of value in the data that is collected from drug checking results that simply validate what was expected. That's useful information. All of this data is helpful, there are public health and individual health benefits to all drug checking and monitoring of unregulated markets. (Stakeholder 24)*

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The immediacy of information generated by drug checking also allowed for speedy adaptation of health responses.

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*… to be able to say, this is real time intelligent that this substance everyone's worried about is present in our drug supply, in a way that's not waiting until someone's hospitalised. (Stakeholder 25)*

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Stakeholders also spoke of the services providing evidence to support advocacy work and encourage further development of evidence-based policy within the drug and alcohol space.

#### 3.5.2.4 Informing client-facing services

Stakeholders spoke about the use of word-of-mouth through discussions with clients attending the service. Clients were encouraged to share information among their peers to help spread information about substances of concern.

During the drug checking process, clients reported receiving valuable information related to harm reduction strategies and reducing harm while using the substances they had tested. This including sharing resources related to different drugs, information related to reducing harms related to dosage, sharing medical information and referrals to other medical services, and providing information on how to access AOD specialist treatment and harm reduction services. The sharing of harm reduction information happened throughout time the client was at the drug checking service, including discussion and sharing information pamphlets in the waiting room to sharing more individualised information during the testing process.

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*I was in the waiting room, there was one staff member who was very informative and went out of his way to offer information, pamphlets on different substances, access to resources.(Client 14).*

*we got like a really long conversation about like side effects, potentially what people generally could experience when consuming, like what an overdose could look like, how to take care of each other and ourselves whilst consuming drugs. So, there was*

*a lot of harm minimisation conversation, and my friend, when she came back from getting the MDMA tested, it was clear that she had also had a very similar talk, but about MDMA, because she shared that relevant information with us as well. (Client 6)*

Some participants also spoke about discarding of drugs following the testing process and harm reduction discussion. Some comments related to the benefits of drug checking in allowing clients to make timely and informed decisions about the substances they were using and improving the clients knowledge of the harms associated with the tested substance.

*we were told by young people for them to be able to access information, and they used it in a lot of the conversations we were having daily. Young people were gathering information to be better informed, not just about their own choices, but about people that they know, their friends. There was that messaging, and I think the Drug Checking really supports this. That's the messaging of community care and what harm reduction looks like in terms of saving lives [laughs] and making better choices. (Stakeholder 23).*

Medical personnel who were interviewed also spoke of the benefits of having event-based drug checking services as this allowed them to tailor their responses to patrons. This allowed the medical personnel to make more informed and timely decisions about patient care, ultimately resulting in better health outcomes for the patient.

*if you can find out that you've got say double or triple strength MDMA out there or you've got say fentanyl laced cocaine out there, when you're getting your patient coming through you're able to have that understanding. We saw a couple of cases of that where when we're having a patient come through and you're hearing someone talk about oh they had some cocaine or whatever it is you are seeing those opiate traits there as well and going well I know that's there because testing has determined it's there so let's go after this thing and sort it out. Previous to that it was always clinical assessment, you know, and we still do full clinical assessment but now we've got information to back that up. (Stakeholder 3).*

### 3.5.3 How did the information collected, and activities conducted, by the drug checking services contribute to broader harm reduction initiatives in Queensland and other jurisdictions?

**KEY OBSERVATIONS**

- Provision of harm reduction information during consultations with clients reduced client risk when taking substances.
- Client interaction with drug checking services increased distribution of naloxone into the broader community and to population groups at risk of overdose.
- Client referrals to other health services such as mental health and AOD treatment services increased due to client use of drug checking services.
- Drug checking services facilitated the identification of clients with complex mental health and drug dependence needs who may not have presented at other health services.

- QLD and ACT has established policy and/or guidelines that stipulate how service providers must manage and provide drug checking services in fixed site and festival settings.
- Comparison of QLD drug checking services to similar government funded services in other jurisdictions is discussed below. The key elements of service models were similar across jurisdictions, with key elements being testing of sample/s provided by clients and a discussion (sometimes called 'brief intervention') with clients about the content of the sample and the provision of harm reduction information. Services require informed consent. A key difference is in the policy environment, with Victoria being the only jurisdiction where the drug checking services are enabled by legislation rather than policy frameworks and/or guidelines.

#### 3.5.3.1 Harm Reduction Information

Clients and stakeholders commented that the provision of harm reduction information in both the fixed site and festival site services had a positive impact. Clients felt better informed, and that they could make safer decisions, while event-based support services noted that overall event safety was improved.

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*…even just in that waiting room reading about all the different substances, that alone was impacting, or I was just gaining more knowledge about things and about what's going around at the moment with those other substances that have been found...It is reducing people from dying, from overdosing, from taking something that they didn't think they would take, or providing something that they thought was one thing and not the other. (Client 27)*

*We normally send five to eight people to the hospital every year with overdoses that we can't treat locally. This year we sent no one and we're relatively confident it's because the people knew what they were taking. We still had drug affected people, but they're not - how can I put this? They're not as high. They're not overdosing. They're not medically unwell. They might be drug affected but they're not bad. I think that's the biggest impact that we're finding, is that people are - it's just safer. People are able to adjust what they take and take less or take more or know what they're taking so they can expect it, things like that. (Stakeholder 6)*

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#### 3.5.3.2 Naloxone distribution and the Take Home Naloxone program

Clients and stakeholders commented on how the services had a positive impact on naloxone distribution in the broader community. Both stated that harm reduction education was available to clients on how naloxone can reverse an opioid overdose as well as where it can be sourced from. Both observed that the fixed site services distributed free naloxone to clients as part of the Take Home Naloxone program.

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*They also gave me some naloxone for free, which is very good. I ended up taking it to a festival. I didn't end up having to use it, although I'm aware that other people did use it at that same event...If there's naloxone available for – it can – these programs can really only help people – can really only help save lives, save hospital admissions and presentations and reduce the cost to society (Client 3)*

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Detections of nitazenes found in substances not expected to contain a synthetic opioid was information used to inform the state-wide roll-out of naloxone nasal sprays to all operational vehicles within the QPS.

#### 3.5.3.3 Increased contact with other health services and health workers through referrals

Stakeholders observed that client referrals to other health services such as mental health and AOD increased due to client contact with drug checking service. Stakeholders also commented that drug checking services facilitated increased client interactions with other health workers at the services. As discussed in section 3.4.4.2, 15% of clients were referred on to a GP or other health professional to discuss their substance use, and a further 2-6% of clients were referred onto specialist AOD services. Data on whether those referrals were taken up was not recorded, however, 4% of clients reported that they would benefit from an external referral to specialist AOD services whilst 2% reported that they would benefit from an internal referral at QuIHN.

> *I'm noticing the amount of people that have had an interaction with health workers. It is slowly creeping up. The more interactions that people have with us, the more knowledge they leave with and the more power to them…even other health workers, sexual health nurses, they are then in the same space and they just have that opportunity to have a chat...I see a lot of positives in that aspect. (Stakeholder 18).*

Due to co-location with a needle and syringe program, one client also commented that they *"were able to access clean needles... other resources" (client 3)* as part of AOD treatment.

Stakeholders also observed that through the drug checking services, health workers have been able to identify clients with significant mental health and drug dependence concerns who may not have presented to other health services to get support.

> *I don't know whether that's been highlighted very much, but some of those interventions with clients have been incredibly significant, like people who have quite significant mental health concerns, were particularly worried about their substance use and those interventions with the health harm reduction worker and with the peer workers as well and the referrals that have come from that, like we've had quite a number – a few people coming back regularly to get more support. (Stakeholder 13)*

Drug checking services have also contributed to harm reduction services in other jurisdictions, including informing the design and delivery of other drug checking services. These models are discussed in the following section.

#### 3.5.3.4 Drug checking services in other Australian jurisdictions

During 2024, in addition to the drug checking services operational in ACT and Queensland, Victoria and New South Wales Governments announced that they would fund drug checking services in their jurisdictions. These included both fixed site and event-based services.

Victoria announced an 18-month festival trial to commence in December 2024 with a fixed site as part of the trial to open mid-2025.(34) New South Wales Government (NSW) announced a 12-month festival trial to commence in March 2025. (Prior to this, a 4-month research project funded by The Loop & NCCRED was hosted at the Medically Supervised Injecting Centre (MSIC) in inner Sydney). (35, 36)

State Governments in Western Australia, South Australia and Tasmania remain opposed to drug checking services and there has been no subsequent action taken in the Northern Territory since the former chief minister supported investigating a proposed service in 2021.(37)

Table 6 below compares the key features of government funded fixed site services currently or soon to be in operation in QLD, ACT and VIC; Table 7 compares event-based services.

*Table 6. Comparison of fixed site drug checking programs*

| State/Territory | ACT | QLD | VIC |
|---|---|---|---|
| Service name | CanTEST | CheQpoint | Pill Testing Trial |
| Operation dates | July 2022 - current | April 2024 (Brisbane), July 2024 (Gold Coast) – 4 April 2025 | Opening mid-2025 |
| Operational status | Permanent – to continue until at least June 2027.(31, 32) | Contract expired 18 April 2025 | Trial 18-months |
| Site/s location | Canberra CBD | Brisbane & Gold Coast | Inner city Melbourne (TBA) |
| Funding source | ACT Health | QLD Health | VIC Health |
| Investment | 2024 – 2027 $1.8million(31) | ~$740,000 (includes event based) | $4 million (includes event based)(38) |
| Policing guidelines | Y(39, 40) | Y(41)(p.1150) | Unknown |
| Service model specifications | | | |
| Co-location | Directions Health Service, city community health centre | Queensland Injectors Health Network services (QuIHN) | Unknown |
| Opening hours | 6hrs/week<br>Thurs 3-6pm; Fri 6-9pm | 4hrs/week per location<br>Fri 2-6pm | Unknown |
| Workforce | Chemical analysts, Registered Nurses, harm reduction workers. | Peer harm reduction worker, chemists, social worker, nurse, AOD counsellor. | Health care workers, technical experts, harm reduction workers. |
| Free, voluntary & anonymous | Y | Y | Y |
| Waiver required | Y | Unspecified | Unspecified |
| Other services | Amnesty bin<br>“Drop-in” Nurse consultations; take-home naloxone. | Referrals to other support services; optional health assessments; take-home naloxone. | Unknown |
| Analysis methods | FTIR, UPLC – PDA, FTS | FTIR (all samples)<br>Colorimetric reagent tests | Unknown |

| | | | |
|---|---|---|---|
| Substances tested | Pills, capsules, powders, crystals, liquids & blotters. | Powder, crystals, rocks, pills, blotters & liquid. | Most pills, capsules, powders, crystals or liquids. |
| Substances not tested | Organic matter & oil-based liquids. | Plant & fungi, drug equipment (after use), or confectionery | Organic |
| Wait time | 30 mins minimum | 21 mins (average) | Unknown |
| Off-site secondary analysis | Y(42) | Y – all samples(43) | Unknown |

**Key:**
*Fourier transform infra-red (FTIR)* - identifies drugs from their infrared spectrum.
*Ultra-performance liquid chromatography-photo-diode-array (UPLC-PDA)* - separates compounds, then identifies and quantifies them from their UV absorbance.
*FTS* – Fentanyl Test Strips
*Organic matter* – e.g., cannabis, fungi.
*Oil-based liquids* - e.g., some steroids.

Four governments in Australia fund or funded event-based drug checking programs (QLD, NSW, VIC and ACT). Table 7 below compares the service models for event-based drug checking across these jurisdictions.

*Table 7. Comparison of event based drug checking programs*

| State/Territory | NSW | VIC | QLD | ACT |
|---|---|---|---|---|
| Service name or governing policy | NSW Drug Checking Trial(36) | Victoria's Pill Testing Trial(34) | CheQpoint(33) & Pill Testing Australia | The Festivals Pill Testing Policy(44) |
| Operations dates | March 2025 | Summer 2024/25 – mid 2026 | April 2024-April 2025 | Oct 2024 - Oct 2026 |
| Program type | Trial 12-months | Trial 18-months | Now ceased | Ongoing |
| Site/s | Music Festivals x 12 maximum | Event based x 10 maximum | 4 events | On-demand |
| Funding source | NSW Health | VIC Health | QLD Health | Festival provider |
| Investment | $1 million | $4 million (includes fixed site – yet to be opened)(38) | Included in overall funding with fixed site operations | N/A |
| Policing guidelines | Unknown | Unknown | Y(41)[p.1150] | Y(39, 40) |
| Service model specifications | | | | |
| Co-location | Alongside other harm reduction and medical services, at selected festivals. | Unspecified | Stand-alone service: work in cooperation and co-located with onsite first aid/health service providers & peer support services.(9) | Stand-alone service, located out of sight of general population within event, or directly adjacent to medical/ first aid area. |
| Workforce | Analytical scientists, clinicians, health | Health care workers & technical experts, | Appropriately trained and supported health and harm reduction | Staff trained to use testing equipment, licenced to handle |

| | | | | |
|---|---|---|---|---|
| | staff, harm reduction peer workers. | harm reduction workers. | workers and qualified analytical chemists.(9) | controlled substances & staff trained in drug counselling. |
| Free, voluntary & anonymous | Y | Y | Y(9) | Unspecified |
| Waiver required | Y | Unspecified | Y(9) | Unspecified |
| Other services | Amnesty bin | | Amnesty bin(9) | Amnesty bin |
| Analytical methods | Main components & indication of potency (where possible). Using a mix of technologies. | Unspecified | Required to be of best practice standard (e.g., FTIR) and supplementary testing (e.g., FTS and reagent colorimetric testing)(9)[10] | Must be able to identify drug component and detect adulterants and/or unknown substances. |
| Substances tested | Unspecified | Most pills, capsules, powders, crystals or liquids. | Powder, crystals, rocks, pills, blotters & liquid. | |
| Substances not tested | Unspecified | Organics | Plant & fungi, drug equipment (after use), or confectionery | |
| Wait time | "Rapid Evaluation" | 10mins(45) | Not recorded | Within an acceptable time period. |
| Off-site secondary analysis | Offered if main components unable to be identified. | Y | Y | If required, must be agreed with ACT Health Directorate. |

**Key**
*Fourier transform infra-red (FTIR)* - identifies drugs from their infrared spectrum.
*Ultra-performance liquid chromatography-photo-diode-array (UPLC-PDA)* - separate compounds, then identify and quantify them from their UV absorbance.
*Organic matter* - e.g., cannabis, fungi.
*Oil-based liquids* - e.g., some steroids.

#### *3.5.3.4.1 Service models*

Service models do not differ significantly across the programs listed within Tables 6 and 7, with many common features across fixed site drug checking services and event-based drug checking.

The listed drug checking programs commonly involve partnerships between several organisations for service delivery and/or evaluation, as shown in Table 8.(31, 33-35)

*Table 8. Drug checking program partnerships and evaluation agencies*

| Program | Delivery Partnerships | Evaluation |
|---|---|---|
| CanTEST (ACT) | Directions Health Services<br>Pill Testing Australia (auspiced by Harm Reduction Australia) | Australian National University |

| | | |
|---|---|---|
| | Canberra Alliance for Harm Minimisation and Advocacy (CAHMA) | |
| CheQpoint (QLD) | Queensland Injectors Health Network (QuIHN)<br>Queensland Injectors Voice for Advocacy & Action (QuIVAA)<br>The Loop Australia<br>Griffith University Analytical Facility | University of Queensland Institute for Social Science Research |
| PTA | Pill Testing Australia<br>Griffith University Analytical Facility<br>Australian National University | University of Queensland Institute for Social Science Research |
| Victoria's Pill Testing Trial | The Loop Australia<br>Youth Support and Advocacy Service (YSAS)<br>Harm Reduction Victoria<br>Melbourne Health and Youth Projects<br>Metabolomics Australia (University of Melbourne) | Not yet specified |
| NSW Drug Checking Trial | Health Pathology Forensic & Analytical Science Service (FASS)<br>NUAA | Intended to be independently evaluated. |

The workforce across all programs listed (fixed and event based) to deliver the service comprise similar groupings of roles within the service teams.(31, 33, 34, 36) Most programs state they have:

1. Peer workers (referred to as Peer Harm Reduction Worker)
2. Qualified person/s to conduct the sample testing (referred to as a chemist, chemical analyst, analytical scientist etc) and
3. Qualified health professional/s (referred to Registered Nurse, health staff or health care worker).

The fixed site programs (CanTEST and CheQpoint) are co located within buildings with other health services.(32, 33) The NSW Drug Checking Trial (event based) plans for the program to be co-located with other harm reduction and medical services, at selected festivals.(36)

Fixed sites are open similar durations (6hrs and 4hrs respectively) within one week, with CanTEST (ACT) splitting their opening hours across two afternoons rather than one and CheQpoint operating at two locations.(32, 33)

#### *3.5.3.4.2 Service process*

The process a client engages in is similar between all listed programs. Following an initial conversation with a peer worker, a sample is provided by the client to the analyst, which is then tested and the results delivered to the client in addition to harm reduction advice.(31, 33, 34, 36)

All listed programs make the client and public aware that the service is voluntary and anonymous.(31, 33, 34, 36) In addition to this, CanTEST (ACT) stipulates no Medicare card or ID is required and provides a detailed explanation that the signed waiver is stored in a separate database with no linking of name to waiver.(32) No other listed program was found to detail how the service user's information is handled/stored once collected. The NSW Drug Checking Trial states that a service user's information will not be linked to their personal identity, however does not specify what information related to their personal identity is collected.(36)

All sites stipulate that the sample is a small size and offered by the service user, i.e. it is not taken by a member of the program workforce.(32-34, 36) The NSW Drug Checking Trial, CanTEST (ACT) and Queensland Drug Checking Service Requirements(9) request that service users sign a waiver noting limitations of the test and their understanding that no level of drug consumption is safe.(9, 32, 36)

The Queensland Drug Checking Service Requirements(9) stipulates that people under the age of 18 years should still be able to access the services, however informed consent is required to be obtained and a waiver signed.(9)

CheQpoint is the only program listed (fixed and event based) that stipulates to the service user (via their webpage) that it "must be to the person who is planning on taking the substance to get their drugs checked".(33)

Fixed site programs (CanTEST & CheQpoint) offer additional services such as health assessments (general, sexual, mental health) and other service referrals; it is not specified if these are offered at the event based programs(32, 33). Access to take home naloxone was offered by all.(46, 47)

#### *3.5.3.4.3 Drug checking policy and guidelines*

As highlighted in Section 3.1.1, Queensland has developed formalised requirements for service providers that set out how service providers within Queensland must manage and provide drug checking services.(9) Similarly, ACT Health has developed "The Festivals Pill Testing Policy" which is described as a guide for event organisers to implement harm minimisation, including pill testing.(44)

New South Wales Department of Health has published guidelines to support event organisers to deliver safer festivals.(48) However, these guidelines have no reference to drug checking or pill testing requirements, programs, services or trials.(48)

The NSW guidelines provide guidance on harm minimisation, harm reduction, harm reduction messaging and peer-based harm reduction services. There is mention of the provision of medical waste bins (labelled as clinical waste, rather than amnesty bins) to be accessible in discreet areas for disposal of unwanted drugs or drugs found by festival patrons. This is similar to the provision of dedicated sharp bins for the safe disposal of needles and other drug paraphernalia, also to be in discreet key locations, such as toilets and event based medical facilities.(48)

All listed programs have used similar language when describing the service, workforce roles and the purpose for providing the service. To describe the service, the terminology 'drug checking' is primarily used, except for Victoria's program that uses 'pill testing' primarily and 'drug checking' secondary.(32-34, 36) The purpose of providing the service across all programs (fixed and event based) has commonly been described as, *providing harm reduction advice for the user, to make an informed choice and manage/reduce risks*.(32-36, 47)

The term 'harm reduction' is also commonly used throughout the listed programs when referring to the advice provided to service users and the peer worker job title.(32-34, 36)

The language used in the NSW guidelines and QLD *Requirements* does not differ significantly from ACT Health documents, or the other webpages mentioned, however both introduce the term 'brief interventions' when referring to the provision of peer-based education to patrons.(9, 48) The NSW guidelines suggest only specifically trained peers should deliver these interventions and that these can take various forms, but may not always be useful or appropriate to conduct.(48)(pp14-15)

All programs state that only a small amount of a drug needs to be tested and that the sample is to be provided by the user (i.e. service staff do not take the sample).(32-34, 36) CheQpoint, MSIC and PTA all emphasise that the sample will not be returned to the service user.(33, 47)

In Victoria, the passing of the *Drugs, Poisons and Controlled Substances Amendment (Pill Testing) Bill 2024* made Victoria the first jurisdiction in Australia to have dedicated legislation to support pill testing. The Victorian Department of Health publicly announced that this new legislation "provides protections for the services, for its staff, and for its clients – so no one is breaking the law by operating or using the pill testing service".(34)

#### *3.5.3.4.4 Drug-checking related policing*

All drug checking service delivery models have different approaches to how police are to interact with the service. The advice for Queensland Police members is outlined in specific updates to the Queensland Police Service Operations Procedures Manual.(41)(p.1150) The manual states that "officers should be mindful of the need for members of the public to freely use these services" and that a person should not be under suspicion if in the vicinity of a drug checking service. It refers to being mindful of the proximity of Police units from a drug checking service operating at a music festival, to ensure patrons are not deterred from using the service. Queensland Police were involved in developing the *Requirements for Drug Checking Services*.

CanTEST and NSW Drug Checking Program also mention support of drug checking services from the Police on their webpages.(32, 36)

In the initial stages of the 6-month pilot for CanTEST (ACT), the Australian Federal Police (AFP) released a Better Practice Guide for Fixed-Site Drug Checking Service.(39) This document is a functional governance instrument and describes the service as a harm minimisation service that is co-located with other health services and encourages AFP members to use discretion whether to exercise their duties on patrons entering the building. It highlights that possessing drugs remains a criminal offence. However at that time, changes were proposed to decriminalise possession of certain amounts of illicit substances in the ACT.(39) These changes came into effect in October 2023, which reduced the maximum penalty for possessing small amounts of some illegal drugs for personal use.(44) A Memorandum of Understanding (MOU) between the AFP and ACT Health Directorate regarding the service was also under development at that time.(39)

For the NSW Drug Checking Trial, the NSW Health webpage publicly advises that it is not illegal to use the drug checking services that are part of the trial.[7] A NSW ministerial release on 19 December 2024 included that "the amnesty provided as part of this trial, is strictly limited to people seeking to check drugs for their own personal use and it will remain an offence to possess illicit drugs at any event where pill testing is provided."(49)

#### *3.5.3.4.5 Communication and promotion*

Both currently operating fixed site programs listed provide user-friendly webpages that are targeted to the service user, rather than information for the general public.(32, 33) For example:

1. Designs that contain useful information including social media links, locational information that includes parking, opening hours and the service process.
2. Use of colours, infographics, pictures (photos of substances) and information written in easy-to-read language.
3. Easily accessible reports and drug notifications published directly to the webpages.

Some event-based programs listed have provided service information via publicly accessible webpages/reports, such as CheQpoint who published the *Earth Frequency Festival* report and quarterly service reports on their webpage.(33, 50) Harm Reduction Victoria (HRV) has also published the first three festival reports included in the Victorian Pill Testing trial, with the fourth advertised as expected soon.(51)

Most of the service information for event-based programs is delivered through health department online pages for each state and media releases. The first five events planned to offer pill testing service in Victoria were named on VIC Health webpage, with subsequent events to be announced later in the year.(34) To date there has been one event (of 12 maximum planned) named on NSW Health webpage to participate in the NSW Drug Checking Trial.(36) At the time of this report, no additional information was publicly available on which future events (other than those named) will offer event based services or how this will be communicated to service users, for either Victoria's Pill Testing program or NSW Drug Checking Trial.

The analytical results of the event based NSW Drug Checking Trial are planned to be integrated into NSWs existing rapid drug surveillance, early warning and response system to alert the community when there is a health risk related to a substance circulating in the community.(36) It is unspecified how Victoria's (event based) Pill Testing program analytical results will be communicated to the community or integrated into VIC Health drug surveillance, apart from the reports published on the HRV website and released through The Loop Australia's social media. Queensland based service providers that offer a drug checking service are required to participate in Queensland's early warning/drug alert systems.(9) Both have published analytical findings on their social media and web pages.

### 3.5.4 Were there any unexpected consequences of the services?

**KEY OBSERVATIONS**

- Some clients presented with more complex needs than initially expected: mental health, housing and employment supports were able to be offered.
- Increased provision of naloxone was recorded, including to groups not previously expecting to need it.
- The presentation of substances on behalf of other people, not allowable under current service models, provided opportunities for communication with unexpected clients such as parents.
- There were reports of service clients changing the person from whom they obtained their drugs as a result of drug checking findings.
- Potential misinterpretation of test results by clients was not widely noted due to efforts of service staff to reiterate the limitations of information provided.

#### 3.5.4.1 Supporting clients presenting with complex needs

As noted in the Client Characteristics section above (3.4.1.1), services reported engaging with and providing assistance to clients with more complex needs than initially expected. A number of clients who reported acute mental health concerns, polysubstance use and social challenges such as housing and employment, were able to be supported through both immediate interaction and facilitated referrals.

#### 3.5.4.2 Increased provision of naloxone

Services co-located with drug checking recorded an increase in the provision of take-home naloxone during operation of the drug checking services, noting that clients other than those who would normally use an NSP service were collecting and learning how to administer naloxone, in response to concerns about the detection of nitazenes and other potential overdose-causing agents in the samples presented for testing. This generated increased awareness of the risks and knowledge of how to respond so such overdoses, often in a population not usually regarding this

as a relevant risk for themselves. Naloxone was also provided at event-based services, where patrons may not have previously considered themselves at risk of needing naloxone.

> *I guess probably the naloxone going to communities that wouldn't typically have presented to a Needle and Syringe Program but are vulnerable to overdose in that they don't know a lot about it, and they're able to receive education about how to respond to someone if they are having an opioid overdose. (Stakeholder 16)*

#### 3.5.4.3 Presentation of substances on behalf of other people

Services reported occasions when people had presented drugs on behalf of another person without consent. In these situations, the service was unable to test the substance as the user of the substance had not provided consent for testing. Examples included parents bringing in substances that they had found in their child's room. While the service was not able to test the substance, this did provide the opportunity for the service to provide support and resources to the parent to help frame future discussions with the child regarding drug use from a harm reduction perspective. The service also encouraged the parents to bring the family member to the service if they were willing.

> *"we get a lot of parents coming in going, hey, I found this in my son's drawer or my daughter's car or wherever, can you test it, and we're like, we can't test that unfortunately because we only test substances for people who are intending to take the substance. But through that, having all these parents come along or concerned loved ones, we've had so many conversations with them about how to talk to their child or their family member or their friend about substance use and offering them a lot of support." (Stakeholder 28).*

#### 3.5.4.4 Impact on people who sell drugs

During the evaluation design process, the potential for impact of drug checking information on unregulated markets was raised. Both client and stakeholder interviewees suggested that drug checking may also deter drug manufacturers and people who sell drugs from adding adulterants to products if they knew clients had the option to get their substance tested. If substances were found to contain adulterants, they may be less likely to purchase the substance from the same person in the future. (Such occurrences were reported by more than one interview participant.) Participants felt that people who sell drugs may be held more accountable and inclined to test substances prior to selling, although this was not the intention of the services, where the person presenting the substance is required to be the person intending to *use* it.

> *"I think drug checking is also great for preventing suppliers from putting dangerous substances in their drugs before they do sell it because they know drug checking is available." (Stakeholder 2).*
>
> *"Another positive though is people are being held more accountable and people are able to see who's ethical and who's not as well. I know of people that go there and they will get their shit tested and then go and sell it, which is admirable in my eyes." (Stakeholder 18).*

#### 3.5.4.5 Potential for misinterpretation of test results

Some stakeholders expressed concerns that clients may misunderstand or misinterpret the results from testing, and perceive the substance as safe to use. Service staff however spoke of the consistent efforts made to carefully discuss the substance with each client to ensure that the client understood the risks of the substances they had tested and strategies to mitigate risk when using the substances. At fixed site services, clients were required to sign a waiver acknowledging that no use of illicit drugs is safe. This highlights the ongoing need for drug testing results to be accompanied by contextualised harm reduction information.

> *"there is potential for people to misinterpret the educated opinion that us as chemists give, then go out and say that we've certified that as something. That the results that we're giving them are a tick of approval I guess when we're just providing our best opinion based on the information that we've got. We try to reiterate to people that when they bring in tablets or small amounts of sample that those things aren't necessarily representative of the rest of the sample you might have." (Stakeholder 21)*

### 3.5.5 Key implications at system level

**KEY IMPLICATIONS**

- Drug checking services may provide broader avenues for harm reduction than originally expected, including to broader client groups (e.g., parents), by encouraging and providing training in overdose response via take-home naloxone provision, and connecting clients with support for additional needs.
- Broad collaboration across sectors is required to ensure that findings are shared across services and agencies to ensure information is fed into surveillance and care systems in a timely manner.
- It is important to continue ensuring that information conveyed to service clients clearly articulates that test results do not indicate safety of the substance analysed, and that providing individual, contextualised harm reduction information continues to be an integral part of the service.

## 3.6 What were the key strengths of drug checking services?

A series of key strengths of the drug checking services became apparent across the evaluation period:

- The value of drug checking services as an effective harm reduction strategy was widely appreciated by the AOD sector, the community of people who use drugs, and the broader community.
- Service providers were perceived as well-established, trusted and expert, with staff regarded as respectful and knowledgeable.
- Service provision was relatively smooth, with appropriate analytical technology, relatively short wait times and helpful brief interventions/health conversations, even in busy festival environments.
- Testing was able to identify substances of concern, including identifying novel forms of emerging substances.
- Services were located in 'safe spaces', co-located with other health supports, which facilitated transfer between services at event locations, contextualised drug checking as a health offering and helped reduce the stigma associated with access.
- Service data showed engagement with a wide range of clients of differing demographics and substance use patterns. Importantly, the services were able to reach several significant groups of people: some who had never before engaged with health professionals about their substance use, some naïve to substance use who benefited from timely and accurate harm reduction information, and some with complex needs who were able to be referred to multiple support services.
- Drug checking services were effective: clients demonstrated important intended and actual behaviour change to increase safety, reduce risks and address related health concerns.
- Services were cost-effective. The estimated cost per test was similar to commercial testing options, but testing was delivered alongside health and harm reduction support for no additional cost.

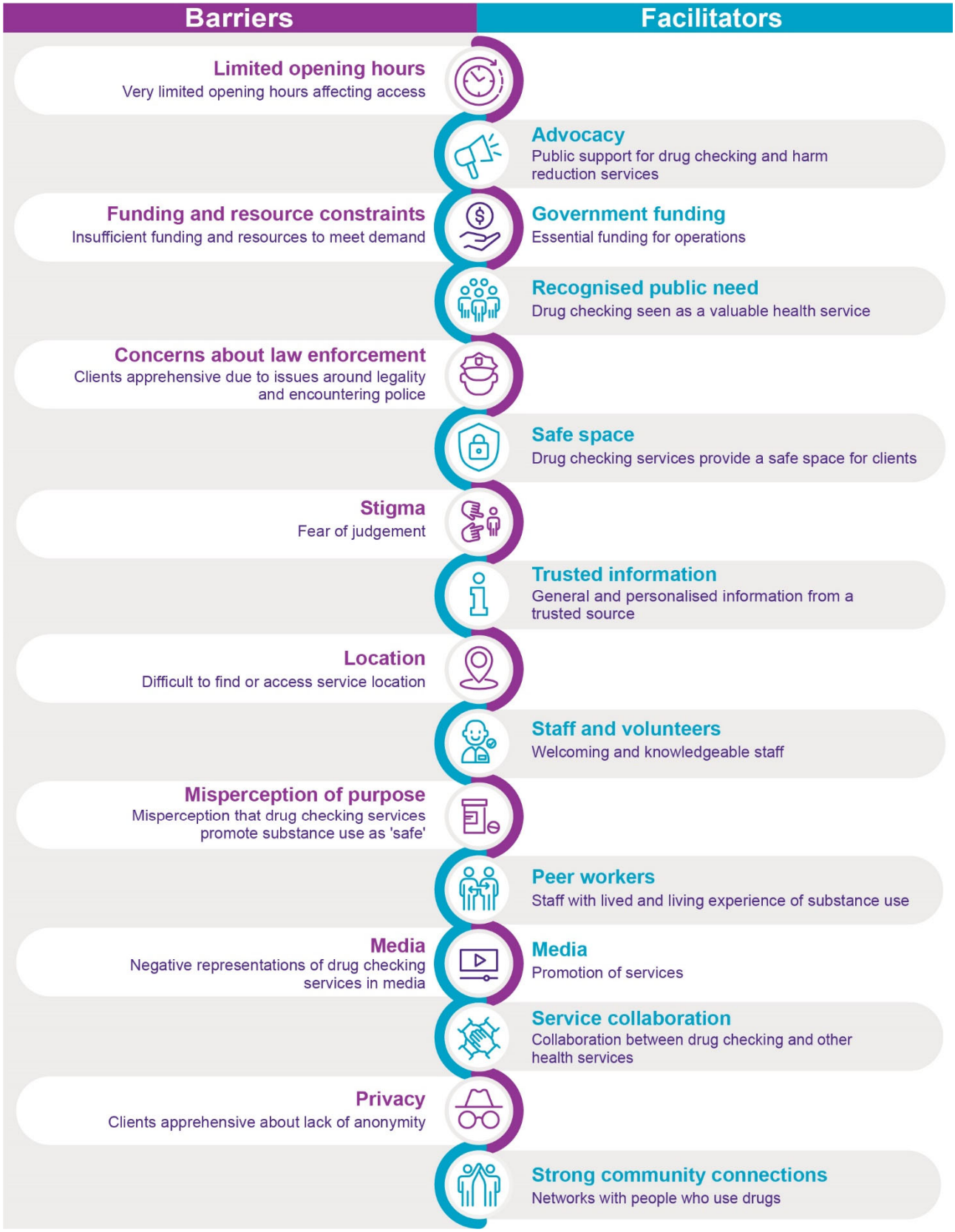
### 3.6.1 What were the facilitators of and barriers to effective drug checking service delivery?

**KEY OBSERVATIONS**

- Many of the factors identified below have both enabling and challenging aspects. May have been discussed in previous sections but are summarised below and in Figure 43.
- Barriers to service delivery included limited hours, resources, and locations, as well as concerns about law enforcement and substance use stigma.
- Media was perceived as both facilitator and barrier, raising awareness of drug checking and acting as advocates for need, but sometimes portraying the services and clients in a negative light
- Community support and need was identified as a major facilitator of service delivery, as well as the positive effects of advocacy, inter-service collaboration, and creating a safe space to obtain trusted drug information.

These are summarised in Figure 43, noting that some factors acted as both facilitator and barrier.

*Figure 43. Barriers and facilitators to drug checking.*



#### 3.6.1.1 Facilitating factors

##### *3.6.1.1.1 Advocacy*

A range of enabling factors were observed during the implementation of both fixed and mobile services, with advocacy being mentioned by many as being extremely valuable. Leadership in the non-government AOD sector has been highly visible, with an emphasis on clear messaging and safety promotion. Although the politics surrounding drug checking was often regarded as a barrier to the implementation of services, there was also acknowledgement of government advocacy.

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*The [government] was helpful; the coalition explored every angle to achieve it. [Other advocates] strongly supported it after [one young person]'s passing. They considered legal standings, political allies, and possible actions. At the 2019 Winter School conference, the Mental Health, Alcohol and Other Drugs Commissioner emphasised that Australia and Queensland need …courage to become like Portugal (Stakeholder 1).*

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##### *3.6.1.1.2 Perceived public need*

One of the most resounding facilitators from both clients and stakeholders was the public interest in drug checking services. Interviewees pointed out that the community has long desired these services and has embraced the concept after a hard-fought battle. Despite the challenges, the service has been well-accepted by patrons and staff, who feel it's overdue and necessary. Furthermore, being able to participate in the evaluation made people feel heard and supported, especially in a community that often feels overlooked and marginalised.

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*The community itself has been wanting this for so long, there's been such a hard fight to get drug checking here that people have really embraced the concept. Even if they haven't had an opportunity to use the service, they're talking about it (Stakeholder 13).*

*It just felt very accepted. There were a lot of patrons, but also broader event staff working there that were along the lines of 'it's about time this is here, we really need this, we want to provide this information to our patrons' (Stakeholder 14).*

*I've accepted to be part of this research because it benefits me and my friends. I've spoken to many people for some time, no one was listening, so having a service like this makes us feel heard and that someone is trying to make a difference for this often overlooked and marginalised community (Client 9).*

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Clients and stakeholders acknowledged that drug checking services provide people with health options that may otherwise not exist. Accessing the service provided an opportunity for early intervention by encouraging behaviour modification to reduce risks and promoting regular health checks.

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*For the individual accessing the service, it's an opportunity for an early intervention when someone's pre-contemplative even. Or they might never contemplate giving up drug use, but they might consider modifying their behaviour to reduce risks. They might be more proactive with regular health checks. It's a preventative and early intervention health service (Stakeholder 9).*

*For me, I think, where else would they get that help from if they're too ashamed to talk to their doctor about it? Their friends are in similar situations, they don't see a way out, I'm just so glad that they're able to talk to somebody (Stakeholder 21).*

*It just felt really good going in there. It felt even better leaving, because for drug use, you don't have support. There's no support out there until you're in hospital. So you're getting support for the wrong reasons. So to have support before you use these things, that you don't really know what's in them, it's just that element of safety, which is something that I've never really experienced before. So pleasantly surprised. (Client 11).*

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For many clients, visiting a drug checking service was the first time they had spoken to a health professional about their drug use. The services were seen as creating a safer environment compared to the past, particularly for young people. Parents also expressed support, wanting the service available for their children and others, highlighting the community's desire for increased safety.

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*I feel relieved that there's a service like this available, especially for the young people trying new things. I feel that we're providing a safer environment. A lot safer than back in the last century when I was 20. I have a 12-year-old… the safer we [make it] for them, the better (client 17).*

*We've had parents calling us saying that they want our service to be there, whether it's their kids or their kids' friends or other people (Stakeholder 10).*

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#### *3.6.1.1.3 Safe spaces*

Drug checking services were perceived as being a safe space where clients could have open and honest conversations about their substance use. This supportive environment attracted individuals who might not have otherwise engaged with health services, highlighting the importance of a non-judgmental, safe space.

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*I think one of the biggest things in the beginning was the community of people who use drugs who are aware of QuIHN and have a great deal of trust in QuIHN. We've got very solid reputation with the community, people know that we are harm reduction advocates and QuIHN is a very safe space for people to come, so they trust us. I think that has incredibly helped in the beginning (Stakeholder 13).*

*When people feel safe and not judged, they open up about relationships, sexual health, and mental health. Many who wouldn't approach a drug health service engage because of drug checking (Stakeholder 10).*

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#### *3.6.1.1.4 Trusted information*

Within this safe setting, trusted and tailored information was a strong enabler of the success of the services. Clients found the service highly personalised and informative. Staff were seen as enthusiastic, knowledgeable, and making clients feel comfortable. They provided detailed information about not only the drug, but how to reduce harms in particular settings (such as a very hot day, reduced sleep, etc). Conversations also covered individualised information, such as contraindications, dosing suggestions, recovery, and general wellbeing. Clients appreciated the

discussions on the risks of mixing substances, and felt supported in reducing harm. Many highlighted how the service's approach fostered trust and encouraged open dialogue about drug use and safety.

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*They personalised the information a lot. I probably asked five to 10 different questions, and they were all super-enthusiastic to answer all my questions. They were very good at sort of just making you feel comfortable, and holding a great conversation and, yeah, they were all really kind. I appreciated It (Client 7).*

*I had good conversations around the pharmacological mode of action. Contraindications as well as dosing suggestions, recovery and sort of preparation, and general wellbeing stuff around the use of those different substances (Client 10).*

*The team there are great. I came in with a large number of samples and a variety of drugs. We had a long conversation about whether we had taken that specific sample or batch before, what to expect, interactions, and do's and don'ts to reduce risk, especially mixing with alcohol or other drugs (Client 13).*

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Some participants already had knowledge from their own research but commented that they were unable to find the information given at the service elsewhere.

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*I'd spoken to them a bit around the potential harm associated with mixing alcohol and ketamine. Because online I couldn't find any real clear explanation. I know plenty of people that do so we had a discussion around it (Client 13).*

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Clients valued the information provided in these conversations, trusting it as factual and well-presented. They emphasised the importance of sourcing information from knowledgeable and reliable drug advocacy groups and support networks, rather than mainstream media or biased publications.

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*I'd go straight here first because all the information was just so well presented. I just know it would all be factual. So, I trust that source very much (Client 4).*

*It emphasises the need to be aware of where you get your information. Based on the staff's knowledge at CheQpoint, they would be my first point of call for resources. It reinforces that you need to get information from specific drug advocacy groups and support networks rather than biased mainstream media (Client 2).*

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It was not only the clients who gained from these informative conversations - a chemist working at the drug checking service commented on enjoying the interaction with clients, especially due to their enthusiasm to learn more about the processes of drug checking as well as the substances. The similar demographic between staff and festival attendees helped build rapport and trust.

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*The interactions with the clients and education between us was really good. As chemists, we did the technical side, but it was great to see the harm minimisation side too. Clients were super interested in the science and technical aspects, and it was*

*cool for them to speak to scientists. Also, being of a similar demographic to the festival attendees helped with rapport (Stakeholder 5).*

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While stigma may have prevented some from using the service, others said despite feeling apprehensive, they found the support and benefits of the service valuable enough to overcome their hesitation.

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*What we're doing isn't legal, and there's also society's opinion. There were nerves beforehand but knowing there's support behind those doors and what I would get from it was very useful. The hesitation was there, but it wasn't going to stop me from using the service (Client 11).*

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#### *3.6.1.1.5 Staff*

In fact, staff working at the services were credited as being a major facilitator of successful implementation. They were reported to be personable, non-judgmental, and made clients feel safe and comfortable. They provided personalised information, especially considering individual needs like disabilities. Clients appreciated the respectful and caring interactions, the detailed explanations about the testing process, and the open, flowing conversations. Their positive experience was largely attributed to the supportive and understanding staff.

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*The people that were there definitely made it. They were happy for me to ask questions, have a conversation. Or I noticed some people who didn't want to talk and they understood that. So it was definitely the people that ran the service that made it what it was. We need more of those people (Client 11).*

*One of my concerns was judgement by other staff in the building but it wasn't an issue at all, even the people at the main desk were really friendly. They were really welcoming, it wasn't like rushed or anything, it was a really good service and they gave me lots of information and opened up for me to ask them any questions that I had as well, so yeah it was a great service (Client 2)*

*It was really good. I liked how they treated us. They gave me personalised information about my disability. They seemed to care and made me feel comfortable with an open, flowing conversation, not awkward lecturing. I felt very comfortable and was able to open up about some issues (Client 1)*

*Yeah, it was really respectful. I was quite interested in the actual mechanics of how they test it. They were very good to answer every question that I had. Everybody was kind and considerate and caring and all those lovely things (Client 6).*

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#### *3.6.1.1.6 Peer workers*

In particular, peer workers were commended for their work by both clients and other staff of the drug checking service, who reported that the service's accessibility was greatly enhanced by involving people with lived-living experience in harm reduction roles. Their presence brought a sense of calm and encouraged open communication, making clients more likely to ask questions and accept advice. This peer involvement, combined with the expertise of chemists conducting the analysis, created a supportive and safe environment for honest discussions. The blend of technical

knowledge and empathetic interaction made the service particularly effective and welcoming for the community.

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*One key thing that made it accessible for the community was having people with lived experience. It instantly brings a sense of calm, making people more likely to ask questions and take advice. We've got the knowledge, tools, and creativity to apply harm reduction techniques in various environments for unique people because we've been there ourselves. So, by having peers, it was really accessible to the community who needs it most (Stakeholder 17).*

*It's a perfect combination of scientists doing the analysis and 'people' people handling harm minimisation discussions. This setup fosters open and honest conversations, providing a safe space to talk openly (Client 13).*

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Stakeholders noted the valuable contribution provided by peer workers at the service and recommended expansion of the peer worker role in drug checking. This included providing peer workers with training to operate the testing machinery and have a chemist on call to assist in the interpretation of results. This would help reduce the number of chemists required on staff to successfully operate the drug checking service.

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*The other thing I really like about one of the Canadian systems is they've integrated into so many of their NSPs an FTIR machine. They've trained the staff on the ground just how to show the person to put the sample on the screen, and then having off-site chemists get all the data coming in, analyse it and then send it straight back to the NSPs. That means you don't have to have a chemist, which costs a lot, in every single site. (Stakeholder 10)*

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#### *3.6.1.1.7 Service collaboration*

One factor reported by stakeholders as a strong facilitator of both fixed site and event based services was the collaboration between services and other support organisations. Interviewees acknowledged strong collaboration and support between health-based services, event managers, and extended sector stakeholders, making the service feel welcomed and integrated. The multidisciplinary approach, involving people from different industries and backgrounds, has been crucial in finding effective solutions. The existing knowledge and networks of local organisations like The Loop, QuIHN, and QuIVAA, along with support from the Queensland Government, police, and community service groups, have been instrumental. Similar long-term relationships between PTA and other harm reduction services and their established presence at events have fostered a positive attitude towards the necessity of the health service, helping to overcome obstacles. The strong relationships and shared goals among these organisations have been reported by many as a key factor of the success of the implementation of drug checking services.

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*There seemed to be very good interaction between the other health-based services and the event managers themselves. They were very supportive of the service and quite interested and I felt as a worker, part of the overall festival event team (Stakeholder 14).*

*Definitely it's been a big collaboration from a lot of people who have different experience in very different industries. Because it is multi-disciplined, it's very nice to*

*have the input of a lot of different people with very different backgrounds to come up with good solutions for everything (Stakeholder 2).*

*I think how well QuIHN, QuIVAA and The Loop work together. I think that has just been amazing. We've all got really good relationships, we're all heading towards the same goal, so that's been fantastic. I think that, to me, is probably the most important thing, how well organisations work together (Stakeholder 13).*

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Finally, stakeholder interview participants spoke of the value of stakeholder buy-in and involvement in the successful implementation of drug checking. Stakeholder participants encouraged ongoing collaboration between stakeholder groups to share regular updates on recent findings, help reduce barriers to accessing drug checking services, and expand the use of drug checking services.

#### 3.6.1.2 Barriers

A number of barriers to the implementation of the services were highlighted throughout the interviews. Issues related to opening hours and wait times, insufficient resourcing, concern about law enforcement, stigma, location, government policies, perceptions of drug checking services, media and anonymity were raised in many cases.

##### *3.6.1.2.1 Limited opening hours*

Consistent with stakeholders noting that resources impacted on opening hours, one of the most prominent barriers mentioned was the limited opening hours of fixed services. Being open only one weekday per week made it difficult for some, particularly those who worked.

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*The opening hours are a bit restrictive and that's part of the reason that I'm testing things for friends because they just can't get there (Client 10).*

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##### *3.6.1.2.2 Funding and resources*

Stakeholders highlighted that funding and resources were major challenges. Many tasks, including social media and promotional activities, were undertaken on a voluntary basis, leading to significant time imposts. Opinions were frequently expressed that the trial was under-resourced, and budgets needed to be reviewed. The reliance on volunteers, who had other commitments, further complicated the situation.

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*You've got wages for social media since people don't work for free. A lot has been done in kind by all of us. Resources include printed flyers and advertising boards. The biggest cost is staff time, with many working voluntarily. Resourcing for this trial is way under where it should be, so budgets need to be reviewed (Stakeholder 19).*

*I definitely think funding has been a bit of a barrier. Because The Loop has heavily relied on volunteers and a lot of volunteers have other commitments as well. That has been a bit of a barrier (Stakeholder 2).*

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One stakeholder appreciated the role of volunteers but expressed concern about what would happen without proper recognition and funding. They believed that more funding was crucial to retain talented volunteers and maintain effective teams in the long term.

Participants suggested improvement to drug checking testing equipment and the expansion of testing options. They felt that the provision of additional FTIR testing machines would be beneficial, allowing multiple clients to have their substances tested at the same time, helping to reduce wait times and improving the progression of clients through the service.

Clients also noted that while the FTIR machine provided valuable information, purity testing would provide valuable insight into the substances clients bring for testing and improve client decision making around their substance use. The costs of this were however also acknowledged.

> *"I genuinely think information about purity of the substance is critical to be provided because if I received information about purity, then that would extremely significantly impact my usage." (Client 15)*

A small number of participants also felt it would be valuable for the service to also be able to test organic matter and steroids[4]. Participants also felt that the process of sharing the results of the confirmatory tests could be improved.

#### *3.6.1.2.3 Concerns around law enforcement*

Despite explicit police protocols to reduce enforcement activities in the vicinity of drug checking services, concerns around law enforcement were expressed by many. One NSP worker expressed frustration at this, highlighting the need for more publicity emphasising that NSPs are a safe environment and that clients will not face negative consequences for attending drug checking services there.

> *Unfortunately, we can't legally say, "bring your drugs in, the police will leave you alone". I wish we could, and I wish we could do more education to reassure people that NSPs are safe and nothing bad will happen to them there. (Stakeholder 8).*

However, it was recognised that clients need time to build trust in the service regarding concerns about police involvement and the service's intent.

> *There's still trust to be developed in many clients. They're concerned about whether we're working with police or the intent of the service. Hopefully, this will improve over time. Like when needle and syringe programs were introduced, they weren't popular at first. Consumer confidence that the cops aren't waiting to swoop in takes time to develop (Stakeholder 4).*

#### *3.6.1.2.4 Stigma*

Stigma related to the use of drugs was also cited as a major hurdle that contributed to a feeling of apprehension when accessing the service.

> *I was concerned that maybe there might have been some judgement from the staff there because I knew that it was public - it wasn't necessarily just a drug checking*

[4] The RoidCheck project operated during the period of the drug checking evaluation, receiving samples at the drug checking sites and sending them to the Griffith University laboratories for testing. This project was not funded by the Queensland Government and was not part of the drug checking services.

*facility, there were other services there. So [I was concerned about] going in and saying, 'oh hey, I'm here to get some drugs tested' (Client 2).*

Apart from potential stigma from staff at the service, judgement in the community was acknowledged as an issue, potentially restricting availability of service locations.

*People don't want it in their backyard. They don't like injecting centres. People want them around but can never decide where to have them. That's a limitation (Stakeholder 18).*

#### *3.6.1.2.5 Location of services*

Unfamiliarity with service locations was also highlighted for both fixed site and event based drug checking services. Festival goers suggested that prominent signage would have been helpful.

*I think because it was their first event in Queensland, I think their signage could have been better. I think that the [service]'s informational signage and signs probably could have been better (Stakeholder 22).*

It was recognised that discretion was a priority to be balanced with promotion of the service; however, while confidentiality and anonymity are important, the need for better visibility of the service's location was emphasised.

*So yeah, being tucked away down one particular corner of the [festival] site might have been a barrier. But I feel like it's a barrier that would have been reasonably easy to overcome for most people (Stakeholder 15).*

*I was familiar with where the [fixed site] place was but didn't know where the drug testing would be. The signage wasn't clear, but I understand why. It wasn't difficult to get in, get the information I needed, and know where to go once inside (Client 9).*

#### *3.6.1.2.6 Government processes and support*

Government support was widely acknowledged as critical to the success of drug checking services. The provision of funding enabled the establishment of the services, and the opportunity to demonstrate their effectiveness in the Queensland context.

The efforts of Queensland Health were valued, acknowledging they were working within constraints, and noting that as with all health services, appropriate support and resourcing were critical to effective operations and that this service showed potential for significant health gains to be achieved.

*The staff at Queensland Health have been lovely and are doing their best within the given restraints. There might be room for advocacy to push back and say the service needs more to work properly… It's a frustrating space, and the topic has been highly politicised. It needs to calm down; it's just another health service (Stakeholder 10).*

*Politics …are a challenge. I hope [government] see the public good it can do. We'll see what happens, but it's very political. There are groups in Queensland who can do the work well (Stakeholder 20).*

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One worker commented on a situation where they perceived the urgency to get an alert out into the public was hindered by unnecessary delays, but may have been unaware of the communication protocols in place. A purported nitazene was detected in a tablet expected to be oxycodone, resulting in the person who had bought the tablets illicitly and sought verification potentially avoiding a fatal overdose. With purported nitazene detections, both the service providers and Queensland Health wait for secondary confirmation (from an external partner laboratory) before issuing an alert. In other non-nitazene cases, services publish their own alerts immediately through media channels. This highlights the importance of timely drug alerts through multiple channels, while ensuring accuracy of information provided.

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*Queensland Health wanted to identify the specific nitazene, requiring multiple off-site tests. Sometimes, the community doesn't care which one it is. The fact that this oxycodone tablet tested positive is crucial to share. We're lucky this person hadn't taken any. They use pain medication at home alone, which could've led to a fatality in Queensland. Who knows who else has bought these illicit oxycodone tablets? (Stakeholder 10).*

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Despite frustration at the barriers mentioned, there was also confidence in the services showing their value once implemented, and reflecting the success of these programs internationally.

#### *3.6.1.2.7 Misperception that drug checking promotes substance use*

Interview participants made recommendations regarding adverting the service and helping to improve public perceptions and understanding of drug checking. It was recommended that, should the services continue, ongoing efforts be made to help promote the service to encourage client uptake. This included continued advertising on social media to share the findings from the services, advocating for the benefits of the service, and encouraging the public to come to the service to better understand its operations.

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*I think advertising, getting it out into the local community — even if it's just local around that particular location — that it is available, what it does and obviously the value people are going to get from it. The fact that it's free, the opening hours. (Client 11)*

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Participants also discussed the ongoing work that needs to be done to improve public perceptions and understanding of drug checking. Participants spoke of how the negative perception of drug checking among the public may act as a deterrent to new potential clients.

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*Way more education around it and lots more education around stigma and discrimination too, because it's still one of the biggest barriers, I think, to accessing health services around drugs, as people are so scared of being judged and so nervous. I watch so many clients come into the drug checking service shaking,*

*because they're that nervous, and then by the end, their world has changed in terms of they're not judged and it's okay. (Stakeholder 10)*

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One major challenge to address relates to the view held by some that drug checking services endorse substance use. Common misconceptions include the belief that services encourage and condone drug use, and that substances are returned to users with assurances of safety. Interviewees expressed concern about these misunderstandings, noting that people will use substances regardless of government approval and that harm reduction aims to keep people safe.

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*When talking to people outside the sector, I frequently encounter two myths. One is that providing this service encourages drug use, which is a common argument against harm reduction. The idea is that if you tell people how to stay safe, they're more likely to do it. This misunderstands people, who aren't waiting for the government's permission to live their lives. The second myth is that drugs are given back to people, and they're told they're safe (Stakeholder 25).*

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One participant noted it was difficult to overcome this view when some reports in the media suggest that drug checking services tell people that drugs are safe. Clients of the services confirmed that safety assurances were never part of the conversation during testing or elsewhere. The focus was on harm reduction, not on promoting substance use.

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*I had prior knowledge, but it's always good to get additional feedback. It's a well-structured conversation, but it never says, "this is safe to do." Everyone knows there's risk involved. It's more about how to minimise the potential risk (Client 13).*

*The claim that the service tells people drugs are safe is completely false and misleading. Anyone who has used the service can tell you that those words are never part of any conversation, whether at the test or elsewhere (Client 15).*

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On the contrary, one client explained that their interactions with the service had the effect of reducing their substance use and encouraged healthier choices, even leading some to stop drinking alcohol altogether, despite it being a legal substance.

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*That has definitely helped me and my friends. Interestingly, using the service has made many of us take less of the drugs and even stop drinking alcohol, which is another dangerous, legal drug (Client 9).*

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#### *3.6.1.2.8 Media representation*

Media representation provided key opportunities to promote the services to the wider public and raise awareness of the utility of drug checking, particularly in the early implementation phases, but negative representation in the media was also noted by staff and participants of both fixed and mobile sites as a potential barrier to people accessing the services.

> *There wasn't widespread support for drug checking services initially, with people thinking we were condoning or encouraging drug use. There was a lot of negative press in the media (Stakeholder 8).*

One stakeholder believed that the public support for drug checking services outweighed negative media portrayals:

> *If you look past the media noise, there's more support than they make out. The media portrayed it as if people would be banging down our doors, with many negative comments. But that didn't happen. I think the majority of the public supports it, whether they say so or not, which helped (Stakeholder 19).*

It was reported that media attention in combination with political uncertainty may have affected the Gold Coast site which had fluctuating patronage. A stakeholder commented that reports in the media caused confusion.

> *Numbers [at the Gold Coast site] have fluctuated up and down. I think the numbers have also been affected by the political uncertainty and the media attention, too. Reports that the service is ending…people are confused about what's happening. Certainly, Schoolies thrown in there, the whole debate around 'will Schoolies happen?' had potential to affect the fixed sites. So, there's been all those sorts of challenges as well (Stakeholder 26).*

*Privacy concerns*

Both fixed and event-based service clients were aware of the privacy issues related to media presence. Public discussions of the service by previous and current Queensland Governments attracted media attention, with media outlets wishing to visit the services to report, but requiring careful coordination to protect attendees' privacy.

At one festival, media outlets filming outside the service created distrust and privacy concerns, as the service was meant to be confidential and anonymous.

> *The good thing about Earth Frequency as well at Rabbits was it was new, so we were contending with media, and the media were there with their cameras just driving people away from us. So, I feel we would have been far more popular if the media weren't allowed to sit straight outside the front. That's the sociopolitical side of stuff (Stakeholder 18).*

# 4. Key considerations for future implementation

**KEY CONSIDERATIONS**

- Stakeholders and clients strongly advocated for the **continuation of drug checking services** in Queensland, citing the valuable contributions of the services to harm reduction and informed decision making.
- A **broader roll-out of services** across Queensland was also encouraged, particularly outside Southeast Queensland. Both stakeholders and clients noted that increasing the number of service locations, opening hours, and including drug checking as a standard service at festivals and other events would improve the reach and accessibility of the services across priority groups in Queensland.
- **Expanding the available drug testing equipment** to allow for purity testing, as well as the testing of organic matter and steroids, would increase the capabilities of the services to provide comprehensive drug testing results.
- **Expanding funding and support** would allow the services to reach a broader client base and create a more sustainable, standardised service model.

Consideration for future implementation of drug checking services have been organised across several broad categories: service continuation; resourcing and site features; equipment and testing; advertising and public perceptions; governance and legislation and resourcing; and stakeholder engagement.

### 4.1.1 Service continuation

Continue monitoring of the unregulated drug market via consumer-accessible drug checking services to ensure ongoing currency of information available to consumers and to the health sector.

Continue to ensure that drug checking services provide health and harm reduction conversations in addition to the findings of drug checking analytics.

Across the evaluation period, the services have achieved significantly against their intentions, design and implementation. Significant achievements have been noted. There is evidence of public support of harm reduction broadly across Australia and in Queensland, and specifically of drug checking. It is recognised in national strategy documents and international health priorities. Drug checking services are gradually being implemented in other jurisdictions, and Queensland's early uptake was widely lauded.

Sector stakeholders have referred to the valuable contribution the drug checking services provide to harm reduction and advocated for the service's ability to help improve client's knowledge and understanding of drugs and drug use. Clients have reflected on how the services provided valuable information which assisted in helping them to make informed decisions about their substance use and reduce associated harms.

> *We need to continue it. Yeah. It's saving people's lives. For example, if I brought stuff in and there was some nitazene in it, for example, I could contact someone straight away and say, don't sell that to anyone. It's a necessary service to save people's lives. (Client 25)*

### 4.1.2 Resourcing

Analysis of the funding envelope provided and resource utilisation over the first 12 months of operation showed that although operations were effective within the resourcing constraints, a reconsideration of the original resourcing and plans would allow for greater scope of service delivery, increased reach into the community across the state, and a longer funding period would support sustainability of the service by reducing the extensive reliance on volunteers for key roles.

*Expansion of peer worker roles*

Consider expanding the peer worker role in drug checking, so peers are involved in all roles in drug checking, including testing, with appropriate support from senior chemists on call to assist in the interpretation of results. This would help reduce the number of chemists required on staff to successfully operate the drug checking service.

### 4.1.3 Equipment and testing

Ensure that analytical methods and reference libraries are continuously updated to keep abreast of emerging substances and contaminants. Ensure that harm reduction information is continuously updated to address emerging substances and/or patterns of use.

Further investment in analytical technology, such as multiple FTIRs per site, particularly at events, would support greater throughput at services. Exploration of more sensitive detection methods, expanded reference libraries and quantitative analytical capabilities appear to be essential to ensure the services are able to continue detecting the newer emerging substances on the unregulated drug market

### 4.1.4 Locations and service requirements

Continue to provide drug checking services at a variety of sites and events to reach a broad range of people who use drugs in differing circumstances.

An expanded range of locations would benefit the broader Queensland community. Drug checking would provide a valuable adjunct to health and harm reduction services in regional cities. Co-location with existing harm reduction services would provide suitable context for drug checking as a health intervention, and leverage existing infrastructure and client bases.

Event based services would continue to be a useful adjunct, providing harm reduction in potentially higher-risk environments.

Expansion of service opening hours would be beneficial to improve service access for those who are not able to attend on a Friday afternoon. Suggestions were made to open the service over the weekend, or for a short number of hours over multiple days per week.

### 4.1.5 Communication of findings and improving public perception

Continue the provision and promote awareness of drug checking services as a source of trustworthy, timely information on substance contents and harm reduction information.

Consideration should be given to greater advertising and promotion of the service. Drug checking services are overwhelmingly supported by the public (National Drug Strategy Household Survey), however there has been some negative media coverage.

### 4.1.6 Utilisation of drug checking findings

Continue to ensure that drug checking findings are provided in a timely manner and used to inform clinicians and health services, who can then best support clients.

Ensure that findings from drug checking services are distributed broadly via formal media releases, clinical networks and peer-to-peer mechanisms such as social media platforms.

### 4.1.7 Integration of drug checking into the broader health context

Ensure that referral pathways are in place to support easy entry of clients (especially those not previously engaged) into health/support systems as needed.

### 4.1.8 Governance and policy

*Requirements for drug checking services in Queensland*

Continue providing clear guidelines for services, ensuring these are aligned across jurisdictions. Some consideration should be given to amending the requirement in Queensland that clients present their own sample. This created some challenges for service delivery in particular contexts (for example, parents), and may present missed opportunities.

*Coordination with the Australian Government and State and Territory Governments*

A Commonwealth-led approach to drug checking would assist with streamlining and standardising the implementation of drug checking services around Australia. A national approach to drug checking would also support a national monitoring framework to allow for easier analysis of trends in drugs detected in drug checking facilities. This would also help facilitate data sharing between state jurisdictions.

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*Then how do we feed this knowledge across all the other states is really important, not just going, this happened in Queensland, or this happened in other states, how do we actually share - build on knowledge? (Stakeholder 7)*

---

# 5. Limitations and constraints of the evaluation

There are some key limitations and constraints associated with this evaluation, most notably in the data available for the evaluation.

## 5.1 Service data collection

Variations in data collected by services over time, between different service providers, and between event and fixed-site services limited components of our analysis to specific services. For example, differences in recording of the content of harm reduction interventions across sites prevents more detailed analysis into differences between harm reduction interventions at fixed site versus event-based sites. Likewise, some service providers did not collect information such as First Nations status or gender/sexual identity, which limited our quantitative analysis of the reach of these services to priority groups.

More broadly, all data was anonymous, which limited our ability to differentiate new clients from repeat clients. Data included in this report are also limited to clients who consented to inclusion in the evaluation: clients who did not consent to the evaluation may differ in demographics, substance use profiles, and motivations for using the service.

## 5.2 Primary data collection

Despite promotion of the follow-up survey through services, social media platforms, and events, the follow-up survey represents a small sample of people who attended the services. This sample is thus unlikely to be representative of all clients and may be biased towards those with strongly positive or strongly negative experiences.

In qualitative data collection, interview participants reflect the views of clients and stakeholders who agreed to participate. Interviewed clients may differ from those who were not willing to participate in the evaluation. Stakeholders were deliberately chosen to provide coverage of a range of roles but do not represent all stakeholders, and direct quotes from these clients and stakeholders represent the opinions of those individuals and may not be representative of all attitudes and beliefs.

The Queensland Drug Trends data (drawn on for triangulation purposes) comprise a sentinel sample of people who use drugs who are based in Brisbane and the Gold Coast. These participants are thus not representative of all people who use drugs. The wastewater analyses also used for triangulation are collected sporadically, and the catchment areas analysed may not be reflective of the areas from which drug checking clients were drawn.

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# 7. Appendices

This report should be read in conjunction with the following companion documents:

- Evaluation Plan: Evaluation of Queensland Drug Checking Services (5 September 2024)
- Literature Review of Evaluations of Drug Checking Services (5 February 2025)

The following appendices are included:

- Appendix 1: Ethics approvals received for this evaluation
- Appendix 2: Primary data collection instruments
- Appendix 3: Detailed quantitative analytical findings
- Appendix 4: Library of supplementary quotes
- Appendix 5: Timeline of drug alert and social media post releases

# Appendix 1: Ethics approvals

THE UNIVERSITY OF QUEENSLAND
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Research Ethics and Integrity

## Human Research Ethics Approval

| | |
|---|---|
| **Project Number:** | 2024/HE000436 |
| **Project Title:** | Drug Checking Monitoring and Evaluation in Queensland |
| **Version:** | 1.01 |
| **Chief Investigator:** | Associate Professor Caroline Salom<br>Institute for Social Science Research |
| **Co-Investigator(s)** | Associate Professor Amy Peacock<br>Associate Professor Anna Olsen<br>Ms Catherine Daly<br>Miss Tayla Barber<br>Dr Jennifer Juckel<br>Ms Jerissa McLachlan<br>Mr Kieren Lilly<br>Mr Louis de Waal<br>Dr Natalie Thomas<br>Associate Professor Raimondo Bruno<br>Dr Sebastian Kocar |
| **Funding Body (UQ ref#):** | |
| **Approving Committee:** | University of Queensland Human Research Ethics Committee A |
| **Approval End Date:** | 31 Dec 2025 |
| **Date of Approval:** | Wednesday, 28 August, 2024 |

*University of Queensland Human Research Ethics Committee A confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research (2023). The University's human research ethics committees are organised and operate in accordance with the National Statement on Ethical Conduct in Human Research (2023).*

### Approved Documents

| Document Type | File Name | Document Tile | Application Version | Document Version | Last Modified |
|---|---|---|---|---|---|
| Third Party Evaluation Outcome | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 0.02 | 1 | 19/08/2024 7:58:13 PM |
| Change Tracking | 2024_HE000436 v0_02 - v1_01 Changes.pdf | 2024/HE000436 v0_02 - v1_01 Changes | 1.01 | 1 | 19/08/2024 7:58:20 PM |

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# Human Research Ethics Approval

| | |
|---|---|
| **Project Number:** | 2024/HE000436 |
| **Project Title:** | Drug Checking Monitoring and Evaluation in Queensland |
| **Version:** | 0.02 |
| **Chief Investigator:** | Associate Professor Caroline Salom<br>The University of Queensland |
| **Co-Investigator(s)** | Associate Professor Amy Peacock<br>Associate Professor Anna Olsen<br>Ms Catherine Mary Daly<br>Dr Jennifer Juckel<br>Dr Natalie Thomas<br>Associate Professor Raimondo Bruno<br>Miss Tayla Megan Barber |
| **Funding Body (UQ ref#):** | |
| **Approving Committee:** | University of Queensland Human Research Ethics Committee A |
| **Approval End Date:** | 31 Dec 2025 |
| **Date of Approval:** | Tuesday, 30 April, 2024 |

*University of Queensland Human Research Ethics Committee A confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research (2023). The University's human research ethics committees are organised and operate in accordance with the National Statement on Ethical Conduct in Human Research (2023).*

## Approved Documents

| Document Type | File Name | Document Tile | Application Version | Document Version | Last Modified |
|---|---|---|---|---|---|
| Third Party Evaluation Outcome | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 0.2 | 1 | 28/04/2024 7:11:14 PM |
| Change Tracking | 2024_HE000436 v0_01 - v0_02 Changes.pdf | 2024/HE000436 v0_01 - v0_02 Changes | 0.2 | 1 | 28/04/2024 7:11:20 PM |
| Application Attachment | Appendix A - PIS - Service Survey.docx | Appendix A - PIS - Service Survey Participants | 0.1 | 1 | 28/04/2024 7:11:11 PM |
| Application Attachment | Appendix B - PIS - Patron Interview.docx | Appendix B - PIS - Patron Interview | 0.1 | 1 | 28/04/2024 7:11:11 PM |

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# Human Research Ethics Approval

| | |
|---|---|
| **Project Number:** | 2024/HE000436 |
| **Project Title:** | Drug Checking Monitoring and Evaluation in Queensland |
| **Version:** | 2.01 |
| **Chief Investigator:** | Associate Professor Caroline Salom<br>Institute for Social Science Research |
| **Co-Investigator(s)** | Associate Professor Amy Peacock<br>Associate Professor Anna Olsen<br>Ms Catherine Daly<br>Dr Jennifer Juckel<br>Ms Jerissa McLachlan<br>Mr Kieren Lilly<br>Mr Louis de Waal<br>Dr Natalie Thomas<br>Associate Professor Raimondo Bruno<br>Dr Sebastian Kocar<br>Miss Tayla Barber |
| **Funding Body (UQ ref#):** | |
| **Approving Committee:** | University of Queensland Human Research Ethics Committee A |
| **Approval End Date:** | 31 Dec 2025 |
| **Date of Approval:** | Thursday, 12 December, 2024 |

*University of Queensland Human Research Ethics Committee A confirms that this project meets the requirements of the National Statement on Ethical Conduct in Human Research (2023). The University's human research ethics committees are organised and operate in accordance with the National Statement on Ethical Conduct in Human Research (2023).*

## Approved Documents

| Document Type | File Name | Document Tile | Application Version | Document Version | Last Modified |
|---|---|---|---|---|---|
| Third Party Evaluation Outcome | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 18.18 - 2021.ETH.00197 - Olsen - Approval_Anna Olsen.pdf | 0.02 | 1 | 27/11/2024 10:15:39 PM |
| Change Tracking | 2024_HE000436 v1_01 - v2_01 Changes.pdf | 2024/HE000436 v1_01 - v2_01 Changes | 2.01 | 1 | 27/11/2024 10:15:44 PM |
| Application Attachment | Stakeholder Email Invitation.docx | Appendix | 2.01 | 1 | 27/11/2024 10:15:39 PM |

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## Appendix 2: Data collection instruments

# Drug checking Follow Up Survey

Start of Block: Consent

**Participant Information Sheet – Service Survey Participants**
**Project Title:** The Monitoring and Evaluation of the Queensland Drug Checking Service
**Project sponsor:** Queensland Health
**Project team:** Associate Professor Caroline Salom, Evaluation Lead (University of Queensland), Dr Natalie Thomas (University of Queensland), Associate Professor Anna Olsen (Australian National University), Associate Professor Raimondo Bruno (University of Tasmania), Associate Professor Amy Peacock (University of New South Wales), Dr Jennifer Juckel (University of Queensland), Ms Catherine Daly (University of Queensland), Ms Tayla Barber (University of Queensland)
**Project team email address:** dceval@uq.edu.au

**What is this project about?**
The purpose of this project is to evaluate the Queensland Drug Checking Services. The evaluation is looking at the process of delivering the drug checking services, whether the services are reaching people they need to, outcomes for people who use the services, and what impact the services have on the service and health system in Queensland. This evaluation is important for shaping the future of drug checking services in Queensland.

**Do I have to take part in this survey?**
No. Your participation is the evaluation is voluntary, so it is your choice to take part or not. You may, without negative consequences, decline to take part in this project. You can also decline to answer any of the questions if you wish to skip them. If you decide to take part and then change your mind, you are free to stop at any time. If you choose to stop before completing and submitting the survey, your information will not be used in the research at any time. Once the survey has been submitted, it will not be able to withdraw your responses as your specific information is not identifiable.
Your decision whether you take part, or not to take part, or to take part and then withdraw, will not affect how you are treated by the University of Queensland, the Drug Checking Service Provider, or the Queensland Department of Health.

**What will I need to do?**
If you agree, you will complete a short survey about your experience of using the Drug Checking Service. You will be reimbursed $20 for completing the survey. This will be in the form of a $20 Gift Card. You will need to leave a contact email or phone number for us to send the gift card to you. This will be on a secure web form that is separate to your survey responses so we will not be able to link them, and the information will only be accessible to the research team.
Additionally, there is the option to take part in an interview with a member of the UQ Research Team to discuss your experience of using the Drug Checking Service, and you will receive a $50 gift card for your time. The interview will take approximately 30 minutes to complete.
There is a further opportunity to participate in a follow-on UQ study looking at the longer-term outcomes of people accessing Drug Checking services.

**What are the possible benefits of taking part?**
You will receive a gift card to the value of $20 to reimburse you for completing the survey. There is no other direct benefit to you from your participation in this research. However, the information you give, and this project more broadly, will help to assess the impact of the Queensland Drug Checking services, understand how well the program works, and help improve the understanding of the effectiveness of drug checking in reducing the harms of illicit drug use.

**What are the possible risks and disadvantages of taking part?**
Your data will only be available to the research team, expect where required by law. The survey questions will be about your experience of using the Drug Checking Service and we do not ask you details about your

illicit drug use.
There is no physical risk associated with participating. However, there is a small risk that thinking about your experiences may cause distress. Should you experience any distress, we recommend you speak to a Lifeline counsellor on 13 11 14 or via www.lifeline.org.au or the Alcohol and Drug Service (ADIS) on 07 3837 5666.
Please remember, you do not have to answer any questions you do not want to.

**What will happen to the information about me?**
All information collected about you will be kept confidential. The research team will make sure that you and your information cannot be identifiable in any publications or materials from the research.
All the information for this research will be stored on the Research Data Manager (RDM), the University of Queensland's secure data management system. No one will have access to the information other than the researchers involved in the project (outlined on previous page). Raw data will not be provided outside this secure environment. The data will be kept for five years after publication, after which it will be destroyed.
We expect to publish the results of this research project and/or present in in a variety of forms. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.
If you would like to access the findings of the evaluation, you may contact the Evaluation Lead at c.salom@uq.edu.au
The information you provide will remain confidential and will only be disclosed with your permission, except where required by law. However, if you disclose any serious or imminent threat to harm yourself or others, this may have to be reported to another person (the project leader in the first instance), and any information regarding the safety of children will be reported to the relevant authorities.

**What will happen if I decide to withdraw?**
Your decision to take part in this evaluation is voluntary and you are free to stop taking part without needing to explain, and there will be no penalty if you choose to stop. If you decide to stop, all the information collected from/about you will not be submitted and so will not be used in the evaluation. However, once the survey has been completed, your responses cannot be withdrawn because they are anonymous and therefore we will not be able to determine which survey is yours. To withdraw from this study, please contact the project team on DCeval@uq.edu.au

**Who can I contact if I have any concerns about the project?**
This study adheres to the Guidelines of the ethical review process of The University of Queensland and the National Statement on Ethical Conduct in Human Research. You are free to talk about your part in this study with the researcher at c.salom@uq.edu.au. If you would like to talk to an officer of the University not involved in the study, you may contact the Ethics Coordinator on +617 3365 3924 / +617 3443 1656 or email humanethics@research.uq.edu.au
If you would like to access the findings of the evaluation, you may contact the Evaluation Lead at c.salom@uq.edu.au or DCeval@uq.edu.au
This research Ethics ID number: 2024/HE000436

By selecting "I agree", I consent to take part in this research project.
- I agree
- I disagree

End of Block: Consent

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How do you describe your gender?
- Man or Male
- Woman or Female
- Non-binary
- Transgender man
- Transgender woman
- Transgender NFD
- Agender
- Genderfluid
- I use a different term (please specify) _____

How do you describe your sexual orientation?
- Straight (heterosexual)
- Lesbian, Gay, Homosexual
- Bisexual
- Pansexual
- Asexual/Aromantic
- I use a different term (please specify) _____

What is your year of birth?

▼ 2007 ... 1924

Could you possibly share with us which age group you belong to? [only if no answer to year of birth question]
- 18-29
- 30-39
- 40-49
- 50-59
- 60+

In which country were you born?
- Australia
- New Zealand
- England
- India
- China
- Philippines
- Other (please specify) _____

Are you of Aboriginal, Torres Strait Islander or South Sea Islander origin? Please select all that apply.
- ⊗No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, South Sea Islander
- ⊗Prefer not to say

We are trying to understand how far people are travelling to access drug checking services. Therefore, we will ask you a few questions about your experience with travelling to drug checking services. If you traveled several times and/or to different drug checking services, please answer for the last time you attended it.

First of all, can you please provide your postcode?
*If you do not live at a permanent address due to reasons such as experiencing homelessness or living a nomadic lifestyle, please write in 'no fixed address'.*

_____

Could you possibly share with us whether you are a resident of Queensland?

- Yes
- No

What was your travel time from your place of residence to the drug checking service?
- Less than 30 minutes
- Between 30 minutes and less than 1 hour
- Between 1 hour and less than 1.5 hours
- Between 1.5 hours and less than 2 hours
- Between 2 hours and less than 2.5 hours
- Between 2.5 hours and less than 3 hours
- 3 hours or more

How did you get to the drug checking service?

- Walked
- Cycled
- Drove (e.g. car, motorcycle)
- Public transport (e.g. bus, train)
- Taxi
- Rideshare (e.g. Uber, Ola)
- Carpool (e.g. with peers/friends)
- Flew
- Other (please specify) _____

In the last 6 months, have you used any of the following substances?
*Please be advised that for prescription or over-the-counter drugs, we are asking about non-prescribed use, which means using them differently from their intended purpose (e.g., taking more drugs than prescribed, using medication not prescribed for you, or sharing prescriptions).*

- Cannabis/Marijuana
- MDMA/Ecstasy
- Cocaine
- Ketamine
- LSD/DMT/mescaline/magic mushrooms
- Methamphetamine
- Pharmaceutical stimulants (e.g. Adderall, Dexamphetamine, Ritalin)
- GHB, GBL, 1,4-butanediol
- Inhalants (e.g. amyl nitrite/poppers, nitrous oxide)
- Heroin
- Methadone/Buprenorphine/Suboxone
- Painkillers and other opioids (e.g. morphine, oxycodone, codeine, tapentadol, tramadol)
- Benzodiazepines (e.g. Valium, Xanax, Alprazolam, Diazepam)
- Steroids
- Drugs other than listed, for non-medical purposes (please specify)
  _____

How often have you used the following substances in the last 6 months?
*Please estimate your frequency for each substance and select the option that best applies. If your use varied, please indicate an average.*

| | Less frequently than monthly | Monthly | Fortnightly | Weekly | Several times a week | Daily |
|---|---|---|---|---|---|---|
| Cannabis/Marijuana | | | | | | |
| MDMA/Ecstasy | | | | | | |
| Cocaine | | | | | | |
| Ketamine | | | | | | |
| LSD/DMT/mescaline/magic mushrooms | | | | | | |
| Methamphetamine | | | | | | |
| Pharmaceutical stimulants (e.g. Adderall, Dexamphetamine, Ritalin) | | | | | | |
| GHB, GBL, 1,4-butanediol | | | | | | |
| Inhalants (e.g. amyl nitrite/poppers, nitrous oxide) | | | | | | |
| Heroin | | | | | | |
| Methadone/Buprenorphine/Suboxone | | | | | | |
| Painkillers and other opioids (e.g. morphine, oxycodone, codeine, | | | | | | |

| | |
|---|---|
| tapentadol, tramadol) | |
| Benzodiazepines (e.g. Valium, Xanax, Alprazolam, Diazepam) | |
| Steroids | |
| Drugs other than listed, for non-medical purposes (please specify) | |

In the last 6 months, have you injected any substances?
- Yes
- No

What of the following substances have you injected?
- Cocaine
- Ketamine
- Methamphetamine
- GHB, GBL, 1,4-butanediol
- Heroin
- Methadone/Buprenorphine/Suboxone
- Painkillers and other opioids (e.g. morphine, oxycodone, codeine, tapentadol, tramadol)
- Benzodiazepines (e.g. Valium, Xanax, Alprazolam, Diazepam)
- Steroids
- Drugs other than listed, for non-medical purposes (please specify) _____
- ⊗None of the above

Which drug checking services have you visited? Please select all that apply.
- Fixed site (Brisbane)
- Fixed site (Gold Coast)
- Festival service (Rabbits Eat Lettuce)
- Festival Service (Earth Frequency)
- Other event (please specify) _____

Had you accessed any QuIHN services before attending a drug checking service?
- ⊗No
- Yes - QuIHN NSP
- Yes - QuIHN counselling / groups
- Yes - QuIHN doctor / medical services
- ⊗Prefer not to say

How many times have you visited a drug checking service in Queensland? Please select number of times visited for each site.

| | |
|---|---|
| Fixed site (Brisbane) | ▼ 1 ... 20+ |
| Fixed site (Gold Coast) | ▼ 1 ... 20+ |
| Festival service (Rabbits Eat Lettuce) | ▼ 1 ... 20+ |
| Festival Service (Earth Frequency) | ▼ 1 ... 20+ |

How long ago did you last visit a Queensland drug checking service?
- Less than 2 weeks ago
- Between 2 weeks and less than 1 month ago
- Between 1 and less than 3 months ago
- Between 3 and 6 months ago
- More than 6 months ago

Which Queensland drug checking service did you attend last?
- Fixed site (Brisbane)
- Fixed site (Gold Coast)
- Festival service (Rabbits Eat Lettuce)
- Festival Service (Earth Frequency)

We would now like to understand whether your drug checking experience has affected your drug-related attitudes, behaviours, and knowledge.

What changes, if any, have you observed since having the drug(s) tested at the drug checking service(s)? Please select all that apply.
- I am more likely to look out for festivals offering drug checking.
- I have decided to stop taking drugs to festivals.
- I am more aware of the potential risks associated with drugs.
- I am more aware that drugs contain other substances.
- I more strongly support drug checking services.
- I am more likely to use a drug checking service in the future.
- I know more about how to stay safe when using drugs.
- I try to find out more information about substances.
- I follow posts about drugs and safer use more often.
- I talk about contents of drugs with my friends or peers more often.
- I talk to friends or peers more openly about my substance use.
- I have talked to a professional about my substance use.
- I have made contact with a health care service about my drug use.
- ⊗None of the above

You mentioned that you have made contact with a health care service about your drug use. Was that a new drug related health service, a drug related health service you were previously engaged with, or both?
- A new drug related health service
- A drug related health service you were previously engaged with
- Both a new drug related health service and a service you were previously engaged with

Additionally, what changes to your substance use, if any, have you observed since having the drug(s) tested at the drug checking service(s)? Please select all that apply.
- I am less likely to obtain drugs from unfamiliar providers.
- I am more cautious about using drugs.
- I am more cautious about mixing different drugs.
- I generally take more of the substance at the time.
- I typically space out my substance use more.
- I generally take less drugs.
- I have not used drugs at all.
- I have accessed naloxone.
- Other (please specify) _____
- ⊗None of the above

You've indicated that the last Queensland drug checking service you visited was the fixed site [piped answer]. We will now ask you a few questions about that experience.

What would you say were the main reasons you attended it? Please select all that apply.
- To reduce the potential harm of using substances
- To check the amount of the substance present
- To identify all components within the sample
- To reduce the harm associated with prohibition of drugs
- To make well-informed decisions about my substance use
- To gain access to informational materials
- To ensure the safety of my peers
- Due to past negative experiences with substance use

Due to past emergency incidents after substance use
I do not trust the provider
I do not trust the black market
To understand if there are interactions with other medications or drugs
Other (please specify) _____

Were you offered any harm reduction information by the drug checking service?
Yes
No
Unsure

What harm reduction information were you provided by the drug checking service?
Effects of substances
Dosage guidance
Associated risks and effects
Harm reduction strategies
Referral to other support services
Legal information
Other (please specify) _____
⊗I cannot remember

Did you share any of the harm reduction information provided to you by the drug checking service with any of your friends or peers?
Yes
No
Unsure

Whom did you share the harm reduction information provided to you by the drug checking service with? Please select all that apply.
Peers/other people who use drugs
Friends/family members
People on social media
Healthcare provider(s)
Support service(s)
Other (please specify) _____
⊗I cannot remember

Thinking about your most recent experience, please indicate whether you agree or disagree with different statements about the drug checking service on a 5-point scale (with 1 being 'Strongly disagree' and 5 being 'Strongly agree').

| | 1 Strongly disagree | 2 Disagree | 3 Neutral | 4 Agree | 5 Strongly agree | *Prefer not to answer* |
|---|---|---|---|---|---|---|
| I found the service to be confidential and anonymous. | | | | | | |
| I felt comfortable using the service. | | | | | | |
| The service was easy to use. | | | | | | |
| Information about how the service works was clearly explained. | | | | | | |
| Information about testing results was clearly explained. | | | | | | |
| Information | | | | | | |

| | |
|---|---|
| provided about how to reduce risks was easy to understand. | |
| The information given helped me make decisions about my substance use. | |

Using the same 5-point scale, please indicate whether you agree or disagree with different statements about your most recent experience with the drug checking service.

| | 1 Strongly disagree | 2 Disagree | 3 Neutral | 4 Agree | 5 Strongly agree | *Prefer not to answer* |
|---|---|---|---|---|---|---|
| The service met my needs. | | | | | | |
| The service was in a convenient location. | | | | | | |
| I felt like staff treated me poorly because of my substance use. | | | | | | |
| I would use the drug checking service again. | | | | | | |
| I would recommend the drug checking service to friends. | | | | | | |
| I felt staff treated me with respect. | | | | | | |
| The service felt culturally safe for me. | | | | | | |

We will now ask you a few questions about the drug checking test results. Please recall your experience at the last Queensland drug checking service you attended, which you indicated was [piped text]

How many samples did you submit for testing the last time you attended a drug checking service?
- One
- Two
- Three
- More than three

Was the sample you submitted for testing your own, or did you submit the sample on behalf of other people?
- My own sample
- Sample submitted on behalf of other people

Were the samples you submitted for testing your own, or did you submit samples on behalf of other people? Please select all that apply.
- My own sample(s)
- Sample(s) submitted on behalf of other people

We will begin with a few questions about [first, second or third, this block below is repeated for >1 sample] sample you submitted for testing.

What did you expect this drug to be?

- 2CB
- Benzodiazepines (e.g. Valium, Xanax, Alprazolam, Diazepam)
- Cathinones (3-MMC, pentylone)
- CBD
- Cocaine
- DMT
- GHB, GBL, 1,4-butanediol
- Heroin
- Inhalants (e.g. amyl nitrite/poppers, nitrous oxide)
- Ketamine
- LSD
- MDA
- MDMA/Ecstasy
- Mescaline
- Methadone/Buprenorphine/Suboxone
- Methamphetamine
- Modafinil/fluorenol/hydrafinil
- Painkillers and other opioids (e.g. morphine, oxycodone, codeine, tapentadol, tramadol)
- Pharmaceutical stimulants (e.g. Adderall, Dexamphetamine, Ritalin)
- Psilocybin/magic mushrooms
- Steroids
- Synthetic cannabinoids
- THC
- A drug other than listed (please specify) _____
- It was purchased as unknown substance

Had you taken this drug before?

- Yes
- No
- Unsure

How often have you used this drug in the last 6 months?

*Please estimate your frequency and select the option that best applies. If your use varied, please indicate an average.*

- Less frequently than monthly
- Monthly
- Fortnightly
- Weekly
- Several times a week
- Daily

Was the drug you expected detected in the sample?

- Yes
- No

What substances were detected in the sample?

*Please select all detected substances and write in any additional substances (including drugs and additives) that are not listed in the dropdown menu.*

| | |
|---|---|
| Substance 1 | ▼ 2CB ... THC |
| Substance 2 | ▼ 2CB ... THC |
| Substance 3 | ▼ 2CB ... THC |
| Substance 4 | ▼ 2CB ... THC |

| | |
|---|---|
| Substance 5 | ▼ 2CB ... THC |

Other drugs:

_____
_____

Other additives (e.g. caffeine, sucrose, lactose, creatine, paracetamol):

_____
_____

Were there any other substances detected in the sample?

Yes
No
I cannot remember what other substances were found

What substances were detected in the sample?
*Please select all detected substances and write in any additional substances (including drugs and additives) that are not listed in the dropdown menu.*

| | |
|---|---|
| Substance 1 | ▼ 2CB ... THC |
| Substance 2 | ▼ 2CB ... THC |
| Substance 3 | ▼ 2CB ... THC |
| Substance 4 | ▼ 2CB ... THC |
| Substance 5 | ▼ 2CB ... THC |

Other drugs:

_____
_____

Other additives (e.g. caffeine, sucrose, lactose, creatine, paracetamol):

_____
_____

What did you do with the drug after having it tested?

I used the tested drug
I disposed of the tested drug
I still have the tested drug

What changes, if any, did you make to the way you used the drug?
*Please select only the changes that were a result of having the drug tested.*

⊗No changes compared to what I had planned
I used less of this drug than I had planned
I used more of this drug than I had planned
I spaced out my use of this drug (i.e., had multiple doses)
I had a test dose of this drug
I purposely used it with alcohol at the same time
I purposely used it with other drugs at the same time
I purposely didn't use any other drugs at the same time

I made sure I had naloxone around
I made sure someone else was with me when I used this drug
I bought more of this drug
⊗Not sure

What of the following did you do? Please select all that apply.
I discarded the drug at the drug checking service
I discarded the drug elsewhere (i.e., not at the drug checking service)
I gave it back to the provider
I told the provider about its contents
I gave the drug to someone else other than the provider
I provided online feedback to the seller
⊗Not sure

Do you plan to use the tested drug in the future?
Yes
No
Unsure

Did you tell anyone about the results of the drug test?
Yes
No
Unsure

Who did you tell about the results of the drug test? Please select all that apply.
Other people who use drugs
Friends/family members
People on social media
Shared on online forum
Healthcare provider(s)
Support service(s)
Provider
Other people (please specify) _____
⊗I cannot remember

How much did you know about the positive/desired effects of ${Q7.4/ChoiceGroup/SelectedChoices}, both before you first attended the drug checking service and after attending it the last time?

| | No knowledge | Limited knowledge | Moderate knowledge | Advanced knowledge | Extensive knowledge |
|---|---|---|---|---|---|
| Before you first attended the drug checking service | | | | | |
| After you attended the drug checking service the last time | | | | | |

How much did you know about the positive/desired effects of 'Other substance: ${Q7.4/ChoiceTextEntryValue/20}', both before you first attended the drug checking service and after attending it the last time?

| | No knowledge | Limited knowledge | Moderate knowledge | Advanced knowledge | Extensive knowledge |
|---|---|---|---|---|---|
| Before you first attended the drug checking service | | | | | |

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After you attended the drug checking service the last time

How could the service be changed or improved?

_____
_____
_____
_____
_____

Was there anything that made you nervous or reluctant to access the drug checking service?

_____
_____
_____
_____

Start of Block: Invitation

To receive your $20 gift card for completing the questionnaire, please leave your details at this separate link*.

https://uniofqueensland.syd1.qualtrics.com/jfe/form/SV_e39uQ4qOOs4PsKG

We would also like to invite you to participate in additional research related to this project. At this link, you can choose to be contacted about an interview (for which you will receive a $50 gift card) and/or another follow-up survey (for which you will receive a $20 gift card).

**We are collecting your contact information in a separate form to ensure that your survey responses are stored separately from your contact information.*

End of Block: Invitation

**Interview Guide: Follow Up with Drug Checking Participants**

ORAL CONSENT SCRIPT (to be read at commencement interviews)

My name is [Interviewer Name], from the University of Queensland. Thank you for agreeing to talk with me about the Evaluation of Queensland Drug Checking Services.

The Queensland Department of Health of Health has commissioned the University of Queensland to conduct an evaluation of the Queensland Drug Checking Services. The evaluation is looking at the process of delivering the drug checking services, whether the services are reaching people they need to, outcomes for people who use the services, and what impact the services have on the service and health system in Queensland. This evaluation is important for shaping the future of drug checking services in Queensland.

Your participation in this interview today is entirely voluntary. All information collected about you will be kept confidential. The data will be kept for five years after publication, after which it will be destroyed. We expect to publish the results of this research project and/or present in in a variety of forms. In any publication and/or presentation, information will be provided in such a way that you cannot be identified.

Your interview recording will be transcribed using the Zoom in-built functions and checked for accuracy by a project team member. The audio recordings will be sent to a paid transcription company but will remain anonymous. The service will also keep your information safe and private, and your information will be given safely and securely to the research team only. Otherwise, files will only accessible by the project team, and the recording will be deleted after the transcript has been checked for accuracy.

If you choose to take part in this study, you will be reimbursed $50 in total for your time when you have completed the interview. This will be in the form of a $50 Gift Card.

The information you provide will remain confidential and will only be disclosed with your permission, except where required by law. However, any serious or imminent threat to harm yourself or others may have to be reported to another person (the project leader in the first instance), and any information regarding the protective safety of children will be reported to the relevant authorities.

Your decision to take part in this research is voluntary and you are free to stop taking part anytime without needing to explain, and there will be no penalty if you choose to stop. If you decide to stop, all the information collected from/about you will be destroyed and will not be used in the research.

Do you have any questions about the information I have provided or questions about information outlined in the participant information sheet?

Do you agree to participate in this project? Yes / No

Do you agree for this interview to be audio-recorded? Yes / No

**<u>Accessing the service</u>**

The following questions are about the last time you accessed a drug checking service (the last drug checking service you attended), including the fixed-site services or a service at a music festival in Queensland.

1. Which drug checking service did you access last?
2. How did you hear about the drug checking service?
3. Why did you decide to use the service?
    a. Did you have any reservations or doubts about *going to the service?* Was there anything that

made you nervous or reluctant to access the drug checking service?

4. Before you went to the drug checking service, what were your plans for using the drugs you had tested? *(prompt for types, amounts, timing)*
    a. Had you taken an illicit drug other than cannabis before? (Yes – ask b; if No – skip to Q 5)
    b. If yes: You don't need to give too much detail, but can you give me an indication of the types of drugs you'd used in the past and how often you would use them?
5. Without drug checking, how would you usually get information about drugs?
    a. Can you tell me why you use these sources? Are there sources of information you avoid? Why?
    b. Have you ever spoken to a healthcare provider (e.g. GP) about drug use? Why/why not?

**Before testing**

1. At the drug checking service, did you present the drug for testing or did another person?
2. Before you went to the service, what did you (or your friend) think the drug being tested was?
    a. What made you (or them) think that?
    b. You don't need to go into any specific detail about who you bought it from, but where was it sourced (e.g., inside venue)?
3. Were you planning to take the drug you (or your friend) had tested? Was anyone else planning to use it? *(e.g. others in group/was it part of larger batch)*

**Receiving the results**

1. After the sample had been tested, what were you told was in the sample/s you provided?
    a. Was the result different to what you were expecting?
4. What were you told by staff about the content of the sample that was tested? *(Prompt for: did they tell you about side effects of the substance, any risks when using the substance, or other drugs in general?)*
    a. What were your thoughts when you heard that - did that change anything for you?
5. After receiving the test result, what other information did you receive from the service staff? *(Prompt for: What kind of information did they provide? Was it personalised to you? How did you find the conversation overall?)*
6. How did you feel you were treated by staff at the service?
7. How did you find the process of accessing the drug checking service? *(Prompt for: was the location easy to find? Did you have any issues accessing it during opening hours?)*
8. Do you have any other comments about the information that was provided at the drug checking service?
9. Did you discard the rest of the drugs you had tested? Why or why not? *(Prompt for: What would stop you from discarding drugs inside the service?)*

**After you left the service**

Now I'd like to ask you a few questions about what happened after you left the drug checking service.

1. Can you tell me whether the service impacted your use of the drug you had tested (if at all)? *(Prompt for: did you use the same amount as planned, did you use more/less of the drug, did you not use the drug, did you use a different drug, did you only use alcohol?):*
    2. Did the drug checking result or the information you received have any impact on how confident you

felt about taking the drug you had tested?

3. Who else did you tell about the information you'd received in the drug checking service? *(What did you say, what was their reaction?)*

**After using drug checking**

Now I'd like to ask you a few questions about your experiences since visiting the drug checking service.

1. Has your experience of drug checking had any impact on your drug use since visiting the service? *(If so, how? If not, why not?)*
2. How do you feel going to drug checking changed your knowledge about illicit drugs?
3. Has using the drug checking service changed how much you trust any particular sources of information about drugs?
4. How has using the drug checking service changed how you feel about talking to healthcare services about drug use? *(Which services would you feel comfortable talking to in the future?)*

**Attitudes to drug checking**

These are the last few questions. They are about your thoughts on whether drug checking services should continue and if so, how.

1. Would you use a drug checking service again? *(Why or why not?)*
2. What do you think could be done to improve the drug checking services? *(Do you like the location? The service delivery process? The staff? The time taken?)*
3. Do you think drug checking should be rolled out more widely? *(If so, how? If not, why not?)*
4. What impact do you think the availability of drug checking services has on people's drug use? (*Why do you say that?)*
5. Is there anything else you'd like to share about drug checking?

**Thank you for your time and contribution.**

**Should you experience any distress, we recommend you speak to a Lifeline counsellor on 13 11 14 or via www.lifeline.org.au or the 24/7 Alcohol and Drug Support (ADIS) for free, confidential and anonymous support on 1800 177 833 or you can use the webchat at www.adis.health.qld.gov.au/adis-web-chat.**

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**Interview Guide: Semi-Structured Interview with Stakeholders**

1. What is your current role and what involvement or contact have you had with the Queensland drug checking services?
2. Which services have you been involved with or had contact with?
3. What has been your experience to date with the operational aspects of the drug checking service?
    a. Have there been any challenges encountered in implementation?
    b. What helped implementation?
4. How have the services impacted on your workload?
5. Do you think there have been any barriers for the drug checking services? If so, what were they?
6. What do you think have been the facilitators of the drug checking services?
7. Can you comment on the resources available for the Queensland drug checking services?
8. Are you able to comment on the accessibility of drug checking services and to what extent services are reaching the people who could most benefit from them?
9. Have you been involved in the festival-based drug checking services?
    a. How do you think that the fixed sites compare to festival service delivery? (Prompt: in terms planning and operational aspects, client uptake)
10. How effectively do you feel that relationships between stakeholders are managed (e.g. police, drug checking service, security, Queensland Health)?
    a. How well do you feel information is shared or communicated between parties?
11. Has the service produced any previously unavailable information about illicit drug availability and use in Queensland? If so, how was that information used or how will it be used? (Prompt: contributions to public health notifications)
12. Do you feel that the program had any unintended outcomes, either positive or negative? If so, what?
13. Do you have any recommendations for how the drug checking services could be improved?
14. What is your opinion of drug checking in general (i.e. not just in Queensland)?
    a. What benefits do you see of the drug checking services?
    b. What risks or downsides do you see to the drug checking services?
15. What are your thoughts on a broader roll out of drug checking services in Queensland?
16. Are there any other thoughts on drug checking you'd like to share?

**Thank you for your time and contribution.**
Should you experience any distress, we recommend you speak to a Lifeline counsellor on 13 11 14 or via www.lifeline.org.au or the Alcohol and Drug Support (ADIS) 24/7 Alcohol and Drug Support for free, confidential, and anonymous support on 1800 177 833 or use the webchat https://www.adis.health.qld.gov.au/adis-web-chat.

# Appendix 3: Detailed quantitative analyses

## 3.1: Service operations

Table A1 displays the independent sample tests of differences in the mean clients per visit, wait times, and intervention times across CheQpoint Brisbane and Gold Coast services. As shown here, there were no significant differences in the mean number of clients per visit. However, there were small differences in the mean wait and intervention times, with CheQpoint Brisbane having, on average, higher wait times and shorter intervention times than CheQpoint Gold Coast. As noted earlier in this report, this is likely due to the larger demands on the CheQpoint Brisbane service, as this site had a larger number of service visits per day.

*Table A1. Independent sample tests of differences in service operations between CheQpoint Brisbane and Gold Coast services.*

| | Brisbane | | Gold Coast | | Independent t-test | | |
|---|---|---|---|---|---|---|---|
| Test | Mean | *SD* | Mean | *SD* | *t* | df | *p*-value |
| Clients per visit | 1.2 | 0.4 | 1.2 | 0.4 | 0.02 | 503 | 0.985 |
| Wait time (mins) | 25.8 | 25.7 | 14.6 | 22.6 | -2.42 | 486 | 0.016 |
| Intervention time (mins) | 20.2 | 11.7 | 22.7 | 11.6 | 3.94 | 493 | < .001 |

## 3.3: Client ratings of services

Figure A1 displays the distribution of ratings of the REL and Wildlands drug checking services. As shown here, 66.7% of REL clients and 83.8% of Wildlands clients reported full confidence (10 out of 10) that the equipment used for drug checking accurately identified the substances in their samples. The majority of clients at both REL (91.1%) and Wildlands (92.6%) also reported full satisfaction with the information provided by the services. Finally, 100% of REL clients and 98.8% of Wildlands clients rated the staff 10 out of 10 in their respect towards clients. Table A2 displays the independent sample tests of mean differences in ratings across sites and shows that no significant differences emerged in ratings of REL and Wildlands drug checking services.

*Figure A1. Distribution of ratings of REL and Wildlands drug checking services.*

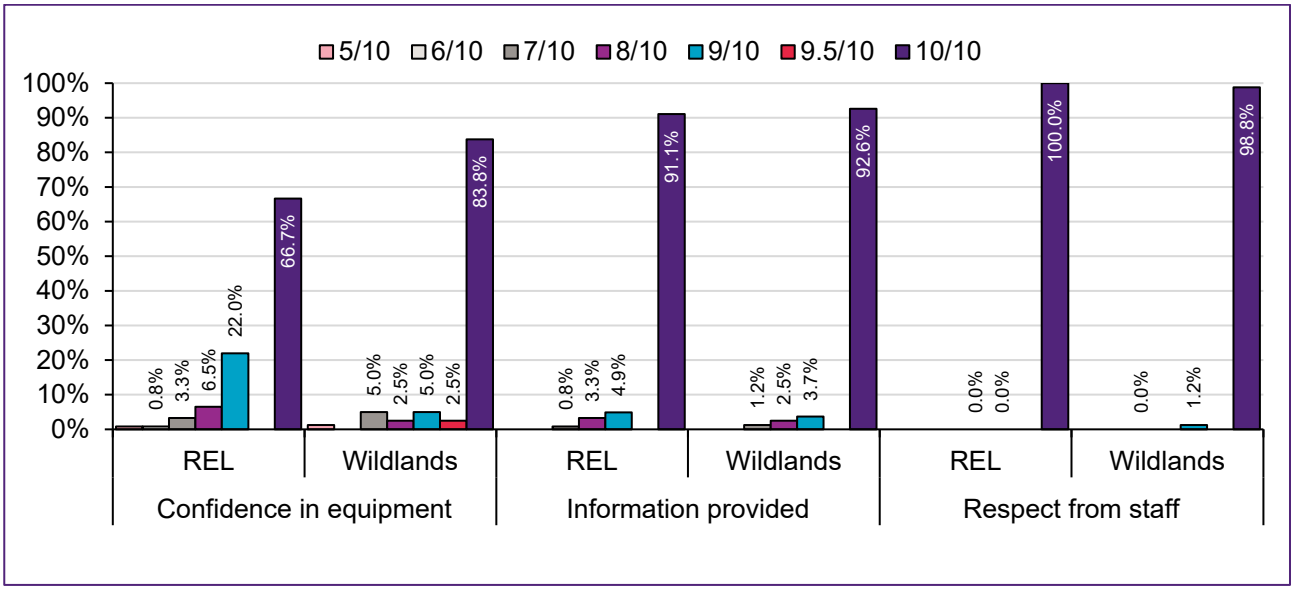

*Table A2. Independent sample tests of differences between ratings of PTA's REL and Wildlands drug checking services.*

| Rating | *t* | df | *p*-value | Mean diff. | SE (diff) | 95% Confidence Intervals Lower Bound | 95% Confidence Intervals Upper Bound |
|---|---|---|---|---|---|---|---|
| Confidence in testing equipment | -1.49 | 201 | 0.138 | -0.20 | 0.13 | -0.454 | 0.063 |
| Information provided | -0.21 | 202 | 0.832 | -0.01 | 0.07 | -0.151 | 0.122 |
| General service | -0.34 | 202 | 0.736 | -0.02 | 0.05 | -0.107 | 0.076 |
| Respect from staff | 1.23 | 202 | 0.219 | 0.01 | 0.01 | -0.007 | 0.032 |

Notes. No significant differences between REL and Wildlands service ratings emerged, *p*s > .050.

### 3.4: Client demographics

Table A3 displays the chi-square difference tests (and independent samples t-test, in the case of age) testing for demographic differences between CheQpoint Brisbane and Gold Coast sites. As displayed here, no significant gender, Indigenous status, migrant status, and labour force-based differences emerged across fixed sites. That said, CheQpoint Brisbane and Gold Coast clients did significantly differ in their place of residence (see Section 3.4.1.1). Additionally, CheQpoint Brisbane clients were slightly younger, and a greater proportion identified as LGBTQIA+SB.

*Table A3. Tests of differences between client demographics at CheQpoint Brisbane and Gold Coast sites.*

| | **Chi-square difference test** | | | **Independent samples t-test** | | |
|---|---|---|---|---|---|---|
| **Demographic** | $\chi^2$ | df | *p*-value | *t* | df | *p*-value |
| Gender | 7.4 | 4 | 0.116 | — | — | — |
| Place of residence | 339.3 | 19 | < .001 | — | — | — |
| Age | — | — | — | -2.6 | 458 | 0.011 |
| Indigenous status | 7.7 | 4 | 0.105 | — | — | — |
| Born in Australia | 4.1 | 4 | 0.398 | — | — | — |
| Sexual orientation | 20.5 | 10 | 0.025 | — | — | — |
| Labour force status | 16.1 | 9 | 0.065 | — | — | — |

Table A4 presents a more detailed analysis of differences in sociodemographic characteristics between clients attending different services (see Demographic differences across drug checking services, page 77).

We performed a series of binary logistic regressions to compare clients who attended different drug checking services. For example, the first model, i.e. "CheQpoint: Fixed sites vs Festivals", compared CheQpoint fixed sites (Brisbane and Gold Coast, coded as 1) with CheQpoint festivals (Schoolies and Earth Frequency, coded as 0) using binary logistic regression analysis.

*Table A4. Differences in socio-demographic characteristics between clients attending different drug checking services (Source: CheQpoint fixed-site and festival data, PTA festival data)*

| **Objective of regression modelling** | ***Comparing CheQpoint events*** | ***Comparing fixed sites and festivals*** | ***Only comparing individual festivals*** | | |
|---|---|---|---|---|---|
| **Model** | **CheQpoint: Fixed sites vs Festivals (n=505)[a]** | **All festivals vs Fixed sites (n=779)** | **Rabits Eat Lettuce vs Other festivals (n=326)** | **Wildlands vs Other festivals (n=316)** | **CheQpoint festivals[b] vs Other festivals (n=316)** |
| **Predictors** | **Coef. (SE)** | **Coef. (SE)** | **Coef. (SE)** | **Coef. (SE)** | **Coef. (SE)** |
| Age group: 30-39 yrs | -0.33 (0.30) | -0.57** (0.20) | 0.58* (0.27) | -1.72*** (0.38) | 0.77** (0.29) |
| Age group: 40-49 yrs | 1.32** (0.46) | -2.50*** (0.36) | -1.29 (0.67) | -2.21* (1.06) | 2.54*** (0.61) |
| Age group: 50+ yrs | 1.65** (0.52) | -3.00*** (0.46) | -1.09 (1.13) | / | 2.82* (1.12) |
| Gender: Male | 0.48 (0.30) | -0.63** (0.20) | -0.34 (0.25) | 0.21 (0.27) | 0.22 (0.28) |
| Gender: Non-binary and other | 1.58 (1.09) | -2.33** (0.84) | 1.02 (1.21) | / | 0.13 (1.20) |
| Residence: Gold Coast | -0.24 (0.47) | 0.14 (0.28) | 0.85 (0.45) | -1.04* (0.53) | 0.04 (0.52) |
| Residence: Other Queensland | -1.78*** (0.36) | 1.44*** (0.25) | 0.05 (0.32) | -0.50 (0.32) | 0.49 (0.34) |
| Residence: Other states/territories | -3.73*** (0.48) | 3.62*** (0.39) | 0.94** (0.29) | -1.20*** (0.33) | 0.02 (0.32) |
| Residence: Not specified | -1.19** (0.38) | -0.20 (0.31) | / | / | / |
| Sexual orientation: Bisexual | -0.03 (0.37) | | | | |
| Sexual orientation: Homosexual | -0.13 (0.52) | | | | |
| Sexual orientation: Other | 0.38 (0.91) | | | | |
| Born in Australia: Yes | 0.70* (0.31) | | | | |
| Indigenous: No | -0.27 (0.70) | | | | |
| *Constant* | *0.92 (0.81)* | *0.24 (0.20)* | *-0.72** (0.26)* | *0.10 (0.27)* | *-1.59*** (0.31)* |
| *Pseudo R Squared* | *0.254* | *0.310* | *0.064* | *0.124* | *0.086* |

Notes. ***p<0.001, **p<0.01, *p<0.05; Reference groups: Age group: 17-29 yrs, Gender: Female, Residence: Brisbane, Sexual orientation: Heterosexual or straight, Born in Australia: No, Indigenous: Yes; [a]CheQpoint data included additional socio-demographic variables compared to data from Rabbits Eat Lettuce and Wildlands festivals; [b]CheQpoint festivals, namely Earth Frequency, were combined into one group due to a small sample of Schoolies festival clients

*Table A5. Identification of client profiles at fixed sites that benefit the most from harm reduction actions, regressions modelling (Source: CheQpoint fixed-site data)*

| **Type of regression modelling** | ***Poisson regression*** | | ***Negative binomial regression*** | ***Multiple linear regression*** |
|---|---|---|---|---|
| **Model** | **Number of all samples presented, *1-7 samples* (n=283)** | **Number of harm reduction interventions *1-9 interventions* (n=270)** | **Number of referrals, *0-4 referrals* (n=270)** | **Proportion of presented samples with unexpected psychoactive substance, *0-100%* (n=283)** |
| **Predictors** | **Coef. (SE)** | **Coef. (SE)** | **Coef. (SE)** | **Coef. (SE)** |
| Age group: 17-29 yrs | -0.10 (0.14) | 0.32* (0.14) | 0.44 (0.36) | 0.00 (0.04) |
| Age group: 30-39 yrs | -0.06 (0.14) | 0.02 (0.15) | -0.03 (0.39) | 0.08 (0.04) |
| Age group: 50+ | -0.16 (0.16) | 0.19 (0.16) | 0.61 (0.33) | 0.07 (0.05) |
| Gender: Male | -0.05 (0.13) | 0.20 (0.13) | 0.44 (0.32) | 0.04 (0.04) |
| Gender: Non-binary and other | -0.19 (0.51) | -0.16 (0.51) | / | -0.03 (0.14) |
| Residence: Gold Coast | -0.07 (0.28) | 0.05 (0.29) | 0.43 (0.59) | -0.04 (0.08) |
| Residence: Other Queensland | -0.06 (0.17) | -0.05 (0.18) | -0.12 (0.38) | 0.01 (0.05) |
| Residence: Other states/territories | -0.02 (0.40) | 0.50 (0.36) | 0.63 (1.17) | -0.09 (0.11) |
| Residence: Not specified | -0.09 (0.18) | 0.14 (0.17) | 0.40 (0.42) | -0.07 (0.05) |
| Sexual orientation: Bisexual | -0.06 (0.14) | -0.10 (0.14) | 0.78** (0.29) | 0.08* (0.04) |
| Sexual orientation: Homosexual | 0.02 (0.18) | -0.16 (0.17) | -0.29 (0.46) | 0.05 (0.05) |
| Sexual orientation: Other | 0.00 (0.28) | -0.04 (0.29) | 0.51 (0.51) | -0.01 (0.09) |
| Employment status: employed part-time/casual | -0.04 (0.14) | 0.04 (0.14) | 0.23 (0.38) | -0.05 (0.04) |
| Employment status: studying | 0.14 (0.26) | -0.02 (0.24) | 0.09 (0.59) | 0.02 (0.07) |
| Employment status: Other | 0.12 (0.17) | 0.19 (0.16) | 0.94** (0.36) | -0.03 (0.05) |
| Born in Australia: Yes | -0.03 (0.13) | -0.18 (0.13) | 0.40 (0.31) | 0.00 (0.04) |
| Indigenous: No | -0.04 (0.29) | -0.25 (0.25) | -0.46 (0.43) | 0.09 (0.08) |
| Drug checking location: Gold Coast | 0.10 (0.26) | -0.18 (0.27) | -0.84 (0.58) | 0.04 (0.07) |
| Previous drug checking service use: Yes | 0.06 (0.13) | 0.06 (0.13) | 0.15 (0.29) | -0.07 (0.04) |
| Previous AOD-related health conversation(s): Yes | 0.04 (0.12) | 0.03 (0.12) | 0.76* (0.32) | 0.01 (0.03) |
| Source of the drug: Unknown dealer | -0.19 (0.17) | -0.16 (0.16) | -0.17 (0.42) | 0.06 (0.05) |
| Source of the drug: Friend or relative | -0.13 (0.14) | -0.14 (0.14) | 0.15 (0.33) | 0.05 (0.04) |
| Source of the drug: Dark net/internet | -0.16 (0.17) | -0.16 (0.18) | 0.32 (0.43) | 0.02 (0.05) |
| Source of the drug: Occasional dealer | -0.13 (0.17) | -0.39* (0.17) | -0.10 (0.42) | 0.04 (0.05) |
| Source of the drug: Other | 0.14 (0.25) | -0.35 (0.30) | 0.59 (0.57) | -0.01 (0.08) |
| Expected substance: MDMA | 0.51*** (0.11) | 0.37** (0.12) | -0.57 (0.33) | -0.02 (0.04) |
| Expected substance: Cocaine | 0.64*** (0.12) | 0.22 (0.13) | 0.86* (0.34) | -0.03 (0.04) |

| | | | | |
|---|---|---|---|---|
| Expected substance: Ketamine | 0.49***<br>(0.13) | 0.06<br>(0.14) | 0.34<br>(0.37) | -0.06<br>(0.04) |
| Expected substance: Methamphetamine | 0.44*<br>(0.19) | 0.03<br>(0.20) | 0.86*<br>(0.38) | 0.00<br>(0.06) |
| Expected substance: LSD | 0.51**<br>(0.18) | -0.04<br>(0.21) | -0.52<br>(0.77) | -0.09<br>(0.06) |
| Expected substance: Alprazolam | 0.43<br>(0.26) | 0.10<br>(0.29) | 1.41**<br>(0.47) | 0.15<br>(0.08) |
| Expected substance: Heroin | 0.54<br>(0.26) | -0.07<br>(0.28) | 0.50<br>(0.46) | -0.09<br>(0.08) |
| Expected substance: Other less common substances | 0.63***<br>(0.13) | 0.15<br>(0.14) | -0.05<br>(0.37) | 0.21***<br>(0.04) |
| *Constant* | *-0.03*<br>*(0.34)* | *0.36*<br>*(0.32)* | *-2.76****<br>*(0.69)* | *-0.09*<br>*(0.10)* |
| *Measure and reported statistic* | *Pseudo R Squared= 0.099* | *Pseudo R Squared= 0.042* | *Pseudo R Squared= 0.235* | *Adjusted R Squared= 0.150* |

Notes. ***p<0.001, **p<0.01, *p<0.05; Reference groups: Age group: 40-49 yrs, Gender: Female, Residence: Brisbane, Sexual orientation: Heterosexual or straight, Employment status: employed full time, Born in Australia: No, Indigenous: Yes; Drug checking location: Brisbane; Previous drug checking service use: No, Previous AOD-related health conversation(s): No, Source of the drug: Regular dealer

## Appendix 4: Library of additional quotes from interviews

*But also as well that if you feel safe to do it recreationally and you have any issues or any uncertainty that that service is available for you to get that tested and it could be a matter between life and death which is really, you know, the main thing. (Client 2)*

*I think also it goes almost without saying that from a safety perspective in terms of detecting dangerous additives, that's a huge benefit. Like these drugs are going to be out there, and people are going to take them, regardless, and so simply removing this kind of service is not going to have any positive benefit whatsoever. It's just going to take us back to the era of less informed and more risky substance use amongst the community. (Client 10)*

*The use of these substances, particularly in this country, from what I know, is wide-spread, and if we can save as many lives as possible by allowing for people to have their stuff tested, that's always going to be a win, to save people's lives, and to give people the information that they require, so they can make an informed decision. (Client 11)*

*We're not naïve about it but – that we know that no one from the service is telling you that this is safe to take. That's not what the discussion is and it's quite frustrating when I hear [other people] claiming that that's what the service does because that is not what the service does and anyone that's used the service would know that. (Client 13)*

*Being present in the fixed site service, and seeing some of the – I could go through individual cases, which I won't, but some of the interventions that you can see has made a positive impact on the choices that people will make in future. Or, even the information they have to guide them in making choices in future, I've definitely seen a positive impact from the fixed site service. (Stakeholder 4)*

*...having Naloxone on hand is something that I would never have been exposed to if I wasn't within this - within health organisation that does drug checking. (Client 24)*

*Then they gave me the training to dispense [naloxone], so I've been dispensing it to - because it's just a more efficient way of doing it. Gets it into more hands. So, I'll go through and have the discussion about the drug and what it's used for and all of the overdose and response education and that sort of thing...I guess probably the naloxone going to communities that wouldn't typically have presented to a Needle and Syringe Program but are vulnerable to overdose in that they don't know a lot about it, and they're able to receive education about how to respond to someone if they are having an opioid overdose. (Stakeholder 16)*

*...we've done like decent numbers of referrals for people, decent numbers of people that become interested in treatment or interested in reducing or ceasing after talking with someone. I don't know how unexpected those outcomes were though. I think we did think we'd find like hidden populations and people who are not otherwise connected that should be and I think we've done that. (Stakeholder 12)*

*...were able to access clean needles... other resources. (Client 3)*

*…a world-leading perfect service that prevents harms and does everything when really - particularly for big music festivals, they are months if not years in the making of organising and setting up the infrastructure and where services will sit. (Stakeholder 14)*

## Appendix 5: Timeline of release of drug alerts and social media posts.

| Date | Drug expected/detected | Alert created |
|---|---|---|
| 1 April 2024 | Expected MDMA pill, detected N,N-dimethylpentylone and MDMA | PTA, PTA social media post |
| 1 April 2024 | Expected MDMA, detected MDMA (high dosage) and starch | PTA, PTA social media post |
| 1 April 2024 | Expected ketamine, detected 2-FDCK | PTA, PTA social media post |
| 1 April 2024 | Expected ketamine, detected procaine and tiletamine | PTA, PTA social media post |
| 1 April 2024 | Expected ketamine, detected 2F-NENDCK and 2F-DCK | PTA, PTA social media post |
| 1 April 2024 | Expected MDMA, detected ketamine and creatine | PTA, no social media post |
| 1 April 2024 | Expected 2CB, detected caffeine and ketamine | PTA, CheQpoint |
| April 2024 | Expected methamphetamine, detected DMP | PTA social media post, NO Alert |
| April 2024 | Expected MDMA, detected Cocaine | PTA social media post, NO Alerts |
| April 2024 | Expected ketamine, detected MDMA | PTA social media post, NO Alerts |
| May 2024 | Expected fake nucynta tablets, detected strong nitazene opioid | Queensland Health |
| 26 June 2024 | Expected 2-CB, detected Tusi (ketamine, caffeine and MDMA detected). | CheQpoint, CheQpoint social media post |
| 8 August 2024 | Expected cocaine, detected cocaine and phenacetin | Queensland Health, CheQpoint, CheQpoint social media post |
| 27 August 2024 | Expected oxandrolone, detected stanozolol and testosterone | CheQpoint, CheQpoint social media post |
| 18 September 2024 | Expected methamphetamine, detected 2F-NENDCK (novel dissociative) | CheQpoint, CheQpoint social media post |
| November 2024 (QH), 26 November 2024 (CheQpoint) | Expected oxycodone (fake), detected strong nitazene opioid | Queensland Health, CheQpoint, CheQpoint social media post, CheQpoint social media update (3 Jan 2025) |
| March 2025 | Detected protodesnitazene (new nitazene) | Queensland Health |
| April 2025 (QH), 4 April 2025 (CheQpoint) | Expected oxycodone pill (Green Bear), detected strong nitazene | Queensland Health, CheQpoint, CheQpoint social media |
| April 2025 (QH), 31 March 2025 (CheQpoint) | Expected oxycodone, detected nitazene | Queensland Health, CheQpoint, CheQpoint social media |
| April 2025 | Expected Xanax pill/off white powder, detected ethylbromazolam (novel benzo) | CheQpoint, CheQpoint social media post |

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