HARM REDUCTION AUSTRALIA

POLICY BRIEF

DRUG CONSUMPTION ROOMS IN AUSTRALIA

More rooms and different models

Executive Summary

Australia is facing a growing crisis of drug-related harm, with overdose deaths rising and inadequate investment in proven harm reduction strategies (Ritter et al, 2024). Despite the evidence supporting drug consumption rooms (DCRs) as effective public health interventions, currently only two such facilities are permitted by government to operate nationally - leaving many high-need communities underserved. This policy brief makes the case for expanding access to DCRs in Australia.

DCRs provide safe, supervised environments for drug use that reduce the risk of fatal overdose, connect people to health and social services, and reduce public drug use (and the associated law enforcement risks). The success of existing facilities in Sydney and Melbourne, backed by multiple independent evaluations (KPMG, 2010; MSIR Panel, 2023; Salmon et al., 2005), demonstrates their effectiveness and public benefit. Yet, access remains geographically and socially inequitable for some of Australia's most disadvantaged communities. Further, current services in Australia have also faced criticism for focusing exclusively on injecting drug use, due to access restrictions that prevent people who smoke or inhale drugs from using the services.

Public criticism of DCRs often centre on misconceptions about their impact on public safety. However, evidence consistently shows these concerns are unfounded. DCRs do not increase crime or drug use; rather, they improve community amenity and reduce emergency service demand. Introducing peer-based and mobile models offers a more cost-effective, scalable solution.

This policy brief outlines recommendations to expand and diversify Australia's DCR model, proposing cost-effective service designs, improved reach and community engagement, and the implementation of mobile units. These recommendations not only respond to the evidence base but also align with growing public, community and sector support for a more compassionate and responsive drug policy approach.

RECOMMENDATIONS

- Expand drug consumption rooms
- Implement peer-based service models in newly established drug consumption rooms
- Introduce the operation of mobile drug consumption rooms
- Deliver community education

Statement of the Problem

In Australia, drug-related deaths continue to increase (AIHW, 2025a), yet government investment in evidence-based harm reduction approaches is decreasing. Recent research has shown that harm reduction expenditure only made up 1.6% of Australia's drug budget in 2022 (Ritter et al., 2024). It is clear that more can and must be done to reduce drug related harm in Australia.

Drug consumption rooms are an effective and evidence-based approach that have been proven to reduce drug-related harms and prevent fatal overdoses (KPMG, 2010; Medically Supervised Injecting Room (MSIR) Review Panel, 2023). However, with only two drug consumption rooms in Australia, in metropolitan Sydney and Melbourne, expansion of drug consumption rooms beyond their current locations is necessary - particularly in areas where more drug-induced deaths are occurring (AIHW, 2025a). Limited access to drug consumption rooms denies people who use drugs a safe environment and the opportunity to receive appropriate medical attention and referrals to relevant health and social services. This is particularly important for the community of people who use drugs, some of whom experience high levels of social vulnerability and marginalisation due to ongoing criminalisation and associated stigma and discrimination (Sutherland et al., 2024).

Despite the need for expansion, drug consumption rooms face resistance and image problems based on concerns regarding increased crime and drug use, particularly from local businesses and politicians (Goodall, 2021; Smith, 2020). This is despite evidence showing the positive impact of DCRs on these very same issues (Day et al., 2022).

Less clinical models, that utilise peer workers and other community-based harm reduction specialists, have been shown to be highly successful in other countries

The current drug consumption rooms in Australia have also been criticised for their high cost, making the possibility of expansion seem limited. This expense is primarily due to the highly medicalised model that has been adopted in Australia. In Australia, the work in current DCRs is undertaken by a diverse team of health professionals that includes (often under government mandate) highly qualified clinicians and other medical professionals. Although this approach has been successful in reducing drug related overdoses and public drug use, other, less clinical (and more cost-effective) models, that utilise peer workers and other community-based harm reduction specialists, have been shown to be highly successful in other countries (Kennedy et al., 2019).

The current 'medically supervised' service model is not only expensive to establish and operate (due to the costs involved in paying highly qualified clinical staff), but HRA would argue, is also unnecessary, and moreover risks over-medicalising and further pathologising people who use drugs. As such, alternative models of care, such as peer-based and community service models, must be utilised in the expansion of DCRs.

Policy Context & Evidence

In Australia, there are currently two existing DCRs, located in Kings Cross, New South Wales and North Richmond, Victoria. Both of which have been deemed successful through multiple independent evaluations (KPMG, 2010; MSIR Panel, 2023; Salmon et al., 2005). With the success of the two existing DCRs, there has been increasing calls for further expansion of these facilities from a range of stakeholders, including academics, health and medical practitioners, policymakers and people with lived/living experience (Dertadian and Tomsen, 2019; McDonald, 2021). Not only do we see support from experts and those directly involved in the sector, but additionally, there is a growing level support for drug consumption rooms from within the general community (AIHW, 2025b; HRA et al., 2025).

Policy Context & Evidence (continued)

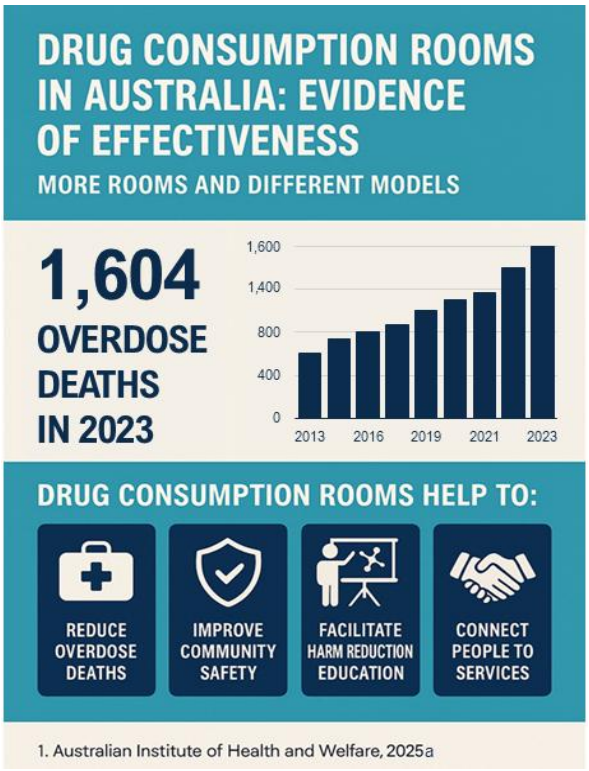
Drug consumption rooms are found to be effective in not only reducing drug-related harms and fatal overdoses, but also because they increase access to health care and social services for people who use drugs (Belackova & Salmon, 2017). For communities, the establishment of drug consumption rooms has proven to be beneficial. This is shown by evidence which points to a reduction in public drug use, ambulance callouts and no increase in crime from both existing DCRs (KPMG, 2010; MSIR Panel, 2023).

Evidence illustrates that expansion is necessary in order to provide greater access to these lifesaving, harm reduction services for people who use drugs and surrounding communities. This is particularly necessary as drug-induced deaths are increasingly occurring outside the areas where existing DCRs are located - in some of Australia's most disadvantaged communities (AIHW, 2025a). Research also shows that individuals who frequently use these services are more likely to live in close proximity to the facility (Van Den Boom et al., 2021). This illustrates how the location of a DCR, or lack thereof, influences use of the service and shows why it is integral for these services to expand further and gain greater reach to facilitate increased access.

Despite the need for expansion, drug consumption rooms face resistance and image problems which impede on the adoption of these services. Concerns regarding crime and public drug use as well as a general opposition to the services have created backlash from businesses, local councils and the public (Goodall, 2021; Smith, 2020). This is despite evidence that finds a decrease in public drug use, no increase in crime, nor any increase in attracting drug users (KPMG, 2010). The evidence illustrates that these concerns are unwarranted and unsupported by evidence.

The possibility of expansion also appears limited due to the costly service model which involves increased medicalisation and supervision. Yet, highly medicalised service models and medical supervision have been found to be unnecessary (Kirwan et al., 2020). In a review of the MSIR in Victoria (2020), it was recommended that the current medicalised and highly clinical model of care be reconsidered (MSIR Panel, 2020).

DCRs in Europe and North America illustrate the efficacy of alternative models, like peer-led or community-based models (Kerr et al., 2014). These have been found to be more beneficial for service users, as peers can draw from experiential expertise



1. Australian Institute of Health and Welfare, 2025a

alongside learned technical knowledge and they foster environments of comfort and safety (Kennedy et al., 2019; Olding et al., 2022). Additionally, due to the lower operational costs of reduced medicalisation and supervision, these service models would be more cost-effective to establish and operate. It is therefore evident that alternative models of care are needed to improve the harm reduction response to drug use.

Mobile drug consumption rooms (DCRs) present a flexible and scalable approach to addressing the growing need for harm reduction services in underserved or geographically dispersed communities. These mobile units have been successfully implemented in parts of Europe, such as Germany and Denmark, where they have increased service reach and improved engagement among people who use drugs, particularly those who are highly mobile or lack stable housing (Belackova & Salmon, 2017).

Mobile DCRs provide many of the same benefits as fixed-site services (such as overdose prevention, health referrals, and reduced public injecting) while offering greater adaptability in deployment. They can also help overcome local resistance to permanent sites by offering a lower-profile, lower- cost alternative (Kirwan et al., 2020). Given the growing need to extend services beyond centralised urban areas, mobile DCRs represent a pragmatic policy response that enhances accessibility, equity, and community acceptance.

Policy Recommendations

Australia should revise and expand their approach to drug consumption rooms. The following recommendations aim to increase access to these lifesaving services, reduce operational costs, improve the service model, and address resistance to the establishment of drug consumption rooms:

1

Expand drug consumption rooms

Drug consumption rooms must be established where there is demonstrated community need in order to increase access to these services and reduce drug-related harms and fatal overdoses. This should include expanding service models to meet the specific needs and preferences of local communities of people who use drugs including preferences in relation to the type and range of drugs consumed and routes of administration such as injecting, smoking, inhaling, etc.

2

Implement peer-based service models in newly established drug consumption rooms

The service model of newly established drug consumption rooms should be a peer-led model like the successful community-based models in North America and Europe. People with lived/living experience of drug use should be trained and employed alongside (fewer) nursing staff. As the additional role of a medical supervisor has been found to be unnecessary, shifting to this model of operation will be more cost-effective and will support greater community engagement.

Implementing peer-based service models necessitates robust training, fair compensation, and comprehensive support frameworks for peer workers. Peers offer lived/living experience and cultural competence, but they may also face unique challenges such as grief, ongoing stigma and the impacts of criminalisation. Ongoing professional development and debriefing processes are essential to maintaining workforce wellbeing and service quality.

3

Introduce the operation of mobile drug consumption rooms

Mobile drug consumption rooms are a cost-effective option to increase accessibility and address resistance to the establishment of permanent sites.

High costs associated with clinical supervision can be reduced through peer-led and hybrid staffing models. Mobile DCRs offer further cost savings while expanding geographic reach. Leveraging existing community health infrastructure and redirecting current drug policy expenditures toward harm reduction will enhance financial sustainability and effectiveness.

4

Deliver community education

In order to address resistance from the community to the establishment of drug consumption rooms, further community education on the benefits and effectiveness of drug consumption rooms must be delivered.

Resistance to new DCRs often stems from misinformation or stigma. Proactive, evidence-based community education campaigns must be implemented alongside DCR expansion. Partnering with local health advocates, councils, and business leaders can help demystify DCRs and foster broader public support.

Implementation Considerations

1

Peer-Led Workforce and Support Structures

Implementing peer-based service models necessitates robust training, fair compensation, and comprehensive support frameworks for peer workers. Peers offer lived/living experience and cultural competence, but they may also face unique challenges such as grief, ongoing stigma and the negative impacts of criminalisation. Ongoing professional development and debriefing processes are essential to maintaining workforce wellbeing and service quality.

2

Community Buy-In and Public Education

Resistance to new DCRs often stems from misinformation or stigma. Proactive, evidence-based community education campaigns must be implemented alongside DCR expansion. Partnering with local health advocates, councils, and business leaders can help demystify DCRs and foster broader public support.

3

Financial Sustainability and Cost Efficiency

High costs associated with clinical supervision can be reduced through peer-led and hybrid staffing models. Mobile DCRs offer further cost savings while expanding geographic reach. Leveraging existing community health infrastructure and redirecting current drug policy expenditures toward harm reduction will enhance financial sustainability and effectiveness.

5 Ways Our Recommendations Deliver Public and Policy Wins

1

Reduced Overdose Deaths

Expanding DCRs into high-need areas will save lives by providing immediate overdose response.

2

Improved Community Safety

Evidence shows DCRs reduce public drug use, discarded injecting equipment, and ambulance callouts, which benefit the entire community.

3

Cost-Effective Use of Public Funds

Alternative service models lower operational costs while maintaining or improving health outcomes, offering better returns on investment.

4

Strengthened Community Health Systems

By connecting people who use drugs to housing, mental health, and treatment services, DCRs serve as an essential health access point.

5

Evidence-Based Drug Policy Reform

Implementing these recommendations will position Australia as a leader in public health and harm reduction, aligning policy with international best practice and community support.

References

Australian Institute of Health and Welfare (AIHW). (2025a). *Alcohol, tobacco & other drugs in Australia, Harm reduction*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/data-by-region/drug-induced-deaths

Australian Institute of Health and Welfare (AIHW). (2025b). *Alcohol, tobacco & other drugs in Australia, Harm reduction*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/harm-minimisation/harm-reduction

Belackova, V., & Salmon, A. M. (2017). Overview of international literature - supervised injecting facilities & drug consumption rooms - Issue 1. In *Uniting*. Uniting Medically Supervised Injecting Centre. https://uniting.org/who-we-help/for-adults/sydney-medically-supervised-injecting-centre/resources

Day, C. A., Salmon, A., Jauncey, M., Bartlett, M., & Roxburgh, A. (2022). Twenty-one years at the Uniting Medically Supervised Injecting Centre, Sydney: addressing the remaining questions. *The Medical Journal of Australia*, *217*(8), 385–387. https://doi.org/10.5694/mja2.51716

Dertadian, G. C., & Tomsen, S. (2019). The case for a second safe injecting facility (SIF) in Sydney. *Current Issues in Criminal Justice*, *32*(2), 180–192. https://doi.org/10.1080/10345329.2019.1689787

Goodall, H. (2021, May 17). *Business owners furious over location of drug-injecting room in Melbourne CBD*. 7NEWS. https://7news.com.au/sunrise/on-the-show/business-owners-furious-over-location-of-drug-injection-room-in-melbourne-cbd-c-2867019

Harm Reduction Australia, Family Drug Support, & Students for Sensible Drug Policy Australia. (2025). *Solutions Not Stigma – Community Voices on Drug Law Reform – Harm Reduction Australia*. Harmreductionaustralia.org.au. https://www.harmreductionaustralia.org.au/solutions-not-stigma-community-voices-on-drug-law-reform/

References (continued)

Kennedy, M. C., Boyd, J., Mayer, S., Collins, A., Kerr, T., & McNeil, R. (2019). Peer worker involvement in low-threshold supervised consumption facilities in the context of an overdose epidemic in Vancouver, Canada. *Social Science & Medicine*, *225*, 60–68. https://doi.org/10.1016/j.socscimed.2019.02.014

Kerr, T., Oleson, M., Tyndall, M., Montaner, J., & Wood, E. (2014). A Description of a Peer-Run Supervised Injection Site for Injection Drug Users. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, *82*(2), 267–275. https://doi.org/10.1093/jurban/jti050

Kirwan, A., Winter, R., Gunn, J., Djordjevic, F., Curtis, M., & Dietze, P. (2020). *ACT Medically Supervised Injecting Facility Feasibility Study*. Burnet Institute & Canberra Alliance for Harm Minimisation and Advocacy. https://www.act.gov.au/__data/assets/pdf_file/0006/2464467/ACT-Medically-Supervised-Injecting-Facility-Feasability-Study.pdf

KPMG. (2010). *Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011)*. NSW Health. https://www.health.nsw.gov.au/aod/resources/Documents/msic-kpmg.pdf

McDonald, P. (2021, May 26). *More injecting rooms will save lives, reduce community pressure*. The Age. https://www.theage.com.au/national/victoria/more-injecting-rooms-will-save-lives-reduce-community-pressure-20210526-p57v8v.html

Medically Supervised Injecting Room Review Panel. (2020). Review of the Medically Supervised Injecting Room. In *Vic.gov.au*. Victoria Government. https://www.health.vic.gov.au/publications/review-of-the-medically-supervised-injecting-room-2020

Medically Supervised Injecting Room Review Panel. (2023). Review of the Medically Supervised Injecting Room 2023. In *Vic.gov.au*. Victoria Government. https://www.health.vic.gov.au/publications/review-of-the-medically-supervised-injecting-room-2023

Olding, M., Boyd, J., Kerr, T., Fowler, A., & McNeil, R. (2022). (Re)situating expertise in community-based overdose response: Insights from an ethnographic study of overdose prevention sites (OPS) in Vancouver, Canada. *International Journal of Drug Policy*, *111*, 103929. https://doi.org/10.1016/j.drugpo.2022.103929

Ritter, A., Grealy, M., Kelaita, P., & Kowalski, M. (2024). *The Australian "drug budget": Government drug policy expenditure 2021/22*. https://doi.org/10.26190/unsworks/30075

Salmon, A., Maher, L., & Kaldor, J. (2005). *Sydney Medically Supervised Injecting Centre Interim Evaluation Report No. 1 Operation & Service Delivery*. https://www.kirby.unsw.edu.au/sites/default/files/documents/INT_EVAL_REP_%2B1_SYD_%2BMSIC.pdf

Smith, A. (2020, February 17). *Growing push for Sydney's second medically supervised injecting room*. The Age; The Age. https://www.theage.com.au/politics/nsw/growing-push-for-sydney-s-second-medically-supervised-injecting-room-20200217-p541j6.html

Sutherland, R., King, C., Karlsson, A., Treloar, C., Broady, T., Chandrasena, U., Salom, C., Dietze, P., & Peacock, A. (2024). Stigma, and factors associated with experiencing stigma, while visiting health-care services among samples of people who use illegal drugs in Australia. *Drug and Alcohol Review*, *43*(5), 1264–1279. https://doi.org/10.1111/dar.13846

Van Den Boom, W., del Mar Quiroga, M., Fetene, D. M., Agius, P. A., Higgs, P. G., Maher, L., Hickman, M., Stoové, M. A., & Dietze, P. M. (2021). The Melbourne Safe Injecting Room Attracted People Most in Need of Its Service. *American Journal of Preventive Medicine*, *61*(2). https://doi.org/10.1016/j.amepre.2021.02.018.

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This policy brief is part of a series that provides summaries of evidence-based best practices and/or policy options on key harm reduction issues. Find the rest of the series here: https://www.harmreductionaustralia.org.au/