Searching for a needle in a haystack? An exploratory study into the policing of 'needle spiking' in the UK

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Abstract

In autumn 2021 social media posts about ‘needle’ spiking - the injecting of a person with drugs without their consent – began to circulate in the UK. This research supplements media articles and official documents with new empirical data (885 incidents from 32 police forces obtained via Freedom of Information requests and five interviews with victims). The purpose of the article is to document what is known about needle spiking and to identify how this might improve policing and research on spiking in the UK.

The FOI data showed that there was a peak in reported incidents in October and November 2021, that the most frequent location of the needle stick injury was the arm (followed by the leg), and that while three quarters of the incidents took place in a pub, bar or club, but that needle spiking was not exclusively a night-time economy problem. Needle spikings were rarely perpetrated as a ‘gateway crime’ to commit another criminal offence such as sexual assault, it was not restricted only to young women, and that victims faced disbelief from a number of directions including some parts of the media and police. Few drugs were identified (mamba, insulin, and cocaine) but there are acknowledged problems with forensic testing which are described, meaning that greater emphasis on other forms of evidence collection is required.

We propose that greater multi-agency working is required to tackle needle-spiking as there are overlapping needs in terms of needle (and other forms) of spiking relating to health and policing. More research is needed, particularly on offender motivations to fully understand and respond to the problem of spiking.

Keywords

Spiking, drugs, night-time economy, gender-based violence

Introduction

The administering of drugs (including alcohol) or poison to someone without their consent (in a non-medical capacity) is known as 'spiking'. In England, it is illegal under a range of legislation, including the administering of poison under s. 23 and 24 of the Offences Against the Person Act 1861 and the administering of a substance with the intent to overpower a person under s. 61 of the Sexual Offences Act 2003, and punishable by up to ten years in prison. The current framework has been criticised for using archaeic language (Home Office, 2023) and for not failing to reflect the intrusion on personal autonomy that spiking constitutes (Marks, 2024). New legislation which will introduce an updated, single offence of spiking is being developed at the time of writing.

Despite having little attention from criminologists, spiking is a widespread crime that can have serious and long-term impacts on victims (Burrell et al., 2023). According to the National Police Chief's Council in the UK, the police receive an average of 561 reports of spiking per month – and they acknowledge this is an under-recorded crime making the actual figures likely higher (NPCC, 2024). A spiking survey was conducted across three universities in the US (Swan et al., 2017), and found that one in 13 students (7.8%, 462/6,064) students said they had experienced being drugged (spiked). In addition, 83 students said they had drugged someone or knew someone who had drugged someone on 172 occasions. Female students were more likely to report negative outcomes including sexual assault and physical ill health and one participant choked on their own vomit and went on to require CPR on their way to hospital (Swan et al., 2017). Spiking is not confined to students though. The largest UK study found a similar rate of spiking in a nationally representative general population

study of 1,693 adults conducted by YouGov in 2021. In total, they found that 8% of participants said that they had had a drink spiked (6% of men and 11% of women).

Most consumables can be spiked, including food and cigarettes, but it is drinks that are thought to be most often spiked and it is drink spiking that has received the most attention. This changed suddenly and unexpectedly in the UK in autumn 2021, when the news media began reporting on a seemingly new phenomenon of 'needle spiking' that was being talked about on social media.

'Needle spiking' or 'injection spiking' refers to the administering of drugs or poison without consent via a syringe directly into a person's body rather than by a drink or other consumable. Some of the earliest social media accounts were made by female students in Nottingham reporting they felt unwell for reasons they could not explain, suffered memory loss, and suspected they might have been spiked (BBC 2021a). Some of these reports referred to specific pain in a limb, a pinprick type mark on their skin, and reports of feeling a scratch just before feeling unwell (BBC 2021b; Ng 2021). Around the same time, and in the weeks that followed, multiple reports were made from students at other universities across the UK including the Universities of Glasgow and Edinburgh. In response, students in Scotland set up 'Girls Night In, Edinburgh' which proposed a boycott of night time economy venues for one date in October to raise awareness of the problem, stating:

> The purpose of this boycott is to bring attention to the severity of the situation and to encourage you all to take this seriously and do everything within your power and means to prevent these heinous spiking incidents to the best of your ability. (Open letter from Girls Night In – Edinburgh and the community of Edinburgh, 20 October 2021 in Brown and Bryan 2021).

As awareness spread, more accounts were shared, and it became clear that the problem was not confined to female students – with male students and members of the public starting to make similar reports. By 31 July 2022 there had been 2,065 needle spiking incidents recorded by the police in England and Wales (comparable figures not made available from Scotland or Northern Ireland), and a national police operation launched (Operation Lester), a Home Affairs Committee inquiry conducted, a Department for Education working group established, and guidance sent to all Vice Chancellors from Universities UK (author ref). The statement 'Myth: Needle spiking isn't real' is now included on the Metropolitan Police Website ('Spiking Myths', https://www.met.police.uk/advice/advice-and-information/spiking-advice/spiking/spiking-myths/#Needle) and the Government factsheet about spiking now includes 'injecting someone with prescription or illegal drugs without their knowledge.' (https://www.gov.uk/government/publications/spiking-factsheet/spiking-factsheet). The Global Drugs Survey which asked about spiking in 22 countries found that nearly one in twenty (4.2%) of those who suspected they had been spiked said they thought this was using an injection (Davies et al., 2024).

As awareness of this problem arose quickly and unexpectedly, this article brings together information from different sources and analyses new empirical data (FOI data and a small number of victim interviews), supplemented by media commentary and official responses including a Parliamentary Inquiry. Due to extremely limited existing research on needle spiking (a review of 87 articles on spiking by Burrell et al. (2023) found only one reference to needle spiking in one article) this paper is presented in an exploratory style – bringing together a picture of what happened rather than in a traditional journal article layout. As feminist social scientists teaching students about violence and abuse, we were being educated

about this emerging problem from our own students in 'real time' as they described to us what they were seeing on a night out. In turn, we attempted to research the problem in real time to understand what was happening. The purpose of the article is to document what is known about needle spiking and to identify how this might improve policing and research on spiking in the UK. We describe the research approach first, then outline what we learnt about the nature and extent of the problem from both our empirical data and from the supplementary sources. We then present our findings framed as findings that could be taken forward in considering new research and police responses to all forms of spiking.

Research approach

Two research methods were used to collect the empirical data. First, we used Freedom of Information requests to identify the nature and extent of needle spiking reported to UK police forces. Second, we used interviews to explore the experiences of people who suspected they had been a victim of needle spiking. The empirical data collection was supplemented by information coming from a Parliamentary Inquiry and from first person narratives published in social or mainstream media. As additional context, but not used as data, our analysis is also informed by [advisory position held by author anonymised for peer review]. Ethical approval was granted by [anonymised for peer review].

Freedom of Information requests have increased in popularity over the last five years as a relatively low-cost criminological research method (Westmarland and Bows 2019). We sent a Freedom of Information request to all UK police forces – 49 in total: the 43 territorial forces in England and Wales, the two national police forces in Scotland and Northern Ireland, and four specialist police forces (British Transport Police, Civil Nuclear Constabulary, Ministry of Defence Police, and Port of Dover Police). There were two parts to the request; the first

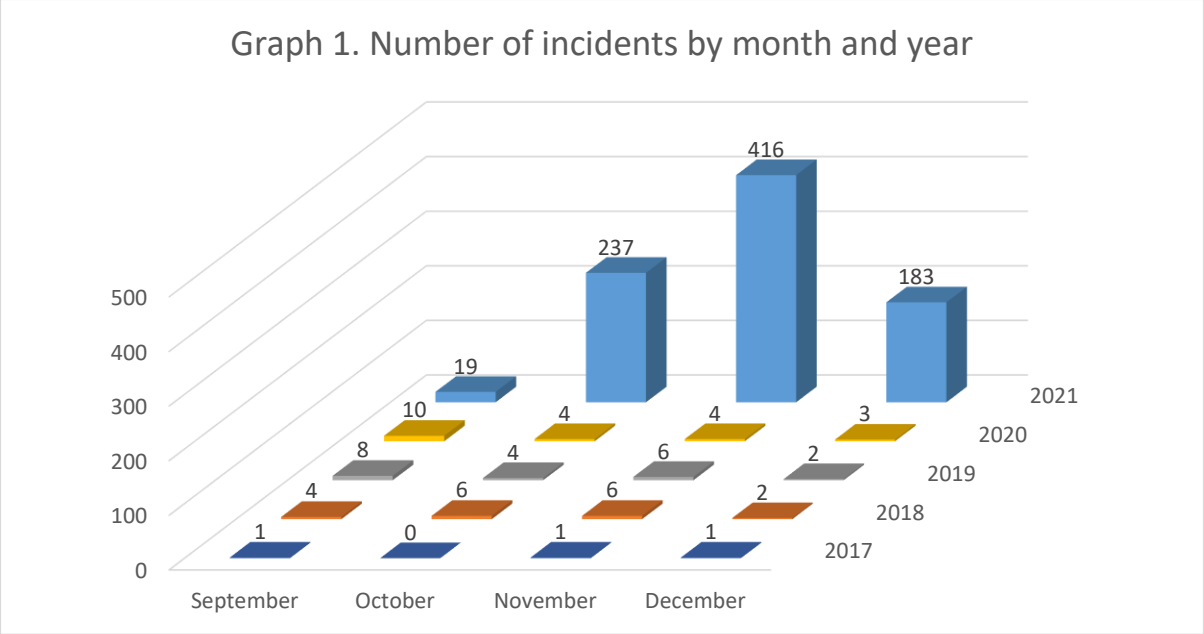
part asked for the number of needle spiking reports they had received in the months of September, October, November, and December in 2021 compared to the same months in the four previous years (the numbers were negligible in previous years so are not reported in this analysis). 33 of the 49 forces supplied us with this information or part of this information, including four nil returns (a response rate of 66%). The total number of incidents was 875. The second part of the request asked for more detail about the incidents. We asked for victim sex, suspect sex, whether the suspect was known to the victim, the location of the incident, whether any other allegations were made alongside the needle spiking, which drugs had been identified, the location of the needle wound, and whether a suspect had been identified, charged, and/or outcome known. 27 of the 50 forces (a response rate of 54%) responded to this part of the request, giving us information about 489 incidents, although there were high levels of missing data for some variables. After data collation and cleaning in Microsoft Excel, frequencies were calculated.

Five telephone interviews were conducted by [name of first author] to understand the experiences of those who had been needle spiked. Participants were self-selecting from across England and Wales and were recruited through social media. Four participants were women, and one was a man (Participant 2). Four of the five participants were university students. Respondents were asked to explain, in their own words, what had happened to them and were encouraged to go at their own speed and tell their own experience in the way that suited them. Prompts included asking about responses from the police, from any medical professionals they had sought help from, and from their university if relevant. Referrals to support services were made at the end of the interview where needed. Several interviewees thanked us for the opportunity to tell their story and to feel believed and have their experience validated – sometimes for the first time. Given the small number of interviews, they are

treated as individual case studies rather than attempting any form of thematic analysis. The number of interviews is small – in part because the study received no external funding due to the speed at which the problem and opportunity for data collection started and in part because they were designed to add additional depth to the FOI rather than to develop conclusions in themselves. However, they do constitute the only interviews with needle spiking victims in academic research to date.

Overall patterns from the FOI data

Despite some differences in how police forces searched their recording systems for the needle spiking incidents in response to our request, the reporting pattern they followed as a whole data set was fairly consistent. 25 police forces provided the number of recorded incidents broken down by the month requested. From an extremely low base rate in September 2021, the overall pattern was a rapid increase in needle spiking in October, with the increase continuing into November 2021 for the majority of forces, before a reduction in December that same year. This was substantially higher than for the same months in previous years. We do not name individual forces here as the purpose is to show the pattern across the autumn/winter months, rather than to show which forces had 'more' or 'less'. It is also important to note that some of the largest forces, including the Metropolitan Police, Police Scotland, and the location that saw the first recorded case – Nottinghamshire – all failed to supply data despite a number of follow ups. Hence, it is the *pattern* (a sudden increase for October and November followed by a reduction in December) not the overall number of recorded incidents (which is certainly a substantial undercount) that is relevant here.



The location of the needle stick injury was recorded in 309 incidents. The most frequently recorded location was an arm (the injury location in 127 incidents, 41% of the 309 incidents where injury location was recorded). Next most frequent were leg (85 incidents, 28%), back (25 incidents, 8%), hand (21 incidents, 7%) shoulder (15 incidents, 5%), and buttock (14 incidents, 5%). Also recorded but for under ten incidents each were hip, wrist, groin, stomach, and neck.

Spiking victims do not always know where they were at when the spiking happened. This means there are some limitations to location data. This was also the case for some of the victims we interviewed, athough some had clearer recollections:

> Basically, I'd been out on an afternoon with two other couples, we went to a bar to celebrate someone's 50th. We'd been there an hour, maybe an hour and a half and I bumped into someone when I walked out of the toilets, and clearly they had spiked me with a syringe. Within 10-15 minutes I had collapsed, this is at 6pm on a Saturday

> afternoon. I went outside and collapsed again, and then went from bad to worse. That's what I can remember. (Participant 2)

For those incidents where there was some recollection or suspicion about where the incident had taken place, a pub, bar or club was the most common venue (the location of 240 incidents - 75% of the 321 incidents where the venue was recorded). However, not all took place in busy nightlife venues, with a number of offences taking place at a residential (including university) address (61 incidents, 19%), on the street (14 incidents, 4%) on a train (4 incidents, 1%) or at a live music event (2 incidents, >1%). As with previous caveats, it is important to note that different police forces recorded locations in different ways, and that victims did not always know where the incident had taken place, so this should be considered a general pattern and understood with that limitation. The takeaway point here is that while *most* incidents happened in pubs, bars, and clubs, needle spiking is not *exclusively* a night time economy problem. This echoes findings from research on other forms of spiking (Burrell et al 2023; Swan et al 2017).

These findings show that needle spiking followed a pattern of reporting across England and Wales, that a wide range of places on the body were suspected as being spiked by a syringe, and that although most incidents took place within the night time economy, this was not exclusively the case.

Needle spikings were rarely perpetrated as a 'gateway crime' to another criminal offence

Until now, research on spiking in the UK has focused almost exclusively on spiking as a means to committing other offences, particularly rape and serious sexual offences. While

drug facilitated sexual assault undoubtedly requires research, looking at spiking only through the sexual assault lens has limited our understandings and excluded other possibilities, such as 'for a laugh/for fun' (McPherson, 2017; Swan et al. 2017). Research in the UK and internationally shows that the most frequently detected substance in drug facilitated sexual assault is alcohol rather than 'date rape drugs' (Gee at al. 2006; Alderson, Flynn and Pilgram 2017). Looking at spiking only through the lens of sexual assault is a problem for a number of reasons. First, it is not always the case 'date rape' drugs are used. The 'Black Cab rapist' John Worboys spiked glasses of champagne with sleeping tablets before sexually assaulting his female passengers. He was convicted in 2009 of 12 cases, but the number of reports exceeded 100 (Siddique 2021). The second problem is that it assumes that there will always be a follow on, 'more serious' offence than spiking. This may imply that the spiking offence does not warrant a full investigation in itself, despite its seriousness. This was how one victim we spoke to was made to feel, despite experiencing a secondary offence of serious sexual assault, when she tried to report the spiking:

> The whole ordeal was horrible. I don't want to badmouth the police or the NHS, but the police were really quite rude to me - unnecessarily rude - they said if you're not going to talk to us about the assault, then there's not much point speaking to us. (Participant 5)

The other four participants had no secondary offences that they were aware of (bearing in mind memory loss and confusion is a symptom of spiking), and they had all spent time trying to work out what possible potential motivations the perpetrator may have had for targeting them. Two participants wondered whether the spiking in their cases could have been a homophobic hate crime, but the sample is too small to draw any conclusions.

The FOI data in our study showed that secondary offending was relatively rare. This finding was consistent across the forces. Most often, the listed offences (178 incidents had a criminal offence recorded) were linked directly to the needle spiking itself. In other words, spiking was the primary and sole offence – spiking was not used as a gateway to commit a different type of crime. Assault was the most frequently used offence type – usually at the level of ABH (actual bodily harm) or the more serious GBH (grievous bodily harm) (117 incidents, 66% of the 178 incidents where an offence type was recorded). This contrasts with what we might see for drink spiking – since there is a physical injury with a needle in this form of spiking, it opens up the opportunity for assault charges to be brought. The next most frequent offence type was the 'administering of poison', including 'to administer poison so as to endanger life', 'administer poison with intent to injure or annoy', and 'administer poison with intent to commit sexual assault' (42 incidents, 24%). In the small number of linked offences that were recorded beyond the spiking itself, these were sexual offences (in 13 incidents, 7%), theft (5 incidents, 3%) and criminal damage (1 incident, >1%).

Hence, while there was some secondary offending, and some of these were sexual offences, looking at needle spiking only through the lens of rape and serious sexual offences closes off other possibilities in understanding the motivations and intentions behind needle spiking. The question of why these offences are being committed has not been explored, and the low number of identified perpetrators makes researching perpetrator motives almost impossible. Government enquiries in both England and Wales and in Scotland have concluded that spiking motives remain unknown and there is a need for research:

> We are not always able to determine the reasons why a perpetrator carries out an assault in this way, and it may not always be for a sexual purpose. It can put people at significant risk of harm. (Assistant Chief Constable Judi Heaton, Police Scotland, Oct 2021, giving evidence to the Education, Young People and Children Committee)

> The motivations of spiking offenders remain unclear, particularly around the newly identified incidences of needle spiking, and that the lack of understanding limits our ability to effectively tackle spiking through targeted interventions. (Government response to the House of Commons Home Affairs Committee 2022: 8).

Our FOI data has shown that in the case of needle spiking, assault and poisoning offences were recorded as being the primary and sole offence type in most incidents where a crime was recorded. Although there were some additional offences reported, these were in the minority. Future research and criminal investigations should be more open to motives other than rape and serious sexual offences and treat needle spiking as a form of assault or poisoning in its own right. Greater intelligence about perpetrator motives is essential to gain a fuller understanding of the problem, to identify perpetrators, and to develop crime disruption-based interventions. The planned introduction of spiking as a single criminal offence in England and Wales may help with this as it will make it more straightforward to research (police reported) spiking through the criminal justice system.

Needle spiking was not restricted to young women – men were also targeted

As described earlier, some of the first reports of needle spiking on social media were mainly from young women students, many of which were dismissed as being young women who

could not ‘handle their alcohol’ as the night time economy began to reopen after Covid-19 lockdown restrictions. Drink spiking has also traditionally been seen as a ‘young women’s problem’, with devices such as ‘spikey’s’ (plastic bottle stoppers) and hair scrunchie drink covers being marketed at this demographic. However, men have been spiked using so called ‘date rape’ drugs in some of the most high-profile serial rape cases in the UK against men – such as Reynhard Sinaga who was convicted in 2020 for using GHB to drug 48 men before he raped them (with the investigation team finding evidence linking over 190 potential victims to him) (Greater Manchester Police, 2020). GHB was also used by serial killer Stephen Port when he spiked and murdered four men in 2014.

As mentioned earlier, the largest spiking prevalence study in the UK asked only about drink spiking not needle or other forms of spiking and found that 6% of men and 11% of women said they suspected that they had had their drink spiked (YouGov, 2021). Participants were also asked how confident they were that they would be believed if they said someone had spiked their drink. Participants felt most confident that they would be believed by family (82% fairly or very confident) and friends (81% fairly or very confident). However, only 43% were fairly or very confident that they would be believed if they reported it to the police and only 29% were fairly or very confident that they would be believed if they reported it to the venue/place where their drink was spiked. The sex differences were interesting – with men being more confident than women that they would be believed if they told the police or the venue/place where their drink was spiked, whilst women were more confident than men they would be believed if they told their friends or their family (YouGov 2021).

The FOI data in our study showed that both women and men were recorded as being victimised, although women were disproportionately targeted. For the 437 incidents where

sex was recorded, 374 victims (86%) were women and 63 (14%) were men. There was a very small number of suspects identified – just 25 – and all of these were recorded as being men. Therefore, we would describe the problem as being gendered in that the suspected perpetrators were men and the majority of victims were women but would also note that it is important to recognise that this is not only a problem for 'young, drunk women'. This is important in the next section which addresses the lack of belief in victims' testimonies of needle spiking.

Disbelief in victim's testimonies

While there were some media reports that treated victim's testimonies in a respectful manner, the primary narrative when needle spikings started to be reported was that spiking could not be happening and that it was a case of young women who could not handle their alcohol coming out of Covid-19 lockdowns. News reports pointed to the lack of arrests, the lack of identified drugs, and used expert voices on drugs as their evidence to why needle spiking could not be happening and that it was 'fake news'.

Various newspapers took this approach, such as the 2021 Mail on Sunday (20.11.21) article which was headlined '*Did all those nightclub needle attacks actually never happen*?'. This article reported: '*It's an uncomfortable truth, not least for the young women who sincerely believe that they are victims, but it's entirely possible that there is no epidemic of needle spiking. And that what is taking place is in our heads'* (no page numbers). This news article, written by a criminologist, refutes the reality of needle spiking through reference to his 'friends' who believe women simply imagine that they have been spiked. In conclusion, the

author, Waiton, states that needle spiking is actually '*victim-feminism*' and a '*very modern form of bigotry* [against men]' (no page numbers).

Similarly, a 2021 article for The Herald, entitled '*Spiking by injection: Experts say scenario is 'far-fetched*'' repeats this dismissal of victim's accounts:

> Experts have said that a sudden spate of women being spiked by injection is 'far-fetched' and 'deeply improbable' due to the difficulties involved with using a syringe on someone against their will […] experts say the scenario is unlikely as it is almost impossible to administer the type of drugs needed to render someone unconscious without that person noticing, and could only be carried out by someone with a very specialised set of skills. (Harrison 2021: no page numbers).

Our interviews with victims of needle spiking spoke of a lack of belief by some they told. Although this was a small, self-selecting sample, and their negative experiences might have motivated them to speak to researchers, this finding is in line with other documented experiences of victims speaking out via social media and some mainstream media. One participant told us the reaction from security at the club where she had been needle spiked:

> The first time we went back a few weeks afterwards, I said the last time I was there I was needle spiked. And the doorman said we were liars and we hadn't been. Then I started getting upset at being called a liar, and then the manager came out and said 'yes she was needle spiked'. They said it had happened - but the CCTV now had been wiped. (Participant 4)

Participant 5 got a mixed reaction when she reported needle spiking to the police, with all but one police officer doubting her story. One male officer told her '*If you hadn't been out for three months, you probably just weren't used to the alcohol.'* Another told her '*Yeah that's not a spike mark, it's just a spot*.' After getting upset about not being believed, a female officer did reassure her and blamed or excused the officer's comment about the spot on his age, suggesting that his attitude was outdated: '*The policewoman said 'He's old. If you think you've been spiked, then they will take it seriously*.' However, overall, the impact of the earlier comments had been for Participant 5 to feel disbelieved, and this compounded the harm she experienced. She concluded '*Basically, no one really took me seriously, and it made me feel worse about it all*.'

In place of victim disbelief, time and attention could more usefully be placed on developing how evidence could be gathered to support (or indeed not support) victim testimony. This could include consideration of: how CCTV evidence could be improved, retained, and used; how victim interviews could be better conducted to achieve best evidence; and the use of timely forensic medical examinations including photography of any needle stick injuries.

Limitations of evidential drug testing for spiking

One of the reasons given by those sceptical that needle spiking was happening was the lack of identified drugs in people's bodies. The lack of confirmatory toxicology reports was generally interpreted as evidence that needle spiking was not happening (such as in the Waiton 2021 article) rather than potential limitations of drug testing accuracy and availability. In another case, a student at Aberdeen University reported being needle spiked to Police Scotland but was 'dismissed' by officers and 'was told there was nothing officers could do

because she had not had blood samples taken - and so there was no proof she had been spiked' (Allen 2021: no page numbers).

In our FOI data, there were indeed a very small number of drugs identified (however this may have increased as more results may have come back outside of the research period and/or as testing protocols improved over time). At the time of responding to our request, just 7 incidents had drugs identified in our sample. The 7 incidents related to three drugs: mamba (a form of synthetic cannabinoid), insulin, and cocaine.

In our interview data, there were examples of participants being passed between health and police for blood testing, and of delays to forensic tests being taken. Sometimes these were policing delays, and some were due to a time delay between falling ill and the participant suspecting they had been spiked.

Our data is only from the first few months of the needle spiking, and testing regimes did get more organised over time. For example, the National Police Chief's Council launched 'Operation Lester' to gain national intelligence and provide a more coordinated forensic testing regime for all forms of spiking. In addition, some night time economy venues sourced their own testing kits including rapid testing kits for drinks (author ref). However, there remains significant issues using existing drug testing methods as a way of 'proving' spiking.

Many of these issues were explored in the Home Affairs Committee report on Spiking (House of Commons 2022a). They highlighted the lack of, and delays in, forensic testing in (all forms of) spiking cases. Giving evidence to the review, Dr Adrian Boyle (Vice President of The Royal College of Emergency Medicine) stated that health settings are not always able to

test samples in a way which is admissible in a court of law and that police should take forensic samples:

> Victims are often ping-ponged between the health service and the police, who told us they have insufficient forensic testing capacity and that late reporting reduces the viable testing window. (House of Commons Home Affairs Committee 2022a: 3)

We also saw examples of this 'ping ponging' between health and criminal justice in our interviews, which we discuss later in this article in terms of the need for a more joined up multi-agency approach to a multi-agency problem.

There exists strong evidence that delays to drug testing impact on confirmatory toxicology reports, as a systematic review of the toxicology of drug-facilitated sexual assault (DFSA), demonstrated:

> As was mentioned in nearly all studies in this review, it is likely that current prevalence rates are under-estimated due to limited toxicological results of samples provided after a lengthy delay following the suspected DFSA. A delay of even 12 h can impede the detection of fast metabolising substances, such as alcohol and GHB. (Anderson *et al*. 2017: 53)

Given the existing known problems in gaining timely toxicology reports for spiking generally, the victims' experiences in our study, and the low number of drugs confirmed in our FOI sample, we concur with the recommendations from the House of Common's Home Affairs Committee (2022) that a rapid forensic testing service should be developed to ensure timely provision of forensic testing which is admissible as evidence in court. We also further emphasise that it is important that the limitations of testing are made clear to both victims and

to professionals who are responding (author ref). Taylor and colleagues (2004: xiv) argued in relation to drink spiking that:

> In the absence of evidence, it should be assumed that incidents do occur while we move to build a comprehensive database and improve the coordination between relevant agencies relating to forensic procedures.

We propose that this approach should also be followed for needle and other forms of spiking.

Need to improve evidence collection for the identification of suspects

Given the known limitations of evidential drug testing for spiking, it follows that broader evidence collection is important. We do not have any FOI data on additional evidence collected, however all five of our small sample of interviewees reported negative experiences of trying to report what had happened to them. Four out of five attempted to make a police report. The fifth did not attempt to report to the police having previously had a negative experience with the police. One of the criticisms made about police responses was the lack of timely evidence collection. In particular, the late timing of collecting forensic samples and CCTV was criticised:

> I reported it to the police both [force name] and [force name]. They've done absolutely nothing … I don't think the police have a grip on it. I think its new to them, but this was a club with 38 high-definition cameras, it's a very small club, you could have picked it out dead easy, and now it's all deleted and gone. The case is now closed believe it or not. (Participant 2)

> The response officer took a full statement, and the person in charge of our case took urine samples. But that was far too late, it was five days later. They tried to send a photographer but they sent the photographer too late and the needle hole had closed up. (Participant 4)

When listing the evidence she thought could have been collected, one participant exclaimed at the end: '*I feel like we could solve it quicker than they are!*' (Participant 3)

As noted earlier, this is a small, self-selecting sample of victims who may have had disproportionately negative experiences in reporting to the police. However, we also note that there is a heavy emphasis across the media, academic research, and parliamentary committees about forensic drug testing as evidence. Given the limitations outlined above (some of which cannot be quickly resolved), we propose that greater emphasis and research on broader forms of evidence collection would be useful such as those suggested earlier in the article and as called for by the Home Office (2023).

A multi-agency problem: the need to coordinate health and policing responses better on a local and national scale

One of the problems linked to evidence collection is that victims often require immediate medical attention. The victims we spoke to told us about health problems similar to those reported by other needle spiking victims speaking out on social media. All described feeling extremely ill – '*I've never felt as ill in my life'* as Participant 2 described it – and having memory loss, and in some cases collapsing. Some also experienced vomiting:

> I was sick that night when I got back, in bed, and I urinated myself as well in bed. (Participant 4)

Disturbed vision was also described. Participant 1 described it as ‘everything was just black’ even though she had her eyes open. Participant 5 decribed her vision being blurred, similar to the start of a migraine, and another described it as:

> I felt like I couldn’t see, obviously I could see as I was walking around, but I felt like I couldn’t. (Participant 3)

Some participants felt that the hospital had not fully understood what spiking was or have a procedure to follow in terms of liaising with the police:

> At the hospital – they took my blood, they didn’t do anything they just kept them, they didn’t know what they were doing. The Dr couldn’t understand what the idea of spiking was, I had to explain it to her for about 20 minutes. (Participant 3)

> I went to the hospital, in [name of town] and they weren’t interested at all. I’ve just found the whole scenario I find myself in frightening. I went to the NHS emergency walk in, I said ‘a few days ago I was spiked with a syringe in the side of my body’ and they said ‘no we don’t do that, we don’t do that here.’ They said ‘do you have any other injuries?’ They said ‘Oh well if you want to hang around I’ll have a look at the bruise for you.’ (Participant 2)

Participant 2 had been hoping in attending the walk in to obtain PEP – post-exposure prophylaxis for HIV – as he was concerned that the injection he was spiked with may not have been clean. He then went to the sexual health clinic and his General Practitioner. However, the only thing he was able to obtain was a HIV test that could be done three months after the incident and was told he did not meet the criteria for PEP.

We agree with Blandamer and colleagues (2023) that there needs to be greater consideration on responses from a healthcare perspective. They argue that efficient testing will improve a coordinated response and 'information sharing between Eds [emergency departments], public health bodies and the police. This could potentially enhance police and healthcare responses, particularly to injection spiking, given the current paucity of data' (Blandamer *et al*. 2023: 4).

The health impacts were not limited to short term acute problems. In the weeks and months following the needle spiking, participants spoke longer term health impacts linked to anxiety, as demonstrated in these examples:

> I'm not the same person now. I'm very cautious about going into bars and clubs. I had a birthday party, but I've not had a drink of alcohol since. I'm very subdued. Very quiet. (Participant 2)

> I had a panic attack and couldn't breathe … the first time I walked past the clubs on the high street I had an anxiety attack. (Participant 3)

Most of the media coverage and national responses have been focused on criminal justice, and specifically on policing of spiking. However, there are clear overlapping needs from needle (and other forms of) spiking in terms of health and criminal justice. Greater multi-agency

working is required both on practical and strategic fronts, at a local and national level to respond in a multi-agency way to a multi-agency problem.

Conclusions

This research has joined together existing research, media articles, and government documents along with new empirical data to offer new knowledge about needle spiking. In paying attention to the new form of spiking using needles, debates about how we respond to drink spiking have also been reignited. To date, spiking has not been given the priority it deserves in terms of policing, healthcare, or academic research – in part because it has too often been approached only through the lens of drug facilitated sexual assault . This research is the first to have included detail about needle spikings reported to the police for example where on the body the victim suspected they were spiked, the suspected location that the incident took place, and the sex of the victim and also the first to include victim's voices directly. However, the qualitative sample size is small (five victims) and the police data was extracted soon after the problem emerged – policing recording and responses are likely to have improved after this intitial period. It is hoped that this exploratory research can be built upon to support greater multi-agency working, including improved victim care pathways within and between the police and health services. Multi-disciplinary research is needed to improve responses to victims and understand more about offender motives – although the latter will require some methodological innovation. There will be new research opportunities when the planned introduction of spiking as a standalone criminal offence in England and Wales comes into force, as it will make the identification and tracking of cases through the criminal justice system more straightforward. However, the voices of victims who do not report to the police must also continue to be heard and future research should not be limited to new criminal justice responses.

Needle spiking, as with other forms of spiking, is a life-changing crime that can have profound short and long term physical and mental health impacts. Poor criminal justice and health responses can exacerbate these harms. By integrating existing research on drink spiking with new empirical research on needle spiking, set against the backdrop of media and government reactions, this article contributes towards a renewed academic, policy and practice focus on all forms of spiking. While much attention is being placed on the promised legislative reform, this article has highlighted other, non-legislative problems that that persist. The introduction of a new criminal offence should be the beginning - not the conclusion - of renewed efforts to prevent spiking.

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The authors report there are no competing interests to declare.

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