National Project on Drink Spiking: Investigating the nature and extent of drink spiking in Australia

THE NATIONAL DRUG STRATEGY

Commissioned by the
Ministerial Council on Drug Strategy
as a project under the
cost shared funding arrangement

November 2004

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Australian Institute of Criminology
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- the Sexual Assault Counselling Services around the country who agreed to provide telephone counselling services to sexual assault victims during the drink spiking hotline and who agreed to distribute pamphlets about the hotline to victims;
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Foreword

The *National Project on Drink Spiking: Investigating the nature and extent of drink spiking in Australia*, prepared by the Australian Institute of Criminology, is the first comprehensive report on drink spiking in Australia.

The report is an important piece of work and is the first to be published by the Ministerial Council on Drug Strategy. It is funded under a cost-shared funding arrangement, reflecting the cooperation between the Australian, State and Territory governments.

The report is founded on evidence obtained directly from victims of drink spiking. In addition to data received from police in each Australian jurisdiction and data from the Centre Against Sexual Assault, comprehensive data was obtained through the operation of a national Drink Spiking Hotline. The hotline operated for one month between November and December 2003 and obtained reports from 201people who claimed to be victims of drink spiking, or people calling on their behalf.

The contributors are to be commended for their efforts. They include all jurisdictions, the Australian Institute of Criminology, and in particular the Advisory Group representatives from the Australian Government Department of Health and Ageing, Victoria Police, South Australia Police, Northern Territory Police, ACT Police, Tasmania Police, the Office of the Status of Women, the Australian Hotels Association and the Australian Government Attorney-General's Department.

Particular acknowledgement should also be given to organisations that respond to sexual assault issues who provided valuable information for this report.

The report highlights the degree to which drink spiking is under-reported, a fundamental challenge in measuring the extent of drink spiking in the community.

Of significant concern is the finding that while one third of all drink spiking incidents are associated with sexual assault, less than one sixth of suspected drink spiking sexual assaults are believed to be reported to police.

Some of the key messages in the report include the need to raise awareness of reporting all suspected drink spiking incidents to the police and for victims to seek medical assistance at the earliest possible opportunity after an incident has occurred.

It is evident that there is no 'typical' incident of drink spiking however many incidents of drink spiking appear to involve alcohol rather than illicit drugs.

Estimates provided within this report indicate a need for improved procedural responses to drink spiking incidents, and improved data collection methods.

The second phase of the project will focus on awareness raising and will involve police, sexual assault counsellors, accident and emergency staff in hospitals and the hospitality industry. It should also be acknowledged that public awareness campaigns have already been undertaken in many jurisdictions.

I commend this report to you as the first step in raising awareness of drink spiking within the community. I trust that you will find it a well-researched, clearly written, and useful addition to the body of knowledge on drink spiking.

Senator Chris Ellison
Minister for Justice and Customs
November 2004

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Executive Summary

Overview

In July 2003 the AIC was commissioned by the Australian Government Attorney-General's Department, on behalf of the Intergovernmental Committee on Drugs, to conduct Stage One of a national project on drink spiking. Drink spiking was identified as an emerging issue for examination under the alcohol priority area identified by the Ministerial Council on Drug Strategy and has received considerable media attention in the last couple of years. Drink spiking is where drugs and/or alcohol are added to a drink without the consent of the person consuming it. The potential consequences of drink spiking can be severe, both physically and emotionally, depending on the type of additive used and the motivation of the perpetrator. Knowledge about drink spiking in Australia is currently very limited but suggestions that incidents of drink spiking have been increasing in recent times has resulted in a need to greatly improve the knowledge base on drink spiking.

The national drink spiking project is a major project being conducted in two stages – the first stage focuses on identifying the nature and extent of drink spiking in Australia and identifying communication and educational initiatives to prevent and respond to drink spiking. The second stage of the project will focus on improving awareness and practices of key organisations in the community that come into contact with those at risk of drink spiking. The AIC was commissioned to undertake Stage One of this project.

Aims of the project

The aims of the project were to:

- estimate the extent of drink spiking and associated criminal victimisation;
- document current legislative and procedural arrangements that relate to drink spiking and associated criminal victimisation; and
- identify effective communication and educational initiatives to prevent and respond to drink spiking.

The key tasks for Stage One involved:

- reviewing the international and Australian literature on drink spiking;
- consulting with key stakeholders;
- conducting a review of relevant data collections; and
- compiling a report outlining findings and including recommendations for future directions.

In acknowledgement of the fact that there is very little data on drink spiking to date and no published research with drink spiking victims, one key task proposed for this report was to conduct a national telephone hotline with drink spiking victims. It was proposed that the hotline would provide a valuable empirical data source on the circumstances in which incidents of drink spiking occur and the variety of situations in which they occur. The telephone hotline with drink spiking victims was therefore a key outcome of this report.

This report brings together information about drink spiking from a variety of sources across Australia and internationally. The report summarises the literature and research to date on drink spiking, analyses data from a range of sources (including police data and AIC Hotline data) to build an empirical evidence base on drink spiking, highlights what needs to be done to improve evidence collection and rates of prosecution, summarises key themes which emerged from discussions with stakeholders and identifies potential educational initiatives to prevent and respond to drink spiking.

Background

What is drink spiking?

The term 'drink spiking' refers to drugs or alcohol being added to a drink (alcoholic or non-alcoholic) without the consent of the person consuming it. For an incident to be defined as drink spiking in this report, it need not involve further criminal victimisation, even though such offences can occur after an incident of drink spiking.

How does someone know if their drink has been spiked?

Unless someone has actually seen someone else put a substance into their drink, or had blood and urine tests which returned a positive result, it is very difficult to know for certain whether a drink has been spiked. In the majority of cases where a victim suspects that his/her drink has been spiked the suspicion stems from the effects which occur after drinks have been consumed. Such effects include memory loss, nausea, vomiting, unconsciousness and dizziness. Due to the fact that these effects can also occur after voluntary consumption of alcohol and drugs some people have argued that victims may misattribute these effects and therefore mistakenly believe that their drink had been spiked when in fact they had consumed more alcohol or drugs than they thought they had.

While this cannot be ruled out as a possible explanation for some reported incidents it would be dangerous to assume that this explanation applied to all or most incidents of drink spiking. Many victims who called in to the hotline stated explicitly that the effects which they had experienced *were very different from* the effects of voluntary alcohol consumption. In particular victims were at pains to point out that they knew the difference between the effects which they had experienced after the suspected drink spiking incident and the effects they had previously experienced as a result of voluntary excessive alcohol consumption. Given the inherent obstacles associated with verifying reported incidents of drink spiking highlighted in this report a cautious approach is recommended. In particular it is suggested that all reported incidents of drink spiking should be taken seriously in the first instance and investigated

where possible rather than dismissing instances on the basis of a judgement that a person's own consumption of alcohol or drugs was responsible for the effects.

Main findings

What is the extent of drink spiking in Australia?

There is currently no way to determine the exact number of drink spiking incidents which occur within the community. This is due to (a) high levels of under-reporting, (b) fluctuations in reporting due to awareness campaigns, (c) jurisdictional differences in data recording and extraction procedures and (d) difficulty in verifying whether a reported incident actually occurred. In the absence of exact numbers, rough estimates of drink spiking prevalence are calculated in this report based on a procedure which inflates the number of incidents which are reported to police by the level of under-reporting in self-report victim surveys. It is important to remember that this procedure is based on certain assumptions and the resulting estimates should be taken as a rough guide only to the number of incidents which may have been suspected by people to have occurred to them in 2002-03.

In this report it is roughly estimated that between 1 July 2002 and 30 June 2003 (i.e. over a twelve month period):

- between 3000 and 4000 suspected incidents of drink spiking occurred in Australia;
- approximately one third of these incidents involved sexual assault;
- between 60 and 70 per cent of these incidents involved no additional victimisation;
- between 15 and 19 suspected drink spiking incidents occurred per 100,000 persons in Australia during 2002/03.

It is important to bear in mind that the number of suspected drink spiking sexual assaults estimated to have occurred during 2002-03 is very very small compared with the much larger numbers of sexual assaults in general which were reported to police during that year.

What is the nature of drink spiking?

There is no single 'typical' incident of drink spiking. Rather, drink spiking appears to be a complicated phenomenon which can occur in a variety of locations, against a variety of victims, with a variety of different spiking additives, for a number of different reasons resulting in disparate effects and consequences. Based on analyses of police data, sexual assault data and AIC hotline data it was found that:

- 4 out of 5 victims are female;
- about half of drink spiking victims are aged under 24, while about one third are aged between 25 and 34;
- the majority of reported drink spiking incidents have no associated criminal victimisation, indicating that 'prank spiking' may be a common motivation for drink spiking;

- between 20 and 30 per cent of incidents reported to police involve sexual assault, while it is estimated that about one third of all drink spiking incidents are associated with sexual assault;
- about five per cent of incidents involve robbery;
- two thirds of suspected drink spiking incidents occur in licensed premises (although for sexual assault victims the location is equally likely to be at the victim or offender's home or another location);
- many victims do not know who the offender was;
- where offenders can be identified, drink spiking can be perpetrated by strangers or known acquaintances, while incidents involving sexual assault are more likely to occur with a known offender;
- many victims experience memory loss after drink spiking;
- apprehension of offenders is very uncommon;
- forensic testing of blood and urine samples is relatively rare and does not conclusively prove that drink spiking has occurred; and
- the vast majority of incidents of drink spiking are not reported to police.

Reporting to police

It is estimated that less than 15 per cent of suspected drink spiking sexual assaults are reported to police, and between 20 and 25 per cent of suspected drink spiking non-sexual assault cases are reported to police. This means that the vast majority of suspected drink spiking incidents are not reported to police. If we are to gain a better understanding of how often drink spiking occurs and if police are to be able to identify patterns of drink spiking and develop targeted policing strategies there is clearly a need to improve the rates of reporting to police. This message could be articulated in awareness and education campaigns. Reporting rates could also be improved through a public perception that all incidents of drink spiking will be treated seriously by police regardless of knowledge of offender, memory loss and associated victimisation.

What evidence is there that drugs are used in drink spiking?

Despite considerable media and public perceptions concerning the prevalence of drugs such as flunitrazepam, GHB and Ketamine being used in drink spiking, the forensic evidence to date does not support these claims. Alcohol has tended to dominate results and it is not clear whether this is because (a) alcohol is commonly used to spike drinks, (b) other drugs have left the body by the time of testing and so only alcohol is left to detect, or (c) people are unaware how much alcohol they are actually drinking. The only way to test for the presence of drugs is to conduct scientific analyses. However scientific analyses can only confirm whether or not drugs or alcohol are in the body at the time of testing and cannot confirm that a positive result means that a drink was spiked.

Is drink spiking illegal in Australia?

There is currently no separate offence category in any Australian jurisdiction for the act of spiking someone's drink *per se*. Rather, the use of criminal laws to prosecute drink spiking depends on:

- the state/territory in which the incident occurred;
- the motivation of the person spiking the drink;
- the type of substance used to spike the drink; and
- the effects of the spiking.

This means that there is some degree of flexibility in how an incident of drink spiking is recorded by police within each jurisdiction and how courts may interpret the law in relation to such incidents. It is recommended that each jurisdiction review its criminal law provisions in terms of their applicability to different forms of drink spiking and appropriate maximum penalties. Consideration of these issues could also be given by the Model Criminal Code Officers Committee (Parliament of Australia 1998).

Prosecuting offenders

Successful prosecution of drink spiking should be an important objective in any attempts to prevent drink spiking. Not only does it have deterrent value for both actual offenders and potential offenders, but it sends a very clear message that drink spiking is a crime and that governments are serious about stopping it. No data are currently available on the number or nature of prosecutions of drink spiking in Australia. However based on the findings in this report that drink spiking is heavily under-reported to police, that many victims cannot identify the offender and that evidence of drink spiking is difficult to obtain, it is likely that very few drink spiking offenders are successfully prosecuted. A 'chain of evidence'is very important for a successful prosecution.

Targeting prevention strategies

This report has identified that drink spiking is a complicated phenomenon which can occur in a variety of locations, against a variety of victims, with a variety of different spiking additives, for a number of different reasons. This means that prevention strategies which target only one type of audience (e.g. young women or young people at licensed premises) will be limited in effectiveness because the message may not reach or may be inappropriate for other types of audience. For example, this report found that males can also be victims of drink spiking but there are currently no awareness campaigns which are targeted toward preventing males from being victims. Similarly 'prank spiking' has been identified in this report as being a possible motivation for many incidents yet awareness campaigns to date tend to focus on sexually motivated drink spiking. Strategies to tackle and prevent drink spiking must take into account the fact that victims and situations differ widely. Prevention strategies therefore must:

- identify the range of audiences which need to be targeted;

- identify what the specific characteristics and needs of those audiences might be;
- develop appropriately targeted intervention and education initiatives which are directly relevant to those specific audiences;
- pilot these intervention and education initiatives to ensure that they are reaching the target audience and communicating the intended message; and
- build in a clear evaluation strategy prior to commencement of the intervention so that it can be determined whether the goals of the intervention were successful.

Recommendations for improving data collection

The only way to obtain a good understanding of the prevalence and nature of drink spiking so that prevention strategies can be appropriately targeted is to have a solid and reliable empirical data base on reported drink spiking incidents. This involves data collected by police, hospitals, forensic laboratories and sexual assault agencies. Currently there is no systematic and reliable data available within any of these agencies which can identify problem locations, offenders or trends. It is recommended that:

- police recording procedures be improved and standardized and that all incidents which are reported to police be systematically recorded to ensure easier and more reliable data extraction;
- hospitals and emergency departments record all cases of suspected drink spiking which present to them, details of treatment provided to victims and outcomes of tests conducted;
- forensic and therapeutic laboratories keep records of all samples provided to them by police, hospitals and sexual assault agencies, and details of circumstances and outcomes for each sample (including those not analysed);
- sexual assault agencies maintain a deidentified database of all suspected drink spiking sexual assault victims who present to them, with details of circumstances surrounding incidents;
- a centralised database be set up which maintains the above drink spiking data for the health sector in a format which is regularly updated and where data can be easily extracted for purposes of furthering knowledge about drink spiking and monitoring trends; and
- the liquor industry encourage licensed premises to keep a record of all drink spiking incidents which are either seen or suspected by staff, or reported to staff.

Options for trialling educational initiatives with stakeholders

One of the key outcomes for this project was to identify potential options for information kits for stakeholders that could be trialled in Stage 2 of the National Project on Drink Spiking. The options identified in this report are for police, sexual assault counsellors, hospital emergency staff, liquor industry staff, potential victims, secondary and tertiary students, and organisations interested in better understanding and responding to drink spiking. For each of these stakeholders, the options outline:

- the problems to be addressed;

- the goals to be achieved;
- possible strategies for each information kit; and
- the content which could be included in each kit.

The proposed options for police, sexual assault counsellors, hospital emergency staff and liquor industry staff are based primarily on the themes and issues which emerged from the discussions with these stakeholders. The proposed options for potential victims and organisations are based on the findings from the AIC drink spiking hotline and localised campaigns currently being conducted. All of the options presented are centred on particular problems identified. These options are outlined in Section 6 of the report.

Conclusions

Suspected incidents of drink spiking appear to happen frequently enough to merit concern. About one third of all suspected drink spiking incidents are estimated to involve sexual assault, based on estimates of under-reporting to police. About five per cent of reported incidents involve robbery, indicating that sexual assault is the primary criminal victimisation associated with drink spiking. However many incidents are also reported where no associated victimisation is experienced. Many of these may be due to 'prank spikings' where the intention is to see what happens or to have a joke; others may occur for more sinister reasons but are for some reason thwarted before the intention can be carried out. Yet again it is possible that some people may be unaware of how much alcohol they have consumed and mistakenly attribute the effects to drink spiking.

The difficulties associated with verifying the incident mean that in most cases suspected drink spiking cases will remain just that – suspected. This however is not a reason to dismiss these cases. Rather it is a reason to pursue better recording and data extraction practices, and better coordination between police, hospitals, forensic laboratories, sexual assault agencies and licensed venues. The stories told by victims ringing in to the hotline, although not verifiable, indicated that drink spiking does occur in the community and that the effects can be devastating and long-lasting. It would therefore be both dangerous and a huge disservice to victims to assume that lack of evidence means that an incident did not occur. 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.

Section 1.0 Introduction

1.1 Setting the scene

Over the last couple of years reports of drink spiking have appeared on a regular basis in the Australian media. Suggestions that drinks are being spiked with drugs such as Rohypnol, GHB and ketamine for the purposes of committing sexual assault are common and the community at large (parents in particular) have become increasingly concerned and confused about the prevalence and risks of drink spiking. Community perceptions about the prevalence of drink spiking are fuelled by the media which can sensationalise the issue by offering often unsubstantiated and sensationalised accounts of drink spiking leading to sexual assault or indeed, in one case, to death. Such unsubstantiated media reports can contribute to an unwarranted fear within the community that drink spiking is widespread and that victims can die from drink spiking.

This concern about the prevalence and risks of drink spiking have led to a number of localised awareness and education campaigns being conducted around Australia in the last couple of years to educate people (primarily young people) about the dangers of drink spiking and how to reduce the risk of it happening to them. This concern within the broader community has also led to Australian state and federal governments identifying drink spiking as an emerging issue to be investigated as a priority area. It is evident that, despite the increased publicity surrounding drink spiking and suggestions that it is becoming more frequent, its prevalence has not been quantified and the circumstances in which drink spiking occurs have not been identified. Research conducted both overseas and in Australia has tended to focus almost exclusively on drug and/or alcohol facilitated sexual assault[1] rather than drink spiking *per se* and no research has previously been conducted either solely with victims of drink spiking or which brings together police or other official data at a national level.

This report stems from this lack of knowledge about the nature and extent of drink spiking and begins with the premise that if we are to understand where, how and why drink spiking occurs and if we are to develop effective strategies to prevent it, we need to know how often it occurs and the circumstances in which it occurs. The aims of this report then were to provide a comprehensive review of what is known about drink spiking and to start building a solid empirical evidence base from which conclusions can be drawn and prevention strategies developed.

1.2 What is drink spiking?

The term 'drink spiking' refers to drugs or alcohol being added to a drink (alcoholic or non-alcoholic) without the consent of the person consuming it (Australian Drug Foundation 2002).

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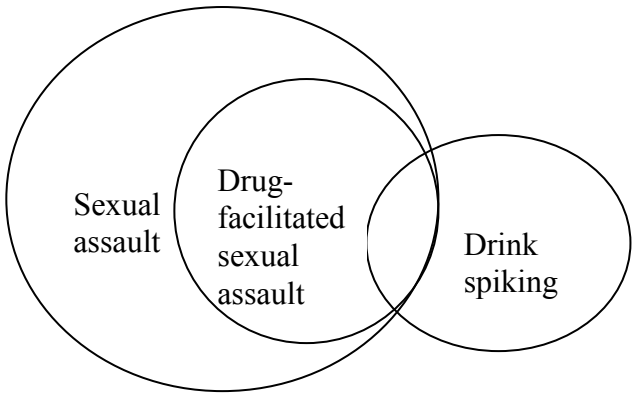
[1] In this report the term "drug facilitated sexual assault" will be used to imply the use of either drugs or alcohol.

For an incident to be defined as drink spiking in this report, it need not involve further criminal victimisation, even though such offences can occur after an incident of drink spiking.

Drink spiking is not drug facilitated sexual assault. Drug facilitated sexual assault refers to a sexual assault which was facilitated through the consumption of alcohol and/or drugs by the victim. Drugs and/or alcohol may have been administered by someone else to the victim or may have been taken voluntarily by the victim. Where a drink spiking incident is associated with a sexual assault this will constitute a drug facilitated sexual assault (since drugs and/or alcohol were administered to the victim prior to the sexual assault). Many incidents of drink spiking however will not involve a sexual assault and hence will not be classified as a drug facilitated sexual assault.

The main difference between a drink spiking incident (followed by a sexual assault) and a drug facilitated sexual assault is that the former refers specifically to where drugs and/or alcohol were administered to a victim without their consent via a drink, while the latter may involve the voluntary or involuntary consumption of drugs and/or alcohol via a drink or other process. This means that drink spiking which is followed by sexual assault comprises part of drug facilitated sexual assault but the reverse does not follow. The inter-relationships between drink spiking, sexual assault and drug facilitated sexual assault are shown in Figure 1 below. It can be seen that there is some degree of overlap and it is important to keep this in mind when discussing drink spiking. Reference to drink spiking in this report will refer solely to an incident in which drugs or alcohol are added to a drink without the consent of the person consuming it.

Figure 1: Interrelationship between drink spiking, sexual assault and drug-facilitated sexual assault



In drink spiking, the spiking substance can be added to any drink including soft drinks, juice, tea/coffee and alcohol. The substance itself can vary from a shot of alcohol to a multitude of different types of drugs including benzodiazepines, amphetamines and muscle relaxants. The effects from drink spiking depend on the type and quantity of the additive used and can include vomiting, loss of consciousness, poor coordination and balance, slurred speech, muscle spasms, respiratory difficulties and loss of control.

The type of drug/alcohol used, in turn, is likely to depend on the motivation of the offender, the location of the incident and the ease with which drugs or alcohol may be added to a drink. As the motivations for drink spiking can vary widely, this means that there is no single 'typical' incident of drink spiking. Rather, drink spiking is a complicated phenomenon which can occur in a variety of locations, against a variety of victims, with a variety of different spiking additives, for a number of different reasons resulting in disparate effects and consequences.

1.3 Why is it important to investigate drink spiking?

Due to the relative ease with which drinks can be spiked and then drunk by unsuspecting victims, particularly when alcohol is the additive, the probability of individuals becoming sick or behaving unusually increases. The consequences associated with drink spiking can, in some instances, be devastating. Criminal victimisation is one possible consequence of drink spiking whereby victims may be sexually or physically assaulted or robbed after having consumed a spiked drink. Other possible consequences of drink spiking could relate to drug overdoses or proceeding to drive while unknowingly under the influence of drugs or alcohol, potentially resulting in the death of the victim or a third party.

While we can identify what drink spiking is and know what can occur as a consequence of drink spiking, there is currently very little research or empirical data to indicate how often drink spiking occurs in the community (prevalence), or the circumstances in which drink spiking occurs, that is, additional victimisation, characteristics of victims, nature of offenders, time and place of incident, type of additive used etc. Without such knowledge it is virtually impossible to gauge whether drink spiking has been increasing, or what the hidden impact of drink spiking might be within the broader community. This report sets out to investigate, more comprehensively than has yet been attempted, the nature and extent of drink spiking within Australia so that we can begin to answer some of these questions and move toward the development of appropriately targeted and effective prevention strategies.

1.4 Identifying the nature and extent of drink spiking

Identifying the nature and extent of drink spiking is hampered by several obstacles relating to

- police and other official data; and
- previous research and literature.

Police and other official data

Research into drink spiking using police and other official data suffers from three key obstacles which also hamper sexual assault research (State Crime Command Drug Squad 2003). These relate to issues of reporting, recording and verification.

Reporting incidents of drink spiking

In order for authorities and the community to know that an incident of drink spiking has occurred, it is necessary for the victim to report it to someone. For the incident to be pursued and to provide information which could assist in improving the policing response more generally to drink spiking, incidents should ideally be reported to the police. However it is very likely that many incidents of drink spiking are not reported to police. This may be because the incident is regarded as too trivial (i.e. if there were no additional victimisation, or no severe consequences from the incident), or because the victim may know the offender and not wish to report him/her, or because of embarrassment that the incident occurred. Alternatively, if victims suffered memory loss from the incident and cannot remember precise details of what happened they may believe that they will not be taken seriously if they report the incident (Abarbanel 2001). Finally, they may be unaware that they have been a victim of drink spiking and would therefore be unlikely to report to any authorities.

Where sexual assault took place after a drink being spiked, the reasons for non-reporting are likely to be very similar to those for sexual assault victims more generally. Non-reporting of sexual assault is known to be high (Lievore 2003) and the reasons behind non-reporting are varied. Box 1 provides a list of the most common barriers to reporting sexual assault. These generally fall into either personal barriers or those founded in perceptions of the criminal justice system.

Box 1: Barriers to reporting sexual assault

Personal barriers
• Too trivial or inappropriate to report to police
• Not a "real" crime
• Not clear that harm was intended
• Dealt with it themselves
• Regard it as a private matter
• Shame, embarrassment
• Did not want family or others to know
• Fear of reprisal by assailant
• Self-blame or blamed by others for the attack
• Desire to protect offender, relationship, or children
Justice System
• Police would not or could not do anything
• Police would not think it was serious enough, or would not want to be bothered with the incident
• Fear of not being believed by police
• Fear of being treated hostilely by police or other parts of the justice system
• Fear/dislike of police
• Fear of the legal process
• Lack of proof that the incident happened
• Did not know how to report

Source: Lievore 2003 p.28.

To the degree that drink spiking incidents are associated with sexual assault, it is expected that non-reporting will be high, consistent with levels of non-reporting identified in sexual assault research. In addition, if victims suffered memory loss as a result of drink spiking and have no clear recollection of details surrounding the sexual assault, non-reporting may be even higher since reliability of the victim's testimony may be severely weakened. Clearly, for purposes of trying to identify the prevalence of drink spiking, non-reporting to police means that police data are likely to heavily under-estimate both the nature and extent of drink spiking and will not provide an accurate picture of drink spiking within the broader community.

Recording of drink spiking incidents

Incidents of drink spiking which are reported – with or without a formal complaint – to police need to be recorded in a way which means that the information can be usefully extracted and used to inform policing strategies. To determine what levels of police resources should be devoted to the detection and prevention of drink spiking, police need to be able to extract accurate information about the numbers of incidents reported, as well as the circumstances in which they occurred. For example, if a number of incidents were reported to have occurred at a particular venue with a similar description of the offender, police could devote attention to that venue. Without such intelligence-led policing, however, there is little to guide whether and how police should allocate resources in relation to drink spiking, or indeed whether drink spiking is deserving of attention.

It is apparent that, across all jurisdictions, there are problems in how police record reported incidents of drink spiking in their databases (see Section 2). As drink spiking does not have a separate offence category associated with it in any Australian state or territory (it falls under different legislation depending on which state/territory the incident occurred in, the effect of the drink spiking, the intention of the perpetrator and the substance used), police in each jurisdiction have some degree of flexibility in how they record such incidents.

Further, police databases are often constructed such that, to the degree that details surrounding an incident are recorded in a database, the details of each incident can usually be accessed only through a manual and time-consuming search of the narrative for each incident. Another complication relates to the way in which police code reports in their database. Typically the code assigned to each case will be based only on the most serious charge. This means that where someone is charged with drink spiking in conjunction with a more serious charge, such as rape, only the latter may be highlighted.

Verification of the incident

In many ways, verification of the incident is perhaps the most central to explaining the difficulties associated with identifying the nature and extent of drink spiking. Being able to prove whether the incident occurred can affect both the victim's decision to report the incident (McGregor, Lipowska, Shah, Du Mont & De Siato 2003) and may also affect whether and how the incident is recorded by police. Drink spiking (regardless of what additive is used) is

often associated with memory loss meaning that the victim is unable to provide reliable details about the incident, who the offender was, or what happened afterward.

While blood and urine tests can reveal the presence of particular types of drugs or alcohol if they are in the system at the time of testing, there are issues surrounding false positives and negatives, namely:

(a) Lack of positive findings does not necessarily mean that someone's drink was not spiked. Some drugs can leave the body in a matter of hours which means that if urinalysis or blood testing is not conducted within a short space of time after ingesting the drink the additive may have left the body by the time of testing.

(b) Positive findings do not necessarily mean that the positively identified drug was used to spike a drink. For example, a positive finding of alcohol may mean that additional alcohol was added to someone's drink, *or* it may simply reflect the fact that the person was drinking alcohol voluntarily. A positive finding of either drugs or alcohol means that this was present in the body at the time of testing but does not conclusively prove that the drug or alcohol was used to spike someone's drink.

While education campaigns can improve forensic testing for drink spiking by alerting the community to the need for victims to have forensic tests conducted as soon as possible after a suspected drink spiking incident, there are three obstacles which limit the success of this strategy:

- First, if a victim has suffered memory loss or does not regain consciousness until a day or two after the incident, it is highly unlikely that the victim will be physically able to present for testing within the required time period.
- Second, given the cost of forensic testing, victims may not be able to access drug testing without either: presenting to hospital; alleging a sexual assault to a sexual assault service; or making a formal complaint to police.
- Third, where a sexual assault has also occurred, victims may be reluctant to come forward, for the reasons specified above. Sexual assault victims would not only be tested for drugs in their blood or urine, but would be subject to more invasive testing relating to the sexual assault. It may take victims of sexual assault some time to decide whether they wish, if at all, to proceed with such testing in which case blood and urine testing for drugs is unlikely to be useful.

This implies that in cases where only alcohol has been found in urinalysis it is possible that alcohol was the only drug present in the first place, or that another drug had left the body by the time of forensic testing. Urinalysis can only show whether alcohol or drugs were present at the time of testing; it does not conclusively prove that a drink was or was not spiked.

Previous research and literature

Given the difficulties in identifying the nature and extent of drink spiking through recorded data, two alternative approaches are to use self-report surveys or analysis of blood and urine samples. Self-report surveys have the benefit of being able to estimate levels of under-reporting to police as well as ask a wide range of questions surrounding the incident. The primary issue concerning surveys however, is their generalisability to the broader population. When a survey is conducted with a sample of respondents, the aim is usually to use the results from that sample and extrapolate them to the wider population of interest. The degree to which survey results can be generalised depend upon:

(a) being able to define and access the population of interest; and

(b) random sampling to ensure that the sample is representative of that population of interest.

With drink spiking, as with party drugs more generally (Deehan & Saville 2003), it is not at all clear what the target population should be or how to access it in a representative manner. For example, when investigating drink spiking in Australia, should the target population be all Australians, just young Australians or young females, only those Australians who go out to bars and clubs, or only those who drink alcohol? How the population is defined in research terms will affect the results both in terms of prevalence and nature. Assumptions would need to be made about who constitutes a potential drink spiking target and narrowing the population to those specifications. This however is not an easy task since it is by no means clear who comprises a potential drink spiking victim – defining the population too narrowly may mean that potential types of victim are excluded and results are skewed while defining the population too broadly may heavily underestimate the true risks of drink spiking.

Analysis of blood and urine samples is problematic because of the issues identified earlier of false positives and negatives. Further, forensic analysis tends to be conducted on samples provided by sexual assault victims rather than drink spiking victims, meaning that the results may not be indicative of the degree to which drug and alcohol are used as spiking agents in drink spiking incidents in general.

In sum, identifying the prevalence and nature of drink spiking through surveys and forensic analyses are hampered by difficulties in identifying and accessing the target population. Some studies focus exclusively on prevalence amongst sexual assault victims while others focus on patrons of licensed premises. Some studies focus on drink spiking while the large majority focus more broadly on drug facilitated sexual assault. It is important to note that research conducted to date is based primarily on drug facilitated sexual assault which means that findings will be weighted heavily toward sexual assault victims. Moreover, almost all studies use convenience samples. Combined, this means that comparison between surveys can be highly problematic and findings differ markedly.

Table 1 at the end of this section provides an overview of previous research conducted to date[2]. It can be seen that most of the studies presented relate to drug facilitated sexual assault. As:

(a) there is a vast literature on drug facilitated sexual assault and

(b) the emphasis in this report is on drink spiking (which may or may not include sexual assault),

this section includes some studies relating to drug facilitated sexual assault to give a flavour of the types of research conducted. It is not an exhaustive list of drug facilitated sexual assault research as the findings in this area do not directly address issues associated with drink spiking and will not accurately reflect the characteristics associated with non-sexual assault drink spiking incidents. The following reviews as far as possible the studies which have been conducted into drink spiking and will attempt to draw together threads as well as highlight gaps in the literature.

Prevalence of drink spiking

The reported prevalence of drink spiking varies widely between studies. Out of seventeen young women, aged between 16 and 30 years, who contacted the Centre Against Sexual Assault in Melbourne (CASA House) between 1 December 1999 and 29 February 2000 regarding a sexual assault, eight believed that their drink had been spiked (Watson 2000). Of 297 female sexual assault victims who contacted a sexual assault agency in Melbourne between December 2000 and July 2001, 82 (40%) suspected that they had been a victim of drink spiking prior to the assault (CASA House 2001). It is not clear however whether these cases involved drink spiking or voluntary consumption of drugs and/or alcohol.

In the Australian component of the International Violence Against Women Survey (IVAWS) which is being conducted on behalf of the Australian Government Office of the Status of Women and which was conducted during 2003 (Mouzos and Makkai 2004), a question on prevalence of drug facilitated sexual assault was included in the second stage of the survey. A total of 3,047 women participated in the second stage and about one in every 100 women (1 per cent) reported that since the age of 16 they had had a sexual act committed against them while they were under the influence of drugs which had been given to them without their consent. As this question did not refer specifically to drink spiking, it is not known whether these drugs were administered via a drink or some other mechanism.

McGregor et al (2003) analysed data comprising 1421 cases where a sexual assault victim had presented to the Sexual Assault Service in the Emergency Department of Vancouver General Hospital between 1993 and 1999. The aim was to determine the percentage of these cases

2 Databases searched were: Criminal Justice Periodicals Index, Swetswise, Austrom, Australian Medical Index, Medline/Pubmed, Criminal Justice Abstracts and the National Criminal Justice Reference Service (NCJRS). A general search over the internet was also undertaken.

which were drug facilitated. They defined a drug facilitated sexual assault as 'a sexual assault victim who presented to the SAS with a self-reported suspicion of having been drugged, unexplained anterograde amnesia and/or other evidence that suggested to the attending examiner that deliberate drugging may have been involved' (McGregor et al 2003: 73). Overall, 12 per cent of sexual assault cases were identified as suspected drug-facilitated sexual assaults (although this does not necessarily mean that drugs had been administered via a drink) and the proportion of sexual assaults defined as drug facilitated had increased from 7 per cent in 1993 to 23 per cent in 1999.

Anderson, Earl and Fleming (2002: 10), using convenience sampling, surveyed 325 men and women at twelve licensed venues in Queensland (about 30 people were interviewed at each venue). Approximately 25 per cent of respondents believed their drink had been spiked at some time in the past and over half knew of someone else whose drink was believed to have been spiked. However, 'in almost all of these cases there was no proof that drinks had been spiked'.

Hindmarch et al (2001) conducted a forensic investigation into drug facilitated sexual assault. They analysed 3303 urine samples which were submitted to the laboratory by rape crisis centres, law enforcement agencies and hospital emergency rooms between June 1996 and February 2000. Ninety-nine per cent of the samples were taken within 72 hours of the incident, with 73 per cent collected within 24 hours. Sixty-one per cent of the 3303 urine samples tested positive to drugs, although it must be remembered that some of the drugs which were found in these samples may have been ingested voluntarily as this study was not specifically testing for drink spiking.

Where drink spiking occurs

There is not much research to date which addresses this question although the studies which have appear to indicate that licensed premises are a common focus for drink spiking. Of the eight women who contacted CASA House and believed that their drink had been spiked prior to a sexual assault, five reportedly occurred at or after leaving a nightclub, two were after leaving a restaurant and one was after leaving a bar (Watson 2000). Of the 123 self-selected victims of drug-facilitated sexual assault who returned mail surveys, Sturman (2000) found that almost 50 per cent of drug facilitated sexual assault victims reported the drugging to have occurred at clubs and licensed venues, while the victim's home and university campus were also common venues for drugging. The Roofie Foundation (Roofie Foundation 2004) in the United Kingdom has been collecting retrospective data since 1997 from sexual assault victims who contact them who believe that their drink had been spiked prior to the incident. As of January 2004 the Roofie Foundation had 6650 incidents which had been reported to them listed on their website. Of these, 62 per cent of incidents reportedly occurred at a licensed venue. Ten per cent occurred at a private house and 12 per cent occurred at a private party.

Knowledge of offender

The degree to which victims know the offender varies considerably. Of the eight women who contacted CASA House after a sexual assault, three were acquainted with the offender (Watson 2000). Of the 82 sexual assault victims who believed that their drink had been spiked in Melbourne and who contacted a sexual assault agency, 50 per cent knew the offender (CASA House 2001). In Sturman's (2000) survey with 123 drug facilitated sexual assault victims, 27 per cent of offenders were considered friends of the victim while 65 per cent of offenders were acquaintances of the victim (e.g. neighbours, fellow university students). Only eight per cent of cases involved offenders who were strangers to the victim. Finally, of the 172 drug facilitated sexual assault victims analysed by McGregor et al (2003) approximately 50 per cent knew the offenders. It would appear that, at least where sexual assault occurs, many victims know the offender prior to the incident.

Age and sex of victim

Of the 123 drug facilitated sexual assault victims in Sturman's (2000) survey, 42 per cent were aged in their 30s. Of the 172 drug facilitated sexual assault victims in Vancouver (McGregor et al 2003) the mean age of victims was 26 years. In a study analysing 34 successful prosecutions of drug-facilitated sexual assault (Welner 2001), it was found that the ages of both the perpetrators and the victims varied widely. Sturman (2000) also identified 14 male victims in his study (11% of the sample), which suggests that although they may not be the majority, there are incidents involving male victims of drug rape. This is corroborated by findings from the Roofie Foundation in the United Kingdom in which 12 per cent of victims were male and 51 per cent of victims were aged under 30.

Type of drugs used

Verification of drugs used in drink spiking is very difficult due to the fact that urine and blood testing need to be conducted within a short space of time after ingestion of the drink. While a positive result provides verification of alcohol or drugs being in the body at the time of testing, a negative result does not necessarily mean that alcohol or drugs were not ingested but perhaps that the drug has metabolised too rapidly for detection. Further, it is often not clear in forensic testing whether drugs which test positive in blood or urine samples were administered in a drink without the victim's knowledge or had been voluntarily ingested by the victim.

Of the 20 drug facilitated sexual assault cases from which toxicology results were available in McGregor et al's (2003) study, 13 tested positive for drugs or alcohol; four were positive for alcohol; four for benzodiazepines; three for cannabinoids; and one each for amphetamines and cocaine.

Of the 3303 urine samples tested by Hindmarch et al (2001), 41 per cent tested positive to alcohol, 19 per cent tested positive to cannabis, 10 per cent were positive for benzodiazepines and in only three per cent of cases was GHB identified. Flunitrazepam (Rohypnol) was found in less than 0.5 per cent of all cases, leading the authors to conclude that there is little evidence 'supporting the allegations of widespread use of this drug in drug-mediated sexual assault' (Hindmarch et al 2001: 203).

Slaughter (2000) reported on 2003 samples from sexual assault victims which had been analysed in US laboratories for the presence of various drugs in 1999. In 39 per cent of cases no drugs were found at all. In cases which tested positive, alcohol was the drug most commonly identified, followed by marijuana, benzodiazepines and GHB. Flunitrazepam was only found in a very small percentage of cases. Slaughter argues that while flunitrazepam and GHB have received a lot of media attention and are often referred to as 'date rape' drugs, these drugs are in fact not very common. Rather, she argues that alcohol, marijuana and other drugs are more likely to be used in drug facilitated sexual assault. To focus public attention almost exclusively on GHB and flunitrazepam as date rape drugs is, she argues, 'misleading and potentially dangerous' (Slaughter 2000: 430).

The Chemistry Centre (2002) in Western Australia analysed 44 urine and 29 blood samples to test for evidence of drugs used in alleged drink spiking cases. The samples were submitted to the Chemistry Centre by the Western Australia police between 11 June 2002 and 18 February 2003. Again, alcohol topped the list, with 76 per cent of urine samples testing positive for alcohol. Amphetamines and cannabinoids were found in nine per cent of cases each, while ecstasy was found in two per cent of urine samples. Neither benzodiazepines nor GHB were found in any of the samples, once again implying that alcohol may be a key agent in drink spiking. However, as acknowledged by the Chemistry Centre itself, the length of time which elapsed between the alleged incident and the urinalysis was not controlled and it is possible that traces of other short-acting drugs may have disappeared before urinalysis could identify them.

What does previous research tell us about the nature and extent of drink spiking?

The studies summarised above have revealed difficulties in identifying both the nature and extent of drink spiking. Table 1 below provides an overview of these studies and their findings. Primarily research into drink spiking has tended to be survey-based and difficulties in identifying and accessing the target population has meant that convenience and non-representative samples have had to be used. Because convenience sampling and self-completion surveys, by their very nature, are biased by who happens to be available at the time, or who happens to respond to the survey, it is often difficult to know how reliable the findings are or how widely the results might be generalised. Further, the vast majority of the research conducted to date has focused on drug facilitated sexual assault rather than drink spiking *per se*, meaning that the characteristics associated with incidents identified above may not necessarily reflect the characteristics associated with sexual assaults arising from drink spiking, or incidents of drink spiking in which no additional victimisation occurs.

The above research points to drink spiking often occurring at bars and nightclubs, with known offenders and ages of victims ranging widely. Although the majority of victims appear to be female it is evident that males can also be victims of drink spiking. Forensic testing (at least in published data) to date has not generally yielded results consistent with the use of drugs. Alcohol has tended to dominate positive blood and urine tests but such tests (a) cannot confirm that the alcohol was added to someone's drink rather than being drunk voluntarily and (b) only show that drugs were not present in blood or urine *at the time of testing*. For forensic testing to assist in identifying the nature and prevalence of drink spiking, the procedures leading to such testing and co-ordination between all relevant agencies needs to be better streamlined so that analysis of blood or urine occurs only within a short space of time after ingestion and essential known information about consumption of alcohol or drugs by the victim (voluntary or otherwise) is provided to toxicologists.

The risks associated with drink spiking are likely to vary with age, type of drink consumed, type of location at which drinks are consumed, degree to which drinks are bought or provided by friends or strangers, time of consuming drink and motivations of offenders. As the circumstances in which drink spiking occurs are difficult to gauge from previous research, it is impossible to specify with any degree of certainty what the drink spiking population may look like and therefore how to define it for survey purposes. Any survey which is conducted on drink spiking therefore is based on underlying assumptions about the target population and this must be borne in mind when interpreting results and comparing findings between surveys.

Even when an assumption has been made about the target population, however, accessing that population in a representative manner can be very difficult. This is because to randomly survey a population requires a complete sampling frame from which it is possible to select individuals for inclusion on a random basis. Only when individuals are selected and surveyed randomly (each individual in the sampling frame having an equal chance of being selected and included) can the results be confidently generalised to the broader population. When the target population is defined as 'young people' or 'people frequenting bars' there is no available sampling frame and it is not possible to survey these populations randomly. Accessibility to them is also very limited.

Despite the problems associated with survey-based research, it should not be dismissed as a potential tool for assisting in understanding the nature and extent of drink spiking. Given the difficulties with using official data, survey-based research can contribute to the development of a more complete picture of drink spiking. In particular, surveys which are targeted at specific populations and where respondents are randomly selected from those populations (such as the ABS Women's Safety Survey or the International Violence Against Women Survey) could be useful in estimating prevalence levels of drink spiking amongst female populations if they were to include appropriately targeted and worded questions relating specifically to drink spiking. At present it is not possible to estimate drink spiking prevalence levels from these types of surveys because they do not include specific questions relating solely to drink spiking.

1.5 What will be included in this report

The previous section highlighted that, while some research has been done in relation to drink spiking, differences in methodologies and samples mean that we still do not have a clear understanding of the nature and extent of drink spiking in Australia. Previous research has focused almost exclusively on drug facilitated sexual assault which means that the degree to which other types of criminal victimisation may occur (robbery, physical assault) or where no additional victimisation may occur are unknown. No research has yet been conducted solely with drink spiking victims and no attempt has yet been made to draw together official data at a national level. A solid empirical evidence base, however, is essential to answering the questions of prevalence and nature. As part of building this empirical evidence base this report proceeds in Section 2 to draw together and analyse police data at a national level, drink spiking sexual assault data provided by CASA House in Melbourne and data obtained through a national telephone hotline with victims of drink spiking. Each of these data sources provides valuable information about drink spiking. On the basis of the empirical findings from the data presented in this section, estimates of the prevalence of drink spiking in Australia are presented.

Section 3 summarises the key themes and concerns which emerged from discussions with stakeholders in the liquor industry, police, hospitals, sexual assault agencies, forensics and the gay community. Views expressed by stakeholders about drink spiking were diverse but these discussions were invaluable in highlighting problems faced by each stakeholder group in trying to deal with and prevent drink spiking. Section 4 discusses what is needed to prosecute offenders including an analysis of legislation in each jurisdiction and collection of evidence. Efforts to prevent drink spiking, including a summary of awareness campaigns conducted to date, are discussed in Section 5, while options for trialling information / education kits for stakeholders are presented in Section 6. These options are based largely on the outcomes of discussions held with stakeholders. Finally, the conclusions and recommendations in Section 7 draws together the emergent issues, conclusions and recommendations stemming from the report.

Table 1: Summary of published studies investigating nature and extent of drink spiking

Author(s)	Year	Country	Aim(s)	Method	Participants	Mean age of participants	Key findings
Watson, J.	2000	Australia	Determine incidence of sexual assault in Melbourne	Database Focus groups Surveys	17 women 37 women 87 women	Between 16 and 30	8 of 17 sexual assault victims alleged drink spiking 3 of 8 victims knew offender
CASA House	2001	Australia	Identify extent of sexual violence against women at or after leaving licensed premises	Database of women who contacted service due to assault at or after leaving licensed premises	297 women	Unknown	40% believed their drink had been spiked 50% knew their assailant
Griffiths, M.	2001	Australia	Identify trends in drug facilitated sexual assault	Referrals between June 2000 and May 2001	205 males and females	Unknown	22% believed drug-facilitated
Sturman, P.	2000	UK	Examine nature and extent of drug facilitated sexual assault	Survey of victims of drug facilitated sexual assault	123 males and females	42% in their 30s	50% of incidents occurred at public licensed venues 54% facilitated via alcohol
McGregor et al	2003	United States	Assess % of sexual assaults which are drug facilitated	Examination of records on hospital database	1421 cases	26 years	12% of assaults drug facilitated 50% of victims knew offender
Anderson et al	2002	Australia	Assess prevalence of drink spiking	Face to face survey	203 female, 122 male	Unknown	25% believed their drink had been spiked in past
Hindmarch et al	2001	United States	Assess presence of alcohol or drugs for sexual assault victims	Urinalysis	3303 urine samples	Unknown	41% positive to alcohol 19% positive to cannabis 10% positive to benzos (not flunitrazepam)
Slaughter, L.	2000	United States	Investigate relationship between alcohol, drug use and sexual assault	Forensic testing	2003 samples	Unknown	Alcohol most common drug found, followed by marijuana
Chemistry Centre WA	2003	Australia	Test for alcohol and drugs in alleged drink spikings	Urinalysis and blood analysis	44 urine samples	Unknown	76% positive to alcohol. No benzos or GHB found.
Roofie Foundation	2004	UK	To maintain a database on drink spiking sexual assaults reported to them	Database on website	6650 incidents as at Jan 04	51% aged under 30	12% of victims male 62% of incidents occurred at licensed venue

Note: The emphasis on drug facilitated sexual assault research in the above table reflects the fact that previous research has focused almost exclusively on drug facilitated sexual assault rather than drink spiking per se.

Section 2.0 Building the empirical evidence base on drink spiking

2.1 Police data

When asking the question 'how many incidents of drink spiking occur in Australia?', the most obvious place to start is with the police. Police data comprise officially recorded incidents of crime and can provide a baseline against which estimates of drink spiking from self-report surveys can be compared. The degree to which police data are likely to accurately reflect levels of drink spiking and associated victimisation in the community will depend largely on two factors:

(1) the degree to which all incidents which occur within the community are reported to police; and

(2) the degree to which reported incidents are recorded in police databases *accurately* and *in an easily extractable and accessible format.*

Accuracy of police data and easy accessibility are vital if police are to use intelligence-led policing to identify and tackle crime problems within the community. Intelligence-led policing means that police resources can be deployed where they are most needed and in the most effective manner, through determining the use of resources based on analysis of crime data (Ratcliffe 2003). For police to know whether drink spiking is a serious problem, whether there are recidivist offenders and specific locations in which it might occur and what level of resources should be devoted to preventing it, accurate and accessible police crime data on drink spiking must be maintained and analysed.

However, as with many other types of crime (Taylor 2002) and sexual assault in particular (Lievore 2003), it is likely that a large number of drink spiking incidents go unreported to police, meaning that the number of incidents reported will not accurately reflect the number of incidents occurring in the community. Accuracy of recording of reported incidents and accessibility by police will compound the problem through further attrition if reported incidents are not recorded accurately in the police database and cannot be easily accessed.

A further problem in relying solely on police data, given the above two problems, is that the tendency to report incidents of drink spiking may increase in areas where awareness and education campaigns about drink spiking have taken place (State Crime Command Drug Squad 2002). In the Australian Capital Territory, for example, a publicity campaign in relation to drink spiking and drug facilitated sexual assault was conducted during the period of 'Operation Skeet' and a consequent increase in reporting occurred. This means that an increase in reporting to police may occur *in the absence of an actual increase in drink spiking incidents*. Similarly in Western Australia, a campaign run state-wide in the summer of 2002/03 is likely to have resulted in an increase in reported incidents, purely as a product of greater awareness in the general community. These issues make it extremely difficult to judge

whether an increase in reported levels of drink spiking have occurred due to an increase in actual incidents, or simply reflect greater awareness of the crime.

The above caveats aside for the moment, levels of reporting of drink spiking incidents at a national level have not previously been established. It is therefore useful as a first step in building the empirical evidence base firstly to investigate the levels of reporting to police (so as to establish a baseline of reporting at a national level) and secondly to investigate the characteristics associated with reported incidents. For the above reasons, these numbers will not and should not be interpreted as reflecting the prevalence of drink spiking in the community. Rather, by identifying problems associated with recording and extraction of data, these can hopefully be addressed at the jurisdictional level and this should assist in improving recording practices in the future.

Procedure

As a first step in building the empirical evidence base on drink spiking, each Australian police jurisdiction was approached by the AIC in September 2003 and asked to provide deidentified unit record data on drink spiking incidents reported to police between 1 July 2002 and 30 June 2003. A table listing the characteristics requested for each incident (if available) was also submitted, as well as a request that information about the data extraction and any difficulties with extraction be provided.

Unit record data, with various associated characteristics depending on availability, were provided to the AIC from five jurisdictions for the time period requested:

- Queensland;
- Victoria;
- Western Australia;
- Northern Territory; and
- Tasmania.

New South Wales had previously compiled a confidential report on drink spiking for internal purposes during the period December 2002 to May 2003 and agreed to provide the AIC with a copy of this report. New South Wales police indicated that, unfortunately, it was not possible to provide the AIC with unit record data for the time period requested due to resource constraints. In the New South Wales report 89 incidents were identified over the six month period investigated. This number was doubled in this report to provide a conservative estimate of the number of incidents which may have been reported to New South Wales police over the entire twelve month period.

The ACT was also unable to provide the requested unit record data, stating that

> [The AIC's] requirements are extremely complex in nature as drink spiking incidents are not recorded separately on our database although a manual register is maintained with limited information therefore the provision of answers would be unduly resources intensive [letter dated 21 October 2003].

A report of an AFP project 'Operation Skeet', which included some basic information on drink spiking incidents reported to AFP over an earlier time frame, was instead provided to the AIC. Upon further request, ACT Policing also provided an overall estimate of 70 incidents over the specified twelve month period [email of 5 February 2004].

South Australia was the third jurisdiction which could not provide the AIC with the requested data. In lieu, South Australia provided comprehensive information about what is and is not recorded by South Australia police (referred to later) and also estimated that 82 incidents were reported to police over the specified twelve month period. It was stated that:

> If reporting to police does take place, the act of drink spiking is difficult to search for in SAPOL's reporting systems, with a high likelihood of cases being overlooked. In addition, much of the detail requested for the AIC study is not captured in coded fields, is labour intensive to extract from narrative-based data and largely unavailable. For this reason, SAPOL is unable to provide useful unit record data for the AIC study [letter dated 24 November 2003].

Hence, it was by no means a straightforward task for police in each jurisdiction to extract the requested information. Even for those jurisdictions which did provide unit record data, some fields were left empty as some variables are simply not collected or recorded. There is also no guarantee that the number of incidents provided to the AIC by each jurisdiction reflects the number of drink spiking incidents actually reported to or recorded by police. These issues and the implications stemming from them will be elaborated on later.

Results

The total number of drink spiking incidents estimated to have been reported to police across Australia between 1 July 2002 and 30 June 2003 is 660 (see Table 2). Clearly, the numbers for each state and territory do not reflect their population distributions and it must be kept in mind that these numbers do not necessarily reflect the numbers of drink spiking incidents occurring within the community. Rather, the variation between states/territories in reported numbers per population is likely to reflect both differences in (a) recording and extraction procedures between jurisdictions and (b) awareness and education campaigns.

Table 2: Estimated number of drink spiking incidents reported to police between 1 July 2002 and 30 June 2003.

Jurisdiction	*Number reported to police*
New South Wales	89 (6 months) x 2 = 178
Victoria	51
Queensland	30
Western Australia	210
Northern Territory	31
South Australia	82
Australian Capital Territory	70
Tasmania	8
Australia	660

Source: AIC drink spiking police data [computer file]
Note: The above numbers should not be used as a direct reflection of the number of incidents occurring in the community as the numbers of incidents reported to police will vary with recording and data extraction procedures, and awareness and education campaigns.

Unit record data

For the five jurisdictions who provided unit record data (Victoria, Queensland, Western Australia, Tasmania and Northern Territory), a total of 330 incidents were reported within the prescribed period of 1 July 2002 to 30 June 2003. The amount of information associated with each incident which was able to be provided to the AIC varied by jurisdiction. Table 3 provides a summary of the characteristics associated with victims of drink spiking, while Table 4 provides a summary of characteristics (where available) relating to offenders.

Overall, the variables on which police in the five jurisdictions were able to provide information for each incident related to:

- sex of victim (99% of incidents);
- age of victim (94%);
- date the incident occurred (99%);
- time the incident occurred (100%);
- date the incident was reported to police (100%);
- associated crimes (88%);
- offence under which the report was recorded (98%);
- location of incident (89%);
- whether the offender was apprehended (98%); and
- outcome of the investigation (88%).

The other variables listed in Tables 3 and 4 had considerably less information provided for each incident, either because (a) the information is not recorded by one or more jurisdictions, (b) natural attrition such as lack of information about the offender, or (c) data was inadvertently omitted or simply not available.

Out of the incidents where information was largely available, key findings were that:

- 87 per cent of victims were female;
- half the victims were aged between 16 and 24 years;
- 10 per cent of incidents overall involved sexual or indecent assault (note however that this number varied substantially by jurisdiction. In particular the percentage for Western Australia was 4% while for Victoria it was 26% and New South Wales was 35%);
- 83 per cent of incidents involved no associated crime;
- two thirds of incidents occurred at a nightclub, bar or pub;
- one quarter of incidents were reported on the same day to police, while a third were reported the day after the incident occurred;
- two thirds of incidents were recorded under the offence of 'Administer drug or poison'; and
- only ten per cent of offenders were apprehended by police.

Table 3: Characteristics associated with drink spiking victims who reported to police[a]

	No.	%[b]		No.	%[b]		No.	%(b)
Sex (N=329)			*Offence recorded (N=322)*			*After effects (N=104)* [c]		
Female	288	87	Drink spiking (NT)	31	10	Memory loss	37	36
Male	41	13	Assault	25	8	Nausea/vomiting	29	28
Age (N=309)			Rape	5	2	Lethargy	13	13
Under 16 years	8	3	Administer drug/poison	210	65	Dizziness	15	14
16-24 years	149	48	Introduce drug in other's body	37	12	Disorientation	11	11
25-34 years	102	33	Administer drug for sexual penetration	10	3	Unconsciousness	17	16
35-44 years	38	12	Administer substance	4	1	Blurred vision	9	9
45 and over	12	4	*Location of incident (N=292)*			Paralysis	8	8
Associated crimes (N=291)			Nightclub	88	30	Trouble breathing	4	4
Sexual/indecent assault	29	10	Bar/Pub	109	37	*Forensic testing (N=102)*		
Robbery	10	3	Victim or offender's home	37	13	Yes	55	54
Abduction	1	1	Hotel/motel	24	8	No	47	46
Assault	5	2	Outdoors	6	2	*Type of drug found (N=55)*		
Stupefying /cause injury	4	1	Restaurant	7	2	Benzodiazepines	5	9
No associated crimes	242	83	Other	21	7	Amphetamines	2	4
Time before reporting (N=326)			*Type of drink spiked (N=90)*			Opiates	6	11
Reported same day	82	25	Non-alcoholic	12	13	Other	5	9
Reported next day	105	32	Alcoholic	78	87	None	10	18
Reported 2-7 days after	91	28	*Knowledge of offender (N=90)*			Unknown	27	49
Reported 8 days or more	48	15	Yes	29	32	*Formal investigation (N=96)*		
			No	58	64	Yes	66	69
			Maybe	3	3	No	30	31

Source: AIC drink spiking police data [computer file]

(a) Data provided by Western Australia, Queensland, Victoria, Tasmania and Northern Territory.

(b) Percentages based on number of incidents in which information was provided.

(c) Some victims experienced multiple effects therefore percentages do not total 100.

Table 4: Characteristics associated with offenders implicated by victims who reported to police (where known)[a]

	No.	%[b]		No.	%[b]
Sex (N=48)[c]			*Reasons for not laying charges (N=121)*		
Female	5	10	Offender unknown	20	17
Male	42	88	Complaint withdrawn	29	23
Age (N=34)			Investigation ongoing	3	2
Under 16 years	1	3	Not an offence	20	17
16-24 years	6	18	Insufficient information/evidence	24	20
25-34 years	5	15	False/mistaken report	25	21
35-44 years	20	59	*Outcome of investigation (N=290)*		
45 and over	2	5	Not applicable	58	20
History of drink spiking (N=31)			Uncleared/filed	104	36
Yes	12	39	Other clearance (not specified)	34	12
No	19	61	Complaint withdrawn	22	8
Apprehension of offender (N=323)			Insufficient evidence	12	4
Yes	31	10	Person processed (summonsed etc.)	9	3
No	292	90	Mistakenly reported	25	9
Charges laid (N=16) [d]			Offender committed for trial	12	4
Sexual assault/rape	2	-	Investigation ongoing	11	4
Indecent assault	1	-	Case dismissed	1	-
Introduce drug in body of other	9	-	Conviction	1	-
Administer drug for sexual penetration	8	-	Civil action recommended	1	-
Drug possession	1	-			
Assault	2	-			
Robbery/theft	1	-			

Source: AIC drink spiking police data [computer file]

(a) Data provided by Western Australia, Queensland, Victoria, Tasmania and Northern Territory.

(b) Percentages based on number of incidents in which information was provided

(c) In one case both a male and a female perpetrator was identified

(d) Cases do not total 16 because some offenders had multiple charges laid

Problems with police data

Table 5 provides an overview of the searches undertaken by police in each of the five jurisdictions to identify drink spiking incidents, the variables which could not be provided and issues arising from these searches. As mentioned earlier, it is essential for purposes of intelligence-led policing that incidents of drink spiking reported to police are accurately recorded and able to be easily extracted. Apart from the fact that recording procedures differ markedly between jurisdictions, it is clear that:

- recording of drink spiking incidents (who, what, when, where, how and why) *within* jurisdictions varies;
- searching for drink spiking incidents in police databases is difficult and time-consuming;
- finding information on characteristics surrounding each incident can often only be determined through a manual narrative or text search (extremely time-consuming); and
- there is no guarantee that a search will locate all incidents which have been reported and/or recorded.

These same issues also apply to the jurisdictions which were unable to provide data to the AIC. By definition, data extraction problems were arguably more difficult for these jurisdictions. Recording and data extraction problems in relation to drink spiking were identified in the NSW report on drink spiking (State Crime Command Drug Squad 2002), while South Australia Police [in their letter of 24 November 2003] referred to considerable obstacles in terms of recording and extracting data.

For purposes of improving the ability of police to reduce and prevent drink spiking incidents, some clear recommendations stemming from these findings are that:

- police recording procedures be improved and standardized (at the very least within jurisdictions if not between jurisdictions);
- all incidents which are reported to police be recorded accurately and systematically;
- a specific drink spiking code be used to record any incidents in which a suspected drink spiking occurred (such as now applies with the PROMIS database);
- the variety of information which is collected about drink spiking incidents be properly coded and entered into police databases (not left as text in narratives to be ignored); and
- consideration be given to how data can and should be extracted and in what form, which would be most useful in understanding where, how and why reported drink spiking occurs.

Table 5: Summary of police data extraction processes

State	*Codes searched*	*Variables not provided*	*Issues arising*
WA	Administer drug/poison	Type of drink spiked Drug believed to be used Effects of drug on victim Forensic information Victim knowledge of offender Relationship of victim to offender Motivation for drink spiking Offender's drink spiking history Charges laid	Drink spiking not a specific offence category. Drink spiking incidents which may have been reported in categories other than 'Administer drug/poison' were not searched and not included. The number provided is therefore an under-estimate of incidents. Systems used for recording reported offences and recording charge details are not linked so charge information cannot be extracted. Obtaining further information would require manual search of individual reports which is time-prohibitive. Extent of information recorded and how recorded highly dependent upon officer taking the report.
Vic.	LEAP database codes searched: Administer drug for sexual penetration Administer substance – interfere body function Introduce drug into the body of another Attempt to introduce drug in body of other	Motivation for drink spiking Who reported incident to police	
Qld.	CRISP database searched: Assault – not elsewhere classified Sexual assault Free format MO and Officer's report text fields searched for 'spiked drinks' string in above fields	Offender's drink spiking history Previous apprehensions Outcome of investigation	Data extraction was a manual process. It was estimated that extracting required information for 25 incidents took two (2) person days. QPS has rules about which codes drink spiking incidents should be recorded in CRISP system. However, it is up to individual police officers as to what is recorded and how. Training occurs to try and minimise incorrect recording. Modus Operandi (MO) is free format text and searching this depends on entering appropriate string text searches.

State	*Codes searched*	*Variables not provided*	*Issues arising*
NT	Police PROMIS database searched: Drink Spiking	Sex of offender Age of offender Offender's drink spiking history Previous apprehensions Motivation for drink spiking Crimes associated with incident Location of incident Charges laid Outcome of investigation	In September 2002 PROMIS was updated to include the confirmed incident type of drink spiking. Drink Spiking is now recorded and searched by this incident type in the Northern Territory. Prior to this updating drink spiking incidents were entered under a variety of different incident types. Almost no information available about offenders. Three victims reported 2 or 3 incidents in the one police report but this was recorded as one incident so the number is likely to be an underestimate. Took a whole day to manually search for requested information.
Tas.	Offence Reporting System and Information and Data Management System (IDM) Search strings 'spike', 'spiking' and 'spiked'	Offence under which incident recorded Offender's drink spiking history Previous apprehensions Drug believed to be used Crimes associated with incident Charges laid Outcome of investigation	Information reports only. No actual offences confirmed or persons charged during reporting period.

Conclusions

In building the empirical evidence base on drink spiking, it makes sense as a first step to investigate how many incidents are reported to police and the nature of those incidents. This has not been done previously at a national level and so this information is being provided here for the first time. While police data cannot and should not be used as a direct reflection of the number of incidents which occur in the community (due to under-reporting, differences in levels of reporting between jurisdictions and different recording practices), it is nonetheless instructive to use police data as a base against which to compare other data sources and from which to build a broader picture of drink spiking. Reported incidents can then be used, along with estimated levels of under-reporting, to provide a rough indication of how many incidents might be occurring within the broader community (see Section 2.4 below).

It is clear however that substantial problems exist in relation to the recording and extraction of police data concerning drink spiking incidents. These problems, combined with the difficulty in knowing whether fluctuations in reporting are due to increased incidence or increased awareness, make the task difficult. Estimates of prevalence which use police data as a base must therefore be interpreted with caution. Having looked at police data, the next step is to investigate other sources of data which might provide some additional insight into drink spiking.

2.2 Centre Against Sexual Assault (CASA) data

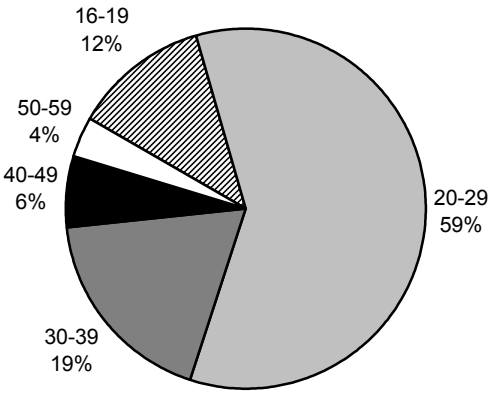
The numbers of people who report to sexual assault agencies around the country and, in particular, who have experienced sexual assault as a result of suspected drink spiking are not currently known. Such data are not recorded or kept centrally and the degree to which data are recorded on databases within each agency varies. The Centre Against Sexual Assault (CASA House) in Melbourne has been actively involved in campaigns to raise awareness about drug and alcohol facilitated sexual assault and is currently involved in a drink spiking project in collaboration with Victoria Police. CASA House has recently developed a database of drug and alcohol facilitated sexual assault cases reported to them and they kindly agreed to provide the AIC with deidentified data from this database. Data provided covered the period 1 February 2002 to 8 July 2003. As we were interested only in those victims who had presented to CASA House as a result of sexual assault suspected to have been associated with drink spiking, cases were included in the final dataset (determined by the AIC) only if it appeared that drink spiking (either through alcohol or drugs) had been suspected by the victim.

The final dataset comprised 115 sexual assault cases where drink spiking appeared to have been suspected by the victim to have occurred prior to the assault. Incidents where this information was missing or where it was possible that the incident may have involved drug facilitated sexual assault rather than a suspected drink spiking were excluded from the final dataset. Of the resulting 115 incidents:

- 96 per cent of victims were female;
- 97 per cent of known offenders were male; and
- 80 per cent of victims reported to CASA within two weeks of the incident.

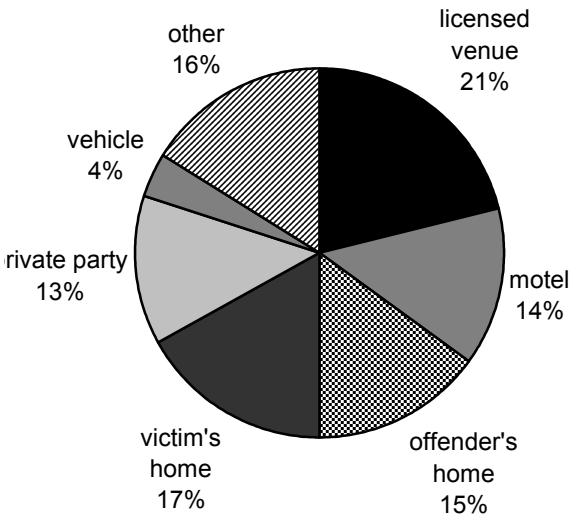
Figure 2 shows that of those victims where the victim's age was recorded (70% of cases), just over half were aged between 20 and 29 years, while 12 per cent were aged between 16 and 19 years. Figure 3 shows that where the location of the incident could be determined (70% of cases), incidents were relatively evenly distributed between licensed premises, the offender's or victim's home and other types of location. One third of incidents occurred at either the victim or offender's home, with only one fifth occurring at a licensed venue. Figure 4 shows that where the relationship of the victim to the offender was known (64% of cases), 61 per cent of offenders were acquaintances of the victim and 10 per cent were family members. Only one quarter of offenders were strangers.

Figure 2: Age of victims who reported to CASA House (N=81)



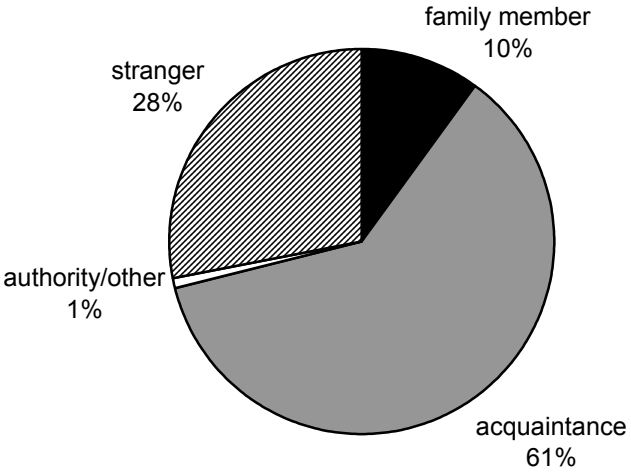
Source: CASA House drug and alcohol assisted sexual assault data 2003 [computer file]

Figure 3: Location of incidents reported to CASA House (N=80)



Source: CASA House drug and alcohol assisted sexual assault data 2003 [computer file]

Figure 4: Relationship of victim to offender reported to CASA House (N=74)



Source: CASA House drug and alcohol assisted sexual assault data 2003 [computer file]

Three important findings from this data are that:

- In the majority of instances victims knew their offenders prior to the incident. Only one quarter of offenders were strangers to victims, again highlighting the fact that 'stranger danger' does not appear to be the appropriate message to prevent drink spiking and associated sexual assault.
- The location where the incident occurred varied widely. It appears that for drink spiking sexual assault victims about one third of incidents occurred at either the victim's home or the offender's home which is consistent with the finding that the majority of offenders were known to victims. Only one fifth of incidents occurred at licensed venues.
- The overwhelming majority of offenders were men while the overwhelming majority of victims were women.

2.3 AIC drink spiking hotline

As part of the project requirements, a drink spiking victim telephone hotline was established in late 2003, the aims of which were:

- to develop a greater understanding of the characteristics associated with drink spiking;
- to identify the broad range of contexts in which drink spiking might occur; and
- to get a better understanding of how drink spiking affects victims.

To date, no survey has yet investigated drink spiking *only with suspected victims of drink spiking* – hence the telephone hotline was seen as a valuable means of obtaining information about drink spiking and victims not elsewhere available. The anonymity of the hotline, the freecall number attached to it and the fact that it was open between 8.00 am and 8.00 pm weekdays meant that victims calling in to the hotline could do so at their convenience and be safe in the knowledge that they would not be personally identifiable.

However, as respondents were necessarily self-selected, the responses obtained in the survey may not be representative of drink spiking victims generally. As such the findings from this hotline are not interpreted as being reflective of drink spiking in general; rather they are presented to show the enormous diversity in drink spiking situations, ages, knowledge of perpetrators, reporting to police and effects on victims. Such information is invaluable in highlighting that there is no 'single type' of drink spiking incident or victim – drink spiking is complex and it is important to understand this complexity if we are to move forward in terms of developing effective prevention strategies and assistance for victims.

Qualitative interviews

A qualitative approach was employed in the telephone interviews as it was deemed more appropriate to allow the victims to 'tell their story' rather than impose a structured instrument. After being asked to confirm whether they believe they had been a victim of drink spiking and whether this had occurred in the previous two years [screening questions], respondents were asked to describe what happened to them in some detail and interviewers then probed further into certain issues to:

- verify that information provided by the respondent had been correctly noted; and
- ensure that a baseline standard set of information was obtained from each respondent.

Advertising the hotline

The hotline was advertised through a number of mediums in order to achieve maximum publicity (within resource constraints) among victims:

- advertisements were placed with local community newspapers in every capital city – these ran in most newspapers over two non-consecutive weeks while the hotline was open;
- pamphlets were distributed to sexual assault agencies, selected hospitals and other relevant personnel across Australia;
- a press release by the Hon Senator Chris Ellison about the hotline produced considerable media coverage in major newspapers and radio across Australia;
- bulk emails were sent out to students in selected universities across Australia; and
- details about the hotline were given on the AIC website.

Counselling

As it was likely that some victims ringing in to the hotline would have experienced sexual assault as a result of the drink spiking incident, interviewers attended a training session with Canberra Rape Crisis Centre prior to commencement of the hotline. This was to obtain a better understanding of some of the issues which sexual assault victims may have to deal with and how best to respond to victims, particularly in the event of a victim becoming distressed on the telephone. In addition, Drug and Alcohol centres and sexual assault counselling services in each state/territory were advised of the project and asked if they would be willing for the AIC interviewers to distribute their phone numbers to victims who rang into the hotline. All drug and alcohol centres and sexual assault counselling services approached agreed to be listed on pamphlets and for interviewers to distribute their numbers to victims who called the hotline.

Details of hotline

The hotline commenced on the 17th November 2003 and closed on the 17th December 2003. During that period, interviewers were available between the hours of 8.00 am and 8.00 pm weekdays and the number for victims to call was free to the caller from all public, private and mobile telephones in Australia. All interviewers were trained to utilise the qualitative survey methodology employed and also how to interact with victims of drink spiking who may be traumatised or anxious about their experience (particularly if they suffered further victimisation such as a sexual assault). Since the hotline was not offered as a counselling service and it was possible that some respondents could become upset during the course of recalling the incident, interviewers provided callers with telephone numbers for counselling. The phone numbers provided were specific to whether the victim had suffered sexual assault or drink spiking without sexual assault and also to the state and area from which victims had phoned.

Number of victims

Overall, the hotline received 201 calls:

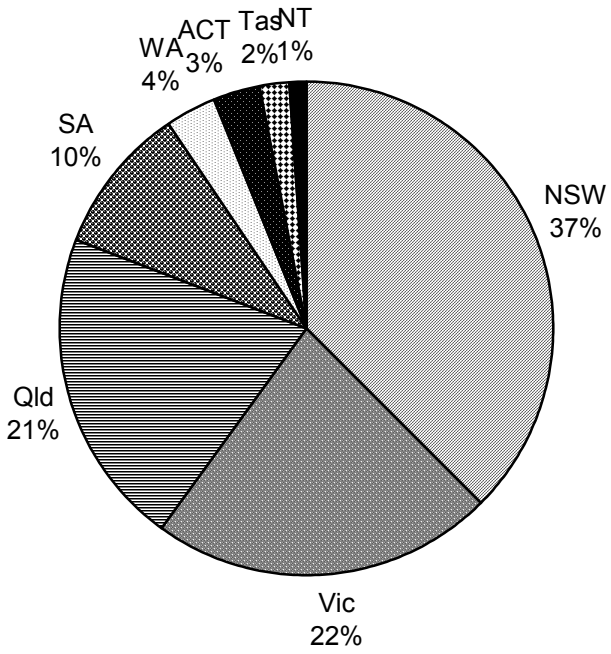
- 197 of which were victims or persons calling on behalf of victims who were included in the scope of the study; and
- four of which were excluded from the main data on the basis of the amount of time that had lapsed since the incident in question (this ranged from approximately 15 years to over 30 years).

Of the 197 calls from persons within the scope of the study, 201 incidents were recorded and analysed (four victims described two incidents). The majority of incidents occurred in either 2002 or 2003 (84%), with a smaller number occurring prior to January 2002.

Sample Demographics

Eighty two per cent of victims were female, 18 per cent were male (there was also one transgender victim). Figure 5 shows the breakdown of incidents by state/territory. It can be seen that the state distribution in the sample largely reflects the state distribution in Australia at large.

Figure 5: State in which drink spiking incidents reported to hotline occurred (N=201)



Source: AIC Drink Spiking Hotline 2003 [computer file]

Respondents were also asked about the type of area in which the incident occurred: metropolitan, regional or rural. A metropolitan area was designated as a capital city, regional areas were defined as populated areas elsewhere in the state and rural areas included other, more sparsely populated regions. Table 6 displays this information for each of the 200 incidents (one missing) by state. It can be seen from the table that the vast majority of incidents (79%) had occurred in metropolitan areas.

Table 6: State and type of area in which drink spiking incidents reported to the hotline occurred (column percentages)[(a)]

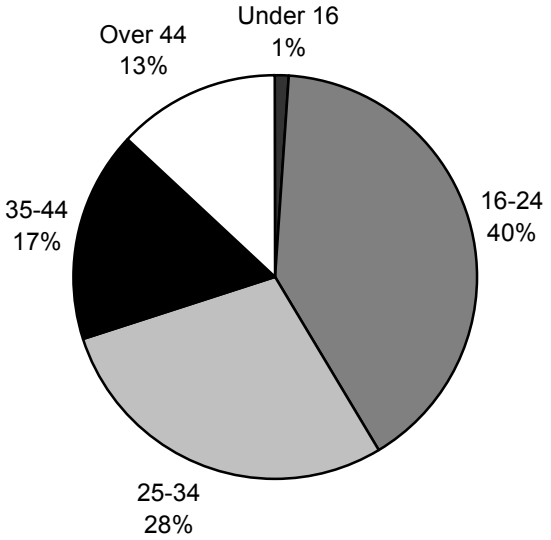
	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Total
Metro	75	78	69	100	100	100	50	100	79
Regional	24	13	26	0	0	0	50	0	18
Rural	1	9	5	0	0	0	0	0	4
N	75	45	42	19	7	4	2	6	200

Source: AIC Drink Spiking Hotline 2003 [computer file]
(a) One case missing demographic data – not included in total

Age of victims

It can be seen from Figure 6 that the largest age group for victims at the time of calling into the hotline was between 16 and 24 years, followed by those in the 25-34 year age group. This age breakdown is similar to that of victims in the police data reported earlier, whereby 16-24 year olds comprised the majority of victims.

Figure 6: Age of drink spiking victims who reported to AIC hotline (N=201)



Source: AIC Drink Spiking Hotline 2003 [computer file]

Key Information

The following section details the results from the telephone hotline pertaining to:

- location;
- effects;
- drugs;
- perpetrators;
- associated victimisation;
- reporting; and
- sexual assault.

Table 7 provides an overview of the characteristics associated with the incidents of drink spiking from the hotline.

Table 7: Characteristics of drink spiking incidents from hotline (N=201)

	No.	%
Female victims	164	82
Male victims	36	18
Victim aged under 25	83	41
Victim aged 25-34	57	28
Victim aged 35 and over	60	30
Sexually assaulted	32	16
Robbed	9	5
No further victimisation	153	76
Victim knew perpetrator before incident occurred	52	26
Victim could not identify offender at all	91	45
Occurred at licensed premises	157	78
Reported to police	51	25
Believes aware of drug used	72	36
Forensic testing done	36	18
Did the victim suffer memory loss as a result of drink spiking?	117	58

Source: AIC Drink Spiking Hotline 2003 [computer file]

Location

Table 8 shows that incidents were most likely to occur in licensed premises (78%) and that this was so for all age groups. The majority of victims had been drinking alcohol at the time their drink was spiked (78%), with the highest number of victims reporting that they were consuming spirits at the time, followed by wine and then beer.

Table 8: Number of incidents reported to the hotline, by location for different age groups[a]

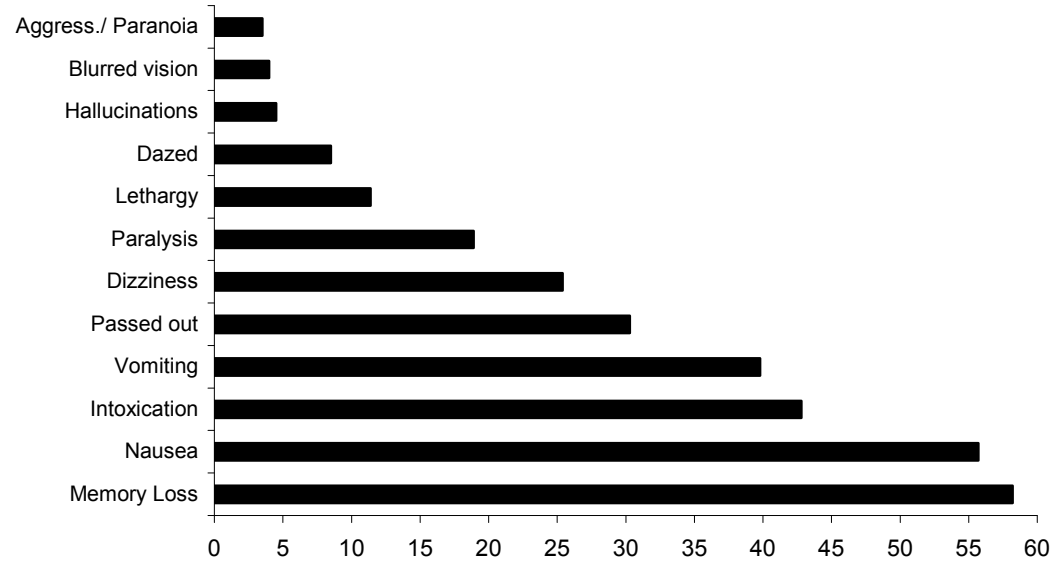
	<25[b]	25-34	35-44	Over 44	Total
Bar/Nightclub	63	44	19	14	140
Private party	10	0	1	4	15
Perpetrator's home	3	5	1	0	9
Victim's home	0	0	1	1	2
Casino	1	1	2	0	4
Café/Restaurant	0	2	2	3	7
Members-only club	1	0	1	2	4
Workplace	0	0	1	2	3
Sporting/leisure club/activity	2	2	2	0	6
Private function on licensed premises	1	3	4	0	8
Total	**81**	**57**	**34**	**26**	**198**

Source: AIC Drink Spiking Hotline 2003 [computer file]
(a) 3 cases were excluded from this table because of missing data
(b) Two victims in this group were aged under 16 years

Effects of drink spiking

A wide variety of physical and emotional effects resulting from drink spiking were reported by victims and these are shown in Figure 7. It can be seen that the majority of incidents involved victims experiencing memory loss and nausea. Intoxication, vomiting and passing out were also common effects. Approximately one fifth of incidents resulted in paralysis effects.

Figure 7: Percentage of incidents reported to hotline involving effects from drink spiking (N=201)



Source: AIC Drink Spiking Hotline 2003 [computer file]

Drugs

Victims were asked whether they knew what substance their drink had been spiked with. This is a particularly difficult question to answer as, unless victims actually saw the substance being added or were forensically tested, it is highly improbable that victims could know what substance was used. Most participants (64%) were unable to respond to this question. In only 18 per cent of incidents were victims forensically tested after the incident. Of these:

- ten per cent were negative; and
- eight per cent allegedly tested positive to (variously) benzodiazepines and amphetamines. Two and four victims claimed to have tested positive to GHB and flunitrazepam respectively.

The remaining 18 per cent of the sample took a guess as to what the additive may have been. Interestingly, but perhaps not surprisingly, these guesses tended to revolve around flunitrazepam, GHB and other benzodiazepines (substances commonly associated in the media with drink spiking).

Perpetrators

In almost half of the incidents (45%) victims did not know who the perpetrator was. This may be attributed to the fact that in the vast majority of cases no additional criminal victimisation occurred and many victims were taken care of by friends and had no further contact (that they were aware of) with the perpetrator. In 26 per cent of incidents, the victim had known the offender prior to the incident (e.g. friend, partner, work colleague) while in a further 29 per cent they had not known the offender prior to the incident (e.g. stranger, bartender).

Associated victimisation

Although the majority (76%) of drink spiking incidents involved no further victimisation, there were a number of victims who had experienced crimes such as sexual assault, robbery or physical assault after their drink had been spiked. Sexual assault was the most common associated crime (16% of incidents) followed by robbery (5%), while three drink spiking victims experienced a physical assault.

Reporting

Official

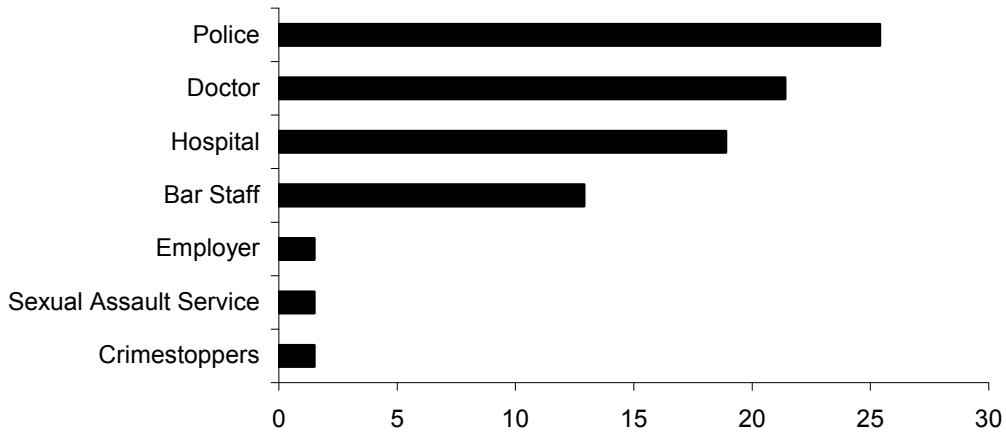
Victims were asked whether they had reported the incident to any official authorities. Figure 8 shows that:

- one quarter of incidents were reported to the police;
- close to 20 per cent were reported to a hospital and just over 20 per cent reported to a doctor; and
- about 13 per cent were reported to bar staff.

Forty-three per cent of incidents that were reported to police were reported on either the day of the incident or the day after. The remainder were reported after two days or later, with 31 per cent not reported until at least a week had passed (some waited longer than a month). This has implications for the ability of the police to collect sufficient evidence for prosecution and may be a reason for the low proportion of victims who received drug testing. However, it should be noted that 87 per cent of victims who reported to a hospital did so within a day – often because they required treatment.

Almost 30 per cent of incidents where the victim could not identify the perpetrator were reported to police, suggesting that some victims are willing to report officially even if they cannot give the police information about the perpetrator.

Figure 8: Percentage of drink spiking incidents reported to hotline that were reported to authorities (N=201)



Source: AIC Drink Spiking Hotline 2003 [computer file]

Victims who reported to police were asked what happened after they reported the incident. It was found that:

- very few cases proceeded to investigation, let alone prosecution, with 42 per cent of reported incidents involving a report being taken but no further action;
- in 32 per cent of reported incidents, victims believed they had been dismissed with little or no information recorded about their experience;
- in 18 per cent of cases, victims' reports had been or were being investigated. however, in half of these the investigation had terminated due to insufficient evidence; and
- only one victim reported that her case was currently being prosecuted.

When victims who had reported to medical authorities such as hospitals or doctors were asked what had happened after reporting:

- about 40 per cent indicated that they had been tested for drugs in their system. However, as was stated earlier, only eight per cent of all victims actually received positive test results from any authority; and
- victims frequently stated that the hospital had placed under them observation or that their doctor had counselled them about the incident.

Finally, of the 26 drink spiking incidents that were reported to bar staff or management:

- just under half were dismissed with victims either not responded to or no report/action taken; and
- one quarter of incidents involved a report being taken.

Unofficial

Victims were also asked about their degree of unofficial reporting; that is, the extent to which they spoke with family members, friends and others about the incident informally. It was found that:

- the vast majority of victims (88%) informally discussed the incident with someone;
- assistance was most commonly sought from friends (68%); followed by
- parents (40%);
- other relatives (29%); and
- partners (26%).

These findings demonstrate that very few victims kept the details of the incident to themselves, instead choosing to seek support from (usually) close family and/or friends.

Sexual assault victims

Sexual assault was experienced by victims in 16 per cent of all drink spiking incidents and was the crime most frequently associated with drink spiking. The characteristics associated with both sexual assault victims and non- sexual assault victims were compared to determine if any differences existed between the two types of victim. In comparison to other types of drink spiking victims, it was more likely for victims of drink spiking in combination with sexual assault:

- to know the identity of the offender;
- to have met or been acquainted with the offender prior to the drink spiking incident;
- to have had their drink bought or poured for them;
- to have had their drink spiked at their own or the perpetrator's home; and
- to report the incident to police (possibly due to the severity of the consequences for sexual assault victims who called in to the hotline).

Long-term effects on sexual assault victims

An important issue deserving of more research is the long-term effects resulting from drink spiking and sexual assaults which may still be apparent some time afterward. A number of victims (of primarily sexual assault but also non sexual assault victims) stated that they were anxious about visiting licensed premises after the incident especially when out alone. Some sexual assault victims expressed an ongoing concern about not knowing what exactly was done to them while they were unconscious and, more specifically, who the offenders were. It is important to note that while victims may be aware of who spiked their drink initially, they may not know how many people assaulted them and indeed the identity of these people. This concern may manifest in a fear that the victim might see the attacker(s) after the incident without being aware of who they are.

Some sexual assault victims mentioned the effects that the assault has had on others close to them. The effect on male relatives (partners, brothers, fathers) was raised as an issue for some victims in that the men in their life may want to seek retribution and have the incident reported officially, which may conflict with the victim's priorities and needs. These additional effects on victims' lives – apparent sometimes long after the assault – indicate the ongoing trauma inflicted on many victims of drink spiking and sexual assault.

Victim quotes

Direct quotes from victims of drink spiking can succinctly capture the points of view and ongoing concerns that they have about their experience. During the hotline, a number of quotes were recorded from victim interviews and these are provided in Box 2. These comments highlight victims' personal views on a number of topics including:

- reflections on their experience during the incident;
- the perpetrator; and
- reporting to authorities.

Box 2: Quotes from victims

Victim's experiences	
	'He just said we got really drunk'
	'I woke up with guys all over me'
	'I just remember someone saying 'its okay'' [during the rape]
	'I passed out and when I woke up a guy was having sex with me'
	'It was like going to hell and back'
	'I lost control of my body'
Perpetrators	
	'I thought they were my friends'
	'Drink spiking is not always done by strangers'
Reporting	
	'I thought it would be a wild goose chase [if I reported to police]'
	'I did not want to accuse anyone'
	'I did not want to waste police time'
Memory loss	
	'I have never not remembered [my evening]'
	'The worst part is not remembering'
	'I do not know what happened'
	'The rest of the night was a blur'
Feelings	
	'I'm always really careful with my drinks'
	'I did not want to make a fuss'
	'I should have realised'
	'I was embarrassed at losing control and worried that they would think I drank too much'
Informal reporting	
	'I told everyone – they should be aware of the danger'
	'I want my friends to know how easily it can happen'
Alcohol consumption	
	'I was only on my second drink'
	'I only had a few beers'

Case studies

The following case studies (provided in Boxes 3 through 7) describe five incidents which were included in the analysis of this study. While they have been selected because the type of incident and effects were representative of a number of similar incidents reported to the hotline, they also serve to illustrate the variety of victims and circumstances in which incidents of drink spiking occurred for victims in this study.

Box 3: Case study #1: Drink spiking of female aged between 16 and 24 yrs

The victim was at a nightclub in Adelaide in May 2002 with friends when her vodka was spiked. She is unaware exactly how it could have occurred, but believed it may have happened when the perpetrator was walking past her group of friends. Not long after finishing the drink, she began to feel very intoxicated, despite the fact that she had not yet consumed enough alcohol to warrant such an effect. She then passed out, at which point her friends took her to hospital. She has no memory of the period when she was unconscious. She awoke the next day in hospital where she had been placed under observation. She had not been tested for any drugs in her system so she was unaware what her drink had been spiked with. She did not report to any other authorities but spoke informally with her parents and friends. Over the next few days she was still very ill, vomiting and very lethargic.

Box 4: Case study #2: Drink spiking of female aged 19 yrs

The victim had drunk four glasses of rum while at a local pub in Brisbane with some friends in November 2003. She is unsure at which point her drink was spiked, but as she went to leave, she felt excessively intoxicated (for the amount of alcohol she had consumed). She went home in a taxi and when she arrived home she began to vomit, sweat, twitch and her heart was racing. The symptoms were present all night and although she considered going to hospital, when her flatmate rang up they were told it would be a three hour wait, so they declined. Instead the victim visited her doctor the next morning who gave her a check-up and advised her that she may have taken amphetamines, given that she had not passed out and her heart was racing. The victim did not report the incident to police because she wants to remain anonymous, however she rang the pub and gave them the information.

Box 5: Case Study #3: Drink spiking and sexual assault of female aged over 44 yrs

The victim visited a pub in regional NSW with a friend in April 2000 and encountered a man at the bar that she had previously met once before. She went to the bathroom at one point and when she returned he had purchased drinks for her and her friend. She accepted the gin and tonic and finished it and began to feel vague and her body was ‘tingly’. Shortly afterward she left the pub to go across the road at which point he followed her outside and took her hand. The victim has no further memory of the evening, until the next morning when she recalls walking the streets physically injured (bruised thighs and broken collarbone) with items of clothing missing. She returned home in a taxi unaware of what had transpired during the evening, but visited a doctor two days later because of her concern that she had been sexually assaulted. The doctor treated her injuries, gave the victim the morning-after pill and tested her for sexually transmitted infections.

Box 6: Case study #4: Drink spiking and sexual assault of female aged between 35 and 44 yrs

The victim was at a local hotel with her husband and some friends in rural Victoria in September 2002. She was dancing with a male friend and she believes he spiked her drink with flunitrazepam. Although she has been told by others that she started to appear very intoxicated after this point and that he carried her out of the hotel, she has no memory of the night after drinking the spiked drink and can only recall from when she awoke naked in the perpetrator's living room. At first she did not know what had happened, as he appeared to be helpful and drove her to a taxi stand where she could ride home (his excuse for not driving her home was that he still had high blood alcohol from the night before). She slept all day at home and when she awoke she could not move and had severe memory loss. She did not realise that her drink had been spiked until two months later when she discovered that he had drugged and raped another woman and that the police were going to prosecute. She told the police of her experience and although they would not be prosecuting her case, they will be for three other victims.

Box 7: Case study #5: Drink spiking of male aged between 16 and 24 yrs

The male victim was at a bar in Sydney with friends in November 2003, where they were speaking with some girls he had not met before. While drinking beer, he began to feel 'euphoric', hyperactive and delusional. He then started to feel confused, anxious and ill. At some point he realised his drink had been spiked and he believes the girls were responsible. His friends eventually sent him home in a taxi and the next day he felt very depressed and anxious. He did not report the incident to any official authorities and only spoke with his friends about it. He does not feel there was any need to report it because he is now okay and was not hurt after the incident.

Typology

Table 9 provides a typology of drink spiking incidents by three variables: whether a sexual assault occurred; the sex of the victim; and the age of the victim. The typology examines the characteristics of incidents which fall into these categories including:

- prior contact with the perpetrator;
- location of the incident;
- the experience of memory loss; and
- reporting (official and unofficial).

Table 9: Characteristics associated with type of victim based on hotline data

Victim	Did they know the perpetrator prior to the incident?	Where did the incident occur?	Did they experience memory loss?	Did they report to police?	Did they tell a friend?	Did they tell a parent?
Sexual assault victim[(a)]	Half knew the perpetrator before the incident	Half at public, licensed premises (others at private gatherings)	Nine in ten experienced	Half reported	Almost two thirds told a friend	One third told a parent
Non-sexual assault victim	One quarter knew the perpetrator before the incident	Three quarters were at public, licensed premises	Half experienced	One in five reported	Three quarters told a friend	Almost half told a parent
Male	One quarter knew the perpetrator before the incident	Two thirds were at public, licensed premises	One third experienced	Less than one in five reported	Half told a friend	Less than one in five told a parent
Female			Two thirds experienced	One quarter reported	Three quarters told a friend	Half told a parent
Aged under 35 yrs	One in five knew the perpetrator before the incident	Three quarters were at public, licensed premises	Over half experienced	One quarter reported	Two thirds told a friend	Half told a parent
Aged 35 yrs and over	Two in five knew the perpetrator before the incident	Half were at public, licensed premises	Half experienced			Less than one in five told a parent

Source: AIC Drink Spiking Hotline 2003 [computer file]
(a) Includes one male victim

Conclusions from hotline data

It is clear from the telephone interviews with self-reported victims of drink spiking that there is *no single type of victim or situation* in which drink spiking occurs. Victims vary widely in terms of age, location of incident, knowledge of the offender's identity, recall of the incident, reporting and associated victimisation. Further, although the percentage of sexual assault victims was relatively small compared with other types of drink spiking victim, it was evident from the interviews that many sexual assault victims experienced severe and ongoing trauma long after the incident.

The variety of circumstances in which drink spiking can occur means that strategies to prevent drink spiking which target only one type of audience (e.g. young women or young people at licensed premises) will be limited in effectiveness because the message will not reach or may be inappropriate for other types of audience. Strategies to tackle and prevent drink spiking must take into account the fact that victims and situations differ widely. Prevention strategies therefore must:

- identify the range of audiences which need to be targeted;
- identify what the specific characteristics and needs of those audiences might be; and then
- develop appropriately targeted intervention and education initiatives which are directly relevant to those specific audiences.

The findings from the hotline data will be very useful for this purpose as they provide an indication of how victims and situations differ. Those, for example, who are interested in developing strategies to prevent drink spiking and associated sexual assault should look at the characteristics surrounding incidents of drink spiking *for these types of victims* and base prevention strategies on this information. From the findings in this study, it could be suggested that interventions for potential sexual assault drink spiking victims may include education initiatives that state:

- drink spiking and associated sexual assault can occur with known and familiar people and is not just 'stranger danger' (this fact is consistent with sexual assault research more generally);
- sexual assault is a crime regardless of whether the offender is a stranger, a date or an acquaintance;
- drink spiking and sexual assault often occurs at the victim's or perpetrator's home;
- memory loss is a common symptom for many drink spiking sexual assault victims and memory loss does not necessarily mean that an assault did not occur or that the incident will not be taken seriously by authorities; and
- victims should try to report to their doctor or hospital (if not police) as soon as possible after the incident if they suspect they have been a victim of drink spiking and sexual assault.

The findings in this study also highlighted that males can be victims of drink spiking. In the hotline, 18 per cent of incidents occurred with male victims (compared with 13 per cent in the police data) and the most common age group for male victims was 25-34 years. Prevention strategies for males could include education initiatives that state:

- males can be victims of drink spiking too;
- regardless of sex of victim, all incidents of drink spiking should be reported to police;
- if a male believes his drink was spiked and that he was sexually assaulted he should report to a doctor or hospital as soon as possible following the incident;
- if a male believes his drink was spiked and he was robbed he should report this to the police as soon as possible; and
- there is *no shame* in being a victim of drink spiking.

Under-reporting to police

The findings also highlighted that drink spiking is heavily under-reported to police and other authorities. Overall, only one quarter of victims who rang into the hotline reported the incident to police, indicating that police data on reported incidents of drink spiking are likely to heavily underestimate the degree to which drink spiking occurs in the community. Reporting to police, however, varied depending on the type of victim. In this study, half of sexual assault victims reported to police while only about 20 per cent of non-sexual assault victims reported the incident to police.

The reporting level for sexual assault in this study is arguably high given that previous research estimates levels of reporting of sexual assault more generally to be very low (Lievore 2003). Two possibilities for this difference exist:

(1) as the victims who called into the hotline were self-selected, it is possible that the sample is biased toward sexual assault victims who were more likely to report to police; and/or

(2) the severity of the sexual assaults for victims who called into the hotline may have been so great as to have required police attendance/intervention.

Given the self-selected nature of the sample, it is not possible to say with any certainty why the levels of reporting for sexual assault victims in this study were higher than those reported for sexual assault victims in general.

While reasons for non-reporting are likely to be many (see Box 1 in Section 1), it was disappointing to find that for those victims who did report the incident to police, one third of victims believed they had been dismissed with little or no information recorded about their experience. If levels of reporting to police are to be improved in the future (and this must be encouraged if more accurate estimates of the prevalence of drink spiking are to be derived) then it is imperative that victims feel that it is worth their time and effort to report the incident, that victims believe that the police are interested in the details of the incident, will

listen to their concerns, will devote some time to it and will faithfully record everything that the victim can recollect about the incident.

2.4 Estimating the prevalence of drink spiking in Australia

One important reason for building the empirical evidence base on drink spiking is so that the prevalence and incidence of drink spiking in Australia can be estimated. That is, how many incidents occur over a one year period? Being able to quantify the prevalence of drink spiking would provide a means of knowing how big an issue it might be within the community and how many resources should be devoted to preventing it. However, similarly to sexual assault more generally, it is not possible to state exactly how many incidents of drink spiking occur within the community due to (a) high levels of under-reporting, (b) fluctuations in reporting due to awareness campaigns and (c) difficulty in verifying whether a reported incident actually occurred. This means that there is currently no way to determine the exact number of drink spiking incidents which occur within the wider community, or the exact number of incidents which are suspected by individuals to have occurred.

Given this situation, the only alternative option is to try and calculate estimates of the degree to which drink spiking might be suspected to be occurring within the community. This can be done through applying a methodology known as the "unreported crime adjustment" (Mayhew 2003, Walker 1992) whereby the number of incidents of a particular type of crime which are reported to police are inflated by estimates of under-reporting identified in self-report surveys. This methodology therefore uses both incidents which are reported to police and what survey victims themselves say about the percentage of incidents which are reported to police. While this methodology is not perfect in that (a) the number of incidents recorded by police may not necessarily reflect the number of incidents reported to police (see Carcach & Makkai 2002); (b) the number of incidents reported to and recorded by police will likely vary with jurisdictional and other factors; (c) responses given in surveys may not necessarily be accurate; (d) estimates of reporting identified in self-report surveys will vary depending on which survey is used and (e) certain assumptions need to be made in the calculations; it is nonetheless a useful means of trying to calculate estimates of a particular crime when exact numbers are not available (Mayhew 2003).

In this report estimates of suspected drink spiking will be calculated using the unreported crime adjustment methodology. However, given that there are no random and representative self-report surveys of drink spiking (in the same sense that there are random surveys of sexual assault) certain assumptions will need to be made when estimating drink spiking. For example, suspected drink spiking sexual assault estimates will be based on under-reporting rates identified in sexual assault surveys. As the Roofie Foundation in the UK believes that drink spiking sexual assaults are likely to be reported even less than sexual assault in general, this means that the estimates derived from sexual assault surveys may be conservative ones. Further, rather than take under-reporting rates from only one survey several surveys will be compared and a range of estimates will be calculated rather than a single number. Some assumptions will also need to be made about proportions of drink spiking incidents reported to police which are associated with sexual assault and reporting rates for drink spiking in the absence of sexual assault. In sum, while the drink spiking estimates in this report will be based on certain assumptions, it is important to remember that:

- there is currently no way to identify the exact number of drink spiking incidents which occur within the community;

- the estimates derived in this report are rough estimates only and are the best that can be determined at this point in time; and

- the estimates in this report refer to the number of drink spiking incidents which are suspected by people to have occurred (after all, incidents which are reported to police are based on incidents which people believe have occurred, regardless of the truth or accuracy of the reported incident). The estimates in this report do not refer to incidents which have been verified, given the enormous difficulties surrounding issues of verification (see Section 1.4).

Estimating drink spiking in this report

Based on the police data provided to the AIC and using estimates of under-reporting to police based on the hotline data (for non-sexual assault drink spiking incidents) as well as other survey research into sexual assault, rough estimates were calculated of the total number of suspected drink spiking incidents which may have occurred across Australia between 1 July 2002 and 30 June 2003 (see Table 10a). These estimates are based on certain assumptions and calculations and should be used as a rough guide only. In this report prevalence is estimated through:

- estimating the number of drink spiking incidents reported to each jurisdiction by whether or not a sexual assault occurred;
- estimating levels of reporting for both sexual assault and non-sexual assault drink spiking incidents; and
- multiplying the number of incidents reported to police by the level of under-reporting to produce a national estimate.

It is necessary to classify drink spiking incidents by whether or not a sexual assault occurred because the reporting rates for sexual assault are likely to be different from instances in which other or no victimisation occurred. The number of drink spiking incidents (by whether a sexual assault occurred or not) were provided to the AIC by Victoria, Queensland and Western Australia. Data from the Northern Territory and Tasmania had substantially missing data on associated victimisation so estimates needed to be made. The ACT and South Australia provided an overall estimate of the number of drink spiking incidents which were recorded by police during the specified time period. New South Wales, in its drink spiking report covering a six month period, identified an overall number of drink spiking cases to have been reported to police between December 2002 and May 2003 and an estimate of the percentage related to sexual assault. For the purposes of our estimation this number was doubled to provide a conservative estimate of the number which may have been reported to police over the entire 12 month period in New South Wales.

For the Australian Capital Territory, South Australia, New South Wales and the Northern Territory, then, an overall estimate of the number of incidents reported to police was able to be determined, however these incidents needed to be classified into sexual assault versus other cases. As the percentage of sexual assault drink spiking cases, out of all drink spiking cases,

varied between Victoria (26%), NSW (35%), Queensland (20%), Western Australia (4%) and the drink spiking hotline (16%), a conservative estimate of 20 per cent for sexual assault cases was applied to the total number of reported incidents for the Australian Capital Territory, South Australia, Tasmania and the Northern Territory. This then yielded an estimate for each jurisdiction of the number of reported drink spiking incidents by whether the incident was associated with a sexual assault or not.

Reporting levels then needed to be estimated for both sexual assault and non-sexual assault drink spiking cases.

Estimating reporting rates for sexual assault

Reporting rates for sexual assault are generally known to be low (Lievore 2003). From the International Violence Against Women Survey (Australian component)[3], it is estimated that of the women in the survey who had experienced a recent incident of sexual violence perpetrated by an intimate partner (N=1337), 14 per cent had reported the incident to police. For women who had experienced a recent incident of sexual violence by someone other than an intimate partner (N=1967), 11 per cent had reported the incident to police[4]. The 1996 Women's Safety Survey (ABS 1996) found that 15 per cent of victims reported the most recent incident of sexual violence while the 2000 International Crime Victims Survey also found a reporting rate of 15 per cent. In the United Kingdom the Roofie Foundation states on its website that, of the 6650 suspected drink spiking sexual assaults reported to them, less than 15 per cent had been reported to police. The Roofie Foundation also believes that drink spiking sexual assaults are likely to be more under-reported than sexual assaults in general. On the basis of the above findings an estimate of 10 per cent will be used as the lower reporting rate for drink spiking sexual assaults to police[5] while 15 per cent will be used as an estimated upper reporting rate. Note that the reporting rate for sexual assault drink spiking victims identified in the AIC drink spiking hotline is not being used here as an estimate of reporting as the percentage of victims in the hotline who reported to police was substantially higher than numbers for sexual assault research generally and it is unclear why this might be (see earlier discussion in previous section).

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3 The Australian component of The International Violence Against Women Survey (IVAWS) is currently being conducted by the Australian Institute of Criminology. This project is funded by and being conducted on behalf of, the Australian Government Office of the Status of Women. The telephone survey interviewed a random sample (n=6677) of the female Australian population between the ages of 18 and 69. Data provided here are unpublished.

4 Confidence intervals for this reporting rate ranged from ten per cent to thirteen per cent with an acceptably low relative standard error of 6.8 per cent.

5 Note that the ABS 2002 National Crime and Safety Survey (4509.0) states a reporting rate for female victims of sexual assault of 19.8%, however the ABS urges caution in using this number due to the extremely high relative standard error associated with this estimate.

Estimating reporting rates for drink spiking (non sexual assault)

Estimating the reporting rate for incidents of drink spiking not involving sexual assault (i.e. with robbery or no associated victimisation) is somewhat more difficult as there are no comparable estimates of reporting for this type of incident. To use Australian Bureau of Statistics (2002) reporting rates for robbery (50%) or assault (31%) will substantially overestimate the degree to which drink spiking incidents in general are reported to police since the vast majority of drink spiking incidents have no additional victimisation associated with them. In the absence of any other data on the degree to which drink spiking in general is reported, the AIC hotline finding of 20 per cent reporting levels for non-sexual assault drink spiking victims was used as the lower reporting rate while a more conservative estimate of 25 per cent was used as the upper reporting rate.

It should be kept in mind that, as mentioned earlier, awareness campaigns and differences in recording procedures are likely to affect the numbers of incidents reported to and provided by police in each jurisdiction. Applying the same multiplier to all jurisdictions means that these differences are not taken into consideration – this is unfortunate but unavoidable given that it is not possible to estimate how police data might be affected by these differences.

Table 10a shows the calculations for estimating the prevalence of suspected drink spiking in Australia. On the basis of the above assumptions and calculations, it is roughly estimated that between 1 July 2002 and 30 June 2003:

- between 3000 and 4000 suspected incidents of drink spiking occurred in Australia;
- between 850 and 1300 suspected incidents involved sexual assault
- between 2100 and 2700 suspected incidents occurred which did not involve sexual assault.

Table 10a: Estimating the prevalence of drink spiking in Australia 2002/2003[(a)]

	Australia		
	Sexual Assault	**No sexual assault**	**Total**
No. reported to police in QLD, VIC, TAS, WA, NT[(b)]	96	404	500
Estimates for NSW, ACT and SA[(b)]	32	128	160
Total estimated reported 1/7/02 – 30/6/03	128	532	660
Estimated reporting rate % (lower)	10	20	
Estimated reporting rate % (upper)	15	25	
Multiplier (for lower estimate)	10.0	5.0	
Multiplier (for upper estimate)	6.67	4.0	
Total estimated incidents 1/7/02 – 30/6/03	854 -1280	2128 - 2660	2982 - 3940
No. incidents per 100,000 persons	4 - 6	11 – 13	15 - 19

Source: AIC drink spiking police data [computer file]

(a) Estimates based on assumptions identified earlier

(b) Estimates based on assumption of 20% of all reported incidents being related to sexual assault for NT, TAS, ACT and SA

Drink spiking estimates – Putting them in perspective

It is important to place these drink spiking sexual assault estimates in perspective. A comparison with the numbers of sexual assaults which were recorded by police in the same year shows that the estimates for drink spiking sexual assault are very small indeed in the context of recorded sexual assaults in general. Table 10b shows the number of victims of sexual assault recorded by police across Australia in 2002-03 and the number of incidents of sexual assault and related offences recorded by police across Australia in 2002-03. When considered in combination with the fact that sexual assault is heavily under-reported and that these numbers are therefore likely to heavily under-represent the numbers of sexual assault which are actually occurring within the community, it is clear that the estimates identified in this report for drink spiking sexual assault within the community are relatively small compared with sexual assault in general. It is important to keep this in mind when interpreting the drink spiking sexual assault estimates in this report.

Table 10b: Victims and incidents of sexual assault recorded by police 2002-03[a]

Victims of sexual assault recorded by police across Australia 2002-03 [b]	Incidents of sexual assault and related offences recorded by police across Australia 2002-03[c]	AIC estimates of drink spiking sexual assault across Australia 2002-03
18 026	27 292	854 – 1 280

a. The definitions and methods by which victims and incidents of sexual assault are recorded by police vary across jurisdictions. This means that the number of victims and incidents summarised in Table 10b are dependent upon definitions and calculations used by each jurisdiction.
b. Australian Bureau of Statistics (ABS) Recorded Crime Victims Australia 2003 companion table cat. 4510.0
c. Compiled from: South Australia Police Annual Report 2002-03; Victoria Police *Crime Statistics*; Western Australia Police Annual Report 2002-03; NSW Bureau of Crime Statistics and Research Recorded Crime Statistics 1999-2003; Queensland Police Annual Report 2002-03; Northern Territory Police Annual Report 2002-03; Tasmania Police Annual Report 2002-03; AFP ACT Policing Annual Report 2002-03. Note that the numbers for NSW relate to the 2003 calendar year.

2.5 What evidence is there that drugs are used in drink spiking?

Despite media claims and public perceptions that drugs such as flunitrazepam, GHB and Ketamine are commonly used to spike drinks, forensic testing to date does not appear to support these suggestions. Of the 55 drink spiking cases in the police unit record data in Section 2.1 in which forensic tests were conducted, five returned a positive finding for benzodiazepines, six for opiates and two for amphetamines. Table 11 provides a summary of the drugs often linked with drink spiking in the media. [Appendix B provides a comprehensive overview of these drugs and their effects.] Although forensic tests of blood and urine samples have limited utility since they cannot conclusively prove that drugs or alcohol were not present at the time of ingestion and they do not prove that a drink was 'spiked' rather than being consumed voluntarily, it might be expected that if drugs were being used as commonly as suspected that some evidence of their presence might be apparent. This however does not appear to be so. While there is no centralised register of blood and urine samples tested in relation to suspected drink spiking, data from the Forensic Toxicology Unit in Queensland, the Chemistry Centre in Western Australia and the Forensic Science Service in Tasmania all point to alcohol being a dominant finding.

Table 11: Summary of drugs commonly associated in the media with drink spiking

Drug	Legal status in Australia	Form of production	Time to onset of effects	Length of time in body	Effects of drug
Alcohol	Legal in Australia	Liquid	Variable	Variable	Disinhibition Reduced motor coordination
Flunitrazepam (Rohypnol)	Available by prescription in Australia	Tablet	30 minutes Peaks within 2 hours Can last up to 8 hours	48-96 hours in urine 12 hours in blood	Drowsiness Impaired motor skills Amnesia, dizziness Disinhibition
GHB *	Illegal in Australia	Powder or Liquid	10 – 30 minutes	Short	Euphoria Drowsiness Disinhibition Reduced heart rate
Ketamine	Legal in veterinary surgery Sometimes used as general anaesthetic for children	Powder, Liquid, Tablet	One to five hours	24-48 hrs in urine	Amnesia Insensitivity to pain Hallucinations
Benzodiazepines	By prescription to treat insomnia and anxiety	Tablet	Variable	Variable – From 12 hrs to 7 days	Drowsiness Difficulty concentrating Slow reflexes
MDMA (Ecstasy)	Illegal	Tablet	20 – 60 minutes	Up to 72 hrs	Euphoria Happiness Nausea
Amphetamines	Illegal	Powder or crystal	20 minutes Can last up to 12 hours	48-92 hrs	Increased energy Alertness Reduced appetite

* Gamma-butyrolactone (GBL) is a precursor to GHB and is a common ingredient in paint thinners.GBL and a similar chemical 1-4 butanediol are metabolised into GHB in the body when consumed.

Forensic Toxicology Unit, Queensland Health

Data on blood and urine samples suspected for drink spiking which were analysed by the Forensic Toxicology Unit, Scientific Services, Queensland Health between 1 January 2003 and 31 December 2003 were provided to the AIC. A total of 39 samples were analysed and Table 12 provides a summary of results. In only five cases was the presence of alcohol tested and in each of these cases alcohol levels ranged from 0.017 to 0.122. In 14 cases no drugs were found in the specimen, however, given that no time period was provided between estimated ingestion and analysis it is not possible to say with any certainty whether the negative findings mean that no drugs were ingested, or that the drug may have left the body by the time of testing.

Table 12: Summary of results from samples provided by Queensland Health Scientific Services between 1 January 2003 and 31 December 2003

	No.	%
Gender[(a)]		
Female victim	32	82
Male victim	5	13
Specimen type		
Blood only	7	18
Urine only	15	38
Blood and urine	13	34
Other	4	10
Drugs detected[(b)]		
None	14	36
Benzodiazepines	5	
Cannabis	6	
Methylamphetamine	4	
Ecstasy (MDMA)	1	
Other	6	
Total	**39**	**100**

Source: Qld Health Forensic Toxicology Unit Data 2003 [computer file]
(a) Gender of victims was unknown for two specimens.
(b) Ten specimens had not had analysis completed at the time the AIC received the data. Numbers do not total 39 because some specimens contained more than one drug. Note that no samples contained flunitrazepam, GHB or ketamine.

Chemistry Centre, Western Australia

Between 1 June 2002 and 30 June 2003 the Forensic Science Centre worked closely with the Western Australia Police Service in connection with community allegations of drink spiking in hotels and nightclubs (Chemistry Centre 2004). A total of 48 blood samples and 55 urine samples for alleged drink spiking were received by the Forensic Science Centre and analysed for the presence of drugs and alcohol. Initially the WA Police had suspected GHB had been used as the symptoms reported by victims were consistent with the usual effects of GHB. However, GHB was not found in any of the samples tested, although the Chemistry Centre acknowledges that since GHB rapidly exits the body the lack of a positive finding does not mean that it did not exist initially.

The drugs which were detected in the samples were:

- methylamphetamine (3 cases);
- amphetamines (1 case);
- MDMA (1 case); and
- cannabinoids (3 cases).

Blood alcohol was detected in 37 out of 48 samples, while urine alcohol was detected in 44 out of 55 samples. In particular, 17 out of 48 blood samples tested positive to a concentration of alcohol greater than 0.150 per cent, leading the Chemistry Centre to conclude:

> The overall results of these analyses do not support the widely held and publicised belief that drink spiking with drugs is rife in our community. The results do indicate however that the role of alcohol in these incidents needs to be more closely considered. It is apparent that many people do not fully appreciate the effects of alcohol and underestimate the deleterious effects it can have and its potential use as a stupefying agent. (p.16)

Forensic Science Service Tasmania

Between 29 November 1997 and 21 January 2004 the Forensic Science Service Tasmania received requests to analyse 33 blood and/or urine samples in relation to sexual assault. It is not clear whether these samples related to drink spiking specifically or drug facilitated sexual assault more generally. Of these 33 samples:

- four tested positive to alcohol only;
- four tested positive to alcohol and drugs;
- three tested negative to alcohol and drugs;
- 12 tested positive to drugs only;
- seven tested positive to cannabis; and
- four tested positive to the following impairing drugs (temazepam, diazepam, alprazolam, methadone and morphine).

Conclusions

Despite considerable media and public perceptions concerning the prevalence of drugs such as flunitrazepam, GHB and Ketamine being used in drink spiking, the evidence to date does not support these claims. Alcohol has tended to dominate results and it is not clear whether this is because (a) alcohol is commonly used to spike drinks, (b) other drugs have left the body and so only alcohol is left to detect, or (c) people are unaware how much alcohol they are actually drinking. The only way to test for the presence of drugs is to conduct scientific analyses. However scientific analyses can only confirm whether or not drugs or alcohol are in the body at the time of testing and cannot confirm that a positive result means that a drink was spiked.

This means that the value of scientific testing at least at present is limited in relation to confirming whether or not an incident of drink spiking has occurred.

Further, obtaining reliable data from forensic and therapeutic laboratories on tests conducted with blood and urine samples is currently a difficult task. There is no centralised register of samples tested specifically for drink spiking and, even within individual agencies, no database is kept which can be used to further knowledge about how often drugs are found in these samples. Hence it can be seen that the data presented above from individual agencies does not allow us to draw together a coherent picture of tested blood and urine samples. If we are to further our knowledge about the degree to which drugs are used in drink spiking, if we are to have any confidence in the findings from such tests and if we are serious about ensuring an evidence chain for the purposes of improving rates of prosecution, then it is recommended that:

- blood and urine testing be conducted as far as possible only with samples which have been provided within a specified time period since ingestion (to avoid false negatives);
- samples which are provided to forensic and therapeutic labs attach relevant information about the victim, such as whether and how much alcohol and/or drugs were self-reportedly consumed voluntarily by the victim, length of time since ingestion, types of symptoms in victim, suspected drug ingested;
- victims be encouraged to report to police and provide blood and urine samples as soon as possible after the alleged incident;
- individual forensic and therapeutic laboratories be actively encouraged to keep records of all suspected drink spiking samples which are submitted to them for testing with all relevant details and any findings from the samples; and
- a centralised register be established in each state and territory to record details of all suspected drink spiking blood and urine samples presented to and analysed by forensic and therapeutic labs.

2.6 Pulling it all together

What do we now know about drink spiking from the empirical evidence?

Prevalence of drink spiking in Australia

- It is roughly estimated that between 3000 and 4000 suspected incidents of drink spiking occurred across Australia in the 2002/03 financial year.
- Approximately one third of incidents are estimated to have been associated with sexual assault.
- About five per cent of incidents reported to the AIC Hotline involved robbery while three per cent of incidents reported to police involved robbery.
- Between 15 and 19 suspected drink spiking incidents are estimated to have occurred per 100,000 persons in Australia during 2003/03.

Age of victims

- In the AIC Hotline 41 per cent of incidents involved victims aged under 25, while in the police unit record data 51 per cent of victims were aged under 25 years. In the CASA House sexual assault data 12 per cent of victims were aged between 16 and 19 while 59 per cent were aged between 20 and 29 years.
- The vast majority of victims in all three data sources were aged under 34 years. Based on these findings it would appear that younger women are at greater risk of drink spiking.

Sex of victim

- 82 per cent of victims in the AIC Hotline and 87 per cent of victims in the police data were female. 96 per cent of victims in the CASA House sexual assault data were female.
- One to two victims in ten is male.

Location of incidents

- In the AIC Hotline and police data, about two thirds to three quarters of incidents occurred at a licensed premises.
- In the CASA House sexual assault data the location was more likely to be evenly spread with one fifth of incidents occurring at a licensed premises and a third of incidents occurring at either the victim's or offender's home.

Effects of drink spiking

- Effects such as memory loss, nausea, vomiting, lethargy, dizziness and unconsciousness were commonly reported by victims in both the AIC Hotline and police data.
- Memory loss was frequently experienced by victims in both the hotline (58%) and the police data (36%), indicating that memory loss for drink spiking victims is common.
- Unconsciousness was experienced by 30 per cent of victims in the hotline and 16 per cent of victims in the police data.
- Together, these findings for memory loss and unconsciousness suggest that it may indeed be difficult if not impossible for many victims to provide blood and urine samples within a short period of time after ingestion.

Knowledge of offender

- In 45 per cent of incidents reported to the AIC Hotline victims did not know who the offender was at all, 26 per cent had known the offender prior to the incident and 29 per cent did not know the offender prior to the incident.
- In the police data (where data were available) two thirds of victims did not know who the offender was while one third did.
- Many victims do not know the identity of the offender meaning that prospects of prosecution are low.

Relationship to offender

- In those cases where the victim could identify the offender, 40 per cent of offenders in the hotline data were strangers to the victim and 30 per cent were an acquaintance.
- This pattern was reversed for sexual assault drink spiking victims reporting to CASA House (where known), however, where 28 per cent of offenders were strangers and 61 per cent of offenders were acquaintances.
- These findings imply that while drink spiking may occur with strangers, known acquaintances can also be offenders and are more commonly offenders with sexual assault drink spiking victims. This has consequences for how education and awareness campaigns should be targeted.

Type of drugs used

- Knowledge of type of drugs used (if any) generally requires scientific analysis of blood and/or urine samples. The percentage of victims who had samples tested in both the hotline and police data were small. In the police data only five cases tested positive to benzodiazepines, six tested positive to opiates and two tested positive to amphetamines.
- Although difficult to say with any certainty, given that drugs can exit the body quickly and there is no centralised database which provides information on all drink spiking

samples submitted for testing, there is currently little evidence that drugs such as Rohypnol, GHB or Ketamine are used in drink spiking. Where samples yield positive results, alcohol has tended to dominate findings from forensic testing to date.

Type of drink spiked

- In the police data, of those cases where information was available, 87 per cent of drinks which were suspected to have been spiked were alcoholic drinks while 13 per cent were non-alcoholic.
- In the AIC Hotline data 78 per cent of drinks suspected to have been spiked were alcoholic.

Associated victimisation

- In the AIC hotline 16 per cent of victims had experienced sexual assault while five per cent had experienced robbery.
- In the police data the percentage of drink spiking incidents in which a sexual assault occurred varied by state. In general between 20 and 30 per cent of incidents reported to police involved a sexual assault.
- Based on the prevalence estimates it is estimated that about one third of all drink spiking incidents involve sexual assault.
- Sexual assault is the most common crime associated with drink spiking.

Reporting to police

- Levels of reporting of drink spiking to police are very low.
- In the AIC hotline one quarter of victims reported the incident to police.
- It is estimated that less than 15 per cent of sexual assault drink spikings are reported to police, and between 20 and 25 per cent of non-sexual assault drink spikings are reported to police.
- Forty-three per cent of victims who reported to police in the AIC hotline did so on either the day of the incident or the day after. Fifty-seven per cent of victims in the police data reported on the day of the incident or the day after. This means that about half of victims who report to police do so more than 48 hours after the incident occurred, reducing the likelihood that forensic testing will be able to detect any substances which may have been in the blood or urine at the time of the incident.

While some differences are evident between the police data, the hotline data and the sexual assault data, some similarities are also evident (see Table 13). All three sources of data point to victims being primarily female and relatively young. The police and hotline data both point to the fact that the majority of drink spiking incidents occur both in the absence of any additional victimisation and at licensed venues. It also appears from both the police and

hotline data that if incidents are reported to police they are most likely to be reported within seven days of the incident.

It is important to remember that these three sources of data differ from each other due to (a) police data reflecting only those victims who reported the incident, (b) hotline data reflecting a broader range of victims who may or may not have reported the incident and (c) sexual assault data reflecting only drink spiking victims who experienced sexual assault and reported it to CASA House. It is therefore quite striking to see such similarities between these data sources and points to the value in building the empirical evidence base through utilising as many data sources as possible.

Table 13: Comparison of findings between police data, AIC hotline data and CASA House data

	Police data %[(a)]	AIC hotline %[(a)]	CASA House data %[(a)]
Sex of victim			
Female	87	82	96
Male	13	18	4
Age of victim			
Under 25 years	51	41	-
25-34 years	33	28	-
35 and over	16	30	-
16 – 19 years	-	-	12
20-29 years	-	-	59
30 and above	-	-	29
Associated crimes			
Sexual assault	10	16	100
Robbery	3	5	-
None	83	76	-
Location			
Licensed venue	67	78	21
Private party	-	8	13
Victim/offender home	13	6	32
Hotel/motel	8	-	14
Other	11	8	20
Relationship to offender			
Family member/relative	-	-	10
Acquaintance	-	30	61
Partner/date	-	6	-
Stranger	-	40	28
Other	-	23	1
Time elapsed since reporting to police			
Same day	25	6	-
Next day	32	37	-
2-7 days after	28	45	-
8 or more days after	15	12	-
Memory loss	36	58	-

Sources: AIC Drink Spiking Hotline [computer file]; AIC drink spiking police data [computer file]; CASA House sexual assault data [computer file]

(a) Percentages refer to number of cases in which data were available.

Section 3.0 Discussions with stakeholders and emergent themes

This section of the report contains some of the most important qualitative information gathered for the drink spiking project. It condenses the opinions of key stakeholders on drink spiking into four sub-topics:

- perceptions of its prevalence;
- special concerns and issues;
- ideas for preventative strategies; and
- recommendations for the content of separate education / information kits for police officers, sexual assault counsellors, workers in the emergency departments of hospitals and workers in the liquor industry.

A total of 113 interviews[6] were conducted across Australia with police officers, sexual assault agencies, forensic scientists, government departments, hospitals, AHA representatives and service providers for the gay community. A list of all stakeholders interviewed is contained in Appendix A.

In relation to perceptions of prevalence, one common perception was that drink spiking with alcohol without any substantial motive is extremely common in Australia in licensed premises and private settings. The types of motives that stakeholders referred to included pranks, wanting one or several friends to 'have a good time' or to facilitate 'seduction'. Those who made comments on these forms of drink spiking were typically drawing on their own life experience rather than their professional capacities. Numerous references were made to parties with punches laced with more alcohol than the guests expected. Others recalled many slang terms – some of them decades old – used in pubs for a beverage with extra shots of alcohol, such as 'vodka bombs' (a glass of beer with a nip of vodka), 'leg openers' and 'mickey finns'.

However, the question of the prevalence of drink spiking (a) with alcohol or drugs and (b) for serious motivations, such as rape or robbery, drew a far greater variety of views. It is these views that are discussed in detail here.

The stakeholders approached drink spiking from very different angles, depending on their client group, motivations and interests. It was therefore important at the outset of the interviews to clearly define the parameters of this project. In particular, that the project primarily concerned 'drink spiking' (not just drug facilitated sexual assault) and any additional associated victimisation or motive – sexual assault, robbery, through to pranks or an attempt to liven a party. Stakeholders were also advised that drink spiking *might*:

[6] 99 face-to-face interviews and 14 telephone interviews.

- be perpetrated with alcohol;
- take place in any number of settings (not just licensed premises);
- involve male and female victims; and
- victims and perpetrators of different ages.

It was evident from the interviews that several important issues often overlapped in discussions about drink spiking, namely alcohol and drug abuse, sexual assault and drug-facilitated sexual assault. This overlap is not surprising given the different motivations and agendas of each stakeholder group.

Drug-facilitated sexual assault was often confused with drink spiking. Drug facilitated sexual assault overlaps with drink spiking only where a drug or alcohol is administered to a person *via a drink without their consent*. Although this report acknowledges the importance of drug-facilitated sexual assaults, it was important to draw the distinction between these crimes in discussions with stakeholders, given the aims of this project.

The broader issues of alcohol/drug abuse and sexual abuse obviously were not confused with drink spiking. However, since the interviews asked for stakeholders' opinions it is important to be aware how the background of some stakeholders could affect their perceptions of and beliefs about drink spiking. For example, interviews were conducted with government employees who work in the alcohol and drug sector. They tended to see drink spiking as part of a wider problem of ignorance of the dangers associated with excessive alcohol consumption and drug use. Sexual assault workers, on the other hand, often saw drink spiking as another manifestation of an endemic social problem: the use of sex to exert power and control. These examples of course do not encompass the wide range of views held by stakeholders within each of these groups, but serve to demonstrate how the meaning of 'drink spiking' has different hues and emphases – requiring quite different problem-solving strategies. The aim of this section is to collate the perceptions from different paradigms and attempt to provide a holistic understanding of how stakeholders perceive drink spiking.

3.1 Liquor Industry

Nine representatives of the liquor industry were interviewed from all states and territories. All representatives were members of the Australian Hotels Association (AHA). In addition, several representatives of state government liquor licensing commissions were spoken with.

Perceptions of prevalence

AHA representatives were unsure about the true prevalence of drink spiking and opinions about its prevalence varied markedly between stakeholders. A common view was that there is currently no empirical evidence on which to base a judgement about drink spiking and that solid data was necessary before opinions could be expressed about how and where drink spiking occurred.

The increased public attention to drink spiking was attributed largely to a media 'beat up'. The suggestion was also made that in many drink spiking cases the complainants may have either (a) drunk too much alcohol and made an innocent mistake when reporting drink spiking, or (b) were seeking to use drink spiking to excuse some behaviour or event.

Special concerns and issues

Understandably the AHA representatives expressed concern about the impact that drink spiking could have upon the businesses of their members. This should not be misinterpreted to mean that they were uncaring about victims of drink spiking. Rather, an emphasis on drink spiking occurring at licensed premises and public fear of drink spiking might affect the number of patrons frequenting licensed premises or in other ways could negatively affect business.

Some representatives empathised with the public fear of drink spiking. They tended to be interested in preventing a down-turn in patronage by adopting visible preventative strategies. They also hoped that the extent of drink spiking in licensed premises could be quantified by research and that this might dispel any inflated estimates held by members of the public.

Many of the AHA representatives were also worried that strategies to counter drink spiking could place unreasonable expectations upon licensed premises. Certainly the representatives were very aware of their legal responsibilities regarding the responsible service of alcohol. There was also a recognition of their responsibility to ensure that liquor is not 'corrupted' in any way that could affect customers. Yet some of those interviewed were eager to emphasise that drink spiking be thought of as a community problem and that preventative strategies were therefore a 'community responsibility' – not something to be borne by licensed premises alone.

There was also some concern that the police might attempt to place too much emphasis on the staff of licensed premises to prevent drink spiking and even to 'catch offenders'. One representative highlighted that whilst many establishments were interested in helping, there were limits to the amount of monitoring they could do. Although licensed premises are private property in many instances large numbers of the general public could effectively enter and leave at their will. This may mean that higher levels of monitoring of patrons require police involvement. In this vein one representative distinguished between licensed premises 'being responsible' and 'being *held* responsible' in regards to drink spiking.

Preventative strategies

It seemed relatively clear that licensed premises could differ markedly in the types of strategies that they were willing to endorse. For instance, some establishments would welcome an increased visible police presence. Others were concerned that this would reduce their regular clientele. Some establishments viewed displaying anti-drink spiking posters as an

admission to their patrons that 'drink spiking happens here', a message which most establishments would not wish to advertise.

A common idea proposed by the representatives was that the general public should be encouraged to take more care of themselves and their friends when they went to licensed premises. This included not accepting drinks from strangers, not leaving drinks unattended and being aware of symptoms – experienced by one's self or evident in others – consistent with drink spiking. Some AHA representatives thought it would be appropriate to have education about drink spiking incorporated into the national responsible service of alcohol course (information about this course is given in Section 5.1).

One practical suggestion was for licensed premises to have video cameras taping their entrances. The videotapes might detect if anyone escorted a drink spiking victim from a licensed premises. The value of this footage, of course, depends upon a complaint being made by the victim. The police would also need to collect the evidence before it was taped over.

Education/ Information kits

Most of the AHA representatives considered that basic and accurate facts about drink spiking – including its estimated prevalence – would be important information to include in the education kits. Some thought that specific information about how drugs might be added to drinks would be useful. Other recommendations included information about:

- being vigilant of behaviour consistent with symptoms of drink spiking;
- informing the management if a patron falls unconscious and keep the individual's glass;
- observing lone females;
- observing unattended drinks;
- being aware of unusual requests for beverages (such as a beer with a nip of vodka);
- being ready to report suspicious behaviour of other staff members; and
- crowd controllers should record in their incident notebooks a description of males escorting inebriated females away from a licensed premises.

Liquor licensing boards

Liquor licensing boards or commissions in each state and territory are additional stakeholders involved with the liquor industry, who can potentially make significant contributions to any future initiatives involving drink spiking. Primarily, these authorities are tasked with assessing liquor licenses and mandating requirements for licensees – including mandatory training courses such as the Responsible Service of Alcohol course (see Section 5.1). As such, their input is valuable in determining whether education regarding drink spiking could be introduced (if it has not been already) and whether it should be made compulsory or optional. The licensing authorities contacted in Tasmania, Queensland, Victoria and South Australia

discussed their role in the liquor industry and the South Australia Office of the Liquor and Gambling Commissioner raised the importance of involving the liquor industry in decision-making and that licensees' preference for training is (generally) that it be encouraged rather than mandated.

3.2 Police

A total of 31 police officers and civilian members of the police force were interviewed from all jurisdictions. The officers ranged in rank from constables to commanders. The interviewees either (a) occupied positions relevant to drink spiking, such as positions in drug squads, (b) dealt directly with the investigation of drink spiking cases, or (c) had been involved in anti-drink spiking initiatives.

Perceptions of prevalence

Perceptions of prevalence varied amongst stakeholders. A number of police officers around the country felt that drink spiking is a genuine problem that has increased in prevalence in recent years while others felt that awareness campaigns had increased reporting rates but not prevalence. Yet other stakeholders believed that many young people are unaware of how much alcohol they are drinking and attribute the effects of the alcohol consumption to drink spiking.

There was some suggestion that the prevalence of drink spiking may be higher in tourist regions of Australia and where young people tend to congregate. For example, the Gold Coast was suggested as having a higher incidence of drink spiking than other areas of Queensland due to its high tourism and 'schoolies' week.

Special concerns and issues

The issues raised by the police stakeholders in regard to drink spiking related to the nature of drink spiking, the role of alcohol and obstacles in drink spiking investigations.

The nature of drink spiking

For the more serious forms of drink spiking, most of the police stakeholders considered sexual motives to be more common than robbery or poisonings**.** A number of the police stakeholders suggested that victims of drink spiking could be any age and either sex. A small number of male victims of drink spiking had been encountered in some parts of the country. Some of these appeared to be sexually motivated cases and others were related to robberies. However, the bulk of those interviewed were concerned about females aged between 17 to 35 years. Transient people – such as tourists and backpackers – were also identified as being at risk.

Generally it was felt that a determined and savvy perpetrator could spike the drinks of even relatively cautious people. Still, naïveté and recklessness were identified as characteristics that might increase the chance of victimisation. Easy targets for sexually motivated drink spiking were those who were:

- too trusting of strangers;
- unacquainted with the 'pub scene';
- poor at sensing unusual social interaction; and
- lacked caution about the situations in which they put themselves.

The police stakeholders were more inclined to keep an open mind about typical offenders and were ready to state that little is known about them. One stakeholder commented that drink spiking in combination with sexual assault may be a type of crime which easily becomes a pattern of behaviour for some offenders. The reasoning was that after the first 'successful' drink spiking and sexual assault, offenders may be gripped by the ease with which the crime was perpetrated and the apparently low risk of detection.

The role of alcohol

Much attention was paid to alcohol when the police stakeholders were asked for their opinions on the substances used in drink spiking. The view that people may simply drink too much alcohol and then misattribute the effects to drink spiking was a common thread. Alcohol was also viewed as a substance that (a) could be used alone to perpetrate drink spiking with malicious motives or (b) could be combined with another drug to perpetrate such crimes. For the most part the interviewees did not express firm opinions on other substances associated with drink spiking, such as benzodiazepines, Ketamine or GHB. However, a couple of stakeholders were evidently dubious about the reputation of flunitrazepam as a substance commonly used in drink spiking. This was because the drug has so rarely been found in toxicology samples taken from drink spiking complainants. One stakeholder thought it was unlikely that perpetrators would use drugs – at least in the setting of a pub. He felt that it would be very difficult to accurately gauge the correct dose to administer for the victim to become relaxed without collapsing and attracting attention.

Obstacles in drink spiking investigations

A long litany of reasons was given by the police stakeholders as to why drink spiking is a very difficult crime to tackle. It seems that many genuine victims of drink spiking may never report their experiences because:

- they simply *never* realise what happened to them, for instance because they wrongly attribute their experience to their own alcohol consumption;
- they are unsure what happened;
- the substance they consumed caused memory loss and they are embarrassed or reluctant to make a vague report; or
- they suspect they were sexually assaulted by someone they know and are reluctant or scared to report the incident.

Even where the victim is aware of what happened to them and does report to the police the evidence necessary to continue the investigation may be difficult or impossible to collect. Frequently the victim cannot remember where the drink spiking may have occurred – such as the name or location of a licensed premises. Likewise, often victims cannot supply any information whatsoever about the person who may have spiked their drinks. Generally there are no witnesses to the crime that could provide this information in place of the victim.

In the few cases where there appears to be sufficient evidence collected for a strong prosecution case, the victim may not want to make a formal complaint or appear as a witness in court. This appears to be most likely to occur in drink spiking involving sexual assault. The police were sympathetic to sexual assault victims and understood that they may be fearful of a very emotionally confronting experience in court. Nonetheless, a certain frustration was expressed about a 'catch 22' facing the police; they usually need victims to participate in trials for a prosecution to be successful and for offenders to be 'caught' and yet the horrible nature of the crime and the difficulties facing victims throughout the prosecution process can easily dissuade victims from participating.

One stakeholder explained that an additional obstacle is whether blood and urine samples are collected properly by the agency to which drink spiking victims report, namely sexual assault services, hospitals or general practitioners. The main problem seemed to be that there are very strict rules of procedure governing the collection of evidence, such as blood or urine samples, as well as the passage of the evidence to the police and finally the court. If these procedures are not followed evidence may be inadmissible in court.

In other circumstances it may be the police who do not respond appropriately to drink spiking complaints and do not react quickly to gather evidence, including from blood and urine samples. Even when blood and/or urine samples have been taken by, for example, a hospital, if the police do not request the samples within a matter of weeks the hospital procedures require that the samples be destroyed.

Problems were also identified in relation to the way in which drink spiking is recorded by the police. Intelligence databases may not be structured in a way that drink spiking offences are actually highlighted when the system is reviewed. Other problems in the usefulness of databases may reflect the lack of clear procedures for police officers when they actually enter the data.

Alcohol was given special consideration by some of those interviewed. One view was that alcohol is not considered by the general public – nor indeed many police officers – to be a 'real' drink spiking substance. That is, in the public eye drink spiking is something that occurs with illicit drugs or pharmaceuticals, whilst lacing drinks with extra alcohol is a relatively innocuous activity. To a certain degree, it was argued that there is a *cultural acceptance* of drink spiking with alcohol across Australia. Arguably this may impact upon victims' choices to report, for instance because they do not view what has occurred to them as illegal or immoral, or because they believe no one will take their complaint seriously.

Another problem from the police perspective is that alcohol is not consumed responsibly, particularly by young people. It was widely felt that many people simply do not understand

what constitutes a standard alcoholic drink and this makes them ill equipped to gauge how much alcohol they are consuming. Deliberate, heavy binge drinking by young people places them at risk of sexual assault (without the involvement of drink spiking). However, it may also cause over-reporting of drink spiking incidents – when unconsciousness is attributed to a spiked drink rather than the amount of alcohol consumed. Many people may not be aware that amongst other things medication, the amount of food eaten and sleep deprivation may exacerbate the effects of alcohol. As noted previously, the police are also concerned about deliberate – as opposed to unintentional – false reporting of drink spiking. One implication of false claims is that they may make police officers less likely to respond to genuine cases in a classic 'boy who cried wolf' fashion.

Finally, one stakeholder was concerned that media coverage of drink spiking may actually be encouraging more people to try and perpetrate the crime. This worrying prospect may have implications for future strategies directed against drink spiking, particularly in respect to the amount of detail that is dispersed about the pharmacological effects of specific substances, where those substances may be obtained and so on.

Preventative strategies

Quite a variety of different views were expressed about strategies that the police and other agencies could use to confront drink spiking. Broad public education strategies were discussed, perhaps the broadest of which was education for high school students about the effects of alcohol and education about what constitutes consent in sexual relations. This long-term strategy appeared to be targeted towards:

- highlighting the risk of drug-facilitated sexual assault from binge drinking;
- dispelling perceptions that alcohol is not a 'real' drink spiking substance;
- explaining that sexual intercourse with inebriated or unconscious people is not only unethical but may well constitute rape; and
- confronting attitudes about women as sexual objects and male 'entitlements' to women's bodies.

Simpler public advertising campaigns were also recommended. Generally it was thought that the campaigns should specifically try to counter public hysteria about drink spiking whilst recommending basic protective strategies. These included not accepting drinks from strangers, not leaving drinks unattended in licensed premises and being vigilant about the safety of friends.

There was some disagreement about whether to challenge perpetrators and potential perpetrators of drink spiking in campaigns. A number of those interviewed thought it was necessary to adopt this strategy:

- so that the public was made aware that drink spiking is immoral and can be illegal and;
- to avoid a myopic message that concentrated solely upon potential victims – as if it is up to them *not to be victimised* – without discouraging offenders and potential offenders *not to victimise*.

On the other hand, some police stakeholders imagined that advertising campaigns directed against offenders and potential offenders would be ineffective and an unnecessary drain on resources.

A number of options centred upon police procedures. As well as education for general duties police officers about the effects of different drugs and the legislative provisions available to prosecute offenders, a number of stakeholders recommended clear procedures for responding to drink spiking complainants. It was suggested that the procedures should encourage officers to take allegations seriously and also encompass the collection of evidence.

Quite a defined strategy directed at drink spiking in licensed premises was described in Queensland. On the Gold Coast the police have concentrated upon maximising their uniformed and non-uniformed presence in licensed premises. The two main objectives of the increased presence are to (a) deter potential offenders and (b) to enforce licensing laws relating to the service of alcohol. By enforcing licensing laws, for instance fining licensed premises for serving alcohol to intoxicated patrons, the police hope to make the management more vigilant in detecting heavily intoxicated people and responding to their needs appropriately.

Education / information kits

Police

Education kits are being developed for police officers in Queensland but at the time of compiling this report they were unavailable. Recommendations for the content of future police officer education kits included explanations of:

- the drugs that can be used in drink spiking and their pharmacological effects;
- how long these drugs remain detectable in the blood and urine;
- why many complainants will have vague reports, with an emphasis on taking all reports seriously;
- clear procedures for the prompt collection of blood and urine samples as well as other evidence (witness statements, video recordings and so forth); and
- the different offences with which drink spiking perpetrators can be charged and the circumstances in which those offences apply.

Sexual assault workers, hospital emergency staff and liquor industry staff

Similar education kits were proposed for sexual assault workers, hospital emergency staff and liquor industry staff. As well as an explanation of the drugs, their effects and the importance of collecting blood and urine samples promptly, it was recommended that particularly hospital staff should seek second opinions in cases where they doubted the credibility of a complainant's story – for example by telephoning suitably trained police officers.

It was recommended that security staff at licensed premises write down identifying information, such as physical descriptions or license plates, of males they witness escorting inebriated females away from licensed premises.

3.3 Sexual assault agencies

A total of 25 stakeholders were interviewed from sexual assault agencies, the bulk of whom were counsellors. In addition, a significant amount of information was gathered from attendance at a bi-annual meeting of 30 sexual assault workers from different regions of NSW.

Perceptions of prevalence

Many of the counsellors reported that there has been an increase in the number of clients presenting to them where either (a) the client raises the issue of drink spiking or (b) the counsellor suspects drink spiking was a factor preceding the alleged sexual assault. Services in Sydney and the Gold Coast claimed that they had noticed a marked increase in suspected drink spiking cases since the very late 1990's. Those present at the NSW sexual assault workers' meeting felt that suspected drink spiking cases were rising in frequency.

Some stakeholders made reference to environmental factors that may affect the prevalence of drink spiking. One environmental factor mentioned was whether an area has a high density of popular nightclubs and licensed premises. Rural areas that were popular tourist destinations were considered to have a higher prevalence of drink spiking than some other regions. In some small towns it was suggested that the same women may be repeatedly victimised with sexually motivated drink spiking as well as other forms of drug-facilitated sexual assault.

Special issues and concerns

Sexual assault service providers expressed quite clear views about the underlying societal causes of sexually motivated drink spiking. In general they felt that a sizeable proportion of Australian society promulgates views of women as sexual objects and men's right to dominate female bodies. One view was that teenage males and females do not have a clear understanding of what constitutes consent in sexual intercourse. It was argued that pressuring others into sexual activity is commonplace as is having sexual relations with inebriated people. It was also suggested that particularly young men may not see much of a distinction between having sexual intercourse with a female who had become very drunk of her own accord and actually spiking the drinks of a chosen female to facilitate a sexual assault. Grave concerns that these views were widespread amongst students were made in relation to two university campuses.

Since they came in comparatively frequent contact with people who suspected they had been the victim of sexually motivated drink spiking, the sexual assault service providers were, like the police, ready to explain what they thought about typical victims, typical offenders and places where drink spiking occurs. However, it is important to note that the counsellors emphasised that the information that they received about sexually motivated drink spiking from complainants *may well not be representative* of what occurs in the wider community because:

- sexual assault victims are less likely to report assault perpetrated by people they know than assaults perpetrated by strangers;
- males may be less likely to report sexual assaults than females; and
- clients may simply make no reference to drink spiking in their counselling sessions and, since it is not the counsellor's role to probe for details, drink spiking may never be brought to the counsellor's attention.

More than any other stakeholder group, the sexual assault service providers highlighted why victims of drink spiking combined with sexual assault might be disinclined to report their experiences. Many references were made to the 'shame and blame' that female and male survivors of sexual assault experience. That is, in addition to psychological reactions to the assault – feeling unclean, violated and degraded – victims may blame themselves for what they perceive as contributing to the assault. Examples of such contributions might include the clothes they wore, how much alcohol they had to drink, or simply for being 'so stupid' by allowing themselves to get into a dangerous situation.

Intertwined with this is the fear of how their friends and family may react; many victims worry that others will blame them – even angrily – for what occurred. Victims may be frightened to tell their parents about an assault because it would reveal that they were at licensed premises under the legal age. Other social considerations may add to their distress, such as the concern that their report would also cause trouble for their friends who accompanied them under age to a licensed premises. Worse fears may relate to physical violence or retribution from the perpetrator if they reveal the assault. Male victims of drink spiking and sexual assault may not report their experiences because of a lack of sexual assault services specifically designed to respond to males.

As noted above in the police stakeholder section, some victims of drink spiking may be unwilling to report to the police because they simply cannot remember many details. Others suggested that some victims may have negative views of the police that discourage them from reporting. The stakeholders themselves varied to some degree in their opinion of the police. In one jurisdiction the stakeholder gave a vivid example of how general duty police officers responded inappropriately to a sexual assault victim. The victim was caused additional trauma and decided to withdraw her formal complaint to the police – despite the fact that solid evidence existed in support of her case.

At times those interviewed intimated that from their perspective the police were more often focused upon successful prosecutions than the wellbeing of the victim. Balancing the different foci of (a) sexual assault services (caring for survivors of sexual assault) and (b) the police (protecting the community and seeking justice through prosecutions) can arguably be a source of tension between the two agencies around the country.

Different systemic problems were associated with the collection of blood and urine samples. As noted elsewhere in the report, forensically trained physicians follow strict procedures to gather biological evidence in a manner that satisfies the courts. Some stakeholders suggested that sexual assault agencies, hospitals and even small medical centres vary greatly in their ability to access forensically trained personnel to take blood and urine from (willing)

complainants. This may thwart prosecutions even where the victim is completely willing to participate as a witness.

Access to forensically trained personnel was just one of many barriers that may be faced by drink spiking complainants in rural areas. Face-to-face counselling for sexual assault survivors may be unavailable. Indeed the distance needed to travel to the police may cause delays in the collection of biological evidence. It was suggested that small communities may be more restrictive for victims in the sense of disclosing sexual assault; amongst other things victims feel too worried that the whole community will find out about the incident and judge the victim negatively.

Preventative strategies

A number of long-term broad strategies were identified to tackle drink spiking and especially sexually motivated drink spiking. Some stakeholders believed that community attitudes had changed over the decades towards domestic violence to some degree. This was attributed to ongoing programs targeting cultural attitudes. In the same vein it was felt that long-term campaigns needed to tackle attitudes towards 'ethical' sexual relations. Another suggestion was that any such campaign should focus equally on highlighting for males the features of positive relationships that might be emulated as well as negative behaviours that may be illegal and/or unethical. It was also recommended that any campaigns should address myths about rape, for instance that rape is mostly perpetrated by strangers.

A number of stakeholders recommended that primary school children should be educated about respectful relationships and high school students educated about consent in ethical sexual relations. Early intervention for juvenile sex offenders was considered by two stakeholders to be an important preventative method for all sexual offences, including sexually motivated drink spiking. In Victoria, MAPPS (Male Adolescent Program for Positive Sexuality) is a cognitive behaviour based module that has the potential to reduce adult sexual offences. One suggestion was that different early intervention programs could be directed at children and adolescents who perpetrated crimes that suggested a lack of empathy, such as cruelty to animals, severe bullying and so forth.

Another view was that drink spiking should be incorporated into the government drug sector as an issue of harm minimisation. In this sense drink spiking was equated to other dangerous drug-related behaviours, such as drink driving and sharing needles for intravenous drug use. The harms that should be highlighted with drink spiking include physical injury and emotional/psychological trauma. The benefit of including drink spiking into an ongoing program is that the crime could be kept in the public mind for years, as opposed to short and intense media campaigns that are eventually forgotten. A similar idea was that drink spiking could be incorporated into the current national strategy against domestic violence.

Media campaigns explaining to the public ways in which people could protect themselves and others from drink spiking in licensed premises were generally viewed favourably by the stakeholders. It was also felt that (a) victims of drink spiking should be encouraged to report their experiences and (b) processes should exist for victims to make reports anonymously to

the police. However, generally it was thought that such campaigns should avoid causing panic. Further, some stakeholders urged that media campaigns should carefully avoid any messages that could be construed as 'victim blaming'. That is, some of those interviewed worried that messages that focused solely upon protective strategies could reinforce social beliefs than the onus lies upon potential victims to avoid sexual assault. For this reason, several stakeholders thought that media campaigns should target male attitudes that underpin drug and alcohol assisted sexual assault. One suggestion was that a prominent male sporting figure could be involved in such a campaign. Some suggested that campaigns directed at males should not be stigmatising of males in general.

Specific strategies for universities were recommended by one group of student counsellors. From their experience they thought that story-driven examples were an effective way of underscoring basic dangers which could be included in introductory lectures for first year students. Another specific strategy proposed was basic information about the dangers of (a) drink spiking and (b) drug-facilitated sexual assault for the thousands of high school students that holiday on Australia's east coast after their exams.

Education / information kits

Police

The sexual assault stakeholders recommended that education kits for police officers focus on interactions with drink spiking complainants. Specifically that:

- vague stories should not be dismissed as lacking credibility even if the complainant appears to still be under the influence of drugs or alcohol;
- where drink spiking is a possibility the complainants should be asked if they are willing to undergo a physical examination to search for signs of sexual intercourse, regardless of whether the complainant has made sexual assault allegations; and
- officers should deal with victims respectfully and particularly avoid pressuring victims of sexual assault into making formal complaints.

Finally, it was suggested that if police officers were searching a suspect's house they should search (a) for photographs and (b) examine computers and related equipment for images of the complainant.

Sexual Assault Workers

Again it was recommended that full physical examinations be offered to the complainant when the counsellor suspects drink spiking. If the complainant is prepared to give blood and urine, two sets of samples should be taken. One set can be sent to a hospital or therapeutic laboratory. The other set can be taken and stored according to the procedures surrounding the

chain of evidence. This allows the complainant some time to decide whether they want to make a formal complaint to the police and submit forensically gathered samples for examination by forensic laboratories. Finally, it was emphasised that the kits should encourage counsellors not to ask leading questions about drink spiking from their clients.

3.4 Service providers for the gay community

The gay and lesbian community has to date been neglected in drink spiking research, yet it is likely that drink spiking may not only occur within this community, but that the issues relating to drink spiking may be somewhat different from those affecting young people generally or females overall. Drug use at gay clubs is a common occurrence and the variety of drugs used for recreational purposes is considerable. Recreational drug use at gay clubs may comprise cannabis, ecstasy, amphetamines, cocaine, amyl nitrate, ketamine, solvents and GHB (Deehan & Saville 2003). The regular recreational use of these drugs means that they are both more likely to be readily accessible and therefore potentially more easily slipped unnoticed into drinks. The consequences of drink spiking in the gay community may also differ somewhat in relation to levels of sexual assault and robbery and it is unclear what proportion of incidents are likely to be reported to police.

Representatives from three service providers for the lesbian and gay community were interviewed. Although the number of interviews with these stakeholders is small, valuable information was provided in the interviews which can assist in identifying issues about drink spiking relevant to this community. It can also assist in highlighting areas for future research.

Perceptions of prevalence

The stakeholders' perceptions of the prevalence of drink spiking differed noticeably. One respondent simply stated that drink spiking was not considered a problem by the gay community and was rarely ever discussed. Another stakeholder did not perceive drink spiking as a crime that normally affected the gay community to a higher degree than any other section of society. However, he believed that there had been one period where sexually motivated drink spiking was occurring frequently, targeting particularly young men and youths. Anecdotal reports made to him and other staff suggested that a series of drink spiking incidents occurred over a two to three month period at two particular nightclubs. He estimates that between 20 and 30 young men, some of whom were under the age of 18, related similar stories concerning these two nightclubs. The complainants remembered being in one of the clubs, blacking out and then awakening in a hotel or a 'squat'[7] with physical injuries consistent with anal rape. Approximately half of the youths remembered consuming one or two drinks in the nightclub. The stakeholder could not remember if any of the reports made specific reference to accepting drinks from others. However, he highlighted that the youths were vulnerable to drink spiking because (a) some of them lived 'on the streets', were poor and might have been ready to accept drinks, (b) many of them were naïve in regard to nightclubs, the 'gay scene' and alcohol consumption and (c) they were unlikely to have been accompanied by savvy friends who could protect them.

One stakeholder believed drink spiking to be an ongoing threat to the gay community and that it has been increasing in recent years. He stated that they have received six reports of suspected drink spiking followed by sexual assault from gays (with no reports from lesbians).

7 A 'squat' is a slang term for a house or unoccupied building which is inhabited on an unlawful basis

There were also six to eight reports of drink spiking where the victim had been robbed. He suggested that the similarities in robberies indicated that the same individual or individuals had developed drink spiking as part of a modus operandi. All the incidents appear to have taken place in the same licensed premises, a nightclub. The complainants were either alone or lured away from their friends by a stranger. On the assumption that the stranger was interested in casual sexual relations the complainant would agree to a suggestion to travel to their own home. Once inside the complainant's home the pair would have a drink, the complainant would fall unconscious and awake to find many of their valuables missing.

Special concerns and issues

One service provider expressed some concern about the possibility of the media reporting that gay men had been the victim of drink spiking and robbed in their own homes. He stated that in the past reports about gay hate crimes had resulted, apparently, in 'copy cat' behaviour. He was concerned that the media effectively explaining a modus operandi for drugging and robbing gay men might encourage others to perpetrate the same crime.

Preventative strategies

Two of the service providers emphasised that they would like to see advertising campaigns that did not focus upon young women as potential victims of drink spiking. Males too, they urged, should be aware of the potential dangers regardless of whether they identify themselves as gay. One provider was dissatisfied with previous advertising campaigns for other reasons. He felt that some messages about drink spiking promoted fear of licensed premises and busy nightspots in particular. A more realistic approach he thought would be to, first, recognise that people want to 'go out and have a good time' and, second, to encourage people to look out for their friends and others. By this he meant watching other's drinks and to be aware of any symptoms consistent with drink spiking. Interestingly, he perceived some messages directed towards young women as moralizing. In particular encouraging young women to plan how to get home safely he felt ignored that they might want to spend the night in the home of a stranger. Similarly, it was thought unrealistic to discourage women or men from accepting drinks from strangers when this is an everyday means of social interaction.

Finally one service provider also took exception to what he regarded as inconsistent messages about the effects of alcohol upon women and men. He felt that some of the advertising material produced warned women that because alcohol is a disinhibitor it may lead them to consent to sexual intercourse in circumstances that they would later regret. On the other hand the material highlights that men may use alcohol as an *excuse* for their behaviour. These messages, in his view, implied that alcohol disinhibited females but not males.

Education/ Information kits

It was suggested that education kits for liquor industry staff explain:

- the physical symptoms that drink spiking victims might exhibit; and
- that both sexes may be victims.

3.5 Hospitals and medical centres

Interviews were conducted with senior staff from three hospitals as well as staff from two medical centres.

Perceptions of prevalence

Perceptions of prevalence varied amongst stakeholders. The Sir Charles Gairdner Hospital in Western Australia evidently considers the issue of drink spiking to at least be worthy of investigation. It is currently conducting a project that takes samples from all complainants that report to the hospital within 12 hours of the alleged incident.

Special issues and concerns

One stakeholder in an emergency medicine department highlighted various pressures and considerations that affected the hospital's response to drink spiking complainants. He explained that the emergency department's primary focus in dealing with complainants is critical care. That is, to assess the medical condition of the patients that present in the emergency section and to treat those patients. Obviously treatment is avoided where it is deemed unnecessary because of, amongst other things, the cost implications and the drain on resources. An additional cost involved in responding to drink spiking complainants – and others who have ingested dangerous substances – is the analysis of blood and urine samples. The hospital is reluctant to examine blood and urine samples unless the complaint relates to a recent incident and there is a good chance of identifying substances which may be currently affecting the complainant's health. Consequently, patients who report drink spiking several days or weeks after the alleged incident generally only require a cursory examination to verify that they are in good health

One medical centre raised different issues. Many complainants visit the centre after hours, having come straight from a licensed premises and they may still be intoxicated. Apparently, some drink spiking complainants have become angry with doctors, often expecting immediate action in terms of taking blood and urine samples. These complainants are not prepared for doctors to make their own determination about whether drink spiking has occurred. Some patients have even expected doctors to visit the licensed premises from which they came and try to secure evidence there. It was suggested that many of these complainants should have presented directly to the police – particularly because they wanted investigations to occur.

Preventative strategies

One hospital stakeholder recommended that a central data collection system be developed that covered all the emergency departments in hospitals across Australia. His idea was based upon an initiative in the United States called the Drug Abuse Warning Network system (DAWN). The system would be used to track the appearance of different drugs in cases encountered at

the hospital, mainly drug overdoses but also drink spiking. The system would be extremely beneficial, it was suggested, for a variety of epidemiological studies as well as for detecting trends in drink spiking.

Other brief recommendations were that the public be encouraged to drink bottled or canned beverages at licensed premises to make drink spiking more difficult. Additionally, it was suggested that media campaigns try to avoid causing panic and advise complainants to present to the police – not medical centres – if they are seeking immediate investigation about an incident. Finally, one stakeholder urged that senior members of staff in emergency departments should be provided with any evidence of drink spiking in their region or around the country. This information could be important in re-assessing policies concerning appropriate responses to complaints consistent with drink spiking.

Education /Information kits

Information about types of drugs appearing locally and recently in drink spiking.

3.6 Forensic scientists and physicians

Eleven stakeholders in this category were interviewed, several of whom work at forensic laboratories and have expertise in toxicology or pharmacology.

Perceptions of prevalence

All the analysts interviewed agreed that *allegations* of drink spiking have increased dramatically in the last three to five years. For instance, the Department of Analytical Laboratories in NSW estimated that the number of samples tested for drink spiking allegations had increased between five and tenfold since 1999.

Most of the stakeholders believed that drink spiking occurs but could not say whether it is increasing. The decision to reserve judgement appeared to be motivated by a belief in scientific principles. That is, they felt there was not enough empirical evidence to make an informed estimate of the prevalence of drink spiking and whether drink spiking has been increasing.

Alcohol was found commonly in the samples tested by some laboratories. But the interviewees were reluctant to interpret this to mean that alcohol was necessarily used as a drug for drink spiking when it could be due to voluntary consumption. Importantly, none of the stakeholders had analysed a sample which clearly indicated the existence of abnormal levels of GHB. The analysts preferred to conclude that they did not know whether GHB was used in drink spiking, partly because it is metabolised quickly and disappears from the body and therefore *may* simply have escaped detection.

Special concerns and issues

Collection of blood and urine samples

The analysts universally emphasised that to maximise the chance of detecting substances in blood and urine, the samples should be taken as soon as possible after the alleged incident. It should be made quite clear that the analysts were sympathetic towards potential drink spiking victims. They understood the range of emotional and practical reasons that might delay – or altogether prevent – potential victims from presenting to an agency that could take samples from them. However, in some cases the delay has not been caused by the victim themselves, but rather the agency responding to them. One analyst claimed that in some cases he found that the police had delayed taking samples by two hours and suggested that even this short delay may have been critical. Many of the stakeholders mentioned that it is preferable that both blood and urine samples be taken.

Information reporting to forensic laboratories

In the interviews some very clear systemic problems were identified that impinge upon the ability of the forensic laboratories to analyse samples in alleged drink spiking cases. The forensic scientists emphasised the need for very clear reports from the police to be attached to the sample submitted for testing. The laboratories were generally satisfied with the majority of the police reports. One analyst suggested that about 70 per cent of the reports that the police filed with samples contained sufficient information. Another analyst noted that the standard of the police reports fluctuates, depending on the efforts of personnel conducting specific managerial positions. The analyst referred to some periods where senior officers have encouraged junior officers to maintain a consistently high level of reporting practices. However, changes of personnel in the managerial position have at time resulted in a very noticeable slide in reporting practices. In the worst cases the laboratories received samples from the police with a note attached simply stating 'suspected drink spiking'.

What sort of information do the forensic laboratories need to know? As noted previously, testing samples for traces of drugs is a complex task. The process of conducting screen tests and confirmatory tests involves a large degree of discretion – amongst other things, what drugs to search for, what tests to conduct and, importantly, deciding *when* to stop analysing a sample. There were five types of information that the laboratories identified as essential or at least very useful for the analysis of samples:

- an estimation of the time between the alleged drink spiking incident and when the blood and/or urine samples were taken from the complainant ('latency');
- a full description of the symptoms experienced by the complainant;
- a record of the quantities of drugs or alcohol the complainant reported voluntarily consuming, if any;
- a record of any drugs administered to the complainant at hospital; and
- a general description of the surrounding facts of the case.

Previous sections of the report have explained the rate at which traces of most drugs disappear from the body. Latency may affect the analysts' decision as to whether to conduct tests at all. Where the time between the alleged incident and the taking of the samples exceeds 72 hours there is little chance that any of the drugs associated with drink spiking can be detected. Some drugs are undetectable in less than 12 hours. Since the laboratories have limited resources, information about latency promotes efficiency. Additionally, latency gives the analysts an idea of the quantities of drugs that they will attempt to detect. A long delay that is nevertheless theoretically within the accepted 'window of opportunity' for a particular drug may lead the analysts to use very sensitive confirmatory tests. Where drugs are detected and quantified the latency will become very important in interpreting the results. For instance, if drug X leaves the body at a reasonably predictable rate then analysts can use the latency to estimate how much of drug X was originally administered to a drink spiking victim.

Knowledge of the symptoms experienced by the complainant gives the analysts clues as to which drugs to search for and therefore what types of tests to conduct. For example, unlike some tests that can detect a number of drugs simultaneously, a particular test is required to detect ketamine and GHB. Since ketamine can induce hallucinations as well as drowsiness, cases that included symptoms such as these might lead analysts to search for ketamine.

Obviously it is important for analysts to be aware of any drugs, legal or otherwise, that the complainant has taken of their own accord, including medications. Such information could be crucial in interpreting the results in a wide variety of complex scenarios. By way of example, anti-inflammatory medicines can on occasion interact with other substances present in the urine. This can cause tests to falsely indicate the presence of an illicit drug – one that was never ingested by the complainant (Visher & McFadden 1991). Likewise it is critical to be aware of any medications that the complainant may have been administered at hospital before the sample was taken. In some cases, distraught sexual assault victims that present to a hospital may be given a sedative, such as a low potency benzodiazepine. Clearly, in analysing blood and urine samples, this could be mistaken for a drug that was administered via a spiked drink.

Finally, one of the analysts stated that it was useful for the police to report the general facts of the case, or at least as much as the complainant can remember. General facts might include the information described above, but also age, sex, time, where the complainant can last remember being, who they were with, in what state they awoke and so on. In reality this information provides the analysts with an idea of the *credibility* of the story. A stereotypical questionable story might involve a complainant who admitted drinking large quantities of alcohol until late at night, cannot remember a period of the evening and woke in their own home dishevelled. Indicators of credibility would include (not exclusively):

- no self-reported alcohol consumption;
- accepting a drink from a person;
- substantial loss of memory and awakening in a strange place with valuables missing; or
- clear signs of sexual intercourse.

The more credible a story seems to the analysts the harder they may try to analyse samples taken from the complainant – for instance by testing for drugs of increasing obscurity[8]. The impact of credibility upon the efforts of the laboratory is completely understandable given the resources necessary to analyse a sample. Unfortunately, the inherent nature of drink spiking means that many victims may not appear to have credible stories simply because:

- they cannot remember many details;
- their drink was spiked after they had voluntarily consumed a lot of alcohol; or

8 Sometimes the analysts may consult with the police on their findings and the progress of the analyses (personal communication, 23/10/03). Ultimately the police may decide whether to progress, for example, from screen tests to confirmatory tests.

- it is not obvious that they were sexually assaulted or robbed.

These issues cannot easily be resolved and, while perceived credibility may be a necessary indicator of how and whether to proceed with sample testing for labs which are clearly stretched in terms of resources, it should not be assumed that lack of 'obvious' credibility means that a drink spiking incident has not occurred. The circumstances surrounding and consequences of, drink spiking can vary enormously and a 'credible' story is not going to be available in many drink spiking situations.

Costs

None of the analysts actually complained about insufficient resources for their own laboratories. In fact often they were quite satisfied with their instruments. Rather, their concern was generally for other agencies. As the paragraphs above indicate, analysis is time consuming and resources are finite. Analysing blood and urine samples can become very expensive and this cost is generally borne by the police where the samples are sent to a forensic laboratory, or by a sexual assault service or hospital where the samples are analysed by a therapeutic laboratory. One confirmatory test can detect and quantify a number of different substances without any additional cost. However, in some situations the opportunity to test for multiple substances in one confirmatory test may be missed. For example, the police may direct the laboratory to search for a particular drug that they are confident was used to spike a drink. If the confirmatory test for that drug is negative, the laboratory may be asked to conduct further confirmatory tests. Additional confirmatory tests, focusing on additional substances are more expensive than an initial request to conduct several confirmatory tests at the one time.

Preventative strategies

The preventative strategies identified by the forensic scientists and physicians were practical ideas relating to the problems just discussed:

- Emphasise to relevant agencies the importance of rapidly collecting both blood and urine samples from drink spiking complainants where consent is granted.
- Increase awareness among the general public; specifically that toxicology evidence rapidly disappears from the body. People who suspect that they have been the victim of drink spiking should present promptly to an agency of their choice and consider giving blood and urine samples.
- It may also be appropriate for potential victims to collect their own urine in some circumstances. That is, if after awakening an individual suspects that they have been the victim of drink spiking and they feel they must urinate before they can reach the police (or another agency), they should collect their own urine and present this to the agency for testing. This first urine after a drink spiking victim has awoken may contain vital evidence of the substances they have ingested over the previous day – substances no longer evident in the blood.

- Suitable containers should be used by all relevant agencies when taking blood samples to preserve the blood.
- Clear and comprehensive reports must be attached to the blood and urine samples submitted to laboratories for testing. These reports should contain the information listed above.
- Agencies that collect samples must ensure that both blood and urine be collected wherever possible to avoid the additional cost of conducting screen tests with blood.

Education / Information kits

For police, sexual assault workers and hospital emergency staff:

- an emphasis on the importance of gathering both blood and urine samples without delay;
- personnel qualified to take samples should be informed of using the appropriate blood vestibules that preserve blood samples; and
- for police officers the kit should explain the importance of supplying full reports when submitting samples for testing to forensic laboratories.

For the liquor industry:

- the education kits should contain information about the preservation of evidence in licensed premises. If, for example, it seemed that a patron had had their drink spiked – for instance if they had fallen unconscious at the bar – to preserve their drink in the original glass. The drink itself could be analysed by forensic scientists at a later date.

3.7 Government sector / Other stakeholders

Interviews were conducted with a total of 28 stakeholders from government and other sectors, including the drug and alcohol sectors and policy divisions for women.

Perceptions of prevalence

Again, perceptions of prevalence varied amongst stakeholders, with some believing that there has been an increase in drink spiking and others unable to comment. Consistent with the reports from police officers and sexual assault services in Queensland, one stakeholder from that State spoke specifically about the prevalence of drink spiking in different regions. He stated that it seems that drink spiking is a significant issue in Brisbane, the Gold Coast, the Sunshine Coast and the Whitsunday Islands – generally any 'party zones' which have a high tourist trade and can tend to be highly sexualised areas.

Special issues and concerns

Of the stakeholders who had come in contact with complainants, drink spiking was considered to be a very easy crime to perpetrate and a difficult crime to detect. In the adolescent setting it was suggested that sexually motivated drink spiking did occur and that predominantly this was driven by perceptions of male 'entitlement' over women's bodies. There may also be group dynamics encouraging and inciting drink spiking to take place. It was suggested that teenage cliques may require outsiders to perpetrate drink spiking against a chosen victim as a means of initiation into the group.

Clearly some of those interviewed viewed drink spiking as a phenomenon linked to cultural attitudes, especially the use of alcohol by males to encourage females to engage in consensual sexual activity. It was suggested that this attitude is widely accepted amongst adult males and females, as evidenced by the special offers licensed premises give for female patrons, such as free champagne and even 'all you can drink' functions for university students. It was suggested that many males also consider that spiking drinks with alcohol to facilitate 'seduction' is also acceptable. Similar to those interviewed from the sexual assault stakeholder group, one interviewee expressed concern that in this context some males may not view drink spiking followed by non-consensual sexual intercourse with an unconscious woman as illegal.

Stakeholders from the alcohol and drug policy sector gave a detailed perspective about public attitudes to alcohol. They argued that to date government funded media campaigns have focussed upon the harms associated with 'hard drugs' or 'street drugs', such as cocaine, heroin, amphetamines and ecstasy. For this reason the stakeholders believe that the general dangers associated with alcohol in the public's mind is drink driving. That is, as long as one is not intending to drive there are no real dangers in drinking as much as possible. Insufficient

focus has been paid to the potential for sexual assault or unwanted sex as a significant problem at the policy level or in advertising campaigns[9]. Evidence they pointed to included the results of the National Drug Strategy Household Survey of 2001 First Findings (Australian Institute of Health and Welfare 2002)**.** Notably, in the 14-19 age bracket:

- females were more likely than males to consume alcohol at 'risky' or 'high risk' levels (14.6% compared to 8.8%) for long term harm;
- 21 per cent of females put themselves at risk of 'alcohol related harm' at least on a monthly basis; and
- 12 per cent of females put themselves at risk of 'alcohol related harm' at least on a weekly basis.

Comments also focused on the issue of 'ready to drink' alcoholic products, known as RTD's. RTDs tend to be a mixture of vodka and carbonated soft drink. They have attracted much criticism from various quarters as being deceptive in their potency. That is, they do not taste strong – which might attract inexperienced drinkers – and yet contain more alcohol than beer. However, the stakeholders noted that only certain RTDs are more potent than beer. They also believed that if consumed responsibly RTDs might make drink spiking more difficult because of the narrowness of the containers' opening compared to glasses.

Preventative strategies

The government sector stakeholders provided valuable information about strategies to counter drink spiking. Some concern was expressed about which government departments should oversee the strategies against drink spiking. One stakeholder urged that the police should steer strategies with cooperation from other government departments. Another recommendation was that cooperation between sexual assault agencies and the drug sector is important to ensure that balanced messages are given to the public about drink spiking. In particular it was feared that a focus upon sexually motivated drink spiking might down play the illegality of other types of drink spiking and thereby:

- dissuade victims of other types of drink spiking to report their experiences; and
- encourage a perception that drink spiking is only a crime when it is followed by sexual assault.

An interesting example of an anti-drink spiking strategy exists in Queensland and has been led by the Alcohol, Tobacco and Other Drug Services sector of Queensland Health in conjunction with other agencies including the police and liquor licensing. Amongst other things the strategy aims to mobilise social capital and empower community groups around the State to conduct anti-drink spiking campaigns in local settings (see further Section 5.5).

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9 See <www.alcoholsummit.nsw.gov.au>.

As with most of the other stakeholder groups, interviewees expressed different opinions about the types of messages that should be broadcast to the public in anti-drink spiking campaigns. Again, a common concern was that messages about preventative measures should not reinforce beliefs that sexual assaults are often the fault of the victim. Additionally, a number of those interviewed recommended a cautious approach in directing messages towards potential perpetrators. It was argued that perpetrators are not a homogeneous group and therefore it would be difficult to find an appropriate message to direct at them. One danger is that messages directed at perpetrators or potential perpetrators would be stigmatising and ultimately exacerbate criminal behaviour. On the other hand another stakeholder emphasised that advertising campaigns must not inform the public about how best to perpetrate drink spiking, for instance by explaining the exact effect of certain substances.

Legal strategies were also raised by some stakeholders. Generally the stakeholders thought that an increase in successful prosecutions of drink spiking was essential because:

- of the strong message it would deliver about community disapproval of the behaviour;
- this would increase awareness about the illegal nature of many forms of drink spiking; and
- it may act as a form of deterrence.

Some consideration was given by different stakeholders to the use of peer education in modifying male behaviour towards females. A peer education program has been conducted in South Australian high schools for several years now. The program employs male and female 'peer educators' aged 18-26 to talk to teens about a number of topics including drug-facilitated sexual assault and the hallmarks of respectful relationships. The aim of the program is to prevent abusive patterns of behaviour developing and to date over 9000 students have participated in South Australia. It was suggested that this type of program could be emulated in other jurisdictions to deal with drink spiking in a broader context of avoiding abuse and seeking respectful relationships.

Education / information kits

Generally it was felt that some information was suitable for all stakeholder kits. It was suggested that the kits should contain accurate information about the general features of drink spiking, such as typical symptoms and that drink spiking can occur in apparently a limitless number of contexts. It was also suggested that the kits explain that for many people the decision to report drink spiking is not taken lightly and also that complainants should not be dismissed purely on the basis that they appear to be intoxicated.

Information considered necessary for the police kits included:

- a clear explanation of the processes for recording data into police computer systems to ensure an accurate reflection of the number of drink spiking complaints;
- the importance of responding to drink spiking complaints with consistency;

- the appropriate procedures for responding to male complainants of sexual assault; and
- the importance of searching for all types of evidence to support a victim's complaint to avoid an over-reliance upon biological evidence from blood and urine samples.

For emergency workers in hospitals it was also thought that the kits should explain simple procedures for recording de-identified information that could later be passed to the police. Suggestions for information to be included in the kits for the liquor industry were that:

- anti-drink spiking advertising material be displayed in a prominent part of the licensed premises;
- staff should be prepared to arrange transport for patrons who appeared to be suffering the symptoms of drink spiking; and
- security staff ask for identification from males who are noticed escorting heavily inebriated females away from a licensed premises.

3.8 Conclusions

It was well accepted amongst stakeholders that spiking drinks with alcohol for pranks or entertainment is widespread and even a norm. However, views of drink spiking combined with more sinister motives, such as sexual assault or robbery, were remarkably disparate. The continuum of views about sexually motivated drink spiking ranged from a belief that Australia is experiencing a 'wave of perfect crime', through to a belief that sexually motivated drink spiking is 'an urban myth'. The bulk of stakeholders were alarmed at anecdotal evidence of drink spiking but preferred to reserve judgement as to the accuracy of the anecdotal reports. Variation in views existed between members of the same stakeholder groups, with the exception of the sexual assault counsellors who consistently felt sexually motivated drink spiking is a common problem (see Table 14).

The stakeholders based their views on very many experiences and sources of information, including personal encounters, media reports, rumours, police investigations, prosecutions and their knowledge of drugs and alcohol. A common belief that persuaded some stakeholders to doubt the seriousness of drink spiking is that complainants misinterpret the effects of their own alcohol consumption and/or drug use as signs of drink spiking. On the other hand, the increase in complaints, the similarity of the complaints and a belief that sexually motivated drink spiking is underreported convinced other stakeholders that drink spiking deserves more attention.

The stakeholders identified a great variety of problems that inhibit the detection, investigation and prosecution of drink spiking as well as the gathering of reliable quantitative statistics. Amongst other things, it was believed that many persons are ignorant of ethical and legal implications of drink spiking. Victims may never report their experiences, whilst others may make false complaints unintentionally or intentionally. Pharmacological evidence disappears quickly, is affected by various factors and is not useful if alcohol was the spiking agent. Many problems exist in the way that key agencies interact with each other as well as how each of them respond to drink spiking victims and process their complaints. Suggested strategies to tackle these problems ranged from specific procedures for different stakeholders, to short-term media campaigns, to long-term campaigns targeting social attitudes to substance abuse and sexual relations.

Table 14: Summary of opinions expressed in stakeholder interviews

Stakeholder	Number interviewed	State / Territory	Range of perceptions of prevalence[(a)]	Concerns/Issues	Preventative strategies	Education kits for hospital staff, police, counsellors, and bar staff
Police	31	*All*	- Rare - Not common, but potential serial offence - High prevalence	False reporting (unintentional or intentional). Underreporting and delayed reporting (causing a loss of evidence). Lack of understanding of drink spiking amongst some general duties police officers. Inadequate procedures for collection of all types of evidence (especially pharmacological). Low flow of intelligence from hospitals and sexual assault agencies. Database inadequacies and inconsistent data entry by officers.	Educate teens re substance abuse and consent in sexual relations. Public advertising. Educate officers. Clear procedures for police responses. Maximise police presence in pubs.	Relevant criminal charges. Effects of drugs. Why genuine complaints may not appear credible. Respectful dealings with complainants. Procedures re data entry and gathering all types of evidence. Clear reports for forensic laboratories.
Sexual assault agencies	25 (& meeting of 30)	ACT, NSW, NT, Qld., SA, Tas., WA	- Relatively common - Very high prevalence	Underreporting and delayed reporting (causing a loss of evidence). Cost of blood/ urine tests. Inconsistent or inappropriate police responses. Balancing client's needs with police desire for successful prosecution. Social acceptance of sexual intercourse with very drunk or unconscious women. Lack of services for male victims.	Broad education re consent in sexual relations. Drink spiking incorporated into government drug sector campaigns. Public advertising without victim blaming. Collect two sets of samples for therapeutic / forensic testing.	Effects of drugs and prompt collection of 2 sets of samples. Offer full physical examinations when suspects drink spiking. Avoid leading questions. De-identified intelligence for police.
Hospitals/ Medical Centres	6	ACT, Qld., SA, Tas., WA	- Rare	Delayed reporting (causing a loss of evidence). Medical care main concern – resources restrict other concerns. Misconceptions of patients re doctor's role. Widespread GHB abuse.	National data collection system. Inform senior staff of hospitals of best evidence re prevalence. Public advertising without causing panic.	Effects of drugs. Second opinion about a complainant's credibility. Physical examinations when spiking suspected. De-identified intelligence for police.

Stakeholder	Number interviewed	State / Territory	Range of perceptions of prevalence[(a)]	Concerns/Issues	Preventative strategies	Education kits for police, counsellors, hospital staff and bar staff
Liquor industry	9	*All*	- Rare - Uncertain - Relatively common	Public panic and down-turn in business. Excessive onus placed on licensed premises to prevent drink spiking.	Public education to take care of selves and others. Monitor patrons generally and those leaving premises with very drunk females (with CCTV possibly).	Effects of drugs (basic). Vigilance of undue intoxication, unattended drinks, orders for unusually potent drinks, other staff and suspicious behaviour. Keep glasses of victims.
Forensic laboratories	11	ACT, NSW, Qld., SA, Tas., WA	- Reserved judgement in the absence of clear evidence	Delayed reporting (causing a loss of evidence). Need for blood and urine samples. Inadequate police reports with samples. Numerous potential drink spiking substances.	Public education re prompt reporting and samples. Police to provide full reports with samples.	-
Government sector / other	28	ACT, NSW, NT, Qld., SA, Vic.	- Uncertain - Occasional spree - Relatively common	Underreporting and delayed reporting. Socio-cultural factors of sexual abuse. Ignorance of effects alcohol, binge drinking and substance abuse.	Community packages with standard free advertising. Public education re substance abuse and sexual relations. Increased prosecutions.	-
Gay community	3	NSW, Tas., WA	- Unheard of - Occasional spree - Common	Media coverage leading to increased anti-gay drink spiking. GHB used for drink spiking *and* cause of false reporting.	Services for male sexual assault victims. Adverts that do not discourage risk taking norms.	-

(a) Prank drink spiking with alcohol was considered by all stakeholders to be very common.

Section 4. Prosecuting drink spiking offenders[10]

It is roughly estimated that between 3000 and 4000 suspected incidents of drink spiking overall occurred in Australia between 1 July 2002 and 30 June 2003. It is further estimated that about one third of these incidents involved sexual assault. Where additional victimisation is associated with drink spiking sexual assault appears to be the most common associated crime. Having identified, as far as possible, the prevalence and nature of drink spiking and having established that suspected drink spiking occurs often enough to merit attention, the next question raised relates to what can be done to prevent drink spiking. Prosecution of drink spiking offenders is one means of prevention, as it not only deters prosecuted offenders from repeat offending in the immediate future but can act as a deterrent to potential offenders. Prosecution also sends a very clear message to potential offenders and the community at large that drink spiking is a crime, that it can have serious consequences for victims and that governments are serious about stopping it.

The key issues involved in successful prosecution relate to the following:

- What laws are available in Australia under which drink spiking can be prosecuted?
- How are these laws applied to reported incidents of drink spiking?
- What evidence is needed to prosecute an offender?
- How is evidence collected?

4.1 Laws available in Australia to prosecute drink spiking offenders

There is no separate offence category in any Australian jurisdiction for the act of spiking someone's drink *per se*. Rather, the use of criminal laws to prosecute drink spiking depends on:

- the state/territory in which the incident occurred;
- the motivation of the person spiking the drink;
- the type of substance used to spike the drink; and
- the effects of the spiking.

This has implications for how an incident of drink spiking is recorded by police in each jurisdiction and how courts may interpret the law in relation to such incidents.

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[10] While every effort has been made to ensure that the details provided in this section are accurate at the time of writing this report, legal advice should be sought before relying on the information provided in this section.

In this report the laws in Australia concerning drink spiking will be considered with reference to six main categories of offences. These are:

- murder and manslaughter;
- general provisions regarding dangerous acts
- poisonings;
- administering a stupefying substance with intent to commit further offences;
- assault; and
- administering prescription drugs and prohibited substances.

Not all of these offence categories are available in all jurisdictions (see Table 15)**.** This means that there is some degree of flexibility in how a drink spiking incident will be classified for offence purposes in each jurisdiction.

Importantly, the offence used will also have implications for the maximum penalties which could be imposed. The maximum penalties for each of the six offence categories in each jurisdiction are listed in Table 15 and are as stated in the legislation. These are the upper limits of sentencing only. Actual sentences imposed are often moderated as the courts must take into account sentences given in previous similar cases. For example, whilst the penalties listed for many offences in Tasmania attract a maximum sentence of 21 years imprisonment[11], in practice the maximum penalties for these offences are far lower (see, for example, sentences for manslaughter in Warner 2002). Cases in which the courts have interpreted legislative provisions relating to drink spiking are considered. Additionally, some references are made to higher courts case studies (see Section 4.3) in order to illustrate instances in which different offence categories have been applied in drink spiking prosecutions.[12]

At the date of writing no jurisdictions were considering legislative changes to any of the provisions included in this section. In May 2004 the Victorian Parliamentary Drugs and Crime Prevention Committee (2004) recommended the creation of a new general offence of drink spiking partly to raise the profile of the issue in the community.

4.2 How are these laws applied to incidents of drink spiking?

Police

As there is no specific offence category associated with drink spiking in any Australian jurisdiction, police have some degree of flexibility in how they classify a drink spiking offence. As was seen in Section 2.1, offence categories used by police in recording incidents included versions of the above, such as administering a drug or poison, introducing a drug into another's

[11] Criminal Code Act 1924 (Tas), s. 389.

[12] Every effort has been taken to ensure the accuracy of the information provided. However, independent legal advice should be sought before relying upon the statutory interpretations provided.

body and assault. Police in the Northern Territory recorded incidents under 'drink spiking' in their database but this reflects a change in the way an incident is *recorded* on the PROMIS database and does not reflect the offence under which an offender would be charged.

Murder and manslaughter

Murder

The most serious forms of drink spiking are those incidents that result in death. Table 16 in the following section provides a summary of drink spiking cases which have been dealt with by the higher courts of Australia. In a small number of these cases individuals were found guilty of murder as a result of an act of drink spiking. Murder may involve a deliberate intention to kill, or an unlawful act or omission which is intended to cause harm and that a reasonable person could have foreseen could result in the death of another.[13] This encompasses situations where the person killed by the spiked drink was not the intended murder victim, as occurred in *R v Maxine Byram* [1989] NSWCCA 60232.[14] Murder may also arise where the spiker did not intend the victim's death but was reckless as to causing physical harm to the victim. For instance, in *R v Guider* [2002] NSWSC 756, a drink spiked with a benzodiazepine accidentally killed a girl aged 9 years. The drug was administered with intent to commit sexual offences. The offender was initially charged with murder, but the charge was later substituted with one of manslaughter.

Manslaughter

Accidental or unintended deaths via drink spiking could alternatively be covered by laws relating to manslaughter. Manslaughter encompasses a very wide range of acts (Warner 2002) and may be considered as an alternative verdict for murder. One type of manslaughter involves acts that are unlawful, dangerous and result in a death, even though they are not necessarily intended to cause harm.[15] 'Unlawful acts' are those which themselves break the criminal law.[16]For example, spiking a drink with methamphetamines is an offence in some jurisdictions and therefore constitutes an unlawful act for the purposes of manslaughter.[17]

Another category of manslaughter concerns killing by criminal negligence. This applies where an offender owed a duty of care to the victim, breached that duty through gross negligence or recklessness and the victim died as a result.[18] Potentially this form of manslaughter could

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13 Crimes Act 1900 (ACT), s. 12; Crimes Act 1900 (NSW), s. 18; Criminal Code of the Northern Territory of Australia, s.162; Criminal Code Act 1899 (Qld), s. 302; Criminal Law Consolidation Act 1935 (SA), s. 11; Criminal Code Act 1924 (Tas), s. 158; Crimes Act 1958 (Vic), s. 5; Criminal Code 1913 (WA),s. 279.
14 Unreported, Gleeson CJ, Hope J and Loveday J, 10 December 1990.
15 *Wilson v The Queen* (1991) 174 CLR 313.
16 *Pemble v The Queen* (1971) 124 CLR 107.
17 In *R v Guider* [2002] NSWSC 756 the unlawful act was administering a drug with the intention of taking indecent photographs of the victim – breaching s. 38 of the *Crimes Act 1900* (NSW).
18 *Wilson v The Queen* (1991) 174 CLR 313.

involve drink spiking with alcohol that resulted in a death via drink driving. It is worth noting that in the higher court cases described in Section 4.2, three cases were related to drink driving. In *Barker v Burke* [1970] VR 884 an individual spiked his friend's drinks with alcohol and shortly afterwards did not prevent his friend from driving. Had the driver killed himself or another person arguably the spiker could have been charged with manslaughter.

General provisions regarding dangerous acts

Another category of offences that exists in most jurisdictions, excluding Tasmania[19], concerns deliberately dangerous or reckless acts that do not result in death but injury. The provisions use different terminology such as 'serious injury', 'injury', 'grievous bodily harm' and 'bodily harm'. Importantly the application of these offences to drink spiking cases depends on the level of injuries actually sustained by the victim. For instance, a provision relating to 'serious injury' would be inapplicable to a drink spiking case where the victim sustained minor physical harm. It is not clear whether concepts of harm or injury could include psychological harm.

Generally the offender must have intended the harm or foresaw that the harm might occur. In Victoria section 18 of the *Crimes Act 1958* (Vic) states that it is a crime to 'intentionally or recklessly' cause 'injury to another person'. Interestingly, section 15 of the same act defines 'injury' to include unconsciousness, hysteria and 'any impairment of bodily function' – which suggests that the provision may be applicable to a very wide variety of acts of drink spiking, including pranks.[20]

In the Australian Capital Territory and New South Wales it is slightly less clear how appropriate the provisions may be to acts of drink spiking. Appropriate provisions in the ACT appear to be sections 19, 20 and 23 of the *Crimes Act 1900* (SA), relating to intentionally or recklessly causing 'grievous bodily harm' and 'actual bodily harm'. Initially it seems that the relevant NSW section encompasses only malicious acts – that is, where the offender intended to wound or cause grievous bodily harm. However, the term 'malicious' is interpreted broadly to include an act done 'with indifference to human suffering … or done recklessly or wantonly'.[21]

The Northern Territory, Western Australia and Queensland have provisions which cover a wide variety of acts, such as transmitting diseases, causing an explosion, casting corrosive fluids and causing any substance to be taken by another. The provision criminalizes these acts when they are done with the intention of, amongst other things, causing grievous bodily harm, maiming, disfiguring or disabling another person.[22] Interestingly, the Queensland provision was very recently used to successfully prosecute an offender for spiking a person's drink with

19 See Criminal Code Act 1924 (Tas), s. 172.
20 See also Crimes Act 1958 (Vic), s.s 16 (intentionally causing serious injury) and 17 (recklessly causing serious injury).
21 Crimes Act 1900 (NSW), ss. 5 and 35.
22 Criminal Code Act 1899 (Qld), s. 317; Criminal Code of the Northern Territory of Australia, s.177; Criminal Code 1913 (WA), s. 294 (see also ss. 297, 301 and 306).

flunitrazepam (Rohypnol) in *R v Thompson* [2003] QCA 200. The court was satisfied that the offender had caused another to take a noxious thing with intent to disable that person.

The offences described above are applicable where harm or injury has occurred. However, in addition South Australia and Victoria have subtly different offences which also encompass actions which might have caused injury. Section 29 of South Australia's Criminal Law Consolidation Act 1935 (SA) makes it an offence to intentionally or recklessly endanger the life of another, or to do an act which is likely to cause grievous bodily harm or injury. Similarly, reckless conduct that 'may place another person in danger' of death or serious injury is a crime in Victoria.[23] Theoretically these provisions might be used to prosecute a person for spiking another's drink, even though the drink had not been consumed.[24]

Poisonings

This category of offences specifically concerns poisonings that do not result in death. Neither the Northern Territory nor Victoria have provisions that fall within this category. Most of the relevant sections refer to 'poisons' and 'noxious things'.[25] The courts have interpreted the word 'noxious' quite broadly. The term will include any substance that the prosecution can prove had a noxious effect in the quantity administered.[26] It certainly seems to include strong sedatives, such as flunitrazepam (Rohypnol).[27] Within this category of non-lethal poisonings two levels of seriousness are discernable: poisonings that endanger life and poisonings that endanger health.

Poisonings that endanger life

In the Australian Capital Territory, New South Wales, Queensland, Tasmania and Western Australia it is clearly a crime to administer a noxious thing to another person that could endanger the life of that person.[28] However, the jurisdictions differ as to the requisite intention of the offender. In the Australian Capital Territory it is not specified that the offender needs to have intended to cause physical injury. In contrast, in Queensland, Tasmania and Western Australia it is necessary that the offender intended to cause some physical injury, whilst the New South Wales provision appears to require that the offender actually intended to endanger life or cause grievous bodily harm. These latter provisions would be more difficult to use for a successful prosecution at court than the crime listed in the Australian Capital Territory.

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23 *Crimes Act 1958* (Vic), ss. 22 and 23.
24 One difficulty may be in establishing the immediacy of the danger – that is, how likely it would have been that harm would have resulted from consumption of the drink.
25 The exception to this is the *Crimes Act 1900* (ACT), ss. 27(3)(b), 28(2)(a).
26 *R v Barton* [1931] VR 81; *R v John Lagan* [2001] ACTSC 131.
27 *R v Thompson* [2003] QCA 200.
28 *Crimes Act 1900* (ACT), s. 27(3)(b); *Crimes Act 1900* (NSW), s. 39; *Criminal Code Act 1924* (Tas), s. 175; *Criminal Code 1913* (WA) s. 300.

Poisonings that endanger health

The second category of crimes relating to poisonings addresses acts that endanger health. In general terms the relevant provisions criminalize administering a noxious thing with intent to injure or annoy. Such provisions are found in NSW, South Australia and Tasmania and a similar offence exists in the ACT.[29]

Under section 19 of the Crimes Act 1958 (Vic) it is a crime to administer any substance which is capable of 'interfering substantially with the bodily functions' of a person, which arguably includes unconsciousness or sleep. It is necessary under this provision that the offender knew that the substance he or she administered was capable of interfering substantially with the bodily functions of the victim and did so without the victim's consent. The victim is taken not to have consented if 'had they known the likely consequences' they would not have accepted the substance. This provision appears applicable to a wide variety of acts involving drink spiking.

Administering a stupefying substance with intent to commit further offences

The identifying characteristic of these offences is that they concern acts, such as drink spiking, which are committed with the *intention of perpetrating further crimes*. Under these provisions unless the intention to commit a further offence is proven at court the defendant cannot be found guilty. Once again, this category of offences can be divided into two sub-categories. The first concerns stupefying a person with intent to commit a wide range of crimes. The second category criminalizes administering a stupefying substance to a person specifically with intent to facilitate sexual acts.

Administering a stupefying substance with intent to commit a crime

Most Australian jurisdictions have provisions that fall within this category. The wording of the various provisions are very similar. They tend to criminalize 'administering' to a person any 'stupefying or overpowering drug or thing' with the intention of committing an 'indictable offence'.[30] Two jurisdictions do not have provisions of this sort, namely the Australian Capital Territory and Victoria.

In a number of cases involving charges of this nature juries have been satisfied that an act of drink spiking constituted 'administering' a substance.[31] For the purposes of 'administering' it

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29 Crimes Act 1900 (NSW), s. 41; Criminal Law Consolidation Act 1935 (SA), s. 27; Criminal Code Act 1924 (Tas), s. 176, Crimes Act 1900 (ACT), s. 28.
30 Crimes Act 1900 (NSW), s. 38; Criminal Code of the Northern Territory of Australia, s.176; Criminal Code Act 1899 (Qld), s. 316; Criminal Law Consolidation Act 1935 (SA), s. 25; Criminal Code Act 1924 (Tas), s. 169; Criminal Code 1913 (WA), s. 293.
31 R v Auliff [2001] NSWCCA 393; Drew Anthony Moffitt v R [2002] NSWCCA 73; R v Dawson [2000] NSWCCA 399; R v Robertson [1997] QCA 63; R v Kenneth Hugh Brown [1991] QCA 218 (Unreported, Thomas J, de Jersey J, Cooper J, 7 March 1991); R v Saragozza [1984] VR 187.

may well be sufficient for the spiked drink to be 'prepared and intentionally left in a place where the intended person would be likely to take it' (Watson, Blackmore, & Hosking 2001: 125).[32] Generally the word 'administer' would not include a situation where an adult consented to taking a known substance of a known potency. That is, administering means more than just supplying or providing.[33]

The courts have interpreted the term 'stupefying or overpowering drug or thing' broadly. One Queensland judge has recently commented that anything that has 'the effect of dulling the senses of faculties or blunting the faculties of perception or understanding' would satisfy the meaning of the term.[34] The judge did not think it was necessary that the substance cause 'total deprivation of sensibility'.[35] It seems the courts will require evidence on the effects of the substance used where the effects are not common knowledge. Evidence has not been required as to the stupefying effects of alcohol.[36] Relevant factors in deciding whether a substance was stupefying or overpowering *for the particular victim* include the age, weight and sex of the victim in addition to any particular susceptibilities the victim may have.[37]

Most of the crimes in this category have a limited application to acts of drink spiking, mainly because it must be proven that not only did the accused administer a substance, but also that he or she did so with the intention of committing an indictable offence.[38] In general terms, indictable offences include crimes ranging in seriousness from rape, sexual assault, assault and robbery, through to stealing – although the exact definition differs somewhat between the jurisdictions (Gillies 1993; Warner 2002). Importantly, under these provisions drink spiking with the intent to commit rape would be a crime, whilst drink spiking merely for a prank may not.

Determining whether an intention existed to commit an indictable offence can depend upon the facts of the case. Relevant facts from court cases have included:

- prior sexual advances by the offender;
- the discovery of indecent photographs taken when the victim was stupefied;
- forensic evidence of sexual intercourse;

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[32] *R v Harley* (1830) 4 Car & P 369; *R v Dale* (1852) 6 Cox CC 14.

33 *R v Steedman* [1996] QCA 93; *R v Lancaster* [1998] 4 VR 550. Of course, physically forcing ingestion of a substance equates to administering: *R v Robertson* [1997] QCA 63. See also *R v O'Connor* (1980) 146 CLR 64.
34 *David Lyall Arnold v R* [2002] QCA CA No 287 of 2001 (Unreported, McPherson JA, MacKenzie and Atkinson JJ, 17 September 2002) per MacKenzie J, at 39.
35 *David Lyall Arnold v R* [2002] QCA CA No 287 of 2001 (Unreported, McPherson JA, MacKenzie and Atkinson JJ, 17 September 2002) per MacKenzie J, at 39.
36 *R v Steedman* [1996] QCA 93.
37 *R v Steedman* [1996] QCA 93; *R v Kenneth Hugh Brown* [1991] QCA 218 (Unreported, Thomas J, de Jersey J, Cooper J, 7 March 1991).
38 Tasmania's provision is the broadest in this category. It stipulates that the relevant intention be to stupefy with the intention of committing 'an offence' (*Criminal Code Act 1924* (Tas), s. 169), which includes not only 'indictable offences' but the lesser category of 'summary offences' as well. See Blackwood and Warner (1993) for examples of summary offences in Tasmania.

- the victim awakening unclothed; and
- diary entries by the offender which appeared to record sexual conquest.[39]

Technically, it is irrelevant whether the intended indictable offence actually occurred.[40] Consequently the courts have consistently treated multiple charges distinctly. For instance, in *R v Auliff* [2001] NSWCCA 393 the offender was found not guilty of rape, but guilty of administering a drug with intent to rape. Forensic evidence indicated (a) the presence of stupefying drugs in the victim's blood sample and (b) the offender's semen stain on the victim's underwear. On appeal the offender's council argued that the jury's findings were inconsistent – if the offender was not guilty of rape he could not be guilty of drugging the victim with intent to rape. The NSW Supreme Court in a unanimous decision rejected this argument. The court stated that on the evidence the jury was entitled to conclude that whilst non-consensual sexual intercourse had not occurred the offender had drugged the victim with the intention of engaging in non-consensual intercourse with her.[41]

Administering a stupefying substance with intent to facilitate sexual acts

Whilst the offences discussed above encompassed many crimes, including sexual offences, four states, Queensland, Tasmania, Western Australia and Victoria, have legislative provisions that specifically concern the use of substances to facilitate sex acts. In Victoria it is a crime to administer a substance 'with the intention of rendering a person incapable of resistance' and thereby facilitating the sexual penetration of that person by anyone.[42] This section appears to require an intention that someone will commit rape – non-consensual sexual penetration – and not other types of sexual acts, such as removing another's clothing without consent or non-consensual indecent touching. Similarly, the relevant offence in Western Australia criminalizes administering 'any drug or other thing with intent to stupefy or overpower' in order to have 'unlawful carnal knowledge' of a person.[43] The relevant Queensland provision criminalizes the administering of substances 'with intent to stupefy or overpower … to enable a sexual act to be engaged'.[44] This section is broader than the Victorian one because it refers to 'sexual acts' rather than rape in particular.

Tasmania's provision is similar to Victoria's in that it appears to concern rape to the exclusion of other sexual crimes.[45] However, in this provision the requisite intention is that 'any other person' has sexual intercourse with the victim. That is, seemingly this section would only apply

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39 *R v Dawson* [2000] NSWCCA 399; *R v Auliff* [2001] NSWCCA 393.
40 *R v TA* [2003] NSWCCA 191.
41 See also *Drew Anthony Moffitt v R* [2002] NSWCCA 73. In *R v Upton* [2000] NSWCCA 305 the same logic resulted to reject an appeal where the offender had been found guilty of rape and not guilty of administering a substance with intent to rape.
42 *Crimes Act 1958* (Vic), s. 53.
43 *Criminal Code 1913* (WA), s. 192. Subsection 3 of this provision refers specifically to females and subsection 4 appears to extend the offence to encompass the rape of males.
44 *Criminal Code Act 1899* (Qld), s. 218.
45 *Criminal Code Act 1924* (Tas), s. 129. Section 1 defines 'sexual intercourse' as non-consensual sexual penetration.

to cases where the person who administered the substance did so with the intention that someone else could rape the victim.

Assault

By national standards the Northern Territory, Queensland and Western Australia have particularly broad definitions of assault. In these jurisdictions assault is defined as the direct or indirect 'application of force', which includes 'striking, touching, moving and the application of heat, light, noise, electrical or other energy, gas, odour or any other substance or thing if applied to such a degree as to cause injury or personal discomfort'.[46] For an act to constitute an assault it needs to be done without the consent of the victim. The victim's consent to the act will be irrelevant where consent was given out of fear or because of false and fraudulent representations about the nature of the act. Arguably drink spiking could be prosecuted under these sections where it resulted in injury or personal discomfort. 'Personal discomfort' appears to be quite a general term applicable to many reactions to different substances. Interestingly in the Northern Territory the penalties for assault are longer if the victim is female and the offender male, or, if the victim is a minor and the offender an adult.

Victoria's definition of assault is relevant to a special provision. It deals with cases where assaults are perpetrated *with intent to commit an indictable offence*[47] and the discussion of that phrase above is obviously relevant to this provision also. This provision defines assault as the direct or indirect 'application of force', which includes the 'application of matter in a liquid form'. In short, the provision requires the following elements:

- an intention to inflict (or being reckless as to the infliction of) bodily injury, pain, discomfort, insult or the deprivation of liberty;
- the actual infliction of one of these consequences upon the victim; and
- the purpose behind the assault is an intention to commit an indictable offence.

Administering prescription drugs and prohibited substances

The previous five categories of offences were all drawn from general criminal legislation. This final category lists provisions in state and territory legislation designed to regulate the use of (a) prescription drugs and (b) prohibited substances such as poisons, hazardous substances and street drugs. The unauthorised use of the substances associated with drink spiking, such as benzodiazepines, GHB, Ketamine, speed and ecstasy, is banned (see Table 11 in Section 4). However, this section is specifically concerned with the *administration* of such substances to

46 Criminal Code of the Northern Territory of Australia, ss. 1, 187 and 188; Criminal Code Act 1899 (Qld), ss. 245, 246 and 335; Criminal Code 1913 (WA), ss.222, 223 and 313.
47 Crimes Act 1958 (Vic), s. 31(1)(a).

other people. Notably, none of the offences listed in this section apply to drink spiking using alcohol alone.[48]

It appears that Western Australia is the only jurisdiction that does not have a provision that fits within this category.[49] In all other jurisdictions there are provisions that effectively state that it is an offence to administer to another person particular substances unlawfully.[50] The legal meaning of 'administer' was discussed above. In one court case 'administer' was described as a 'fairly plain English word' – suggesting that it probably encompasses drink spiking for the purposes of these sections.[51] 'Unlawfully' means that the person who administered the substance did not have a lawful excuse. Medical practitioners, for instance, are allowed to administer drugs to another.[52] The interesting aspect of these offences is that, unlike most of those discussed above, they do not require any specific *intention* in the mind of the offender. That is, it only need be proven that (a) the accused (b) administered to another person (c) a particular substance (d) without a lawful excuse. These provisions seem applicable to acts of drink spiking, except where alcohol is used. In most jurisdictions these sections encompass benzodiazepines, GHB, Ketamine, speed and ecstasy. Notably, the relevant ACT provisions do not cover Ketamine.[53]

Double punishment

An important principle in sentencing in Australia is that an offender cannot be punished twice for the same act or omission (Warner 2002). Double punishment had interesting implications in the drink spiking cases analysed above. This was particularly so in those cases where the offender was found guilty of a sexual offence (such as rape or indecent assault) and the offence of administering a stupefying substance with intent to commit an indictable offence. In *R v Robertson* [1997] QCA 63 the rule of double punishment seemed to be applied. The offender was given four years imprisonment for administering a stupefying substance with intent to commit an indictable offence and one year for indecent sexual assault. However, the offender was given 'concurrent' sentences, meaning that the sentences for the different offences ran together and the total sentence was still four years. A similar approach was taken in the more complex sentencing calculations of *Klavins v R* [1999] WASCA 37. There the court stated that

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48 For the most part alcohol is not a controlled substance or prohibited drug. Ethanol is regulated in some instances but not in way applicable to drink spiking. See for example the *Controlled Substances Act 1984* (SA), s. 19 and the *Controlled Substances (Volatile Solvents) Regulations 1996* (SA).
49 The *Misuse of Drugs Act 1981* (WA) states that it is an offence to supply prohibited drugs to another (s. 6). However, 'supply' does not seem to incorporate 'administering'; section 3 defines 'supply' to include 'to deliver, dispense, distribute, foreward, furnish, make available, provide, return or send'.
50 The provisions in the ACT, NSW, South Australia and Tasmania actually use the term 'administer': *Drug of Dependence Act 1989* (ACT), ss. 169 and 171; *Drug Misuse and Trafficking Act 1985* (NSW), s. 13; *Poisons and Therapeutic Goods Regulations 2002* (NSW), s. 58; *Misuse of Drugs Act 2001* (Tas), s. 24; *Controlled Substances Act 1984* (SA), ss. 18 and 32. In the Northern Territory and Queensland the provisions use the term 'supply', but define 'supply' to include 'administer'; *Misuse of Drugs Act* (NT), ss. 3 and 5; *Drugs Misuse Act 1986* (Qld), ss. 4 and 6. The more specific Victorian provision, section 74 of the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), states that it is a crime to 'introduce a drug of dependence into the body of another person'.
51 *R v Steedman* [1996] QCA 93, per Davies J and McPherson J, at 94.
52 See for example *Drugs Misuse Act 1986* (Qld), ss. 6 and 124.
53 *Drug of Dependence Act 1989* (ACT), ss. 3, 169 and 171; *Drugs of Dependence Regulations, Schedule 1* (ACT).

the sexual offences, the violent offences and the administration of drugs were 'all bound up together … the criminal conduct was linked' (per Ipp, J at 30).

Aside from having important sentencing implications, the rule of double punishment might influence the decisions made by police and public prosecutors. If a defendant has been charged with more than one offence, prosecutors can decide for which offences the defendant appears in court (or for which they are 'arraigned'). Where a defendant is willing to plead guilty to sexual offences, such as rape and drink spiking offences, such as administering a stupefying substance with intent to commit a crime, the prosecutors may decide not to arraign the defendant for both offences because of a perception that this would have no effect on the sentence given.

However, a very recent NSW case has adopted a new approach which may influence future court cases in other jurisdictions. It did not involve drink spiking but the deceptive administration of powerful sedatives via an injection, followed by a rape and an indecent sexual assault. The court stated that the two sexual offences 'were substantially different in kind' from the administration of the drugs (per Adams, J, at 34).[54] A part of the distinction between the offences lay in the offender's decision to carry through with his intentions. That is, it is a crime to administer a stupefying drug to a person with the intention of committing, amongst other things, sexual offences. However, once the victim is stupefied, it is another separate offence for the offender to actually carry out their original intention; once the victim is stupefied *the offender still can decide not commit the additional violation they once desired*. Consequently, the court concluded that the principle of double punishment did not apply. Justice Adams stated that the 'distinction between the offences is real and punishment for both should reflect the considerable additional criminality involved in fulfilling the intention with which the drug is given' (per Adams, J at 34). The offender was sentenced to five years for the administration of the drug and another four years and six months for the sexual offences – a total of nine and a half years.

Conclusion

Clearly, the laws as they currently stand in each jurisdiction allow for drink spiking to be prosecuted under a range of different offence categories. This makes drink spiking different from other types of crimes which have their own offence categories. The downside of such flexibility is that there is little consistency in how an incident is recorded by police. Proving the intention of the offender can be a difficult task and offence classification affects maximum penalties which can be imposed. Double punishment may also influence successful prosecutions. Given the possibility that a concurrent sentence may be given to an offender charged with several crimes, police and prosecutors may wish to consider what charge to lay and how to do it so that separate crimes are not perceived as one crime.

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54 *R v TA* [2003] NSWCCA 191.

Table 15: Maximum penalties for criminal offences relating to drink spiking, in all jurisdictions

	Murder	Manslaughter	General provisions regarding dangerous acts	Poisonings that endanger life	Poisonings that endanger health	Stupefying w/intent of crime	Stupefying w/intent of sex acts	Assault	Administering prescription drugs /prohibited substances
NSW	Life imprisonment	25 yrs	7 yrs	10 yrs	5 yrs	25 yrs	N/A	N/A	2 yrs or $2000
Vic.	Life imprisonment	20 yrs	5 yrs (injury recklessly) 10 yrs (injury intentionally; conduct endangering life) 15 yrs (serious injury recklessly) 20 yrs (serious injury intentionally)	N/A	5 yrs	N/A	10 yrs	5 yrs	1 yr or $3000
Qld.	Life imprisonment	Life imprisonment	Life imprisonment	14 yrs	N/A	Life imprisonment	Life imprisonment	3 yrs	15 yrs or 20 yrs if victim minor
SA	Life imprisonment	Life imprisonment	5 yrs (risk injury) 10 yrs (risk grievous bodily harm) 15 yrs (risk life)	N/A	3 yrs	Life imprisonment	N/A	N/A	2 yrs or $10,000
WA	Life imprisonment	20 yrs	20 yrs	14 yrs	N/A	20 yrs	2 yrs	N/A	N/A
Tas.	Life imprisonment	21 yrs	N/A	21 yrs	21 yrs	21 yrs	21 yrs	N/A	2 yrs or $5000
NT	Life imprisonment	Life imprisonment	Life imprisonment	N/A	N/A	Life imprisonment	N/A	1 yr or 5 yrs (if female minor victim and male adult offender)	14 yrs (if victim minor) otherwise 5 yrs or $10,000
ACT	Life imprisonment	20 yrs	5 yrs (intentionally or recklessly causing bodily harm) 10 yrs (recklessly causing grievous bodily harm) 15 yrs (intentionally causing grievous bodily harm)	10 yrs	5 yrs	N/A	N/A		2 yrs and/or $5000 (except for Ketamine)

4.3 How many incidents of drink spiking are prosecuted?

It is clear that the vast majority of drink spiking incidents are not prosecuted. Similarly to sexual assault cases where attrition rates between reporting to police and prosecution are very high (Lievore 2004), drink spiking is also likely to have high attrition. This is due (variously) to:

- low levels of reporting of drink spiking to police;
- inability of many victims to identify offenders;
- unwillingness of victims to identify offender or proceed with investigation/prosecution;
- lack of credible victim testimony; and
- lack of sufficient evidence that drink spiking occurred (no forensic tests conducted, tests yielded negative results for drugs).

Figure 9 summarises the processes involved in the lead up to prosecution. It can be seen that a degree of attrition occurs at each step. From Section 2 it was estimated that reporting rates of drink spiking to police vary between 10 and 25 per cent. This means the majority of drink spiking incidents are not reported to police. Further, where information was available, only one third of victims were aware who the offender was, meaning that two thirds of cases could not proceed with prosecution due to lack of knowledge of the offender. From the police data it was also found that only four per cent of drink spiking cases were committed for trial. The process of attrition for drink spiking is clearly very problematic in relation to prosecution.

Although national data on the number of sexual assault offenders appearing before the courts and being successfully prosecuted is scant, the Australian Bureau of Statistics has begun to publish annual statistics on higher court criminal cases finalised by adjudication (see Lievore 2004). Compared with other types of indictable offences, sexual assault offenders appearing before the higher courts in Australia in 2001/02 were more likely to be acquitted (Lievore 2004). A quarter of sexual assault offenders who appeared before these courts were acquitted compared with 19 per cent of homicide related offenders, five per cent of robbery offenders and three per cent of burglary offenders. No similar data are available for drink spiking, primarily because there is no separate offence category for drink spiking.

However a search of online legal databases[55] located twenty-eight cases of drink spiking which were heard before the higher courts in Australia, including the supreme courts that exist in every state and territory, or the High Court, which is the highest court of appeal in Australia. As only cases appearing before the higher courts are available electronically and, as the bulk of court cases in Australia are not heard before the higher courts, these cases will not necessarily be representative of all drink spiking cases which appear before the courts. Their inclusion in this report is simply to provide some insight into the types of cases which may be prosecuted (otherwise lacking),the variety of circumstances in which these incidents can occur and the evidence involved in successful prosecutions.

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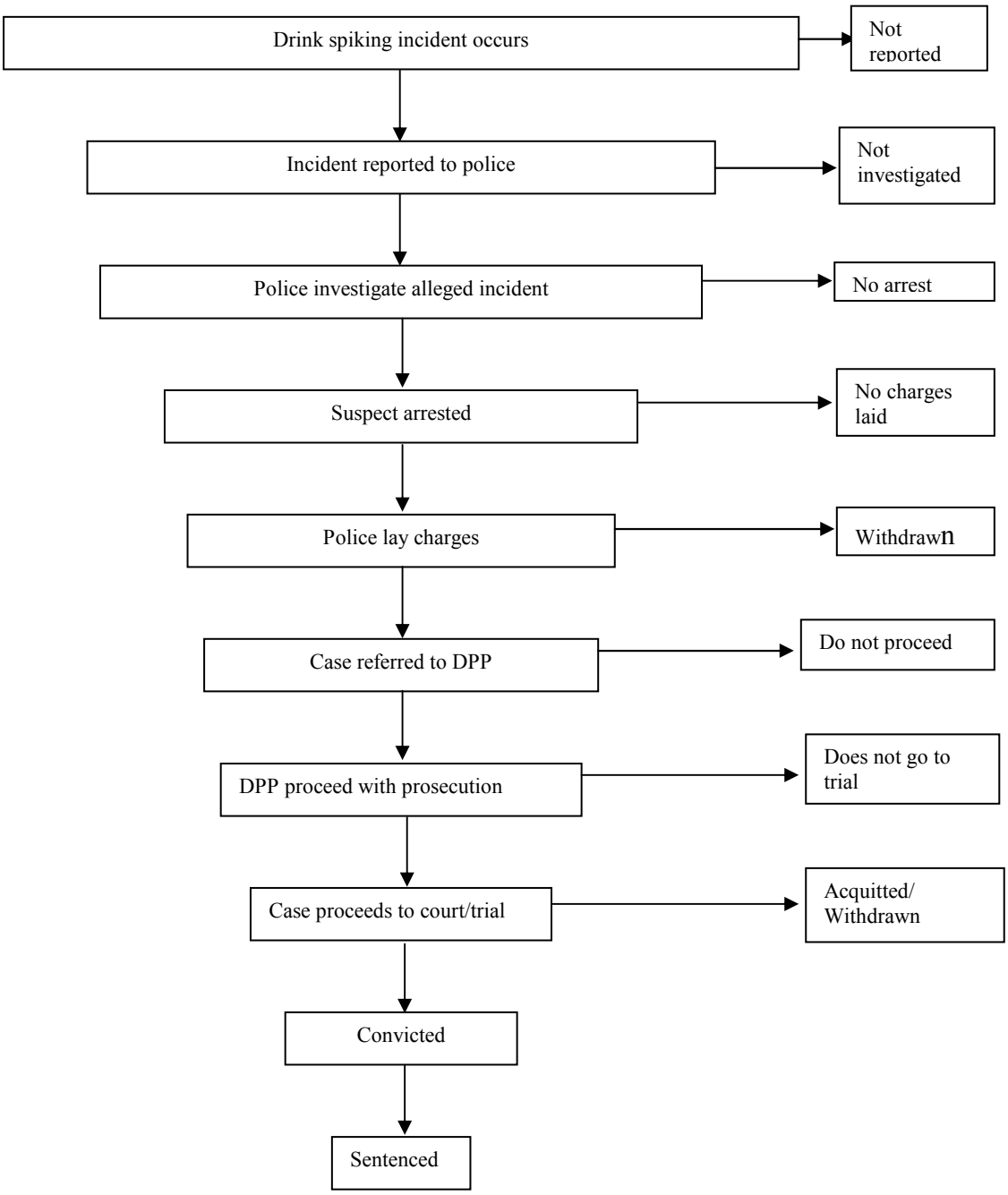
55 Namely <www.austlii.edu.au> and <www.butterworths.com.au>.

Figure 9: Summary of prosecution procedures for drink spiking and associated attrition



Source: Adapted from Lievore (2004)

In the online search, cases were sought that fitted the scope of the present research. That is, only cases in which it was alleged or proven that drugs or alcohol were added to a drink without the consent of the person who consumed it were included. The main features of the cases identified and the wide variety of circumstances in which they occurred are presented.

Main features of the higher court cases

Table 16 summarises all of the 28 court cases identified in the online database search, including the charges, sentences and essential information about the nature of the offences. Details of the sentences, such as terms of imprisonment, are provided only where reported in the judgments. Most of the cases uncovered were heard before the courts between 1990 and 2003 (n=27), although one case was found that took place in 1845[56]. The 28 cases involved drink spiking in a variety of contexts and it was found that:

- There were 14 sexually motivated drink spiking cases. In these cases all the offenders were adult males, only four of whom were strangers to the victim. One victim was a 21 year-old male. The remaining 13 female victims were mostly adults, although four victims were aged 9, 10, 12 and 15 respectively. None of the cases involved bars or nightclubs.
- Benzodiazepines were used or were alleged to have been used in 10 of these cases. Other substances included alcohol (n=2), an epileptic medication and ecstasy.
- In seven of the sexually motivated drink spiking cases drugs were found in blood and/or urine samples obtained from the victim.
- Other forms of evidence included witness statements, nude photographs, physiological evidence of sexual intercourse and complaints made by other people that were similar to the victim's complaint.
- Seven cases related to incidents of violence and murder perpetrated by four females and three males. In one of these cases the initial motive was robbery.
- One defendant was found guilty of the manslaughter of three people by crashing a car whilst under the influence of drugs and alcohol. The court accepted that her drinks had been spiked with ecstasy and took this into account in sentencing. Drink spiking arose in another two drink-driving cases.
- In the only civil case uncovered, a problem gambler successfully sued a casino for negligence because, amongst other things, the casino spiked the drinks that they provided him for free with additional shots of alcohol.

56 This is probably mostly due to the fact that the bulk of the cases contained in Austlii and Butterworths On-Line were held in the last decade. See further drink driving cases *Barker v Burke* [1970] VR 884 *(Vic.); Brain v Bentley* (1992) 15 MVR 537*(SA)*.

- The criminal cases often involved (a) different charges made against the defendant and (b) multiple counts of those charges. For instance, in *Klavins v R* [1999] WASCA 37 the accused was found guilty of one count of supplying methamphetamine to another, three counts of indecent assault, three counts of rape, two counts of administering a stupefying substance with intent to commit an indictable offence and one count of stealing.

Table 16: Higher courts cases in Australia relating to drink spiking

Case citation	Result	Spiker	Victim	Relationship	Drug	Circumstances
R v Thompson [2003] QCA 200	Guilty: intent to disable giving noxious thing and indecent assault – 5 yrs	Male 42 yrs	Male 21 yrs	Acquaintance	Flunitrazepam	Defendant (dentist) offered victim to stay over at his home. Indecent assault followed drink spiking.
R v Guider [2002] NSWSC 756	Guilty: manslaughter and other counts – 17 yrs	Male 45 yrs	Female 9 yrs	Stranger	Temazepam	Paedophile spiked victim's soft drink with temazepam for nude photographs. Victim died from temazepam.
Moffitt v R [2002] NSWCCA 73)	Guilty: rape; administer substance with intent and false imprisonment.	Male 45 yrs	Female Adult	Stranger	Temazapam	Defendant met victim (prostitute), asked her to drink spiked drink in his car which aided rape. Temazepam in fluid found at his home and in victim's urine.
R v Auliff [2001] NSWCCA 393	Guilty: administer substance with intent. Not guilty: rape & act of indecency.	Male Adult	Female Adult	Acquaintance	Flunitrazepam	Victim met defendant few days prior and rapidly fell unconscious at dinner with him. Flunitrazepam found in blood and also at defendant's home (in liquid).
R v Rankin[2001] VSCA 158	Guilty: rape – 7 yrs	Male 42 yrs	Female 15 yrs	Friends' dad	Alcohol	Victim invited to stay night at defendant's home (he was drinking w/sons) – he laced her less alcoholic drinks with whiskey.
Baker v R [2000] TASSC 66)	Guilty: rape	Male Adult	Female 17 yrs	Stranger	Clonazepam	Victims accepted job offer w/travel. At hotel, defendant spiked her drinks with epilepsy medication. Evidence of semen found.
R v Dawson [2000] NSWCCA 399	Guilty: admin. substance w/ intent & other counts-13.5yrs	Male Adult	Female 16 yrs	Music teacher	Benzodiazepine (non-specified)	Defendant asked victim to stay at his house and sedated her for photos and indecent assault. Victim sick next day – drugs found.
R v Upton [2000] NSWCCA 305	Guilty: rape – 1.5 yrs. Not guilty: administer substance with intent.	Male Adult	Female 26 yrs	Friend of family	Temazapam	Defendant made advances to victim & he allegedly spiked drink at table w/others – witnesses later saw her stagger to bed. He told victim they had consensual sex. Temazepam found in blood.
Klavins v R [1999] WASCA 37	Guilty: 2 counts administer substance w/intent; rape and other offences – 14 yrs.	Male 49yrs	Female 16 yrs	Stranger	Ecstasy	Defendant offered victim job in outback. Victim saw defendant put powder into her drink, but afraid to refuse it. Defendant committed series of rapes and later forced her to swallow pills.
R v Soo [1997] VSCA 96	Guilty: rape – 2 yrs (entirely suspended)	Male 37 yrs	Female 22 yrs	Family friend	Temazapam	Defendant's attempt to seduce victim included spiking her drink with temazepam at a restaurant. Sexual assault followed. Victim taken to hospital and drugs found in samples.
R v White [1998] QCA 68	Guilty: administer substance w/intent; 2 counts indecent dealing– 3.5 yrs	Male Adult	Female 10 yrs	Mother's boyfriend	Alcohol	Defendant spiked victim's soft drink.

Case citation	Result*	Spiker	Victim	Relationship	Drug	Circumstances
R v Robertson [1997] QCA 63	Guilty: administer substance with intent and indecent assault – 5 yrs	Male 35 yrs	Female Adult	Flight attendant colleague	Flunitrazepam	Victim's hot choc spiked. After drinking, she saw double and later woke in underwear. Nude photos of her and others found in defendant's home. Similar fact evidence critical to prosecution.
R v Brown [1991] QCA 218	Guilty: indecent dealing w/ young girl; administer substance w/intent – 13 yrs	Male 53 yrs	Female 12 yrs	Family friend	Oxepam Temazepam	On holiday defendant gave three girls in his care juice. All fell asleep. He raped one victim who felt sick next day. Her parents complained to police. Drugs in blood. Physical signs of rape.
R v Lowrie & Ross [2000] QCA 405 *(Qld.)*	Guilty: murder	Female Adult	Female Adult	Unknown	'Valium based syrup'	Defendant made time to meet fellow prostitute, she took a spiked bottle of champagne. Intended robbery went wrong and defendant's and another bashed victim to death.
R v Saragozza [1984] VR 187 *(Vic.)*	Guilty: administering drug w/ intent for sex outside of marriage and rape – 11 yrs	Male Adult	Female 21 yrs	Employer	Oxepam	Victim arrived to clean defendant's home, had juice and blacked out. She woke in bed with him & had trouble walking. She had had no memory of having phoned her dad. Semen & drug found.
Conway v R [2000] FCA 461	Guilty: murder	Male Adult	Female Adult	Husband	Heroin	Defendant spiked coffee with heroin so that when defendant faked victim overdose would appear victim was a user.
Robertson v Smith [1998] 4 VR 165*)*	Guilty: murder	Female Adult	Male Adult	Wife	Paraquat	Defendant poisoned husband in ginger wine.
R v Hewitt[1993] QCA 405	Guilty: attempted murder – 15 yrs	Male Adult	Female Adult	Friend	Strychnine	Victim rejected defendant's advances for a relationship so placed poison in victim's sugar bowl.
R v Madhavi Rao [1999] ACTSC 132	Not guilty: murder	Female Adult	Male Adult	Friend of victim's wife	Flunitrazepam	Defendant alleged to have helped friend murder her husband. Accepted fact that flunitrazepam twice used to stupefy victim, who was then injected w/ heroin. Victim died on 2nd occasion.
R v Walkden & Others (1845) 1 Cox CC *(Vic.)*	Not guilty: common assault and multiple other charges	Males -	- -	Wedding guest	Spanish flies	Defendant spiked large quantity of drinks for bridal party with aphrodisiac used for bullocks. Injuries resulted.
R v Catt [1993] NSWCCA 606	Guilty: numerous violence charges – 3 yrs	Female Adult	Male Adult	Wife	Lithium Rivot	Defendant spiked flavoured milk that victim drank from fridge in his garage.

Case citation	Result	Spiker	Victim	Relationship	Drug	Circumstances
R v Sumner [2001] SASC 261	Retrial ordered on charges of robbery/assault w/ GBH	Male Adult	Male Adult	Neighbour	-	Victim saw defendant spike drink with tablet; he drank it although he did not know what tablet it was.
R v O'Dea [2002] NSWCCA 91	Guilty: manslaughter	- -	Female 29 yrs	N/A	Ecstasy	Defendant lost control of car & killed three passengers. Blood test showed ecstasy, marijuana and blood alcohol<.05. Court accepted that she had ingested ecstasy through drink spiking.
Siviour-Ashman v Police [2003] SASC 29	Not guilty: drink driving	Male Adult	Female Adult	Bartender	Alcohol	Defendant convinced court that when she asked a bartender for water she was given juice spiked with alcohol that caused her to be just over the legal blood alcohol limit for driving.
R v Truelove [2001] VSCA 78	Guilty: drink driving	- -	Male Adult	N/A	Ecstasy	Defendant claimed his drinks were spiked at party, after which he had non-serious car crash. Claim did not seem to influence court; he had ingested marijuana and blood alcohol <.05.
R v Ang [2001] NSWSC 758	Guilty: manslaughter (sentence suspended)	- -	Male 16 yrs	N/A	Amphetamines	Defendant at party where his drink spiked with speed. His uncle asked him to push him out into a river when unconscious (instead of suiciding). Little emphasis placed on claim.
R v Furlong [2002] SASC 139	Guilty: breach of probation and other offences	- -	Male Adult	N/A	Amphetamines	Defendant said became drug addicted after 12 months abstinence after drink spiked with speed. Little emphasis placed on claim.
Reynolds v Katoomba RSL[2001]NSWCA234	Civil case	N/A	Male Adult	Casino staff	Alcohol	Victim was problem gambler and sued casino for, among other things, spiking drinks. Drink spiking accepted fact in case.

Source: Online legal databases

Conclusions

While there are no data at a national level to identify the numbers of drink spiking cases which are passed to the Director of Public Prosecutions, or how many of these actually proceed to court or are successfully prosecuted, it is clear that the numbers of drink spiking incidents which proceed to prosecution are very low. Primarily we know this from the fact that drink spiking is heavily under-reported to police (see Section 2.1) and many victims will not know their offender. From the higher courts cases it appears that circumstances surrounding cases which have appeared before the higher courts vary considerably and that an offender may be tried for more than one crime. Evidence of the type of drug used to perpetrate the drink spiking was critical in some of these cases. But what other types of evidence are important for prosecutions?

4.4 What evidence is needed to prosecute a drink spiking offender?

For purposes of prosecution it is essential that as much evidence as possible be collected in relation to an alleged drink spiking incident. Prosecutors do not have unlimited resources and must weigh up the likelihood of achieving a successful prosecution if they decide to proceed with a case. Evidence that an incident of drink spiking occurred and its consequences (if any) needs to be carefully and systematically documented so that the likelihood of a successful prosecution is increased. This is often referred to as a 'chain of evidence' – evidence which is clearly linked and systematically collected and documented. Evidence is also often important for the victim's emotional state as obtaining evidence allows the victim to know what h/she may only have suspected. As already noted, however, obtaining evidence in relation to a drink spiking incident can be difficult due to the:

- loss of memory and an inability to recall the circumstances surrounding the incident accurately;
- unreliable victim testimony;
- inability to present for forensic testing within the required time after ingestion
- possibility that drugs and/or alcohol may have exited the body by time of testing;
- possibility that victim may have consumed alcohol or drugs voluntarily; and
- victim may have been given a sedative or other drugs upon presenting to a medical centre or hospital prior to testing.

Where a sexual assault occurred following a drink spiking incident evidentiary obstacles may include the above as well as additional obstacles faced by sexual assault victims more generally in relation to prosecuting a case. One means of obtaining evidence that a drink was spiked is to conduct forensic testing of blood and urine samples or the drink itself. In most cases the drink is not available for testing. Hence blood and urine testing is regarded as a means of collecting evidence of drink spiking. Additionally, however, given the above obstacles in relation to blood and urine analysis, other types of evidence should also be

sought, collected and documented. As highlighted in the higher courts cases, these could include obtaining witness statements, photographs or other 'mementos' which may have been left in either the victim's or offender's home or at the scene of the incident and corroborating complaints from other victims.

4.5 How is evidence collected?

Forensic testing

When someone who believes they have had their drink spiked reports to a medical centre/hospital, a sexual assault service or the police within a short time after the alleged incident there is a chance that drugs may be detected in their blood or urine. However, depending upon a number of factors blood and urine samples may be analysed by laboratories with different capabilities in detecting drugs in those samples.

The most highly specialised laboratories in Australia tend to be the forensic laboratories used by the police. Forensic laboratories focus upon gaining scientific evidence to help the police to solve crimes and to assist public prosecution teams to assemble strong cases in court. This generally requires the ability to detect even the slightest traces of drugs or alcohol, even when the sample is taken some time after the incident. Therapeutic laboratories (often in hospitals and some private centres) typically deal with health and medical issues. In analysing blood and urine samples, amongst other things, their goal will be to determine whether any substances exist in quantities that could affect the health or threaten the life of a patient. The need to detect minute traces of drugs is therefore not usually a requirement for these types of laboratories. This means that the degree to which blood or urine may be analysed and the likelihood of finding traces of drugs and other substances will vary depending on which type of laboratory analyses the sample and what the goals of the analysis are. Analysts that work in both therapeutic and forensic laboratories may be trained in pharmacology, toxicology or both[57].

Two main types of procedures used in analysing blood and urine samples are:

- 'screening' tests; and
- 'confirmatory' tests.

The purpose of screening is to detect broad families of drugs in a sample, such as for the existence of benzodiazepines (Makkai 2000). The more sensitive and specific confirmatory test can identify the exact compound, such as flunitrazepam – a potent benzodiazepine. Confirmatory tests can also accurately measure the quantity of a compound in a sample.

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57 Pharmacology is primarily concerned with the study of medicinal drugs and their effects upon the body. Toxicology is concerned particularly with toxic substances and their effects upon the body, including poisons, illicit drugs and different substances ingested at dangerous levels.

Some therapeutic laboratories only conduct screening tests because these meet most of the requirements of medical doctors. However, in general their confirmatory tests are less sensitive than those used in the forensic laboratories. Greater sensitivity means that the forensic laboratories' instruments can detect much lower quantities of drugs in urine or blood.

Processing of urine/blood samples by sexual assault services, hospitals and the police

There are many reasons why people who suspect that they have had their drinks spiked may report their suspicions to different agencies or services. Some services do not have the option of arranging a blood or urine sample and in other cases clear protocols around analysing procedures have not yet been established. Good examples are the drug and alcohol anonymous information telephone services, which occasionally deal with potential victims of drink spiking. In many cases sexual assault services, hospitals and the police interact with complainants face-to-face and can arrange for samples to be taken when appropriate. The situation of different sexual assault services, hospitals and police stations vary enormously across the country. However, some common processes exist which are worth describing.

Sexual Assault Services

The priority for *sexual assault services* is to provide a crisis service for their clients for sexually related traumas and to meet their clients' emotional and psychological needs. In some cases concerning allegations of recent sexual assaults, a service may believe that a client would benefit emotionally from knowing if drugs can be found in their system. Indeed it is not unusual for a client to suggest that for their own peace of mind they just want to know whether there is any evidence that they were drugged. A positive result might also assist the client to decide whether they wish to make a formal complaint to the police58. In these situations blood and urine samples may be collected and sent to a therapeutic laboratory.

If a client thinks they may want to make a formal complaint to the police the sexual assault service can arrange for the blood and urine samples to be taken according to certain procedures. The collection of evidence, including blood and urine, needs to follow strict procedures to satisfy a court that the samples were protected from tampering (this is called maintaining a chain of evidence). To follow these procedures personnel who take samples need to be forensically trained. These samples are analysed by forensic laboratories. Some sexual assault services are attached to hospitals and have easy contact with forensically trained doctors. Other sexual assault services have to take different steps to facilitate the collection of samples by forensically trained personnel, such as escorting their client to a police station or a hospital.

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58 For some survivors of sexual assault being able to pursue their options through the criminal justice system is very important. Forensic evidence obviously can play a vital role in a successful prosecution.

A problem arises if, as described above, initially a client just wants to find out if there were drugs in their system and had samples sent to a therapeutic laboratory and then, later, the client or the police want to use the results of those tests as evidence in a prosecution. Without a chain of evidence the samples may not be admissible in court.

The cost of analysing the samples can be expensive (personal communication, 8/10/03). Where samples have been collected maintaining the chain of evidence and the client wishes to proceed with a formal complaint to the police, the police will typically cover the cost of the analysis by forensic laboratories. However, if the client does not want to involve the police, the cost of the analysis by a therapeutic laboratory may fall to the sexual assault services. Some services may not be funded to meet these costs. In other scenarios hospitals may decide to analyse the samples without the cost being borne by the sexual assault agencies.

Hospitals and medical centres

The priority for *hospitals and medical centres* is the health and wellbeing of their patients. Patients who make allegations of drink spiking, but whose medical condition appears fine are not likely to have samples taken from them. Concerns about their medical condition, on the other hand, may prompt hospitals to take samples and analyse them in their laboratories. Typically the collection of evidence in these scenarios is not a priority for hospitals. Because therapeutic laboratories deal with such a large volume of samples, most are destroyed after a week and some of these may not have been analysed.

However, it seems that some hospitals with a sexual assault service attached have streamlined forensic procedures for dealing with complaints of recent sexual assault. These include gathering biological evidence and a thorough examination of the complainant. If the hospital suspects some type of drug has facilitated a sexual assault (via drink spiking or other methods) then this is recorded in the victim's statement to the examining doctor and samples may be taken with the patient's consent. In these scenarios, all evidence is gathered in a way that maintains a chain of evidence. Depending on the patient's medical condition and whether they wish to make a complaint to the police, samples may be analysed by the hospital laboratories or passed onto the police, who will send them to forensic laboratories.

Police

The *police* balance two priorities in dealing with complaints of drink spiking: the needs of the complainant and the possibility of a successful criminal investigation and prosecution. Complainants may approach the police directly with an allegation of drink spiking. If the alleged incident was recent a forensically trained doctor may take samples with the complainant's consent at the police station. As explained above, in different circumstances the police may be able to arrange for samples to be passed to them from sexual assault agencies or hospitals. Any samples that the police wish to have analysed will be sent to forensic laboratories.

4.6 Conclusions

Successfully prosecuting an instance of drink spiking is not straightforward. It requires knowledge of the offender, a willingness by the victim to report to and cooperate with police, confidence that one's testimony will be credible, evidence that the incident occurred, a chain of evidence which can be upheld in court and a belief by the Director of Public Prosecutions that there is some chance of success. In addition to this and something not referred to earlier are the attitudes of the police, judiciary and juries in relation to impacting on a successful prosecution. The fact that there is no specific offence category associated with drink spiking in any jurisdiction means that there is some flexibility in how police record incidents and how courts interpret and apply relevant laws.

Successful prosecution of drink spiking should be an important objective in any attempts to prevent drink spiking. Not only does it have deterrent value for both actual offenders and potential offenders, but it sends a very clear message that drink spiking is a crime and that governments are serious about stopping it. Successful prosecutions will also send a message to the community at large that drink spiking is not humorous but can lead to serious consequences for both victims and offenders.

However, to obtain successful prosecutions, a coordinated approach is required involving victims, witnesses, police, hospitals, forensic labs and DPPs:

- Victims must be willing to report incidents as soon as possible after the incident, to obtain forensic evidence, to cooperate fully with police and be willing to proceed with prosecution. Prosecution without victim and witness testimony is not likely to be successful and DPPs are unlikely to pursue a case without victim testimony.
- Police must be willing to listen to victims reporting suspected incidents, to treat victims with sensitivity and respect and to record faithfully everything that a victim and witnesses are able to recall about the incident.
- Consideration should be given (by both police and DPPs) to how drink spiking offences should be classified, what sort of evidence will be needed to prosecute under that offence category and the likelihood of being able to obtain such evidence (i.e. proving intent).
- Blood and urine samples should be tested where the period since ingestion is believed to fall within the specified time frames. In submitting samples to forensic labs police, sexual assault centres and hospitals should submit additional information such as gender and age of victim, whether and how much alcohol or drugs were consumed voluntarily by the victim before and after the incident, whether particular drugs are suspected to be involved and what the symptoms of the victim were after the incident.
- Where a victim presents to a hospital with a suspected drink spiking hospital staff should not attempt to give drugs to the victim prior to blood and urine samples being taken.
- In essence a solid chain of evidence needs to be built for the case to proceed to prosecution and this chain of evidence requires coordination and commitment between all relevant agencies.

Section 5.0 Efforts to prevent drink spiking

The surreptitious nature of drink spiking and the often busy and social environments in which it may occur (e.g., licensed venues, parties) can make its prevention difficult. Prosecution is one means of potential prevention through deterrence. However prosecution essentially deals with a crime once it has occurred. Given the difficulties in prosecuting drink spiking identified in Section 4, strategies which are aimed at preventing drink spiking from occurring in the first place are clearly potentially more efficient. Numerous efforts have been implemented in recent times to try and prevent drink spiking. This section summarises a number of tools which have been used in prevention efforts:

- training for the liquor industry and police;
- the drink spike detector; and
- campaigns aimed at educating the public and others about drink spiking.

Many of these efforts (in particular education campaigns) tend to be highly localised and for this reason this section is not exhaustive in terms of prevention efforts. Rather it gives a 'flavour' of the types of prevention strategies used to date.

5.1 Liquor industry training: Responsible Service of Alcohol course

Training for the liquor industry can be instrumental in assisting with the prevention of drink spiking in licensed premises, given that licensees, bar and security staff may be in a position to monitor the behaviour of patrons and intervene in circumstances where a victim may be at risk. Although formal training regarding drink spiking has not been widely implemented across all states and territories, The Responsible Service of Alcohol (RSA) course operates in each state and territory, is a short course – sometimes run in isolation, sometimes as part of a broader curriculum – and educates licensees, managers and other staff working in licensed venues as to the responsible service of alcohol. This course has been in some states (and may soon be in others) a forum for discussing drink spiking in the broader context of responsible alcohol service and consumption.

Responsible Service of Alcohol Course content

Although some elements may differ, the content of the RSA course is largely consistent across all states and territories. Components can include:

- Identifying customers to whom service may be refused (e.g., intoxicated persons).
- Preparing and serving alcoholic beverages responsibly – may include providing information to patrons about the type, strength and alcohol percentage of drinks.

- Assisting customers to drink within appropriate limits, for instance, monitoring the emotional and physical state of patrons for signs of intoxication, politely declining requests for alcohol by intoxicated persons.
- Assisting alcohol affected customers – will include both assessing drunkenness and making offers of assistance and/or using conflict resolution skills (e.g.,. warnings, requests to leave, seeking assistance from others).
- Problems associated with excessive consumption of alcohol.

Drink spiking in RSA

Since the rise of drink spiking in the public domain and media, the Australian Capital Territory, Victoria, Tasmania and Western Australia have chosen to include material relating to drink spiking in their RSA course. Queensland and NSW advise that future courses will incorporate this (and others may follow). Drink spiking material in the RSA course may include the following:

- drink spiking by bar staff as an unacceptable service practice;
- declining requests from patrons to add extra alcohol to unknowing friends/partners;
- the types of drugs thought to be used in drink spiking and the resulting effects;
- dealing with an incident of drink spiking; and
- advising patrons about unsafe drinking practices – e.g., leaving drinks unattended.

Administration

The administration of the Responsible Service of Alcohol course, the different roles played by government (liquor licensing boards), industry (e.g., the Australian Hotels Association) and training schools (e.g., TAFE) and the degree to which the course is mandated by legislation and who is mandated for (licensees, staff etc) varies across states and territories. Table 17 provides the specific details of the Responsible Service of Alcohol course in each state and territory.

Table 17: Responsible Service of Alcohol courses in each state and territory

	Management			**Operation**			**Mandatory**	
	Liquor licensing	AHA	Training school	Liquor licensing	AHA	Training school	Licensee/ manager	All staff
NSW	✓	-	-	-	-	✓	✓	✓
Vic.	✓	-	-	-	-	✓	-	-
Qld.	✓	-	-	-	-	✓	-	-
SA	✓	-	-	-	-	✓	✓	-
WA	-	✓	-	-	✓	-	✓	-
Tas.	✓	-	-	✓	-	-	✓	✓
NT	-	-	✓	-	-	✓	✓	-
ACT	-	✓	-	-	-	✓	-	-

5.2 Police and other industry training

In addition to the Responsible Service of Alcohol course offered nationwide for the liquor industry, other agencies may offer groups such as police, liquor industry staff and security staff information about drink spiking in attempts to reduce it. For instance, the NSW Attorney General's Violence Against Women Specialist Unit has previously provided education to police and security staff. This included information regarding:

- the nature and extent of drug-facilitated sexual assault;
- substances that could potentially be used in drink spiking;
- reporting to police;
- monitoring activity in licensed premises;
- protective behaviours to advise to patrons; and
- (for police) how to enter an incident of drink spiking into the system.

It should be noted that this training module may reflect similar programs in other states; the NSW training is given merely as an example of these efforts.

5.3 Other moves to prevent drink spiking

The Office of the Liquor and Gambling Commissioner in South Australia has advised that planned amendments to the *Liquor Licensing Act 1997* are currently before cabinet. These amendments will require licensed venues to adopt procedures aimed at preventing drink spiking (it has not been specified what these procedures will be).

5.4 Drink Testers

There are – at the time of writing this report – only two known drink testing kits currently available in Australia; the Drink Spike Detector and DrinkChecker. Both are cards which can be used to test for illicit drugs in a drink by placing drops of the drink onto the card for a positive or negative result. The Drink Spike Detector only claims to test for two drugs (GHB and ketamine) while the DrinkChecker claims to test for these and benzodiazepines. These tools are limited in their application to certain types of drinks, given that some bases (e.g., milk) may not produce an accurate result. These drink testers are mentioned in this report merely for completeness and *are not* here being endorsed given that their effectiveness in preventing drink spiking is yet to be assessed.

5.5 Public Campaigns

Awareness campaigns targeting (primarily) young people about the risks of drink spiking have become popular in the last couple of years. These campaigns tend to be highly localised and their content and duration varies. While strategies to raise awareness of the risks of drink

spiking and promote safer drink practices are to be commended, such campaigns mean that it can be difficult to determine whether increases in reporting to police reflect actual increases in drink spiking incidents or are a result of an increased awareness of the crime and the need to report it (State Crime Command Drug Squad 2003). It is also often the case that campaigns and studies to raise awareness of drink spiking are not fully or appropriately evaluated, meaning that it is difficult to know how effective such campaigns are in educating the community and changing attitudes and behaviour.

Since awareness and education campaigns are many and highly localised, it is not possible to include information on all campaigns to date. Instead, those on which some information is publicly available or which have involved the stakeholders spoken to in the context of the project have been included in Table 18. Moreover, the details given for each project may not include all components of a program and although the list refers largely to physical materials distributed for the public, workshops, presentations and other elements may have been incorporated. Although the precise materials used in each campaign and the location may vary, the aims of each are generally similar and could be assumed in large part to reflect the majority of awareness campaigns around Australia.

What are they trying to achieve?

Generally, awareness campaigns variously attempt to:

- increase knowledge about drink spiking;
- improve awareness of the risks of drink spiking and associated victimisation;
- provide strategies for protecting one's drink from being spiked;
- highlight the criminal nature of drink spiking and sexual assault; and
- encourage perpetrators to take responsibility for their own actions and those of other perpetrators by reporting incidents of which they are aware.

How are they conducted?

When targeting young patrons of licensed premises, awareness campaigns are generally conducted by placing materials such as A4 poster messages and stickers on mirrors, the backs of cubicle doors and above urinals in venue toilets. These posters generally contain information about the nature and risks of drink spiking and suggested strategies to reduce the likelihood of being a victim. Such strategies include:

- watching your drink;
- watching your friends' drinks;
- not accepting drinks from strangers;
- staying with friends when at bars and nightclubs; and

- leaving licensed venues with friends;
- Additionally, some campaigns have produced drink coasters and drink tags which bar staff can place over a drink that has been left unattended.

When targeting staff of licensed premises, information booklets may be distributed to staff about the dangers of drink spiking and how to identify and watch out for possible incidents and victims. Signs may also be placed near bars.

Are awareness campaigns successful?

The success of an awareness campaign depends upon both the objectives of the campaign and the appropriateness of the evaluation. Awareness campaigns can be difficult to evaluate because:

- there are often few concrete outcomes which can be measured;
- the initial objectives of the campaign are often ambitious and little thought is given to how all objectives will be measured in an evaluation;
- evaluations are often conducted as an afterthought rather than built into the design of the campaign; and
- levels of awareness prior to implementation of the campaign are generally not measured, meaning that there is usually no baseline against which to measure increases in awareness resulting from the campaign.

Measurement of the success of awareness campaigns usually revolves around surveying a sample of patrons at licensed venues to determine their level of recall of the messages in the campaign.

A campaign in action

It is worth mentioning one comprehensive drink spiking campaign recently launched in Queensland which attempts to link many agencies and community groups. A working group (including personnel from Queensland Health, Queensland Police, Liquor Licensing, Office for Women, Office for Youth Affairs, and Gold Coast and Logan sexual assault agencies) was formed over two years ago to respond to increasing community concern about drink spiking. With a central aim of raising awareness of drink spiking the campaign includes:

- resources and education for community groups to initiate local anti-drink spiking programs;
- advertising material (coasters, posters and postcards) for public venues including licensed premises; and

- funding for anti-drink spiking campaigns in universities.[59]

Arguably a strength of this approach is that it has the potential to mobilise any interested groups – volunteers, university student groups, women's groups etc. – to respond to drink spiking in any part of the State, in rural areas as well as cities. The working group also recognised that significant amounts of time and money are required to produce quality advertising material. To avoid this problem for the community groups the working group ensured that an arrangement was reached whereby the Queensland Government or community groups could reproduce the materials indefinitely without paying royalties. The materials are distributed free of charge. This approach not only circumvents the problem of interested groups 'reinventing the wheel' in terms of advertising material but it also assists to provide a standard message across Queensland.

Conclusions

Clearly, the success of awareness campaigns can vary and the quality of evaluations (whether they target the initial objectives of the campaign and whether they are conducted appropriately) will affect the outcomes and conclusions drawn. Several of the campaigns referred to above had listed a large number of initial objectives which were not measured in the reported evaluations. Perhaps even more importantly, awareness campaigns which are conducted without an analysis of the level of awareness existing prior to the campaign are likely to minimise their chances of being found to be successful. Awareness campaigns to date also, unfortunately, lack any attempt to measure the degree to which knowledge gained during the campaign is translated into changes in actual behaviour. Indeed, some of the above studies explicitly listed behavioural change as a specific objective of the awareness campaign but then did not measure (or even refer to) the degree to which awareness affected behaviour. Given that the ultimate goal of increasing awareness of drink spiking in the community is to prevent drink spiking through changing behaviour, it is somewhat surprising that no awareness studies to date have attempted to quantify the degree to which increased knowledge results in changed behaviour. This is clearly a direction for future research into awareness of drink spiking.

59 Other materials still being developed include educational guidelines for teachers and general practitioners and training courses for police officers.

Table 18: Public campaigns aimed at preventing drink spiking

Managers	Dates	Aims	Target audience	Project details	Outcomes
Qld Health; Qld Police; Whitsunday Sexual Assault Service	May 1999 (3 mths)	To raise awareness, reduce drink spiking, highlight potential harms & increase reporting.	Young female backpackers and local females in Whitsundays.	'Do you know what you're drinking?' A4 posters displayed in female toilets at accommodation centres and selected licensed venues in North Queensland.	No published evaluation; believed increased reports, venues/stakeholders positive about campaign (Qld Health 2002).
Gold Coast Sexual Assault Support Service	October 2000	To help to eliminate drug-facilitated sexual violence.	Young men and women – students and patrons of licensed venues.	'Drink spiking happens' Posters at venues warning of drink spiking and protective behaviours. Bookmarks/brochures about signs, protective behaviours and referral services.	No details of specific evaluation; outcomes said to include increased awareness and safer licensed venues.
Manly Council	Sept 2000 (1 mth)/Nov 2000 (2 mths)	To raise awareness, reduce drink spiking, encourage reporting and inform offenders of criminal nature.	Male and female licensed venue patrons aged 15-35 and female backpackers.	'Do not get spiked' A4 posters in toilets of licensed premises. Volunteers in licensed venues wearing 'Do not get spiked' t-shirts.	534 surveys of men and women showed advertising recall improved, but males thought spiking humorous (Meyers-Brittain 2001).
CASA House	August 2001 (3 mths).	To affirm women's rights in venues and highlight drink spiking as a crime.	Men and women in licensed venues and staff of venues.	'Right to party safely' A4 messages in toilets and bars of venues. Training for bar staff on responses to drink spiking incidents.	No published evaluation but licensee interviews showed positive attitude and bar staff more aware (CASA House 2001).
ACT Policing	August 2001 (ongoing)	Encourage govt approach, increase awareness; improve intelligence.	Young women (potential victims) and friends of potential victims.	'Drug rape: watch yourself, watch your friends' Posters, booklets and take-away cards distributed to schools, universities Television ads and website – warnings and protective behaviours. DVD for schools etc – warning signs, how to help, consequences Drink coasters/ tags warning patrons.	No published evaluation.
WA Police	Summer 2001/02 (Perth only) and Summer 2002/03 (State)	To increase awareness of drink spiking and ultimately reduce incidence.	Male and female patrons of licensed premises. Staff of licensed venues.	A4 posters with take-away cards in women's bathrooms in venues depicting harms of drink spiking, tips and assistance. A4 posters in men's bathrooms about criminal nature of drink spiking. Brochures and response cards for staff when incident occurs.	155 interviews conducted at three licensed venues: 37% had seen drink spiking messages in venues, but most females had not seen the take-away cards (Survey Research Centre 2003).

Managers	Dates	Aims	Target audience	Project details	Outcomes
Crime Prevention Victoria	May 2002 (8 mths)	To raise awareness, reduce drink spiking, improve awareness of potential harms and encourage reporting/ protective behaviours.	Male/female patrons of licensed venues aged 18-30. Staff of licensed premises	'Keep an eye out' A4 posters in toilets with take-away cards (for women – about signs and getting help) and warnings for men. Information for staff– detailed signs and how to deal with incidents.	142 interviews conducted with moderate recall of info; men identified criminal nature of drink spiking and women aware of available resources (Munro 2003).
Qld Liquor Licensing	June 2002(3 mths)	To increase awareness of drink spiking and improve staff response.	Patrons of licensed venues. Staff of licensed venues.	'Left it? Do not drink it' Posters in bathrooms and bars of venues and drink coasters/tags warning about unattended drinks. Brochures for staff about drink spiking.	325 males and females surveyed in 12 venues; moderate recall of information but other info not in campaign was similarly recalled (Anderson, Earl & Fleming 2002).
NSW Lesbian and Gay Anti-Violence Project	October 2002 and Summer 2002/03 (3 mths)	To reduce the incidence of drink spiking.	Homosexual patrons of licensed venues– residents and tourists Staff of licensed venues.	'A drink with a twist?' Posters in venues describing safety tips and referral information. Drink coasters warning of drink spiking. Information for staff of licensed venues about dealing with incidents.	No published evaluation.
Surry Hills community Drug Action Team	2003	To increase awareness of drug rape among young women who attend licensed venues/backpackers.	Young women aged 16-30 yrs.	'Drug rape: Watch yourself, watch your friends' Drug rape booklets distributed on weekend in licensed venues, cafes, backpacker hostels and chemists.	Quasi-evaluation with 101 women showed knowledge of high regardless of information and lower knowledge with NESB women (Bell 2003).
NSW Attorney General's Dept	2003 (starting dates varied by location)	To improve awareness, protective behaviours and the criminal nature of drink spiking.	Young women and other potential victims Potential perpetrators	Posters in venues warning of signs, consequences and protective behaviours. Posters warning perpetrators. Drink coasters warning victims and perpetrators (about crime of drink spiking).	No published evaluation.
NSW Attorney General's Dept	May 2003 (ski season)	To improve awareness about drink spiking and its criminal nature.	Young women and other victims Potential perpetrators	Posters in public toilets and venues. Information provided to seasonal ski workers, police, teachers, venue staff and bus drivers.	Survey showed that 63% had seen posters and 93% saw drink spiking as a crime (Meyers-Brittain 2003).
Qld Health	March 2004	To improve awareness and encourage protective behaviours.	Patrons of licensed venues. University students.	Posters in venues warning about drink spiking, protective behaviours, helpline. Drink coasters warning potential victims. Workshops with universities.	Project not yet completed.

5.6 Changing attitudes toward drink spiking

Developing strategies to prevent drink spiking will meet with limited success without an analysis of and attempt to change, societal attitudes toward drink spiking and drug facilitated sexual assault. In particular, where sexual assault is the motivation, attitudes of perpetrators toward the use of alcohol and drugs to stupefy victims is critical if prevention strategies are to be effective. Previous research into drug facilitated sexual assault (primarily conducted through surveys with college students) has highlighted serious concerns relating to attitudes of male perpetrators. Koss, Gidycz & Wisniewski (1987; see also Koss, 1988) surveyed 3187 female students and 2972 male students across the United States to document the incidence and prevalence of sexual assault among young people attending college in the US. It was found that:

- 74 per cent of self-reported male sexual assault perpetrators indicated doing so when the victim was intoxicated through alcohol and/or drugs; and
- 88 per cent of self-reported male perpetrators did not categorise the incident as rape.

Tyler, Hoyt & Whitbeck (1988) examined the use of coercive sexual strategies by men and the outcomes of these behaviours for women through the use of a self-report survey with 190 male and 351 female college students in the United States. Key findings were that:

- 23 per cent of male respondents admitted to getting a date drunk or stoned to engage in sexual intercourse; and
- males who drank alcohol more frequently in general were more likely to use alcohol or drugs with females as a means of obtaining sex.

Abbey, McAusland, Zawacki, Clinton & Buck (2001) investigated the extent of sexual assault perpetration amongst 343 college men in the United States and attitudinal correlates. Key findings were that:

- 33 per cent reported perpetrating some form of sexual assault;
- 35 per cent of these assaults involved alcohol consumption and that it was 'most likely during rapes, with both the man and the woman drinking' (p.794);
- rapists tended to attribute responsibility for the assault to their own and the woman's alcohol consumption; and
- men who committed rape tended to use more alcohol or other drugs to obtain sex during the assault.

Abbey et al argue that alcohol and sexual assault prevention efforts need to be combined and that 'men need to know…that having sex with a woman too intoxicated to give consent is illegal' (p.804). They advocate such education commencing in high school and continuing through to university. These concerns about the need to educate young people about sexual relations and consent was also a theme which emerged strongly in discussions with stakeholders, and provides the basis for one of the information options proposed in Section 6.

Section 6.0: Options for trialling information / education kits for stakeholders

One of the outcomes for this project was to identify potential options for information kits for stakeholders which could be trialled in Stage 2 of the National Project on Drink Spiking. The options identified in this section are for police, sexual assault counsellors, hospital emergency staff, liquor industry staff, patrons of licensed venues, secondary and tertiary students, and other groups/organisations wishing to know more about and prevent drink spiking. For each of these stakeholders, the options outline:

- the problems to be addressed;
- the goals to be achieved;
- possible strategies for each information kit; and
- the content which could be included in each kit.

These options are proposed in Boxes 8 through 16 below and are based primarily on the themes and issues which emerged from the discussions with stakeholders (see Section 3). The options proposed for patrons of licensed venues are based on findings from the AIC hotline data as well as current drink spiking campaigns.

6.1 General duties police officers

Box 8: Problem 1 – Police attitudes to drink spiking

Problems	Goals	Kit format	Kit content
Belief that drink spiking is only a crime when associated with a sexual assault 'Cultural acceptance' of spiking drinks with alcohol for pranks or similar motives. Media influence on police attitudes High rate of false complaints (unintentional or intentional) may engender cynicism	Officer should have a rounded understanding of the complexities of drink spiking based on the best available evidence and intelligence. Officers should respond to complaints with an open mind.	Well indexed written manual for quick reference to technical information. Handbook with condensed information from the manual. Video for group training, focussing on real prosecutions with a story-driven format. Investigating officers to give narration. Posters to be displayed in police stations – at the front desk/ public foyer and interview rooms.	*Manual* Canvass available evidence on the nature and extent of drink spiking, making reference to both male and female victims. Use criminal cases to highlight variety of circumstances regarding people, places, times and substances. *Manual and Handbook* Specific to each jurisdiction, a list of offences applicable to different forms of drink spiking (covering different motives and/or substances). Explanation of dangers associated with 'prank' drink spiking, including death via car accidents. *Manual, Handbook and Posters* List of reasons why • false complaints may sometimes be made (unintentionally or intentionally); • victims may never report their experiences; and • genuine complaints may not appear credible *Video* A number of acted scenes of victims reporting drink spiking, conveying emotional states and unsettling, vague memories. Details of cases where prank drink spiking resulted in death, possibly reproducing actual photographs from police files. Description of cases by investigating officers, leading onto an explanation of officer's own change in attitudes away from stereotypes.

Box 9: Problem 2 – Inappropriate or inconsistent responses to drink spiking complainants

Problems	Goals	Kit format	Kit content
Inappropriate questioning, bluntness and insensitivity may cause emotional distress and result in the victim withdrawing his or her formal complaint. Different and confusing messages may be given to the community about the police interest in both formal complaints and informal reports of drink spiking.	Consistency between general duties police officers in the way that they react to drink spiking complaints. Complainants must be treated respectfully.	Well indexed written manual for quick reference to technical information. Handbook with condensed information from the manual. Video for group training, focussing on real prosecutions with a story-driven format. Investigating officers to give narration. Posters to be displayed in police stations – at the front desk/ public foyer and interview rooms Stickers for dashboards of police cars.	*Manual* Summarise main characteristics of psychological reactions to sexual assault. It should be emphasised that sexual assault complainants require special care to avoid emotional distress and jeopardising a potential investigation. *Manual and Handbook* General duties officers to refer all complaints of sexually motivated drink spiking to specialist officers, e.g., in sexual assault or sexual crimes units. If in accordance with local police procedures, advise officers to arrange a sexual assault counsellor to accompany the complainant through the process of making a formal complaint to the police. Male sexual assault services should be contacted in situations where the complainant is a male. Manual to contain blank spaces into which contact details could be inserted of specialist officers, sexual assault counsellors for females and sexual assault counsellors for males. Officers to be discouraged from dismissing complaints without discussing the situation with an officer identified as having relevant experience. Officers on duty at the front desk of police stations to locate appropriate officer to respond to drink spiking complainants. At a potential crime scene (e.g. nightclub), officers to attempt to make phone or radio contact with an appropriate officer before dismissing a drink spiking complaint. Informal reports of drink spiking to be accepted and encouraged. *Posters* Outline procedures for complaints and informal reports. Contact details of relevant officers and sexual assault counsellors highlighted. *Stickers* Designed so that contact details of relevant officers and agencies can be written on them. *Video* Dramatised scenes of inappropriate and appropriate police responses to complainants, highlighting the victim's perspective.

Box 10: Problem 3 – Unclear procedures governing the intelligence/evidence collection by police

Problems	Goals	Kit format	Kit content
Officers do not enter data on drink spiking offences accurately or at all. This limits the ability of databases to reflect trends. Some officers discourage anonymous reporting, or, do not interact positively with sexual assault agencies. These practices may hamper the flow of intelligence to the police Delays in arranging blood and urine samples cause toxicological evidence to be lost. Sending samples to forensic labs with insufficient documentation increases delay and costs. Officers may neglect to seek evidence from hospitals, private residences and licensed premises.	General duties police officers should recognise the importance of intelligence for police responses to drink spiking. Officers should understand the appropriate steps to enter information about drink spiking complaints into police databases. Officers should have a good knowledge of the common forms of evidence in drink spiking cases, where they can be located and how the evidence should be processed.	Well indexed written manual for quick reference to technical information. Handbook with condensed information from the manual. Video for group training, focussing on real prosecutions with a story-driven format. Investigating officers to give narration. Posters to be displayed in police stations – at the front desk/ public foyer and interview rooms	*Manual* Information on the rates at which substances associated with drink spiking leave the blood and urine, with an emphasis on collecting samples without delay. This should be balanced with warnings against pressuring complainants into providing samples or breaching local procedures governing when a person is deemed to be incapable to give consent. Sexual assault services can refer complaints/intelligence to police; networks with such agencies are often informal and must not be damaged by negative behaviour of officers. *Manual and Handbook* Actual images of the relevant 'windows' used to explain where and how information should be stored (specific to each jurisdiction). Emphasis to be placed on the importance of entering even vague reports. *Manual, Handbook and Poster* Both blood and urine samples need to be collected. When samples are submitted to a forensic laboratory they need to be accompanied by a report containing: • an estimation of the time between the alleged drink spiking incident and when the blood and/or urine samples were collected; • the symptoms experienced by the complainant; • the quantities of drugs and alcohol that the complainant reported voluntarily consuming, if any; • drugs administered to the complainant at hospital; and • the surrounding facts of the case. Where police cannot take samples because of delay, officers must investigate whether samples were taken by another agency before the samples are destroyed. Although toxicological evidence is valuable emphasise (a) a successful prosecution could be based on other evidence and (b) evidence gathered in relation to one complaint may be crucial after further complainants come forward and more evidence is gathered. It *may* be appropriate for officers to ask a drink spiking complainant to undergo a physical examination for signs of sexual intercourse. Video Case studies of successful prosecutions that drew on a wide variety of evidence.

6.2 Sexual assault counsellors

Box 11: Problems and responses for sexual assault counsellors

Problems	Goals	Kit format	Kit content
Only some clients present within the time frame in which substances can be detected in their samples, later to be used as evidence. Frequently these clients are confused about whether to give samples and what they wish the samples to be used for: (a) only to know if their drinks were spiked, or (b) to collect evidence for a formal complaint to the police. If samples are not collected by forensically trained physicians and processed in a way that maintains the chain of evidence they cannot be tendered as evidence in a criminal trial.	Sexual assault counsellors should be able to promptly facilitate the taking of blood and urine. Counsellors should be able to provide their clients with all available options in a way that respects the client's wishes and maximises their legal choices in the long-term. Counsellors must have a rounded knowledge of the complexities of drink spiking to be able to counsel their clients as effectively as possible.	Content to recognise the variability of responding to the needs and emotions of individual sexual assault survivors. Handbook with condensed information. Video for group training conveying general information narrated by experienced counsellor. Powerpoint presentations for email distribution to counsellors in regional and urban areas and private viewing. Posters to be displayed in staffrooms.	*Handbook, Video and Powerpoint* Information on time that substances associated with drink spiking are detectable in the body. Telephone counsellors to advise clients to present to an agency directly. Advise client to collect their own urine if necessary. Suggest to their client that they give two sets of blood and urine as soon as drink spiking appears to be a likely element of the complaint. Clients to be reassured that they can give samples and decide what to do with them later. Where counsellor not adequately trained, local forensic physician to be contacted to take the samples. Outline the benefit of collecting two sets of samples; (a) the set collected according to the rules of evidence can be analysed by forensic laboratories if the client makes a formal complaint to the police and used in a prosecution; (b) the other set can be sent to a hospital or a commercial laboratory for testing if the client simply wants to know whether their drink was spiked without making a formal police complaint. Inform clients that forensic laboratories tend to be better placed at detecting substances than therapeutic laboratories. Explain steps counsellors can take to have the samples stored whilst the client decides what actions they wish to take. Emphasise that these procedures empower the client by maximising their choices; for some clients criminal prosecutions are important for healing. Provide information about why people may falsely report or may not realise their drinks were spiked. Highlight that many substances cause people to become disinhibited before falling unconscious (this may help to reduce self-blame). Be ready to inform clients that they may never be able to remember what happened; counselling can then perhaps progress to dealing with different issues important for healing. Counsellors to be wary of suggesting drink spiking if not raised by the clients, unless it is urgent. *Poster* Diagram listing steps for collection of samples. Emphasise value of de-identified data for police; encourage support of any systems for gathering data by their agency. Blank spaces for entry of contact details of forensically trained physicians and police contacts.

6.3 Emergency staff in hospitals

Box 12: Problems and responses for emergency staff in hospitals

Problems	Goals	Kit format	Kit content
Staff at all levels vary in their perception of drink spiking. Some do not perceive drink spiking to be a very common occurrence. Genuine complainants may not have blood and urine samples taken. Genuine complaints may not be referred to police unless they also present with a recent sexual assault. Victims may form impression from reaction of the hospital that other agencies will not take their complaints seriously, that they have no options or that drink spiking is not illegal. Hospitals do not have resources to provide a high level of care or info for complainants.	Emergency staff at all levels should be cognisant of the evidence exists about the prevalence of drink spiking and prepared to respond to drink spiking complainants on a case by case basis. Emergency staff should be able to provide contact information of other agencies that can respond to drink spiking complainants.	Handbook with condensed information to be (a) delivered to directors of emergency departments and (b) stored in the front desk of the accident and emergency section. Posters to be displayed behind counter of front desk. Information cards for complainants to take away with contact details of other agencies.	*Handbook, Video and Powerpoint* Information on drugs linked with drink spiking and the prevalence around the country. Summary of why drink spiking is difficult to detect, investigate and prosecute. Explanation of the complexities underlying false reports, though drink spiking is difficult to quantify there are indicators it is a crime hospitals need to be aware of. After explaining causes of false reporting, underscore that genuine complainants are actually *likely* to present with vague reports, which appear to lack credibility. If emergency staff are undecided about the credibility of a drink spiking complaint they should seek the opinion of an appropriately trained or experienced police officer. Where drink spiking is suspected collect two sets of blood/urine samples promptly. One could be tested immediately to establish medical condition (immediate wellbeing of victim). The other sample should be collected according to the rules of evidence so that it can be used to make a formal complaint to the police if required. This sample should be processed by a forensically trained physician for evidentiary purposes. It is important to follow the correct procedures so that the evidence is admissible for purposes of building the "chain of evidence". Where a patient is brought to hospital unconscious, any indications of sexual assault or robbery should prompt consideration of the collection of these samples. Where recent drink spiking is suspected, emergency staff should note facts that may help police investigate, including: • the people or vehicle that delivered the patient; • names or relevant information given by the patient, even if inebriated; • symptoms evident in the patient; and • any substances that may have been administered to the patient in the care of the hospital. *Poster* Common symptoms of drink spiking and blank spaces for the contacts details of (a) forensic physicians and (b) relevant local police officers. *Information cards* All patients that complain of drink spiking should be given contact details of specialist police officers; sexual assault agencies; drug and alcohol information services.

6.4 Liquor industry staff

Box 13: Problems and responses for liquor industry staff

Problems	Goals	Kit format	Kit content
Varied perceptions of the prevalence and seriousness of drink spiking. Lack of acceptance that sexually motivated drink spiking can occur in some settings, such as quiet licensed premises. Influence of the 'cultural acceptance' of drink spiking with alcohol for pranks or entertainment. Amongst other things, the fact that some bar staff allegedly spike drinks with extra alcohol indicates that this form of drink spiking is not seen as dangerous or potentially illegal.	Bar staff and managers must be aware of the potential for sexually motivated drink spiking. Bar staff and managers must be aware of the seriousness of prank drink spiking with alcohol or other substances. Managers at least must have strategies in place to respond to drink spiking incidents.	Education kits to distribute to licensed premises, or incorporate into the responsible service of alcohol courses. Kits must cater for variety of establishments – quiet pubs to busy nightclubs. Handbook with condensed information. Video for group training conveying general information narrated by experienced police officer. Very durable laminated stickers for the surface of bars or behind bars. These will be designed to remind bar staff to be vigilant.	*Video* Description of cases by police, leading to explanation of officer's own change in attitudes from stereotypes. Explore the variety of contexts of drink spiking (e.g. sexually motivated drink spiking in restaurants). Emphasis of pranks that resulted in death. Interviews with managers/bar staff of licensed premises relating their encounters with drink spiking, preferably experiences that led to police investigations. *Handbook and Video* Basic summary of available evidence on the nature and extent of drink spiking, making reference to both male and female victims. Generalized summary of the types of criminal applicable to different forms of drink spiking (covering different motives and/or substances). Explanation of dangers associated with prank drink spiking (including death via car accidents) and associated criminal charges, including manslaughter. Explanation of drugs that can be used in drink spiking to be avoided. Strategies to include: • vigilance of male and female patrons' behaviour consistent with symptoms of drink spiking (e.g. sudden intoxication); • inform manager if a patron falls unconscious and keep the victim's glass; manager to call ambulance; • managers to preserve any CCTV footage after any apparent drink spiking incidents; • observe lone females and unattended drinks • be aware of unusual requests for beverages (e.g. beer with a nip of vodka) – refuse such drinks if managerial policy; • report suspicious behaviour of other staff members • maintain anti-drink spiking advertising in well lit. prominent parts of the licensed premises; and • crowd controllers to record in their incident notebooks a description of males escorting inebriated females away from a licensed premises. *Stickers* Eye-catching reminder to be vigilant of drink spiking, to report incidents to managers and to secure glasses of apparent victims.

6.5 Secondary and tertiary students

Box 14: Issues and opportunities for students

Issues	Goals	Kit format	Kit content
Young people are an at-risk group for drink spiking. They increase their use of alcohol/ drugs into their 20s. Narrow beliefs exist regarding drink spiking: - victims are young women in cities - perpetrators are strangers - specific drugs are used - it is only illegal if it involves rape and/or drugs - drink spiking with alcohol is only a bit of fun. Misconceptions of consent in sexual relations may underlie sexually motivated drink spiking. Misconceptions may develop during teens. Various factors may hinder young victims from reporting experiences.	Stereotypical views of drink spiking held by young people must be challenged. Young people need to be educated about sexual relations /consent. Young people should be equipped with basic knowledge of protective strategies against drink spiking. Young people should be informed how to respond to drink spiking if they or another person have been victimised.	Group education Secondary students: incorporated into existing life-skills classes (separate for boys and girls). Tertiary students: incorporated into introductory lectures. Video and PowerPoint presentation for teachers, lecturers, counsellors or university student groups. Advertising material Succinct information to be added to existing websites (e.g National Union of Students). Information brochure. Stickers for students' diaries or for toilet doors etc. Posters for common rooms, student facilities etc.	*Video* Documentary narrated by male police officer describing actual cases. Potential for narration by carefully chosen male celebrity. If possible, actual victims to explain the impact of the crime. *Video, PowerPoint and brochures* The varied contexts of drink spiking Places: urban and regional, public and domestic. Victims: females or males of any age. Perpetrators: friends or strangers. Motives: include sexual assault, robbery or pranks. Many substances can be used including alcohol (no specifics regarding drugs). Symptoms outlined. Drink spiking is illegal and dangerous Penalties for drink spiking. Describe requisite consent in sexual relations – heavily inebriated people cannot consent. Story-driven format for dangers of prank drink spiking. Medical dangers regarding allergies, interaction with other drugs, driving after being spiked etc. Preventative strategies Effects of alcohol/drugs. Be wary of drinks from strangers. Withdraw from dangerous situations. Quickly report to bar staff, police, hospitals etc if sense symptoms of drink spiking. Watch friends. Call parents/ guardians for help even if have 'broken the rules'. Help for victims Agencies understand why reports may be vague. They aim to empower and assist victims. Can get help anonymously. Anonymous reports help police. Intentional false claims have negative effects. *Sticker* Basic reminder of the danger, illegality and immorality of drink spiking. *Poster* Highlight help for victims with space for contact details of local agencies. Outline basic preventative strategies.

6.6 Mobilising social capital – community groups / organisations

Box 15: General information for parents, communities and associations

Issues	Goals	Kit format	Kit content
Drink spiking may become a problem in any region and affect different social groups. Drink spiking may be a persistent problem in a city. It can also be a short-term but intense problem in a particular premises. Members of the community are unaware of prevention strategies, support for victims and misunderstand the nature of drink spiking. Attitudinal problems concerning drink spiking with alcohol and consent in sexual relations may aggravate offending.	Social groups of any description should be able to access a simple and inexpensive kit that enables them to promote effective public education. Different groups should be able to tailor the kits to form strategies directly applicable to their situation.	Example target groups: hotels, pubs, restaurants, hostels, sporting clubs, ethnic associations, church groups and charities, 'parents and friends'/school associations, university societies and women support groups. Video/DVD for group presentations narrated by police officers conveying general information whilst specifically tackling attitudinal issues. PowerPoint presentation for email distribution. Information brochure. Posters for foyers, reception areas, toilets etc.	*Video* Documentary narrated by male police officer describing actual cases. Potential for narration by carefully chosen male celebrity. If possible, actual victims to explain the impact of the crime. *Video, PowerPoint and brochures* The varied contexts of drink spiking Places: urban and regional, public and domestic. Victims: females or males of any age. Perpetrators: friends or strangers. Motives: include sexual assault, robbery or pranks. Many substances can be used including alcohol (no specifics regarding drugs). Symptoms outlined. Drink spiking is illegal and dangerous. Penalties for drink spiking. Describe requisite consent in sexual relations – heavily inebriated people cannot consent. Story-driven format for dangers of prank drink spiking. Medical dangers regarding allergies, interaction with other drugs, driving after being spiked etc. Preventative strategies Effects of alcohol/drugs. Be wary of drinks from strangers. Withdraw from dangerous situations. Quickly report to bar staff, police, hospitals etc if sense symptoms of drink spiking. Watch friends. Call parents/ guardians for help even if have 'broken the rules'. Help for victims Agencies understand why reports may be vague. They aim to empower and assist victims. Can get help anonymously. Anonymous reports help police. Intentional false claims have negative effects. *Sticker* Basic reminder of the danger, illegality and immorality of drink spiking. *Poster* Highlight help for victims with space for contact details of local agencies. Outline basic preventative strategies.

6.7 Patrons of licensed premises

Box 16: Problems and responses for patrons of licensed premises

Issues	Goals
Perpetrators target licensed premises because of high alcohol consumption, gregarious social contexts in which it is socially acceptable for people to buy each other drinks, low level lighting and high levels of noise which ease the act of spiking. Licensed premises probably are places where prank drink spiking with alcohol is common. Patrons may be unaware of the dangerousness and illegality of prank drink spiking. Many campaigns have targeted patrons of licensed premises with advertising material. No strategies have considered the need for different messages for premises which attract different age groups, namely those under 30 and those over 30. Under 30s are more likely to be victimised in licensed premises and more likely to be victimised by strangers than over 30s.	Patrons of licensed premises should be informed of the danger, illegality and immorality of all forms of drink spiking. Patrons of licensed premises should be aware of basic preventative strategies. Different emphases should exist in licensed premises that predominately attract clientele aged under 30 and over 30.

Kit format	Kit content
Durable laminated stickers for the surface of bars or behind bars. Posters and stickers for toilets and general areas. Coasters for tables and bar surfaces.	*Laminated stickers* Remind staff to be vigilant about drink spiking. Inform patrons that unusual beverages not sold unless the person intending to consume it is aware of the alcohol content. **<u>Under 30 age bracket</u>** *General: posters, coasters and stickers (varied content)* -effects of standard shots of alcohol -monitor carefully how much alcohol you are drinking -wariness of accepting drinks from strangers without seeing the drink prepared -friends/ acquaintances can also be perpetrators -report to bar staff if sense symptoms of drink spiking -watch friends and designate a non-drinking friend. -call parents/ guardians for help even if have 'broken the rules'. *Male toilets: posters and stickers (varied content)* danger, illegality and immorality of sexually motivated and prank drink spiking **<u>Over 30 age bracket</u>** *General: posters, coasters and stickers (varied content)* -can happen in bars and restaurants, at parties or at victim or offender's home, -can happen with people you know (friends, work colleagues) -report to bar staff or police if sense symptoms of drink spiking -perpetrators may win confidence and trust of their victims *Male toilets: posters and stickers (varied content)* danger, illegality and immorality of sexually motivated and prank drink spiking

Section 7.0 Conclusions and Recommendations

The issue of drink spiking in the community has been of increasing concern in the last few years. Considerable media attention has placed drink spiking squarely in the public eye, and this has led to an increase in awareness campaigns being conducted on a localised level around the country. This report has stemmed from this increasing interest in drink spiking, and the lack of knowledge to date about the nature and extent of drink spiking in Australia. While this section will provide recommendations relating to ways in which data collection and synthesis can be improved, it is acknowledged that there will be resource implications involved which may make the implementation of some of the recommendations difficult or impractical. The recommendations in this section should be viewed as a means of highlighting where gaps currently exist in relation to drink spiking and where improvements could potentially be made in the future if it were deemed appropriate, practical and not too resource-intensive.

7.1 Difficulties in researching drink spiking

Research into drink spiking is not straightforward. Survey-based research is severely hampered by difficulties in both identifying and accessing the target population (i.e. potential drink spiking victims). Findings from surveys which use convenience samples are likely to produce conflicting results relating to prevalence and nature of incidents due to the different types of survey respondents used. Due to the difficulties in identifying potential drink spiking victims, prior survey research has tended to focus largely on drug facilitated sexual assault victims. This has meant that such research has:

- tended to focus on sexual assault as associated criminal victimisation (neglecting other types of criminal victimisation);
- treated drug facilitated sexual assault as though it were the same as drink spiking (it is not); and
- provided some insights into the circumstances in which drug facilitated sexual assault may occur, but not many insights into the variety of circumstances in which drink spiking *per se* may occur.

Police data and other official data, on the other hand, will not accurately reflect the extent of drink spiking within the community due to very low levels of reporting and differences in recording and extraction procedures both within and between jurisdictions. Verification of suspected drink spiking incidents provides an added dimension of difficulty in determining prevalence since forensic testing of blood and/or urine needs to be conducted within a short space of time after ingestion of the drink and even if drugs or alcohol are found at the time of testing this does not necessarily mean that one's drink was spiked. Alcohol or drugs could have been ingested voluntarily.

7.2 What do we now know about the nature and extent of drink spiking?

Based on analyses of police data, sexual assault data and AIC hotline data it was found that:

- 4 out of 5 victims are female;
- 1 in 5 victims is male;
- about half of drink spiking victims are aged under 24, while about one third are aged between 25 and 34;
- the majority of suspected drink spiking incidents have no additional criminal victimisation. It is not clear whether these incidents result from (a) 'prank spiking', (b) an inability of the offender to carry out additional victimisation, or (c) people being unaware of how much alcohol they are consuming and misattributing the effects to alcohol. Based on views of stakeholders and anecdotal evidence it is likely that at least some of these instances involve 'prank spiking'.
- between 20 and 30 per cent of reported incidents involve sexual assault, while it is estimated that about one third all drink spiking incidents are associated with sexual assault;
- two thirds of drink spiking incidents occur in licensed premises (although for sexual assault victims the location is just as likely to be at the victim or offender's home or another location);
- many victims do not know who the offender was;
- where offenders can be identified, drink spiking in general is equally likely to be perpetrated by a stranger or known acquaintance, while incidents involving sexual assault are more likely to occur with a known offender;
- many victims experience memory loss after drink spiking;
- apprehension of offenders is very uncommon;
- forensic testing of blood and urine samples is relatively rare and does not conclusively prove that drink spiking has or has not occurred; and
- the vast majority of incidents of drink spiking are not reported to police.

Further, based on the police data provided by each jurisdiction to the AIC and estimates of reporting levels to police, it was roughly estimated that during the period 1 July 2002 and 30 June 2003:

- between 3000 and 4000 suspected incidents of drink spiking overall occurred in Australia;
- about one third of incidents are believed to have involved sexual assault;
- between 15 and 19 suspected incidents occurred per 100,000 persons.

Again, it must be emphasised that the estimates calculated in this report are based on a range of assumptions and should be used as a rough guide only while we move to improve the empirical evidence base on drink spiking. It is precisely because it is not currently possible to identify the exact numbers of incidents which are occurring that estimates have been calculated. These estimates are the best which can be calculated at the present time and represent a step forward in the quest for quantification of drink spiking given that this is the first time that police data on drink spiking has been compiled at a national level. As data collection and extraction procedures improve, the ability to estimate the prevalence of drink spiking with greater accuracy in the future should also improve.

We now have an empirical evidence base from which to inform discussion and policy about drink spiking. Suspected incidents of drink spiking do appear to happen frequently enough to justify concern. About one third of all suspected drink spiking incidents are estimated to involve sexual assault, based on estimates of under-reporting to police. This is a substantial figure, compounded by the fact that many victims experience memory loss and physical dysfunction. Many of the sexual assault victims in the AIC hotline described their pain and anguish about the incident, the severity of the attack and their continuing feelings of vulnerability and mental torment. Those for whom memory loss meant that they could not recall details of the incident or the offender described their fear of going out in case the offender was watching them and their frustration at simply not knowing what happened. Less than five per cent of reported incidents involved robbery, indicating that sexual assault is the primary criminal victimisation associated with drink spiking.

Given that the majority of drink spiking incidents do not involve any additional criminal victimisation the findings also suggest that 'prank spiking' may be a common motivation for drink spiking. This finding is important because it highlights that drink spiking incidents should be considered in terms of whether they are motivated by intent to commit further crimes (e.g. sexual assault, robbery) or desire to liven up a party, see the results etc. While it is possible and indeed likely that in some instances no additional victimisation may occur due to the offender being somehow thwarted in carrying out any additional victimisation, it is also likely that many instances of drink spiking occur in which no additional victimisation is intended. Getting a better understanding of motivations in drink spiking should be a goal of future research as the findings will assist in refining and better targeting messages for both victims and offenders, as well as assist in refining prevention strategies. The findings in this report also highlight that the use of 'stranger danger' in awareness campaigns may be missing the mark since known acquaintances are commonly offenders in both sexual assault and non-sexual assault cases.

Further, we now have a better understanding of where drink spiking occurs. In the police data 67 per cent of reported incidents occurred at a bar or nightclub while 78 per cent of incidents in the hotline data occurred at a licensed premises. Licensed premises then are clearly a prime location for drink spiking. This has implications for targeting prevention strategies – bar staff and crowd controllers need to be well informed about the dangers of drink spiking and what to watch out for. While licensed premises should not be held responsible for preventing drink spiking in licensed premises (this distinction between 'being responsible' and 'being held responsible' was raised by liquor industry stakeholders) there are clearly ways that licensed premises can assist in improving the detection of possible drink spikings and offenders. This may involve being more watchful and wary of people who appear 'intoxicated' being escorted

out of licensed venues by another person. Reporting suspected incidents or offenders to police by licensed premises is also recommended as a useful strategy.

For sexual assault victims, the location is equally likely to be the victim or offender's home or another location. In targeting strategies to prevent drink spiking sexual assaults, consideration needs to be given to the fact that, *compared with non-sexual assault victims*, offenders are more likely to be known to the victim and less likely to occur in a licensed premises. This reinforces the need for prevention strategies to be appropriately targeted to accommodate different types of victim and offender – one size does not fit all.

7.3 Has drink spiking been increasing?

This report has not been able to address the question of whether drink spiking has been increasing over the last couple of years. Primarily this is due to the difficulties referred to throughout this report associated with distinguishing *actual* increases in incidence from *reported* increases in incidence. The increase in awareness and education campaigns around the country undoubtedly impact on the degree to which suspected drink spiking incidents are reported to police, hospitals and other agencies in those areas. This was suspected to be the case in this report for reported incidents to the Australian Capital Territory and Western Australia police in particular during 2002/2003.

Beliefs about prevalence and perceived increases in prevalence varied markedly between and within stakeholder groups. Sexual assault stakeholders more generally believed that the incidence of drink spikings associated with sexual assault have been increasing but again this is likely due to the increases in reports to these agencies. There appears to be no doubt that *reporting* of drink spiking has been increasing in recent times; what remains unclear however is whether the actual incidence of drink spiking has been increasing. This remains an important question for future research but it will only be able to be answered if systematic procedures are put in place which will allow such analysis to be conducted. Perhaps a first step would be to try and determine whether and how reporting varies as a function of awareness campaigns through pre-selecting two similar sites, determining reporting rates, implementing an awareness campaign in one of those sites and treating the other site as a control group, and then determining reporting rates at the conclusion of the awareness campaign. Following on from this would need to be data collection by police, hospitals and forensic laboratories which is systematic, reliable and easily accessible so that trends over time in reporting could be identified and compared between data sources.

7.4 Improving reporting of drink spiking to police

If we are to gain a better understanding of how often drink spiking occurs and if police are to be able to identify patterns of drink spiking and develop targeted policing strategies there is clearly a need to improve the rates of reporting to police. It is clear that awareness campaigns in the past have resulted in increased reporting levels to police (e.g. ACT, Western Australia) – this implies that publicity campaigns do impact on reporting levels.

However publicity campaigns are expensive to conduct and usually last only a short period of time. It is not feasible to maintain them over long periods which means that reporting levels will reduce once the campaign has stopped. Other measures are therefore required to improve reporting rates. It was noticeable that in the AIC hotline data, in 32 per cent of incidents which were reported to police victims believed they had been dismissed with little or no information recorded about their experience. If victims are to report incidents of drink spiking to police they must believe that it is worthwhile for them to report and that the police will listen sympathetically, treat the incident seriously and record all the information which victims are able to provide. As many victims experience memory loss after an incident of drink spiking, they may feel that their testimony is not credible, that authorities will not believe them or that there is no point in reporting the incident. Police and other authorities need to understand that many victims will not be able to remember details of the incident but that this should not discourage victims from reporting and authorities should not dismiss such reports simply because victims cannot remember or the story does not sound plausible.

The community should also be advised that all incidents of drink spiking (with or without additional victimisation) should be reported to police and other authorities – to counter any belief that only serious drink spiking incidents or only incidents involving sexual assault or robbery should be reported.

7.5 Improving police recording practices

A major finding in this report was that police recording and data extraction procedures need to be considerably improved if police wish to use intelligence-led policing in the area of drink spiking. Apart from the fact that recording procedures differ markedly between jurisdictions, it is clear that:

- recording of drink spiking incidents (who, what, when, where, how and why) *within* jurisdictions varies;
- searching for drink spiking incidents in police databases is difficult and time-consuming;
- finding information on characteristics surrounding each incident can often only be determined through a manual narrative or text search (extremely time-consuming); and
- there is no guarantee that a search will locate all incidents which have been reported and/or recorded.

To address these issues it is recommended that:

- police recording procedures be improved and standardized (at the very least within jurisdictions if not between jurisdictions);
- all incidents which are reported to police (even where only suspected or story sounds implausible) be recorded accurately and systematically. If such incidents are later shown to be inaccurate or incorrect this information will be useful in indicating the percentage of all reported incidents which are found to be incorrect;

- a specific drink spiking code be used to record any and all incidents in which a suspected drink spiking occurred (such as now applies with the PROMIS database);
- the variety of information which is collected about drink spiking incidents is properly coded and entered into police databases (not left as text in narratives to be ignored); and
- consideration be given to how data can and should be extracted and in what form, which would be most useful for police in understanding and mapping where, how and why reported drink spiking occurs.

7.6 Improving verification procedures

In many ways, verification of the incident is perhaps the most central to explaining the difficulties associated with identifying the nature and extent of drink spiking. Being able to prove whether the incident occurred can affect both the victim's decision to report the incident and may also affect whether and how the incident is recorded by police. However, drink spiking is often associated with memory loss meaning that the victim is unable to provide reliable details about the incident, who the offender was, or what happened afterward. Victims may feel that this lack of ability to recall details invalidates their claims and makes their testimony unreliable. This makes forensic testing (as well as collection of other types of evidence) all the more important in allegations of drink spiking. As noted, however, forensic testing must be done within a very short space of time after ingestion of the drink or potential additives may disappear from the body without trace.

Discussions with forensics stakeholders identified several issues relating to the improvement of forensic testing procedures. In particular, when receiving samples from the police, hospitals or other agencies forensic labs need:

- an estimation of the time between the alleged drink spiking incident and when the blood and/or urine samples were taken from the complainant ('latency');
- a full description of the symptoms experienced by the complainant;
- a record of the quantities of drugs or alcohol the complainant reported voluntarily consuming, if any;
- a record of any drugs administered to the complainant at hospital; and
- a general description of the surrounding facts of the case.

Further, it was suggested that there could be better coordination between police, hospitals and forensic labs when processing victims and blood and urine samples. Sir Charles Gairdner Hospital in Perth would be an example of where such coordination between all agencies works well. Sir Charles Gairdner Hospital is presently undertaking a project investigating drink spiking which requires victims to present to the hospital for samples to be taken and analysed. This effort requires coordination with other agencies since victims don't always report immediately to Sir Charles Gairdner Hospital; they may do so later, or simply choose another agency (e.g., police, sexual assault agency). Therefore, the police, other Perth hospitals and sexual assault agencies have been asked to refer victims who present within a

specified time period to Sir Charles Gairdner hospital and this is now ongoing, resulting in the researchers gaining access to victims that they may not have otherwise had access to.

7.7 Improving hospital and forensic data collection

Similarly to the need for police to improve their recording and data extraction procedures, it is also necessary for the health sector to improve its data collection and recording practices. Currently there is no centralised or systematic data register of victims who present to hospitals for suspected drink spiking, or of blood and urine samples presented to and analysed by forensic and therapeutic laboratories. As many victims who present to hospitals may not have blood or urine samples tested if it is not apparent to hospital staff that there is a need for this (e.g. it is not a suspected sexual assault) there is no record of how many suspected drink spiking victims present to hospitals or what happens when they do. Similarly there is no centralised register of how many blood and urine samples are sent to and tested by forensic and therapeutic labs for suspected drink spiking, what percentage are tested within the specified time periods, what percentage are discarded and not tested at all and what the results of tests are.

Without such a systematic approach to collecting and recording this data it is not possible to use hospital and forensic data to assist in building the picture of drink spiking. Hence there is a process of attrition within the health sector which it is not possible to monitor at present. This is unfortunate as the amount of information which is potentially available from these sources would be extremely beneficial if properly collected and recorded. It is recommended that consideration be given to developing a centralised and systematic database for the health sector in which information about victims who present and are tested for suspected drink spiking in any relevant health area is recorded for purposes of furthering knowledge about drink spiking in this area.

7.8 Changing attitudes toward drink spiking

Preventing drink spiking will meet with limited success without an awareness that attitudes toward drink spiking need to change. At a broader community level there may be the belief among some that spiking a drink with extra alcohol for a laugh or to liven up a party is just a bit of fun (‘prank spiking’). This view is perhaps understandable given that this type of activity has long been portrayed on television and in films as an acceptable and comical prank. It is also possible that this type of drink spiking (adding alcohol for a prank) may be perceived as just a bit of fun and differentiated in people’s minds from situations in which drugs are added to drinks or where sexual assault or robbery occurs. The message needs to be communicated to the community at large that even adding alcohol to a drink to liven up a party is drink spiking *and potentially illegal and dangerous.*

Where alcohol or drugs are added to drinks without consent for the purposes of committing a sexual act, young people need to be educated about sexual relations and issues surrounding consent. This was a common theme which emerged from discussions with stakeholders and is also identified in previous research on drug facilitated sexual assault. It is clearly the case that many young males (in particular) do not believe that giving a victim alcohol or drugs without their knowledge for the purposes of obtaining sex is wrong or illegal. Abbey et al (2001)

argued that alcohol and sexual assault prevention efforts need to be combined and that 'men need to know…that having sex with a woman too intoxicated to give consent is illegal' (p.804). They advocate such education commencing in high school and continuing through to university.

Several stakeholders also referred to the high consumption of alcohol amongst young people and the popularity of Ready-to-Drink alcoholic beverages. Findings from the 2001 National Drug Household Survey (Australian Institute of Health and Welfare 2002) suggest that 34 per cent of 14-17 year olds consumed alcohol at short-term risky or high risk levels. It was felt by several stakeholders that many young people simply do not understand what constitutes a standard alcoholic drink and this makes them ill equipped to gauge how much alcohol they are consuming. Deliberate, heavy binge drinking by young people can place them at risk of sexual assault or associated victimisation (without the involvement of drink spiking).

7.9 Amending legislation

There is currently no separate offence category in any Australian jurisdiction for the act of spiking someone's drink *per se*. Rather, the use of criminal laws to prosecute drink spiking depends on:

- the state/territory in which the incident occurred;
- the motivation of the person spiking the drink;
- the type of substance used to spike the drink; and
- the effects of the spiking.

This means that there is some degree of flexibility in how an incident of drink spiking is recorded by police within each jurisdiction and how courts may interpret the law in relation to such incidents. It also makes data extraction and comparisons difficult since a drink spiking incident may be recorded under various crime categories or noted only in the narrative which may be missed during the process of data extraction. As noted above, at the time of writing this report no changes to the legislation in any jurisdiction in relation to drink spiking were known to be imminent, although a Victorian parliamentary committee in May 2004 recommended the creation of a new general offence of drink spiking partly to raise the profile of the issue in the community.

It is recommended that each jurisdiction review its criminal law provisions in terms of their applicability to different forms of drink spiking and appropriate maximum penalties. Consideration of these issues and possible avenues for investigating further legislative reform in the area of drink spiking could perhaps be undertaken by the Model Criminal Code Officers Committee (Parliament of Australia 1998), established in the early 1990's by the Standing Committee of Attorneys-General. This committee is responsible for producing the *Model Criminal Code*, a comprehensive paper examining legislation in areas including fraud, theft, offences against the person and drug offences. They function for two purposes: firstly to codify the principles of criminal responsibility that apply to Commonwealth offences and secondly to provide - in the *Model Criminal Code* - a model for adoption by all states and territories with regard to criminal law. Particularly given their previous investigation of drug

offences, it is foreseeable that the committee could examine the different legislation applicable to drink spiking in the various jurisdictions to determine whether any legislative amendments may be warranted in the future.

7.10 Prosecution of offenders

The ability to prosecute offenders depends very much on:

- whether incidents of drink spiking are reported to police;
- whether victims are able to identify offenders;
- whether victims are willing to identify offenders and proceed with investigation/prosecution;
- whether police proceed with an investigation;
- the offence under which an incident is charged;
- the extent and reliability of evidence (including forensic evidence); and
- credibility of victim and victim's story.

Similarly to sexual assault cases more generally, there is likely to be a high rate of attrition in drink spiking between reporting to police and prosecution. From the police and hotline data it is clear that knowledge of the offender was very poor, that forensic testing of blood and urine does not occur very often and sometimes at too late a stage to produce reliable results and that memory loss and unconsciousness may hamper a victim's credibility. Taken together, it is perhaps not surprising that only one victim in the hotline data reported that her case was currently being prosecuted while in the police data only 12 incidents had the offender committed for trial and only one conviction was recorded.

The Higher Courts cases identified evidence as a key factor in prosecutions. In particular,

- tests which indicated the presence of drugs in blood or urine were a vital form of evidence; and
- prosecutions could succeed with other forms of evidence, such as evidence of rape, other evidence left at the scene such as photographs, or similar complaints made by different people.

Successful prosecution of drink spiking should be an important objective in any attempts to prevent drink spiking. Not only does it have deterrent value for both actual offenders and potential offenders, but it sends a very clear message that drink spiking is a crime and that governments are serious about stopping it. Successful prosecutions will also send a message to the community at large that drink spiking is not humorous but can lead to serious consequences for both victims and offenders.

However, to obtain successful prosecutions, a coordinated approach is required involving victims, witnesses, police, hospitals, forensic labs and DPPs:

- Victims must be willing to report incidents as soon as possible after the incident, to obtain forensic evidence, to cooperate fully with police and be willing to proceed with prosecution. Prosecution without victim and witness testimony is not likely to be successful and DPPs are unlikely to pursue a case without victim testimony.
- Police must be willing to listen to victims reporting suspected incidents, to treat the incident seriously, to treat victims with sensitivity and respect and to record faithfully everything that a victim and witnesses are able to recall about the incident.
- Consideration should be given (by both police and DPPs) to how drink spiking offences should be classified, what sort of evidence will be needed to prosecute under that offence category and the likelihood of being able to obtain such evidence (i.e. proving intent).
- Blood and urine samples should be tested where the period since ingestion is believed to fall within the specified time frames. In submitting samples to forensic labs police, sexual assault centres and hospitals should submit additional information such as gender and age of victim, whether and how much alcohol or drugs were consumed voluntarily by the victim before and after the incident, whether particular drugs are suspected to be involved and what the symptoms of the victim were after the incident.
- Where a victim presents to a hospital with a suspected drink spiking hospital staff should not attempt to give drugs to the victim prior to blood and urine samples being taken.
- Consideration should be given to obtaining as much secondary evidence as possible, including witness statements and potentially incriminating evidence left at the scene.
- In essence a solid chain of evidence needs to be built for the case to proceed to prosecution and this chain of evidence requires coordination and commitment between all relevant agencies.

7.11 Underscoring the importance of sexual assault

While the primary difference between drink spiking (followed by a sexual assault) and drug facilitated sexual assault relates to whether the alcohol and/or drug was administered voluntarily or involuntarily, it is emphasised that this distinction in this report does not and should not imply that a sexual assault should be considered more of a crime when a drug or alcohol has been administered involuntarily than when consumed voluntarily.

Voluntary ingestion of alcohol or drugs does *not* imply consent to sexual activity. Indeed someone who is incapacitated as a result of the voluntary or involuntary ingestion of alcohol or drugs, is clearly not capable of giving consent to sex and hence any sexual act which occurs after such incapacitation could be classed as a sexual assault. Sexual assault is a serious crime, no matter how it was perpetrated, where it was perpetrated or against whom. Therefore, although drink spiking is differentiated from drug facilitated sexual assault in this report, it is should be noted that this in no way implies that the seriousness of sexual assault is influenced by whether drugs or alcohol were consumed voluntarily or involuntarily and does not intend to reduce or diffuse the importance of sexual assault as a serious crime in its own right.

7.12 Memory loss

Memory loss was found to be a common symptom associated with drink spiking, experienced by 58 per cent of victims in the AIC hotline and 35 per cent of victims in the police data. Memory loss means that not only do victims not remember what happened (which can be very frightening and emotionally damaging for victims since it removes their sense of control) but victims are also confronted with the prospect of not being perceived as credible when reporting the incident. These two things together can be incredibly stressful for victims and may mean that they choose not to report an incident but will try to deal with it alone. It was found in the AIC Hotline that while only a quarter of victims reported the incident to police, the majority of victims told a friend or family member. Family and friends of victims may not know how to respond to a victim's revelations and may feel helpless to assist the victim. One recommendation stemming from this finding is to educate people that memory loss is common for drink spiking victims and that family and friends can help victims by being supportive, encouraging them to talk about the incident and listening to them sympathetically.

7.13 Targeting prevention strategies

This report has shown that there is no single type of drink spiking victim or situation or offender. Rather, drink spiking is a complicated phenomenon which can occur in a variety of locations, against a variety of victims, with a variety of different spiking additives, for a number of different reasons resulting in disparate effects and consequences. This means that prevention strategies which target only one type of audience (e.g. young women or young people at licensed premises) will be limited in effectiveness because the message will not reach or may be inappropriate for other types of audience. For example, we know that males can also be victims of drink spiking but there are currently no awareness campaigns which are targeted toward preventing males from being victims. Similarly 'prank spiking' has been identified in this report (primarily through anecdotal evidence) as being a possible motivation yet awareness campaigns to date tend to focus on sexually motivated drink spiking. Strategies to tackle and prevent drink spiking must take into account the fact that victims and situations differ widely. Prevention strategies therefore must:

- identify the range of audiences which need to be targeted;
- identify what the specific characteristics and needs of those audiences might be; and then
- develop appropriately targeted intervention and education initiatives which are directly relevant to those specific audiences.

This is a particularly important point to make in relation to awareness campaigns. These can often be conducted in a manner which implies that there is only one type of victim or offender or situation. To ensure that a message is reaching the target audience and getting across the intended message (often assumed) the messages should be carefully considered and then piloted with intended audiences prior to distributing them more widely. An evaluation strategy should also be built into prevention campaigns prior to commencement of the intervention so that it can be determined if the intervention was successful in meetings its objectives.

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Appendix A: List of stakeholders interviewed by Jurisdiction

Australian Capital Territory

Australian Hotels Association
Australian Hotels Association (ACT) (PO Box 4286, Manuka 2603) Ph: 02 6273 6633
Michael Capezio (President)
Forensic Scientists, Pharmacologists and Toxicologists
ACT Government Analytical Laboratory, Toxicology and Forensic Chemistry (PO Box 1844 Canberra 2601) Ph: 02 62058732
Dennis Pianca (Manager)
ACT Health, Scientific Services (Locked Bag 5, Weston Creek 2611) Ph: 02 6205 8701
Peter Smith (Manager)
Government / Other Departments
Alcohol and Other Drugs Council of Australia (17 Napier Close, Deakin 2600) Ph: 02 6281 0686
Cheryl Wilson (Chief Executive Officer)
Sarah Ward (Policy / Project Officer)
Office for Women (GPO Box 158 Canberra 2601) Ph: 02 6207 0961
Sue Hall (Director)
Hospitals and Medical Centres
Canberra Hospital, Canberra Clinical School (Canberra Hospital, PO Box 11, Woden ACT 2606) Ph: 02 6244 3782
Dr Nick Buckley (Clinical Pharmacology and Toxicology)
Police
Australian Federal Police (GPO Box 401, ACT 2601) Ph: 02 6275 7068
Dr Klaus Czoban (Director of Medical Services, Occupational and Forensic Medicine)
Dr Deborah Thornton (Forensic Physician)
Dr Graeme Thomson (Forensic Physician)
Dr Charles Howse (Forensic Physician)
Tanya Swift (Federal Agent)
Acting Sergeant Kylie Hemiak
Constable Giuliana Serenellini
Sexual Assault Services
Canberra Rape Crisis Centre (PO Box 916, Dickson ACT 2602) Ph: 02 6247 8071
Tania Brown (Coordinator, Service Management)
Canberra Sexual Health Centre (Building 5, The Canberra Hospital, PO Box 11, Woden, ACT, 2606) Ph: 02 6244 2184
Dr Vanita Parekh (Staff Specialist, Sexual Health and Sexual Assault Medicine; Medical Coordinator, Forensic and Medical Sexual Assault Care)
Cassandra Beaumont-Brown (Clinical Nurse Consultant, RN Coordinator, Forensic & Medical Sexual Assault Care)

New South Wales

Australian Hotels Association
Australian Hotels Association (NSW) (Level 5, Prince Centre, 8 Quay St, Sydney, 2000)
Ph: 02 9281 6922
Brian Ross (NSW Chief Executive)
Charles Shields
Forensic Scientists, Pharmacologists and Toxicologists
Division of Analytical Laboratories (Joseph St, PO Box 162, Lipcombe) Ph: 02 9646 0418
Allan Hodda, (Deputy Director)
Keith Lewis (Senior Forensic Scientist)
Glyn Hansen (Forensic Scientist)
Pacific Laboratory Medicine Services (Level 5, Royal North Shore Hospital, Pacific Highway, St Leonards, NSW) Ph: (02) 9887-5666
Dr John Lewis [Telephone interview]
Government / Other Departments
Attorney General's Department (Level 19, Goodsell Building, 8-12 Chifley Square, Sydney)
Ph: 02 9228 8081
Gaby Marcus (Manager)
Rochelle Braaf
Attorney General's Department, Violence Against Women Unit, Crime Prevention Division (357 Glebe Point Rd Glebe) Ph: 02 9976 8020 / 4929 0921
Jillian Meyers-Brittain (Violence Prevention Specialist, Newcastle)
Jennifer Huxley (Violence Prevention Specialist, North Sydney)
Department of Health, Primary Health and Community Care (73 Miller Street North Sydney)
Ph: 02 9391 9283
Tricia O'Riordan (Senior Project Analyst)
Department for Women (Level 4, 175-183, Castlereagh St, Sydney) Ph: 02 9287 1860
Robyn Henderson (Director-General)
Carole Ruthchild (Senior Policy Officer)
National Drug and Alcohol Research Centre (University of New South Wales Sydney NSW 2052) Ph: 02 9385 0226
Paul Dillon (Information/Media Liaison Manager) [Telephone interview]
Police
Child Protection and Sex Crimes Squad (Tower A Level 6, Locked Bag 5102 Parramatta 2124) Ph: 9265 4920
Detective Superintendent Kim McKay (Commander)
Senior Constable Jane Hastie
Crimes Against the Person Team (Police HQ, Level 8, 1 Charles Street Parramatta 2150)
PH: 02 8835 9155
Kevin Gardener (Manager)
Forensic Service Group (7/130 George St, Parramatta 2150) Ph: 02 8831 0060.
Karen Webb
State Crime Command, Drug Squad (Level 4, 219-241 Cleveland St, Strawberry Hills 2012)
Ph: 9384 6484
Nerys Evans (Intelligence Co-ordinator)
Emily Pritchard

Sexual Assault Services
Bankstown SAS (Bankstown Community Health Centre, 36-38 Raymond St, Bankstown) 02 9780 2777
Robyn Frame
Eastern & Central SAS (Royal Prince Alfred Hospital, Level 9, Queen Mary Building, Grose St, Camperdown) Ph: 02 9515 3680
Mark Griffiths (Deputy Manager)
North Sydney SAS (Royal North Shore Hospital, Pacific Highway, St Leonards) 02 9926 7580
Susan Kendall
South Sydney SAS (St George Hospital, 36 Belgrave St, Kogarah) Ph: 02 9350 2494
Karen Doherty
Service Providers for the Gay Community
Lesbian and Gay Anti-Violence Project (PO Box 350 Darlinghurst Sydney 1300) Ph: 02 9206 2000
Brad Gray (Coordinator) [Telephone interview]

Northern Territory

Australian Hotels Association
Australian Hotels Association (NT) (GPO Box 3270, Darwin NT 0801) Ph: 08 8945 0155
Greg Weller (Executive Director)
Government / Other Departments
Department of Justice (GPO Box 1722 Darwin 0801) Ph: 61 8 8999 6047
Kate Halliday
Office for Women's Policy (GPO Box 4396, Darwin 0801) Ph: 08 8999 3734
Pippa Rudd (Director)
Pam Pemberton
Liz Brown
Women's Health Strategy Unit, Health and Community (PO Box 40596,
Casuarina 0811) Ph: 08 8999 2715
Elizabeth Kasteel
Police
Criminal Investigation Branch (PO Box 39764 Winnellie NT 0871) Ph: 08 8922 3167
Senior Constable Travis Wurst
Drug and Alcohol Policy Unit (PO Box 39764 Winnellie NT 0871) Ph: 08 8922 3527
Scott Mitchell (Senior Policy Advisor)
Sexual Assault Services
Ruby Gaea Centre Against Rape (PO Box 42082 Casuarina NT 0811) Ph: 08 8945 0155
Yianna Paterakis
Sexual Assault Referral Centre (PO Box 40596, Casuarina, NT, 0811) Ph: 08 8922 7156
Sue Moore (Coordinator)

Queensland

Australian Hotels Association
Australian Hotels Association (Qld) (GPO Box 343 Brisbane 4001) Ph: 07 3221 6999)
Geoff Parker (Business Development and Training Manager)
Forensic Scientists, Pharmacologists and Toxicologists
Queensland Medical Laboratories, North Queensland Branch (51 Fulham Rd, Pimlico, Townsville) Ph: 07 4779 0158 F: 07 4779 0348
Sam Rowe (Manager) [Telephone interview]
Government /Other Departments
Alcohol and Drug Information Service (Level 5, 270 Roma St Brisbane) Ph: 07 3236 2414
Gail Hamilton (Manager)
Alcohol and Drug Service, Melaleuca Opiod Substitution Clinic (PO Box 8161 Brisbane 4001) Ph: 07 3350 8156
Pauline Barnes (Manager)
Alcohol, Tobacco and Other Drug Services, Queensland Health (Level 9, 147-163 Charlotte St Brisbane) Ph: 07 3234 1073
Stephen Anstis (Senior Advisor Prevention)
Management of Public Intoxication Project ('Chill Out Zone') (PO Box 1796 Broadbeach 4218) Ph: 07 5571 8387
Angela Driscoll
Hospital and Medical Centres
'The Doctors' (PO Box 5924 Cairns 4870) Ph: 07 4041 3811
Dr Evan Nicholls
Police
Criminal Investigations Branch, Brisbane (GPO Box 1440 Brisbane 4001) Ph: 07 3364 3754
Senior Constable Fiona Hinshelwood
Criminal Investigations Branch, Surfers Paradise (PO Box 561 Surfers Paradise BC 4217) Ph: *07 5570 7888*
Detective Inspector Ken Bemi [Telephone interview]
Detective Inspector Matthew Rosevear (Gold Coast District Tactician) [Telephone interview]
Drug & Alcohol Coordination, Operations Support Command (GPO Box 1440 Brisbane 4001) Ph: 07 3364 3754
Senior Sergeant Damien Hansen
Sexual Assault Services
Brisbane Sexual Assault Service (PO Box 126 Hurston Brisbane) Ph: 07 36365207
Jan Rodwell (Team Leader)
Dr Margaret Mobbs
Bond University (Gold Coast 4229) Ph: 07 5595 4003
Mark Stringer (Student Counsellor)
Kate Bartlett (Student Counsellor)
Valerie Evans (Nurse)
Gold Coast Sexual Assault Support Services (PO Box 1924 Southport) Ph: 07 5591 2397
Di Macleod
Sexual Health Clinic (Level 1 270 Roma St Brisbane) Ph: 07 3227 8666
Judy Dean (Sexual Health Clinic, Nurse)
Joe Dobattista (Zonal Coordinator, Sexual Health/HIV)

South Australia

Australian Hotels Association
Australian Hotels Association (SA) (PO Box 3092, Rundle Mall 5000) Ph: 08 8232 4525
John Lewis
Forensic Scientists, Pharmacologists and Toxicologists
Forensic Services (60 Wakefield St Adelaide 5000) Ph: 08 8463 7630
Senior Sergeant Dianne Reynolds
University of Adelaide, Department of Experimental Pharmacology (University of Adelaide, Adelaide 5005) Ph: 08 8303 5987
Dr Jason White [Telephone interview]
Government / Other Departments
Drug and Alcohol Services Council (161 Greenhill Road, Parkside 5063) Ph: 08 8274 3315
Simone Cormack (Director, Population Health Programs)
Marina Bowshall-Noone (Manager, Health Promotion)
Inner Southern Community Health Service ('Relationship Violence – No Way!') (c/- Department of Human Services, 11 Hindmarsh Square, Adelaide 5000) Ph: 08 8331 1103
Brook Friedman (Manager) [Telephone interview]
Office of the Liquor and Gambling Commissioner (GPO Box 2169 Adelaide, 5000) Ph: 08 8226 8453
Karen Earle
Hospitals and Medical Centres
Royal Adelaide Hospital (North Terrace, Adelaide 5000) Ph: 08 8222 2206
Dr David Caldicott (Traumatox Project Manager)
Youth Health Services (The Second Story) (Adelaide 57 Hyde St) Ph: 08 8232 0233
Dorian Marsland (Manager) [Telephone interview]
Police
Sexual Assault Unit (60 Wakefield St Adelaide 5000) Ph: 08 8463 7601
Sergeant David Racz
Drug and Alcohol Policy Section (GPO Box 1539, Adelaide 5001) Ph: 08 8204 2815
Sergeant Jane Reed
Sexual Assault Services
Yarrow Place Rape and Sexual Assault Service (PO Box 620 North Adelaide 5006) Ph: 08 8226 8777
Lucia Arman (Rape Prevention Project Officer)

Tasmania

Australian Hotels Association
Australian Hotels Association (Tas) (PO Box 60 New Town 7008) Ph: 03 6278 1930
Daniel Hanna (General Manager)
Forensic Scientists, Pharmacologists and Toxicologists
Forensic Science Service Tasmania (20 St Johns Ave, New Town 7008) Ph: 03 6278 5656
Dr Kathryn Campbell (Senior Specialist, Toxicology)
Hospitals and Medical Centres
Royal Hobart Hospital (GPO Box 1061L Hobart 7001) Ph: 03 6222 8609
Dr Alastair Meyer (Director of Emergency Medicine)
Police
Glenorchy Police Station (43 Main Road, Glenorchy 7010) Ph: 03 6230 2777
Constable Elaina Deayton
Southern Drug Investigation Service (GPO Box 308C Hobart) Ph: 03 6230 2670
Detective Sergeant Adam Stanwix
Detective Constable Richard Lane
Detective Constable Adam Hunter
Detective Constable Michael Callinan
Detective Constable Natalie McIntee
Constable Emily Hawtin
Sexual Assault Services
Sexual Assault Support Service (PO Box 217 North Hobart 7002) Ph: 03 6231 1811
Karen Jones (Manager)
Jacqueline Bain
Sam Ling
Sexual Assault Support Service For Children (PO Box 217 North Hobart 7002) Ph: 03 6231 1811
Di Collett
Service Providers for the Gay Community
Tasmanian Council on Aids and Related Diseases (319 Liverpool St Hobart 7000) Ph: 03 6234 1242
Rachael Day [Telephone interview]

Victoria

Australian Hotels Association
Australian Hotels Association Victoria (Level 1, 322 Glenferrie Rd, Malvern 3144) Ph: 03 9822 0900
Alan Giles (Chief Executive Officer) [Telephone interview]
Government / Other Departments
Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies (300 Queen Street, Melbourne 3000) Ph: 03 9214 7888
Melanie Heenan
Male Adolescent Program for Positive Sexuality, Juvenile Justice Section, Community Care Division (19/555 Collins Street Melbourne 3000) Ph: 03 9389 4272
Patrick Tidmarsh (Coordinator)
Office of Women's Policy, Department for Victorian Communities (1 Spring St, Melbourne 3000) Ph: 03 9208 3122
Rena De Francesco (Policy Officer)
Police
Drug and Alcohol Strategy Unit (637 Flinders Street Melbourne 3005) Ph: 03 9247 6724
Inspector Steve James (Manager)
Senior Sergeant Phil Harrison
Sexual Assault Services
Centre Against Sexual Assault (CASA House) (270 Cardigan St, Carlton 3053) Ph: 03 9347 3066
Marg D'Arcy (Manager)
Sheri Lawson (Counsellor/Advocate)

Western Australia

Australian Hotels Association
Australian Hotels Association (WA) (PO Box 660, West Perth 6872) Ph: 08 9321 7701
Bradley Woods (Executive Director)
Forensic Scientists, Pharmacologists and Toxicologists
Chemistry Centre (125 Hay St, East Perth 6004) Ph: 08 9222 3177
Robert Hansson
Government / Other Departments
Pilbara Community Drug Service Team, Pilbara Population Health, Country Health Service, Health Department of Western Australia (Karratha 6714) Ph: 08 9143 1370
Emily Deves (Community Drug Worker) [Telephone interview]
Hospitals and Medical Centres
Sir Charles Gairdner Hospital, Emergency Department (Hospital Avenue Nedlands 6009) Ph: 08 9346 3333
Dr Paul Quigley
Police
Alcohol and Drug Co-ordination Unit (60 Beaufort St Perth 6000) Ph: 08 9223 3121
Barry Newell
Sexual Assault Services
Sexual Assault Resource Centre (PO Box 842 Subicao 6904) Ph: 08 9340 1820
Paula Chatfield (Manager)
Service Providers for the Gay Community
AIDS Council (PO Box 1510 West Perth 6872) Ph: 08 9482 0000
Kevin Shanks (Education Manager) [Telephone interview]

Appendix B: Types of drugs commonly associated in the media with drink spiking

In recent times drugs such as flunitrazepam (Rohypnol), GHB and Ketamine have been cited in the media as drugs commonly used in drink spiking. Partly the focus on these drugs is due to the fact that they have sedative properties which make them seem intuitively a drug of choice for drink spiking offenders; partly the focus on these drugs is due to the fact that they are also known as party drugs and are commonly used in the dance and clubs cultures (Deehan & Saville 2003; Dillon & Degenhardt 2000). However, while it seems to be widely accepted that these drugs, in combination with others such as Ecstasy and Speed, are used in the dance and clubbing scene, there is currently little evidence to suggest that flunitrazepam, GHB and Ketamine are commonly used in drink spiking.

Generally speaking, any drug that is readily absorbed into a drink (alcoholic or otherwise) without the victim's knowledge (i.e., it comes in tablet, liquid, powder or crystal form), can be used in drink spiking (LeBeau 1999). However, in cases where drink spiking is intended as an antecedent to a more serious crime (e.g., robbery, sexual assault), it is reasonable to assume that a perpetrator might use a drug which has a sedative or depressant effect, in order to produce the desired symptoms (disorientation, semi-consciousness etc) in their victim. In other cases where drink spiking is done for other reasons (to liven up a party, play a trick), any drugs could be used and stimulant drugs which have the opposite effect to depressants (ecstasy, amphetamines) might be more popular. This section provides information about a number of different drugs and their effects on users.

In addition to alcohol, a legal substance, there are three specific drugs which have, in recent times, been associated with drug facilitated sexual assault (mentioned in the media particularly) and as such they are discussed in this section. They are:

- flunitrazepam (Rohypnol);
- gamma hydroxybutyrate (GHB); and
- Ketamine.

In addition to these specific drugs, the class of drugs known as benzodiazepines (this class includes flunitrazepam but also a variety of other sedative/hypnotic drugs which could be used in drink spiking) is discussed, as are other amphetamine-related substances.

Alcohol

Alcohol is a central nervous system depressant which is available on a largely unrestricted basis in Western countries. Despite assertions (particularly in the media) that illicit drugs are used in date rape, the suggestion is starting to emerge that alcohol is the drug most commonly used in drink spiking and drug-facilitated sexual assaults (Chemistry Centre 2002; Garriott & Mozayani 2001; Payne-James & Rogers 2002). Given that it may be purchased legally in

Australia by anyone aged 18 or over and those under the legal age may still find it accessible through friends or family, its use as a spiking substance would not be surprising. This would be particularly so where alcoholic drinks are being purchased anyway (i.e. a bar or nightclub) – victims would not easily notice double or triple shots of alcohol in alcoholic drinks. Spirits of varying strengths can be readily absorbed in other drinks, whether they are spirits of less concentration, or soft drinks which may disguise the taste. The effects of alcohol (a central nervous depressant) are such that they may impact on the physical and mental state of the victim and possibly make them vulnerable to sexual assault or robbery.

Effects of alcohol

The effects of alcohol can vary considerably depending on the size and tolerance of the user. Drummer (2001) noted that blood concentrations of alcohol in excess of 0.02 could produce detrimental effects on motor coordination, speech articulation, intellectual performance, judgement and sensory discrimination. Other effects include slurred speech and imbalance and users of alcohol may also experience a sense of euphoria producing subsequent disinhibition. At higher levels (0.09 to upwards of 0.25) alcohol may induce amnesia, a loss of motor functioning, impaired consciousness and coma (Garriott & Mozayani 2001).

When alcohol is combined with other drugs such as sedatives, hypnotics, antidepressants and opiates, a synergistic effect may be created (Garriott & Mozayani 2001) in that the effect of the drugs are enhanced and can have a profound impact on the victim. Alcohol may also interact with drugs to produce severe toxic effects.

Flunitrazepam (roofies, roche, rope, forget pill, Rohypnol)

Flunitrazepam is a sedative-hypnotic benzodiazepine (Calhoun, Wesson, Galloway & Smith 1996; Upfal 2002), manufactured by Hoffman La Roche and distributed under the trade name Rohypnol overseas (Chapman 2000) and Hypnodorm in Australia (Upfal 2002). The drug is produced in tablet form (0.5 mg, 1 mg, & 2 mg) and until a new coloured tablet was released in 1999, which dissolves more slowly and releases a blue dye in the process (ONDCP 2003; Smith 1999), the drug was tasteless, colourless and rapidly dissolved in any drink (Anglin, Spears & Range-Hutson 1997; Smith 1999).

Flunitrazepam is a short-acting benzodiazepine (Drummer 2001) and is difficult to test for given that ‘it is only traceable in a person’s urine for 48 to 96 hours after ingestion and in blood, only 12 hours’ (Chapman 2000: 40). Flunitrazepam is not usually noticeable to the victim and if they suffer memory impairments or unconsciousness, victims may not recover in time to be tested for the substance. It is for these reasons that flunitrazepam has been commonly referred to as a drug used to more easily procure sexual assault victims (Anglin et al 1997). Flunitrazepam is not available legally in the United States or Canada, but is available by prescription in Australia (Upfal 2002) for the treatment of insomnia (Drummer 2001). Estimated cost for the drug on the streets in the United States is US$5 per tablet (ONDCP 2003; Smith 1999).

Effects of flunitrazepam

Flunitrazepam, similarly to other benzodiazepines, acts as a central nervous system depressant and induces muscle relaxation and sleepiness (ONDCP 2003). The drug essentially sedates the person who has ingested it and the effects usually begin within 30 minutes, peak within two hours and may persist for up to eight hours or more (IACP 1999; Smith & Temple 2000). Further symptoms associated with flunitrazepam are: drowsiness; impaired motor skills; amnesia; dizziness; impaired judgment and disinhibition; decreased blood pressure; and confusion (Chapman 2000; Danylewich 1997; ONDCP 2003). It is unclear what strength of dosage is needed to produce these effects, however it been observed that alcohol may strengthen the severity of symptoms (Danylewich 1997; Smith 1999; Upfal 2002).

Although flunitrazepam has been commonly cited as the date rape drug of choice (Dinnison 1998; Vogel 2002), with authors often referring to the fact that it is 10 times stronger than Valium (generically known as diazepam – a benzodiazepine), (Brenzinger 1998; Negrusz, Moore, Stockham, Poiser, Kern, Palaparthy, Lan T. Le, Janicak & Levy 2000), Robertson and Raymon (2001) argue that there is only a small window of opportunity for rapists using flunitrazepam and Finch and Munro (2003) argue that 'people who have ingested drugs such as Rohypnol … rarely lose consciousness' (p.2). Li (1999) argues that the misnomer of the drug has impeded its legitimate medical uses (it is useful as both a sleeping medication and pre-operative agent).

Gamma Hydroxybutyrate (GHB, easy lay, fantasy, liquid E, grievous bodily harm)

Gamma Hydroxybutyrate (GHB) – a central nervous system depressant – naturally occurs in low levels in humans and has previously been used as both an anaesthetic and hypnotic agent (Drummer 2001; Ferrara, Frison, Tedeschi & LeBeau 2001); and a muscle-building product (Australian Crime Commission 2003; Smith 1999). It was originally developed as an anaesthetic but was withdrawn in most parts of the world due to unwanted side effects (Dillon & Degenhardt 2000). The manufacture and sale of GHB is illegal in Australia and as such it is produced in clandestine laboratories (Asante 1999) using GBL, a chemical solvent often used in paint removers; and sodium or potassium hydroxide. GHB is 'usually a colourless, odourless, slightly salty tasting liquid' (Drummer 2001: 329), sold illegally on the street, in either a powder or liquid form (Brenzinger 1998), which may be readily absorbed into drinks (Pope & Shouldice 2001). GBL and a similar chemical 1-4 butanediol are metabolised into GHB in the body when consumed.

Due to its illicit nature, the average dosage is difficult to determine. In the United States, the ONDCP (2002) suggest that the average dosage is one to five grams and costs between US$5 and US$10. However, Buckley (2003) argues that, due to its illicit nature, the average dosage used is unknown. Similarly, Drummer (2001) does not refer to specific dosage except to say that a low dosage is considered to be less than 25 mg/kg body weight and that such a dose would not elicit effects typically associated with GHB.

Effects of gamma hydroxybutyrate

GHB has been commonly thought to be associated with drink spiking and subsequent sexual assaults because of its rapid effects on the user and the fact that evidence of its ingestion rapidly leaves the body, making it difficult to test for in alleged victims (Ferrara et al 2001; Pope & Shouldice 2001). The fact that GHB is an endogenous (naturally-occurring) substance also means that the 'cut off' levels required for a positive test are set quite high, which may impact on the likelihood of obtaining positive results. GHB has a rapid onset and effects have been recorded as appearing both within 5 to 15 minutes (Drummer 2001) and within 15 to 30 minutes (Smith & Temple 2000) and recovery may take up to approximately eight hours after ingestion.

The effects of GHB can vary depending on the dosage and whether it is mixed with other mood-altering substances such as alcohol (the depressant effects can be compounded when taken with alcohol), (ONDCP 2002). According to the ONDCP, less than one gram of GHB will cause a loss of muscle tone, euphoria and a relaxing of inhibitions, whereas consumption of between one and two grams will produce a stronger feeling of relaxation, in addition to a reduction in heart rate and respiration and interference with circulation, coordination and balance. When ingested at higher doses than these, a pronounced interference with motor skills and speech may be observed, ultimately leading to a loss of consciousness (Drummer 2001).

Ketamine (special K)

Ketamine is a sedative, chemically related to the hallucinogen Phencyclidine, which acts as a central nervous system depressant producing rapid disassociation in the user (Mozayani 2002; Raymon & Robertson 2001). The primary use for Ketamine has been as an anaesthetic and it is still used as such in veterinary surgery and sometimes as a general anaesthetic for children and elderly patients (Mozayani 2002). Ketamine is produced in a liquid form for anaesthetic purposes, but can be reduced down to powder which is often snorted, smoked or dissolved in other liquids (Smith 1999). The effects can last between one and five hours. According to the Australian Party Drug Trends 2003 report (Breen et al 2004) ketamine is most commonly purchased in grams with the median price of a gram ranging from A$150 to A$200.

Effects of ketamine

It is a drug commonly seen in the club/rave scene (Deehan & Saville 2003), with effects ranging from 'out-of-body' experiences (Dillon & Degenhardt 2001) and hallucinations, to paranoia and 'near-death' experiences. Although it does not induce actual sleep like flunitrazepam, its effects allow for the user to appear awake while still experiencing insensitivity to pain and other stimuli (Mozayani 2002). Users also experience elevated blood pressure and heart rate (Raymon & Robertson 2001) and it has been reported to induce amnesia (Pope & Shouldice 2001; Smith 1999), which may make the drug attractive to drink spikers. Drummer (2001: 327) argues that 'Ketamine is used in date rape for its ability to render a victim incapable of defence and to cause amnesia'.

Benzodiazepines (clonazepam, diazepam, temazepam)

Benzodiazepines are a class of widely prescribed medications used to treat insomnia and anxiety and are also sometimes used for anaesthetic purposes on account of the amnesic agents (Robertson & Raymon 2001). They act as central nervous system depressants and as such people under the influence of benzodiazepines may exhibit a variety of effects including drowsiness and difficulty concentrating. They may also appear drunk and show attention, memory and motor coordination impairments (Dowd, Strong, Janicak & Negrusz 2002; Robertson & Raymon 2001).

Although flunitrazepam has been identified in the literature as a 'date-rape drug', there is evidence that other benzodiazepines have been used in past cases (Dowd et al 2002; Welner 2001). Many benzodiazepines exert similar sedative and amnesic effects on the user to flunitrazepam. Indeed, a study by Calhoun et al (1996) found that recreational users of benzodiazepines often used a variety of different drugs from this class, which they wrongly identified as flunitrazepam, suggesting that the effects are quite similar.

Amphetamines and other substances (speed, ecstasy)

Amphetamines are central nervous system stimulants (Australian Crime Commission 2003). They are usually sold in powder or crystal form (ONDCP 1999), which makes them easily dissolved in liquid drinks and, again since they have no medical use, they are not sold or prescribed and so are produced in clandestine laboratories (Drummer 2001). As the chemicals that were used to produce speed were made illegal in the late 1980s, clandestine laboratories have had to find new chemical ingredients, making the quality of speed highly variable (Dillon & Degenhardt 2000).

Although amphetamines are unlikely to be used in drink spiking cases where the primary motive is sexual assault or robbery (because they have no sedative properties), they may be used by offenders for other reasons (to perk someone up, 'liven up' a party etc). Oral ingestion usually produces effects within 20 minutes and these can last up to 12 hours (ONDCP 1999; Raymon & Robertson 2001). Amphetamines speed up the activity of the central nervous system and vital signs are elevated when the drug has been ingested. The drug also produces increases in energy and alertness and decreases in appetite (ONDCP 1999).

Ecstasy is a street term for a number of substances that are related to Methylendioxymethamphetamine (MDMA). Ecstasy tablets can contain a range of amphetamine-related substances including MDEA, MDA or PMA and some tablets contain methamphetamine. Since ecstasy is not considered to have any medical use it is not available for purchase or prescription and so is produced by clandestine laboratories (Drummer 2001) which means the quality of the drug can vary greatly (Dillon & Degenhardt 2000). Ecstasy is taken orally in doses of 50 to 150 mg and effects usually begin within 20 to 60 minutes (Raymon & Robertson 2001), with effects peaking at around one to five hours (Pope & Shouldice 2001). Unlike GHB, it is measurable in urine for up to three days after ingestion.

The effects of ecstasy on users vary greatly. While some users report feeling euphoric, energetic, calm, warm and affectionate, others experience unsteadiness, nausea and vomiting (Dillon & Degenhardt 2000). Other effects can include 'lack of coordination, severe divided attention impairment, a poor perception of time and distance and poor balance' (Raymon & Robertson 2001: 128). These effects may be conducive to a drink spiker trying to incapacitate their victim. However, ecstasy may also be used in cases where the intent is simply to 'liven up' a party (since it does not have the truly sedative effects found with the other 'date-rape' drugs).