Submission to the Health and Social Care Committee

What is the extent of health harms resulting from drug use?

Drug-Related Deaths

The UK has the highest drug-related death rate on record and one which exceeds the rate of other European countries. Those dying from drug use are, on the whole, older heroin users with increasingly complex health needs including: long-term conditions and poly-substance use, social care needs and continuing multiple risk behaviours. In 2017, there were 1,164 deaths involving heroin and morphine, a decline of 4% (45 deaths) and the first decline since 2012.[1]

Fentanyl deaths are also on the rise in the UK, increasing from 58 deaths in 2016 to 75 deaths in 2017. A prevalence study conducted by the charity CGL showed a fentanyl-positive rate in adults receiving treatment for opioid use of 3%. Of those who tested positive for the presence of fentanyl, the majority (80%) were unaware of having purchased or used fentanyl.[2]

Blood-Borne Viruses

In Glasgow, there has been a sharp increase in HIV diagnoses, with more than 120 people testing positive since 2015. The outbreak remains uncontained[3] and almost all patients have co-infection with Hepatitis C.[4]

New diagnoses of HIV among gay and bisexual men is in decline,[5] however, a survey has identified that ‘‘three in ten sexually active HIV positive MSM engaged in chemsex in the past year, which was positively associated with self-reported depression/anxiety, smoking, non-sexual drug use, risky sexual behaviours, STIs, and hepatitis C”. The study concludes that chemsex may therefore play a role in the ongoing HIV and STI epidemics in the UK.[6]

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[1] Office for National Statistics. 2018. Deaths related to drug poisoning in England and Wales: 2017 registrations.
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2017registrations

[2] Bijral, P,. et al. 2018. Prevalence of recent fentanyl use among treated users of illicit opioids in England: based on piloted urine drug screens, Clinical Toxicology, DOI: 10.1080/15563650.2018.1527927

[3] Scottish Drugs Forum. 2018. HIV in Glasgow: Responding to an Outbreak.
http://www.sdf.org.uk/how-has-glasgow-responded-to-the-current-hiv-outbreak-among-people-who-inject-drugs-sdf-special-bulletin/

[4] Metcalfe, R., et al. 2018. An outbreak of HIV amongst homeless people who inject drugs (PWIDs) - describing the epidemic and developing an innovative service model. NHS Greater Glasgow and Clyde https://www.bhiva.org/file/zQqJMSLErmOWk/P67.pdf

[5] Public Health England. 2018. Progress towards ending the HIV epidemic in the United Kingdom. 2018 report - summary, key messages and recommendations.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/759407/HIV_annual_report_2018_-_Summary_key_messages_and_recommendations.pdf

[6] Pufall, EL., et al. 2018. Sexualized drug use (‘chemsex’) and high-risk sexual behaviours in HIV-positive men who have sex with men. HIV Med. 19(4). Pg. 261-270.

Dependence

A recent study by Potter at al analysed a 460 representative sample of seized cannabis which revealed that nearly all of the cannabis available to buy on the black market is of a high potency variety (sinsemilla), increasing from 51% of the market share in 2005 to 94% in 2017.[7] Highly potent varieties of cannabis will contain high amounts of THC (Tetrahydrocannabinol), the psychoactive chemical in cannabis that gets users 'high', and low amounts of CBD (Cannabidiol), a protective chemical that mitigates against THC's negative effects.

Frequent use of highly potent cannabis is associated with problematic use and, as potency has risen in the UK, we can track a corresponding rise in cannabis-related treatment presentations[8] and hospital admissions.[9] A 16-year observational study in the Netherlands found a positive time-dependent relationship between changes in cannabis potency and first time cannabis admissions to drug treatment.[10]

Earlier Onset of Use

There is a wealth of evidence to suggest that early onset substance users are at a higher risk of developing substance abuse disorder[11] and psychosocial problems, including: a psychiatric disorder, fragmented peer and family relationships, and problems adjusting to work.[12]

The '*Smoking, Drinking and Drug Use among Young People in England*'[13] survey indicated that, between 2006 and 2014, drug use amongst 11 to 15-year olds was steadily declining. However, findings from the 2016 survey showed that drug use amongst this population is now rising, with 12 and 13-year olds seeing the largest increase (see Table A).[14]

Table A

Age	**Took drugs in the last year (%)**	**% Increase**

[7] Potter, Hammond, Tuffnell, Walker and Di Forti. (2018). Potency of Δ9 -tetrahydrocannabinol and other cannabinoids in cannabis in England in 2016: Implications for public health and pharmacology. https://www.ncbi.nlm.nih.gov/pubmed/29441730

[8] McCulloch, L. 2017. Black Sheep. London: Volteface.

[9] North, P. 2017. Street Lottery. London: Volteface;
McCulloch, Matharu and North. (2018). The Children's Inquiry. http://volteface.me/app/uploads/2018/09/The-Childrens-Inquiry-Full-Report-2.pdf

[10] Freeman, TP. et al. 2018. Changes in cannabis potency and first-time admissions to drug treatment: a 16-year study in the Netherlands. Psychological Medicine 48, pg. 2346-2352. https://doi.org/10.1017/S0033291717003877

[11] Rioux, C. Castellanos-Ryan, N. Parent, S. Vitaro, F. Tremblay, RV. Séguin, JR. 2018. "Age of Cannabis Use Onset and Adult Drug Abuse Symptoms: A Prospective Study of Common Risk Factors and Indirect Effects". The Canadian Journal of Psychiatry.63(7), pp.457-464.

[12] Poudel, A Gautam, S. 2017. Age of onset of substance use and psychosocial problems among individuals with substance use disorders. BMC Psychiatry. 17(10).

[13] NHS Digital. 2017. Smoking, Drinking and Drug Use Among Young People in England - 2016. https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016

[14] This data excludes psychoactive substances looked at for the first time in 2016, in order for the impact of the change to be seen.

	2014	2016	
11 years	*4*	*5*	25
12 years	*4*	*8*	100
13 years	*7*	*13*	86
14 years	*14*	*17*	21
15 years	*19*	*27*	42
Total (11-15)	***10***	***15***	**50**

Source: NHS Digital (2017)

Growing Prevalence of Synthetic Cannabinoid Receptor Agonists (SCRAs) Among Vulnerable Groups

Since the introduction of the Psychoactive Substances Act 2016, synthetic cannabinoid receptor agonists (SCRAs) – a group of psychoactive drugs more commonly known as the brand names 'Spice' or 'Mamba' – have become more potent and their usage is an increasing concern among the prison and rough sleeping populations. According to the Government's own review of the impact of the 2016 Act, areas of "concern have remained or emerged since the Act, such as the supply of NPS by street dealers, the continued development of new substances, the potential displacement from NPS to other harmful substances, and continued high levels of synthetic cannabinoid use among the homeless and prison populations".[15] These populations do not readily appear in official statistics.

What are the reasons for both the initial and the continued, sustained use of drugs?

Availability

A poll commissioned by Volteface in 2018 revealed an association between access to drugs and their use. According to its findings, young people who had tried alcohol were 11.6% more likely to think alcohol was 'somewhat easy' or 'very easy' to access. Equally, young people who had tried cannabis were 28.2% more likely to think that cannabis was 'somewhat easy' or 'very easy' to access. Similarly, a US survey of young people and parents found that accessibility of alcohol is associated with significant increases in the trajectories of young adolescent alcohol use.[16]

Why Do People Use Drugs?

However, within the context of availability, there are a number of complex reasons why people use drugs.

[15] Ralphs, R. et al. 2017. Adding Spice to the Porridge: The development of a synthetic cannabinoid market in an English prison. International Journal of Drug Policy. Vol 40. Pg. 57-69.
[16] Komro, KA. Maldonado-Molina, MM. Tobler, AL. Bonds, JR. Muller, KE. 2007. "Effects of home access and availability of alcohol on young adolescents' alcohol use". Addiction. 102(10), pp.1597-1608.

Initial drug use may occur due to: boredom,[17] peer or spousal pressure,[18] in order to escape from thoughts and feelings or trauma,[19] or through curiosity and experimentation.[20]

Sustained drug use could occur due to: pleasure,[21] to relax or to enhance an activity,[22] peer or spousal pressure, to alleviate a depressed mood,[23] and addiction.[24]

How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.

Education/Schools

Research shows that there has been an absence of frequent, high-quality early drugs education in mainstream schools.[25] In recent years, the prioritisation of performance targets has further squeezed PSHE (Personal, Social, Health and Economic education) out of timetables and funding cuts to schools and local support services have limited training and delivery.

The introduction of mandatory drugs education in schools in 2020[26] is welcomed, but it is concerning that the accompanying guidance does not require schools to: implement a health education policy and programme that has been co-produced with pupils, parents and local partners; draw from Department for Education recommended resources; deliver drugs education in sixth forms and other educational settings for 16 to 18-year-olds; deliver drugs education, at least, every year; and cover topics that relate to real life decision-making. The guidance does not specify any additional funding and there are concerns that they will be just another burden placed upon an already overstretched education system.

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[17] Boys, A., Marsden, J., & Strang, J. 2001. Understanding reasons for drug use amongst young people: a functional perspective. Health Education Research. Theory & Practice. Vol 16. No.4 pg. 457-469.
[18] O'Malley, P., & Valverde, M. 2004. Pleasure, Freedom and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption. Sociology. Vol 38. (1) pg. 25-42.
[19] Valentine, K. & Fraser, S. 2008. Trauma, damage and pleasure: Rethinking problematic drug use. International Journal of Drug Policy. Vol 19. Issue 5. Pg. 410-416.
[20] O'Malley, P., & Valverde, M. 2004. Pleasure, Freedom and Drugs: The Uses of 'Pleasure' in Liberal Governance of Drug and Alcohol Consumption. Sociology. Vol 38. (1) pg. 25-42.
[21] Ibid.
[22] Boys, A., Marsden, J., & Strang, J. 2001. Understanding reasons for drug use amongst young people: a functional perspective. Health Education Research. Theory & Practice. Vol 16. No.4 pg. 457-469.
[23] Ibid.
[24] Wise, R. & Koob, G. 2013. The Development and Maintenance of Drug Addiction. Neuropsychopharmacology. 39(2). Pg. 254-262.
[25] Thurman, B. Boughelaf, J. 2015. 'We don't get taught enough'. Mentor. Drugs and Alcohol Today. 15(3), pp.127-140.
[26] Department for Education. 2019. 'Relationships Education, Relationships and Sex Education (RSE) and Health Education: Guidance for governing bodies, proprietors, head teachers, principals, senior leadership teams, teachers'. February 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/781150/Draft_guidance_Relationships_Education__Relationships_and_Sex_Education__RSE__and_Health_Education2.pdf

Mainstream schools' ability to identify risk factors or early indicators of drug-related harm and provide supportive interventions, through a whole-system approach, has been compromised by a reduction in staff contact time, PSHE lessons and pastoral support and the withdrawal of external services.[27]

How effective and evidence-based is treatment provision? This refers to both healthcare services and wider agencies, and the extent to which joined-up care pathways operate.

A Move Away from Harm Reduction

Whilst the Government's latest Drug Strategy, published in 2017,[28] placed emphasis on harm reduction, it appears that treatment provision has moved away from some harm reduction approaches. For example, anecdotal evidence indicates that there are now fewer needle and syringe programmes operating in the UK. Additionally, there is low coverage of take home naloxone (THN), despite the high number of opiate-related deaths, with it being estimated that the cover of THN among opiate clients in community drug treatment was 11% in 2017/18.[29] There is very limited coverage of THN among people who are not in direct contact with drug treatment services. For example, among police officers, there is only 6% coverage, and, among health care services and GPs, there is only 9%.[30]

Opioid Substitution Treatment

Opioid substitution treatment (OST) is an effective preventative measure against drug-related overdoses. Yet, with treatment being measured on drug-free outcomes, OST is often used as a tool to stabilise and reduce heroin use rather than it being prescribed to reduce the risk of overdose. Being monitored on drug- free outcomes reduces the likelihood of drug users attending treatment if they do not want to reduce their illicit drug use.[31] Moreover, there has been a "concern that treatment services were not providing the optimal dose of OST medication, leading to risks of patients using heroin in combination with OST and so an increased risk of overdose".[32]

Due to the nature of commissioned drug treatment contracts, there is no standardised way of using OST, with each provider adopting its own system. This leads to a great deal of variation in how OST clients are treated across the UK and a wide range of OST programmes and protocols. Such varied practice at the frontline and between local authorities suggests we are seeing insufficient regulation of drug treatment.

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[27] McCulloch, L. Furlong, S. 2019. Making the Grade. London: Volteface. Forthcoming.
[28] Home Office. 2017. Drug Strategy 2017.
https://www.gov.uk/government/publications/drug-strategy-2017
[29] Carre, Z. & Ali, A. (2019) Finding a Needle in a Haystack: Take-Home Naloxone in England 2017/18, London: Release
[30] Ibid.
[31] Advisory Council on the Misuse of Drugs. 2016. Reducing Opioid-Related Deaths in the UK.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdf pg. 26
[32] Ibid.

Non-Opiate Cohort

Research by Volteface has identified that treatment provision is not effectively meeting the needs of non-opiate groups, such as cannabis users.[33]

Lack of Guidance and Qualifications

In drug treatment, clinical interventions are based on evidence in NICE guidance. However, for psychosocial interventions, there is no framework as to what these interventions should look like and how they should be delivered. Moreover, professionals who work in drug treatment are not required to undertake any formal industry standard qualification, which impacts on the effectiveness of frontline interventions.

Volteface recommends that people who work with problematic drug users need to have qualifications and a framework that helps them deliver interventions based on the best available evidence.

Joined-Up Care Pathways

Many patients admitted to mental health hospitals have coexisting substance misuse, known as 'dual diagnosis'.[34] People with mental health problems who use substances problematically are often bounced between treatment and mental health services.[35]

Is policy sufficiently geared towards treatment?

Whilst the 2017 Drug Strategy[36] placed emphasis on providing evidence-based approaches to treatment, there is a need for adequate resourcing at both national and local levels. More than half of the local authorities in England have cut their budgets for alcohol and drug treatment, even though admissions to hospitals for problems related to addiction are rising.[37]

Data obtained under Freedom of Information from local authorities has identified that 93% of local authorities say that addiction treatment budgets will stand still or fall next year.[38] In the coming year, local authorities expect a further 2% average drop in drug and alcohol treatment services.

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[33] McCulloch, L. 2017. Black Sheep. London: Volteface.
[34] Graham, H.L., et al. 2019. Mental Health Hospital Admissions: a Teachable Moment and Window of Opportunity To Promote Change in Drug and Alcohol Misuse. International Journal of Mental Health Addiction. Vol 17. Pg. 22-40. https://doi.org/10.1007/s11469-017-9861-9
[35] Saunder, L. 2003. An audit of interventions for dual diagnosis in a psychiatric unit. Vol. 99 Issue 27 pg. 34.
https://www.nursingtimes.net/clinical-archive/assessment-skills/an-audit-of-interventions-for-dual-diagnosis-in-a-psychiatric-unit/205347.article
[36] Home Office. 2017. Drug Strategy 2017.
https://www.gov.uk/government/publications/drug-strategy-2017
[37] Boseley, S. 2019. England hospital admissions for addiction soar as treatment budgets fall. The Guardian. Online:
https://www.theguardian.com/politics/2019/feb/11/uk-hospital-admissions-for-addiction-soar-as-treatment-budgets-fall
[38] Ibid.

What would a high-quality, evidence-based response to drugs look like?

- To facilitate innovation, any response should be evidence-informed, rather than evidence-based.
- Policy-makers should monitor the evidence available from across the UK, and internationally.
- There should be sufficient investment in prevention, early intervention and treatment.
- A continuum should exist between harm reduction and recovery from drugs.
- Services should aspire to be as low threshold as possible.
- There should be joined-up care pathways and integrated care.
- Service provision should be personalised and, where needed, specialised services should be made available.
- Centralised guidance is required of what a high-quality, evidence-based response to drug looks like, with the flexibility for the approach to be tailored to individuals and local environments.

What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

Iceland: Drugs Education[39]

In the 1990s, Icelandic youth experienced high levels of drug use and, as problematic use rose, a new approach to drug prevention was implemented by the Icelandic Government. The concept was to teach young people aged 14 and over new skills and give them positive experiences which would produce a natural 'high'. Alongside new skills, young people were given quality life education, which taught them how to manage their thoughts, feelings and interactions with people.[40]

To encourage young people to engage with their families and reduce the amount of time they spent outside of the home (which was perceived as times of risk with regards to drug and alcohol use), Iceland introduced a curfew for all young people aged 13 to 16.

The Government also raised the legal age of buying cigarettes to 18 and to 20 for alcohol, and banned all advertising for cigarettes and alcohol, although this has been relaxed in recent years.

An additional law was brought into effect which involved every school in Iceland having to establish parental organisations and a school council with parental representation. To provide parents with additional guidance and support, the Government created an organisation called 'Home and School' which had four key areas of focus:

1. To raise the importance of spending quality time with children in the home.
2. To talk to children about their lives and experiences.
3. To learn who the children's associates were.
4. To ensure children stuck to the curfew and were in their homes at night.

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[39] North, P. 2018. Icelandic Youth. London: Volteface.
[40] Young, E. 2017. Iceland knows how to stop teen substance abuse but the rest of the world isn't listening. https://mosaicscience.com/story/iceland-prevent-teen-substance-abuse/

Parents in Iceland were given $500 to spend on after-school activities to keep children occupied, with the Government investing heavily in sports facilities. Participation in after-school activities was not only encouraged, but made easily available as leagues were established for children of all abilities.[41]

The decline in drug use and increase in family engagement took place at the same time as the 'Youth in Iceland' project was implemented.[42]

Canada: Legalisation of Recreational Cannabis

On the 31st October 2018, Canada became the first G7 country to legalise the sale and possession of cannabis. The case for legalisation was explicitly made on the grounds of protecting young people.

The reform seeks to: restrict youth access to cannabis; protect young people from promotion or enticements to use cannabis; deter and reduce criminal activity by imposing serious criminal penalties for those breaking the law, especially those who import, export or provide cannabis to youth; protect public health through strict product safety and quality requirements; reduce the burden on the criminal justice system; provide the legal production of cannabis to reduce illegal activities; allow adults to possess and access regulated, quality controlled legal cannabis; and enhance public awareness of the health risks associated with cannabis.

The Cannabis Act states that no person can sell or provide cannabis to any person under the age of 18 (in some provinces the age is 19). It created two new criminal offences, with maximum penalties of 14 years in prison, for giving or selling cannabis to youth, and using a youth to commit a cannabis-related offence.

The Act also prohibits: products that are appealing to youth; packaging or labelling cannabis in a way that makes it appealing to youth; selling cannabis through self-service displays or vending machines; and promoting cannabis, except in narrow circumstances where the promotion could not be seen by a youth. Penalties for violating these laws include a fine of up to $5million or three years in prison.[43]

The Canadian Government has committed to spending close to $46million over the next five years on public education and awareness activities to inform Canadians, especially young people, of the health and safety risks of using cannabis.[44] Young people have been placed at the centre of the Canadian Government's proposed policies and assessing their outcomes would be a worthwhile exercise.

Europe, Australia, North America: Drug Consumption Rooms (DCRs)

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[41] North, P. 2018. Icelandic Youth. London: Volteface.

[42] Sifusdottir, ID. et al. 2008. Trends in prevalence of substance use among Icelandic adolescents, 1995-2006. *Substance Abuse Treatment, Prevention, and Policy.* 2008 **3**:12 https://doi.org/10.1186/1747-597X-3-12

[43] Government of Canada. 2018. Legalizing and strictly regulating cannabis: the facts (online). Available at: https://www.canada.ca/en/services/health/campaigns/legalizing-strictly-regulating-cannabis-facts.html

[44] Government of Canada. 2018. Cannabis Public Education Activities. (online). Available at: https://www.canada.ca/en/health-canada/news/2018/10/backgrounder-cannabis-public-education-activitie s.html

Recent reviews[45] of the evidence base conclude that DCRs can be efficacious in:

- Reducing drug-related deaths at a city level, where coverage is adequate.
- Reducing self-reported injection risk behaviors, such as syringe sharing.
- Promoting safer injecting conditions.
- Reaching and staying in contact with highly marginalised target populations.
- Increasing uptake of detoxification and drug dependence treatment, including opioid substitution.
- Enhancing access to primary healthcare.
- Decreasing public injecting.
- Reducing the number of syringes discarded in the vicinity.

The evidence does not suggest that a DCR:

- Increases drug use or frequency of injecting in the surrounding environment.
- Increases drug dealing, drug trafficking or drug-related crime in the surrounding environment.

Switzerland, the UK, Germany, the Netherlands, and Canada: Heroin Assisted Treatment (HAT)

Heroin Assisted Treatment (HAT) involves prescribing pharmaceutical grade heroin, diamorphine. It is typically used as a second line treatment for those who have proven unresponsive to other forms of treatment. In 2012, the EMCDDA reviewed the evidence base[46] and concluded that there was "substantial improvement in health and well-being" of the patients receiving Heroin Assisted Treatment, "compared with those provided with oral methadone treatment". This included:

- A major reduction in the extent of the continued injecting of 'street' heroin.
- Improvements in general health, psychological well-being and social functioning.
- Major disengagement from criminal activities (such as acquisitive crime to fund continued use of 'street' heroin and other street drugs).

HAT also saves money. The EMCDDA review estimates that, based on figures from the UK, the €18,300 a year spent on HAT compares positively to the €50,400 spent on imprisonment.

Portugal:[47] Decriminalisation of All Illicit Drugs for Personal Use

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[45] Potier, C. et al. 2014. Supervised injection services: what has been demonstrated? A systematic literature review. Drug Alcohol Depend. 1(145). Pg. 48-68;
European Monitoring Centre for Drugs and Drug Addiction. 2018. Perspectives on Drugs - Drug consumption rooms: an overview of provision.
http://www.emcdda.europa.eu/system/files/publications/2734/POD_Drug%20consumption%20rooms.pdf

[46] Strang, J. Groshkova,T. Metrebian, N. 2012. EMCDDA Insights. New Heroin-Assisted Treatment. Recent evidence and current practices of supervised injectable heroin treatment in Europe and beyond. Lisbon; EMCDDA., p.161.

[47] As Portugal's decriminalisation was a conscious policy choice, which only decriminalised one offence and was subjected to repeated monitoring and evaluation from the very start, the evidence base is more robust than what has been produced in the Netherlands. It is difficult to isolate the effects in the

By 1999, Portugal had the highest rate of drug-related AIDS in the EU and the second highest prevalence of HIV amongst injecting drug users. There were concerns that the criminalisation of drug use was increasing drug health harms by socially excluding and marginalising drug users. Within this context, the Government accepted a proposal from an expert commission to decriminalise all illicit drugs for personal use in 2001.

A 2010 review of the policy found that the following changes occured after Portugal decriminalised:

Drug use

- Small increases in reported illicit drug use amongst adults.
- Decline in use among young people.

Health

- Reduced illicit drug use among problematic drug users and adolescents.
- Increased uptake of drug treatment.
- Reduction in opiate-related deaths and infectious diseases.
- Increases in the amounts of drugs seized by the authorities.
- Reductions in the retail prices of drugs.[48]

Crime

- It is not yet clear what impact decimalisation has had on crime, apart from reducing the burden on the criminal justice system.
- Between 2001-2006, homicide rates increased by 40%,[49] though these homicides were not drug-related. Between 1995/96-2000/04, opportunistic crimes linked to drugs – most notably street robberies, theft from motor vehicles and theft of motor vehicles – increased by 66%, 30% and 15%, respectively. It is possible that this increase in opportunistic offence rates may have been because police were able to use the time they saved by no longer arresting drug users to tackle (and record) other low-level crimes.

Netherlands as both possession and sale (coffee shops) were de-facto decriminalised at the same time and there has been limited evaluation of the policy change.

[48] Hughes, C. Steves, A. 2010. What Can We Learn From The Portuguese Decriminalisation of Illicit Drugs? The British Journal of Criminology, Volume 50, Issue 6, 1 November 2010, Pages 999–1022.

[49] Tavares, C. and Thomas, G. 2008. 'Statistics in focus: Crime and criminal justice', Eurostat, p.3. http://ec.europa.eu/eurostat/documents/3433488/5581196/KS-SF-08-019-EN.PDF/c7c329c6-ec2d-4bef-9e68-e9e9a882f346?version=1.0