HM Government

Drug Strategy 2010 Evaluation Framework – evaluating costs and benefits

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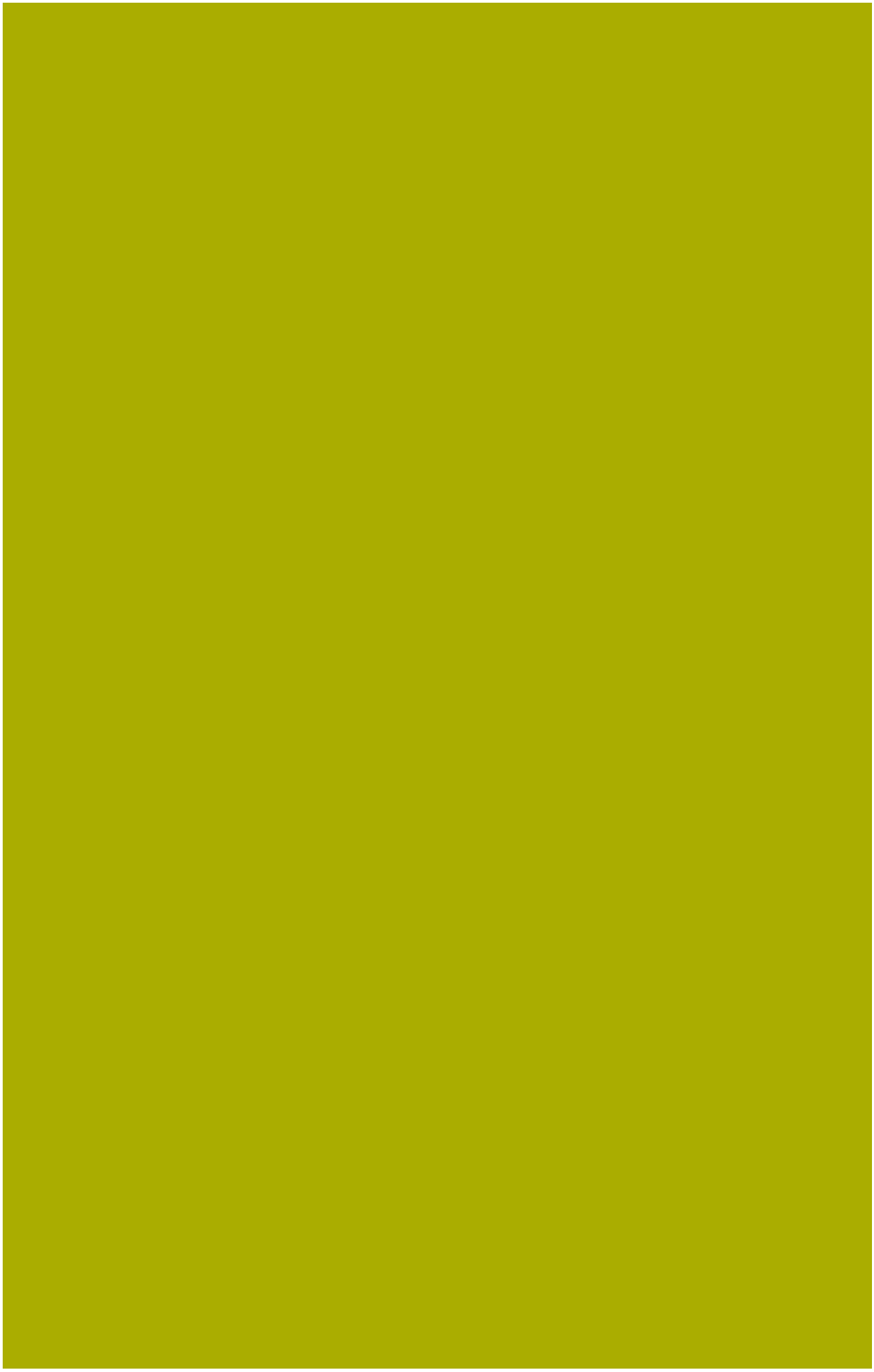

1. Introduction

Background

The Government's Drug Strategy 2010 *'Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life',*[1] made a commitment to develop an evaluation framework to assess its effectiveness and value for money (VfM).[2]

This will enable a more in-depth evaluation than has been adopted for any previous Drug Strategy and fulfils a recommendation from the National Audit Office (NAO) review into government action to tackle problem drug use.[3] The NAO review concluded that whilst there was significant government activity aimed at tackling problem drug use, building the evidence base and evaluating its effectiveness – with good progress being made – there was no framework for evaluating the VfM achieved.

The first step towards the evaluation has been establishing an Evaluation Framework to outline the approach to assessing VfM. This first document sets out the stages involved, including a discussion of the type of evidence required to assess impact and a first estimate of government spend on tackling drug use. This document has been developed internally by the cross-government Drug Strategy Research Group (DSRG).[4] Note that this Evaluation Framework is not designed to provide a structure for the ongoing monitoring of the Drug Strategy nor does it in itself comprise an evaluation of the Strategy.

The approach to evaluation is an evolving process, and whilst this document summarises the current position, this is likely to develop as new information and evidence come on stream. We will also now be seeking views and input from external experts in the field to develop and refine the approach.

The evaluation is currently planned to report at the end of the life of the 2010 Drug Strategy.[5] However, dependent on the timescale for the reporting of findings from new evidence,

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1 HM Government (2010) *Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug free life*. London: Home Office. http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-strategy/drug-strategy-2010

2 For the purposes of this framework, VfM is taken to mean the societal return on investment at a national level.

3 National Audit Office (2010) *Tackling problem drug use*. London: National Audit Office. http://www.nao.org.uk/publications/0910/problem_drug_use.aspx

4 The Drug Strategy Research Group (DSRG) was formerly known as the Cross Government Research Programme on Drugs (CGRPD), which was established in 2008 to improve the quality and use of the drugs evidence base by better co-ordinating drugs research across Government. DSRG members come from Whitehall departments and UK Research Councils, as well as the Association of Chief Police Officers and the Advisory Council on the Misuse of Drugs.

5 The current Drug Strategy is due to run until 2015.

consideration will be given as to whether it will be possible to conclude the evaluation in 2014. In the meantime, updates on the evaluation will be provided in subsequent Drug Strategy Annual Reviews.[6]

Context

The 2010 Drug Strategy is a high level document which sets out the Coalition Government's vision for tackling drugs. Unlike previous strategies it does not have specific targets, nor an accompanying action plan.

Since the publication of the NAO recommendations in 2010 there has been a fundamental shift in the role of centralised government which is reflected in the Drug Strategy. The Drug Strategy makes clear the Government is shifting power and accountability to the local level from top-down state intervention through the introduction of Police and Crime Commissioners, the reform of the NHS and the creation of Public Health England. It will be for local areas to design and commission drug services which meet the needs of all in their communities.

Devolution and localism potentially provide new opportunities for natural experiments in drug policy, although it is also recognised that the devolution of powers to local decision making presents challenges for a national evaluation.[7] In particular it will not be possible to obtain detailed information about how the Drug Strategy is implemented at a local level or get accurate estimates of the proportion of mainstreamed funding which is allocated to interventions to prevent or tackle drug-related harm. Instead, the evaluation will be reliant on assumptions about implementation and effectiveness; these would be based on the current available evidence and any new evidence produced throughout the life of the Strategy. For example, we would assume that the national Drug Strategy is being implemented in each local area consistently and with the same impact.

Given the above, this document concentrates on setting out the initial position on identifying costs and benefits. Work will continue across government and with the external academic community to build on this approach and deliver the evaluation.

6 The Drug Strategy Annual Reviews provide an update on progress in meeting the commitments in the Strategy and sets out priorities for the next 12 months.

7 Local variation in the implementation of drug-related interventions may provide the opportunity to evaluate outcomes in a particular area against another, matched area where the intervention has not been employed, and identify which, if any outcomes were due to the intervention.

2. The evaluation

Evaluation Framework objectives

The Framework sets out the proposed approach to evaluation and explores the feasibility of assessing value for money (VfM) of the Drug Strategy.

The Framework has a number of objectives:

1. To aid the identification of the costs and benefits associated with the Government's spend on tackling drugs as set out in the process models (usually called 'logic models') below. By setting out how a particular intervention area should operate to achieve its aims, these models also help identify which programmes and interventions are within scope of the evaluation (i.e. those that contribute to achieving the aims of the Strategy).
2. To identify the various data sources that are used to measure aspects of drug use and harm in England and Wales and the types of evaluation evidence required to assess impacts.
3. To provide, as far as possible, first estimates of direct government spend on tackling drug use in 2011/12.
4. To identify the requirements and challenges associated with conducting an evaluation of the VfM of the Strategy.

The scope of the evaluation

In assessing the impact of the Drug Strategy the evaluation must firstly assess whether the Drug Strategy has met the two overarching aims (see box below), and secondly, whether the Government achieved VfM in doing so.

Box 1: Themes and aims of the 2010 Drug Strategy

The 2010 Drug Strategy is structured around three themes:

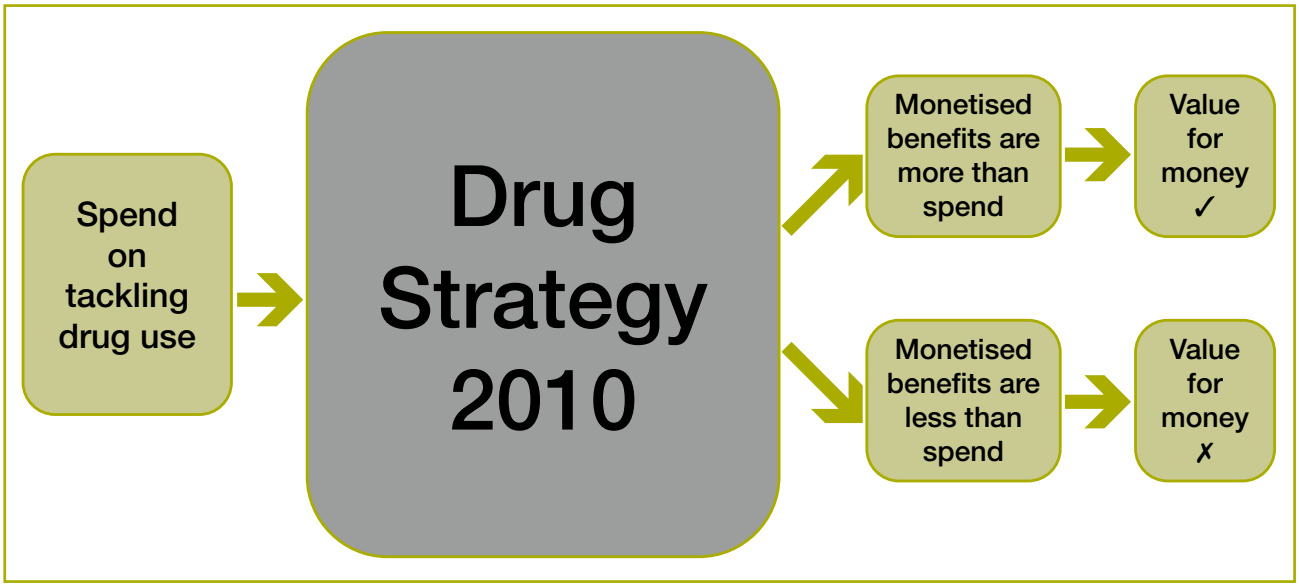
- Reducing demand;
- Restricting supply; and
- Building recovery in communities.

With two overarching aims:

- Reduce illicit and other harmful drug use; and
- Increase the numbers recovering from their dependence.

Value for money will have been achieved if the money spent on tackling drug use is less than the monetised benefits resulting from the Drug Strategy (see Figure 1).[8]

Figure 1: Evaluating the 2010 Drug Strategy



Data are available to monitor the trends in drug use and also the numbers leaving drug treatment drug free. However, it is not sufficient only to consider changes in these data as this does not enable us to attribute changes, whether they be good or bad, to the effects of the Strategy (i.e. we would not be able to prove that it was the Strategy that *caused* any changes in drug use or recovery). In order to robustly assess the effectiveness of the Strategy in meeting its aims we need to evaluate the *impacts* of the programmes and interventions that fall within the Strategy as far as we can, given the challenges described later in the document.

[8] In this context, this is the direct government spend on those programmes and interventions that are within scope of the evaluation, as set out by the parameters of the logic models presented in Figures 2 to 6.

Activity Groups

In developing the Evaluation Framework, it was accepted that it would not be desirable or achievable to undertake a single evaluation encompassing the whole of the Strategy, nor to provide a single VfM estimate. This is due to the complexity and overlapping nature of the various programmes and interventions identified as contributing to achieving the two overarching aims of the Strategy.

Due to this complexity, the programmes and interventions identified have been divided into five different activity groups based on the Strategy's three themes, where common aims and measurement can be applied:

1. Early interventions

These interventions aim to alter early environments and prevent future adverse outcomes including (but not only) drug use, by alleviating and countering known risk factors in the early years of children's lives.

2. Education and information approaches

These interventions centre on the logic that if rational individuals are aware of the dangers associated with drugs, they will choose not to take them. By providing information, the interventions aim to make drug users more likely to reduce or quit and non-users less likely to start.

3. Treatment

These interventions include unstructured and structured treatments, pursuing goals of abstinence, harm reduction, and medically-assisted recovery for individual drug users.

4. Non-treatment rehabilitative activity

These interventions, including (re)employment and housing programmes, are aimed at improving aspects of the drug user's life that will help them reintegrate into society where necessary.

5. Enforcement

These interventions aim to reduce drug use in a variety of ways: deterring use by enforcing the illegality of drugs and punishing individuals caught using, and also by diversion into treatment and by restricting the supply and therefore availability of drugs.

We plan to take a meta-evaluation[9] approach to combine the results from different evaluations within each activity group. Where sufficient evidence is available, separate VfM estimates will then be calculated for the five activity groups.

[9] By 'meta-evaluation' we mean the synthesis of results from individual evaluations falling within the same activity group (e.g. enforcement), to provide an overall estimate.

How the interventions are intended to work

The development of logic models is helpful at the beginning of any policy evaluation, and particularly so when evaluating a policy as complex as the Drug Strategy, as they explain how a policy is intended to achieve its objectives. Logic models describe the theory, assumptions and evidence underlying the rationale for a policy, by linking the intended outcomes (both short and long-term) with the policy inputs, activities, processes and theoretical assumptions.[10]

For each of the five activity groups, logic models have been developed to identify the activities that are within scope of the evaluation; that is, they receive, at least in some part, government funding which contributes to the aims of the Strategy, although they may not necessarily have been directly mentioned in the Strategy. The logic models also set out how these activities aim to achieve their objectives.

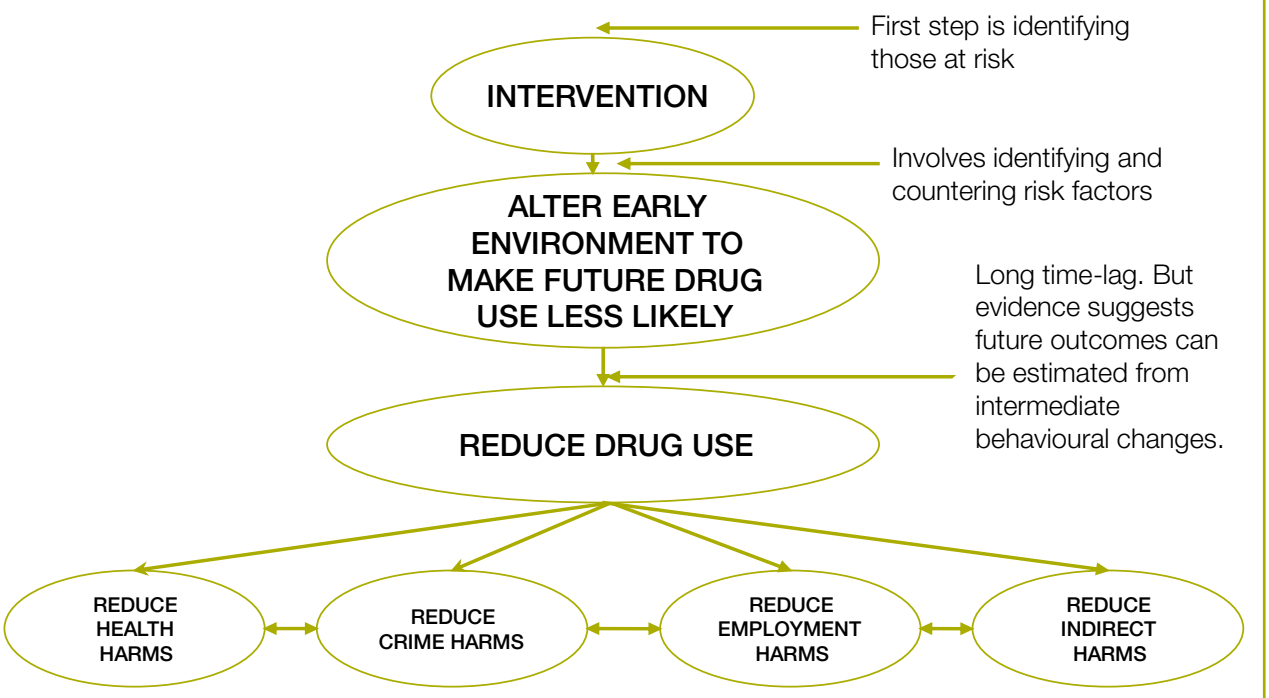
All interventions across the five groups aim to reduce drug use and/or build recovery either directly or indirectly. By reducing drug use, interventions may also reduce the associated health, crime, employment and other indirect harms (e.g. harms to family). Improving aspects such as health may also positively impact on crime and employment prospects and vice versa, hence the connecting arrows between bubbles in the logic models.

It is recognised that the logic models presented here are very high level and the complexity behind the models will be explored further as part of the overall evaluation. The current models aim to provide a condensed overview of the mechanisms through which each type of activity group is expected to achieve the aims of the Strategy, in order to provide an initial framework for identifying the relevant costs and benefits.

The logic model for each activity group is presented in Figures 2 to 6.

[10] For more information on the use of logic models in evaluation see the Magenta Book (http://www.hm-treasury.gov.uk/d/magenta_book_combined.pdf).

Figure 2: Logic model for early interventions

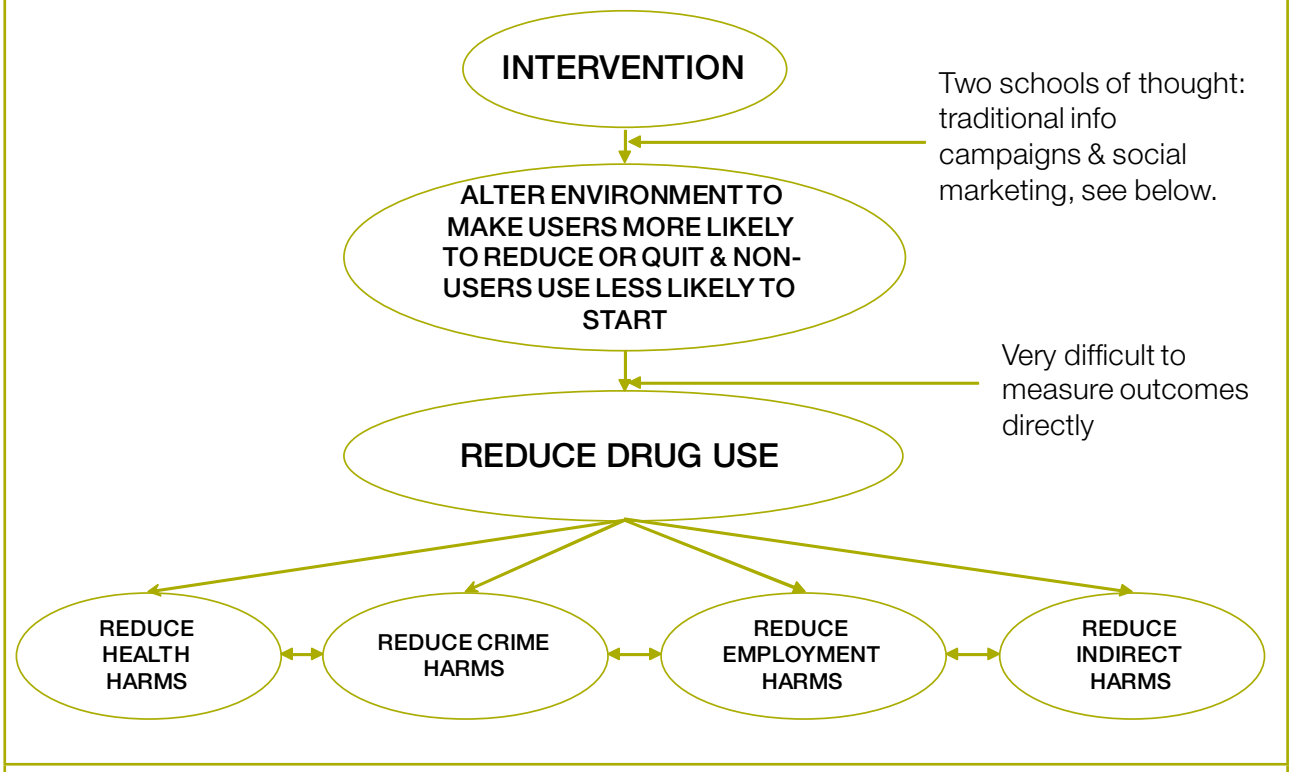


- Interventions aim to alter individuals' early environments to make future drug use less likely.
- The main issue for evaluation is the length of lag needed for results. However, proxy international evidence is available, which might be allied to evaluated intermediate outcomes.
- Early interventions are generally intended to reap social benefits through preventing adverse social outcomes, other than just drug use, but these are not modelled as part of the Drug Strategy evaluation.

Examples include:

- The Family Nurse Partnership Programme
- Sure Start Programme
- Intensive Family Pathfinders/Family Intervention Programmes

Figure 3: Logic model for education and information approaches

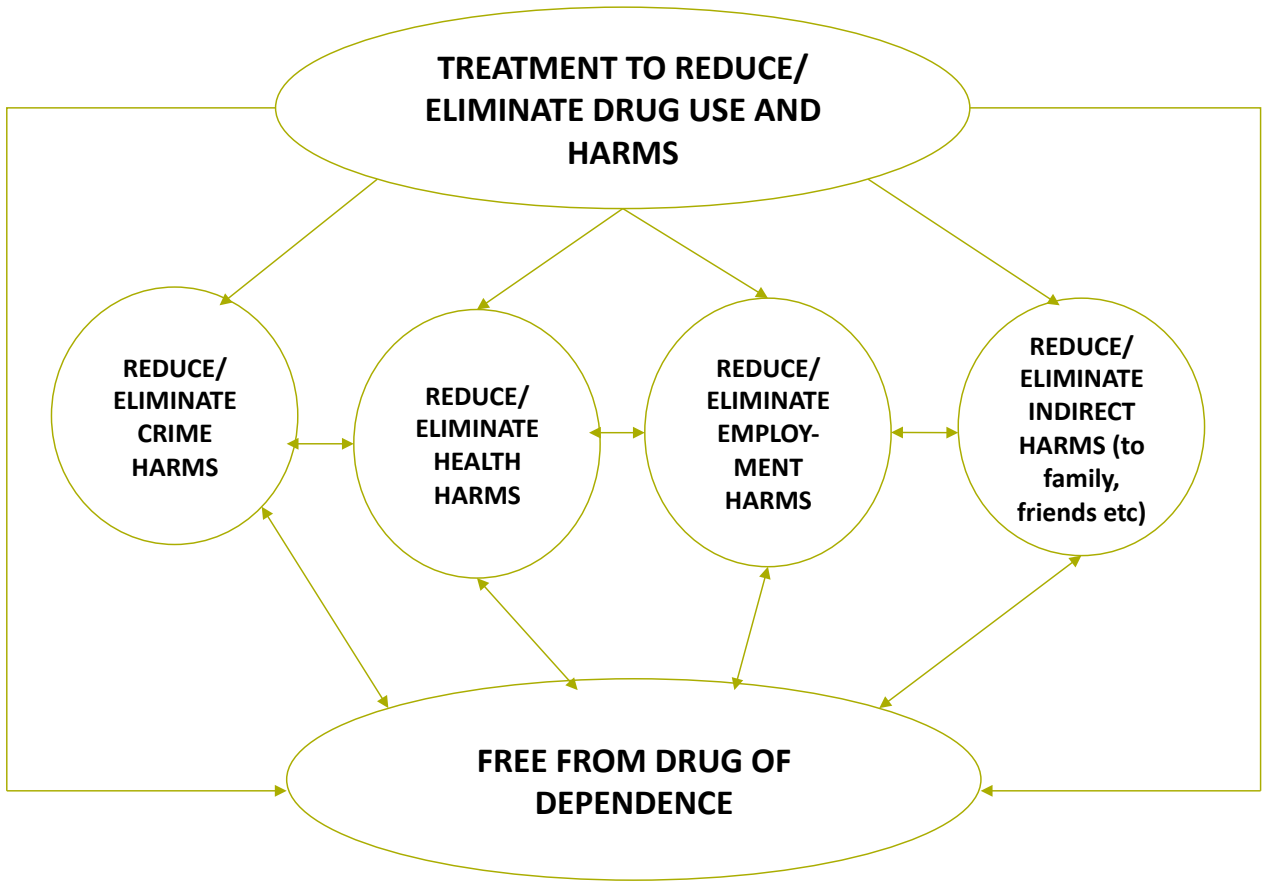


- The logic for this intervention has traditionally centred on rationality and information failure (i.e. if rational individuals knew the extent of the harms associated with drugs, they would not take them). Campaigns aim to fill the information gap. Recent evidence has however suggested that social marketing tactics, which stress more immediate appeal, are more effective.
- The major problem for evaluation is measuring hard outcomes; generally it is only possible to measure exposure or changes in attitudes, not actual behavioural change.

Examples include:

- FRANK (the FRANK website provides both young people and parents with information and advice about drugs)

Figure 4: Logic model for treatment

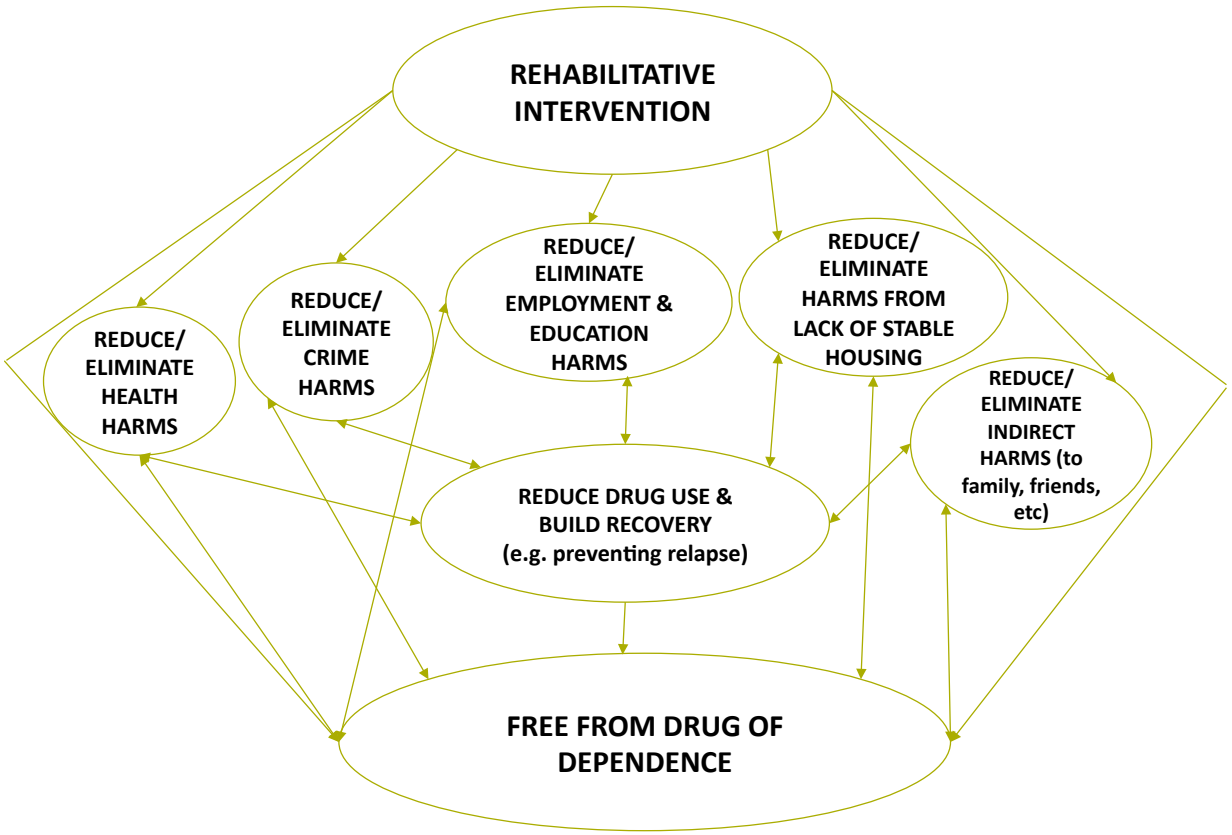


- These interventions include unstructured and structured treatment covering person-centred goals of abstinence, harm reduction, and medicinally-assisted recovery. Applies in all settings: community, hospital and residential.
- Treatment interventions aim to reduce/eliminate drug use and the associated health, crime, employment and other indirect harms. It is understood that certain harms cannot be fully eliminated, such as irreversible health harms associated with past drug use. Where this is the case interventions aim to eliminate further harms to the individual or wider society.
- Note that whilst unstructured and structured treatments are grouped together in the logic model, their costs and benefits will be assessed separately.

Examples include:

- Psychological intervention
- Opioid substitution therapy
- Needle and syringe programmes
- Mutual aid

Figure 5: Logic model for non-treatment rehabilitative activity

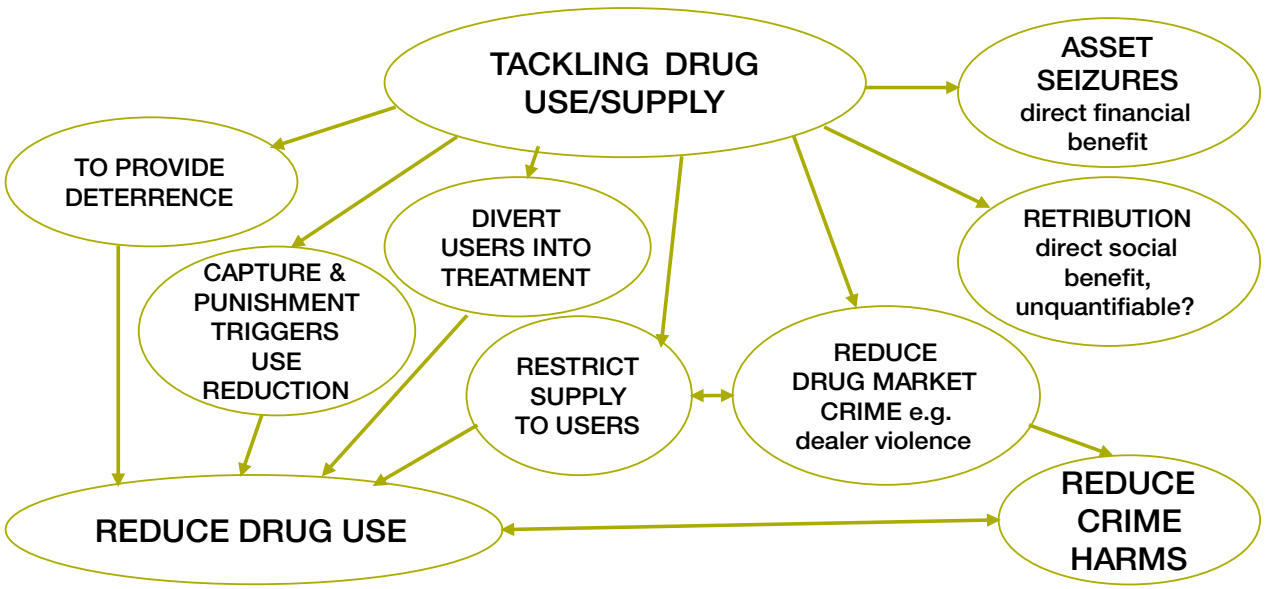


- Interventions are targeted to improve aspects of the user's life that will help them reintegrate into society (where necessary) and/or promote resilience to drug use.
- They may also have an effect on drug use and recovery, notably by helping to prevent relapse.
- A range of varied interventions fall within this group, such as those which help individuals into employment or secure housing.

Examples include:

- The Work Programme
- Employment provision
- Recovery champions
- Provision of stable housing for drug using offenders

Figure 6: Logic model for enforcement



- Enforcement has the most complicated logic model. It aims to cut drug use via four different channels: i) as a general deterrent by enforcing the illegality of drug use; ii) as a specific deterrent, by punishing individuals caught possessing drugs, those individuals, in turn, may reduce use; iii) by diversion into treatment (e.g. the Drug Interventions Programme, DIP) and; iv) by restricting supply (thereby reducing availability and/or use, by raising purity-adjusted price or preventing new drugs entering the market).
- Enforcement also has possible direct benefits: i) through incapacitation and other methods drug market crime (e.g. dealer violence) may be reduced directly; ii) the assets of drug dealers may be recovered by enforcement agencies; and iii) society as a whole may benefit from a sense of 'retribution'.
- UK-funded enforcement activity that impacts on source countries with the aim of restricting supply within the UK will be included in the evaluation. Any benefits occurring outside the UK (e.g. reduced instability) will not be included.

Existing evidence

To evaluate the Drug Strategy, we will use existing data, evidence and results from evaluations of programmes planned or underway.

The UK has a wide range of data that measure aspects of drug use and harm over time. Whilst these sources do not provide evidence of the impact of the Drug Strategy per se, they provide wider context and an indication of the general direction of travel against the aims of the Strategy, and may be useful to use as proxy measures where necessary. Table 1 provides a list of the current key measures available and those which map onto the two overarching aims of the Drug Strategy have been highlighted. These data are also useful for more complex analysis, for example recent work has matched various data sources to improve understanding about drug users and their experiences and contact with services and the Criminal Justice System (CJS). As part of the evaluation we will be exploring how best we can use these measures and others which are available.

In order to robustly measure VfM, good quality impact evidence is required. By impact evidence we mean testing, usually through evaluation, whether an intervention (e.g. treatment) has led to changes in the outcomes of interest (e.g. drug use) over and above that which would have occurred in the absence of the intervention. Impact evaluation requires both a measure of the outcome and a means of estimating the counterfactual, that is, what would have happened without the intervention, usually using a control group.

Unsurprisingly, some of the activity group areas have a more developed and robust evidence base than others. In areas such as drug treatment, the evidence base is relatively strong. There are challenges in other areas, however, particularly around developing a suitable counterfactual, or measuring impact on actual behaviour. For example, establishing the conditions for a robust counterfactual for enforcement is difficult and as a result, little robust evidence of impact is available either nationally or internationally. In the area of early interventions, some good impact evaluation evidence exists, although there is a lack of evidence of long-term outcomes. Evidence is also available showing that education and information campaigns (e.g. the FRANK service) influence awareness and attitudes but little is known about how this translates into behaviour change. Furthermore, the non-rehabilitative activity group is a new strand of the Drug Strategy and as such would benefit from new research and evaluation to understand the impact of the interventions contained in this area.

One of the intentions of the evaluation is to stimulate debate about how to fill gaps in the evidence base. Where there are evidence gaps and it is not possible to undertake new robust evaluation, we will need to take a more indirect approach to assessing impacts using the best existing evidence available as a proxy (further detail is provided in Section 2.6).

Where possible, relevant results from the evaluation of the Payment by Results (PbR) drug and alcohol recovery pilots will be fed into the evaluation. The 2010 Drug Strategy set out an ambition to explore how to use PbR to incentivise the drug treatment system to improve delivery of recovery outcomes. A number of pilots have since been set up to test this. An independent evaluation of the pilots is underway, which includes an impact evaluation to assess the effectiveness of the PbR pilots against key outcome measures[11] and an economic evaluation to assess the extent to which PbR schemes are affordable and represent good VfM.

[11] The pilots focus on delivery within three high-level outcome measure: free from drug(s) of dependence; offending; and health well-being.

Table 1: Summary of existing measures and sources of drug use, drug-related harm and enforcement data

Measure		Source
Drug use	Drug use in adults (aged 16 to 59) in England and Wales	Drug Misuse Crime Survey for England and Wales, Home Office
	Drug use in young people (aged 11 to 15) in England	Smoking, drinking and drug use among young people survey Health and Social Care Information Centre
	Estimates of the prevalence of opiate use and/or crack cocaine use in England	Estimates based on drug treatment, probation, police and prison data
Drug treatment	Adults (aged 18 and over) in treatment contact in England	National Drug Treatment Monitoring System (NDTMS) Public Health England[12]
	Young people (under 18) in treatment contact in England	NDTMS
	Of those presenting for drug treatment for the first time over a three-year period, the proportion who had successfully completed treatment and not returned by the end of that period	NDTMS
Drug-related deaths	Number of drug misuse deaths in England and Wales	Deaths relating to drug poisoning in England and Wales Office for National Statistics
Drug offending	Drug offences recorded in England and Wales	Police Recorded Crime Home Office
	Convictions for drug offences in England and Wales	Criminal Justice Statistics Ministry of Justice
	Drug misusing offenders	Reoffending Statistics Ministry of Justice
Drug enforcement	Number and quantity of seizures in England and Wales	Home Office data collected from police forces, UK Border Agency and HM Revenue and Customs
	Drug assets and seizures – those seized both abroad and within the UK by the National Crime Agency (NCA)	NCA
	Price/purity data	To be confirmed

[12] In April 2013, the National Treatment Agency (NTA) became part of Public Health England (PHE), an executive agency of the Department of Health (DH).

Key to Table 1:

Maps onto the 'Reduce illicit and other harmful drugs use' aim of the Drug Strategy

Maps onto the 'Increasing the numbers recovering from their dependence' aim of the Drug Strategy

Initial estimates of government spend on tackling drug use

Table 2 sets out initial estimates of direct government spend on tackling drug use.[13] Spend data is provided for 2011/12 where possible (the most recent data available when this document was produced), for each of the five types of activity that contribute to the aims of the Drug Strategy 2010. Assumptions made in calculating the estimates are noted.

In some instances, it has been difficult to obtain accurate spend information. This has long been the case in some areas, such as enforcement, where for example, it is difficult to disaggregate how much is spent enforcing drug laws from enforcement activity against other types of illegal behaviour. This has become a wider issue in part due to mainstreaming ring fenced spend on tackling drugs into wider pooled budget streams and less direct central funding in the context of the move to localism. It may be that in the future, increasing levels of local control over resource allocation mean it will not be possible to obtain accurate spend figures and, where this is the case in the evaluation, we will use the most recent available figures.

[13] Direct government spend in this context refers to spend on those programmes and interventions that are within scope of the evaluation, as set out by the parameters of the logic models discussed in section 2.3.

Table 2: Estimate of direct government spend on tackling drug use in 2011/12

Intervention group	Funding department	Types of intervention	Overall estimate of spend (£m) in 2011/12	Assumptions
Early interventions	Department for Education (DfE)/ Department of Health (DH)/ Home Office (HO)	The Family Nurse Partnership; Sure Start Programme; Intensive Family Pathfinders; Family Intervention Programmes; Myplace; Personal, Social, Health and Economic (PSHE) education; Positive Futures; Choices	341	Interventions within this group aim to prevent a variety of health, crime, employment and indirect harms, meaning calculating drug-specific spend from the overall budget for the intervention is, in some instances, difficult. Where possible an estimate of drug-specific spend has been calculated from the aggregate budget For example, the Early Interventions Grant (EIG) covers all indirect interventions (Family Nurse Partnership, Sure Start etc.). The overall EIG budget is £2.2bn for 2011/12 and drug-specific spend has been estimated as £220m; 10 per cent of the total. PSHE spend is for 2010/11, all other spend is based on actual or expected spend for 2011/12.
Education and information campaigns	DfE/DH/HO	FRANK; new media information campaigns	7	Estimate based on actual spend in previous years.
Treatment	DH/National Treatment Agency (NTA)[15]	Young people; adults; prisons and secure settings for children and young people	542	Actual figures for treatment spend in 2011/12. Covers both structured and unstructured treatment.

Intervention group	Funding department	Types of intervention	Overall estimate of spend (£m) in 2011/12	Assumptions
Non-rehabilitative treatment activity	Department for Work and Pensions (DWP)/DH/ Department for Communities and Local Government (DCLG)	Work Programme; tailored conditionality; employment provision; employment engagement; Recovery Champions; homelessness prevention; Supporting People.	155	As per early interventions, activities within this group have diverse aims and calculating drug specific spend is difficult. For example, homelessness prevention spend data is not collected on specific groups such as drug users; the overall spend has been provided for 2009/10. Spend for Supporting People is based on spend for people with drug and/or alcohol problems in 2010/11. More recent spend data is difficult to obtain due to funding being subsumed into the Formula Grant from April 2011; this can be used by Local Authorities for any purpose. No estimate of spend is currently available for the Work Programme, employment provision and Recovery Champions. Tailored conditionality and employer engagement spend neutral/likely to be small.
Enforcement	HO/DH/Ministry of Justice (MoJ)/British Foreign and Commonwealth Office (FCO)/ Serious and Organised Crime Agency (SOCA)[14]	Drug Interventions Programme (DIP); police enforcement; dedicated drugs courts; tackling prison supply; SOCA activity; named drug workers; temporary banning orders; UKBA border control; international enforcement.	1460	Mix of actual spend (e.g. DIP and named drugs workers) and estimated costs. Spend for police enforcement is based on an estimate of police and knock-on CJS costs generated by drug possession and supply offences, based on the published costs of crime methodology (2003/04). To note, this estimate does not include spend on tackling drug-related crime (such as thefts to fund drug use). UKBA border control and international enforcement spend is for 2009/10. No estimate of spend is currently available for dedicated drugs courts, tackling supply of drugs into prisons, or temporary banning orders.
				TOTAL ESTIMATE FOR INTERVENTIONS WHERE SPEND IS AVAILABLE: £2.5bn

Note: The NAO report on tackling problem drug misuse estimated government spend on tackling drugs to be £1.2bn in 2008/09, this did not include the majority of enforcement costs. http://www.nao.org.uk/publications/0910/problem_drug_use.aspx

14 The new National Crime Agency (NCA) became operational in October 2013, replacing SOCA.

3. Approach to evaluation

Estimating costs and benefits

For each of the five activity groups, we will assess direct return on investment (RoI) through gathering information on direct spend. This will be more difficult for some interventions than for others. For example, it has long been problematic trying to identify the drug related proportion of enforcement spend (such as police activity). Where it is found impossible to obtain direct spend information, alternative methods for estimating costs (e.g. modelling approaches or qualitative investigations) will be used.

For interventions which are *not* specifically aimed at drug users, such as early interventions, the total budget will be scaled down by the proportion of individuals receiving the intervention who are or would go on to become drug misusers. The above approaches rely on having sufficient, reliable information on spend on tackling drug use. Where this information is not available, an alternative, but less robust, strategy would be to project forward from old spends (where available), allowing for predicted changes in spending levels.

Difficulties also apply in relation to evaluating benefits. Both drug-specific benefits and wider benefits relating to health, crime and employment will be identified with the help of the logic models. The scale of these benefits, and the extent to which they were caused by the Drug Strategy, will then be evaluated. Evaluating benefits will be made more complex in certain areas, such as the non-treatment rehabilitative activity group, due to the outcomes and benefits of one intervention likely overlapping with the outcomes from another. Any overlap will need to be recognised and benefits shared appropriately across the activity groups.

In some areas, such as drug treatment, existing evidence on benefits can be used. In others, where evidence gaps are identified, the possibility of gathering new evidence will be explored. If this is found to be unfeasible, the possibility of using other sources to evaluate benefits will be investigated. For example, monitoring evidence coupled with proxy international evidence could be used. In all cases we intend to aim for the most robust approach possible but accept that we may have to settle for 'second best' options where optimal evaluations are not feasible.

Work will continue in consultation with government departments and agencies, and independent experts in the field, to further refine the approach to evaluating costs and benefits.

Challenges

In developing the Evaluation Framework a number of key issues have arisen which have implications for evaluating the effectiveness and VfM of the Drug Strategy:

Increasing local control and accountability

We have acknowledged throughout that the move to localism is likely to present a fundamental challenge to conducting a national evaluation of the Drug Strategy. It will be up to local areas through new mechanisms such as Police and Crime Commissioners and Health and Wellbeing Boards to decide what aspects of the Drug Strategy they implement and fund to meet the drug-related needs of their communities. Furthermore, there will be no requirement from central Government for local areas to report the effectiveness (or otherwise) of the programmes and interventions employed in their areas. Where it is not possible to get accurate information on effectiveness and spend at the local level we will need to rely on assumptions, for example that all local areas are implementing the programmes underpinning the Drug Strategy in the same way and achieving the same impact. Where we have made assumptions we will make this clear.

Resource constraints

In an environment of resource constraints it is possible that insufficient research resource is available to undertake the level and scale of evaluation necessary to fill all identified evidence gaps. Where this is the case the risks will be flagged and alternative approaches to estimating VfM developed.

Methodological constraints

Some interventions/activities do not lend themselves to the robust experimental design necessary to produce reliable and direct estimates of effect or return on investment. This is particularly true of the enforcement/supply side and also for prevention based interventions. Alternative methods for estimating benefits will therefore need to be developed in some areas.

4. Next steps

This first iteration of the Evaluation Framework has outlined how we will approach evaluating the 2010 Drug Strategy. The next step is to begin to identify and evaluate the costs and benefits of the various strands of the Drugs Strategy as set out in this document.

Departments across Whitehall and other agencies will continue to consider how they can improve the evidence base within the constraints highlighted in this document. Work will also continue to refine the approach and the mechanisms for delivering the evaluation. This includes exploring ways in which central Government can encourage local areas to evaluate their activity and identify opportunities for natural experimentation.

The approach to evaluation, and importantly how the evidence from various sources is brought together to produce an overall evaluation for each of the five activity groups is an evolving process. Whilst this document summarises the current position, this is likely to develop as new information and evidence comes on stream.

Any new evidence that becomes publicly available throughout the life of the 2010 Drug Strategy will be considered, and where it adds to the evidence base, will be included in the evaluation. Alongside internal work with other government departments and agencies, external input and quality assurance will be sought to help further develop the evaluation approach and delivery. This would include any relevant evidence that becomes available on issues such as welfare expenditure, crime, housing and social care. The evaluation framework will remain live, and look to draw upon the most up to date evidence that there is.

The evaluation is currently planned to report at the end of the life of the 2010 Drug Strategy, although the actual completion date is still under consideration. We will provide further updates on the progress of the evaluation in the Drug Strategy Annual Reviews.