London Borough of Havering

Substance Misuse Needs Assessment Refresh 2026

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Abbreviations

Abbreviation	Full term
AI	Artificial Intelligence
APMS	Adult Psychiatric Morbidity Survey
ATR	Alcohol Treatment Requirement
BBV	Blood Borne Viruses
CDP	Combatting Drugs Partnership
CI	Confidence Interval
CGL	Change, Grow, Live
CYP	Children and Young People
DARDs	Drug and Alcohol-Related Deaths
DATRIG	Drug and Alcohol Treatment and Recovery Improvement Grant
DRR	Drug Rehabilitation Requirement
GP	General Practitioner
HCV	Hepatitis C Virus
HES	Hospital Episode Statistics
HIV	Human Immunodeficiency Virus
HMO	House in Multiple Occupation
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICD-10	International Classification of Diseases, 10th Revision
ICS	Integrated Care System
IMD	Index of Multiple Deprivation

Abbreviation	Full term
IPS	Individual Placement and Support
JSNA	Joint Strategic Needs Assessment
LAPE	Local Alcohol Profiles for England
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, and others
MHCLG	Ministry of Housing, Communities and Local Government
NDTMS	National Drug Treatment Monitoring System
NFOs	Non-Fatal Overdoses
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PCR	Polymerase Chain Reaction
PWLE	People With Lived Experience
SRO	Senior Responsible Owner
SSMTRG	Supplemental Substance Misuse Treatment and Recovery Grant
YOT	Youth Offending Team

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1. Executive Summary

This refresh of Havering's Substance Misuse Needs Assessment updates the 2023 evidence base to reflect the current policy context, the latest available local and national data, and emerging patterns of need, harm, and service activity. It has been prepared to support the Havering Combatting Drugs Partnership (CDP) to review progress since the previous assessment, reaffirm priorities, and inform service delivery, partnership action, and future commissioning.

The refreshed evidence shows that substance misuse remains a significant and evolving issue in Havering. Alcohol continues to account for the greatest population-level burden and the highest level of unmet treatment need. The latest modelled estimate suggests around 2,336 adults in Havering were alcohol dependent in 2019/20, of whom 588 were in treatment in 2024/25, leaving a substantial unmet treatment need. Broad alcohol-related hospital admissions increased by 2023/24, while alcohol-specific admissions were relatively stable overall. Alcohol-related mortality and alcohol-specific mortality improved in 2024, but both had worsened in the preceding years, and premature mortality from alcoholic liver disease remains an ongoing concern. Taken together, this indicates continuing need for prevention, early identification, treatment access, and wider action on alcohol-related harm.

The adult treatment system has expanded since the previous needs assessment. Adults in treatment increased from 675 in 2019/20 to 1,050 in 2024/25, and referrals into treatment rose, particularly from adult mental health, hospital, prison, and arrest referral pathways. This suggests improved identification and engagement across partner services as well as continued demand. The treatment population is also ageing: the number of adults aged 50 and over in treatment increased from 210 in 2019 to 310 in 2025. The treatment profile has shifted gradually, with alcohol and non-opiate presentations becoming more prominent. At the same time, opiate and crack-related need remains important. The latest estimate suggests 745 people in Havering were using opiates and/or crack cocaine in 2022/23, lower than the previous estimate of 924 in 2019/20, but with more than half still estimated to be outside treatment.

The assessment continues to show high levels of complexity. Housing insecurity remains a recurring feature among new presentations, economic inactivity has increased, smoking prevalence among people in treatment remains far above the general population, and co-occurring mental health need is common. In 2025, 67% of new treatment presentations reported needing mental health treatment. Although most were already receiving support, a persistent minority were not, and qualitative findings suggest that thresholds, fragmented pathways, and delayed access remain barriers for people with co-occurring needs. This reinforces the need for stronger joint working across substance misuse, mental health, housing, physical health, and wider support services.

Children and young people remain an important part of the local picture. The number in structured treatment rose from 25 in 2019 to 65 in 2025, although this was lower than the 2024 peak of 85. This should be interpreted as increased service activity rather than a direct measure of prevalence alone. However, wider evidence also points to ongoing concern: cannabis remains the predominant substance among those in treatment, alcohol is more visible than previously, local safeguarding assessments identify child drug misuse more often than comparator areas, and the 2025 BeeWell survey suggests that alcohol use was more commonly self-reported than drug use among the pupils surveyed. These findings support continued focus on prevention, early intervention, transitions, and stronger links between treatment, education, youth support, children's services, and safeguarding partners.

The illicit drug picture is mixed. Some benchmarked hospital admission and mortality indicators remain below national comparators, but there is evidence of continuing local harm. Drug misuse mortality has slightly increased across recent rolling periods, drug offences have risen despite a fall in total crime, and hospital data suggest continuing acute harm linked particularly to opioids and other non-cocaine drug-related poisonings. Qualitative evidence also points to a more volatile local drug market, with concerns about ketamine, benzodiazepines, contamination, synthetic opioids, and hidden use among younger people. This suggests that local need cannot be understood through comparator statistics alone and requires continued attention across health, safeguarding, and community safety systems.

Overall, the refreshed assessment suggests that Havering has made progress in treatment reach, referral pathways, and service activity, but that this sits alongside substantial ongoing need and increasing complexity. The evidence supports continued strategic focus on alcohol harm, older adults, co-occurring mental health need, housing and wider recovery support, children and families, and targeted responses to localised drug-related harm and offending. It also highlights the importance of strengthening local intelligence, overdose and mortality surveillance, operational partnership working, and expanding recovery-oriented community support beyond formal treatment.

2. Background

2.1 National Context

In December 2021, a previous UK government published "From harm to hope: A 10-year drugs plan to cut crime and save lives"[1]. This strategy set out an approach to:

1) Reduce the supply of illicit drugs.
2) Deliver a word class treatment and recovery system.
3) Reduce demand for drugs and,
4) Increase accountability through local partnerships.

The strategy was informed by the findings of the independent review of drugs led by Dame Carol Black, which identified significant disinvestment in treatment services, rising drug-related harms, and increasing complexity of need among people who use drugs. The review highlighted the need for sustained investment in the sector, system-wide reform, and stronger cross-government coordination.

In response, the government in 2021 committed to a substantial increase in funding for substance misuse treatment and recovery services. This included the introduction of additional grant funding for local authorities through the Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG). In later years, this additional treatment and recovery funding was incorporated into wider public health grant arrangements as the Drug and Alcohol Treatment and Recovery Improvement Grant (DATRIG). This investment was intended to rebuild treatment capacity, improve service quality and enhance outcomes, particularly for individuals with multiple and complex needs relating to their use of substances.

The national drugs strategy set interim ambitions to be achieved between 2022/23 to 2024/25. These included expanding access to high-quality treatment, increasing the number of people in treatment, strengthening recovery support, and intensifying efforts to disrupt drug supply, such as tackling county lines activity and increasing organised crime disruptions. Progress against these ambitions has been monitored through a National Combatting Drugs Outcomes Framework, which provides a national mechanism for tracking performance and system impact.

At the time of drafting this refresh, no new standalone national alcohol strategy for England had been published. Alcohol-related policy and service expectations therefore continued to be shaped through wider government, NHS, OHID and NICE policy, guidance, and commissioning frameworks.

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[1] Home Office, *From harm to hope: A 10-year drugs plan to cut crime and save lives* (2021) From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK

2.2 Local Context

National guidance for local delivery of the national drugs strategy was initially published in June 2022 and was most recently updated in January 2024[2]. This guidance required local areas in England to establish a Combatting Drugs Partnership (CDP) to oversee delivery of the national strategy at 'place' level, with a named Senior Responsible Owner (SRO) and multi-agency governance. This governance spanned the three strategy pillars of breaking drug supply, treatment and recovery, and reducing demand. It also set expectations for senior-level leadership and accountability across local government, criminal justice partners, and health partners, including Integrated Care Systems and Boards (ICS's & ICB's).

Under this guidance, local partnerships were expected to:

- Maintain a shared understanding of local need through a Joint Strategic Needs Assessment (JSNA)
- Agree and deliver a local drugs strategy and delivery plan aligned to national priorities.
- Put in place appropriate arrangements for data collection, information sharing, performance monitoring, and partnership oversight.
- Progress is expected to be reviewed routinely, allowing partnerships to respond to emerging issues and track delivery using the National Combatting Drugs Outcomes Framework and its supporting metrics.

This meant local needs assessments and subsequent refreshes, were not stand-alone documents. Instead, they are a core part of the wider partnership infrastructure which provides an evidence base for decision making on local priorities and supports strategic planning and commissioning.

2.3 Havering Combatting Drugs Partnership Board

The Havering Combatting Drugs Partnership (CDP) was established in May 2022 to lead local implementation of the national drugs strategy. Membership has remained broadly consistent and includes representation from local health partners, criminal justice agencies, Havering Safeguarding Adults Board, communications, voluntary and community sector representatives, and Havering's commissioned treatment providers. Further details of the partnership's role, membership and governance is set out in Havering's Substance Misuse Strategy[3].

[2] Guidance for local delivery partners Guidance for local delivery partners (accessible version) - GOV.UK
[3] Havering launches plan to tackle substance misuse | London Borough of Havering

2.4 Havering Needs Assessment Refresh

A core function of the CDP is to lead and maintain a joint needs assessment. National guidance expects local areas to complete an initial comprehensive assessment and refresh it at least once every three years. As Havering's last needs assessment was completed during 2023, a refresh is being undertaken in 2026.

This needs assessment refresh uses a wide range of data sources, including local drugs intelligence, community safety strategic assessments, and the Joint Strategic Needs Assessment (JSNA). It also uses national datasets and indicators, including OHID Fingertips profiles and the Local Alcohol Profiles for England (LAPE), to support analysis of need, trend monitoring, and comparisons at local authority level. Where data are available, the refresh also draws attention to issues that were not covered in detail in the previous needs assessment, including prescribed and over-the-counter medication misuse and other emerging local concerns such as ketamine and hospital episode statistic (HES) data.

2.5 Aims and objectives.

This document aims to inform delivery planning and commissioning intentions, identify unmet needs and support the CDP to reaffirm local priorities for action and assess progress since 2023.

The objectives of this refresh are to:

(i) Update and synthesise the most recent quantitative and qualitative evidence to describe current needs, trends, inequalities, and emerging risks relating to drugs and alcohol in Havering.

(ii) Review progress and changes since the 2023 needs assessment, including changes in substance use patterns, service provision, pathways, partnership arrangements, and performance monitoring.

(iii) Identify gaps, unmet needs and pressure areas across prevention, treatment, and recovery, drawing on insights gained from partners and People With Lived Experience (PWLE) and learning from relevant reviews where available.

(iv) Provide recommendations to support prioritisation, service improvement, and future commissioning, including actions to reduce harm and address inequalities.

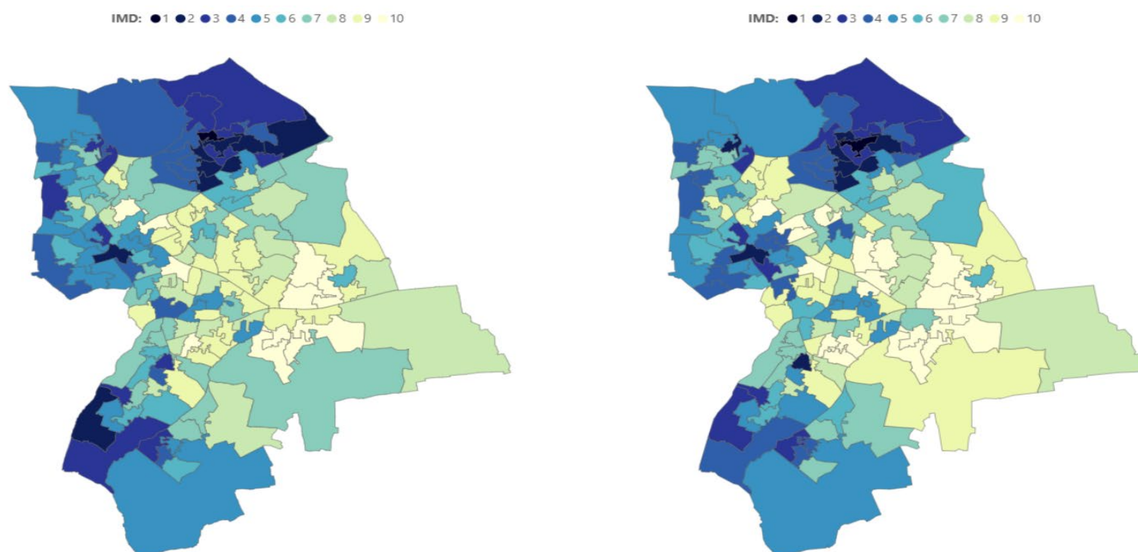
3. Substance misuse risk factors

Substance use and harms are influenced by a range of social, economic, and environmental factors. It is beyond the scope of this needs assessment refresh to outline every substance misuse risk factor. Instead, this section concentrates on factors that have been identified in research to link with the propensity to use substances. Additional information about the borough's population is available in the Havering JSNA Demographic Profile (2026)[4].

3.1 Deprivation and inequality

There is a well-established association between socioeconomic disadvantage, social exclusion, and risk of using substances, experiencing substance-related harm, drug-related death, and poorer outcomes[5]. In relation to deprivation and inequality in Havering, 10 lower Layer Super Output Areas (LSOAs) remain classed as within the 20% most deprived in England. In contrast the number of areas within the 20% least deprived LSOA's across Havering has increased from 36 in 2019 to 42 in 2025 (see Figure 1 below). This suggests that, although Havering includes several relatively affluent areas, pockets of deprivation remain. in relation to deprivation and inequality.

Figure 1. LSOA by Index of Multiple Deprivation (IMD) (darker areas have higher deprivation) 2019 (left) and 2025 (right)



Source: Department of Housing, Communities and Local Government (MHCLG) IMD 2019 & 2025

[4] Havering – Joint Strategic Needs Assessment
[5] ACMD Drug misuse prevention review (accessible) - GOV.UK May 2022

3.2 Rough Sleeping, housing insecurity, and homelessness

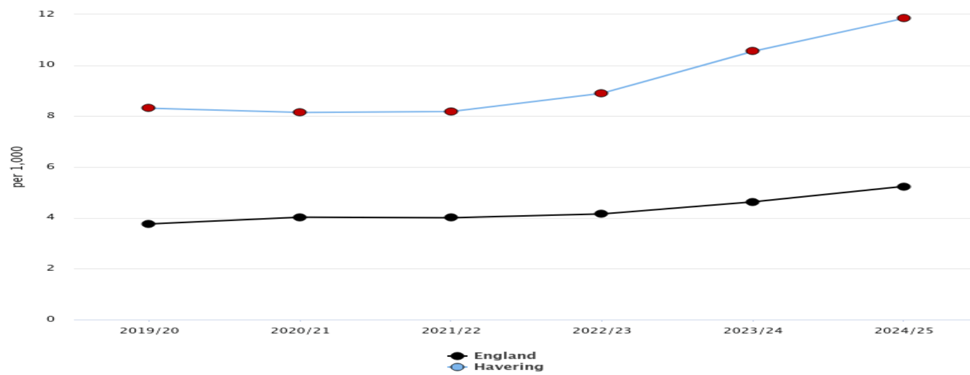
Rough Sleeping, housing insecurity, and homelessness are associated with a higher likelihood of substance use along with greater levels of substance-related harm, and poorer engagement with substance use treatment and recovery support[6]. In Havering, the number and rate of households in temporary accommodation, a proxy measure of housing insecurity, have increased steadily since 2020/21, reaching 1,285 households, or 11.8 per 1,000 households, in 2024/25 (Figure 2). Over the same period, the number of households owed a duty under the Homelessness Reduction Act (2017) has remained high, with 2,039 households, or 18.7 per 1,000 households, recorded in 2024/25 (Figure 3). The Homelessness Reduction Act gave duties to local authorities to intervene and provide support to all eligible homeless people or those at risk within 56 days. It introduced a new "relief" duty for those already homeless, and mandated personalised housing plans.

There is no direct link between living in temporary accommodation, and a substance use treatment need, but local data from our drug and alcohol service shows housing insecurity features significantly in identified issues amongst people entering treatment in Havering. Qualitative findings from staff and stakeholders strengthen this, describing temporary accommodation, hostels, HMOs, and homelessness as environments that can actively undermine recovery. Staff also highlighted out-of-borough placements as especially destabilising because they can disrupt continuity of care, reduce informal support, increase isolation, and contribute to disengagement or relapse.

The number of households with people aged 55 years and over, in addition who are owed a duty under the Homelessness Reduction Act has increased (Figure 4), alongside a rise in the number of adults aged 50 years and over engaged in substance use treatment from 180 (27%) in 2020 to 310 (30%) in 2025[7]. Individuals who are older may have more complex needs due to longer time spent using substances and the impact of this on physical and mental health. Staff feedback suggests that in these contexts' disengagement is often less a matter of motivation and more a reflection of people trying to engage with recovery while living in unstable and risky environments.

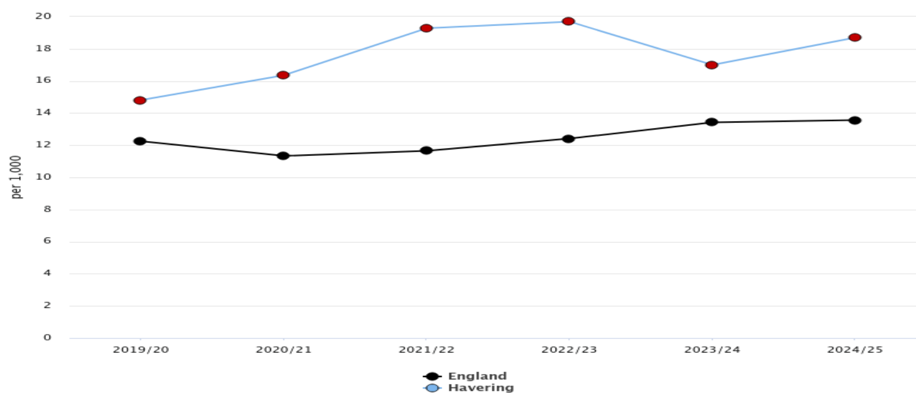
[6] Rough sleeping questionnaire 2025: Headline findings - GOV.UK
[7] NDTMS - ViewIt - Adult

Figure 2. Households in temporary accommodation, crude rate per 1,000 estimated total households



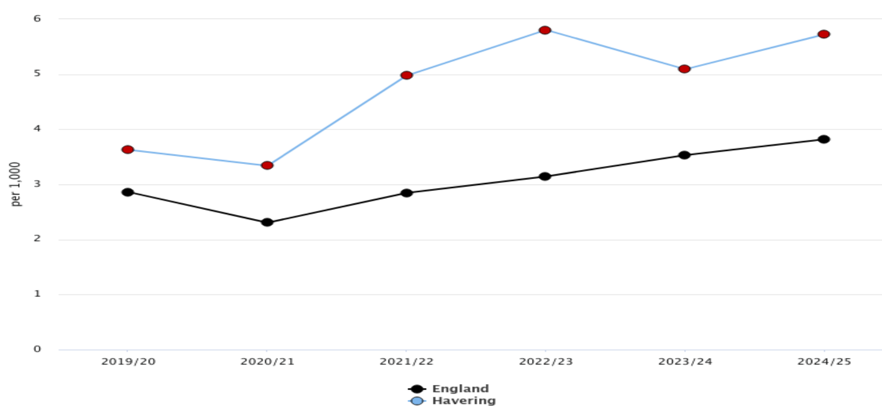
Source: OHID Fingertips

Figure 3. Households owed a duty under the Homelessness Reduction Act, crude rate per 1,000 estimated total households.



Source: OHID Fingertips

Figure 4. Households owed a duty under the Homelessness Reduction Act (main applicant aged 55 and over), crude rate per 1,000 estimated total households.



Source: OHID Fingertips

Substance use and any related needs in Havering are influenced by a range of other factors such as mental health issues, domestic abuse and coercive control, relationship issues, adverse childhood experiences, trauma and contact with the criminal justice system. These factors can interact with deprivation, housing insecurity, and inequalities to increase risk of substance use, hinder access to treatment, complicate recovery journeys, and create barriers to accessing support. It is beyond the scope of this needs assessment to cover each of the above areas in detail, however some factors are covered later in this refresh.

4. Prevalence of substance use

4.1 Illicit drug use

Crime Survey for England and Wales data[8] provides national estimates of the proportion of people reporting illicit drug use. Applying England and Wales age-specific prevalence rates to Havering's 2024 mid-year population estimates suggests that around 4,042 people aged 16 to 24 years and 9,456 people aged 25 to 59 years in Havering may have used an illicit drug during the last year.

Nationally, estimated prevalence of using a substance is highest among younger adults, with 16.7% of people aged 20 to 24 years and 15.4% of those aged 16 to 19 years estimated to have used an illicit drug in the last year. The estimated number of people using drugs in Havering is highest among those aged 35 to 44 years, at around 2,910, reflecting the larger population size in this age group.

Compared with the previous estimates for the year ending March 2020, the modelled number of people aged 16 to 24 reporting illicit drug use in Havering in the last year is estimated to have fallen by 23.5%, from 5,282 to 4,042. In contrast, the estimated number among those aged 25 to 59 years is estimated to have increased by 14.5%, from 8,260 to 9,456.

Around 2.0% of people in England and Wales were classed as frequent drug users (more than once a month) by Crime Survey data in 2024/25.

Table 1. Proportion of people reporting illicit drug use in the last year, year ending December 2025

Age group	Estimated % reporting use (England & Wales)	Population in Havering	Estimated number of people in Havering
16–19	13.2%	12,510	1,651
20–24	16.7%	14,259	2,381
25–29	13.2%	17,853	2,357
30–34	9.6%	19,820	1,903
35–44	7.0%	41,574	2,910
45–54	5.5%	33,431	1,839
55–59	3.1%	16,851	522
16–24	**15.1%**	**26,769**	**4,042**
25–59	**7.3%**	**129,529**	**9,456**

Source: Office for National Statistics (ONS) - Crime Survey for England and Wales & ONS - Mid Year Population Estimates 2024

[8] Drug misuse in England and Wales - Office for National Statistics

In 2024/25, 3.3% of people aged 16 to 59 years (around 1.1 million people) and 4.5% of people aged 16 to 24 years (approximately 271,000 people) had taken a Class A drug in the last 12 months[9]. The definition of a Class A drug in the Crime Survey data was Cocaine, Heroin, Methadone, Methamphetamine, Magic Mushrooms and LSD. Please note for 16-24 years old this was lower than the 2014/15 data, when it was 7.5%[10]. The harm associated with Class A drug use is greater than other drug types and therefore, along with the legal drug of alcohol, this needs assessment refresh will primarily focus on data relating to these drug types.

4.2 Estimated prevalence of opiate and/or crack cocaine use

The most recently available estimates suggests that in Havering there were 745 (95% CI 612 to 952) people aged 15 to 64 using opiates and/or crack cocaine in 2022/23, equivalent to a rate of 4.4 per 1,000 population[11]. This is a decrease from the previous 2019/20 estimate of 924 (95% CI 717 to 1,094) people, representing a decrease of 19.4% over the period.

National Drug Treatment Monitoring Data (NDTMS) estimates that based on 745 people in Havering using Opiates and/or crack cocaine and 327 people in treatment in 2024/25, that 56.11% (418 people) of people who use this drug type may have an unmet treatment need[12]. The unmet treatment need for opiate and/or crack users has been decreasing since 2022/23, which could be suggested is an indication that Havering's commissioned treatment services are engaging people who use this drug type into treatment.

4.3 Estimated prevalence of Opiates only:

NDTMS data estimates in 2022/23 that there are 230 (95% CI 183 to 295) people in Havering who used opiates, equivalent to 1.4 per 1,000 population. In 2024/25 with 110 people in treatment and a potential 120 people with an unmet treatment need (52.17%). The unmet treatment need for opiate users has been reducing since 2022/23, indicating that treatment services are increasingly engaging opiate users into treatment.

4.4 Estimated prevalence of both Opiates and Crack:

As substance use can consist of using more than one substance at a time, NDTMS also provides estimates of people who use both Opiates and Crack. In 2022/23, NDTMS

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[9] Drug misuse in England and Wales - Office for National Statistics
[10] Drug misuse in England and Wales - Office for National Statistics
[11] NDTMS - ViewIt - Adult
[12] NDTMS - ViewIt - Adult

estimates that 337 people (95% CI 279 to 427) in Havering use these drugs and 197 people are in treatment. This would mean that approximately 140 people have an unmet treatment need (41.54%) and like other drug types, the level of unmet need has been reducing in Havering since 2022/23.

4.5 Alcohol

Alcohol use is more common than illicit drug use across the UK, with 77% of adults aged over 16 years consuming alcohol in the last 12 months[13]. Alcohol contributes to population-level harm despite being a legal drug. National survey data shows that, in 2024, 44% of adults aged 16 and over drank alcohol at least once a week. For both men and women, the proportion drinking at least once a week increased with age, from 30% among adults aged 16 to 24 to 55% among those aged 55 to 74, then decreased to 48% among those 75 and over.[14]

The proportion of adults who drank at increasing or higher risk levels (over 14 units per week) varied by age, with the highest prevalence observed among those aged 65 to 74 (29%) and the lowest among those aged 25 to 34 (14%)[15]. Men were more likely than women to report weekly drinking, with 50% of men reporting that they had drunk alcohol in the last week[16].

Although up-to-date local survey estimates of alcohol consumption are limited, the latest available modelled estimate suggests that around 2,336 (11.6 per 1,000) adults in Havering were alcohol dependent in 2019/20[17]. As this is a modelled estimate a range is provided so the lowest number of people could be 1,786 and the highest is 3,150 adults[18]. This indicates a substantial level of potential treatment need in the borough, particularly when considered alongside later evidence on hospital admissions and alcohol-related mortality.

NDTMS data from 2024/25 outlines that 588 people out of the 2,336 are currently in treatment, meaning that 1,748 (74.8%) Havering residents have an unmet treatment need. Alcohol therefore has the highest level of unmet treatment needs out of all drug types.

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[13] Adults' health-related behaviours - NHS England Digital
[14] Adults' health-related behaviours - NHS England Digital
[15] Adults' health-related behaviours - NHS England Digital
[16] Adults' health-related behaviours - NHS England Digital
[17] NDTMS - ViewIt - Adult
[18] Adults' health-related behaviours - NHS England Digital

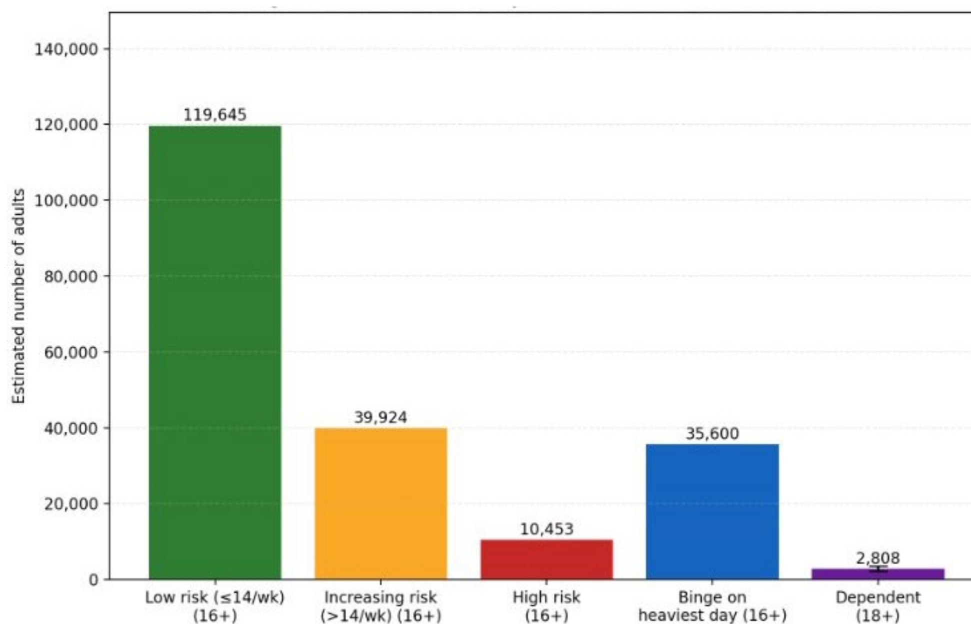
4.6 Patterns of alcohol consumption

Concerning patterns of alcohol drinking, the most used terms are low risk drinking, increasing risk drinking, high risk, possible dependence, and binge drinking. Each pattern is defined as below:

Pattern Name	Definition
Low Risk Drinking	Under 14 units of alcohol per week with 2 nondrinking days.
Increasing Risk/Hazardous drinking	Between 14-35 units per week for women, 14-50 units per week for men.
High Risk	Over 35+ units of alcohol per week for women and over 50+ units per week for men,
Dependent drinking	Person is physically or psychologically dependent, not defined in units alone.
Binge Drinking	6+ units for women and 8+ units in a single drinking session for men.

Using national estimates of the percentage of people who fall into the patterns of drinking above and mapping that with the census data for Havering (2021) for adults aged over 16 years, the data below can be generated in relation to potential number of Havering residents who are consuming alcohol in the patterns above.

Figure 5. Estimated numbers by alcohol measure (Census 2021 base), Havering



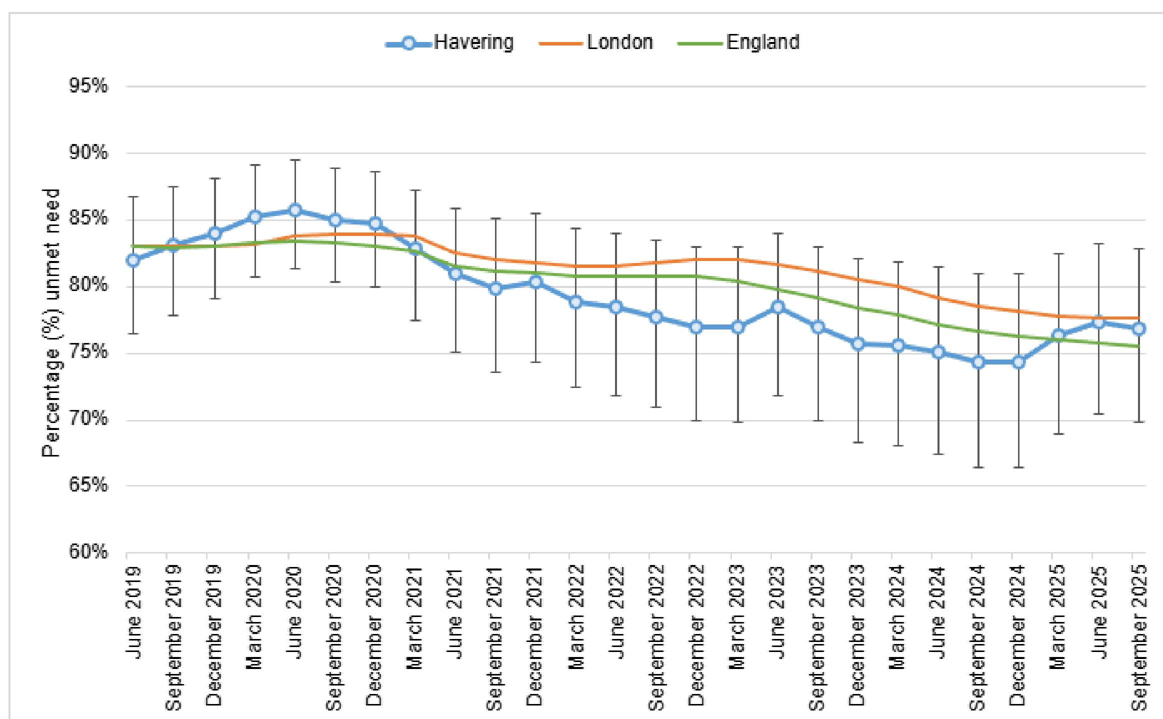
Please note that people who are binge drinking can also be included in the numbers of increasing risk, high risk and dependent drinkers. Whilst most alcohol consumption does not result in a treatment need, high risk and dependent drinking is associated with increased risks of physical and mental ill health, hospital admission, injury, family harm, and wider social impacts.

4.7 Dependent drinkers not in treatment

Figure 19 shows the proportion of dependent drinkers estimated not to be in treatment in Havering. The proportion fell from 85.7% in June 2020 to 76.9% in September 2025, indicating some improvement in structured alcohol treatment coverage over the period, although a substantial majority of dependent drinkers are still not engaged. The lowest value in the time series was 74.3% (95% CI 66.5% to 81.0%) in September and December 2024, followed by a slight increase during 2025 to 76.9% by September 2025. Compared with regional and national benchmarks, Havering has tracked below London and at times below England, but the error bars shown in the figure indicate that Havering's rate is not statistically significantly different at any given point. Overall, the direction of travel is encouraging, but unmet need remains high, with around three quarters of dependent drinkers still estimated not to be in treatment.

The qualitative evidence helps explain why this gap may persist. Focus group participants often described reaching support late, commonly through crisis or hospital contact, rather than through earlier planned help-seeking. They also suggested that awareness of local support among the public and families can be limited. This implies that while treatment coverage has improved, earlier visibility of services and more proactive case-finding remain important if unmet need is to reduce further.

Figure 6. Percentage of dependent drinkers not in treatment June 2019 to September 2025 for Havering, London and England



Source: OHID Fingertips

5. Adults in treatment

5.1 Number in treatment

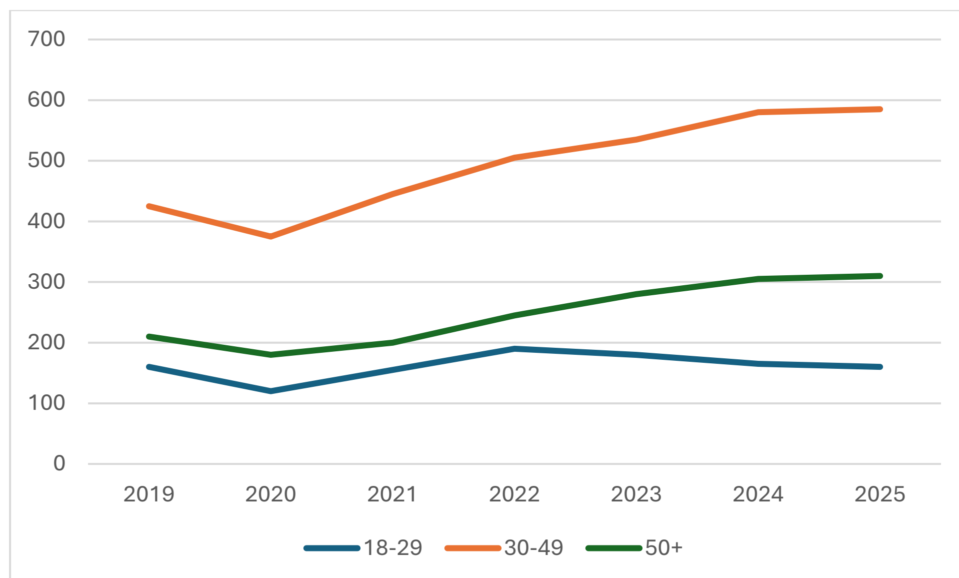
The number of adults in treatment, which is defined as anyone aged over 18 years in Havering increased from 675 people in 2019/20 to 1,050 in 2024/25, a rise of 55.6% over 5 years. As the Supplemental Treatment and Recovery Grant (SSMTRG) was given with the aim of expanding capacity and the number of people entering treatment, an increase in people entering treatment can be taken as a measure of the success of the grant. The currently commissioned provider of Havering adult drug and alcohol treatment service is Change, Grow, Live (CGL) Aspire.

5.2 Age

The age profile of adults in treatment has shifted gradually towards older age groups over time. The number of adults aged 18 to 29 years has remained broadly stable overall, at 160 people in both 2019 and 2025, but their proportion of the treatment population fell from 20% to 15%. By contrast, the number of adults aged 30 to 49 years increased from 425 to 585 over the same period and consistently accounted for the largest share of the treatment population, remaining stable at around 54% to 56%.

The number of adults aged 50 years and over also increased, rising from 210 in 2019 to 310 in 2025. Their proportion of all adults in treatment increased from 26% to 29%.

Figure 7. All in treatment by age group

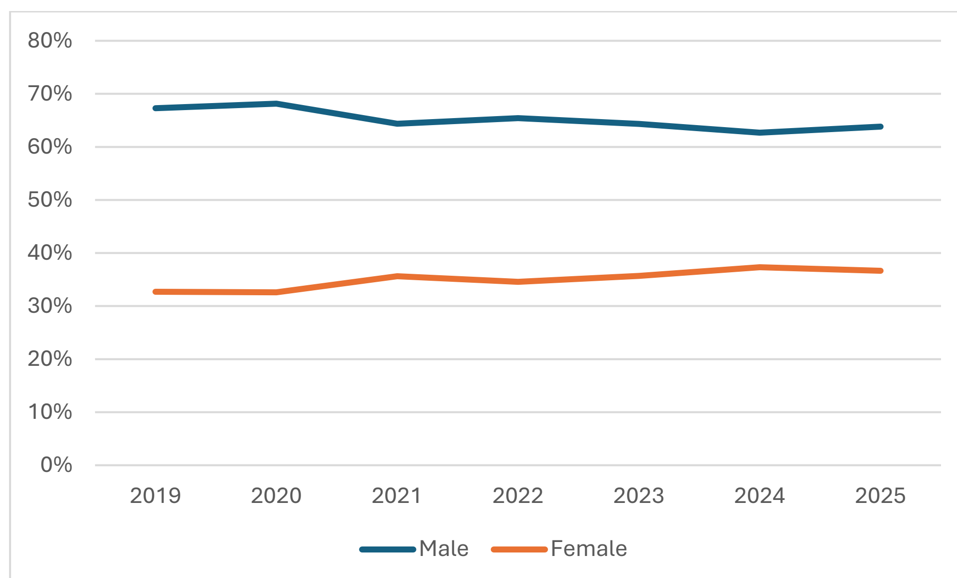


Source: NDTMS

5.3 Sex

Between 2019 and 2025 there has been a slight increase in the proportion of females in treatment, rising from 33% in 2019 to 37% in 2025. This suggests a modest shift towards a more balanced treatment profile, although men continue to account for around two thirds of adults in treatment in Havering. A pattern of two thirds males in treatment compared to one third female is replicated at a national level, and this pattern has been observed for several years.

Figure 8. Proportion of all adults in treatment by sex



Source: NDTMS

5.4 Substance type

Between 2020 and 2025, the mix of substances used by people entering treatment appears to have altered.

- The proportion of adults in treatment for opiates fell from 35% (235) to 30% (315)[19],
- The proportion of adults in treatment for 'alcohol only' increased from 33% (225) to 37% (385).
- Treatment for non-opiates only also increased, from 14% (95) to 18% (185).

The most notable increase in non-opiate treatment was among adults aged 18 to 29, where the proportion rose from 33% to 44% over the same period. By contrast, the combined non-opiate and alcohol group decreased slightly from 19% (125) to 16%

[19] The proportion has decreased however the number of adults has increased as the local service has seen an increase in adults in treatment.

(170)[20]. Overall, this suggests a gradual shift away from opiate treatment towards alcohol and non-opiate presentations[21]. Staff and stakeholder feedback suggests this shift is also being shaped by a more volatile local drug market, with growing concerns about ketamine, benzodiazepines, contamination, cocaine, and emerging synthetic opioids alongside ongoing alcohol-related harm.

At a national level concern has been raised over increasing use and harms experienced by Ketamine use. The Adult Psychiatric Morbidity Survey (APMS) collects information from adults aged 16 to 100 years using face-to-face interviews at home. In the 2023 to 2024 APMS survey, ketamine use in the last year was reported by 4.3% of those aged 16 to 24. If we use census data (2021) on the number of 16 to 24 years olds in Havering, it equates to approximately 25,469 people, 4.3% of this number equals a crude estimate of 1,095 people for the number of individuals aged 16-24 years who have used Ketamine in the last year. Please note this is a crude estimate and does not translate to any treatment need.

In Havering, the available data on the number of referrals for treatment for Ketamine use has been increasing year on year with 23 referrals in 2023, 27 in 2024 and 36 in 2025. The number of referrals for treatment remains low, however it is an area that the CDP needs to be updated on should the number of people entering treatment for Ketamine continue to rise. This concern is reinforced by staff and service user accounts linking ketamine to severe physical and psychological harms, hidden use among younger people, and crisis-led engagement with services.

5.5 Ethnicity

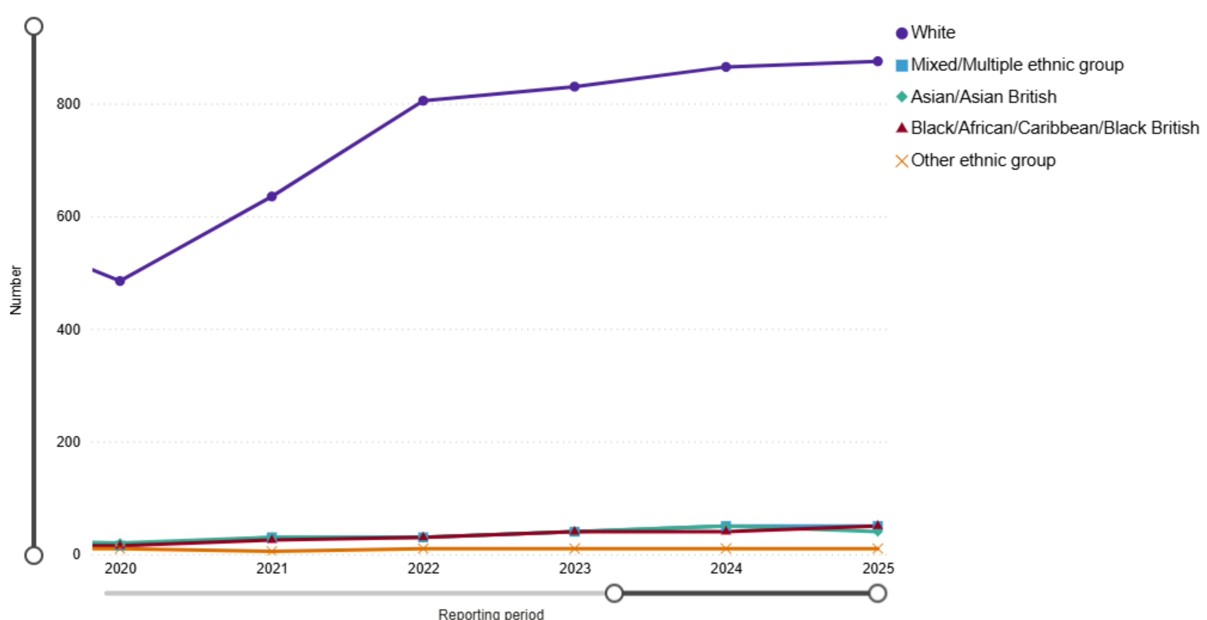
Between 2020 and 2025 the ethnicity profile of people in treatment in Havering remained predominantly White (86%), although the overall cohort has grown and the proportion from Black/African/Caribbean/Black British and Mixed/Multiple ethnic groups has increased to 10% in 2025 from 6% in 2020. The ethnic group of Asian/Asian British has remained at 4% during 2020-25.

An Institute of Alcohol Studies report noted that in general, people from global majority groups drink less alcohol and are more likely to be abstain from alcohol, compared to White British people[22]. There are relatively high rates of higher risk drinking among certain groups, for example older Irish men and men belonging to the Sikh religion[23].

[20] The proportion has decreased however the number of adults has increased as the local service has seen an increase in adults in treatment.
[21] NDTMS - ViewIt - Adult
[22] Microsoft Word - Ethnic minorities and alcohol.docx
[23] Microsoft Word - Ethnic minorities and alcohol.docx

People belonging to global majority groups can be less likely to access alcohol treatment services and often do not seek help until they have experienced serious health consequences. There are multiple barriers to seeking help that are experienced by people from global majority groups, with some barriers specific to certain higher-risk groups, such as Irish Travellers. Some global majority groups experience more alcohol harm. For example, White Irish men experience higher rates of alcoholic liver disease and other alcohol-related diseases, and Sikh men experience higher rates of liver cirrhosis[24]. Although most people in treatment are White British it is important to continue considering the needs of the 14% of people in treatment who do not fall into the White British category to ensure that their needs are being met and any barriers to treatment are minimised.

Figure 9. Ethnic breakdown of all adults in treatment



Source: NDTMS

5.6 Housing situation of new presentations

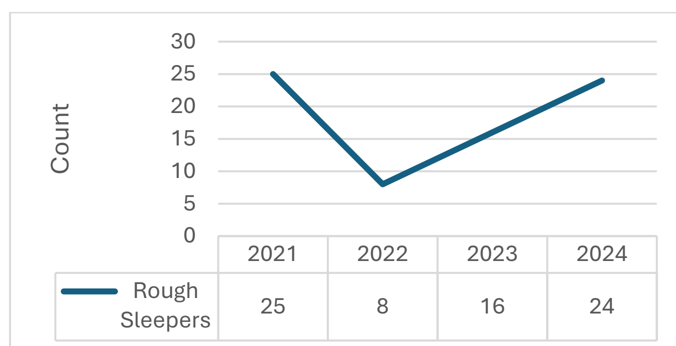
Housing vulnerability is a feature of new presentations to substance misuse treatment in Havering. In 2024/25, among 515 new presentations with housing status recorded, 3% were rough sleeping (15 people) and 19% (100 people) had no fixed abode but were not rough sleeping. Overall, this indicates a slight increase in housing insecurity among new presentations, from 20% in 2022/23 to 22% in 2024/25[25]. Havering's level of housing vulnerability among new presentations is like England where 3% were rough sleeping and

[24] Microsoft Word - Ethnic minorities and alcohol.docx
[25] NDTMS - ViewIt - Adult

18% had no fixed abode not rough sleeping, and lower than London where 5% were rough sleeping and 21% had no fixed abode not rough sleeping.

In 2024 out of all adults who were currently in treatment, 24 were recorded as rough sleepers, which is an increase on 2023 figures but not as high as 2021. This pattern is consistent with frontline reports that housing instability is one of the strongest influences on both engagement and recovery, particularly where people are placed in environments that expose them to ongoing substance use and make it harder to maintain routines, mental wellbeing and contact with services. Alongside this needs picture, Havering also has a local service response for people experiencing homelessness and rough sleeping, including joint working between substance misuse services, housing, rough sleeping services, and public health-funded support for people living in homeless or temporary accommodation. These arrangements are important because they provide routes into care for people with elevated levels of need and help sustain engagement where standard pathways may be less effective.

Figure 10. Number of rough sleepers among adults in treatment



	2021	2022	2023	2024
Rough Sleepers	25	8	16	24

Source: Havering CGL

5.7 Employment

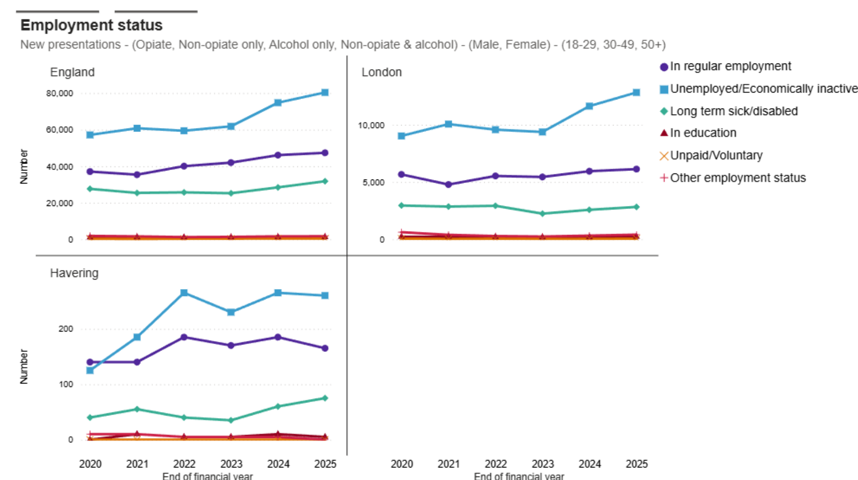
Among new presentations to substance misuse treatment in Havering, the employment profile has shifted towards greater levels of unemployment or economic inactivity. Figure 10 shows that in 2019/20, 44% of new presentations were in regular employment, while 40% were unemployed or economically inactive, and 13% were long-term sick or disabled. By 2024/25, the proportion in regular employment had reduced to 32%, while the proportion who were unemployed or economically inactive had increased to 51%. The proportion who was long-term sick or disabled also increased slightly to 15%.

This pattern is consistent with wider London and England trends. It is important because problematic drug and alcohol use can make it difficult to obtain or sustain employment, and barriers may continue even during recovery, including poor mental health, physical ill health, unstable housing, or previous contact with the criminal justice system. This underlines the importance of employment support as part of a wider recovery offer.

Service users likewise described employment, routine and purpose as important stabilising factors in recovery, reinforcing the importance of employment support as part of a wider recovery offer.

Havering residents can be supported through the Individual Placement and Support (IPS) service, which helps people in treatment or recovery to move towards paid employment. Recent service performance suggests growing local demand. In Q2 2025/26, Havering recorded 12 IPS referrals, 5 engagements and 1 job start, by Q3 this had increased to 24 referrals, 11 engagements and 2 people with job starts. Across the whole IPS service, year-to-date performance to February 2026 shows 135 referrals, 61 engagements and 28 people with job starts, with an active caseload of 43 against a capacity of 75 clients. While this indicates that a recovery-focused employment offer is in place, there remains scope to strengthen take-up and progression into work.

Figure 11. Employment status of adult new presentations by drug type and area



Source: NDTMS

5.8 Blood Borne Viruses (BBV)

Cases of Blood Borne Viruses (BBV) among people who inject drugs in Havering remain low overall, and Hepatitis C virus (HCV) continues to be the most common BBV identified among people who inject drugs locally and nationally. In 2024, there were 10 people in treatment with Hepatitis C and fewer than five who were diagnosed as HIV positive. No one in treatment has received a positive diagnosis of Hepatitis B since 2021. Everyone in treatment who is identified as being in a high-risk group is offered Hepatitis B vaccination.

All service users are offered BBV testing as part of routine care. Everyone who receives a positive Hepatitis C screening test is offered a PCR test to confirm whether this reflects a past infection or current infection, and anyone with confirmed infection is referred to specialist services for treatment. Anyone testing HIV positive is also referred on to specialist services. Local service data indicate a strong BBV pathway in Havering. CGL

Havering reported that 100% of service users were offered a test, 98% of people with a history of injecting had been tested, and 90% of those with current risk factors had been tested in the last 12 months. In addition, 90% of people with Hepatitis C had been successfully linked into treatment and had commenced treatment. These achievements indicate exceedingly high levels of BBV testing and treatment linkage and are consistent with CGL Havering achieving Hepatitis C micro-elimination within its treatment population.

Table 2. Number of adults in treatment with Blood Borne Viruses (BBV)

Type of BBV	Number of cases per year			
	2021	2022	2023	2024
HIV	<5	<5	<5	<5
Hep C	36	8	11	10
Hep B	0	0	0	0

Source: Havering CGL

5.9 Priority groups

In October 2023 Havering published an Independent cultural competency review of drug and alcohol services. In this review it was noted that when a comparison of census data with people in treatment in 2022/23, there was a under representation of people with the protected characteristics of sex, age, ethnicity, and pregnancy/maternity. Sexual orientation and disability were found not to be statistically significant in relation to under representation.

The previous substance misuse needs assessment had flagged veterans and pregnant women as priority groups. Local treatment data show that the number of veterans in treatment has fluctuated over time, with 10 recorded in 2021, fewer than 5 in 2022, 9 in 2023 and 17 in 2024. This suggests that overall numbers remain low. The cultural competency review noted “although the census in 2021 suggested Havering had the second highest proportion of veterans in London (2.4%) (behind Bexley (2.5%) and Bromley (2.5%), the review found that half of this group were over 80 years old, so not necessarily using alcohol or drugs.

Pregnant women are an important group to consider as substance misuse during pregnancy can have significant implications for both maternal health, infant outcomes, and potential lifetime implications for a child. Any intervention needs to be timely, with coordinated support involving treatment, maternity, and safeguarding services.

The number of pregnant women in treatment has remained below 5 in each year shown, indicating that this is a small cohort locally, but one where the potential risks are high and where effective multi-agency working remains essential.

Table 3. Number of veterans and pregnant women among adults in treatment

Year	Veterans	Pregnant women
2021	10	<5
2022	<5	<5
2023	9	<5
2024	17	<5

Source: Havering CGL

5.10 LGBTQI+

LGBTQI+ people are included as a specific group in this refresh because they may experience distinct risk factors that can increase vulnerability to substance misuse and affect access to support. These can include stigma, discrimination, poor mental health, social exclusion, trauma, and barriers to accessing services that feel safe, inclusive, and culturally competent. Monitoring this group within the treatment population is important in understanding whether services are reaching people equitably and whether support is responsive to different experiences and needs.

The table below is taken from the cultural competency review. Although not statistically significant, it is interesting to note the higher than England average percentages in Havering for heterosexual, bisexual and the lower rate of missing records. In addition, the percentage of people not asked or does not know, not stated and other is higher in Havering. This data is from 2022/23 however and may have changed more recently.

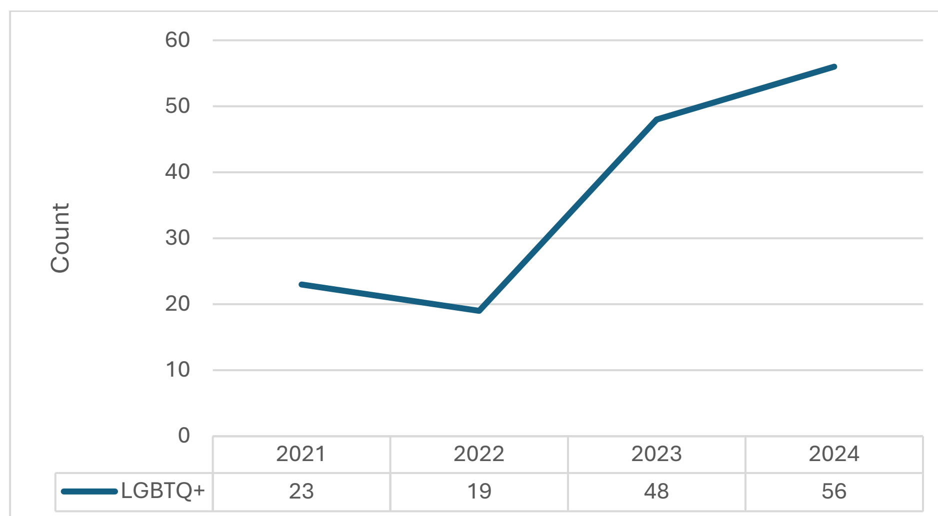
Table 4. Sexual orientation of adults in treatment compared with the Havering population and England, 2022/23

Sexuality	Havering population % (2021 census)	Havering 2022/23 % in treatment	England 2022/23 % in treatment
Heterosexual	91.1%	87.8%	86.9%
Gay/Lesbian	1.0%	2.5%	2.7%
Bi-Sexual	0.7%	2.9%	2.3%
Person asked and does not know or is not sure	0.0%	0.5%	0.2%
Not stated	7.0%	4.5%	3.7%
Other	0.3%	0.5%	0.3%
Missing / inconsistent	0.0%	1.4%	3.9%
In treatment' data relates to all clients entering treatment within the date parameters shown and sexuality as recorded at the start of their treatment journey			

Source: NDTMS

Local treatment data outlines that the number of LGBTQ+ service users has generally increased, from 23 in 2021 to 19 in 2022, before rising sharply to 48 in 2023 and 56 in 2024. While the numbers remain relatively small, this upward trend may reflect increased need, or greater confidence in disclosing sexual orientation or gender identity within treatment settings. This reinforces the importance of ensuring that local services remain inclusive, accessible, and responsive to LGBTQ+ people.

Figure 12. Number of LGBTQI+ among adults in treatment



Source: Havering CGL

5.11 Alcohol Treatment Requirements (ATR) Requirements

The Alcohol Treatment Requirement (ATR) is a provision under the Criminal Justice Act 2003 that allows courts to require offenders to engage in structured alcohol treatment where alcohol use is linked to their offending. ATRs can form part of a Community Order or Suspended Sentence Order and typically last between 6 and 36 months.

Recent data show an increase in ATR activity in Havering compared with earlier years. Referrals rose from 22 in 2021 and 26 in 2022 to 42 in 2023 and 70 in 2024. The number of orders granted also increased significantly, from 12 in 2021 and 10 in 2022 to 16 in 2023 and 38 in 2024. Treatment completions have improved also, rising from less than 5 completion in 2021 and 6 in 2022 to 11 in 2023 and 19 in 2024.

Table 5. Number of ATR referrals and treatment completions

Year	Referrals	Granted	Completed
2023	42	16	11
2024	70	38	19

Source: Havering CGL

5.12 Referrals into Treatment

Overall, referrals into treatment have increased substantially compared with 2021 and 2022, which is likely to have contributed to the overall rise in the number of people in treatment over recent years. Most referrals continue to come from self-referral and NELFT adult mental health services, indicating the continued importance of both mental health pathways and direct access into treatment. There have also been increases in referrals from arrest referral, prison, and hospital settings. Arrest referrals increased from 5 in 2021 to 140 in 2024, prison referrals from 14 to 134, and hospital referrals from 20 to 153. This suggests growing identification of substance misuse need across criminal justice and acute health settings and may reflect both increasing demand and improved referral pathways from partner agencies into treatment. Arrest referral, prison and probation pathways are also important from a community safety perspective because they can identify unmet need, support diversion into treatment, and contribute to reduced reoffending.

The qualitative findings, however, suggest more complex routes into treatment. Service users often described access to treatment as crisis-driven, particularly following hospitalisation or acute deterioration in mental or physical health. Staff also identified hospital discharge, prison release, and referrals from other parts of the system as vulnerable transition points, where late referrals, poor information sharing and unclear accountability can leave people unsupported at moments of heightened risk. Stakeholders similarly highlighted the need for clearer referral pathways, defined points of contact and better communication across agencies. Taken together, this suggests that referral volume has improved, but pathway quality and consistency remain key areas for development.

Table 6. Number of referrals to CGL from other services

Services	2023	2024
Self-Referral	505	484
Adult mental health services	286	380
Arrest referral	118	140
Prison	103	134
GP	72	77
Children and Family Services	70	63
Hospital alcohol care team/liaison nurse	55	24
ATR	42	70
Hospital	42	153
DRR	38	66
Adult treatment provider	32	31
Other	28	35
Probation	25	13

Adult social care services	22	34
Housing/homelessness team	22	24
Domestic abuse service	12	7
Employment/education service	5	12
Relative/peer/concerned other	5	<5
Outreach	<5	<5
Self-referred via health professional	<5	<5
Liaison and Diversion	<5	<5
YP structured treatment provider	0	<5
TOTAL	1488	1761

Source: Havering CGL

5.13 Tier 3 and 4 treatment

Structured treatment in Havering is delivered across various levels of intensity. Tier 3 treatment refers to structured, community-based specialist treatment, including psychosocial support and clinical interventions delivered while a person remains living in the community. Tier 4 treatment refers to more intensive residential or inpatient care, typically used where someone cannot be safely or effectively managed in the community.

The profile of adults in structured treatment in Havering has changed over time. In Tier 3 treatment, alcohol has continued to account for a substantial share of the treatment population, but the most notable change has been the rise in opiate treatment from 291 in 2023 to 321 in 2024.

This shift should be understood in the context of the national drugs strategy and the additional treatment and recovery funding introduced from 2022 onwards. Local treatment systems were expected to increase engagement with opiate and crack users, as this group accounts for a disproportionate share of drug-related deaths, offending, and treatment need. The increase in opiate treatment in Havering from 2023 therefore likely reflects both improved identification and engagement of this higher-risk group, and the impact of national expectations on local service delivery. Staff feedback also indicates that treatment pathways do not always match current patterns of need. Respondents highlighted the value of clinical interventions such as long-acting injectable treatments, but also described limited detoxification and inpatient capacity, especially for people presenting with ketamine and benzodiazepine use who meet clinical thresholds but cannot readily access funded placements.

Table 7. Number in Tier 3 treatment by type (opiate, crack, other drugs, alcohol) (All In Treatment); no. of client in treatment at any point in the last 12 months

Year	Alcohol	Non-Opiate	Opiate	Alcohol & Non-Opiate
2023	422	187	291	157
2024	425	185	321	181

Source: Havering CGL

In Tier 4 treatment, numbers remain exceedingly small, but there has been a slight increase compared with 2021 and 2022 data[26]. Alcohol continues to be the main reason for Tier 4 placements. The qualitative evidence suggests that these small numbers should be interpreted cautiously, as they may reflect not only low demand but also access constraints within intensive treatment pathways.

Table 8. Number in Tier 4 treatment by type (opiate, crack, other drugs, alcohol) (All in Treatment); no. of client in treatment at any point in the last 12 months

Year	Alcohol	Non-Opiate	Opiate	Alcohol & Non-Opiate	Total Completed treatment
2023	10	<5	0	0	5
2024	14	0	0	0	6

Source: Havering CGL

5.14 Number of adults who are in stable accommodation following treatment.

The number of adults who were already in stable accommodation who completed treatment across all drug categories and achieved positive treatment outcomes (alcohol free in treatment, drug free in treatment, sustained reduction in drug use) has increased compared with earlier years. Total completed treatment rose from 124 in 2021 to 220 in 2024. The number of people alcohol free in treatment also increased from 47 in 2021 to 83 in 2024. The number of adults drug free in treatment rose slightly from 39 in 2021 to 47 in 2024, while those achieving a sustained reduction in drug use increased from 38 in 2021 to 90 in 2024.

Qualitative evidence suggests they should be understood within a wider recovery context. Staff and service users consistently described housing stability, aftercare, peer support, groups, mental health support, employment, and community connection as important to sustaining recovery beyond the formal treatment episode. This suggests that positive outcomes for those in stable accommodation reflect not only treatment effectiveness, but also the degree to which people are able to build wider recovery capital around them. These improvements should also be viewed in the context of a larger treatment population, as the total number of adults in treatment has increased in recent years following additional capacity created through the Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG).

Table 9. Number of adults who are in stable accommodation and who have completed treatment, are drug-free in treatment, or have sustained reduction in drug use.

[26] London Borough of Havering Substance Misuse Needs Assessment 2023

Year	Total Completed treatment	Alcohol free in treatment	Drug free in treatment	Sustained reduction in drug use
2023	243	113	47	83
2024	220	83	47	90

Source: Havering CGL

5.15 Smoking prevalence of those in treatment

Smoking prevalence among adults in treatment is higher than in the wider Havering population. In 2024, current smoking prevalence among adults aged 18 and over in Havering was 8.2%, compared with 65% of males and 59% of females in substance misuse treatment.

This indicates that smoking remains highly concentrated among people in treatment for substance misuse and is likely to contribute to additional long-term health risks within this cohort. It also reinforces the importance of integrating tobacco dependence support into treatment and recovery pathways.

Table 10. Smoking prevalence of adults in treatment

Year	Male	Female
2023	63%	59%
2024	65%	59%

Source: Havering CGL

6. Children and young people in treatment

For the purposes of this needs assessment, children and young people refer to those aged under 18 who are receiving specialist substance misuse support. The commissioned provider is named CGL Wize Up. In Havering, once a person reaches 18 years old, they will transition to the adult service. A transitions worker is employed by the adult service, CGL Aspire to ensure a smooth transition is completed to the unfamiliar environment and treatment approach. Treatment services for Children and Young People (CYP) are based on a wider resilience building approach due to both the type of substances more likely to be used and the fact that CYP's have less entrenched substance use.

Structured treatment for children and young people is typically psychosocial and recovery-focused, with a strong emphasis on early intervention, risk reduction, safeguarding, family context, and wider vulnerabilities. Compared with adults, presentations are more likely to involve cannabis, alcohol, and other emerging substances such as ketamine, alongside issues such as poor mental health, school exclusion, family difficulties, or contact with youth justice services.

6.1 Children and young people in treatment

The number of children and young people in structured substance misuse treatment in Havering has increased in recent years. In 2019, there were 25 children in treatment; by 2025, this had risen to 65, more than tripling over the period, although this represents a reduction from a peak of 85 in 2024.

In 2025, 62% of those in treatment are male (40) and 38% female (25). The majority (74%) are living with parents or relatives (40), while 11% are living in care, highlighting the overlap with safeguarding and children's social care.

Substance profiles have also shifted. In 2020, there were no children in treatment for alcohol as a primary substance, by 2025, alcohol accounts for 8% of primary presentations (15), although cannabis remains the predominant primary substance accounting for 61% (40) of primary citations. This pattern is also seen in national data where majority of those aged 17 and under are in treatment for cannabis (71%) and alcohol (15%). Due to small numbers in Havering, this data is not standardised and should be interpreted with caution. This means the figures are presented as raw local counts or proportions and have not been adjusted in a way that would make them more directly comparable with larger populations or benchmark areas. Stakeholder and staff feedback suggests this picture should also be read alongside concerns about ketamine, vaping and nitrous oxide among younger people, and the close links between substance

use, poor mental health, exploitation, school issues, and weak transitions into adulthood.

6.2 Number of Children who are in stable accommodation following treatment.

The number of children and young people completing treatment and achieving positive outcomes (alcohol free in treatment, drug free in treatment, sustained reduction in drug use) and who are in stable accommodation has increased compared with earlier years. Total completed treatment rose from 28 in 2021 to 63 in 2024. The number who were drug free in treatment increased from 16 in 2021 to 21 in 2024, while those achieving a sustained reduction in drug use increased significantly from 11 in 2021 to 40 in 2024.

Table 11. Number of children who are in stable accommodation and who have completed treatment, are drug-free in treatment, or have sustained reduction in drug use.

Year	Total Completed treatment	Alcohol free in treatment	Drug free in treatment	Sustained reduction in drug use
2023	49	0	15	34
2024	63	<5	21	40

Source: Havering CGL

6.3 Referrals into treatment

Referrals into children and young people's treatment remained broadly stable overall, between 2021[27] and 2024. Universal Education continued to be the largest referral source. Children and Family Services remained another key route into treatment, increasing slightly from 43 to 46 referrals.

These referral patterns underline the importance of schools and safeguarding services in identifying need. However, stakeholder feedback suggests that there is still scope to strengthen prevention and early intervention, particularly in schools, colleges, and youth settings, and to improve transitions between youth and adult services. This suggests that while referral routes are established, earlier identification and smoother progression through support pathways remain critical areas for improvement.

Table 12. Number of referrals to CGL from other services

Year	2023	2024
Universal Education	72	61
Children and Family Services	43	46
YOT	22	31
Crime Prevention	37	23

[27] London Borough of Havering Substance Misuse Needs Assessment 2023

Alternative education	5	18
Children's mental health services	9	13
Self	11	12
Relative/peer/concerned other	13	10
YP structured treatment provider	<5	5
Targeted youth support	8	<5
Adult treatment provider	0	<5
YP housing	<5	<5
GP	<5	<5
Non-structured treatment substance misuse services	<5	<5
Outreach	<5	0
Hospital	<5	0
School Nurse	<5	0
TOTAL	235	232

Source: Havering CGL

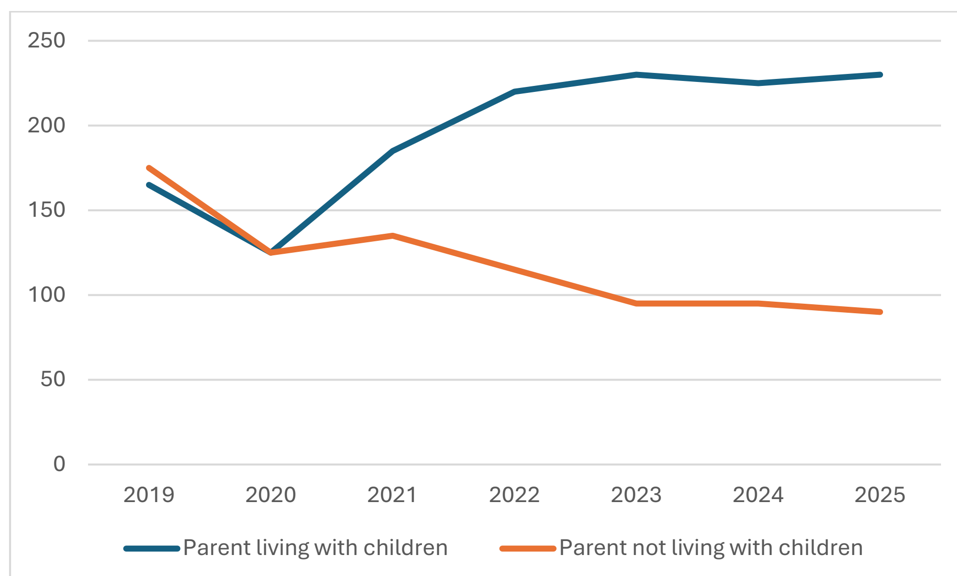
7. Substance misuse in people with parental responsibility

7.1 Parental status of those in treatment

The parental profile of adults in treatment in Havering has changed over time. The number of parents in treatment who were living with children increased from 165 in 2019 to 230 in 2025, despite some fluctuation across the period. By contrast, the number of parents in treatment who were not living with children fell from 175 in 2019 to 90 in 2025, with a steady decline after 2021. Compared with benchmarks in 2025, Havering has a higher proportion of parents living with children who are in treatment than both England (19%) and London (13%), and a lower proportion of parents not living with children than England (16%) and London (12%).

This suggests that a growing proportion of the treatment population includes adults with dependent children in the household. This is important because parental substance misuse can have significant implications for children's wellbeing, safeguarding, family functioning, and wider support needs. It also reinforces the importance of family-focused practice, effective links between treatment and children's services, and approaches that consider the needs of both parents and children together. Particularly as family members in the focus group described themselves as important first responders in crises while also reporting that they often lacked enough information and support.

Figure 13. Number of parents in treatment for all substance categories



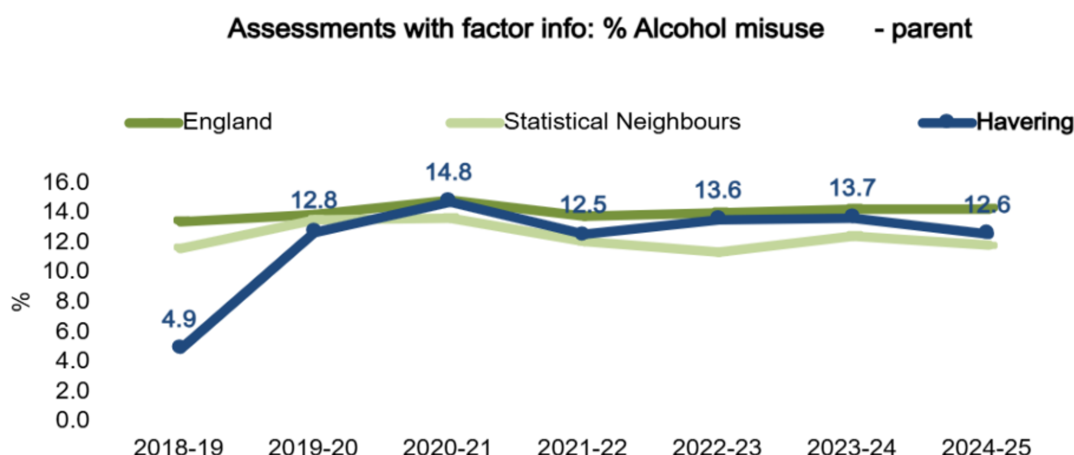
Source: NDTMS

7.2 Parental substance misuse identified in children's social care assessments.

In Havering, parental substance misuse remains a consistent feature of children's social care assessments. The proportion identifying parental alcohol misuse fell slightly from 14.8% in 2020/21 to 12.6% in 2024/25 but remained present in around one in eight assessments across the period. The proportion identifying parental drug misuse fluctuated, peaking at 14.5% in 2021/22 before falling to around 12% and rising again to 13.1% in 2024/25. For both indicators, Havering has remained broadly in line with England and its statistical neighbours[28].

Together, these findings suggest that parental substance misuse continues to be an important safeguarding issue locally and remains a regular factor in children's social care involvement. This reinforces the importance of early identification, family-focused practice, and effective joint working between adult treatment services, children's social care and wider family support services. The qualitative findings suggest that this should include clearer information and support for wider family members who are often actively involved in day-to-day risk management and recovery.

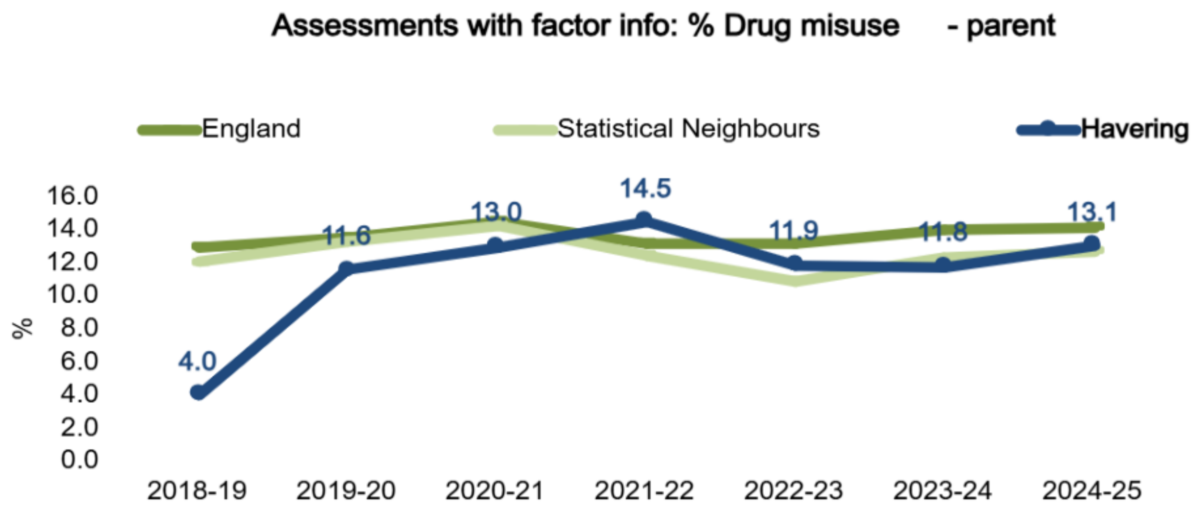
Figure 14. Episodes with assessment factor information, alcohol misuse by a parent identified at the end of assessment, for Havering, Statistical Neighbours and England



Source: NDTMS

[28] Statistical neighbours are local authorities identified by the Department for Education as having similar demographic and socioeconomic characteristics for comparison purposes. Source: Local Government Outcomes: Statistical Neighbours model - GOV.UK

Figure 15. Episodes with assessment factor information, drug misuse by a parent identified at the end of assessment, for Havering, Statistical Neighbours and England



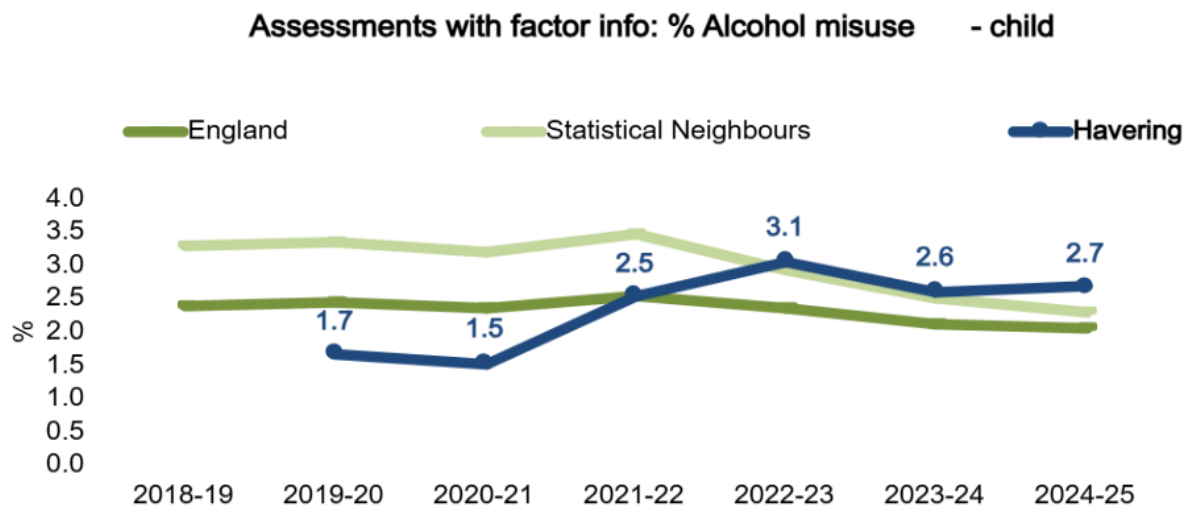
Source: NDTMS

7.3 Child substance misuse identified in children's social care assessments.

In Havering, the proportion of children's social care assessments identifying alcohol misuse by a child increased from 1.7% in 2019/20 to 3.1% in 2022/23, before falling slightly and remaining broadly stable at 2.7% in 2024/25. Over time, Havering has moved from below to slightly above the averages for England and its statistical neighbours. The proportion identifying drug misuse by a child rose more steadily, from 5.8% in 2019/20 to 7.1% in 2024/25, with Havering remaining consistently above both England and its statistical neighbours from 2020/21 onwards.

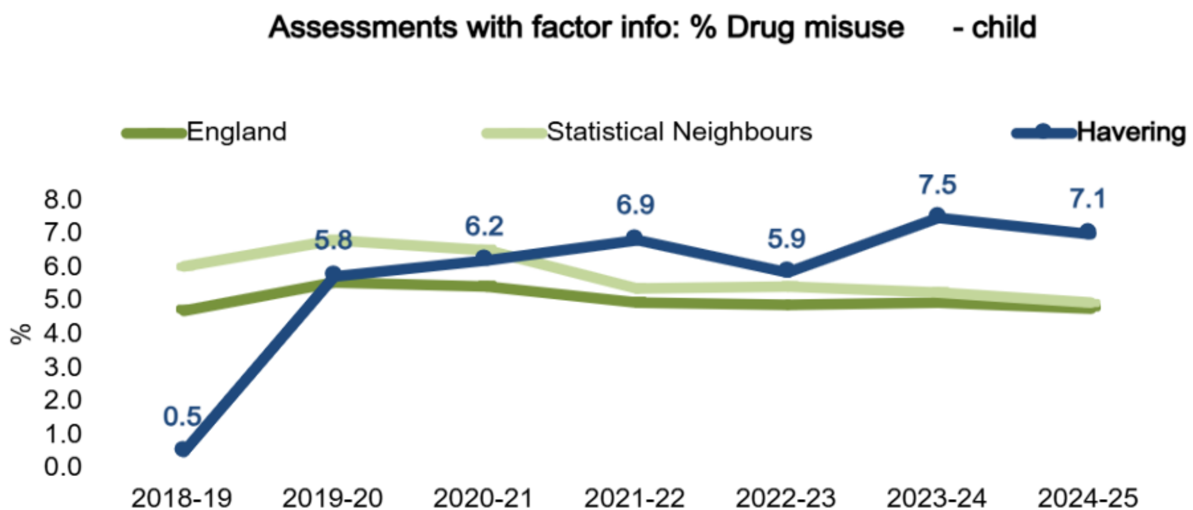
Taken together, these findings suggest that substance misuse among children and young people is a persistent issue within local safeguarding assessments, with drug misuse in particular identified more frequently in Havering than in comparator areas. This underlines the importance of prevention, early intervention and accessible specialist support for children and young people whose substance use is linked to wider vulnerability.

Figure 16. Episodes with assessment factor information, alcohol misuse by a child identified at the end of assessment, for Havering, Statistical Neighbours and England



Source: NDTMS

Figure 17. Episodes with assessment factor information, drug misuse by a child identified at the end of assessment, for Havering, Statistical Neighbours and England



Source: NDTMS

7.4 Children and young people self-reported substance use

Local survey evidence from the Havering Youth Wellbeing Census, based on the #BeeWell survey, provides additional insight into self-reported substance use among secondary school pupils in Havering. The survey is designed for pupils in Year 8 and Year 10, so it does not represent all children and young people in the borough and does not include sixth form as part of its core survey population.

The 2025 survey indicates that 3.5% of pupils reported any drug use in the last 6 months. This included 1.4% reporting drug use a few times every week, 0.8% reporting use more than 4 times in the last 6 months, and 1.3% reporting use 1 to 3 times in the last 6 months. The same survey found that 21.5% of pupils reported any alcohol use in the last 6 months. This included 1.8% reporting drinking a few times every week, 4.7% reporting drinking more than 4 times in the last 6 months, and 15.0% reporting drinking 1 to 3 times in the last 6 months.

These findings suggest that self-reported alcohol use is more common than self-reported drug use among the pupils surveyed, although a smaller group report more frequent use and may be at greater risk of harm. This is important because it provides a broader picture of substance use among young people than treatment data alone, including lower-level or emerging use that may not come to the attention of services. Stakeholder feedback suggests that this wider picture should also include vaping, nitrous oxide and other emerging substances among children and teenagers, reinforcing the need for prevention approaches that extend beyond the substances most visible in treatment data.

These findings should, however, be interpreted with caution. The survey is school-based and therefore may not capture the experiences of children and young people who are absent from school or not in mainstream education, who may be at greater risk. In addition, substance use is self-reported and may be under-disclosed, particularly where behaviour is illegal or stigmatised.

8. Community Safety

Substance misuse has important implications for community safety as well as health. Drug and alcohol use can contribute to offending, exploitation, antisocial behaviour, unsafe driving, and wider harm affecting individuals, families, and communities. This section considers the available evidence on the links between substance misuse and community safety in Havering, including crime, criminal justice activity, and other indicators of local harm.

8.1 Drug offences

Between February 2022 to January 2023 and February 2025 to January 2026, the number of total notifiable offences in Havering fell from 19,448 to 18,563, a decrease of 4.6%. Over the same period, however, the number of recorded drug offences increased from 996 to 1,351, an increase of 35.6%. Intermediate years show some fluctuation, with 1,084 drug offences recorded between February 2023 and January 2024, and 1,054 between February 2024 and January 2025[29]. Overall, this suggests that drug-related offending has increased over the period despite a reduction in total recorded crime. These figures should be interpreted with caution. Drug offences are recorded at the point of detection and are therefore influenced by enforcement activity, resource deployment, stop and search activity, and warrant execution, as well as underlying offending. In this section, drug offences are discussed collectively and are not broken down into possession and supply offences, so the data provides a broad indication of community safety impact rather than a detailed typology of offending.

St Edward's Ward, in the Romford area of Havering, recorded the highest rate and highest number of drug offences across the borough. In the latest period, the rate in St Edward's was 21.4 per 1,000 population, followed by St Albans at 12.0 per 1,000. This indicates that drug-related offending is not evenly distributed across Havering and remains particularly concentrated in specific parts of the borough. Although the proportion of recorded offences that were drug-related in Havering remains lower than the London average of 5.9%, the increase locally points to an ongoing community safety concern and supports the need for targeted prevention, enforcement, and partnership activity in the areas most affected.

Operational and stakeholder evidence strengthens this interpretation by highlighting county lines activity, cuckooing, exploitation and the links between substance misuse, antisocial behaviour, and crime as continuing concerns. Substance misuse in Havering therefore remains linked to patterns of offending, vulnerability, and community harm, reinforcing the importance of strong joint intelligence, targeted enforcement, safeguarding and problem-solving approaches alongside treatment and prevention.

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[29] Crime data dashboard | Metropolitan Police

9. Alcohol-related issues

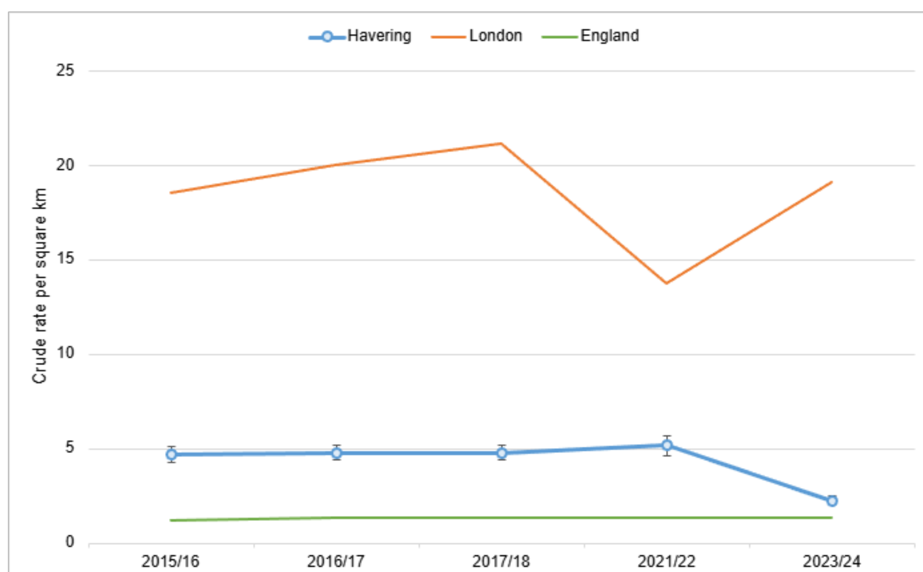
9.1 Sale of Alcohol

Alcohol availability is an important part of the local picture because increased availability and easier access to alcohol can contribute to higher consumption and, in turn, greater alcohol-related harm. Licensing is one of the main levers available to local areas to influence alcohol availability, particularly through the number, type and location of premises permitted to sell alcohol.

In Havering, the density of premises licensed to sell alcohol per square kilometre was broadly stable at around 4.75 in 2015/16 and 2017/18 and increased to 5.2 in 2021/22. The latest reported value for 2023/24 is substantially lower at 2.2, although this is likely to reflect a data anomaly rather than a true reduction in premises density, based on local validation with licensing colleagues. Overall, Havering has remained above the England average across the series, while London is higher overall because of greater commercial density.

The way alcohol is made available locally is also important. Both on-trade sales, such as pubs, bars and restaurants, and off-trade sales, such as supermarkets, shops and other retail outlets, can shape drinking behaviour in diverse ways. In addition, the growth of online alcohol sales means that access is no longer limited to physical premises alone. Taken together, this means that alcohol availability should be considered alongside local patterns of alcohol-related harm when assessing the potential impact of licensing and wider prevention activity.

Figure 18. Premises licensed to sell alcohol per square kilometre in Havering, London, and England 2015-24



Source: OHID Fingertips

9.2 Brief interventions

Brief interventions are an important part of the local alcohol pathway because different patterns of drinking require various levels of response. People drinking at increasing risk, higher risk or binge drinking levels may benefit from brief or extended brief interventions, while people with more severe or dependent drinking are more likely to require structured specialist treatment. In practice, brief interventions provide an opportunity to identify risky drinking early and offer advice, motivational support and signposting before alcohol use progresses to more serious harm. Local data from CGL show that brief intervention activity has increased over time, from 120 interventions in 2022/23 to 129 in 2023/24 and 142 in 2024/25. This included 49 brief interventions and 93 extended brief interventions in 2024/25. This indicates that early intervention activity is taking place and has grown over the last three years. This is important because brief interventions can help reduce escalation of alcohol-related harm and support a broader prevention approach alongside specialist treatment for those with more complex needs.

Table 13. Number of brief and extended brief interventions completed between 2022 and 2025 by Havering CGL

Pathway	2022/2023	2023/2024	2024/2025
Brief Intervention	36	43	49
Extended Brief Intervention	84	86	93
Total	**120**	**129**	**142**

Source: Havering CGL

10. Hospital admissions

10.1 Alcohol related hospital admissions

Alcohol contributes to hospital admissions and deaths from a wide range of conditions, and its impact extends beyond the health system. Recent estimates suggest that alcohol harm costs society in England around £27.44 billion per year[30], including costs relating to healthcare, crime and disorder, lost productivity, and social care.

Alcohol-related hospital admissions are commonly used as a proxy indicator for the impact of alcohol on population health. Two measures are used in Local Alcohol Profiles for England and related profiles. The broad measure includes admissions where an alcohol-related condition is recorded either as the primary reason for admission or as a contributing factor. This means it captures admissions where alcohol may be partly responsible for the hospital episode, even if it is not the main cause. The narrow measure includes only admissions where the primary diagnosis is alcohol-related and is therefore less affected by coding practice.

Taken together, these measures provide a fuller picture of alcohol-related harm. The broad measure reflects the wider burden alcohol places on the NHS, while the narrow measure provides a clearer indication of admissions primarily caused by alcohol.

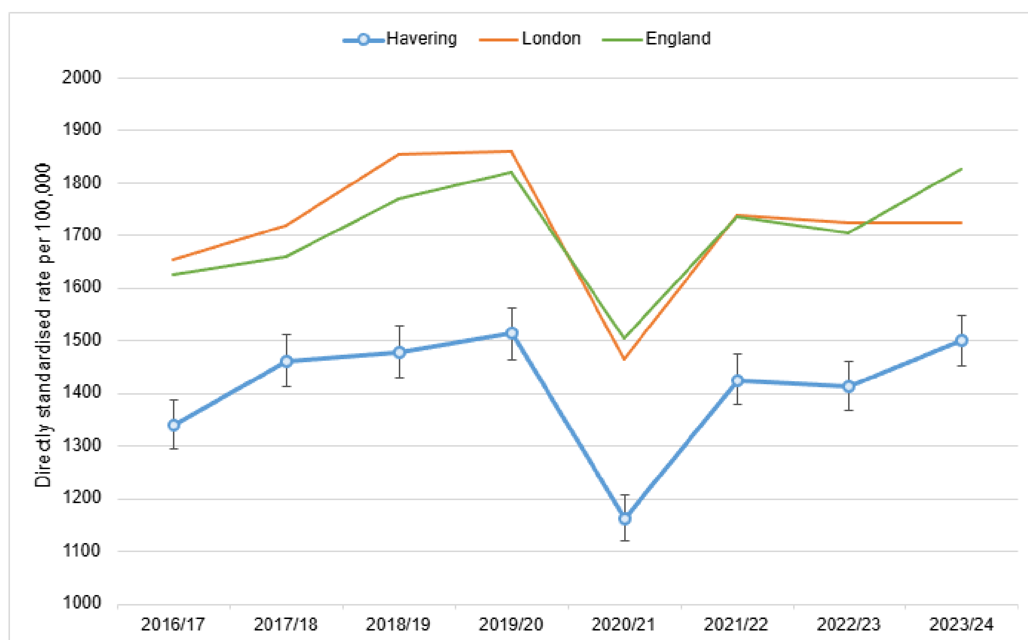
10.1.1 Admission episodes for alcohol-related conditions (broad)

Havering's rate of hospital admissions for alcohol-related conditions has increased since the pandemic-related low point in 2020/21 and has returned close to pre-pandemic levels. In 2020/21, there were 2,862 admission episodes for alcohol-related conditions in Havering, equivalent to a rate of 1,164 (95% CI 1,121 to 1,207) per 100,000 population. By 2023/24, this had increased to 3,734 admission episodes and a rate of 1,500 (95% CI 1,453 to 1,550) per 100,000.

Despite this increase, Havering's rate has remained lower than both London and England. In 2023/24, the rate was 1,724 per 100,000 in London and 1,824 per 100,000 in England.

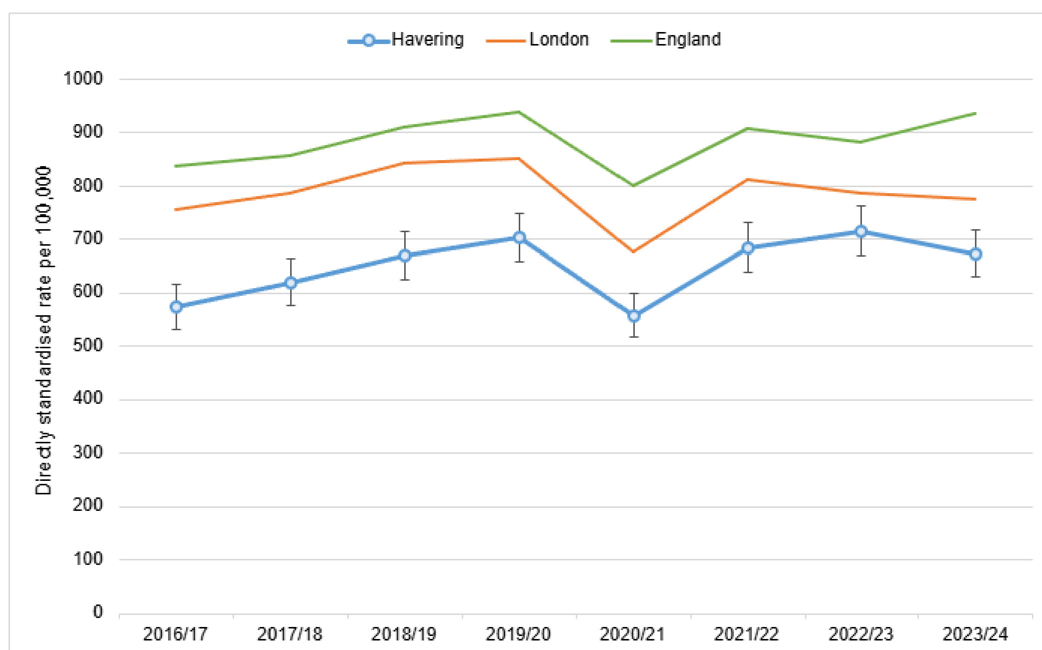
[30] Chapter 5: Alcohol: hazardous, harmful and dependent patterns of drinking - NHS England Digital

Figure 19. Admission episodes for alcohol-related conditions (broad) per 100,000 population, Havering, London, and England (2016/17–2023/24)



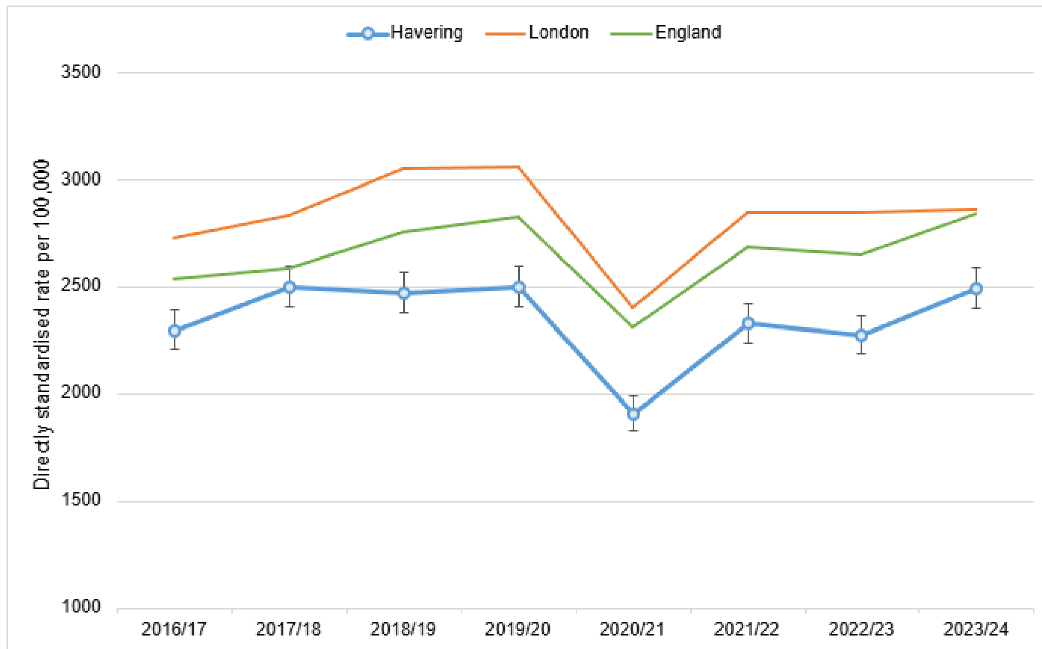
Source: OHID Fingertips

Figure 20. Admission episodes for alcohol-related conditions (Broad) (Females) in Havering, London, and England (2016-24) per 100,000 population



Source: OHID

Figure 21. Admission episodes for alcohol-related conditions (Broad) (Males) in Havering, London, and England (2016-24) per 100,000 population



Source: OHID Fingertips

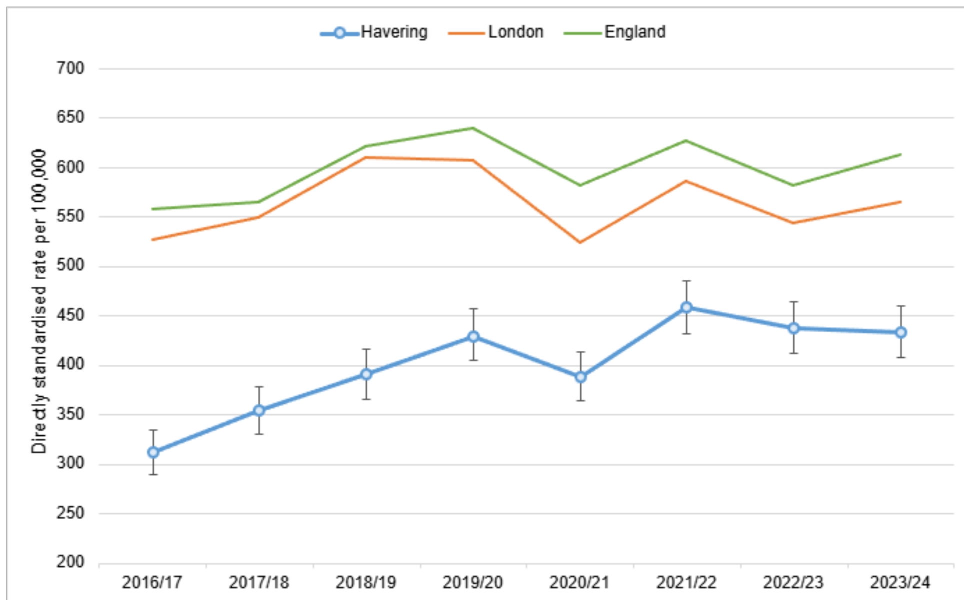
10.1.2 Admission episodes for alcohol-specific conditions (narrow)

From 2019/20 to 2023/24, Havering's rate of admission episodes for alcohol-specific conditions remained broadly stable, changing only slightly from 430 to 433 per 100,000 population. In 2023/24, there were 1,084 admission episodes for alcohol-specific conditions in Havering.

Across the five-year period, Havering's overall rate remained statistically significantly below both London and England. In 2023/24, the rate was 433 per 100,000 (95% CI 408 to 460) in Havering, compared with 564 per 100,000 in London and 612 per 100,000 in England.

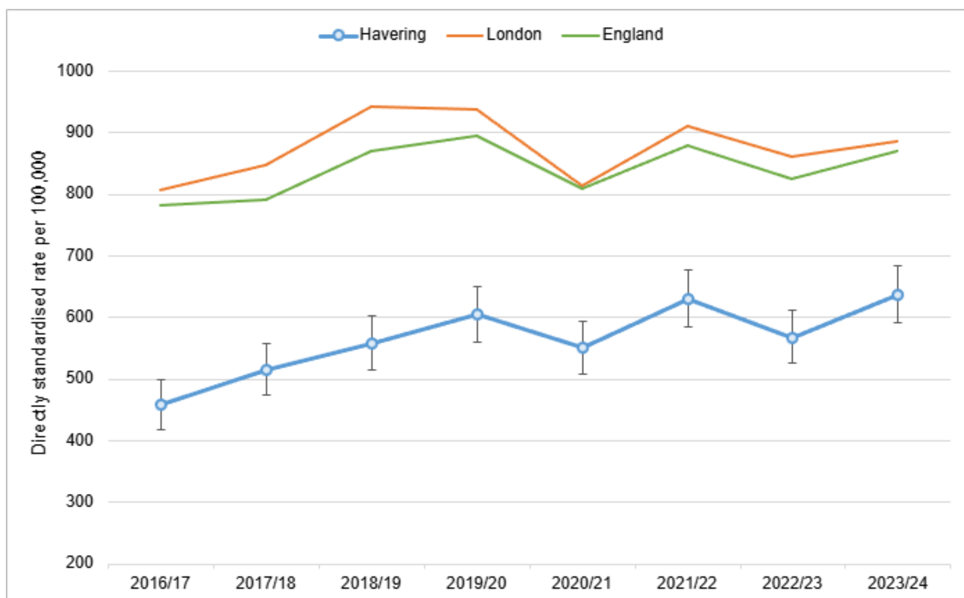
Rates were consistently higher among males than females. In 2023/24, the male admission rate in Havering was 637 (95% CI 592 to 684) per 100,000, compared with 251 (95% CI 224 to 279) per 100,000 for females. Male rates remained statistically significantly below both London and England throughout the period. Female rates remained below England across the five years but were higher than the London rate in 2021/22 and 2022/23 before falling below it again in 2023/24 although it was not statistically significant. This however is expected and mirrored in national figures.

Figure 22. Admission episodes for alcohol-specific conditions (Persons) in Havering, London, and England (2016-24) per 100,000 population



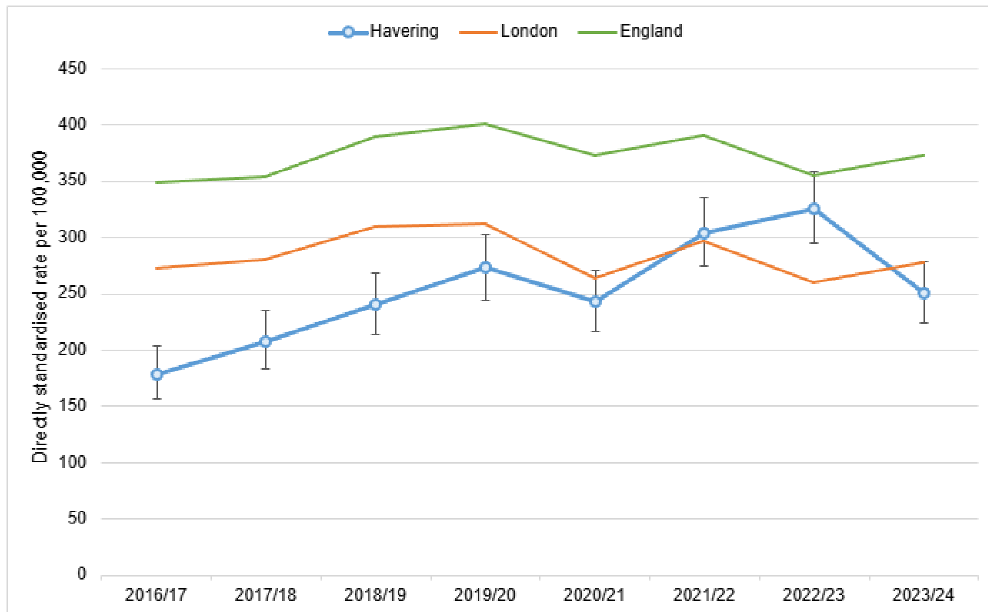
Source: OHID Fingertips

Figure 23. Admission episodes for alcohol-specific conditions (males) in Havering, London, and England (2016-24) per 100,000 population



Source: OHID

Figure 24. Admission episodes for alcohol-specific conditions (females) in Havering, London, and England (2016-24) per 100,000 population



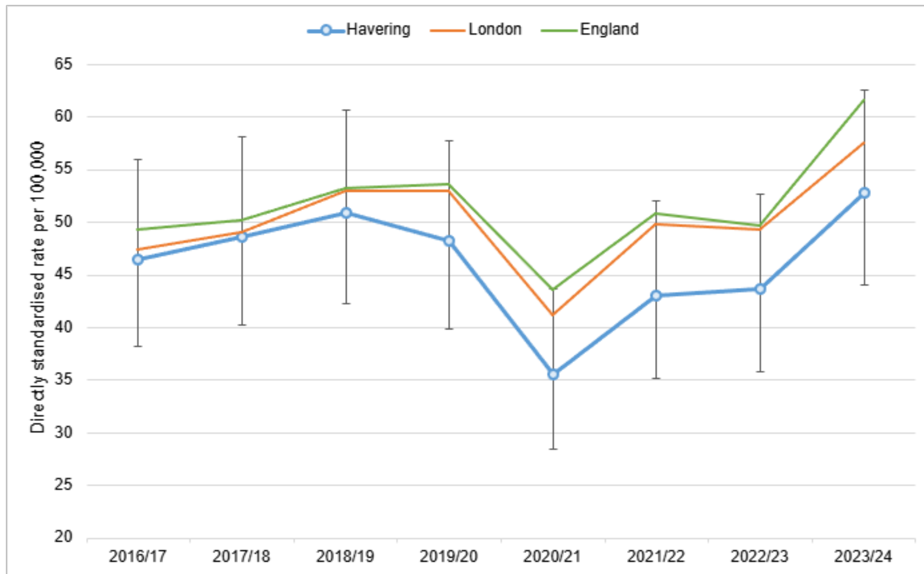
Source: OHID Fingertips

10.1.3 Admission episodes for alcohol-related unintentional injuries

From 2019/20 to 2023/24, Havering's rate of admission episodes for alcohol-related unintentional injuries increased from 48.2 to 52.8 per 100,000 population. After falling to 35.5 per 100,000 in 2020/21, the rate rose in each of the following years, reaching 133 admission episodes in 2023/24.

In 2023/24, Havering's rate was 52.8 per 100,000 (95% CI 44.1 to 63.0), compared with 58 in London and 62 in England. Havering's 95% confidence interval includes both comparator point estimates, suggesting that the local rate was broadly similar to the London and England figures in the latest year rather than clearly higher or lower. Overall, this indicates that alcohol-related unintentional injury admissions remain an ongoing issue locally, but that the latest Havering rate is not clearly different from the regional and national picture.

Figure 25. Admission episodes for alcohol-related unintentional injuries (Narrow) (Persons) in Havering, London, and England (2016-24) per 100,000 population



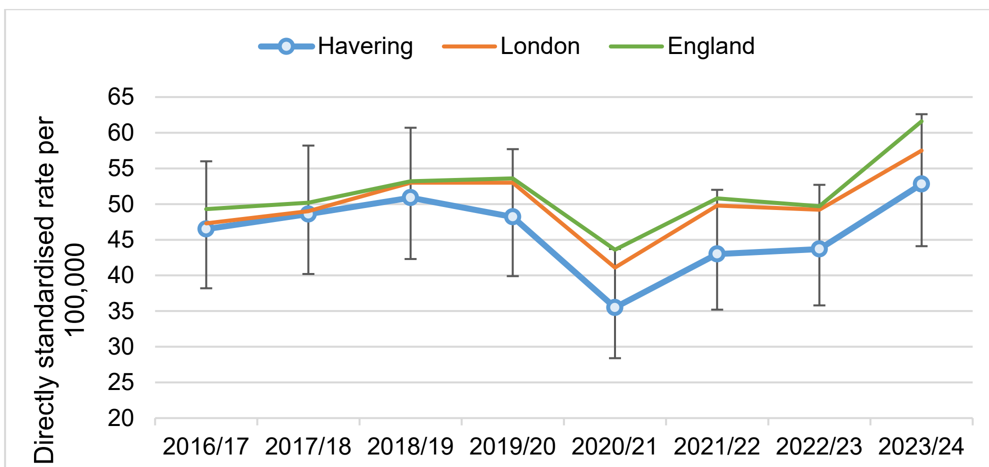
Source: OHID Fingertips

10.1.4 Admission for mental and behavioural disorders due to use of alcohol

From 2019/20 to 2023/24, Havering's rate of admission episodes for mental and behavioural disorders due to use of alcohol increased from 48.2 to 52.8 per 100,000 population. After falling to 35.5 per 100,000 in 2020/21, the rate rose in each subsequent year, reaching 133 admission episodes in 2023/24.

In 2023/24, Havering's rate was 52.8 per 100,000 (95% CI 44.1 to 63.0), compared with 58 in London and 62 in England. Havering's 95% confidence interval includes both comparator point estimates, suggesting that the local rate was broadly similar to the London and England figures in the latest year rather than clearly higher or lower.

Figure 26. Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow) (Persons) in Havering, London, and England (2016-24) per 100,000 population



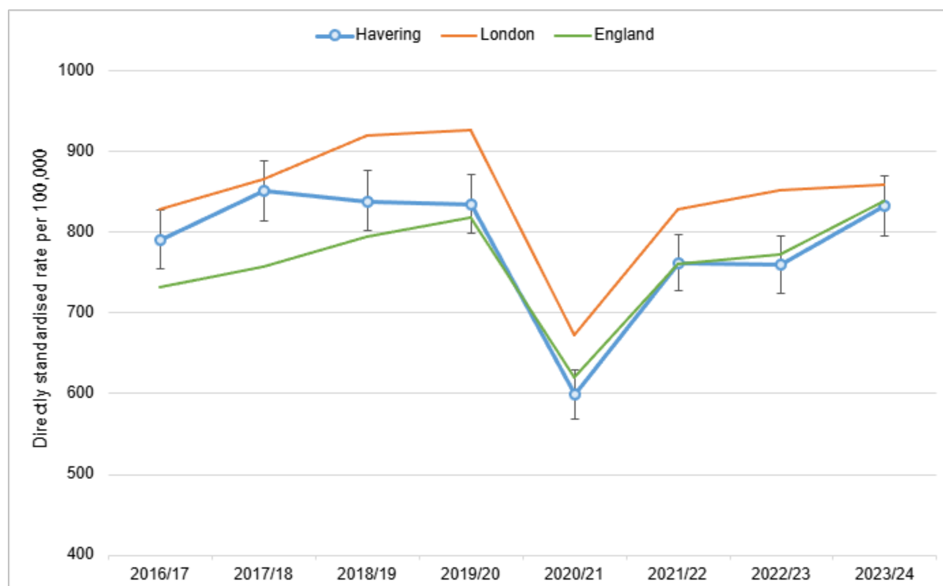
Source: OHID Fingertips

10.1.5 Admission episodes for alcohol-related cardiovascular disease

From 2019/20 to 2023/24, Havering's rate of admission episodes for alcohol-related cardiovascular disease was broadly stable overall, changing slightly from 834 to 832 per 100,000 population. After falling to 599 per 100,000 in 2020/21, the rate increased again in the following three years, reaching 2,059 admission episodes in 2023/24.

In 2023/24, Havering's rate was 832 per 100,000 (95% CI 796 to 869), compared with 857 in London and 837 in England. Havering's 95% confidence interval includes both comparator point estimates, suggesting that the local rate was broadly similar to the regional and national picture in the latest year. Admission rates were substantially higher among males than females. In 2023/24, the male rate was 1,553 per 100,000 population (1,728 admission episodes), compared with 245 per 100,000 among females (331 admission episodes). This is particularly relevant in Havering, where an ageing population and increasing numbers of older adults in treatment are likely to increase the overlap between alcohol-related harm, long-term conditions and wider complexity of need.

Figure 27. Admission episodes for alcohol-related cardiovascular disease (Broad) (Persons) in Havering, London, and England (2016-24) per 100,000 population



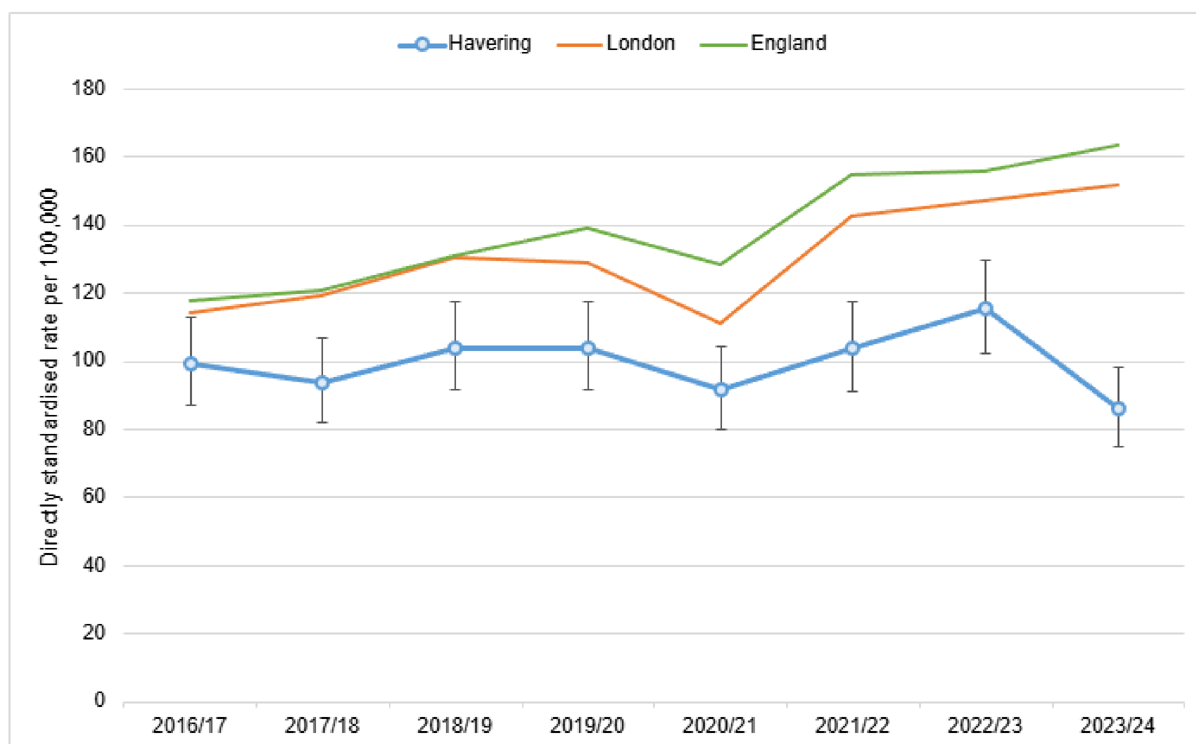
Source: OHID Fingertips

10.1.6 Admission episodes for alcoholic liver disease

From 2019/20 to 2023/24, Havering's rate of admission episodes for alcoholic liver disease fell from 103.9 to 85.9 per 100,000 population. After falling to 91.7 per 100,000 in 2020/21, the rate rose again in 2021/22 and 2022/23 before falling in 2023/24 to 212 admission episodes.

In 2023/24, Havering's rate was 85.9 per 100,000 (95% CI 74.7 to 98.0), compared with 152 in London and 163 in England. Havering's upper confidence limit remained well below both comparator point estimates, suggesting that the local rate was clearly lower than both London and England in the latest year.

Figure 28. Admission episodes for alcoholic liver disease (Broad) (Persons) in Havering, London, and England (2010-23) per 100,000 population



Source: OHID Fingertips

10.1.7 Alcohol-related hospital admissions summary

Taken together, the hospital admission indicators show that alcohol continues to place a substantial burden on health services in Havering. While Havering remained below the London and England averages for many admission measures, the local picture was mixed, with some indicators rising over the five-year period and others remaining stable or falling in the latest year. This reflects the wider national position: in England, there were over 1 million alcohol-related hospital admissions using the broad measure and almost 340,000 alcohol-specific admissions in 2023/24[31]. Overall, the evidence suggests continued alcohol-related hospital burden locally, but not a consistent pattern of Havering being clearly higher or lower than comparators across all indicators.

[31] Alcohol profile: short statistical commentary, February 2025 - GOV.UK

Broad alcohol-related admissions increased by 2023/24, while alcohol-specific admissions were stable overall. Admissions for mental and behavioural disorders due to alcohol also increased, suggesting continued need linked to more acute and complex alcohol-related harm. By contrast, admission rates for alcoholic liver disease fell sharply in the latest year, although this should be interpreted cautiously unless the pattern is sustained. Across the indicators considered, males consistently experienced higher rates of admission than females, indicating a disproportionate burden of alcohol-related harm.

Overall, these findings suggest that alcohol continues to generate avoidable ill health and hospital activity in Havering. This underlines the importance of prevention, early identification, and timely access to treatment, particularly for those with more severe or long-term alcohol-related conditions and for groups experiencing higher levels of harm. NICE guidance on alcohol-use disorders highlights that reducing alcohol consumption and improving assessment and treatment can help reduce harms including liver disease, heart problems, depression, and anxiety, while NICE public health guidance recommends local screening and brief interventions alongside integrated treatment pathways[32].

This is especially important in Havering given the borough's ageing population and the increasing proportion of older adults in treatment, which may increase the overlap between alcohol-related harm, chronic disease, and wider health need. That makes joined-up prevention, treatment, and physical health care particularly important locally. This emphasis is consistent with current UK alcohol treatment guidance, which stresses that services should work together for people with co-occurring alcohol and mental or physical health needs[33].

[32] Overview | Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence | Guidance | NICE

[33] Draft UK clinical guidelines for alcohol treatment: core elements of alcohol treatment - GOV.UK

10.2 Drug related hospital admissions

10.2.1 Hospital admissions for drug related mental and behavioural disorders

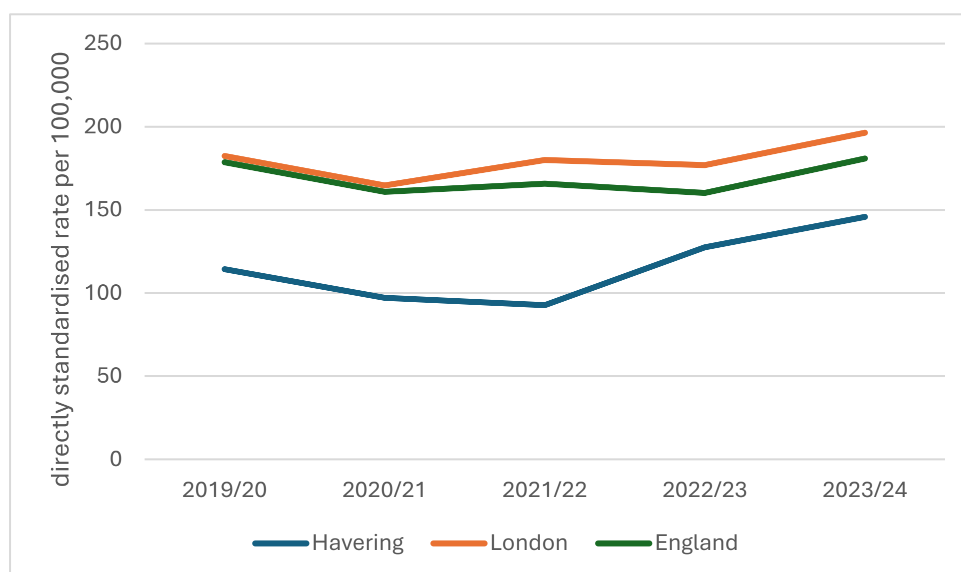
Local review identified that the coding used for this measure includes tobacco-related admissions, and confirmation from NELFT indicated that tobacco is being captured within the data. This means the measure does not provide a clear or specific picture of illicit drug-related hospital admissions in Havering. It is therefore of limited value for assessing trends in illicit drug harm and should not be used in isolation to draw conclusions about local need.

10.2.2 Hospital admissions where drug-related mental and behavioural disorders were a factor.

From 2019/20 to 2023/24, the rate of hospital admissions where drug-related mental and behavioural disorders were a factor fell initially and then increased in the most recent two years. In Havering, the rate declined from 114.3 per 100,000 population in 2019/20 to 92.7 in 2021/22, before rising to 145.8 in 2023/24.

In 2023/24, Havering's rate was 145.8 per 100,000 (95% CI 131.5 to 161.3), compared with 180.9 in England. Havering's upper confidence limit remained below the England point estimate, suggesting that the local rate was lower than England in the latest year. Overall, this indicates growing hospital activity in which drug-related mental and behavioural disorders are a contributing factor, although the local rate remains lower than the national picture.

Figure 29. Hospital admissions with a primary or secondary diagnosis of drug related mental and behavioural disorders. Directly age standardised rate per 100,000 population



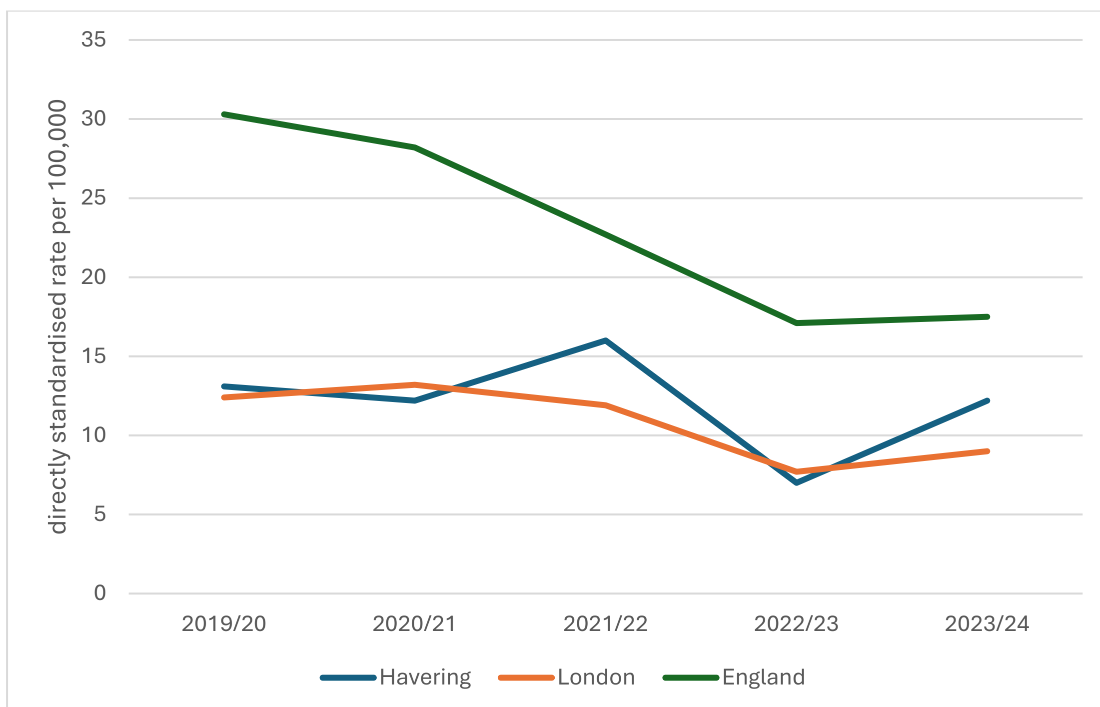
Source: OHID Fingertips

10.2.3 Hospital admissions for poisoning by drug misuse

From 2019/20 to 2023/24, hospital admissions for poisoning by drug misuse in Havering fluctuated, with no consistent upward or downward trend. The rate was 13.1 per 100,000 population in 2019/20 and 12.2 per 100,000 in 2023/24.

In 2023/24, Havering's rate was 12.2 per 100,000 (95% CI 8.3 to 17.3), compared with 17.5 in England. Havering's confidence interval extended close to the England point estimate, suggesting that the local rate was not clearly different from the national figure in the latest year. Given the small numbers involved and the width of the confidence intervals, year-to-year changes should be interpreted cautiously.

Figure 30. Hospital admissions with a primary diagnosis of poisoning by drugs that are listed as controlled under the Misuse of Drugs Act 1971 directly age standardised rate per 100,000.



Source: OHID Fingertips

10.2.4 Hospital admissions for drug-related mental & behavioural disorders

Using admissions data where a drug-related mental and behavioural disorder was recorded as the primary diagnosis (ICD-10 F11–F16, F18 and F19), the number of admissions in Havering remained relatively stable between 2020 and 2023, ranging from 29 to 37 admissions per year, before falling to 11 in 2024 and 7 in 2025.

Overall, this suggests that admissions primarily caused by drug-related mental and behavioural disorders are relatively small in number in Havering and have fallen in the most recent years. A broader contributing-factor measure was reviewed but has not been

included here because local review indicated that tobacco-related coding may be captured within that measure, which would overstate drug-related hospital activity.

Table 14. Hospital admissions *for* drug-related mental and behavioural disorders

Ref	**Indicator**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
1	Drug related mental and behavioural disorder admissions F11-F16, F18, F19 (primary diagnosis 5 years)	31	32	37	29	11	7

Source: Hospital Episode Statistics, LBH Public Health Intelligence

10.2.5 Hospital admissions for drug-related poisoning by drug category

Hospital admissions for drug-related poisoning varied by substance type between 2020 and 2025. Overall, opioid poisoning (T40.0–T40.4) accounted for the highest number of admissions across the period, peaking at 42 admissions in 2021 before falling to 14 in 2025. Admissions for other drug-related poisonings (T42.3, T42.4, T43.6, T52), which include benzodiazepines, antiepileptic drugs, psychostimulants excluding cocaine, and toxic effects of organic solvents and related substances, were also consistently recorded and formed the second largest group.

Cocaine poisoning (T40.5) admissions remained low throughout the period and exceeded five admissions only in 2021 and 2022. Admissions relating to cannabis and hallucinogens (T40.7–T40.9), as well as other narcotics and psychodysleptics (T40.6), remained very low across the series.

The overall number of drug-related poisoning admissions (T40.0–T40.9, T42.3, T42.4, T43.6, T52) fell from 76 in 2021 to 26 in 2025. This suggests that although hospital admissions for poisoning have reduced in recent years, opioid poisonings (T40.0–T40.4) and other non-cocaine drug-related poisonings (T42.3, T42.4, T43.6, T52) continue to account for most of the acute drug-related harm recorded in hospital data.

Table 15. Hospital admissions for *drug related* poisoning by drug category*, Havering 2020-2025*

Indicator	2020	2021	2022	2023	2024	2025
Drug-related poisoning admissions, T40.0–T40.9 plus T42.3, T42.4, T43.6, T52 (primary diagnosis)	55	76	51	44	36	26
Drug related poisoning admissions by type of drug						
i. Opioid poisoning (T40.0–T40.4)	26	42	26	28	17	14
ii. Cocaine poisoning (T40.5)	<5	6	6	<5	<5	<5
iii. Other T40.6	<5	<5	<5	<5	<5	<5
iv. Cannabis and hallucinogens (T40.7–T40.9)	<5	<5	<5	<5	<5	0

v. Other drug-related poisoning (T42.3, T42.4, T43.6, T52)	26	27	16	11	14	9

Source: Hospital Episode Statistics, LBH Public Health Intelligence, Values below 5 have been suppressed and shown as <5 to reduce disclosure risk.

Note: admitted drug related poisoning does not include paid medication.

10.3 Drug-related hospital admissions summary

Taken together, the hospital admission indicators show a mixed picture of drug-related harm in Havering. The most direct measure of drug-related mental and behavioural disorder admissions is affected by local coding issues, as tobacco-related admissions are included, which limits its value as an indicator of illicit drug harm on its own.

Other indicators suggest that drug-related hospital activity remains present but does not show a consistent pattern across all measures. Admissions where drug-related mental and behavioural disorders were a contributing factor increased in the most recent two years, although the local rate remained below the England point estimate in the latest year. Admissions for poisoning by drug misuse fluctuated across the period, with small numbers and no sustained upward trend, and the latest Havering rate was not clearly different from England.

The qualitative and operational evidence suggests, however, that emerging harms may be broader than hospital data alone can show. Staff, stakeholders, and operational partners described a changing and more volatile drug market, with concerns about ketamine, synthetic opioids, contamination, and hidden use among younger people. These risks can affect not only people who use substances, but also communities and frontline responders. This suggests that hospital indicators remain important but may not fully capture the nature or extent of local risk, particularly where people present late, use multiple substances, or are using in less visible ways. It reinforces the need for strong local intelligence, safeguarding, enforcement and treatment responses alongside prevention and harm reduction.

11. Mortality

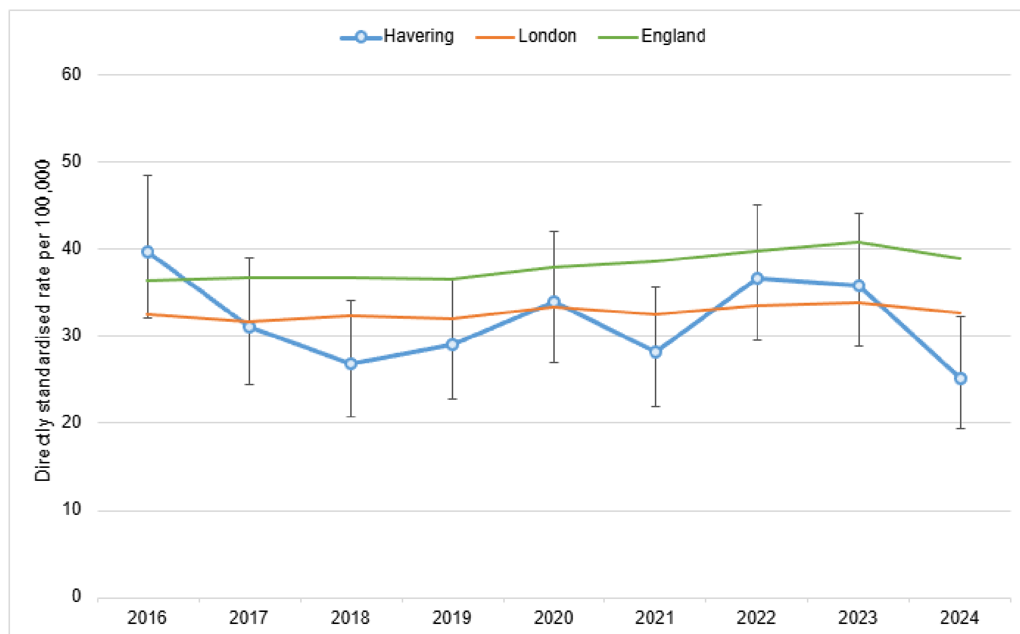
11.1 Alcohol-related mortality

11.1.1 Alcohol-related mortality

From 2020 to 2024, alcohol-related mortality in Havering fluctuated, rising to 36.7 per 100,000 in 2022 and remaining high in 2023 before falling to 25.2 per 100,000 in 2024. In 2024, Havering recorded 64 alcohol-related deaths, the lowest number since 2016.

In 2024, Havering's rate was 25.2 per 100,000 (95% CI 19.4 to 32.0), compared with 33 in London and 39 in England. Havering's upper confidence limit was below both comparator point estimates, suggesting that the local rate was lower than both London and England in the latest year. However, this should be interpreted in the context of earlier fluctuation: in 2022 and 2023 Havering's confidence intervals overlapped the London and England point estimates, so the recent improvement should not yet be interpreted as a stable long-term downward trend. In the most recent year, mortality remained higher among males than females, with a male rate of 38.6 per 100,000 (44 deaths) compared with 14.5 per 100,000 among females (20 deaths).

Figure 31. Alcohol-related mortality (Persons) in Havering, London, and England (2016-24) per 100,000 population



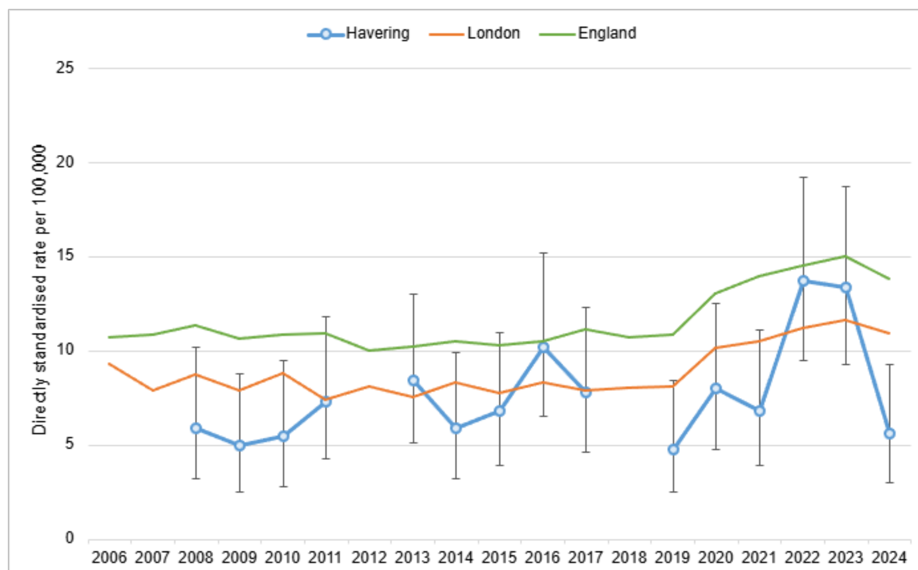
Source: OHID Fingertips

11.1.2 Alcohol-specific mortality

From 2020 onwards, alcohol-specific mortality in Havering fluctuated, with a marked rise in 2022 and 2023 followed by a substantial fall in 2024. In 2024, Havering recorded 14

alcohol-specific deaths and a rate of 5.6 per 100,000 population (95% CI 3 to 9), statistically lower than both London and England.

Figure 32. Alcohol-specific mortality in Havering, London, and England (2006-24) per 100,000 population



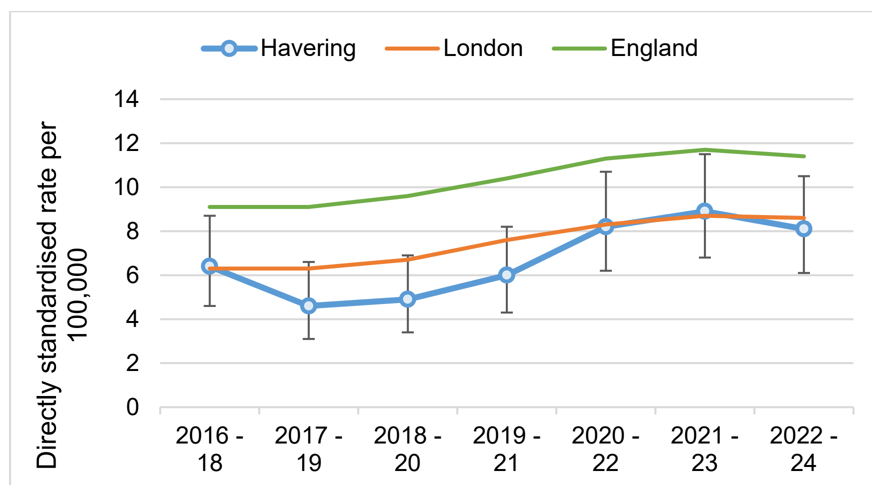
Source: OHID Fingertips

11.1.3 Alcohol liver disease mortality (under 75)

Havering's under-75 mortality rate from alcoholic liver disease increased from 6.0 per 100,000 in 2019–21 to 8.9 in 2021–23, before falling slightly to 8.1 per 100,000 in 2022–24. In the latest three-year period, this equated to 55 deaths.

In 2022–24, Havering's rate was 8.1 per 100,000 (95% CI 6.1 to 10.5), compared with 8.6 in London and 11.4 in England. Havering's confidence interval includes the London point estimate, suggesting a broadly similar rate to London in the latest period, while the upper confidence limit remained below the England point estimate. Overall, this suggests that premature mortality from alcoholic liver disease remains an ongoing issue locally, despite some recent improvement.

Figure 33. Under 75 mortality rates from alcoholic liver disease (Persons) (3-year range) in Havering, London, and England (2016-24) per 100,000 population



Source: OHID Fingertips

11.1.4 Mortality summary

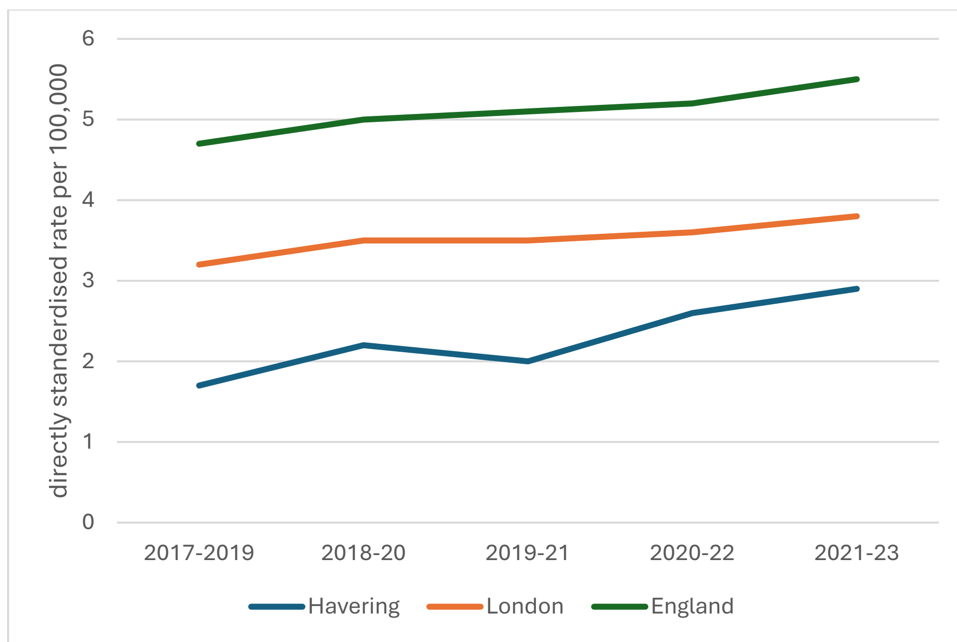
Taken together, the mortality indicators show a mixed picture of alcohol-related harm in Havering. Alcohol-related mortality and alcohol-specific mortality fluctuated over recent years, with rates worsening in 2022 and 2023 before improving in 2024. In the latest year, Havering's alcohol-related mortality rate was lower than the London and England point estimates, and the 95% confidence interval also sat below both comparator point estimates. However, earlier overlap with comparator values means this should be interpreted as recent improvement rather than unambiguous evidence of a sustained long-term decline. Premature mortality from alcoholic liver disease remains a critical issue, with the latest Havering rate broadly like London.

11.2 Drug misuse mortality

From 2019–21 to 2022–24, the age-standardised mortality rate from drug misuse in Havering increased from 2.0 to 3.7 per 100,000 population. This indicates an upward direction of travel over recent rolling periods, although the number of deaths remains small and the confidence intervals are relatively wide.

In 2022–24, Havering's rate was 3.7 per 100,000 (95% CI 2.4 to 5.3), compared with 5.8 in England. Havering's upper confidence limit remained below the England point estimate, suggesting that the local rate was still lower than England in the latest period despite the increase over time. Overall, this points to a worsening local trend that should be monitored closely, while recognising that small numbers can lead to instability between periods.

Figure 34. Age standardised mortality rate from drug misuse per 100,000 population



Source: OHID Fingertips

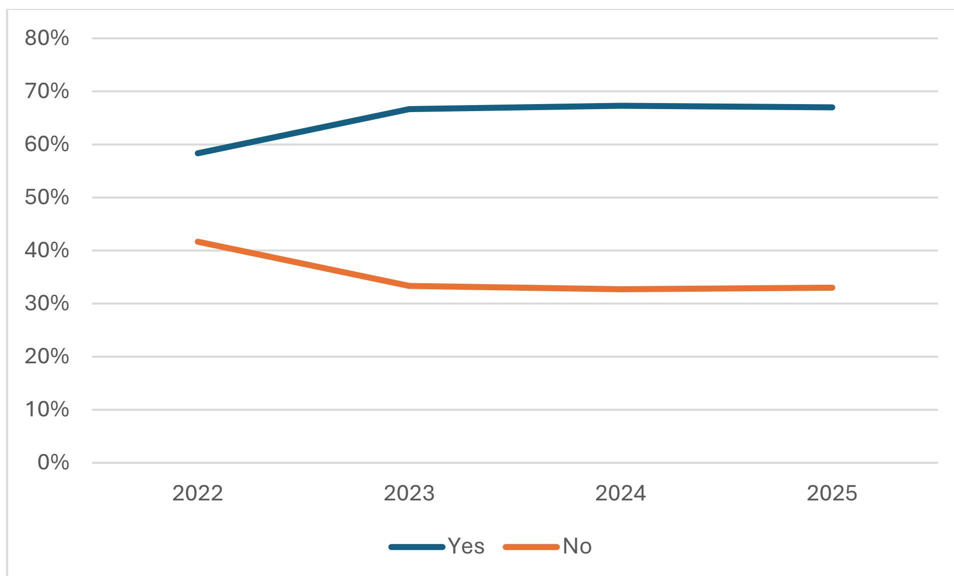
12. Co-occurring conditions (Dual diagnosis)

12.1 Mental health treatment need amongst new adults in treatment

Data on new presentations for all drugs shows an elevated level of reported mental health treatment need among people entering treatment in Havering. In 2025, 345 new presentations, equivalent to 67%, reported that they needed mental health treatment. This has remained consistently high in recent years. The proportion reporting a mental health treatment need increased from 58% in 2022 to 67% in 2023 and remained at a similar level in 2024 and 2025. This indicates that co-occurring mental health need is common among people presenting to drug treatment and remains an important consideration for assessment, care planning and partnership working between substance misuse and mental health services.

The qualitative findings strongly reinforce this. Staff and service users consistently described substance use as intricately linked to trauma, distress, and self-medication, and often viewed mental health as the first priority at the point of contact with services. This suggests that co-occurring need is not a secondary issue affecting a minority, but a central feature of local substance misuse presentations.

Figure 35. Mental health treatment need of new presentations



Source: NDTMS

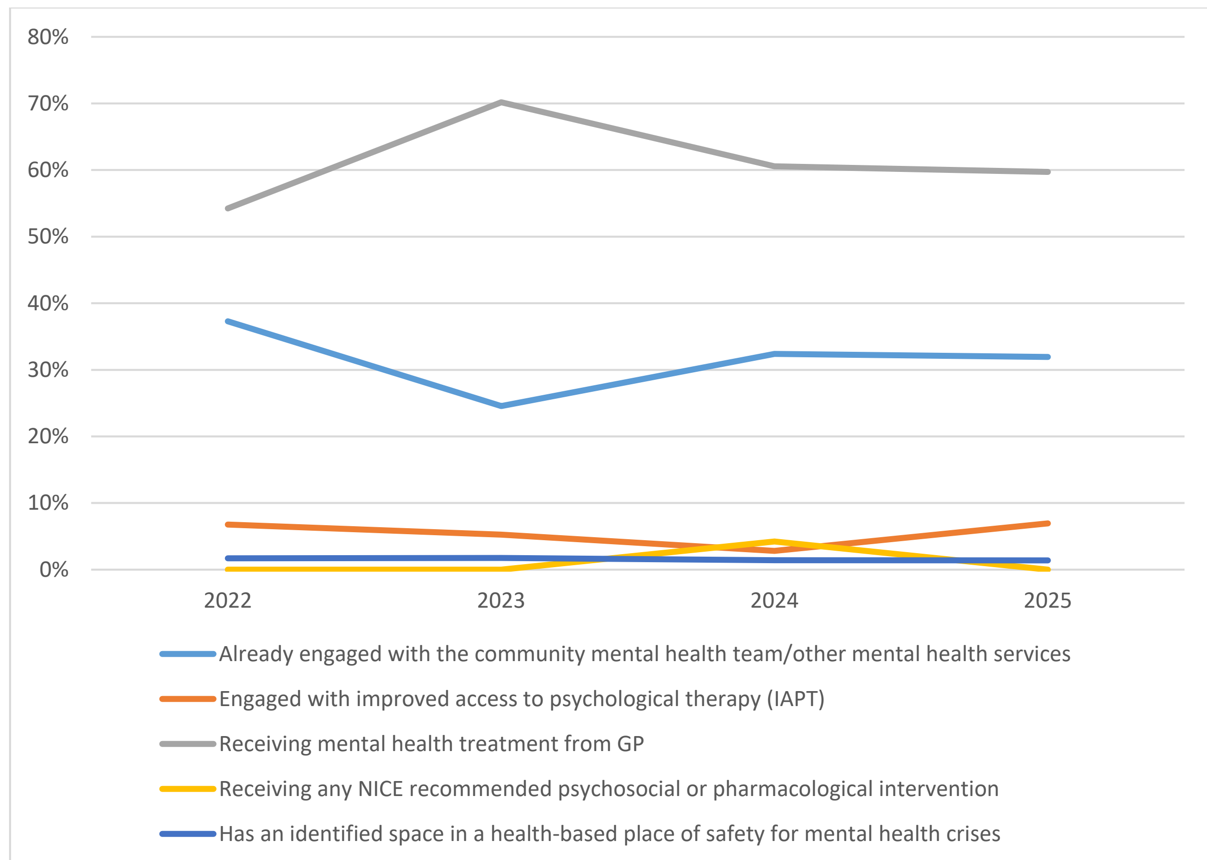
12.2 Type of mental health treatment received by new adults in treatment.

Among new adults in treatment who were already receiving mental health treatment, most were receiving support from their GP. In 2025, 60% were receiving mental health treatment from their GP, 32% were already engaged with the Community Mental Health

Team or other mental health services, and 7% were accessing Improving Access to Psychological Therapies (IAPT).

The focus group findings provide useful context here. Participants described long waits, limited specialist provision, and continued reliance on GPs even where needs were complex. Although integrated mental health support within CGL was viewed positively, the wider system was often experienced as difficult to access or insufficiently responsive to the combination of mental health and substance use problems.

Figure 36. Type of mental health treatment being received by new presentations



Source: NDTMS

12.3 Unmet need

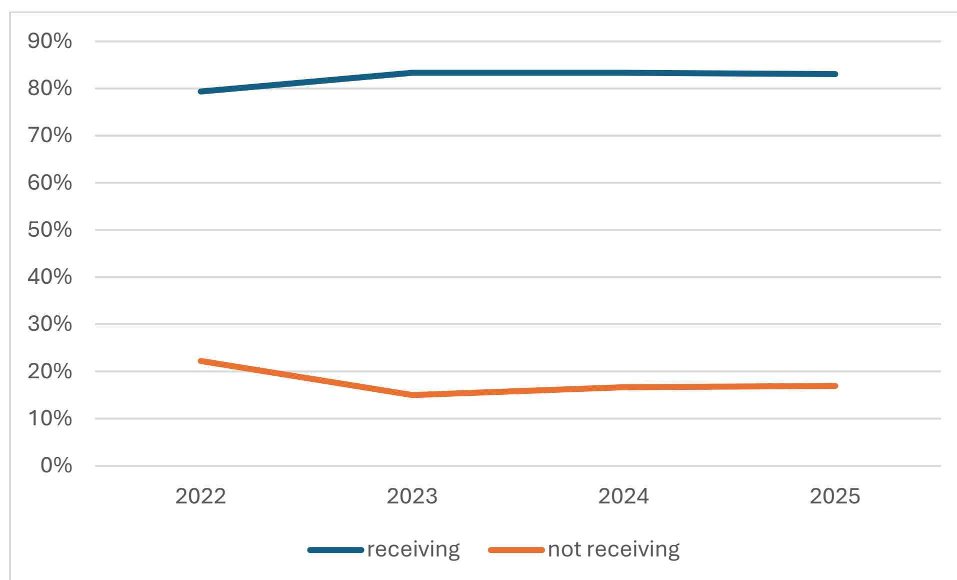
Among new presentations who identified a mental health treatment need, most were already receiving treatment. In 2025, 84% were recorded as receiving mental health treatment, while 16% were not[34]. The proportion not receiving treatment fell from 22% in 2022 to 15% in 2023 and was 17% in 2024 before falling slightly to 16% in 2025. This suggests that, although most people with identified mental health treatment need are

[34] NDTMS

already in contact with services, a continuing minority are not receiving support at the point they enter treatment.

The qualitative evidence suggests that this unmet need is shaped not only by availability, but also by pathway design. Staff repeatedly described people with co-occurring needs struggling to access appropriate help because of abstinence-based thresholds, sequential models, and fragmented responsibilities across services. Stakeholders also identified dual diagnosis as a particular gap. Taken together, this suggests that some people continue to fall between substance misuse and mental health services even when need is clearly recognised.

Figure 37. The number of people who have been identified as having a mental health treatment need that are either currently receiving treatment or who are not receiving treatment.



Source: NDTMS

13. Findings and conclusion

The refreshed evidence shows that substance misuse need in Havering has grown in both scale and complexity since the 2023 needs assessment. Treatment numbers have increased, referral routes have broadened, and the local system is now engaging more people through mental health, hospital, prison, and criminal justice pathways. This reflects progress in identification and access, but it also points to sustained and, in some areas, increasing demand. Across the evidence, substance misuse rarely appears in isolation. Instead, it is often bound up with co-occurring mental health need, housing insecurity, safeguarding concerns, economic inactivity and contact with the criminal justice system, which means the effectiveness of the local response depends on how well these wider needs are addressed alongside treatment itself.

A key change since the previous assessment is the profile of the adult treatment population. The population in treatment is ageing, with more adults aged 50 and over now engaged in services, and alcohol has become increasingly prominent within the treatment system. At the same time, opiate and crack-related need remains important. Although the latest modelled prevalence estimate is lower than the previous estimate, this group continues to account for a disproportionate share of harm, mortality, offending, and treatment complexity. The overall picture is therefore not one of one substance replacing another, but of a broader and more varied treatment population requiring differentiated responses. This is especially important given wider qualitative feedback that the local drug picture is also being shaped by ketamine, benzodiazepines, hidden use, and contamination, suggesting that some emerging harms may not yet be fully visible in the headline treatment data.

Alcohol remains the most significant contributor to population-level harm in Havering. Hospital admission data show continuing burden across a range of indicators, while mortality data show some improvement in the latest year but not a sustained downward trend. Harms remain particularly concentrated among males, and the local age profile suggests increasing overlap between alcohol-related harm, chronic disease, and older age. Taken together, this makes alcohol a continuing priority for prevention, early identification, treatment and joined-up physical and mental health care. This is reinforced by lived experience evidence indicating that many people still reach support only after crisis or hospitalisation, suggesting that earlier identification and engagement remain important.

The illicit drug picture is more mixed, but it does not suggest a low-harm local situation. Some comparator indicators remain below London and England, and small numbers mean some trends should be interpreted with caution. However, drug misuse mortality has increased across recent rolling periods, drug offences have risen, and hospital data point to continuing activity associated with multiple drug use, cannabinoids, opioids, and benzodiazepines. Community safety, stakeholder, and operational evidence add to this

picture by highlighting exploitation, county lines, cuckooing, and a drug market that is becoming more volatile and unpredictable, including risks linked to ketamine, synthetic opioids, and contaminated supply. Arrest referral, prison and probation pathways also have a vital role in identifying unmet need and supporting diversion into treatment. Taken together, this points to a local pattern of drug-related harm that cuts across health, safeguarding, and community safety systems, and reinforces the need for strong joint intelligence, targeted enforcement, safeguarding, treatment, and prevention responses.

Co-occurring need is one of the clearest cross-cutting themes in the assessment. Mental health treatment need is common among new presentations, yet a minority of those with identified need are not receiving treatment when they enter substance misuse services. Housing insecurity, unemployment, and wider family-related vulnerabilities are also prominent in the local picture. Quantitative indicators show the scale of this complexity, while the qualitative evidence helps explain how it operates in practice: unstable housing can undermine recovery, thresholds and fragmented pathways can leave people falling between services, and treatment providers can end up holding risk that extends beyond their formal remit. This means that treatment outcomes depend not only on the quality of substance misuse interventions, but on the strength of partnership working across mental health, housing, safeguarding, employment, and physical health services.

Children and young people also remain an important part of the local picture, both and through the wider impact of parental substance misuse. More children and young people are accessing structured treatment, while safeguarding data continue to show concern around parental alcohol and drug misuse and comparatively high identification of child drug misuse in local assessments. Survey and stakeholder evidence suggest that the picture extends beyond treatment figures alone, with concern about earlier substance use, emerging patterns among young people, and the need for stronger prevention, resilience-building, and transitions into adulthood. This reinforces the case for family-focused practice and for stronger links between treatment, education, youth support, children's social care and safeguarding partners.

Although this refresh has not undertaken a formal local economic evaluation, wider evidence suggests that investment in drug and alcohol treatment and recovery services is cost-effective and generates wider social value.[35] Public Health England's and OHID's commissioning evidence estimates that adult alcohol treatment returns around £3 for every £1 invested and adult drug treatment around £4 for every £1 invested, with higher returns accruing over a 10-year period[36]. This is consistent with the PHE evidence review of drug treatment outcomes in England, which concluded that investment in drug treatment can reduce the economic and social costs of drug-related harm and reported

[35] Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK
[36] Alcohol and drug prevention, treatment and recovery: why invest? - GOV.UK

an overall benefit-cost ratio of approximately 2.5:1[37]. For alcohol, evidence from England also suggests that earlier interventions such as screening and brief intervention in primary care can be cost-effective, supporting the case for prevention alongside specialist treatment[38]. Taken together, this strengthens the case for sustained investment in treatment, recovery, and earlier intervention as part of a whole-system response to substance-related harm in Havering.

Overall, the evidence suggests that Havering has made genuine progress in treatment reach, referral pathways, and service activity, but that this progress sits alongside substantial ongoing need and increasing complexity. The priorities for the next phase are therefore less about setting a new direction and more about strengthening the current response around the clearest areas of need: alcohol harm, complex and co-occurring need, older adults, children and families, and targeted responses to drug-related risk, harm, and offending. The qualitative findings also point to several practical priorities within that broader direction, including clearer pathways, stronger operational partnership working, better recovery support, and sustaining the relational, flexible approach that underpins much of what is working well locally.

[37] Drug misuse treatment in England: evidence review of outcomes - GOV.UK

[38] Purshouse RC, Brennan A, Rafia R, Latimer NR, Archer RJ, Angus CR, Preston LR, Meier PS. Modelling the cost-effectiveness of alcohol screening and brief interventions in primary care in England. Alcohol. 2013 Mar-Apr;48(2):180-8. doi: 10.1093/alcalc/ags103. Epub 2012 Sep 25. PMID: 23015608.

14. Recommendations

1. Maintain alcohol as a central strategic priority and strengthen engagement of dependent drinkers not currently in treatment

Alcohol should remain a core priority for the Havering Combatting Drugs Partnership because it continues to account for substantial hospital activity, ongoing mortality burden, and the highest level of unmet treatment need. Local planning should therefore continue to prioritise prevention, early identification, treatment access, harm reduction, and initiative-taking engagement of dependent drinkers who are not currently in treatment. This should include stronger case-finding and referral across primary care, hospitals, mental health, criminal justice, and community settings, alongside making support visible and accessible before people reach crisis point.

2. Maintain an age and culturally responsive treatment and recovery offer across the life course

The treatment and recovery system in Havering should remain responsive to the needs of different age groups and communities. This includes adults in mid-life and older age, children and young people requiring age-appropriate support, and people from diverse ethnic and cultural backgrounds who may experience different risks, barriers to access and service preferences. Local pathways should therefore continue to strengthen culturally competent practice, age-appropriate interventions and transition arrangements between children's and adult services.

3. Strengthen co-occurring pathways and align local practice with national standards

Given the high proportion of new presentations reporting a mental health treatment need, substance misuse and mental health partners should review joint pathways, thresholds, care coordination, and information sharing. This should include attention to people who fall between services, the impact of sequential or abstinence-based models, and alignment with the OHID commissioning quality standard for alcohol and drug services and NHS England's drug and alcohol treatment and recovery workforce capability framework, which emphasise integrated, high-quality treatment and recovery responses and the capabilities needed to meet complex need.

4. Maintain focus on high-harm drug use while broadening the local drug response

Local strategy should continue to prioritise opiate and crack use because of the level of harm associated with this group, while also responding to new emerging patterns of drug use as they present locally.

5. Consolidate and strengthen wider recovery support

Housing insecurity, unemployment, economic inactivity, and high smoking prevalence remain key features of the treatment population. The partnership should continue to support and embed existing recovery-focused provision, including homelessness-related support and the IPS employment offer, while strengthening links between treatment, housing, employment, aftercare, peer support, and recovery groups so that people can sustain progress beyond the formal treatment episode.

6. Strengthen family-focused practice and the response to parental substance misuse

Given the proportion of adults in treatment living with children, and the continued identification of parental substance misuse in children's social care assessments, the local system should maintain a strong family-focused response. This should include effective joint working between adult treatment, children's social care, family support and safeguarding services, alongside clearer support and information for family members who may play a significant role in crisis response and recovery.

7. Use community safety intelligence to target local responses

The increase in drug offences, particularly in specific localities, supports a more targeted response that combines enforcement, prevention, treatment, and safeguarding. The Combatting Drugs Partnership should continue to use crime, referral, and operational intelligence to focus activity geographically and through the pathways where drug-related harm, exploitation and offending are most visible.

8. Strengthen local intelligence, overdose and mortality surveillance, and operational partnership working

Some indicators remain affected by data quality and coding limitations, and there are important intelligence gaps in areas such as non-fatal overdose (NFOs), suspected drug-related deaths, drug, and alcohol-related deaths (DARDs), and prescribed or non-prescribed medication misuse. The qualitative evidence also suggests that partnership working can still be inconsistent across parts of the system. The Combatting Drugs

Partnership should therefore strengthen local intelligence arrangements, improve the consistency of data interpretation, and agree how key gaps such as overdose and mortality-related intelligence will be monitored routinely. This should include regular review of DARDs, suspected drug-related deaths and NFOs to identify patterns, missed opportunities and required action, alongside clearer referral routes, defined points of contact, stronger feedback loops, and better operational follow-through across agencies. Learning from reviews should be translated into service and partnership action, including harm reduction activity, naloxone distribution, and engagement of high-risk groups.

9. Expand the recovery hub and explore options for community cohesion activities.

Recovery is supported not only through treatment, but through social connection, peer support, purposeful activity, and access to ongoing community-based support. The partnership should therefore explore opportunities to expand the recovery hub offer and wider community cohesion activities to reduce isolation, strengthen recovery capital and support sustained recovery beyond formal treatment.

Appendix

Thematic analysis of CGL Staff Qualitative Survey

23 respondents from CGL staff (Aspire & WizeUp) between 02/12/2025 – 16/12/2025.

Purpose and context

This document outlines the thematic analysis of twenty-three qualitative survey responses from staff working within CGL Aspire and CGL Wize Up, the commissioned drug and alcohol treatment services in Havering. The analysis captures frontline and operational insight into emerging substance use trends, service user complexity, barriers to engagement, partnership working, and the conditions required to support sustained recovery.

The findings are particularly valuable as they reflect current staff experience across both adult and young people's services, including those working with individuals facing multiple disadvantage. The analysis does not seek to evaluate individual services in isolation, but rather to understand how the entire local system currently functions in response to changing patterns of need. The themes identified here directly inform the identification of gaps, pressures, and strengths within the current system and provide a robust qualitative foundation for future recommendations.

Theme 1: A changing drug landscape is increasing risk and complexity.

Staff consistently described a significant shift in the local drug landscape, with ketamine emerging as the most prominent and concerning substance trend. Ketamine use was reported across multiple responses as increasing in prevalence, particularly among young adults and younger service users, and increasingly associated with severe physical and psychological harms. These harms include bladder damage, chronic pain, anxiety, low mood, and impaired daily functioning, which in turn drive crisis-led engagement with services.

Several staff noted that ketamine use is no longer confined to traditional recreational contexts. Instead, it is increasingly characterised by isolated and hidden use, particularly among young people using substances alone in bedrooms. This pattern reduces visibility, delays intervention, and increases the risk of serious harm before services become involved.

Alongside ketamine, respondents identified growing concerns around benzodiazepine use and contamination, including service users testing positive for substances they were unaware of having taken. This points to an increasingly volatile and unpredictable drug market, with heightened overdose and dependency risks. Emerging concerns were also raised around novel synthetic opioids, cocaine, and ongoing elevated levels of alcohol-

related harm. Alcohol was repeatedly described as the most prevalent substance in terms of population-level impact, despite often receiving less urgent prioritisation compared to illicit drugs.

Overall, staff described a misalignment between current treatment pathways and the substances now driving harm, with existing models struggling to keep pace with the complexity and acuity of presentations.

Theme 2: Housing instability and social environments actively undermine recovery.

Housing instability emerged as one of the most significant determinants of both substance use and engagement with treatment. Staff described people living in temporary accommodation, hostels, HMOs, or experiencing homelessness as presenting with the most complex and rapidly changing needs. These environments were consistently described as actively undermining recovery efforts, particularly where substance use is widespread among other residents.

Out-of-borough placements were highlighted as especially destabilising. Respondents described how these placements disrupt continuity of care, sever informal support networks, and increase isolation, often leading to disengagement or relapse. Housing instability was also linked to mental health deterioration, financial insecurity, and difficulty maintaining routines, all which compound substance use.

Importantly, staff narratives emphasised that disengagement in these contexts is rarely a matter of lack of motivation. Instead, individuals are attempting to engage with recovery while living in environments that continually expose them to risk. This suggests that treatment effectiveness is significantly constrained by structural and environmental factors outside the control of individuals or services.

Theme 3: Fragmented systems and threshold-based models exclude those with greatest need.

A dominant and consistent theme was the impact of system fragmentation, particularly at the interface between substance use services, mental health services, social care, hospitals, and criminal justice. Staff repeatedly described situations where individuals with co-occurring mental health and substance use needs are unable to access appropriate support due to abstinence-based thresholds or sequential treatment requirements.

Mental health services were most frequently cited as withdrawing or refusing support while individuals continue to use substances, despite substance use often being intricately linked to unmanaged mental health symptoms. This creates a cycle in which

individuals are unable to meet the criteria of either service, resulting in disengagement, relapse, and increased risk.

One respondent summarised this clearly:

"Mental health want clients to be abstinent first, but clients are using because of their mental health."

Critical transition points were also identified as high-risk moments where system failures are particularly evident. These include hospital discharge, prison release (especially late or unplanned releases), and referrals from social care. Poor information sharing, unclear accountability, and last-minute referrals were described as common, leaving services unable to plan effectively and service users unsupported during periods of heightened vulnerability.

Collectively, these issues suggest that current system design disproportionately excludes those with the most complex needs, placing additional pressure on substance use services to hold risk without corresponding authority or resources.

Theme 4: CGL's relational, low-threshold model is effective but carrying unsustainable pressure.

Across responses, staff were clear about what is working well within Havering. CGL's service model was consistently described as a key strength, particularly its emphasis on non-judgemental, person-centred practice, harm reduction, and flexibility. Staff highlighted the importance of meeting people "where they are," maintaining engagement through relapse, and prioritising continuity over discharge.

Group work, one-to-one keyworking, outreach, and proactive follow-up were all cited as effective engagement tools, particularly for people who have previously disengaged from services. Relationships between practitioners and service users were repeatedly described as the central mechanism through which engagement and progress are achieved.

Staff frequently capacity issues to support housing issues, mental health crises, and social care gaps. While this approach enables engagement and prevents immediate harm, it also creates risks of workforce burnout, service user dependency, and long-term sustainability challenges.

As one respondent noted:

"The service is punching above its weight, but it's not sustainable."

This theme highlights a critical tension: the very qualities that make CGL effective also place it under increasing strain in the absence of wider system support.

Theme 5: Partnership working is inconsistent and person dependent.

Partnership working across Havering was described as variable and uneven. While some respondents reported strong collaboration with housing services, probation, youth justice, and rough sleeping teams, others described partnership working as inconsistent and heavily dependent on individual relationships rather than embedded systems.

Mental health and adult social care were most frequently identified as areas where collaboration is weakest, particularly in relation to people with ongoing substance use. Several respondents described an imbalance in which CGL provides extensive support to other services but receives limited reciprocal input.

This inconsistency leads to unequal experiences for service users and reinforces reliance on the drug and alcohol service as a default point of support. The findings suggest a need for more formalised, accountable partnership arrangements that do not depend on individual goodwill.

Theme 6: Treatment capacity and pathways do not match current levels of need.

Staff identified multiple areas where treatment capacity and pathway design are misaligned with presenting need. Delays between referral, assessment, and intervention were described as undermining motivation, particularly when individuals are ready to engage. Lengthy and duplicative assessments were also cited as barriers.

There was strong support for expanded access to clinical interventions, particularly long-acting injectable treatments such as Buvidal, which staff described as effective in reducing risk and improving adherence. In contrast, respondents consistently highlighted insufficient detoxification and inpatient capacity, especially for individuals presenting with ketamine and benzodiazepine use who meet clinical thresholds but cannot access funded placements.

Geographic barriers, travel costs, and limited evening or weekend provision were also identified as limiting accessibility, particularly for people in unstable circumstances or employment.

Theme 7: Sustainable recovery requires long-term, integrated, whole system support.

Finally, staff were clear that recovery cannot be sustained through treatment alone. Long-term recovery was associated with consistent relationships, aftercare, housing stability, mental health support, employment opportunities, and community connection. Mutual aid, peer support, and community-based resources were seen as essential components of recovery, rather than optional additions.

Short-term, siloed interventions were widely viewed as insufficient for people with complex needs. Instead, respondents emphasised the importance of integrated, whole-system approaches that continue beyond formal treatment episodes.

Thematic analysis of service user and family perspectives on drug and alcohol support in Havering

Approximately 15 focus group participants consisting of adult service users and family group attendees conducted on 4th December 2025.

CGL Aspire Focus Group

Introduction

This section presents findings from a focus group conducted with eight service users and family members engaged with CGL Aspire in Havering. The focus group forms part of the wider Drugs and Alcohol Needs Assessment refresh and contributes qualitative insight into lived experience of treatment, recovery, and the wider system of support.

The focus group included a mix of service users and family members with experience of alcohol, crack cocaine, and ketamine use. Participants reflected on their journeys into treatment, their experiences of support, and perceived gaps both within services and across the wider system.

Methodology and use of Artificial Intelligence (AI)

Qualitative data from the CGL staff survey, and a service user and family focus group were analysed using a structured, multi-stage thematic analysis approach. Focus group data were captured through detailed contemporaneous notes, which were treated as qualitative data and analysed alongside survey responses. All data was first reviewed and coded inductively using line-by-line open coding to capture issues raised by participants in their own terms, which produced a comprehensive set of initial codes.

Codes were then organised into descriptive topical groups (Stage 2 coding) to map the breadth of issues identified across data sources. An axial coding stage was subsequently undertaken to explore relationships between code groups and to link individual experiences with wider service and system contexts. Finally, axial categories were synthesised into a small number of core themes describing key patterns of need and provision in Havering.

A large language model (LLM) was used as an analytical support tool to assist with systematic coding, organisation, and synthesis under close human direction. The LLM did not generate data or make independent analytical judgments; all interpretations and decisions were reviewed and shaped by the analyst to ensure relevance, rigour, and alignment with public health objectives.

Limitations:

The main limitation of this data is that the number of participants in the focus group were small and self-selected. It therefore cannot be assumed that the views expressed by this select group are representative of all service users or people who live in Havering who are using drugs and/or alcohol.

Findings:

Theme 1: Access, Engagement and Pathways into Support

Participants described access to support as often crisis-driven, with many entering treatments following hospitalisation or acute deterioration in mental or physical health. Contact with CGL in hospital settings was consistently described as reducing fear and lowering barriers to engagement, highlighting the importance of assertive outreach and presence at points of crisis.

Several participants reported finding CGL through self-directed routes such as online searches or third-sector directories, rather than through planned referral pathways. This contributed to a sense that awareness of local services is limited, particularly among families, and that opportunities for earlier intervention are being missed. Participants reflected that earlier access to support may have prevented escalation to crisis in some cases.

Despite this, CGL was widely viewed as accessible once known about. The ability to return to the service after previous disengagement, to walk in without an appointment, and to re-engage at different stages of readiness was seen as a significant strength. Recovery was described as non-linear, and the service's openness to repeat engagement was valued.

Overall, this theme highlights a contrast between late entry into services and strong accessibility once engaged, suggesting that earlier visibility and intervention remain key challenges across the system.

Theme 2: The Central Role of Mental Health in Recovery

Mental health was consistently described as fundamental to substance use and recovery. Participants strongly identified substance use as a response to poor mental health, trauma, or distress, often described in terms of self-medication. Recovery was therefore seen as inseparable from addressing underlying mental health needs.

The integration of mental health support within CGL, particularly through IAPT provision, was repeatedly highlighted as a positive development. Participants reported gaining awareness of therapeutic approaches such as Cognitive Behavioural Therapy only after

entering CGL, suggesting prior gaps in access to or understanding of mental health support.

However, participants also identified significant gaps in wider mental health provision. Long waiting lists, limited specialist support, and reliance on primary care were described as barriers. GPs were often perceived as lacking the expertise or capacity to respond to complex mental health and substance use needs beyond medication or signposting.

Mental health support was frequently described as the 'first priority' at initial contact with CGL, reinforcing the importance of integrated, specialist provision within substance use service's and across the wider system.

Theme 3: Quality of Relationships, Continuity and Trust

Relationships were central to participants' experiences of support. CGL staff were frequently described as approachable, understanding, and non-judgemental, contributing to a sense of psychological safety and trust. The service was characterised as a "safe place" and a community rather than a purely clinical setting.

However, continuity of care emerged as a significant concern. Staff turnover and changes in keyworkers were described as disruptive, particularly where individuals had to repeatedly retell their story. Participants emphasised the importance of routine, consistency, and strong therapeutic relationships in sustaining recovery, especially during preliminary stages of engagement.

Some participants were unaware that they could request a change of keyworker if the relationship were not effective, suggesting gaps in communication and empowerment. More frequent contact at the start of treatment was also identified as potentially beneficial for building trust and engagement.

This theme highlights the tension between high-quality relational practice and system-level workforce instability, with implications for both service experience and recovery outcomes.

Theme 4: Recovery Capital – Groups, Purpose, and Practical Support

Participants consistently emphasised the importance of recovery capital beyond clinical treatment. Peer groups were described as reducing isolation, fostering belonging, and supporting accountability. Substance use was frequently characterised as deeply isolating, with group-based support offering a crucial counterbalance.

A wide range of groups, including aftercare, family support and themed groups, were viewed positively. Participants also valued learning opportunities and structured activities, such as external sessions, which contributed to personal growth and motivation. Recovery was described as involving a shift in identity, with peer mentoring and "giving back" seen as important markers of progress.

Practical support, including employment assistance through the IPS scheme, was highlighted as particularly impactful. Employment and routine were seen as stabilising factors that supported longer-term recovery. However, physical space constraints and limited resources were noted as barriers to expanding activities and group provision.

Family members were recognised as playing a critical role in recovery, often acting as first responders in crises, yet lacking sufficient knowledge or training. Participants expressed a desire for greater support and information for families to strengthen recovery networks.

Theme 5: System Pressures, Gaps and Sustainability

Participants identified a range of pressures affecting both CGL and the wider system. Delays in accessing mental health services, limited counselling capacity, and reliance on trainee staff were all described as challenges. These pressures were seen as contributing to risk, with CGL often retaining clients longer than intended due to concerns about safe discharge.

Emerging drug trends, particularly ketamine use, were highlighted as an area where both service users and practitioners felt there was limited understanding and support. This points to a need for ongoing workforce development and system responsiveness to changing patterns of substance use.

While abstinence-based mutual aid groups such as AA and NA were acknowledged, participants noted that these models do not suit everyone and may not align with all stages of recovery. Choice and flexibility were therefore seen as important principles.

Despite these challenges, participants expressed strong appreciation for CGL's role in Havering and a clear sense of hope. The service was widely viewed as doing the best it could within constrained resources, reinforcing the importance of sustainability and system-wide alignment.

Summary of findings

Overall, the focus group findings present a largely positive picture of CGL Aspire's role in supporting recovery in Havering, particularly in relation to accessibility, relational practice, and holistic support. However, they also highlight persistent challenges around early intervention, mental health provision, workforce stability, and system capacity.

These findings will be considered alongside other qualitative and quantitative evidence to inform the final Needs Assessment conclusions and recommendations.

Thematic analysis of stakeholder survey

14 respondents from CDP membership, survey conducted between 25/11/2025 – 09/01/2026.

Introduction

As part of the Havering Drugs and Alcohol Needs Assessment refresh, a stakeholder survey was undertaken to gather insight from organisations involved in the local response to substance misuse. The aim was to understand how partners perceive the current challenges relating to drugs and alcohol in the borough, whether the existing system is effectively addressing these issues, and where improvements could strengthen the overall response.

Fourteen responses were received from a range of stakeholders including NHS organisations, local authority teams, policing, probation, hospital services, housing and supported accommodation providers, community safety teams, licensing services, and Healthwatch. These perspectives provide valuable insight into how drug and alcohol issues are experienced across distinct parts of the local system and help to highlight both strengths and areas for development in Havering's partnership response.

While many stakeholders recognised positive examples of partnership working and coordinated initiatives already in place, responses also highlighted emerging pressures linked to changing drug markets, increasing complexity of need, and the importance of improving communication and coordination across services.

Key Drug and Alcohol Challenges Affecting Havering

Stakeholders were asked what they believed to be the most pressing drug and alcohol-related challenges currently affecting the borough. Responses reflected a combination of substance trends, system pressures, and wider social issues.

Several respondents highlighted criminal exploitation linked to the drug market, including county lines activity and cuckooing. These were seen as ongoing threats affecting vulnerable residents and communities.

Substance trends were also identified, including:

- alcohol misuse

- cocaine use
- cannabis use
- ketamine use among young people.
- vaping and nitrous oxide among children and teenagers
- emerging concerns around synthetic opioids and contaminated drug supply

Some respondents highlighted that drugs and alcohol are often linked to antisocial behaviour, crime, and mental health challenges, suggesting that substance misuse should not be viewed in isolation from these wider issues.

Stakeholders working in health services emphasised the impact of substance misuse on the healthcare system, including longer hospital stays, missed appointments, and complications in managing other long-term conditions.

Housing-related issues were also mentioned, particularly the relationship between substance misuse and homelessness or rough sleeping, which creates additional pressures for housing and support services.

Overall, stakeholders described substance misuse in Havering as a multi-faceted issue involving health, crime, and social vulnerability, requiring coordinated responses across services.

Perceptions of the Effectiveness of the Current System

Stakeholders were asked whether the current drug and alcohol support system is effectively addressing these challenges.

Of the 14 respondents:

- 5 respondents felt the system is effective.
- 8 respondents felt it is only partially effective.
- 1 respondent felt it is not effective.

This indicates that while many stakeholders recognise positive aspects of the current system, most believe there is scope for improvement.

Respondents who felt the system was working well pointed to:

- strong partnership working in certain areas.
- coordinated initiatives such as Project ADDER
- collaboration between CGL and health services
- operational responses to exploitation and crime

However, those who reported the system as only partially effective identified a number of limitations.

These included:

insufficient treatment capacity

- pressures within the mental health system
- unclear referral pathways
- delays in accessing support.
- limited coordination between services
- the increasing complexity of substance misuse issues

One respondent noted that drug and alcohol issues are often addressed separately from mental health and behavioural problems, despite their close connection.

Meeting the Needs of Children, Young People and Adults

Stakeholders were also asked whether the current system meets the needs of different population groups.

Responses were mixed:

- 7 respondents believed the system meets current needs.
- 6 respondents felt it only partially meets needs.
- 1 respondent felt it does not meet needs.

A number of respondents highlighted gaps in services for children and young people, particularly in relation to prevention and early intervention.

Concerns raised included:

- increasing vaping and substance use among young people.
- limited intelligence about drug use within schools and colleges
- the need for stronger education and prevention programmes
- the importance of smoother transitions between youth and adult services

Some respondents suggested that prevention efforts should focus on building resilience and supporting young people before problems escalate, rather than relying primarily on treatment services.

Stakeholders also emphasised the importance of supporting vulnerable young people, particularly those leaving education without clear pathways into employment or training, as this can increase the risk of exploitation.

Improvements Suggested by Stakeholders

Where respondents felt the system was only partially effective, they were asked to suggest improvements.

The most frequently mentioned areas for improvement included:

Better integration between mental health and substance misuse services

- Several stakeholders highlighted challenges for individuals with dual diagnosis who struggle to access appropriate mental health support.

Clearer referral pathways

- Respondents suggested the need for clearer processes, defined points of contact, and improved guidance for professionals making referrals.

Improved communication between services

- Stakeholders emphasised the importance of regular information sharing between partners to improve coordination and avoid duplication.

Greater focus on prevention

- A number of respondents highlighted the importance of early intervention, particularly in schools and youth settings.

Expanded harm reduction measures

- Suggestions included wider naloxone distribution, outreach to high-risk groups, and improved responses to emerging drug threats such as synthetic opioids.

Partnership Working

Stakeholders were asked to share examples of effective partnership working in Havering.

Several existing collaborative initiatives were highlighted, including:

- the Havering Combatting Drugs Partnership
- Project ADDER
- joint working between CGL and NELFT
- safeguarding partnerships
- criminal behaviour panels
- rough sleeping outreach work
- hospital discharge coordination
- complex needs referral panels

These examples demonstrate that multi-agency collaboration is already a significant strength within Havering's system.

Co-location and joint case discussions were also mentioned as effective ways of improving coordination between services.

Areas Where Partnership Working Could Improve

Despite these positive examples, stakeholders identified areas where partnership working could be strengthened.

The most commonly mentioned issues included:

- limited communication between some services
- inconsistent engagement between partners
- lack of clarity around responsibilities
- insufficient feedback between agencies

Some respondents also suggested that the system currently involves a large number of meetings without clear actions or accountability, which can limit the effectiveness of partnership structures.

Improving communication between substance misuse services and mental health services was highlighted as a particular priority.

Improving Communication and Multi-Disciplinary Working

When asked how communication could be improved across Havering, stakeholders emphasised the importance of:

- clearer referral pathways
- defined points of contact
- improved information sharing between agencies.
- better dissemination of intelligence and data
- clearer operational guidance for partners

Some respondents suggested practical measures such as regular updates or newsletters sharing changes in legislation, novel approaches, and examples of good practice.

Others emphasised the need for stronger coordination between services supporting young people, particularly during transitions into adulthood.

Role of the Combatting Drugs Partnership

Stakeholders broadly recognised the value of the Combatting Drugs Partnership in bringing agencies together to address substance misuse.

Respondents suggested that the CDP could further support the system by:

- coordinating partners across sectors
- providing oversight of emerging drug trends
- improving information sharing
- identifying gaps in service provision
- aligning strategic priorities across organisations

Some stakeholders suggested that the partnership could benefit from stronger operational oversight, ensuring that strategic discussions translate into practical actions.

Summary

The stakeholder survey highlights both strengths and opportunities within Havering's response to drug and alcohol harm.

Stakeholders recognised a number of positive developments, particularly the presence of active partnership structures and collaborative initiatives across the borough.

However, the survey also identified several areas where the system could be strengthened, including:

- improving integration between mental health and substance misuse services
- strengthening prevention and early intervention for young people
- improving communication and referral pathways between agencies
- addressing emerging drug market risks
- ensuring partnership structures translate into coordinated action.

These findings provide valuable insight into how partners across Havering perceive the current system and will inform the development of recommendations for the Combatting Drugs Partnership.