Devon Drug and Alcohol Strategic Partnership Communications Strategy, 2025-28

V1.0

Contents

Executive Summary

The Devon Drug and Alcohol Strategic Partnership (DDASP) brings together local authority, health, social care, criminal justice, voluntary sector, and community organisations to reduce the harms caused by drugs and alcohol across Devon. This Communications Strategy outlines how DDASP will use communications and engagement to support this goal between 2025 and 2028.

Purpose of the Strategy

This strategy sets out shared principles, priorities, and practical actions to guide how DDASP and its partners communicate about drug and alcohol-related issues. It aims to:

- Promote consistent, stigma-free messaging across the system.
- Raise awareness of risks, services, and support.
- Embed two-way communication with people with lived experience.
- Prepare partners for effective communication during incidents.

Guiding Principles

All communications will be shaped by five core principles:

1. **Two-way communication and coproduction**: involving people with lived experience in shaping messages and priorities.
2. **Clarity and accessibility**: using plain English and inclusive formats.
3. **Anti-stigma and trauma-informed**: avoiding blame and promoting empathy.
4. **Evidence-based**: drawing on research, data, and lived experience.
5. **Partnership-led**: aligning messaging across organisations for greater impact.

Framework for Communications

Based on the evidence-based Building Blocks of Health approach, the following framing of communications is recommended:

1. Show why it matters: lives are being cut short
2. Harness the power of explanation
3. Show change is possible
4. Use financial arguments with caution
5. Use data to strengthen your story, not to tell it

Strategic Priorities

DDASP communications will focus on seven key areas:

1. Raising awareness of risks, including novel substances, adulteration, poly-substance use, and harm reduction strategies.
2. Embedding lived experience into the DDASP including communications planning and delivery.
3. Promoting an "everyone's business" approach to intervention across the system.
4. Increasing awareness of treatment services and support options.
5. Tackling stigma and promoting respectful, person-first language.
6. Ensuring a strong communications response during incidents.
7. Building public understanding of DDASP and its work.

Actions and Implementation

The strategy includes a detailed action plan covering:

- Internal coordination and intelligence sharing.
- Public-facing campaigns and harm reduction messaging.
- Training and engagement with health professionals and wider services.
- Media guidance and proactive storytelling.
- Development of a lived experience engagement structure.

This strategy is a living document, designed to evolve with emerging risks, community needs, and feedback from partners and people with lived experience.

1. Scope and function of this document

This document lays out the aims, principles and practicalities of communications for the Devon Drug and Alcohol Strategic Partnership (DDASP).

This strategy applies to:

- Outward facing comms from DDASP partners to stakeholder organisations and the public on the topic of drugs and alcohol
- Communication from partners, the public and those with lived experience into the DDASP
- Non-emergency, regular communications processes
- Preparation for emergency/incident-related communications

This strategy does not cover:

- The process of gathering local intelligence on incidents or disseminating emergency alerts, which is covered by the local drug information system (LDIS) SOP
- Internal communications policies of individual organisations making up the DDASP as these will be covered by internal processes
- Clinical communications with drug and alcohol service users regarding their care as this is dictated by clinical processes

The function of this document is to:

- Identify shared communication priorities and principles for the DDASP
- Coordinate how the system communicates, avoiding duplication and contradiction
- Set out a process for recording comms outputs and plans
- Ensure the quality of DDASP partner communications
- Embed a two-way communication structure between the DDASP and those with lived experience
- Prepare system partners for communications during an incident

2. Principles of DDASP communications

All DDASP partners are encouraged to align their communications with the following five principles, with the understanding that each partner organisation maintains its own autonomy and ways of working.

Principle 1: Two-way communication and coproduction

"Nothing about us without us."

Involving people with lived experience in all we do is a stated deliverable of the DDASP delivery plan. Two-way communication which actively listens to the needs of those with lived experience and uses this knowledge to feed into work prioritisation and practice should be at the heart of DDASP activities. Practical steps to embed this are described in section 4.7.

Where feasible, coproduction of comms outputs from DDASP partners with relevant parties should be the default. DDASP activities should be planned in partnership with people with lived (and, where appropriate, living) experience, frontline workers, those of different ages, and communities for relevance and effectiveness and to prevent unintended harms.

Principle 2: Clarity and accessibility

Use plain English, inclusive language, and age-appropriate formats. Ensure content is accessible for people with learning difficulties, neurodivergence, or low literacy. Ensure key information is available for those without reliable access to digital technology. Adapt information for the specific contexts that will need to use it.

Consider when it is necessary to translate into key community languages. The most commonly spoken non-English languages in Devon are Polish and Romanian, spoken by 3,900 and 2,100 people respectively, but there may be circumstances where specific communities have particular needs for translated materials due to risks impacting their community, or low rates of English language comprehension.

Principle 3: Anti-stigma and trauma-informed

All DDASP communications will avoid language that reinforces stigma, shame, or blame, and will use comms to actively destigmatise. We will use a trauma-informed lens that respects individual journeys.

Principle 4: Evidence-based

Base messaging on the best available research and local and national intelligence. This may include evidence from LDIS, treatment data, service feedback, qualitative studies of communications impact, published trends in substance usage or research on the effects of harm minimisation approaches and communication styles.

Principle 5: Working in partnership where possible

As a partnership, DDASP aims to communicate with consistency and shared purpose. Wherever possible, we will align messaging across organisations to reinforce key priorities, avoid duplication, and extend our collective reach.

Partners will share DDASP messages through their respective channels, adapting them where needed for different audiences, and amplify partner-led communications that align with our shared aims.

Effective partnership communication depends on trust, clarity, and transparency. This may include the sharing of data, information and intelligence where appropriate in order to build an informed picture of local trends and risks. Drug and alcohol-related intelligence should be shared between partners as standard, in order to prevent duplication of work and enable all parties to work using the most accurate and up to date information.

3. Framing of communications: The Building Blocks of Health

Based on the FrameWorks Building Blocks of Health research, we will consciously frame communications to make them most effective and minimise unintended harms. This means being deliberate in how we explain issues and avoiding frames that reinforce stigma and individualism.

This framing uses the idea of the "Building Blocks of Health" as a metaphor for the positive things that everyone needs to live a healthy life. We can use this metaphor to explain drug and alcohol harms and dependence in a way that emphasises systemic reasons and minimises unhelpful personal blame. If possible, always frame communications of risk or "bad news" with a solution to avoid encouraging fatalism.

e.g. "In Devon today, lives are being cut short by drugs and alcohol. We all need the fundamental building blocks of safe housing, secure jobs and strong communities to live a healthy life. Living in poverty can wear away at all of these blocks. Without enough money to live, people in our communities experience the constant stress of not being able to afford to heat their home or buy enough food. Drugs and alcohol can temporarily relieve this chronic stress, but over time people can become dependent and suffer further harms. But if we work together across Devon to rebuild these building blocks of health, fewer people will turn to drugs and alcohol, and lives will be saved."

The five Building Blocks of Health principles, as applied to drug and alcohol communications, are:

1. Show why it matters: lives are being cut short

Drug and alcohol harms are not abstract issues: they shorten lives.

Framing communications around preventable deaths creates urgency, encourages empathy and underlines why action is needed.

- Instead of *"Drug-related deaths have increased in Devon,"* say *"Too many people in Devon are dying younger than they should because of preventable harms from drugs and alcohol."*

2. Harness the power of explanation

Many people don't understand how trauma, poverty, housing, or mental health connect with drug and alcohol use. Without explanation, audiences tend to fill the gaps with stereotypes and individualised blame.

We should explain why people use substances, how risks like adulteration or synthetic opioids cause harm, and how our proposed solutions will work.

- Instead of *"People with trauma are more likely to use drugs."*, we could say *"Experiencing trauma changes how the brain processes stress. Drugs and alcohol can temporarily relieve this stress, which makes people more likely to use them. Over time, this relief becomes harder to achieve without substances, which can lead to dependency."*
- Instead of just *"Recovery is possible.",* we could say *"With the right treatment, people's brains and bodies begin to heal. Medication can reduce cravings, therapy helps people cope with stress in healthier ways, and community support builds motivation. This combination is why thousands of people in England leave treatment each year and stay in recovery."*

3. Show change is possible

Drug and alcohol harms can feel overwhelming, and people often default to fatalistic ideas about people and systems. To counter this, we need to show clearly but also realistically that change happens for individuals, for systems, and across populations. Recovery is best framed as a continuum of improvement rather than a simple "success/failure" state. Communications should avoid implying that people are either "recovered" or "not recovered," and instead highlight progress over time, such as improved health, stronger relationships, or reduced substance use. This framing respects individual journeys and reduces stigma.

- Instead of*: "Only half of people complete treatment successfully."* We could say*: "Many people need more than one attempt at treatment, just like with other long-term conditions. What matters is that people can return to support when they need it."*
- Instead of just *"Opioid overdoses are fatal if untreated",* we could add *"Over X people in Devon now carry naloxone: a medicine that can restart breathing during an overdose. That's potential lifesavers in our communities."*

- Instead of *"Communities suffer because of drug use"*, we could say: *"Where communities have invested in safe spaces, peer support, and recovery groups, fewer people relapse and more families stay together. Local action is changing lives."*

4. Use financial arguments with caution

Avoid leading with economic arguments (e.g. cost to the NHS), as these risk portraying people as burdens and put audiences into an individualistic frame of mind.

Instead, lead with health, dignity, safety, and community wellbeing. Economic arguments can be used when needed but only as a backup and never as the explanation of why something is important.

- Example: Instead of *"Substance misuse costs the economy £X million a year,"* say *"Supporting recovery keeps families together and communities safer."*

5. Use data to strengthen your story, not to tell it

Data should be paired with explanation and solutions, not presented in isolation. Numbers alone rarely change minds. They need context and meaning. A useful framing here is: Data → Meaning → Solution (*"Here's the number → here's why it matters → here's what we can do about it"*).

- Example: Instead of *"Devon recorded X drug-related deaths last year,"* say *"Drug poisoning is now one of the leading causes of death among people under 50 in England. Last year, X people in Devon died- their lives cut short, and their families left grieving. These deaths are preventable with the right support."*

More detail on the principles of this approach can be found here: FrameWorks Building Blocks of Health.

An alcohol-specific approach is here: How to talk about alcohol - FrameWorks UK

4. Priorities of DDASP communications

4.1. Raise awareness of risks around use of drugs and alcohol, especially of novel substances, synthetic opioids, poly-substance use and adulteration, and harm reduction strategies to mitigate these risks.

Owner: DCC Public Health Team with support from all DDASP partners.

Sharing information on risks and planned communications

So that every partner organisation can act on the most up to date information and work is not duplicated, it would be beneficial if partners met on a regular basis to share intelligence around drugs and alcohol. This would include new intelligence as well as updates on regular data feeds. This meeting should also include discussion of any planned comms outputs from all partners, to ensure that the content matches the principles, framing and priorities of the DDASP. This will also give partners the opportunity to uplift partner communications via their own comms networks.

Actions:

- Develop regular 'drug and alcohol harm reduction information and comms' meetings for relevant partners to share intelligence, review recent drug alerts and discuss any planned or reactive comms outputs.

Developing harm reduction information:

The current situation regarding novel substances and adulteration is changing rapidly, and this makes it difficult for both members of the public and professionals to stay up to date on the risks. As risks and contexts are continually changing, development of harm reduction information should be an ongoing activity. Harm reduction messaging should be checked with people with lived experience of using such messaging to check it is effective, appropriate and doesn't have harmful unintended consequences. This should ideally include those living in Exeter and also in more rural areas as the context for using this information is likely to be different. Harm reduction messages can also be informed by national partners - such as advice from OHID, UKHSA, or examples of harm reduction messages used in other local authorities.

Development of harm reduction information could include the following approaches:

- Direct discussion with people with lived experience of using drugs or alcohol
- Paper feedback opportunities in the waiting areas of CoLab, treatment services or similar organisations. CoLab have offered their waiting area for this purpose.
- Digital feedback opportunities using touch screens in CoLab waiting area.
- Dissemination of paper feedback sheets to key contacts within communities for them to gather thoughts from peers and return papers to a central point. These key contacts could be identified through recovery or advocacy groups such as Common Ground.
- Run any potential communications through NHS Document Readability Tool.

A description of an example focus group process and results that was used to develop the messaging in this strategy which could be followed again in future is included as appendix 4.

Fundamental harm reduction messages

The core messages underlying all our more nuanced communications are:

- Don't use alone
- Don't mix drugs
- Start by taking low amounts and space the doses out (start low go slow)
- Seek support
- Don't share equipment
- Carry and use naloxone
- You can't always know what you're taking

However, these messages will need to be altered dependent on the needs of the audience, context and specific risk in question, or could be expanded upon when there's time/space. Sometimes core pieces of advice might be impossible or unrealistic given the audience or context, and an appropriate secondary message or messages might need to be included too. Essentially, these messages are to empower people to be able to carry out good decision-making and risk assessment, so they must be pragmatic to the circumstances of an individual, while also emphasising that following the advice fully is always safer.

Examples of harm minimisation advice on specific risks is included as appendix 1.

Examples of nuanced harm reduction messages

Don't use alone

The advice to not use alone is a core message, as most overdoses happen when someone is alone. However, if this is unfeasible, we would advise to tell a trusted person who can check up on you. Testing of this message revealed a reluctance to tell others due to a perceived risk of being robbed while unconscious, and a dislike of the phrase "tell a friend" where individuals may feel they have no friends. Having a trusted person with you who is capable of getting help if its needed is the fundamental message.

Carry and use naloxone

In testing of this message, some focus group attendees stated they would not tell others they had naloxone because they wanted it to only be used on themselves. Naloxone training and information should be very clear that you must tell others that you have it and teach them how to use it, as you will not be able to use it on yourself.

Start by taking low amounts and space the doses out (start low go slow)

The phrase “start low go slow” or alternatively “stay low go slow” is well known in people who access drug services, but is completely unfamiliar in other parts of society. If speaking to younger people or those not usually in contact with drug services, the phrase will need to be explained. A related piece of advice is that if everyone present is taking the same substance, to space out doses between you so there is less chance of the whole group being incapacitated at the same time.

Know what you’re taking

Knowledge of the content and concentration of substances gives people more agency to make more informed personal risk assessments and apply appropriate harm reduction strategies. However, this can be practically difficult. For street drugs, the only way to be certain is to send a portion of the substance to a lab, for example Wedinos, for testing. There are often long wait times for results, which makes this unfeasible in the context of addiction. For medications bought online, the only way to be sure is to buy from a reputable website with the correct registrations (described below). Testing strips for specific adulterants (e.g. Nitazenes, Fentanyl and Xylazines) exist but these will only test for that one particular adulterant, and carry risks of both false positives and false negatives. While they may be potentially useful if local intelligence suggests a specific adulterant to be both detectable and a risk, under usual circumstances they may provide false reassurance. Therefore the recommendation would be to use lab testing where this is available and feasible, and where it isn’t proceed on the assumption that the substance could contain anything at all. This links to the above advice of “start low, go slow”.

Harm reduction messages for specific risks are listed in appendix 1.

Actions:

- Use opportunities to promote key harm reduction messages in appendix 1 when talking to partners or the media.
- Engage with GPs via their regular local CPD sessions to continue to raise awareness of risks of counterfeit medications.
- Develop visual messaging communicating the key harm reduction messages to be used in posters and social media
- Distribute posters to GP surgeries, ED waiting rooms and community services such a libraries, community centres, food banks and community cafes.
- If resource allows, develop a series of simple, visually engaging graphics highlighting each key message for use on social media and posters, and run targeted online advertising aimed at demographics more likely to be at risk.
- Integrate adulteration awareness into all harm reduction communications and training, especially naloxone distribution.
- Coordinate with needle and syringe programmes (NSPs) to include messaging and naloxone information in their packs.
- Coordinate with Exeter University and with key local DDASP partners to see what messaging if any they are currently using on this subject
- Work with nightlife safety initiatives (e.g. community safety partnerships, community alcohol partnerships) to incorporate messaging into their communications.

Harm reduction communication with professionals

Health professionals (as well as any other professionals in regular contact with vulnerable groups) need to be aware of harm reduction approaches in order to pass those messages to those who need it. They also need to be aware of how to work with people vulnerable to alcohol and drug harm in a way that reduces that harm. In order to target this information well, any training material should be developed alongside or tested with GPs, mental health professionals or other targeted health professionals before general dissemination.

Useful healthcare worker CPD on harm reduction would include:

- General awareness of present day drug and alcohol risks and harm
- General awareness of key harm reduction advice
- The importance of understanding the whole person and their context including housing situation, general mental and physical health, and community support

- Brief interventions that can be made for drugs and alcohol
- Health inequalities experienced by people who use drug and alcohol
- How GPs might risk profile patient lists to proactively contact people likely to be vulnerable to harm (especially after a non-fatal overdose or other hospital admission relating to drug or alcohol use)
- Drug and alcohol dependency in the context of adult safeguarding, and powers available to protect people lacking capacity to control their drug or alcohol use[1]
- Risks associated with prescribing and de-prescribing opioids , benzodiazepines and pain medication relating to online pharmaceuticals

Other organisations may also find updated risk and harm reduction information adapted to their audience useful, including:

- Sexual Health services
- Social Care
- Domestic Abuse services
- Blue light services
- Schools
- Exeter University
- Housing
- Night time economy businesses
- Libraries
- Organisations working with vulnerable adults

Actions:

- Develop CPD materials for GPs and for pharmacy staff including the above key points
- Engage with GPs via Safeguarding leads GP network, the Primary Care Bulletin, the LMC and/or Kerry Ross ICB comms lead to present/disseminate these materials
- Engage with pharmacists via Leah Wolf from Community Pharmacy Devon to present/disseminate these materials
- Develop broad risk and harm reduction education materials for dissemination through all above networks
- Integrate adulteration awareness into all harm reduction communications and training, especially naloxone distribution.

[1] How to use legal powers to safeguard highly vulnerable dependent drinkers | Alcohol Change UK

4.2. Embed two-way communication between those with lived experience and the DDASP

Owner: DCC Public Health team with support from all DDASP partners

Involving people with lived experience in all we do is a stated deliverable of the DDASP strategic plan for 2025-28. Many partner organisations within the DDASP have pre-existing lived experience structures, or plans to develop them. For example, Devon County Council has produced a document describing the need for involvement of people with lived experience throughout the commissioning cycle: Embedding Lived Experience in Commissioning Final Version 0.01 RT May 25.docx

The DDASP plan to develop a structure by which the learning from these pre-existing lived experience structures and the direct voices of those with lived experience are fed into the DDASP.

This will:

- Enable people with lived experience to directly influence the agenda of DDASP meetings to ensure the things they experience as most important are discussed
- Enable partners within the DDASP to learn from those with lived experience sharing information with DDASP partners other than themselves
- Provide a structure for future co-production efforts to be coordinated e.g. if DDASP partners have material they want to produce with people with lived experience they can attend this meeting.

Developing a two-way engagement and co-production structure

In order to co-produce this structure, a task and finish group will be set up within the DDASP including some representatives from lived experience organisations (for example, Common Ground) to decide on the best way for this to be organised.

Initial discussions with DDASP partners and drug and alcohol advocacy organisations indicate that the best solution may be to create a lived experience engagement subgroup under the DDASP. This would meet on the same schedule as the DDASP, but some time before the DDASP so attendees would have the opportunity to feed into development of the DDASP agenda.

Specifics that will need to be decided by the lived experience engagement task and finish group include:

- Practicalities of meeting, including:
    - Whether to meet in person or online (considering both digital exclusion and the wide geographic context)

    - The time of day to meet to maximise participation
- Whether to renumerate participants and how to do this without influencing eligibility for benefits
- Whether to invite professional representatives from partners' lived experience organisations or solely those with lived experience themselves
- How to engage a wide variety of people with lived experience including women and those with other protected characteristics
- How the group will practically feedback to and from the main DDASP meetings

Learning from the Adult Social Care Joint Engagement Forum (JEF)

Adult Social Care already has a forum which fulfils this need from a social care perspective. The JEF has professional and lived experience representatives from organisations relating to social care (including learning disability, dementia, older age groups, autism, physical disability, sensory disabilities and carers organisations) and those representing protected characteristics (including race/ethnicity and LGBTQ+). They meet quarterly online. They found that with their group attendance is much better online than in-person and that most attendees have capacity to join online or can be facilitated to do so by others. It is a space for people to share their experiences and be asked specific questions by professionals who attend the meeting to ask their advice.

It may be that for some questions, particularly where we need to get the perspective of people with protected characteristics or where issues relate to general adult social care, members of the DDASP can attend the JEF meetings to gain their perspective. However, the JEF does not generally cover the topics of drugs and alcohol, and the range of individuals and organisations who would need to be involved to have these discussions will be different to those commonly participating in the JEF. Therefore it would be beneficial for the DDASP to have their own lived experience structure. However, we should learn from the experience of the JEF in setting this up.

Actions:

- Set up a task and finish group of the DDASP to develop the specifics of the engagement structure based on the list of issues to decide above
- Ensure working group includes representation from people with lived experience of drug and/or alcohol use, ideally from Exeter and elsewhere
- Attend JEF to learn more from how it operates.
- Work together to coproduce the structure using a test and learn model, and then embed this in the DDASP system
- Work alongside the new group to coproduce future messaging and comms outputs

4.3. Raise awareness of need for assistance and intervention in all areas of the system: an everyone's business approach

Owner: DCC Public Health team with support from all DDASP partners

This approach recognises that opportunities to prevent and address harmful drug and alcohol use exist in every part of the health, care, and community system, not only in specialist drug and alcohol services. All partners have a role to play in spotting risk, offering early advice, and supporting access to appropriate help.

This work intersects with DCC work around developing an alcohol strategy, following on from the 2024/5 Annual Public Health Report on alcohol. This strategy will include plans to increase alcohol identification and brief advice (IBA), and develop improved cross-service tertiary care.

This means:

- Ensuring staff across frontline settings (e.g., primary care, emergency departments, mental health, housing, social care, criminal justice, community organisations) are confident in using simple screening tools, raising the topic sensitively, and providing brief interventions, harm minimisation and referral for specialist treatment.
- Increasing professional awareness that GPs can prescribe anti-relapse medication and support community-based detoxification alongside specialist services, and encouraging appropriate referrals to primary care for these interventions.
- Encouraging non-specialist services to view drug and alcohol-related harm prevention as part of their core business, and equipping them with the knowledge and resources to act.
- Normalising conversations about drugs and alcohol, by creating a culture across the system where it is routine and acceptable to talk about drug and alcohol use in a non-judgemental, supportive way.

In addition to the specific ways healthcare professionals can engage more in reducing drug and alcohol-related harm, material targeted at wider organisations should emphasise the importance of normalising non-judgemental conversations about drug and alcohol use, signposting to (and, ideally, assisting into) support, sharing harm reduction information and distribution and training in take home Naloxone. These organisations include:

- Sexual Health services
- Social Care
- Domestic Abuse services

- Blue light services
- Schools
- Exeter University
- Housing
- Libraries
- Night time economy staff
- Community organisations supporting vulnerable people
- General population

Actions:

- Develop simple, shareable briefing materials for staff in health, care, and community services on how to identify risk and provide brief advice, working with DCC colleagues developing the IBA training offer in Devon.
- Promote local training opportunities in alcohol screening and intervention.
- Use partner newsletters, intranets, and social media to reinforce the "everyone's business" message and signpost to resources.
- Use naloxone distribution and training as an opportunity to talk raise awareness of an everyone's business approach.

4.4. Raise awareness of treatment services and other support available

Owner: Waythrough and Y-SMART with support from all DDASP partners.

Many people who use drugs or alcohol are unaware of the treatment and support options available to them, or may hold outdated, negative perceptions about what treatment involves. Stigma, fear of judgment, and misinformation can act as barriers to seeking help.

Adult drug and alcohol treatment in Devon is provided by Together, who are run by Waythrough. There is also peer support available through SMART, AA and NA. Community organisations also provide informal support. Engagement in community organisations can increase recovery capital. Y-Smart is the substance misuse, advice and recovery service for young people aged up to 18yrs old (up to 25 yrs' old for care leavers and people with additional needs) living in the Devon County Council footprint.

Raising awareness of local services, peer support, harm reduction interventions, and confidential advice can help individuals to access the right help at the right time. It also ensures that professionals, families, and communities know how to signpost effectively.

Key messages:

- Support is available, and recovery is possible. Help is confidential, respectful, and non-judgmental.
- There are different options to suit individual needs, including harm reduction, community support, and abstinence-based treatment.
- You can talk to someone without pressure to stop completely
- You don't need to hit 'rock bottom' to get help - it's ok to reach out at any stage.
- Naloxone, needle exchange, and harm reduction advice are free and easy to access in your local area regardless of if you are in active treatment – include information on how to access.
- Anyone can refer to drug and alcohol treatment services, including self referral or via your GP. There is an online form: Together adult drug and alcohol referral form - Waythrough or you can call 0800 233 5444 (Mon – Fri 9am –5pm)
- Professionals including GPs can help individuals access support through referring (and not relying on self-referral)

Actions:

- Engage with GPs to raise awareness of how to refer, and find out barriers to referral to work towards overcoming these
- Waythrough to promote services and raise awareness of referral pathways
- Use any media opportunity to signpost to support and myth-bust about treatment
- Coordinate with the Naloxone strategy to produce information on how to access take-home Naloxone
- Carry out service mapping and maintain a list of formal and informal organisations supporting people through substance dependency and in recovery to aid in signposting
- Develop and disseminate continuously maintained information on how to refer for:
    - GPs
    - ED clinicians
    - Other secondary care clinicians
    - Mental health services
    - Sexual health
    - Social care
    - Domestic abuse services
    - Blue light services
    - Schools
    - Housing
    - Exeter University
    - Community organisations supporting vulnerable people
- Ensure all referral information on internal systems for the above services is up to date.
- Develop media assets which use people's personal stories of recovery, with a focus on reducing inequalities.

4.5. Raise awareness of the impact of stigma in people accessing the services they need and actively promote anti stigma approaches

Owner: All partners

Stigma surrounding drug and alcohol use is a powerful public health barrier. Stigma leads many people to delay or avoid help altogether. Using person-first language, explaining the reasons and context behind substance dependency, and promoting empathy and lived-experience narratives helps reduce stigma, improve engagement with care, and support long-term recovery and community reintegration.

Unkind or inefficient structures can also produce stigma. The experiences of those who have navigated these systems, gathered through two-way engagement, should be taken into account when designing systems to avoid this stigmatisation.

Key messages for the public:

- Dependence on alcohol or other drugs happens for a reason, and is usually linked to trauma or a challenging context
- Use person-first language, avoiding terms like 'addict', 'user' or 'alcoholic'
- Recovery is possible
- People in recovery from addiction play a vital role in our communities

Additional key messages for professionals:

- Stigma is a barrier to accessing help. When people feel stigmatised it makes them less likely to engage with services
- By reducing stigma we can improve outcomes and encourage earlier help-seeking

Actions:

- Produce a guide for media professionals reporting on drug and alcohol which will include:
  - Guidance on the impact of stigmatising language
  - Guidance on less harmful language and framing that can be used instead
  - Advice that can be used to accompany reports on drug and alcohol use such as how to self-refer to treatment services
- Ensure all incidental communications with the public, professionals or media reaffirms the above key messages
- Link across teams and community leaders to collaborate on anti-stigma work relevant to wider topics such as mental health, obesity and sexual health.
- Consider co-designing anti-stigma posters with those with lived experience for wider advertising on bus stops, Facebook and Instagram.

4.6. Ensure a strong system comms response during incidents

Owner: DCC Public Health team with support from all DDASP partners

The Local Drug Information System (LDIS), coordinated by Public Health Devon, is a process that assesses and responds to drug information provided by the public and partner organisations on new, potent, or contaminated drugs in Devon. It collates the reports which are then verified and a response follows i.e. Issuing drug alerts and harm reduction messages to partner organisations working with at risk groups. The purpose

of the LDIS is to prevent or reduce harm to people of all ages (including young people) who use, or are at risk of using, illicit or illegal drugs.

It is important that all relevant parties know how to complete an LDIS report and interpret (and if necessary, act on) an LDIS alert. This includes:

- GPs
- ED clinicians
- Other secondary care clinicians
- Mental health services
- Sexual health
- Social care
- Domestic abuse services
- Blue light services
- Schools
- Housing
- Exeter University
- Community organisations supporting vulnerable people

Partners have reported that in healthcare settings and schools understanding of the LDIS system is low, and therefore we are unlikely to receive reports from these settings.

We have also had reports from partners that the wording for alerts is not always readily accessible to their populations, and so they adapt it before dissemination. These adaptations take partners time and effort and could potentially change the meaning of the information.

LDIS alerts have also historically contained a lot of general harm reduction information in addition to the information specific to the alert. Sometimes it will be appropriate to use the alert as an opportunity to disseminate wider harm reduction or support information, but sometimes this will make alerts less effective. Individual assessments will need to be made based on risk and audience.

Actions:

- Create template print-ready alerts for different settings for use when disseminating alerts so recipients no longer need to adapt them themselves
- Promote the LDIS reporting system among relevant parties by creating:
    - LDIS cards for ambulance workers to carry with QR code linking to form
    - Posters for placement in ED explaining the threshold for reporting to LDIS with QR code linking to form
- Raise awareness of the meaning of LDIS alerts among relevant parties and how they should be responded to by:
    - Producing text and/or video materials for schools explaining how/when to submit a report, and how to respond to an alert

4.7. Raise awareness of the DDASP and its work to reduce drug and alcohol related harm

Owner: All DDASP partners.

For the DDASP to be effective, stakeholders need to know who we are, what we do, and how our work benefits communities. Raising awareness of the partnership will help strengthen public trust, attract engagement from stakeholders who may want to join the partnership, and ensure that our messages on harm reduction are amplified through a broader network.

This means:

- Ensuring communications clearly state that they come from the Devon Drug and Alcohol Strategic Partnership, and explain our role and purpose in plain language.
- Sharing tangible examples of how DDASP work has made a difference locally, such as improved access to services, reduced harm, or successful community initiatives.
- Targeting communications towards stakeholders from which we have less engagement
- Using consistent language, tone, and visual identity so people can easily recognise DDASP communications.
- Clearly signposting how individuals and organisations can get involved, contribute, or partner with us.

Actions:

- Disseminate an “About the DDASP” explainer (appendix 2 and 3) for use across all partner channels.
- Regularly publish case studies, news updates, and success stories on the DDASP webpage and via partner social media.
- Use partner newsletters, events, and networks to promote DDASP’s work and priorities.
- Develop a simple media engagement plan to share key achievements and local stories with press and community media outlets.
- Ensure consistent branding and key messages across all DDASP-produced materials.

5. Summary of actions

Internal Actions

#	Action	Type	Notes / Future maintenance
1	Develop regular 'Drug and Alcohol Harm Reduction Intelligence and Comms' meetings for partners to share intelligence and planned outputs	Routine (systematised)	Once established, these become standing 6-weekly meetings.
2	Develop an audit of public-facing Devon-based information about drugs and alcohol	Hybrid	One-off to create, then annual review to keep current.
3	Identify or develop visual messaging for key harm reduction messages to be used in posters and social media	Hybrid	Initial creative or identification work is one-off; refresh annually to maintain relevance.
4	Develop shareable briefing materials for frontline staff on how to identify risk and provide brief advice (link to alcohol IBA training)	Hybrid	Develop once, update periodically as training or risks evolve.
5	Coordinate with Naloxone strategy to produce info on importance and access	Routine	Once produced, integrate into ongoing comms and training.
6	Develop simple media engagement plan for sharing key achievements	Hybrid	Initial creation, then review annually.
7	Ensure consistent branding and key messages across DDASP materials	Routine	Needs to be embedded in all future comms processes.

#	Action	Type	Notes / Future maintenance
8	Create template print-ready alerts for rapid dissemination during incidents	One-off	Once produced, can be reused and periodically reviewed.
9	Create LDIS cards for ambulance workers (QR link to form)	One-off	Review only if LDIS process changes.
10	Create posters for ED on LDIS thresholds (QR link)	One-off	Review for updates every few years.
11	Carry out service mapping and maintain a list of support organisations to aid in signposting	Hybrid	One-off mapping, then annual update to keep accurate.

Public-facing work

#	Action	Type	Notes / Future maintenance
12	Develop or identify and distribute posters on counterfeit meds and adulteration to key venues	Hybrid	Repeat periodically; refresh materials as risks evolve.
13	Use targeted Facebook/Instagram ads for at-risk groups	Routine (episodic)	Schedule short campaigns around emerging risks.
14	Integrate adulteration awareness into all harm reduction comms/training	Routine	Embed as standard message across all outputs.

Work with professionals

#	Action	Type	Notes / Future maintenance
15	Develop CPD materials for GPs and pharmacists (with specified content)	Hybrid	One-off development; update annually or with new risks.
16	Engage with GPs via networks/bulletins to disseminate materials	Routine	Embed in communication calendar.
17	Engage with pharmacists via Community Pharmacy Devon	Routine	Maintain as ongoing relationship.
18	Engage with GPs to identify and address referral barriers	Routine (iterative)	Repeat periodically to capture evolving feedback.
19	Use local GP CPD sessions to highlight evolving risks	Routine	Ongoing schedule (e.g. twice yearly).
20	Coordinate with needle and syringe programmes to include harm reduction and naloxone info	Routine	Embed in NSP standard packs and communications.
21	Develop a basic CPD/training package for non-health professionals. Ensure their internal referral info is up to date.	Hybrid	Develop once; refresh content annually.
22	Disseminate/present training to key sectors (mental health, housing, etc.)	Routine (rolling)	Build relationships for regular training opportunities.
23	Work with nightlife safety initiatives to include DDASP messaging	Routine	Maintain collaboration; update messages as needed.

#	Action	Type	Notes / Future maintenance
24	Disseminate “About the DDASP” explainer across partner channels	Hybrid	One-off creation; review annually.
25	Use partner newsletters, events, and networks to promote DDASP’s work	Routine	Standard ongoing partnership activity.

Media actions

#	Action	Type	Notes / Future maintenance
26	Use opportunities to promote key messages relating to risk, harm reduction, anti-stigma, support, and our work when engaging with media	Routine	Ongoing practice for all spokespeople.
27	Produce a media guide on reporting drug and alcohol issues	Hybrid	One-off development, review every 2 years.
28	Regularly publish case studies and updates via website and social media	Routine	Build into regular communications cycle.
29	Develop media assets which use people’s personal stories of recovery, with a focus on reducing inequalities.	Hybrid	Develop once, keep up to date with changing processes and use opportunities to share

Work to develop two-way communication with people with lived experience

#	Action	Type	Notes / Future maintenance
30	Set up a task and finish group to design engagement structure	One-off	Establishes framework for ongoing participation.

#	Action	Type	Notes / Future maintenance
31	Ensure representation from people with lived experience across Devon	Routine	Maintain involvement through continuous feedback.
32	Coproduce engagement structure using a test-and-learn model	Hybrid	Initial setup; refine and sustain as ongoing process.
33	Coproduce future messaging and comms outputs with lived experience group	Routine	Embed as standing co-production mechanism.

Appendix 1: Risk-specific messages

These messages will need to be adapted based on audience to consider appropriate tone and reading age.

Ketamine (particularly in relation to young people)

- The best way to reduce the likelihood young people will take drugs is to build supportive communities with opportunities for young people to learn, socialise and explore their interests.
- Effective drug education teaches independent risk assessment. The evidence says that scare tactics don't work and can paradoxically increase the likelihood of use.
- Without testing, it is not possible to tell what's in a drug before you take it. Adulteration is common. Carry naloxone, and make sure you and your friends know how to use it.
- Long-term use of ketamine can cause bladder issues – see your GP if you are worried about this.
- Help for addiction is available: signpost to Together

Synthetic opioids

- Synthetic opioids can be up to 500 times stronger than heroin
- They can be present in any drug as an adulterant, and significantly increase the risk of overdose
- If you take any drug, including medications bought online, make sure you carry naloxone. Tell people you're carrying it and make sure you and your friends know how to use it.
- Know the signs of an overdose:
    - Very slow or stopped breathing
    - Unresponsive or unconscious
    - Pinpoint pupils
    - Blue or purple lips and fingernails
    - Cold, pale, or clammy skin
    - Limp body
    - Snoring, choking, or gurgling sounds
    - Vomiting
- If you think someone is having an overdose, use naloxone and call an ambulance
- Help for addiction is available: signpost to Together

Spice

- Spice is not the same as cannabis. It's a mix of chemicals sprayed onto paper or plant material.

- It's much stronger and more unpredictable than cannabis.
- You never really know what's in it, even if the packet looks familiar. Test if possible using Wedinos.
- Spice can cause anxiety, paranoia, seizures, psychosis, and even heart problems.
- Effects can kick in slowly, sometimes up to an hour, so don't redose too quickly.
- Know the warning signs and call an ambulance if someone has:
    - Excessive vomiting
    - Chest pain
    - Breathing problems
    - Fits, seizures or collapse
    - Hallucinations
    - Can't walk or move normally
- Help for addiction is available: signpost to Together

Counterfeit medications bought online

There are a number of online companies appearing to provide pharmacy-like services, but which may be selling counterfeit versions of medications. These counterfeit medications can look identical to the real thing, but may contain more or less of the advertised substance, or adulterants not listed on the box. Nearly half (44%) of UK adults aged between 18–30 years old have bought medicine or medical product online.

This is an area of high risk, as people purchasing these products may be an entirely different cohort to those in contact with drug and alcohol services, and may be unaware of the risks. Social media and poster campaigns may be a useful way to reach this group as they are not otherwise in contact with services. The DHSC has just launched a new campaign covering this, with a video and factsheets which could be adapted in the development of local information.

Key messages:

- Medications bought online could contain anything
- You can test any drugs or medications bought online before taking them (link to Wedinos)
- Let your GP know if you're taking medications bought online
- If you choose to buy medications online make sure any online pharmacy is registered with the General Pharmaceutical Council (GPhC) and any online doctor service is registered with the Care Quality Commission (CQC) and the General Medical Council (GMC)
- Carry Naloxone and know how to use it. Teach friends and family to use it too.
- Help for dependency is available

Poly-substance use

Taking more than one substance at a time can significantly impact the risk of overdose, death or other negative outcomes. Drug interactions checkers exist however none could be found which were from a trusted source, they will not include all novel substances and cannot account for adulteration as individuals may not fully know what exactly they are taking. When looking in August 2025, no appropriate pre-existing comms campaigns could be found to meet this need.

Key messages:

- Avoid mixing drugs - Taking two or more substances (including alcohol) together can cause highly toxic, unpredictable and dangerous reactions.
- Stay low, go slow, especially if adding substances.
- Alcohol counts as a drug, as do prescription medications.
- Avoid using alone.

Always carry naloxone and know how to use it. Train friends in how to use it too

Adulteration and synthetic opioids

Adulteration refers to drugs containing other substances not expected by the user, often added to increase bulk, mimic effects, or reduce production costs. These adulterants can dramatically increase the risk of harm. For example, the growing presence of potent synthetic opioids, which can be 500 times stronger than heroin, greatly increases the risk of overdose and death. Synthetic opioids (e.g. Nitazenes) are particularly dangerous because they can cause rapid respiratory depression even in tiny amounts. The presence of these drugs has been identified in the UK drug market, including in counterfeit benzodiazepines and stimulants.

Adulterated substances can be indistinguishable from unadulterated ones in appearance, taste, or smell. Users may not realise they are taking a stronger or entirely different drug. This risk affects people across all substance-using groups, including those who may not see themselves as at risk from opioids such as people using ‘recreational’ drugs occasionally, or people purchasing prescription-style pills from informal sources.

DCC has a synthetic opioid response plan which details response to a specific incident involving synthetic opioids. Proactive comms work to support this emergency response is detailed in section 4.5. This section will detail the business as usual communications to raise general awareness of this risk.

Key messages:

- Drugs could contain anything at all, and increasingly contain dangerous adulterants mixed in

- Test any substances before taking them (Wedinos)
- Stay low, go slow (start with a very small amount and wait before taking more)
- Avoid using alone
- Always carry naloxone and know how to use it. Train friends in how to use it too.

Appendix 2: One-page DDASP Explainer

About the Devon Drug and Alcohol Strategic Partnership (DDASP)

Who we are

The Devon Drug and Alcohol Strategic Partnership (DDASP) brings together local organisations, services, and people to reduce the harms caused by drugs and alcohol in our communities. We are a partnership of local authority, health, social care, community, criminal justice, and voluntary sector partners working towards shared goals.

Our priorities

We work collectively to:

- Increase numbers of people in treatment and ensure more people can access the support they need.
- Reduce drug and alcohol–related deaths
- Improve continuity of care for people engaged in the criminal justice system
- Reduce the supply and demand for harmful substances

How we work

Our approach is defined by:

- Evidence-informed decision making, drawing on research and local data.
- System-wide collaboration across health, justice, voluntary, and community sectors
- Two-way communication with communities and people with lived experience
- Respectful, inclusive, and anti-stigma messaging

Why it matters

Drug and alcohol harms affect individuals, families, and communities across Devon. By increasing treatment uptake, improving continuity of care, reducing deaths, and addressing supply and demand, DDASP is working to create safer, healthier futures.

Find out more / Get involved

Contact us: publichealth-mailbox@devon.gov.uk

Learn more: Devon Drug and Alcohol Strategic Partnership

Appendix 3: One-line DDASP Explainer

The Devon Drug and Alcohol Strategic Partnership is a partnership of organisations and people working together to support more people into treatment, reduce harm and deaths, and reduce the availability and use of harmful substances.

Appendix 4: Harm reduction and anti-stigma insights from Common Ground focus group, September 2025

Date: 25 September 2025
Location: St Sidwell's Community Centre, Exeter
Duration: 2 hours
Facilitation: Devon County Council Public Health Team and Common Ground
Participants: ~15 people with lived and learnt experience
Compensation: £25 per participant

"Is there any shame in looking for an escape from a difficult situation, or is there shame from having a difficult society to live in?" – Focus group participant

1. Purpose

The focus group aimed to gather insights from people with lived and learnt experience on:

- Effective and ineffective anti-stigma messaging
- How people understand and use harm reduction advice
- Barriers to accessing harm reduction equipment (e.g., needle exchange, naloxone)

This exercise also supports the Devon Drug and Alcohol Strategic Partnership's aim to embed lived experience involvement in routine practice.

The work was approved by Devon County Council Public Health's internal ethics review.

2. Methods

- A two-hour facilitated discussion using prompt sheets on three core topics:
    - Anti-stigma messaging
    - Harm reduction messaging
    - Naloxone carriage and use
- Session recorded and transcribed.
- Thematic analysis conducted by DCC Public Health.
- Themes validated in a follow-up discussion with Common Ground to ensure accurate interpretation.

3. Summary of Key Themes and Recommendations

3.1 Anti-Stigma Insights

Understanding Addiction in Context

Participants repeatedly emphasised that addiction is rooted in trauma, mental health difficulty, and life context, not simply an isolated "health condition."
Recommendation:

- Frame addiction within life context and cause. Avoid oversimplified "health condition" messaging.

Systemic and Service-Level Stigma

- GP uncertainty and poor signposting contribute to stigma.
- People are sometimes told they are "not bad enough" for treatment, undermining prevention efforts.
- Lack of dual diagnosis support forces people to navigate fragmented services.
- Supported housing loss during recovery was cited as an example of structural stigma.

Recommendations:

- Expand primary care training on pathways and signposting.
- Prioritise integrated, wrap-around support (especially dual diagnosis).
- Deliver stigma-awareness training for all professionals involved in prevention and treatment.

Alcohol-Specific Stigma

- Alcohol's legality normalises use and hides risk.
- People often reject labels like "alcoholic," delaying recognition of harm.
- The absence of societal monitoring systems (e.g., France's breathalysers) places responsibility solely on individuals.

Recommendations:

- Increase education on risk thresholds and habit-forming behaviours.
- Reduce stigma around higher-risk drinking so people feel able to self-identify concerns.

Messaging Considerations

- "Sugarcoated" or overly soft messaging loses credibility -"the lifestyle can be brutal."
- Divided views on terms like "addict" mean messaging must allow for different recovery identities.
- Lack of sober or non-alcoholic community spaces limits opportunities for inclusion.

Recommendations:

- Support community development and fund diversionary, sober activities.
- Use peer messengers to deliver honest, straightforward messages.
- Keep messaging short, factual, and direct.

3.2 Harm Reduction Insights

Messaging

Participants rated factual, practical messages ("don't share equipment", "you don't know what you're taking") as useful. They felt other messaging, such as "start low, go slow," is often ignored in real-world use.

Gaps identified:

- Mental health harm reduction messages
- Alcohol-focused harm reduction messages
- Messages tailored to people with limited capacity to absorb information while intoxicated

There was a strong preference for visual, bold, practical materials and trusted messengers delivering advice in person.

Recommendations:

- Develop separate alcohol and drug harm reduction messages.
- Add mental-health-specific harm reduction messaging.
- Make messaging more practical, visual, and grounded in real-world use.
- Prioritise education delivered through peer networks, trusted spaces, and frontline staff, not posters alone.

Don't use alone

Participants found "tell a friend before using" unclear or unrealistic due to:

- Safety concerns (risk of robbery or exploitation)
- Low trust in peers' ability to handle an emergency, or sense they had no friends to ask
- Fear of criminalisation
- Normalisation of high-risk use
- Some homeless participants had naloxone training but still chose not to carry it.

Recommendation:

- Switch to "tell a trusted person" rather than specifically "friend"

- Run peer-led naloxone training groups specifically for people experiencing homelessness, focusing on confidence, safety, and skills.

4. Learning from this process

If other partners or services wish to run similar engagement:

1. Work with a trusted lived experience group (e.g., Common Ground).
2. Use facilitators with lived experience to ensure credibility and psychological safety.
3. Pay participants fairly.
4. Use open questions + printed prompts covering stigma, harm reduction, and access.
5. Record, transcribe, and theme the discussion.
6. Validate findings with participants before finalising.
7. Feed back where their input has influenced the strategy (“you said, we did”).