Special Commission to Study and Make Recommendations on the Public Health and Safety Concerns Posed by the Proliferation of Xylazine ("Xylazine Commission")

June 23, 2025 Meeting Notes

Agenda

1. Welcome and Introductions
2. Background Information on the Commission and Updates
3. Listening Session
4. Next Steps and Discussion

Attendees *(listed alphabetically by last name after the Co-Chairs)*

Appointing Body	Name	Present?
House Chair of the Joint Committee on Mental Health, Substance Use and Recovery	State Representative **Mindy Domb** ***(Co-Chair)***	Yes
Senate Chair of the Joint Committee on Mental Health, Substance Use and Recovery	State Senator **John Velis** ***(Co-Chair)***	Yes
Secretary of the Executive Office of Health and Human Services ("EOHHS") or designee	**Millie Bhatia**, MPH, Health Policy Manager, Office of EOHHS Undersecretary Kiame Mahaniah	Yes
Secretary of the Executive Office of Public Safety and Security ("EOPSS") or designee	Undersecretary **Angela Davis**, EOPSS Undersecretary for Law Enforcement and Criminal Justice	Yes
Speaker of the House of Representatives	State Representative **Kate Donaghue**	Yes
Senate Minority Leader	**Ernie Gates**, President/CEO, Gates Healthcare Associates, Inc.	Yes
Massachusetts Veterinary Medical Association	**Matthew Hogan**, BVetMed, MS, MRCVS, DACLAM - Attending Veterinarian at McLean Hospital	Yes
Senate President	State Senator **John Keenan**	Yes
Bureau of Substance Addiction Services ("BSAS")	**Simeon Kimmel**, MD, MA, Assistant Professor of Medicine, Boston University Chobanian and Avedisian School of Medicine and Boston Medical Center	Yes
Commissioner of the Department of Mental Health ("DMH") or designee	**David McGarry**, MD, Medical Director, Worcester Recovery Center and Hospital Facility; Acting Medical Director, Office of Inpatient Management	Yes
Commissioner of the Department of Public Health ("DPH") or designee	**Sarah Ruiz**, MSW, Deputy Director for Strategy and Community Health, DPH	Yes
Governor	**Kevin Simon**, MD, MPH, Pediatric Addiction Medicine Psychiatrist, Boston Children's Hospital; Chief Behavioral Health Officer, City of Boston; Assistant Professor of Psychiatry, Harvard Medical School	Yes
House Minority Leader	State Representative **Steven George Xiarhos**	Yes

1. Welcome and Introductions

Chair Domb called the meeting to order at 12:06PM. **Chair Domb** and **Chair Velis** offered brief opening remarks. Both Chairs noted the importance of this topic, and **Chair Velis** noted and expressed gratitude for the work being done by DPH and BSAS relative to drug supply contamination. **Chair Domb** took attendance for the record; all Commission Members were present for the meeting.

2. Background Information on the Commission and Updates

Section 36 of Chapter 285 of the Acts of 2024, *An Act relative to treatments and coverage for substance use disorder and recovery coach licensure*, establishes the Xylazine Commission. **Chair Domb** referred Members to the packet of information provided prior to the meeting and reviewed the Commission's legislative charge, noting that the House extended the deadline for the Commission's Final Report. The House and Senate are working to codify the extension.

3. Listening Session - Testimony by Invitation Only

At 12:15PM, **Chair Domb** welcomed and thanked Listening Session participants for their testimony. Additional information on participants and presentations can be found in the powerpoint slides.

Deirdre Calvert, LICSW
Director of BSAS

Director Calvert began by discussing the impact xylazine has had on Massachusetts people and families in addition to the physical pain caused by xylazine. She referred Members to a position brief sent to Members prior to the meeting by DPH (the "DPH Memo") and information on xylazine in opioid overdose toxicology contained in the BSAS dashboard, which is updated every 6 months and was last updated in May. Director Calvert reviewed DPH actions related to xylazine, which was first detected in 2020 by the Massachusetts Drug Supply Data Stream ("MADDS") partnership and was present in opioid overdose toxicology data in 2022 when the medical examiner's office began routinely testing for the substance. Director Calvert acknowledged the role MADDS and people working in harm reduction play in understanding and collecting this information for the community and to inform public health action, as well as the importance of law enforcement in monitoring the drug supply and providing helpful data.

Director Calvert discussed the Centers for Disease Control and Prevention ("CDC") Epi Aid, an in depth epidemiological investigation and partnership to investigate emerging public health issues at the request of a state and in collaboration with Brandeis University. The CDC Epi Aid studied the impact of xylazine on overdose, withdrawal, and wounds to inform best practices, which has improved the experience of first responders and harm reduction workers ("HRWs") with overdose, their ability to respond, and their ability to meet the changing needs of people who use drugs ("PWUDs"). Currently, BSAS and Brandeis partners are monitoring the increase of medetomidine in samples and the reduction in the presence of xylazine, among other changes in the drug supply and contaminants. Director Calvert reviewed the xylazine public health alert, first issued in 2022 and updated in 2023, and the Brandeis website. The CDC Epi Aid recommendations are found in the DPH Memo and slides and include reducing stigma, expanding self-directed wound care and enabling providers to bill for these services, expanding access to and legal protections for reliable test strips and drug checking services, and supporting the creation and expansion of low barrier care for PWUDs.

Director Calvert noted the importance of increasing the number of low threshold care settings, including harm reduction multi-service drop in centers where PWUDs feel safe seeking care. She noted that current funding for hospital-based substance use disorder ("SUD") care will also help, and that BSAS is partnering with these programs to ensure their sustainability. She further noted that wound care and related billing remains difficult as insurance does not cover these services and harm reduction programs ("HRPs") are providing this care out of their own budgets. She then took questions.

Questions for Director Calvert

Senator Keenan asked about drug checking and harm reduction drop in centers in the context of a changing federal partner and whether these programs will still be allowed to be provided. Director Calvert has not heard anything specific about these programs being disallowed but conceded that harm reduction appears to be in the Trump Administration's crosshairs. She reiterated BSAS' commitment to expanding these services and indicated there may be more to share on this topic and the work of BSAS in this area in the future.

Chair Velis asked whether first responders and law enforcement know enough about xylazine (i.e., to still use naloxone, the extended period of oversedation). Director Calvert responded that this is a good question for first responders and law enforcement as she cannot speak to whether they feel they have enough information about these issues. She provided examples of common misinformation and miscommunication about xylazine that persist (i.e., naloxone should still be administered because xylazine is most often combined with fentanyl).

Chair Domb asked whether BSAS is involved in medical education to reduce stigma or whether it would be valuable. Director Calvert clarified that it is not even stigma; rather, discrimination. She stressed that BSAS includes positive messaging in everything it does and noted BSAS is working with providers to reduce stigma. She stated that providers are amazing partners and BSAS is doing this work at every step and in every initiative, but stigma is still prevalent and the Commonwealth must do more. She welcomes partnering on anti-stigma efforts because stigma affects everything (i.e., care and treatment of PWUDs by providers, Medicaid reimbursement, etc.).

Representative Xiarhos, following up on Chair Velis' question, noted that many first responders do not know enough about xylazine and suggested including first responder education in the Commission's recommendations, including working with the Training Council ("MPTC"). Director Calvert agreed, noting that BSAS provides xylazine-related clinical technical assistance and training for medical providers through its hospital-based services. Director Calvert also noted that BSAS has engaged partners at EOPSS to expand xylazine training.

Undersecretary Davis noted that, in 2024, EOPSS launched xylazine training for first responders in collaboration with DFS and MPTC. Over 1,500 first responders have received training on white powders with a focus on xylazine, fentanyl, and analogues. There have been seven trainings to date and EOPSS will be rolling out more to ensure first responders have accurate information when encountering white powders and rendering aid to people who need it.

Ernie Gates stated that many healthcare providers may not know that xylazine is an issue and noted the need for educating providers on the substance.

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Dr. Raagini Jawa, MD, MPH

Assistant Professor of Medicine, Center for Research on Health Care, Department of General Internal Medicine, University of Pittsburgh Medical Center

Dr. Jawa practices in Pennsylvania, which she calls the epicenter of the adulterated drug supply. She discussed how she has led national educational efforts to address xylazine contamination as a frontline provider who is also deeply ingrained in the harm reduction community, which detected xylazine long before any state or federal alerts were issued. Dr. Jawa emphasized that xylazine is just one example of increasingly toxic and rapidly evolving contamination in the drug supply, and noted that today xylazine is not just an adulterant, but a common component in the unregulated opioid supply.

Dr. Jawa discussed how health care providers continue to struggle with unfamiliar symptoms and the health harms of xylazine, which underscores the urgent need for support for drug checking and coordinated public health responses to rapidly share information on drug supply contamination. Groups that need real-time accessible education on evolving drug supply include PWUDs, the harm reduction community, public health workers and health care providers, first responders, and the general public.

She noted the universal desire for updated public health guidance that includes actionable next steps for each community and profession.

Dr. Jawa discussed her collaboration with the Grayken Center, which began in 2022 and involved rapid research translation and data sharing. Thousands of providers, first responders, and communities have participated in bimonthly virtual trainings on xylazine for frontline providers and HRWs not only in Pennsylvania and Massachusetts, but across the United States and Canada. She noted that people are desperate for free, ready-to-use community resources (e.g., public education videos, multilingual pamphlets on wounds and xylazine-related overdose). Dr. Jawa stressed the importance of sustainable funding for content development, which was created in collaboration with and with feedback from frontline HRWs, PWUDs, and non-traditional sources. This content was free, available via a virtual interactive platform, and monitored and adapted in real time based on feedback and changes. Dr. Jawa urged Members to support the creation of similar teams and to support timely information on emerging issues by funding real-time and adaptive educational materials that are multilingual and accessible (see, e.g., a 2024 paper published by Dr. Jawa and her colleagues).

Dr. Jawa reviewed key findings from a study she conducted in Massachusetts on the harms of xylazine in August of 2023. She interviewed 171 people in three syringe services programs ("SSPs") in eastern and western Massachusetts, and 80% thought they had been exposed to xylazine within the past three months. The majority of respondents did not want xylazine and many only realized they were exposed after experiencing physical effects or harms. Many responded that, if given access to drug checking (from harm reduction organizations), they would choose to dispose of xylazine-positive substances or switch suppliers. Respondents reported nasal ulcers, productive coughs, and new wounds, and 87% reported having a xylazine wound in the past 90 days. Three-quarters of respondents with wounds received wound care at the SSP (i.e., not in medical settings), and one-fifth of respondents were denied admission to an inpatient treatment setting due to their wounds. Dr. Jawa noted that amputations and other preventable harm can occur if hospitals do not have updated protocols for managing xylazine withdrawal or wound care.

Dr. Jawa highlighted and thanked HRWs on the frontline who recognize the importance of addressing xylazine contamination. She noted that, because health centers are often ill prepared or lack comprehensive addiction services to help PWUDs, HRPs become the default infectious disease or wound care doctor. This involves engaging volunteer nurses and stretching budgets to get wound care materials (see, e.g., Tapestry, which has seen a massive uptick in the need for wound care services in western Massachusetts since 2022). Dr. Jawa noted that PWUDs could seek these services at ERs, but they choose not to go due to lack of trust. She further stressed that xylazine wounds can heal if there is access to low barrier wound care by trusted community HRPs and adequate supplies for daily dressing changes. She noted that HRPs also provide linkage to addiction and harm reduction services.

Dr. Jawa ended by stressing that, regardless of the contaminant, HRPs remain committed to dealing with the harms of contamination and stretching budgets to help PWUDs. She recommends strengthening harm reduction and clinical response infrastructure, including expanding access to drug checking technology for real-time surveillance and safer use; wound care supplies; outreach; and education led by trusted, local harm reduction organizations. She also stressed the importance of support for the health system, which includes standardizing and regularly updating clinical protocols (e.g., xylazine withdrawal and wound care) to reflect the evolving drug supply because the drug supply continues to change (e.g., seeing more patients needing ICU care for medetomidine, a non-opioid veterinary anesthetic, contamination, including breathing support). She then took questions.

Questions for Dr. Jawa

Senator Keenan asked if everyone who uses xylazine ends up with wounds or whether it requires multiple uses. He also asked how long it takes between use and the appearance of wounds. Dr. Jawa noted this is an area of active research, which Dr. Green will discuss. She further noted that not everyone experiences xylazine wounds, but that intravenous ("IV") use puts PWUDs at higher risk and

the amount of xylazine may also contribute to wounds. She stressed that, even without wounds, PWUDs will experience other harms, including loss of consciousness and physical dependence that requires medically managed withdrawal services.

Chair Domb asked Dr. Jawa to elaborate on the experience of being denied entrance to detox due to wounds. Dr. Jawa stated that, in Pennsylvania, many patients report attempting to enter detox but being denied admission due to the facility lacking supplies or the clinical ability to manage related medical needs. She confirmed that, at least in August 2023, PWUDs in Massachusetts who she interviewed had similar experiences. She stressed that the entire continuum of care needs updated protocols because lack of clinical competency in wound care can be a deterrent to treatment.

Representative Donaghue asked about access to and availability of drug testing (i.e., whether access is similar to naloxone) and any legal issues that exist. Dr. Jawa deferred to Dr. Green, but noted that her research indicated that drug checking was available in two of the three SSPs and all sites distributed xylazine test strips (though they are not perfect).

Chair Velis asked Dr. Jawa to discuss the implications of the transition of xylazine from an adulterant to a common component in the drug supply (see, e.g., fentanyl). Dr. Jawa noted the importance of having access to surveillance and drug checking as it allows public health professionals to monitor trends. She noted similar ebbs and flows with drug trends and that surveillance and drug checking enable early detection and responses, such as linking people to HRPs. She further noted that tools like fentanyl test strips are available but there is no utility to these test strips for people who use substances for which there are no alternatives (i.e., if all available substances contain fentanyl or xylazine).

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Alan Young

Recovery Coach and Person with Lived Experience

Mr. Young shared his lived experience as a person in recovery from fentanyl use and the wounds caused by xylazine. He noted that this public health crisis affects everyone, including PWUDs and taxpayers. He discussed his experience with xylazine wounds typically experienced by IV users, and noted that his experience differed from people who are unhoused because he had a safe place to shower and treat wounds. Mr. Young noted that fentanyl has mostly replaced heroin, and - because fentanyl does not last as long as heroin and people get much sicker much quicker - people on the streets are more focussed on avoiding withdrawal symptoms than addressing wounds. Mr. Young noted that even people with xylazine wounds that went down to the bone avoid going to the hospital due to limits on methadone doses which deter people from seeking medical care in hospital settings to avoid withdrawal symptoms.

Mr. Young believes opioid abatement funds should be used to expand mobile care vans in high traffic areas for PWUDs because mobile care vans are cost efficient and enable easier access to care, including medications for opioid use disorder ("MOUDs") like methadone or suboxone and first aid for people suffering from wounds. He noted that a person already on methadone or suboxone can receive their prescribed dose in the ER (i.e., the person does not have to start at the lowest dose). Mr. Young ended by stressing the value of mobile care vans in letting people, who are only thinking about avoiding withdrawal, know we care by meeting them where they are. He then took questions.

Questions for Mr. Young

Chairs Velis and **Domb** thanked Mr. Young for sharing his lived experience, and Chair Domb expressed appreciation that Mr. Young highlighted the importance of mobile care vans that provide MOUDs and wound care. Mr. Young reiterated the positive impact of mobile care vans.

Deputy Director Ruiz asked whether Mr. Young accessed services from mobile vans or if he knew people who did. Mr. Young stated that he personally only stopped at a van to grab water during active addiction but did not use their services because he was not homeless. He knows people who utilized these services and, in addition to receiving MOUDs and wound care, they made lasting relationships with people working on the vans. Mr. Young confirmed there is a mobile van in Worcester (Spectrum)

but the public health crisis affects people everywhere. He believes this Commission was needed.

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Dr. Sarah Wakeman, MD

Medical Director, SUD Initiative, Mass General Brigham

Dr. Wakeman practices addiction medicine and general medicine in Massachusetts, providing clinical consultation, primary care, addiction care, perinatal SUD care, and - most recently - mobile care. Dr. Wakeman explained that xylazine is a non-opioid veterinary tranquilizer used for blood pressure management and other conditions in animals but is not approved for use in humans. Xylazine extends fentanyl effects and staves off withdrawal symptoms, but also causes heavy sedation. It was first seen in Puerto Rico over 2 decades ago but is now found in over 30 states, particularly the Northeast, and is present in 99% of opioids tested in Philadelphia. She reviewed the major safety issues with xylazine, including accidents and injuries due to the heavy sedation and necrotic wounds that appear beyond the injection site, in people who do not inject (i.e., smoke or sniff), and compression injuries. She noted that researchers continue to study xylazine wounds and the reasons they appear more similar to burn injuries with respect to the risk of infection occurring well after the appearance of wounds, and posits that this may be caused by constriction of blood vessels or other reasons. She emphasized the importance of wound care and the danger of amputation without it.

Dr. Wakeman noted that xylazine causes worse withdrawal symptoms (i.e., separate from and in addition to opioid withdrawal symptoms), which makes it harder for people to enter and stay in medical settings, including SUD treatment. She noted that patients are worried about contaminants, want to stay healthy, and want more information and options, but continue to use drugs because barriers to treatment are too high. She believes treatment must be as welcoming and accessible as possible, which means continuously updating SUD treatment models. Dr. Wakeman discussed the expanded focus by care teams on wound care, which is now offered at Mass General's Bridge Clinic in addition to wound care kit distribution and discussions about wound management with patients. She stated that, because xylazine use is often concurrent with fentanyl, Bridge Clinic providers offer escalating doses of MOUDs and other medications like clonidine to avoid withdrawal symptoms and get people comfortable as quickly as possible. She stressed the need for expanding MOUD induction and access to low barrier treatment, which includes mobile care, HRPs, and bridge clinics.

Dr. Wakeman noted that drug checking resources are crucial tools that provide people with information they need to make better decisions and stay safer. She stressed the importance of: having and administering naloxone even though it does not reverse the effects of xylazine; not using alone; and receiving basic education on overdose response, including recognizing the symptoms of overdose versus oversedation, administering rescue breaths and overdose reversal drugs, and calling for emergency medical services. Dr. Wakeman believes medical settings need to be welcoming, non-stigmatizing settings for PWUDs because people who experience medical trauma and stigma avoid seeking care. Dr. Wakeman highlighted recent BSAS funding that expanded hospital SUD services.

Dr. Wakeman reminded Members that xylazine is just one contaminant. She urged shifting from a criminal to a public health approach as a way to prevent further contamination because criminalization and punitive drug laws will continue to punish PWUDs and worsen contamination issues. She believes drug checking must be accessible and legal, with protections in place. She ended by noting Massachusetts is a leader in SUD work, care, and policy, and should continue to be a leader in other areas. *There were no questions*.

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Sarah Mackin, MPH

Director, Harm Reduction Services, AHOPE, Boston Public Health Commission ("BPHC")

Ms. Mackin began by noting that AHOPE is the largest and oldest HRP in New England and provided a history of the program. She stressed that harm reduction is a vital part of the SUD continuum of care, with a mission to reduce harms associated with drug use. Ms. Mackin reviewed AHOPE's services,

which includes testing drug residue (i.e., half the size of a grain of rice) using a Fourier Transform Infrared ("FTIR") spectrometer to identify active drugs, contaminants, and inert additives. Depending on the mixture of a particular sample, drug checking can sometimes estimate the amount of fentanyl, which varies widely (e.g., 1% [less potent] to 15% [significantly potent]). Ms. Mackin noted that drug checking has changed the game for minimizing harm and preventing overdose, including how harm reduction providers approach service delivery, because people with this knowledge might choose to use less, use a different route of administration, use with someone who has naloxone, or not use at all.

Ms. Mackin discussed the partnership with MADDS, to which AHOPE sends samples for further analysis. MADDS provides a "birds eye view" of all the data and overall trends, which enables AHOPE to anticipate educational or programmatic needs. AHOPE carefully monitoring various active cuts and contaminants, working to actively adjust programming and education to minimize harm. While xylazine is the most common contaminant seen in Boston (i.e., present in about 20-30% of samples), it has been declining in recent months. She stated that, while xylazine is not an opioid, AHOPE still educates people to use naloxone because presentation can be very different (i.e., breathing may be restored but the person remains very sedated so HRWs might keep them for longer or take them to supported observation programs). She stressed that HRWs need to understand what cases they can handle and which people need to be sent to the ER. She noted that HRWs are getting better at knowing these distinctions, which also applies to wound care. She discussed partnering with Boston Medical Center ("BMC") to train staff in providing wound care to avoid sending people elsewhere for care and BMC even coming to AHOPE at times to speak with someone in their trusted environment.

Ms. Mackin noted that xylazine is not the only threat because the drug market is unregulated and very volatile, which puts people at heightened risk of harm, injury, overdose, and death. Because fentanyl analogues, medetomidine, and benzodiazepine analogues have also been detected, she believes these other contaminants should be studied. She expressed gratitude that recent legislation provided some legal protection for drug checking, but more work needs to be done. Ms. Mackin asked for continued investment not only in frontline drug checking, but harm reduction services generally, particularly in response to federal opposition. She noted that drug checking not only saves lives, prevents harm, and enables people to make educated decisions about what to do, but also provides real time data to better equip public health efforts. She ended by stressing that harm reduction is a pragmatic, fiscally responsible, effective, and evidence-based public health approach. She then took questions.

Questions for Ms. Mackin

Chair Velis echoed Ms. Mackin and others who noted that xylazine is one of many contaminants and that, although the statutory charge says "xylazine," the Commission's work will include contaminants in general. He asked whether there is data on how many people take advantage of drug checking services and who does so before using a substance. Ms. Mackin noted that drug checking is a relatively new intervention in the United States, but that not nearly enough people utilize these services often because they do not have access to a machine or HRWs trained in using a machine. Ms. Mackin meets often with other HRPs around the globe to discuss these issues. Specifically, it takes a long time working under someone who has more intimate knowledge of testing protocols to understand what you are seeing and how you are reading it. Ms. Mackin feels comfortable letting a person use the machine independently after about 100 samples and high percentage of concordance with a second set of eyes. She reiterated that drug checking is a new tool that people are just starting to understand, and noted the need for better technology that is easier to use in addition to more people trained on how to use these machines and how to interpret drug checking equipment and results. She looks forward to a time when we can find validated, easy to use technology. **Chair Velis** also asked if drug checking services are typically sought by people in a two mile radius similar to On-Point, the overdose prevention center ("OPC") he previously visited in New York City. Ms. Mackin confirmed this is the case and is true for most SSPs - most people come from two to three miles away. This distance barrier is why AHOPE does so much street and van outreach: to help people who are not able to come to the physical location.

Ms. Bhatia asked about the slight decline over the last few months in presence of xylazine and whether Ms. Mackin has seen this in the past or if it is an anomaly and is there another contaminant in the supply that is replacing xylazine or emerging. Ms. Mackin deferred to Dr. Green.

Chair Domb asked Ms. Mackin to provide her top three priorities for HRPs. Ms. Mackin stressed the importance of preserving syringe access as it is most at risk, most controversial, and experiences the most opposition but remains the best intervention for PWUDs. She stated that preserving naloxone access is equally important and noted that, while drug checking services are in the top 10 and she does not want to see it go away, HRPs have done okay without it. Ms. Mackin stressed AHOPE's focus on providing linkage to care and HIV testing.

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Traci Green, PhD, MSc

Principal Investigator, Massachusetts Drug Supply Data Stream ("MADDS")

Dr. Green began by providing more detail on the ongoing work of MADDS to test and monitor the drug supply in Massachusetts. MADDS utilizes Fourier Transform Information Spectrometer ("FTIR") and more real time options such as testing strips and cassettes. She referenced that there are some specific processes for testing for xylazine vs fentanyl. She referenced her slides with data on sensitivity and specificity of each tool. Dr. Green noted that MADDS uses both methods and confirmatory lab testing to track drug supply trends, in addition to providing counseling, other supports, and referrals for PWUDs.

Dr. Green noted that xylazine contamination started during the COVID-19 pandemic in 2020, and that xylazine appearance varies regionally and has changed over time (e.g., color, contents, form, ratio, etc.). Xylazine is typically present in fentanyl, but has also been found in the stimulant supply in places with pre-existing fentanyl contamination in the stimulant supply. Dr. Green referenced the recent notable declining trend of xylazine presence and a similar/inverse rise in the presence of medetomidine everywhere xylazine was previously detected. Dr. Green stressed that it is xylazine today, medetomidine tomorrow, and something else the next day, and this is why Massachusetts needs drug checking.

Dr. Green noted that PWUDs share information on supply contamination with others, including suppliers, and this information influences where they use, who they are with, how they use (i.e., Safe Spot, taking smaller doses), or whether to use at all. Dr. Green stressed that arming people with information on what they have been exposed to helps everyone. Specifically, drug checking helps PWUDs by enabling better conversations with service providers, and enables providers to better understand what PWUDs might need in service settings. It helps suppliers, who may change the supply , warn others of supply changes, or distribute harm reduction materials . It helps HRPs and HRWs have richer conversations about drugs used and what happened after use; offer services, supplies, and referrals that are concrete and linked to use-specific risks; engage high risk and diverse populations about the supply; and share information with other staff/programs. It helps health care providers adjust care plans and testing practices, emphasize different patient communications, more quickly diagnose and treat, and avoid unhelpful or unnecessary treatments that could cause harm. And it helps municipalities, public safety officials, and other state entities better inform local taskforces, community partners, and public safety (i.e., increases efficiency); refine local responses and initiatives; and measure changes.

Responding to an earlier question regarding drug checking utilization, Dr. Green stated about 35% of PWUD in Massachusetts use drug checking services, which is good but not good enough. She noted that most testing occurs after use, not before; however, with the recent change in the law that implemented some protections for drug checking services, more people are seeking drug checking services before they use. Dr. Green noted that further amendments to the law are needed to better define terms (e.g., harm reduction services, premises, assists) as well as to protect participants who bring/take drugs away from HRPs performing drug checking. She also stressed the need for funding to support and expand operations and services.

Dr. Green discussed RACK and the CDC Epi-Aid, the federal and state partnership to understand how the presence of xylazine in Massachusetts is affecting clinical presentation of opioid overdose,

withdrawals, and other measures. She discussed the rapid onset of symptoms from xylazine exposure, including immediate sedation and wounds appearing within 24-48 hours. The study found 50% of people exposed reported experiencing wounds in the past six months and 90% of those individuals still had wounds at the time they were interviewed. People had, on average, 7.8 wounds from xylazine and two-thirds of respondents reported their largest wound was between a dime and a quarter in size. People with past month wounds reported wounds as occurring at sight of injection (50%), somewhere else (30%), and the remaining 20% reported wounds on their bodies despite not injecting.

Dr. Green reported that women, people who use by injection, and those who inject at multiple sites are at increased wound risk. Avoiding injection and xylazine decreased wound risk. Dr. Green reported several factors that had no impact on wound risk, including the amount/dose consumed, housing status, and non-IV routes of administration. People attributed healed or no wounds to modifying or ceasing use, practicing IV hygiene, and avoiding xylazine through drug checking or speaking with their dealer. She noted the importance of low barrier wound care. Dr. Green discussed the effect of xylazine on overdose presentation, as sedation and breathing difficulties often continue after naloxone administration. She reported that overdose has a very fast, almost immediate onset and rescue breathing is required with most cases. Dr. Green ended with her recommendations for next steps, which can be found in her slides. Highlights include what PWUDs say they need - drug checking, community wound care services, and low barrier care - as well as updated and accessible educational materials. She then took questions.

Questions for Dr. Green

Dr. Hogan noted that, as a veterinarian who works with animals, he uses xylazine often and asked why the human medical community does not use xylazine reversal agents. Dr. Green noted that, like xylazine, the reversal agents are not safe for humans. Dr. Green noted that an Australian clinician has suggested buprenorphine in addition to or instead of naloxone as a xylazine reversal agent.

Representative Xiarhos noted his skepticism of harm reduction generally but thanked Dr. Green for her presentation. He requested more information about women experiencing wounds at greater frequency than men. Dr. Green noted that there would not be drug checking in Massachusetts without close partnership with law enforcement and public safety, and stated that she is working to address community attitudes towards harm reduction. Regarding wound rates, she noted that there may be biological, behavioral, or gendered rationales for what is being observed, both with help seeking and with biological or hormonal differences with respect to xylazine effects (e.g., women injecting might have different behaviors).

Undersecretary Davis acknowledged and expressed appreciation for Dr. Green's work and presentation. She noted that staff from Brandeis/MADDS conducted the first EOPSS training for first responders and they did a great job.

Dr. Simon, responding to Representative Xiarhos' earlier comment, discussed his experience as a child and adult psychiatrist and the success he has had with talking to patients about what is in their supply and counseling patients to pivot or change how they use or where they obtain their drugs. He noted that just providing info about what is in the supply and aiding them in decision making helps and is harm reduction because it can mitigate use, change use, and even stop use. In regards to Dr. Hogan's question, he noted that first responders cannot utilize xylazine antidotes because they are not for humans, so drug testing remains the only tool.

Dr. Kimmel discussed his work in infectious disease and addiction medicine and asked how often people use drug checking services (i.e., only when they suspect contamination/change in content or every week/day similar to syringe services, which he sees working at one of the drop in centers). He also noted the unregulated drug supply and substances in the supply; specifically, how fentanyl has replaced heroin and some people now prefer it. He asked if people are seeking xylazine or if everyone is actively avoiding it and, if the former, if that explains increased presence of medetomidine. Dr. Green stated that there is limited data on patterns of drug checking in Massachusetts, but that MADSS is looking at the

Rhode Island OPC (operating since January 2025) to understand drug checking practices. She stated that some people go regularly and it is part of their routine, others batch and will test with friends, others just happen to go, and some people test exclusively before use then report back. She noted that expanded access allows people to integrate drug checking into their routine. Regarding seeking xylazine, Dr. Green stated that her colleagues in Philadelphia have reported that people are seeking xylazine to avoid withdrawal and that the increase in medetomidine produces similar behavior because withdrawal is so profound. She clarified that PWUDs do not seek these substances for their effect, but to avoid symptoms of withdrawal and stressed the importance of better access to care for withdrawal symptoms.

Jess Bresler (Chair Domb's staff) asked about wound care and whether there was any data regarding the provision of these services by mobile care vans. Dr. Green stated every mobile van offers this service but was unsure about usage rates. **Deputy Director Ruiz** noted that DPH collects information from mobile vans and it is possible information on wound care services are included in the reports sent to the agency. **Dr. Kimmel** believes there is data collection on wound care kit distribution, but is unsure about dressing changes and other wound care services and information might be found in intervention documentation.

Dr. Simon followed up on the discussion around the rates of xylazine wounds in women.

Representative Donaghue asked whether xylazine posed a real or perceived danger to bystanders or first responders. Dr. Green noted that there are no documented harms regarding xylazine exposure other than people who use the xylazine (i.e., no skin or inhalation exposure or harms). She states the more pressing issue is that first responders arrive at the site of an overdose, administer naloxone, and expect the person to wake up but they remain unresponsive. This puts PWUDs at risk of receiving multiple, unnecessary doses of naloxone and experiencing withdrawal symptoms when they regain consciousness.

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Justin Alves, MSN, FNP-BC, ACRN, CARN, CNE and Tehya Johnson, NP
Grayken Center for Addiction Training and Technical Assistance

Mr. Alves introduced himself and Ms. Johnson, the Grayken Center's lead xylazine consultant working on the ground with the street team. He discussed their DPH and BSAS funded roles conducting trainings across New England on drug supply contamination with a focus on opioids and stimulants. He noted that fentanyl contamination in the stimulant supply is deadly but also usually accidental, and increasing. Mr. Alves stressed the importance of ensuring first responders and medical teams are on the same page when treating PWUDs, which is accomplished by providing facts and combating myths (e.g., the mere presence of fentanyl does not present an overdose risk to first responders).

Ms. Johnson discussed her background in providing outreach services and trainings to people looking for information on drug supply contamination, including first responders, medical staff, and HRPs. She highlighted the need for more conversations about xylazine-related issues, including overdose response and chronic wounds. Ms. Johnson noted that the extended sedation caused by xylazine, particularly with people who also use stimulants, is less predictable and makes people less prepared. She noted that an emergency opioid antagonist should still be administered but sedation will persist if there is xylazine contamination. For this reason, it is important to use the least amount of naloxone as possible (i.e., using 2mg instead of 4mg), provide respiratory support (i.e., supplemental oxygen for breathing support), and to expand access to sobering spaces and monitoring services for people who use without safe space or who are homeless. These spaces reduce the risks of sunburn, frostbite, heatstroke, and overdose fatality.

Ms. Johnson discussed chronic wounds caused by xylazine, which take a long time to heal but do heal. She stressed the need for widespread availability of wound care across the continuum of care because lack of knowledge around wounds leads to people being sent to hospitals, which can lead to the loss of trust and relationships between PWUDs and service providers. Ms. Johnson noted the importance of drug checking services that provide PWUDs with critical information to make better decisions for themselves. She stated that clients who learned they were exposed to xylazine became more interested in

MOUDs. Ms. Johnson ended by encouraging conversations with people about their experiences and concerns as they are most knowledgeable about their needs and bodies, and what might help them. *There were no questions for these speakers.*

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Officer Heather Longley

Northampton Police Department, Drug Addiction Response Team ("DART")

Officer Longley discussed her specialized role on DART, which she began working with in 2017, as a collaborative, public health (rather than criminal justice) effort between HRPs and police officers to provide post-overdose resources to PWUDs. She is the homeless community liaison and works with unhoused people and is certified as a drug impairment recognition specialist. In her work, Officer Longley has studied the effects of xylazine, which presents clinical and behavioral issues that make field identification and response difficult and more complex. Specifically, overdoses can present as purely opioid-related due to oversedation and naloxone having no effect on consciousness causes officers to feel confused and powerless.

Officer Longley noted that, while Northampton has a focus on harm reduction, not all police departments are as well equipped. She further noted that there has been an overreliance on Narcan as a public health response, but xylazine changes this and there is not enough understanding about its impact despite HRPs efforts to provide information and education. Officer Longley noted that homeless populations are particularly at risk. She discussed Northampton's and partnered organizations'efforts to provide xylazine test kits and fentanyl test strips, but these tools are not entirely accurate and there is a need to improve reliability. Officer Longley discussed wounds, including a case where a woman who was unhoused and already an amputee lost her second leg due to xylazine wounds. She discussed the work of Tapestry's mobile harm reduction services and noted that, while xylazine use is decreasing in Northampton, they now see rises in local anesthetic, fentanyl analogs, and other contaminants.

Officer Longley ended by providing three recommendations: (1) limiting prosecution for drug possession to large purchases (i.e, not small, street level possession charges); (2) supporting and funding harm reduction programs, especially mobile wound care; and (3) supporting public education campaigns regarding xylazine contamination; She then took questions.

Questions for Officer Longley

Representative Xiarhos asked about the size of the Northampton Police Department. Officer Longley stated that the department has 60 people with a small detective bureau as well.

4. Next Steps and Discussion

Chair Domb led a discussion regarding next steps.

Deputy Director Ruiz noted that the first two proposed working group topics might overlap and could be combined, and also noted the recurring theme about training, information sharing, and the different elements that could benefit from both. She proposed convening a working group focused on education and a working group on outreach and treatment options, with the first two proposed working groups (best practices to regulate and oversee the production and distribution of xylazine *and* whether xylazine should be classified as a controlled substance) being combined into one. **Chair Domb** noted the potential need for experts on classifying xylazine as a controlled substance.

Chair Domb will send a follow up email regarding potential working groups and a proposed schedule, as well as a form to collect working group preference, availability, and any comments or suggestions.

Chair Velis reiterated the recurring theme of broader drug supply contamination and encouraged interpreting the Commission's charge to enable examining supply contamination beyond xylazine.

At 2:28PM, **Chair Domb** moved to **ADJOURN** the meeting and **Chair Velis** seconded.