**Drug and Alcohol Planning Council**
**Meeting Minutes**
**Microsoft Teams**
**Wednesday, May 12, 2025**

**Present:** Fred Quinn, Charles Davis, Jessica Northcott-Brillati, Daniel Garrighan, Tonisha Wilson, Anne Cox; Bryan Bass-Riley, CCBH; Alice Bell, Prevention Point Pittsburgh; Cameron Judge, OBH Family Support Coordinator; Cheri Norfolk, OBH Drug and Alcohol Program Representative Supervisor; Colleen Sokira, OBH Special Projects Manager; Sarah Bigelow, OBH Special Projects Assistant

## I. Introductions, Attendance, and Minute Approval

Charles Davis called the meeting to order at 4:37 pm.

All present introduced themselves.

March 2025 minutes approved.
Motion by Charles, seconded by Tonisha

## II. Prevention Point Presentation

1. Harm reduction services since 1995
2. How do we know what's in the drug supply?
    i. Historically – death data
        1. Significant lag – often over a year
        2. Can still show general trends
        3. Preliminary 2024 data – 403 deaths, or around a 22% decrease compared to 2023
        4. In 2023, 103 deaths involved xylazine, but none were due to xylazine alone
            a. This was the first year that xylazine was tested for
        5. Limitations of using death data
            a. Deaths with multiple substances present don't necessarily mean that drugs were "contaminated", only that the person consumed more than one drug on the same day

        b. More deaths where stimulants were present don't mean that stimulants are causing more deaths
    ii. Prevention Point Program Data
        1. PPP surveys people who get naloxone – 20 years of data
        2. Very common that people use both meth and opioids on a regular basis
        3. However, there are a small number of isolated cases where this does happen
        4. Data comparison (2013 to 2017) of doses required for overdose reversal as fentanyl supply rose
            a. As the % of overdose deaths in AC involving fentanyl rose, the number of naloxone doses required to treat overdose did not
    iii. First indications of xylazine in the local drug supply – 2022
        1. 3rd quarter of 2022 – 5% decrease to 82% of reversal using 1 or 2 doses
        2. Knew that in Philadelphia, xylazine was in the drug supply
        3. In March 2023, xylazine test strips became available and were used to confirm its presence in the local supply
        4. A driver of why people were using more naloxone – people were still sedated after reversal
            a. PPP increased its education – once someone is breathing, more naloxone doesn't help
        5. As restrictions have increased on xylazine, we've seen the introduction of other sedatives and numbing agents into the drug supply
            a. Includes: medetomidine, procaine, tetracaine, noracaine
            b. BTMPS (brand name Tinuvin 770)– industrial chemical used in plastics as a light stabilizer
                i. No one knows why it's in the drug supply; it doesn't seem to have any psychoactive effects
                ii. Harm reduction message: a new industrial chemical is causing a bad cough, ringing ears, blurred vision, and puking. It sometimes has a taste/smell like bug spray, plastic, or adhesive. We've seen it in blue fentanyl pills and powder. Stop using it if you smell it.
3. Changes in Local Drug Supply 2023-2025
    i. Based on results from Opioid Data Lab UNC
        1. 2023 – 31 samples

    a. 27 expected fentanyl – 100% included fentanyl
    b. 68% included xylazine in primary or trace amounts
    c. Average 2 ingredients (1-4)
    d. 2 expected cocaine were cocaine
    e. 1 expected meth was meth
2. 2024
    a. 196 samples
    b. 89% included any fentanyl, and only 77% fentanyl was the primary ingredient
    c. 68% also included xylazine
    d. 23% included medetomidine
    e. 14% included BTMPS
    f. 0-12 ingredients, 3 had no drugs, 50% contained 5 or more ingredients
3. 2025 so far
    a. 37 samples
    b. 83% included any fentanyl, and 54% fentanyl was the primary
    c. 55% xylazine
    d. 72% medetomidine
    e. 59% BTMPS
    f. 21% heroin
    g. 2-9 ingredients present, average 4.1
    h. Samples of other drugs so far contained what was expected, except one cocaine contained fentanyl analogues, and 1 meth sample contained cocaine
4. Question (TW): Are these folks who voluntarily gave samples?
    a. Answer: yes
5. Question: Why is this sample size so small?
    a. Answer: Yes, drugs are illegal. Also, this is in the first four months of the year, around 10 samples a month. Even though people are bringing us an empty stamp bag, people are still understandably uncomfortable carrying that around, and it's a sign of trust to bring them to us. Early on, we did see that people were mainly bringing samples they were concerned about, but now we're seeing more "voluntary scientists" because they know we want to know what's out there
6. Question: What's the processing time?

    a. Answer: 1-2 weeks. What we'd love to see, based on what other cities have established with FTIR machines, is being able to do it in real time. It's not easy to do. There's a lot of training, choosing how and where to do this. I've been involved in a lot of the work around The Alliance for Community Drug Checking and hope that we'll be able to do this around here at some point. That still only goes so far. When we first saw xylazine, people hated it, but at a certain point, all the drug supply had it in it
    b. In an illegal drug supply, there's no quality control. Knowing what's in your drugs only takes you so far
4. One thing that's really important with the increase in medetomidine and the decrease in fentanyl is that people are developing less of a tolerance for opioids
    i. There was a spate of overdose deaths in Downtown and Southside recently
        1. It's more critical than ever that people have access to naloxone because you don't know from one bag to the next how strong the supply is
    ii. Another thing we're seeing with medetomidine is heavy sedation – concerns about people passing out on a limb and cutting off circulation
    iii. Seeing a drop in deaths
    iv. Seeing fewer wounds – speculation that medetomidine
    v. Reports that medetomidine withdrawal is particularly intense, intractable vomiting
        1. Since it's not an opioid, it doesn't respond to typical meds
5. Critical point – the political decision to criminalize drugs and make it a health issue has led to a black market in which consumers don't know what they're getting
6. Comparison to alcohol – a rational alternative
7. **Question (CD):** Did you pay attention to what neighborhood drug samples came from?
    i. Answer: Yes, but we also find that it's not particularly relevant because people go to different neighborhoods to buy drugs. We think it used to be much more insular, and in some neighborhoods it might still be that way, but for the most part, people are buying from multiple neighborhoods.
        1. Gabby: Agree
    ii. Answer: We also emphasize that there's no quality control in stamp bags, and just because you buy one stamp one week, doesn't mean it will be the same the next
8. Question (TW): How many other programs do this work, especially locally?

i. Answer: PA Groundhogs in Philadelphia, which works with the Center for Forensic Research Education – does a lot of drug checking, including by mail in
    1. Also, make sure to emphasize drug checking rather than testing
ii. Limitations include staff (Alice is the one who processes all the samples), the drug checking kits from UNC (ACHD helps with this currently)
    1. Some discussion about using opioid settlement $ to set up an FTIR locally
iii. Question (BB-R): Can we get a copy of the slides?
    1. Answer: Yes, will email them to Colleen to distribute
iv. Comment (CN): Dr Lynch presented on Monday that UPMC will present next week on Medetomidine
    1. Colleen just sent information to all council members
v. Comment (GW): When people are getting samples tested or getting test strips, they often mention that they're taking them to their dealers so they can know what they have. We don't have to advertise our services because people take care of each other.
    1. Alice: survey after a few months of test strips – across the board, the biggest feedback was that people were telling each other
        a. Informal community medics, especially after naloxone distribution started
    2. BB-R – studies showing that test strips do change behavior
vi. CD: When you give Narcan out, do you just do it at your sites or?
    1. Alice: Not Narcan, but naloxone. Originally, only the injectable form – now 40% injectable
    2. Now using the Revive brand, which is a 3mg nasal spray
    3. Summit last year about compassionate overdose response
        a. Poor experiences when people receive massive doses of naloxone are reported by PWUD and EMS
    4. Lobbying the state to add revive to what they distribute
        a. Has been added to the state standing order
        b. ACHD using some opioid settlement dollars to buy some 3mg doses
    5. BB-R – Thank you, that makes a lot of sense
    6. GW – To answer your question, yes, we distribute at our 5 sites, for participants/clients, not
        a. Programs that want naloxone can get it from ACHD
        b. Outside the county (or if you can't get it from ACHD for some reason), you can get it mailed to you from the state.
        c. GW - typically see 100 people in a 3-hour shift –

d. If needed – the Sunday East Liberty site tends to be much quieter
7. CD – The reason I ask is because I made a blessing box outside my house that I put Narcan in, but if there's a different dose that you'd recommend, I'd like to be able to use that instead
8. If you want the lower dose version and typically get yours through ACHD, they should get their supply soon if they don't have it already – just ask

9. Frank Quinn has to leave early – left at 5:34 pm

## III. Bureau Updates

**1.** Typically, Maisha has given this update, but as we let you know via email, Maisha has taken a different position in DHS
- **i.** The BDAS Administrator, Kathryn Gadd, is now acting Assistant Director
  - **1.** It will be a longer-term acting position
  - **2.** Kathryn is currently on PTO, so Cheri Norfolk is here tonight

**2.** BDAS is charged every 5 years to complete a Prevention Needs Assessment
- **i.** Began at the beginning of this fiscal year (July 1, 2024)
- **ii.** Substance Use Disorder and Gambling Disorder

**3.** OBH Special Projects team and members of BDAS have gathered data through focus groups
- **i.** Parents and caregivers in McKeesport
- **ii.** System-involved TAY
- **iii.** ACCR community members
- **iv.** Interview with Casa San Jose
- **v.** Several different surveys for community providers (both contracted and non-contracted) and community members

**4.** Next steps – analysis and program planning
- **i.** Data analysis is due to the State in June

**5.** Question (JN-B): Will we get to see the results?
- **i.** Answer: We believe so. We will make sure we are able to share it with this group.

**6.** Question (TW): Level 3.5 funding provider alert recently came out with only 6 months of funding. Does this PNA process have anything to do with that?
- **i.** Answer: No. That is a pretty major change, and Kathryn can answer all questions regarding allocations
- **ii.** CS – This is loosely attached to the justification of money, but it doesn't determine AC's allocation versus other counties. It's the state requiring AC to go through data and decide priorities for prevention and which groups to outreach to. The conversations were really interesting to see the

similarities and differences between what the data said and what community members said in conversations. This helps us think about what types of programs we want to advocate for over the next couple of years.

iii. Question: Was the TAY group SITY?
    1. Answer: Yes, they were fun!

## IV. New Business

1. The by-law rewriting project has fallen off and we need to reschedule it.
    i. Yes, we'll reschedule a new meeting
    ii. CS – let me know if you need me to coordinate scheduling a meeting
2. BB-R moving back into clinical work (private practice), and it's his last meeting representing CCBH in this role
    i. Will let Colleen know who will attend as the CCBH representative
    ii. At CCBH for almost 9 years
3. CD: Difficulty getting adults 65+ into treatment
    i. Medicare only pays for hospital-based treatment – limits options
    ii. DG: Medicare is a real struggle for us, too
    iii. JN-B: has also experienced this
    iv. CD: Thank you, this didn't make me feel any better, but it's good to know it's not the person, but the system
    v. DG: Could share some trainings from Area Agency on Aging
    vi. TW: We've had a few older adults, been able to finagle it with some county funding and other sources
        1. Another issue at Alpha House, and not limited to older adults, is the number of steps we have – three flights
    vii. BB-R: many fewer hospital-based beds
    viii. DG: importance of wrap-around care and not going directly from inpatient to outpatient for Medicare patients
    ix. BB-R: Benedum Geriatric Clinic is another place to look for resources

## V. Public Comments

## VI. Adjournment

The meeting was adjourned at 5:59.

## VII. Next Public Meeting

The next public Drug and Alcohol Planning Council meeting will be on **Wednesday, July 9,** from 4:30 – 6 p.m. **via Teams.**

Colleen Sokira will send out the Teams invite for this meeting the week before. There is also a link posted on the DHS advisory board webpage.