

Pathways of Long-Term Recovery and the Rhetoric of “Zombie Drugs”

“Words are important. If you want to care for something, you call it a flower; if you want to kill something, you call it a weed.” – Don Coyhis

The very term “Zombie Drugs” drives drug hysteria. A specter that these drugs are so powerful and bad that people who have used them are no longer human. Zombies are dangerous insentient beings that can harm you. Words matter, and these words drive out hope and magnify fear. Words that tell us we need to be afraid and to lock them up or just let them die in the gutter as we see them as hopeless cases. They are gawked at and judged and blamed for their plight. This is a lesson repeated throughout modern drug trend history. Zombies never recover so investing in their wellness become pointless. Failure to do so fulfills these negative perceptions. This is the very kind of drug hysteria which leads to a double down on punitive approaches and affirms all the negative societal perceptions.



The term "zombie drug" most frequently refers to [Xylazine](#) (tranq), a veterinary tranquilizer, but it has been used to describe other drugs known for causing severe sedation or tissue damage including Medetomidine, Desomorphine (Krokodil), and Alpha-Pyrrolidinopentiophenone (Flakka). Xylazine has actually been present on our streets for a generation, as has Flakka and Krokodil. Medetomidine was first identified in the US drug supply around five years ago. We have all seen the myriad of videos posted on the internet of people stumbling around with open wounds. Perversely, there is now even a form of tourism in which people profit off the suffering via YouTube videos. Who is actually sicker, is a debatable question here, those who propagate the videos, people who watch them or those they train the camera on.

Published research on the resolution of these newer drug combinations is pretty much limited to first aid. Xylazine was first seen on the streets of Philadelphia in April of 2006, yet we still lack academic research on recovery from it. The peer-reviewed literature currently focuses on [acute medical stabilization](#), wound care and medical detox. The journals discuss how medical care depends on long-term recovery. They articulate how our addiction treatment system is ill prepared for integrating the requisite care but fail to highlight pathways to long term recovery. Low expectation tainted research. Nothing has changed in any appreciable way since [I first wrote about it in 2023](#). To summarize, the medical care journals emphasize that achieving sustained recovery from xylazine requires navigating unique, multi-layered clinical challenges but fails to highlight how that is to occur and very little if any of that emerging information has been used to formulate real world services to meet these highly specialized needs. These are zombies, not people. The lack of focus on long-term recovery is driven by the pejorative terms as has long occurred over the course of our history.

Drug Hysteria in Recent History

One of the most visible examples of drug hysteria occurred with crack cocaine in 80s. As background, our national drug policy at that time was most cogently embodied by the ill-conceived "Len Bias Law" (the Anti-Drug Abuse Act of 1986). [Papers examine how the law came to be](#) show that it was fueled by pervasive fear. The alarm was focused around the narrative of crack babies and that one use led to instant addiction. This led to mass incarceration of Black Americans as crack cocaine tended to be used in lower income communities while powder cocaine was associated with higher income communities. The law created severe mandatory minimum penalties for drug offenses and infamously established a 100:1 sentencing disparity between crack cocaine and powder cocaine.

The media portrayal was that these children were doomed to a life of permanent disability. The false sense that smoking crack led to severe, lasting neurological damage to newborns exposed to it. There was a stark divide between the sensationalism and crack babies in the real world. Women who used it, and particularly black women who used crack cocaine were vilified as public enemy number one instead of being viewed as persons with treatable conditions that we should focus resources and support with help. Over time the wild claims [were shown to be false](#), but mass incarceration has had intergenerational consequences for entire communities.

Observations and Questions:

- The lack of visible, accessible and attractive evidence based strategies drives down both hope and service funding.

- We continue to frame emerging drug use patterns in ways that dehumanize the people who are addicted.
- While these drugs have been on our streets for years the evidence base for supporting care starts with street wound care and only takes us as far as acute treatment in a hospital setting, long term recovery is not properly investigated.
- There tend to be huge lags in our evidence base in respect to addiction recovery efforts that would not be permitted to occur with a less stigmatized condition, not just in respect to these drugs.
- How can we illuminate pathways of recovery from emerging drug patterns when narratives of hope and recovery are absent from our academic journals? How does this vacuum perpetuate false narratives about zombies?
- Archaic attitudes on addiction and recovery are very much with us in 2026. A large survey my organization did with Elevyst found that the majority of medical care professionals [saw us as unworthy of helping](#). How do we change this?

Penny Wise & Pound Foolish Practice

Truckloads of money are being spent on these band aid solutions in acute care settings. A recently published journal article [The Economic Impact of Medetomidine on Critical Care Utilization: A Longitudinal Analysis of Intensive Care Unit Charges for Opioid Withdrawal Across the Adulterated Era](#) did a retrospective analysis at 2 intensive care units (ICUs) in Philadelphia, PA, USA, from April 1, 2017, to September 30, 2025. In part, the study compared ICU charges in the Fentanyl only era to the period in which xylazine combinations became dominant. It found that during the fentanyl-only era, median quarterly ICU charges for opioid-withdrawal admissions were \$5.59 million per quarter with a median of 18 ICU admissions/quarter and \$193,492 median charge per patient. This changed dramatically as xylazine became more prevalent on the streets. There was a 72% increase in quarterly ICU charges and an 89% increase in ICU admissions, although charge per patient declined, the increase was driven primarily by more patients requiring ICU care. The costs increased to \$9.63 million per quarter with a median of 34 ICU admissions/ quarter and a cost of \$176,225 median charge per patient. During approximately the same period, Philadelphia ED visits for [these conditions increased from about 125 per quarter to approximately 300 per quarter](#) due to xylazine-associated wounds.

Looking Forward:

Funding and support care consistent with the chronicity and the complexity of the condition is the thing we still have not built. If we lack the knowledgebase and infrastructure to get people into long term recovery, these high costs at the front end of our service system become a revolving door of patients requiring the most expensive care. A viscous and expensive cycle with poor outcomes. This is also not a new phenomenon as I wrote about in Alcohol and Drug Abuse Weekly, [It Costs More to Kill Us Than to Help Us Get Back on Our Feet: Investing in Recovery is Cheaper and Yields Dividends](#) (2025). Directly from William White [Racism, Moral Panics, and Drug War Casualties: An Update](#) (2019):

“how frontline addiction professionals and recovery support specialists can avoid complicity when such moral panics rise within the culture. The following suggestions:

1. Recognize the existence of moral panics related to new drug trends and maintain a healthy skepticism of all alarmist information being promoted during such periods--even when it seems to come from credible sources. Information emanating from the earliest stages of moral panics is notoriously unreliable. The objective voice that will stand the test of time is the one least likely to be heard at the height of a moral panic.
2. The fact that a piece of information has been published in a scientific or professional journal does not in itself mean that this information has been scientifically validated. Early reports may not hold up to more methodologically rigorous studies. The way of science is that all knowledge is on probation pending further investigation and new discoveries.
3. When you find you have been an accomplice in the dissemination of misinformation, do everything you can to correct what you have disseminated and correct it within the specific venues in which it was originally presented. Remember, those you originally communicated with may be continuing to act on the misinformation you provided; harm may be continuing to unfold. Consider this correction process a highly ethical form of professional amends.
4. When alarmist voices are fanning the flames of cultural hysteria (often in pursuit of their own personal or institutional interests), bring your professional calmness to bear on this situation by tempering calls to impulsive action with more reasoned approaches to problem assessment and problem resolution. Always ask, "Are there any unintended consequences that could flow from what is being proposed?" A long tradition of harm in the name of help exists within the histories of addiction treatment and recovery support. One of the major goals of our professional careers should be to avoid to the greatest extent possible participating in this tradition.

5. Moral panics have a way of turning people into objects that need to be extruded from the life of the community. In this climate, awful things can be perpetrated in the name of the most noble of values. Protest any emerging labels that turn people into things. As my friend Don Coyhis often reminds us: *Words are important. If you want to care for something, you call it a flower; if you want to kill something, you call it a weed.*"

False information and hysteria do great harm. What we term things and what we measure matters a great deal. We can reasonably anticipate that drug use patterns will continue to evolve and that we will continue to see these changes occur at a more rapid rate than in preceding decades. Push back against the use of degrading labels by our media. Provide accurate information about long term recovery and what people need to get better. These are people who can and do recover, given the proper resources just like any other condition. The solution to find effective care strategies would be to allow for more flexibility in program design while investing in longer-term treatment and recovery support strategies. We could also more rapidly expand our knowledge base by connecting research groups to front line practice as we learn through trial and error how to navigate recovery in real world conditions from these new drug combinations.

We would also be well served by using language that is humanizing and fosters hope for those communities impacted by these powerful new drug combinations. We would be well served in investing in the infrastructure needed to support long-term recovery. Perhaps our measure here could be one that I have often thought of over the years I have been in this field. If this was someone you loved who was addicted to these drugs how would you want them referred to and what services and supports would you want to have available to them so that they had what they needed to get into and to sustain long term recovery? That is what we should do for everyone.

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