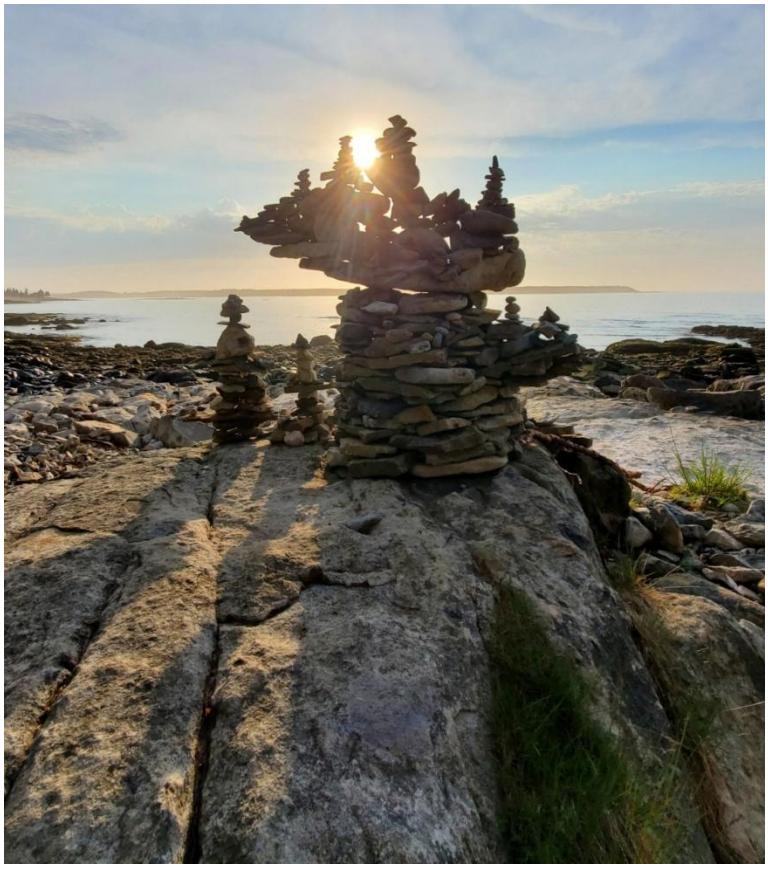
Will We Ever Move Beyond an Acute Crisis Orientation?
The Absence of Recovery Research and Emerging Drugs – William Stauffer

"*What remains in diseases after the crisis is apt to produce relapses*." — Hippocrates



Our SUD evidence base tends to be myopic and crisis oriented. It is focused on first aid and short-term stabilization rather than on developing sustained recovery over time. Nowhere is this more evident than in our response to emerging drug combinations being used on streets across America. Drug use patterns are shifting rapidly, with increasingly potent combinations producing more severe dependency and medical complications. If our stated goal is sustained recovery, it should follow that we would invest in academic, clinical and practice bases knowledge focused on recovery trajectories for people exposed to these drugs. We do not, and as a direct consequence, recovery outcomes are neglected.

Emerging Drug Combinations and New Care Challenges

One defining shift in the illicit drug supply is the routine use of fentanyl in combination with other substances for synergistic effects. Heroin, once longer acting, has largely been replaced by fentanyl, which has a short duration of effect. Combining fentanyl with drugs such as xylazine and, more recently, medetomidine give fentanyl "legs," extending the high. Many users are unaware of these additives, but addiction drives people toward substances that "work better," reinforcing both supply and demand for more potent combinations.

These drug mixtures create novel clinical challenges. Yet we lack objective knowledge about long-term recovery trajectories for people exposed to them. For example, we do not know whether xylazine use worsens relapse risk or impairs long-term abstinence compared to opioid exposure alone. Evidence beyond anecdote is largely absent. The literature acknowledges that long-term recovery outcomes for people exposed to xylazine are "not well characterized," and medetomidine research on recovery is even more limited.

What the Literature Prioritizes — and What It Omits

While xylazine has shown up sporadically in the drug supply for a generation, it emerged more consistently around ten years ago in Philadelphia. It then became prevalent nationally. A decade in, one might reasonably expect an evidence base addressing recovery process following exposure to fentanyl–xylazine combinations. Instead, the literature focuses almost exclusively on acute care interventions. If we fail to focus on getting people into long term recovery, we should be honest about the outcomes we pursue, which are short term amelioration in a turn style process of ever increased chronicity and eroding outcomes that get more expensive at every turn.

Recent publications illustrate this pattern clearly:

- Management of Xylazine Withdrawal in a Hospitalized Patient (*Journal of Addiction Medicine*, 2022). Describes a hospitalized patient and makes no mention of counseling or support strategies.
- Xylazine in Overdose Deaths and Forensic Drug Reports (*JAMA Network Open*, 2024). Examines xylazine in overdose/fatality data yet makes no mention of clinical treatment or long-term recovery/remission.
- "Xylazine in the Opioid Epidemic: A Systematic Review of Case Reports and Clinical Implications" (Cureus, 2023) A review of case reports/clinical implications of acute overdose, with no mention of long term recovery / remission.

- Xylazine-associated Wounds: Clinical Experience From a Low-barrier Wound Care Clinic in Philadelphia (*Journal of Addiction Medicine*, 2024) clinically describes chronic wound complications in people exposed to xylazine. Important for long-term morbidity but does not track clinical care or remission trajectories.
- Xylazine Toxicity (StatPearls 2023) provides information on toxicity and longer-term complications of repeated exposure but no mention of clinical care or remission / recovery focused strategies.

The same pattern is repeating with medetomidine. First detected in the street drug supply in 2021, it rapidly became common on our streets. The emerging literature focuses on severe withdrawal syndromes, emergency responses, and short-term clinical management in hospital settings. There is nearly zero meaningful exploration of recovery pathways or sustained outcomes in current literature. This narrow focus reinforces a societal narrative that recovery is rare possible but not probable, that the best we can offer is a bandage. That is neither scientifically justified nor ethically acceptable.

What can be found in the current literature in respect to the emergence of medetomidine:

- Profound Opioid and Medetomidine Withdrawal: A Case Series and Narrative Review of Available Literature (Psychoactives 2025) Considers the rapid rise of medetomidine as a fentanyl adulterant, and the severity of the withdrawal it induces, the discussion on clinical treatment is entirely withdrawal focused.
- Responding to medetomidine: clinical and public health needs (Lancet 2025) This paper only discusses clinical and outreach efforts related to wound care and withdrawal protocols.
- A Powerful New Drug Is Creating a 'Withdrawal Crisis' in Philadelphia (NYT 2025, December 15) Frames the challenge in respect to medetomidine as acute medical withdrawal with no reference to long-term recovery.

The Limits of Crisis Metrics

We herald current drug policy as successful because there is a reduction in overdoses. Yet, stopping a death from an overdose is not recovery, it is the short-term preservation of life. Our eyes are not on the prize. This is an issue I broached in Overdoses in Decline - Progress on a One-Dimensional Measure. Crisis framing drives acute research priorities. Emerging drug threats like xylazine and medetomidine enter the policy arena as public health emergencies, not as chronic conditions. Once framed this way, funding and research rapidly concentrate on facets such as overdose mortality, soft tissue injury, wound care, acute withdrawal syndromes, Emergency Department management, surveillance and toxicology. This occurs because these area of focus are 1) Immediately measurable, 2) Politically defensible "we are saving lives now" and 3) Compatible with our medical model orientation within the context of emergency medical and infectious disease research infrastructures.

We stay stuck in crisis mode by design. Sustained remission and long-term recovery receives scant attention as this focus would require more sustained examination and effort. Processes to understand the challenges and resolutions require crosses systems focus (healthcare, housing, employment, social networks) and produce outcomes that are less immediately visible to policymakers which lead to lower prioritization. In a system under constant acute change with an ever-evolving drug supply, we never get beyond the acute crisis orientation. As a result, recovery as a lifelong process is perceived as non-urgent, even though it is essential to reduce the population of most severe substance users and to sustain resolution and evidence-based strategies.

Structural Incentives That Sustain Crisis Orientation

Policy incentives consistently favor crisis containment over sustained resolution. Addiction is out of sight and out of mind. Acute responses reduce publicly visible harms. We fail to address chronicity nor realize the benefits of sustained recovery at the individual and community levels. A recovery-oriented research agenda would also require confronting uncomfortable truths: our treatment and recovery support systems are underfunded, fragmented, and poorly aligned with the severity of today's drug use patterns. It would require accountability for long-term outcomes and systems of care comparable to those used for other chronic conditions with behavioral components.

We remain locked in a design that prioritizes short-term cost containment. Level-of-care tools are increasingly used to justify shorter durations of treatment despite growing complexity and severity. Reports from the field indicate shorter care episodes for more acute cases — a mismatch that society ultimately pays for in lives lost and escalating costs.

The Impact on Workforce and Infrastructure

The trend toward more powerful drug combinations is pushing treatment and recovery systems beyond their capacity. This contributes to workforce demoralization: clinicians and peer workers know the care they provide is inadequate to meet the need, yet they continue to show up because the alternative is far worse.

Unlike oncology, where remission and disease status are tracked within an evidence-based continuum of care, addiction lacks long-term metrics and protocols to guide recovery-oriented solutions. This absence is increasingly untenable as drug combinations intensify dependency and complexity. Yet funding discussions have increasingly framed treatment and recovery support as discretionary rather than a necessity, particularly in the context of recent Medicaid cuts.

One would think that with standard level of care tools being utilized, that given the increased severity and complexity of what is occurring, we would expect to see longer durations of care with more structured programming. The reports I hear from the field are quite the opposite. Shorter care despite more complex and severe cases. This suggests that level of care tools are being utilized more for short-term cost containment and not actually focused on delivering what people need to recover. Society pays the ultimate cost in lives and resources for this systems failure that focuses on short term cost containment and not delivering the proper duration, design and intensity of care.

Practice-Based Evidence and the Missing Voices

The other facet of this dynamic is that there is practice based evidence that can inform improved care. People are sustaining recovery from these drug combinations. There are front line workers who are helping people find what works for them to sustain recovery, but these cases are nearly invisible to researchers and policymakers. We should not discount their knowledge as it can help us save lives.

Perhaps the major thrust of the new recovery advocacy movement was to get our systems to meaningfully include our communities in matters that impact our lives. That scores of us are dying on the streets and our research institutions have not focused on recovery pathways for emerging drugs puts in bold relief how we have simply not made enough progress. Nothing about us, without us, at the very least includes prioritizing insight into the strategies for our recovery.

Moving Beyond Band-Aid Solutions

Recovery is at least as important as wound care. If one of our loved ones were on the streets, we would want them to get immediate first aid followed by comprehensive, effective care for as long as it took for them to sustain recovery. We should treat everyone on our streets in this same way.

A Recovery Research Agenda for Emerging Drugs

If we are serious about sustained recovery, we must explicitly build a recovery-oriented research agenda for emerging drug combinations. At minimum, this agenda should include:

- **Longitudinal recovery outcome studies** that follow people exposed to fentanyl combined with substances such as xylazine and medetomidine over multiple years, examining remission, relapse, stability, and global functioning rather than survival alone.
- **Comparative analyses of care intensity and duration**, identifying what levels, designs, and lengths of treatment and recovery supports are associated with sustained recovery for people with high-severity, polysubstance use patterns.
- **Recovery-oriented outcome measures** that extend beyond overdose reduction to include housing stability, global health status, social capital, employment or meaningful activity, as well as quality of life facets.
- **Practice-based evidence integration**, formally incorporating knowledge from frontline clinicians, peers, and recovery communities who are already supporting people to recover from these challenging drug combinations.
- **Subpopulation analyses** to determine what works for whom and under what conditions, recognizing that recovery pathways differ based on medical complexity, social context, trauma exposure, and access to recovery capital.
- **System-level research** examining how housing, employment supports, continuity of care, and long-term engagement influence recovery trajectories in the context of emerging drugs.

Without this kind of research, we will continue to respond to evolving drug threats with tools designed only for acute containment with a band aid mindset. A recovery research agenda would not replace harm reduction or emergency care; it would complete the continuum by addressing what happens after the crisis passes.

The question is not whether we can afford to focus on recovery. It is whether we can afford not to.

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