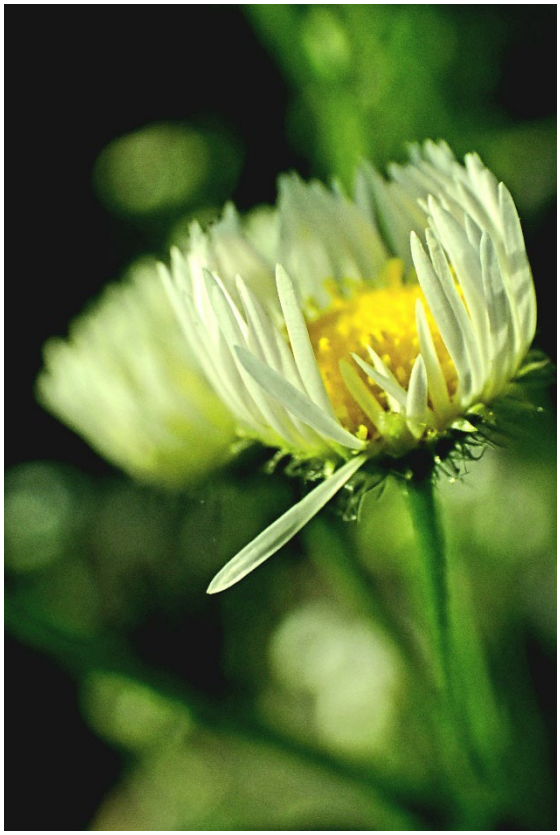
Where Are They Going to Heal?



In April of 2023, the Office of National Drug Control Policy (ONDCP) designated the combination of xylazine with fentanyl an emerging threat. Over the preceding year, it started to become apparent that xylazine was rapidly spreading across the nation. By mid-July, a plan was formulated for a national response to address what was unfolding. One of the major focuses of the ONDCP plan includes learning from people working close to what is occurring on the streets to develop insight into what is happening and learn how to more effectively respond. That is a vital and too often ignored facet.

It is important to recognize that the people working closest to emerging problems tend to figure out ways to address it first through trial and error. In this current emerging threat, I am not on the ground, but talk to a lot of people who are. I currently run the statewide recovery community organization of Pennsylvania. We facilitate a weekly statewide open call. Xylazine was something we began to hear about in the state street drug supply in mid-2021, with cases primarily on the eastern side of the state, from Philadelphia to NE PA.

On April 5th of 2022, we organized a call focused on xylazine. We knew it was spreading across the state drug supply and wanted to provide attendees information to help direct care workers and others what it was and how it was impacting persons who were using drugs. The call included a PhD Pharmacist with expertise on street drug use in the US. Very few hospitals and healthcare experts in PA were aware that the patients they were seeing were using it.

Sixteen months later and there are still hospitals in PA that do not know much at all about it. Healthcare providers who do not know what they are seeing or how to respond. Steeped in negative perceptions, some may not even care, always a profound facet of the problem. Persons who use drugs are often not seen as worthy of help, even in our healing institutions. Of course, what we saw unfolding here in PA last year in respect to xylazine is now occurring across the nation. The spread of xylazine is our most recent example of the dynamic of ground up problem identification and adaptation to develop effective care strategies in the face of overwhelming barriers and stigma fueled ignorance.

Because “ground up” dynamics are often important in understanding drug use patterns on the street, I ask every SUD treatment and recovery service provider I come in contact with about current trends and challenges. This includes if they are seeing people using xylazine enter treatment. It is an anecdotal process; analytical strategies take a long time and end up being a look in the rearview mirror during rapidly changing field conditions.

There is very little on the web to assist providers understand how to help people heal who are using xylazine in combination with other drugs. A google search for xylazine addiction treatment will yield FAQ pages explaining what it is, some data on preliminary withdrawal protocols and information on street wound care. There is nothing on SUD treatment and recovery strategies beyond withdrawal management. That is alarming.

What I am hearing: People who are using xylazine are not openly presenting in significant numbers for SUD treatment. It is probable that they are and there is a failure to identify cases involving xylazine. This may also include people who are using stimulant drugs which are increasingly being tainted with xylazine. When these cases are identified, they tend to be the most severe ones. The types of cases we can anticipate seeing many more of as people using this drug physically deteriorate. These severe cases often have medical needs that exceed what providers have the capacity to handle.

Severe cases, which will in all probability increase as xylazine becomes more prevalent likely require close coordination of medical care in combination with SUD treatment. Things our SUD systems is ill equipped to provide. Expensive care. The kind that runs at cross purposes to a system that rations care with a tendency to place patients at lower structured, less expensive levels of care to save resources. Over several decades this has led to the shuttering of longer-term, structured care. The very type of care these clients are likely to need but is not available.

So far, the interventional strategies most commonly being deployed focus on street medicine and wound care. These are important engagement strategies. Wound care and street medicine is perhaps the first rung of care, what do we do then? Hospital care to medically stabilize these patients is most probably the second rung for persons with significant medical complications. SUD Treatment would logically be the third rung. Are we even gathering data on who is making it through rungs one and two onto the third rung of the ladder of healing? Would we be surprised if what we find is that few people make it through to recovery given all of the inherent barriers within our care system? What is this costing in lives and resources?

To be clear, I am not suggesting that people who are using xylazine in combination with fentanyl will not be able to heal. I suspect this will be part of the narrative. There is a long list of drugs where such moral panic claims spread. I am actually in recovery from two drugs in which such claims were historically made. What is true is it is likely we will need to retool our services to effectively address the needs of people who seek out help. Understanding how requires learning what workers on the ground are doing and how to adapt our care system accordingly.

I have seen "ground up" solutions that our care systems ended up adapting before in my career. I was a counselor working on the ground in our SUD care system as HIV/AIDS unfolded in the 1980s. People were dying. We made condoms available. We spent time in treatment getting people to understand how HIV and other blood born conditions spread. We gave out information on how to clean needles to prevent the spread of infection. Similarly, a decade later in the late 90s we started to see drug use patterns change and knew that opioid use was rapidly expanding in ways that it would take Main Street USA another full decade to understand. In those early days I had a lot of conversations with parents ill prepared for what opioid addiction meant for their child. So many of these kids died. We adapted as best we could given the limited resources we had. How many lives we save depends on how nimbly we can learn and respond.

What we can learn from what is occurring on the ground? Questions to consider may include:

- Are people using xylazine in combination with other drugs being identified across all service settings?
- Are they making it into the proper types of SUD treatment and staying for appropriate durations of care?
- What if any measures are we finding to help engage and retain people using xylazine to help them heal?
- Are they sustaining SUD recovery in any appreciable numbers? What seems to work best to support this outcome?
- What are we doing to resource ground level service systems to meet the needs of these clients right now? What do they need to address the presenting needs of these clients?
- What changes need to occur in our systems of care in order to provide better support for persons using xylazine to heal moving forward?

One of the underlying lessons here is that learning is bidirectional. We tend to think of effective care strategies stemming from academic research on what works for whom under what conditions as the primary focus of improving practice. The truth is that this is in part because our systems have the same stigma that everyone else has and the closer you are to the problem, the more you are discounted. There are a lot of smart, resourceful people with lived recovery experience working on the ground and learning through trial and error what works. We should not discount them.

Drug use patterns in the US are shifting at an unprecedented rate. As a care system we should be looking at ways to gain insight from workers on the ground on emerging drug trends and adaptations to address these needs more rapidly. Similarly, knowing that drug use trends are so rapidly changing, grants and funding mechanisms to support healing should have mechanisms built into them to allow for adaptation to rapidly changing needs on the ground.

War analogies related to drugs generally have not helped us, but I will add one more. In war, the tendency is to prepare for the battle last fought, which leaves the force ill prepared for changes in strategies required in the current struggle. We do the very same in how we address substance misuse and addiction in America. We need to rethink our strategies to better adapt to changing needs more quickly if we are to effectively help people heal. This incudes listening to those workers on the front lines.

Many lives are counting on it.

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