Public Health Guidance on High-Potency Synthetic Opioids

Considerations in Assessing Child Safety

In fulfillment of the legislative requirements of Engrossed Senate Substitute Bill 6109

Preliminary

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Guidance Goal

This guidance was developed to help Washington juvenile courts consider how high-potency synthetic opioids (HPSO) impact child safety. For the purposes of this guidance, child safety is generally defined as a risk of overdose that could cause fatality or near fatality. A thorough literature review was completed to understand the current scope and recommendations around this issue. Much of the available public literature does not currently include a discussion of illicit HPSOs on children and youth. Washington state overdose data indicates that deaths due to HSPOs on the illicit drug market began to accelerate in 2018.[1]

Washington is among the first states to pass legislation to address HPSOs as a unique consideration in child abuse and neglect. To our knowledge, these are the first published public health guidelines around HPSOs to be used by the courts in determination of child placement.

This guidance was informed by a review of available literature related to HPSO-related overdose deaths in children and adolescents, expert opinion, and Washington state data, including a review of death certificates in Washington (2016-2023) and coroner/medical examiner reports for overdose fatalities (2021-2023) of children 5 and under.

This guidance will evolve as public health science deepens and community and partner conversations emerge around this topic and should be considered preliminary. Updates will be provided at doh.wa.gov.

Key Points

- Opioids exist on a spectrum of potency. High-potency synthetic opioids can include:
    - prescribed medications, including fentanyl.
    - illicit substances, including fentanyl and fentanyl analogs (a slightly modified type of fentanyl that still functions the same). Illicit fentanyl (including analogs) can have a much higher degree of risk because they are unregulated, so the potency as well as the presence of other substances is unknown to the user.
- Nationally, pediatric deaths of young children due to opioid overdose have increased dramatically in the last five years. Data from the last 2 years in Washington shows we may be experiencing a similar trend. The increase in opioid-related overdose deaths is indicative of the lethality of fentanyl as compared to previous drivers of the overdose crisis (heroin and oxycodone).
- Deaths due to overdose from high-potency synthetic opioids, particularly due to illicit fentanyl, have increased in the last 4 years among youth and young adults aged 15-20 in Washington, mirroring national trends.
- The Washington State Office of the Family and Children's Ombuds data on child fatalities and near fatalities shows an increase in reported incidences connected to accidental ingestion and overdose due to fentanyl. (WA State Office of Family and Children's Ombuds).[2]
- Infants and toddlers are at risk of overdose from high-potency synthetic opioids in large part because of their developmental stage (i.e. accidental ingestion) and their lack of a developed opioid tolerance.

- Teenagers are at risk of overdose from high-potency synthetic opioids in large part because of their developmental stage (i.e. risk-taking behavior) and their lack of a developed opioid tolerance.
- There are effective strategies to reduce the risk of accidental overdose from high-potency synthetic opioids, including safe storage in homes, ensuring children are under the care of a capable person while using, treatment for opioid use disorder, and improving access to naloxone, as well as teaching people how to use it.
- Families do best in systems that provide stigma-free, non-biased, culturally competent care
- Not all parental behavior is negatively impacted by using high-potency synthetic opioids. As with all substance use, including legal substances, risk varies by family and changes over time. Public health practice supports making efforts to keep children in the care of their families when it is safe to do so. If removal is necessary, intentions should be made to support the caregivers to re-establish custody as quickly as is safe.

Definitions

An opioid is a substance that when ingested binds to a receptor in a person's brain and produces an effect. Effects can include reduction of pain, feelings of euphoria, possible dependency, withdrawal, and addiction. In medicine, well-regulated and monitored opioid medications can help manage pain while reducing the risk of addiction and misuse. This applies to patients taking substances for pain reduction or as a part of a medication-assisted treatment program (MOUD).

Synthetic opioids are manufactured from chemicals and artificial substances. This is different from other opioids, such as heroin, where some of the components were grown and harvested from the poppy plant. By comparison, synthetic opioids are relatively cheap to produce and can cause a large effect from a small dose.

Potency is a term used to describe how powerful a substance is. Illicit fentanyl has an unknown potency because it is unregulated which increases the risk to the user. **Lethality** is the capacity of a substance to cause harm. Lethality is dependent on a person's current opioid tolerance, body size, and other health factors; any amount is potentially lethal, especially in children and toddlers who have not developed tolerance and are in small bodies.

High Potency Synthetic Opioids are synthetic opioids that have stronger effects than other opioids. They are typically used to treat severe pain when used in a medical setting. Because they are stronger, they come with a higher risk of addiction. HPSOs can also be produced and sold illegally. Currently, most HPSOs concerning child welfare are fentanyl or fentanyl analogs.[3]

The primary HPSO on the illegal drug market currently is fentanyl. Illicit fentanyl can be pressed into pill form or distributed as a powder. Because synthetic fentanyl is much cheaper to produce, it has become the predominant HPSO in Washington.[4]

Physical Dependence happens when a person's body gets used to the substance and they experience withdrawal symptoms, including flu-like symptoms. Physical dependence is distinct from addiction. Any opioid of any potency, when taken over a period, will result in physical dependence.

Substance Use Disorder (SUD) "Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." [5] A person with SUD may experience physical dependence and withdrawal, but a person who is experiencing physical dependence doesn't necessarily meet the criteria for a SUD diagnosis.

Opioid Use Disorder (OUD) is a type of SUD that is defined by a person's use of opioids.

Overdose If a person takes too much of an opioid it can alter their consciousness and slow or stop their breathing, which can lead to death. All opioids carry a risk of overdose. The risk increases with HPSOs because a person needs to consume much less because of the high potency. This risk increases again when using illicit HPSO, as a person may not know how high the potency is, and that potency will likely change from batch to batch (and even within a single batch).

MOUD Medications for Opioid Use Disorder

A person being on MOUD does not, absent other factors, constitute a threat to child safety.

Treatment Opioid use disorder (OUD) is a treatable medical condition where opioid use leads to significant problems or distress.[6] Historically, treatment for substance use has been done inpatient in facilities, but opioid use disorder does not require inpatient treatment. There are three main medications used in MOUD: methadone, buprenorphine, or naltrexone. The decision about which medication is right for a patient will depend on their unique circumstances and needs to be made in consultation with their medical provider.

Methadone and buprenorphine reduce the risk of overdose and can improve an individual's chances of achieving sobriety if that is their goal. It can also improve their overall health outcomes. Both methadone and buprenorphine are known to reduce overdose risk and death by any other cause for people with OUD. Unsecured medication can pose a risk to children, so safe storage is critical for patients taking these medications.[7] Naltrexone does not reduce overdose risk long-term for people with OUD.[8]

Methadone and buprenorphine provide a two-pronged approach to OUD treatment. It does this by:

1. Maintaining people's tolerance so that they are less likely to overdose if they return to opioid use while in treatment.
    a. In the early stages of treatment, tolerance to opioids changes rapidly, even over a matter of day(s) of non-use or less use. The desire to avoid painful withdrawal symptoms drives continued opioid use and many of the behaviors that disrupt the lives of people with OUD.
    b. As treatment progresses, patients in long-term recovery do see their tolerance go down.
2. Helping manage cravings and withdrawal symptoms.

MOUD is provided in outpatient settings. Methadone is only available at Opioid Treatment Programs (OTPs). At first, patients attend daily and receive therapy under observation. This makes transportation necessary and creates barriers to access given the appointment burden. Once a person is stable, they can receive some take-home doses. Buprenorphine is widely available at OTPs. Patients can also get it from primary care providers, specialized substance use disorder centers, and some harm reduction sites.

FDA-Approved Medication Treatments for OUD[9]

Medication	Mechanism	Risk of Overdose and All-Cause Mortality	Other Benefits	Notes
Methadone	Full Agonist (activates opioid receptors)	Reduces overdose risk; reduces overall mortality risk	Helps manage cravings and withdrawal symptoms.	Methadone is preferred by some patients but is difficult to access due to state and federal regulations.
Buprenorphine	Partial Agonist-Antagonist (partially activates opioid receptors)	Reduces overdose risk; reduces overall mortality risk	Helps manage cravings and withdrawal symptoms.	Buprenorphine is easier to get from providers, but there is not enough available in most communities.
Naltrexone	Antagonist (blocks opioid receptors)	Does not reduce overdose risk or death by other cause	May reduce cravings	Reduces tolerance to opioids, increases the risk of overdose if a relapse occurs.

How HPSOs Enter the Body and the Risk They Pose

The primary risks to children and adolescents regarding HSPOs are:

- swallowing
- snorting
- inhaling
- direct skin contact via a **transdermal patch**
- injecting

HPSOs can come as pills that can be swallowed or crushed and then smoked, snorted, or injected. HPSOs in pill form are available as prescribed medications, and there are also pills available in the illicit drug market.

There are also powder forms of illicit fentanyl available that can be smoked, snorted, or injected. Medically prescribed fentanyl is available in a transdermal patch, which is specifically designed to be absorbed by the skin.

Fentanyl in pill or powder form is not readily absorbed by the skin if touched. Injection can carry a higher risk of overdose, followed by snorting and smoking. Taking illicitly manufactured HPSO by mouth also carries a risk of overdose because the strength of the opioid in the pill is unregulated and unknown. The

risk of overdose while taking opioids, including HPSOs and MOUDS, as directed by a medical provider is low.

Some individuals experience health problems, and failure to meet major responsibilities at work, school, or home when in periods of HPSO use. These struggles can be intermittent and interdependent with other challenges and supports in the individual's life.

Overdose Risk via Direct Skin Contact
There are no known cases of overdose from direct skin contact with opioids in powder or pill form, as these do not absorb well through the skin. Prescribed fentanyl patches are an exception, as they are specifically designed to deliver medication through the skin.

Secondary and Environmental Exposure
There is no known risk of overdose from exposure to HPSO second-hand smoke or environmental smoke. HPSOs are quickly taken up by the lungs and most of the drug is not exhaled. The long-term impact of environmental exposure to HPSO secondhand smoke is currently unknown.

Lactation
Opioids enter human milk, but the amount depends on the type of opioid that was taken and how long it has been since it was taken. Opioid levels are the highest 1-3 hours after use and naloxone does not remove them from human milk. We do not know how long it takes for HPSOs like fentanyl to be completely eliminated from human milk. If a parent uses fentanyl their milk should be pumped and discarded. Once the parent has not used fentanyl for 3-5 days, they can resume feeding the child their milk. Giving your child human milk is safe when taking MOUDs, like methadone and buprenorphine. For more guidance, see the DOH Lactation and Substance Use Guidance for Health Care for Professionals.[10]

Risk Considerations by Life Stage

For risk considerations during pregnancy and birth, see Appendix C.

Infants and Toddlers
The age group at highest risk for unintentional exposure to any substance, including opioids, is children ages 1-4 with the highest risk falling around age 2.[10, 11] Children in this age group explore their surroundings actively to discover things.[12] This includes putting things they find in their mouths. Additionally, children who have not taken opioids do not have tolerance built up which also increases their overdose risk.

Parents and caregivers should be taught to be extra vigilant due to their child's increased mobility and exploratory behavior. Taking any dose of an opioid meant for an adult puts a child in this age group at overdose risk. Because HPSOs are so powerful, any amount poses risk to an infant and child.

Children in this age group are usually exposed to opioids at home. Caregivers should be taught about multiple harm reduction tactics to keep their children safe, including:

- Storing substances safely
- Keeping naloxone available and knowing how to use it

- Disposing of paraphernalia safely
- Using with a trusted person
- Making sure children are cared for by a capable person while using
- The importance of safe sleep practices and storing medications, substances, and paraphernalia away from the bed [12]

As children grow older, their risk of exposure through accidental ingestion decreases by 6% for each year of age.[13] Please note that children reach developmental stages at their own pace, especially children with disabilities. Developing relationships with parents and children can help you provide more tailored support.

Middle Childhood

Middle childhood (ages 5-12) has the lowest risk of accidental or intentional exposure to opioids. Children in this age group are generally past the developmental milestones of exploratory behavior and putting things in their mouths. They have also not reached the developmental milestone of adolescence that involves increased experimentation. Children reach developmental milestones at their own pace, so risk cannot be determined based solely on numerical age.

Adolescents

Nationally, drug overdose deaths increased among people ages 14-18 by 109% from July- December 2021 compared to the same period in 2019. Approximately 90% of these deaths involved opioids.[14] This age group is typically exposed through intentional experimentation with substances. Two-thirds of adolescent overdose deaths occurred in the youth's home. Often there is another person there who didn't know the youth was using opioids.

Teens experimenting with substances is different than small children accidentally swallowing substances. Caregivers and professionals must use different ways to prevent teens from overdosing. While most teen substance use interventions focus on prevention, a harm reduction approach is also warranted. Harm reduction can help youth engaged in developmentally normal risk-taking behaviors to do so with more knowledge and capacity to engage in safer practices.[15] These strategies should be shared with teens regardless of whether they say they and/or their friends are using substances, as some may not be forthright about this experimentation. Universally providing naloxone and harm reduction education will ensure that those at risk will have needed access to life-saving practices.

Like adults, adolescents experiencing OUD can benefit from MOUD. The Washington State Poison Control can be reached at 800 – 222 – 1222 for any concerns around substance exposure.

Risk Reduction and Protective Factors

The decision to remove a child from their primary caregiver is a complex issue. Here are some risk reduction and protective factors to take into consideration when assessing child safety.

Safe Storage

Safely storing medications and potentially dangerous substances is key to protecting children and adults. High-potency synthetic opioids, and drug paraphernalia, must be stored in child-resistant containers, out of sight and out of reach of children. This includes putting locks or child-safety latches on cabinet drawers and keeping bags or coats that may contain medicine and substances out of reach. Families

should be given these safety tools if they can't purchase them. Securing prescribed and unprescribed substances from teens can also be protective.

Prescribed and unprescribed substances should be discarded in secure garbage cans where a child cannot access them or be stored out of children's reach. Storage guidance mirrors the safe storage of medication guidance. Ideally, opioids would be discarded at safe medication return sites.

Drug paraphernalia (straws, spoons, bags, foil, pipes, syringes, etc.) may have residual amounts of HPSOs on them which could cause an overdose. Thus, this paraphernalia should be stored or disposed of where it is not accessible to children to avoid accidental ingestion. Sharps containers, available through Safe Syringe Programs and health care providers, prevent the removal of objects placed in them and can be adequately used for disposal of drug paraphernalia. These containers can then be returned for disposal with other medical waste. Additional resources regarding disposal can be found at EPA, King County, CDSS.CA.GOV, and Cowlitz online.

In Washington, children under age 5 have died due to both high-potency synthetic opioids and medications for opioid use disorder. While the number of children who have died from MOUD is very low, it is still a risk that caregivers should be made aware of. Making sure families can store substances safely is key to preventing overdose deaths.

Providing Naloxone

Making sure caregivers have access to naloxone is a key factor in preventing overdose. Currently available, over-the-counter formulations of naloxone are safe and effective doses for adults and children."

Naloxone is safe to use in adults, adolescents, and children. Naloxone use is relatively safe in pregnancy and can save the lives of both the person who is pregnant and the fetus. Naloxone is safe for infants and children when given to a breast/chest-feeding parent.[16] Teaching parents how to administer naloxone in the case of accidental ingestion could help to prevent fatal overdoses; welfare workers are uniquely situated to be able to both provide this life-saving medication and teaching on how and when to use it to these at-risk populations. Training resources can be found on the Washington State Department of Health website.

Safe Sleep

Infants and toddlers co-sleeping with adults can create a risk to child safety for many reasons, including an increasing risk of overdose if the child is placed in a bed where HPSO use occurs. Caregivers should follow safe sleep guidance and place infants in a separate sleeping location on their backs with minimal bedding. Infants 4 months or younger should not bed share, especially "with someone who is impaired in his or her alertness or ability to arouse because of fatigue or use of sedating medications (e.g., certain antidepressants, pain medications) or substances (e.g., alcohol, illicit drugs)".[17] Young children should not sleep with HPSOs, unlocked medications, or drug paraphernalia in reach.

Harm Reduction and Reducing Stigma

There are proactive evidence-based strategies and promising practices people who use HPSOs engage in to reduce the negative consequences of drug use, also known as harm reduction approaches. Regular access to services like syringe service programs can help to provide tools necessary for safer use, an understanding place to discuss strategies of harm reduction and overdose prevention and a connection

to ancillary support services. The use of these types of services strongly implies that a person is actively engaged in their own health. For example, someone engaging in practices like testing a small amount of their drugs before using a larger dose or using with another person demonstrates not only an active engagement in evidence-based practices of overdose prevention but furthermore, a desire for more positive health outcomes.[18]

Caregivers are less likely to seek substance use disorder treatment due to fear of child welfare involvement. Long-term, this may mean a caregiver is less likely to access or know how to use naloxone.[19] Teaching harm reduction strategies and providing access to SUD services without fear of losing children is a critical intervention for both parent and child.

Families do best when they have trusted relationships with providers. Building trust with families involves respect for their autonomy, acceptance, and hospitality, giving many options to get support, promoting safety, engaging before acting, and prioritizing listening. Systemic racism combined with drug user stigma leads to disproportionate consequences in systems. This makes trust-building more important. These relationships can help to engage caregivers in carrying naloxone, understanding the dangers of HPSOs, using lockboxes, accessing treatment, connecting to age-appropriate therapeutic services, learning positive parenting skills, and supporting family reunification.[20]

For more information on reducing stigma, see Appendix E.

Supporting Social and Physical Needs

Nurturing and stable relationships with caring adults are necessary for child development. While young children can establish healthy relationships with more than one or two adults, prolonged separations from their familiar caregivers are distressing. Efforts must focus on supporting parent-child stability as much as possible. According to the World Health Organization, "Efforts should be directed primarily towards enabling the child to remain in, or return to the care of their parents, including by assisting drug-dependent parents in carrying out their childcare responsibilities."[21]

Parental opioid use is impacted by the social determinants of health – the non-medical factors that impact a person's health. Some of the determinants include:

- poverty
- health care access and quality
- housing stability
- community environment

Reducing negative impacts related to social determinants can have a huge impact on families. For example:

1. Increasing access to MOUDs for caregivers and adolescents experiencing OUD.
2. Helping families connect with social and health service programs, including legal services, public benefits, and affordable housing, can mitigate substance use and promote stability and safety in the home.
3. Offering respite care for parents and connections to medical and behavioral health treatment, including medications for opioid use disorder, can prevent the need for removal from the home, or reduce the time of removal.

4. Providing access to quality childcare makes sure children have positive, engaging relationships outside of the home. It also allows the parent to use safely while a child is under care.[22, 23, 24]

Making sure a collaborative system is in place to support parents and children is recommended. Understanding harm reduction and issues surrounding SUD and treatment can lead to early identification of needed resources, equitable access to treatment, and a family-centered approach.[25]

Summary Table

This table summarizes example risk and protective factors to consider when assessing child safety. This list is intended to provide examples. It is not an exhaustive list and should not be used as a checklist to determine whether the child welfare system has met any of its statutory requirements.

	Developmental and Other Risk Considerations	Protective Factors and Signs of Stability	Supports to Families
Prenatal and Birth	• Exposure through human milk • Stressors during pregnancy and postpartum • Withdrawal symptoms for newborn and birthing parent • Hesitancy to initiate prenatal care due to fear of stigma or loss of custody	• Birthing parent and newborn participate in Eat, Sleep, Console • Parent receives withdrawal management and Medications for Opioid Use Disorder • Birthing parent receives a warm connection to long-term supports through postpartum and early parenting stages • Family establishes Plan of Safe Care • Caregiver uses harm reduction strategies • Child welfare (and other) service providers are trained on how to engage without stigma, identify needs, connect families to resources, and help teach and operationalize harm reduction strategies	• Lactation Consultation • Legal consultation • Parenting education • Screening for intimate partner violence and perinatal mental health • Transportation support to MOUD and other treatment • Housing and economic support • Referral to home visiting services • Access to quality health care • Stigma-free, non-biased, and culturally competent care

Infants	• Oral exploration stage • Accidental ingestion of illicit and prescribed opioids, primarily hand-to-mouth • Vulnerable to sleep-related deaths	• Caregivers are educated on and follow safe sleep practices • Caregivers are educated on poison proofing for infants and have access to lock boxes and child safety devices • Caregivers have another person to care for their infant while they are using substances • Family is actively engaged in Plan of Safe Care • Family has stable housing • Caregiver uses harm reduction strategies, including carrying naloxone • Caregiver is receiving SUD treatment and mental healthcare • Caregiver has safety plan around return to use • Child welfare (and other) service providers are trained on how to engage without stigma, identify needs, connect families to resources, and help teach and operationalize harm reduction strategies	• Lactation Consultation • Legal consultation • Parent education on safe storage of substances, risk of overdose for child • Screening for intimate partner violence and perinatal mental health • Transportation support to MOUD and other treatment • Housing and economic support • Childcare subsidies • Stigma-free, non-biased, and culturally competent care
Toddlers	• Moving, exploring, reaching • Accidental ingestion of illicit and prescribed opioids, primarily hand to mouth. • Skin exposure to fentanyl patch (rare)	• Caregivers are educated on and follow safe sleep practices • Caregivers are educated on poison proofing for infants and have access to lock boxes and child safety devices • Caregivers have another person to care for their	• Legal consultation • Parent education on safe storage of substances, risk of overdose for child • Screening for intimate partner violence and perinatal mental health

		infant while they are using substances • Family is actively engaged in Plan of Safe Care • Family has stable housing • Caregiver uses harm reduction strategies, including carrying naloxone • Caregiver is receiving SUD treatment and mental healthcare • Caregiver has safety plan around return to use • Child welfare (and other) service providers are trained on how to engage without stigma, identify needs, connect families to resources, and help teach and operationalize harm reduction strategies	• Transportation support to MOUD and other treatment • Housing and economic support • Childcare subsidies • Stigma-free, non-biased, and culturally competent care
Youth	• Developmentally at experimentation age • Substances use in the home • Co-occurring substance use or mental health disorder • Family instability • Housing and economic instability	• Caregiver engaging in harm reduction strategies, youth taught about harm reduction strategies, including naloxone in home • Caregivers are educated on safe storage for adolescents • Youth have a relationship with nurturing adult within or outside the home • Preventing early childhood trauma • mitigating harm and building resilience for those who've experienced trauma • Youth have access to stigma free care and	• Treatment of co-occurring disorders and trauma • Parent education on safe storage of substances, risk of overdose for youth • Parenting education • Housing and economic support • Other mentor adults • Stigma free, non-biased and culturally competent care

		harm reduction strategies • Child welfare (and other) service providers are trained on how to engage without stigma, identify needs, connect families to resources, and help teach and operationalize harm reduction strategies	

Appendix A: Legislative Environment in Washington State

Washington State law concerning child abuse and child removal includes chapters 26.44 and 13.34 RCW.[26, 27] These chapters do not equate substance use alone to child abuse and neglect, rather RCW 13.34.065 explicitly states both that the existence of substance abuse or prenatal drug or alcohol exposure "does not by itself constitute imminent physical harm," and that there must be a causal relationship between the conditions of the home and the imminent risk of physical harm to the child in order for a child to be removed from the home.[28] The use of high-potency synthetic opioids does not equate to substance use disorder, which is characterized by a problematic pattern of use leading to impairments in behavior or ability to have control over substance use.[29]

Chapters 26.44 and 13.34 RCW have prioritized keeping families intact or ensuring reunification when possible. RCW 13.34.020 states that "the legislature declares that the family unit should remain intact unless a child's right to conditions of basic nurture, health, or safety is jeopardized." [30] Similarly, RCW 13.34.025 directs the Department of Children, Youth, and Families to "ensure that parents in dependency proceedings under this chapter receive priority access to remedial services…" [31] Remedial services are defined in the same RCW as "family reunification services that facilitate the reunification of the child safely and appropriately within a timely fashion." This aligns with well-established public health research, which prioritizes supporting parental-child attachment in a nurturing environment.[32]

The 2021 Keeping Families Together Act amended chapters 26.44 and 13.34 RCW in order to "safely reduce the number of children in foster care and reduce racial bias in the system by applying a standard criteria for determining whether to remove a child from a parent when necessary to prevent imminent physical harm to the child due to child abuse or neglect, including that which results from sexual abuse, sexual exploitation, or a pattern of severe neglect." [33] Prior to the passage of 2024 SB 6109, the removal standards in chapters 26.44 and 13.34 RCW have aimed to keep families intact except when: [34]

- Removal is necessary to prevent imminent physical harm due to child abuse or neglect, including that which results from sexual abuse, sexual exploitation, or a pattern of severe neglect; or
- A manifest danger exists that the child will suffer serious abuse or neglect if the child is not removed from the home, and a temporary restraining order or injunction under RCW 26.44.063 would not protect the child from danger.

Passed in 2024, SB 6109 also amends chapters 26.44 and 13.34 RCW and directs courts that the lethality of high-potency synthetic opioids and public health guidance from the Department of Health related to high-potency synthetic opioids should be given great weight in deciding if removal of a child is necessary to prevent imminent physical harm or manifest danger due to child abuse or neglect. It also adds high-potency synthetic opioids to the list of factors that may result in imminent physical harm due to child abuse or neglect.

Appendix B: Data Snapshot

For children 5 and under, deaths per year due to accidental drug overdose remained steady from 1999 – 2021, with slightly under the average of 2 deaths per year. In 2022, we saw a statistically significant increase in the number of overdose deaths due to fentanyl (n<10 for 2022). Preliminary data from 2023 indicates there were at least as many overdose deaths due to fentanyl as seen in 2022. For children aged 6-10, deaths per year due to drug overdose have remained less than 2 from 1999 – 2023.

For youth aged 11-15, annual deaths due to overdose ranged from 0-4 from 1999-2019. From 2019 – 2023 (preliminary data for 2023), numbers oscillated between 5 and 10 deaths per year. For older youth and young adults aged 16 – 20, annual deaths ranged from 9 to 45 depending on the year from 1999 – 2019. From 2019-2023 (preliminary data for 2023), overdose deaths for this age group were notably higher than in the twenty years prior, with 85 deaths occurring in 2021 and 83 in 2022.

The Washington State Office of the Family and Children's Ombuds reports on child fatalities and near fatalities, which are critical incidences that occur when a family was involved in the child welfare system within the preceding 12 months.[2] These data include critical incidences connected to accidental ingestion and overdose.

Appendix C: Risk Considerations During Pregnancy and Birth

Pregnancy and Birth

Pregnancy can be a unique time of life when people are open to change and often want to find stability for themselves and their families. A compassionate approach can help a person who is pregnant enter treatment for OUD. It is also a very physically and emotionally stressful time. Without support, parents face an increased risk of substance use disorder. Pregnant people need compassionate, stigma-free care that focuses on supporting their mental health and treatment needs and encourages them to see a doctor early on in their pregnancy.

Opioid use disorder can negatively impact maternal health, including increasing the risk of maternal death due to overdose.[35] While the effects of prenatal opioid exposure on children over time are largely unknown, best practice for caring for a newborn with opioid withdrawal is well established.

Opioid use disorder is treatable during pregnancy. The American Society of Addiction Medicine and American College of Obstetrics and Gynecology released a joint opinion in 2017 stating:

"For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse outcomes. More research is needed to assess the safety (particularly regarding maternal relapse), efficacy, and long-term outcomes of medically supervised withdrawal."[36]

Eat, Sleep, Console

The Eat, Sleep, Console model is a non-stigmatizing or inclusive approach to care. It prioritizes the birthing parent's role in comforting and caring for the newborn. It lets staff monitor the infant to check how well they eat, sleep, and can be consoled. This inclusive approach lets the infants stay in the same

room with their parents. It is linked to a reduced need for medication, improved rates of chest or breastfeeding, and higher rates of newborns being discharged in family custody.[37]

The care delivery should include managing withdrawal symptoms for newborns and the birthing parent. Medications for Opioid Use Disorder (MOUDs) should be offered during pregnancy, at delivery, and after childbirth. It's important to prioritize stigma-free support to parents receiving treatment for opioid use disorder, as this is a stressful life stage for families. Washington State's Plan of Safe Care takes a family-centered approach to promote the safety and well-being of birthing parents and their infants affected by the parent's use of substances during pregnancy. The plan helps make sure families receive the mental health, social, developmental, parenting, and physical support they need to help reduce negative outcomes for their infant.

Appendix D: Fentanyl Test Strips and Drug Testing

Fentanyl test strips allow people to test substances to make more informed decisions while using. While these test strips are not confirmatory because they can produce false positives and false negatives, they can provide some risk reduction when combined with other harm reduction strategies like using with others who could help respond to an overdose and administer naloxone. People using test strips should be educated about how the strips work, their accuracy, and how to combine them with other harm reduction techniques.[38]

Appendix E: Additional Reading

Stigma

- Respect to Connect: Undoing Stigma.[39]
- Disrupting Stigma: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use and Mental Disorders[40]

Harm Reduction

- Principles of Harm Reduction[41]
- Harm Reduction at SAMHSA[42]
- Harm Reduction International: What is Harm Reduction?[43]
- Johns Hopkins: What is Harm Reduction?[44]

Cleaning Guidelines

- Decontamination options for indoor surfaces contaminated with realistic fentanyl preparations[45]
- Minnesota Department of Health and Minnesota Poison Control System: Fentanyl Exposures and Cleanup[46]

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