



PUBLIC HEALTH GUIDANCE ON HIGH  
POTENCY SYNTHETIC OPIOIDS  
JUNE 2025  
KATIE EILERS AND EMALIE HURIAUX

# What we will cover today

Background: Senate Bill 6109

Public Health Framing

Data and Surveillance

Updated Guidance

Group Discussion

# Background on Senate Bill 6109

Passed in 2024

---

First law of its type in the nation

---

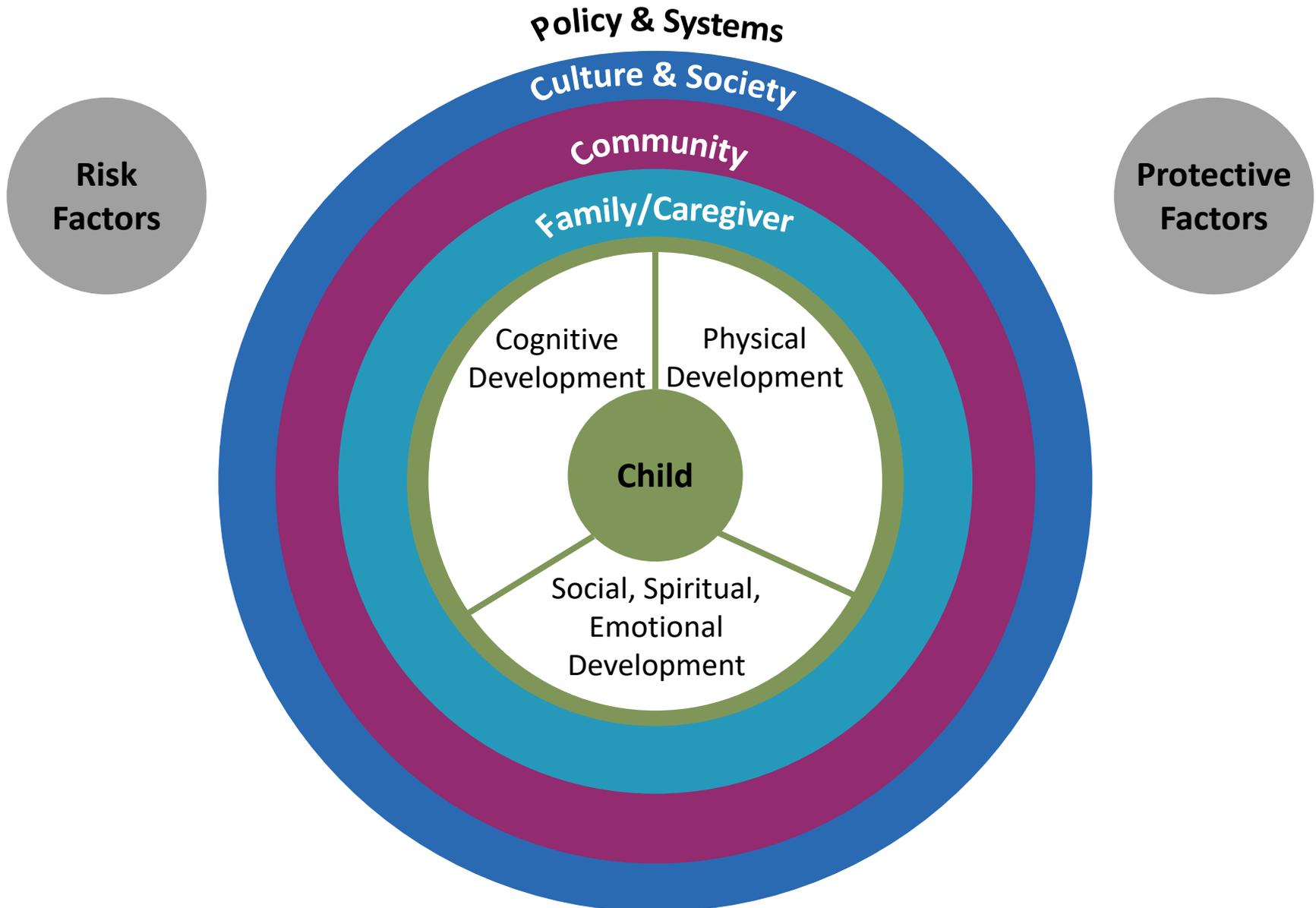
Directs DOH to create  
public health guidance  
and establish a workgroup





# Framing HB 6109 in Public Health

# Child Health in the Context of Social Determinants



# Harm Reduction

---

Harm Reduction comes from a community-based history that centers

Recognition that some harms are inherent

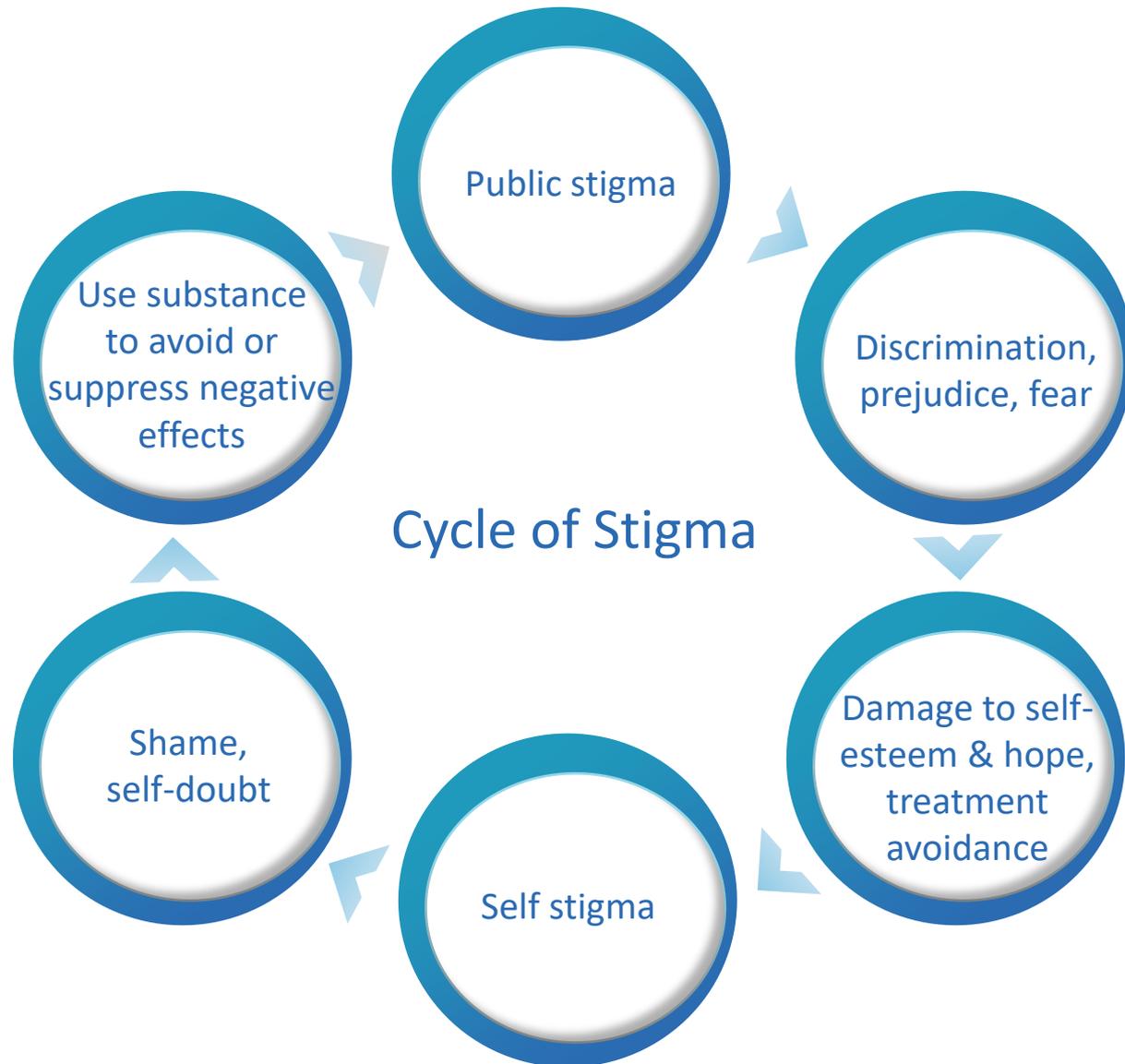
Recognition that some harms can be mitigated

Understanding of the context(s) in which harm occurs

Genuine relationships with those receiving services

Self-determination

# Stigma and Recovery

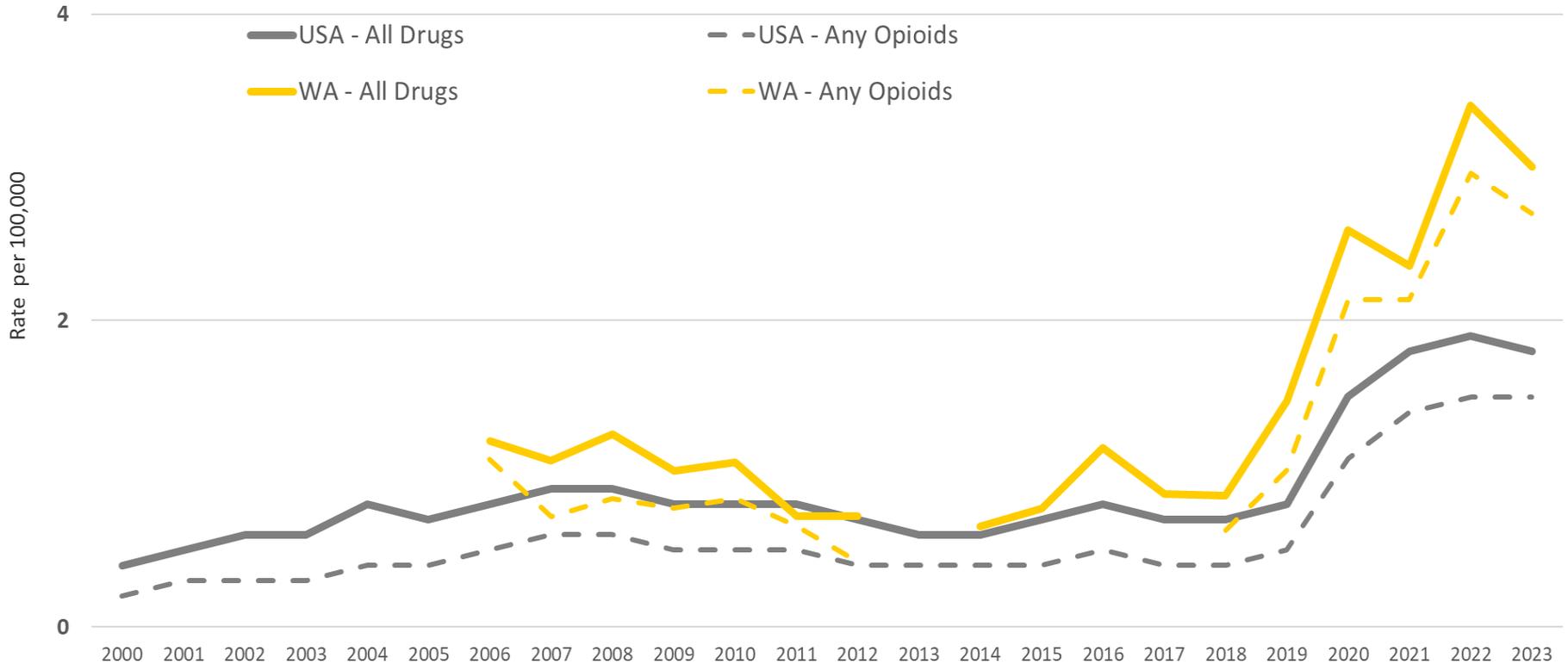




# DATA AND SURVEILLANCE

# Youth Overdose Rates

Drug Overdose Death Rates among Youth (ages 0-18),  
USA and WA State (2000 - 2023)



USA Data Source: [CDC WONDER](#)

WA Data Source: Washington State Department of Health,  
Center for Health Statistics, Death Certificate Data.

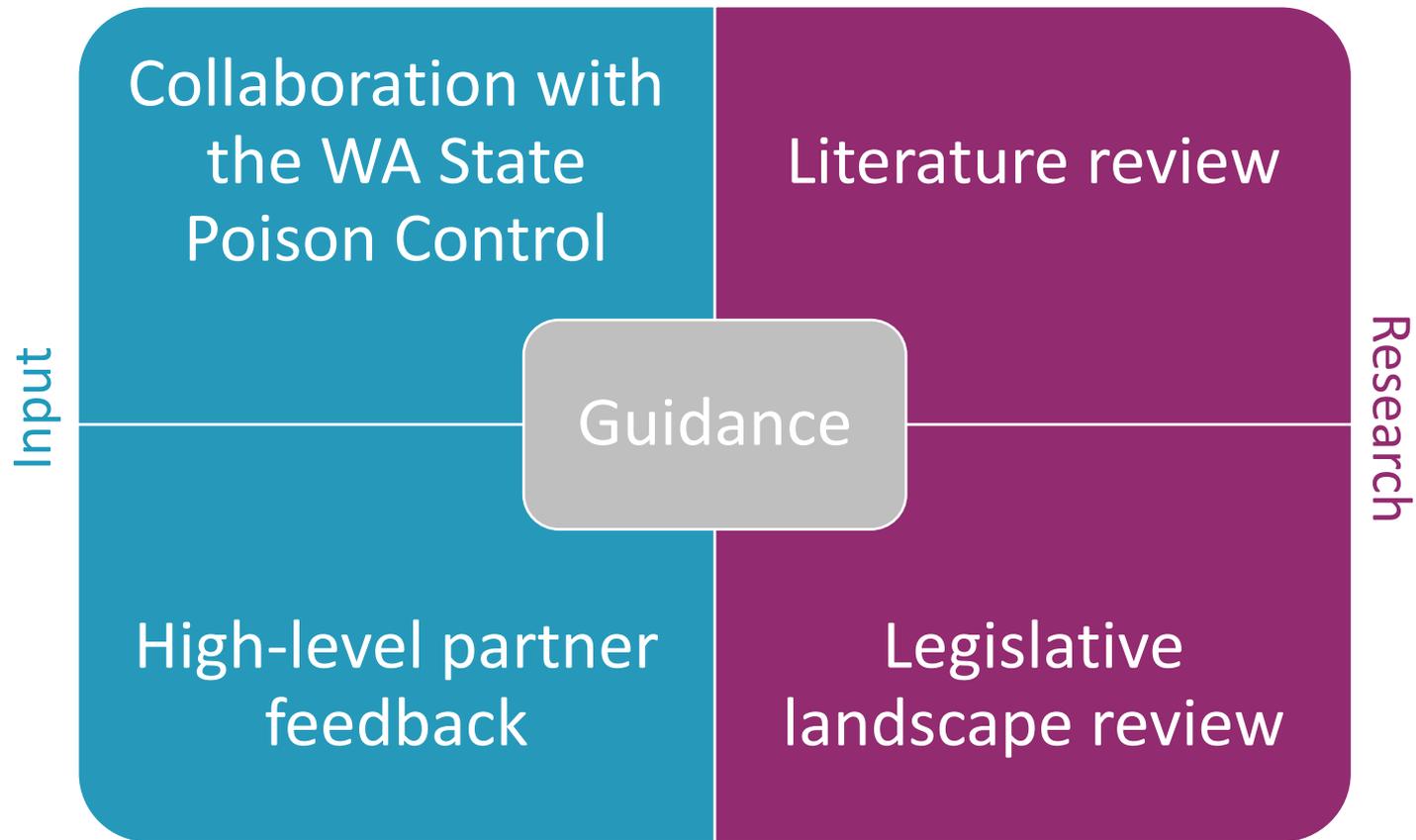
Data Last Updated on: 5Jue2025.



Guidance

# Guidance Development

---



# Strengths of Guidance

---

Dynamic, can be updated with emerging evidence

Incorporates scientific understanding of developmental risk

Incorporates actionable harm reduction steps

Holistic approach

# Limitations of Guidance

---

Not prescriptive, static, or algorithmic

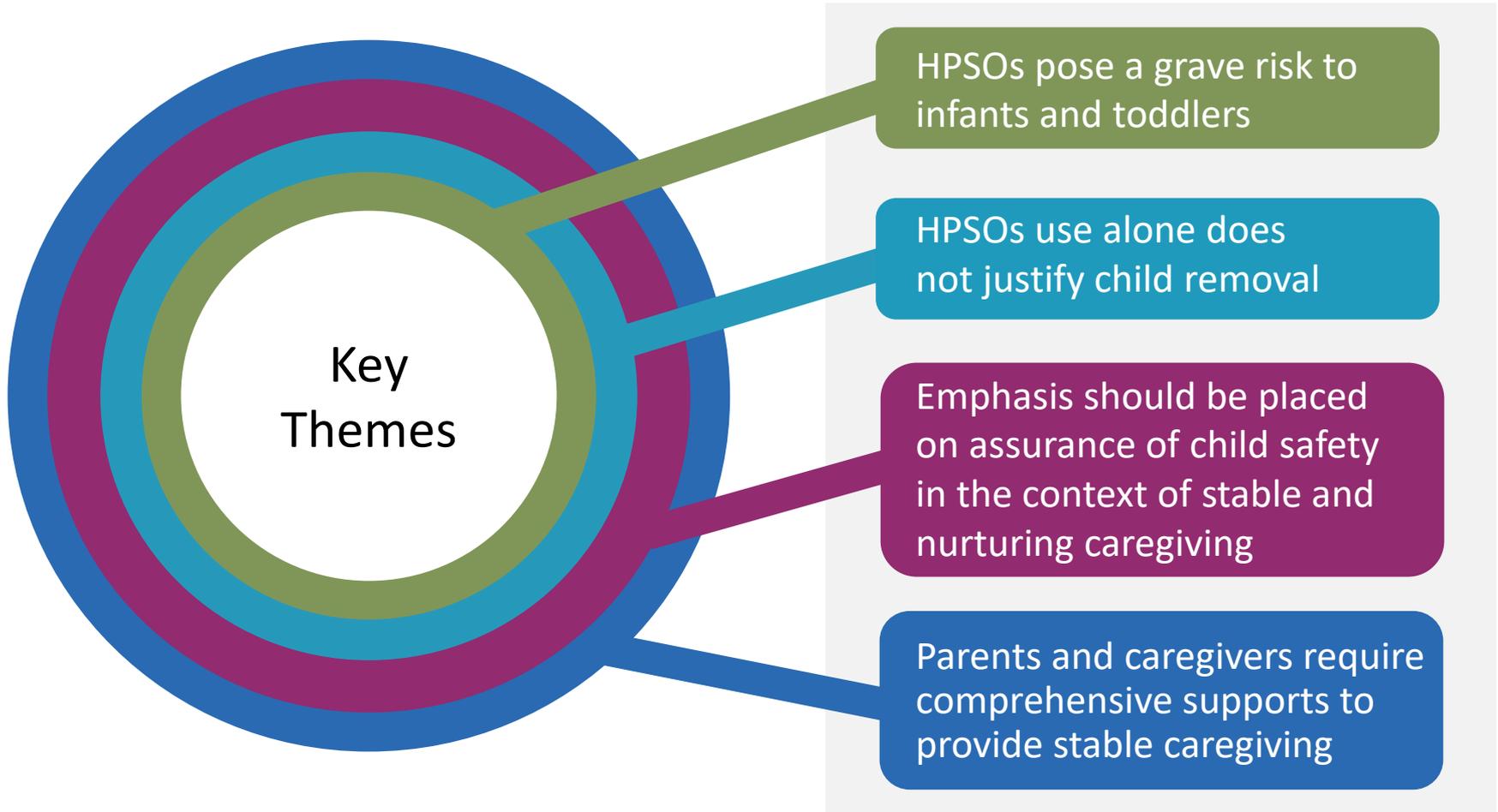
Not one-size-fits-all as each case is unique

Understanding of High-Potency Synthetic Opioids (HPSO)  
risk to children is still emerging



Key themes

# Key Themes from the Guidance





# DEFINITIONS

# High-Potency Synthetic Opioids

Manufactured opioids with stronger effects than other opioids. Because they are stronger they can cause more harm. Fentanyl is currently the primary HPSO on the illegal drug market.

Enters the body through:

- Swallowing
- Snorting
- Inhaling
- Injecting

# Opioid Use Disorder

---

A type of substance use disorder involving use of opioids resulting in

Health  
problems

Disability

Disruption of  
one's life

Note: Not all people who use opioids have a substance use disorder.

# Medication for Opioid Use Disorder (MOUD)

	Buprenorphine & Methadone	Naltrexone	Treatment without MOUD
Reduce opioid-related mortality	✓		
Reduce all-cause mortality	✓		
Increase overdose risk		✓	✓

**MOUD keeps people alive**

Note: While not all people who use opioids have a substance use disorder, medication can still be helpful in keeping tolerance up and keeping them alive.

# Overdose and Naloxone

Reverses opioid overdose,  
including fentanyl

---

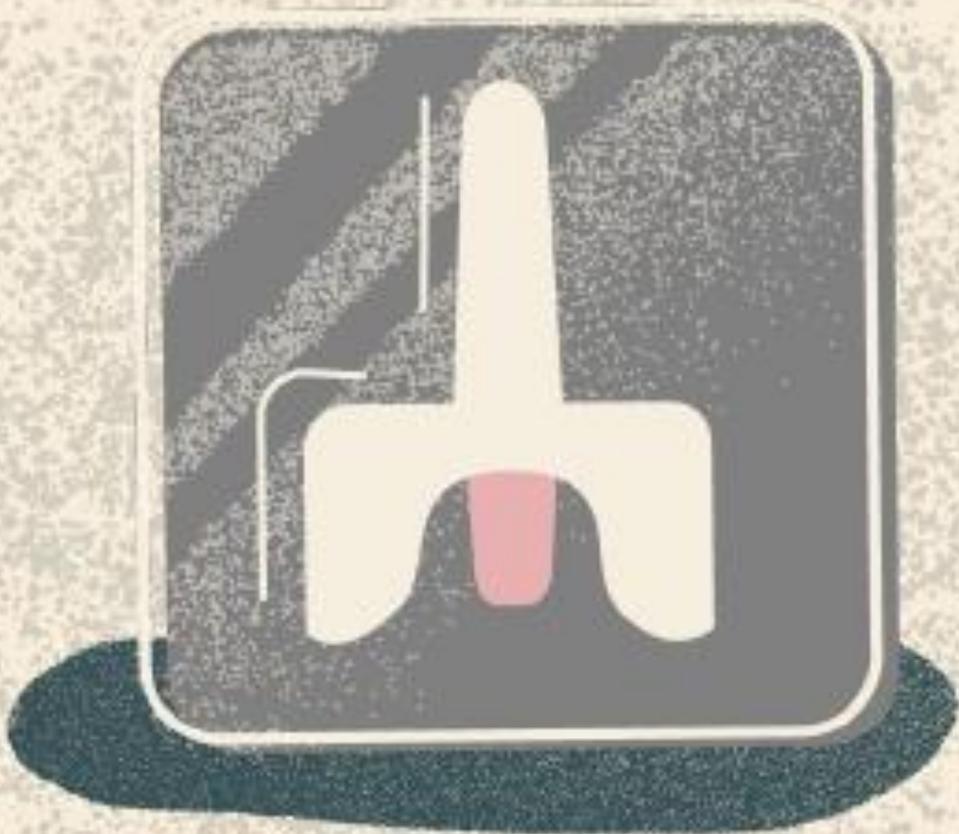
No effect on other  
substances

---

Cannot be administered by  
the person experiencing  
overdose

---

Safe for children, including  
infants!



# Child Opioid Overdose Deaths

---

**75.0%**

**of children were not  
administered Naloxone**

Among the cases of fatal  
synthetic opioid overdose in  
children ages 0-18 from  
2019 to 2023

Data source: State Unintentional Drug Overdose  
Reporting System (SUDORS), 2019-2023  
(Total Deaths = 176)

# Where to get naloxone

Over the counter with  
WA standing order

Billed to insurance  
(including Medicaid)

Syringe service programs

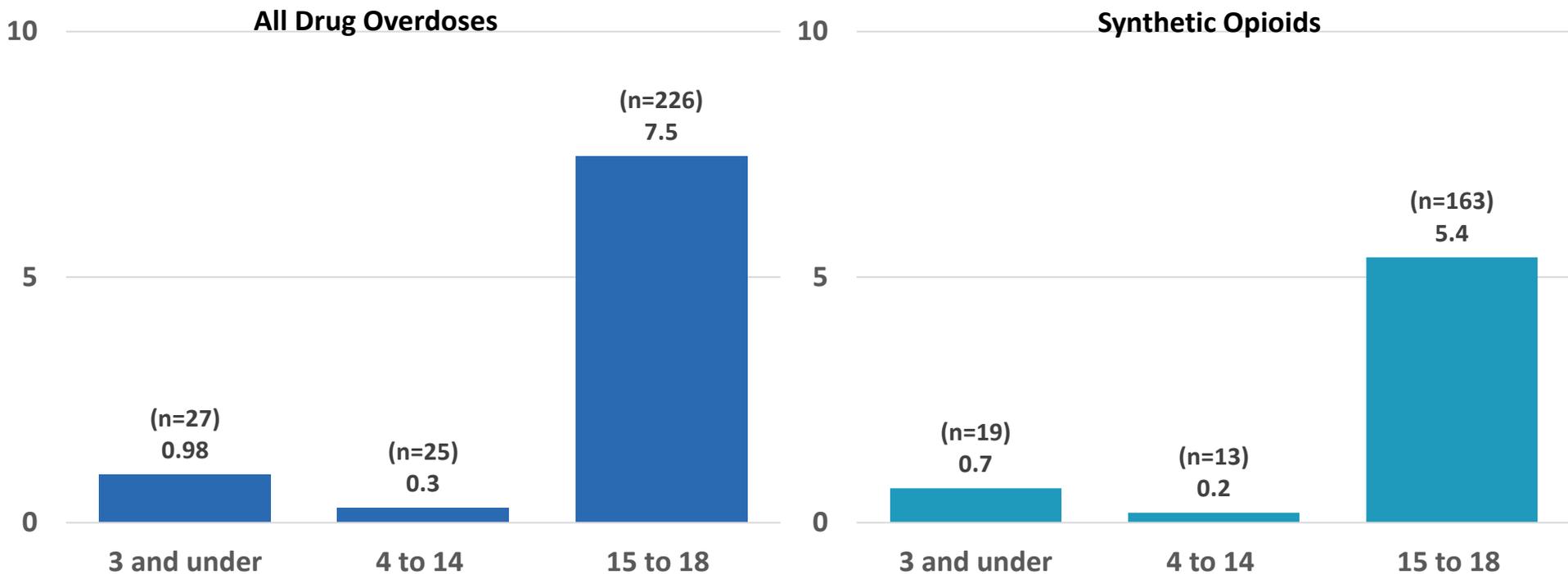
Through the mail



# DEVELOPMENTAL RISK OF HIGH POTENCY SYNTHETIC OPIOIDS

# Child Overdose Death Rates by Age

Overdose death rates (and counts) by age range among youth (ages 0-18) (2016-2023)



Data Source: Washington State Department of Health, Center for Health Statistics, Death Certificate Data. Data Last Updated on: 5 June 2025

# Child Overdose Death Rates by Location

Synthetic opioid overdose deaths (ages 0-18)  
by Location of Injury, 2016-2023

Location of Injury	# of Deaths	% of Deaths
Decedent's Residence	109	56%
Other Person's Residence	34	17%
Other or Unknown	52	27%
<b>Total</b>	<b>195</b>	<b>100%</b>

# Common Circumstances in Toddler Overdose Deaths

Common Circumstances in Synthetic opioid overdose deaths (ages 0-3), 2019-2024\*

Circumstances	# of Deaths	% of Deaths
Bed Sharing/Unsafe Sleeping Conditions	11	52%
Overdose Death Occurred while Parent Was Asleep	13	62%
Parental Drug Use	10	48%

Data source: State Unintentional Drug Overdose Reporting System (SUDORS), 2019-2024 (Total Deaths = 21)

\*Data for 2024 includes the first 6 months of 2024.

# Infants and Toddlers

Infants: Ages 0 to 6 months

High risk for unsafe sleep

Toddlers: Ages 6 months  
to 4 years

## Highest risk for unintentional exposure

- Exploratory behavior
- Increased mobility
- Putting things in their mouths

- Usually exposed at home
- Naloxone is critical



# Middle Childhood

Ages 5 to 12 years

Lowest risk for intentional and non-intentional exposure



# Adolescents

Ages 12 to 18 years

## Highest risk for intentional exposure

- Experimental behavior
- Overdoses often occur at home with another person there
- Naloxone is critical
- Teens can be treated with MOUDs





# PROTECTIVE FACTORS AND REDUCING RISK

# Safe storage

---

Medications, substances, &  
paraphernalia

Locked in safe storage and safely  
disposed of

Medication lock boxes  
should be made  
available

Parents and caregivers  
need training on safe  
storage

# Safe Sleep

---

Infants should be placed on their backs

Sleep environment free of hazards



**SAFE TO SLEEP**®

Prevent co-sleeping, especially for young infants

Medications not stored in or near bed

Parents/caregivers need education regarding safe sleep practices



Breastfeeding should not be discouraged. A plan for breastfeeding must be made in partnership with a health care provider.

# Protections and Supports for Families

---

Stable, supported caregivers are more likely to seek care for their substance use

Reducing stigma & recognizing bias supports caregivers who use drugs

Supporting basic needs, including housing, is critical to stability

Children & teens need nurturing environments

Families need practical supports to achieve harm reduction strategies

# Considerations

---

Emerging evidence on the impact of fentanyl on families

Data impacted by small numbers

Modified with significant input

First guidance of its kind in the nation



To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email [civil.rights@doh.wa.gov](mailto:civil.rights@doh.wa.gov).

A photograph of a woman with curly hair carrying a young girl on her back. Both are laughing heartily. The woman is wearing a purple long-sleeved shirt, and the girl is wearing a white long-sleeved shirt and blue overalls. They are outdoors with a blurred green background of trees.

# Medications for the Treatment of Opioid Use Disorder

(MOUD)

# Introductions

---

**Jessica K. Blose SUDP, LMHC, NCC, CCMHC**

Pronouns: she/her

Washington State Opioid Treatment Authority  
Manager of Behavioral Health Clinical Support  
Washington State Health Care Authority

**Email:** [jessica.blose@hca.wa.gov](mailto:jessica.blose@hca.wa.gov)

**Telephone:** 360-643-7850

# Medications for Opioid Use Disorder (MOUD)

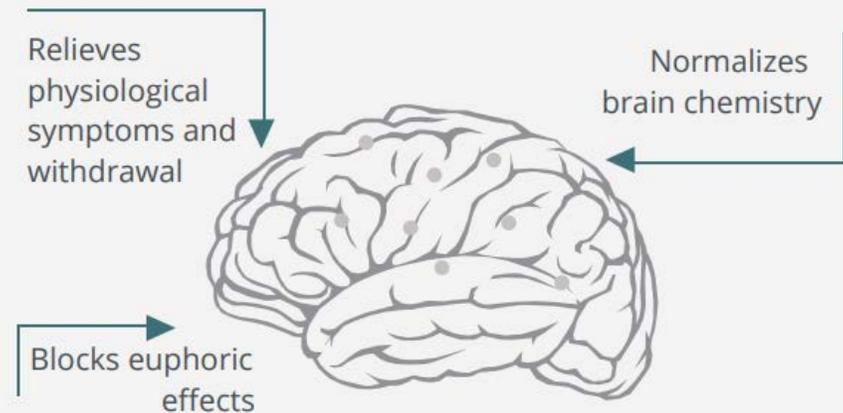
- ▶ They help:
  - ▶ Manage cravings and withdrawal symptoms
  - ▶ Reduce illicit opioid use
  - ▶ Decrease the risk of having an overdose

Medications can provide stability, allowing people to address other things in their lives.

Individuals can be in recovery and on medications at the same time!

## Medications for Opioid Use Disorder (MOUD)

### How It Works



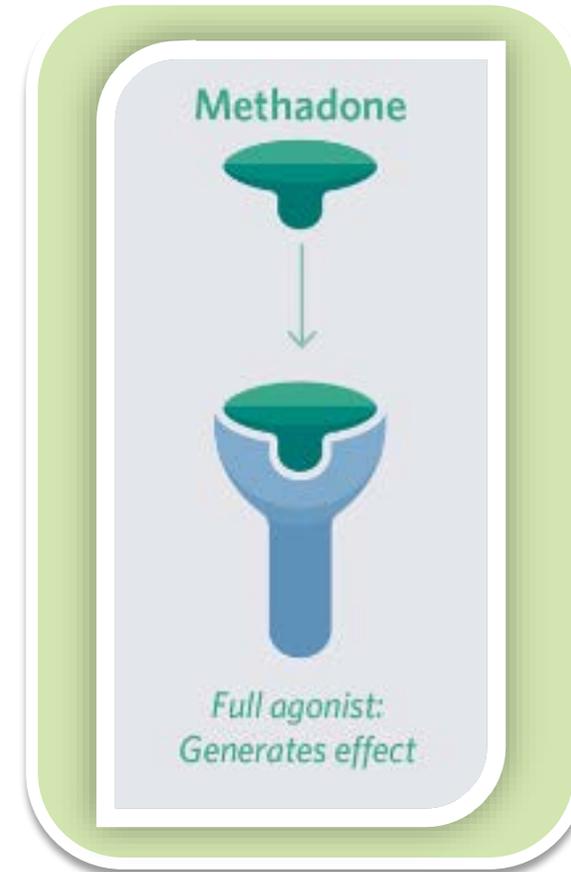
# Medications for Opioid Use Disorder (MOUD)

---

- ▶ There are 3 FDA-Approved medications for the treatment of opioid use disorder:
  - ▶ Methadone
  - ▶ Buprenorphine containing medication products
    - ▶ Such as suboxone, sublocade, brixadi.
  - ▶ Naltrexone containing medication products
    - ▶ Naltrexone.

# Methadone

- ▶ Methadone is a full opioid agonist medication.
- ▶ Most potent of the 3 FDA approved MOUD types.
- ▶ Reduces opioid withdrawal symptoms and cravings by binding more fully to opioid receptors in the brain.
- ▶ When taken as directed, lowers risk of overdose death by around 50%
- ▶ Increases patient's retention in treatment
- ▶ Lasts about 24 hours in the body, taken by mouth.



# Methadone

- ▶ Does have abuse potential if a patient takes more than the recommended dose.
- ▶ Potential for respiratory depression, overdose and death increases when taken along with other substances such as alcohol, hypnotics or sedatives, benzodiazepines.
- ▶ Overdose risk is present when taken by opioid naïve individual



# Methadone

- ▶ Medication can only be dispensed at Opioid Treatment Programs (OTP).
- ▶ OTPs are one of the most highly regulated treatment settings.
- ▶ OTP physicians review patient for adequate dosage amounts and can titrate medication upward for patients to reach a stable therapeutic doses, safely.
- ▶ If individual is injured, or a pain management patient, they may need higher doses of methadone to treat them.

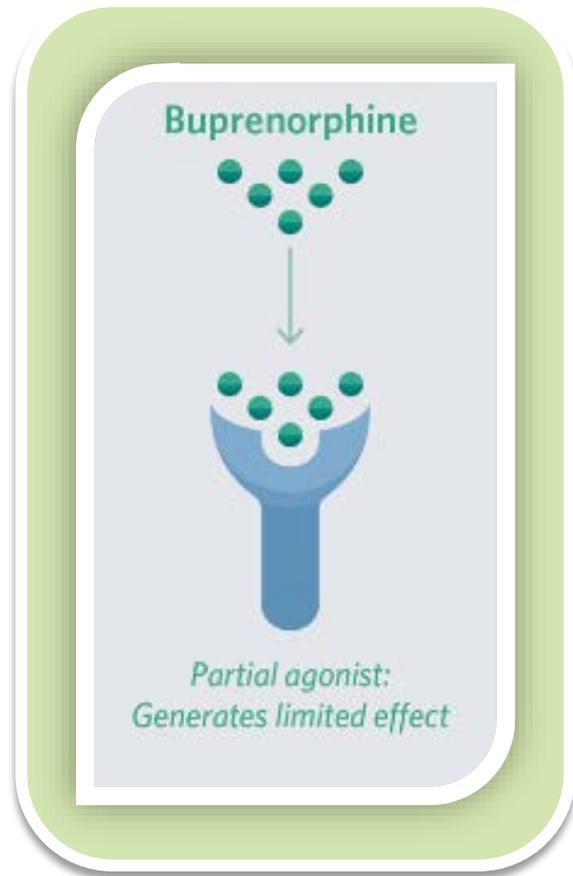


# Methadone

- ▶ Covered by WA Medicaid, with no prior authorizations
- ▶ There may be limited access to OTP in some regions of the state
  - ▶ [How to find an OTP: HCA's WA State Opioid Treatment Program Guide](#)

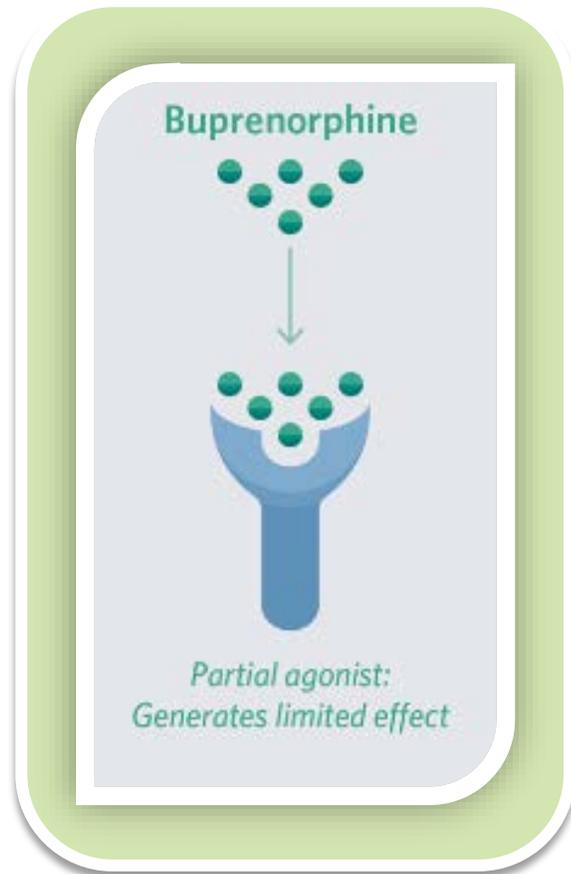


# Buprenorphine



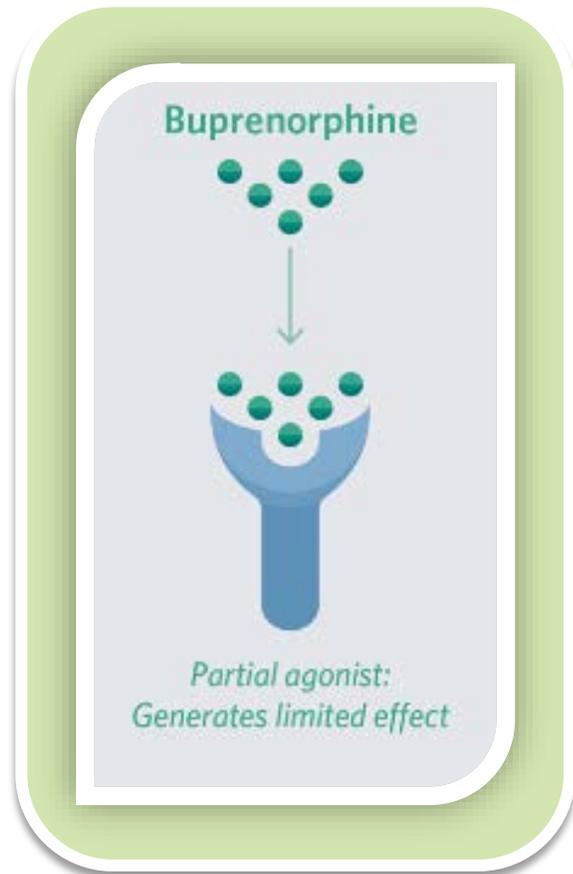
- ▶ Buprenorphine is a partial opioid agonist medication
- ▶ Reduces opioid withdrawal symptoms and cravings by binding to opioid receptors in the brain.
- ▶ Above a certain dose, medication has a built in “ceiling effect”.
  - ▶ Meaning that above a certain dose, you stop feeling more of its effects. Thus, a high unlikelihood of potential overdose in those who take it.
- ▶ When taken as directed, lowers risk of overdose death by 50%.

# Buprenorphine



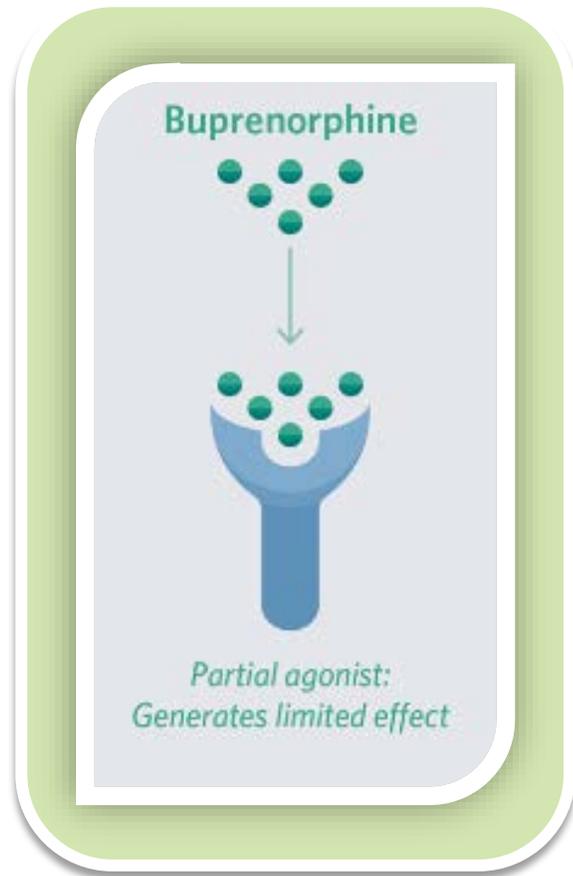
- ▶ Due to the “ceiling effect” referenced, the abuse potential of medication itself among opioid-dependant individuals is low.
- ▶ Does have abuse potential if taken by opioid naïve individuals.
- ▶ Combination products with naloxone- are theoretically less likely to be abused by IV route of administration.
- ▶ Potential for respiratory depression, overdose and death increases when taken along with other substances such as alcohol, hypnotics or sedatives, benzodiazepines.

# Buprenorphine



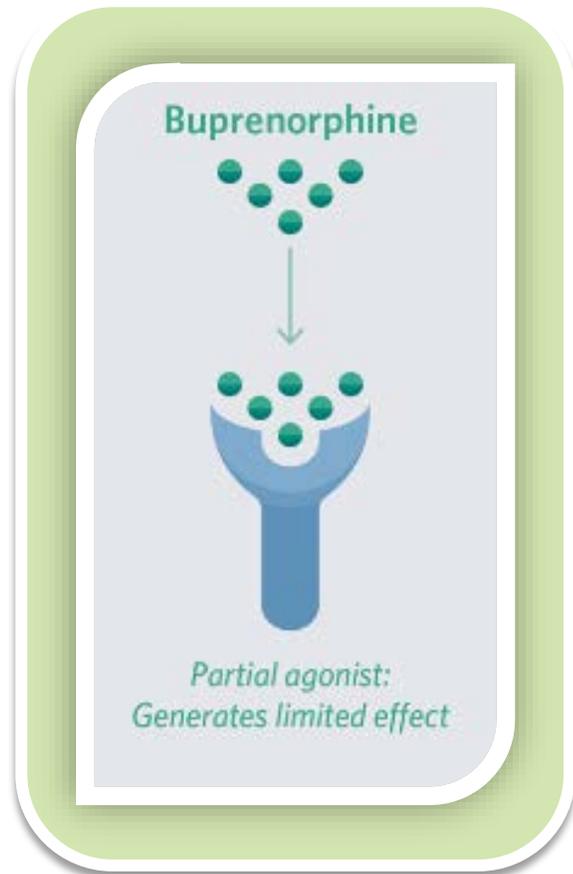
- ▶ Medical providers review patient for adequate dosage amounts and can titrate medication upward for patients to reach a stable therapeutic doses, safely.
- ▶ Medical providers know how to use low dose titration initiations to allow for individuals to start on buprenorphine when they may be taking a high dose of methadone or fentanyl.
- ▶ Increases patient's retention in treatment.
- ▶ If individual is injured, or a pain management patient, they may need higher doses of buprenorphine to treat them.

# Buprenorphine



- ▶ Oral, and sublingual formulations exist. The medication effects last about 24 hours in body.
- ▶ Injectable formulations of buprenorphine are available. Some can last 7 days in the body, and some can last up to 28 days in the body.

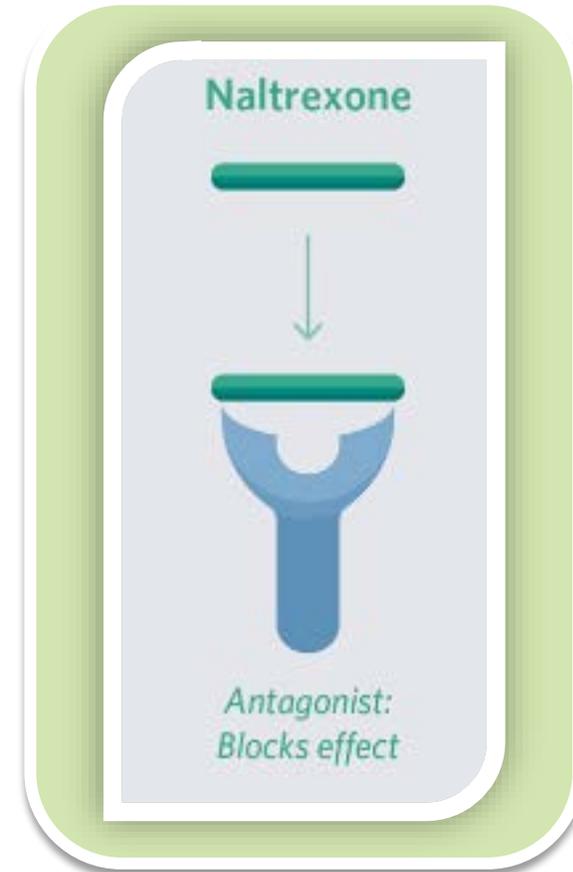
# Buprenorphine



- ▶ Can be prescribed by a medical provider and picked up at a community pharmacy; or given as an injection by a medical provider in a clinic setting or at some community pharmacy settings.
- ▶ Covered by WA Medicaid, with no prior authorizations.
- ▶ [How to find a buprenorphine provider: Washington State Recovery Helpline- MOUD Locator](#)

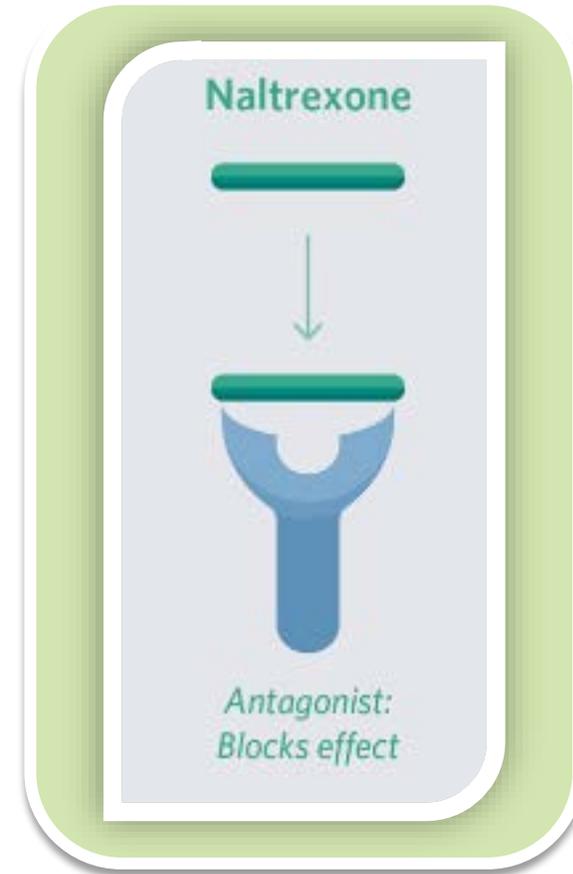
# Naltrexone

- ▶ Is an opioid antagonist medication. Not an opioid. Works by blocking opioid receptors in the brain.
- ▶ Can help manage opioid craving symptomology for some patients.
- ▶ Injection formulation is most common medication formulation used, and what is covered by WA Medicaid.
- ▶ Lasts 4 weeks in body.



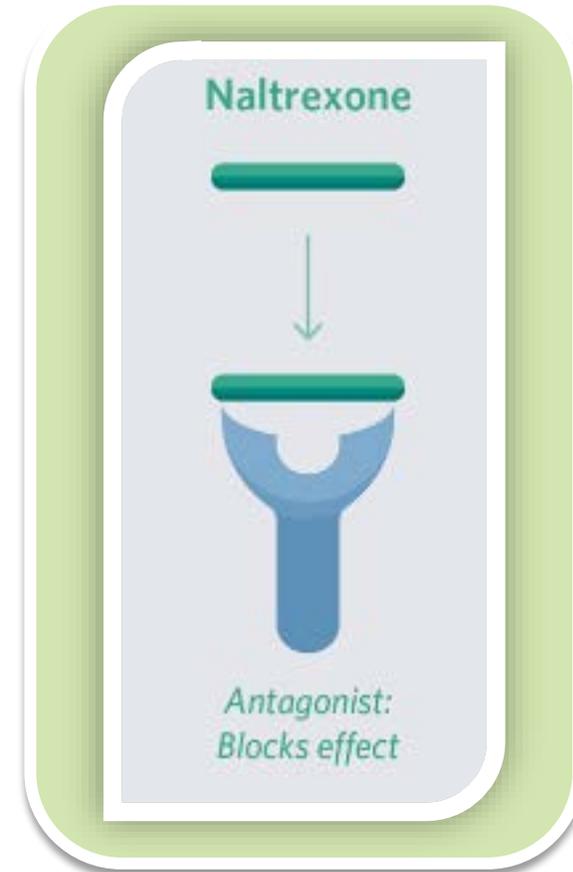
# Naltrexone

- ▶ An individual **must not have any** opioids in system prior to injection
- ▶ When using for treatment of opioid use disorder, a potential patient must wait 7-10 days after last opioid use to receive the injection (Sometimes up to 14 days after last methadone use)
- ▶ Naltrexone effects can be overcome with high dose opioids, if an individual relapses.



# Naltrexone

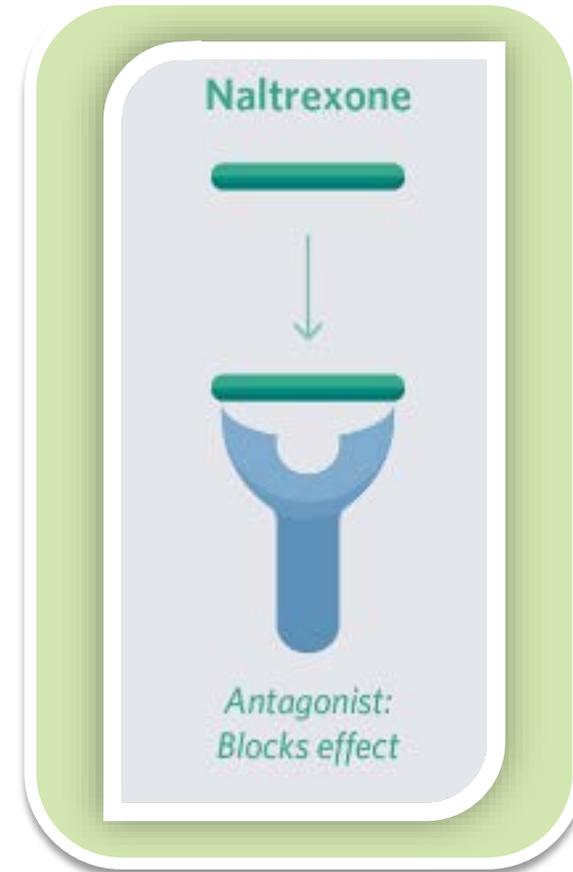
- ▶ Has **not** been shown to lower the risk of death.
- ▶ Tolerance of opioids resolves extremely fast upon cessation of medication, and any return to prior doses of opioids (during a patient relapse) can quickly lead to patient overdose
- ▶ Also, the required period of cessation of opioids prior to medication initiation, can also lead to loss of tolerance in potential patients, during a time when they may be more likely to relapse- Leading to a higher risk of potential overdose.



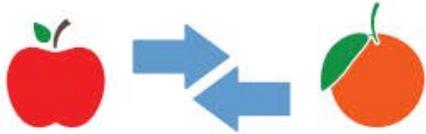
# Naltrexone

---

- ▶ Can be prescribed by a medical provider and given an injection by a medical provider in a clinic setting.
- ▶ Covered by WA Medicaid, with no priori authorizations
- ▶ [How to find a naltrexone: Washington State Recovery Helpline- MOUD Locator](#)



# Understanding the Truth behind Medication for Opioid Use Disorder (MOUD)



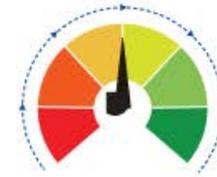
**Myth:** MOUD just trades one addiction for another.

**Truth:** MOUD bridges the biological and behavioral components of addiction. Research indicates that a combination of medication and behavioral therapies can successfully treat substance use disorder (SUD) and help sustain recovery. (1)



**Myth:** MOUD is only for the short term.

**Truth:** Research shows that residents on MOUD for at least 1-2 years have the greatest rates of long-term success. Reducing or stopping medication should be a resident-driven decision, and some people stay on MOUD for many years. (2)



**Myth:** My resident's condition is not severe enough to require MOUD.

**Truth:** Encourage residents to discuss options with their opioid treatment program (OTP)/ office-based opioid treatment (OBOT) providers. Encourage residents to call the MA Helpline where they can find appropriate treatment providers to meet with/explore their options. (3)

1) <http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>

2) <https://www.health.harvard.edu/blog/opioid-addiction-long-term-treatment-for-a-chronic-condition-2017050511379>

3) <https://www.pharmacytimes.com/contributor/jeffrey-budin/2018/01/opioid-agonists-partial-agonists-antagonists-obt-my>

4) "MAT Maintenance Treatment and Superior Outcomes" PowerPoint, Dr. Arthur Williams

5) <https://recoveryrecoverynetwork.com/medication-assisted-treatment/> 6) <http://www.samhsa.gov/medication-assisted-treatment/training-resources/support-organizations>

6) Adapted from the National Council Infographics.

7) <https://www.wa.gov/media/pdf/challenging-myths-about-medication-assisted-treatment-mat-opioid-use-disorder-ouid>

# Understanding the Truth behind Medication for Opioid Use Disorder (MOUD)



**Myth:** MOUD increases the risk for overdose.

**Truth:** MOUD helps to prevent overdoses from occurring. Even a single use of opioids after detoxification can result in a life-threatening or fatal overdose. Following detoxification, tolerance to the euphoria brought on by opioid use remains higher than tolerance to respiratory depression. (4)



**Myth:** Providing MOUD will only disrupt and hinder a resident's recovery process.

**Truth:** MOUD has been shown to assist residents in recovery by improving quality of life, level of functioning, and the ability to handle stress. Above all, MOUD helps reduce mortality throughout a resident's recovery. Encourage residents to call the MA Consultation Service for Treatment of Addiction and Pain (MCSTAP) for a consult if their provider is unsure. (5)

$$l \leq \frac{1,2}{k}; k = \frac{4}{\sqrt{4EJ}} \sqrt{a_0 b}$$

**Myth:** There isn't any proof that MOUD is better than abstinence.

**Truth:** MOUD is evidence-based and the recommended course of treatment for opioid use disorder (OUD). The American Academy of Addiction Psychiatry, American Medical Association, National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, and other agencies emphasize MOUD as first line treatment. (6)

1) <http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview>

2) <https://www.health.harvard.edu/blog/opioid-addiction-long-term-treatment-for-a-chronic-condition-201705051479>

3) <https://www.pharmacytimes.com/contributor/jeffrey-fujin/2018/01/opioid-agonists-partial-agonists-antagonists-oh-my>

4) "MAT Maintenance Treatment and Superior Outcomes" PowerPoint, Dr. Arthur Williams

5) <https://pubkeyrecoverynetwork.com/medication-assisted-treatment/> 6) <http://www.samhsa.gov/medication-assisted-treatment/training-resources/support-organizations>

6) Adapted from the National Council Infographics.

7) <https://tmb.mo.gov/media/pdf/challenging-myths-about-medication-assisted-treatment-mat-opioid-use-disorder-nid>

# MOUD Patient Stigma and Discrimination

---

- ▶ Federal and Washington State law (ADA and WLAD) protects individuals taking medications for the treatment of their mental health and substance use disorders against discrimination in all health care setting environments.
  - ▶ This includes medications specifically for the treatment of opioid use disorder.
  - ▶ This population is considered to have a disability and are therefore protected from discrimination.
- ▶ Refusing or limiting a person from accessing treatment because they take prescribed medications for opioid use disorder could violate state and federal law.
- ▶ Similarly, requiring individuals to stop taking or to change their medication for opioid use disorder, as a condition of participating in protected activities that they are otherwise eligible for, may be considered discrimination.

# MOUD Patient Stigma and Discrimination

---

## ▶ RCW 71.24.580 (9)

- ▶ **Criminal justice treatment account.**
- ▶ “(9) If a region or county uses criminal justice treatment account funds to support a therapeutic court, the therapeutic court must allow the use of all medications approved by the federal food and drug administration for the treatment of opioid use disorder as deemed medically appropriate for a participant by a medical professional.”
- ▶ “If appropriate medication-assisted treatment resources are not available or accessible within the jurisdiction, the health care authority's designee for assistance must assist the court with acquiring the resource.”