High-Potency Synthetic Opioids Module

Introduction

Welcome to the High-Potency Synthetic Opioids Module. The information contained within this module is intended for educational purposes only.

Course Accessibility

Navigate this course by using the on-screen prompts and buttons on the toolbar below. Click the Accessibility icon on the toolbar below for more navigation options. This course contains audio. Please take a moment to adjust the volume on your device. Closed Captioning is available. Turn on captions using the toolbar below. Materials available for download can be accessed in the Resources tab located above. If you experience trouble viewing the course module, please try accessing it using a different internet browser. When you are ready, click the Next button on the toolbar below to continue.

High-Potency Synthetic Opioids

High-potency synthetic opioids, or HPSO, such as fentanyl and its analogs, pose significant challenges within the child welfare system in Washington State. These powerful substances are not only highly addictive but also dangerously potent, leading to increased risks of overdose and severe health consequences. Understanding how high-potency synthetic opioids impact child welfare–involved families allows court systems to better protect the safety of children while providing families with the tailored supports and services they need to address opioid misuse.

This module aims to equip child dependency court judicial officers with the knowledge and skills necessary to effectively address the challenges posed by high-potency synthetic opioids, ensuring the safety and well-being of children in affected environments.

Purpose of this Module

The purpose of this module is to support judicial understanding and application of the following in child dependency cases:

- What HPSOs are, how they enter the body, and the potency and risks associated with use.
- The national and statewide trends involving rising critical incidents and child fatalities where HPSOs are involved.
- The unique risks of accidental ingestion of HPSOs by children based on stage of development, including harm reduction strategies.
- The treatment of Opioid Use Disorder.

- The harmful impacts of stigma on children and families.

To learn more about the link between child safety and HPSOs, please see the Safety Framework module of the Dependency 201 course.

Definitions

Opioids are a class of drugs, including prescription medications and illegal substances, that produce effects like pain relief and euphoria. They can cause dependency, withdrawal symptoms, and opioid use disorder.

High-Potency Synthetic Opioids (HPSOs) are synthetic opioids that have stronger effects than other opioids. R.C.W. 13.34.030 defines HPSOs as unprescribed synthetic opioids classified as a Schedule II controlled substance or controlled substance analog in chapter 69.50 R.C.W., or by the pharmacy quality assurance commission in rule, including but not limited to fentanyl.

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.

Physical dependence is when a person's body gets used to a substance and they experience withdrawal symptoms. Any opioid of any potency, when taken over a period, will result in physical dependence, but this alone does not necessarily meet the criteria for a Substance Use Disorder diagnosis.

Substance Use Disorder (SUD) is when the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, or failure to meet major responsibilities at work, school, or home.

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

Medications for Opioid Use Disorder (MOUD) are medications approved by the Food and Drug Administration for the treatment of Opioid Use Disorder. Examples of MOUD include methadone, buprenorphine, and naltrexone.

Agonist medications activate the opioid receptors by binding to the receptor. Brain receptors are specialized protein molecules located on the surface of neurons that receive and respond to chemical signals in the brain. An example of an agonist medication is methadone, which binds to opioid receptors and activates them, leading to a significant reduction in the perception of pain.

Antagonist medications bind to the receptor without activating it. They block or reduce the effect of the neurotransmitter. While receptors are specialized protein molecules located on the surface of neurons that receive and respond to chemical signals in the

brain, neurotransmitters are chemical messengers in the brain that play a crucial role in communication between neurons. An example of an antagonist medication is naloxone, which binds to opioid receptors in the brain and blocks or reverses the effects of opioid drugs.

Fentanyl

Fentanyl has been a driving force in the opioid overdose crisis. Fentanyl is also the primary HPSO available on the illegal drug market. Depending on the potency and delivery method, illicit fentanyl can be up to 50 times stronger than heroin and 100 times stronger than morphine. Illicit fentanyl is commonly pressed into pill form or distributed as a powder. It can be sold alone or added to other drugs, such as heroin, methamphetamine, MDMA, and counterfeit pills, to make them cheaper and more powerful. When mixed into other drugs, fentanyl cannot be seen, smelled, or tasted without detecting equipment, like fentanyl test strips. This can result in people unintentionally and unknowingly ingesting potentially lethal amounts of fentanyl. Even tiny amounts of fentanyl can cause fatal overdoses.

Children are particularly vulnerable to accidental ingestion through contaminated surfaces, secondhand contact, or parental substance use. In homes where fentanyl is present, child welfare professionals must assess safety threats, ensure harm reduction measures, and intervene when necessary. Fentanyl is a major contributor to the ongoing opioid epidemic, which has led to an increase in family separations, child fatalities, parental overdoses, and complex reunification challenges. This makes it necessary for child dependency systems to adopt trauma-informed, evidence-based approaches to protect affected children while supporting family stability.

How HPSOs Enter the Body

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 but can also be produced illegally and sold on the illicit drug market. Taking illicitly manufactured HPSOs by mouth carries a heightened risk of overdose because the strength of the opioid in the pill is unregulated and unknown.

Powder forms of illicit HPSOs can be smoked, snorted, or injected. Smoking or snorting HPSOs carries a higher risk of overdose than ingestion due to the unknown potency of the substance and faster method of delivery to the bloodstream.

HPSOs in pill or powder form can be dissolved into a liquid that can then be directly injected into a vein with a hypodermic needle. Injection results in 100% of the substance entering the bloodstream at once, which greatly increases the chance of overdose compared to other delivery methods. In addition, poor injection techniques or sharing used needles can lead to infections, abscesses, and transmission of diseases like HIV and hepatitis.

HPSOs in pill or powder form are not readily absorbed by the skin if touched. There are no known cases of overdose from direct skin contact with opioids in powder or pill form. There are also no reports of someone overdosing from inhaling fentanyl vapor or smoke, as will be discussed more on the next slide. Adverse effects could occur when someone touches an HPSO and then touches their eyes, nose, or mouth. Prescribed fentanyl patches are an exception, as they are specifically designed to deliver medication through the skin.

Secondhand Smoke Exposure

Second-hand exposure to HPSO smoke poses almost zero risk of overdose. This is because fentanyl, when smoked, absorbs quickly into the lungs. Exhaled air may have extremely low traces of HPSO, but these disperse immediately in the air. The long-term impact of environmental exposure to HPSO secondhand smoke is currently unknown. However, it should be noted that while second-hand exposure to HPSO smoke may not pose a risk of overdose, inhalation of any smoke can result in negative short-term and long-term health outcomes, especially for children.

Signs of Use

There are many signs of fentanyl use and withdrawal that impact parenting both medically and behaviorally. On the screen is a list of some signs of fentanyl use. It is not complete, and any one of these alone does not mean that someone is using fentanyl. It is also important to note that signs of fentanyl use may not be observable. Click Next on the toolbar below when you are ready to continue.

Health Risks

Exposure to fentanyl poses severe health risks. Even small amounts can cause respiratory depression, unconsciousness, and death. Long-term effects of use may include multisystem organ failure, deterioration of mental health conditions, immune system suppression, increased risk of suicide, and other long-term health and behavioral problems.

Overdose

Overdose occurs when a person takes too much of a high-potency synthetic opioid, such as fentanyl, overwhelming the body’s ability to breathe and leading to life-threatening effects. Since HPSOs are far more potent than other drugs, even tiny doses can cause severe reactions, including respiratory failure, unconsciousness, and death. Because they are often mixed into other drugs without the user’s knowledge, the risk of accidental overdose is incredibly high. Rapid medical intervention, including the use of naloxone, is essential to prevent fatal outcomes.

The risk of overdose from illicit fentanyl is high due to the lack of governmental regulation of ingredients, potency, or dose. Even fentanyl produced from the same

batch can differ greatly in concentration. Fentanyl is especially lethal when combined with other drugs. It is not possible to detect the presence of fentanyl with the naked eye, and even test strips are not 100% effective and reliable. A lethal dose of fentanyl is equivalent to:

- A few grains of salt
- 2 milligrams of sand
- The size of a small ant

Impact on Children

Over 321,000 children in the United States lost a parent to drug overdose between 2011 and 2021, many of which resulted from opioids. The rate of children who experienced parental loss due to overdose more than doubled during this ten-year period. Children with non-Hispanic American Indian and Alaska Native parents consistently experienced the highest rate of loss of a parent from overdose during this time period. While the number of affected children increased across all racial and ethnic populations, children with young, non-Hispanic Black parents experienced the highest rate increase.

Naloxone (Narcan)

Naloxone, also commonly referred to by the brand name Narcan, is a lifesaving medication to reverse opioid overdose. It is safe to use on newborns, toddlers, children, and adults, and can even be used on animals. It is also relatively safe in pregnancy and can save the lives of both the person who is pregnant and the fetus. Naloxone works by binding with opioid receptors without activating them. The most common form of Naloxone is nasal spray, but it also comes in an injectable form. Nasal Naloxone is very easy to administer and can be administered more than once, as needed after 2 to 3 minutes, to prevent overdose death.

Good Samaritan Laws protect individuals who administer naloxone in good faith to someone experiencing an overdose. These laws offer immunity from legal prosecution and may contribute to a reduction in overdose deaths.

Courts can work with system partners to help ensure that Naloxone is available in every home where a parent or child may be using or exposed to HPSOs. Having Naloxone in the home is a safety precaution that has saved many lives—not only to prevent overdose death to a child but also for a parent.

Symptoms of Opioid Overdose

Roughly two out of three overdose deaths are linked to opioids. Today, you'll learn how to recognize and respond to an opioid overdose and potentially save a life. Opioids are drugs that include Morphine, OxyContin or Percocet, fentanyl, and heroin. They slow breathing and heart rate. When the person has more opioid in their system than their

body can handle, their breathing slows and without intervention, could stop. An overdose can happen to anyone using opioids but is more likely when a person uses drugs again after stopping or reducing use for even a few days because drug tolerance can decrease very quickly.

When a person mixes opioids with other drugs or alcohol. When a person uses drugs alone because no one is there to help them in the event of an overdose. Opioids can cause people to seem sleepy so it may be difficult to tell if someone is experiencing an overdose.

A person displaying these signs and symptoms may need help:

- Unconscious or awake but unable to talk
- Bluing lips on a lighter-skinned person
- Ashy or white lips on a darker-skinned person
- Fingernails turning blue or purplish black
- Slow, shallow breathing
- Choking or snore-like gurgling sounds
- Vomiting, limp body
- Clammy or pale face
- No breathing or a slow or erratic pulse
- Not responsive to shaking or yelling
- Not responsive to pain such as a sternal rub

If you suspect an overdose, shake the person and rub their sternum or pull their ear lobe. Take two knuckles and rub and tap the person's sternum hard for 10 seconds. Call their name if you know it. If the person responds, they are not overdosing. If there is no response after 10 seconds, call 911. Give the operator your location and a simple description like “someone is here and not breathing. Please send help.” If you need to leave the person to call 911 or for any reason, put them in the recovery position. Place them on their side and use their top arm and leg as kickstands. After you call 911, administer naloxone. There are two common types of naloxone: Narcan nasal spray and one you inject into a muscle.

To use Narcan nasal spray:

- Place the person flat on their back if possible
- Peel back the film from the spray and hold it in your hand, pointer and middle fingers on the top, thumb on the plunger
- Insert the spray device into the nostril as far as your knuckles will allow
- Push up hard on the plunger with your thumb

- Give them all the spray in the device

To use injectable naloxone:

- Place the person flat on their back if possible
- Pop the cap off the vial and insert the syringe into the hole at the top of the vial
- Turn the vial upside down and draw up all the liquid
- Inject all of it into the upper, outer part of the thigh or the upper arm or a butt cheek
- There is no need to remove clothing. The syringe will go through

After you've administered naloxone, begin rescue breathing if the person is not breathing:

- Put the person flat on their back
- Tilt their head back by holding the chin with one hand and the forehead with the other
- Pinch the nostrils shut and give two short breaths to verify you have a clean airway
- You should see their chest rise. If you see their belly rise, readjust the position
- If you do not see the chest or belly rise, check airway for blockages
- After you make sure the airway is clear, give one full breath every five seconds
- You do not need to do chest compressions

If there's no change after three minutes, administer a second dose of naloxone and continue rescue breathing. If you administer naloxone and the person wakes up, tell them you gave them naloxone and stay with them until paramedics arrive. Make paramedics aware of any other conditions you know of that can complicate recovery. If you witness an overdose, don't wait to call for help, even if you are also using drugs. Washington's Good Samaritan Law protects you from criminal penalties for minor drug possession or having alcohol under age 21 when you get help for someone experiencing an overdose. Naloxone wears off after 30 to 90 minutes. Depending on the drugs in someone's system, they could fall back into an overdose when naloxone wears off, so you may need to give another dose.

An opioid-dependent person will wake up in withdrawal after being given naloxone. Try to keep them calm and awake while the naloxone wears off. Encourage them not to use any more drugs and remind them that the naloxone will block the opioids. If you're unsure about their condition, take them to the emergency room for further observation or evaluation. In Washington state, you do not need a prescription from your doctor. There is a statewide prescription for naloxone called a standing order that anyone can use.

Naloxone is a safe medication that reverses the effects of opioids. It only works if a person has opioids in their system and will not work on drugs such as methamphetamine, cocaine, or alcohol. Anyone can buy naloxone at a pharmacy using the statewide standing order. If you have health insurance, check with your provider to see if your plan will provide a kit to you for free or at a reduced cost. Store naloxone out of sunlight and at room temperature. Naloxone can work past its expiration date but works best when not expired. Replace expired naloxone as soon as possible, but don't hesitate to use expired naloxone if that's all that's available. We hope you now feel confident to recognize the symptoms of an opioid overdose, then take action. Stay tuned for more information about where to get naloxone.

Risk by Developmental Stage

HPSOs can be extremely dangerous to children, with the greatest danger seen in two developmental stages: infants and toddlers, and adolescents. Infants and toddlers are especially vulnerable due to their frequent hand-to-mouth behavior and proximity to the floor, making accidental ingestion or skin contact with even trace amounts potentially fatal. Adolescents face a different but equally severe threat—unintentional overdose from experimenting with counterfeit pills or substances they don’t realize contain fentanyl. In both age groups, exposure can result in rapid respiratory failure and death, making prevention and education critically important. This section will take a deeper dive into the specific safety risks posed by HPSOs across the different stages of child development.

Infants and Toddlers

Infants and toddlers are at a high risk of unintentional HPSO exposure and overdose due to their unique developmental stage. During this age period, children become increasingly mobile when they start to crawl and then walk. However, they lack the ability to protect themselves from danger.

Infants and toddlers learn by exploring their environment through touch, including putting things in their mouths, which puts them at a high risk of accidental ingestion. In addition, infants and toddlers will not have a tolerance built up to HPSOs, and because they are so powerful, any amount poses a serious threat of overdose and death.

When exposure happens to children in this age group, it usually occurs in the home. Parents and caregivers should be taught to be extra vigilant due to their child’s increased mobility and exploratory behavior.

Safe Storage: Accidental ingestion of HPSOs by toddlers and infants is a life-threatening emergency.
HPSOs are an extremely powerful opioid—even a tiny amount can be deadly for a child.

Toddlers are naturally curious, and they explore their world by putting things in their mouths.
This means that any pill, powder, or residue left within reach—on a table, in a purse, or even on the floor—can quickly turn into a tragedy. If an HPSO is present in the home, it must be kept in a locked, childproof container—completely out of sight and out of reach. Never rely on hiding it, and if you find an HPSO or any suspected drug, dispose of it safely through law enforcement or a designated hazardous disposal site—don't throw it in the trash where a child could still find it.

Naloxone: Naloxone is a life-saving medication that can reverse an opioid overdose—including an accidental HPSO exposure in a toddler or infant. Because HPSOs act so quickly, having naloxone in the home can mean the difference between life and death while waiting for emergency responders. It's safe to use on children, and there's no harm in giving it if you're not sure. But naloxone is not a substitute for prevention—it doesn't replace the need to store drugs securely, dispose of them safely, and keep dangerous substances completely out of children's reach. It's one part of a harm reduction plan, and it can save precious time when every second counts.

Proper Supervision: One of the most powerful ways to prevent accidental HPSO exposure is to make sure an infant or toddler is always in the care of a safe, responsible adult. Young children move fast, explore everything, and don't understand danger. Even a few moments without supervision can be enough for them to find and put something harmful in their mouth. A safe adult is someone who is alert, able to respond quickly, and free from the influence of drugs or alcohol. This level of supervision isn't just about watching—it's about actively creating a safe environment and stepping in before harm can happen. Consistent, attentive care can make all the difference in keeping little ones out of danger.

Safe Sleep: Safe sleep is critical to protecting infants from accidental death—and it's especially important in homes where HPSO use is present. Babies should always be placed on their backs to sleep, in their own safe space like a crib, bassinet, or play yard, with a firm mattress and fitted sheet, and nothing else in the sleep area. When a parent or caregiver is using an HPSO, the risk of unsafe sleep deaths rises sharply. HPSOs can cause extreme drowsiness, slowed breathing, or unconsciousness, making it more likely for an adult to accidentally roll over onto a baby or for the baby's airway to be blocked without anyone noticing. Co-sleeping, or falling asleep with an infant on a couch or chair, is never safe—and when HPSOs are involved, it can be deadly. Following safe sleep guidelines every time—for every nap and every night—is one of the most effective ways to prevent these tragedies.

Clean Surfaces: Keeping surfaces clean is a vital step in protecting infants and toddlers from accidental HPSO exposure. HPSOs can leave behind invisible residue—on countertops, tables, floors, or any place they've been handled. Babies and young children spend a lot of time on the floor and often put their hands and toys in their mouths, which means even a tiny trace of an HPSO can be dangerous. Regularly and thoroughly cleaning all surfaces, especially in areas where children play, crawl, or eat,

can remove harmful particles before they become a risk. Soap and water break down and remove HPSO residue effectively, while bleach can spread particles or create harmful fumes. This isn't just routine housework—it's a life-saving step. Consistent cleaning with the right method helps create a safer home and reduces the risk of a tragic accident.

Isolate Areas of Use: Another critical step to protect infants and toddlers is making sure they are never in or near spaces where fentanyl is being used. When drugs are handled or smoked, residue and particles can linger on surfaces, in the air, and on clothing, creating hidden risks for little ones. Babies and toddlers are especially vulnerable because they crawl, play, and put things in their mouths—and even the smallest amount of fentanyl can be deadly. Children should always be kept completely separate from any area where drug use is happening and never left in the same room. Creating this clear boundary—isolating infants and toddlers from places of use—is a powerful harm reduction measure and helps prevent accidental poisoning.

Plan of Safe Care

In Washington State, a Plan of Safe Care is a required process for infants born affected by substance use, withdrawal, or fetal alcohol spectrum disorders. The Plan of Safe Care is not a dependency filing or court order—it is a coordinated plan to ensure the infant's immediate safety and connect the family with services that promote stability and well-being. When hospitals notify the Department of Children, Youth, and Families that an affected infant is born, it triggers development of a Plan of Safe Care. The plan may include referrals for substance use treatment, mental health services, home visiting, parenting supports, or other resources. Its focus is prevention and support, not punishment, and many families can safely parent with the right services in place.
For judicial officers, the Plan of Safe Care provides context in cases where a substance-exposed infant comes before the court. While it does not itself determine a finding of dependency, a Plan of Safe Care can show what supports are in place and whether reasonable efforts are being made to keep the child safely at home.

Middle Childhood

Children in middle childhood, ages five to twelve, have the lowest risk of accidental or intentional HPSO exposure. At this stage, most kids are past the phase of exploring their world by putting things in their mouths. They also haven't yet reached adolescence, when experimentation tends to increase. But it's important to remember—children reach developmental milestones at different times. Risk can't be judged by age alone. Children in middle childhood are still very vulnerable to overdose and death if they do ingest an HPSO.

Adolescents

Adolescents are typically exposed to HPSOs through intentional experimentation with substances.

Because HPSOs are often added to other illicit substances, adolescents may not be aware they are ingesting them—increasing the chance of overdose. Two-thirds of adolescent overdose deaths occurred in their home, often with another person present who was unaware of the use. Adolescent experimentation is very different from small children accidentally swallowing substances. Caregivers and professionals must use different strategies to prevent adolescent overdose.

Safe Storage: Adolescents are at higher risk for experimenting with substances, including prescription medications, which makes safe storage of opioids critically important. Keeping opioids locked up and out of reach helps prevent accidental ingestion, misuse, and potential overdose. Many teens may find or access medications left unsecured in the home, and even a small amount of opioids can be dangerous or fatal. By practicing safe storage—such as using a lockbox and properly disposing of unused medication—families can play a vital role in reducing the risk of opioid overdose and protecting the health and safety of young people.

Naloxone: Naloxone is a life-saving medication that can quickly reverse the effects of an opioid overdose. It is safe, easy to use, and has no effect if given to someone who has not taken opioids. Having naloxone available at home, in schools, or in the community can make the difference between life and death, especially for adolescents who may be at risk of accidental or intentional opioid misuse. Training family members, peers, and community members to recognize the signs of overdose and to use naloxone empowers them to act quickly in an emergency and provides a critical safety net while waiting for medical professionals to arrive.

Strategies: Open conversations with adolescents about harm reduction strategies are an important way to keep them safe. While the goal is always to prevent substance misuse, it's also critical that young people know practical steps they can take to reduce risk if they or their peers encounter opioids. This includes:

- Never using alone
- Avoiding mixing substances
- Understanding the signs of overdose
- Knowing how and when to use naloxone

When parents, caregivers, and trusted adults talk openly and without judgment, it helps adolescents feel supported, encourages healthier choices, and prepares them to respond safely in high-risk situations.

Treatment: Accessing treatment services is a critical part of supporting adolescents who may be struggling with opioid misuse. Effective treatment often combines counseling, peer and family support, and, when appropriate, medications for opioid use disorder (MOUD). These medications, such as buprenorphine or methadone, are evidence-based, safe, and can help reduce cravings, prevent relapse, and support long-term recovery. Making treatment approachable and reducing stigma around seeking

help ensures that young people and their families know that recovery is possible and that they are not alone. Connecting adolescents to treatment early can make a lasting difference in their health and future.

Child Safety

When we talk about fentanyl, the first thing that often comes to mind is its danger—and rightly so.
Fentanyl is a powerful and potentially deadly substance. But here's an important point to remember: a parent's use of fentanyl does not automatically mean that a child cannot be kept safe in the home. Removing a child from their home is sometimes necessary to protect them. However, this decision carries serious, long-lasting consequences. Research shows that children who are removed from their homes often experience poor long-term outcomes—educationally, financially, in their relationships, and even in their mental and physical health. That's why every removal decision must be taken seriously and made in a fair, unbiased way. To help guide these decisions, the ABA Guide on Child Safety provides a clear framework. This framework helps professionals:

- Assess safety
- Plan around safety
- Articulate safety decisions
- Determine what is truly needed to keep a child safe

You can access the ABA Child Safety Guide using the Resources tab above. You can also learn more about applications of the Safety Guide in child dependency cases in the Safety Framework Module of the Dependency 201 Course.

The Blue Triangle

The Blue Triangle is a visual representation of the three essential elements of child safety outlined in the American Bar Association's Safety Guide for Judges and Attorneys.
These three elements are:

- Threats of danger
- Child vulnerability
- Protective capacities

Together, these elements form the foundation for assessing whether a child can remain safely in their home.

Threats of Danger: Threats of danger must meet specific criteria—they are not vague concerns or possibilities. A threat is specific and observable. You can see it, hear it, or clearly describe it.

For example:

- A parent actively using fentanyl in the home is an observable threat.
- Drug paraphernalia on the counter, the parent appearing impaired—these are concrete signs.

The threat must also be immediate or likely to happen soon. This means the danger is present now or will occur in the near future. For example, ongoing fentanyl use creates a constant, imminent threat of danger for the child. Next, the threat must be out of control. The parent cannot manage or contain the danger. If the parent is unable to stop using fentanyl or refuses help, the situation is beyond their control. Finally, the consequences must be severe. If the threat occurs, the harm to the child would be serious—such as exposure to drugs, neglect, or being left alone if the parent overdoses. These four characteristics—specific and observable, immediate, out of control, and severe—define a true threat of danger. They help professionals make clear, unbiased decisions about child safety.

Child Vulnerability: Child vulnerability refers to how susceptible a child is to harm when threats of danger exist. A child is either vulnerable or not—there are no degrees. This determination is child-specific, based on their age, development, health, and ability to protect themselves.
If a threat of danger exists, we assume vulnerability unless there is clear evidence to the contrary.

Examples:

- Infants and toddlers: Extremely high vulnerability. They explore their world by putting things in their mouths. If fentanyl or drug residue is left on a surface or within reach, even a tiny amount can be fatal.
- Medical conditions or developmental delays: Increase vulnerability even more.
- Older children and teens: Different risks—they may access fentanyl in the home and experiment with it, not understanding its deadly potency.

In short, when fentanyl use is present, the child's age, health, and ability to protect themselves are critical factors. The more dependent and curious the child—or the more access a teen has—the greater the urgency to ensure safety.

Protective Capacities: Protective capacities are the caregiver's strengths and actions that can control threats of danger and keep a child safe.
They fall into three domains:

- Cognitive: The parent understands the extreme risk fentanyl poses and can plan effectively for safety.

- Behavioral: Demonstrated through concrete actions such as engaging in treatment, following safety plans, and ensuring the child is never exposed to drugs.
- Emotional: Reflects the parent's genuine concern for the child's well-being and motivation to make necessary changes.

These capacities must be observable and actionable, not just promises. When they are strong and reliable, combined with a clear safety plan, they may allow the child to remain safely at home. If they are absent or insufficient, removal may be necessary.

Treatment

Accessing treatment services is critical for people with opioid use disorder because it greatly reduces the risk of overdose and supports long-term recovery. Without treatment, opioid use disorder can lead to severe health complications, disrupted relationships, and barriers to stability in work, housing, and overall well-being. Evidence-based care—especially when it includes medications for opioid use disorder, counseling, and recovery supports—can help individuals regain control of their lives, improve physical and mental health, and rebuild connections with family and community. Ensuring timely access to treatment is not only life-saving but also essential for breaking the cycle of addiction and fostering lasting stability.

Opioid Use Disorder

Opioid use disorder is a chronic but treatable condition, and effective care can be delivered in both inpatient and outpatient settings. Inpatient or residential treatment provides a structured, supportive environment, often used for people with severe OUD or complex medical and social needs. Outpatient treatment allows individuals to remain in their communities while receiving care, which may include regular visits with providers, counseling, and medication management.

In both settings, medications for opioid use disorder, or MOUD—such as methadone, buprenorphine, and naltrexone—are the gold standard, helping to reduce cravings, manage withdrawal symptoms, and lower overdose risk.

Medications for Opioid Use Disorder (MOUD)

It is a common myth that treatment for opioid use disorder must include an inpatient treatment component to be truly effective. Medications for opioid use disorder are a safe, effective, and often life-saving treatment option for many parents involved in the child welfare system that creates a solid foundation for long-term recovery. Methadone and buprenorphine are actually considered the gold standard treatment for opioid use disorder. These medications help by reducing physical craving and withdrawal symptoms that make a person suffer and lead them to return to use.

For families impacted by opioid misuse, the ability of a parent to be on MOUD can be the key factor in whether or not they are able to reunify with their children. If a child is found to be unsafe related to fentanyl use, it is often difficult to safety plan due to the lack of predictability of the use and the level of resources needed to monitor the safety plan. MOUD helps to stabilize brain chemistry, helping to establish and maintain recovery. It can also increase predictability, making it less difficult to safety plan for families.

There are three FDA-approved medications for the treatment of opioid use disorder. The decision about which medication is right for a parent will depend on their unique circumstances and needs to be made in consultation with their medical provider.

Click each type of medication below to learn more about how it works. When you have viewed all medications, click the Next button on the toolbar below to continue.

Methadone

Methadone is a full agonist, which means it fully activates the opioid receptor by binding to it. Methadone is taken orally and is covered by Medicaid. It lasts 24 hours, so it is taken daily. When used as a treatment for opioid use disorder, methadone reduces opioid withdrawal symptoms and cravings. When taken as directed, it has been shown to lower risk of overdose death by 50%. It has also been shown to increase retention in treatment programs.

Methadone does come with a risk for potential misuse. Likelihood of overdose death increases when taken with other substances such as alcohol, hypnotics or sedatives, and benzodiazepines. Methadone is only available at opioid treatment programs. The treatment begins with daily visits, which can create barriers to people due to childcare needs, location of the clinic, transportation, and time constraints. In addition, methadone is recommended for the treatment of opioid use disorder during pregnancy and is preferred over medically supervised withdrawal.

Buprenorphine

Buprenorphine is a partial agonist, meaning it partially activates the opioid receptor. It can be taken orally, under the tongue, or injected. When taken orally or under the tongue, buprenorphine lasts 24 hours. Injections last 7 to 28 days. It is covered by state Medicaid.

Buprenorphine reduces opioid withdrawal symptoms and cravings. When taken as directed, it can lower risk of overdose death by 50%. It has also been shown to increase retention in treatment programs. Above a certain dose, the person stops feeling more of its effects. This results in a high unlikelihood of potential overdose in those who take it. It has low misuse potential for opioid-dependent individuals.

Likelihood of overdose death increases when taken with other substances such as alcohol, hypnotics or sedatives, and benzodiazepines. Buprenorphine can be prescribed through a medical provider and filled at a pharmacy for home use or given as an injection by a medical provider in a clinic setting or at some community pharmacies. Supply is limited in some areas, leading to access issues for some patients. In addition, buprenorphine is recommended for the treatment of opioid use disorder during pregnancy and is preferred over medically supervised withdrawal.

Naltrexone

Naltrexone is an opioid antagonist medication, which means it blocks opioid receptors in the brain. Naltrexone is given as an injection in a clinic setting by a medical provider. It lasts up to 4 weeks in the body and is covered by state Medicaid.

Naltrexone helps manage opioid craving symptoms. It has not been shown to lower the risk of overdose death. Naltrexone has a low risk for potential misuse. However, the effects of naltrexone can be overcome with high doses of opioids.

When starting naltrexone, a person must wait 7 to 10 days after their last opioid use to receive the first injection. Naltrexone significantly lowers the body's tolerance to opioids, which makes the period after stopping naltrexone an incredibly high-risk time for relapse and overdose.

MOUD Laws

Federal and Washington State laws protect individuals taking medications for the treatment of their mental health and substance use disorders against discrimination. This includes medications specifically for the treatment of opioid use disorder.

This population is considered to have a disability and is therefore protected from discrimination. Refusing or limiting a person from accessing treatment because they take prescribed medications for opioid use disorder, or requiring them to stop taking or change their dose of medication, could violate state and federal law. For additional information, please see the Resources tab above.

More on MOUD

Pregnancy: Opioid use disorder during pregnancy is treatable. The recommended approach is a form of MOUD, such as methadone or buprenorphine, rather than medically supervised withdrawal. This is because withdrawal carries high relapse rates, which can lead to negative outcomes for both parent and baby. Specifically, unsupervised withdrawal carries risks of preterm labor, fetal distress, and miscarriage. Pregnant people benefit most from compassionate, stigma-free care that supports their mental health and treatment needs, and it is important to encourage them to see a doctor as early as possible in their pregnancy.

Breastfeeding: When a parent is using opioids, the decision to breastfeed or formula feed should always be made with guidance from a healthcare provider who understands both opioid use and treatment. Breastfeeding can offer powerful benefits—supporting the infant's nutrition, immune system, and brain development, while also strengthening the parent-child bond. In many cases, it's not only safe but protective. However, there are situations where breastfeeding may not be appropriate, such as certain medical conditions or when the parent is unable to stay alert during feedings, which can pose serious safety risks.

No matter how an infant is fed, it's important to monitor their response—looking for signs like weight gain, sleepiness, or unusual fussiness. If a parent's opioid use changes—whether they stop, relapse, or use occasionally—this can affect the nursing infant and should prompt medical consultation. While judicial officers don't make medical decisions, understanding these factors can help support safe, informed outcomes for families in court.

Stigma: MOUDs often have a tremendous amount of stigma associated with them. People often talk about them as a drug to replace a drug rather than a medication to treat a disease. People with opioid use disorder need support like those with any other disease.

Where to Find MOUD

Stigma or fear of stigma can make it hard for people who need help. It may prevent them from seeking the health or behavioral health services and support services they need. This can have severe consequences in every facet of our society, including parents and children, including losing housing, income, positive relationships, educational stability, incarceration, and even death.

An opioid treatment program is a behavioral health treatment agency which is licensed by the state and federal government. The program offers both counseling services and medical services to all clients who attend. It is also the only type of outpatient treatment setting where an individual can receive all three types of medication for the treatment of an opioid use disorder.

A list of these programs can be found in the Washington State Opioid Treatment Program Guide, located in the Resources tab above. Clinics that prescribe buprenorphine and naltrexone can be located using the Washington Recovery Help Line, which you can also find in the Resources tab.

Finally, the Washington Telebuprenorphine Hotline is a statewide telehealth program providing low-barrier access to buprenorphine to anyone ages 13 years of age or older. More information on this hotline can be found in the Resources tab.

Closing

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