RACIAL AND ETHNIC DISPARITIES IN OPIOID USE OUTCOMES IN KING COUNTY

May 2026

Public Health
Seattle & King County

CONTENTS

KEY TAKEAWAYS

- Despite recent declines in overdose rates in King County, racial and ethnic disparities persist in key opioid-related outcomes, including overdose mortality, ED visits for opioid overdose, opioid use disorder (OUD) diagnosis, medications for opioid use disorder (MOUD) receipt, and naloxone possession.
- Black/African American people experience a rate of opioid overdose approximately 3 times higher than people of all other racial/ethnic groups and are significantly less likely to receive MOUD and possess naloxone.
- The overdose rates measured for American Indian/Alaska Native people are higher compared to people of all other racial/ethnic groups, though the magnitude of the disparity is heavily influenced by how race/ethnicity is categorized and analyzed.
- The percentage of King County Medicaid members diagnosed with OUD varies by race/ethnicity and housing status.
- Among Medicaid members diagnosed with OUD, MOUD receipt was lower among all people of color, particularly Black/African American and Native Hawaiian and Pacific Islander members.
- Most survey participants who use opioids reported recent possession of naloxone.
- These data provide insight into possible approaches to reduce the disproportionate impact of the opioid epidemic on AIAN and Black/African American communities through (1) improved access to harm reduction services, treatment, and prevention; (2) improved quality of treatment care and prevention support; and (3) access to tailored cultural and contextual services and support.

INTRODUCTION

National and local data show racial and ethnic disparities exist in overdose rates.[1,2] These disparities are the result of historic and ongoing policies in the United States and must be interpreted within the context described in 'Box 2: This Data in Context'. Reducing racial disparities in overdose and other drug related harms is central to Public Health Seattle & King County's overdose prevention strategy. To inform these efforts, this report describes differences across racial and ethnic groups in four key indicators: overdose, opioid use disorder (OUD) diagnosis, receipt of medication for opioid use disorder (MOUD) and naloxone possession.

APPROACH

This report uses data from the King County Medical Examiner's Office (KCMEO), Washington State Department of Health's Rapid Health Information NetwOrk (RHINO), ProviderOne (Medicaid Claims), PHKSC's Syringe Services Program (SSP) survey, 'Get High? Get Heard.' Survey, and the National Behavioral Health Surveillance (NHBS) survey. These data sources allow for more than one racial and ethnic group to be documented per person. Analyses conducted for this report assigned individuals to all documented racial and ethnic groups, with multiracial individuals represented in multiple racial and ethnic categories, unless otherwise specified. The publicly available dashboard allows viewers to choose whether race/ethnicity is presented in this manner (referred to as "alone or in combination") or in mutually exclusive groups. Throughout this report, comparisons are made between a specified group and people that are not in that group; for example, "Asian (alone or in combination with another race)" compared to "people of other racial/ethnic groups". Details on each data source, ascertainment of race/ethnicity, and categorization of race and ethnicity are described in detail in the 'Technical Notes' section at the end of this report.

FINDINGS

Fatal Overdose

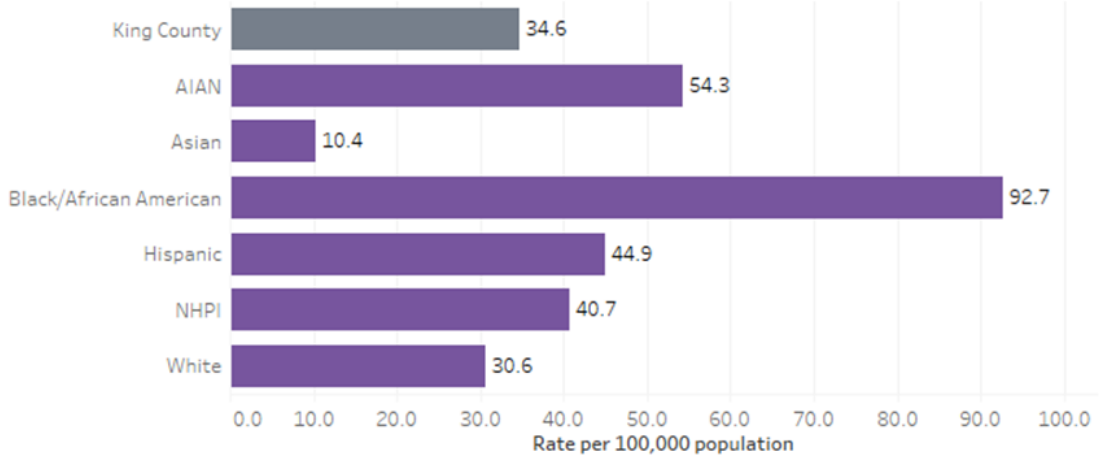
The overdose mortality rate in King County in 2025 was 34.6 per 100,000 population (Figure 1). In 2025, the overdose mortality rate among Black/African American people was over 3.2 times the rate of all other people in King County. The mortality rate estimated for the Hispanic population was 1.4 times higher than all other people in King County. The overdose mortality

[1] Data to Inform King County's Overdose Response: www.kingcounty.gov/overdose/data

[2] Kumi Smith, M., Planalp, C., Bennis, S., Stately, A., Nelson, I., Martin, J., Evans, P. Widening Racial disparities in the U.S. Overdose Epidemic. American Journal of Preventive Medicine. 2025;68(4):745-753.

rate among the American Indian and Alaska Native (AIAN) population ranges from 1.6 (AIAN alone or in combination; shown in Figure 1) to 6.3 times (AIAN alone) the rate of all other individuals in King County. The wide range in estimates is due to unique challenges to estimating rates for the AIAN population, which are described in more detail below (Box 1).

Figure 1: Rate of fatal overdose in King County by race/ethnicity, 2025

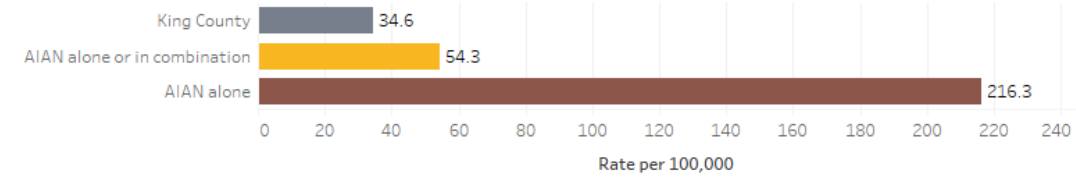


AIAN = American Indian/Alaska Native, NHPI = Native Hawaiian/Pacific Islander; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.
Data source: King County Medical Examiner's Office

Box 1: Overview of unique challenges to measuring overdose among the American Indian and Alaska Native population

There are several unique challenges to accurately measuring the count and rate of overdose deaths among the AIAN population. Racial misclassification is common for AIAN people in public health data (and has contributed to the historical erasure of this population),[3] which can lead to the underestimation of morbidity and mortality estimates.[4] In an evaluation of overdose deaths in Washington, the estimated drug overdose rate was 36% greater in a dataset that linked Vital Statistics records with the Northwest Tribal registry compared to the

Figure 2: Rate of fatal overdose among American Indian and Alaska Native alone vs. alone or in combination with another race/ethnicity, 2025



AIAN = American Indian/Alaska Native Race/ethnicity data are presented as alone or in combination with another race or ethnicity.
Data source: King County Medical Examiner's Office

[3] Echo-Hawk, A., Locklear, S., McNally, S., Baker, L., Gurule, S., How should epidemiologists respond to data genocide? AMA Journal of ethnics. 2025;27(1):E44-50
[4] Gartner, D, Maples C, Nash M, Howard-Bobiwash H. Misracialization of Indigenous people in population health and mortality studies: a scoping review to establish promising practices. Epidemiol Rev. 2023;45(1):63-81.

Vital Statistics data alone.[5] Additionally, in a national evaluation of all-cause mortality data, only 51% of decedents who had self-reported AIAN as their race when they participated in a national survey were indicated as AIAN on their death certificate.[6]

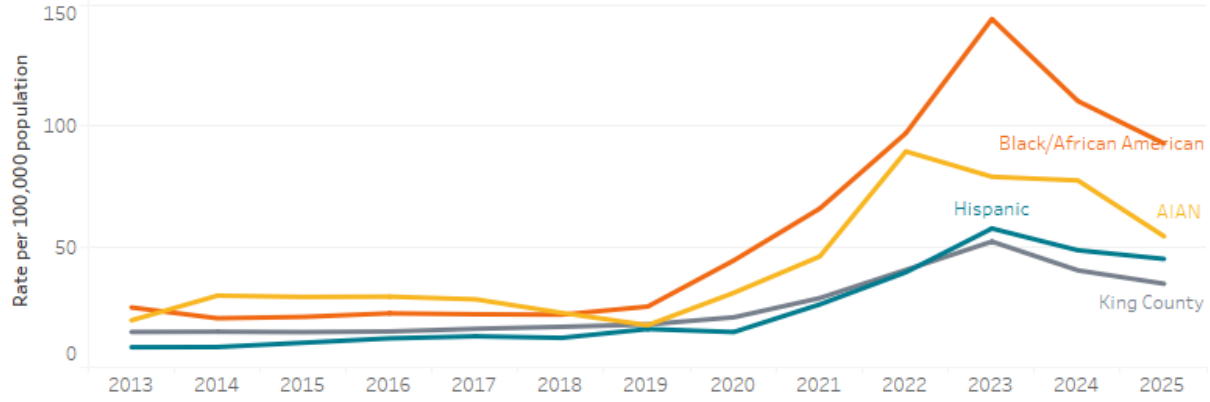
Another challenge pertains to the calculation of rates, which are generated from a combination of data sources. If data sources differ in their approach to collecting race/ethnicity, including how they ascertain single- and multi-racial identities, the resulting rate estimates may be distorted, especially for groups in which multi-racial identities are common. In 2020, the US Census adopted a broader approach to measuring race/ethnicity, which resulted in a near doubling of the estimated size of the AIAN population compared to 2010 population estimates.[7,8] In particular, the multi-racial AIAN population grew 157% between 2010 and 2020, while the single-race AIAN population grew 27%. Per King County census data, 90% of King County residents who identify as AIAN also report other racial and/or ethnic identities. In contrast, 44% of all 2025 overdose deaths among AIAN people also had additional races or ethnicities indicated on their death certificate. This discrepancy leads to rate and disparity estimates for the AIAN population that vary drastically depending on what definition is used (e.g. AIAN alone or AIAN alone or in combination with another race/ethnicity, Figure 2). This report presents multiple estimates for the AIAN population, when appropriate, to provide the range of estimates due to these complexities.

Trends and characteristics of fatal overdose among disproportionately impacted groups

The overdose mortality rate (measured per 100,000 King County residents) increased from 17.8 in 2019 to 52.1 in 2023 and then declined to 34.6 in 2025 (Figure 3). While this general pattern was evident for most racial and ethnic groups, notable differences between groups emerged during this period. The overdose mortality rate for Black/African American people, compared to all other people, grew from 1.5 times to 3.2 times higher between 2019 and 2025. Prior to 2023, Hispanic people had lower overdose mortality rates relative to other people; however, since 2023, overdose mortality rates have been 1.1-1.4 times higher among Hispanic people compared to other individuals. Among AIAN people, the overdose mortality rate was higher compared to all other people in all years between 2012 and 2025, except for 2019.

[5] Joshi S, Weiser T, Warren-Mears V. Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives - Washington, 1999-2015. MMWR Morb Mortal Wkly Rep. 2018;67(50):1384-1387.
[6] Arias E, Heron M, National Center for Health S, Hakes J, Bureau USC. The Validity of Race and Hispanic-origin Reporting on Death Certificates in the United States: An Update. Vital Health Stat 2. 2016(172):1-21.
[7] Arias E, Liebler C, Garcia, M, Saenz, R. Data impacts of changes in U.S. Census Bureau procedures for race and ethnicity data. SSM-Population Health. 2025 (29).
[8] Race and Ethnicity in the United States: 2020 Census and 2020 Census. United States Census Bureau. 2021.

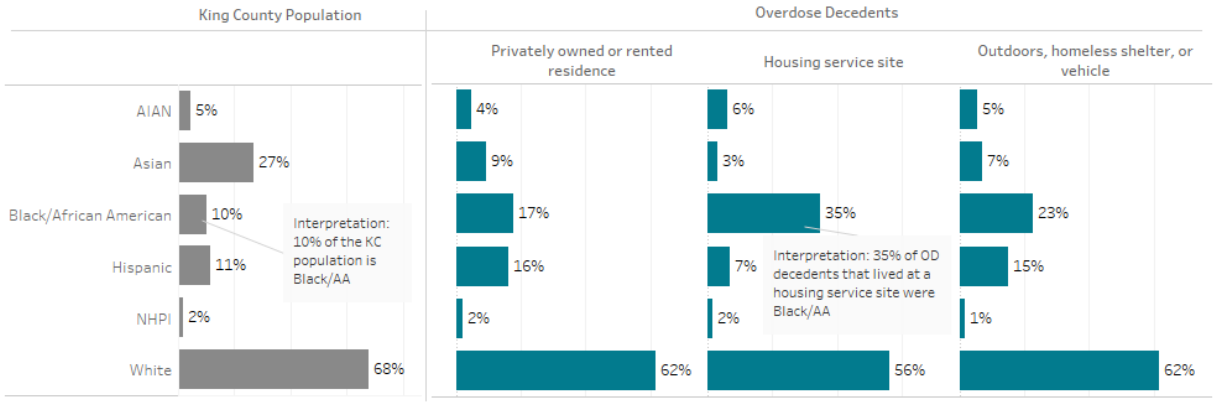
Figure 3: Rate of fatal overdose per 100,000 people by race/ethnicity in King County, 2013-2025



Note: Race/ethnicity data are presented as alone or in combination with another race or ethnicity. This graph shows data for Black/African American, AIAN, and Latino or Hispanic pouplations, as they have a higher overdose rate compared to King County overall.
AIAN = American Indian/Alaska Native
Data source: King County Medical Examiner's Office

Nearly half of all overdose deaths in King County occur among people who were unhoused or unstably housed at time of death, which is defined here as living at a housing service site, outdoors, in a homeless shelter, vehicle, or some other temporary housing situation.[9] Homelessness and housing instability disproportionately impact people of color, particularly Black/African American and AIAN people.[10] Figure 4 details how the race/ethnicity of overdose decedents varies by living situation. Although Black/African American people compose 10% of the King County population, they experienced 35% of overdose deaths occurring at housing service sites and 23% of overdose deaths occurring among people experiencing homelessness. AIAN people experienced 6% of overdose deaths occurring at housing service sites even though they comprise 5% of the King County population.

Figure 4: Overdose deaths by presumed living situation in King County in 2025



AIAN = American Indian/Alaska Native, NHPI = Native Hawaiian/Pacific Islander;AA = African American; KC = King County; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.
Note : KCMEO Medicolegal death investigators categorize *presumed living situation* based on where the decedent was living at the time of death based on information collected from place and circumstances of death and/or testimony from witnesses or next of kin.

[9] Data to Inform King County's Overdose Response: www.kingcounty.gov/overdose/data
[10] King County Regional Homelessness Authority Data Overview: https://kcrha.org/data-overview/

With such a large percentage of overdose deaths occurring among people who were unhoused or unstably housed, the geographic distribution of overdose deaths is closely tied to the geographic distribution of housing service sites and encampments in King County, which are concentrated in Seattle. Across all racial and ethnic groups, 65% of fatal overdoses among people who were unhoused or living at a housing service site occurred in Seattle. While more geographically dispersed, the rate of fatal overdose measured for Black/African American, AIAN, and Hispanic people who privately owned or rented housing remained higher in Seattle than other regions of the county.

Emergency department visits for opioid overdoses

Two data sources are available to measure emergency department (ED) visits for opioid overdose: RHINO healthcare encounter data and Medicaid claims data.[11] RHINO data includes all ED visits to non-federally funded EDs in the county, inclusive of both Medicaid-insured and non-Medicaid insured patients. Rates using RHINO data are calculated using the King County population as the denominator (see Box 1 for considerations when interpreting these data). Approximately 24% of the King County population are Medicaid-insured. Eligibility for Medicaid primarily depends on household income (less than 138% of the federal poverty level for adults). Rates using Medicaid data were calculated using the Medicaid population as a denominator and represent the experience of a population with a lower income than the King County population as a whole.

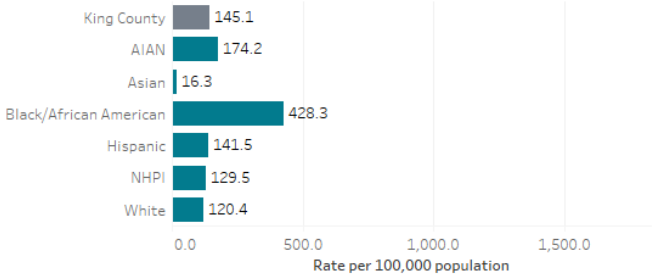
In 2024, the rate of opioid overdose ED visits among Medicaid members was more than 3 times higher than the rate measured for all of King County (501.4 per 100,000 Medicaid members vs. 145.1 per 100,000 King County residents). In both RHINO and Medicaid data, the rate of opioid overdose ED visits in 2024 was higher among Black/African American people: 3.6 times higher compared to all other people in all of King County and 1.6 times higher in the Medicaid population (Figure 6). This disparity has grown over time in both data sources, similar to trends in fatal overdose. In the RHINO data, the rate of opioid overdose ED visits for Black/African American people, compared to all other people, grew from 1.7 times higher in 2019 to 3.6 times higher in 2024. Among Medicaid members, the rate of opioid ED visits for Black/African American members was comparable to other members in 2019 and grew to 1.6 times higher in 2024.

For all King County ED visits, the estimated rate of opioid overdose ED visits among AIAN people differed drastically depending on whether AIAN was categorized to include people who reported being AIAN alone or in combination with other races and ethnicities (174.2 per 100,000) or was restricted to people who reported AIAN as their only race (816.7 per 100,000). This wide range in estimates complicates interpretation: the rate of opioid overdose ED visits among AIAN people was 1.2-5.7 times greater than all other groups in King County. In the Medicaid data, the rate of opioid overdose ED visits among AIAN members was over 2.6 times higher than the rate estimated for all other members, regardless of how race was categorized.

[11] All data reported represent *suspected* opioid overdoses treated in the ED; opioid overdoses are not confirmed. Suspected opioid overdoses are identified in RHINO data by querying the chief complaint and diagnosis fields in ED visit records. Suspected opioid overdoses are identified in Medicaid Claims data by searching diagnosis codes in claims from the emergency department.

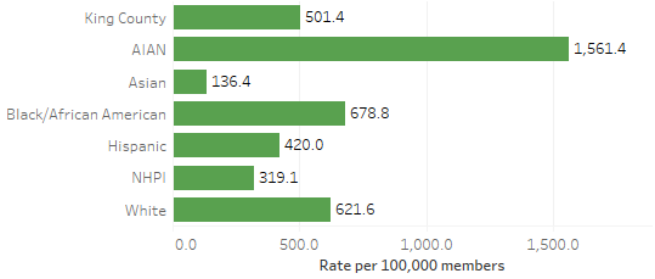
In Medicaid, but not RHINO data, the rate of opioid overdose ED visits was 1.5 times higher among White members compared to all other members.

Figure 6a: Rate of opioid overdose emergency department (ED) visits at King County EDs by race/ethnicity, 2024



Data source: Washington State Department of Helath, Rapid Health Information NetwOrk (RHINO)
Data presented are suspected opioid overdoses identified by querying various fields in the data source; overdoses are not confirmed.

Figure 6b: Rate of opioid overdose emergency department (ED) visits among King County Medicaid members by race/ethnicity, 2024



Data source: Medicaid Claims

AIAN = American Indian/Alaska Native, NHPI = Native Hawaiian/Pacific Islander; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.

Prevalence of Opioid Use Disorder and receipt of Medications for Opioid Use Disorder

The 'true' prevalence of OUD is difficult to measure. Instead, documentation of a ***diagnosis*** of OUD indicated during healthcare encounters is used. This type of estimate underrepresents people who have fewer opportunities for OUD to be identified, for example because of limited access to or use of healthcare, and people who are less likely to disclose their substance use when opportunities arise. It is also affected by the following factors: (1) stigma that diminishes patients' willingness to disclose OUD symptoms to healthcare providers,[12] (2) provider-level factors – including biases - that influence OUD screening practices,[13] (3) clinic- and provider-differences in documentation practices, and (4) healthcare- and treatment-seeking behavior.[14,15]

In 2024, 5% of King County Medicaid members were diagnosed with OUD. When stratified by presumed living situation, 3% of Medicaid members who were presumed to be housed had a documented OUD diagnosis, compared to 29% of King County Medicaid members with evidence of unstable housing (Figure 7). Racial differences in the prevalence of diagnosed OUD were more pronounced among Medicaid members with unstable housing, with a higher prevalence of diagnosed OUD documented for AIAN and White Medicaid members than all other members.

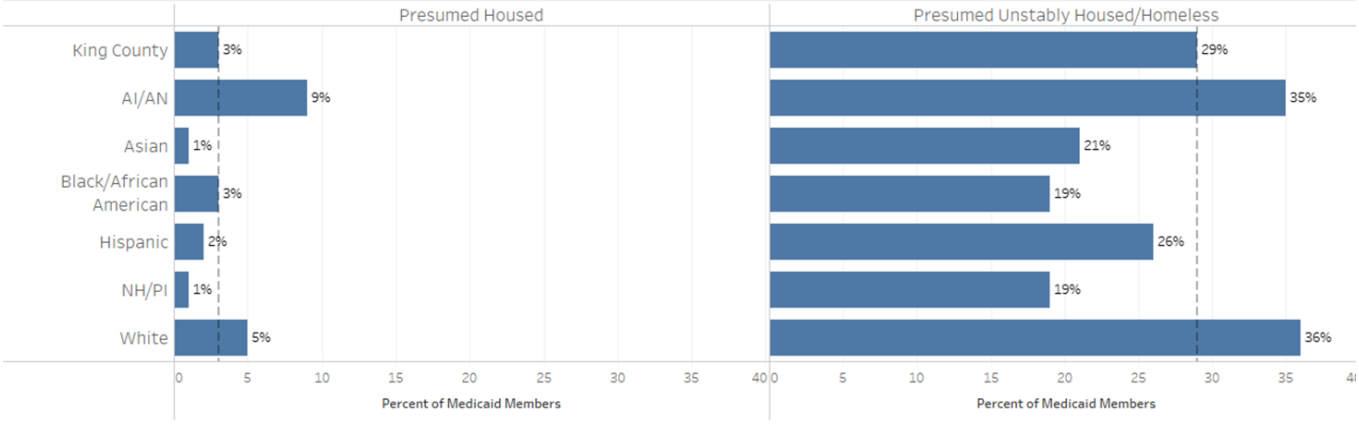
[12] McCurry, MK., Avery-Desmarais, S., Schuler, M., Tyo, M., Viveiros, J. Kauranen, K. Perceived stigma, barriers, and facilitators experienced by members of the opioid use disorder community when seeking healthcare. Journal of Nursing Scholarship. 2022;55:701-710

[13] Stone, EM., Kennedy-Hendricks, A., Barry, CL., Bachhuber, MA., McGinty., EE. The role of stigma in U.S. primary care physicians' treatment of opioid use disorder. Drug and Alcohol Dependence. 2021; 221:108627

[14] Austin.EJ., Chen, J., Briggs, ES. Ferro, L., Barry, P., Heald, A., Merrill, JO, Curran, GM., Saxon, AJ., Fortney, JC., Ratzliff, AD., Williams, EC. Integrating Opioid Use Disorder Treatment Into Primary Care Settings. Substance Use and Addiction. 2023;6(8).

[15] Howell, BA., Abel, EA., Park, D., Edmond, SN., Leisch, LJ., Becker, WC. Validity of Incident Opioid Use Disorder (OUD) Diagnosis in Administrative Data: a Cart Verification study. Journal of General Internal Medicine. 2021;36: 1264-1270

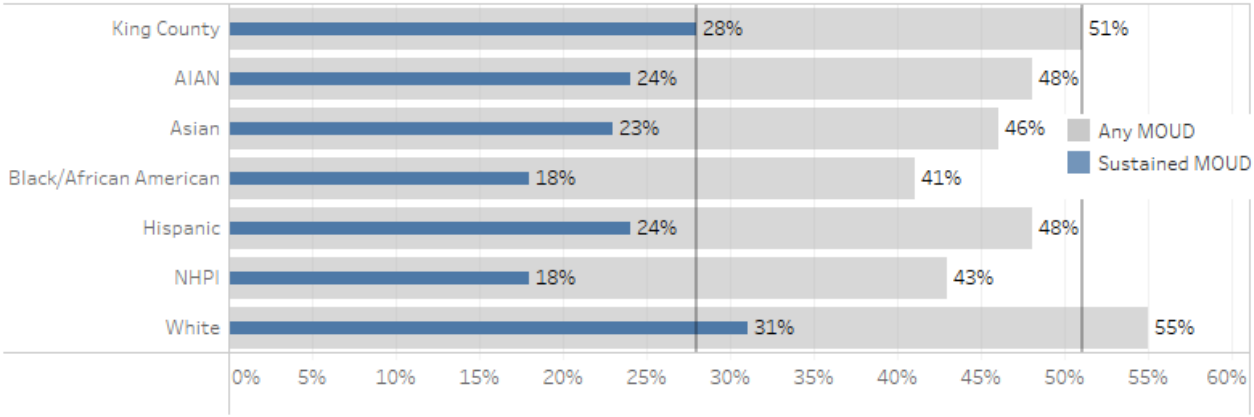
Figure 7: Medicaid Members with an Opioid Use Disorder (OUD) diagnosis by presumed living situation and race/ethnicity, 2024



Data source: Medicaid Claims
AIAN = American Indian/Alaska Native. NHPI = Native Hawaiian/Pacific Islander; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.

Among people with OUD, receipt of MOUD prescriptions (i.e. buprenorphine, methadone, injectable naltrexone) was measured quarterly. Medicaid members were considered to have received MOUD if Medicaid claims were generated for MOUD pharmacy fills or healthcare encounters in which MOUD was given to the patient. In the 4th quarter of 2024, 51% of OUD-diagnosed members received at least one day of MOUD, and 28% were considered to have received MOUD on a sustained basis (defined as 61 or more days of MOUD in the 90-day quarter, Figure 8). Receipt of MOUD was highest among White Medicaid members and lowest amongst Black/African American and NHPI Medicaid members. Black and African American members, compared to all other members, were 40% less likely to receive MOUD and 51% less likely to be engaged in MOUD on a long-term basis. NHPI members were 24% less likely to receive MOUD and 38% less likely to be engaged in MOUD on a long-term basis compared to all other members. Overall, AIAN, Asian, Black/African American, Hispanic, and NHPI members with OUD diagnoses were all less likely to receive MOUD and they were less likely to sustain use. Measures of MOUD receipt were lower among Medicaid members with unstable housing, though the same pattern of racial disparities was observed for both members with and without access to stable housing. Although MOUD indicators have changed over time, the racial and ethnic disparities reported here have remained stable over time. These data suggest further effort is needed to ensure those individuals with an OUD diagnosis receive MOUD and there are supports in place to ensure sustained MOUD use over time to meet access and quality of care indicators for MOUD receipt.

Figure 8: Medicaid members with an OUD diagnosis who received Medications for Opioid Use Disorder (MOUD), Q4 2024

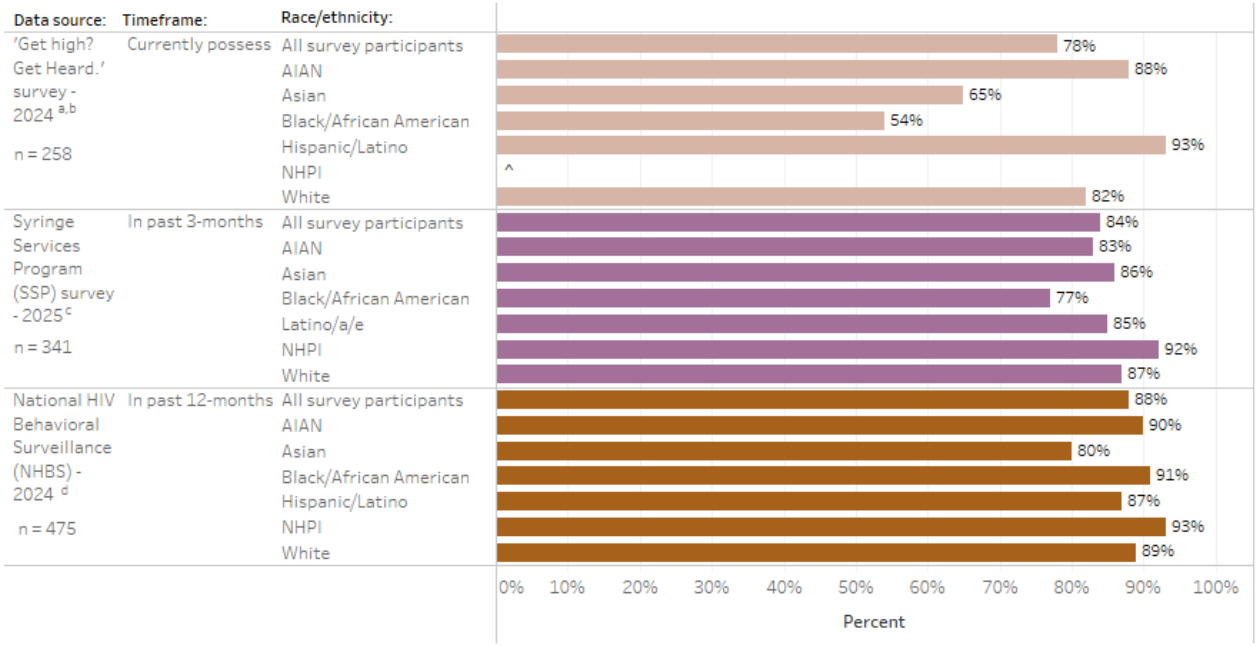


Any MOUD = received MOUD prescriptions that covered 1+ days in a 90-day quarter; Sustained MOUD = received MOUD prescriptions that covered more than 60 days in a 90-day quarter
Note: Percentages represent quarter 4 2024 data. These data include members who had 1 or more days covered by MOUD prescriptions.
AIAN = American Indian/Alaska Native, NHPI = Native Hawaiian/Pacific Islander; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.

Naloxone possession

Three surveys in King County measure possession of naloxone, a life-saving medication that reverses opioid overdose. The sample of the three surveys vary: Seattle-area people (ages 16-35) with a history of opioid or stimulant use were recruited via print and online advertisements for the 'Get High? Get Heard' Survey; SSP clients were recruited for the SSP Survey; and people who inject drugs were recruited for the NHBS survey. Naloxone possession was high across the three surveys; 78% of people who used opioids *currently* possessed naloxone in the 'Get High? Get Heard' Survey, 84% of all SSP clients that used opioids possessed naloxone in the *past 3 months*, and 88% of all NHBS participants that used opioids possessed naloxone in the *past 12 months* (Figure 9). The 'Get High, Get Heard' and SSP surveys provide evidence that naloxone possession may be lower among Black/African American people that use opioids compared to other people who use opioids. Among 'Get High? Get Heard" survey participants, *current* naloxone possession was reported by 54% of Black/African American survey participants (compared to 82% of all other survey respondents) and naloxone possession in the *past 3 months* was reported by 77% of Black/African American surveyed SSP clients (compared to 86% of all other SSP survey respondents). There were no significant differences in naloxone possession over *the past 12 months* by racial and ethnic group among NHBS participants.

Figure 9: Naloxone possession



AIAN = American Indian/Alaska Native, NHPI = Native Hawaiian/Pacific Islander, AA = African American; Race/ethnicity data are presented as alone or in combination with another race or ethnicity.
^Data are suppressed when numbers are less than 10 to protect confidentiality.
a Among survey participants who used fentanyl, heroin, or prescription opioids in the past 12 months
b Although data collection spanned Nov 2023 through Feb. 2025, most (83%) surveys were completed 2024
c Among survey participants who used opioids in the past 3 months
d Among survey participants who used opioids in the past 12 months..

IMPLICATIONS OF FINDINGS

This report highlights stark racial disparities in overdose, opioid use disorder diagnosis, MOUD receipt and naloxone possession among people of color in King County, but particularly Black/African American and AIAN communities. Strategies to increase access to harm reduction and treatment services for communities disproportionately impacted by overdose and other opioid-related outcomes are urgently needed. PHSKC and other community partners have implemented several initiatives to increase MOUD and harm reduction supply access, train clinicians, and reduce substance use-related stigma within Black and African American and American Indian and Alaska Native populations. Additionally, PHSKC is working with housing service providers to expand the reach of overdose prevention interventions in populations experiencing unstable housing, which are disproportionately people of color. As investment in these areas continue, these services must be low-barrier, available in places where people want to receive care and tailored to meet the needs of a range of patients and communities. Partnering with and resourcing communities to co-create solutions is essential to ensure that their voices are heard and that they lead this work.

This work also highlights the need to better understand the barriers to care and services for these disproportionately impacted groups. Exploring potential challenges to accessing care and ongoing care, patient perceptions of service access and understanding the preceding factors

such as lack of trust in institutions and providers represent critical data to improve the provision of care to groups experiencing the highest risk of overdose. Focusing on strength-based attributes including community connections, familial, peer, and other relationships, cultural connections, and related support could also provide additional possibilities for improving care to these communities as well.

Structural solutions play an important role in addressing the overdose epidemic and fostering equity as these disparities are rooted in long-standing historic as well as ongoing policies (see Box 2: Data in Context). Multilevel strategies are needed to address (i) the social drivers of health, (ii) structural racism in healthcare and human service systems, (iii) systemic barriers to treatment and harm reduction services, and (iv) substance use-related stigma and bias.

LIMITATIONS OF REPORTED FINDINGS

This report already described limitations corresponding to imperfect ascertainment of race/ethnicity, misalignment between numerator and denominator data sources in the measurement of race/ethnicity, and inability to measure the true prevalence of OUD (inclusive of undiagnosed OUD). In addition, local estimates of the prevalence of non-prescribed opioid use are unavailable. Therefore, we cannot discern whether disparities in overdose occurrence reflect differential rates in opioid use, differential overdose risk among people who use opioids, or both.

There are limitations to the representativeness of the data presented. The overdose data are limited to those that are fatal or that are treated in the ED; an unknown number of non-fatal overdoses are not treated in the ED and thus are not included here. Medicaid data are limited to people in King County insured by Medicaid (24% of King County population); people who have private insurance, Medicare, utilize the Indian Health Service (and aren't Medicaid insured) or who are uninsured are not represented. Survey data are not representative of all people that use opioids in King County.

CONCLUSIONS

The data described above illustrate that much work remains to reduce overdose morbidity, mortality, and other harms for people who use drugs and to address entrenched racial disparities. Public Health – Seattle & King County remains committed to address these disparities through continued partnership with organizations and people across King County to bring about meaningful and sustainable change.

Box 2: Data in Context

The disproportionate impact of the opioid epidemic on communities of color[2,16] – particularly Black/African American people and American Indian and Alaska Native (AIAN) people – is the result of targeted historical and ongoing structural racism which has defined drug policy and public policy generally, influenced social drivers of health (e.g. access to healthcare, housing, employment), and shaped economic investment in the United States.[17] In the 1970s, governmental policies in the United States (declared the 'war on drugs') intensified the approach of addressing illicit drug use through punitive tactics overwhelmingly targeting Black and African American communities and other communities of color, including unequal enforcement of drug laws, mass incarceration, and family separation.[4,18] Communities of color across the country – including in King County – continue to suffer the far-reaching consequences of these past and present racist laws and enforcement. Colonization and other forms of erasure and marginalization have impacted AIAN communities in a myriad of ways that have direct implications on this group's health outcomes, in addition to the policies mentioned above.[19] The historical and present context that has led to racial disparities in overdose and opioid-use outcomes can be understood in more detail here.[17,20,21,22]

TECHNICAL NOTES

Data Sources

This report summarizes information from the following data sources:

Death Data

King County Medical Examiner's Office (KCMEO) investigates and certifies all deaths that occur in King County that are unexpected, sudden, unnatural, and/or lack a known cause, including overdoses. Following their investigation, KCMEO completes the death certificate indicating cause and circumstances of death, which are submitted to the Washington State Department of Health and subsequently processed by the National Center for Health Statistics. Death data in this report are presented directly from KCMEO. If there is discrepant race/ethnicity recorded between KCMEO records and Washington State Vital Statistics (death certificate) records, then

[16] Friedman, J., Beletsky, L., Jordan, A. Surging Racial Disparities in the US Overdose Crisis. Am J Psychiatry. 2022;179(2):166-169
[17] Bailey ZD., Feldman JM., Bassett MT. How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. N Engl J Med 2021;384(8):768–73.
[18] Cohen, A., Vakharia, SP, Netherland, J., Frederique, K., How the war on drugs impacts social determinants of health beyond the criminal legal system. Ann Med. 2022;54(1):2024-20238
[19] Cunningham, M. (2009). Health. United Nations, State of the world's Indigenous peoples (pp. 155–187). Retrieved from https://www.un.org/esa/socdev/unpfii/documents/SOWIP/en/SOWIP_web.pdf
[20] Hansen, H., Netherland, J., Herzberg, D. (2023) Whiteout: How Racial Capitalism Changed the Color of Opioids in America. University of California Press.
[21] Drug Policy Alliance, Drug War History. Accessed on 4/15/2026 from: https://drugpolicy.org/drug-war-history/
[22] Alexander, Michelle. (2020) The New Jim Crow: Mass Incarceration in the Age of Colorblindness. The New Press.

the information recorded in Vital Statistics is prioritized. More information on data collection and processing for KCMEO data is available here.

Washington State Department of Health's Rapid Health Information NetwOrk (RHINO) Data

The Washington State Department of Health's RHINO program receives, processes, and analyzes healthcare encounter data at 100% of non-federally funded hospital emergency departments (ED) in the state.[23,24] ED visit records are queried using key terms and diagnosis codes to identify suspected opioid overdoses treated in the ED.[25] All data reported represent *suspected* opioid overdoses treated in the ED; overdoses are not confirmed. These data are *visit-based*, not patient-based and thus individuals with multiple ED visits are counted multiple times. ED visit data are reported in near-real-time and thus are preliminary and subject to change as records are added, updated, and validated over time.

Medicaid Claims

Medicaid provides free or low-cost health care insurance for individuals and families with limited income or people with disabilities. It is administered by the Washington State Health Care Authority (HCA) which collects claims data from healthcare providers following a medical, dental, and pharmacy visit or service that was paid for by Medicaid. More information on concept definitions and Medicaid data can be found here.

Surveys

This report summarizes naloxone possession in in three local survey samples of people who use drugs (PWUD). The 'Get High? Get Heard' survey utilized community-based recruitment techniques (e.g. social media advertisements, print advertisements posted on outdoor telephone poles and within retail spaces) to enroll Seattle-area, young adults (ages 16-35) who use drugs to participate in a mixed methods, CDC-funded study. The CDC-funded National HIV Behavioral Surveillance (NHBS) survey utilized respondent driven sampling (or "snowball sampling") to recruit people who inject drugs. The Public Health – Seattle & King County Syringe Services Program (SSP) survey recruited PHSKC clients at the time of their SSP encounter.[26] All three surveys were interviewer administered and covered a range of topics pertaining to drug-related health outcomes and related risk and protective factors.

Classification of race/ethnicity

The ascertainment of race and ethnicity varies by data source. Race/ethnicity is self-reported in survey data. Race/ethnicity is documented at time of Medicaid enrollment or renewal – either directly by the Medicaid member or by someone on behalf of the member (e.g. family member,

---

[23] CDC National Syndromic Surveillance Program: https://www.cdc.gov/nssp/index.html

[24] Washington State Department of Health Syndromic Surveillance (RHINO): https://doh.wa.gov/public-health-provider-resources/healthcare-professions-and-facilities/data-exchange/syndromic-surveillance-rhino

[25] National Syndromic Surveillance Program, BioSense Platform. Query Development: Community and Technical Resources: https://www.cdc.gov/nssp/documents/guides/Query-Development-Job-Aid-508-FCx.pdf

[26] Findings from the 2023 Public Health – Seattle & King County Syring Services Program Survey. (March 2024) *PHSKC HIV/STI/HCV Program.* https://cdn.kingcounty.gov/-/media/king-county/depts/dph/documents/health-safety/disease-illness/hiv-sti/syringe-services-program-survey.pdf

health navigator, social worker). Discrepant race/ethnicity information is sometimes recorded in death data (KCMEO records and Vital Statistics). When this occurs, the race/ethnicity information recorded in Vital Statistics (death certificates), which is usually collected by funeral directors in conjunction with an informant (usually a family member) was utilized for this report. If race/ethnicity is missing or inaccessible from Vital Statistics, data collected by KCMEO was utilized for this report. KCMEO documents race/ethnicity based on information provided by family members or others present at the death scene, review of medical and administrative records, and post-mortem examination.[27] Methods of ascertainment at point of care are unknown for RHINO data (i.e. may be from previous electronic health record or assessed at point of care via patient/guardian self-report, provider/staff asking patient, provider/staff observation); these data are required to be reported, but there are no requirements for how they are to be collected.

Different methods exist for categorizing race and ethnicity, especially with regard to the categorization of multiracial individuals. Mutually exclusive categorization assigns individuals to a single race category, with multiracial individuals assigned to a separate, heterogeneous category comprising many different combinations of race and ethnicity. This approach may simplify comparisons across groups and align with common practice, but it can obscure the complexity of multiracial identities and reduce visibility for smaller racial or ethnic populations. The second approach ("alone or in combination") assigns individuals to all documented racial and ethnic groups, with multiracial individuals represented in multiple racial and ethnic categories. By capturing full group membership, this approach may better reflect the racial and ethnic diversity within a broad racial category, shared influences, and population size. However, counting individuals in multiple categories can introduce complications for analyses and interpretation. This report presents data using the more inclusive definition of those that identify as "alone or in combination" with another race or ethnicity, unless otherwise specified. Data can be viewed by both approaches on the publicly available dashboard.

Measures

Data are presented for the most recent calendar year available. All population rates are age-adjusted. Population data are reported from Washington State's Office of Financial Management. Rates utilizing Medicaid data are presented as per 100,000 Medicaid members. Other Medicaid data and all survey data report percentages. Data are suppressed if counts are under 10 due to confidentiality restrictions, agreements with data providers about what can be shared, or because rates are unstable in a small population.

[27] See Methods Report: Documentation and Analysis of Fatal Overdose Data for more information on the relationship between KCMEO and Vital Statistics data.

Public Health
Seattle & King County