

This argues for the importance of special data collection on alcohol and other drug involvement in ER cases. Parenthetically, no Tennessee hospitals were included in DAWN.

Highly relevant to the potential for referral to AOD treatment, hospital ERs serve as a major nexus between the public and medical care.¹⁰⁻¹⁴ Besides the sociodemographic groups previously mentioned, the ER study will tap other population elements under-represented in household surveys like the TAODNA survey. They are injection drug users (IDUs), homeless persons, and persons with no telephones. Moreover, the hospital is a very appropriate setting in which to intervene to persuade individuals about the benefits of receiving treatment for AOD abuse and dependence. But provision of in-house treatment intervention or referral to treatment in a comprehensive manner in these settings requires accurate case ascertainment.

The ER-based prevalence estimates obtained through this study will help close the gap between a DAWN-identified and survey-identified need for AOD treatment among ER patients. An important component of this effort, eventually, will be the provision of prevalence estimates related to injection drug use. Telephone surveys probably markedly under-report such behavior. Injection drug users are more likely to be non-responders and refusers, and to be under-represented in sampling units, such as households. IDUs, however, are more likely to be frequent users of ERs because of their high risk for HIV/AIDS, drug overdose and injury.

RESEARCH DESIGN AND METHODS

Study Population

Personal interviews among a sample of patients 18 years of age and older comprised the principal data source. ER logs of seven randomly selected Tennessee hospitals were used to generate the sampling frame. Hospitals were selected from among registered acute care, civilian, non-psychiatric, non-pediatric, non-rehabilitation facilities with a minimum annual volume of 10,000 ER patient visits.

All hospitals in the statewide sampling frame were stratified by seven geographic health care regions, from each of which one ER was randomly selected. Within each region, a single ER was selected by the *probability proportional to estimate size* (PPES) sampling method. Estimated sizes were based on the volume of patient visits in 1993, the most recent year for which data were available. With PPES, the probability of selecting a given ER equaled the proportion of all ER visits in the region made to that ER. This approach ensured that all ERs had a non-zero chance of appearing in the sample, but gave those that treated large numbers of patients a greater likelihood of selection than their smaller counterparts. Interviewing occurred over a three-week period, divided into 42 shifts, with three eight-hour shifts per day. Each shift was covered twice during data collection.