

Injured patients were more likely to test positive for alcohol and/or illegal drug use than ill patients (21% versus 14%) (Table 18 and Figure 19). They exhibited an excess prevalence of positive test results for alcohol and marijuana specifically, alcohol only, and illegal drugs in the absence of alcohol.

A leading question in this study concerned the degree to which patients' self-reporting of AOD use reflected their test results. Table 19 reveals a very consistent pattern. The discrepancies between self-reports and test results widened as the time frame for the former shifted from the distal to the more proximal - from lifetime to 30-day use. For example, 100% of patients testing positive for alcohol use also reported lifetime use as compared to 94% reporting use in the past 12 months and 90% in the past 30 days. Corresponding percentages for marijuana were 76%, 53% and 43%. The largest discrepancies between self-reported use and positive test results occurred with hallucinogens. Of those testing positive for hallucinogen use, only 15% admitted lifetime hallucinogen use, and all denied such use within the 12-month and 30-day windows. When drug category was not distinguished, 90% of those testing positive for any alcohol or any other drug use admitted such use during their lifetimes, 80% during the past 12 months, and 68% during the past 30 days. Overall, the findings presented in Table 19 speak to the problem of denial, particularly regarding more proximate use. Thus, ensuing estimates of AOD dependence and need for treatment must necessarily be conservative.

Prevalence of Dependence

Table 20 and Figure 20 provide a comparison of the prevalence of AOD dependence among ER patients that was derived from the application of DSM-IV clinical criteria to their responses to lifetime and 30-day drug usage questions and prevalence based on "self-diagnosis." For comparability, this analysis replicates that found in the Tennessee SANTA Arrestee Study.²² Almost one-quarter of the ER sample was assigned a DSM-IV diagnosis of lifetime dependence compared to 18% who "self-diagnosed" lifetime dependence. "Self-diagnosis" of lifetime dependence was based on respondents who reported that they were ever addicted to one or more drugs, including alcohol, but excluding tobacco and caffeine. In contrast to the lifetime comparison, patients were slightly more likely to "self-diagnose" current dependence (based on self-reported current addiction) than to receive a corresponding DSM-IV diagnosis. This suggests a shortcoming in using DSM-IV to assess current dependence.

Need for Treatment

Given potential for recovery from AOD dependence, through treatment or lifestyle change, lifetime DSM-IV diagnoses and "self-diagnoses" appear inadequate for assessing current need for treatment. Since denial by respondents would very likely underestimate current AOD dependence, based on DSM-IV criteria or "self-diagnosis," this diminishes their utility as valid gauges of treatment need.