APPENDIX A: ICCPUD Members

Jerome Adams, M.D., Ph.D.
Surgeon General
U.S. Department of Health and Human Services

Alex M. Azar, II
Secretary
U.S. Department of Health and Human Services

James W. Carroll, Jr.
Deputy Director
Office of National Drug Control Policy

Elaine L. Chao
Secretary
U.S. Department of Transportation

Betsy DeVos
Secretary
U.S. Department of Education

Caren Harp
Administrator
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice

Lynn Johnson
Assistant Secretary
Administration for Children and Families
U.S. Department of Health and Human Services

Heidi King
Deputy Administrator
National Highway Traffic Safety Administration

George F. Koob, Ph.D.
Director
National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health
U.S. Department of Health and Human Services

James N. Mattis
Secretary
U.S. Department of Defense

Elinore F. McCance-Katz, M.D., Ph.D. (Chair)
Assistant Secretary for Mental Health and Substance Use
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Robert R. Redfield, M.D.
Director
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services

Jeff Sessions
Attorney General
U.S. Department of Justice

Joseph Simons
Chair
Federal Trade Commission

Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse
National Institutes of Health
U.S. Department of Health and Human Services

APPENDIX B: Surveys

Information about underage alcohol use, abuse, and consequences primarily comes from three federally funded surveys—the National Survey on Drug Use and Health (NSDUH), Monitoring the Future (MTF; conducted pursuant to federal grants), and the national Youth Risk Behavior Survey (YRBS). Each of these surveys makes a unique contribution to our understanding of the nature of youth alcohol use. NSDUH assesses illicit drug, alcohol, and tobacco use among noninstitutionalized individuals age 12 and older and serves as the major federal source of nationally representative data on substance use in the general population of the United States. MTF examines attitudes and behaviors of 8th, 10th, and 12th graders with regard to alcohol, drug, and tobacco use and provides important data on substance use and the attitudes and beliefs that may contribute to such behaviors. YRBS examines risk behaviors among high school students and provides vital information on specific behaviors that cause the most significant health problems among American youth.

It is important to note that each of these surveys uses different methodologies, and for that reason, sometimes generate different prevalence estimates of youth substance use. To improve federal policymakers' understanding of the influence of methodological differences on those estimates, the Office of the Assistant Secretary for Planning and Evaluation within the Department of Health and Human Services (HHS) commissioned a group of recognized experts in survey design, sampling techniques, and statistical analysis to examine and compare the survey methodologies. The resulting papers and accompanying federal commentaries appeared in a special issue of the *Journal of Drug Issues* (Volume 31, Number 3, Spring 2001). Experts agreed that the overall methodology for each survey is strong and that observed differences are not the result of flaws or serious weaknesses in survey design. In fact, some differences are to be expected—such as those resulting from home- versus school-based settings. From a policy perspective, serious and complex issues such as youth alcohol use and related behavior often require examination and analysis from multiple perspectives. Because no one survey is absolute or perfectly precise, input from multiple sources is not only valuable, but necessary.

National Survey on Drug Use and Health (NSDUH)

As noted, NSDUH is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States age 12 or older. The survey also collects information on mental health and mental health service utilization among youth ages 12 to 17 and adults age 18 or older. Initiated in 1971 and conducted annually since 1990, questionnaires are administered to individuals who constitute a representative sample of the population through face-to-face, home-based interviews. The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the survey, and it is planned and managed by SAMHSA's Center for Behavioral Health Statistics and Quality (CBHSQ). RTI International collects data under contract. NSDUH collects information from residents of households and non-institutional group quarters (e.g., shelters, rooming houses, dormitories), and civilians living on military bases.

Since 1999, NSDUH has been conducted via computer-assisted interviews. Most questions are administered via audio computer-assisted self-interviewing, which provides respondents with a highly private and confidential means of responding to questions. This method increases the

level of honest reporting of illicit drug use and other sensitive behaviors. Less sensitive items are administered using computer-assisted personal interviews.

NSDUH provides estimates for each of the 50 states and the District of Columbia, as well as national estimates. Compared with the 1999 to 2013 design, the 2014 through 2017 sample design allocates more interviews to the largest 12 states, enabling greater precision for national NSDUH estimates. For the 2016 survey, 67,942 interviews were completed, for a weighted response rate of 68.4 percent. Due to improvements in the survey in 2002, the 2002 data constitute a new baseline for tracking trends in substance use (before 2002, NSDUH was called the National Household Survey on Drug Abuse [NHSDA]). For that reason, SAMHSA recommends that estimates from 2002 forward not be compared with estimates from 2001. In 2015, substantial changes were again made to data collection equipment, respondent materials, and the survey questionnaire used for NSDUH to improve quality and address changing research needs. Where noted, some trend data will not be available for several years.

Monitoring the Future Study (MTF)

MTF measures alcohol, tobacco, and illicit drug use, as well as perceived risk, personal disapproval, and perceived availability associated with each substance among nationally representative samples of students in public and private secondary schools throughout the conterminous United States. The National Institute on Drug Abuse (NIDA) supports MTF through a series of investigator-initiated grants to the University of Michigan's Institute for Social Research. Every year since 1975, a national sample of 12th graders has been surveyed. In 1991, the survey was expanded to include comparable numbers of 8th and 10th graders each year. Follow-up surveys are also administered by mail to a representative sample of adults from ages 18 to 55 from previous high school graduating classes. In 2016, completed questionnaires were obtained from 90 percent of all sampled students in 8th grade (n=17,643), 88 percent in 10th grade (n=15,230), and 80 percent in 12th grade (n=12,600). University of Michigan staff members administer the questionnaires to students, usually in their classrooms during a regular class period. Questionnaires are self-completed and formatted for optical scanning. In 8th and 10th grades, the questionnaires are completely anonymous. In the 12th grade, they are confidential (to permit longitudinal follow-up of a random subsample of participants). Extensive procedures are followed to protect the confidentiality of subjects and their data.

Youth Risk Behavior Survey (YRBS)

In the late 1980s, only a limited number of health-related school-based surveys such as MTF existed in the United States. To remedy this, the Centers for Disease Control and Prevention (CDC) developed the Youth Risk Behavior Surveillance System (YRBSS) to monitor six categories of priority health-risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among youth and young adults. YRBSS includes biennial national, state, and local school-based surveys of representative samples of students in grades 9 through 12, as well as other national and special-population surveys. CDC conducts the national survey—YRBS—with a target population composed of all public and private high school students in the 50 states and the District of Columbia. Education and health agencies conduct state and local surveys. The national sample is not an aggregation of state and local

surveys, and state and local estimates cannot be obtained from the national sample. In 2015, the latest year for which data are available, 15,624 students provided usable questionnaires for the national YRBS for an overall student response rate of 68 percent.

Additional Surveys

Three additional federally supported surveys collect alcohol consumption and related information from a segment of the underage population—18- to 20-year-olds.

- *The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)* is a large nationwide household survey sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NESARC assesses the prevalence and patterns of alcohol use, other drug use, and related disorders; related risk factors; and associated mental and physical disabilities based on a nationally representative sample of the civilian non-institutionalized population of the United States aged 18 years and older. The first NESARC survey was conducted in 2001-2002. The second survey was conducted in 2004-2005 among individuals who participated in the first NESARC survey. Both surveys were fielded by the U.S. Census Bureau. A third NESARC survey, NESARC-III, was cross-sectional and conducted in 2012-2013. Fieldwork was performed by Westat, Inc. through a contract under the data collection authorization of Title 42 USC 285n.
- Begun in the early 1980s and fielded every 2 to 4 years, the Department of Defense (DoD) *Survey of Health-Related Behaviors* measures prevalence of substance use and health behaviors among active-duty military personnel on U.S. military bases worldwide. In 2005, DoD expanded the scope of the survey to include the National Guard and Reserves, as well as other special studies. The most recent surveys are the 2014 Health Related Behavior Survey—Reserve Component, which was fielded beginning in September 2014, and the 2015 DoD Survey of Health-Related Behaviors Among Active Duty Military Personnel. The 2011 survey included the most extensive changes in the survey since its inception in 1980. For the first time, the survey was administered through a web-based format.
- Some substance use measures are better aligned with current national civilian health surveys, particularly the *National Health Interview Survey (NHIS)* conducted by the CDC. Begun in 1957, the NHIS is an annual, multistage probability sample survey of households by U.S. Census Bureau interviewers for the CDC National Center for Health Statistics (Pleis & Lethbridge-Cejku, 2007).

Information related to underage users of alcohol (ages 18 to 20) from these three surveys may be added to this report in the future.

Association versus Causation

In reviewing data related to risky behaviors and different categories of alcohol use, readers should keep in mind that association does not prove causation. Just because alcohol use is associated with other risky behaviors does not mean that it *causes* these other risky behaviors. Often, additional research is needed to establish alcohol as a causative factor.

Additional Methodological Caveats

When reviewing studies of the age of initiation of alcohol use, it is important to recognize that different researchers use different methods to describe initiation of drinking and to estimate the

average age at first use of alcohol. In some cases, this has resulted in large differences in estimates, primarily due to differences in how age groups and time periods are specified in the calculations. The following examples will help readers understand these methodological differences and the resulting statistical differences.

A popular method for computing average age involves restricting the age group of estimation to persons who are 12 to 17 years old or 12 to 20 years old, with no restriction on the time period. This method provides an estimate of the average age of first use among those in the age group who have used alcohol at some point in their lifetime, which typically results in a younger estimated average age of first use than other methods. This is because initiation occurring in older age groups is excluded from the calculation and also because the calculation gives too much weight to very early initiation. For example, 15-year-olds who will first use at age 17 are excluded, since they have not yet used alcohol at the time of data collection. Thus, the 2003 NSDUH average age of first use among lifetime alcohol users who are 12 to 20 years old is 14.0 years; among 20-year-olds, 15.4 years; and among all lifetime drinkers, 16.8 years.

The method has limited utility for assessing trends because estimates do not reflect a well-defined recent period. A 20-year-old may have first used alcohol at age 10, so an average age of first use among 12- to 20-year-olds would span a period covering as many as 10 years. In addition to not reflecting the most current patterns, year-to-year change in this average is typically negligible due to the substantial overlap in the covered periods. Trends in average age of initiation are best measured by estimating the average age among those who initiated alcohol use during a specific period (such as a calendar year or within the 12 months prior to interview) in a repeated cross-sectional survey. These estimates can be made with or without age restrictions; for example, the average age of first use among persons in 2003 who initiated within the past 12 months was 16.5 years, but restricting the calculation to only those who initiated before age 21 results in an average age of 15.6. Based on the 2003 NSDUH, an estimated 11 percent of recent initiates were 21 years or older when they first used.

Estimates of average age of first use among recent initiates based on the NSDUH sample of people 12 years old and older is biased upward because it does not capture initiation before age 12. The 2003 NSDUH estimated that 6.6 percent of alcohol initiates from 1990 to 1999 were 11 years old or younger. Excluding these early initiates from calculations inflates the estimate of average age by approximately half a year. This bias can be diminished by making estimates only for time periods at least 2 years prior (e.g., using the 2003 NSDUH, estimate the average age at first use for 2001, but not 2002), an approach used in previous NSDUH reports. Although this approach can provide interesting historical data, it does not give timely information about emerging patterns of alcohol initiation. Further, there are serious bias concerns with historical estimates of the number of initiates and their average age at first use constructed from retrospectively reported age at first use. Older respondents are more likely not to remember accurately when an event occurred. An event may be remembered as having occurred more recently than it actually did—a “forward telescoping” of the recalled timing of events. Evidence of telescoping suggests that trend estimates based on reported age at first use may be misleading.

For example, in the 2013 MTF, alcohol use by the end of 6th grade was reported by 13.2 percent of 8th graders but by only 4.6 percent of 12th graders. Several factors, including telescoping, probably contribute to this difference. Eventual dropouts are more likely than average to drink at

an early age; thus, they will be captured as 8th but not 12th graders. Lower grades also have lower absentee rates. Another factor relates to the issue of what is meant by first use of an alcoholic beverage. Students in 12th grade are more inclined to report use that is not adult-approved, and to not report having less than a glass with parents or for religious purposes. Younger students may be more likely to report first use of a limited amount of alcohol. Thus, 8th- and 9th-grade data probably exaggerate drinking, whereas 11th- and 12th-grade data may understate it.

Websites for Data on Underage Drinking

These federal websites can be useful to persons seeking data related to underage drinking:

- ***Information from SAMHSA on underage drinking:***
  https://www.samhsa.gov/underage-drinking-topic
- ***Information from the YRBS:***
  https://www.cdc.gov/HealthyYouth/data/yrbs/
- ***Information from NHTSA on underage drinking and on drinking and driving:***
  https://www.trafficsafetymarketing.gov/get-materials/drunk-driving/underage-drinking-prevention
  https://one.nhtsa.gov/Driving-Safety/Impaired-Driving
- ***Information from NIAAA on underage drinking:***
  https://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/underage-drinking
  https://www.niaaa.nih.gov/alcohol-health/special-populations-co-occurring-disorders/college-drinking
- ***Information from NIDA on underage drinking:***
  http://www.monitoringthefuture.org

APPENDIX C: Abbreviations

Federal Departments and Agencies

Department of Defense	DoD
Army National Guard	ARNG
Education Activity	DoDEA
U.S. Air Force	USAF
U.S. Army Reserve	USAR
U.S. Coast Guard	USCG
U.S. Marine Corps	USMC
U.S. Navy	USN
Department of Education	ED
Office of Safe and Healthy Students	OSHS
Office of Elementary and Secondary Education	OESE
Department of Health and Human Services	HHS
Administration for Children and Families	ACF
Family and Youth Services Bureau	FYSB
Agency for Healthcare Research and Quality	AHRQ
Centers for Disease Control and Prevention	CDC
Centers for Medicare & Medicaid Services	CMS
Division of Behavioral Health	DBH
Eunice Kennedy Shriver National Institute of Child Health and Human Development	NICHD
Food and Drug Administration	FDA
Health Resources and Services Administration	HRSA
Indian Health Service	IHS
National Cancer Institute	NCI
National Institute on Alcohol Abuse and Alcoholism	NIAAA
National Institute on Drug Abuse	NIDA
National Institutes of Health	NIH
Office of Adolescent Health	OAH
Office of Disease Prevention and Health Promotion	ODPHP
Office of the Assistant Secretary for Health	OASH
Office of the Assistant Secretary for Planning and Evaluation	ASPE
Office of Public Health and Science	OPHS
Office of the Surgeon General	OSG
Substance Abuse and Mental Health Services Administration	SAMHSA
Center for Mental Health Services	CMHS
Center for Substance Abuse Prevention	CSAP
Center for Substance Abuse Treatment	CSAT
Office of Applied Studies	OAS
Department of Justice	DoJ

Drug Enforcement Administration	DEA
Office of Juvenile Justice and Delinquency Prevention	OJJDP
Office of Justice Programs	OJP
Department of Labor	DOL
Employment Training Administration	ETA
Office of Youth Services	OYS
Occupational Safety and Health Administration	OSHA
Federal Trade Commission	FTC
Office of National Drug Control Policy	ONDCP
Department of Transportation	DOT
National Highway Traffic Safety Administration	NHTSA
Department of the Treasury	
Alcohol and Tobacco Tax and Trade Bureau	TTB

Programs, Agencies, and Organizations

Above the Influence	ATI
Access to Recovery	ATR
Addiction Technology Transfer Center	ATTC
Adolescent Brain Cognitive Development Study	ABCD
Adolescent Health: Think, Act, Grow	TAG
Adolescent Support and Counseling Services	ASACS
Adults in the Making	AIM
After Deployment: Adaptive Parenting Tools	ADAPT
Alcohol and Drug Management Tracking System	ADMITS
Alcohol Detection Devices	ADD
Alcohol Policy Information System	APIS
Alcohol-Related Disease Impact	ARDI
Alcohol Screening Program	ASP
American Psychiatric Association	APA
Army Substance Abuse Programs	ASAP
Basic Center Program	BCP
Behavioral Risk Factor Surveillance System	BRFSS
Behavioral Health Services Information System	BHSIS
Birth Control and Alcohol Awareness: Negotiating Choices Effectively Project	BALANCE
Brief Alcohol Screening and Intervention for College Students	BASICS
Center for the Application of Prevention Technologies	CAPT
Center for Behavioral Health Statistics and Quality	CBHSQ
Center for Mental Health Services	CMHS
Center on Alcohol Marketing and Youth	CAMY
Collaborative Research on Addiction at NIH	CRAN
College Alcohol Intervention Matrix	CollegeAIM
Community Anti-Drug Coalitions of America	CADCA
Community Youth Development Study	CYDS
Communities that Care	CTC
Competitive Personal Responsibility Education Program	CPREP

Culture of Responsible Choices	CoRC
Drug Abuse Resistance Education	DARE
Drug Abuse Warning Network	DAWN
Drug and Alcohol Services Information System	DASIS
Drug Education for Youth	DEFY
Drug Free Communities Program	DFC
SAMHSA's Emergency Department Surveillance System	SEDSS
Employment Training Administration	ETA
Enforcing the Underage Drinking Laws	EUDL
European School Survey Project on Alcohol and Drugs	ESPAD
Family and Youth Services Bureau	FYSB
Family Check-Up	FCU
Fatality Analysis Reporting System	FARS
General Military Training	GMT
Girl-Specific Intervention	GSI
Good Behavior Game	GBG
Grants to Reduce Alcohol Abuse in Secondary Schools Program	GRAAP
Health Related Behaviors Survey	HRB
Healthy Base Initiative	HBI
Indian Children's Program	ICP
Institute of Medicine (now Health and Medicine Division of the National Academies)	IOM
Interagency Coordinating Committee on the Prevention of Underage Drinking	ICCPUD
International Association of Chiefs of Police	IACP
International Town and Gown Association	ITGA
Inventory of Behavioral Health Services	I-BHS
Inventory of Substance Abuse Treatment Services	I-SATS
Iowa Strengthening Families Program	ISFP
Life Skills Training	LST
Local Educational Agencies	LEAs
Marine Awareness and Prevention Integrated Training	MAPIT
Methamphetamine and Suicide Prevention Initiative	MSPI
Monitoring the Future Survey	MTF
Mothers Against Drunk Driving	MADD
National Academy of Sciences	NAS
National Alcohol Screening Day	NASD
National Association for Children of Alcoholics	NACoA
National Association of School Resource Officers	NASRO
National Center for Health Statistics	NCHS
National Center for Statistics and Analysis	NCSA
National Center on Birth Defects and Developmental Disabilities	NCBDDD
National Center on Safe Supportive Learning Environments	NCSSLE
National College Health Improvement Project	NCHIP

National Consortium on Alcohol and Neurodevelopment in Adolescence	NCANDA
National Drug and Alcohol Facts Week	NDAFW
National Epidemiologic Survey on Alcohol and Related Conditions	NESARC
National Health Interview Survey	NHIS
National Health and Nutrition Examination Survey	NHANES
National Hospital Ambulatory Medical Care Survey	NHAMCS
National Hospital Care Survey	NHCS
National Hospital Discharge Survey	NHDS
National Household Survey on Drug Abuse	NHSDA
National Liquor Law Enforcement Association	NLLEA
National Mental Health Services Survey	N-MHSS
National Organizations for Youth Safety	NOYS
National Prevention Network	NPN
National Research Council	NRC
National Survey of Substance Abuse Treatment Services	N-SSATS
National Survey on Drug Use and Health	NSDUH
National Survey on Family Growth	NSFG
National Violent Death Reporting System	NVDRS
Navy Alcohol and Drug Abuse Prevention	NADAP
Network for Employees of Traffic Safety	NETS
Offender Reentry Program	ORP
Office of Indian Alcohol and Substance Abuse	OIASA
Office of the Assistant Secretary for Planning and Evaluation	ASPE
Outreach to Children of Parents in Treatment	OCPT
Pacific Institute for Research and Evaluation	PIRE
Partnership for Drug-Free America	PDFA
Partnerships for Success	PFS
Personal Responsibility Education Programs	PREP
Pregnancy Nutrition Surveillance System	PNSS
Pregnancy Risk Assessment Monitoring System	PRAMS
PRIME for Life	PFL
PROmoting School/Community-University Partnerships to Enhance Resilience	PROSPER
Protecting You/Protecting Me	PYPM
Recording Artists, Actors and Athletes Against Drunk Driving	RADD
Robert Wood Johnson Foundation	RWJ
Runaway and Homeless Youth	RHY
Safe and Drug-Free Schools and Communities Act	SDFSCA
Safe Schools/Healthy Students	SS/HS
Screening, Brief Intervention, Referral, and Treatment	SBIRT
School Health Policies and Programs Study	SHPPS
Sexual Assault Prevention and Response	SAPR
Skills, Mastery, and Resistance Training	SMART
Sober Truth on Preventing Underage Drinking Act	STOP Act
State Adolescent Transitional Aged Youth Treatment Enhancement	

and Dissemination Grant	SYT-ED
State Adolescent Treatment Enhancement and Dissemination Grant	SAT-ED
State Highway Safety Offices	SHSOs
State Incentive Grant Program	SIG
Strategic Prevention Framework	SPF
Street Outreach Program	SOP
Strengthening Families Program	SFP
Strong African American Families Program	SAAF
Student Affairs Administrators in Higher Education	NASPA
Students Against Destructive Decisions	SADD
Substance Abuse Prevention and Treatment Block Grant	SABG
Substance Abuse Prevention Interagency Working Group	SAP IWG
Substance Abuse Prevention Skills Training	SAPST
Talk. They Hear You.	TTHY
Targeted Capacity Expansion Program	TCE
Techniques for Effective Alcohol Management	TEAM
Too Smart to Start	TSTS
Transitional Living Program	TLP
Treatment Coordination Group	TCG
Treatment Episode Data Set	TEDS
Treatment Improvement Protocols	TIPS
Underage Drinking Enforcement Training Center	UDETC
Underage Drinking Research Initiative	UDRI
Uniform Accident and Sickness Policy Provision Law	UPPL
Uniform Facility Data	UFDS
Unit Marine Awareness and Prevention Integrated Training	UMAPIT
United Indian Health Program	UIHP
Virginia Commonwealth University	VCU
We Don't Serve Teens	WDST
Web-based Injury Statistics Query and Reporting System	WISQARS™
Young Offender Reentry Program	YORP
Youth Offender Demonstration Project	YODP
Youth Opportunity Grants	YOGs
Youth Regional Treatment Centers	YRTCs
Youth Risk Behavior Surveillance System	YRBSS
Youth Risk Behavior Survey	YRBS

Other Acronyms

Adult preparation subjects	APS
Air force base	AFB
Alcohol and drug abuse managers/supervisors	ADAMS
Alcohol use disorder	AUD
American Indian/Alaska Native	AI/AN
Blood alcohol content	BAC
Caffeinated alcoholic beverages	CABs
Concept of operations	CONOPs

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition	DSM-IV-TR
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition	DSM-V
Driving under the influence	DUI
Driving while intoxicated	DWI
Drug and alcohol program advisor	DAPA
Evidence-based practices	EBPs
Family Violence Prevention and Services Act	FVPSA
Fetal alcohol spectrum disorders	FASDs
Feedback Informed Therapy	FIT
Funding opportunity announcement	FOA
Graduated driver's licensing	GDL
Group coping power	GCP
Individual coping power	ICP
Institute of Higher Education	IHE
Interagency working group	IWG
Knowledge, attitudes, beliefs, and behaviors	KABBs
Lesbian, gay, bisexual, and transgender	LGBT
Memorandum of understanding	MOU
Minimum legal drinking age	MLDA
Personal readiness	PR
Practice and Implementation Centers	PICs
Public service announcement	PSA
Screening and brief intervention	SBI
Substance abuse counseling center	SACC
Substance abuse program	SAP
Training and technical assistance	TTA
Transitional living program	TLP
Underage drinking	UAD
Years of potential life lost	YPLL

APPENDIX D: References

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