Continued from previous page challenging for governments to implement.

"I used to work in Hong Kong. We had one of the most robust, liberal harm-reduction programs: methadone replacement," Chan said. "After its implementation, petty crimes that addicts commit to feed their addiction were reduced."

She added that WHO recommends syringe exchange initiatives along with substitution therapies as the most effective approaches for opioid-dependent individuals.

Office of National Drug Control Policy (ONDCP) Director Michael Botticelli led the U.S. delegation to last week's special session; the ONDCP stated in a news release that the delegation's goals included a call for an increased emphasis on public health approaches, promotion of proportional response in criminal justice systems, and attention to the emergence of new drug threats. In his remarks last month to the UN Commission on Narcotic Drugs, Botticelli called for maintaining and leveraging existing international drug conventions.

"The UN treaties specifically allow member states to adjust domestic drug sentencing laws, and to create a more just and compassionate approach to addressing drugs," Botticelli said. "Punitive solutions targeting drug users do not help people recover."

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**Frequency is best AUD screen for teens: NIAAA**

A new study has found that primary care clinicians can screen adolescents with one question for alcohol problems: How many drinks did you have in the past year? For younger teens, the threshold is 3; for older teens, it's 12.

The study, funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA), is published in the current issue of the Journal of Pediatrics. The findings also support NIAAA's age-based screening thresholds.

"Primary care physicians are encouraged to screen adolescents for alcohol problems, yet many do not, citing time constraints and other issues," said NIAAA Director George Koob, Ph.D. "This study demonstrates that simple screening tools such as those in NIAAA's Youth Guide are efficient and effective."

Researchers found that 10 percent of rural youth over age 14 met diagnostic criteria for an alcohol use disorder (AUD) in the past year, based on the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).

Led by Duncan E. Clark, M.D., Ph.D., professor of psychiatry at the University of Pittsburgh Medical Center, researchers screened 1,200 young people ages 12 through 20 at primary care clinics in rural Pennsylvania for alcohol use disorder using a computer-based questionnaire.

Most adolescents do not receive alcohol screening or referrals in primary care practices. However, self-assessment methods using computers may save time, and be particularly effective in rural settings where youth have higher rates of alcohol use disorders.

The screen typically used in adults — CAGE (Cut down, Annoyed, Guilty, Eye opener) — is not effective with teens. CRAPPT (Car, Relax, Alone, Forget, Friends, Trouble) has been useful but not specific enough and requires too much administration time. An alcohol frequency item was adopted by the NIAAA for teens, and this study looked at whether it would predict AUD diagnoses, as well as testing the NIAAA alcohol use frequency cut-offs that had been developed for DSM-IV.

**DSM-5 defines a single diagnostic for AUD, compared to two (abuse and dependence) in DSM-IV. DSM-5 also requires a minimum of two items to meet diagnostic criteria, compared to one for DSM-IV.**

**Study methods**

The study looked at youth ages 12 to 20 who visited their primary care providers in six rural primary care clinics. They self-reported past-year frequency of alcohol use and DSM-5 AUD symptoms on a tablet computer.

A staff member described the project and asked the teen whether he or she wanted to participate; no information was collected from teens who declined. Subjects received $25 for participating. It took them three to six minutes to complete the survey on a tablet computer. Informed consent was obtained from the parent (if the adolescent was under 18) or from the adolescent.

Subjects were told what a "standard drink" consists of. They were then asked the following questions on alcohol use: age of first drink; alcohol use frequency for the past 30 days and past 12 months; typical number of drinks per occasion (quantity); lifetime greatest number of drinks in 24 hours; age of first binge (traditional definition: five [for a male] or four [for a female] or more drinks within two hours); age of first incident of intoxication ("drunk"); and frequency of binge drinking in the past 30 days. Using the "lifetime greatest number of drinks" response, the estimated blood alcohol concentrations were calculated based on three drinks for ages 9 to 13 years, four (male) or three (female) drinks for ages 14 or 15 years and five (male) or three (female) drinks for 16 or 17 years.

The National Survey on Drug Use and Health computer-administered structured diagnostic assessment for determining DSM-IV AUD symptoms and diagnoses for the past 12 months was expanded to cover the 11 DSM-5 AUD symptoms — which added the
DSM-5 "craving" symptom. The DSM-IV "legal problems" item was assessed but was not used to determine DSM-5 AUD diagnosis.

The researchers examined the screening performance of the alcohol use frequency cut-points recommended in the NIAGAA Youth Guide to identify youth with DSM-5 AUD symptoms, which identifies the following risks by age in terms of number of drinking days per year:

- "Moderate risk" is one or more days per year for ages 12–15 years, three or more days per year for ages 16–17 years, and 12 or more days per year for age 18 years.
- "Highest risk" is three or more days per year for ages 12–15 years, 12 or more days per year for age 16 years, 24 or more days per year for age 17 years, and 52 or more days per year for age 18 years.

The researchers measured the performance of the NIAGAA cut-points against any DSM-5 AUD symptom, any DSM-5 AUD diagnosis (two symptoms), a DSM-5 AUD-moderate diagnosis (four symptoms) and a DSM-5 AUD-severe diagnosis (six symptoms). These DSM-5 AUD severity definitions were included to correspond with DSM-IV AUD severity levels described in the NIAGAA Youth Guide.

Results

For young adolescents (ages 12 through 14), 19 percent met DSM-5 criteria for past-year AUD. For middle adolescents (ages 15 through 17 years), 9.5 percent met DSM-IV AUD criteria. And for late adolescents, 10.0 percent met DSM-IV AUD criteria. The best psychometric threshold was three days of alcohol use in the past year, although a typical quantity of two drinks per occasion was also a good screen, as did an overall quantity of three drinks in the past year. These levels had 91 percent sensitivity (no false negatives) and 93 percent specificity (no false positives) for the early and middle age groups. For late adolescence, 12 days of alcohol use in the past year was the best threshold; alternatively, an overall quantity of 12 drinks consumed in the past year was an optimal threshold.

Implications

A single question can identify the 10 percent of youth over age 14 who have a past-year AUD. For those in this study, 42 percent of adolescents in the middle age group reported past-year alcohol use, which is similar to the 44 percent of 10th-grade students reporting past-year alcohol use in the 2014 Monitoring the Future survey.

In this study, 44 percent of adolescents ages 12 through 17 who reported three or more days of alcohol use in the past year satisfied DSM-5 criteria for an AUD. Those reporting fewer than three days rarely have an AUD.

Screening for AUD using a three-day threshold yielded 91 percent sensitivity — indicating that a youth with AUD was likely to be detected by the screen, and 93 percent specificity, meaning that those without an AUD were likely to screen negative.

For teens ages 18–20, the researchers found that the best screen for alcohol problems was to ask whether individuals had engaged in 12 or more drinking days in the past year. Thirty-one percent of those who reported drinking at this level had an AUD.

"This finding confirms that a single question can be an effective screen for AUD,” said lead author Clark. “We found that this information could be readily collected through our tablet computer system in busy rural clinic settings.”

Researchers found both sets of NIAGAA guidelines to be effective screens for AUD. The moderate risk guidelines showed 85 percent sensitivity and 87 percent specificity, while the highest risk guidelines showed 91 percent sensitivity and 93 percent specificity.


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Briefly Noted

Betty Ford Center is now in-network with major insurers

The Betty Ford Center now is in-network with most major insurance companies. The center has an outpatient program in Los Angeles and a residential program in Rancho Mirage, both in California. “Almost 1 million people in the Los Angeles area alone struggle with alcohol and other drug issues,” said Jim Steinha. Continues on next page