

Correspondence

Re: Identifying Problematic Substance Use in a National Sample of Adolescents Using Frequency Questions

To the Editor: Chavez et al. determined age-specific cut-offs for the frequency of alcohol, tobacco, cannabis, and illicit drug use among adolescents that would put them at a higher risk for substance use disorder.¹ Specifically, for alcohol and cannabis use, these cutoffs were determined to be >3 days/year for children aged 12 to 15 years and >12 days/year for those aged 15 to 20 years. Although these cutoffs may be useful for assessing use among adolescent patients at an average risk for substance use disorder, they may be too lax for higher risk teens. Complacency toward any substance use among higher risk patients creates a missed opportunity to prevent serious complications from substance use disorders.

Childhood trauma, mental health disorders, and being a member of a minority population all place certain individuals at a higher risk for developing substance use disorder. Adolescents who have experienced physical abuse, sexual abuse, or bullying or have been exposed to domestic violence have been found to be diagnosed with substance use disorders and require treatment at a younger age than their peers.² In addition, being diagnosed with major depressive disorder and posttraumatic stress disorder have been found to be predictors of substance use disorder among adolescents.² Systematic barriers to health care for minority populations, also known as minority stress, have been associated with many poor health outcomes, including substance abuse. Sexual minority youth have been found to be more likely to engage in high-risk drug use than heterosexual patients of the same age.³

Substance use among adolescents does not exist in a bubble. Comorbid conditions, psychosocial influences, and past experiences all contribute to the development of substance use disorder in younger patients. Higher risk patients often do not have the resources or ability to seek the care that they need, and they may turn to substance use as a way to cope or self-medicate. Because these populations are especially vulnerable, they need a physician to advocate for them and identify risky patterns before they develop into a dependence. To view substance use by these at risk patients through the lens of an acceptable cutoff point is doing them a disservice. It is the responsibility of primary care providers to identify their young patients who are at risk for developing substance use disorder as early as possible, before their use becomes “problematic.”

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Re: Sugar-Sweetened Beverage Intake in a Rural Family Medicine Clinic

To the Editor: Drs. Pinon, Khandalavala, and Geske recently addressed sugar sweetened beverage (SSB) intake in a rural medicine clinic and showed that their rural population on average only drinks 7 kcals more than the national average per day.¹ The authors’ methods may not have fully captured true intake, as they only sampled during normal business hours over 6 weeks.

The patients who participated during normal business hours were likely only a subset of this community’s population. For example, the working class may only seek primary care during evening and weekend hours. Blue collar workers have been found to eat less fruits and vegetables as well as have less physical activity.^{3,4} SSB intake is likely tied to these other unhealthy lifestyle choices. Rural communities have higher rates of age-adjusted related deaths, which SSB intake could be tied to.² SSB consumption has been associated with elevated cardiovascular risk.⁵ Heart disease and strokes are 2 of the leading causes of death, both in rural and urban communities. However, rural communities continue to lag behind advancements in health care when compared with their urban cohorts.² By better quantifying SSB intake, we can design meaningful interventions to reverse this lag.

In terms of coming up with solutions to help these patients, we need to fully understand their dietary choices. A random sample in a clinic during normal business hours may not capture the entire community.

Future research needs to target broader sampling so there can be more insights into this population.

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will then miss out on its benefits of increased patient followup. Future research in this area should include rigorous measure of wait time to encourage uptake of this promising walk-in psychiatric model.

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Re: A Successful Walk-In Psychiatric Model for Integrated Care

To the Editor: The Kroll et al¹ walk-in model for sustained psychiatric care was able to increase follow-up encounters, especially in vulnerable populations. The authors claim “waiting room time was usually shorter in the afternoon;” however, they did not thoroughly measure it.¹ A primary or integrated care practice that serves these at risk groups may hesitate to use this model because of the fear of its effects on wait time.

Wait time and total time in office or clinic have a significant effect on patient satisfaction.² Satisfaction is time limited, noted by the existence of a “golden hour” patients are willing to wait for a medical encounter.³ Positive satisfaction correlates with “improved medication adherence” in patients with mental health conditions.⁴ Practices may worry patient dissatisfaction could be exacerbated by unknown wait times in a patient population that is already prone to poor adherence and return visits as the authors recognize.

Failing to rigorously measure waiting room time limits the generalizability and applicability of this model. With the risk of patient dissatisfaction and worsened outcomes, practices may hesitate trying this model and

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Response: Re: A Successful Walk-In Psychiatric Model for Integrated Care

To the Editor: Dr. Brinn¹ is right to point out that that the walk-in psychiatry model we developed at Brigham Health² fails to manage waiting room times in a way that proactively engages patients who might otherwise leave before receiving treatment. A trade-off was made between risking all the pitfalls that Dr. Brinn described and the potential consequences of prolonging lag times for a scheduled appointment in a traditional model, including a higher risk of missing that appointment,³ decreased patient satisfaction,³ and in some cases a higher mortality risk.⁴ Neither model is so seamless that it works well enough for all patients, and measuring and reducing wait times is the right next step.

It is a shame that most health systems have been so slow to adapt to the waiting time problem when other industries figured it out long ago. Restaurants that do not take advance reservations find a variety of ways to keep prospective diners occupied until their tables are ready or else they would leave. We sometimes send