dependence, a fear of negative judgment by the clinician, and a perception that the patient will no longer be welcome at treatment facilities if his or her drug use is known.

A further difficulty with the Carey report is that 82 percent of the patients who volunteered to participate were rated as not using drugs at all, and an additional 9 percent were rated as being mild drug users. Similarly, alcohol use was rated as none to mild for 90 percent of the patients. Yet it has been estimated that up to half of the patients admitted to mental health treatment settings are substance abusers (5).

Carey and associates acknowledge that the patient group they describe is not representative of the general population of psychiatric patients and is skewed away from those in whom detection of substance abuse is most important, that is, those whose drug or alcohol use would be described as moderate or severe.

The detection of comorbid substance abuse in patients with psychiatric illness is important in both diagnosis and management. However, future studies in this area require the use of objective measures of substance use before any meaningful conclusions can be drawn about the validity of the rating scales under evaluation.

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In Reply: Dr. Galletly's objections to our study appear to be based on two assumptions: that the clinician ratings relied entirely on self-reports, and that because patient self-reports are sometimes inaccurate, they are always suspect.

First, the strength of the clinician rating scales combines their longitudinal perspective with explicit instructions to use all information available. Although self-reports represented a proportion of the input available to the primary therapists in our study, other available sources of data included the therapists' own observations of the patients and other behavioral data such as patterns of attendance or treatment response. In addition, therapists had input from medication nursing, treating psychiatrists, payees, group home supervisors, and family members, most of whom had clear incentives for keeping the primary therapist informed of suspected or confirmed substance abuse.

Second, unlike the assessments in the studies cited by Galletly, the assessment in our study did not take place on inpatient admission, when acute symptoms are likely to interfere with accurate self-reports. Objective measures such as urine screens are essential in such contexts. In our outpatient sample, urinalysis tests more often underdetected than overdetected patients who were using drugs or alcohol. This problem is probably a result of the narrow window of detection for most drugs and the relative psychiatric stability of our sample.

Finally, one could argue that clinicians could more easily identify the more severe and dysfunctional substance abusers who did not enter our study had they known the patients for a comparable period of time. Our participants controlled their substance use enough to maintain regular clinic visits, enhancing the risk of nondetection. The utility of the clinician rating scales would be limited in acute care settings and with individuals who have strong incentives to misrepresent their substance use. However, all available evidence supports their reliability and validity for the majority of psychiatric outpatients.

Kate Carey, Ph.D.

Why Elderly Veterans Choose VA Services

To the Editor: A popular perception of the Veterans Affairs health care system is that veterans who use it do so because they cannot afford care elsewhere. Indeed, the 1978 National Survey of Veterans found that the most important factor affecting veterans' choice of VA hospitalization was the availability of health insurance; veterans without health insurance were nearly five times more likely to choose VA hospitals than those with health insurance, regardless of age, income, or service-connected disabilities (1).

A more recent study in 1993 determined that veterans most likely to use the VA health care system were age 65 or older, were unemployed, lived alone, and had low income and limited or no insurance (2). They were more likely to have a service-connected psychiatric disorder, to reside near a VA facility, and to have previously used VA benefits or VA health care services.

These studies suggest that limited access to other health care delivery systems is a major factor behind the demand for VA care (3). Studies of factors influencing the use of VA mental health services are particularly sparse, even though such services constitute a major portion of VA health care delivery.

To better understand elderly psychiatric patients' reasons for choosing VA mental health services and their satisfaction with VA care, in September 1995 we mailed a confidential survey to 240 veterans age 65 or older (114 inpatients and 126 outpatients) who were treated in the geriatric psychiatry program at the Houston VA Medical Center between August 1, 1994, and July 31, 1995. A to-